CDAR2\_IG\_CCDA\_CLINNOTES\_DSTUR2\_D1\_2013SEP\_V2\_Templates\_and Supporting

HL7 Implementation Guide for CDA® Release 2:

Consolidated CDA Templates for Clinical Notes

(US Realm)

Draft Standard for Trial Use Release 2

September 2013

Volume 1 — Introductory Material

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# Document-Level Templates

Document-level templates describe the purpose and rules for constructing a conforming CDA document. Document templates include constraints on the CDA header and indicate contained section-level templates.

Each document-level template contains the following information:

•  Scope and intended use of the document type

•  Description and explanatory narrative

•  Template metadata (e.g., templateId, etc.)

•  Header constraints (e.g., document type, template id, participants)

•  Required and optional section-level templates

US Realm Header (V2)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.1.2 (open)]

This template defines constraints that represent common administrative and demographic concepts for US Realm CDA documents. Further specification, such as documentCode, are provided in document templates that conform to this template.

1. SHALL contain exactly one [1..1] realmCode="US" (CONF:16791).
2. SHALL contain exactly one [1..1] typeId (CONF:5361).
   1. This typeId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.1.3" (CONF:5250).
   2. This typeId SHALL contain exactly one [1..1] @extension="POCD\_HD000040" (CONF:5251).
3. SHALL contain exactly one [1..1] templateId (CONF:5252) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.1.2" (CONF:10036).
4. SHALL contain exactly one [1..1] id (CONF:5363).
   1. This id SHALL be a globally unique identifier for the document (CONF:9991).
5. SHALL contain exactly one [1..1] code (CONF:5253).
   1. This code SHALL specify the particular kind of document (e.g. History and Physical, Discharge Summary, Progress Note) (CONF:9992).
6. SHALL contain exactly one [1..1] title (CONF:5254).  
   Note: The title can either be a locally defined name or the displayName corresponding to clinicalDocument/code
7. SHALL contain exactly one [1..1] effectiveTime (CONF:5256).
   1. The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:29287).
8. SHALL contain exactly one [1..1] confidentialityCode, which SHOULD be selected from ValueSet [HL7 BasicConfidentialityKind](#HL7_BasicConfidentialityKind) 2.16.840.1.113883.1.11.16926 STATIC 2010-04-21 (CONF:5259).
9. SHALL contain exactly one [1..1] languageCode, which SHALL be selected from ValueSet [Language](#Language) 2.16.840.1.113883.1.11.11526 DYNAMIC (CONF:5372).
10. MAY contain zero or one [0..1] setId (CONF:5261).
    1. If  setId is present versionNumber SHALL be present (CONF:6380).
11. MAY contain zero or one [0..1] versionNumber (CONF:5264).
    1. If versionNumber is present setId SHALL be present (<CONF:6387>).

Particpants and actRelationships

#### recordTarget

The recordTarget records the administrative and demographic data of the patient whose health information is described by the clinical document; each recordTarget must contain at least one patientRole element

1. SHALL contain at least one [1..\*] recordTarget (CONF:5266).
   1. Such recordTargets SHALL contain exactly one [1..1] patientRole (CONF:5267).
      1. This patientRole SHALL contain at least one [1..\*] id (CONF:5268).
      2. This patientRole SHALL contain at least one [1..\*] addr (CONF:5271).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10412).
      3. This patientRole SHALL contain at least one [1..\*] telecom (CONF:5280).
         1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet [Telecom Use (US Realm Header)](#Telecom_Use_US_Realm_Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:5375).
      4. This patientRole SHALL contain exactly one [1..1] patient (CONF:5283).
         1. This patient SHALL contain at least one [1..\*] name (CONF:5284).
            1. The content of name SHALL be a conformant US Realm Patient Name (PTN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1) (CONF:10411).
         2. This patient SHALL contain exactly one [1..1] administrativeGenderCode, which SHALL be selected from ValueSet [Administrative Gender (HL7 V3)](#Administrative_Gender_HL7_V3) 2.16.840.1.113883.1.11.1 DYNAMIC (CONF:6394).
         3. This patient SHALL contain exactly one [1..1] birthTime (CONF:5298).
            1. SHALL be precise to year (CONF:5299).
            2. SHOULD be precise to day (CONF:5300).
         4. This patient SHOULD contain zero or one [0..1] maritalStatusCode, which SHALL be selected from ValueSet [Marital Status Value Set](#Marital_Status_Value_Set) 2.16.840.1.113883.1.11.12212 DYNAMIC (CONF:5303).
         5. This patient MAY contain zero or one [0..1] religiousAffiliationCode, which SHALL be selected from ValueSet [Religious Affiliation Value Set](#Religious_Affiliation_Value_Set) 2.16.840.1.113883.1.11.19185 DYNAMIC (CONF:5317).
         6. This patient SHOULD contain zero or one [0..1] raceCode, which SHALL be selected from ValueSet [Race Value Set](#Race_Value_Set) 2.16.840.1.113883.1.11.14914 DYNAMIC (CONF:5322).

The sdtc:raceCode is only used to record additional values when the patient has indicated multiple races.

* + - 1. This patient MAY contain zero or more [0..\*] sdtc:raceCode, which SHALL be selected from ValueSet [Race Value Set](#Race_Value_Set) 2.16.840.1.113883.1.11.14914 DYNAMIC (CONF:7263).
         1. If sdtc:raceCode is present, then the patient SHALL contain 1..1] raceCode (CONF:31347).
      2. This patient SHOULD contain zero or one [0..1] ethnicGroupCode, which SHALL be selected from ValueSet [EthnicityGroup](#EthnicityGroup) 2.16.840.1.114222.4.11.837 DYNAMIC (CONF:5323).
      3. This patient MAY contain zero or more [0..\*] guardian (CONF:5325).
         1. The guardian, if present, SHOULD contain zero or one [0..1] code, which SHALL be selected from ValueSet [Personal And Legal Relationship Role Type](#Personal_And_Legal_Relationship_Role_Ty) 2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:5326).
         2. The guardian, if present, SHOULD contain zero or more [0..\*] addr (CONF:5359).

The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10413).

* + - * 1. The guardian, if present, MAY contain zero or more [0..\*] telecom (CONF:5382).

The telecom, if present, SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet [Telecom Use (US Realm Header)](#Telecom_Use_US_Realm_Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7993).

* + - * 1. The guardian, if present, SHALL contain exactly one [1..1] guardianPerson (CONF:5385).

This guardianPerson SHALL contain at least one [1..\*] name (CONF:5386).

The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10414).

* + - 1. This patient MAY contain zero or one [0..1] birthplace (CONF:5395).
         1. The birthplace, if present, SHALL contain exactly one [1..1] place (CONF:5396).

This place SHALL contain exactly one [1..1] addr (CONF:5397).

This addr SHOULD contain zero or one [0..1] country, which SHALL be selected from ValueSet [CountryValueSet](#CountryValueSet) 2.16.840.1.113883.3.88.12.80.63 DYNAMIC (CONF:5404).

This addr MAY contain zero or one [0..1] postalCode, which SHALL be selected from ValueSet [PostalCodeValueSet](#PostalCodeValueSet) 2.16.840.1.113883.3.88.12.80.2 DYNAMIC (CONF:5403).

If country is US, this addr SHALL contain exactly one 1..1] state, which SHALL be selected from ValueSet 2.16.840.1.113883.3.88.12.80.1 StateValueSet DYNAMIC (CONF:5402).

* + - 1. This patient SHOULD contain zero or more [0..\*] languageCommunication (CONF:5406).
         1. The languageCommunication, if present, SHALL contain exactly one [1..1] languageCode, which SHALL be selected from ValueSet [Language](#Language) 2.16.840.1.113883.1.11.11526 DYNAMIC (CONF:5407).
         2. The languageCommunication, if present, MAY contain zero or one [0..1] modeCode, which SHALL be selected from ValueSet [LanguageAbilityMode Value Set](#LanguageAbilityMode_Value_Set) 2.16.840.1.113883.1.11.12249 DYNAMIC (CONF:5409).
         3. The languageCommunication, if present, SHOULD contain zero or one [0..1] proficiencyLevelCode, which SHALL be selected from ValueSet [LanguageAbilityProficiency](#LanguageAbilityProficiency) 2.16.840.1.113883.1.11.12199 DYNAMIC (CONF:9965).
         4. The languageCommunication, if present, SHOULD contain zero or one [0..1] preferenceInd (CONF:5414).
    1. This patientRole MAY contain zero or one [0..1] providerOrganization (CONF:5416).
       1. The providerOrganization, if present, SHALL contain at least one [1..\*] id (CONF:5417).
          1. Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:16820).
       2. The providerOrganization, if present, SHALL contain at least one [1..\*] name (CONF:5419).
       3. The providerOrganization, if present, SHALL contain at least one [1..\*] telecom (CONF:5420).
          1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet [Telecom Use (US Realm Header)](#Telecom_Use_US_Realm_Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7994).
       4. The providerOrganization, if present, SHALL contain at least one [1..\*] addr (CONF:5422).
          1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10415).

Figure 1: recordTarget Example

<recordTarget>

<patientRole>

<id extension="444-22-2222" root="2.16.840.1.113883.4.1"/>

<!-- Example Social Security Number using the actual SSN OID. -->

<addr use="HP">

<!-- HP is "primary home" from codeSystem 2.16.840.1.113883.5.1119 -->

<streetAddressLine>2222 Home Street</streetAddressLine>

<city>Beaverton</city>

<state>OR</state>

<postalCode>97867</postalCode>

<country>US</country>

<!-- US is "United States" from ISO 3166-1 Country Codes: 1.0.3166.1 -->

</addr>

<telecom value="tel:+1(555)555-2003" use="HP"/>

<!-- HP is "primary home" from HL7 AddressUse 2.16.840.1.113883.5.1119 -->

<patient>

<!-- The first name element represents what the patient is known as -->

<name use="L">

<given>Eve</given>

<family qualifier="SP">Betterhalf</family>

</name>

<!-- The second name element represents another name associated with the patient -->

<name>

<given>Eve</given>

<family qualifier="BR">Everywoman</family>

</name>

<administrativeGenderCode code="F" displayName="Female"

codeSystem="2.16.840.1.113883.5.1" codeSystemName="AdministrativeGender"/>

<!-- Date of birth need only be precise to the day -->

<birthTime value="19750501"/>

<maritalStatusCode code="M" displayName="Married" codeSystem="2.16.840.1.113883.5.2"

codeSystemName="MaritalStatusCode"/>

<religiousAffiliationCode code="1013"

displayName="Christian (non-Catholic, non-specific)"

codeSystem="2.16.840.1.113883.5.1076" codeSystemName="HL7 Religious Affiliation"/>

<!-- CDC Race and Ethnicity code set contains the five minimum race and ethnicity

categories defined by OMB Standards -->

<raceCode code="2106-3" displayName="White" codeSystem="2.16.840.1.113883.6.238"

codeSystemName="Race &amp; Ethnicity - CDC"/>

<!-- The raceCode extension is only used if raceCode is valued -->

<sdtc:raceCode code="2076-8" displayName="Hawaiian or Other Pacific Islander"

codeSystem="2.16.840.1.113883.6.238" codeSystemName="Race &amp; Ethnicity - CDC"/>

<ethnicGroupCode code="2186-5" displayName="Not Hispanic or Latino"

codeSystem="2.16.840.1.113883.6.238" codeSystemName="Race &amp; Ethnicity - CDC"/>

<guardian>

<code code="POWATT" displayName="Power of Attorney"

codeSystem="2.16.840.1.113883.1.11.19830" codeSystemName="ResponsibleParty"/>

<addr use="HP">

<streetAddressLine>2222 Home Street</streetAddressLine>

<city>Beaverton</city>

<state>OR</state>

<postalCode>97867</postalCode>

<country>US</country>

</addr>

<telecom value="tel:+1(555)555-2008" use="MC"/>

<guardianPerson>

<name>

<given>Boris</given>

<given qualifier="CL">Bo</given>

<family>Betterhalf</family>

</name>

</guardianPerson>

</guardian>

<birthplace>

<place>

<addr>

<streetAddressLine>4444 Home Street</streetAddressLine>

<city>Beaverton</city>

<state>OR</state>

<postalCode>97867</postalCode>

<country>US</country>

</addr>

</place>

</birthplace>

<languageCommunication>

<languageCode code="eng"/>

<!-- "eng" is ISO 639-2 alpha-3 code for "English" -->

<modeCode code="ESP" displayName="Expressed spoken"

codeSystem="2.16.840.1.113883.5.60" codeSystemName="LanguageAbilityMode"/>

<proficiencyLevelCode code="G" displayName="Good"

codeSystem="2.16.840.1.113883.5.61"

codeSystemName="LanguageAbilityProficiency"/>

<!-- Patient's preferred language -->

<preferenceInd value="true"/>

</languageCommunication>

</patient>

<providerOrganization>

<id extension="219BX" root="1.1.1.1.1.1.1.1.2"/>

<name>The DoctorsTogether Physician Group</name>

<telecom use="WP" value="tel: +(555)-555-5000"/>

<addr>

<streetAddressLine>1007 Health Drive</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

</providerOrganization>

</patientRole>

</recordTarget>

#### author

The author element represents the creator of the clinical document.  The author may be a device or a person.

1. SHALL contain at least one [1..\*] author (CONF:5444).
   1. Such authors SHALL contain exactly one [1..1] time (CONF:5445).
      1. The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:16866).
   2. Such authors SHALL contain exactly one [1..1] assignedAuthor (CONF:5448).
      1. This assignedAuthor SHALL contain at least one [1..\*] id (CONF:5449).
         1. If this assignedAuthor is an assignedPerson, the assignedAuthor SHOULD contain zero to one 0..1] id such that it (CONF:31135).
            1. SHALL contain exactly one 1..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:31694).
      2. This assignedAuthor SHOULD contain zero or one [0..1] code (CONF:16787).
         1. The code, if present, SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet [Healthcare Provider Taxonomy (HIPAA)](#Healthcare_Provider_Taxonomy_HIPAA) 2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:16788).
      3. This assignedAuthor SHALL contain at least one [1..\*] addr (CONF:5452).
         1. The content SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:16871).
      4. This assignedAuthor SHALL contain at least one [1..\*] telecom (CONF:5428).
         1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet [Telecom Use (US Realm Header)](#Telecom_Use_US_Realm_Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7995).
      5. This assignedAuthor SHOULD contain zero or one [0..1] assignedPerson (CONF:5430).
         1. The assignedPerson, if present, SHALL contain at least one [1..\*] name (CONF:16789).
            1. The content SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:16872).
      6. This assignedAuthor SHOULD contain zero or one [0..1] assignedAuthoringDevice (CONF:16783).
         1. The assignedAuthoringDevice, if present, SHALL contain exactly one [1..1] manufacturerModelName (CONF:16784).
         2. The assignedAuthoringDevice, if present, SHALL contain exactly one [1..1] softwareName (CONF:16785).
      7. There SHALL be exactly one assignedAuthor/assignedPerson or exactly one assignedAuthor/assignedAuthoringDevice (CONF:16790).

Figure 2: author Example

<author>

<time value="201209151030-0800" />

<assignedAuthor>

<id extension="5555555555" root="2.16.840.1.113883.4.6" />

<code code="207QA0505X" displayName="Adult Medicine" codeSystem="2.16.840.1.113883.6.101" codeSystemName="NUCC" />

<addr>

<streetAddressLine>1004 Healthcare Drive </streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:+1(555)555-1004" />

<assignedPerson>

<name>

<given>Patricia</given>

<given qualifier="CL">Patty</given>

<family>Primary</family>

<suffix qualifier="AC">M.D.</suffix>

</name>

</assignedPerson>

</assignedAuthor>

</author>

#### dataEnterer

The dataEnterer element represents the person who transferred the content, written or dictated, into the clinical document. To clarify, an author provides the content found within the header or body of a document, subject to their own interpretation; a dataEnterer adds an author's information to the electronic system.

1. MAY contain zero or one [0..1] dataEnterer (CONF:5441).
   1. The dataEnterer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:5442).
      1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:5443).
         1. Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:16821).
      2. This assignedEntity SHALL contain at least one [1..\*] addr (CONF:5460).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10417).
      3. This assignedEntity SHALL contain at least one [1..\*] telecom (CONF:5466).
         1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet [Telecom Use (US Realm Header)](#Telecom_Use_US_Realm_Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7996).
      4. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:5469).
         1. This assignedPerson SHALL contain at least one [1..\*] name (CONF:5470).
            1. The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10418).
      5. This assignedEntity MAY contain zero or one 0..1] code which SHOULD be selected from coding system NUCC Health Care Provider Taxonomy 2.16.840.1.113883.6.101 (CONF:9944).

Figure 3: dateEnterer Example

<dataEnterer>

<assignedEntity>

<id extension="333777777" root="2.16.840.1.113883.4.6" />

<addr>

<streetAddressLine>1007 Healthcare Drive</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:+1(555)555-1050" />

<assignedPerson>

<name>

<given>Ellen</given>

<family>Enter</family>

</name>

</assignedPerson>

</assignedEntity>

</dataEnterer>

#### informant

The informant element describes an information source for any content within the clinical document. This informant is constrained for use when the source of information is an assigned health care provider for the patient.

1. MAY contain zero or more [0..\*] informant (CONF:8001) such that it
   1. SHALL contain exactly one [1..1] assignedEntity (CONF:8002).
      1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:9945).
         1. If assignedEntity/id is a provider then this id, SHOULD include zero or one 0..1] id where id/@root ="2.16.840.1.113883.4.6" National Provider Identifier (CONF:9946).
      2. This assignedEntity SHALL contain at least one [1..\*] addr (CONF:8220).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10419).
      3. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:8221).
         1. This assignedPerson SHALL contain at least one [1..\*] name (CONF:8222).
            1. The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10420).
      4. This assignedEntity MAY contain zero or one 0..1] code which SHOULD be selected from coding system NUCC Health Care Provider Taxonomy 2.16.840.1.113883.6.101 (CONF:9947).

Figure 4: Assigned Health Care Provider informant Example

<informant>

<assignedEntity>

<id extension="888888888" root="1.1.1.1.1.1.1.3" />

<addr>

<streetAddressLine>1007 Healthcare Drive</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:+1(555)555-1003" />

<assignedPerson>

<name>

<given>Harold</given>

<family>Hippocrates</family>

<suffix qualifier="AC">M.D.</suffix>

</name>

</assignedPerson>

<representedOrganization>

<name>The DoctorsApart Physician Group</name>

</representedOrganization>

</assignedEntity>

</informant>

#### informant

The informant element describes an information source for any content within the clinical document. This informant would be used when the source of information has a personal relationship with the patient.

1. MAY contain zero or more [0..\*] informant (CONF:31355) such that it
   1. SHALL contain exactly one [1..1] relatedEntity (CONF:31356).

Figure 5: Personal Relation informant Example

<informant>

<relatedEntity classCode="PRS">

<!-- classCode "PRS" represents a person with personal relationship with the patient -->

<code code="SPS" displayName="SPOUSE" codeSystem="2.16.840.1.113883.1.11.19563" codeSystemName="Personal Relationship Role Type Value Set" />

<relatedPerson>

<name>

<given>Boris</given>

<given qualifier="CL">Bo</given>

<family>Betterhalf</family>

</name>

</relatedPerson>

</relatedEntity>

</informant>

The informant element describes an information source for any content within the clinical document. This informant would be used when the source of information has a personal relationship with the patient.

1. MAY contain zero or more [0..\*] informant (CONF:31839) such that it
   1. SHALL contain exactly one [1..1] assignedEntity (CONF:31840).

#### custodian

The custodian element represents the organization that is in charge of maintaining and is entrusted with the care of the document.

There may only be exactly one custodian per CDA document. Allowing that CDA is an exchange standard and may not represent the original form of the authenticated document, the custodian represents the steward of the original source document. The custodian may be the document originator, a health information exchange, or other responsible party.

1. SHALL contain exactly one [1..1] custodian (CONF:5519).
   1. This custodian SHALL contain exactly one [1..1] assignedCustodian (CONF:5520).
      1. This assignedCustodian SHALL contain exactly one [1..1] representedCustodianOrganization (CONF:5521).
         1. This representedCustodianOrganization SHALL contain at least one [1..\*] id (CONF:5522).
            1. Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:16822).
         2. This representedCustodianOrganization SHALL contain exactly one [1..1] name (CONF:5524).
         3. This representedCustodianOrganization SHALL contain exactly one [1..1] telecom (CONF:5525).
            1. This telecom SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet [Telecom Use (US Realm Header)](#Telecom_Use_US_Realm_Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7998).
         4. This representedCustodianOrganization SHALL contain exactly one [1..1] addr (CONF:5559).
            1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10421).

Figure 6: custodian Example

<custodian>

<assignedCustodian>

<representedCustodianOrganization>

<id extension="321CX" root="1.1.1.1.1.1.1.1.3" />

<name>Good Health HIE</name>

<telecom use="WP" value="tel:+1(555)555-1009" />

<addr use="WP">

<streetAddressLine>1009 Healthcare Drive </streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

</representedCustodianOrganization>

</assignedCustodian>

</custodian>

#### informationRecipient

The informationRecipient element records the intended recipient of the information at the time the document was created. In cases where the intended recipient of the document is the patient's health chart, set the receivedOrganization to the scoping organization for that chart.

1. MAY contain zero or more [0..\*] informationRecipient (CONF:5565).
   1. The informationRecipient, if present, SHALL contain exactly one [1..1] intendedRecipient (CONF:5566).
      1. This intendedRecipient MAY contain zero or one [0..1] informationRecipient (CONF:5567).
         1. The informationRecipient, if present, SHALL contain at least one [1..\*] name (CONF:5568).
            1. The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10427).
      2. This intendedRecipient MAY contain zero or one [0..1] receivedOrganization (CONF:5577).
         1. The receivedOrganization, if present, SHALL contain exactly one [1..1] name (CONF:5578).

Figure 7: informationRecipient Example

<informationRecipient>

<intendedRecipient>

<informationRecipient>

<name>

<given>Sara</given>

<family>Specialize</family>

<suffix qualifier="AC">M.D.</suffix>

</name>

</informationRecipient>

<receivedOrganization>

<name>The DoctorsApart Physician Group</name>

</receivedOrganization>

</intendedRecipient>

</informationRecipient>

#### legalAuthenticator

The legalAuthenticator identifies the single person legally responsible for the document and must be present if the document has been legally authenticated. A clinical document that does not contain this element has not been legally authenticated.

The act of legal authentication requires a certain privilege be granted to the legal authenticator depending upon local policy. Based on local practice, clinical documents may be released before legal authentication.

All clinical documents have the potential for legal authentication, given the appropriate credentials.

Local policies MAY choose to delegate the function of legal authentication to a device or system that generates the clinical document. In these cases, the legal authenticator is a person accepting responsibility for the document, not the generating device or system.

Note that the legal authenticator, if present, must be a person.

1. SHOULD contain zero or one [0..1] legalAuthenticator (CONF:5579).
   1. The legalAuthenticator, if present, SHALL contain exactly one [1..1] time (CONF:5580).
      1. The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:29402).
   2. The legalAuthenticator, if present, SHALL contain exactly one [1..1] signatureCode (CONF:5583).
      1. This signatureCode SHALL contain exactly one [1..1] @code="S" (CodeSystem: Participationsignature 2.16.840.1.113883.5.89 STATIC) (CONF:5584).

#### sdtc:signatureText

The sdtc:signatureText extension provides a location in CDA for a textual or multimedia depiction of the signature by which the participant endorses and accepts responsibility for his or her participation in the Act as specified in the Participation.typeCode. Details of what goes in the field are described in the HL7 CDA Digital Signature Standard balloted in Fall of 2013..

* 1. The legalAuthenticator, if present, MAY contain zero or one [0..1] sdtc:signatureText (CONF:30810).  
     Note: The signature can be represented either inline or by reference according to the ED data type. Typical cases for CDA are:  
     1) Electronic signature: this attribute can represent virtually any electronic signature scheme.  
     2) Digital signature: this attribute can represent digital signatures by reference to a signature data block that is constructed in accordance to a digital signature standard, such as XML-DSIG, PKCS#7, PGP, etc.

Figure 8: Digital signature

<sdtc:signatureText mediaType="text/xml" representation="B64">omSJUEdmde9j44zmMiromSJUEdmde9j44zmMirdMDSsWdIJdksIJR3373jeu83

6edjzMMIjdMDSsWdIJdksIJR3373jeu83MNYD83jmMdomSJUEdmde9j44zmMir

... MNYD83jmMdomSJUEdmde9j44zmMir6edjzMMIjdMDSsWdIJdksIJR3373jeu83

4zmMir6edjzMMIjdMDSsWdIJdksIJR3373jeu83==</sdtc:signatureText>

* 1. The legalAuthenticator, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:5585).
     1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:5586).
        1. Such ids MAY contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:16823).
     2. This assignedEntity MAY contain zero or one [0..1] code, which SHOULD be selected from ValueSet [Healthcare Provider Taxonomy (HIPAA)](#Healthcare_Provider_Taxonomy_HIPAA) 2.16.840.1.114222.4.11.1066 STATIC (CONF:17000).
     3. This assignedEntity SHALL contain at least one [1..\*] addr (CONF:5589).
        1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10429).
     4. This assignedEntity SHALL contain at least one [1..\*] telecom (CONF:5595).
        1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet [Telecom Use (US Realm Header)](#Telecom_Use_US_Realm_Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7999).
     5. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:5597).
        1. This assignedPerson SHALL contain at least one [1..\*] name (CONF:5598).
           1. The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10430).

Figure 9: legalAuthenticator Example

<legalAuthenticator>

<time value="20120915223615-0800" />

<signatureCode code="S" />

<assignedEntity>

<id extension="5555555555" root="2.16.840.1.113883.4.6" />

<code code="207QA0505X" displayName="Adult Medicine" codeSystem="2.16.840.1.113883.6.101" codeSystemName="NUCC" />

<addr>

<streetAddressLine>1004 Healthcare Drive </streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:+1(555)555-1004" />

<assignedPerson>

<name>

<given>Patricia</given>

<given qualifier="CL">Patty</given>

<family>Primary</family>

<suffix qualifier="AC">M.D.</suffix>

</name>

</assignedPerson>

</assignedEntity>

</legalAuthenticator>

#### authenticator

The authenticator identifies a participant or participants who attest to the accuracy of the information in the document.

1. MAY contain zero or more [0..\*] authenticator (CONF:5607).
   1. The authenticator, if present, SHALL contain exactly one [1..1] time (CONF:5608).
      1. The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:16874).
   2. The authenticator, if present, SHALL contain exactly one [1..1] signatureCode (CONF:5610).
      1. This signatureCode SHALL contain exactly one [1..1] @code="S" (CodeSystem: Participationsignature 2.16.840.1.113883.5.89 STATIC) (CONF:5611).

The sdtc:signatureText extension provides a location in CDA for a textual or multimedia depiction of the signature by which the participant endorses and accepts responsibility for his or her participation in the Act as specified in the Participation.typeCode. Details of what goes in the field are described in the HL7 CDA Digital Signature Standard balloted in Fall of 2013..

* 1. The authenticator, if present, MAY contain zero or one [0..1] sdtc:signatureText (CONF:30811).  
     Note: The signature can be represented either inline or by reference according to the ED data type. Typical cases for CDA are:  
     1) Electronic signature: this attribute can represent virtually any electronic signature scheme.  
     2) Digital signature: this attribute can represent digital signatures by reference to a signature data block that is constructed in accordance to a digital signature standard, such as XML-DSIG, PKCS#7, PGP, etc.
  2. The authenticator, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:5612).
     1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:5613).
        1. Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier  (CONF:16824).
     2. This assignedEntity MAY contain zero or one [0..1] code (CONF:16825).
        1. The code, if present, MAY contain zero or one [0..1] @code, which SHOULD be selected from ValueSet [Healthcare Provider Taxonomy (HIPAA)](#Healthcare_Provider_Taxonomy_HIPAA) 2.16.840.1.114222.4.11.1066 STATIC (CONF:16826).
     3. This assignedEntity SHALL contain at least one [1..\*] addr (CONF:5616).
        1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10425).
     4. This assignedEntity SHALL contain at least one [1..\*] telecom (CONF:5622).
        1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet [Telecom Use (US Realm Header)](#Telecom_Use_US_Realm_Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:8000).
     5. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:5624).
        1. This assignedPerson SHALL contain at least one [1..\*] name (CONF:5625).
           1. The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10424).

Figure 10: authenticator Example

<authenticator>

<time value="201209151030-0800" />

<signatureCode code="S" />

<assignedEntity>

<id extension="5555555555" root="2.16.840.1.113883.4.6" />

<code code="207QA0505X" displayName="Adult Medicine" codeSystem="2.16.840.1.113883.6.101" codeSystemName="NUCC" />

<addr>

<streetAddressLine>1004 Healthcare Drive </streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:+1(555)555-1004" />

<assignedPerson>

<name>

<given>Patricia</given>

<given qualifier="CL">Patty</given>

<family>Primary</family>

<suffix qualifier="AC">M.D.</suffix>

</name>

</assignedPerson>

</assignedEntity>

</authenticator>

#### participant

The participant element identifies supporting entities, including parents, relatives, caregivers, insurance policyholders, guarantors, and others related in some way to the patient.

A supporting person or organization is an individual or an organization with a relationship to the patient. A supporting person who is playing multiple roles would be recorded in multiple participants (e.g., emergency contact and next-of-kin).

1. MAY contain zero or more [0..\*] participant (CONF:10003) such that it
   1. MAY contain zero or one [0..1] time (CONF:10004).
   2. SHALL contain associatedEntity/associatedPerson AND/OR associatedEntity/scopingOrganization (CONF:10006).
   3. When participant/@typeCode is IND, associatedEntity/@classCode SHOULD be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:10007).

Figure 11: Supporting Person participant Example

<participant typeCode="IND">

<!-- typeCode "IND" represents an individual -->

<associatedEntity classCode="NOK">

<!-- classCode "NOK" represents the patient's next of kin-->

<addr use="HP">

<streetAddressLine>2222 Home Street</streetAddressLine>

<city>Beaverton</city>

<state>OR</state>

<postalCode>97867</postalCode>

<country>US</country>

</addr>

<telecom value="tel:+1(555)555-2008" use="MC"/>

<associatedPerson>

<name>

<given>Boris</given>

<given qualifier="CL">Bo</given>

<family>Betterhalf</family>

</name>

</associatedPerson>

</associatedEntity>

</participant>

<!-- Entities playing multiple roles are recorded in multiple participants -->

<participant typeCode="IND">

<associatedEntity classCode="ECON">

<!-- classCode "ECON" represents an emergency contact -->

<addr use="HP">

<streetAddressLine>2222 Home Street</streetAddressLine>

<city>Beaverton</city>

<state>OR</state>

<postalCode>97867</postalCode>

<country>US</country>

</addr>

<telecom value="tel:+1(555)555-2008" use="MC"/>

<associatedPerson>

<name>

<given>Boris</given>

<given qualifier="CL">Bo</given>

<family>Betterhalf</family>

</name>

</associatedPerson>

</associatedEntity>

</participant>

#### inFulfillmentOf

The inFulfillmentOf element represents orders that are fulfilled by this document such as a radiologists’ report of an x-ray.

1. MAY contain zero or more [0..\*] inFulfillmentOf (CONF:9952).
   1. The inFulfillmentOf, if present, SHALL contain exactly one [1..1] order (CONF:9953).
      1. This order SHALL contain at least one [1..\*] id (CONF:9954).

Figure 12: inFulfillmentOf Example

<inFulfillmentOf typeCode="FLFS">

<order classCode="ACT" moodCode="RQO">

<id root="2.16.840.1.113883.6.96" extension="1298989898" />

<code code="388975008" displayName="Weight Reduction Consultation" codeSystem="2.16.840.1.113883.6.96" codeSystemName="CPT4" />

</order>

</inFulfillmentOf>

#### documentationOf

A serviceEvent represents the main act being documented, such as a colonoscopy or a cardiac stress study. In a provision of healthcare serviceEvent, the care providers, PCP, or other longitudinal providers, are recorded within the serviceEvent. If the document is about a single encounter, the providers associated can be recorded in the componentOf/encompassingEncounter template.

1. MAY contain zero or more [0..\*] documentationOf (CONF:14835).
   1. The documentationOf, if present, SHALL contain exactly one [1..1] serviceEvent (CONF:14836).
      1. This serviceEvent SHALL contain exactly one [1..1] effectiveTime (CONF:14837).
         1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:14838).
      2. This serviceEvent SHOULD contain zero or more [0..\*] performer (CONF:14839).

The performer participant represents clinicians who actually and principally carry out the serviceEvent. In a transfer of care this represents the healthcare providers involved in the current or pertinent historical care of the patient. Preferably, the patient’s key healthcare care team members would be listed, particularly their primary physician and any active consulting physicians, therapists, and counselors

* + - 1. The performer, if present, SHALL contain exactly one [1..1] @typeCode (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:14840).
      2. The performer, if present, MAY contain zero or one [0..1] functionCode (CONF:16818).
         1. The functionCode, if present, SHOULD contain zero or one [0..1] @codeSystem, which SHOULD be selected from CodeSystem participationFunction (2.16.840.1.113883.5.88) STATIC (CONF:16819).
      3. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:14841).
         1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:14846).

Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:14847).

* + - * 1. This assignedEntity SHOULD contain zero or one [0..1] code (CONF:14842).

The code, if present, SHALL contain exactly one [1..1] @code, which SHOULD be selected from CodeSystem NUCCProviderTaxonomy (2.16.840.1.113883.6.101) STATIC (CONF:14843).

Figure 13: documentationOf Example

<documentationOf>

<serviceEvent classCode="PCPR">

<!-- The effectiveTime reflects the provision of care summarized in the document.

In this scenario, the provision of care summarized is the lifetime for the patient -->

<effectiveTime>

<low value="19750501" />

<!-- The low value represents when the summarized provision of care began.

In this scenario, the patient's date of birth -->

<high value="20120915" />

<!-- The high value represents when the summarized provision of care being ended.

In this scenario, when chart summary was created -->

</effectiveTime>

<performer typeCode="PRF">

<functionCode code="PP" displayName="Primary Performer" codeSystem="2.16.840.1.113883.12.443" codeSystemName="Provider Role">

<originalText>Primary Care Provider</originalText>

</functionCode>

<assignedEntity>

<id extension="5555555555" root="2.16.840.1.113883.4.6" />

<code code="207QA0505X" displayName="Adult Medicine" codeSystem="2.16.840.1.113883.6.101" codeSystemName="NUCC" />

<addr>

<streetAddressLine>1004 Healthcare Drive </streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:+1(555)555-1004" />

<assignedPerson>

<name>

<given>Patricia</given>

<given qualifier="CL">Patty</given>

<family>Primary</family>

<suffix qualifier="AC">M.D.</suffix>

</name>

</assignedPerson>

<representedOrganization>

<id extension="219BX" root="1.1.1.1.1.1.1.1.2" />

<name>The DoctorsTogether Physician Group</name>

<telecom use="WP" value="tel: +(555)-555-5000" />

<addr>

<streetAddressLine>1004 Health Drive</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

</representedOrganization>

</assignedEntity>

</performer>

</serviceEvent>

</documentationOf>

#### authorization

The authorization element represents information about the patient’s consent.

The type of consent is conveyed in consent/code. Consents in the header have been finalized (consent/statusCode must equal Completed) and should be on file. This specification does not address how 'Privacy Consent' is represented, but does not preclude the inclusion of ‘Privacy Consent’.

1. MAY contain zero or more [0..\*] authorization (CONF:16792) such that it
   1. SHALL contain exactly one [1..1] consent (CONF:16793).
      1. This consent MAY contain zero or more [0..\*] id (CONF:16794).

The type of consent (e.g., a consent to perform the related serviceEvent) is conveyed in consent/code

* + 1. This consent MAY contain zero or one [0..1] code (CONF:16795).
    2. This consent SHALL contain exactly one [1..1] statusCode (CONF:16797).
       1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:16798).

Figure 14: authorization Example

<authorization typeCode="AUTH">

<consent classCode="CONS" moodCode="EVN">

<id root="629deb70-5306-11df-9879-0800200c9a66" />

<code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="64293-4" displayName="Procedure consent" />

<statusCode code="completed" />

</consent>

</authorization>

#### componentOf

The componentOf element contains the encompassing encounter for the document. The encompassing encounter represents the setting of the clinical encounter during which the document act(s) or ServiceEvent(s) occurred.

In order to represent providers associated with a specific encounter, they are recorded within the encompassingEncounter as participants.

In a CCD, the encompassingEncounter may be used when documenting a specific encounter and its participants. All relevant encounters in a CCD may be listed in the encounters section.

1. MAY contain zero or one [0..1] componentOf (CONF:9955).
   1. The componentOf, if present, SHALL contain exactly one [1..1] encompassingEncounter (CONF:9956).
      1. This encompassingEncounter SHALL contain at least one [1..\*] id (CONF:9959).
      2. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:9958).

Figure 15: componentOf Example

<componentOf>

<encompassingEncounter>

<id extension="9937012" root="2.16.840.1.113883.19" />

<code codeSystem="2.16.840.1.113883.5.4" code="IMP" displayName="Inpatient" />

<!-- captures that this is an inpatient encounter -->

<effectiveTime>

<low value="20130320" />

<high value="20130329" />

</effectiveTime>

</encompassingEncounter>

</componentOf>

3: HL7 BasicConfidentialityKind

|  |  |  |
| --- | --- | --- |
| Value Set: HL7 BasicConfidentialityKind 2.16.840.1.113883.1.11.16926 | | |
| Code | Code System | Print Name |
| N | ConfidentialityCode | normal |
| R | ConfidentialityCode | restricted |
| V | ConfidentialityCode | very restricted |

4: Language

|  |  |  |
| --- | --- | --- |
| Value Set: Language 2.16.840.1.113883.1.11.11526 | | |
| Code | Code System | Print Name |
| aa | Language | Afar |
| ab | Language | Abkhazian |
| ace | Language | Achinese |
| ach | Language | Acoli |
| ada | Language | Adangme |
| ady | Language | Adyghe; Adygei |
| ae | Language | Avestan |
| af | Language | Afrikaans |
| afa | Language | Afro-Asiatic (Other) |
| afh | Language | Afrihili |
| ... | | |

5: Telecom Use (US Realm Header)

|  |  |  |
| --- | --- | --- |
| Value Set: Telecom Use (US Realm Header) 2.16.840.1.113883.11.20.9.20 | | |
| Code | Code System | Print Name |
| HP | AddressUse | Primary home |
| HV | AddressUse | Vacation home |
| WP | AddressUse | Work place |
| MC | AddressUse | Mobile contact |

6: Administrative Gender (HL7 V3)

|  |  |  |
| --- | --- | --- |
| Value Set: Administrative Gender (HL7 V3) 2.16.840.1.113883.1.11.1  Administrative Gender based upon HL7 V3 vocabulary. This value set contains only male, female and undifferentiated concepts. | | |
| Code | Code System | Print Name |
| F | AdministrativeGender | Female |
| M | AdministrativeGender | Male |
| UN | AdministrativeGender | Undifferentiated |

7: Marital Status Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Marital Status Value Set 2.16.840.1.113883.1.11.12212  Marital Status is the domestic partnership status of a person. | | |
| Code | Code System | Print Name |
| A | MaritalStatus | Annulled |
| D | MaritalStatus | Divorced |
| T | MaritalStatus | Domestic partner |
| I | MaritalStatus | Interlocutory |
| L | MaritalStatus | Legally Separated |
| M | MaritalStatus | Married |
| S | MaritalStatus | Never Married |
| P | MaritalStatus | Polygamous |
| W | MaritalStatus | Widowed |

8: Religious Affiliation Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Religious Affiliation Value Set 2.16.840.1.113883.1.11.19185 | | |
| Code | Code System | Print Name |
| 1001 | ReligiousAffiliation | Adventist |
| 1002 | ReligiousAffiliation | African Religions |
| 1003 | ReligiousAffiliation | Afro-Caribbean Religions |
| 1004 | ReligiousAffiliation | Agnosticism |
| 1005 | ReligiousAffiliation | Anglican |
| 1006 | ReligiousAffiliation | Animism |
| 1007 | ReligiousAffiliation | Atheism |
| 1008 | ReligiousAffiliation | Babi & Baha'I faiths |
| 1009 | ReligiousAffiliation | Baptist |
| 1010 | ReligiousAffiliation | Bon |
| ... | | |

9: Race Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Race Value Set 2.16.840.1.113883.1.11.14914  Concepts in the race value set include the OMB minimum categories, 5 races, along with a sixth race category, Other race, and a more detailed set of race categories used by the Bureau of Census. | | |
| Code | Code System | Print Name |
| 1006-6 | Race & Ethnicity - CDC | Abenaki |
| 1579-2 | Race & Ethnicity - CDC | Absentee Shawnee |
| 1490-2 | Race & Ethnicity - CDC | Acoma |
| 2126-1 | Race & Ethnicity - CDC | Afghanistani |
| 2060-2 | Race & Ethnicity - CDC | African |
| 2058-6 | Race & Ethnicity - CDC | African American |
| 1994-3 | Race & Ethnicity - CDC | Agdaagux |
| 1212-0 | Race & Ethnicity - CDC | Agua Caliente |
| 1045-4 | Race & Ethnicity - CDC | Agua Caliente Cahuilla |
| 1740-0 | Race & Ethnicity - CDC | Ahtna |
| ... | | |

10: EthnicityGroup

|  |  |  |
| --- | --- | --- |
| Value Set: EthnicityGroup 2.16.840.1.114222.4.11.837 | | |
| Code | Code System | Print Name |
| 2135-2 | Race & Ethnicity - CDC | Hispanic or Latino |
| 2186-5 | Race & Ethnicity - CDC | Not Hispanic or Latino |

11: Personal And Legal Relationship Role Type

|  |  |  |
| --- | --- | --- |
| Value Set: Personal And Legal Relationship Role Type 2.16.840.1.113883.11.20.12.1  A personal or legal relationship records the role of a person in relation to another person, or a person to himself or herself. This value set is to be used when recording relationships based on personal or family ties or through legal assignment of responsibility.    Specific URL Pending  Valueset Source: [http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary\_tables/infrastructure/vocabulary/vocabulary.html](http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html%20) | | |
| Code | Code System | Print Name |
| ONESELF | RoleCode | self |
| MTH | RoleCode | mother |
| FTH | RoleCode | father |
| DAU | RoleCode | natural daughter |
| SON | RoleCode | natural son |
| DAUINLAW | RoleCode | daughter in-law |
| SONINLAW | RoleCode | son in-law |
| GUARD | RoleCode | guardian |
| HPOWATT | RoleCode | healthcare power of attorney |
| ... | | |

12: CountryValueSet

|  |  |  |
| --- | --- | --- |
| Value Set: CountryValueSet 2.16.840.1.113883.3.88.12.80.63  This identifies the codes for the representation of names of countries, territories and areas of geographical interest. | | |
| Code | Code System | Print Name |

13: PostalCodeValueSet

|  |  |  |
| --- | --- | --- |
| Value Set: PostalCodeValueSet 2.16.840.1.113883.3.88.12.80.2  This identifies the postal (ZIP) Code of an address in the United States | | |
| Code | Code System | Print Name |

14: LanguageAbilityMode Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: LanguageAbilityMode Value Set 2.16.840.1.113883.1.11.12249  This identifies the language ability of the individual. A value representing the method of expression of the language. | | |
| Code | Code System | Print Name |
| ESGN | LanguageAbilityMode | Expressed signed |
| ESP | LanguageAbilityMode | Expressed spoken |
| EWR | LanguageAbilityMode | Expressed written |
| RSGN | LanguageAbilityMode | Received signed |
| RSP | LanguageAbilityMode | Received spoken |
| RWR | LanguageAbilityMode | Received written |

15: LanguageAbilityProficiency

|  |  |  |
| --- | --- | --- |
| Value Set: LanguageAbilityProficiency 2.16.840.1.113883.1.11.12199 | | |
| Code | Code System | Print Name |
| E | LanguageAbilityProficiency | Excellent |
| F | LanguageAbilityProficiency | Fair |
| G | LanguageAbilityProficiency | Good |
| P | LanguageAbilityProficiency | Poor |

16: Healthcare Provider Taxonomy (HIPAA)

|  |  |  |
| --- | --- | --- |
| Value Set: Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066  The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct Levels including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category. Providers may have one or more than one value associated to them. When determining what value or valuess to associate with a provider, the user needs to review the requirements of the trading partner with which the value(s) are being used. | | |
| Code | Code System | Print Name |
| 171100000X | Healthcare Provider Taxonomy (HIPAA) | Acupuncturist |
| 363LA2100X | Healthcare Provider Taxonomy (HIPAA) | Acute Care |
| 364SA2100X | Healthcare Provider Taxonomy (HIPAA) | Acute Care |
| 101YA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 103TA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 163WA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 207LA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 207QA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 207RA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 2084A0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| ... | | |

17: INDRoleclassCodes

|  |  |  |
| --- | --- | --- |
| Value Set: INDRoleclassCodes 2.16.840.1.113883.11.20.9.33 | | |
| Code | Code System | Print Name |
| PRS | RoleClass | personal relationship |
| NOK | RoleClass | next of kin |
| CAREGIVER | RoleClass | caregiver |
| AGNT | RoleClass | agent |
| GUAR | RoleClass | guarantor |
| ECON | RoleClass | emergency contact |

Care Plan (NEW)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.15 (open)]

18: Care Plan (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Goals Section (NEW)](#S_Goals_Section_NEW)  [Health Concerns Section (NEW)](#S_Health_Concerns_Section_NEW)  [Health Status Evaluations/Outcomes Section (NEW)](#S_Health_Status_EvaluationsOutcomes_Sec)  [Interventions Section (V2)](#Interventions_Section_V2) |

CARE PLAN FRAMEWORK

A Care Plan is a consensus-driven dynamic plan that represents all of a patient’s and Care Team Members’ prioritized concerns, goals, and planned interventions. It serves as a blueprint shared by all Care Team Members, including the patient, to guide the Care Team Members (including Patients, their caregivers, providers and patient’s care. A Care Plan integrates multiple interventions proposed by multiple providers and disciplines for multiple conditions.

A Care Plan represents one or more Plan(s) of Care and serves to reconcile and resolve conflicts between the various Plans of Care developed for a specific patient by different providers. While both a plan of care and a care plan include the patient’s life goals and require Care Team Members (including patients) to prioritize goals and interventions, the reconciliation process becomes more complex as the number of plans of care increases. The Care Plan also serves to enable longitudinal coordination of care.

The CDA Care Plan represents an instance of this dynamic Care Plan at a point in time. The CDA document itself is NOT dynamic.

19: Care Plan (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| ClinicalDocument[templateId/@root = '2.16.840.1.113883.10.20.22.1.15'] | | | | | |
| templateId | 1..1 | SHALL |  | [28741](#C_28741) |  |
| @root | 1..1 | SHALL |  | [28742](#C_28742) | 2.16.840.1.113883.10.20.22.1.15 |
| id | 1..1 | SHALL |  | [28743](#C_28743) |  |
| @root | 1..1 | SHALL |  | [28744](#C_28744) |  |
| code | 1..1 | SHALL |  | [28745](#C_28745) |  |
| @code | 1..1 | SHALL |  | [28746](#C_28746) | XXXXX-X |
| @codeSystem | 1..1 | SHALL |  | [28747](#C_28747) | 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [28748](#C_28748) |  |
| custodian | 1..1 | SHALL |  | [28749](#C_28749) |  |
| assignedCustodian | 1..1 | SHALL |  | [28750](#C_28750) |  |
| representedCustodianOrganization | 1..1 | SHALL |  | [28751](#C_28751) |  |
| name | 1..1 | SHALL |  | [28752](#C_28752) |  |
| component | 1..1 | SHALL |  | [28753](#C_28753) |  |
| structuredBody | 1..1 | SHALL |  | [28754](#C_28754) |  |
| component | 1..1 | SHALL |  | [28755](#C_28755) |  |
| section | 1..1 | SHALL |  | [28756](#C_28756) |  |
| component | 1..1 | SHALL |  | [28761](#C_28761) |  |
| section | 1..1 | SHALL |  | [28762](#C_28762) |  |
| component | 1..1 | SHALL |  | [28763](#C_28763) |  |
| section | 1..1 | SHALL |  | [28764](#C_28764) |  |
| component | 1..1 | SHALL |  | [29596](#C_29596) |  |
| section | 1..1 | SHALL |  | [29597](#C_29597) |  |
| relatedDocument | 0..\* | MAY |  | [29893](#C_29893) |  |
| parentDocument | 1..1 | SHALL |  | [29894](#C_29894) |  |
| setId | 1..1 | SHALL |  | [29895](#C_29895) |  |
| versionNumber | 1..1 | SHALL |  | [29896](#C_29896) |  |
| participant | 0..\* | SHOULD |  | [31677](#C_31677) |  |
| @typeCode | 1..1 | SHALL |  | [31678](#C_31678) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = IND |
| functionCode | 1..1 | SHALL |  | [31679](#C_31679) |  |
| @code | 1..1 | SHALL |  | [31680](#C_31680) | 425268008 |
| @codeSystem | 1..1 | SHALL |  | [31681](#C_31681) | 2.16.840.1.113883.6.96 |
| time | 1..1 | SHALL |  | [31682](#C_31682) |  |
| associatedEntity | 1..1 | SHALL |  | [31683](#C_31683) |  |
| @classCode | 1..1 | SHALL |  | [31686](#C_31686) | 2.16.840.1.113883.5.110 (RoleClass) = ASSIGNED |
| id | 1..\* | SHALL |  | [31684](#C_31684) |  |
| code | 0..1 | SHOULD |  | [31685](#C_31685) | 2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type) |

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:28741) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.15" (CONF:28742).
3. SHALL contain exactly one [1..1] id (CONF:28743).
   1. This id SHALL contain exactly one [1..1] @root (CONF:28744).
4. SHALL contain exactly one [1..1] code (CONF:28745).
   1. This code SHALL contain exactly one [1..1] @code="XXXXX-X" \*\*TODO\*\* (CONF:28746).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CONF:28747).
5. SHALL contain exactly one [1..1] title (CONF:28748).
6. SHALL contain exactly one [1..1] custodian (CONF:28749).
   1. This custodian SHALL contain exactly one [1..1] assignedCustodian (CONF:28750).
      1. This assignedCustodian SHALL contain exactly one [1..1] representedCustodianOrganization (CONF:28751).
         1. This representedCustodianOrganization SHALL contain exactly one [1..1] name (CONF:28752).

This participant represents the Care Plan Review. If the date in the time element is in the past, then this review has already taken place. If the date in the time element is in the future, then this is the date of the next scheduled review.

1. SHOULD contain zero or more [0..\*] participant (CONF:31677) such that it
   1. SHALL contain exactly one [1..1] @typeCode="IND" Indirect target (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:31678).
   2. SHALL contain exactly one [1..1] functionCode (CONF:31679).
      1. This functionCode SHALL contain exactly one [1..1] @code="425268008" Review of Care Plan (CONF:31680).
      2. This functionCode SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CONF:31681).
   3. SHALL contain exactly one [1..1] time (CONF:31682).
   4. SHALL contain exactly one [1..1] associatedEntity (CONF:31683).
      1. This associatedEntity SHALL contain exactly one [1..1] @classCode="ASSIGNED" (CodeSystem: RoleClass 2.16.840.1.113883.5.110) (CONF:31686).
      2. This associatedEntity SHALL contain at least one [1..\*] id (CONF:31684).
      3. This associatedEntity SHOULD contain zero or one [0..1] code (ValueSet: [Personal And Legal Relationship Role Type](#Personal_And_Legal_Relationship_Role_Ty) 2.16.840.1.113883.11.20.12.1) (CONF:31685).
2. MAY contain zero or more [0..\*] relatedDocument (CONF:29893).
   1. The relatedDocument, if present, SHALL contain exactly one [1..1] parentDocument (CONF:29894).
      1. This parentDocument SHALL contain exactly one [1..1] setId (CONF:29895).
      2. This parentDocument SHALL contain exactly one [1..1] versionNumber (CONF:29896).
3. SHALL contain exactly one [1..1] component (CONF:28753).
   1. This component SHALL contain exactly one [1..1] structuredBody (CONF:28754).
      1. This structuredBody SHALL contain exactly one [1..1] component (CONF:28755) such that it
         1. SHALL contain exactly one [1..1] [Health Concerns Section (NEW)](#S_Health_Concerns_Section_NEW) (templateId:2.16.840.1.113883.10.20.22.2.58) (CONF:28756).
      2. This structuredBody SHALL contain exactly one [1..1] component (CONF:28761) such that it
         1. SHALL contain exactly one [1..1] [Goals Section (NEW)](#S_Goals_Section_NEW) (templateId:2.16.840.1.113883.10.20.22.2.60) (CONF:28762).
      3. This structuredBody SHALL contain exactly one [1..1] component (CONF:28763) such that it
         1. SHALL contain exactly one [1..1] [Interventions Section (V2)](#Interventions_Section_V2) (templateId:2.16.840.1.113883.10.20.21.2.3.2) (CONF:28764).
      4. This structuredBody SHALL contain exactly one [1..1] component (CONF:29596) such that it
         1. SHALL contain exactly one [1..1] [Health Status Evaluations/Outcomes Section (NEW)](#S_Health_Status_EvaluationsOutcomes_Sec) (templateId:2.16.840.1.113883.10.20.22.2.61) (CONF:29597).
      5. This structuredBody SHALL NOT contain Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:31044).

20: Personal And Legal Relationship Role Type

|  |  |  |
| --- | --- | --- |
| Value Set: Personal And Legal Relationship Role Type 2.16.840.1.113883.11.20.12.1  A personal or legal relationship records the role of a person in relation to another person, or a person to himself or herself. This value set is to be used when recording relationships based on personal or family ties or through legal assignment of responsibility.    Specific URL Pending  Valueset Source: [http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary\_tables/infrastructure/vocabulary/vocabulary.html](http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html%20) | | |
| Code | Code System | Print Name |
| ONESELF | RoleCode | self |
| MTH | RoleCode | mother |
| FTH | RoleCode | father |
| DAU | RoleCode | natural daughter |
| SON | RoleCode | natural son |
| DAUINLAW | RoleCode | daughter in-law |
| SONINLAW | RoleCode | son in-law |
| GUARD | RoleCode | guardian |
| HPOWATT | RoleCode | healthcare power of attorney |
| ... | | |

Consultation Note (V2)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.4.2 (open)]

21: Consultation Note (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Advance Directives Section (entries optional) (V2)](#Advance_Directives_Section_entries_opti)  [Allergies Section (entries required) (V2)](#S_Allergies_Section_entries_required_V2)  [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2)  [Assessment Section](#S_Assessment_Section)  [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S)  [Chief Complaint Section](#S_Chief_Complaint_Section)  [Family History Section](#S_Family_History_Section)  [Functional Status Section (V2)](#S_Functional_Status_Section_V2)  [General Status Section](#S_General_Status_Section)  [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2)  [History of Present Illness Section](#S_History_of_Present_Illness_Section)  [Immunizations Section (entries optional) (V2)](#S_Immunizations_Section_entries_optiona)  [Medical Equipment Section (V2)](#S_Medical_Equipment_Section_V2)  [Medications Section (entries required) (V2)](#S_Medications_Section_entries_required_)  [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW)  [Nutrition Section (NEW)](#S_Nutrition_Section_NEW)  [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2)  [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2)  [Problem Section (entries required) (V2)](#S_Problem_Section_entries_required_V2)  [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2)  [Reason for Referral Section (V2)](#Reason_for_Referral_Section_V2)  [Reason for Visit Section](#S_Reason_for_Visit_Section)  [Results Section (entries required) (V2)](#S_Results_Section_entries_required_V2)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Social History Section (V2)](#S_Social_History_Section_V2)  [Vital Signs Section (entries required) (V2)](#S_Vital_Signs_Section_entries_required_) |

Consultation Note is generated as a result of a request from a clinician for an opinion or advice from another clinician. Consultations involve face-to-face time with the patient or may fall under the guidelines for tele-medicine visits. A consultation note includes the reason for the referral, history of present illness, physical examination, and decision-making component (Assessment and Plan).

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:8375) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.4.2" (CONF:10040).
3. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [ConsultDocumentType](#ConsultDocumentType) 2.16.840.1.113883.11.20.9.31 DYNAMIC (CONF:17176).
4. SHALL contain exactly one [1..1] title (<CONF:29837>).

Participants and actRealtionships

#### participant

The participants (contact) represent the clinician to contact for questions about the consultation note. The primary clinician(s) involved in the consultation are included here as contacts.

1. SHOULD contain zero or more [0..\*] participant (CONF:31656).
   1. The participant, if present, SHALL contain exactly one [1..1] @typeCode="CALLBACK" call back contact (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 DYNAMIC) (CONF:31657).
   2. The participant, if present, SHALL contain exactly one [1..1] associatedEntity (CONF:31658).
      1. This associatedEntity SHALL contain exactly one [1..1] @classCode="ASSIGNED" assigned entity (CodeSystem: RoleClass 2.16.840.1.113883.5.110 DYNAMIC) (CONF:31659).
      2. This associatedEntity SHALL contain at least one [1..\*] id (CONF:31660).
      3. This associatedEntity SHOULD contain zero or more [0..\*] addr (CONF:31661).
      4. This associatedEntity SHALL contain at least one [1..\*] telecom (CONF:31662).
      5. This associatedEntity SHALL contain exactly one [1..1] associatedPerson (CONF:31663).
         1. This associatedPerson SHALL contain at least one [1..\*] name (CONF:31664).
      6. This associatedEntity MAY contain zero or one [0..1] scopingOrganization (CONF:31665).

#### inFulfillmentOf

The inFulfillmentOf element describes prior orders that are fulfilled (in whole or part) by the service events described in the Consultation Note.  For example, a prior order might be the the consultation that is being reported in the note.

1. SHALL contain at least one [1..\*] inFulfillmentOf (CONF:8382).
   1. Such inFulfillmentOfs SHALL contain exactly one [1..1] order (CONF:29923).
      1. This order SHALL contain at least one [1..\*] id (CONF:29924).

Figure 16: InFulfillmentOf Sample

<inFulfillmentOf typeCode="FLFS">

<order classCode="ACT" moodCode="RQO">

<id root="2.16.840.1.113883.6.96" extension="1298989898" />

<code code="388975008" displayName="Weight Reduction Consultation" codeSystem="2.16.840.1.113883.6.96" codeSystemName="CPT4" />

</order>

</inFulfillmentOf>

#### componentOf

A Consultation Note is always associated with an encounter; the componentOf element must be present and the encounter must be identified.

1. SHALL contain exactly one [1..1] componentOf (CONF:8386).

CDA R2 requires encompasingEncounter and the id element of the encompassingEncounter is required to be present and represents the identifier for the encounter.

* 1. This componentOf SHALL contain exactly one [1..1] encompassingEncounter (CONF:8387).
     1. This encompassingEncounter SHALL contain exactly one [1..1] id (CONF:8388).
     2. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:8389).
        1. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10132).
     3. This encompassingEncounter MAY contain zero or one [0..1] responsibleParty (CONF:8391).
        1. The responsibleParty element records  only the party responsible for the encounter, not necessarily the entire episode of care (CONF:8393).
        2. The responsibleParty element, if present, SHALL contain an assignedEntity element which SHALL contain an assignedPerson element, a representedOrganization element, or both (CONF:8394).

The encounterParticipant element represents persons who participated in the encounter and not necessarily the entire episode of care.

* + 1. This encompassingEncounter MAY contain zero or more [0..\*] encounterParticipant (CONF:8392).
       1. The encounterParticipant element, if present, records only participants in the encounter, not necessarily in the entire episode of care (CONF:8395).
       2. An encounterParticipant element, if present, SHALL contain an assignedEntity element which SHALL contain an assignedPerson element,  a representedOrganization element, or both (CONF:8396).

Figure 17: ComponentOf Sample

<componentOf>

<encompassingEncounter>

<id extension="9937012" root="2.16.840.1.113883.19" />

<code codeSystem="2.16.840.1.113883.6.12" codeSystemName="CPT-4" code="99213" displayName="Evaluation and Management" />

<effectiveTime>

<low value="20130203" />

<high value="20130203" />

</effectiveTime>

<location>

<healthCareFacility>

<id root="2.16.540.1.113883.19.2" />

</healthCareFacility>

</location>

</encompassingEncounter>

</componentOf>

1. SHALL contain exactly one [1..1] component (CONF:8397).

#### structuredBody

* 1. This component SHALL contain exactly one [1..1] structuredBody (CONF:28895).
     1. This structuredBody MAY contain zero or one [0..1] component (CONF:28896) such that it
        1. SHALL contain exactly one [1..1] [Assessment Section](#S_Assessment_Section) (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:28897).
     2. This structuredBody MAY contain zero or one [0..1] component (CONF:28898) such that it
        1. SHALL contain exactly one [1..1] [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) (CONF:28899).
     3. This structuredBody MAY contain zero or one [0..1] component (CONF:28900) such that it
        1. SHALL contain exactly one [1..1] [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:28901).
     4. This structuredBody MAY contain zero or one [0..1] component (CONF:28902) such that it
        1. SHALL contain exactly one [1..1] [Reason for Referral Section (V2)](#Reason_for_Referral_Section_V2) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.1.2) (CONF:28903).
     5. This structuredBody MAY contain zero or one [0..1] component (CONF:28904) such that it
        1. SHALL contain exactly one [1..1] [Reason for Visit Section](#S_Reason_for_Visit_Section) (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:28905).
     6. This structuredBody SHALL contain exactly one [1..1] component (CONF:28906) such that it
        1. SHALL contain exactly one [1..1] [History of Present Illness Section](#S_History_of_Present_Illness_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:28907).
     7. This structuredBody SHOULD contain zero or one [0..1] component (CONF:28908) such that it
        1. SHALL contain exactly one [1..1] [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2) (templateId:2.16.840.1.113883.10.20.2.10.2) (CONF:28909).
     8. This structuredBody SHALL contain exactly one [1..1] component (CONF:28910) such that it
        1. SHALL contain exactly one [1..1] [Allergies Section (entries required) (V2)](#S_Allergies_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.6.1.2) (CONF:28911).
     9. This structuredBody MAY contain zero or one [0..1] component (CONF:28912) such that it
        1. SHALL contain exactly one [1..1] [Chief Complaint Section](#S_Chief_Complaint_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:28913).
     10. This structuredBody MAY contain zero or one [0..1] component (CONF:28915) such that it
         1. SHALL contain exactly one [1..1] [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S) (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:28916).
     11. This structuredBody MAY contain zero or one [0..1] component (CONF:28917) such that it
         1. SHALL contain exactly one [1..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:28918).
     12. This structuredBody MAY contain zero or one [0..1] component (CONF:28919) such that it
         1. SHALL contain exactly one [1..1] [General Status Section](#S_General_Status_Section) (templateId:2.16.840.1.113883.10.20.2.5) (CONF:28920).
     13. This structuredBody MAY contain zero or one [0..1] component (CONF:28921) such that it
         1. SHALL contain exactly one [1..1] [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.20.2) (CONF:28922).
     14. This structuredBody MAY contain zero or one [0..1] component (CONF:28923) such that it
         1. SHALL contain exactly one [1..1] [Immunizations Section (entries optional) (V2)](#S_Immunizations_Section_entries_optiona) (templateId:2.16.840.1.113883.10.20.22.2.2.2) (CONF:28924).
     15. This structuredBody SHOULD contain zero or one [0..1] component (CONF:28925) such that it
         1. SHALL contain exactly one [1..1] [Medications Section (entries required) (V2)](#S_Medications_Section_entries_required_) (templateId:2.16.840.1.113883.10.20.22.2.1.1.2) (CONF:28926).
     16. This structuredBody SHALL contain exactly one [1..1] component (CONF:28928) such that it
         1. SHALL contain exactly one [1..1] [Problem Section (entries required) (V2)](#S_Problem_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.5.1.2) (CONF:28929).
     17. This structuredBody MAY contain zero or one [0..1] component (CONF:28930) such that it
         1. SHALL contain exactly one [1..1] [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.7.2) (CONF:28931).
     18. This structuredBody SHOULD contain zero or one [0..1] component (CONF:28932) such that it
         1. SHALL contain exactly one [1..1] [Results Section (entries required) (V2)](#S_Results_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.3.1.2) (CONF:28933).
     19. This structuredBody MAY contain zero or one [0..1] component (CONF:28934) such that it
         1. SHALL contain exactly one [1..1] [Social History Section (V2)](#S_Social_History_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:28935).
     20. This structuredBody MAY contain zero or one [0..1] component (CONF:28936) such that it
         1. SHALL contain exactly one [1..1] [Vital Signs Section (entries required) (V2)](#S_Vital_Signs_Section_entries_required_) (templateId:2.16.840.1.113883.10.20.22.2.4.1.2) (CONF:28937).
     21. This structuredBody MAY contain zero or one [0..1] component (CONF:28942) such that it
         1. SHALL contain exactly one [1..1] [Advance Directives Section (entries optional) (V2)](#Advance_Directives_Section_entries_opti) (templateId:2.16.840.1.113883.10.20.22.2.21.2) (CONF:28943).
     22. This structuredBody MAY contain zero or one [0..1] component (CONF:28944) such that it
         1. SHALL contain exactly one [1..1] [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.14.2) (CONF:28945).
     23. This structuredBody MAY contain zero or one [0..1] component (CONF:30237) such that it
         1. SHALL contain exactly one [1..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:30238).
     24. This structuredBody MAY contain zero or one [0..1] component (CONF:30904) such that it
         1. SHALL contain exactly one [1..1] [Medical Equipment Section (V2)](#S_Medical_Equipment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.23.2) (CONF:30905).
     25. This structuredBody MAY contain zero or one [0..1] component (CONF:30906) such that it
         1. SHALL contain exactly one [1..1] [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW) (templateId:2.16.840.1.113883.10.20.22.2.56) (CONF:30907).
     26. This structuredBody MAY contain zero or one [0..1] component (CONF:30909) such that it
         1. SHALL contain exactly one [1..1] [Nutrition Section (NEW)](#S_Nutrition_Section_NEW) (templateId:2.16.840.1.113883.10.20.22.2.57) (CONF:30910).
     27. MAY include an Assessment and Plan Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.9.2) OR both an Assessment Section (templateId: 2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.10.2) (CONF:28938).
     28. SHALL NOT include an Assessment and Plan Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId: 2.16.840.1.113883.10.20.22.2.8) and a Plan of Care Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.10.2) are present (CONF:28939).
     29. SHALL NOT include a Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) with a Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:28940).
     30. SHALL NOT include Reason for Referral Section V2 (templateId: 1.3.6.1.4.1.19376.1.5.3.1.3.1.2)  when a Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) is present (CONF:28941).

Figure 18: Consult Note StructuredBody Sample

<component>

<structuredBody>

<component>

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.6.1.2"/>

<!-- Alergies section template -->

<code code="48765-2" codeSystem="2.16.840.1.113883.6.1"

displayName="Allergies, adverse reactions, alerts" codeSystemName="LOINC"/>

<title>Allergies, Adverse Reactions, Alerts</title>

...

</section>

</component>

<component>

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.8"/>

<!-- Assessment-->

<code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="51848-0"

displayName="ASSESSMENT"/>

<title>ASSESSMENT</title>

...

</section>

</component>

<component>

<section>

<templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.4"/>

<!-- History of Present Illness -->

<code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="10164-2"

displayName="HISTORY OF PRESENT ILLNESS"/>

<title>HISTORY OF PRESENT ILLNESS</title>

...

</section>

</component>

<component>

<section>

<!--MEDICATION SECTION (V2) (coded entries required) -->

<templateId root="2.16.840.1.113883.10.20.22.2.1.1.2"/>

<code code="10160-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="HISTORY OF MEDICATION USE"/>

<title>MEDICATIONS</title>

...

</section>

</component>

<component>

<section>

<templateId root="2.16.840.1.113883.10.20.2.10.2"/>

<!-- Physical Exam (V2) -->

<code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="29545-1"

displayName="PHYSICAL FINDINGS"/>

<title>PHYSICAL EXAMINATION</title>

...

</section>

</component>

<component>

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.10.2"/>

<!-- Plan of Treatment Section (V2) template -->

<code code="18776-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="Treatment plan"/>

<title>PLAN OF CARE</title>

...

</section>

</component>

<component>

<section>

<!-- Problem Section (entries required) (V2) -->

<templateId root="2.16.840.1.113883.10.20.22.2.5.1.2"/>

<code code="11450-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="PROBLEM LIST"/>

<title>PROBLEMS</title>

...

</section>

</component>

<component>

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.7.2"/>

<!-- Procedures Section (entries optional) (V2) -->

<code code="47519-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="HISTORY OF PROCEDURES"/>

<title>PROCEDURES</title>

...

</section>

</component>

<component>

<section>

<templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.1.2"/>

<!-- Reason for Referral Section V2 -->

<code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="42349-1"

displayName="REASON FOR REFERRAL"/>

<title>REASON FOR REFERRAL</title>

...

</section>

</component>

<component>

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.3.1.2"/>

<!-- Results Section (entries required) (V2) -->

<code code="30954-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="RESULTS"/>

<title>RESULTS</title>

...

</section>

</component>

<component>

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.17.2"/>

<!-- Social history section(V2)-->

<code code="29762-2" codeSystem="2.16.840.1.113883.6.1"

displayName="Social History"/>

<title>SOCIAL HISTORY</title>

...

</section>

</component>

<component>

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.4.1.2"/>

<!-- Vital Signs-->

<code code="8716-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="VITAL SIGNS"/>

<title>VITAL SIGNS</title>

...

</section>

</component>

</structuredBody>

</component>

</ClinicalDocument>

23: ConsultDocumentType

|  |  |  |
| --- | --- | --- |
| Value Set: ConsultDocumentType 2.16.840.1.113883.11.20.9.31  A Consultation Note is provided to a referring physician or provider and contains reason for the referral, history of present illness, physical examination, and decision-making components. | | |
| Code | Code System | Print Name |
| 11488-4 | LOINC | {Provider} |
| 34100-8 | LOINC | {Provider} |
| 34104-0 | LOINC | {Provider} |
| 51845-6 | LOINC | {Provider} |
| 51853-0 | LOINC | {Provider} |
| 51846-4 | LOINC | {Provider} |
| 34101-6 | LOINC | General medicine |
| 34749-2 | LOINC | Anesthesia |
| 34102-4 | LOINC | Psychiatry |
| 34099-2 | LOINC | Cardiology |
| ... | | |

Continuity of Care Document (CCD) (V2)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.2.2 (open)]

24: Continuity of Care Document (CCD) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Advance Directives Section (entries optional) (V2)](#Advance_Directives_Section_entries_opti)  [Allergies Section (entries required) (V2)](#S_Allergies_Section_entries_required_V2)  [Encounters Section (entries optional) (V2)](#S_Encounters_Section_entries_optional_V)  [Family History Section](#S_Family_History_Section)  [Functional Status Section (V2)](#S_Functional_Status_Section_V2)  [Immunizations Section (entries required) (V2)](#S_Immunizations_Section_entries_require)  [Medical Equipment Section (V2)](#S_Medical_Equipment_Section_V2)  [Medications Section (entries required) (V2)](#S_Medications_Section_entries_required_)  [Payers Section (V2)](#S_Payers_Section_V2)  [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2)  [Problem Section (entries required) (V2)](#S_Problem_Section_entries_required_V2)  [Procedures Section (entries required) (V2)](#S_Procedures_Section_entries_required_V)  [Results Section (entries required) (V2)](#S_Results_Section_entries_required_V2)  [Social History Section (V2)](#S_Social_History_Section_V2)  [Vital Signs Section (entries required) (V2)](#S_Vital_Signs_Section_entries_required_) |

The Continuity of Care Document (CCD) represents a core data set of the most relevant administrative, demographic, and clinical information facts about a patient's healthcare, covering one or more healthcare encounters. It provides a means for one healthcare practitioner, system, or setting to aggregate all of the pertinent data about a patient and forward it to another to support the continuity of care.

The primary use case for the CCD is to provide a snapshot in time containing the germane clinical, demographic, and administrative data for a specific patient. More specific use cases, such as a Discharge Summary or Progress Note, are available as alternative documents in this guide.

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:8450) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.2.2" (CONF:10038).

In accordance with the CDA specification, the ClinicalDocument/code element must be present and specify the type of the clinical document. CCD requires the document type code 34133-9 "Summarization of Episode Note".

1. SHALL contain exactly one [1..1] code (CONF:17180).
   1. This code SHALL contain exactly one [1..1] @code="34133-9" Summarization of Episode Note (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:17181).
2. SHALL contain at least one [1..\*] author (CONF:9442).
   1. Such authors SHALL contain exactly one [1..1] assignedAuthor (CONF:9443).
      1. SHALL contain exactly one 1..1] assignedPerson or exactly one 1..1]  representedOrganization (CONF:8456).
      2. If assignedAuthor has an associated representedOrganization with no assignedPerson or assignedAuthoringDevice, then the value for “ClinicalDocument/author/assignedAuthor/id/@NullFlavor” SHALL be “NA” “Not applicable” 2.16.840.1.113883.5.1008 NullFlavor STATIC (CONF:8457).
3. SHALL contain exactly one [1..1] documentationOf (CONF:8452).
   1. This documentationOf SHALL contain exactly one [1..1] serviceEvent (CONF:8480).
      1. This serviceEvent SHALL contain exactly one [1..1] @classCode="PCPR" Care Provision (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8453).
      2. This serviceEvent SHALL contain exactly one [1..1] effectiveTime (CONF:8481).
         1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:8454).
         2. This effectiveTime SHALL contain exactly one [1..1] high (CONF:8455).

serviceEvent/performer represents the healthcare providers involved in the current or pertinent historical care of the patient. Preferably, the patient’s key healthcare providers would be listed, particularly their primary physician and any active consulting physicians, therapists, and counselors

* + 1. This serviceEvent SHOULD contain zero or more [0..\*] performer (CONF:8482).
       1. The performer, if present, SHALL contain exactly one [1..1] @typeCode="PRF" Participation physical performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8458).
       2. The performer, if present, MAY contain zero or one [0..1] assignedEntity (CONF:8459).
          1. The assignedEntity, if present, SHALL contain at least one [1..\*] id (CONF:8460).

SHOULD include zero or one 0..1] id where id/@root ="2.16.840.1.113883.4.6" National Provider Identifier (CONF:10027).

* + - * 1. The assignedEntity, if present, SHOULD contain zero or one [0..1] id (CONF:30882) such that it

SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:30883).

* + - * 1. The assignedEntity, if present, MAY contain zero or one [0..1] code (CONF:8461).

I.  The code MAY be the NUCC Health Care Provider Taxonomy (CodeSystem: 2.16.840.1.113883.6.101). (See http://www.nucc.org) (CONF:8462).

1. SHALL contain exactly one [1..1] component (CONF:30659).
   1. This component SHALL contain exactly one [1..1] structuredBody (CONF:30660).
      1. This structuredBody SHALL contain exactly one [1..1] component (CONF:30661) such that it
         1. SHALL contain exactly one [1..1] [Allergies Section (entries required) (V2)](#S_Allergies_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.6.1.2) (CONF:30662).
      2. This structuredBody SHALL contain exactly one [1..1] component (CONF:30663) such that it
         1. SHALL contain exactly one [1..1] [Medications Section (entries required) (V2)](#S_Medications_Section_entries_required_) (templateId:2.16.840.1.113883.10.20.22.2.1.1.2) (CONF:30664).
      3. This structuredBody SHALL contain exactly one [1..1] component (CONF:30665) such that it
         1. SHALL contain exactly one [1..1] [Problem Section (entries required) (V2)](#S_Problem_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.5.1.2) (CONF:30666).
      4. This structuredBody SHALL contain exactly one [1..1] component (CONF:30667) such that it
         1. SHALL contain exactly one [1..1] [Procedures Section (entries required) (V2)](#S_Procedures_Section_entries_required_V) (templateId:2.16.840.1.113883.10.20.22.2.7.1.2) (CONF:30668).
      5. This structuredBody SHALL contain exactly one [1..1] component (CONF:30669) such that it
         1. SHALL contain exactly one [1..1] [Results Section (entries required) (V2)](#S_Results_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.3.1.2) (CONF:30670).
      6. This structuredBody MAY contain zero or one [0..1] component (CONF:30671) such that it
         1. SHALL contain exactly one [1..1] [Advance Directives Section (entries optional) (V2)](#Advance_Directives_Section_entries_opti) (templateId:2.16.840.1.113883.10.20.22.2.21.2) (CONF:30672).
      7. This structuredBody MAY contain zero or one [0..1] component (CONF:30673) such that it
         1. SHALL contain exactly one [1..1] [Encounters Section (entries optional) (V2)](#S_Encounters_Section_entries_optional_V) (templateId:2.16.840.1.113883.10.20.22.2.22.2) (CONF:30674).
      8. This structuredBody MAY contain zero or one [0..1] component (CONF:30675) such that it
         1. SHALL contain exactly one [1..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:30676).
      9. This structuredBody MAY contain zero or one [0..1] component (CONF:30677) such that it
         1. SHALL contain exactly one [1..1] [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.14.2) (CONF:30678).
      10. This structuredBody MAY contain zero or one [0..1] component (CONF:30679) such that it
          1. SHALL contain exactly one [1..1] [Immunizations Section (entries required) (V2)](#S_Immunizations_Section_entries_require) (templateId:2.16.840.1.113883.10.20.22.2.2.1.2) (CONF:30680).
      11. This structuredBody MAY contain zero or one [0..1] component (CONF:30681) such that it
          1. SHALL contain exactly one [1..1] [Medical Equipment Section (V2)](#S_Medical_Equipment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.23.2) (CONF:30682).
      12. This structuredBody MAY contain zero or one [0..1] component (CONF:30683) such that it
          1. SHALL contain exactly one [1..1] [Payers Section (V2)](#S_Payers_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.18.2) (CONF:30684).
      13. This structuredBody SHOULD contain zero or one [0..1] component (CONF:30685) such that it
          1. SHALL contain exactly one [1..1] [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30686).
      14. This structuredBody SHALL contain exactly one [1..1] component (CONF:30687) such that it
          1. SHALL contain exactly one [1..1] [Social History Section (V2)](#S_Social_History_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:30688).
      15. This structuredBody SHALL contain exactly one [1..1] component (CONF:30689) such that it
          1. SHALL contain exactly one [1..1] [Vital Signs Section (entries required) (V2)](#S_Vital_Signs_Section_entries_required_) (templateId:2.16.840.1.113883.10.20.22.2.4.1.2) (CONF:30690).

Diagnostic Imaging Report (V2)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.5.2 (open)]

26: Diagnostic Imaging Report (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Code Observations](#E_Code_Observations)  [DICOM Object Catalog Section - DCM 121181](#S_DICOM_Object_Catalog_Section__DCM_121)  [Fetus Subject Context](#S_Fetus_Subject_Context)  [Findings Section (DIR)](#S_Findings_Section_DIR)  [Observer Context](#S_Observer_Context)  [Physician of Record Participant (V2)](#E_Physician_of_Record_Participant_V2)  [Physician Reading Study Performer (V2)](#U_Physician_Reading_Study_Performer_V2)  [Procedure Context](#E_Procedure_Context)  [Quantity Measurement Observation](#E_Quantity_Measurement_Observation)  [SOP Instance Observation](#E_SOP_Instance_Observation)  [Text Observation](#E_Text_Observation)  [US Realm Person Name (PN.US.FIELDED)](#U_US_Realm_Person_Name_PNUSFIELDED) |

A Diagnostic Imaging Report (DIR) is a document that contains a consulting specialist’s interpretation of image data.  It conveys the interpretation to the referring (ordering) physician and becomes part of the patient’s medical record.  It is for use in Radiology, Endoscopy, Cardiology, and other imaging specialties.

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:8404) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.5.2" (CONF:10042).
3. SHALL contain exactly one [1..1] id (CONF:30932).
   1. This id SHALL contain exactly one [1..1] @root (CONF:30933).

OIDs SHALL be represented in dotted decimal notation, where each decimal number is either 0 or starts with a nonzero digit. More formally, an OID SHALL be in the form (0-2])(.(1-9]0-9]\*|0))+

* + 1. The ClinicalDocument/id/@root attribute SHALL be a syntactically correct OID, and SHALL NOT be a UUID (CONF:30934).
    2. OIDs SHALL be no more than 64 characters in length (CONF:30935).

Given that DIR documents may be transformed from established collections of imaging reports already stored with their own type codes, there is no static set of Document Type codes. The set of LOINC codes listed in the DIR LOINC Document Type Codes table may be extended by additions to LOINC and supplemented by local codes as translations.

The DIR document recommends use of a single document type code, 18748-4 "Diagnostic Imaging Report", with further specification provided by author or performer, setting, or specialty. Some of these codes in the DIR LOINC Document Type Codes table are pre-coordinated with either the imaging modality, body part examined, or specific imaging method such as the view. Use of these codes is not recommended, as this duplicates information potentially present with the header. When pre-coordinated codes are used, any coded values describing the author or performer of the service act or the practice setting must be consistent with the LOINC document type. This table is drawn from LOINC Version 2.36, June 30, 2011, and consists of codes whose scale is DOC and that refer to reports for diagnostic imaging procedures.

1. SHALL contain exactly one [1..1] code (CONF:14833).
   1. This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet [DIRDocumentTypeCodes](#DIRDocumentTypeCodes) 2.16.840.1.113883.11.20.9.32 DYNAMIC (CONF:14834).
2. SHALL NOT contain [0..0] informant (CONF:8410).
3. MAY contain zero or more [0..\*] informationRecipient (CONF:8411).
   1. The physician requesting the imaging procedure (ClincalDocument/participant@typeCode=REF]/associatedEntity), if present, SHOULD also be recorded as an informationRecipient, unless in the local setting another physician (such as the attending physician for an inpatient) is known to be the appropriate recipient of the report (CONF:8412).
   2. When no referring physician is present, as in the case of self-referred screening examinations allowed by law, the intendedRecipient MAY be absent. The intendedRecipient MAY also be the health chart of the patient, in which case the receivedOrganization SHALL be the scoping organization of that chart (CONF:8413).

  If participant is present, the associatedEntity/associatedPerson element SHALL be present and SHALL represent the physician requesting the imaging procedure (the referring physician AssociatedEntity that is the target of ClincalDocument/participant@typeCode=REF).

1. MAY contain zero or one [0..1] participant (CONF:8414) such that it
   1. SHALL contain exactly one [1..1] associatedEntity (CONF:31198).
      1. This associatedEntity SHALL contain exactly one [1..1] associatedPerson (CONF:31199).
         1. This associatedPerson SHALL contain exactly one [1..1] [US Realm Person Name (PN.US.FIELDED)](#U_US_Realm_Person_Name_PNUSFIELDED) (templateId:2.16.840.1.113883.10.20.22.5.1.1) (CONF:31200).

An inFulfillmentOf element represents the Placer Order that is either a group of orders (modeled as PlacerGroup in the Placer Order RMIM of the Orders & Observations domain) or a single order item (modeled as ObservationRequest in the same RMIM). This optionality reflects two major approaches to the grouping of procedures as implemented in the installed base of imaging information systems. These approaches differ in their handling of grouped procedures and how they are mapped to identifiers in the Digital Imaging and Communications in Medicine (DICOM) image and structured reporting data. The example of a CT examination covering chest, abdomen, and pelvis will be used in the discussion below.

In the IHE Scheduled Workflow model, the Chest CT, Abdomen CT, and Pelvis CT each represent a Requested Procedure, and all three procedures are grouped under a single Filler Order. The Filler Order number maps directly to the DICOM Accession Number in the DICOM imaging and report data.

A widely deployed alternative approach maps the requested procedure identifiers directly to the DICOM Accession Number. The Requested Procedure ID in such implementations may or may not be different from the Accession Number, but is of little identifying importance because there is only one Requested Procedure per Accession Number. There is no identifier that formally connects the requested procedures ordered in this group.

1. MAY contain zero or more [0..\*] inFulfillmentOf (CONF:30936).
   1. The inFulfillmentOf, if present, SHALL contain exactly one [1..1] order (CONF:30937).

inFulfillmentOf/order/id is mapped to the DICOM Accession Number in the imaging data.

* + 1. This order SHALL contain at least one [1..\*] id (CONF:30938).

Each documentationOf/serviceEvent indicates an imaging procedure that the provider describes and interprets in the content of the DIR. The main activity being described by this document is the interpretation of the imaging procedure. This is shown by setting the value of the @classCode attribute of the serviceEvent element to ACT, and indicating the duration over which care was provided in the effectiveTime element. Within each documentationOf element, there is one serviceEvent element. This event is the unit imaging procedure corresponding to a billable item. The type of imaging procedure may be further described in the serviceEvent/code element. This guide makes no specific recommendations about the vocabulary to use for describing this event.

In IHE Scheduled Workflow environments, one serviceEvent/id element contains the DICOM Study Instance UID from the Modality Worklist, and the second serviceEvent/id element contains the DICOM Requested Procedure ID from the Modality Worklist. These two ids are in a single serviceEvent.

The effectiveTime for the serviceEvent covers the duration of the imaging procedure being reported. This event should have one or more performers, which may participate at the same or different periods of time.

Service events map to DICOM Requested Procedures. That is, documentationOf/serviceEvent/id is the ID of the Requested Procedure.

1. SHALL contain exactly one [1..1] documentationOf (CONF:8416) such that it
   1. SHALL contain exactly one [1..1] serviceEvent (CONF:8431).
      1. This serviceEvent SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8430).
      2. This serviceEvent SHOULD contain zero or more [0..\*] id (CONF:8418).
      3. This serviceEvent SHALL contain exactly one [1..1] code (CONF:8419).
         1. The value of serviceEvent/code SHALL NOT conflict with the ClininicalDocument/code. When transforming from DICOM SR documents that do not contain a procedure code, an appropriate nullFlavor SHALL be used on serviceEvent/code (CONF:8420).
      4. This serviceEvent SHOULD contain zero or more [0..\*] [Physician Reading Study Performer (V2)](#U_Physician_Reading_Study_Performer_V2) (templateId:2.16.840.1.113883.10.20.6.2.1.2) (CONF:8422).

A DIR may have three types of parent document:

• A superseded version that the present document wholly replaces (typeCode = RPLC). DIRs may go through stages of revision prior to being legally authenticated. Such early stages may be drafts from transcription, those created by residents, or other preliminary versions. Policies not covered by this specification may govern requirements for retention of such earlier versions. Except for forensic purposes, the latest version in a chain of revisions represents the complete and current report.

• An original version that the present document appends (typeCode = APND). When a DIR is legally authenticated, it can be amended by a separate addendum document that references the original.

• A source document from which the present document is transformed (typeCode = XFRM). A DIR may be created by transformation from a DICOM Structured Report (SR) document or from another DIR. An example of the latter case is the creation of a derived document for inclusion of imaging results in a clinical document.

1. MAY contain zero or one [0..1] relatedDocument (CONF:8432) such that it
   1. When a Diagnostic Imaging Report has been transformed from a DICOM SR document, relatedDocument/@typeCode SHALL be XFRM, and relatedDocument/parentDocument/id SHALL contain the SOP Instance UID of the original DICOM SR document (CONF:8433).
   2. SHALL contain exactly one [1..1] id (CONF:10030).
      1. OIDs SHALL be represented in dotted decimal notation, where each decimal number is either 0 or starts with a nonzero digit. More formally, an OID SHALL be in the form (0-2])(.(1-9]0-9]**|0))+** (CONF:10031).
      2. OIDs SHALL be no more than 64 characters in length (CONF:10032).

The id element of the encompassingEncounter represents the identifier for the encounter. When the diagnostic imaging procedure is performed in the context of a hospital stay or an outpatient visit for which there is an Encounter Number, that number should be present as the ID of the encompassingEncounter.

The effectiveTime represents the time interval or point in time in which the encounter took place. The encompassing encounter might be that of the hospital or office visit in which the diagnostic imaging procedure was performed. If the effective time is unknown, a nullFlavor attribute can be used.

1. MAY contain zero or one [0..1] componentOf (CONF:30939).
   1. The componentOf, if present, SHALL contain exactly one [1..1] encompassingEncounter (CONF:30940).
      1. This encompassingEncounter SHALL contain at least one [1..\*] id (CONF:30941).
         1. In the case of transformed DICOM SR documents, an appropriate null flavor MAY be used if the id is unavailable (CONF:30942).
      2. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:30943).
         1. This effectiveTime SHALL contain exactly one 1..1] US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:30944).
      3. This encompassingEncounter MAY contain zero or one [0..1] responsibleParty (CONF:30945).
         1. The responsibleParty, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:30946).
            1. SHOULD contain zero or one 0..1] assignedPerson OR contain zero or one 0..1] representedOrganization (CONF:30947).
      4. This encompassingEncounter SHOULD contain zero or one [0..1] [Physician of Record Participant (V2)](#E_Physician_of_Record_Participant_V2) (templateId:2.16.840.1.113883.10.20.6.2.2.2) (CONF:30948).
2. SHALL contain exactly one [1..1] component (CONF:14907).
   1. This component SHALL contain exactly one [1..1] structuredBody (CONF:30695).
      1. This structuredBody SHALL contain exactly one [1..1] component (CONF:30696) such that it
         1. SHALL contain exactly one [1..1] [Findings Section (DIR)](#S_Findings_Section_DIR) (templateId:2.16.840.1.113883.10.20.6.1.2) (CONF:30697).
      2. This structuredBody SHOULD contain zero or one [0..1] component (CONF:30698) such that it
         1. SHALL contain exactly one [1..1] [DICOM Object Catalog Section - DCM 121181](#S_DICOM_Object_Catalog_Section__DCM_121) (templateId:2.16.840.1.113883.10.20.6.1.1) (CONF:30699).
            1. The DICOM Object Catalog section (templateId 2.16.840.1.113883.10.20.6.1.1), if present, SHALL be the first section in the document Body (CONF:31206).

A Diagnostic Imaging Report may contain CDA entries that represent, in coded form findings, image references, annotation, and numeric measurements based on DICOM Basic Diagnostic Imaging Report (Template 2000) and Transcribed Diagnostic Imaging Report (Template 2005). Most of the constraints for this document have been inherited from the DICOM PS 3.20 “Transformation of DICOM to and from HL7 Standards”.

This document type and the companion DICOM PS 3.20 “Transformation of DICOM to and from HL7 Standards  guidefurther constrain the transformation because image Spatial Coordinates region of interest (SCOORD) for linear, area, and volume measurements are not encoded in the CDA document.  If it is desired to show images with such graphical annotations, the annotations should be encoded in DICOM Softcopy Presentation State objects that reference the image.  Report applications that display referenced images and annotation should retrieve a rendered image using a WADO reference, including the image and Presentation State, or other DICOM retrieval and rendering methods.  This approach avoids the risks of errors in registering a region of interest annotation with DICOM images.

DICOM Template 2000 defines imaging report documents that are comprised of a number of optional sections.

* + 1. This structuredBody MAY contain zero or more [0..\*] component (CONF:31055) such that it
       1. SHALL contain exactly one [1..1] section (CONF:31056).
          1. This section SHALL contain exactly one [1..1] code (CONF:31057).

For sections listed in the DIR Section Type Codes table, the code element must contain a LOINC code or DCM code for sections that have no LOINC equivalent

This code SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet [DIRSectionTypeCodes](#DIRSectionTypeCodes) 2.16.840.1.113883.11.20.9.59 DYNAMIC (CONF:31207).  
Note: The section/code SHOULD be selected from LOINC or DICOM for sections not listed in the DIR Section Type Codes table

There is no equivalent to section/title in DICOM SR, so for a CDA to SR transformation, the section/code will be transferred and the title element will be dropped.

* + - * 1. This section SHOULD contain zero or one [0..1] title (CONF:31058).
        2. This section SHOULD contain zero or one [0..1] text (CONF:31059).

If clinical statements are present, the section/text SHALL represent faithfully all such statements and MAY contain additional text (CONF:31060).

All text elements SHALL contain content. Text elements SHALL contain PCDATA or child elements (CONF:31061).

The text elements (and their children) MAY contain Web Access to DICOM Persistent Object (WADO) references to DICOM objects by including a linkHtml element where @href is a valid WADO URL and the text content of linkHtml is the visible text of the hyperlink (CONF:31062).

This subject is used if the subject of a section is a fetus. The information on the mother is in the CDA header.

* + - * 1. This section MAY contain zero or more [0..\*] subject (CONF:31215) such that it

SHALL contain exactly one [1..1] [Fetus Subject Context](#S_Fetus_Subject_Context) (templateId:2.16.840.1.113883.10.20.6.2.3) (CONF:31216).

This author element is used when the author of a section is different from the author(s) listed in the Header

* + - * 1. This section MAY contain zero or more [0..\*] author (CONF:31217) such that it

SHALL contain exactly one [1..1] [Observer Context](#S_Observer_Context) (templateId:2.16.840.1.113883.10.20.6.2.4) (CONF:31218).

If the service context of a section is different from the value specified in documentationOf/serviceEvent, then the section SHALL contain one or more entries containing Procedure Context (templateId 2.16.840.1.113883.10.20.6.2.5), which will reset the context for any clinical statements nested within those elements

* + - * 1. This section MAY contain zero or more [0..\*] entry (CONF:31213) such that it

SHALL contain exactly one [1..1] [Procedure Context](#E_Procedure_Context) (templateId:2.16.840.1.113883.10.20.6.2.5) (CONF:31214).

* + - * 1. This section MAY contain zero or more [0..\*] entry (CONF:31357) such that it

SHALL contain exactly one [1..1] [Text Observation](#E_Text_Observation) (templateId:2.16.840.1.113883.10.20.6.2.12) (CONF:31358).

* + - * 1. This section MAY contain zero or more [0..\*] entry (CONF:31359) such that it

SHALL contain exactly one [1..1] [Code Observations](#E_Code_Observations) (templateId:2.16.840.1.113883.10.20.6.2.13) (CONF:31360).

* + - * 1. This section MAY contain zero or more [0..\*] entry (CONF:31361) such that it

SHALL contain exactly one [1..1] [Quantity Measurement Observation](#E_Quantity_Measurement_Observation) (templateId:2.16.840.1.113883.10.20.6.2.14) (CONF:31362).

* + - * 1. This section MAY contain zero or more [0..\*] entry (CONF:31363) such that it

SHALL contain exactly one [1..1] [SOP Instance Observation](#E_SOP_Instance_Observation) (templateId:2.16.840.1.113883.10.20.6.2.8) (CONF:31364).

* + - * 1. This section MAY contain zero or more [0..\*] component (CONF:31208).

SHALL contain child elements (CONF:31210).

* + - * 1. All sections defined in the DIR Section Type Codes table SHALL be top-level sections (CONF:31211).
        2. SHALL contain at least one text element or one or more component elements (CONF:31212).

28: DIRDocumentTypeCodes

|  |  |  |
| --- | --- | --- |
| Value Set: DIRDocumentTypeCodes 2.16.840.1.113883.11.20.9.32  This is the set of LOINC (http://www.loinc.org/) codes used for DIR Document Types. The set of LOINC codes listed in this table may be extended by additions to LOINC and supplemented by local codes as translations.    This table is drawn from LOINC Version 2.36, June 30, 2011, and consists of codes whose scale is DOC and that refer to reports for diagnostic imaging procedures.  Valueset Source: <http://www.loinc.org/> | | |
| Code | Code System | Print Name |
| 18748-4 | LOINC | Diagnostic Imaging Report |
| 18747-6 | LOINC | CT Report |
| 18755-9 | LOINC | MRI Report |
| 18760-9 | LOINC | Ultrasound Report |
| 18757-5 | LOINC | Nuclear Medicine Report |
| 18758-3 | LOINC | PET Scan Report |
| 18745-0 | LOINC | Cardiac Catheterization Report |
| 11522-0 | LOINC | Echocardiography Report |
| 18746-8 | LOINC | Colonoscopy Report |
| 18751-8 | LOINC | Endoscopy Report |
| ... | | |

29: DIRSectionTypeCodes

|  |  |  |
| --- | --- | --- |
| Value Set: DIRSectionTypeCodes 2.16.840.1.113883.11.20.9.59  The Section Type codes used by DIR are all narrative document sections. The codes in this table are drawn from LOINC (http://www.loinc.org/) and DICOM (http://medical.nema.org/). The section/code should be selected from LOINC or DICOM for sections not listed in this table.  Valueset Source: <http://www.loinc.org/> | | |
| Code | Code System | Print Name |
| 121181 | DCM | DICOM Object Catalog |
| 121060 | DCM | History |
| 121062 | DCM | Request |
| 121064 | DCM | Current Procedure Descriptions |
| 121066 | DCM | Prior Procedure Descriptions |
| 121068 | DCM | Previous Findings |
| 121070 | DCM | Findings (DIR) |
| 121072 | DCM | Impressions |
| 121074 | DCM | Recommendations |
| 121076 | DCM | Conclusions |
| ... | | |

Figure 19: Diagnostic Imaging Report Example

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

CDA Header

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

<realmCode code="US"/>

<typeId root="2.16.840.1.113883.1.3" extension="POCD\_HD000040"/>

<!-- US General Header Template -->

<templateId root="2.16.840.1.113883.10.20.22.1.1.2"/>

<!-- Diagnostic Imaging Report Template -->

<templateId root="2.16.840.1.113883.10.20.22.1.5.2"/>

<id root="2.16.840.1.113883.19.4.27" extension="20060828170821659"/>

<code code="18748-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="Diagnostic Imaging Report"/>

<title>Chest X-Ray, PA and LAT View</title>

<effectiveTime value="20050329171504+0500"/>

<confidentialityCode code="N" codeSystem="2.16.840.1.113883.5.25"/>

<languageCode code="en-US"/>

<setId extension="111199021" root="2.16.840.1.113883.19"/>

<versionNumber value="1"/>

<recordTarget>

<!--NEW CONF per base CDA - patientRole SHALL be present of [1..\*]-->

<patientRole>

<id extension="12345" root="2.16.840.1.113883.19.5"/>

<addr use="HP">

<streetAddressLine>17 Daws Rd.</streetAddressLine>

<city>Blue Bell</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

<telecom value="tel:(781)555-1212" use="HP"/>

<patient>

<name use="L">

<given>Adam</given>

<family>Everyman</family>

</name>

<administrativeGenderCode code="M" codeSystem="2.16.840.1.113883.5.1"/>

<birthTime value="19541125"/>

<maritalStatusCode code="M" displayName="Married" codeSystem="2.16.840.1.113883.5.2"

codeSystemName="MaritalStatusCode"/>

<religiousAffiliationCode code="1013" displayName="Christian"

codeSystemName="HL7 Religious Affiliation "

codeSystem="2.16.840.1.113883.5.1076"/>

<raceCode code="2106-3" displayName="White" codeSystem="2.16.840.1.113883.6.238"

codeSystemName="Race &amp; Ethnicity - CDC"/>

<ethnicGroupCode code="2186-5" displayName="Not Hispanic or Latino"

codeSystem="2.16.840.1.113883.6.238" codeSystemName="Race &amp; Ethnicity - CDC"/>

<guardian>

<code code="GRFTH" displayName="Grandfather"

codeSystem="2.16.840.1.113883.5.111" codeSystemName="HL7 Role code"/>

<addr use="HP">

<streetAddressLine>17 Daws Rd.</streetAddressLine>

<city>Blue Bell</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

<telecom value="tel:(781)555-1212" use="HP"/>

<guardianPerson>

<name>

<given>Ralph</given>

<family>Relative</family>

</name>

</guardianPerson>

</guardian>

<birthplace>

<place>

<addr>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

</place>

</birthplace>

<languageCommunication>

<languageCode code="fr-CN"/>

<modeCode code="RWR" displayName="Received Written"

codeSystem="2.16.840.1.113883.5.60" codeSystemName="LanguageAbilityMode"/>

<proficiencyLevelCode code="G" displayName="Good"

codeSystem="2.16.840.1.113883.5.61"

codeSystemName="LanguageAbilityProficiency"/>

<preferenceInd value="true"/>

</languageCommunication>

</patient>

<providerOrganization>

<id root="2.16.840.1.113883.19.5"/>

<name>Good Health Clinic</name>

<telecom value="tel:(781)555-1212" use="WP"/>

<addr>

<streetAddressLine>21 North Ave</streetAddressLine>

<city>Burlington</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

</providerOrganization>

</patientRole>

</recordTarget>

<author>

<time value="20050329224411+0500"/>

<assignedAuthor>

<id extension="KP00017" root="2.16.840.1.113883.4.6"/>

<code code="200000000X" codeSystem="2.16.840.1.113883.6.101"

displayName="Allopathic &amp; Osteopathic Physicians"/>

<addr>

<streetAddressLine>21 North Ave.</streetAddressLine>

<city>Burlington</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

<telecom value="tel:(555)555-1003" use="WP"/>

<assignedPerson>

<name>

<given>Henry</given>

<family>Seven</family>

</name>

</assignedPerson>

</assignedAuthor>

</author>

<dataEnterer>

<assignedEntity>

<id root="2.16.840.1.113883.19.5" extension="43252"/>

<addr>

<streetAddressLine>21 North Ave.</streetAddressLine>

<city>Burlington</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

<telecom value="tel:(555)555-1003" use="WP"/>

<assignedPerson>

<name>

<given>Henry</given>

<family>Seven</family>

</name>

</assignedPerson>

</assignedEntity>

</dataEnterer>

<custodian>

<assignedCustodian>

<representedCustodianOrganization>

<id root="2.16.840.1.113883.19.5"/>

<name>Good Health Clinic</name>

<telecom value="tel:(555)555-1212" use="WP"/>

<addr use="WP">

<streetAddressLine>17 Daws Rd.</streetAddressLine>

<city>Blue Bell</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

</representedCustodianOrganization>

</assignedCustodian>

</custodian>

<informationRecipient>

<intendedRecipient>

<informationRecipient>

<name>

<given>Henry</given>

<family>Seven</family>

</name>

</informationRecipient>

<receivedOrganization>

<name>Good Health Clinic</name>

</receivedOrganization>

</intendedRecipient>

</informationRecipient>

<legalAuthenticator>

<time value="20050329224411+0500"/>

<signatureCode code="S"/>

<assignedEntity>

<id extension="KP00017" root="2.16.840.1.113883.19.5"/>

<addr>

<streetAddressLine>21 North Ave.</streetAddressLine>

<city>Burlington</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

<telecom value="tel:(555)555-1003" use="WP"/>

<assignedPerson>

<name>

<given>Henry</given>

<family>Seven</family>

</name>

</assignedPerson>

</assignedEntity>

</legalAuthenticator>

<authenticator>

<time value="20050329224411+0500"/>

<signatureCode code="S"/>

<assignedEntity>

<id extension="KP00017" root="2.16.840.1.113883.19.5"/>

<addr>

<streetAddressLine>21 North Ave.</streetAddressLine>

<city>Burlington</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

<telecom value="tel:(555)555-1003" use="WP"/>

<assignedPerson>

<name>

<given>Henry</given>

<family>Seven</family>

</name>

</assignedPerson>

</assignedEntity>

</authenticator>

<participant typeCode="REF">

<associatedEntity classCode="PROV">

<id nullFlavor="NI"/>

<addr nullFlavor="NI"/>

<telecom nullFlavor="NI"/>

<associatedPerson>

<name>

<given>Amanda</given>

<family>Assigned</family>

<suffix>MD</suffix>

</name>

</associatedPerson>

</associatedEntity>

</participant>

<inFulfillmentOf>

<order>

<id extension="10523475" root="1.2.840.113619.2.62.994044785528.27"/>

<!-- {root}.27 of accession number added based on organizational policy (not present in SR sample document because root is not specified by DICOM)-->

<id extension="123452" root="1.2.840.113619.2.62.994044785528.28"/>

<!-- {root}.28 of filler order number added based on organizational policy (not present in SR sample document because root is not specified by DICOM)-->

<id extension="123451" root="1.2.840.113619.2.62.994044785528.29"/>

<!-- {root}.29 of placer order number added based on organizational policy (not present in SR sample document because root is not specified by DICOM)-->

</order>

</inFulfillmentOf>

<documentationOf>

<serviceEvent classCode="ACT">

<id root="1.2.840.113619.2.62.994044785528.114289542805"/>

<!-- study instance UID -->

<id extension="123453" root="1.2.840.113619.2.62.994044785528.26"/>

<!-- {root}.26 of requested procedure ID added based on organizational policy (not present in SR sample document because root is not specified by DICOM)-->

<code code="70544"

displayName="Magnetic resonance angiography, head; without contrast material(s)"

codeSystem="2.16.840.1.113883.6.12" codeSystemName="CPT4"/>

<effectiveTime>

<low value="20060823222400"/>

</effectiveTime>

<performer typeCode="PRF">

<templateId root="2.16.840.1.113883.10.20.6.2.1"/>

<assignedEntity>

<id extension="121008" root="2.16.840.1.113883.19.5"/>

<code code="2085R0202X" codeSystem="2.16.840.1.113883.6.101"

codeSystemName="NUCC" displayName="Diagnostic Radiology"/>

<addr nullFlavor="NI"/>

<telecom nullFlavor="NI"/>

<assignedPerson>

<name>

<given>Christine</given>

<family>Cure</family>

<suffix>MD</suffix>

</name>

</assignedPerson>

</assignedEntity>

</performer>

</serviceEvent>

</documentationOf>

<!-- transformation of a DICOM SR -->

<relatedDocument typeCode="XFRM">

<parentDocument>

<id root="1.2.840.113619.2.62.994044785528.20060823.200608232232322.9"/>

<!-- SOP Instance UID (0008,0018) of SR sample document-->

</parentDocument>

</relatedDocument>

<componentOf>

<encompassingEncounter>

<id extension="9937012" root="1.3.6.4.1.4.1.2835.12"/>

<effectiveTime value="20060828170821"/>

<encounterParticipant typeCode="ATND">

<templateId root="2.16.840.1.113883.10.20.6.2.2"/>

<assignedEntity>

<id extension="44444444" root="2.16.840.1.113883.4.6"/>

<code code="208D00000X" codeSystem="2.16.840.1.113883.6.101"

codeSystemName="NUCC" displayName="General Practice"/>

<addr nullFlavor="NI"/>

<telecom nullFlavor="NI"/>

<assignedPerson>

<name>

<prefix>Dr.</prefix>

<given>Fay</given>

<family>Family</family>

</name>

</assignedPerson>

</assignedEntity>

</encounterParticipant>

</encompassingEncounter>

</componentOf>

<component>

<structuredBody>

<component>

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

DICOM Object Catalog Section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

<section classCode="DOCSECT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.1.1"/>

<code code="121181" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM"

displayName="DICOM Object Catalog"/>

<entry>

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Study

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.6"/>

...

</act>

</entry>

</section>

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

End of DICOM Object Catalog Section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

</component>

<component>

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Reason for study Section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

The original DICOM SR document that is mapped does not contain a "Indications for Procedure" section. The attribute value "Reason for the Requested Procedure" (0040,1002) within the Referenced Request Sequence (0040,A370) of the SR header has been mapped under the assumption that the header attribute value has been displayed to and included by the legal authenticator.

-->

<section>

<code code="121109" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM"

displayName="Indications for Procedure"/>

<title>Indications for Procedure</title>

<text>Suspected lung tumor</text>

</section>

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

End of Reason for study Section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

</component>

<component>

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

History Section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

<section>

<code code="11329-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="History"/>

<title>History</title>

<text>

<paragraph>

<caption>History</caption>

<content ID="Fndng1">Sore throat.</content>

</paragraph>

</text>

<entry>

<!-- History report element (TEXT) -->

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.12"/>

...

</observation>

</entry>

</section>

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

End of History Section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

</component>

<component>

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Findings Section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

<section>

<templateId root="2.16.840.1.113883.10.20.6.1.2"/>

<code code="121070" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM"

displayName="Findings"/>

<title>Findings</title>

<text>

<paragraph>

<caption>Finding</caption>

<content ID="Fndng2">The cardiomediastinum is within normal limits. The

trachea is midline. The previously described opacity at the medial

right lung base has cleared. There are no new infiltrates. There is

a new round density at the left hilus, superiorly (diameter about

45mm). A CT scan is recommended for further evaluation. The pleural

spaces are clear. The visualized musculoskeletal structures and the

upper abdomen are stable and unremarkable.</content>

</paragraph>

<paragraph>

<caption>Diameter</caption>

<content ID="Diam2">45mm</content>

</paragraph>

<paragraph>

<caption>Source of Measurement</caption>

<content ID="SrceOfMeas2">

<linkHtml

href="http://www.example.org/wado?requestType=WADO&amp;studyUID=1.2.840.113619.2.62.994044785528.114289542805&amp;seriesUID=1.2.840.113619.2.62.994044785528.20060823223142485051&amp;objectUID=1.2.840.113619.2.62.994044785528.20060823.200608232232322.3&amp;contentType=application/dicom"

>Chest\_PA </linkHtml>

</content>

</paragraph>

</text>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Text Observation -->

<templateId root="2.16.840.1.113883.10.20.6.2.12"/>

...

</observation>

</entry>

</section>

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

End of Findings Section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

</component>

<component>

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Impressions Section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

<section>

<code code="121072" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM"

displayName="Impressions"/>

<title>Impressions</title>

<text>

<paragraph>

<caption>Impression</caption>

<content ID="Fndng3">No acute cardiopulmonary process. Round density in

left superior hilus, further evaluation with CT is recommended as

underlying malignancy is not excluded.</content>

</paragraph>

</text>

<entry>

<!-- Impression report element (TEXT) -->

<observation classCode="OBS" moodCode="EVN">

<!-- Text Observation -->

<templateId root="2.16.840.1.113883.10.20.6.2.12"/>

...

</observation>

</entry>

<entry>

<act moodCode="EVN" classCode="ACT">

<templateId root="2.16.840.1.113883.10.20.6.2.5"/>

<!-- Procedure Context template -->

...

</act>

</entry>

</section>

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

End of Impressions Section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

</component>

</structuredBody>

</component>

Discharge Summary (V2)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.8.2 (open)]

30: Discharge Summary (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Allergies Section (entries optional) (V2)](#S_Allergies_Section_entries_optional_V2)  [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S)  [Chief Complaint Section](#S_Chief_Complaint_Section)  [Family History Section](#S_Family_History_Section)  [Functional Status Section (V2)](#S_Functional_Status_Section_V2)  [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2)  [History of Present Illness Section](#S_History_of_Present_Illness_Section)  [Hospital Admission Diagnosis Section (V2)](#S_Hospital_Admission_Diagnosis_Section_)  [Hospital Admission Medications Section (entries optional) (V2)](#S_Hospital_Admission_Medications_Sectio)  [Hospital Consultations Section](#S_Hospital_Consultations_Section)  [Hospital Course Section](#S_Hospital_Course_Section)  [Hospital Discharge Diagnosis Section (V2)](#Hospital_Discharge_Diagnosis_Section_V2)  [Hospital Discharge Instructions Section](#S_Hospital_Discharge_Instructions_Sectio)  [Hospital Discharge Medications Section (entries optional) (V2)](#S_Hospital_Discharge_Medications_Sectio)  [Hospital Discharge Medications Section (entries required) (V2)](#S_Hospital_Discharge_Medications_reqd_v2)  [Hospital Discharge Physical Section](#S_Hospital_Discharge_Physical_Section)  [Hospital Discharge Studies Summary Section](#S_Hospital_Discharge_Studies_Summary_Sec)  [Immunizations Section (entries optional) (V2)](#S_Immunizations_Section_entries_optiona)  [Nutrition Section (NEW)](#S_Nutrition_Section_NEW)  [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2)  [Problem Section (entries optional) (V2)](#S_Problem_Section_entries_optional_V2)  [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2)  [Reason for Visit Section](#S_Reason_for_Visit_Section)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Social History Section (V2)](#S_Social_History_Section_V2)  [Vital Signs Section (entries optional) (V2)](#Vital_Signs_Section_entries_optional_V2) |

The Discharge Summary is a document which synopsizes a patient's admission to a hospital; it provides pertinent information for the continuation of care following discharge. The Joint Commission requires the following information to be included in the Discharge Summary:

•  The reason for hospitalization

•  The procedures performed

•  The care, treatment, and services provided

•  The patient’s condition and disposition at discharge

•  Information provided to the patient and family

•  Provisions for follow-up care

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:8463) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.8.2" (CONF:10044).
3. SHALL contain exactly one [1..1] code (CONF:17178).
   1. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [DischargeSummaryDocumentTypeCode](#DischargeSummaryDocumentTypeCode) 2.16.840.1.113883.11.20.4.1 DYNAMIC (CONF:17179).
4. MAY contain zero or more [0..\*] participant (CONF:8467).
   1. If present, the participant/associatedEntity element SHALL have an associatedPerson or scopingOrganization element (CONF:8468).
   2. B.  When participant/@typeCode is IND, associatedEntity/@classCode SHALL be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:8469).
5. SHALL contain exactly one [1..1] componentOf (CONF:8471).
   1. This componentOf SHALL contain exactly one [1..1] encompassingEncounter (CONF:8472).
      1. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime/low (CONF:8473).
      2. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime/high (CONF:8475).
      3. The dischargeDispositionCode SHALL be present where the value of code SHOULD be selected from ValueSet 2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status DYNAMIC (www.nubc.org) (CONF:8476).
         1. The dischargeDispositionCode, @displayName, or NUBC UB-04 Print Name, SHALL be displayed when the document is rendered (CONF:8477).
      4. The encounterParticipant elements MAY be present. If present, the encounterParticipant/assignedEntity element SHALL have at least one assignedPerson or representedOrganization element present (CONF:8478).
      5. The responsibleParty element MAY be present. If present, the responsibleParty/assignedEntity element SHALL have at least one assignedPerson or representedOrganization element present (CONF:8479).
6. SHALL contain exactly one [1..1] component (CONF:9539).

In this template (templateId 2.16.840.1.113883.10.20.22.1.8.2), coded entries are optional.

* 1. This component SHALL contain exactly one [1..1] structuredBody (CONF:30518).
     1. This structuredBody SHALL contain exactly one [1..1] component (CONF:30519) such that it
        1. SHALL contain exactly one [1..1] [Allergies Section (entries optional) (V2)](#S_Allergies_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.6.2) (CONF:30520).
     2. This structuredBody SHALL contain exactly one [1..1] component (CONF:30521) such that it
        1. SHALL contain exactly one [1..1] [Hospital Course Section](#S_Hospital_Course_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.5) (CONF:30522).
     3. This structuredBody SHALL contain exactly one [1..1] component (CONF:30523) such that it
        1. SHALL contain exactly one [1..1] [Hospital Discharge Diagnosis Section (V2)](#Hospital_Discharge_Diagnosis_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.24.2) (CONF:30524).
     4. This structuredBody SHOULD contain zero or one [0..1] component (CONF:30525) such that it
        1. SHALL contain exactly one [1..1] [Hospital Discharge Medications Section (entries optional) (V2)](#S_Hospital_Discharge_Medications_Sectio) (templateId:2.16.840.1.113883.10.20.22.2.11.2) (CONF:30526).
     5. This structuredBody SHALL contain exactly one [1..1] component (CONF:30527) such that it
        1. SHALL contain exactly one [1..1] [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30528).
     6. This structuredBody MAY contain zero or one [0..1] component (CONF:30529) such that it
        1. SHALL contain exactly one [1..1] [Chief Complaint Section](#S_Chief_Complaint_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:30530).
     7. This structuredBody MAY contain zero or one [0..1] component (CONF:30531) such that it
        1. SHALL contain exactly one [1..1] [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S) (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:30532).
     8. This structuredBody MAY contain zero or one [0..1] component (CONF:30533) such that it
        1. SHALL contain exactly one [1..1] [Nutrition Section (NEW)](#S_Nutrition_Section_NEW) (templateId:2.16.840.1.113883.10.20.22.2.57) (CONF:30534).
     9. This structuredBody MAY contain zero or one [0..1] component (CONF:30535) such that it
        1. SHALL contain exactly one [1..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:30536).
     10. This structuredBody MAY contain zero or one [0..1] component (CONF:30537) such that it
         1. SHALL contain exactly one [1..1] [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.14.2) (CONF:30538).
     11. This structuredBody MAY contain zero or one [0..1] component (CONF:30539) such that it
         1. SHALL contain exactly one [1..1] [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.20.2) (CONF:30540).
     12. This structuredBody MAY contain zero or one [0..1] component (CONF:30541) such that it
         1. SHALL contain exactly one [1..1] [History of Present Illness Section](#S_History_of_Present_Illness_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:30542).
     13. This structuredBody MAY contain zero or one [0..1] component (CONF:30543) such that it
         1. SHALL contain exactly one [1..1] [Hospital Admission Diagnosis Section (V2)](#S_Hospital_Admission_Diagnosis_Section_) (templateId:2.16.840.1.113883.10.20.22.2.43.2) (CONF:30544).
     14. This structuredBody MAY contain zero or one [0..1] component (CONF:30545) such that it
         1. SHALL contain exactly one [1..1] [Hospital Admission Medications Section (entries optional) (V2)](#S_Hospital_Admission_Medications_Sectio) (templateId:2.16.840.1.113883.10.20.22.2.44.2) (CONF:30546).
     15. This structuredBody MAY contain zero or one [0..1] component (CONF:30547) such that it
         1. SHALL contain exactly one [1..1] [Hospital Consultations Section](#S_Hospital_Consultations_Section) (templateId:2.16.840.1.113883.10.20.22.2.42) (CONF:30548).
     16. This structuredBody MAY contain zero or one [0..1] component (CONF:30549) such that it
         1. SHALL contain exactly one [1..1] [Hospital Discharge Instructions Section](#S_Hospital_Discharge_Instructions_Sectio) (templateId:2.16.840.1.113883.10.20.22.2.41) (CONF:30550).
     17. This structuredBody MAY contain zero or one [0..1] component (CONF:30551) such that it
         1. SHALL contain exactly one [1..1] [Hospital Discharge Physical Section](#S_Hospital_Discharge_Physical_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.26) (CONF:30552).
     18. This structuredBody MAY contain zero or one [0..1] component (CONF:30553) such that it
         1. SHALL contain exactly one [1..1] [Hospital Discharge Studies Summary Section](#S_Hospital_Discharge_Studies_Summary_Sec) (templateId:2.16.840.1.113883.10.20.22.2.16) (CONF:30554).
     19. This structuredBody MAY contain zero or one [0..1] component (CONF:30555) such that it
         1. SHALL contain exactly one [1..1] [Immunizations Section (entries optional) (V2)](#S_Immunizations_Section_entries_optiona) (templateId:2.16.840.1.113883.10.20.22.2.2.2) (CONF:30556).
     20. This structuredBody MAY contain zero or one [0..1] component (CONF:30557) such that it
         1. SHALL contain exactly one [1..1] [Problem Section (entries optional) (V2)](#S_Problem_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.5.2) (CONF:30558).
     21. This structuredBody MAY contain zero or one [0..1] component (CONF:30559) such that it
         1. SHALL contain exactly one [1..1] [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.7.2) (CONF:30560).
     22. This structuredBody MAY contain zero or one [0..1] component (CONF:30561) such that it
         1. SHALL contain exactly one [1..1] [Reason for Visit Section](#S_Reason_for_Visit_Section) (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:30562).
     23. This structuredBody MAY contain zero or one [0..1] component (CONF:30563) such that it
         1. SHALL contain exactly one [1..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:30564).
     24. This structuredBody MAY contain zero or one [0..1] component (CONF:30565) such that it
         1. SHALL contain exactly one [1..1] [Social History Section (V2)](#S_Social_History_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:30566).
     25. This structuredBody MAY contain zero or one [0..1] component (CONF:30567) such that it
         1. SHALL contain exactly one [1..1] [Vital Signs Section (entries optional) (V2)](#Vital_Signs_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.4.2) (CONF:30568).
     26. This structuredBody MAY contain zero or one [0..1] component (CONF:31586) such that it
         1. SHALL contain exactly one [1..1] [Hospital Discharge Medications Section (entries required) (V2)](#S_Hospital_Discharge_Medications_reqd_v2) (templateId:2.16.840.1.113883.10.20.22.2.11.1.2) (CONF:31587).
     27. SHALL NOT include a Chief Complaint and Reason for Visit Section with either a Chief Complaint Section or a Reason for Visit Section (CONF:30569).

32: DischargeSummaryDocumentTypeCode

|  |  |  |
| --- | --- | --- |
| Value Set: DischargeSummaryDocumentTypeCode 2.16.840.1.113883.11.20.4.1 | | |
| Code | Code System | Print Name |
| 18842-5 | LOINC | {Provider} |
| 11490-0 | LOINC | Physician |
| 28655-9 | LOINC | Attending physician |
| 29761-4 | LOINC | Dentistry |
| 34745-0 | LOINC | Nursing |
| 34105-7 | LOINC | {Provider} |
| 34106-5 | LOINC | Physician |

History and Physical (V2)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.3.2 (open)]

33: History and Physical (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Allergies Section (entries optional) (V2)](#S_Allergies_Section_entries_optional_V2)  [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2)  [Assessment Section](#S_Assessment_Section)  [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S)  [Chief Complaint Section](#S_Chief_Complaint_Section)  [Family History Section](#S_Family_History_Section)  [General Status Section](#S_General_Status_Section)  [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2)  [History of Present Illness Section](#S_History_of_Present_Illness_Section)  [Immunizations Section (entries optional) (V2)](#S_Immunizations_Section_entries_optiona)  [Instructions Section (V2)](#Instructions_Section_V2)  [Medications Section (entries optional) (V2)](#S_Medications_Section_entries_optional_)  [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2)  [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2)  [Problem Section (entries optional) (V2)](#S_Problem_Section_entries_optional_V2)  [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2)  [Reason for Visit Section](#S_Reason_for_Visit_Section)  [Results Section (entries optional) (V2)](#S_Results_Section_entries_optional_V2)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Social History Section (V2)](#S_Social_History_Section_V2)  [Vital Signs Section (entries optional) (V2)](#Vital_Signs_Section_entries_optional_V2) |

A History and Physical (H&P) Note is a medical report that documents the current and past conditions of the patient. It contains essential information that helps determine an individual's health status.

The first portion of the report is a current collection of organized information unique to an individual.  This is typically supplied by the patient or their caregiver, concerning the current medical problem or the reason for the patient encounter. This information is followed by a description of any past or ongoing medical issues, including current medications and allergies. Information is also obtained about the patient's lifestyle, habits, and diseases among family members.

The next portion of the report contains information obtained by physically examining the patient and gathering diagnostic information in the form of laboratory tests, imaging, or other diagnostic procedures.

The report ends with the clinician's assessment of the patient's situation and the intended plan to address those issues.

A History and Physical Examination is required upon hospital admission as well as before operative procedures. An initial evaluation in an ambulatory setting is often documented in the form of an H&P note.

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:8283) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.3.2" (CONF:10046).
3. SHALL contain exactly one [1..1] code (CONF:17185).
   1. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [HPDocumentType](#HPDocumentType) 2.16.840.1.113883.1.11.20.22 DYNAMIC (CONF:17186).
4. MAY contain zero or more [0..\*] participant (CONF:8286).
   1. A participant element, if present, SHALL contain an associatedEntity element which SHALL contain either an associatedPerson or scopingOrganization element (CONF:8287).
   2. A special class of participant is the supporting person or organization:  an individual or an organization that has a relationship to the patient, including  parents, relatives, caregivers, insurance policyholders, and guarantors. In the case of a supporting person who is also an emergency contact or next-of-kin, a participant element should be present for each role recorded (CONF:8288).
   3. C.  When participant/@typeCode is IND, associatedEntity/@classCode SHALL be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:8333).
5. MAY contain zero or more [0..\*] inFulfillmentOf (CONF:8336).
   1. An inFulfillmentOf element records the prior orders that are fulfilled (in whole or part) by the service events described in this document.  For example, the prior order might be a referral and this H&P Note may be in partial fulfillment of that referral (CONF:8337).
6. SHALL contain exactly one [1..1] componentOf (CONF:8338).
   1. This componentOf SHALL contain exactly one [1..1] encompassingEncounter (CONF:8339).
      1. This encompassingEncounter SHALL contain exactly one [1..1] id (CONF:8340).
      2. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:8341).
         1. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10135).
      3. This encompassingEncounter MAY contain zero or one [0..1] responsibleParty (CONF:8345).
         1. The responsibleParty element records only the party responsible for the encounter, not necessarily the entire episode of care (CONF:8347).
         2. The responsibleParty element, if present, SHALL contain an assignedEntity element, which SHALL contain an assignedPerson element, a representedOrganization element, or both (CONF:8348).
      4. This encompassingEncounter MAY contain zero or more [0..\*] encounterParticipant (CONF:8342).
         1. An encounterParticipant element, if present, SHALL contain an assignedEntity element, which SHALL contain an assignedPerson element, a representedOrganization element, or both (CONF:8343).
         2. The encounterParticipant element, if present, records only participants in the encounter, not necessarily in the entire episode of care (CONF:8346).
      5. This encompassingEncounter MAY contain zero or one [0..1] location (CONF:8344).
7. SHALL contain exactly one [1..1] component (CONF:8349).

In this template (templateId 2.16.840.1.113883.10.20.22.1.3.2), coded entries are optional.

* 1. This component SHALL contain exactly one [1..1] structuredBody (CONF:30570).
     1. This structuredBody SHALL contain exactly one [1..1] component (CONF:30571) such that it
        1. SHALL contain exactly one [1..1] [Allergies Section (entries optional) (V2)](#S_Allergies_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.6.2) (CONF:30572).
     2. This structuredBody MAY contain zero or one [0..1] component (CONF:30573) such that it
        1. SHALL contain exactly one [1..1] [Assessment Section](#S_Assessment_Section) (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:30574).
     3. This structuredBody MAY contain zero or one [0..1] component (CONF:30575) such that it
        1. SHALL contain exactly one [1..1] [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30576).
     4. This structuredBody MAY contain zero or one [0..1] component (CONF:30577) such that it
        1. SHALL contain exactly one [1..1] [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) (CONF:30578).
     5. This structuredBody MAY contain zero or one [0..1] component (CONF:30579) such that it
        1. SHALL contain exactly one [1..1] [Chief Complaint Section](#S_Chief_Complaint_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:30580).
     6. This structuredBody MAY contain zero or one [0..1] component (CONF:30581) such that it
        1. SHALL contain exactly one [1..1] [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S) (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:30582).
     7. This structuredBody SHALL contain exactly one [1..1] component (CONF:30583) such that it
        1. SHALL contain exactly one [1..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:30584).
     8. This structuredBody SHALL contain exactly one [1..1] component (CONF:30585) such that it
        1. SHALL contain exactly one [1..1] [General Status Section](#S_General_Status_Section) (templateId:2.16.840.1.113883.10.20.2.5) (CONF:30586).
     9. This structuredBody SHALL contain exactly one [1..1] component (CONF:30587) such that it
        1. SHALL contain exactly one [1..1] [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.20.2) (CONF:30588).
     10. This structuredBody SHOULD contain zero or one [0..1] component (CONF:30589) such that it
         1. SHALL contain exactly one [1..1] [History of Present Illness Section](#S_History_of_Present_Illness_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:30590).
     11. This structuredBody MAY contain zero or one [0..1] component (CONF:30591) such that it
         1. SHALL contain exactly one [1..1] [Immunizations Section (entries optional) (V2)](#S_Immunizations_Section_entries_optiona) (templateId:2.16.840.1.113883.10.20.22.2.2.2) (CONF:30592).
     12. This structuredBody MAY contain zero or one [0..1] component (CONF:30593) such that it
         1. SHALL contain exactly one [1..1] [Instructions Section (V2)](#Instructions_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.45.2) (CONF:31385).
     13. This structuredBody SHALL contain exactly one [1..1] component (CONF:30595) such that it
         1. SHALL contain exactly one [1..1] [Medications Section (entries optional) (V2)](#S_Medications_Section_entries_optional_) (templateId:2.16.840.1.113883.10.20.22.2.1.2) (CONF:30596).
     14. This structuredBody SHALL contain exactly one [1..1] component (CONF:30597) such that it
         1. SHALL contain exactly one [1..1] [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2) (templateId:2.16.840.1.113883.10.20.2.10.2) (CONF:30598).
     15. This structuredBody MAY contain zero or one [0..1] component (CONF:30599) such that it
         1. SHALL contain exactly one [1..1] [Problem Section (entries optional) (V2)](#S_Problem_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.5.2) (CONF:30600).
     16. This structuredBody MAY contain zero or one [0..1] component (CONF:30601) such that it
         1. SHALL contain exactly one [1..1] [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.7.2) (CONF:30602).
     17. This structuredBody MAY contain zero or one [0..1] component (CONF:30603) such that it
         1. SHALL contain exactly one [1..1] [Reason for Visit Section](#S_Reason_for_Visit_Section) (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:30604).
     18. This structuredBody SHALL contain exactly one [1..1] component (CONF:30605) such that it
         1. SHALL contain exactly one [1..1] [Results Section (entries optional) (V2)](#S_Results_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.3.2) (CONF:30606).
     19. This structuredBody SHALL contain exactly one [1..1] component (CONF:30607) such that it
         1. SHALL contain exactly one [1..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:30608).
     20. This structuredBody SHALL contain exactly one [1..1] component (CONF:30609) such that it
         1. SHALL contain exactly one [1..1] [Social History Section (V2)](#S_Social_History_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:30610).
     21. This structuredBody SHALL contain exactly one [1..1] component (CONF:30611) such that it
         1. SHALL contain exactly one [1..1] [Vital Signs Section (entries optional) (V2)](#Vital_Signs_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.4.2) (CONF:30612).
     22. SHALL include a Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13), a Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1), or a Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:30613).
     23. SHALL include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2), or an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a  Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30614).
     24. SHALL NOT include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) are present (CONF:30615).
     25. SHALL NOT contain a Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) is present (CONF:30616).

35: HPDocumentType

|  |  |  |
| --- | --- | --- |
| Value Set: HPDocumentType 2.16.840.1.113883.1.11.20.22 | | |
| Code | Code System | Print Name |
| 34117-2 | LOINC | History & Physical |
| 11492-6 | LOINC | History & Physical: Hospital |
| 28626-0 | LOINC | Physician |
| 34774-0 | LOINC | General surgery |
| 34115-6 | LOINC | History & Physical: Hospital: Medical Student |
| 34116-4 | LOINC | History & Physical: Nursing Home: Physician |
| 34095-0 | LOINC | Comprehensive History & Physical |
| 34096-8 | LOINC | Comprehensive History & Physical: Nursing Home |
| 51849-8 | LOINC | Admission History & Physical |
| 47039-3 | LOINC | Admission History & Physical: Inpatient |
| ... | | |

Operative Note (V2)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.7.2 (open)]

36: Operative Note (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Anesthesia Section (V2)](#S_Anesthesia_Section_V2)  [Complications Section (V2)](#S_Complications_Section_V2)  [Operative Note Fluids Section](#S_Operative_Note_Fluids_Section)  [Operative Note Surgical Procedure Section](#S_Operative_Note_Surgical_Procedure_Sect)  [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2)  [Planned Procedure Section (V2)](#Planned_Procedure_Section_V2)  [Postoperative Diagnosis Section](#S_Postoperative_Diagnosis_Section)  [Preoperative Diagnosis Section (V2)](#S_Preoperative_Diagnosis_Section_V2)  [Procedure Description Section](#S_Procedure_Description_Section)  [Procedure Disposition Section](#S_Procedure_Disposition_Section)  [Procedure Estimated Blood Loss Section](#S_Procedure_Estimated_Blood_Loss_Section)  [Procedure Findings Section (V2)](#S_Procedure_Findings_Section_V2)  [Procedure Implants Section](#S_Procedure_Implants_Section)  [Procedure Indications Section (V2)](#Procedure_Indications_Section_V2)  [Procedure Specimens Taken Section](#S_Procedure_Specimens_Taken_Section)  [Surgical Drains Section](#S_Surgical_Drains_Section) |

The Operative Note is a frequently used type of procedure note with specific requirements set forth by regulatory agencies.

The Operative Note is created immediately following a surgical or other high-risk procedure. It records the pre and post-surgical diagnosis, pertinent events of the procedure, as well as the condition of the patient following the procedure.  The report should be sufficiently detailed to support the diagnoses, justify the treatment, document the course of the procedure, and provide continuity of care.

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:8483) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.7.2" (CONF:10048).
3. SHALL contain exactly one [1..1] code (CONF:17187).
   1. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [SurgicalOperationNoteDocumentTypeCode](#SurgicalOperationNoteDocumentTypeCode) 2.16.840.1.113883.11.20.1.1 DYNAMIC (CONF:17188).
4. SHALL contain at least one [1..\*] documentationOf (CONF:8486).
   1. Such documentationOfs SHALL contain exactly one [1..1] serviceEvent (CONF:8493).
      1. This serviceEvent SHALL contain exactly one [1..1] effectiveTime (CONF:8494).
         1. The serviceEvent/effectiveTime SHALL be present with effectiveTime/low (CONF:8488).
         2. If a width is not present, the serviceEvent/effectiveTime SHALL include effectiveTime/high (CONF:10058).
         3. When only the date and the length of the procedure are known a width element SHALL be present and the serviceEvent/effectiveTime/high SHALL not be present (CONF:10060).
         4. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10136).
      2. This serviceEvent SHALL contain exactly one [1..1] performer (CONF:8489) such that it
         1. SHALL contain exactly one [1..1] @typeCode="PPRF" Primary performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8495).
         2. SHALL contain exactly one [1..1] assignedEntity (CONF:10917).
            1. This assignedEntity SHALL contain exactly one [1..1] code (CONF:8490).

This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet [Provider Role Value Set](#Provider_Role_Value_Set) 2.16.840.1.113883.3.88.12.3221.4 DYNAMIC (CONF:8491).

* + 1. The value of Clinical Document /documentationOf/serviceEvent/code SHALL be from ICD9 CM Procedures (CodeSystem 2.16.840.1.113883.6.104), CPT-4 (CodeSystem 2.16.840.1.113883.6.12), or values descending from 71388002 (Procedure) from the SNOMED CT (CodeSystem 2.16.840.1.113883.6.96) ValueSet Procedure 2.16.840.1.113883.3.88.12.80.28 DYNAMIC (CONF:8487).
  1. Any assistants SHALL be identified and SHALL be identified as secondary performers (SPRF) (CONF:8512).

1. SHALL contain exactly one [1..1] component (CONF:9585).
   1. This component SHALL contain exactly one [1..1] structuredBody (CONF:30485).
      1. This structuredBody SHALL contain exactly one [1..1] component (CONF:30486) such that it
         1. SHALL contain exactly one [1..1] [Anesthesia Section (V2)](#S_Anesthesia_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.25.2) (CONF:30487).
      2. This structuredBody SHALL contain exactly one [1..1] component (CONF:30488) such that it
         1. SHALL contain exactly one [1..1] [Complications Section (V2)](#S_Complications_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.37.2) (CONF:30489).
      3. This structuredBody SHALL contain exactly one [1..1] component (CONF:30490) such that it
         1. SHALL contain exactly one [1..1] [Preoperative Diagnosis Section (V2)](#S_Preoperative_Diagnosis_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.34.2) (CONF:30491).
      4. This structuredBody SHALL contain exactly one [1..1] component (CONF:30492) such that it
         1. SHALL contain exactly one [1..1] [Procedure Estimated Blood Loss Section](#S_Procedure_Estimated_Blood_Loss_Section) (templateId:2.16.840.1.113883.10.20.18.2.9) (CONF:30493).
      5. This structuredBody SHALL contain exactly one [1..1] component (CONF:30494) such that it
         1. SHALL contain exactly one [1..1] [Procedure Findings Section (V2)](#S_Procedure_Findings_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.28.2) (CONF:30495).
      6. This structuredBody SHALL contain exactly one [1..1] component (CONF:30496) such that it
         1. SHALL contain exactly one [1..1] [Procedure Specimens Taken Section](#S_Procedure_Specimens_Taken_Section) (templateId:2.16.840.1.113883.10.20.22.2.31) (CONF:30497).
      7. This structuredBody SHALL contain exactly one [1..1] component (CONF:30498) such that it
         1. SHALL contain exactly one [1..1] [Procedure Description Section](#S_Procedure_Description_Section) (templateId:2.16.840.1.113883.10.20.22.2.27) (CONF:30499).
      8. This structuredBody SHALL contain exactly one [1..1] component (CONF:30500) such that it
         1. SHALL contain exactly one [1..1] [Postoperative Diagnosis Section](#S_Postoperative_Diagnosis_Section) (templateId:2.16.840.1.113883.10.20.22.2.35) (CONF:30501).
      9. This structuredBody MAY contain zero or one [0..1] component (CONF:30502) such that it
         1. SHALL contain exactly one [1..1] [Procedure Implants Section](#S_Procedure_Implants_Section) (templateId:2.16.840.1.113883.10.20.22.2.40) (CONF:30503).
      10. This structuredBody MAY contain zero or one [0..1] component (CONF:30504) such that it
          1. SHALL contain exactly one [1..1] [Operative Note Fluids Section](#S_Operative_Note_Fluids_Section) (templateId:2.16.840.1.113883.10.20.7.12) (CONF:30505).
      11. This structuredBody MAY contain zero or one [0..1] component (CONF:30506) such that it
          1. SHALL contain exactly one [1..1] [Operative Note Surgical Procedure Section](#S_Operative_Note_Surgical_Procedure_Sect) (templateId:2.16.840.1.113883.10.20.7.14) (CONF:30507).
      12. This structuredBody MAY contain zero or one [0..1] component (CONF:30508) such that it
          1. SHALL contain exactly one [1..1] [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30509).
      13. This structuredBody MAY contain zero or one [0..1] component (CONF:30510) such that it
          1. SHALL contain exactly one [1..1] [Planned Procedure Section (V2)](#Planned_Procedure_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.30.2) (CONF:30511).
      14. This structuredBody MAY contain zero or one [0..1] component (CONF:30512) such that it
          1. SHALL contain exactly one [1..1] [Procedure Disposition Section](#S_Procedure_Disposition_Section) (templateId:2.16.840.1.113883.10.20.18.2.12) (CONF:30513).
      15. This structuredBody MAY contain zero or one [0..1] component (CONF:30514) such that it
          1. SHALL contain exactly one [1..1] [Procedure Indications Section (V2)](#Procedure_Indications_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.29.2) (CONF:30515).
      16. This structuredBody MAY contain zero or one [0..1] component (CONF:30516) such that it
          1. SHALL contain exactly one [1..1] [Surgical Drains Section](#S_Surgical_Drains_Section) (templateId:2.16.840.1.113883.10.20.7.13) (CONF:30517).
2. A consent, if present, SHALL be represented as ClinicalDocument/authorization/consent (CONF:8485).

38: SurgicalOperationNoteDocumentTypeCode

|  |  |  |
| --- | --- | --- |
| Value Set: SurgicalOperationNoteDocumentTypeCode 2.16.840.1.113883.11.20.1.1 | | |
| Code | Code System | Print Name |
| 11504-8 | LOINC | {Provider} |
| 34137-0 | LOINC | {Provider} |
| 28583-3 | LOINC | Dentistry |
| 28624-5 | LOINC | Podiatry |
| 28573-4 | LOINC | Physician |
| 34877-1 | LOINC | Urology |
| 34874-8 | LOINC | Surgery |
| 34870-6 | LOINC | Plastic surgery |
| 34868-0 | LOINC | Orthopedics |
| 34818-5 | LOINC | Otorhinolaryngology |

39: Provider Role Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Provider Role Value Set 2.16.840.1.113883.3.88.12.3221.4  The Provider type vocabulary classifies providers according to the type of  license or accreditation they hold or the service they provide.  http://www.nucc.org/index.php?option=com\_content&view=article&id=14&Itemid=125 | | |
| Code | Code System | Print Name |
| CP | Provider Role (HL7) | Consulting Provider |
| PP | Provider Role (HL7) | Primary Care Provider |
| RP | Provider Role (HL7) | Referring Provider |

Procedure Note (V2)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.6.2 (open)]

40: Procedure Note (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Allergies Section (entries optional) (V2)](#S_Allergies_Section_entries_optional_V2)  [Anesthesia Section (V2)](#S_Anesthesia_Section_V2)  [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2)  [Assessment Section](#S_Assessment_Section)  [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S)  [Chief Complaint Section](#S_Chief_Complaint_Section)  [Complications Section (V2)](#S_Complications_Section_V2)  [Family History Section](#S_Family_History_Section)  [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2)  [History of Present Illness Section](#S_History_of_Present_Illness_Section)  [Medical (General) History Section (V2)](#Medical_General_History_Section_V2)  [Medications Administered Section (V2)](#S_Medications_Administered_Section_V2)  [Medications Section (entries optional) (V2)](#S_Medications_Section_entries_optional_)  [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2)  [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2)  [Planned Procedure Section (V2)](#Planned_Procedure_Section_V2)  [Postprocedure Diagnosis Section (V2)](#S_Postprocedure_Diagnosis_Section_V2)  [Procedure Description Section](#S_Procedure_Description_Section)  [Procedure Disposition Section](#S_Procedure_Disposition_Section)  [Procedure Estimated Blood Loss Section](#S_Procedure_Estimated_Blood_Loss_Section)  [Procedure Findings Section (V2)](#S_Procedure_Findings_Section_V2)  [Procedure Implants Section](#S_Procedure_Implants_Section)  [Procedure Indications Section (V2)](#Procedure_Indications_Section_V2)  [Procedure Specimens Taken Section](#S_Procedure_Specimens_Taken_Section)  [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2)  [Reason for Visit Section](#S_Reason_for_Visit_Section)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Social History Section (V2)](#S_Social_History_Section_V2) |

Procedure Note encompasses many types of non-operative procedures including interventional cardiology, gastrointestinal endoscopy, osteopathic manipulation, and many other specialty fields. Procedure Notes are differentiated from Operative Notes because they do not involve incision or excision as the primary act.

The Procedure Note is created immediately following a non-operative procedure. It records the indications for the procedure and, when applicable, post-procedure diagnosis, pertinent events of the procedure, and the patient’s tolerance for the procedure. It should be detailed enough to justify the procedure, describe the course of the procedure, and provide continuity of care.

The Procedure Note is created immediately following a non-operative procedure and records the indications for the procedure and, when applicable, post-procedure diagnosis, pertinent events of the procedure, and the patient’s tolerance of the procedure. The document should be sufficiently detailed to justify the procedure, describe the course of the procedure, and provide continuity of care.

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:8496) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.6.2" (CONF:10050).
3. SHALL contain exactly one [1..1] code (CONF:17182).
   1. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [ProcedureNoteDocumentTypeCodes](#ProcedureNoteDocumentTypeCodes) 2.16.840.1.113883.11.20.6.1 DYNAMIC (CONF:17183).
4. MAY contain zero or more [0..\*] participant (CONF:8504) such that it
   1. SHALL contain exactly one [1..1] @typeCode="IND" Individual (CodeSystem: participationFunction 2.16.840.1.113883.5.88 STATIC) (CONF:8505).
   2. SHALL contain exactly one [1..1] functionCode="PCP" Primary Care Physician (CodeSystem: participationFunction 2.16.840.1.113883.5.88 STATIC) (CONF:8506).
   3. SHALL contain exactly one [1..1] associatedEntity/@classCode="PROV" Provider (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8507).
      1. This associatedEntity/@classCode SHALL contain exactly one [1..1] associatedPerson (CONF:8508).
5. SHALL contain at least one [1..\*] documentationOf (CONF:8510) such that it
   1. SHALL contain exactly one [1..1] serviceEvent (CONF:10061).
      1. This serviceEvent SHALL contain exactly one [1..1] effectiveTime (CONF:10062).
         1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:26449).
         2. The serviceEvent/effectiveTime SHALL be present with effectiveTime/low (CONF:8513).
         3. If a width is not present, the serviceEvent/effectiveTime SHALL include effectiveTime/high (CONF:8514).
         4. When only the date and the length of the procedure are known a width element SHALL be present and the serviceEvent/effectiveTime/high SHALL not be present (CONF:8515).
         5. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10063).
      2. This serviceEvent SHALL contain exactly one [1..1] performer (CONF:8520).
         1. This performer SHALL contain exactly one [1..1] @typeCode="PPRF" Primary Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8521).
         2. This performer SHALL contain exactly one [1..1] assignedEntity (CONF:14911).
            1. This assignedEntity SHOULD contain zero or one [0..1] code (CONF:14912).

The code, if present, SHOULD contain zero or one [0..1] @code, which SHALL be selected from ValueSet [Healthcare Provider Taxonomy (HIPAA)](#Healthcare_Provider_Taxonomy_HIPAA) 2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:14913).

* + 1. The value of Clinical Document /documentationOf/serviceEvent/code SHALL be from ICD9 CM Procedures (codeSystem 2.16.840.1.113883.6.104), CPT-4 (codeSystem 2.16.840.1.113883.6.12), or values descending from 71388002 (Procedure) from the SNOMED CT (codeSystem 2.16.840.1.113883.6.96) ValueSet 2.16.840.1.113883.3.88.12.80.28 Procedure DYNAMIC (CONF:8511).
  1. Any assistants SHALL be identified and SHALL be identified as secondary performers (SPRF) (CONF:8524).

1. SHOULD contain zero or one [0..1] componentOf (CONF:30871).
   1. The componentOf, if present, SHALL contain exactly one [1..1] encompassingEncounter (CONF:30872).
      1. This encompassingEncounter SHALL contain exactly one [1..1] code (CONF:30873).
      2. This encompassingEncounter MAY contain zero or one [0..1] encounterParticipant (CONF:30874) such that it
         1. SHALL contain exactly one [1..1] @typeCode="REF" Referrer (CONF:30875).
      3. This encompassingEncounter SHALL contain at least one [1..\*] location (CONF:30876).
         1. Such locations SHALL contain exactly one [1..1] healthCareFacility (CONF:30877).
            1. This healthCareFacility SHALL contain at least one [1..\*] id (CONF:30878).
2. SHALL contain exactly one [1..1] component (CONF:9588).
   1. This component SHALL contain exactly one [1..1] structuredBody (CONF:30352).
      1. This structuredBody SHALL contain exactly one [1..1] component (CONF:30353) such that it
         1. SHALL contain exactly one [1..1] [Complications Section (V2)](#S_Complications_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.37.2) (CONF:30387).
      2. This structuredBody SHALL contain exactly one [1..1] component (CONF:30355) such that it
         1. SHALL contain exactly one [1..1] [Procedure Description Section](#S_Procedure_Description_Section) (templateId:2.16.840.1.113883.10.20.22.2.27) (CONF:30356).
      3. This structuredBody SHALL contain exactly one [1..1] component (CONF:30357) such that it
         1. SHALL contain exactly one [1..1] [Procedure Indications Section (V2)](#Procedure_Indications_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.29.2) (CONF:30358).
      4. This structuredBody SHALL contain exactly one [1..1] component (CONF:30359) such that it
         1. SHALL contain exactly one [1..1] [Postprocedure Diagnosis Section (V2)](#S_Postprocedure_Diagnosis_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.36.2) (CONF:30360).
      5. This structuredBody MAY contain zero or one [0..1] component (CONF:30361) such that it
         1. SHALL contain exactly one [1..1] [Assessment Section](#S_Assessment_Section) (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:30362).
      6. This structuredBody MAY contain zero or one [0..1] component (CONF:30363) such that it
         1. SHALL contain exactly one [1..1] [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) (CONF:30364).
      7. This structuredBody MAY contain zero or one [0..1] component (CONF:30365) such that it
         1. SHALL contain exactly one [1..1] [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30366).
      8. This structuredBody MAY contain zero or one [0..1] component (CONF:30367) such that it
         1. SHALL contain exactly one [1..1] [Allergies Section (entries optional) (V2)](#S_Allergies_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.6.2) (CONF:30368).
      9. This structuredBody MAY contain zero or one [0..1] component (CONF:30369) such that it
         1. SHALL contain exactly one [1..1] [Anesthesia Section (V2)](#S_Anesthesia_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.25.2) (CONF:30370).
      10. This structuredBody MAY contain zero or one [0..1] component (CONF:30371) such that it
          1. SHALL contain exactly one [1..1] [Chief Complaint Section](#S_Chief_Complaint_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:30372).
      11. This structuredBody MAY contain zero or one [0..1] component (CONF:30373) such that it
          1. SHALL contain exactly one [1..1] [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S) (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:30374).
      12. This structuredBody MAY contain zero or one [0..1] component (CONF:30375) such that it
          1. SHALL contain exactly one [1..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:30376).
      13. This structuredBody MAY contain zero or one [0..1] component (CONF:30377) such that it
          1. SHALL contain exactly one [1..1] [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.20.2) (CONF:30378).
      14. This structuredBody MAY contain zero or one [0..1] component (CONF:30379) such that it
          1. SHALL contain exactly one [1..1] [History of Present Illness Section](#S_History_of_Present_Illness_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:30380).
      15. This structuredBody MAY contain zero or one [0..1] component (CONF:30381) such that it
          1. SHALL contain exactly one [1..1] [Medical (General) History Section (V2)](#Medical_General_History_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.39.2) (CONF:30382).
      16. This structuredBody MAY contain zero or one [0..1] component (CONF:30383) such that it
          1. SHALL contain exactly one [1..1] [Medications Section (entries optional) (V2)](#S_Medications_Section_entries_optional_) (templateId:2.16.840.1.113883.10.20.22.2.1.2) (CONF:30384).
      17. This structuredBody MAY contain zero or one [0..1] component (CONF:30388) such that it
          1. SHALL contain exactly one [1..1] [Medications Administered Section (V2)](#S_Medications_Administered_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.38.2) (CONF:30389).
      18. This structuredBody MAY contain zero or one [0..1] component (CONF:30390) such that it
          1. SHALL contain exactly one [1..1] [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2) (templateId:2.16.840.1.113883.10.20.2.10.2) (CONF:30391).
      19. This structuredBody MAY contain zero or one [0..1] component (CONF:30392) such that it
          1. SHALL contain exactly one [1..1] [Planned Procedure Section (V2)](#Planned_Procedure_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.30.2) (CONF:30393).
      20. This structuredBody MAY contain zero or one [0..1] component (CONF:30394) such that it
          1. SHALL contain exactly one [1..1] [Procedure Disposition Section](#S_Procedure_Disposition_Section) (templateId:2.16.840.1.113883.10.20.18.2.12) (CONF:30395).
      21. This structuredBody MAY contain zero or one [0..1] component (CONF:30396) such that it
          1. SHALL contain exactly one [1..1] [Procedure Estimated Blood Loss Section](#S_Procedure_Estimated_Blood_Loss_Section) (templateId:2.16.840.1.113883.10.20.18.2.9) (CONF:30397).
      22. This structuredBody MAY contain zero or one [0..1] component (CONF:30398) such that it
          1. SHALL contain exactly one [1..1] [Procedure Findings Section (V2)](#S_Procedure_Findings_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.28.2) (CONF:30399).
      23. This structuredBody MAY contain zero or one [0..1] component (CONF:30400) such that it
          1. SHALL contain exactly one [1..1] [Procedure Implants Section](#S_Procedure_Implants_Section) (templateId:2.16.840.1.113883.10.20.22.2.40) (CONF:30401).
      24. This structuredBody MAY contain zero or one [0..1] component (CONF:30402) such that it
          1. SHALL contain exactly one [1..1] [Procedure Specimens Taken Section](#S_Procedure_Specimens_Taken_Section) (templateId:2.16.840.1.113883.10.20.22.2.31) (CONF:30403).
      25. This structuredBody MAY contain zero or one [0..1] component (CONF:30404) such that it
          1. SHALL contain exactly one [1..1] [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.7.2) (CONF:30405).
      26. This structuredBody MAY contain zero or one [0..1] component (CONF:30406) such that it
          1. SHALL contain exactly one [1..1] [Reason for Visit Section](#S_Reason_for_Visit_Section) (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:30407).
      27. This structuredBody MAY contain zero or one [0..1] component (CONF:30408) such that it
          1. SHALL contain exactly one [1..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:30409).
      28. This structuredBody MAY contain zero or one [0..1] component (CONF:30410) such that it
          1. SHALL contain exactly one [1..1] [Social History Section (V2)](#S_Social_History_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:30411).
      29. SHALL include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2), or an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a  Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30412).
      30. Each section SHALL have a title and the title SHALL NOT be empty (CONF:30413).
      31. SHALL NOT include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) are present (CONF:30414).
      32. SHALL NOT include a Chief Complaint and Reason for Visit Section with either a Chief Complaint Section or a Reason for Visit Section (CONF:30415).
3. A consent, if present, SHALL be represented as ClinicalDocument/authorization/consent (CONF:8509).

42: ProcedureNoteDocumentTypeCodes

|  |  |  |
| --- | --- | --- |
| Value Set: ProcedureNoteDocumentTypeCodes 2.16.840.1.113883.11.20.6.1 | | |
| Code | Code System | Print Name |
| 28570-0 | LOINC | {Setting} |
| 11505-5 | LOINC | {Setting} |
| 18744-3 | LOINC | Respiratory system |
| 18745-0 | LOINC | Heart |
| 18746-8 | LOINC | Lower GI tract |
| 18751-8 | LOINC | Upper GI tract |
| 18753-4 | LOINC | Lower GI tract |
| 18836-7 | LOINC | Cardiac stress study |
| 28577-5 | LOINC | {Setting} |
| 28625-2 | LOINC | {Setting} |
| ... | | |

43: Healthcare Provider Taxonomy (HIPAA)

|  |  |  |
| --- | --- | --- |
| Value Set: Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066  The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct Levels including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category. Providers may have one or more than one value associated to them. When determining what value or valuess to associate with a provider, the user needs to review the requirements of the trading partner with which the value(s) are being used. | | |
| Code | Code System | Print Name |
| 171100000X | Healthcare Provider Taxonomy (HIPAA) | Acupuncturist |
| 363LA2100X | Healthcare Provider Taxonomy (HIPAA) | Acute Care |
| 364SA2100X | Healthcare Provider Taxonomy (HIPAA) | Acute Care |
| 101YA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 103TA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 163WA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 207LA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 207QA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 207RA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 2084A0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| ... | | |

Progress Note (V2)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.9.2 (open)]

44: Progress Note (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Allergies Section (entries optional) (V2)](#S_Allergies_Section_entries_optional_V2)  [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2)  [Assessment Section](#S_Assessment_Section)  [Chief Complaint Section](#S_Chief_Complaint_Section)  [Instructions Section (V2)](#Instructions_Section_V2)  [Interventions Section (V2)](#Interventions_Section_V2)  [Medications Section (entries optional) (V2)](#S_Medications_Section_entries_optional_)  [Objective Section](#S_Objective_Section)  [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2)  [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2)  [Problem Section (entries optional) (V2)](#S_Problem_Section_entries_optional_V2)  [Results Section (entries optional) (V2)](#S_Results_Section_entries_optional_V2)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Subjective Section](#S_Subjective_Section)  [Vital Signs Section (entries optional) (V2)](#Vital_Signs_Section_entries_optional_V2) |

This template represents a patient’s clinical status during a hospitalization or outpatient visit; thus, it is associated with an encounter.

Taber’s medical dictionary defines a Progress Note as “An ongoing record of a patient's illness and treatment. Physicians, nurses, consultants, and therapists record their notes concerning the progress or lack of progress made by the patient between the time of the previous note and the most recent note.”

Mosby’s  medical dictionary defines a Progress Note as “Notes made by a nurse, physician, social worker, physical therapist, and other health care professionals that describe the patient's condition and the treatment given or planned.”

A Progress Note is not a re-evaluation note. A Progress Note is not intended to be a Progress Report for Medicare. Medicare B Section 1833(e) defines the requirements of a Medicare Progress Report.

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:7588) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.9.2" (CONF:10052).
3. SHALL contain exactly one [1..1] code (CONF:17189).
   1. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [ProgressNoteDocumentTypeCode](#ProgressNoteDocumentTypeCode) 2.16.840.1.113883.11.20.8.1 DYNAMIC (CONF:17190).
4. SHOULD contain zero or one [0..1] documentationOf (CONF:7603).
   1. The documentationOf, if present, SHALL contain exactly one [1..1] serviceEvent (CONF:7604).
      1. This serviceEvent SHALL contain exactly one [1..1] @classCode="PCPR" Care Provision (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:26420).
      2. This serviceEvent SHALL contain exactly one [1..1] templateId (CONF:9480) such that it
         1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.21.3.1" (CONF:10068).
      3. This serviceEvent SHOULD contain zero or one [0..1] effectiveTime (CONF:9481).
         1. The serviceEvent/effectiveTime element SHOULD be present with effectiveTime/low element (CONF:9482).
         2. If a width element is not present, the serviceEvent SHALL include effectiveTime/high (CONF:10066).
         3. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10137).
5. SHALL contain exactly one [1..1] componentOf (CONF:7595).
   1. This componentOf SHALL contain exactly one [1..1] encompassingEncounter (CONF:7596).
      1. This encompassingEncounter SHALL contain at least one [1..\*] id (CONF:7597).
      2. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:7598).
         1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:7599).
         2. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10138).
      3. This encompassingEncounter SHALL contain exactly one [1..1] location (CONF:30879).
         1. This location SHALL contain exactly one [1..1] healthCareFacility (CONF:30880).
            1. This healthCareFacility SHALL contain at least one [1..\*] id (CONF:30881).
6. SHALL contain exactly one [1..1] component (CONF:9591).

In this template (templateId 2.16.840.1.113883.10.20.22.1.9.2), coded entries are optional

* 1. This component SHALL contain exactly one [1..1] structuredBody (CONF:30617).
     1. This structuredBody MAY contain zero or one [0..1] component (CONF:30618) such that it
        1. SHALL contain exactly one [1..1] [Assessment Section](#S_Assessment_Section) (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:30619).
     2. This structuredBody MAY contain zero or one [0..1] component (CONF:30620) such that it
        1. SHALL contain exactly one [1..1] [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30621).
     3. This structuredBody MAY contain zero or one [0..1] component (CONF:30622) such that it
        1. SHALL contain exactly one [1..1] [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) (CONF:30623).
     4. This structuredBody MAY contain zero or one [0..1] component (CONF:30624) such that it
        1. SHALL contain exactly one [1..1] [Allergies Section (entries optional) (V2)](#S_Allergies_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.6.2) (CONF:30625).
     5. This structuredBody MAY contain zero or one [0..1] component (CONF:30626) such that it
        1. SHALL contain exactly one [1..1] [Chief Complaint Section](#S_Chief_Complaint_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:30627).
     6. This structuredBody MAY contain zero or one [0..1] component (CONF:30628) such that it
        1. SHALL contain exactly one [1..1] [Interventions Section (V2)](#Interventions_Section_V2) (templateId:2.16.840.1.113883.10.20.21.2.3.2) (CONF:30629).
     7. This structuredBody MAY contain zero or one [0..1] component (CONF:30639) such that it
        1. SHALL contain exactly one [1..1] [Instructions Section (V2)](#Instructions_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.45.2) (CONF:31386).
     8. This structuredBody MAY contain zero or one [0..1] component (CONF:30641) such that it
        1. SHALL contain exactly one [1..1] [Medications Section (entries optional) (V2)](#S_Medications_Section_entries_optional_) (templateId:2.16.840.1.113883.10.20.22.2.1.2) (CONF:30642).
     9. This structuredBody MAY contain zero or one [0..1] component (CONF:30643) such that it
        1. SHALL contain exactly one [1..1] [Objective Section](#S_Objective_Section) (templateId:2.16.840.1.113883.10.20.21.2.1) (CONF:30644).
     10. This structuredBody MAY contain zero or one [0..1] component (CONF:30645) such that it
         1. SHALL contain exactly one [1..1] [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2) (templateId:2.16.840.1.113883.10.20.2.10.2) (CONF:30646).
     11. This structuredBody MAY contain zero or one [0..1] component (CONF:30647) such that it
         1. SHALL contain exactly one [1..1] [Problem Section (entries optional) (V2)](#S_Problem_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.5.2) (CONF:30648).
     12. This structuredBody MAY contain zero or one [0..1] component (CONF:30649) such that it
         1. SHALL contain exactly one [1..1] [Results Section (entries optional) (V2)](#S_Results_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.3.2) (CONF:30650).
     13. This structuredBody MAY contain zero or one [0..1] component (CONF:30651) such that it
         1. SHALL contain exactly one [1..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:30652).
     14. This structuredBody MAY contain zero or one [0..1] component (CONF:30653) such that it
         1. SHALL contain exactly one [1..1] [Subjective Section](#S_Subjective_Section) (templateId:2.16.840.1.113883.10.20.21.2.2) (CONF:30654).
     15. This structuredBody MAY contain zero or one [0..1] component (CONF:30655) such that it
         1. SHALL contain exactly one [1..1] [Vital Signs Section (entries optional) (V2)](#Vital_Signs_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.4.2) (CONF:30656).
     16. SHALL include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2), or an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a  Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30657).
     17. SHALL NOT include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) are present (CONF:30658).

46: ProgressNoteDocumentTypeCode

|  |  |  |
| --- | --- | --- |
| Value Set: ProgressNoteDocumentTypeCode 2.16.840.1.113883.11.20.8.1 | | |
| Code | Code System | Print Name |
| 11506-3 | LOINC | {Provider} |
| 18733-6 | LOINC | Attending physician |
| 18762-5 | LOINC | Chiropractor |
| 28569-2 | LOINC | Consulting physician |
| 28617-9 | LOINC | Dentistry |
| 34900-1 | LOINC | General medicine |
| 34904-3 | LOINC | Mental health |
| 18764-1 | LOINC | Nurse practitioner |
| 28623-7 | LOINC | Nursing |
| 11507-1 | LOINC | Occupational therapy |
| ... | | |

Referral Note (NEW)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.14 (open)]

47: Referral Note (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Advance Directives Section (entries optional) (V2)](#Advance_Directives_Section_entries_opti)  [Allergies Section (entries required) (V2)](#S_Allergies_Section_entries_required_V2)  [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2)  [Assessment Section](#S_Assessment_Section)  [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S)  [Chief Complaint Section](#S_Chief_Complaint_Section)  [Family History Section](#S_Family_History_Section)  [Functional Status Section (V2)](#S_Functional_Status_Section_V2)  [General Status Section](#S_General_Status_Section)  [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2)  [History of Present Illness Section](#S_History_of_Present_Illness_Section)  [Immunizations Section (entries required) (V2)](#S_Immunizations_Section_entries_require)  [Medical Equipment Section (V2)](#S_Medical_Equipment_Section_V2)  [Medications Section (entries required) (V2)](#S_Medications_Section_entries_required_)  [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW)  [Nutrition Section (NEW)](#S_Nutrition_Section_NEW)  [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2)  [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2)  [Problem Section (entries required) (V2)](#S_Problem_Section_entries_required_V2)  [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2)  [Reason for Referral Section (V2)](#Reason_for_Referral_Section_V2)  [Results Section (entries required) (V2)](#S_Results_Section_entries_required_V2)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Social History Section (V2)](#S_Social_History_Section_V2)  [Vital Signs Section (entries required) (V2)](#S_Vital_Signs_Section_entries_required_) |

This clinical document communicates pertinent patient information to the consulting provider from a referring provider. The information in this document would include the reason for the referral and additional medical information that would augment care delivery. Examples of referral situations are when a patient is referred from a family physician to a cardiologist for follow up for a cardiac condition or a when patient is sent by a  primary care provider to an emergency department.

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:28947) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.14" (CONF:28948).

The Referral note recommends use of the document type code 57113-1 "Referral Note", with further specification provided by author or performer, setting, or specialty. When pre-coordinated codes are used, any coded values describing the author or performer of the service act or the practice setting must be consistent with the LOINC document type. For example, an Obstetrics and Gynecology Referral note would not be authored by a Pediatric Cardiologist.

1. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [ReferralDocumentType](#ReferralDocumentType) 2.16.840.1.113883.1.11.20.2.3 DYNAMIC (CONF:28949).
2. SHALL contain exactly one [1..1] title (<CONF:29840>).

Participants and actRelationships

#### informationRecipient

The information recipient represents the intended recipient of the referral note.

1. SHALL contain exactly one [1..1] informationRecipient (CONF:31589).
   1. This informationRecipient SHALL contain exactly one [1..1] intendedRecipient (CONF:31590).
      1. This intendedRecipient SHOULD contain zero or more [0..\*] addr (CONF:31591).
      2. This intendedRecipient MAY contain zero or more [0..\*] telecom (CONF:31592).
      3. This intendedRecipient SHALL contain exactly one [1..1] informationRecipient (CONF:31593).
         1. This informationRecipient SHALL contain exactly one [1..1] name (CONF:31594).
            1. This name SHALL contain exactly one [1..1] family (CONF:31595).
            2. This name SHALL contain exactly one [1..1] given (CONF:31596).
      4. This intendedRecipient MAY contain zero or one [0..1] receivedOrganization (CONF:31597).

#### participant

The Participants (support) identifies participants who support the patient such as a relative or caregiver.

1. MAY contain zero or more [0..\*] participant (CONF:31642).
   1. The participant, if present, SHALL contain exactly one [1..1] associatedEntity (CONF:31643).
      1. This associatedEntity SHALL contain exactly one [1..1] associatedPerson (CONF:31644).
         1. This associatedPerson SHALL contain exactly one [1..1] name (CONF:31645).
   2. Unless otherwise specified by the document specific header constraints, when participant/@typeCode is IND, associatedEntity/@classCode SHALL be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:31646).

#### participant

The participants (contact) represent the clinician to contact for questions about the referral summary.  This may represent the clinician who made the referral or the referral nurse.

1. SHOULD contain zero or more [0..\*] participant (CONF:31647).
   1. The participant, if present, SHALL contain exactly one [1..1] @typeCode="CALLBACK" call back contact (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 DYNAMIC) (CONF:31648).
   2. The participant, if present, SHALL contain exactly one [1..1] associatedEntity="ASSIGNED" assigned entity (CodeSystem: RoleClass 2.16.840.1.113883.5.110) (CONF:31649).
      1. This associatedEntity SHALL contain at least one [1..\*] id (CONF:31650).
      2. This associatedEntity SHOULD contain zero or more [0..\*] addr (CONF:31651).
      3. This associatedEntity SHALL contain at least one [1..\*] telecom (CONF:31652).
      4. This associatedEntity SHALL contain exactly one [1..1] associatedPerson (CONF:31653).
         1. This associatedPerson MAY contain at least one [1..\*] name (CONF:31654).
      5. This associatedEntity MAY contain zero or one [0..1] scopingOrganization (CONF:31655).
2. SHALL contain exactly one [1..1] component (CONF:29062).

#### structuredBody

* 1. This component SHALL contain exactly one [1..1] structuredBody (CONF:29063).
     1. This structuredBody SHOULD contain zero or one [0..1] component (CONF:29066) such that it
        1. SHALL contain exactly one [1..1] [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:29067).
     2. This structuredBody MAY contain zero or one [0..1] component (CONF:29068) such that it
        1. SHALL contain exactly one [1..1] [Advance Directives Section (entries optional) (V2)](#Advance_Directives_Section_entries_opti) (templateId:2.16.840.1.113883.10.20.22.2.21.2) (CONF:29069).
     3. This structuredBody MAY contain zero or one [0..1] component (CONF:29070) such that it
        1. SHALL contain exactly one [1..1] [Chief Complaint Section](#S_Chief_Complaint_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:29073).
     4. This structuredBody SHALL contain exactly one [1..1] component (CONF:29071) such that it
        1. SHALL contain exactly one [1..1] [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S) (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:29072).
     5. This structuredBody MAY contain zero or one [0..1] component (CONF:29074) such that it
        1. SHALL contain exactly one [1..1] [History of Present Illness Section](#S_History_of_Present_Illness_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:29075).
     6. This structuredBody MAY contain zero or one [0..1] component (CONF:29076) such that it
        1. SHALL contain exactly one [1..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:29077).
     7. This structuredBody MAY contain zero or one [0..1] component (CONF:29082) such that it
        1. SHALL contain exactly one [1..1] [Immunizations Section (entries required) (V2)](#S_Immunizations_Section_entries_require) (templateId:2.16.840.1.113883.10.20.22.2.2.1.2) (CONF:29083).
     8. This structuredBody SHALL contain exactly one [1..1] component (CONF:29086) such that it
        1. SHALL contain exactly one [1..1] [Problem Section (entries required) (V2)](#S_Problem_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.5.1.2) (CONF:29087).
     9. This structuredBody MAY contain zero or one [0..1] component (CONF:29088) such that it
        1. SHALL contain exactly one [1..1] [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2) (templateId:2.16.840.1.113883.10.20.22.2.7.2) (CONF:29089).
     10. This structuredBody SHOULD contain zero or one [0..1] component (CONF:29090) such that it
         1. SHALL contain exactly one [1..1] [Results Section (entries required) (V2)](#S_Results_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.3.1.2) (CONF:29091).
     11. This structuredBody MAY contain zero or one [0..1] component (CONF:29092) such that it
         1. SHALL contain exactly one [1..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:29093).
     12. This structuredBody MAY contain zero or one [0..1] component (CONF:29094) such that it
         1. SHALL contain exactly one [1..1] [Social History Section (V2)](#S_Social_History_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:29095).
     13. This structuredBody MAY contain zero or one [0..1] component (CONF:29096) such that it
         1. SHALL contain exactly one [1..1] [Vital Signs Section (entries required) (V2)](#S_Vital_Signs_Section_entries_required_) (templateId:2.16.840.1.113883.10.20.22.2.4.1.2) (CONF:29097).
     14. This structuredBody SHOULD contain zero or one [0..1] component (CONF:29098) such that it
         1. SHALL contain exactly one [1..1] [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.14.2) (CONF:29099).
     15. This structuredBody MAY contain zero or one [0..1] component (CONF:29100) such that it
         1. SHALL contain exactly one [1..1] [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2) (templateId:2.16.840.1.113883.10.20.2.10.2) (CONF:29101).
     16. This structuredBody MAY contain zero or one [0..1] component (CONF:29564) such that it
         1. SHALL contain exactly one [1..1] [Advance Directives Section (entries optional) (V2)](#Advance_Directives_Section_entries_opti) (templateId:2.16.840.1.113883.10.20.22.2.21.2) (CONF:29565).
     17. This structuredBody SHOULD contain zero or one [0..1] component (CONF:30780) such that it
         1. SHALL contain exactly one [1..1] [Nutrition Section (NEW)](#S_Nutrition_Section_NEW) (templateId:2.16.840.1.113883.10.20.22.2.57) (CONF:30781).
     18. This structuredBody SHOULD contain zero or one [0..1] component (CONF:30796) such that it
         1. SHALL contain exactly one [1..1] [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW) (templateId:2.16.840.1.113883.10.20.22.2.56) (CONF:30926).
     19. This structuredBody MAY contain zero or one [0..1] component (CONF:30798) such that it
         1. SHALL contain exactly one [1..1] [Medical Equipment Section (V2)](#S_Medical_Equipment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.23.2) (CONF:30799).
     20. This structuredBody SHALL contain exactly one [1..1] component (CONF:30911) such that it
         1. SHALL contain exactly one [1..1] [Allergies Section (entries required) (V2)](#S_Allergies_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.6.1.2) (CONF:30912).
     21. This structuredBody MAY contain zero or one [0..1] component (CONF:30913) such that it
         1. SHALL contain exactly one [1..1] [Assessment Section](#S_Assessment_Section) (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:30914).
     22. This structuredBody MAY contain zero or one [0..1] component (CONF:30915) such that it
         1. SHALL contain exactly one [1..1] [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) (CONF:30916).
     23. This structuredBody MAY contain zero or one [0..1] component (CONF:30917) such that it
         1. SHALL contain exactly one [1..1] [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.20.2) (CONF:30918).
     24. This structuredBody MAY contain zero or one [0..1] component (CONF:30919) such that it
         1. SHALL contain exactly one [1..1] [General Status Section](#S_General_Status_Section) (templateId:2.16.840.1.113883.10.20.2.5) (CONF:30920).
     25. This structuredBody SHALL contain exactly one [1..1] component (CONF:30922) such that it
         1. SHALL contain exactly one [1..1] [Medications Section (entries required) (V2)](#S_Medications_Section_entries_required_) (templateId:2.16.840.1.113883.10.20.22.2.1.1.2) (CONF:30923).
     26. This structuredBody SHALL contain exactly one [1..1] component (CONF:30924) such that it
         1. SHALL contain exactly one [1..1] [Reason for Referral Section (V2)](#Reason_for_Referral_Section_V2) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.1.2) (CONF:30925).
     27. SHALL include an Assessment and Plan Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.9.2) OR an Assessment Section (templateId: 2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.10.2) (CONF:29102).
     28. SHALL NOT include an Assessment and Plan Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId: 2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.10.2) are present (CONF:29103).

49: ReferralDocumentType

|  |  |  |
| --- | --- | --- |
| Value Set: ReferralDocumentType 2.16.840.1.113883.1.11.20.2.3  A referral note provides a consulting physician specified patient information about the patient referred. | | |
| Code | Code System | Print Name |
| 57133-1 | LOINC | Referral note |
| 57170-3 | LOINC | Cardiovascular disease Referral note |
| 57178-6 | LOINC | Critical Care Medicine Referral note |
| 57134-9 | LOINC | Dentistry Referral note |
| 57135-6 | LOINC | Dermatology Referral note |
| 57136-4 | LOINC | Diabetology Referral note |
| 57137-2 | LOINC | Endocrinology Referral note |
| 57138-0 | LOINC | Gastroenterology Referral note |
| 57139-8 | LOINC | General medicine Referral note |
| 57140-6 | LOINC | General surgery Referral note |
| ... | | |

Transfer Summary (NEW)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.13 (open)]

50: Transfer Summary (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Advance Directives Section (entries required) (V2)](#S_Advance_Directives_Section_entries_re)  [Allergies Section (entries required) (V2)](#S_Allergies_Section_entries_required_V2)  [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2)  [Assessment Section](#S_Assessment_Section)  [Encounters Section (entries required) (V2)](#S_Encounters_Section_entries_required_V)  [Family History Section](#S_Family_History_Section)  [Functional Status Section (V2)](#S_Functional_Status_Section_V2)  [General Status Section](#S_General_Status_Section)  [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2)  [History of Present Illness Section](#S_History_of_Present_Illness_Section)  [Hospital Discharge Diagnosis Section (V2)](#Hospital_Discharge_Diagnosis_Section_V2)  [Immunizations Section (entries optional) (V2)](#S_Immunizations_Section_entries_optiona)  [Medical Equipment Section (V2)](#S_Medical_Equipment_Section_V2)  [Medications Section (entries required) (V2)](#S_Medications_Section_entries_required_)  [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW)  [Nutrition Section (NEW)](#S_Nutrition_Section_NEW)  [Payers Section (V2)](#S_Payers_Section_V2)  [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2)  [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2)  [Problem Section (entries required) (V2)](#S_Problem_Section_entries_required_V2)  [Procedures Section (entries required) (V2)](#S_Procedures_Section_entries_required_V)  [Reason for Referral Section (V2)](#Reason_for_Referral_Section_V2)  [Results Section (entries required) (V2)](#S_Results_Section_entries_required_V2)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Social History Section (V2)](#S_Social_History_Section_V2)  [Vital Signs Section (entries required) (V2)](#S_Vital_Signs_Section_entries_required_) |

This document describes constraints on the  Clinical Document Architecture (CDA) header and body elements for a Transfer Summary. The Transfer summary standardizes critical information for exchange of information between providers of care when a patient moves between health care settings. Standardization of information used in this form will promote interoperability; create information suitable for reuse in quality measurement, public health, research, and for reimbursement.

51: Transfer Summary (NEW) Constraints Overview

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:28239) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.13" (CONF:28240).
3. SHALL contain exactly one [1..1] id (CONF:28241).
   1. This id SHALL contain exactly one [1..1] @root (CONF:28242).
4. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [TransferDocumentType](#TransferDocumentType) 2.16.840.1.113883.1.11.20.2.4 DYNAMIC (CONF:28243).
5. SHALL contain exactly one [1..1] title (<CONF:29838>).

Participants and actRelationships

#### participant

The Participants (support) identifies participants who support the patient such as a relative or caregiver.

1. SHOULD contain zero or more [0..\*] participant (CONF:31599).
   1. The participant, if present, SHALL contain exactly one [1..1] associatedEntity (CONF:31600).
      1. This associatedEntity SHALL contain exactly one [1..1] associatedPerson (CONF:31601).
         1. This associatedPerson SHALL contain at least one [1..\*] name (CONF:31602).
   2. Unless otherwise specified by the document specific header constraints, when participant/@typeCode is IND, associatedEntity/@classCode SHALL be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:31603).

Figure 20: Transfer Summary Participant (Support)

<participant typeCode="IND">

<time xsi:type="IVL\_TS">

<low value="19590101"/>

<high value="20111025"/>

</time>

<associatedEntity classCode="ECON">

<code code="MTH" codeSystem="2.16.840.1.113883.5.111"/>

<addr>

<streetAddressLine>17 Daws Rd.</streetAddressLine>

<city>Ann Arbor</city>

<state>MI</state>

<postalCode>97857</postalCode>

<country>US</country>

</addr>

<telecom value="tel:(999)555-1212" use="WP"/>

<associatedPerson>

<name>

<prefix>Mrs.</prefix>

<given>Martha</given>

<family>Jones</family>

</name>

</associatedPerson>

</associatedEntity>

</participant>

<participant typeCode="IND">

<functionCode code="407543004" displayName="Primary Carer"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED-CT"/>

<time xsi:type="IVL\_TS">

<low value="19590101"/>

<high value="20111025"/>

</time>

<associatedEntity classCode="CAREGIVER">

<code code="MTH" codeSystem="2.16.840.1.113883.5.111"/>

<addr>

<streetAddressLine>17 Daws Rd.</streetAddressLine>

<city>Ann Arbor</city>

<state>MI</state>

<postalCode>97857</postalCode>

<country>US</country>

</addr>

<telecom value="tel:(999)555-1212" use="WP"/>

<associatedPerson>

<name>

<prefix>Mrs.</prefix>

<given>Martha</given>

<family>Jones</family>

</name>

</associatedPerson>

</associatedEntity>

</participant>

#### participant

The participants (contact) represent the clinician to contact for questions about the transfer summary.  This call back contact may be different from the author and legal authenticator of the document.

1. SHOULD contain zero or more [0..\*] participant (CONF:31626).
   1. The participant, if present, SHALL contain exactly one [1..1] @typeCode="CALLBACK" Call back contact (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:31627).
   2. The participant, if present, SHALL contain exactly one [1..1] associatedEntity (CONF:31628).
      1. This associatedEntity SHALL contain exactly one [1..1] @classCode="ASSIGNED" assigned entity (CodeSystem: RoleClass 2.16.840.1.113883.5.110) (CONF:31641).
      2. This associatedEntity SHALL contain at least one [1..\*] id (CONF:31629).
      3. This associatedEntity SHOULD contain zero or more [0..\*] addr (CONF:31630).
      4. This associatedEntity SHALL contain at least one [1..\*] telecom (CONF:31631).
      5. This associatedEntity SHALL contain exactly one [1..1] associatedPerson (CONF:31632).
         1. This associatedPerson SHALL contain at least one [1..\*] name (CONF:31633).
      6. This associatedEntity MAY contain zero or one [0..1] scopingOrganization (CONF:31634).

Figure 21: Transfer Summary Callback Contact

<participant typeCode="CALLBCK">

<time value="20050329224411+0500" />

<associatedEntity classCode="ASSIGNED">

<id extension="99999999" root="2.16.840.1.113883.4.6" />

<code code="200000000X" codeSystem="2.16.840.1.113883.6.101" displayName="Allopathic &amp; Osteopathic Physicians" />

<addr>

<streetAddressLine>1002 Healthcare Drive </streetAddressLine>

<city>Ann Arbor</city>

<state>MI</state>

<postalCode>97857</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:555-555-1002" />

<associatedPerson>

<name>

<given>Henry</given>

<family>Seven</family>

</name>

</associatedPerson>

</associatedEntity>

</participant>

1. SHALL contain exactly one [1..1] documentationOf (CONF:31570).
   1. This documentationOf SHALL contain exactly one [1..1] serviceEvent (CONF:31571).
      1. This serviceEvent SHALL contain exactly one [1..1] @classCode="PCPR" Care Provision (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:31572).
      2. This serviceEvent SHALL contain exactly one [1..1] effectiveTime (CONF:31573).

#### performer

The performer(s) represents the healthcare providers involved in the current or historical care of the patient.The patient’s key healthcare providers would be listed here which would include the primary physician and any active consulting physicians, therapists, counselors, and care team members.

* + 1. This serviceEvent SHALL contain exactly one [1..1] performer (CONF:31574).
       1. This performer SHALL contain exactly one [1..1] @typeCode="PRF" Participation of Physical Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 DYNAMIC) (CONF:31575).
       2. This performer SHOULD contain zero or one [0..1] assignedEntity (CONF:31576).
          1. The assignedEntity, if present, SHOULD contain at least one [1..\*] id (CONF:31577).
          2. The assignedEntity, if present, MAY contain zero or one [0..1] code (CONF:31578).

1. SHALL contain exactly one [1..1] component (CONF:28251).
   1. This component SHOULD contain exactly one [1..1] structuredBody (CONF:28252) such that it
      1. SHOULD contain zero or one [0..1] component (CONF:28253) such that it
         1. SHALL contain exactly one [1..1] [Advance Directives Section (entries required) (V2)](#S_Advance_Directives_Section_entries_re) (templateId:2.16.840.1.113883.10.20.22.2.21.1.2) (CONF:28254).
      2. SHALL contain exactly one [1..1] component (CONF:28255) such that it
         1. SHALL contain exactly one [1..1] [Allergies Section (entries required) (V2)](#S_Allergies_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.6.1.2) (CONF:28256).
      3. MAY contain zero or one [0..1] component (CONF:28257) such that it
         1. SHALL contain exactly one [1..1] [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2) (templateId:2.16.840.1.113883.10.20.2.10.2) (CONF:28258).
      4. MAY contain zero or one [0..1] component (CONF:28261) such that it
         1. SHALL contain exactly one [1..1] [Encounters Section (entries required) (V2)](#S_Encounters_Section_entries_required_V) (templateId:2.16.840.1.113883.10.20.22.2.22.1.2) (CONF:28262).
      5. MAY contain zero or one [0..1] component (CONF:28263) such that it
         1. SHALL contain exactly one [1..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:28264).
      6. SHOULD contain zero or one [0..1] component (CONF:28265) such that it
         1. SHALL contain exactly one [1..1] [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.14.2) (CONF:28266).
      7. SHOULD contain zero or one [0..1] component (CONF:28271) such that it

Required for hospital discharges.

* + - 1. SHALL contain exactly one [1..1] [Hospital Discharge Diagnosis Section (V2)](#Hospital_Discharge_Diagnosis_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.24.2) (CONF:28272).
    1. MAY contain zero or one [0..1] component (CONF:28273) such that it
       1. SHALL contain exactly one [1..1] [Immunizations Section (entries optional) (V2)](#S_Immunizations_Section_entries_optiona) (templateId:2.16.840.1.113883.10.20.22.2.2.2) (CONF:28274).
    2. MAY contain zero or one [0..1] component (CONF:28275) such that it
       1. SHALL contain exactly one [1..1] [Medical Equipment Section (V2)](#S_Medical_Equipment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.23.2) (CONF:28276).
    3. SHALL contain exactly one [1..1] component (CONF:28277) such that it
       1. SHALL contain exactly one [1..1] [Medications Section (entries required) (V2)](#S_Medications_Section_entries_required_) (templateId:2.16.840.1.113883.10.20.22.2.1.1.2) (CONF:28278).
    4. MAY contain zero or one [0..1] component (CONF:28279) such that it
       1. SHALL contain exactly one [1..1] [Payers Section (V2)](#S_Payers_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.18.2) (CONF:28280).
    5. MAY contain zero or one [0..1] component (CONF:28281) such that it
       1. SHALL contain exactly one [1..1] [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:28282).
    6. SHALL contain exactly one [1..1] component (CONF:28283) such that it
       1. SHALL contain exactly one [1..1] [Problem Section (entries required) (V2)](#S_Problem_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.5.1.2) (CONF:28284).
    7. SHOULD contain zero or one [0..1] component (CONF:28285) such that it

Required for hospitals.

* + - 1. MAY contain zero or more [0..\*] templateId (CONF:31348).
      2. SHALL contain exactly one [1..1] [Procedures Section (entries required) (V2)](#S_Procedures_Section_entries_required_V) (templateId:2.16.840.1.113883.10.20.22.2.7.1.2) (CONF:28286).
    1. SHALL contain exactly one [1..1] component (CONF:28287) such that it
       1. SHALL contain exactly one [1..1] [Results Section (entries required) (V2)](#S_Results_Section_entries_required_V2) (templateId:2.16.840.1.113883.10.20.22.2.3.1.2) (CONF:28288).
    2. SHOULD contain zero or one [0..1] component (CONF:28289) such that it
       1. SHALL contain exactly one [1..1] [Social History Section (V2)](#S_Social_History_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:28290).
    3. SHALL contain exactly one [1..1] component (CONF:28291) such that it
       1. SHALL contain exactly one [1..1] [Vital Signs Section (entries required) (V2)](#S_Vital_Signs_Section_entries_required_) (templateId:2.16.840.1.113883.10.20.22.2.4.1.2) (CONF:28292).
    4. SHOULD contain zero or one [0..1] component (CONF:28327) such that it
       1. SHALL contain exactly one [1..1] [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW) (templateId:2.16.840.1.113883.10.20.22.2.56) (CONF:28328).
    5. MAY contain zero or one [0..1] component (CONF:28838) such that it
       1. SHALL contain exactly one [1..1] [General Status Section](#S_General_Status_Section) (templateId:2.16.840.1.113883.10.20.2.5) (CONF:28839).
    6. MAY contain zero or one [0..1] component (CONF:30239) such that it
       1. SHALL contain exactly one [1..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:30240).
    7. SHOULD contain [0..0] component (CONF:30776) such that it
       1. SHALL contain exactly one [1..1] [Nutrition Section (NEW)](#S_Nutrition_Section_NEW) (templateId:2.16.840.1.113883.10.20.22.2.57) (CONF:30777).
    8. SHALL contain exactly one [1..1] component (CONF:31342) such that it
       1. SHALL contain exactly one [1..1] [Reason for Referral Section (V2)](#Reason_for_Referral_Section_V2) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.1.2) (CONF:31343).
    9. MAY contain zero or one [0..1] component (CONF:31561) such that it
       1. SHALL contain exactly one [1..1] [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.20.2) (CONF:31562).
    10. SHOULD contain zero or one [0..1] component (CONF:31563) such that it
        1. SHALL contain exactly one [1..1] [History of Present Illness Section](#S_History_of_Present_Illness_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:31564).
    11. MAY contain zero or one [0..1] component (CONF:31565) such that it
        1. SHALL contain exactly one [1..1] [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) (CONF:31566).
    12. MAY contain zero or one [0..1] component (CONF:31567) such that it
        1. SHALL contain exactly one [1..1] [Assessment Section](#S_Assessment_Section) (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:31568).
    13. SHALL include an Assessment and Plan Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.9.2) OR an Assessment Section (templateId: 2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.10.2) (CONF:31582).
    14. SHALL NOT include an Assessment and Plan Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId: 2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.10.2) are present (CONF:31583).

52: TransferDocumentType

|  |  |  |
| --- | --- | --- |
| Value Set: TransferDocumentType 2.16.840.1.113883.1.11.20.2.4  A transfer document is exchanged between care providers when a patient transfers from one care setting to another. | | |
| Code | Code System | Print Name |
| 18761-7 | LOINC | Provider-unspecified Transfer summary |
| 68618-8 | LOINC | Adolescent medicine Transfer summarization note |
| 68632-9 | LOINC | Allergy and immunology Transfer summarization note |
| 68647-7 | LOINC | Child and adolescent psychiatry Transfer summarization note |
| 68660-0 | LOINC | Clinical genetics Transfer summarization note |
| 34755-9 | LOINC | Critical Care Medicine Transfer summarization note |
| 68669-1 | LOINC | Developmental-behavioral pediatrics Transfer summarization note |
| 34770-8 | LOINC | General medicine Transfer summarization note |
| 68680-8 | LOINC | Multi-specialty program Transfer summarization note |
| 68704-6 | LOINC | Neurology w special qualifications in child neuro Transfer summarization note |
| ... | | |

Unstructured Document (V2)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.10.2 (open)]

53: Unstructured Document (V2) Contexts

| Contained By: | Contains: |
| --- | --- |

An Unstructured Document (UD) document type can (1) include unstructured content, such as a graphic, directly in a text element with a mediaType attribute, or (2) reference a single document file, such as a word-processing document  using a text/reference element.

For guidance on how to handle multiple files, on the selection of media types for this IG, and on the identification of external files, see the subsections which follow the constraints below.

IHE’s XDS-SD (Cross-Transaction Specifications and Content Specifications, Scanned Documents Module) profile addresses a similar, more restricted use case, specifically for scanned documents or documents electronically created from existing text sources, and limits content to PDF-A or text. This Unstructured Documents implementation guide is applicable not only for scanned documents in non-PDF formats, but also for clinical documents produced through word processing applications, etc.

For conformance with both specifications, please review the appendix on XDS-SD and US Realm Clinical Document Header Comparison and ensure that your documents at a minimum conform to all the SHALL constraints from either specification.

54: Unstructured Document (V2) Constraints Overview

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:7710) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.10.2" (CONF:10054).
3. SHALL contain exactly one [1..1] recordTarget (CONF:31089).
   1. This recordTarget SHALL contain exactly one [1..1] patientRole (CONF:31090).
      1. This patientRole SHALL contain exactly one [1..1] id (CONF:31091).
4. SHALL contain exactly one [1..1] author (CONF:31092).
   1. This author SHALL contain exactly one [1..1] assignedAuthor (CONF:31093).
      1. This assignedAuthor SHALL contain exactly one [1..1] addr (CONF:31094).
      2. This assignedAuthor SHALL contain exactly one [1..1] telecom (CONF:31095).
5. SHALL contain exactly one [1..1] custodian (CONF:31096).
   1. This custodian SHALL contain exactly one [1..1] assignedCustodian (CONF:31097).
      1. This assignedCustodian SHALL contain exactly one [1..1] representedCustodianOrganization (CONF:31098).
         1. This representedCustodianOrganization SHALL contain exactly one [1..1] id (CONF:31099).
         2. This representedCustodianOrganization SHALL contain exactly one [1..1] name (CONF:31100).
         3. This representedCustodianOrganization SHALL contain exactly one [1..1] telecom (CONF:31101).
         4. This representedCustodianOrganization SHALL contain exactly one [1..1] addr (CONF:31102).
6. SHALL contain exactly one [1..1] component (CONF:31085).
   1. This component SHALL contain exactly one [1..1] nonXMLBody (CONF:31086).
      1. This nonXMLBody SHALL contain exactly one [1..1] text (CONF:31087).
         1. This text MAY contain zero or one [0..1] @mediaType, which SHALL be selected from ValueSet [SupportedFileFormats](#SupportedFileFormats) 2.16.840.1.113883.11.20.7.1 (CONF:31088).
         2. The text element SHALL either contain a reference element with a value attribute, or have a representation attribute with the value of B64, a mediaType attribute, and contain the media content (CONF:31103).

55: SupportedFileFormats

|  |  |  |
| --- | --- | --- |
| Value Set: SupportedFileFormats 2.16.840.1.113883.11.20.7.1  A value set of the file formats supported by the Unstructured Document IG. | | |
| Code | Code System | Print Name |

US Realm Header - Patient Generated Document (NEW)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.29.1 (open)]

56: US Realm Header - Patient Generated Document (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |

The US Realm Patient Generated Document header template must conform to the Universal Realm Patient Generated Document header template. This template is designed to be used in conjunction with the US C-CDA General Header. It includes additional conformances which further constrain the US C-CDA General Header.

1. Conforms to [US Realm Header (V2)](#D_US_Realm_Header_V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:28458) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.29.1" (CONF:28459).

### recordTarget

The recordTarget records the patient whose health information is described by the clinical document; each recordTarget must contain at least one patientRole element. If the document receiver is interested in setting up a translator for the encounter with the patient, the receiver of the document will have to infer the need for a translator, based upon the language skills identified for the patient, the patients language of preference and the predominant language used by the organization receiving the CDA.

The patient MAY include 0..**] guardian(s). When that role is present, it SHOULD include a code element. The guardian/code element encodes the relationship between the person in the role of guardian and the patient.**

Does the patient/guardian role refer to legal guardian?

HL7 Vocabulary simply describes guardian as a relationship to a ward.  This need not be a formal legal relationship.

If legal guardian exists for the patient, should it be included or only if they are “present” for the generation of the PGD?

When a guardian relationship exists for the patient, it may be represented, regardless of who is present at the time the document is generated.

Examples for the use of the patient/guardian role:

A child’s parent MAY be represented in the guardian role.  In this case, the guardian/code element would encode the personal relationship of “mother” for the child’s mom or “father” for the child’s dad.

An elderly person’s child MAY be represented in the guardian role. In this case, the guardian/code element would encode the personal relationship of “daughter” or “son”, or if a legal relationship existed, the relationship of “legal guardian” could be encoded.

1. SHALL contain exactly one [1..1] recordTarget (CONF:28460).
   1. This recordTarget SHALL contain exactly one [1..1] patientRole (CONF:28461).
      1. This patientRole SHALL contain at least one [1..\*] id (CONF:28462).

The combination of the @root and @extension attributes record the person’s identity in a secure, trusted, and unique way.

* + - 1. Such ids SHALL contain exactly one [1..1] @root (CONF:28463).
      2. Such ids SHOULD contain zero or one [0..1] @extension (CONF:28464).
    1. This patientRole SHALL contain exactly one [1..1] patient (CONF:28465).
       1. This patient MAY contain zero or more [0..\*] guardian (CONF:28469).
          1. The guardian, if present, SHOULD contain zero or more [0..\*] id (CONF:28470).

The combination of the @root and @extension attributes record the person’s identity in a secure, trusted, and unique way.

The id, if present, SHALL contain exactly one [1..1] @root (CONF:28471).

The id, if present, SHOULD contain zero or one [0..1] @extension (CONF:28472).

* + - * 1. The guardian, if present, SHOULD contain zero or one [0..1] code, which SHALL be selected from ValueSet [Personal And Legal Relationship Role Type](#Personal_And_Legal_Relationship_Role_Ty) 2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:28473).
      1. This patient SHOULD contain zero or more [0..\*] languageCommunication (CONF:28474).
         1. The languageCommunication, if present, MAY contain zero or one [0..1] preferenceInd (CONF:28475).  
            Note: Indicates a preference for information about care delivery and treatments be communicated (or translated if needed) into this language.  
              
            If more than one languageCommunication is present, only one languageCommunication element SHALL have a preferenceInd with a value of 1.

If present, this organization represents the provider organization where the person is claiming to be a patient.

* + 1. This patientRole MAY contain zero or one [0..1] providerOrganization (CONF:28476).  
       Note: If present, this organization represents the provider organization where the person is claiming to be a patient.

### author

The author element represents the creator of the clinical document.  The author may be a device, or a person. The person is the patient or the patient’s advocate.

1. SHALL contain at least one [1..\*] author (CONF:28477).
   1. Such authors SHALL contain exactly one [1..1] assignedAuthor (CONF:28478).
      1. This assignedAuthor SHALL contain at least one [1..\*] id (CONF:28479).

The combination of the @root and @extension attributes record the person’s identity in a secure, trusted, and unique way.

* + - 1. Such ids SHOULD contain zero or one [0..1] @root (CONF:28480).

When the author is a person who is not acting in the role of a clinician, this code encodes the personal or legal relationship between author and the patient.

* + 1. This assignedAuthor SHALL contain exactly one [1..1] code (CONF:28481).
       1. This code SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet [Personal And Legal Relationship Role Type](#Personal_And_Legal_Relationship_Role_Ty) 2.16.840.1.113883.11.20.12.1 (CONF:28676).

Figure 23: author Example

<author>

<time value="20121126145000-0500" />

<assignedAuthor>

<!-- Identifier based on the person's Direct Address which is a secure and trusted mechanism for identifying

a person discretely. The root of the id is the OID of the HISP Assigning Authority for the Direct Address-->

<id extension="adameveryman@direct.sampleHISP.com" root="2.16.123.123.12345.1234" />

<!--

The PGD Header Template includes further conformance constraints on the code element to encode the personal or legal

relationship of the author when they are person who is not acting in the role of a clinician..

-->

<code code="ONESELF" displayName="Oneself" codeSystem="2.16.840.1.113883.5.111" codeSystemName="HL7 Role code" />

<addr use="HP">

<!-- HP is "primary home" from codeSystem 2.16.840.1.113883.5.1119 -->

<streetAddressLine>2222 Home Street</streetAddressLine>

<city>Boston</city>

<state>MA</state>

<postalCode>02368</postalCode>

<!-- US is "United States" from ISO 3166-1 Country Codes: 1.0.3166.1 -->

<country>US</country>

</addr>

<!-- HP is "primary home" from HL7 AddressUse 2.16.840.1.113883.5.1119 -->

<telecom value="tel:(555)555-2004" use="HP" />

<assignedPerson>

<name>

<given>Adam</given>

<family>Everyman</family>

</name>

</assignedPerson>

</assignedAuthor>

</author>

Figure 24: author device Example

<!-- The Author below documents the system used to create the Patient Generated Document.

In this scenario the Patient is using a fictitious PHR Service called MyPersonalHealthRecord.com.

It is a service which consumers purchase to receive and create their electronic health records.

It is not a Patient Portal that is tethered to some other EMR or medical insurance records system.

The service is developed by a company call ACME PHR Solutions,Inc. -->

<author>

<time value="20121126145000-0500" />

<assignedAuthor>

<id extension="777.11" root="2.16.840.1.113883.19" />

<addr nullFlavor="NA" />

<telecom nullFlavor="NA" />

<assignedAuthoringDevice>

<manufacturerModelName>ACME PHR</manufacturerModelName>

<softwareName>MyPHR v1.0</softwareName>

</assignedAuthoringDevice>

<representedOrganization>

<id extension="999" root="1.2.3.4.5.6.7.8.9.12345" />

<name>ACME PHR Solutions,Inc.</name>

<telecom use="WP" value="tel:123-123-12345" />

<addr>

<streetAddressLine>4 Future Way</streetAddressLine>

<city>Provenance</city>

<state>RI</state>

<postalCode>02919</postalCode>

</addr>

</representedOrganization>

</assignedAuthor>

</author>

### dataEnterer

The dataEnterer element represents the person who transferred the content, written or dictated by someone else, into the clinical document. The guiding rule of thumb is that an author provides the content found within the header or body of the document, subject to their own interpretation, and the dataEnterer adds that information to the electronic system. In other words, a dataEnterer transfers information from one source to another (e.g., transcription from paper form to electronic system). If the DataEnterer is missing, this role is assumed to be played by the Author.

1. MAY contain zero or one [0..1] dataEnterer (CONF:28678).
   1. The dataEnterer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:28679).
      1. This assignedEntity MAY contain zero or one [0..1] code, which SHOULD be selected from ValueSet [Personal And Legal Relationship Role Type](#Personal_And_Legal_Relationship_Role_Ty) 2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:28680).

Figure 25: dataEnterer Example

<dataEnterer>

<assignedEntity>

<!-- Identifier based on the person's Direct Address which is a secure and trusted mechanism for identifying

a person discretely. The root of the id is the OID of the HISP Assigning Authority for the Direct Address-->

<id extension="adameveryman@direct.sampleHISP.com" root="2.16.123.123.12345.1234" />

<code code="ONESELF" displayName="Oneself" codeSystem="2.16.840.1.113883.5.111" codeSystemName="HL7 Role code" />

<addr use="HP">

<!-- HP is "primary home" from codeSystem 2.16.840.1.113883.5.1119 -->

<streetAddressLine>2222 Home Street</streetAddressLine>

<city>Boston</city>

<state>MA</state>

<postalCode>02368</postalCode>

<!-- US is "United States" from ISO 3166-1 Country Codes: 1.0.3166.1 -->

<country>US</country>

</addr>

<!-- HP is "primary home" from HL7 AddressUse 2.16.840.1.113883.5.1119 -->

<telecom value="tel:(555)555-2004" use="HP" />

<assignedPerson>

<name>

<given>Adam</given>

<family>Everyman</family>

</name>

</assignedPerson>

</assignedEntity>

</dataEnterer>

### informant

The informant element describes the source of the information in a medical document.

Assigned health care providers may be a source of information when a document is created. (e.g., a nurse's aide who provides information about a recent significant health care event that occurred within an acute care facility.) In these cases, the assignedEntity element is used.

When the informant is a personal relation, that informant is represented in the relatedEntity element, even if the personal relation is medical professional.  The code element of the relatedEntity describes the relationship between the informant and the patient. The relationship between the informant and the patient  needs to be described to help the receiver of the clinical document understand the information in the document.

1. MAY contain zero or more [0..\*] informant (CONF:28681).

The informant element describes the source of the information in a medical document.

Assigned health care providers may be a source of information when a document is created. (e.g., a nurse's aide who provides information about a recent significant health care event that occurred within an acute care facility.) In these cases, the assignedEntity element is used.

When the informant is a personal relation, that informant is represented in the relatedEntity element, even if the personal relation is medical professional.  The code element of the relatedEntity describes the relationship between the informant and the patient. The relationship between the informant and the patient  needs to be described to help the receiver of the clinical document understand the information in the document.

* 1. The informant, if present, SHALL contain exactly one [1..1] relatedEntity (CONF:28682).  
     Note: Each informant can be either an assignedEntity (a clinician serving the patient) OR a relatedEntity (a person with a personal or legal relationship with the patient).  
       
     NOTE: RelatedEntity seems to be missing an id element.
     1. This relatedEntity MAY contain zero or one [0..1] code (CONF:28683).
        1. The code, if present, SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet [Personal And Legal Relationship Role Type](#Personal_And_Legal_Relationship_Role_Ty) 2.16.840.1.113883.11.20.12.1 (CONF:28684).

Figure 26: informant Example

<informant>

<assignedEntity>

<!-- id using HL7 example OID. -->

<id extension="999.1" root="2.16.840.1.113883.19" />

<code code="ONESELF" displayName="Oneself" codeSystem="2.16.840.1.113883.5.111" codeSystemName="HL7 Role code" />

<addr use="HP">

<!-- HP is "primary home" from codeSystem 2.16.840.1.113883.5.1119 -->

<streetAddressLine>2222 Home Street</streetAddressLine>

<city>Boston</city>

<state>MA</state>

<postalCode>02368</postalCode>

<!-- US is "United States" from ISO 3166-1 Country Codes: 1.0.3166.1 -->

<country>US</country>

</addr>

<!-- HP is "primary home" from HL7 AddressUse 2.16.840.1.113883.5.1119 -->

<telecom value="tel:(555)555-2004" use="HP" />

<assignedPerson>

<name>

<given>Adam</given>

<family>Everyman</family>

</name>

</assignedPerson>

</assignedEntity>

</informant>

Figure 27: informant RelEnt Example

<informant>

<!-- An Errata has been accepted to allow relatedEntity under Informant. #XXXX -->

<relatedEntity classCode="IND">

<!-- id using HL7 example OID. -->

<id extension="999.17" root="2.16.840.1.113883.19" />

<code code="SIS" displayName="Sister" codeSystem="2.16.840.1.113883.11.20.12.1" codeSystemName="Personal And Legal Relationship Role Type" />

<addr use="HP">

<!-- HP is "primary home" from codeSystem 2.16.840.1.113883.5.1119 -->

<streetAddressLine>2222 Home Street</streetAddressLine>

<city>Boston</city>

<state>MA</state>

<postalCode>02368</postalCode>

<!-- US is "United States" from ISO 3166-1 Country Codes: 1.0.3166.1 -->

<country>US</country>

</addr>

<!-- HP is "primary home" from HL7 AddressUse 2.16.840.1.113883.5.1119 -->

<telecom value="tel:(555)555-2004" use="HP" />

<assignedPerson>

<name>

<given>Alice</given>

<family>Everyman</family>

</name>

</assignedPerson>

</relatedEntity>

</informant>

### custodian

The custodian element represents the organization or person that is in charge of maintaining the document. The custodian is the steward that is entrusted with the care of the document. Every CDA document has exactly one custodian. The custodian participation satisfies the CDA definition of Stewardship. Because CDA is an exchange standard and may not represent the original form of the authenticated document (e.g., CDA could include scanned copy of original), the custodian represents the steward of the original source document. The custodian may be the document originator, a health information exchange, or other responsible party. Also, the custodian may be the patient or an organization acting on behalf of the patient, such as a PHR organization.

1. SHALL contain exactly one [1..1] custodian (CONF:28685).
   1. This custodian SHALL contain exactly one [1..1] assignedCustodian (CONF:28686).

The representedCustodianOrganization may be the person when the document is not maintained by an organization.

* + 1. This assignedCustodian SHALL contain exactly one [1..1] representedCustodianOrganization (CONF:28687).

The combined @root and @extension attributes record the custodian organization’s identity in a secure, trusted, and unique way.

* + - 1. This representedCustodianOrganization SHALL contain at least one [1..\*] id (CONF:28688).
         1. Such ids SHALL contain exactly one [1..1] @root (CONF:28689).

Figure 28: custodian Example

<custodian>

<assignedCustodian>

<representedCustodianOrganization>

<!-- id using HL7 example OID. -->

<id extension="999.3" root="2.16.840.1.113883.19" />

<name>MyPersonalHealthRecord.Com</name>

<telecom value="tel:(555)555-1212" use="WP" />

<addr use="WP">

<streetAddressLine>123 Boylston Street</streetAddressLine>

<city>Blue Hill</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

</representedCustodianOrganization>

</assignedCustodian>

</custodian>

### informationRecipient

The informationRecipient element records the intended recipient of the information at the time the document is created. For example, in cases where the intended recipient of the document is the patient's health chart, set the receivedOrganization to be the scoping organization for that chart.

1. MAY contain zero or more [0..\*] informationRecipient (CONF:28690).
   1. The informationRecipient, if present, SHALL contain exactly one [1..1] intendedRecipient (CONF:28691).

The combined @root and @extension  attributes to record the information recipient’s identity in a secure, trusted, and unique way.

* + 1. This intendedRecipient SHOULD contain zero or more [0..\*] id (CONF:28692).

For a provider, the id/@root ="2.16.840.1.113883.4.6" indicates the National Provider Identifier where id/@extension is the NPI number for the provider.

The ids MAY reference the id of a person or organization entity specified elsewhere in the document.

* + - 1. The id, if present, SHOULD contain zero or one [0..1] @root (CONF:28693).

Figure 29: informationRecipient

<!-- The document is intended for multiple recipients, Adam himself and his PCP physician. -->

<informationRecipient>

<intendedRecipient>

<!-- Identifier based on the person's Direct Address which is a secure and trusted mechanism for identifying

a person discretely. The root of the id is the OID of the HISP Assigning Authority for the Direct Address-->

<id extension="adameveryman@direct.sampleHISP.com" root="2.16.123.123.12345.1234"/>

<informationRecipient>

<name>

<given>Adam</given><family>Everyman</family>

</name>

</informationRecipient>

<receivedOrganization>

<!-- id using HL7 example OID. -->

<id extension="999.3" root="2.16.840.1.113883.19"/>

<name>MyPersonalHealthRecord.Com</name>

</receivedOrganization>

</intendedRecipient>

</informationRecipient>

<informationRecipient>

<intendedRecipient>

<!-- Unique/Trusted id using HL7 example OID. -->

<id extension="999.4" root="2.16.840.1.113883.19"/>

<!-- The physician's NPI number -->

<id extension="1122334455" root="2.16.840.1.113883.4.6"/>

<!-- The physician's Direct Address -->

<!-- Identifier based on the person's Direct Address which is a secure and trusted mechanism for identifying

a person discretely. The root of the id is the OID of the HISP Assigning Authority for the Direct Address-->

<id extension="DrP@direct.sampleHISP2.com" root="2.16.123.123.12345.4321"/>

<telecom use="WP" value="tel:(781)555-1212"/>

<telecom use="WP" value="mailto:DrP@direct.sampleHISP2.com"/>

<informationRecipient>

<name>

<prefix>Dr.</prefix>

<given>Patricia</given>

<family>Primary</family>

</name>

</informationRecipient>

<receivedOrganization>

<!-- Unique/Trusted id using HL7 example OID. -->

<id extension="999.2" root="2.16.840.1.113883.19"/>

<!-- NPI for the organization -->

<id extension="1234567890" root="2.16.840.1.113883.4.6"/>

<name>Good Health Internal Medicine</name>

<telecom use="WP" value="tel:(781)555-1212"/>

<addr>

<streetAddressLine>100 Health Drive</streetAddressLine>

<city>Boston</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

</receivedOrganization>

</intendedRecipient>

</informationRecipient>

### legalAuthenticator

In a patient authored document, the legalAuthenticator identifies the single person legally responsible for the document and must be present if the document has been legally authenticated. (Note that per the following section, there may also be one or more document authenticators.)

Based on local practice, patient authored documents may be provided without legal authentication. This implies that a patient authored document that does not contain this element has not been legally authenticated.

The act of legal authentication requires a certain privilege be granted to the legal authenticator depending upon local policy. All patient documents have the potential for legal authentication, given the appropriate legal authority.

Local policies MAY choose to delegate the function of legal authentication to a device or system that generates the document. In these cases, the legal authenticator is the person accepting responsibility for the document, not the generating device or system.

Note that the legal authenticator, if present, must be a person.

1. MAY contain zero or one [0..1] legalAuthenticator (CONF:28694).
   1. The legalAuthenticator, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:28695).

The combined @root and @extension  attributes to record the information recipient’s identity in a secure, trusted, and unique way.

* + 1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:28696).
    2. This assignedEntity MAY contain zero or one [0..1] code (CONF:28697).
       1. The code, if present, MAY contain zero or one [0..1] @code, which SHOULD be selected from ValueSet [Personal And Legal Relationship Role Type](#Personal_And_Legal_Relationship_Role_Ty) 2.16.840.1.113883.11.20.12.1 (CONF:28698).

Figure 30: legalAuthenticator

<legalAuthenticator>

<time value="20121126145000-0500" />

<signatureCode code="S" />

<assignedEntity>

<!-- Identifier based on the person's Direct Address which is a secure and trusted mechanism for identifying

a person discretely. The root of the id is the OID of the HISP Assigning Authority for the Direct Address-->

<id extension="adameveryman@direct.sampleHISP.com" root="2.16.123.123.12345.1234" />

<addr use="HP">

<!-- HP is "primary home" from codeSystem 2.16.840.1.113883.5.1119 -->

<streetAddressLine>2222 Home Street</streetAddressLine>

<city>Boston</city>

<state>MA</state>

<postalCode>02368</postalCode>

<!-- US is "United States" from ISO 3166-1 Country Codes: 1.0.3166.1 -->

<country>US</country>

</addr>

<!-- HP is "primary home" from HL7 AddressUse 2.16.840.1.113883.5.1119 -->

<telecom value="tel:(555)555-2004" use="HP" />

<assignedPerson>

<name>

<given>Adam</given>

<family>Everyman</family>

</name>

</assignedPerson>

</assignedEntity>

</legalAuthenticator>

### authenticator

1. MAY contain zero or more [0..\*] authenticator (CONF:28699).
   1. The authenticator, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:28700).

The combined @root and @extension  attributes to record the authenticator’s identity in a secure, trusted, and unique way.

* + 1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:28701).
    2. This assignedEntity SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet [Personal And Legal Relationship Role Type](#Personal_And_Legal_Relationship_Role_Ty) 2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:28702).

Figure 31: authenticator Example

<authenticator>

<time value="20121126145000-0500" />

<signatureCode code="S" />

<assignedEntity>

<!-- Identifier based on the person's Direct Address which is a secure and trusted mechanism for identifying

a person discretely. The root of the id is the OID of the HISP Assigning Authority for the Direct Address-->

<id extension="adameveryman@direct.sampleHISP.com" root="2.16.123.123.12345.1234" />

<addr use="HP">

<!-- HP is "primary home" from codeSystem 2.16.840.1.113883.5.1119 -->

<streetAddressLine>2222 Home Street</streetAddressLine>

<city>Boston</city>

<state>MA</state>

<postalCode>02368</postalCode>

<!-- US is "United States" from ISO 3166-1 Country Codes: 1.0.3166.1 -->

<country>US</country>

</addr>

<!-- HP is "primary home" from HL7 AddressUse 2.16.840.1.113883.5.1119 -->

<telecom value="tel:(555)555-2004" use="HP" />

<assignedPerson>

<name>

<given>Adam</given>

<family>Everyman</family>

</name>

</assignedPerson>

</assignedEntity>

</authenticator>

### participant

The participant element identifies other supporting participants, including parents, relatives, caregivers, insurance policyholders, guarantors, and other participants related in some way to the patient.

A supporting person or organization is an individual or an organization with a relationship to the patient. A supporting person who is playing multiple roles would be recorded in multiple participants (e.g., emergency contact and next-of-kin)

1. MAY contain zero or more [0..\*] participant (CONF:28703).

Unless otherwise specified by the document specific header constraints, when participant/@typeCode is IND, associatedEntity/@classCode SHALL be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30

* 1. The participant, if present, SHALL contain exactly one [1..1] @typeCode (CONF:28704).
  2. The participant, if present, SHALL contain exactly one [1..1] associatedEntity (CONF:28705).
     1. This associatedEntity SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet [Personal And Legal Relationship Role Type](#Personal_And_Legal_Relationship_Role_Ty) 2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:28706).

Figure 32: participant Example

<participant typeCode='IND'>

<time xsi:type="IVL\_TS">

<low value="19551125"/>

<high value="20121126"/>

</time>

<associatedEntity classCode='NOK'>

<code code='MTH' codeSystem='2.16.840.1.113883.5.111'/>

<addr>

<streetAddressLine>17 Daws Rd.</streetAddressLine>

<city>Blue Bell</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>US</country>

</addr>

<telecom value='tel:(555)555-2006' use='WP'/>

<associatedPerson>

<name>

<prefix>Mrs.</prefix>

<given>Martha</given>

<family>Mum</family>

</name>

</associatedPerson>

</associatedEntity>

</participant>

### inFulfillmentOf

1. MAY contain zero or more [0..\*] inFulfillmentOf (CONF:28707).
   1. The inFulfillmentOf, if present, SHALL contain exactly one [1..1] order (CONF:28708).

A scheduled appointment or service event in a practice management system may be represented using this id element.

* + 1. This order SHALL contain at least one [1..\*] id (CONF:28709).

Figure 33: inFulfillmentOf Example

<inFulfillmentOf>

<order>

<!-- The root identifies the EMR system at the Good Health Internal Medicine Practice -->

<id extension="Ord12345" root="2.16.840.1.113883.4.6.1234567890.4" />

</order>

</inFulfillmentOf>

### documentationOf

1. MAY contain zero or more [0..\*] documentationOf (CONF:28710).
   1. The documentationOf, if present, SHALL contain exactly one [1..1] serviceEvent (CONF:28711).

The code should be selected from a value set established by the document-level template for a specific type of Patient Generated Document.

* + 1. This serviceEvent SHOULD contain zero or one [0..1] code (CONF:28712).

serviceEvent/performer represents the healthcare providers, allied health professionals or other individuals involved in the current or pertinent historical care of the patient during the time span covered by the document

* + 1. This serviceEvent SHOULD contain zero or more [0..\*] performer (CONF:28713).

The functionCode SHALL be selected from value set ParticipationType 2.16.840.1.113883.1.11.10901

When indicating the performer was the primary care physician the functionCode shall be =”PCP”

* + - 1. The performer, if present, MAY contain zero or one [0..1] functionCode (CONF:28714).
      2. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:28715).

The combined @root and @extension  attributes record the performer’s identity in a secure, trusted, and unique way.

* + - * 1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:28716).

If the assignedEntity is an individual, the code SHOULD be selected from value set PersonalandLegalRelationshipRoleType value set

* + - * 1. This assignedEntity MAY contain zero or one [0..1] code, which SHOULD be selected from ValueSet [Personal And Legal Relationship Role Type](#Personal_And_Legal_Relationship_Role_Ty) 2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:28718).

Figure 34: documentationOf/ServiceEvent Example

<documentationOf typeCode="DOC">

<!-- Service Event class code is no longer constrained to be PCPR as with CCD or C-CDA-CCD -->

<serviceEvent classCode="ACT">

<effectiveTime>

<low value="19551125" />

<high value="20121126145000" />

</effectiveTime>

<performer typeCode="PRF">

<functionCode code="PCP" displayName="Primary Care Provider" codeSystem="2.16.840.1.113883.5.88" codeSystemName="Participation Function">

<originalText>Primary Care Provider (PCP)</originalText>

</functionCode>

<time>

<low value="201101" />

</time>

<assignedEntity>

<!-- Unique/trusted id using HL7 example OID. -->

<id extension="999.4" root="2.16.840.1.113883.19" />

<!-- The physician's NPI number -->

<id extension="1122334455" root="2.16.840.1.113883.4.6" />

<!-- Type of Physician -->

<code code="207R00000X" displayName="Internal Medicine" codeSystemName="NUCC Health Care Provider Taxonomy" codeSystem="2.16.840.1.113883.6.101" />

<addr>

<streetAddressLine>100 Health Drive</streetAddressLine>

<city>Boston</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

<telecom use="WP" value="tel:(781)555-1212" />

<assignedPerson>

<name>

<prefix>Dr.</prefix>

<given>Patricia</given>

<family>Primary</family>

</name>

</assignedPerson>

<representedOrganization>

<!-- Unique/Trusted id using HL7 example OID. -->

<id extension="999.2" root="2.16.840.1.113883.19" />

<name>Good Health Internal Medicine</name>

<telecom use="WP" value="tel:(781)555-1212" />

<addr>

<streetAddressLine>100 Health Drive</streetAddressLine>

<city>Boston</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>USA</country>

</addr>

</representedOrganization>

</assignedEntity>

</performer>

<performer typeCode="PRF">

<functionCode code="PCP" displayName="Primary Care Provider" codeSystem="2.16.840.1.113883.5.88" codeSystemName="Participation Function">

<originalText>Primary Care Provider (PCP)</originalText>

</functionCode>

<time>

<low value="1971" />

<high value="201101" />

</time>

<assignedEntity>

<!-- Unique/trusted id using HL7 example OID. -->

<id extension="99.5" root="2.16.840.1.113883.19" />

<!-- The physician's NPI number -->

<id extension="1122334466" root="2.16.840.1.113883.4.6" />

<!-- Type of Physician -->

<code code="207Q00000X" displayName="Family Medicine" codeSystemName="NUCC Health Care Provider Taxonomy" codeSystem="2.16.840.1.113883.6.101">

<originalText>General Practitioner</originalText>

</code>

<addr>

<streetAddressLine>103 Rue Champlain</streetAddressLine>

<city>Roxboro</city>

<state>QC</state>

<postalCode>H8Y 3S6</postalCode>

<country>CAN</country>

</addr>

<telecom use="WP" value="tel:514-555-1212" />

<assignedPerson>

<name>

<prefix>Dr.</prefix>

<given>Fay</given>

<family>Family</family>

</name>

</assignedPerson>

<representedOrganization>

<!-- Unique/Trusted id using HL7 example OID. -->

<id extension="999.5" root="2.16.840.1.113883.19" />

<name>Roxboro Family Practice</name>

<telecom use="WP" value="tel:514-555-1212" />

<addr>

<streetAddressLine>103 Rue Champlain</streetAddressLine>

<city>Roxboro</city>

<state>QC</state>

<postalCode>H8Y 3S6</postalCode>

<country>CAN</country>

</addr>

</representedOrganization>

</assignedEntity>

</performer>

<performer typeCode="PRF">

<functionCode code="PCP" displayName="Primary Care Provider" codeSystem="2.16.840.1.113883.5.88" codeSystemName="Participation Function">

<originalText>Primary Care Provider (PCP)</originalText>

</functionCode>

<time>

<low value="19551125" />

<high value="1971" />

</time>

<assignedEntity>

<!-- Unique/Trusted id using HL7 example OID. -->

<id extension="999.6" root="2.16.840.1.113883.19" />

<!-- The physician's NPI number -->

<id extension="1122334477" root="2.16.840.1.113883.4.6" />

<!-- Type of Physician -->

<code code="208000000X" displayName="Pediatrics" codeSystemName="NUCC Health Care Provider Taxonomy" codeSystem="2.16.840.1.113883.6.101">

<originalText>Pediatrician</originalText>

</code>

<addr>

<streetAddressLine>10 Rue De Seville</streetAddressLine>

<city>Pointe-Claire</city>

<state>QC</state>

<postalCode>H9R 1E9</postalCode>

<country>CAN</country>

</addr>

<telecom use="WP" value="tel:514-333-1234" />

<assignedPerson>

<name>

<prefix>Dr.</prefix>

<given>Karen</given>

<family>Kidder</family>

</name>

</assignedPerson>

<representedOrganization>

<!-- Unique/Trusted id using HL7 example OID -->

<id extension="999.7" root="2.16.840.1.113883.19" />

<name>Pointe-Claire Pediatrics</name>

<telecom use="WP" value="tel:514-333-1234" />

<addr>

<streetAddressLine>10 Rue De Seville</streetAddressLine>

<city>Pointe-Claire</city>

<state>QC</state>

<postalCode>H9R 1E9</postalCode>

<country>CAN</country>

</addr>

</representedOrganization>

</assignedEntity>

</performer>

</serviceEvent>

</documentationOf>

58: Personal And Legal Relationship Role Type

|  |  |  |
| --- | --- | --- |
| Value Set: Personal And Legal Relationship Role Type 2.16.840.1.113883.11.20.12.1  A personal or legal relationship records the role of a person in relation to another person, or a person to himself or herself. This value set is to be used when recording relationships based on personal or family ties or through legal assignment of responsibility.    Specific URL Pending  Valueset Source: [http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary\_tables/infrastructure/vocabulary/vocabulary.html](http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html%20) | | |
| Code | Code System | Print Name |
| ONESELF | RoleCode | self |
| MTH | RoleCode | mother |
| FTH | RoleCode | father |
| DAU | RoleCode | natural daughter |
| SON | RoleCode | natural son |
| DAUINLAW | RoleCode | daughter in-law |
| SONINLAW | RoleCode | son in-law |
| GUARD | RoleCode | guardian |
| HPOWATT | RoleCode | healthcare power of attorney |
| ... | | |

# Section-Level Templates

This chapter contains the section-level templates referenced by one or more of the document types of this consolidated guide. These templates describe the purpose of each section and the section-level constraints.

Section-level templates are always included in a document. One and only one of each section type is allowed in a given document instance. Please see the document context tables to determine the sections that are contained in in a given document type. Please see the conformance verb in the conformance statements to determine if it is required (SHALL), strongly recommended (SHOULD) or optional (MAY).

Each section-level template contains the following:

•  Template metadata (e.g., templateId, etc.)

•  Description and explanatory narrative

•  LOINC section code

•  Section title

•  Requirements for a text element

•  Entry-level template names and Ids for referenced templates (required and optional)

Narrative Text

The text element within the section stores the narrative to be rendered, as described in the CDA R2 specification, and is referred to as the CDA narrative block.

The content model of the CDA narrative block schema is hand crafted to meet requirements of human readability and rendering. The schema is registered as a MIME type (text/x-hl7-text+xml), which is the fixed media type for the text element.

As noted in the CDA R2 specification, the document originator is responsible for ensuring that the narrative block contains the complete, human readable, attested content of the section. Structured entries support computer processing and computation and are not a replacement for the attestable, human-readable content of the CDA narrative block. The special case of structured entries with an entry relationship of "DRIV" (is derived from) indicates to the receiving application that the source of the narrative block is the structured entries, and that the contents of the two are clinically equivalent.

As for all CDA documents—even when a report consisting entirely of structured entries is transformed into CDA—the encoding application must ensure that the authenticated content (narrative plus multimedia) is a faithful and complete rendering of the clinical content of the structured source data. As a general guideline, a generated narrative block should include the same human readable content that would be available to users viewing that content in the originating system. Although content formatting in the narrative block need not be identical to that in the originating system, the narrative block should use elements from the CDA narrative block schema to provide sufficient formatting to support human readability when rendered according to the rules defined in Section Narrative Block (§ 4.3.5 ) of the CDA R2 specification.

By definition, a receiving application cannot assume that all clinical content in a section (i.e., in the narrative block and multimedia) is contained in the structured entries unless the entries in the section have an entry relationship of "DRIV".

Additional specification information for the CDA narrative block can be found in the CDA R2 specification in sections 1.2.1, 1.2.3, 1.3, 1.3.1, 1.3.2, 4.3.4.2, and 6.

Advance Directives Section (entries optional) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.21.2 (open)]

59: Advance Directives Section (entries optional) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (optional) | [Advance Directive Organizer (NEW)](#E_Advance_Directive_Organizer_NEW) |

This section contains data defining the patient’s advance directives and any reference to supporting documentation, including living wills, healthcare proxies, and CPR and resuscitation status. If the referenced documents are available, they can be included in the exchange package.

The most recent directives are required, if known, and should be listed in as much detail as possible.

This section differentiates between 'advance directives' and 'advance directive documents'. The former is the directions to be followed whereas the latter refers to a legal document containing those directions.

60: Advance Directives Section (entries optional) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.21.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7928](#C_7928) |  |
| @root | 1..1 | SHALL |  | [10376](#C_10376) | 2.16.840.1.113883.10.20.22.2.21.2 |
| code | 1..1 | SHALL |  | [15340](#C_15340) |  |
| @code | 1..1 | SHALL |  | [15342](#C_15342) | 2.16.840.1.113883.6.1 (LOINC) = 42348-3 |
| @codeSystem | 1..1 | SHALL |  | [30812](#C_30812) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [7930](#C_7930) |  |
| text | 1..1 | SHALL |  | [7931](#C_7931) |  |
| entry | 0..\* | MAY |  | [7957](#C_7957) |  |
| organizer | 1..1 | SHALL |  | [15443](#C_15443) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7928) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.21.2" (CONF:10376).
2. SHALL contain exactly one [1..1] code (CONF:15340).
   1. This code SHALL contain exactly one [1..1] @code="42348-3" Advance Directives (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15342).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30812).
3. SHALL contain exactly one [1..1] title (CONF:7930).
4. SHALL contain exactly one [1..1] text (CONF:7931).
5. MAY contain zero or more [0..\*] entry (CONF:7957) such that it
   1. SHALL contain exactly one [1..1] [Advance Directive Organizer (NEW)](#E_Advance_Directive_Organizer_NEW) (templateId:2.16.840.1.113883.10.20.22.4.108) (CONF:15443).

Advance Directives Section (entries required) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.21.1.2 (open)]

61: Advance Directives Section (entries required) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional) | [Advance Directive Organizer (NEW)](#E_Advance_Directive_Organizer_NEW) |

This section contains data defining the patient’s advance directives and any reference to supporting documentation, including living wills, healthcare proxies, and CPR and resuscitation status. If the referenced documents are available, they can be included in the exchange package.

The most recent directives are required, if known, and should be listed in as much detail as possible.

This section differentiates between 'advance directives' and 'advance directive documents'. The former is the directions to be followed whereas the latter refers to a legal document containing those directions.

62: Advance Directives Section (entries required) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.21.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [30227](#C_30227) |  |
| @root | 1..1 | SHALL |  | [30228](#C_30228) | 2.16.840.1.113883.10.20.22.2.21.1.2 |
| entry | 1..\* | SHALL |  | [30235](#C_30235) |  |
| organizer | 1..1 | SHALL |  | [30236](#C_30236) |  |

1. Conforms to [Advance Directives Section (entries optional) (V2)](#Advance_Directives_Section_entries_opti) template (2.16.840.1.113883.10.20.22.2.21.2).
2. SHALL contain exactly one [1..1] templateId (CONF:30227) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.21.1.2" (CONF:30228).
3. SHALL contain at least one [1..\*] entry (CONF:30235) such that it
   1. SHALL contain exactly one [1..1] [Advance Directive Organizer (NEW)](#E_Advance_Directive_Organizer_NEW) (templateId:2.16.840.1.113883.10.20.22.4.108) (CONF:30236).

Figure 35: Advance Directives Section Example

<section>

<!-- C-CDA Advanced Directives Section (required entries)template id -->

<templateId root="2.16.840.1.113883.10.20.22.2.21.1.2" />

<code code="42348-3" codeSystem="2.16.840.1.113883.6.1" />

<!--ZG: Update narrative to match coded entries -->

<title>ADVANCE DIRECTIVES</title>

<text>

Narrative Text

</text>

<entry typeCode="DRIV">

<organizer classCode="CLUSTER" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.108" />

<!-- \*\*\*Advance Directive Organizer template -->

<id root="af6ebdf2-d996-11e2-a5b8-f23c91aec05e" />

</organizer>

</entry>

<entry typeCode="DRIV">

<organizer classCode="CLUSTER" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.108" />

<!-- \*\*\*Advance Directive Organizer template -->

<id root="af6ebdf2-d996-11e2-a5b8-f23c91aec05e" />

</organizer>

</entry>

</section>

Allergies Section (entries optional) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.6.2 (open)]

63: Allergies Section (entries optional) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (required)  [History and Physical (V2)](#D_History_and_Physical_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) | [Allergy Concern Act (V2)](#E_Allergy_Concern_Act_V2) |

This section lists and describes any medication allergies, adverse reactions, idiosyncratic reactions, anaphylaxis/anaphylactoid reactions to food items, and metabolic variations or adverse reactions/allergies to other substances (such as latex, iodine, tape adhesives). At a minimum, it should list currently active and any relevant historical allergies and adverse reactions.

64: Allergies Section (entries optional) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.6.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7800](#C_7800) |  |
| @root | 1..1 | SHALL |  | [10378](#C_10378) | 2.16.840.1.113883.10.20.22.2.6.2 |
| code | 1..1 | SHALL |  | [15345](#C_15345) |  |
| @code | 1..1 | SHALL |  | [15346](#C_15346) | 2.16.840.1.113883.6.1 (LOINC) = 48765-2 |
| title | 1..1 | SHALL |  | [7802](#C_7802) |  |
| text | 1..1 | SHALL |  | [7803](#C_7803) |  |
| entry | 0..\* | SHOULD |  | [7804](#C_7804) |  |
| act | 1..1 | SHALL |  | [15444](#C_15444) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7800) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.6.2" (CONF:10378).
2. SHALL contain exactly one [1..1] code (CONF:15345).
   1. This code SHALL contain exactly one [1..1] @code="48765-2" Allergies, adverse reactions, alerts (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15346).
3. SHALL contain exactly one [1..1] title (CONF:7802).
4. SHALL contain exactly one [1..1] text (CONF:7803).
5. SHOULD contain zero or more [0..\*] entry (CONF:7804) such that it
   1. SHALL contain exactly one [1..1] [Allergy Concern Act (V2)](#E_Allergy_Concern_Act_V2) (templateId:2.16.840.1.113883.10.20.22.4.30.2) (CONF:15444).

Allergies Section (entries required) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.6.1.2 (open)]

65: Allergies Section (entries required) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (required)  [Referral Note (NEW)](#D_Referral_Note_NEW) (required)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (required) | [Allergy Concern Act (V2)](#E_Allergy_Concern_Act_V2) |

This section lists and describes any medication allergies, adverse reactions, idiosyncratic reactions, anaphylaxis/anaphylactoid reactions to food items, and metabolic variations or adverse reactions/allergies to other substances (such as latex, iodine, tape adhesives). At a minimum, it should list currently active and any relevant historical allergies and adverse reactions.

66: Allergies Section (entries required) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.6.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7527](#C_7527) |  |
| @root | 1..1 | SHALL |  | [10379](#C_10379) | 2.16.840.1.113883.10.20.22.2.6.1.2 |
| code | 1..1 | SHALL |  | [15349](#C_15349) |  |
| @code | 1..1 | SHALL |  | [15350](#C_15350) | 2.16.840.1.113883.6.1 (LOINC) = 48765-2 |
| title | 1..1 | SHALL |  | [7534](#C_7534) |  |
| text | 1..1 | SHALL |  | [7530](#C_7530) |  |
| entry | 1..\* | SHALL |  | [7531](#C_7531) |  |
| act | 1..1 | SHALL |  | [15446](#C_15446) |  |

1. Conforms to [Allergies Section (entries optional) (V2)](#S_Allergies_Section_entries_optional_V2) template (2.16.840.1.113883.10.20.22.2.6.2).
2. SHALL contain exactly one [1..1] templateId (CONF:7527) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.6.1.2" (CONF:10379).
3. SHALL contain exactly one [1..1] code (CONF:15349).
   1. This code SHALL contain exactly one [1..1] @code="48765-2" Allergies, adverse reactions, alerts (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15350).
4. SHALL contain exactly one [1..1] title (CONF:7534).
5. SHALL contain exactly one [1..1] text (CONF:7530).
6. SHALL contain at least one [1..\*] entry (CONF:7531) such that it
   1. SHALL contain exactly one [1..1] [Allergy Concern Act (V2)](#E_Allergy_Concern_Act_V2) (templateId:2.16.840.1.113883.10.20.22.4.30.2) (CONF:15446).

Figure 36: Allergies Section (entries required) Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.6.1.2" />

<code code="48765-2" displayName="Allergies, adverse reactions, alerts" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />

<title>Allergies</title>

<text>

...

</text>

<entry typeCode="DRIV">

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.30.2" />

<!-- Allergy Concern Act template -->

...

</act>

</entry>

</section>

Anesthesia Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.25.2 (open)]

67: Anesthesia Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) | [Medication Activity (V2)](#Medication_Activity_V2)  [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) |

The Anesthesia section records the type of anesthesia (e.g., general or local) and may state the actual agent used. This may be a subsection of the Procedure Description section. The full details of anesthesia are usually found in a separate Anesthesia Note.

68: Anesthesia Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.25.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8066](#C_8066) |  |
| @root | 1..1 | SHALL |  | [10380](#C_10380) | 2.16.840.1.113883.10.20.22.2.25.2 |
| code | 1..1 | SHALL |  | [15351](#C_15351) |  |
| @code | 1..1 | SHALL |  | [15352](#C_15352) | 59774-0 |
| @codeSystem | 1..1 | SHALL |  | [30830](#C_30830) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [8068](#C_8068) |  |
| text | 1..1 | SHALL |  | [8069](#C_8069) |  |
| entry | 0..\* | MAY |  | [8092](#C_8092) |  |
| procedure | 1..1 | SHALL |  | [15447](#C_15447) |  |
| entry | 0..\* | MAY |  | [8094](#C_8094) |  |
| substanceAdministration | 1..1 | SHALL |  | [31127](#C_31127) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:8066) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.25.2" (CONF:10380).
2. SHALL contain exactly one [1..1] code (CONF:15351).
   1. This code SHALL contain exactly one [1..1] @code="59774-0" Anesthesia (CONF:15352).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30830).
3. SHALL contain exactly one [1..1] title (CONF:8068).
4. SHALL contain exactly one [1..1] text (CONF:8069).
5. MAY contain zero or more [0..\*] entry (CONF:8092) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) (templateId:2.16.840.1.113883.10.20.22.4.14.2) (CONF:15447).
6. MAY contain zero or more [0..\*] entry (CONF:8094) such that it
   1. SHALL contain exactly one [1..1] [Medication Activity (V2)](#Medication_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:31127).

Figure 37: Anesthesia Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.25.2" />

<code code="59774-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName=" Anesthesia"/>

<title>Procedure Anesthesia</title>

<text> Conscious sedation with propofol 200 mg IV </text>

<entry>

<procedure classCode="PROC" moodCode="EVN">

<!-- Procedure activity procedure template -->

<templateId root="2.16.840.1.113883.10.20.22.4.14"/>

...

</procedure>

</entry>

<entry>

<substanceAdministration classCode="SBADM" moodCode="EVN">

<!-- Medication activity template -->

<templateId root="2.16.840.1.113883.10.20.22.4.16.2"/>

...

</subtanceAdministration>

</entry>

</section>

Assessment and Plan Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.9.2 (open)]

69: Assessment and Plan Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) | [Planned Act (V2)](#E_Planned_Act_V2) |

This section represents the clinician’s conclusions and working assumptions that will guide treatment of the patient. The Assessment and Plan sections may be combined or separated to meet local policy requirements.

See also the Assessment Section: templateId 2.16.840.1.113883.10.20.22.2.8 and Plan of Treatment Section (V2): templateId 2.16.840.1.113883.10.20.22.2.10.2

70: Assessment and Plan Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.9.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7705](#C_7705) |  |
| @root | 1..1 | SHALL |  | [10381](#C_10381) | 2.16.840.1.113883.10.20.22.2.9.2 |
| code | 1..1 | SHALL |  | [15353](#C_15353) |  |
| @code | 1..1 | SHALL |  | [15354](#C_15354) | 51847-2 |
| text | 1..1 | SHALL |  | [7707](#C_7707) |  |
| entry | 0..\* | MAY |  | [7708](#C_7708) |  |
| act | 1..1 | SHALL |  | [15448](#C_15448) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7705) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.9.2" (CONF:10381).
2. SHALL contain exactly one [1..1] code (CONF:15353).
   1. This code SHALL contain exactly one [1..1] @code="51847-2" Assessment and Plan (CONF:15354).
3. SHALL contain exactly one [1..1] text (CONF:7707).
4. MAY contain zero or more [0..\*] entry (CONF:7708) such that it
   1. SHALL contain exactly one [1..1] [Planned Act (V2)](#E_Planned_Act_V2) (templateId:2.16.840.1.113883.10.20.22.4.39.2) (CONF:15448).

Figure 38: Assessment and Plan Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.9.2" />

<code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="51847-2" displayName="ASSESSMENT AND PLAN" />

<title>ASSESSMENT AND PLAN</title>

<text>

...

</text>

<entry>

<act moodCode="RQO" classCode="ACT">

<templateId root="2.16.840.1.113883.10.20.22.4.39" />

<!-- Plan of Care Activity Act -->

...

</act>

</entry>

</section>

Assessment Section

[section: templateId 2.16.840.1.113883.10.20.22.2.8 (open)]

71: Assessment Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) |  |

The Assessment section (also referred to as “impression” or “diagnoses” outside of the context of CDA) represents the clinician's conclusions and working assumptions that will guide treatment of the patient. The assessment may be a list of specific disease entities or a narrative block.

72: Assessment Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.8'] | | | | | |
| templateId | 1..1 | SHALL |  | [7711](#C_7711) |  |
| @root | 1..1 | SHALL |  | [10382](#C_10382) | 2.16.840.1.113883.10.20.22.2.8 |
| text | 1..1 | SHALL |  | [7713](#C_7713) |  |
| code | 1..1 | SHALL |  | [14757](#C_14757) |  |
| @code | 1..1 | SHALL |  | [14758](#C_14758) | 2.16.840.1.113883.6.1 (LOINC) = 51848-0 |
| title | 1..1 | SHALL |  | [16774](#C_16774) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7711) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.8" (CONF:10382).
2. SHALL contain exactly one [1..1] code (CONF:14757).
   1. This code SHALL contain exactly one [1..1] @code="51848-0" Assessments (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:14758).
3. SHALL contain exactly one [1..1] title (CONF:16774).
4. SHALL contain exactly one [1..1] text (CONF:7713).

Figure 39: Assessment Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.8" />

<code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="51848-0" displayName="ASSESSMENTS" />

<title>ASSESSMENTS</title>

<text>

...

</text>

</section>

Chief Complaint and Reason for Visit Section

[section: templateId 2.16.840.1.113883.10.20.22.2.13 (open)]

73: Chief Complaint and Reason for Visit Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (required)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) |  |

This section records the patient's chief complaint (the patient’s own description) and/or the reason for the patient's visit (the provider’s description of the reason for visit).  Local policy determines whether the information is divided into two sections or recorded in one section serving both purposes.

74: Chief Complaint and Reason for Visit Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.13'] | | | | | |
| templateId | 1..1 | SHALL |  | [7840](#C_7840) |  |
| @root | 1..1 | SHALL |  | [10383](#C_10383) | 2.16.840.1.113883.10.20.22.2.13 |
| title | 1..1 | SHALL |  | [7842](#C_7842) |  |
| text | 1..1 | SHALL |  | [7843](#C_7843) |  |
| code | 1..1 | SHALL |  | [15449](#C_15449) |  |
| @code | 1..1 | SHALL |  | [15450](#C_15450) | 2.16.840.1.113883.6.1 (LOINC) = 46239-0 |

1. SHALL contain exactly one [1..1] templateId (CONF:7840) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.13" (CONF:10383).
2. SHALL contain exactly one [1..1] code (CONF:15449).
   1. This code SHALL contain exactly one [1..1] @code="46239-0" Chief Complaint and Reason for Visit (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15450).
3. SHALL contain exactly one [1..1] title (CONF:7842).
4. SHALL contain exactly one [1..1] text (CONF:7843).

Figure 40: Chief Complaint and Reason for Visit Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.13" />

<code code="46239-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="CHIEF COMPLAINT AND REASON FOR VISIT" />

<title> CHIEF COMPLAINT</title>

<text>Back Pain</text>

</section>

Chief Complaint Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1 (open)]

75: Chief Complaint Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) |  |

This section records the patient's chief complaint (the patient’s own description).

76: Chief Complaint Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1'] | | | | | |
| templateId | 1..1 | SHALL |  | [7832](#C_7832) |  |
| @root | 1..1 | SHALL | UID | [10453](#C_10453) | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1 |
| title | 1..1 | SHALL |  | [7834](#C_7834) |  |
| text | 1..1 | SHALL |  | [7835](#C_7835) |  |
| code | 1..1 | SHALL |  | [15451](#C_15451) |  |
| @code | 1..1 | SHALL |  | [15452](#C_15452) | 2.16.840.1.113883.6.1 (LOINC) = 10154-3 |

1. SHALL contain exactly one [1..1] templateId (CONF:7832) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1" (CONF:10453).
2. SHALL contain exactly one [1..1] code (CONF:15451).
   1. This code SHALL contain exactly one [1..1] @code="10154-3" Chief Complaint (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15452).
3. SHALL contain exactly one [1..1] title (CONF:7834).
4. SHALL contain exactly one [1..1] text (CONF:7835).

Figure 41: Chief Complaint Section Example

<section>

<templateId root="1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1" />

<code code="10154-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="CHIEF COMPLAINT" />

<title> CHIEF COMPLAINT</title>

<text>Back Pain</text>

</section>

Complications (OpNote) (obsolete)

[section: templateId 2.16.840.1.113883.10.20.22.2.32.obsolete (open)]

77: Complications (OpNote) (obsolete) Contexts

| Contained By: | Contains: |
| --- | --- |

This template is obsolete and will be deleted completely in the future.

This is replaced by the Complications Section.

78: Complications (OpNote) (obsolete) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.32.obsolete'] | | | | | |

Complications Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.37.2 (open)]

79: Complications Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (required) | [Problem Observation (V2)](#E_Problem_Observation_V2) |

This section contains problems that occurred during or around the time of a procedure. The complications may be known risks or unanticipated problems.

80: Complications Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.37.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8174](#C_8174) |  |
| @root | 1..1 | SHALL |  | [10384](#C_10384) | 2.16.840.1.113883.10.20.22.2.37.2 |
| code | 1..1 | SHALL |  | [15453](#C_15453) |  |
| @code | 1..1 | SHALL |  | [15454](#C_15454) | 55109-3 |
| @codeSystem | 1..1 | SHALL |  | [30860](#C_30860) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [8176](#C_8176) |  |
| text | 1..1 | SHALL |  | [8177](#C_8177) |  |
| entry | 0..\* | MAY |  | [8795](#C_8795) |  |
| observation | 1..1 | SHALL |  | [15455](#C_15455) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:8174) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.37.2" (CONF:10384).
2. SHALL contain exactly one [1..1] code (CONF:15453).
   1. This code SHALL contain exactly one [1..1] @code="55109-3" Complications (CONF:15454).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30860).
3. SHALL contain exactly one [1..1] title (CONF:8176).
4. SHALL contain exactly one [1..1] text (CONF:8177).
5. MAY contain zero or more [0..\*] entry (CONF:8795) such that it
   1. SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15455).  
      Note: Note: When no coded entries or negation of entries are present, narrative section/text will be provided containing details of the complication(s) or that there were no complications.

Figure 42: Complications Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.37.2" />

<code code="10830-8" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Complications" />

<title>Complications</title>

<text>Asthmatic symptoms while under general anesthesia.</text>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Problem Observation -->

...

</observation>

</entry>

</section>

DICOM Object Catalog Section - DCM 121181

[section: templateId 2.16.840.1.113883.10.20.6.1.1 (open)]

81: DICOM Object Catalog Section - DCM 121181 Contexts

| Contained By: | Contains: |
| --- | --- |
| [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (optional) | [Study Act](#E_Study_Act) |

DICOM Object Catalog lists all referenced objects and their parent Series and Studies, plus other DICOM attributes required for retrieving the objects.

DICOM Object Catalog sections are not intended for viewing and contain empty section text.

82: DICOM Object Catalog Section - DCM 121181 Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.6.1.1'] | | | | | |
| templateId | 1..1 | SHALL |  | [8525](#C_8525) |  |
| @root | 1..1 | SHALL | UID | [10454](#C_10454) | 2.16.840.1.113883.10.20.6.1.1 |
| entry | 1..\* | SHALL |  | [8530](#C_8530) |  |
| act | 1..1 | SHALL |  | [15458](#C_15458) |  |
| code | 1..1 | SHALL |  | [15456](#C_15456) |  |
| @code | 1..1 | SHALL |  | [15457](#C_15457) | 1.2.840.10008.2.16.4 (DCM) = 121181 |

1. SHALL contain exactly one [1..1] templateId (CONF:8525) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.1.1" (CONF:10454).
2. SHALL contain exactly one [1..1] code (CONF:15456).
   1. This code SHALL contain exactly one [1..1] @code="121181" Dicom Object Catalog (CodeSystem: DCM 1.2.840.10008.2.16.4 STATIC) (CONF:15457).
3. SHALL contain at least one [1..\*] entry (CONF:8530).
   1. Such entries SHALL contain exactly one [1..1] [Study Act](#E_Study_Act) (templateId:2.16.840.1.113883.10.20.6.2.6) (CONF:15458).
4. A DICOM Object Catalog SHALL be present if the document contains references to DICOM Images. If present, it SHALL be the first section in the document (CONF:8527).

Figure 43: Sample

<section classCode="DOCSECT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.1.1" />

<code code="121181" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM" displayName="DICOM Object Catalog" />

<entry>

<!-- \*\*\*\* Study Act \*\*\*\* -->

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.6" />

<id root="1.2.840.113619.2.62.994044785528.114289542805" />

<code code="113014" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM" displayName="Study" />

<!-- \*\*\*\* Series Act\*\*\*\*-->

<entryRelationship typeCode="COMP">

<act classCode="ACT" moodCode="EVN">

<id root="1.2.840.113619.2.62.994044785528.20060823223142485051" />

<code code="113015" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM" displayName="Series">

...

</code>

<!-- \*\*\*\* SOP Instance UID \*\*\* -->

<!-- 2 References -->

<entryRelationship typeCode="COMP">

<observation classCode="DGIMG" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.8" />

...

</observation>

</entryRelationship>

<entryRelationship typeCode="COMP">

<observation classCode="DGIMG" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.8" />

...

</observation>

</entryRelationship>

</act>

</entryRelationship>

</act>

</entry>

</section>

Discharge Diet Section (DEPRECATED)

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.33.2 (open)]

83: Discharge Diet Section (DEPRECATED) Contexts

| Contained By: | Contains: |
| --- | --- |

THIS SECTION IS DEPRECATED AND MAY BE DELETED IN THE FUTURE. USE THE NUTRITION SECTION INSTEAD.

This section records a narrative description of the expectations for diet and nutrition, including nutrition prescription, proposals, goals, and order requests for monitoring, tracking, or improving the nutritional status of the patient, used in a discharge from a facility such as an emergency department, hospital, or nursing home.

84: Discharge Diet Section (DEPRECATED) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '1.3.6.1.4.1.19376.1.5.3.1.3.33.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7975](#C_7975) |  |
| @root | 1..1 | SHALL | UID | [10455](#C_10455) | 1.3.6.1.4.1.19376.1.5.3.1.3.33.2 |
| code | 1..1 | SHALL |  | [15459](#C_15459) |  |
| @code | 1..1 | SHALL |  | [15460](#C_15460) | 42344-2 |
| @codeSystem | 1..1 | SHALL |  | [31140](#C_31140) |  |
| title | 1..1 | SHALL |  | [7977](#C_7977) |  |
| text | 1..1 | SHALL |  | [7978](#C_7978) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7975) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.33.2" (CONF:10455).
2. SHALL contain exactly one [1..1] code (CONF:15459).
   1. This code SHALL contain exactly one [1..1] @code="42344-2" Discharge Diet (CONF:15460).
   2. This code SHALL contain exactly one [1..1] @codeSystem (CONF:31140).
3. SHALL contain exactly one [1..1] title (CONF:7977).
4. SHALL contain exactly one [1..1] text (CONF:7978).

Encounters Section (entries optional) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.22.2 (open)]

85: Encounters Section (entries optional) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (optional) | [Encounter Activity (V2)](#E_Encounter_Activity_V2) |

This section lists and describes any healthcare encounters pertinent to the patient’s current health status or historical health history. An Encounter is an interaction, regardless of the setting, between a patient and a practitioner who is vested with primary responsibility for diagnosing, evaluating, or treating the patient’s condition. It may include visits, appointments, as well as non-face-to-face interactions. It is also a contact between a patient and a practitioner who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment. This section may contain all encounters for the time period being summarized, but should include notable encounters.

86: Encounters Section (entries optional) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.22.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7940](#C_7940) |  |
| @root | 1..1 | SHALL |  | [10386](#C_10386) | 2.16.840.1.113883.10.20.22.2.22.2 |
| code | 1..1 | SHALL |  | [15461](#C_15461) |  |
| @code | 1..1 | SHALL |  | [15462](#C_15462) | 46240-8 |
| @codeSystem | 1..1 | SHALL |  | [31136](#C_31136) | 2.16.840.1.113883.6.1 (LOINC) |
| title | 1..1 | SHALL |  | [7942](#C_7942) |  |
| text | 1..1 | SHALL |  | [7943](#C_7943) |  |
| entry | 0..\* | SHOULD |  | [7951](#C_7951) |  |
| encounter | 1..1 | SHALL |  | [15465](#C_15465) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7940) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.22.2" (CONF:10386).
2. SHALL contain exactly one [1..1] code (CONF:15461).
   1. This code SHALL contain exactly one [1..1] @code="46240-8" Encounters (CONF:15462).
   2. This code SHALL contain exactly one [1..1] @codeSystem (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31136).
3. SHALL contain exactly one [1..1] title (CONF:7942).
4. SHALL contain exactly one [1..1] text (CONF:7943).
5. SHOULD contain zero or more [0..\*] entry (CONF:7951) such that it
   1. SHALL contain exactly one [1..1] [Encounter Activity (V2)](#E_Encounter_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.49.2) (CONF:15465).

Encounters Section (entries required) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.22.1.2 (open)]

87: Encounters Section (entries required) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional) | [Encounter Activity (V2)](#E_Encounter_Activity_V2) |

This section lists and describes any healthcare encounters pertinent to the patient’s current health status or historical health history. An Encounter is an interaction, regardless of the setting, between a patient and a practitioner who is vested with primary responsibility for diagnosing, evaluating, or treating the patient’s condition. It may include visits, appointments, as well as non-face-to-face interactions. It is also a contact between a patient and a practitioner who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment. This section may contain all encounters for the time period being summarized, but should include notable encounters.

88: Encounters Section (entries required) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.22.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8705](#C_8705) |  |
| @root | 1..1 | SHALL |  | [10387](#C_10387) | 2.16.840.1.113883.10.20.22.2.22.1.2 |
| code | 1..1 | SHALL |  | [15466](#C_15466) |  |
| @code | 1..1 | SHALL |  | [15467](#C_15467) | 46240-8 |
| @codeSystem | 1..1 | SHALL |  | [31137](#C_31137) | 2.16.840.1.113883.6.1 (LOINC) |
| title | 1..1 | SHALL |  | [8707](#C_8707) |  |
| text | 1..1 | SHALL |  | [8708](#C_8708) |  |
| entry | 1..\* | SHALL |  | [8709](#C_8709) |  |
| encounter | 1..1 | SHALL |  | [15468](#C_15468) |  |

1. Conforms to [Encounters Section (entries optional) (V2)](#S_Encounters_Section_entries_optional_V) template (2.16.840.1.113883.10.20.22.2.22.2).
2. SHALL contain exactly one [1..1] templateId (CONF:8705) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.22.1.2" (CONF:10387).
3. SHALL contain exactly one [1..1] code (CONF:15466).
   1. This code SHALL contain exactly one [1..1] @code="46240-8" Encounters (CONF:15467).
   2. This code SHALL contain exactly one [1..1] @codeSystem (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31137).
4. SHALL contain exactly one [1..1] title (CONF:8707).
5. SHALL contain exactly one [1..1] text (CONF:8708).
6. SHALL contain at least one [1..\*] entry (CONF:8709) such that it
   1. SHALL contain exactly one [1..1] [Encounter Activity (V2)](#E_Encounter_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.49.2) (CONF:15468).

Figure 44: Encounters Section (entries required) Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.22.1.2" />

<!-- Encounters Section - Entries required -->

<code code="46240-8" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="History of encounters" />

<title>Encounters</title>

<text>

...

</text>

<entry typeCode="DRIV">

<encounter classCode="ENC" moodCode="EVN">

<!-- Encounter Activities -->

...

</encounter>

</entry>

</section>

Family History Section

[section: templateId 2.16.840.1.113883.10.20.22.2.15 (open)]

89: Family History Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) | [Family History Organizer](#E_Family_History_Organizer) |

This section contains data defining the patient’s genetic relatives in terms of possible or relevant health risk factors that have a potential impact on the patient’s healthcare risk profile.

90: Family History Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.15'] | | | | | |
| templateId | 1..1 | SHALL |  | [7932](#C_7932) |  |
| @root | 1..1 | SHALL |  | [10388](#C_10388) | 2.16.840.1.113883.10.20.22.2.15 |
| title | 1..1 | SHALL |  | [7934](#C_7934) |  |
| text | 1..1 | SHALL |  | [7935](#C_7935) |  |
| entry | 0..\* | MAY |  | [7955](#C_7955) |  |
| organizer | 1..1 | SHALL |  | [15471](#C_15471) |  |
| code | 1..1 | SHALL |  | [15469](#C_15469) |  |
| @code | 1..1 | SHALL |  | [15470](#C_15470) | 2.16.840.1.113883.6.1 (LOINC) = 10157-6 |

1. SHALL contain exactly one [1..1] templateId (CONF:7932) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.15" (CONF:10388).
2. SHALL contain exactly one [1..1] code (CONF:15469).
   1. This code SHALL contain exactly one [1..1] @code="10157-6" Family History (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15470).
3. SHALL contain exactly one [1..1] title (CONF:7934).
4. SHALL contain exactly one [1..1] text (CONF:7935).
5. MAY contain zero or more [0..\*] entry (CONF:7955) such that it
   1. SHALL contain exactly one [1..1] [Family History Organizer](#E_Family_History_Organizer) (templateId:2.16.840.1.113883.10.20.22.4.45) (CONF:15471).

Figure 45: Family History Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.15" />

<!-- Family history section template -->

<code code="10157-6" codeSystem="2.16.840.1.113883.6.1" />

<title>Family history</title>

<text>

...

</text>

<entry typeCode="DRIV">

<organizer moodCode="EVN" classCode="CLUSTER">

<templateId root="2.16.840.1.113883.10.20.22.4.45" />

<!-- Family history organizer template -->

...

</organizer>

</entry>

</section>

Fetus Subject Context

[relatedSubject: templateId 2.16.840.1.113883.10.20.6.2.3 (open)]

91: Fetus Subject Context Contexts

| Contained By: | Contains: |
| --- | --- |
| [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (optional) |  |

For reports on mothers and their fetus(es), information on a mother is mapped to recordTarget, PatientRole, and Patient. Information on the fetus is mapped to subject, relatedSubject, and SubjectPerson at the CDA section level. Both context information on the mother and fetus must be included in the document if observations on fetus(es) are contained in the document.

92: Fetus Subject Context Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| relatedSubject[templateId/@root = '2.16.840.1.113883.10.20.6.2.3'] | | | | | |
| templateId | 1..1 | SHALL |  | [9189](#C_9189) |  |
| @root | 1..1 | SHALL |  | [10535](#C_10535) | 2.16.840.1.113883.10.20.6.2.3 |
| code | 1..1 | SHALL |  | [9190](#C_9190) |  |
| @code | 1..1 | SHALL |  | [26455](#C_26455) | 1.2.840.10008.2.16.4 (DCM) = 121026 |
| subject | 1..1 | SHALL |  | [9191](#C_9191) |  |
| name | 1..1 | SHALL |  | [15347](#C_15347) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:9189) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.3" (CONF:10535).
2. SHALL contain exactly one [1..1] code (CONF:9190).
   1. This code SHALL contain exactly one [1..1] @code="121026" (CodeSystem: DCM 1.2.840.10008.2.16.4) (CONF:26455).
3. SHALL contain exactly one [1..1] subject (CONF:9191).

The name element is used to store the DICOM fetus ID, typically a pseudonym such as fetus\_1.

* 1. This subject SHALL contain exactly one [1..1] name (CONF:15347).

Figure 46: Sample

<relatedSubject>

<templateId root="2.16.840.1.113883.10.20.6.2.3" />

<code code="121026" codeSystem="1.2.840.10008.2.16.4" displayName="Fetus" />

<subject>

<name>fetus\_1</name>

</subject>

</relatedSubject>

Findings Section (DIR)

[section: templateId 2.16.840.1.113883.10.20.6.1.2 (open)]

93: Findings Section (DIR) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (required) |  |

The Findings section contains the main narrative body of the report. While not an absolute requirement for transformed DICOM SR reports, it is suggested that Diagnostic Imaging Reports authored in CDA follow Term Info guidelines  for the codes in the various observations and procedures recorded in this section.

94: Findings Section (DIR) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.6.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8531](#C_8531) |  |
| @root | 1..1 | SHALL | UID | [10456](#C_10456) | 2.16.840.1.113883.10.20.6.1.2 |

1. SHALL contain exactly one [1..1] templateId (CONF:8531) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.1.2" (CONF:10456).
2. This section SHOULD contain only the direct observations in the report, with topics such as Reason for Study, History, and Impression placed in separate sections.  However, in cases where the source of report content provides a single block of text not separated into these sections, that text SHALL be placed in the Findings section (CONF:8532).

Figure 47: Findings Section (DIR)

<section>

<templateId root="2.16.840.1.113883.10.20.6.1.2" />

<code code="121070" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM" displayName="Findings" />

<title>Findings</title>

<text>

<paragraph>

<caption>Finding</caption>

<content ID="Fndng2">The cardiomediastinum is . </content>

</paragraph>

<paragraph>

<caption>Diameter</caption>

<content ID="Diam2">45mm</content>

</paragraph>

...

</text>

<entry>

<templateId root="2.16.840.1.113883.10.20.6.2.12" />

...

</entry>

</section>

Functional Status Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.14.2 (open)]

95: Functional Status Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional) | [Assessment Scale Observation](#E_Assessment_Scale_Observation)  [Caregiver Characteristics](#E_Caregiver_Characteristics)  [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2)  [Functional Status Organizer (V2)](#E_Functional_Status_Organizer_V2)  [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2)  [Self-Care Activities (ADL and IADL) (NEW)](#E_SelfCare_Activities_ADL_and_IADL_NEW)  [Sensory and Speech Status (NEW)](#E_Sensory_and_Speech_Status_NEW) |

The Functional Status section contains observations and assessments of a patient's physical abilities.  A patient’s functional status may include information regarding the patient’s general function such as ambulation, ability to perform Activities of Daily Living (ADLs), (e.g. bathing, dressing, feeding, grooming) Instrumental Activities of Daily Living (IADLs) (e.g. shopping, using a telephone, balancing a check book).  Problems that impact function (e.g. dyspnea, dysphagia) can be contained in the section.

96: Functional Status Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.14.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7920](#C_7920) |  |
| @root | 1..1 | SHALL |  | [10389](#C_10389) | 2.16.840.1.113883.10.20.22.2.14.2 |
| code | 1..1 | SHALL |  | [14578](#C_14578) |  |
| @code | 1..1 | SHALL |  | [14579](#C_14579) | 47420-5 |
| @codeSystem | 1..1 | SHALL |  | [30866](#C_30866) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [7922](#C_7922) |  |
| text | 1..1 | SHALL |  | [7923](#C_7923) |  |
| entry | 0..\* | MAY |  | [14414](#C_14414) |  |
| organizer | 1..1 | SHALL |  | [14415](#C_14415) |  |
| entry | 0..\* | MAY |  | [14418](#C_14418) |  |
| observation | 1..1 | SHALL |  | [14419](#C_14419) |  |
| entry | 0..\* | MAY |  | [14426](#C_14426) |  |
| observation | 1..1 | SHALL |  | [14427](#C_14427) |  |
| entry | 0..\* | MAY |  | [14580](#C_14580) |  |
| observation | 1..1 | SHALL |  | [14581](#C_14581) |  |
| entry | 0..\* | MAY |  | [14582](#C_14582) |  |
| supply | 1..1 | SHALL |  | [30783](#C_30783) |  |
| entry | 0..\* | MAY |  | [16777](#C_16777) |  |
| observation | 1..1 | SHALL |  | [31009](#C_31009) |  |
| entry | 0..\* | MAY |  | [16779](#C_16779) |  |
| observation | 1..1 | SHALL |  | [31011](#C_31011) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7920) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.14.2" (CONF:10389).
2. SHALL contain exactly one [1..1] code (CONF:14578).
   1. This code SHALL contain exactly one [1..1] @code="47420-5" Functional Status (CONF:14579).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30866).
3. SHALL contain exactly one [1..1] title (CONF:7922).
4. SHALL contain exactly one [1..1] text (CONF:7923).
5. MAY contain zero or more [0..\*] entry (CONF:14414) such that it
   1. SHALL contain exactly one [1..1] [Functional Status Organizer (V2)](#E_Functional_Status_Organizer_V2) (templateId:2.16.840.1.113883.10.20.22.4.66.2) (CONF:14415).
6. MAY contain zero or more [0..\*] entry (CONF:14418) such that it
   1. SHALL contain exactly one [1..1] [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.67.2) (CONF:14419).
7. MAY contain zero or more [0..\*] entry (CONF:14426) such that it
   1. SHALL contain exactly one [1..1] [Caregiver Characteristics](#E_Caregiver_Characteristics) (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:14427).
8. MAY contain zero or more [0..\*] entry (CONF:14580) such that it
   1. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:14581).
9. MAY contain zero or more [0..\*] entry (CONF:14582) such that it
   1. SHALL contain exactly one [1..1] [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.50.2) (CONF:30783).
10. MAY contain zero or more [0..\*] entry (CONF:16777) such that it
    1. SHALL contain exactly one [1..1] [Self-Care Activities (ADL and IADL) (NEW)](#E_SelfCare_Activities_ADL_and_IADL_NEW) (templateId:2.16.840.1.113883.10.20.22.4.128) (CONF:31009).
11. MAY contain zero or more [0..\*] entry (CONF:16779) such that it
    1. SHALL contain exactly one [1..1] [Sensory and Speech Status (NEW)](#E_Sensory_and_Speech_Status_NEW) (templateId:2.16.840.1.113883.10.20.22.4.127) (CONF:31011).

Figure 48: Functional Status Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.14.2" />

<!-- Functional Status Section template V2-->

<code code="47420-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Functional Status" />

<title>FUNCTIONAL STATUS</title>

<text>

...

</text>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Self Care Activities (NEW)-->

<templateId root="2.16.840.1.113883.10.20.22.4.128" />

...

</observation>

</entry>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Sensory and Speech Status(NEW)-->

<templateId root="2.16.840.1.113883.10.20.22.4.127" />

...

</observation>

</entry>

<entry>

<organizer classCode="CLUSTER" moodCode="EVN">

<!-- Functional Status Organizer V2-->

<templateId root="2.16.840.1.113883.10.20.22.4.66.2" />

....

</organizer>

</entry>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Functional Status Observation V2-->

<templateId root="2.16.840.1.113883.10.20.22.4.67.2" />

...

</observation>

</entry>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Caregiver characteristics \*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.72" />

...

</observation>

</entry>

</section>

General Status Section

[section: templateId 2.16.840.1.113883.10.20.2.5 (open)]

97: General Status Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (required) |  |

The General Status section describes general observations and readily observable attributes of the patient, including affect and demeanor, apparent age compared to actual age, gender, ethnicity, nutritional status based on appearance, body build and habitus (e.g., muscular, cachectic, obese), developmental or other deformities, gait and mobility, personal hygiene, evidence of distress, and voice quality and speech.

98: General Status Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.2.5'] | | | | | |
| templateId | 1..1 | SHALL |  | [7985](#C_7985) |  |
| @root | 1..1 | SHALL | UID | [10457](#C_10457) | 2.16.840.1.113883.10.20.2.5 |
| title | 1..1 | SHALL |  | [7987](#C_7987) |  |
| text | 1..1 | SHALL |  | [7988](#C_7988) |  |
| code | 1..1 | SHALL |  | [15472](#C_15472) |  |
| @code | 1..1 | SHALL |  | [15473](#C_15473) | 2.16.840.1.113883.6.1 (LOINC) = 10210-3 |

1. SHALL contain exactly one [1..1] templateId (CONF:7985) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.2.5" (CONF:10457).
2. SHALL contain exactly one [1..1] code (CONF:15472).
   1. This code SHALL contain exactly one [1..1] @code="10210-3" General Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15473).
3. SHALL contain exactly one [1..1] title (CONF:7987).
4. SHALL contain exactly one [1..1] text (CONF:7988).

Figure 49: General Status Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.2.5" />

<code code="10210-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="GENERAL STATUS" />

<title>GENERAL STATUS</title>

<text>

<paragraph>Alert and in good spirits, no acute distress.

</paragraph>

</text>

</section>

Goals Section (NEW)

[section: templateId 2.16.840.1.113883.10.20.22.2.60 (open)]

99: Goals Section (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Care Plan (NEW)](#D_Care_Plan_NEW) (required) | [Goal Observation (NEW)](#E_Goal_Observation_NEW) |

This template represents patient Goals.  A goal is a defined outcome or condition to be achieved in the process of patient care. Goals include patient-defined goals (e.g., alleviation of health concerns, positive outcomes from interventions, longevity, function, symptom management, comfort) and clinician-specific goals to achieve desired and agreed upon outcomes.

100: Goals Section (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.60'] | | | | | |
| templateId | 1..1 | SHALL |  | [29584](#C_29584) |  |
| @root | 1..1 | SHALL |  | [29585](#C_29585) | 2.16.840.1.113883.10.20.22.2.60 |
| code | 1..1 | SHALL |  | [29586](#C_29586) |  |
| @code | 1..1 | SHALL |  | [29587](#C_29587) | 61146-7 |
| @codeSystem | 1..1 | SHALL |  | [29588](#C_29588) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| entry | 1..\* | SHALL |  | [30719](#C_30719) |  |
| observation | 1..1 | SHALL |  | [30720](#C_30720) |  |
| title | 1..1 | SHALL |  | [30721](#C_30721) |  |
| text | 1..1 | SHALL |  | [30722](#C_30722) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:29584) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.60" (CONF:29585).
2. SHALL contain exactly one [1..1] code (CONF:29586).
   1. This code SHALL contain exactly one [1..1] @code="61146-7" Goals (CONF:29587).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:29588).
3. SHALL contain exactly one [1..1] title (CONF:30721).
4. SHALL contain exactly one [1..1] text (CONF:30722).
5. SHALL contain at least one [1..\*] entry (CONF:30719) such that it
   1. SHALL contain exactly one [1..1] [Goal Observation (NEW)](#E_Goal_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.121) (CONF:30720).

Figure 50: Goals Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.60" />

<code code="61146-7" displayName="Goals" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />

<title>Goals Section</title>

<text />

<entry>

<observation />

</entry>

</section>

Health Concerns Section (NEW)

[section: templateId 2.16.840.1.113883.10.20.22.2.58 (open)]

101: Health Concerns Section (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Care Plan (NEW)](#D_Care_Plan_NEW) (required) | [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW)  [Health Status Observation (V2)](#Health_Status_Observation_V2) |

The Health Concerns section contains data that describes an interest or worry about a health state or process that has the potential to require attention, intervention or management.

102: Health Concerns Section (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.58'] | | | | | |
| templateId | 1..1 | SHALL |  | [28804](#C_28804) |  |
| @root | 1..1 | SHALL |  | [28805](#C_28805) | 2.16.840.1.113883.10.20.22.2.58 |
| code | 1..1 | SHALL |  | [28806](#C_28806) |  |
| @code | 1..1 | SHALL |  | [28807](#C_28807) | 46030-3 |
| @codeSystem | 1..1 | SHALL |  | [28808](#C_28808) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [28809](#C_28809) |  |
| text | 1..1 | SHALL |  | [28810](#C_28810) |  |
| entry | 0..1 | SHOULD |  | [30483](#C_30483) |  |
| observation | 1..1 | SHALL |  | [30484](#C_30484) |  |
| entry | 1..\* | SHALL |  | [30768](#C_30768) |  |
| act | 1..1 | SHALL |  | [30769](#C_30769) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:28804) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.58" (CONF:28805).
2. SHALL contain exactly one [1..1] code (CONF:28806).
   1. This code SHALL contain exactly one [1..1] @code="46030-3" Health Conditions Section (CONF:28807).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:28808).
3. SHALL contain exactly one [1..1] title (CONF:28809).
4. SHALL contain exactly one [1..1] text (CONF:28810).
5. SHOULD contain zero or one [0..1] entry (CONF:30483) such that it
   1. SHALL contain exactly one [1..1] [Health Status Observation (V2)](#Health_Status_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.5.2) (CONF:30484).
6. SHALL contain at least one [1..\*] entry (CONF:30768) such that it
   1. SHALL contain exactly one [1..1] [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (templateId:2.16.840.1.113883.10.20.22.4.132) (CONF:30769).

Figure 51: Health Concerns Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.58" />

<code code="46030-3" displayName="Health Conditions Section" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />

<title>Health Concerns Section</title>

<text />

<entry>

<observation />

</entry>

<entry>

<act />

</entry>

</section>

Health Status Evaluations/Outcomes Section (NEW)

[section: templateId 2.16.840.1.113883.10.20.22.2.61 (open)]

103: Health Status Evaluations/Outcomes Section (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Care Plan (NEW)](#D_Care_Plan_NEW) (required) | [Outcome Observation (NEW)](#E_Outcome_Observation_NEW) |

This template is a section that contains Health Status Evaluations and Outcomes.  Health Status Evaluations and Outcomes represent status, at a point in time, related to established care plan goals and/or interventions.

104: Health Status Evaluations/Outcomes Section (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.61'] | | | | | |
| templateId | 1..1 | SHALL |  | [29578](#C_29578) |  |
| @root | 1..1 | SHALL |  | [29579](#C_29579) | 2.16.840.1.113883.10.20.22.2.61 |
| code | 1..1 | SHALL |  | [29580](#C_29580) |  |
| @code | 1..1 | SHALL |  | [29581](#C_29581) | 11383-7 |
| @codeSystem | 1..1 | SHALL |  | [29582](#C_29582) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [29589](#C_29589) |  |
| text | 1..1 | SHALL |  | [29590](#C_29590) |  |
| entry | 1..\* | SHALL |  | [31227](#C_31227) |  |
| observation | 1..1 | SHALL |  | [31228](#C_31228) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:29578) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.61" (CONF:29579).
2. SHALL contain exactly one [1..1] code (CONF:29580).
   1. This code SHALL contain exactly one [1..1] @code="11383-7" Patient Problem Outcome (CONF:29581).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:29582).
3. SHALL contain exactly one [1..1] title (CONF:29589).
4. SHALL contain exactly one [1..1] text (CONF:29590).
5. SHALL contain at least one [1..\*] entry (CONF:31227) such that it
   1. SHALL contain exactly one [1..1] [Outcome Observation (NEW)](#E_Outcome_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.144) (CONF:31228).

Figure 52: Health Status Evaluations/Outcomes Section Example

<section>

<!-- Health Status Evaluations/Outcomes Section -->

<templateId root="2.16.840.1.113883.10.20.22.2.61" />

<code code="11383-7" displayName="Patient Problem Outcome" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />

<title>Health Status Evaluations/Outcomes Section</title>

<text>

<list>

<item>

<content styleCode="Bold">Pulse oximetry greater than 92% on room air</content>: MET <list><item>Evaluates Expected Outcome/Goal:

<content styleCode="Bold">

Pulse oximetry greater than 92% on room air

</content></item><item>Supported by: Pulse oximetry 95% on room air (March 21, 2013 at 15:20)</item></list></item>

</list>

</text>

<entry>

<!-- Outcome Observation -->

<observation classCode="OBS" moodCode="EVN">

...

</observation>

</entry>

<entry>

<!-- Outcome Observation -->

<observation classCode="OBS" moodCode="EVN">

...

</observation>

</entry>

...

</section>

History of Past Illness Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.20.2 (open)]

105: History of Past Illness Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) | [Problem Observation (V2)](#E_Problem_Observation_V2) |

This section contains a record of the patient’s past complaints, problems, and diagnoses. It contains data from the patient’s past up to the patient’s current complaint or reason for seeking medical care.

106: History of Past Illness Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.20.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7828](#C_7828) |  |
| @root | 1..1 | SHALL |  | [10390](#C_10390) | 2.16.840.1.113883.10.20.22.2.20.2 |
| code | 1..1 | SHALL |  | [15474](#C_15474) |  |
| @code | 1..1 | SHALL |  | [15475](#C_15475) | 11348-0 |
| @codeSystem | 1..1 | SHALL |  | [30831](#C_30831) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [7830](#C_7830) |  |
| text | 1..1 | SHALL |  | [7831](#C_7831) |  |
| entry | 0..\* | MAY |  | [8791](#C_8791) |  |
| observation | 1..1 | SHALL |  | [15476](#C_15476) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7828) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.20.2" (CONF:10390).
2. SHALL contain exactly one [1..1] code (CONF:15474).
   1. This code SHALL contain exactly one [1..1] @code="11348-0" History of Past Illness (CONF:15475).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30831).
3. SHALL contain exactly one [1..1] title (CONF:7830).
4. SHALL contain exactly one [1..1] text (CONF:7831).
5. MAY contain zero or more [0..\*] entry (CONF:8791) such that it
   1. SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15476).

Figure 53: History of Past Illness Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.20.2" />

<!-- \*\* History of Past Illness Section \*\* -->

<code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="11348-0" displayName="HISTORY OF PAST ILLNESS" />

<title>PAST MEDICAL HISTORY</title>

<text>

<paragraph>Patient has had ..... </paragraph>

</text>

<entry>

<!-- Sample With Problem Observation. -->

<observation classCode="OBS" moodCode="EVN">

<!-- Problem Observation -->

...

</observation>

</entry>

</section>

History of Present Illness Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.4 (open)]

107: History of Present Illness Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (required)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) |  |

The History of Present Illness section describes the history related to the reason for the encounter.  It contains the historical details leading up to and pertaining to the patient’s current complaint or reason for seeking medical care.

108: History of Present Illness Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '1.3.6.1.4.1.19376.1.5.3.1.3.4'] | | | | | |
| templateId | 1..1 | SHALL |  | [7848](#C_7848) |  |
| @root | 1..1 | SHALL | UID | [10458](#C_10458) | 1.3.6.1.4.1.19376.1.5.3.1.3.4 |
| title | 1..1 | SHALL |  | [7850](#C_7850) |  |
| text | 1..1 | SHALL |  | [7851](#C_7851) |  |
| code | 1..1 | SHALL |  | [15477](#C_15477) |  |
| @code | 1..1 | SHALL |  | [15478](#C_15478) | 2.16.840.1.113883.6.1 (LOINC) = 10164-2 |

1. SHALL contain exactly one [1..1] templateId (CONF:7848) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.4" (CONF:10458).
2. SHALL contain exactly one [1..1] code (CONF:15477).
   1. This code SHALL contain exactly one [1..1] @code="10164-2" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15478).
3. SHALL contain exactly one [1..1] title (CONF:7850).
4. SHALL contain exactly one [1..1] text (CONF:7851).

Figure 54: History of Present Illness Section Example

<section>

<templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.4.2" />

<code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="10164-2" displayName="HISTORY OF PRESENT ILLNESS" />

<title>HISTORY OF PRESENT ILLNESS</title>

<text>

<paragraph>This patient was only recently discharged for a recurrent

GI bleed as described below.</paragraph>

<paragraph>He presented to the ER today c/o a dark stool yesterday

but a normal brown stool today. On exam he was hypotensive in the

80s resolved after .... .... .... </paragraph>

<paragraph>Lab at discharge: Glucose 112, BUN 16, creatinine 1.1,

electrolytes normal. H. pylori antibody pending. Admission

hematocrit 16%, discharge hematocrit 29%. WBC 7300, platelet

count 256,000. Urinalysis normal. Urine culture: No growth. INR

1.1, PTT 40.</paragraph>

<paragraph>He was transfused with 6 units of packed red blood cells

with .... .... ....</paragraph>

<paragraph>GI evaluation 12 September: Colonoscopy showed single red

clot in .... .... ....</paragraph>

</text>

</section>

Hospital Admission Diagnosis Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.43.2 (open)]

109: Hospital Admission Diagnosis Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional) | [Hospital Admission Diagnosis (V2)](#E_Hospital_Admission_Diagnosis_V2) |

This section contains a narrative description of the problems or diagnoses identified by the clinician at the time of the patient’s admission. This section may contain coded entries representing the admitting diagnoses.

110: Hospital Admission Diagnosis Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.43.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [9930](#C_9930) |  |
| @root | 1..1 | SHALL |  | [10391](#C_10391) | 2.16.840.1.113883.10.20.22.2.43.2 |
| code | 1..1 | SHALL |  | [15479](#C_15479) |  |
| @code | 1..1 | SHALL |  | [15480](#C_15480) | 46241-6 |
| @codeSystem | 1..1 | SHALL |  | [30865](#C_30865) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [9932](#C_9932) |  |
| text | 1..1 | SHALL |  | [9933](#C_9933) |  |
| entry | 0..1 | SHOULD |  | [9934](#C_9934) |  |
| act | 1..1 | SHALL |  | [15481](#C_15481) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:9930) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.43.2" (CONF:10391).
2. SHALL contain exactly one [1..1] code (CONF:15479).
   1. This code SHALL contain exactly one [1..1] @code="46241-6" Hospital Admission Diagnosis (CONF:15480).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30865).
3. SHALL contain exactly one [1..1] title (CONF:9932).
4. SHALL contain exactly one [1..1] text (CONF:9933).
5. SHOULD contain zero or one [0..1] entry (CONF:9934).
   1. The entry, if present, SHALL contain exactly one [1..1] [Hospital Admission Diagnosis (V2)](#E_Hospital_Admission_Diagnosis_V2) (templateId:2.16.840.1.113883.10.20.22.4.34.2) (CONF:15481).

Figure 55: Hospital Admission Diagnosis Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.43.2"/>

<code code="46241-6" codeSystem="2.16.840.1.113883.6.1"

codeSystemName="LOINC"

displayName="Hospital Admission Diagnosis"/>

<title>HOSPITAL ADMISSION DIAGNOSIS</title>

<text>Appendicitis</text>

<entry>

<act classCode="ACT" moodCode="EVN">

<!—Hospital Admission Diagnosis template -->

...

</entry>

</section>

Hospital Admission Medications Section (entries optional) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.44.2 (open)]

111: Hospital Admission Medications Section (entries optional) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional) | [Admission Medication (V2)](#Admission_Medication_V2) |

The section contains the medications administered prior to admission to the facility. The currently active medications must also be listed.

112: Hospital Admission Medications Section (entries optional) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.44.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [10098](#C_10098) |  |
| @root | 1..1 | SHALL |  | [10392](#C_10392) | 2.16.840.1.113883.10.20.22.2.44.2 |
| code | 1..1 | SHALL |  | [15482](#C_15482) |  |
| @code | 1..1 | SHALL |  | [15483](#C_15483) | 2.16.840.1.113883.6.1 (LOINC) = 42346-7 |
| title | 1..1 | SHALL |  | [10100](#C_10100) |  |
| text | 1..1 | SHALL |  | [10101](#C_10101) |  |
| entry | 0..\* | SHOULD |  | [10102](#C_10102) |  |
| act | 1..1 | SHALL |  | [15484](#C_15484) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:10098) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.44.2" (CONF:10392).
2. SHALL contain exactly one [1..1] code (CONF:15482).
   1. This code SHALL contain exactly one [1..1] @code="42346-7" Medications on Admission (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15483).
3. SHALL contain exactly one [1..1] title (CONF:10100).
4. SHALL contain exactly one [1..1] text (CONF:10101).
5. SHOULD contain zero or more [0..\*] entry (CONF:10102) such that it
   1. SHALL contain exactly one [1..1] [Admission Medication (V2)](#Admission_Medication_V2) (templateId:2.16.840.1.113883.10.20.22.4.36.2) (CONF:15484).

Hospital Consultations Section

[section: templateId 2.16.840.1.113883.10.20.22.2.42 (open)]

113: Hospital Consultations Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional) |  |

The Hospital Consultations section records consultations that occurred during the admission.

114: Hospital Consultations Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.42'] | | | | | |
| templateId | 1..1 | SHALL |  | [9915](#C_9915) |  |
| @root | 1..1 | SHALL |  | [10393](#C_10393) | 2.16.840.1.113883.10.20.22.2.42 |
| title | 1..1 | SHALL |  | [9917](#C_9917) |  |
| text | 1..1 | SHALL |  | [9918](#C_9918) |  |
| code | 1..1 | SHALL |  | [15485](#C_15485) |  |
| @code | 1..1 | SHALL |  | [15486](#C_15486) | 2.16.840.1.113883.6.1 (LOINC) = 18841-7 |

1. SHALL contain exactly one [1..1] templateId (CONF:9915) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.42" (CONF:10393).
2. SHALL contain exactly one [1..1] code (CONF:15485).
   1. This code SHALL contain exactly one [1..1] @code="18841-7" Hospital Consultations Section (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15486).
3. SHALL contain exactly one [1..1] title (CONF:9917).
4. SHALL contain exactly one [1..1] text (CONF:9918).

Figure 56: Hospital Consultations Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.42" />

<code code="18841-7" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Hospital Consultations Section" />

<title>HOSPITAL CONSULTATIONS</title>

<text>

<list listType="ordered">

<item>Gastroenterology</item>

<item>Cardiology</item>

<item>Dietitian</item>

</list>

</text>

</section>

Hospital Course Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.5 (open)]

115: Hospital Course Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (required) |  |

The Hospital Course section describes the sequence of events from admission to discharge in a hospital facility.

116: Hospital Course Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '1.3.6.1.4.1.19376.1.5.3.1.3.5'] | | | | | |
| templateId | 1..1 | SHALL |  | [7852](#C_7852) |  |
| @root | 1..1 | SHALL | UID | [10459](#C_10459) | 1.3.6.1.4.1.19376.1.5.3.1.3.5 |
| title | 1..1 | SHALL |  | [7854](#C_7854) |  |
| text | 1..1 | SHALL |  | [7855](#C_7855) |  |
| code | 1..1 | SHALL |  | [15487](#C_15487) |  |
| @code | 1..1 | SHALL |  | [15488](#C_15488) | 2.16.840.1.113883.6.1 (LOINC) = 8648-8 |

1. SHALL contain exactly one [1..1] templateId (CONF:7852) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.5" (CONF:10459).
2. SHALL contain exactly one [1..1] code (CONF:15487).
   1. This code SHALL contain exactly one [1..1] @code="8648-8" Hospital Course (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15488).
3. SHALL contain exactly one [1..1] title (CONF:7854).
4. SHALL contain exactly one [1..1] text (CONF:7855).

Figure 57: Hospital Course Section Example

<section>

<templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.5" />

<code code="8648-8" displayName="HOSPITAL COURSE" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />

<title>Hospital Course</title>

<text> The patient was admitted and started on Lovenox and

nitroglycerin paste. The patient had ... </text>

</section>

Hospital Discharge Diagnosis Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.24.2 (open)]

117: Hospital Discharge Diagnosis Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (required) | [Hospital Discharge Diagnosis (V2)](#Hospital_Discharge_Diagnosis_V2) |

This template represents problems or diagnoses present at the time of discharge which occurred during the hospitalization or need to be monitored after hospitalization. This section includes an optional entry to record patient conditions.

118: Hospital Discharge Diagnosis Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.24.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7979](#C_7979) |  |
| @root | 1..1 | SHALL |  | [10394](#C_10394) | 2.16.840.1.113883.10.20.22.2.24.2 |
| code | 1..1 | SHALL |  | [15355](#C_15355) |  |
| @code | 1..1 | SHALL |  | [15356](#C_15356) | 11535-2 |
| @codeSystem | 1..1 | SHALL |  | [30861](#C_30861) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [7981](#C_7981) |  |
| text | 1..1 | SHALL |  | [7982](#C_7982) |  |
| entry | 0..1 | SHOULD |  | [7983](#C_7983) |  |
| act | 1..1 | SHALL |  | [15489](#C_15489) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7979) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.24.2" (CONF:10394).
2. SHALL contain exactly one [1..1] code (CONF:15355).
   1. This code SHALL contain exactly one [1..1] @code="11535-2" Hospital Discharge Diagnosis (CONF:15356).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30861).
3. SHALL contain exactly one [1..1] title (CONF:7981).
4. SHALL contain exactly one [1..1] text (CONF:7982).
5. SHOULD contain zero or one [0..1] entry (CONF:7983).
   1. The entry, if present, SHALL contain exactly one [1..1] [Hospital Discharge Diagnosis (V2)](#Hospital_Discharge_Diagnosis_V2) (templateId:2.16.840.1.113883.10.20.22.4.33.2) (CONF:15489).

Figure 58: Hospital Discharge Diagnosis Section Example

<section>

<!-- Discharge Summary Hospital Discharge Diagnosis Template Id -->

<templateId root="2.16.840.1.113883.10.20.22.2.24.2"/>

<code code="11535-2" displayName="Hospital Discharge Diagnosis"

codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>

<title>Hospital Discharge Diagnosis</title>

<text>Diverticula of intestine</text>

<entry>

<act classCode="ACT" moodCode="EVN">

<!—Hospital discharge Diagnosis act -->

...

</act>

</entry>

</section>

Hospital Discharge Instructions Section

[section: templateId 2.16.840.1.113883.10.20.22.2.41 (open)]

119: Hospital Discharge Instructions Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional) |  |

The Hospital Discharge Instructions section records instructions at discharge.

120: Hospital Discharge Instructions Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.41'] | | | | | |
| templateId | 1..1 | SHALL |  | [9919](#C_9919) |  |
| @root | 1..1 | SHALL |  | [10395](#C_10395) | 2.16.840.1.113883.10.20.22.2.41 |
| title | 1..1 | SHALL |  | [9921](#C_9921) |  |
| text | 1..1 | SHALL |  | [9922](#C_9922) |  |
| code | 1..1 | SHALL |  | [15357](#C_15357) |  |
| @code | 1..1 | SHALL |  | [15358](#C_15358) | 2.16.840.1.113883.6.1 (LOINC) = 8653-8 |

1. SHALL contain exactly one [1..1] templateId (CONF:9919) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.41" (CONF:10395).
2. SHALL contain exactly one [1..1] code (CONF:15357).
   1. This code SHALL contain exactly one [1..1] @code="8653-8" Hospital Discharge Instructions (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15358).
3. SHALL contain exactly one [1..1] title (CONF:9921).
4. SHALL contain exactly one [1..1] text (CONF:9922).

Figure 59: Hospital Discharge Instructions Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.41" />

<code code="8653-8" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="HOSPITAL DISCHARGE INSTRUCTIONS" />

<title>HOSPITAL DISCHARGE INSTRUCTIONS</title>

<text>

<list listType="ordered">

<item>Take all of your prescription medication as directed.</item>

<item>Make an appointment with your doctor to be seen two weeks from the

date of your procedure.</item>

<item>You may feel slightly bloated after the procedure because of air

that was introduced during the examination.</item>

<item>Call your physician if you notice:

<br />

Bleeding or black stools.

<br />

Abdominal pain.

<br />

Fever or chills.

<br />

Nausea or vomiting.

<br />

Any unusual pain or problem.

<br />

Pain or redness at the site where the intravenous needle was

placed.

<br /></item>

<item>Do not drink alcohol for 24 hours. Alcohol amplifies the effect of

the sedatives given.</item>

<item>Do not drive or operate machinery for 24 hours.</item>

</list>

</text>

</section>

Hospital Discharge Medications Section (entries optional) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.11.2 (open)]

121: Hospital Discharge Medications Section (entries optional) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional) | [Discharge Medication (V2)](#Discharge_Medication_V2) |

This section contains the medications the patient is intended to take or stop after discharge. Current, active medications must be listed. The section may also include a patient’s prescription history and indicate the source of the medication list.

122: Hospital Discharge Medications Section (entries optional) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.11.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7816](#C_7816) |  |
| @root | 1..1 | SHALL |  | [10396](#C_10396) | 2.16.840.1.113883.10.20.22.2.11.2 |
| code | 1..1 | SHALL |  | [15359](#C_15359) |  |
| @code | 1..1 | SHALL |  | [15360](#C_15360) | 2.16.840.1.113883.6.1 (LOINC) = 10183-2 |
| title | 1..1 | SHALL |  | [7818](#C_7818) |  |
| text | 1..1 | SHALL |  | [7819](#C_7819) |  |
| entry | 0..\* | SHOULD |  | [7820](#C_7820) |  |
| act | 1..1 | SHALL |  | [15490](#C_15490) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7816) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.11.2" (CONF:10396).
2. SHALL contain exactly one [1..1] code (CONF:15359).
   1. This code SHALL contain exactly one [1..1] @code="10183-2" Hospital Discharge Medications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15360).
3. SHALL contain exactly one [1..1] title (CONF:7818).
4. SHALL contain exactly one [1..1] text (CONF:7819).
5. SHOULD contain zero or more [0..\*] entry (CONF:7820) such that it
   1. SHALL contain exactly one [1..1] [Discharge Medication (V2)](#Discharge_Medication_V2) (templateId:2.16.840.1.113883.10.20.22.4.35.2) (CONF:15490).

Hospital Discharge Medications Section (entries required) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.11.1.2 (open)]

123: Hospital Discharge Medications Section (entries required) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional) | [Discharge Medication (V2)](#Discharge_Medication_V2) |

This section defines the medications that the patient is intended to take (or stop) after discharge. At a minimum, the currently active medications should be listed, with an entire medication history as an option.

It may also include a patient’s prescription history and indicate the source of the medication list, (e.g. a pharmacy system, patient).

124: Hospital Discharge Medications Section (entries required) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.11.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7822](#C_7822) |  |
| @root | 1..1 | SHALL |  | [10397](#C_10397) | 2.16.840.1.113883.10.20.22.2.11.1.2 |
| code | 1..1 | SHALL |  | [15361](#C_15361) |  |
| @code | 1..1 | SHALL |  | [15362](#C_15362) | 2.16.840.1.113883.6.1 (LOINC) = 10183-2 |
| title | 1..1 | SHALL |  | [7824](#C_7824) |  |
| text | 1..1 | SHALL |  | [7825](#C_7825) |  |
| entry | 1..\* | SHALL |  | [7826](#C_7826) |  |
| act | 1..1 | SHALL |  | [15491](#C_15491) |  |

1. Conforms to [Hospital Discharge Medications Section (entries optional) (V2)](#S_Hospital_Discharge_Medications_Sectio) template (2.16.840.1.113883.10.20.22.2.11.2).
2. SHALL contain exactly one [1..1] templateId (CONF:7822) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.11.1.2" (CONF:10397).
3. SHALL contain exactly one [1..1] code (CONF:15361).
   1. This code SHALL contain exactly one [1..1] @code="10183-2" Hospital Discharge Medications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15362).
4. SHALL contain exactly one [1..1] title (CONF:7824).
5. SHALL contain exactly one [1..1] text (CONF:7825).
6. SHALL contain at least one [1..\*] entry (CONF:7826) such that it
   1. SHALL contain exactly one [1..1] [Discharge Medication (V2)](#Discharge_Medication_V2) (templateId:2.16.840.1.113883.10.20.22.4.35.2) (CONF:15491).

Figure 60: Hospital Discharge Medication Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.11.1.2" />

<code code="10183-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName=" HOSPITAL DISCHARGE MEDICATIONS" />

<title>Hospital Discharge Medications</title>

<text>

...

</text>

<entry typeCode="DRIV">

<act classCode="ACT" moodCode="EVN">

<!-- Discharge Medication Entry -->

...

</act>

</entry>

...

</section>

Hospital Discharge Physical Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.26 (open)]

125: Hospital Discharge Physical Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional) |  |

The Hospital Discharge Physical section records a narrative description of the patient’s physical findings.

126: Hospital Discharge Physical Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '1.3.6.1.4.1.19376.1.5.3.1.3.26'] | | | | | |
| templateId | 1..1 | SHALL |  | [7971](#C_7971) |  |
| @root | 1..1 | SHALL | UID | [10460](#C_10460) | 1.3.6.1.4.1.19376.1.5.3.1.3.26 |
| title | 1..1 | SHALL |  | [7973](#C_7973) |  |
| text | 1..1 | SHALL |  | [7974](#C_7974) |  |
| code | 1..1 | SHALL |  | [15363](#C_15363) |  |
| @code | 1..1 | SHALL |  | [15364](#C_15364) | 2.16.840.1.113883.6.1 (LOINC) = 10184-0 |

1. SHALL contain exactly one [1..1] templateId (CONF:7971) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.26" (CONF:10460).
2. SHALL contain exactly one [1..1] code (CONF:15363).
   1. This code SHALL contain exactly one [1..1] @code="10184-0" Hospital Discharge Physical (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15364).
3. SHALL contain exactly one [1..1] title (CONF:7973).
4. SHALL contain exactly one [1..1] text (CONF:7974).

Figure 61: Hospital Discharge Physical Section Example

<section>

<templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.26" />

<code code="10184-0" displayName="HOSPITAL DISCHARGE PHYSICAL" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />

<title>Hospital Discharge Physical</title>

<text>GENERAL: Well-developed, slightly obese man.

<br />

NECK: Supple, with no jugular venous distension.

<br />

HEART: Intermittent tachycardia without murmurs or gallops.

<br />

PULMONARY: Decreased breath sounds, but no clear-cut rales or

wheezes.

<br />

EXTREMITIES: Free of edema.

</text>

</section>

Hospital Discharge Studies Summary Section

[section: templateId 2.16.840.1.113883.10.20.22.2.16 (open)]

127: Hospital Discharge Studies Summary Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional) |  |

This section records the results of observations generated by laboratories, imaging procedures, and other procedures. The scope includes hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. This section often includes notable results such as abnormal values or relevant trends, and could record all results for the period of time being documented.

Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory.

Imaging results are typically generated by a clinician reviewing the output of an imaging procedure, such as where a cardiologist reports the left ventricular ejection fraction based on the review of an echocardiogram.

Procedure results are typically generated by a clinician wanting to provide more granular information about component observations made during the performance of a procedure, such as when a gastroenterologist reports the size of a polyp observed during a colonoscopy.

Note that there are discrepancies between CCD and the lab domain model, such as the effectiveTime in specimen collection.

128: Hospital Discharge Studies Summary Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.16'] | | | | | |
| templateId | 1..1 | SHALL |  | [7910](#C_7910) |  |
| @root | 1..1 | SHALL |  | [10398](#C_10398) | 2.16.840.1.113883.10.20.22.2.16 |
| title | 1..1 | SHALL |  | [7912](#C_7912) |  |
| text | 1..1 | SHALL |  | [7913](#C_7913) |  |
| code | 1..1 | SHALL |  | [15365](#C_15365) |  |
| @code | 1..1 | SHALL |  | [15366](#C_15366) | 2.16.840.1.113883.6.1 (LOINC) = 11493-4 |

1. SHALL contain exactly one [1..1] templateId (CONF:7910) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.16" (CONF:10398).
2. SHALL contain exactly one [1..1] code (CONF:15365).
   1. This code SHALL contain exactly one [1..1] @code="11493-4" Hospital Discharge Studies Summary (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15366).
3. SHALL contain exactly one [1..1] title (CONF:7912).
4. SHALL contain exactly one [1..1] text (CONF:7913).

Figure 62: Hospital Discharge Studies Summary Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.16" />

<code code="11493-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="HOSPITAL DISCHARGE STUDIES SUMMARY" />

<title>Hospital Discharge Studies Summary</title>

<text>

...

</text>

</section>

Immunizations Section (entries optional) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.2.2 (open)]

129: Immunizations Section (entries optional) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (optional) | [Immunization Activity (V2)](#E_Immunization_Activity_V2) |

The Immunizations section defines a patient's current immunization status and pertinent immunization history. The primary use case for the Immunization section is to enable communication of a patient's immunization status. The section should include current immunization status, and may contain the entire immunization history that is relevant to the period of time being summarized.

130: Immunizations Section (entries optional) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.2.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7965](#C_7965) |  |
| @root | 1..1 | SHALL |  | [10399](#C_10399) | 2.16.840.1.113883.10.20.22.2.2.2 |
| code | 1..1 | SHALL |  | [15367](#C_15367) |  |
| @code | 1..1 | SHALL |  | [15368](#C_15368) | 2.16.840.1.113883.6.1 (LOINC) = 11369-6 |
| title | 1..1 | SHALL |  | [7967](#C_7967) |  |
| text | 1..1 | SHALL |  | [7968](#C_7968) |  |
| entry | 0..\* | SHOULD |  | [7969](#C_7969) |  |
| substanceAdministration | 1..1 | SHALL |  | [15494](#C_15494) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7965) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.2.2" (CONF:10399).
2. SHALL contain exactly one [1..1] code (CONF:15367).
   1. This code SHALL contain exactly one [1..1] @code="11369-6" Immunizations (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15368).
3. SHALL contain exactly one [1..1] title (CONF:7967).
4. SHALL contain exactly one [1..1] text (CONF:7968).
5. SHOULD contain zero or more [0..\*] entry (CONF:7969) such that it
   1. SHALL contain exactly one [1..1] [Immunization Activity (V2)](#E_Immunization_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.52.2) (CONF:15494).

Immunizations Section (entries required) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.2.1.2 (open)]

131: Immunizations Section (entries required) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (optional) | [Immunization Activity (V2)](#E_Immunization_Activity_V2) |

The Immunizations section defines a patient's current immunization status and pertinent immunization history. The primary use case for the Immunization section is to enable communication of a patient's immunization status. The section should include current immunization status, and may contain the entire immunization history that is relevant to the period of time being summarized.

132: Immunizations Section (entries required) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.2.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [9015](#C_9015) |  |
| @root | 1..1 | SHALL |  | [10400](#C_10400) | 2.16.840.1.113883.10.20.22.2.2.1.2 |
| code | 1..1 | SHALL |  | [15369](#C_15369) |  |
| @code | 1..1 | SHALL |  | [15370](#C_15370) | 2.16.840.1.113883.6.1 (LOINC) = 11369-6 |
| title | 1..1 | SHALL |  | [9017](#C_9017) |  |
| text | 1..1 | SHALL |  | [9018](#C_9018) |  |
| entry | 1..\* | SHALL |  | [9019](#C_9019) |  |
| substanceAdministration | 1..1 | SHALL |  | [15495](#C_15495) |  |

1. Conforms to [Immunizations Section (entries optional) (V2)](#S_Immunizations_Section_entries_optiona) template (2.16.840.1.113883.10.20.22.2.2.2).
2. SHALL contain exactly one [1..1] templateId (CONF:9015) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.2.1.2" (CONF:10400).
3. SHALL contain exactly one [1..1] code (CONF:15369).
   1. This code SHALL contain exactly one [1..1] @code="11369-6" Immunizations (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15370).
4. SHALL contain exactly one [1..1] title (CONF:9017).
5. SHALL contain exactly one [1..1] text (CONF:9018).
6. SHALL contain at least one [1..\*] entry (CONF:9019) such that it
   1. SHALL contain exactly one [1..1] [Immunization Activity (V2)](#E_Immunization_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.52.2) (CONF:15495).

Figure 63:

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.1.2" />

<!-- \*\*\*\*\*\*\*\* Immunizations section template \*\*\*\*\*\*\*\* -->

<code code="11369-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="History of immunizations" />

<title>Immunizations</title>

<text>

<table border="1" width="100%">

<thead>

<tr>

<th>Vaccine</th>

<th>Date</th>

<th>Status</th>

</tr>

</thead>

<tbody>

<tr>

<td>

<content ID="immun1" />Influenza virus vaccine, IM

</td>

<td>Nov 1999</td>

<td>Completed</td>

</tr>

<tr>

<td>

<content ID="immun2" />Influenza virus vaccine, IM

</td>

<td>Dec 1998</td>

<td>Completed</td>

</tr>

<tr>

<td>

<content ID="immun3" />

Pneumococcal polysaccharide vaccine, IM

</td>

<td>Dec 1998</td>

<td>Completed</td>

</tr>

<tr>

<td>

<content ID="immun4" />Tetanus and diphtheria toxoids, IM

</td>

<td>1997</td>

<td>Refused</td>

</tr>

</tbody>

</table>

</text>

<entry typeCode="DRIV">

<substanceAdministration classCode="SBADM" moodCode="EVN" negationInd="false">

<templateId root="2.16.840.1.113883.10.20.22.4.52" />

<!-- \*\*\*\* Immunization activity template \*\*\*\* -->

...

</substanceAdministration>

</entry>

...

</section>

Implants Section

[section: templateId 2.16.840.1.113883.10.20.22.2.33 (open)]

133: Implants Section Contexts

| Contained By: | Contains: |
| --- | --- |

Replaced by template: 2.16.840.1.113883.10.20.22.2.40

134: Implants Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.33'] | | | | | |
| templateId | 1..1 | SHALL |  | [8042](#C_8042) |  |
| @root | 1..1 | SHALL |  | [10401](#C_10401) | 2.16.840.1.113883.10.20.22.2.33 |
| title | 1..1 | SHALL |  | [8044](#C_8044) |  |
| text | 1..1 | SHALL |  | [8045](#C_8045) |  |
| code | 1..1 | SHALL |  | [15371](#C_15371) |  |
| @code | 1..1 | SHALL |  | [15372](#C_15372) | 2.16.840.1.113883.6.1 (LOINC) = 55122-6 |
| @codeSystem | 0..1 | SHALL |  | [26471](#C_26471) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |

1. SHALL contain exactly one [1..1] templateId (CONF:8042) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.33" (CONF:10401).
2. SHALL contain exactly one [1..1] code (CONF:15371).
   1. This code SHALL contain exactly one [1..1] @code="55122-6" Implants (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15372).
   2. This code SHALL contain zero or one [0..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:26471).
3. SHALL contain exactly one [1..1] title (CONF:8044).
4. SHALL contain exactly one [1..1] text (CONF:8045).

Instructions Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.45.2 (open)]

135: Instructions Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [History and Physical (V2)](#D_History_and_Physical_V2) (optional)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) | [Instruction (V2)](#Instruction_V2) |

The Instructions section records instructions given to a patient. List patient decision aids here.

136: Instructions Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.45.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [10112](#C_10112) |  |
| @root | 1..1 | SHALL |  | [31384](#C_31384) | 2.16.840.1.113883.10.20.22.2.45.2 |
| code | 1..1 | SHALL |  | [15375](#C_15375) |  |
| @code | 1..1 | SHALL |  | [15376](#C_15376) | 2.16.840.1.113883.6.1 (LOINC) = 69730-0 |
| title | 1..1 | SHALL |  | [10114](#C_10114) |  |
| text | 1..1 | SHALL |  | [10115](#C_10115) |  |
| entry | 0..\* | SHOULD |  | [10116](#C_10116) |  |
| act | 1..1 | SHALL |  | [31398](#C_31398) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:10112) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.45.2" (CONF:31384).
2. SHALL contain exactly one [1..1] code (CONF:15375).
   1. This code SHALL contain exactly one [1..1] @code="69730-0" Instructions (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15376).
3. SHALL contain exactly one [1..1] title (CONF:10114).
4. SHALL contain exactly one [1..1] text (CONF:10115).
5. SHOULD contain zero or more [0..\*] entry (CONF:10116).
   1. The entry, if present, SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31398).

Figure 64: Instructions Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.21.2.45.2"/>

<code code="69730-0" codeSystem="2.16.840.1.113883.6.1"

codeSystemName="LOINC"

displayName="INSTRUCTIONS"/>

<title>INSTRUCTIONS</title>

<text>

Patient may have low grade fever, mild joint pain and injection area

tenderness

</text>

<entry typeCode="DRIV">

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.20"/>

<!-- \*\*\* Instructions template \*\*\* -->

...

</supply>

</act>

</section>

Interventions Section (V2)

[section: templateId 2.16.840.1.113883.10.20.21.2.3.2 (open)]

137: Interventions Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Care Plan (NEW)](#D_Care_Plan_NEW) (required)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) | [Intervention Act (NEW)](#E_Intervention_Act_NEW) |

This template represents Interventions.  Interventions are actions taken to maximize the prospects of achieving the patient’s or provider’s goals of care, including the removal of barriers to success. Interventions can be planned, ordered, historical, etc.

Interventions include actions that may be ongoing (e.g. maintenance medications that the patient is taking, or monitoring the patient’s health status or the status of an intervention).

Instructions are a subset of interventions and may include self-care instructions. Instructions are information or directions to the patient and other providers including how to care for the individual’s condition, what to do at home, when to call for help, any additional appointments, testing, and changes to the medication list or medication instructions, clinical guidelines and a summary of best practice.

138: Interventions Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.21.2.3.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8680](#C_8680) |  |
| @root | 1..1 | SHALL | UID | [10461](#C_10461) | 2.16.840.1.113883.10.20.21.2.3.2 |
| code | 1..1 | SHALL |  | [15377](#C_15377) |  |
| @code | 1..1 | SHALL |  | [15378](#C_15378) | 62387-6 |
| @codeSystem | 1..1 | SHALL |  | [30864](#C_30864) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [8682](#C_8682) |  |
| text | 1..1 | SHALL |  | [8683](#C_8683) |  |
| entry | 0..\* | SHOULD |  | [30996](#C_30996) |  |
| act | 1..1 | SHALL |  | [30997](#C_30997) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:8680) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.21.2.3.2" (CONF:10461).
2. SHALL contain exactly one [1..1] code (CONF:15377).
   1. This code SHALL contain exactly one [1..1] @code="62387-6" Interventions Provided (CONF:15378).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30864).
3. SHALL contain exactly one [1..1] title (CONF:8682).
4. SHALL contain exactly one [1..1] text (CONF:8683).
5. SHOULD contain zero or more [0..\*] entry (CONF:30996).
   1. The entry, if present, SHALL contain exactly one [1..1] [Intervention Act (NEW)](#E_Intervention_Act_NEW) (templateId:2.16.840.1.113883.10.20.22.4.131) (CONF:30997).

Figure 65: Interventions Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.21.2.3.2" />

<code code="62387-6" displayName="Interventions Provided" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />

<title>Interventions Section</title>

<text />

<entry>

<act />

</entry>

</section>

Medical (General) History Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.39.2 (open)]

139: Medical (General) History Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) | [Medical Equipment Organizer (NEW)](#E_Medical_Equipment_Organizer_NEW) |

The Medical History section describes all aspects of the medical history of the patient even if not pertinent to the current procedure, and may include chief complaint, past medical history, social history, family history, surgical or procedure history, medical device history, medication history, and other history information. The history may be limited to information pertinent to the current procedure or may be more comprehensive. The history may be reported as a collection of random clinical statements or it may be reported categorically. Categorical report formats may be divided into multiple subsections including Past Medical History, Social History.

140: Medical (General) History Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.39.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8160](#C_8160) |  |
| @root | 1..1 | SHALL |  | [10403](#C_10403) | 2.16.840.1.113883.10.20.22.2.39.2 |
| code | 1..1 | SHALL |  | [15379](#C_15379) |  |
| @code | 1..1 | SHALL |  | [15380](#C_15380) | 2.16.840.1.113883.6.1 (LOINC) = 11329-0 |
| title | 1..1 | SHALL |  | [8162](#C_8162) |  |
| text | 1..1 | SHALL |  | [8163](#C_8163) |  |
| entry | 0..\* | MAY |  | [31196](#C_31196) |  |
| organizer | 1..1 | SHALL |  | [31197](#C_31197) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:8160) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.39.2" (CONF:10403).
2. SHALL contain exactly one [1..1] code (CONF:15379).
   1. This code SHALL contain exactly one [1..1] @code="11329-0" Medical (General) History (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15380).
3. SHALL contain exactly one [1..1] title (CONF:8162).
4. SHALL contain exactly one [1..1] text (CONF:8163).
5. MAY contain zero or more [0..\*] entry (CONF:31196) such that it
   1. SHALL contain exactly one [1..1] [Medical Equipment Organizer (NEW)](#E_Medical_Equipment_Organizer_NEW) (templateId:2.16.840.1.113883.10.20.22.4.135) (CONF:31197).

Figure 66: Sample

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.39.2" />

<code code="11329-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="MEDICAL (GENERAL) HISTORY" />

<title>MEDICAL (GENERAL) HISTORY</title>

<text>

<list listType="ordered">

<item>Patient has had recent issue with acne that does not seem to

be related to any particular cause.</item>

<item>Previous concerns of oral cancer was actually irritated gums

as a result of mild food allergy.</item>

<item>Patient had recent weight gain due to sedentary lifestyle and

new job.</item>

<item>

Patient has a history of Stoma Bag Closure usage between 01 Jan 2011 to 06 June 2011

</item>

</list>

</text>

<!-- Medical Equipment Organizer template -->

<entry>

<organizer classCode="CLUSTER" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.135" />

...

</organizer>

</entry>

</section>

Medical Equipment Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.23.2 (open)]

141: Medical Equipment Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (optional) | [Medical Device (NEW)](#E_Medical_Device_NEW)  [Medical Equipment Organizer (NEW)](#E_Medical_Equipment_Organizer_NEW) |

This section defines supportive health and external medical devices and equipment. This section lists any pertinent durable medical equipment (DME) used to help maintain the patient’s health status. All equipment relevant to the diagnosis, care, or treatment of a patient should be included. Any devices in or on a patient are represented using the Medical Device template. These Medical Devices may be grouped together within a Medical Equipment Organizer.

142: Medical Equipment Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.23.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7944](#C_7944) |  |
| @root | 1..1 | SHALL |  | [10404](#C_10404) | 2.16.840.1.113883.10.20.22.2.23.2 |
| code | 1..1 | SHALL |  | [15381](#C_15381) |  |
| @code | 1..1 | SHALL |  | [15382](#C_15382) | 46264-8 |
| @codeSystem | 1..1 | SHALL |  | [30828](#C_30828) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [7946](#C_7946) |  |
| text | 1..1 | SHALL |  | [7947](#C_7947) |  |
| entry | 0..\* | SHOULD |  | [7948](#C_7948) |  |
| organizer | 1..1 | SHALL |  | [30351](#C_30351) |  |
| entry | 0..\* | SHOULD |  | [31125](#C_31125) |  |
| supply | 1..1 | SHALL |  | [31861](#C_31861) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7944) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.23.2" (CONF:10404).
2. SHALL contain exactly one [1..1] code (CONF:15381).
   1. This code SHALL contain exactly one [1..1] @code="46264-8" Medical Equipment (CONF:15382).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30828).
3. SHALL contain exactly one [1..1] title (CONF:7946).
4. SHALL contain exactly one [1..1] text (CONF:7947).
5. SHOULD contain zero or more [0..\*] entry (CONF:7948) such that it
   1. SHALL contain exactly one [1..1] [Medical Equipment Organizer (NEW)](#E_Medical_Equipment_Organizer_NEW) (templateId:2.16.840.1.113883.10.20.22.4.135) (CONF:30351).
6. SHOULD contain zero or more [0..\*] entry (CONF:31125) such that it
   1. SHALL contain exactly one [1..1] [Medical Device (NEW)](#E_Medical_Device_NEW) (templateId:2.16.840.1.113883.10.20.22.4.115) (CONF:31861).

Figure 67: Medical Equipment Section Example

<section>

<!-- Medical equipment section -->

<templateId root="2.16.840.1.113883.10.20.22.2.23.2" />

<code code="46264-8" codeSystem="2.16.840.1.113883.6.1" />

<!-- 10.16.x High Risk Devices, Catheters, Stents -->

<title>MEDICAL EQUIPMENT</title>

<text>...

</text>

<entry typeCode="DRIV">

<organizer classCode="CLUSTER" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.135" />

<!-- Medical Equipment Organizer template -->

...

</organizer>

</entry>

<entry typeCode="DRIV">

<!-- \*\* 10.15.5 Restraints -->

<procedure classCode="PROC" moodCode="EVN">

<!-- Medical Device Applied -->

<templateId root="2.16.840.1.113883.10.20.22.4.115" />

...

</procedure>

</entry>

</section>

Medications Administered Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.38.2 (open)]

143: Medications Administered Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) | [Medication Activity (V2)](#Medication_Activity_V2) |

The Medications Administered section contains medications and fluids administered during a procedure, the procedure's encounter or other activity excluding anesthetic medications. This section is not intended for ongoing medications and medication history.

144: Medications Administered Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.38.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8152](#C_8152) |  |
| @root | 1..1 | SHALL |  | [10405](#C_10405) | 2.16.840.1.113883.10.20.22.2.38.2 |
| code | 1..1 | SHALL |  | [15383](#C_15383) |  |
| @code | 1..1 | SHALL |  | [15384](#C_15384) | 29549-3 |
| @codeSystem | 1..1 | SHALL |  | [30829](#C_30829) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [8154](#C_8154) |  |
| text | 1..1 | SHALL |  | [8155](#C_8155) |  |
| entry | 0..\* | MAY |  | [8156](#C_8156) |  |
| substanceAdministration | 1..1 | SHALL |  | [15499](#C_15499) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:8152) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.38.2" (CONF:10405).
2. SHALL contain exactly one [1..1] code (CONF:15383).
   1. This code SHALL contain exactly one [1..1] @code="29549-3" Medications Administered (CONF:15384).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30829).
3. SHALL contain exactly one [1..1] title (CONF:8154).
4. SHALL contain exactly one [1..1] text (CONF:8155).
5. MAY contain zero or more [0..\*] entry (CONF:8156).
   1. The entry, if present, SHALL contain exactly one [1..1] [Medication Activity (V2)](#Medication_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15499).

Figure 68: Sample

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.38.2" />

<code code="29549-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="MEDICATIONS ADMINISTERED" />

<title>MEDICATIONS ADMINISTERED</title>

<text>

<table border="1" width="100%">

<thead>

<tr>

<th>Medication</th>

<th>Directions</th>

<th>Start Date</th>

<th>Status</th>

<th>Indications</th>

<th>Fill Instructions</th>

</tr>

</thead>

<tbody>

<tr>

<td>

<content ID="MedAdministered\_1">Proventil 0.09 MG/ACTUAT inhalant solution</content>

</td>

<td>0.09 MG/ACTUAT inhalant solution, 2 puffs QID PRN wheezing</td>

<td>20070103</td>

<td>Active</td>

<td>Pneumonia (233604007 SNOMED CT)</td>

<td>Generic Substitition Allowed</td>

</tr>

</tbody>

</table>

</text>

<entry typeCode="DRIV">

<substanceAdministration classCode="SBADM" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.16.2" />

<!-- \*\* MEDICATION ACTIVITY V2 \*\* -->

...

</substanceAdministration>

</entry>

</section>

Medications Section (entries optional) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.1.2 (open)]

145: Medications Section (entries optional) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [History and Physical (V2)](#D_History_and_Physical_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) | [Medication Activity (V2)](#Medication_Activity_V2) |

The Medications section contains a patient's current medications and pertinent medication history. At a minimum, the currently active medications are to be listed, with an entire medication history as an option. The section also could describe a patient's prescription and dispense history and information about intended drug monitoring.

146: Medications Section (entries optional) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7791](#C_7791) |  |
| @root | 1..1 | SHALL |  | [10432](#C_10432) | 2.16.840.1.113883.10.20.22.2.1.2 |
| code | 1..1 | SHALL |  | [15385](#C_15385) |  |
| @code | 1..1 | SHALL |  | [15386](#C_15386) | 10160-0 |
| @codeSystem | 1..1 | SHALL |  | [30824](#C_30824) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [7793](#C_7793) |  |
| text | 1..1 | SHALL |  | [7794](#C_7794) |  |
| entry | 0..\* | SHOULD |  | [7795](#C_7795) |  |
| @nullFlavor | 0..1 | MAY |  | [15984](#C_15984) |  |
| substanceAdministration | 1..1 | SHALL |  | [10076](#C_10076) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7791) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.1.2" (CONF:10432).
2. SHALL contain exactly one [1..1] code (CONF:15385).
   1. This code SHALL contain exactly one [1..1] @code="10160-0" History of medication use (CONF:15386).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30824).
3. SHALL contain exactly one [1..1] title (CONF:7793).
4. SHALL contain exactly one [1..1] text (CONF:7794).
5. SHOULD contain zero or more [0..\*] entry (CONF:7795) such that it
   1. MAY contain zero or one [0..1] @nullFlavor (CONF:15984).
   2. SHALL contain exactly one [1..1] [Medication Activity (V2)](#Medication_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:10076).

Medications Section (entries required) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.1.1.2 (open)]

147: Medications Section (entries required) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (required)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (required) | [Medication Activity (V2)](#Medication_Activity_V2) |

The Medications section contains a patient's current medications and pertinent medication history. At a minimum, the currently active medications are to be listed, with an entire medication history as an option. The section also could describe a patient's prescription and dispense history and information about intended drug monitoring.

This section requires that there be either an entry indicating the subject is not known to be on any medications, or that there be entries summarizing the subject's medications.

148: Medications Section (entries required) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.1.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7568](#C_7568) |  |
| @root | 1..1 | SHALL |  | [10433](#C_10433) | 2.16.840.1.113883.10.20.22.2.1.2 |
| code | 1..1 | SHALL |  | [15387](#C_15387) |  |
| @code | 1..1 | SHALL |  | [15388](#C_15388) | 10160-0 |
| @codeSystem | 1..1 | SHALL |  | [30825](#C_30825) | 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [7570](#C_7570) |  |
| text | 1..1 | SHALL |  | [7571](#C_7571) |  |
| entry | 1..\* | SHALL |  | [7572](#C_7572) |  |
| substanceAdministration | 1..1 | SHALL |  | [10077](#C_10077) |  |

1. Conforms to [Medications Section (entries optional) (V2)](#S_Medications_Section_entries_optional_) template (2.16.840.1.113883.10.20.22.2.1.2).
2. SHALL contain exactly one [1..1] templateId (CONF:7568) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.1.2" (CONF:10433).
3. SHALL contain exactly one [1..1] code (CONF:15387).
   1. This code SHALL contain exactly one [1..1] @code="10160-0" History of medication use (CONF:15388).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CONF:30825).
4. SHALL contain exactly one [1..1] title (CONF:7570).
5. SHALL contain exactly one [1..1] text (CONF:7571).
6. SHALL contain at least one [1..\*] entry (CONF:7572) such that it
   1. SHALL contain exactly one [1..1] [Medication Activity (V2)](#Medication_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:10077).

Figure 69: Sample

<section>

<!--\*\*MEDICATION SECTION (coded entries required) \*\* -->

<templateId root="2.16.840.1.113883.10.20.22.2.1.1.2" />

<!-- Medications Section (entries optional) -->

<templateId root="2.16.840.1.113883.10.20.22.2.1.2" />

<code code="10160-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="HISTORY OF MEDICATION USE" />

<title>MEDICATIONS</title>

<text>

Narrative Text

</text>

<entry>

<substanceAdministration classCode="SBADM" moodCode="EVN">

<!--\*\*MEDICATION ACTIVITY V2 \*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.16.2" />

....

</substanceAdministration>

</entry>

</section>

Mental Status Section (NEW)

[section: templateId 2.16.840.1.113883.10.20.22.2.56 (open)]

149: Mental Status Section (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional) | [Assessment Scale Observation](#E_Assessment_Scale_Observation)  [Caregiver Characteristics](#E_Caregiver_Characteristics)  [Cognitive Abilities Observation (NEW)](#E_Cognitive_Abilities_Observation_NEW)  [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2)  [Cognitive Status Organizer (V2)](#E_Cognitive_Status_Organizer_V2)  [Mental Status Observation (NEW)](#E_Mental_Status_Observation_NEW)  [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2) |

The Mental Status section contains observation and evaluations related to patient's psychological and mental competency and deficits including cognitive functioning (e.g. mood, anxiety, perceptual disturbances) cognitive ability (e.g. concentration, intellect, visual-spatial perception).

150: Mental Status Section (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.56'] | | | | | |
| templateId | 1..1 | SHALL |  | [28293](#C_28293) |  |
| @root | 1..1 | SHALL |  | [28294](#C_28294) | 2.16.840.1.113883.10.20.22.2.14 |
| code | 1..1 | SHALL |  | [28295](#C_28295) |  |
| @code | 1..1 | SHALL |  | [28296](#C_28296) | 2.16.840.1.113883.6.1 (LOINC) = 10190-7 |
| @codeSystem | 1..1 | SHALL |  | [30826](#C_30826) | 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [28297](#C_28297) |  |
| text | 1..1 | SHALL |  | [28298](#C_28298) |  |
| entry | 0..\* | MAY |  | [28301](#C_28301) |  |
| organizer | 1..1 | SHALL |  | [28302](#C_28302) |  |
| entry | 0..\* | MAY |  | [28305](#C_28305) |  |
| observation | 1..1 | SHALL |  | [28306](#C_28306) |  |
| entry | 0..\* | MAY |  | [28311](#C_28311) |  |
| observation | 1..1 | SHALL |  | [28312](#C_28312) |  |
| entry | 0..\* | MAY |  | [28313](#C_28313) |  |
| observation | 1..1 | SHALL |  | [28314](#C_28314) |  |
| entry | 0..\* | MAY |  | [28315](#C_28315) |  |
| supply | 1..1 | SHALL |  | [30782](#C_30782) |  |
| entry | 0..\* | MAY |  | [28323](#C_28323) |  |
| observation | 1..1 | SHALL |  | [28324](#C_28324) |  |
| entry | 0..\* | MAY |  | [28325](#C_28325) |  |
| observation | 1..1 | SHALL |  | [28326](#C_28326) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:28293) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.14" (CONF:28294).
2. SHALL contain exactly one [1..1] code (CONF:28295).
   1. This code SHALL contain exactly one [1..1] @code="10190-7" Mental Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:28296).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CONF:30826).
3. SHALL contain exactly one [1..1] title (CONF:28297).
4. SHALL contain exactly one [1..1] text (CONF:28298).
5. MAY contain zero or more [0..\*] entry (CONF:28301) such that it
   1. SHALL contain exactly one [1..1] [Cognitive Status Organizer (V2)](#E_Cognitive_Status_Organizer_V2) (templateId:2.16.840.1.113883.10.20.22.4.75.2) (CONF:28302).
6. MAY contain zero or more [0..\*] entry (CONF:28305) such that it
   1. SHALL contain exactly one [1..1] [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.74.2) (CONF:28306).
7. MAY contain zero or more [0..\*] entry (CONF:28311) such that it
   1. SHALL contain exactly one [1..1] [Caregiver Characteristics](#E_Caregiver_Characteristics) (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:28312).
8. MAY contain zero or more [0..\*] entry (CONF:28313) such that it
   1. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:28314).
9. MAY contain zero or more [0..\*] entry (CONF:28315) such that it
   1. SHALL contain exactly one [1..1] [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.50.2) (CONF:30782).
10. MAY contain zero or more [0..\*] entry (CONF:28323) such that it
    1. SHALL contain exactly one [1..1] [Cognitive Abilities Observation (NEW)](#E_Cognitive_Abilities_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.126) (CONF:28324).
11. MAY contain zero or more [0..\*] entry (CONF:28325) such that it
    1. SHALL contain exactly one [1..1] [Mental Status Observation (NEW)](#E_Mental_Status_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.125) (CONF:28326).

Figure 70: Mental Status Section

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.14"/>

<!-- Mental Status Section -->

<code code="10190-7" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="MENTAL STATUS"/>

<title>MENTAL STATUS</title>

<text>

...

</text>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Mental Status Observation template -->

<templateId root="2.16.840.1.113883.10.20.22.4.125"/>

...

</entry>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Cognitive Abilities Observation -->

<templateId root="2.16.840.1.113883.10.20.22.4.126"/>

...

</entry>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Cognitive Status Oservation V2 -->

<templateId root="2.16.840.1.113883.10.20.22.4.74.2"/>

...

</entry>

<entry>

<organizer classCode="CLUSTER" moodCode="EVN">

<!-- Cognitive Status Organizer V2-->

<templateId root="2.16.840.1.113883.10.20.22.4.75.2"/>

<id root="a7bc1062-8649-42a0-833d-ekd65bd013c9"/>

...

</organizer>

</entry>

</section>

Nutrition Section (NEW)

[section: templateId 2.16.840.1.113883.10.20.22.2.57 (open)]

151: Nutrition Section (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional) | [Nutritional Status Observation (NEW)](#E_Nutritional_Status_Observation_NEW) |

The Nutrition Section represents diet and nutrition information including special diet requirements and restrictions (e.g. soft mechanical diet, liquids only, enteral feeding). It also represents the overall nutritional status of the patient, nutrition assessment findings, and diet recommendations.

USE THIS SECTION INSTEAD OF DISCHARGE DIET SECTION (DEPRECATED) template id:1.3.6.1.4.1.19376.1.5.3.1.3.33.2

152: Nutrition Section (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.57'] | | | | | |
| templateId | 1..1 | SHALL |  | [30477](#C_30477) |  |
| @root | 1..1 | SHALL | UID | [30478](#C_30478) | 2.16.840.1.113883.10.20.22.2.57 |
| title | 1..1 | SHALL |  | [31042](#C_31042) |  |
| text | 1..1 | SHALL |  | [31043](#C_31043) |  |
| code | 1..1 | SHALL |  | [30318](#C_30318) |  |
| @code | 1..1 | SHALL |  | [30319](#C_30319) | 61144-2 |
| @codeSystem | 1..1 | SHALL |  | [30320](#C_30320) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| entry | 0..\* | SHOULD |  | [30321](#C_30321) |  |
| observation | 1..1 | SHALL |  | [30322](#C_30322) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:30477) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.57" (CONF:30478).
2. SHALL contain exactly one [1..1] code (CONF:30318).
   1. This code SHALL contain exactly one [1..1] @code="61144-2" Diet and nutrition  (CONF:30319).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30320).
3. SHALL contain exactly one [1..1] title (CONF:31042).
4. SHALL contain exactly one [1..1] text (CONF:31043).
5. SHOULD contain zero or more [0..\*] entry (CONF:30321) such that it
   1. SHALL contain exactly one [1..1] [Nutritional Status Observation (NEW)](#E_Nutritional_Status_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.124) (CONF:30322).

Figure 71: Nutrition Section Example

<section>

<!-- General Status Section V2 -->

<templateId root="2.16.840.1.113883.10.20.2.5.2"/>

<code code="61144-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="Diet and Nutrition"/>

<title>NUTRITION SECTION</title>

<text>

<paragraph>Nutritional Status: well nourished</paragraph>

<paragraph>Nutrition Assessment: Dietary Requirements; low sodium diet, Dietary Intake, high carbohydrate diet; BMI 25-29 overweight </paragraph>

<paragraph>Nutritional Recommendations: BMI 22; Nutrition Education "Lean Meats"</paragraph>

</text>

<entry>

<!-- SHOULD HAVE Nutritional Status Observation -->

<observation classCode="OBS" moodCode="EVN">

<!-- contains NUTRITIONAL STATUS Observation -->

<templateId root="2.16.840.1.113883.10.20.22.4.124"/>

...

<entryRelationship typeCode="SUBJ">

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Nutritional Assessment observation\*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.138"/>

<id root="ab1791b0-5c71-11db-b0de-0800200c9a66"/>

...

</observation>

</entryRelationship>

</entry>

</section>

Objective Section

[section: templateId 2.16.840.1.113883.10.20.21.2.1 (open)]

153: Objective Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Progress Note (V2)](#D_Progress_Note_V2) (optional) |  |

The Objective section contains data about the patient gathered through tests, measures, or observations that produce a quantified or categorized result. It includes important and relevant positive and negative test results, physical findings, review of systems, and other measurements and observations.

154: Objective Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.21.2.1'] | | | | | |
| templateId | 1..1 | SHALL |  | [7869](#C_7869) |  |
| @root | 1..1 | SHALL | UID | [10462](#C_10462) | 2.16.840.1.113883.10.20.21.2.1 |
| title | 1..1 | SHALL |  | [7871](#C_7871) |  |
| text | 1..1 | SHALL |  | [7872](#C_7872) |  |
| code | 1..1 | SHALL |  | [15389](#C_15389) |  |
| @code | 1..1 | SHALL |  | [15390](#C_15390) | 2.16.840.1.113883.6.1 (LOINC) = 61149-1 |

1. SHALL contain exactly one [1..1] templateId (CONF:7869) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.21.2.1" (CONF:10462).
2. SHALL contain exactly one [1..1] code (CONF:15389).
   1. This code SHALL contain exactly one [1..1] @code="61149-1" Objective (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15390).
3. SHALL contain exactly one [1..1] title (CONF:7871).
4. SHALL contain exactly one [1..1] text (CONF:7872).

Figure 72: Objective Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.21.2.1" />

<code code="61149-1 " codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="OBJECTIVE DATA " />

<title>OBJECTIVE DATA</title>

<text>

<list listType="ordered">

<item>Chest: clear to ausc. No rales, normal breath sounds</item>

<item>Heart: RR, PMI in normal location and no heave or evidence of

cardiomegaly,normal heart sounds, no murm or gallop</item>

</list>

</text>

</section>

Observer Context

[assignedAuthor: templateId 2.16.840.1.113883.10.20.6.2.4 (open)]

155: Observer Context Contexts

| Contained By: | Contains: |
| --- | --- |
| [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (optional) |  |

The Observer Context is used to override the author specified in the CDA Header. It is valid as a direct child element of a section.

156: Observer Context Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| assignedAuthor[templateId/@root = '2.16.840.1.113883.10.20.6.2.4'] | | | | | |
| templateId | 1..1 | SHALL |  | [9194](#C_9194) |  |
| @root | 1..1 | SHALL |  | [10536](#C_10536) | 2.16.840.1.113883.10.20.6.2.4 |
| id | 1..\* | SHALL |  | [9196](#C_9196) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:9194) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.4" (CONF:10536).

The id element contains the author's id or the DICOM device observer UID

1. SHALL contain at least one [1..\*] id (CONF:9196).
2. Either assignedPerson or assignedAuthoringDevice SHALL be present (CONF:9198).

Figure 73: Observer Context Section Example

<assignedAuthor>

<templateId root="2.16.840.1.113883.10.20.6.2.4" />

<id extension="121008" root="2.16.840.1.113883.19.5" />

<assignedPerson>

<name>

<given>Richard</given>

<family>Blitz</family>

<suffix>MD</suffix>

</name>

</assignedPerson>

</assignedAuthor>

Operative Note Fluids Section

[section: templateId 2.16.840.1.113883.10.20.7.12 (open)]

157: Operative Note Fluids Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (optional) |  |

The Operative Note Fluids section may be used to record fluids administered during the surgical procedure.

158: Operative Note Fluids Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.7.12'] | | | | | |
| templateId | 1..1 | SHALL |  | [8030](#C_8030) |  |
| @root | 1..1 | SHALL | UID | [10463](#C_10463) | 2.16.840.1.113883.10.20.7.12 |
| title | 1..1 | SHALL |  | [8032](#C_8032) |  |
| text | 1..1 | SHALL |  | [8033](#C_8033) |  |
| code | 1..1 | SHALL |  | [15391](#C_15391) |  |
| @code | 1..1 | SHALL |  | [15392](#C_15392) | 2.16.840.1.113883.6.1 (LOINC) = 10216-0 |

1. SHALL contain exactly one [1..1] templateId (CONF:8030) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.7.12" (CONF:10463).
2. SHALL contain exactly one [1..1] code (CONF:15391).
   1. This code SHALL contain exactly one [1..1] @code="10216-0" Operative Note Fluids (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15392).
3. SHALL contain exactly one [1..1] title (CONF:8032).
4. SHALL contain exactly one [1..1] text (CONF:8033).
5. If the Operative Note Fluids section is present, there SHALL be a statement providing details of the fluids administered or SHALL explicitly state there were no fluids administered (CONF:8052).

Figure 74: Operative Note Fluids Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.7.12" />

<code code="10216-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="OPERATIVE NOTE FLUIDS" />

<title>Operative Note Fluids</title>

<text>250 ML Ringers Lactate</text>

</section>

Operative Note Surgical Procedure Section

[section: templateId 2.16.840.1.113883.10.20.7.14 (open)]

159: Operative Note Surgical Procedure Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (optional) |  |

The Operative Note Surgical Procedure section can be used to restate the procedures performed if appropriate for an enterprise workflow.  The procedure(s) performed associated with the Operative Note are formally modeled in the header using serviceEvent.

160: Operative Note Surgical Procedure Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.7.14'] | | | | | |
| templateId | 1..1 | SHALL |  | [8034](#C_8034) |  |
| @root | 1..1 | SHALL | UID | [10464](#C_10464) | 2.16.840.1.113883.10.20.7.14 |
| title | 1..1 | SHALL |  | [8036](#C_8036) |  |
| text | 1..1 | SHALL |  | [8037](#C_8037) |  |
| code | 1..1 | SHALL |  | [15393](#C_15393) |  |
| @code | 1..1 | SHALL |  | [15394](#C_15394) | 2.16.840.1.113883.6.1 (LOINC) = 10223-6 |

1. SHALL contain exactly one [1..1] templateId (CONF:8034) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.7.14" (CONF:10464).
2. SHALL contain exactly one [1..1] code (CONF:15393).
   1. This code SHALL contain exactly one [1..1] @code="10223-6" Operative Note Surgical Procedure (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15394).
3. SHALL contain exactly one [1..1] title (CONF:8036).
4. SHALL contain exactly one [1..1] text (CONF:8037).
5. If the surgical procedure section is present there SHALL be text indicating the procedure performed (CONF:8054).

Figure 75: Operative Note Surgical Procedure Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.7.14" />

<code code="10223-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="OPERATIVE NOTE SURGICAL PROCEDURE" />

<title>Surgical Procedure</title>

<text>Laparoscopic Appendectomy</text>

</section>

Payers Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.18.2 (open)]

161: Payers Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (optional) | [Coverage Activity (V2)](#E_Coverage_Activity_V2) |

The Payers section contains data on the patient’s payers, whether a ‘third party’ insurance, self-pay, other payer or guarantor, or some combination of payers, and is used to define which entity is the responsible fiduciary for the financial aspects of a patient’s care.

Each unique instance of a payer and all the pertinent data needed to contact, bill to, and collect from that payer should be included. Authorization information that can be used to define pertinent referral, authorization tracking number, procedure, therapy, intervention, device, or similar authorizations for the patient or provider, or both should be included. At a minimum, the patient’s pertinent current payment sources should be listed.

The sources of payment are represented as a Coverage Activity, which identifies all of the insurance policies or government or other programs that cover some or all of the patient's healthcare expenses. The policies or programs are sequenced by preference. The Coverage Activity has a sequence number that represents the preference order. Each policy or program identifies the covered party with respect to the payer, so that the identifiers can be recorded.

162: Payers Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.18.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7924](#C_7924) |  |
| @root | 1..1 | SHALL |  | [10434](#C_10434) | 2.16.840.1.113883.10.20.22.2.18.2 |
| code | 1..1 | SHALL |  | [15395](#C_15395) |  |
| @code | 1..1 | SHALL |  | [15396](#C_15396) | 2.16.840.1.113883.6.1 (LOINC) = 48768-6 |
| title | 1..1 | SHALL |  | [7926](#C_7926) |  |
| text | 1..1 | SHALL |  | [7927](#C_7927) |  |
| entry | 0..\* | SHOULD |  | [7959](#C_7959) |  |
| act | 1..1 | SHALL |  | [15501](#C_15501) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7924) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.18.2" (CONF:10434).
2. SHALL contain exactly one [1..1] code (CONF:15395).
   1. This code SHALL contain exactly one [1..1] @code="48768-6" Payers (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15396).
3. SHALL contain exactly one [1..1] title (CONF:7926).
4. SHALL contain exactly one [1..1] text (CONF:7927).
5. SHOULD contain zero or more [0..\*] entry (CONF:7959) such that it
   1. SHALL contain exactly one [1..1] [Coverage Activity (V2)](#E_Coverage_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.60.2) (CONF:15501).

Figure 76: Payers Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.18.2" />

<!-- \*\*\*\*\*\*\*\* Payers section template \*\*\*\*\*\*\*\* -->

<code code="48768-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Payers" />

<title>Insurance Providers</title>

<text>

. . .

</text>

<entry typeCode="DRIV">

<act classCode="ACT" moodCode="DEF">

<templateId root="2.16.840.1.113883.10.20.22.4.60.2" />

<!-- \*\*\*\* Coverage entry template \*\*\*\* -->

...

</act>

</entry>

</section>

Physical Exam Section (V2)

[section: templateId 2.16.840.1.113883.10.20.2.10.2 (open)]

163: Physical Exam Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) | [Highest Pressure Ulcer Stage](#E_Highest_Pressure_Ulcer_Stage)  [Number of Pressure Ulcers Observation](#E_Number_of_Pressure_Ulcers_Observation)  [Wound Observation (NEW)](#E_Wound_Observation_NEW) |

The section includes direct observations made by a clinician. The examination may include the use of simple instruments and may also describe simple maneuvers performed directly on the patient’s body.

It also includes observations made by the examining clinician using only inspection, palpation, auscultation, and percussion. It does not include laboratory or imaging findings.

The exam may be limited to pertinent body systems based on the patient’s chief complaint or it may include a comprehensive examination. The examination may be reported as a collection of random clinical statements or it may be reported categorically.

The Physical Exam section may contain multiple nested subsections; Vital Signs, General Status, and those listed in the Additional Physical Examination Subsections appendix.

164: Physical Exam Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.2.10.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7806](#C_7806) |  |
| @root | 1..1 | SHALL | UID | [10465](#C_10465) | 2.16.840.1.113883.10.20.2.10.2 |
| code | 1..1 | SHALL |  | [15397](#C_15397) |  |
| @code | 1..1 | SHALL |  | [15398](#C_15398) | 29545-1 |
| @codeSystem | 0..1 | MAY |  | [30931](#C_30931) | 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [7808](#C_7808) |  |
| text | 1..1 | SHALL |  | [7809](#C_7809) |  |
| entry | 0..\* | MAY |  | [17094](#C_17094) |  |
| observation | 1..1 | SHALL |  | [30930](#C_30930) |  |
| entry | 0..\* | MAY |  | [17096](#C_17096) |  |
| observation | 1..1 | SHALL |  | [17097](#C_17097) |  |
| entry | 0..\* | MAY |  | [17098](#C_17098) |  |
| observation | 1..1 | SHALL |  | [17099](#C_17099) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7806) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.2.10.2" (CONF:10465).
2. SHALL contain exactly one [1..1] code (CONF:15397).
   1. This code SHALL contain exactly one [1..1] @code="29545-1" Physical Findings (CONF:15398).
   2. This code MAY contain zero or one [0..1] @codeSystem="2.16.840.1.113883.6.1" (CONF:30931).
3. SHALL contain exactly one [1..1] title (CONF:7808).
4. SHALL contain exactly one [1..1] text (CONF:7809).
5. MAY contain zero or more [0..\*] entry (CONF:17094) such that it
   1. SHALL contain exactly one [1..1] [Wound Observation (NEW)](#E_Wound_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.114) (CONF:30930).
6. MAY contain zero or more [0..\*] entry (CONF:17096) such that it
   1. SHALL contain exactly one [1..1] [Number of Pressure Ulcers Observation](#E_Number_of_Pressure_Ulcers_Observation) (templateId:2.16.840.1.113883.10.20.22.4.76) (CONF:17097).
7. MAY contain zero or more [0..\*] entry (CONF:17098) such that it
   1. SHALL contain exactly one [1..1] [Highest Pressure Ulcer Stage](#E_Highest_Pressure_Ulcer_Stage) (templateId:2.16.840.1.113883.10.20.22.4.77) (CONF:17099).

Figure 77: Physical Exam Section Example

<component>

<section>

<templateId root="2.16.840.1.113883.10.20.2.10.2" />

<code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="29545-1" displayName="Physical Findings" />

<title>Physical Examination</title>

<!--\*\*10.4.1 Physical Exam at Transfer -->

<!--\*\*Update with coded entries -->

<text>

<list listType="ordered">

<item>Recurrent GI bleed of unknown etiology; hypotension perhaps

secondary to this but as likely secondary to polypharmacy.</item>

<item>Acute on chronic anemia secondary to #1.</item>

<item>Azotemia, acute renal failure with volume loss secondary to

#1.</item>

<item>Hyperkalemia secondary to #3 and on ACE and K+ supplement.</item>

<item>Other chronic diagnoses as noted above, currently stable.</item>

</list>

</text>

...

</section>

</component>

Physical Findings of Skin Section (NEW)

[section: templateId 2.16.840.1.113883.10.20.22.2.62 (open)]

165: Physical Findings of Skin Section (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Wound Observation (NEW)](#E_Wound_Observation_NEW) |

The Skin Physical Exam section includes direct observations made by the clinician. This section includes only observations made by the examining clinician using inspection and palpation; it does not include laboratory or imaging findings. The examination may be reported as a collection of random clinical statements or it may be reported categorically.

166: Physical Findings of Skin Section (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.62'] | | | | | |
| templateId | 1..1 | SHALL |  | [29899](#C_29899) |  |
| @root | 1..1 | SHALL | UID | [29900](#C_29900) | 2.16.840.1.113883.10.20.22.2.62 |
| code | 1..1 | SHALL |  | [29901](#C_29901) |  |
| @code | 1..1 | SHALL |  | [29902](#C_29902) | 2.16.840.1.113883.6.1 (LOINC) = 10206-1 |
| title | 1..1 | SHALL |  | [29903](#C_29903) |  |
| text | 1..1 | SHALL |  | [29904](#C_29904) |  |
| entry | 0..\* | MAY |  | [29905](#C_29905) |  |
| observation | 1..1 | SHALL |  | [29906](#C_29906) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:29899) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.62" (CONF:29900).
2. SHALL contain exactly one [1..1] code (CONF:29901).
   1. This code SHALL contain exactly one [1..1] @code="10206-1" Physical findings of Skin Narrative (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:29902).
3. SHALL contain exactly one [1..1] title (CONF:29903).
4. SHALL contain exactly one [1..1] text (CONF:29904).
5. MAY contain zero or more [0..\*] entry (CONF:29905) such that it
   1. SHALL contain exactly one [1..1] [Wound Observation (NEW)](#E_Wound_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.114) (CONF:29906).

Figure 78: Physical Findings of Skin Section Example

<component>

<section>

<!-- Physical Findings of Skin Section (entries required) -->

<templateId root="2.16.840.1.113883.10.20.22.2.63"/>

<code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

code="8709-8" displayName="Physical findings of Skin"/>

<title>SKIN, PHYSICAL FINDING</title>

<text>

<list listType="ordered">

<item>Minor open wound on anterior aspect of knee<br/>

<content>Measuring 1"W X 2"L</content>

<content>Wound Characteristic: Offensive wound odor</content>

</item>

</list>

</text>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Wound Observation tempalate -->

<templateId root="2.16.840.1.113883.10.20.22.4.114"/>

....

</observation>

</entry>

</section>

</component>

.

Plan of Treatment Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.10.2 (open)]

167: Plan of Treatment Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (required)  [History and Physical (V2)](#D_History_and_Physical_V2) (optional)  [Operative Note (V2)](#D_Operative_Note_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) | [Handoff Communication (NEW)](#E_Handoff_Communication_NEW)  [Instruction (V2)](#Instruction_V2)  [Nutrition Recommendations (NEW)](#E_Nutrition_Recommendations_NEW)  [Planned Act (V2)](#E_Planned_Act_V2)  [Planned Encounter (V2)](#E_Planned_Encounter_V2)  [Planned Observation (V2)](#E_Planned_Observation_V2)  [Planned Procedure (V2)](#E_Planned_Procedure_V2)  [Planned Substance Administration (V2)](#E_Planned_Substance_Administration_V2)  [Planned Supply (V2)](#E_Planned_Supply_V2) |

The Plan of Treatment section contains data that defines pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only, which are indicated by the @moodCode of the entries within this section. All active, incomplete, or pending orders, appointments, referrals, procedures, services, or any other pending event of clinical significance to the current care of the patient should be listed unless constrained due to privacy issues.

The plan may also contain information about ongoing care of the patient, clinical reminders, patient’s values, beliefs, preferences, care expectations and overarching goals of care. Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and health-care quality improvements, including widely accepted performance measures. Values may include the importance of quality of life over longevity. These values are taken into account when prioritizing all problems and their treatments. Beliefs may include comfort with dying or the refusal of blood transfusions because of the patient’s religious convictions.  Preferences may include liquid medicines over tablets, or treatment via secure email instead of in person. Care expectations could range from only being treated by female clinicians, to expecting all calls to be returned within 24 hours. Overarching goals described in this section are not tied to a specific condition, problem, health concern, or intervention. Examples of overarching goals could be to minimize pain or dependence on others, or to walk a daughter down the aisle for her marriage.  The plan may also indicate that patient education will be provided.

168: Plan of Treatment Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.10.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7723](#C_7723) |  |
| @root | 1..1 | SHALL |  | [10435](#C_10435) | 2.16.840.1.113883.10.20.22.2.10.2 |
| code | 1..1 | SHALL |  | [14749](#C_14749) |  |
| @code | 1..1 | SHALL |  | [14750](#C_14750) | 2.16.840.1.113883.6.1 (LOINC) = 18776-5 |
| @codeSystem | 1..1 | SHALL |  | [30813](#C_30813) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [16986](#C_16986) |  |
| text | 1..1 | SHALL |  | [7725](#C_7725) |  |
| entry | 0..\* | MAY |  | [7726](#C_7726) |  |
| observation | 1..1 | SHALL |  | [14751](#C_14751) |  |
| entry | 0..\* | MAY |  | [8805](#C_8805) |  |
| encounter | 1..1 | SHALL |  | [30472](#C_30472) |  |
| entry | 0..\* | MAY |  | [8807](#C_8807) |  |
| act | 1..1 | SHALL |  | [30473](#C_30473) |  |
| entry | 0..\* | MAY |  | [8809](#C_8809) |  |
| procedure | 1..1 | SHALL |  | [30474](#C_30474) |  |
| entry | 0..\* | MAY |  | [8811](#C_8811) |  |
| substanceAdministration | 1..1 | SHALL |  | [30475](#C_30475) |  |
| entry | 0..\* | MAY |  | [8813](#C_8813) |  |
| supply | 1..1 | SHALL |  | [30476](#C_30476) |  |
| entry | 0..\* | MAY |  | [14695](#C_14695) |  |
| act | 1..1 | SHALL |  | [31397](#C_31397) |  |
| entry | 0..\* | MAY |  | [29621](#C_29621) |  |
| act | 1..1 | SHALL |  | [30868](#C_30868) |  |
| entry | 0..\* | MAY |  | [31841](#C_31841) |  |
| procedure | 1..1 | SHALL |  | [31842](#C_31842) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7723) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.10.2" (CONF:10435).
2. SHALL contain exactly one [1..1] code (CONF:14749).
   1. This code SHALL contain exactly one [1..1] @code="18776-5" Plan of Treatment (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:14750).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30813).
3. SHALL contain exactly one [1..1] title (CONF:16986).
4. SHALL contain exactly one [1..1] text (CONF:7725).
5. MAY contain zero or more [0..\*] entry (CONF:7726) such that it
   1. SHALL contain exactly one [1..1] [Planned Observation (V2)](#E_Planned_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.44.2) (CONF:14751).
6. MAY contain zero or more [0..\*] entry (CONF:8805) such that it
   1. SHALL contain exactly one [1..1] [Planned Encounter (V2)](#E_Planned_Encounter_V2) (templateId:2.16.840.1.113883.10.20.22.4.40.2) (CONF:30472).
7. MAY contain zero or more [0..\*] entry (CONF:8807) such that it
   1. SHALL contain exactly one [1..1] [Planned Act (V2)](#E_Planned_Act_V2) (templateId:2.16.840.1.113883.10.20.22.4.39.2) (CONF:30473).
8. MAY contain zero or more [0..\*] entry (CONF:8809) such that it
   1. SHALL contain exactly one [1..1] [Planned Procedure (V2)](#E_Planned_Procedure_V2) (templateId:2.16.840.1.113883.10.20.22.4.41.2) (CONF:30474).
9. MAY contain zero or more [0..\*] entry (CONF:8811) such that it
   1. SHALL contain exactly one [1..1] [Planned Substance Administration (V2)](#E_Planned_Substance_Administration_V2) (templateId:2.16.840.1.113883.10.20.22.4.42.2) (CONF:30475).
10. MAY contain zero or more [0..\*] entry (CONF:8813) such that it
    1. SHALL contain exactly one [1..1] [Planned Supply (V2)](#E_Planned_Supply_V2) (templateId:2.16.840.1.113883.10.20.22.4.43.2) (CONF:30476).
11. MAY contain zero or more [0..\*] entry (CONF:14695) such that it
    1. SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31397).
12. MAY contain zero or more [0..\*] entry (CONF:29621) such that it
    1. SHALL contain exactly one [1..1] [Handoff Communication (NEW)](#E_Handoff_Communication_NEW) (templateId:2.16.840.1.113883.10.20.22.4.141) (CONF:30868).
13. MAY contain zero or more [0..\*] entry (CONF:31841) such that it
    1. SHALL contain exactly one [1..1] [Nutrition Recommendations (NEW)](#E_Nutrition_Recommendations_NEW) (templateId:2.16.840.1.113883.10.20.22.4.130) (CONF:31842).

Figure 79: Plan of Treatment Section Example

<component>

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.10.1.2"/>

<!-- \*\*\*\* Plan of Treatment section V2 template \*\*\*\* -->

<code code="18776-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="Treatment plan"/>

<title>TREATMENT PLAN</title>

<text>

...

</text>

<entry>

<act classCode="ACT" moodCode="EVN">

<!-- Handoff Communication template -->

<templateId root="2.16.840.1.113883.10.20.22.4.141"/>

...

</entry>

<entry>

<encounter moodCode="INT" classCode="ENC">

<templateId root="2.16.840.1.113883.10.20.22.4.40.2"/>

<!-- Plan Activity Encounter V2 template -->

...

</encounter>

</entry>

</section>

</component>

Planned Procedure Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.30.2 (open)]

169: Planned Procedure Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) | [Planned Procedure (V2)](#E_Planned_Procedure_V2) |

This section contains the procedure(s) that a clinician planned based on the preoperative assessment.

170: Planned Procedure Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.30.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8082](#C_8082) |  |
| @root | 1..1 | SHALL |  | [10436](#C_10436) | 2.16.840.1.113883.10.20.22.2.30.2 |
| code | 1..1 | SHALL |  | [15399](#C_15399) |  |
| @code | 1..1 | SHALL |  | [15400](#C_15400) | 2.16.840.1.113883.6.1 (LOINC) = 59772-4 |
| title | 1..1 | SHALL |  | [8084](#C_8084) |  |
| text | 1..1 | SHALL |  | [8085](#C_8085) |  |
| entry | 0..\* | MAY |  | [8744](#C_8744) |  |
| procedure | 1..1 | SHALL |  | [15502](#C_15502) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:8082) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.30.2" (CONF:10436).
2. SHALL contain exactly one [1..1] code (CONF:15399).
   1. This code SHALL contain exactly one [1..1] @code="59772-4" Planned Procedure (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15400).
3. SHALL contain exactly one [1..1] title (CONF:8084).
4. SHALL contain exactly one [1..1] text (CONF:8085).
5. MAY contain zero or more [0..\*] entry (CONF:8744) such that it
   1. SHALL contain exactly one [1..1] [Planned Procedure (V2)](#E_Planned_Procedure_V2) (templateId:2.16.840.1.113883.10.20.22.4.41.2) (CONF:15502).

Figure 80: Planned Procedure Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.30.2" />

<code code="59772-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Planned Procedure" />

<title>Planned Procedure</title>

<text>

...

</text>

<entry>

<procedure moodCode="RQO" classCode="PROC">

<templateId root="2.16.840.1.113883.10.20.22.4.41.2" />

<!-- \*\* Planned Procedure \*\* -->

...

</procedure>

</entry>

</section>

Postoperative Diagnosis Section

[section: templateId 2.16.840.1.113883.10.20.22.2.35 (open)]

171: Postoperative Diagnosis Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (required) |  |

The Postoperative Diagnosis section records the diagnosis or diagnoses discovered or confirmed during the surgery.  Often it is the same as the preoperative diagnosis.

172: Postoperative Diagnosis Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.35'] | | | | | |
| templateId | 1..1 | SHALL |  | [8101](#C_8101) |  |
| @root | 1..1 | SHALL |  | [10437](#C_10437) | 2.16.840.1.113883.10.20.22.2.35 |
| title | 1..1 | SHALL |  | [8103](#C_8103) |  |
| text | 1..1 | SHALL |  | [8104](#C_8104) |  |
| code | 1..1 | SHALL |  | [15401](#C_15401) |  |
| @code | 1..1 | SHALL |  | [15402](#C_15402) | 2.16.840.1.113883.6.1 (LOINC) = 10218-6 |

1. SHALL contain exactly one [1..1] templateId (CONF:8101) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.35" (CONF:10437).
2. SHALL contain exactly one [1..1] code (CONF:15401).
   1. This code SHALL contain exactly one [1..1] @code="10218-6" Postoperative Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15402).
3. SHALL contain exactly one [1..1] title (CONF:8103).
4. SHALL contain exactly one [1..1] text (CONF:8104).

Figure 81: Postoperative Diagnosis Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.35" />

<code code="10218-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="POSTOPERATIVE DIAGNOSIS" />

<title>Postoperative Diagnosis</title>

<text>Appendicitis with periappendiceal abscess</text>

</section>

Postprocedure Diagnosis Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.36.2 (open)]

173: Postprocedure Diagnosis Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Procedure Note (V2)](#D_Procedure_Note_V2) (required) | [Postprocedure Diagnosis (V2)](#E_Postprocedure_Diagnosis_V2) |

The Postprocedure Diagnosis section records the diagnosis or diagnoses discovered or confirmed during the procedure. Often it is the same as the pre-procedure diagnosis or indication.

174: Postprocedure Diagnosis Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.36.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8167](#C_8167) |  |
| @root | 1..1 | SHALL |  | [10438](#C_10438) | 2.16.840.1.113883.10.20.22.2.36.2 |
| code | 1..1 | SHALL |  | [15403](#C_15403) |  |
| @code | 1..1 | SHALL |  | [15404](#C_15404) | 59769-0 |
| @codeSystem | 1..1 | SHALL |  | [30862](#C_30862) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [8170](#C_8170) |  |
| text | 1..1 | SHALL |  | [8171](#C_8171) |  |
| entry | 0..1 | SHOULD |  | [8762](#C_8762) |  |
| act | 1..1 | SHALL |  | [15503](#C_15503) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:8167) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.36.2" (CONF:10438).
2. SHALL contain exactly one [1..1] code (CONF:15403).
   1. This code SHALL contain exactly one [1..1] @code="59769-0" Postprocedure Diagnosis (CONF:15404).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30862).
3. SHALL contain exactly one [1..1] title (CONF:8170).
4. SHALL contain exactly one [1..1] text (CONF:8171).
5. SHOULD contain zero or one [0..1] entry (CONF:8762) such that it
   1. SHALL contain exactly one [1..1] [Postprocedure Diagnosis (V2)](#E_Postprocedure_Diagnosis_V2) (templateId:2.16.840.1.113883.10.20.22.4.51.2) (CONF:15503).

Preoperative Diagnosis Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.34.2 (open)]

175: Preoperative Diagnosis Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (required) | [Preoperative Diagnosis (V2)](#E_Preoperative_Diagnosis_V2) |

The Preoperative Diagnosis section records the surgical diagnoses assigned to the patient before the surgical procedure which are the reason for the surgery. The preoperative diagnosis is, in the surgeon's opinion, the diagnosis that will be confirmed during surgery.

176: Preoperative Diagnosis Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.34.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8097](#C_8097) |  |
| @root | 1..1 | SHALL |  | [10439](#C_10439) | 2.16.840.1.113883.10.20.22.2.34.2 |
| code | 1..1 | SHALL |  | [15405](#C_15405) |  |
| @code | 1..1 | SHALL |  | [15406](#C_15406) | 10219-4 |
| @codeSystem | 1..1 | SHALL |  | [30863](#C_30863) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [8099](#C_8099) |  |
| text | 1..1 | SHALL |  | [8100](#C_8100) |  |
| entry | 0..1 | SHOULD |  | [10096](#C_10096) |  |
| act | 1..1 | SHALL |  | [15504](#C_15504) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:8097) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.34.2" (CONF:10439).
2. SHALL contain exactly one [1..1] code (CONF:15405).
   1. This code SHALL contain exactly one [1..1] @code="10219-4" Preoperative Diagnosis (CONF:15406).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30863).
3. SHALL contain exactly one [1..1] title (CONF:8099).
4. SHALL contain exactly one [1..1] text (CONF:8100).
5. SHOULD contain zero or one [0..1] entry (CONF:10096) such that it
   1. SHALL contain exactly one [1..1] [Preoperative Diagnosis (V2)](#E_Preoperative_Diagnosis_V2) (templateId:2.16.840.1.113883.10.20.22.4.65.2) (CONF:15504).

Figure 82: Preoperative Diagnosis Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.34.2" />

<code code="10219-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName=" PREOPERATIVE DIAGNOSIS" />

<title>Preoperative Diagnosis</title>

<text>Appendicitis</text>

<entry>

<act moodCode="EVN" classCode="ACT">

<templateId root="2.16.840.1.113883.10.20.22.4.65.2" />

<!-- \*\* Preoperative Diagnosis \*\* -->

...

</act>

</entry>

</section>

Problem Section (entries optional) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.5.2 (open)]

177: Problem Section (entries optional) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (optional)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) | [Health Status Observation (V2)](#Health_Status_Observation_V2)  [Problem Concern Act (Condition) (V2)](#E_Problem_Concern_Act_Condition_V2) |

This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed.  Overall health status may be represented in this section.

178: Problem Section (entries optional) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.5.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7877](#C_7877) |  |
| @root | 1..1 | SHALL |  | [10440](#C_10440) | 2.16.840.1.113883.10.20.22.2.5.1.2 |
| code | 1..1 | SHALL |  | [15407](#C_15407) |  |
| @code | 1..1 | SHALL |  | [15408](#C_15408) | 11450-4 |
| @codeSystem | 1..1 | SHALL |  | [31141](#C_31141) | 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [7879](#C_7879) |  |
| text | 1..1 | SHALL |  | [7880](#C_7880) |  |
| entry | 0..\* | SHOULD |  | [7881](#C_7881) |  |
| act | 1..1 | SHALL |  | [15505](#C_15505) |  |
| entry | 0..1 | MAY |  | [30481](#C_30481) |  |
| observation | 1..1 | SHALL |  | [30482](#C_30482) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7877) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.5.1.2" (CONF:10440).
2. SHALL contain exactly one [1..1] code (CONF:15407).
   1. This code SHALL contain exactly one [1..1] @code="11450-4" Problem List (CONF:15408).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CONF:31141).
3. SHALL contain exactly one [1..1] title (CONF:7879).
4. SHALL contain exactly one [1..1] text (CONF:7880).
5. SHOULD contain zero or more [0..\*] entry (CONF:7881) such that it
   1. SHALL contain exactly one [1..1] [Problem Concern Act (Condition) (V2)](#E_Problem_Concern_Act_Condition_V2) (templateId:2.16.840.1.113883.10.20.22.4.3.2) (CONF:15505).
6. MAY contain zero or one [0..1] entry (CONF:30481) such that it
   1. SHALL contain exactly one [1..1] [Health Status Observation (V2)](#Health_Status_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.5.2) (CONF:30482).

Problem Section (entries required) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.5.1.2 (open)]

179: Problem Section (entries required) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (required)  [Referral Note (NEW)](#D_Referral_Note_NEW) (required)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (required) | [Health Status Observation (V2)](#Health_Status_Observation_V2)  [Problem Concern Act (Condition) (V2)](#E_Problem_Concern_Act_Condition_V2) |

This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed.  Overall health status may be represented in this section.

180: Problem Section (entries required) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.5.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [9179](#C_9179) |  |
| @root | 1..1 | SHALL |  | [10441](#C_10441) | 2.16.840.1.113883.10.20.22.2.5.1.2 |
| code | 1..1 | SHALL |  | [15409](#C_15409) |  |
| @code | 1..1 | SHALL |  | [15410](#C_15410) | 11450-4 |
| @codeSystem | 1..1 | SHALL |  | [31142](#C_31142) |  |
| title | 1..1 | SHALL |  | [9181](#C_9181) |  |
| text | 1..1 | SHALL |  | [9182](#C_9182) |  |
| entry | 1..\* | SHALL |  | [9183](#C_9183) |  |
| act | 1..1 | SHALL |  | [15506](#C_15506) |  |
| entry | 0..1 | MAY |  | [30479](#C_30479) |  |
| observation | 1..1 | SHALL |  | [30480](#C_30480) |  |

1. Conforms to [Problem Section (entries optional) (V2)](#S_Problem_Section_entries_optional_V2) template (2.16.840.1.113883.10.20.22.2.5.2).
2. SHALL contain exactly one [1..1] templateId (CONF:9179) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.5.1.2" (CONF:10441).
3. SHALL contain exactly one [1..1] code (CONF:15409).
   1. This code SHALL contain exactly one [1..1] @code="11450-4" Problem List (CONF:15410).
   2. This code SHALL contain exactly one [1..1] @codeSystem (CONF:31142).
4. SHALL contain exactly one [1..1] title (CONF:9181).
5. SHALL contain exactly one [1..1] text (CONF:9182).
6. SHALL contain at least one [1..\*] entry (CONF:9183).
   1. Such entries SHALL contain exactly one [1..1] [Problem Concern Act (Condition) (V2)](#E_Problem_Concern_Act_Condition_V2) (templateId:2.16.840.1.113883.10.20.22.4.3.2) (CONF:15506).
7. MAY contain zero or one [0..1] entry (CONF:30479) such that it
   1. SHALL contain exactly one [1..1] [Health Status Observation (V2)](#Health_Status_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.5.2) (CONF:30480).

Figure 83: Problem Section (entries required) Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.5.1.2" />

<code code="11450-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="PROBLEM LIST" />

<title>PROBLEMS</title>

<text>

<list listType="ordered">

<item>Pneumonia: Resolved in March 1998 </item>

<item>...</item>

</list>

</text>

<entry typeCode="DRIV">

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.3.2" />

<!-- Problem Concern Act (Condition) template -->

...

</act>

</entry>

</section>

Procedure Description Section

[section: templateId 2.16.840.1.113883.10.20.22.2.27 (open)]

181: Procedure Description Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (required) |  |

The Procedure Description section records the particulars of the procedure and may include procedure site preparation, surgical site preparation, pertinent details related to sedation/anesthesia, pertinent details related to measurements and markings, procedure times, medications administered, estimated blood loss, specimens removed, implants, instrumentation, sponge counts, tissue manipulation, wound closure, sutures used, vital signs and other monitoring data. Local practice often identifies the level and type of detail required based on the procedure or specialty.

182: Procedure Description Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.27'] | | | | | |
| templateId | 1..1 | SHALL |  | [8062](#C_8062) |  |
| @root | 1..1 | SHALL |  | [10442](#C_10442) | 2.16.840.1.113883.10.20.22.2.27 |
| title | 1..1 | SHALL |  | [8064](#C_8064) |  |
| text | 1..1 | SHALL |  | [8065](#C_8065) |  |
| code | 1..1 | SHALL |  | [15411](#C_15411) |  |
| @code | 1..1 | SHALL |  | [15412](#C_15412) | 2.16.840.1.113883.6.1 (LOINC) = 29554-3 |

1. SHALL contain exactly one [1..1] templateId (CONF:8062) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.27" (CONF:10442).
2. SHALL contain exactly one [1..1] code (CONF:15411).
   1. This code SHALL contain exactly one [1..1] @code="29554-3" Procedure Description (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15412).
3. SHALL contain exactly one [1..1] title (CONF:8064).
4. SHALL contain exactly one [1..1] text (CONF:8065).

Figure 84: Procedure Description Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.27" />

<code code="29554-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="PROCEDURE DESCRIPTION" />

<title>Procedure Description</title>

<text>The patient was taken to the endoscopy suite where ... </text>

</section>

Procedure Disposition Section

[section: templateId 2.16.840.1.113883.10.20.18.2.12 (open)]

183: Procedure Disposition Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) |  |

The Procedure Disposition section records the status and condition of the patient at the completion of the procedure or surgery. It often also states where the patent was transferred to for the next level of care.

184: Procedure Disposition Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.18.2.12'] | | | | | |
| templateId | 1..1 | SHALL |  | [8070](#C_8070) |  |
| @root | 1..1 | SHALL | UID | [10466](#C_10466) | 2.16.840.1.113883.10.20.18.2.12 |
| title | 1..1 | SHALL |  | [8072](#C_8072) |  |
| text | 1..1 | SHALL |  | [8073](#C_8073) |  |
| code | 1..1 | SHALL |  | [15413](#C_15413) |  |
| @code | 1..1 | SHALL |  | [15414](#C_15414) | 2.16.840.1.113883.6.1 (LOINC) = 59775-7 |

1. SHALL contain exactly one [1..1] templateId (CONF:8070) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.18.2.12" (CONF:10466).
2. SHALL contain exactly one [1..1] code (CONF:15413).
   1. This code SHALL contain exactly one [1..1] @code="59775-7" Procedure Disposition (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15414).
3. SHALL contain exactly one [1..1] title (CONF:8072).
4. SHALL contain exactly one [1..1] text (CONF:8073).

Figure 85: Procedure Disposition Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.18.2.12" />

<code code="59775-7" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="PROCEDURE DISPOSITION" />

<title>PROCEDURE DISPOSITION</title>

<text>The patient was taken to the Endoscopy Recovery Unit in stable

condition.</text>

</section>

Procedure Estimated Blood Loss Section

[section: templateId 2.16.840.1.113883.10.20.18.2.9 (open)]

185: Procedure Estimated Blood Loss Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) |  |

The Estimated Blood Loss section may be a subsection of another section such as the Procedure Description section. The Estimated Blood Loss section records the approximate amount of blood that the patient lost during the procedure or surgery. It may be an accurate quantitative amount, e.g., 250 milliliters, or it may be descriptive, e.g., “minimal” or “none”.

186: Procedure Estimated Blood Loss Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.18.2.9'] | | | | | |
| templateId | 1..1 | SHALL |  | [8074](#C_8074) |  |
| @root | 1..1 | SHALL | UID | [10467](#C_10467) | 2.16.840.1.113883.10.20.18.2.9 |
| title | 1..1 | SHALL |  | [8076](#C_8076) |  |
| text | 1..1 | SHALL |  | [8077](#C_8077) |  |
| code | 1..1 | SHALL |  | [15415](#C_15415) |  |
| @code | 1..1 | SHALL |  | [15416](#C_15416) | 2.16.840.1.113883.6.1 (LOINC) = 59770-8 |

1. SHALL contain exactly one [1..1] templateId (CONF:8074) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.18.2.9" (CONF:10467).
2. SHALL contain exactly one [1..1] code (CONF:15415).
   1. This code SHALL contain exactly one [1..1] @code="59770-8" Procedure Estimated Blood Loss (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15416).
3. SHALL contain exactly one [1..1] title (CONF:8076).
4. SHALL contain exactly one [1..1] text (CONF:8077).
5. The Estimated Blood Loss section SHALL include a statement providing an estimate of the amount of blood lost during the procedure, even if the estimate is text, such as "minimal" or "none" (CONF:8741).

Figure 86: Procedure Estimated Blood Loss Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.18.2.9" />

<code code="59770-8" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="PROCEDURE ESTIMATED BLOOD LOSS" />

<title>Procedure Estimated Blood Loss</title>

<text>Minimal</text>

</section>

Procedure Findings Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.28.2 (open)]

187: Procedure Findings Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) | [Problem Observation (V2)](#E_Problem_Observation_V2) |

The Procedure Findings section records clinically significant observations confirmed or discovered during a procedure or surgery.

188: Procedure Findings Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.28.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8078](#C_8078) |  |
| @root | 1..1 | SHALL |  | [10443](#C_10443) | 2.16.840.1.113883.10.20.22.2.28.2 |
| code | 1..1 | SHALL |  | [15417](#C_15417) |  |
| @code | 1..1 | SHALL |  | [15418](#C_15418) | 59776-5 |
| @codeSystem | 1..1 | SHALL |  | [30859](#C_30859) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [8080](#C_8080) |  |
| text | 1..1 | SHALL |  | [8081](#C_8081) |  |
| entry | 0..\* | MAY |  | [8090](#C_8090) |  |
| observation | 1..1 | SHALL |  | [15507](#C_15507) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:8078) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.28.2" (CONF:10443).
2. SHALL contain exactly one [1..1] code (CONF:15417).
   1. This code SHALL contain exactly one [1..1] @code="59776-5" Procedure Findings (CONF:15418).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30859).
3. SHALL contain exactly one [1..1] title (CONF:8080).
4. SHALL contain exactly one [1..1] text (CONF:8081).
5. MAY contain zero or more [0..\*] entry (CONF:8090) such that it
   1. SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15507).

Figure 87: Procedure Findings Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.28" />

<code code="59776-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="PROCEDURE FINDINGS" />

<title>Procedure Findings</title>

<text>A 6 mm sessile polyp was found in the ascending colon and removed by snare, no cautery. Bleeding was controlled. Moderate diverticulosis and hemorrhoids were incidentally noted.</text>

<entry>

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.4.2" />

<!-- Problem Observation -->

...

</observation>

</entry>

</section>

Procedure Implants Section

[section: templateId 2.16.840.1.113883.10.20.22.2.40 (open)]

189: Procedure Implants Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) |  |

The Procedure Implants section records any materials placed during the procedure including stents, tubes, and drains.

Notes: This section replaces: 2.16.840.1.113883.10.20.22.2.40

190: Procedure Implants Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.40'] | | | | | |
| templateId | 1..1 | SHALL |  | [8178](#C_8178) |  |
| @root | 1..1 | SHALL |  | [10444](#C_10444) | 2.16.840.1.113883.10.20.22.2.40 |
| title | 1..1 | SHALL |  | [8180](#C_8180) |  |
| text | 1..1 | SHALL |  | [8181](#C_8181) |  |
| code | 1..1 | SHALL |  | [15373](#C_15373) |  |
| @code | 1..1 | SHALL |  | [15374](#C_15374) | 2.16.840.1.113883.6.1 (LOINC) = 59771-6 |

1. SHALL contain exactly one [1..1] templateId (CONF:8178) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.40" (CONF:10444).
2. SHALL contain exactly one [1..1] code (CONF:15373).
   1. This code SHALL contain exactly one [1..1] @code="59771-6" Procedure Implants (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15374).
3. SHALL contain exactly one [1..1] title (CONF:8180).
4. SHALL contain exactly one [1..1] text (CONF:8181).
5. The Implants section SHALL include a statement providing details of the implants placed, or assert no implants were placed (CONF:8769).

Figure 88: Procedure Implants Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.40" />

<code code="59771-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="PROCEDURE IMPLANTS" />

<title>Procedure Implants</title>

<text>No implants were placed.</text>

</section>

Procedure Indications Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.29.2 (open)]

191: Procedure Indications Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (required) | [Indication (V2)](#Indication_V2) |

This section contains the reason(s) for the procedure or surgery. This section may include the preprocedure diagnoses as well as symptoms contributing to the reason for the procedure.

192: Procedure Indications Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.29.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [8058](#C_8058) |  |
| @root | 1..1 | SHALL |  | [10445](#C_10445) | 2.16.840.1.113883.10.20.22.2.29.2 |
| code | 1..1 | SHALL |  | [15419](#C_15419) |  |
| @code | 1..1 | SHALL |  | [15420](#C_15420) | 59768-2 |
| @codeSystem | 1..1 | SHALL |  | [30827](#C_30827) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [8060](#C_8060) |  |
| text | 1..1 | SHALL |  | [8061](#C_8061) |  |
| entry | 0..\* | MAY |  | [8743](#C_8743) |  |
| observation | 1..1 | SHALL |  | [15508](#C_15508) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:8058) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.29.2" (CONF:10445).
2. SHALL contain exactly one [1..1] code (CONF:15419).
   1. This code SHALL contain exactly one [1..1] @code="59768-2" Procedure Indications  (CONF:15420).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30827).
3. SHALL contain exactly one [1..1] title (CONF:8060).
4. SHALL contain exactly one [1..1] text (CONF:8061).
5. MAY contain zero or more [0..\*] entry (CONF:8743) such that it
   1. SHALL contain exactly one [1..1] [Indication (V2)](#Indication_V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:15508).

Figure 89: Procedure Indications Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.29.2" />

<code code="59768-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="PROCEDURE INDICATIONS" />

<title>Procedure Indications</title>

<text>The procedure is performed for screening in a low risk individual.

</text>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Indication Entry -->

<templateId root="2.16.840.1.113883.10.20.22.4.19.2" />

...

</observation>

</entry>

</section>

Procedure Specimens Taken Section

[section: templateId 2.16.840.1.113883.10.20.22.2.31 (open)]

193: Procedure Specimens Taken Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) |  |

The Procedure Specimens Taken section records the tissues, objects, or samples taken from the patient during the procedure including biopsies, aspiration fluid, or other samples sent for pathological analysis. The narrative may include a description of the specimens.

194: Procedure Specimens Taken Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.31'] | | | | | |
| templateId | 1..1 | SHALL |  | [8086](#C_8086) |  |
| @root | 1..1 | SHALL |  | [10446](#C_10446) | 2.16.840.1.113883.10.20.22.2.31 |
| title | 1..1 | SHALL |  | [8088](#C_8088) |  |
| text | 1..1 | SHALL |  | [8089](#C_8089) |  |
| code | 1..1 | SHALL |  | [15421](#C_15421) |  |
| @code | 1..1 | SHALL |  | [15422](#C_15422) | 2.16.840.1.113883.6.1 (LOINC) = 59773-2 |

1. SHALL contain exactly one [1..1] templateId (CONF:8086) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.31" (CONF:10446).
2. SHALL contain exactly one [1..1] code (CONF:15421).
   1. This code SHALL contain exactly one [1..1] @code="59773-2" Procedure Specimens Taken (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15422).
3. SHALL contain exactly one [1..1] title (CONF:8088).
4. SHALL contain exactly one [1..1] text (CONF:8089).
5. The Procedure Specimens Taken section SHALL list all specimens removed or SHALL explicitly state that no specimens were taken (CONF:8742).

Procedures Section (entries optional) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.7.2 (open)]

195: Procedures Section (entries optional) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) | [Procedure Activity Act (V2)](#E_Procedure_Activity_Act_V2)  [Procedure Activity Observation (V2)](#E_Procedure_Activity_Observation_V2)  [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) |

This section defines all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section is intended to include notable procedures, but can contain all procedures for the period of time being summarized. The common notion of ""procedure"" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore this section contains procedure templates represented with three RIM classes: Act. Observation, and Procedure. Procedure act is for procedures the alter that physical condition of a patient (Splenectomy). Observation act is for procedures that result in new information about a patient but do not cause physical alteration (EEG). Act is for all other types of procedures (dressing change).

The length of an encounter is documented in the documentationOf/encompassingEncounter/effectiveTime and length of service in documentationOf/ServiceEvent/effectiveTime.

196: Procedures Section (entries optional) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.7.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [6270](#C_6270) |  |
| @root | 1..1 | SHALL |  | [6271](#C_6271) | 2.16.840.1.113883.10.20.22.2.7.2 |
| code | 1..1 | SHALL |  | [15423](#C_15423) |  |
| @code | 1..1 | SHALL |  | [15424](#C_15424) | 47519-4 |
| @codeSystem | 1..1 | SHALL |  | [31139](#C_31139) | 2.16.840.1.113883.6.1 (LOINC) |
| title | 1..1 | SHALL |  | [17184](#C_17184) |  |
| text | 1..1 | SHALL |  | [6273](#C_6273) |  |
| entry | 0..\* | MAY |  | [6274](#C_6274) |  |
| procedure | 1..1 | SHALL |  | [15509](#C_15509) |  |
| entry | 0..1 | MAY |  | [6278](#C_6278) |  |
| observation | 1..1 | SHALL |  | [15510](#C_15510) |  |
| entry | 0..1 | MAY |  | [8533](#C_8533) |  |
| act | 1..1 | SHALL |  | [15511](#C_15511) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:6270) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.7.2" (CONF:6271).
2. SHALL contain exactly one [1..1] code (CONF:15423).
   1. This code SHALL contain exactly one [1..1] @code="47519-4" History of Procedures (CONF:15424).
   2. This code SHALL contain exactly one [1..1] @codeSystem (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31139).
3. SHALL contain exactly one [1..1] title (CONF:17184).
4. SHALL contain exactly one [1..1] text (CONF:6273).
5. MAY contain zero or more [0..\*] entry (CONF:6274) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) (templateId:2.16.840.1.113883.10.20.22.4.14.2) (CONF:15509).
6. MAY contain zero or one [0..1] entry (CONF:6278) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Observation (V2)](#E_Procedure_Activity_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.13.2) (CONF:15510).
7. MAY contain zero or one [0..1] entry (CONF:8533) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Act (V2)](#E_Procedure_Activity_Act_V2) (templateId:2.16.840.1.113883.10.20.22.4.12.2) (CONF:15511).

Procedures Section (entries required) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.7.1.2 (open)]

197: Procedures Section (entries required) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (required) | [Procedure Activity Act (V2)](#E_Procedure_Activity_Act_V2)  [Procedure Activity Observation (V2)](#E_Procedure_Activity_Observation_V2)  [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) |

This section defines all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section may contain all procedures for the period of time being summarized, but should include notable procedures. The common notion of "procedure" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore this section contains procedure templates represented with three RIM classes: Act. Observation, and Procedure. Procedure act is for procedures the alter that physical condition of a patient (Splenectomy). Observation act is for procedures that result in new information about a patient but do not cause physical alteration (EEG). Act is for all other types of procedures (dressing change).

198: Procedures Section (entries required) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.7.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7891](#C_7891) |  |
| @root | 1..1 | SHALL |  | [10447](#C_10447) | 2.16.840.1.113883.10.20.22.2.7.1.2 |
| code | 1..1 | SHALL |  | [15425](#C_15425) |  |
| @code | 1..1 | SHALL |  | [15426](#C_15426) | 47519-4 |
| @codeSystem | 1..1 | SHALL |  | [31138](#C_31138) | 2.16.840.1.113883.6.1 (LOINC) |
| title | 1..1 | SHALL |  | [7893](#C_7893) |  |
| text | 1..1 | SHALL |  | [7894](#C_7894) |  |
| entry | 0..\* | MAY |  | [7895](#C_7895) |  |
| procedure | 1..1 | SHALL |  | [15512](#C_15512) |  |
| entry | 0..\* | MAY |  | [8017](#C_8017) |  |
| observation | 1..1 | SHALL |  | [15513](#C_15513) |  |
| entry | 0..\* | MAY |  | [8019](#C_8019) |  |
| act | 1..1 | SHALL |  | [15514](#C_15514) |  |

1. Conforms to [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2) template (2.16.840.1.113883.10.20.22.2.7.2).
2. SHALL contain exactly one [1..1] templateId (CONF:7891) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.7.1.2" (CONF:10447).
3. SHALL contain exactly one [1..1] code (CONF:15425).
   1. This code SHALL contain exactly one [1..1] @code="47519-4" History of Procedures (CONF:15426).
   2. This code SHALL contain exactly one [1..1] @codeSystem (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31138).
4. SHALL contain exactly one [1..1] title (CONF:7893).
5. SHALL contain exactly one [1..1] text (CONF:7894).
6. MAY contain zero or more [0..\*] entry (CONF:7895) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) (templateId:2.16.840.1.113883.10.20.22.4.14.2) (CONF:15512).
7. MAY contain zero or more [0..\*] entry (CONF:8017) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Observation (V2)](#E_Procedure_Activity_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.13.2) (CONF:15513).
8. MAY contain zero or more [0..\*] entry (CONF:8019) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Act (V2)](#E_Procedure_Activity_Act_V2) (templateId:2.16.840.1.113883.10.20.22.4.12.2) (CONF:15514).
9. There SHALL be at least one entry conformant to Procedure Activity Act (V2) (templateId 2.16.840.1.113883.10.20.22.4.12.2) or Procedure Activity Observation (V2) (templateId: 2.16.840.1.113883.10.20.22.4.13.2) or Procedure Activity Procedure (V2) (templateId: 2.16.840.1.113883.10.20.22.4.14.2) (CONF:8021).

Figure 90: Procedures Section (entries required) Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.7.2"/>

<!-- Procedures section template -->

<code code="47519-4"

codeSystem="2.16.840.1.113883.6.1"

codeSystemName="LOINC"

displayName="PROCEDURES" />

<title>Procedures</title>

<text>

...

</text>

<entry typeCode="DRIV">

<procedure classCode="PROC" moodCode="EVN">

<!-- Procedure Activity Procedure template -->

<templateId root="2.16.840.1.113883.10.20.22.4.14.2"/>

...

</procedure>

</entry>

</entry>

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.13.2"/>

<!-- Procedure Activity Observation template -->

...

</observation>undefined</entry>undefined<entry>

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.12.2"/>

<!-- Procedure Activity Act template -->

...

</act>undefined</entry>undefined</section>

Reason for Referral Section (V2)

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.1.2 (open)]

199: Reason for Referral Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (required) | [Patient Referral Act (NEW)](#E_Patient_Referral_Act_NEW) |

This section contains the reason(s) for a patient’s referral by a provider to a consulting provider. An optional Chief Complaint section may capture the patient’s description of the reason for the consultation.

200: Reason for Referral Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '1.3.6.1.4.1.19376.1.5.3.1.3.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7844](#C_7844) |  |
| @root | 1..1 | SHALL | UID | [10468](#C_10468) | 1.3.6.1.4.1.19376.1.5.3.1.3.1.2 |
| code | 1..1 | SHALL |  | [15427](#C_15427) |  |
| @code | 1..1 | SHALL |  | [15428](#C_15428) | 42349-1 |
| @codeSystem | 1..1 | SHALL |  | [30867](#C_30867) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [7846](#C_7846) |  |
| text | 1..1 | SHALL |  | [7847](#C_7847) |  |
| entry | 0..\* | MAY |  | [30808](#C_30808) |  |
| observation | 1..1 | SHALL |  | [30897](#C_30897) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7844) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.1.2" (CONF:10468).
2. SHALL contain exactly one [1..1] code (CONF:15427).
   1. This code SHALL contain exactly one [1..1] @code="42349-1" Reason for Referral (CONF:15428).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30867).
3. SHALL contain exactly one [1..1] title (CONF:7846).
4. SHALL contain exactly one [1..1] text (CONF:7847).
5. MAY contain zero or more [0..\*] entry (CONF:30808) such that it
   1. SHALL contain exactly one [1..1] [Patient Referral Act (NEW)](#E_Patient_Referral_Act_NEW) (templateId:2.16.840.1.113883.10.20.22.4.140) (CONF:30897).

Figure 91: Reason for Referral Section Example

<component>

<section>

<templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.1.2" />

<code code="42349-1" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Reason for Referral " />

<title>REASON FOR REFERRAL</title>

<text>Request for Patient referral for consultation.</text>

<entry>

<observation classCode="OBS" moodCode="INT">

<!-- Patient Referral Activity Observation -->

<templateId root="2.16.840.1.113883.10.20.22.4.140" />

...

</observation>

</entry>

</section>

</component>

Reason for Visit Section

[section: templateId 2.16.840.1.113883.10.20.22.2.12 (open)]

201: Reason for Visit Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (optional)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) |  |

This section records the patient’s reason for the patient's visit (as documented by the provider).  Local policy determines whether Reason for Visit and Chief Complaint are in separate or combined sections.

202: Reason for Visit Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.12'] | | | | | |
| templateId | 1..1 | SHALL |  | [7836](#C_7836) |  |
| @root | 1..1 | SHALL |  | [10448](#C_10448) | 2.16.840.1.113883.10.20.22.2.12 |
| title | 1..1 | SHALL |  | [7838](#C_7838) |  |
| text | 1..1 | SHALL |  | [7839](#C_7839) |  |
| code | 1..1 | SHALL |  | [15429](#C_15429) |  |
| @code | 1..1 | SHALL |  | [15430](#C_15430) | 2.16.840.1.113883.6.1 (LOINC) = 29299-5 |

1. SHALL contain exactly one [1..1] templateId (CONF:7836) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.12" (CONF:10448).
2. SHALL contain exactly one [1..1] code (CONF:15429).
   1. This code SHALL contain exactly one [1..1] @code="29299-5" Reason for Visit (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15430).
3. SHALL contain exactly one [1..1] title (CONF:7838).
4. SHALL contain exactly one [1..1] text (CONF:7839).

Figure 92: Reason for Visit Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.12" />

<code code="29299-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="REASON FOR VISIT" />

<title>REASON FOR VISIT</title>

<text>

<paragraph>Dark stools.</paragraph>

</text>

</section>

Results Section (entries optional) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.3.2 (open)]

203: Results Section (entries optional) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [History and Physical (V2)](#D_History_and_Physical_V2) (required)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) | [Result Organizer (V2)](#Result_Organizer_V2) |

The Results section contains the results of observations generated by laboratories, imaging procedures, and other procedures. The scope includes observations such as hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. The section often includes notable results such as abnormal values or relevant trends, and could contain all results for the period of time being documented.

Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory.

Imaging results are typically generated by a clinician reviewing the output of an imaging procedure, such as where a cardiologist reports the left ventricular ejection fraction based on the review of a cardiac echocardiogram.

Procedure results are typically generated by a clinician to provide more granular information about component observations made during  a procedure, such as where a gastroenterologist reports the size of a polyp observed during a colonoscopy.

204: Results Section (entries optional) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.3.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7116](#C_7116) |  |
| @root | 1..1 | SHALL |  | [9136](#C_9136) | 2.16.840.1.113883.10.20.22.2.3.2 |
| code | 1..1 | SHALL |  | [15431](#C_15431) |  |
| @code | 1..1 | SHALL |  | [15432](#C_15432) | 30954-2 |
| @codeSystem | 1..1 | SHALL |  | [31041](#C_31041) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [8891](#C_8891) |  |
| text | 1..1 | SHALL |  | [7118](#C_7118) |  |
| entry | 0..\* | SHOULD |  | [7119](#C_7119) |  |
| organizer | 1..1 | SHALL |  | [15515](#C_15515) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7116) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.3.2" (CONF:9136).
2. SHALL contain exactly one [1..1] code (CONF:15431).
   1. This code SHALL contain exactly one [1..1] @code="30954-2" Relevant diagnostic tests and/or laboratory data (CONF:15432).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31041).
3. SHALL contain exactly one [1..1] title (CONF:8891).
4. SHALL contain exactly one [1..1] text (CONF:7118).
5. SHOULD contain zero or more [0..\*] entry (CONF:7119) such that it
   1. SHALL contain exactly one [1..1] [Result Organizer (V2)](#Result_Organizer_V2) (templateId:2.16.840.1.113883.10.20.22.4.1.2) (CONF:15515).

Results Section (entries required) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.3.1.2 (open)]

205: Results Section (entries required) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (required) | [Result Organizer (V2)](#Result_Organizer_V2) |

The Results section contains observations of results generated by laboratories, imaging procedures, and other procedures. These coded result observations are contained within a Results Organizer in the Results Section. The scope includes observations such as hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. The section often includes notable results such as abnormal values or relevant trends, and could contain all results for the period of time being documented.

Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory.

Imaging results are typically generated by a clinician reviewing the output of an imaging procedure, such as where a cardiologist reports the left ventricular ejection fraction based on the review of a cardiac echocardiogram.

Procedure results are typically generated by a clinician to provide more granular information about component observations made during  a procedure, such as where a gastroenterologist reports the size of a polyp observed during a colonoscopy.

206: Results Section (entries required) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.3.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7108](#C_7108) |  |
| @root | 1..1 | SHALL |  | [9137](#C_9137) | 2.16.840.1.113883.10.20.22.2.3.1.2 |
| code | 1..1 | SHALL |  | [15433](#C_15433) |  |
| @code | 1..1 | SHALL |  | [15434](#C_15434) | 30954-2 |
| @codeSystem | 1..1 | SHALL |  | [31040](#C_31040) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [8892](#C_8892) |  |
| text | 1..1 | SHALL |  | [7111](#C_7111) |  |
| entry | 1..\* | SHALL |  | [7112](#C_7112) |  |
| organizer | 1..1 | SHALL |  | [15516](#C_15516) |  |

1. Conforms to [Results Section (entries optional) (V2)](#S_Results_Section_entries_optional_V2) template (2.16.840.1.113883.10.20.22.2.3.2).
2. SHALL contain exactly one [1..1] templateId (CONF:7108) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.3.1.2" (CONF:9137).
3. SHALL contain exactly one [1..1] code (CONF:15433).
   1. This code SHALL contain exactly one [1..1] @code="30954-2" Relevant diagnostic tests and/or laboratory data (CONF:15434).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31040).
4. SHALL contain exactly one [1..1] title (CONF:8892).
5. SHALL contain exactly one [1..1] text (CONF:7111).
6. SHALL contain at least one [1..\*] entry (CONF:7112) such that it
   1. SHALL contain exactly one [1..1] [Result Organizer (V2)](#Result_Organizer_V2) (templateId:2.16.840.1.113883.10.20.22.4.1.2) (CONF:15516).

Figure 93: Results Section (entries required) Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.3.1.2" />

<code code="30954-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="RELEVANT DIAGNOSTIC TESTS AND/OR LABORATORY DATA" />

<title> Results />

<text />

<entry typeCode="DRIV">

<organizer classCode="BATTERY" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.1.2"/>

...

<organizer>

<component>

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.2.2"/>

. . .

</organizer>

</entry>

</section>

Review of Systems Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.18 (open)]

207: Review of Systems Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) |  |

The Review of Systems section contains a relevant collection of symptoms and functions systematically gathered by a clinician. It includes symptoms the patient is currently experiencing, some of which were not elicited during the history of present illness, as well as a potentially large number of pertinent negatives, for example, symptoms that the patient denied experiencing.

208: Review of Systems Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '1.3.6.1.4.1.19376.1.5.3.1.3.18'] | | | | | |
| templateId | 1..1 | SHALL |  | [7812](#C_7812) |  |
| @root | 1..1 | SHALL | UID | [10469](#C_10469) | 1.3.6.1.4.1.19376.1.5.3.1.3.18 |
| title | 1..1 | SHALL |  | [7814](#C_7814) |  |
| text | 1..1 | SHALL |  | [7815](#C_7815) |  |
| code | 1..1 | SHALL |  | [15435](#C_15435) |  |
| @code | 1..1 | SHALL |  | [15436](#C_15436) | 2.16.840.1.113883.6.1 (LOINC) = 10187-3 |

1. SHALL contain exactly one [1..1] templateId (CONF:7812) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.18" (CONF:10469).
2. SHALL contain exactly one [1..1] code (CONF:15435).
   1. This code SHALL contain exactly one [1..1] @code="10187-3" Review of Systems (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15436).
3. SHALL contain exactly one [1..1] title (CONF:7814).
4. SHALL contain exactly one [1..1] text (CONF:7815).

Figure 94: Review of Systems Section Example

<section>

<templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.18" />

<code code="10187-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="REVIEW OF SYSTEMS" />

<title>REVIEW OF SYSTEMS</title>

<text>

<paragraph>

Patient denies recent history of fever or malaise. Positive

For weakness and shortness of breath. One episode of melena. No recent

headaches. Positive for osteoarthritis in hips, knees and hands.

</paragraph>

</text>

</section>

Social History Section (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.17.2 (open)]

209: Social History Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (required)  [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (required)  [Procedure Note (V2)](#D_Procedure_Note_V2) (optional) | [Caregiver Characteristics](#E_Caregiver_Characteristics)  [Characteristics of Home Environment (NEW)](#E_Characteristics_of_Home_Environment_N)  [Cultural and Religious Observation (NEW)](#E_Cultural_and_Religious_Observation_NE)  [Current Smoking Status (V2)](#E_Current_Smoking_Status_V2)  [Pregnancy Observation](#E_Pregnancy_Observation)  [Social History Observation (V2)](#E_Social_History_Observation_V2)  [Tobacco Use (V2)](#Tobacco_Use_V2) |

This section contains social history data that influences a patient’s physical, psychological or emotional health (e.g. smoking status, pregnancy). Demographic data, such as marital status, race, ethnicity, and religious affiliation, is captured in the header.

210: Social History Section (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.17.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7936](#C_7936) |  |
| @root | 1..1 | SHALL |  | [10449](#C_10449) | 2.16.840.1.113883.10.20.22.2.17.2 |
| code | 1..1 | SHALL |  | [14819](#C_14819) |  |
| @code | 1..1 | SHALL |  | [14820](#C_14820) | 29762-2 |
| @codeSystem | 1..1 | SHALL |  | [30814](#C_30814) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [7938](#C_7938) |  |
| text | 1..1 | SHALL |  | [7939](#C_7939) |  |
| entry | 0..\* | MAY |  | [7953](#C_7953) |  |
| observation | 1..1 | SHALL |  | [14821](#C_14821) |  |
| entry | 0..\* | MAY |  | [9132](#C_9132) |  |
| observation | 1..1 | SHALL |  | [14822](#C_14822) |  |
| entry | 0..1 | SHOULD |  | [14823](#C_14823) |  |
| observation | 1..1 | SHALL |  | [14824](#C_14824) |  |
| entry | 0..\* | MAY |  | [16816](#C_16816) |  |
| observation | 1..1 | SHALL |  | [16817](#C_16817) |  |
| entry | 0..\* | MAY |  | [28361](#C_28361) |  |
| observation | 1..1 | SHALL |  | [28362](#C_28362) |  |
| entry | 0..\* | MAY |  | [28366](#C_28366) |  |
| observation | 1..1 | SHALL |  | [28367](#C_28367) |  |
| entry | 0..\* | MAY |  | [28825](#C_28825) |  |
| observation | 1..1 | SHALL |  | [28826](#C_28826) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7936) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.17.2" (CONF:10449).
2. SHALL contain exactly one [1..1] code (CONF:14819).
   1. This code SHALL contain exactly one [1..1] @code="29762-2" Social History (CONF:14820).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30814).
3. SHALL contain exactly one [1..1] title (CONF:7938).
4. SHALL contain exactly one [1..1] text (CONF:7939).
5. MAY contain zero or more [0..\*] entry (CONF:7953) such that it
   1. SHALL contain exactly one [1..1] [Social History Observation (V2)](#E_Social_History_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.38.2) (CONF:14821).
6. MAY contain zero or more [0..\*] entry (CONF:9132) such that it
   1. SHALL contain exactly one [1..1] [Pregnancy Observation](#E_Pregnancy_Observation) (templateId:2.16.840.1.113883.10.20.15.3.8) (CONF:14822).
7. SHOULD contain zero or one [0..1] entry (CONF:14823) such that it
   1. SHALL contain exactly one [1..1] [Current Smoking Status (V2)](#E_Current_Smoking_Status_V2) (templateId:2.16.840.1.113883.10.20.22.4.78.2) (CONF:14824).
8. MAY contain zero or more [0..\*] entry (CONF:16816) such that it
   1. SHALL contain exactly one [1..1] [Tobacco Use (V2)](#Tobacco_Use_V2) (templateId:2.16.840.1.113883.10.20.22.4.85.2) (CONF:16817).
9. MAY contain zero or more [0..\*] entry (CONF:28361) such that it
   1. SHALL contain exactly one [1..1] [Caregiver Characteristics](#E_Caregiver_Characteristics) (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:28362).
10. MAY contain zero or more [0..\*] entry (CONF:28366) such that it
    1. SHALL contain exactly one [1..1] [Cultural and Religious Observation (NEW)](#E_Cultural_and_Religious_Observation_NE) (templateId:2.16.840.1.113883.10.20.22.4.111) (CONF:28367).
11. MAY contain zero or more [0..\*] entry (CONF:28825) such that it
    1. SHALL contain exactly one [1..1] [Characteristics of Home Environment (NEW)](#E_Characteristics_of_Home_Environment_N) (templateId:2.16.840.1.113883.10.20.22.4.109) (CONF:28826).

Figure 95: Social History Section Example

<component>

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.17.2"/>

<code code="29762-2" codeSystem="2.16.840.1.113883.6.1"

displayName="Social History"/>

<title>SOCIAL HISTORY</title>

<text>

. . .

</text>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Social history observation V2-->

<templateId root="2.16.840.1.113883.10.20.22.4.38.2"/>

...

</observation>

</entry>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Current smoking status observation \*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.78.2"/>

...

</observation>

</entry>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Caregiver Characteristics -->

<templateId root="2.16.840.1.113883.10.20.22.4.72"/>

...

</observation>

</entry>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- \*\*Cultural and Religious Observations(NEW)\*\*-->

<templateId root="2.16.840.1.113883.10.20.22.4.111"/>

...

</observation>

</entry>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Characteristics of Care Environment\*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.109"/>

...

</observation>

</entry>

</section>

Subjective Section

[section: templateId 2.16.840.1.113883.10.20.21.2.2 (open)]

211: Subjective Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Progress Note (V2)](#D_Progress_Note_V2) (optional) |  |

The Subjective section describes in a narrative format the patient’s current condition and/or interval changes as reported by the patient or by the patient’s guardian or another informant.

212: Subjective Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.21.2.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7873](#C_7873) |  |
| @root | 1..1 | SHALL | UID | [10470](#C_10470) | 2.16.840.1.113883.10.20.21.2.2 |
| title | 1..1 | SHALL |  | [7875](#C_7875) |  |
| text | 1..1 | SHALL |  | [7876](#C_7876) |  |
| code | 1..1 | SHALL |  | [15437](#C_15437) |  |
| @code | 1..1 | SHALL |  | [15438](#C_15438) | 2.16.840.1.113883.6.1 (LOINC) = 61150-9 |

1. SHALL contain exactly one [1..1] templateId (CONF:7873) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.21.2.2" (CONF:10470).
2. SHALL contain exactly one [1..1] code (CONF:15437).
   1. This code SHALL contain exactly one [1..1] @code="61150-9" Subjective (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15438).
3. SHALL contain exactly one [1..1] title (CONF:7875).
4. SHALL contain exactly one [1..1] text (CONF:7876).

Figure 96: Subjective Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.21.2.2" />

<code code="61150-9" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="SUBJECTIVE" />

<title>SUBJECTIVE DATA</title>

<text>

<paragraph>

I have used the peripheral nerve stimulator in my back for five days.

While using it I found that I was able to do physical activity

without pain. However, afterwards for one day, I would feel pain but

then it would go away. I also noticed that I didn?t have to take the

Vicodin as much. I took 2 less Vicodin per day and 2 less tramadol

everyday. I have not lain in my bed in a year and a half. I sleep in

a recliner.

</paragraph>

</text>

</section>

Surgery Description Section

[section: templateId 2.16.840.1.113883.10.20.22.2.26 (open)]

213: Surgery Description Section Contexts

| Contained By: | Contains: |
| --- | --- |

replaced by 2.16.840.1.113883.10.20.22.2.27

214: Surgery Description Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.26'] | | | | | |
| templateId | 1..1 | SHALL |  | [8022](#C_8022) |  |
| @root | 1..1 | SHALL |  | [10450](#C_10450) | 2.16.840.1.113883.10.20.22.2.26 |
| title | 1..1 | SHALL |  | [8024](#C_8024) |  |
| text | 1..1 | SHALL |  | [8025](#C_8025) |  |
| code | 1..1 | SHALL |  | [15439](#C_15439) |  |
| @code | 1..1 | SHALL |  | [15440](#C_15440) | 2.16.840.1.113883.6.1 (LOINC) = 29554-3 |

1. SHALL contain exactly one [1..1] templateId (CONF:8022) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.26" (CONF:10450).
2. SHALL contain exactly one [1..1] code (CONF:15439).
   1. This code SHALL contain exactly one [1..1] @code="29554-3" Surgery Description (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15440).
3. SHALL contain exactly one [1..1] title (CONF:8024).
4. SHALL contain exactly one [1..1] text (CONF:8025).

Figure 97: Surgery Description Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.26" />

<code code="29554-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="SURGERY DESCRIPTION" />

<title>Surgical Drains</title>

<text>Penrose drain placed</text>

</section>

Surgical Drains Section

[section: templateId 2.16.840.1.113883.10.20.7.13 (open)]

215: Surgical Drains Section Contexts

| Contained By: | Contains: |
| --- | --- |
| [Operative Note (V2)](#D_Operative_Note_V2) (optional) |  |

The Surgical Drains section may be used to record drains placed during the surgical procedure. Optionally, surgical drain placement may be represented with a text element in the Procedure Description Section.

216: Surgical Drains Section Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.7.13'] | | | | | |
| templateId | 1..1 | SHALL |  | [8038](#C_8038) |  |
| @root | 1..1 | SHALL | UID | [10473](#C_10473) | 2.16.840.1.113883.10.20.7.13 |
| title | 1..1 | SHALL |  | [8040](#C_8040) |  |
| text | 1..1 | SHALL |  | [8041](#C_8041) |  |
| code | 1..1 | SHALL |  | [15441](#C_15441) |  |
| @code | 1..1 | SHALL |  | [15442](#C_15442) | 2.16.840.1.113883.6.1 (LOINC) = 11537-8 |

1. SHALL contain exactly one [1..1] templateId (CONF:8038) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.7.13" (CONF:10473).
2. SHALL contain exactly one [1..1] code (CONF:15441).
   1. This code SHALL contain exactly one [1..1] @code="11537-8" Surgical Drains (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15442).
3. SHALL contain exactly one [1..1] title (CONF:8040).
4. SHALL contain exactly one [1..1] text (CONF:8041).
5. If the Surgical Drains section is present, there SHALL be a statement providing details of the drains placed or SHALL explicitly state there were no drains placed (CONF:8056).

Figure 98: Surgical Drains Section Example

<section>

<templateId root="2.16.840.1.113883.10.20.7.13" />

<code code="11537-8" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="SURGICAL DRAINS" />

<title>Surgical Drains</title>

<text>Penrose drain placed</text>

</section>

Vital Signs Section (entries optional) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.4.2 (open)]

217: Vital Signs Section (entries optional) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) (optional)  [History and Physical (V2)](#D_History_and_Physical_V2) (required)  [Progress Note (V2)](#D_Progress_Note_V2) (optional) | [Vital Signs Organizer (V2)](#E_Vital_Signs_Organizer_V2) |

The Vital Signs section contains relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, pulse oximetry, temperature and body surface area. The section should include notable vital signs such as the most recent, maximum and/or minimum, baseline, or relevant trends.

Vital signs are represented in the same way as other results, but are aggregated into their own section to follow clinical conventions.

218: Vital Signs Section (entries optional) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.4.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7268](#C_7268) |  |
| @root | 1..1 | SHALL |  | [10451](#C_10451) | 2.16.840.1.113883.10.20.22.2.4.2 |
| code | 1..1 | SHALL |  | [15242](#C_15242) |  |
| @code | 1..1 | SHALL |  | [15243](#C_15243) | 2.16.840.1.113883.6.1 (LOINC) = 8716-3 |
| @codeSystem | 1..1 | SHALL |  | [30902](#C_30902) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [9966](#C_9966) |  |
| text | 1..1 | SHALL |  | [7270](#C_7270) |  |
| entry | 0..\* | SHOULD |  | [7271](#C_7271) |  |
| organizer | 1..1 | SHALL |  | [15517](#C_15517) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7268) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.4.2" (CONF:10451).
2. SHALL contain exactly one [1..1] code (CONF:15242).
   1. This code SHALL contain exactly one [1..1] @code="8716-3" Vital Signs (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15243).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30902).
3. SHALL contain exactly one [1..1] title (CONF:9966).
4. SHALL contain exactly one [1..1] text (CONF:7270).
5. SHOULD contain zero or more [0..\*] entry (CONF:7271) such that it
   1. SHALL contain exactly one [1..1] [Vital Signs Organizer (V2)](#E_Vital_Signs_Organizer_V2) (templateId:2.16.840.1.113883.10.20.22.4.26.2) (CONF:15517).

Vital Signs Section (entries required) (V2)

[section: templateId 2.16.840.1.113883.10.20.22.2.4.1.2 (open)]

219: Vital Signs Section (entries required) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) (optional)  [Consultation Note (V2)](#Consultation_Note_V2) (optional)  [Referral Note (NEW)](#D_Referral_Note_NEW) (optional)  [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (required) | [Vital Signs Organizer (V2)](#E_Vital_Signs_Organizer_V2) |

The Vital Signs section contains relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, pulse oximetry, temperature and body surface area. The section should include notable vital signs such as the most recent, maximum and/or minimum, baseline, or relevant trends.

Vital signs are represented in the same way as other results, but are aggregated into their own section to follow clinical conventions.

220: Vital Signs Section (entries required) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| section[templateId/@root = '2.16.840.1.113883.10.20.22.2.4.1.2'] | | | | | |
| templateId | 1..1 | SHALL |  | [7273](#C_7273) |  |
| @root | 1..1 | SHALL |  | [10452](#C_10452) | 2.16.840.1.113883.10.20.22.2.4.1.2 |
| code | 1..1 | SHALL |  | [15962](#C_15962) |  |
| @code | 1..1 | SHALL |  | [15963](#C_15963) | 8716-3 |
| @codeSystem | 1..1 | SHALL |  | [30903](#C_30903) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
| title | 1..1 | SHALL |  | [9967](#C_9967) |  |
| text | 1..1 | SHALL |  | [7275](#C_7275) |  |
| entry | 1..\* | SHALL |  | [7276](#C_7276) |  |
| organizer | 1..1 | SHALL |  | [15964](#C_15964) |  |

1. Conforms to [Vital Signs Section (entries optional) (V2)](#Vital_Signs_Section_entries_optional_V2) template (2.16.840.1.113883.10.20.22.2.4.2).
2. SHALL contain exactly one [1..1] templateId (CONF:7273) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.4.1.2" (CONF:10452).
3. SHALL contain exactly one [1..1] code (CONF:15962).
   1. This code SHALL contain exactly one [1..1] @code="8716-3" Vital Signs (CONF:15963).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30903).
4. SHALL contain exactly one [1..1] title (CONF:9967).
5. SHALL contain exactly one [1..1] text (CONF:7275).
6. SHALL contain at least one [1..\*] entry (CONF:7276) such that it
   1. SHALL contain exactly one [1..1] [Vital Signs Organizer (V2)](#E_Vital_Signs_Organizer_V2) (templateId:2.16.840.1.113883.10.20.22.4.26.2) (CONF:15964).

Figure 99: Vital Signs Section (entries required) Example

<component>

<section>

<!-- \*\* Vital Signs section with entries required \*\* -->

<templateId root="2.16.840.1.113883.10.20.22.2.4.1.2"/>

<code code="8716-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

displayName="VITAL SIGNS"/>

<title>VITAL SIGNS</title>

<text>

. . .

</text>

<entry typeCode="DRIV">

<organizer classCode="CLUSTER" moodCode="EVN">

<!-- \*\* Vital signs organizer \*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.26.2"/>

. . .

</organizer>

</entry>

</section>

# Entry-Level Templates

This chapter describes the clinical statement entry templates used within the sections of the consolidated documents. Entry templates contain constraints that are required for conformance.

Entry-level templates are always in sections.

Each entry-level template description contains the following information:

•  Key template metadata (e.g., templateId, etc.)

•  Description and explanatory narrative.

•  Required CDA acts, participants and vocabularies.

•  Optional CDA acts, participants and vocabularies.

Several entry-level templates require an effectiveTime:

The effectiveTime of an observation is the time interval over which the observation is known to be true. The low and high values should be as precise as possible, but no more precise than known. While CDA has multiple mechanisms to record this time interval (e.g., by low and high values, low and width, high and width, or center point and width), we constrain most to use only the low/high form. The low  value is the earliest point for which the condition is known to have existed. The high value, when present, indicates the time at which the observation was no longer known to be true. The full description of effectiveTime and time intervals is contained in the CDA R2 normative edition.

Provenance in entry templates:

In this version of Consolidated CDA, we have added a “SHOULD” Author constraint on several entry-level templates. Authorship and Author timestamps must be explicitly asserted in these cases, unless the values propagated from the document header hold true.

ID in entry templates:

Entry-level templates may also describe an id element, which is an identifier for that entry. This id may be referenced within the document, or by the system receiving the document. The id assigned must be globally unique.

Act Reference (NEW)

[act: templateId 2.16.840.1.113883.10.20.22.4.122 (closed)]

221: Act Reference (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Goal Observation (NEW)](#E_Goal_Observation_NEW) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Patient Referral Act (NEW)](#E_Patient_Referral_Act_NEW) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional)  [Outcome Observation (NEW)](#E_Outcome_Observation_NEW) (optional) |  |

This template represents the act of referencing another entry in the same CDA document instance. Its purpose is to remove the need to repeat the complete XML representation of the referred entry when relating one entry to another. For example, in a Care Plan it is necessary to repeatedly relate Health Concerns, Goals, Interventions and Outcomes.

The id is required and must be the same id as the entry/id it is referencing. Act/Code is nulled to “NP” (Not Present).

222: Act Reference (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.122'] | | | | | |
| @classCode | 1..1 | SHALL |  | [31485](#C_31485) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [31486](#C_31486) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [31487](#C_31487) |  |
| @root | 1..1 | SHALL |  | [31488](#C_31488) | 2.16.840.1.113883.10.20.22.4.122 |
| id | 1..1 | SHALL |  | [31489](#C_31489) |  |
| code | 1..1 | SHALL |  | [31490](#C_31490) |  |
| @nullFlavor | 1..1 | SHALL |  | [31491](#C_31491) | 2.16.840.1.113883.5.1008 (HL7NullFlavor) = NP |
| statusCode | 1..1 | SHALL |  | [31498](#C_31498) |  |
| @code | 0..1 | MAY |  | [31499](#C_31499) | 2.16.840.1.113883.5.14 (ActStatus) = completed |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:31485).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:31486).
3. SHALL contain exactly one [1..1] templateId (CONF:31487) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.122" (CONF:31488).

The ID must equal another entry/id in the same document instance. Application Software must be responsible for resolving the identifier back to its original object and then rendering the information in the correct place in the containing section's narrative text.

1. SHALL contain exactly one [1..1] id (CONF:31489).
2. SHALL contain exactly one [1..1] code (CONF:31490).
   1. This code SHALL contain exactly one [1..1] @nullFlavor="NP" Not Present (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:31491).
3. SHALL contain exactly one [1..1] statusCode (CONF:31498).
   1. This statusCode MAY contain zero or one [0..1] @code="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31499).

Figure 100: Act Reference Example

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Health Concern section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

...

<act classCode="ACT" moodCode="EVN">

<!-- Health Concern Act of a pneumonia diagnosis -->

<templateId root="2.16.840.1.113883.10.20.22.4.132" />

<id root="4eab0e52-dd7d-4285-99eb-72d32ddb195c" />

<code code="CONC"

codeSystem="2.16.840.1.113883.5.6"

codeSystemName="HL7ActClass"

displayName="Concern" />

...

<entryRelationship typeCode="REFR">

...

<code code="282291009"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED"

displayName="Diagnosis" />

...

<value xsi:type="CD"

code="233604007"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED"

displayName="Pneumonia" />

<!-- This actReference refers to a goal, intervention, actual

outcome, or some other entry present in the Care Plan

that the Health Concern is related to-->

<entryRelationship typeCode="REFR">

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.122" />

<!-- This ID equals the ID of the goal of a pulse ox greater than 92% -->

<id root="3700b3b0-fbed-11e2-b778-0800200c9a66" />

<!-- The code is nulled to "NP" Not Present" -->

<code nullFlavor="NP" />

<statusCode code="completed"/>

</act>

</entryRelationship>

</observation>

</entryRelationship>

</act>

...

<!--

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Expected Outcomes/Goals section

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

-->

...

<entry>

<!-- This is an observation about the expected outcome of a pulse ox reading

of 92 or greater. The Id is the same as the ID as the ID of the

pneumonia problem above -->

<observation classCode="OBS" moodCode="GOL">

<id root="3700b3b0-fbed-11e2-b778-0800200c9a66"/>

<code code="252465000"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED"

displayName="Pulse oximetry" />

<statusCode code="active" />

<value xsi:type="IVL\_PQ">

<low value="92" unit="%"/>

</value>

<!-- There could be another Act Reference here referring to the

related health concern, actual outcome, or intervention -->

...

</observation>

</entry>

...

Figure 101: CCD Containment Example

<!-- Show how an encounter can include a discharge diagnosis which references an item on the problem list using the Act Reference template -->

<!-- Problem Section -->

<observation>

<id root="1234567"/>

<code code="123" codeSystem="1.2.3" displayName="asthma"/>

</observation>

<!-- Encounter Section -->

<encounter>

<entryRelationship typeCode="COMP">

<act>

<code code="145"

codeSystem="4.5.6"

displayName="discharge diagnosis"/>

<templateId root="2.16.840.1.113883.10.20.22.4.33.2"/>

<!-- this is for illustrative purposes only. In this particular

case, the template requires a nested Problem

Observation (V2). In the Health Concern template,

we'd need a constraint that says it's allowable to

include the ActReference template. -->

<entryRelationship typeCode="SUBJ">

<act classCode="ACT" moodCode="XXX">

<templateId root="temp-OID-ActReference" />

<id root="1234567"/>

<code nullFlavor="NP" />

</act>

</entryRelationship>

</act>

</entryRelationship>

</encounter>

Admission Medication (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.36.2 (open)]

223: Admission Medication (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Hospital Admission Medications Section (entries optional) (V2)](#S_Hospital_Admission_Medications_Sectio) (optional) | [Medication Activity (V2)](#Medication_Activity_V2) |

This template represents the medications taken by the patient prior to and at the time of admission.

224: Admission Medication (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.36.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7698](#C_7698) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [7699](#C_7699) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [16758](#C_16758) |  |
| @root | 1..1 | SHALL |  | [16759](#C_16759) | 2.16.840.1.113883.10.20.22.4.36.2 |
| code | 1..1 | SHALL |  | [15518](#C_15518) |  |
| @code | 1..1 | SHALL |  | [15519](#C_15519) | 2.16.840.1.113883.6.1 (LOINC) = 42346-7 |
| entryRelationship | 1..\* | SHALL |  | [7701](#C_7701) |  |
| @typeCode | 1..1 | SHALL |  | [7702](#C_7702) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| substanceAdministration | 1..1 | SHALL |  | [15520](#C_15520) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7698).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7699).
3. SHALL contain exactly one [1..1] templateId (CONF:16758) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.36.2" (CONF:16759).
4. SHALL contain exactly one [1..1] code (CONF:15518).
   1. This code SHALL contain exactly one [1..1] @code="42346-7" Medications on Admission (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15519).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:7701) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7702).
   2. SHALL contain exactly one [1..1] [Medication Activity (V2)](#Medication_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15520).

Figure 102: Admission Medication Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.36.2" />

<code code="42346-7" />

<entryRelationship typeCode="SUBJ">

<substanceAdministration classCode="SBADM" moodCode="EVN">

<!-- \*\* MEDICATION ACTIVITY V2 \*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.16.2" />

...

</substanceAdministration>

</entryRelationship>

</act>

Advance Directive Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.48.2 (open)]

225: Advance Directive Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Advance Directive Organizer (NEW)](#E_Advance_Directive_Organizer_NEW) (required)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) |  |

This clinical statement represents Advance Directives Observations findings (e.g., “resuscitation status is Full Code”) rather than orders, and should not be considered legal documents. The related legal documents are referenced using the reference/externalReference element.

The Advance Directive Observation describes the patient’s directives, including but not limited to

•  Medications

•  Transfer of Care to Hospital

•  Treatment

•  Procedures

•  Intubation and Ventilation

•  Diagnostic Tests

•  Tests

The general category of the patient’s directive is documented in the observation/code element.  The observation/value element contains the detailed patient directive which may be coded or text. For example, a category  directive  may be antibiotics, and the details would be intravenous antibiotics only.

226: Advance Directive Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.48.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [8648](#C_8648) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [8649](#C_8649) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [8655](#C_8655) |  |
| @root | 1..1 | SHALL |  | [10485](#C_10485) | 2.16.840.1.113883.10.20.22.4.48.2 |
| id | 1..\* | SHALL |  | [8654](#C_8654) |  |
| code | 1..1 | SHALL |  | [8651](#C_8651) | 2.16.840.1.113883.1.11.20.2.2 (AdvanceDirectiveTypeCode (V2)) |
| statusCode | 1..1 | SHALL |  | [8652](#C_8652) |  |
| @code | 1..1 | SHALL |  | [19082](#C_19082) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [8656](#C_8656) |  |
| low | 1..1 | SHALL |  | [28719](#C_28719) |  |
| high | 1..1 | SHALL |  | [15521](#C_15521) |  |
| participant | 0..1 | SHOULD |  | [8662](#C_8662) |  |
| @typeCode | 1..1 | SHALL |  | [8663](#C_8663) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = VRF |
| templateId | 1..1 | SHALL |  | [8664](#C_8664) |  |
| @root | 1..1 | SHALL |  | [10486](#C_10486) | 2.16.840.1.113883.10.20.1.58 |
| time | 0..1 | SHOULD |  | [8665](#C_8665) |  |
| participantRole | 1..1 | SHALL |  | [8825](#C_8825) |  |
| code | 0..1 | SHOULD |  | [28446](#C_28446) | 2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA)) |
| addr | 0..\* | MAY |  | [28451](#C_28451) |  |
| playingEntity | 0..1 | MAY |  | [28428](#C_28428) |  |
| code | 0..1 | SHOULD |  | [28429](#C_28429) | 2.16.840.1.113883.11.20.9.51 (Healthcare Agent Qualifier Value Set) |
| name | 0..\* | MAY |  | [28454](#C_28454) |  |
| participant | 0..\* | SHOULD |  | [8667](#C_8667) |  |
| @typeCode | 1..1 | SHALL |  | [8668](#C_8668) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = CST |
| participantRole | 1..1 | SHALL |  | [8669](#C_8669) |  |
| @classCode | 1..1 | SHALL |  | [8670](#C_8670) | 2.16.840.1.113883.5.110 (RoleClass) = AGNT |
| code | 0..1 | SHOULD |  | [28440](#C_28440) | 2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type) |
| addr | 0..1 | SHOULD |  | [8671](#C_8671) |  |
| telecom | 0..\* | SHOULD |  | [8672](#C_8672) |  |
| playingEntity | 1..1 | SHALL |  | [8824](#C_8824) |  |
| code | 0..1 | SHOULD |  | [28444](#C_28444) | 2.16.840.1.113883.11.20.9.51 (Healthcare Agent Qualifier Value Set) |
| name | 1..1 | SHALL |  | [8673](#C_8673) |  |
| reference | 1..\* | SHOULD |  | [8692](#C_8692) |  |
| @typeCode | 1..1 | SHALL |  | [8694](#C_8694) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| externalDocument | 1..1 | SHALL |  | [8693](#C_8693) |  |
| id | 1..\* | SHALL |  | [8695](#C_8695) |  |
| text | 0..1 | MAY |  | [8696](#C_8696) |  |
| @mediaType | 0..1 | MAY |  | [8703](#C_8703) | text/plain |
| reference | 0..1 | MAY |  | [8697](#C_8697) |  |
| value | 0..1 | SHOULD |  | [30804](#C_30804) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8648).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8649).
3. SHALL contain exactly one [1..1] templateId (CONF:8655) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.48.2" (CONF:10485).
4. SHALL contain at least one [1..\*] id (CONF:8654).
5. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [AdvanceDirectiveTypeCode (V2)](#AdvanceDirectiveTypeCode_V2) 2.16.840.1.113883.1.11.20.2.2 DYNAMIC (CONF:8651).
6. SHALL contain exactly one [1..1] statusCode (CONF:8652).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19082).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:8656).
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:28719).
   2. This effectiveTime SHALL contain exactly one [1..1] high (CONF:15521).
8. SHOULD contain zero or one [0..1] value (CONF:30804).

The participant "VRF" represents the clinician(s) who verified the patient advance directive observation.

1. SHOULD contain zero or one [0..1] participant (CONF:8662) such that it
   1. SHALL contain exactly one [1..1] @typeCode="VRF" Verifier (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8663).
   2. SHALL contain exactly one [1..1] templateId (CONF:8664).
      1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.1.58" (CONF:10486).
   3. SHOULD contain zero or one [0..1] time (CONF:8665).
      1. The data type of Observation/participant/time in a verification SHALL be TS (time stamp) (CONF:8666).
   4. SHALL contain exactly one [1..1] participantRole (CONF:8825).
      1. This participantRole SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet [Healthcare Provider Taxonomy (HIPAA)](#Healthcare_Provider_Taxonomy_HIPAA) 2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:28446).
      2. This participantRole MAY contain zero or more [0..\*] addr (CONF:28451).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:28452).
      3. This participantRole MAY contain zero or one [0..1] playingEntity (CONF:28428).
         1. The playingEntity, if present, SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet [Healthcare Agent Qualifier Value Set](#Healthcare_Agent_Qualifier_Value_Set) 2.16.840.1.113883.11.20.9.51 DYNAMIC (CONF:28429).
         2. The playingEntity, if present, MAY contain zero or more [0..\*] name (CONF:28454).
            1. The playingEntity/name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:28455).

This participant identifies a legal representative for the patient. Examples of such  individuals are health care agents, substitute decision makers and/or health care proxies.  If there is an alternate health care agent, a qualifier identifies may be used to designate one as a primary and secondary agent.

1. SHOULD contain zero or more [0..\*] participant (CONF:8667) such that it
   1. SHALL contain exactly one [1..1] @typeCode="CST" Custodian (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8668).
   2. SHALL contain exactly one [1..1] participantRole (CONF:8669).
      1. This participantRole SHALL contain exactly one [1..1] @classCode="AGNT" Agent (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:8670).
      2. This participantRole SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet [Personal And Legal Relationship Role Type](#Personal_And_Legal_Relationship_Role_Ty) 2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:28440).
      3. This participantRole SHOULD contain zero or one [0..1] addr (CONF:8671).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:28453).
      4. This participantRole SHOULD contain zero or more [0..\*] telecom (CONF:8672).
      5. This participantRole SHALL contain exactly one [1..1] playingEntity (CONF:8824).
         1. This playingEntity SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet [Healthcare Agent Qualifier Value Set](#Healthcare_Agent_Qualifier_Value_Set) 2.16.840.1.113883.11.20.9.51 DYNAMIC (CONF:28444).
         2. This playingEntity SHALL contain exactly one [1..1] name (CONF:8673).
            1. The name of the agent who can provide a copy of the Advance Directive SHALL be recorded in the  name element inside the  playingEntity  element (CONF:8674).
            2. The playingEntity/name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:28456).
2. SHOULD contain at least one [1..\*] reference (CONF:8692) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8694).
   2. SHALL contain exactly one [1..1] externalDocument (CONF:8693).
      1. This externalDocument SHALL contain at least one [1..\*] id (CONF:8695).
      2. This externalDocument MAY contain zero or one [0..1] text (CONF:8696).
         1. The text, if present, MAY contain zero or one [0..1] @mediaType="text/plain" (CONF:8703).
         2. The text, if present, MAY contain zero or one [0..1] reference (CONF:8697).
            1. The URL of a referenced advance directive document MAY be present, and SHALL be represented in Observation/reference/ExternalDocument/text/reference (CONF:8698).
            2. If a URL is referenced, then it SHOULD have a corresponding linkHTML element in narrative block (CONF:8699).

227: AdvanceDirectiveTypeCode (V2)

|  |  |  |
| --- | --- | --- |
| Value Set: AdvanceDirectiveTypeCode (V2) 2.16.840.1.113883.1.11.20.2.2 | | |
| Code | Code System | Print Name |
| 52765003 | SNOMED CT | Intubation |
| 61420007 | SNOMED CT | Tube Feedings |
| 78823007 | SNOMED CT | Life Support |
| 14152002 | SNOMED CT | Intravenous infusion |
| 281789004 | SNOMED CT | Antibiotics |
| 439569004 | SNOMED CT | Resuscitation |
| 40617009 | SNOMED CT | Artificial respiration |
| 18629005 | SNOMED CT | Administration of medication |
| 5447007 | SNOMED CT | Transfusion |
| 429202003 | SNOMED CT | Transfer of care to hospital |
| ... | | |

228: Healthcare Agent Qualifier Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Healthcare Agent Qualifier Value Set 2.16.840.1.113883.11.20.9.51 | | |
| Code | Code System | Print Name |
| 63161005 | SNOMED CT | Principal |
| 2603003 | SNOMED CT | Secondary |

229: Personal And Legal Relationship Role Type

|  |  |  |
| --- | --- | --- |
| Value Set: Personal And Legal Relationship Role Type 2.16.840.1.113883.11.20.12.1  A personal or legal relationship records the role of a person in relation to another person, or a person to himself or herself. This value set is to be used when recording relationships based on personal or family ties or through legal assignment of responsibility.    Specific URL Pending  Valueset Source: [http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary\_tables/infrastructure/vocabulary/vocabulary.html](http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html%20) | | |
| Code | Code System | Print Name |
| ONESELF | RoleCode | self |
| MTH | RoleCode | mother |
| FTH | RoleCode | father |
| DAU | RoleCode | natural daughter |
| SON | RoleCode | natural son |
| DAUINLAW | RoleCode | daughter in-law |
| SONINLAW | RoleCode | son in-law |
| GUARD | RoleCode | guardian |
| HPOWATT | RoleCode | healthcare power of attorney |
| ... | | |

230: Healthcare Provider Taxonomy (HIPAA)

|  |  |  |
| --- | --- | --- |
| Value Set: Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066  The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct Levels including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category. Providers may have one or more than one value associated to them. When determining what value or valuess to associate with a provider, the user needs to review the requirements of the trading partner with which the value(s) are being used. | | |
| Code | Code System | Print Name |
| 171100000X | Healthcare Provider Taxonomy (HIPAA) | Acupuncturist |
| 363LA2100X | Healthcare Provider Taxonomy (HIPAA) | Acute Care |
| 364SA2100X | Healthcare Provider Taxonomy (HIPAA) | Acute Care |
| 101YA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 103TA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 163WA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 207LA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 207QA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 207RA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 2084A0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| ... | | |

Figure 103: Advance Directive Observation Example

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Advance Directive Observation V2\*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.48.2"/>

<id root="9b54c3c9-1673-49c7-aef9-b037ed72ed27"/>

<code code="439569004" codeSystem="2.16.840.1.113883.6.96"

displayName="Resuscitation">

<originalText>Cardiopulmonary resuscitation: for a patient

in cardiac or respiratory arrest</originalText>

</code>

<statusCode code="completed"/>

<effectiveTime>

<low value="20110213"/>

<high nullFlavor="NA"/>

</effectiveTime>

<value xsi:type="CD" code="304253006"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED -CT"

displayName="Not for resuscitation">

<originalText>Do not resuscitate</originalText>

</value>

<participant typeCode="VRF">

<templateId root="2.16.840.1.113883.10.20.1.58"/>

<time value="201302013"/>

<participantRole>

<id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c"/>

<code code="163W00000X" codeSystem="2.16.840.1.113883.6.101"

codeSystemName="Health Care Provider Taxonomy" displayName="Registered nurse"/>

<addr>

...

</addr>

<telecom value="tel:(995)555-1006" use="WP"/>

<playingEntity>

<code code="63161005"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED-CT" displayName="Principal"/>

<name>

<given>Nurse</given>

<family>Florence</family>

<suffix>RN</suffix>

</name>

</playingEntity>

</participantRole>

</participant>

<participant typeCode="CST">

<participantRole classCode="AGNT">

<code code="MTH" codeSystem="2.16.840.1.113883.5.111"

displayName="Mother"/>

<addr>

...

</addr>

<telecom value="tel:(999)555-1212" use="WP"/>

<playingEntity>

<code code="63161005"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED-CT" displayName="Principal"/>

<name>

<prefix>Mrs.</prefix>

<given>Martha</given>

<family>Jones</family>

</name>

</playingEntity>

</participantRole>

</participant>

<reference typeCode="REFR">

<externalDocument>

<id root="b50b7910-7ffb-4f4c-bbe4-177ed68cbbf3"/>

<text mediaType="application/pdf">

<reference

value="AdvanceDirective.b50b7910-7ffb-4f4c-bbe4-177ed68cbbf3.pdf"

/>

</text>

<versionNumber value="1"/>

</externalDocument>

</reference>

</observation>

</entry>

Advance Directive Organizer (NEW)

[organizer: templateId 2.16.840.1.113883.10.20.22.4.108 (open)]

231: Advance Directive Organizer (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Advance Directives Section (entries optional) (V2)](#Advance_Directives_Section_entries_opti) (optional)  [Advance Directives Section (entries required) (V2)](#S_Advance_Directives_Section_entries_re) (required) | [Advance Directive Observation (V2)](#Advance_Directive_Observation_V2) |

This clinical statement groups a set of advance directive observations.

232: Advance Directive Organizer (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| organizer[templateId/@root = '2.16.840.1.113883.10.20.22.4.108'] | | | | | |
| component | 1..\* | SHALL |  | [28420](#C_28420) |  |
| observation | 1..1 | SHALL |  | [28421](#C_28421) |  |
| @classCode | 1..1 | SHALL |  | [28410](#C_28410) | 2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER |
| @moodCode | 1..1 | SHALL |  | [28411](#C_28411) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [28412](#C_28412) |  |
| @root | 1..1 | SHALL |  | [28413](#C_28413) | 2.16.840.1.113883.10.20.22.4.108 |
| id | 1..\* | SHALL |  | [28414](#C_28414) |  |
| code | 1..1 | SHALL |  | [28415](#C_28415) |  |
| @code | 1..1 | SHALL |  | [31230](#C_31230) | 310301000 |
| @codeSystem | 1..1 | SHALL |  | [31231](#C_31231) | 2.16.840.1.113883.6.96 (SNOMED CT) |
| statusCode | 1..1 | SHALL |  | [28418](#C_28418) |  |
| @code | 1..1 | SHALL |  | [31346](#C_31346) | 2.16.840.1.113883.5.14 (ActStatus) = completed |

1. SHALL contain exactly one [1..1] @classCode="CLUSTER", which SHALL be selected from CodeSystem HL7ActClass (2.16.840.1.113883.5.6) STATIC (CONF:28410).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:28411).
3. SHALL contain exactly one [1..1] templateId (CONF:28412) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.108" (CONF:28413).
4. SHALL contain at least one [1..\*] id (CONF:28414).
5. SHALL contain exactly one [1..1] code (CONF:28415).
   1. This code SHALL contain exactly one [1..1] @code="310301000" advance healthcare directive status (CONF:31230).
   2. This code SHALL contain exactly one [1..1] @codeSystem (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:31231).
6. SHALL contain exactly one [1..1] statusCode (CONF:28418).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31346).
7. SHALL contain at least one [1..\*] component (CONF:28420) such that it
   1. SHALL contain exactly one [1..1] [Advance Directive Observation (V2)](#Advance_Directive_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.48.2) (CONF:28421).

Figure 104: Advance Directive Organizer Example

<organizer classCode="CLUSTER" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.108"/>

<!-- \*\*\* Advance Directive Organizer template -->

<id root="af6ebdf2-d996-11e2-a5b8-f23c91aec05e"/>

<code code="310301000" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED -CT"

displayName="advance healthcare directive status"/>

<statusCode code="completed"/>

<effectiveTime value="20130202"/>

<component>

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Advance Directive Observation V2\*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.48.2"/>

...

</component>

<component>

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Advance Directive Observation V2\*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.48.2"/>

<id root="9b54c3c9-1673-49c7-aef9-b037ed72ed27"/>

...

</component>

<component>

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Advance Directive Observation V2\*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.48.2"/>

...

</component>

</organizer>

Age Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.31 (open)]

233: Age Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [Family History Observation](#E_Family_History_Observation) (optional)  [Problem Observation (V2)](#E_Problem_Observation_V2) (optional) |  |

This Age Observation represents the subject's age at onset of an event or observation. The age of a relative in a Family History Observation at the time of that observation could also be inferred by comparing RelatedSubject/subject/birthTime with Observation/effectiveTime. However, a common scenario is that a patient will know the age of a relative when the relative had a certain condition or when the relative died, but will not know the actual year (e.g., "grandpa died of a heart attack at the age of 50"). Often times, neither precise dates nor ages are known (e.g. "cousin died of congenital heart disease as an infant").

234: Age Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.31'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7613](#C_7613) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [7614](#C_7614) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| code | 1..1 | SHALL |  | [7615](#C_7615) |  |
| @code | 1..1 | SHALL |  | [16776](#C_16776) | 2.16.840.1.113883.6.96 (SNOMED CT) = 445518008 |
| value | 1..1 | SHALL | PQ | [7617](#C_7617) |  |
| @unit | 1..1 | SHALL | CS | [7618](#C_7618) | 2.16.840.1.113883.11.20.9.21 (AgePQ\_UCUM) |
| templateId | 1..1 | SHALL |  | [7899](#C_7899) |  |
| @root | 1..1 | SHALL |  | [10487](#C_10487) | 2.16.840.1.113883.10.20.22.4.31 |
| statusCode | 1..1 | SHALL |  | [15965](#C_15965) |  |
| @code | 1..1 | SHALL |  | [15966](#C_15966) | 2.16.840.1.113883.5.14 (ActStatus) = completed |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7613).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7614).
3. SHALL contain exactly one [1..1] templateId (CONF:7899) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.31" (CONF:10487).
4. SHALL contain exactly one [1..1] code (CONF:7615).
   1. This code SHALL contain exactly one [1..1] @code="445518008" Age At Onset (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:16776).
5. SHALL contain exactly one [1..1] statusCode (CONF:15965).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:15966).
6. SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:7617).
   1. This value SHALL contain exactly one [1..1] @unit, which SHALL be selected from ValueSet [AgePQ\_UCUM](#AgePQ_UCUM) 2.16.840.1.113883.11.20.9.21 DYNAMIC (CONF:7618).

235: AgePQ\_UCUM

|  |  |  |
| --- | --- | --- |
| Value Set: AgePQ\_UCUM 2.16.840.1.113883.11.20.9.21  A valueSet of UCUM codes for representing age value units | | |
| Code | Code System | Print Name |
| min | UCUM | Minute |
| h | UCUM | Hour |
| d | UCUM | Day |
| wk | UCUM | Week |
| mo | UCUM | Month |
| a | UCUM | Year |

Figure 105: Age Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.31" />

<!-- Age observation -->

<code code="445518008"

codeSystem="2.16.840.1.113883.6.96"

displayName="Age At Onset" />

<statusCode code="completed" />

<value xsi:type="PQ" value="57" unit="a" />

</observation>

Allergy Concern Act (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.30.2 (open)]

236: Allergy Concern Act (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Allergies Section (entries optional) (V2)](#S_Allergies_Section_entries_optional_V2) (optional)  [Allergies Section (entries required) (V2)](#S_Allergies_Section_entries_required_V2) (required) | [Allergy - Intolerance Observation (V2)](#E_Allergy__Intolerance_Observation_V2)  [Author Participation (NEW)](#U_Author_Participation_NEW) |

This template reflects an ongoing concern on behalf of the provider that placed the allergy on a patient’s allergy list. So long as the underlying condition is of concern to the provider (i.e. so long as the allergy, whether active or resolved, is of ongoing concern and interest to the provider), the statusCode is “active”. Only when the underlying allergy is no longer of concern is the statusCode set to “completed”. The effectiveTime reflects the time that the underlying allergy was felt to be a concern.

The statusCode of the Allergy Problem Act is the definitive indication of the status of the concern, whereas the effectiveTime of the nested Allergy - Intolerance Observation is the definitive indication of whether or not the underlying allergy is resolved.

The effectiveTime/low of the Allergy Problem Act asserts when the concern became active. This equates to the time the concern was authored in the patient's chart. The effectiveTime/high asserts when the concern was completed (e.g. when the clinician deemed there is no longer any need to track the underlying condition).

237: Allergy Concern Act (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.30.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7469](#C_7469) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [7470](#C_7470) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7471](#C_7471) |  |
| @root | 1..1 | SHALL |  | [10489](#C_10489) | 2.16.840.1.113883.10.20.22.4.30.2 |
| id | 1..\* | SHALL |  | [7472](#C_7472) |  |
| code | 1..1 | SHALL |  | [7477](#C_7477) |  |
| @code | 1..1 | SHALL |  | [19158](#C_19158) | 2.16.840.1.113883.5.6 (HL7ActClass) = CONC |
| statusCode | 1..1 | SHALL |  | [7485](#C_7485) |  |
| @code | 1..1 | SHALL |  | [19086](#C_19086) | 2.16.840.1.113883.11.20.9.19 (ProblemAct statusCode) |
| effectiveTime | 1..1 | SHALL |  | [7498](#C_7498) |  |
| low | 1..1 | SHALL |  | [31534](#C_31534) |  |
| high | 0..1 | MAY |  | [31535](#C_31535) |  |
| entryRelationship | 1..\* | SHALL |  | [7509](#C_7509) |  |
| @typeCode | 1..1 | SHALL |  | [7915](#C_7915) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| observation | 1..1 | SHALL |  | [14925](#C_14925) |  |
| author | 0..\* | SHOULD |  | [31145](#C_31145) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7469).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7470).
3. SHALL contain exactly one [1..1] templateId (CONF:7471) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.30.2" (CONF:10489).
4. SHALL contain at least one [1..\*] id (CONF:7472).
5. SHALL contain exactly one [1..1] code (CONF:7477).
   1. This code SHALL contain exactly one [1..1] @code="CONC" Concern (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:19158).
6. SHALL contain exactly one [1..1] statusCode (CONF:7485).
   1. This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [ProblemAct statusCode](#ProblemAct_statusCode) 2.16.840.1.113883.11.20.9.19 STATIC 2011-09-09 (CONF:19086).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:7498).
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:31534).  
      Note: The effectiveTime/low asserts when the allergy was noted. This equates to the time the allergy was authored in the patient's chart.
   2. This effectiveTime MAY contain zero or one [0..1] high (CONF:31535).  
      Note: It is clinically rare for an allergy to be "resolved", even for patients undergoing allergy desensitization. As a result, effectiveTime/high will generally not be present.
8. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31145).
9. SHALL contain at least one [1..\*] entryRelationship (CONF:7509) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7915).
   2. SHALL contain exactly one [1..1] [Allergy - Intolerance Observation (V2)](#E_Allergy__Intolerance_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.7.2) (CONF:14925).

238: ProblemAct statusCode

|  |  |  |
| --- | --- | --- |
| Value Set: ProblemAct statusCode 2.16.840.1.113883.11.20.9.19  A ValueSet of HL7 actStatus codes for use on the concern act | | |
| Code | Code System | Print Name |
| completed | ActStatus | Completed |
| aborted | ActStatus | Aborted |
| active | ActStatus | Active |
| suspended | ActStatus | Suspended |

Figure 106: Allergy Problem Act Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.30.2"/>

<id root="36e3e930-7b14-11db-9fe1-0800200c9a66"/>

<code code="CONC" codeSystem="2.16.840.1.113883.5.6"/>

<!-- Problem Act statusCode represents the status of the allergy or intolerance -->

<statusCode code="active"/>

<effectiveTime>

<low value="19980501"/>

<!-- The low value asserts when the allergy was noted-->

</effectiveTime>

<author>

<templateId root="2.16.840.1.113883.10.20.22.4.119"/>

<time value="199805010945-0800"/>

<!-- The time value equates to when the allergy was noted (became a concern)-->

<assignedAuthor>

<id extension="222223333" root="1.1.1.1.1.1.1.3"/>

<addr>

<streetAddressLine>1025 Health Drive</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:+1(555)555-1025"/>

<assignedPerson>

<name>

<given>Ramsey</given>

<family>Reaction</family>

<suffix qualifier="AC">M.D.</suffix>

</name>

</assignedPerson>

<representedOrganization>

<name>The DoctorsApart Physician Group</name>

</representedOrganization>

</assignedAuthor>

</author>

<entryRelationship typeCode="SUBJ" inversionInd="true">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.7.2"/>

. . .

</entryRelationship>

</act>

</entry>

Allergy Status Observation (DEPRECATED)

[observation: templateId 2.16.840.1.113883.10.20.22.4.28.2 (open)]

239: Allergy Status Observation (DEPRECATED) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Substance or Device Allergy - Intolerance Observation (V2)](#E_Substance_or_Device_Allergy__V2) (optional) |  |

This template represents the status of the allergy indicating whether it is active, no longer active, or is an historic allergy. There can be only one allergy status observation per alert observation.

This template has been deprecated in Consolidated CDA Release 2. Per the explanation in Volume 1, section 3.2 "Determining a Clinical Statement's Status", the status of an allergy is determined based on attributes of the Allergy Problem Act and Allergy - Intolerance Observation.

240: Allergy Status Observation (DEPRECATED) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.28.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7318](#C_7318) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [7319](#C_7319) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7317](#C_7317) |  |
| @root | 1..1 | SHALL |  | [10490](#C_10490) | 2.16.840.1.113883.10.20.22.4.28.2 |
| code | 1..1 | SHALL |  | [7320](#C_7320) |  |
| @code | 1..1 | SHALL |  | [19131](#C_19131) | 2.16.840.1.113883.6.1 (LOINC) = 33999-4 |
| statusCode | 1..1 | SHALL |  | [7321](#C_7321) |  |
| @code | 1..1 | SHALL |  | [19087](#C_19087) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL | CD | [7322](#C_7322) | 2.16.840.1.113883.3.88.12.80.68 (Problem Status Value Set) |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7318).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7319).
3. SHALL contain exactly one [1..1] templateId (CONF:7317) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.28.2" (CONF:10490).
4. SHALL contain exactly one [1..1] code (CONF:7320).
   1. This code SHALL contain exactly one [1..1] @code="33999-4" Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19131).
5. SHALL contain exactly one [1..1] statusCode (CONF:7321).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19087).
6. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [Problem Status Value Set](#Problem_Status_Value_Set) 2.16.840.1.113883.3.88.12.80.68 DYNAMIC (CONF:7322).

241: Problem Status Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Status Value Set 2.16.840.1.113883.3.88.12.80.68 | | |
| Code | Code System | Print Name |
| 55561003 | SNOMED CT | Active |
| 73425007 | SNOMED CT | Inactive |
| 413322009 | SNOMED CT | Resolved |

Assessment Scale Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.69 (open)]

242: Assessment Scale Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [Sensory and Speech Status (NEW)](#E_Sensory_and_Speech_Status_NEW) (optional)  [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW) (optional)  [Mental Status Observation (NEW)](#E_Mental_Status_Observation_NEW) (optional)  [Cognitive Abilities Observation (NEW)](#E_Cognitive_Abilities_Observation_NEW) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2) (optional)  [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (optional)  [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2) (optional) | [Assessment Scale Supporting Observation](#E_Assessment_Scale_Supporting_Observati) |

An assessment scale is a collection of observations that together yield a summary evaluation of a particular condition. Examples include the Braden Scale (assesses pressure ulcer risk), APACHE Score (estimates mortality in critically ill patients), Mini-Mental Status Exam (assesses cognitive function), APGAR Score (assesses the health of a newborn), and Glasgow Coma Scale (assesses coma and impaired consciousness.)

243: Assessment Scale Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.69'] | | | | | |
| @classCode | 1..1 | SHALL |  | [14434](#C_14434) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14435](#C_14435) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [14436](#C_14436) |  |
| @root | 1..1 | SHALL |  | [14437](#C_14437) | 2.16.840.1.113883.10.20.22.4.69 |
| id | 1..\* | SHALL |  | [14438](#C_14438) |  |
| code | 1..1 | SHALL |  | [14439](#C_14439) |  |
| statusCode | 1..1 | SHALL |  | [14444](#C_14444) |  |
| @code | 1..1 | SHALL |  | [19088](#C_19088) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [14445](#C_14445) |  |
| value | 1..1 | SHALL |  | [14450](#C_14450) |  |
| entryRelationship | 0..\* | SHOULD |  | [14451](#C_14451) |  |
| @typeCode | 1..1 | SHALL |  | [16741](#C_16741) | COMP |
| observation | 1..1 | SHALL |  | [16742](#C_16742) |  |
| interpretationCode | 0..\* | MAY |  | [14459](#C_14459) |  |
| translation | 0..\* | MAY |  | [14888](#C_14888) |  |
| author | 0..\* | MAY |  | [14460](#C_14460) |  |
| derivationExpr | 0..1 | MAY |  | [14637](#C_14637) |  |
| referenceRange | 0..\* | MAY |  | [16799](#C_16799) |  |
| observationRange | 1..1 | SHALL |  | [16800](#C_16800) |  |
| text | 0..1 | SHOULD |  | [16801](#C_16801) |  |
| reference | 0..1 | SHOULD |  | [16802](#C_16802) |  |
| @value | 0..1 | MAY |  | [16803](#C_16803) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14434).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14435).
3. SHALL contain exactly one [1..1] templateId (CONF:14436) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.69" (CONF:14437).
4. SHALL contain at least one [1..\*] id (CONF:14438).
5. SHALL contain exactly one [1..1] code (CONF:14439).
   1. SHOULD be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) identifying the assessment scale (CONF:14440).

Such derivation expression can contain a text calculation of how the components total up to the summed score

1. MAY contain zero or one [0..1] derivationExpr (CONF:14637).
2. SHALL contain exactly one [1..1] statusCode (CONF:14444).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19088).

Represents clinically effective time of the measurement, which may be when the measurement was performed (e.g., a BP measurement), or may be when sample was taken (and measured some time afterwards)

1. SHALL contain exactly one [1..1] effectiveTime (CONF:14445).
2. SHALL contain exactly one [1..1] value (CONF:14450).
3. MAY contain zero or more [0..\*] interpretationCode (CONF:14459).
   1. The interpretationCode, if present, MAY contain zero or more [0..\*] translation (CONF:14888).
4. MAY contain zero or more [0..\*] author (CONF:14460).
5. SHOULD contain zero or more [0..\*] entryRelationship (CONF:14451) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" has component (CONF:16741).
   2. SHALL contain exactly one [1..1] [Assessment Scale Supporting Observation](#E_Assessment_Scale_Supporting_Observati) (templateId:2.16.840.1.113883.10.20.22.4.86) (CONF:16742).

The referenceRange/observationRange/text, if present, MAY contain a description of the scale (e.g. for a Pain Scale 1 to 10:  1 to 3 = little pain, 4 to 7= moderate pain, 8 to 10 = severe pain)

1. MAY contain zero or more [0..\*] referenceRange (CONF:16799).
   1. The referenceRange, if present, SHALL contain exactly one [1..1] observationRange (CONF:16800).
      1. This observationRange SHOULD contain zero or one [0..1] text (CONF:16801).
         1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:16802).
            1. The reference, if present, MAY contain zero or one [0..1] @value (CONF:16803).

This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:16804).

Figure 107: Assessment Scale Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.69"/>

<id root="c6b5a04b-2bf4-49d1-8336-636a3813df0b"/>

<code code="54614-3"

displayName="Brief Interview for Mental Status"

codeSystem="2.16.840.1.113883.6.1"

codeSystemName="LOINC"/>

<derivationExpr>Text description of the calculation</derivationExpr>

<statusCode code="completed"/>

<effectiveTime value="20120214"/>

<!-- Summed score of the component values -->

<value xsi:type="INT" value="7"/>

<entryRelationship typeCode="COMP">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.86"/>

. . .

</entryRelationship>

</observation>

Assessment Scale Supporting Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.86 (open)]

244: Assessment Scale Supporting Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [Assessment Scale Observation](#E_Assessment_Scale_Observation) (optional) |  |

An Assessment Scale Supporting observation represents the components of a scale used in an Assessment Scale Observation. The individual parts that make up the component may be a group of cognitive or functional status observations.

245: Assessment Scale Supporting Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.86'] | | | | | |
| @classCode | 1..1 | SHALL |  | [16715](#C_16715) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [16716](#C_16716) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| statusCode | 1..1 | SHALL |  | [16720](#C_16720) |  |
| @code | 1..1 | SHALL |  | [19089](#C_19089) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| templateId | 1..1 | SHALL |  | [16722](#C_16722) |  |
| @root | 1..1 | SHALL |  | [16723](#C_16723) | 2.16.840.1.113883.10.20.22.4.86 |
| id | 1..\* | SHALL |  | [16724](#C_16724) |  |
| value | 1..\* | SHALL |  | [16754](#C_16754) |  |
| code | 1..1 | SHALL |  | [19178](#C_19178) |  |
| @code | 1..1 | SHALL |  | [19179](#C_19179) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:16715).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:16716).
3. SHALL contain exactly one [1..1] templateId (CONF:16722) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.86" (CONF:16723).
4. SHALL contain at least one [1..\*] id (CONF:16724).
5. SHALL contain exactly one [1..1] code (CONF:19178).
   1. This code SHALL contain exactly one [1..1] @code (CONF:19179).
      1. Such that the @code SHALL be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) and represents components of the scale (CONF:19180).
6. SHALL contain exactly one [1..1] statusCode (CONF:16720).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19089).
7. SHALL contain at least one [1..\*] value (CONF:16754).
   1. If xsi:type="CD" , MAY have a translation code to further specify the source if the instrument has an applicable code system and valueSet for the integer (CONF:14639) (CONF:16755).

Figure 108: Assessment Scale Supporting Observation

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.86"/>

<id root="f4dce790-8328-11db-9fe1-0800200c9a44"/>

<code code="248240001" displayName="motor response"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED"/>

<statusCode code="completed"/>

<value xsi:type="INT" value="3"/>

</observation>

Authorization Activity

[act: templateId 2.16.840.1.113883.10.20.1.19 (open)]

246: Authorization Activity Contexts

| Contained By: | Contains: |
| --- | --- |

An Authorization Activity represents authorizations or pre-authorizations currently active for the patient for the particular payer.

Authorizations are represented using an act subordinate to the policy or program that provided it.  The authorization refers to the policy or program. Authorized treatments can be grouped into an organizer class, where common properties, such as the reason for the authorization, can be expressed. Subordinate acts represent what was authorized.

247: Authorization Activity Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.1.19'] | | | | | |
| @classCode | 1..1 | SHALL |  | [8944](#C_8944) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [8945](#C_8945) | 2.16.840.1.113883.5.6 (HL7ActClass) = EVN |
| templateId | 1..1 | SHALL |  | [8946](#C_8946) |  |
| @root | 1..1 | SHALL |  | [10529](#C_10529) | 2.16.840.1.113883.10.20.1.19 |
| id | 1..1 | SHALL |  | [8947](#C_8947) |  |
| entryRelationship | 1..\* | SHALL |  | [8948](#C_8948) |  |
| @typeCode | 1..1 | SHALL |  | [8949](#C_8949) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8944).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8945).
3. SHALL contain exactly one [1..1] templateId (CONF:8946) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.1.19" (CONF:10529).
4. SHALL contain exactly one [1..1] id (CONF:8947).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:8948) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8949).
   2. The target of an authorization activity with act/entryRelationship/@typeCode="SUBJ" SHALL be a clinical statement with moodCode="PRMS" Promise (CONF:8951).
   3. The target of an authorization activity MAY contain one or more performer, to indicate the providers that have been authorized to provide treatment (CONF:8952).

Figure 109: Authorization Activity Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.1.19" />

<id root="f4dce790-8328-11db-9fe1-0800200c9a66" />

<code nullFlavor="NA" />

<entryRelationship typeCode="SUBJ">

<procedure classCode="PROC" moodCode="PRMS">

<code code="73761001" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Colonoscopy" />

</procedure>

</entryRelationship>

</act>

Boundary Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.11 (open)]

248: Boundary Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [Referenced Frames Observation](#E_Referenced_Frames_Observation) (required) |  |

A Boundary Observation contains a list of integer values for the referenced frames of a DICOM multiframe image SOP instance. It identifies the frame numbers within the referenced SOP instance to which the reference applies. The CDA Boundary Observation numbers frames using the same convention as DICOM, with the first frame in the referenced object being Frame 1. A Boundary Observation must be used if a referenced DICOM SOP instance is a multiframe image and the reference does not apply to all frames.

249: Boundary Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.6.2.11'] | | | | | |
| @classCode | 1..1 | SHALL |  | [9282](#C_9282) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [9283](#C_9283) | 2.16.840.1.113883.5.6 (HL7ActClass) = EVN |
| code | 1..1 | SHALL |  | [9284](#C_9284) |  |
| @code | 1..1 | SHALL |  | [19157](#C_19157) | 1.2.840.10008.2.16.4 (DCM) = 113036 |
| value | 1..\* | SHALL | INT | [9285](#C_9285) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9282).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9283).
3. SHALL contain exactly one [1..1] code (CONF:9284).
   1. This code SHALL contain exactly one [1..1] @code="113036" Frames for Display (CodeSystem: DCM 1.2.840.10008.2.16.4 STATIC) (CONF:19157).

Each number represents a frame for display.

1. SHALL contain at least one [1..\*] value with @xsi:type="INT" (CONF:9285).

Figure 110: Boundary Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.11"/>

<code code="113036"

codeSystem="1.2.840.10008.2.16.4"

displayName="Frames for Display"/>

<value xsi:type="INT" value="1"/>

</observation>

Caregiver Characteristics

[observation: templateId 2.16.840.1.113883.10.20.22.4.72 (open)]

250: Caregiver Characteristics Contexts

| Contained By: | Contains: |
| --- | --- |
| [Social History Section (V2)](#S_Social_History_Section_V2) (optional)  [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2) (optional)  [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (optional)  [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2) (optional) |  |

This clinical statement represents a caregiver’s willingness to provide care and the abilities of that caregiver to provide assistance to a patient in relation to a specific need.

251: Caregiver Characteristics Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.72'] | | | | | |
| @classCode | 1..1 | SHALL |  | [14219](#C_14219) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14220](#C_14220) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [14221](#C_14221) |  |
| @root | 1..1 | SHALL |  | [14222](#C_14222) | 2.16.840.1.113883.10.20.22.4.72 |
| id | 1..\* | SHALL |  | [14223](#C_14223) |  |
| participant | 1..\* | SHALL |  | [14227](#C_14227) |  |
| @typeCode | 1..1 | SHALL |  | [26451](#C_26451) | IND |
| time | 0..1 | MAY |  | [14830](#C_14830) |  |
| low | 1..1 | SHALL |  | [14831](#C_14831) |  |
| high | 0..1 | MAY |  | [14832](#C_14832) |  |
| participantRole | 1..1 | SHALL |  | [14228](#C_14228) |  |
| @classCode | 1..1 | SHALL |  | [14229](#C_14229) | CAREGIVER |
| code | 1..1 | SHALL |  | [14230](#C_14230) |  |
| statusCode | 1..1 | SHALL |  | [14233](#C_14233) |  |
| @code | 1..1 | SHALL |  | [19090](#C_19090) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL | CD | [14599](#C_14599) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14219).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14220).
3. SHALL contain exactly one [1..1] templateId (CONF:14221) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.72" (CONF:14222).
4. SHALL contain at least one [1..\*] id (CONF:14223).
5. SHALL contain exactly one [1..1] code (CONF:14230).
6. SHALL contain exactly one [1..1] statusCode (CONF:14233).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19090).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:14599).
8. SHALL contain at least one [1..\*] participant (CONF:14227).
   1. Such participants SHALL contain exactly one [1..1] @typeCode="IND" (CONF:26451).
   2. Such participants MAY contain zero or one [0..1] time (CONF:14830).
      1. The time, if present, SHALL contain exactly one [1..1] low (CONF:14831).
      2. The time, if present, MAY contain zero or one [0..1] high (CONF:14832).
   3. Such participants SHALL contain exactly one [1..1] participantRole (CONF:14228).
      1. This participantRole SHALL contain exactly one [1..1] @classCode="CAREGIVER" (CONF:14229).

Figure 111: Caregiver Characteristics Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.72"/>

<id root="c6b5a04b-2bf4-49d1-8336-636a3813df0c"/>

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<statusCode code="completed"/>

<value xsi:type="CD" code="422615001"

codeSystem="2.16.840.1.113883.6.96"

displayName="caregiver difficulty providing

physical care"/>

<participant typeCode="IND">

<participantRole classCode="CAREGIVER">

<code code="MTH" codeSystem="2.16.840.1.113883.5.111"

displayName="Mother"/>

</participantRole>

</participant>

</observation>

Characteristics of Home Environment (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.109 (open)]

252: Characteristics of Home Environment (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Social History Section (V2)](#S_Social_History_Section_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) |  |

This template represents the patient's home environment including, but not limited to, type of residence (trailer, single family home, assisted living), living arrangement (e.g., alone, with parents), and housing status (e.g., evicted, homeless, home owner).

253: Characteristics of Home Environment (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.109'] | | | | | |
| @classCode | 1..1 | SHALL |  | [27890](#C_27890) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [27891](#C_27891) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [27892](#C_27892) |  |
| @root | 1..1 | SHALL |  | [27893](#C_27893) | 2.16.840.1.113883.10.20.22.4.109 |
| id | 1..\* | SHALL |  | [27894](#C_27894) |  |
| statusCode | 1..1 | SHALL |  | [27901](#C_27901) |  |
| @code | 1..1 | SHALL |  | [27902](#C_27902) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL |  | [28823](#C_28823) | 2.16.840.1.113883.11.20.9.49 (Residence and Accommodation Type) |
| code | 1..1 | SHALL |  | [31352](#C_31352) |  |
| @code | 1..1 | SHALL |  | [31353](#C_31353) | 224249004 |
| @codeSystem | 1..1 | SHALL |  | [31354](#C_31354) | 2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96 |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:27890).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:27891).
3. SHALL contain exactly one [1..1] templateId (CONF:27892) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.109" (CONF:27893).
4. SHALL contain at least one [1..\*] id (CONF:27894).
5. SHALL contain exactly one [1..1] code (CONF:31352).
   1. This code SHALL contain exactly one [1..1] @code="224249004" Characteristics of Home Environment (CONF:31353).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:31354).
6. SHALL contain exactly one [1..1] statusCode (CONF:27901).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:27902).
7. SHALL contain exactly one [1..1] value, which SHOULD be selected from ValueSet [Residence and Accommodation Type](#Residence_and_Accommodation_Type) 2.16.840.1.113883.11.20.9.49 DYNAMIC (CONF:28823).

254: Residence and Accommodation Type

|  |  |  |
| --- | --- | --- |
| Value Set: Residence and Accommodation Type 2.16.840.1.113883.11.20.9.49  A value set of SNOMED-CT codes descending from "365508006" "Residence and accommodation circumstances - finding" reflecting type of residence, status of accommodations, living situation and environment.    Specific URL pending  Valueset Source: <http://vtsl.vetmed.vt.edu/> | | |
| Code | Code System | Print Name |
| 424661000 | SNOMED CT | cluttered living space (finding) |
| 160708008 | SNOMED CT | stairs in house (finding) |
| 160751007 | SNOMED CT | eviction from dwelling (finding) |
| 423859003 | SNOMED CT | crowded living space (finding) |
| 160720000 | SNOMED CT | harassment by landlord (finding) |
| 105529008 | SNOMED CT | lives alone (finding) |
| 60585007 | SNOMED CT | slum area living (finding) |
| 365508006 | SNOMED CT | unsatisfactory living conditions (finding) |
| 422491004 | SNOMED CT | housing contains exposed wiring (finding) |
| ... | | |

Figure 112: Characteristics of Home Environment Example

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Characteristics of Home Environment\*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.109"/>

<id root="37f76c51-6411-4e1d-8a37-957fd49d2ceg"/>

<code code="224249004" codeSystem="2.16.840.1.113883.6.96"

displayName="Characteristics of Home Environment"/>

<statusCode code="completed"/>

<effectiveTime value="20130312"/>

<!--SHALL Value. If xsi:type is CD, SHOULD SNOMED -->

<value xsi:type="CD" code="308899009" displayName="unsatisfactory living conditions (finding)"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"

/>

</observation>

Code Observations

[observation: templateId 2.16.840.1.113883.10.20.6.2.13 (open)]

255: Code Observations Contexts

| Contained By: | Contains: |
| --- | --- |
| [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (optional) | [Quantity Measurement Observation](#E_Quantity_Measurement_Observation)  [SOP Instance Observation](#E_SOP_Instance_Observation) |

DICOM Template 2000 specifies that Imaging Report Elements of Value Type Code are contained in sections. The Imaging Report Elements are inferred from Basic Diagnostic Imaging Report Observations that consist of image references and measurements (linear, area, volume, and numeric). Coded DICOM Imaging Report Elements in this context are mapped to CDA-coded observations that are section components and are related to the SOP Instance Observations (templateId 2.16.840.1.113883.10.20.6.2.8) or Quantity Measurement Observations (templateId 2.16.840.1.113883.10.20.6.2.14) by the SPRT (Support) act relationship.

256: Code Observations Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.6.2.13'] | | | | | |
| @classCode | 1..1 | SHALL |  | [9304](#C_9304) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [9305](#C_9305) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| value | 1..1 | SHALL |  | [9308](#C_9308) |  |
| effectiveTime | 0..1 | SHOULD |  | [9309](#C_9309) |  |
| entryRelationship | 0..\* | MAY |  | [9311](#C_9311) |  |
| @typeCode | 1..1 | SHALL |  | [9312](#C_9312) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT |
| observation | 1..1 | SHALL |  | [16083](#C_16083) |  |
| entryRelationship | 0..\* | MAY |  | [9314](#C_9314) |  |
| @typeCode | 1..1 | SHALL |  | [9315](#C_9315) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT |
| observation | 1..1 | SHALL |  | [16084](#C_16084) |  |
| templateId | 1..1 | SHALL |  | [15523](#C_15523) |  |
| @root | 1..1 | SHALL |  | [15524](#C_15524) | 2.16.840.1.113883.10.20.6.2.13 |
| code | 1..1 | SHALL |  | [19181](#C_19181) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9304).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9305).
3. SHALL contain exactly one [1..1] templateId (CONF:15523).
   1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.13" (CONF:15524).
4. SHALL contain exactly one [1..1] code (CONF:19181).
5. SHOULD contain zero or one [0..1] effectiveTime (CONF:9309).
6. SHALL contain exactly one [1..1] value (CONF:9308).
7. MAY contain zero or more [0..\*] entryRelationship (CONF:9311) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9312).
   2. SHALL contain exactly one [1..1] [SOP Instance Observation](#E_SOP_Instance_Observation) (templateId:2.16.840.1.113883.10.20.6.2.8) (CONF:16083).
8. MAY contain zero or more [0..\*] entryRelationship (CONF:9314) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9315).
   2. SHALL contain exactly one [1..1] [Quantity Measurement Observation](#E_Quantity_Measurement_Observation) (templateId:2.16.840.1.113883.10.20.6.2.14) (CONF:16084).
9. Code Observations SHALL be rendered into section/text in separate paragraphs (CONF:9310).

Figure 113: Code Observations Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.13"/>

<code code="18782-3" codeSystem="2.16.840.1.113883.6.1"

codeSystemName="LOINC"

displayName="Study observation"/>

<statusCode code="completed"/>

<value xsi:type="CD" code="309530007"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"

displayName="Hilar mass"/>

<!-- entryRelationship elements referring to SOP Instance Observations

or Quantity Measurement Observations may appear here -->

</observation>

Cognitive Status Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.74.2 (open)]

257: Cognitive Status Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Cognitive Status Organizer (V2)](#E_Cognitive_Status_Organizer_V2) (required) | [Assessment Scale Observation](#E_Assessment_Scale_Observation)  [Author Participation (NEW)](#U_Author_Participation_NEW)  [Caregiver Characteristics](#E_Caregiver_Characteristics)  [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2) |

This template represents a patient’s cognitive status (e.g. mood, memory, ability to make decisions) and problems that limit cognition (e.g. amnesia, dementia, aggressive behavior). The template may include assessment scale observations, identify supporting caregivers and provide information about non-medicinal supplies.

258: Cognitive Status Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.74.2'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [14469](#C_14469) |  |
| @typeCode | 1..1 | SHALL |  | [14595](#C_14595) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| observation | 1..1 | SHALL |  | [14470](#C_14470) |  |
| entryRelationship | 0..\* | MAY |  | [14276](#C_14276) |  |
| @typeCode | 1..1 | SHALL |  | [14594](#C_14594) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [14277](#C_14277) |  |
| @classCode | 1..1 | SHALL |  | [14249](#C_14249) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14250](#C_14250) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [14255](#C_14255) |  |
| @root | 1..1 | SHALL |  | [14256](#C_14256) | 2.16.840.1.113883.10.20.22.4.74.2 |
| id | 1..\* | SHALL |  | [14257](#C_14257) |  |
| code | 1..1 | SHALL |  | [14591](#C_14591) |  |
| @code | 1..1 | SHALL |  | [14592](#C_14592) | 311465003 |
| @codeSystem | 1..1 | SHALL |  | [30870](#C_30870) | 2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96 |
| text | 0..1 | SHOULD |  | [14258](#C_14258) |  |
| statusCode | 1..1 | SHALL |  | [14254](#C_14254) |  |
| @code | 1..1 | SHALL |  | [19092](#C_19092) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [14261](#C_14261) |  |
| value | 1..1 | SHALL |  | [14263](#C_14263) |  |
| author | 0..\* | SHOULD |  | [14266](#C_14266) |  |
| entryRelationship | 0..\* | MAY |  | [14272](#C_14272) |  |
| @typeCode | 1..1 | SHALL |  | [14593](#C_14593) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| supply | 1..1 | SHALL |  | [14273](#C_14273) |  |
| referenceRange | 0..\* | MAY |  | [14267](#C_14267) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14249).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14250).
3. SHALL contain exactly one [1..1] templateId (CONF:14255) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.74.2" (CONF:14256).
4. SHALL contain at least one [1..\*] id (CONF:14257).
5. SHALL contain exactly one [1..1] code (CONF:14591).
   1. This code SHALL contain exactly one [1..1] @code="311465003" Cognitive functions (CONF:14592).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:30870).
6. SHOULD contain zero or one [0..1] text (CONF:14258).
7. SHALL contain exactly one [1..1] statusCode (CONF:14254).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19092).
8. SHALL contain exactly one [1..1] effectiveTime (CONF:14261).
9. SHALL contain exactly one [1..1] value (CONF:14263).
   1. If xsi:type=“CD”, SHOULD contain a code from SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:14271).
10. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:14266).
11. MAY contain zero or more [0..\*] entryRelationship (CONF:14272) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14593).
    2. SHALL contain exactly one [1..1] [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.50.2) (CONF:14273).
12. MAY contain zero or more [0..\*] entryRelationship (CONF:14276) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14594).
    2. SHALL contain exactly one [1..1] [Caregiver Characteristics](#E_Caregiver_Characteristics) (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:14277).
13. MAY contain zero or more [0..\*] entryRelationship (CONF:14469) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14595).
    2. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:14470).

The referenceRange could be used to represent normal or expected capability for the cognitive function being evaluated.

1. MAY contain zero or more [0..\*] referenceRange (CONF:14267).

Figure 114: Cognitive Status Observation Example

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Cognitive Status Oservation V2 -->

<templateId root="2.16.840.1.113883.10.20.22.4.74.2"/>

<id root="c6b5a04b-2bf4-49d1-8336-636a3813df0a"/>

<code code="311465003" displayName="Cognitive functions"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"/>

<statusCode code="completed"/>

<effectiveTime value="20130311"/>

<value xsi:type="CD" code="61372001" displayName="Aggressive behavior"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"></value>

<author>

<time value="200130311"/>

<assignedAuthor>

....

</assignedAuthor>

</author>

</observation>

</entry>

Cognitive Abilities Observation (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.126 (open)]

259: Cognitive Abilities Observation (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Assessment Scale Observation](#E_Assessment_Scale_Observation) |

The Cognitive Abilities Observation conforms to the Cognitive Status Observation and represents a patient’s ability to perform specific cognitive tasks (e.g. ability to plan, logical sequencing ability, ability to think abstractly).

260: Cognitive Abilities Observation (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.126'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [29266](#C_29266) |  |
| @typeCode | 1..1 | SHALL |  | [29267](#C_29267) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| observation | 1..1 | SHALL |  | [29268](#C_29268) |  |
| @classCode | 1..1 | SHALL |  | [29246](#C_29246) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [29247](#C_29247) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [29248](#C_29248) |  |
| @root | 1..1 | SHALL |  | [29249](#C_29249) | 2.16.840.1.113883.10.20.22.4.126 |
| id | 1..\* | SHALL |  | [29250](#C_29250) |  |
| code | 1..1 | SHALL |  | [29251](#C_29251) | 2.16.840.1.113883.11.20.9.48 (Cognitive Abilities Value Set) |
| text | 0..1 | SHOULD |  | [29252](#C_29252) |  |
| statusCode | 1..1 | SHALL |  | [29256](#C_29256) |  |
| @code | 1..1 | SHALL |  | [29257](#C_29257) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [29258](#C_29258) |  |
| value | 1..1 | SHALL | CD | [29264](#C_29264) | 2.16.840.1.113883.11.20.9.44 (Mental and Functional Status Response Value Set) |

1. Conforms to [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2) template (2.16.840.1.113883.10.20.22.4.74.2).
2. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:29246).
3. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:29247).
4. SHALL contain exactly one [1..1] templateId (CONF:29248) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.126" (CONF:29249).
5. SHALL contain at least one [1..\*] id (CONF:29250).
6. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet [Cognitive Abilities Value Set](#Cognitive_Abilities_Value_Set) 2.16.840.1.113883.11.20.9.48 DYNAMIC (CONF:29251).
7. SHOULD contain zero or one [0..1] text (CONF:29252).
8. SHALL contain exactly one [1..1] statusCode (CONF:29256).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:29257).
9. SHALL contain exactly one [1..1] effectiveTime (CONF:29258).
10. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [Mental and Functional Status Response Value Set](#Mental_and_Functional_Status_Response_V) 2.16.840.1.113883.11.20.9.44 DYNAMIC (CONF:29264).
11. MAY contain zero or more [0..\*] entryRelationship (CONF:29266) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:29267).
    2. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:29268).

261: Cognitive Abilities Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Cognitive Abilities Value Set 2.16.840.1.113883.11.20.9.48  This Value Set identifies the specific types of cognitive abilities. | | |
| Code | Code System | Print Name |
| 61254005 | SNOMED CT | judgement (observable entity) |
| 395659009 | SNOMED CT | ability to comprehend (observable entity) |
| 286574007 | SNOMED CT | ability to plan (observable entity) |
| 307082005 | SNOMED CT | ability to process information (observable entity) |
| 304641000 | SNOMED CT | ability to reason (observable entity) |
| 363878000 | SNOMED CT | ability to think abstractly (observable entity) |
| 418907009 | SNOMED CT | ability to verbalize understanding (observable entity) |
| 304645009 | SNOMED CT | logical sequencing ability (observable entity) |
| 311465003 | SNOMED CT | Cognitive functions (observable entity) |

262: Mental and Functional Status Response Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Mental and Functional Status Response Value Set 2.16.840.1.113883.11.20.9.44  A value set containing 2 SNOMED-CT qualifier codes that are common responses to mental and functional ability queries. | | |
| Code | Code System | Print Name |
| 11163003 | SNOMED CT | Intact |
| 260379002 | SNOMED CT | Impaired |

Figure 115: Cognitive Abilities Observation Example

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Cognitive Abilities Observation -->

<templateId root="2.16.840.1.113883.10.20.22.4.126"/>

<id root="c12ecaaf-53f8-4593-8f79-359aeaa39483"/>

<code xsi:type="CD" code="61254005" displayName="Judgement"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"></code>

<text>Judgement</text>

<statusCode code="completed"/>

<effectiveTime value="20130311"/>

<value xsi:type="CD" code="11163003" displayName="Intact"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"></value>

<author>

...

</observation>

</entry>

Cognitive Status Organizer (V2)

[organizer: templateId 2.16.840.1.113883.10.20.22.4.75.2 (open)]

263: Cognitive Status Organizer (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW) (optional) | [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2) |

This template groups related cognitive status observations into categories . A result organizer may be used to group questions in a Patient Health Questionnaire (PHQ).

264: Cognitive Status Organizer (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| organizer[templateId/@root = '2.16.840.1.113883.10.20.22.4.75.2'] | | | | | |
| component | 1..\* | SHALL |  | [14373](#C_14373) |  |
| observation | 1..1 | SHALL |  | [14381](#C_14381) |  |
| @classCode | 1..1 | SHALL |  | [14369](#C_14369) | 2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER |
| @moodCode | 1..1 | SHALL |  | [14371](#C_14371) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [14375](#C_14375) |  |
| @root | 1..1 | SHALL |  | [14376](#C_14376) | 2.16.840.1.113883.10.20.22.4.75.2 |
| id | 1..\* | SHALL |  | [14377](#C_14377) |  |
| code | 1..1 | SHALL |  | [14378](#C_14378) |  |
| @code | 0..1 | SHOULD |  | [14697](#C_14697) |  |
| statusCode | 1..1 | SHALL |  | [14372](#C_14372) |  |
| @code | 1..1 | SHALL |  | [19093](#C_19093) | 2.16.840.1.113883.5.14 (ActStatus) = completed |

1. SHALL contain exactly one [1..1] @classCode="CLUSTER", which SHALL be selected from CodeSystem HL7ActClass (2.16.840.1.113883.5.6) STATIC (CONF:14369).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14371).
3. SHALL contain exactly one [1..1] templateId (CONF:14375) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.75.2" (CONF:14376).
4. SHALL contain at least one [1..\*] id (CONF:14377).

The code selected should indicate the category that groups the contained cognitive status observations (e.g. communication,learning and applying knowledge).

1. SHALL contain exactly one [1..1] code (CONF:14378).
   1. This code SHOULD contain zero or one [0..1] @code (CONF:14697).
      1. Should be selected from ICF (codeSystem 2.16.840.1.113883.6.254) or SNOMED CT (codeSystem 2.16.840.1.113883.6.96) (CONF:14698).
2. SHALL contain exactly one [1..1] statusCode (CONF:14372).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19093).
3. SHALL contain at least one [1..\*] component (CONF:14373) such that it
   1. SHALL contain exactly one [1..1] [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.74.2) (CONF:14381).

Figure 116: Cognitive Status Organizer Example

<entry>

<organizer classCode="CLUSTER" moodCode="EVN">

<!-- Cognitive Status Organizer V2-->

<templateId root="2.16.840.1.113883.10.20.22.4.75.2"/>

<id root="a7bc1062-8649-42a0-833d-ekd65bd013c9"/>

<code code="d3" displayName="Communication"

codeSystem="2.16.840.1.113883.6.254" codeSystemName="ICF"/>

<statusCode code="completed"/>

<component>

<observation classCode="OBS" moodCode="EVN">

<!-- Cognitive Status Oservation V2 -->

<templateId root="2.16.840.1.113883.10.20.22.4.74.2"/>

...

</component>

<component>

<observation classCode="OBS" moodCode="EVN">

<!-- Cognitive Status Oservation V2 -->

<templateId root="2.16.840.1.113883.10.20.22.4.74.2"/>

...

</component>

</organizer>

</entry>

Cognitive Status Problem Observation (DEPRECATED)

[observation: templateId 2.16.840.1.113883.10.20.22.4.73.2 (open)]

265: Cognitive Status Problem Observation (DEPRECATED) Contexts

| Contained By: | Contains: |
| --- | --- |

USE OF COGNITIVE STATUS PROBLEM OBSERVATION IS NOT RECOMMENDED. COGNITIVE STATUS PROBLEM OBSERVATION AND COGNITIVE STATUS RESULT OBSERVATION HAVE BEEN MERGED TOGETHER WITHOUT LOSS OF EXPRESSIVITY INTO COGNITIVE STATUS OBSERVATION (TEMPLATE ID: 2.16.840.1.113883.10.20.22.4.74.2).

266: Cognitive Status Problem Observation (DEPRECATED) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.73.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [14319](#C_14319) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14320](#C_14320) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| @negationInd | 0..1 | MAY |  | [14344](#C_14344) |  |
| templateId | 1..1 | SHALL |  | [14346](#C_14346) |  |
| @root | 1..1 | SHALL |  | [14347](#C_14347) | 2.16.840.1.113883.10.20.22.4.73 |
| id | 1..\* | SHALL |  | [14321](#C_14321) |  |
| code | 1..1 | SHALL |  | [14804](#C_14804) |  |
| @code | 0..1 | SHOULD |  | [14805](#C_14805) | 2.16.840.1.113883.6.96 (SNOMED CT) = 373930000 |
| text | 0..1 | SHOULD |  | [14341](#C_14341) |  |
| reference | 0..1 | SHOULD |  | [15532](#C_15532) |  |
| @value | 0..1 | SHOULD |  | [15533](#C_15533) |  |
| statusCode | 1..1 | SHALL |  | [14323](#C_14323) |  |
| @code | 1..1 | SHALL |  | [19091](#C_19091) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 0..1 | SHOULD |  | [14324](#C_14324) |  |
| low | 1..1 | SHALL |  | [26458](#C_26458) |  |
| high | 0..1 | MAY |  | [26459](#C_26459) |  |
| value | 1..1 | SHALL | CD | [14349](#C_14349) | 2.16.840.1.113883.3.88.12.3221.7.4 (Problem Value Set) |
| methodCode | 0..\* | MAY |  | [14693](#C_14693) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14319).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14320).

Use negationInd="true" to indicate that the problem was not observed.

1. MAY contain zero or one [0..1] @negationInd (CONF:14344).
2. SHALL contain exactly one [1..1] templateId (CONF:14346) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.73" (CONF:14347).
3. SHALL contain at least one [1..\*] id (CONF:14321).
4. SHALL contain exactly one [1..1] code (CONF:14804).
   1. This code SHOULD contain zero or one [0..1] @code="373930000" Cognitive function finding (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:14805).
5. SHOULD contain zero or one [0..1] text (CONF:14341).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15532).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15533).
         1. SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15534).
6. SHALL contain exactly one [1..1] statusCode (CONF:14323).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19091).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:14324).

The value of effectiveTime/low represents onset date.

* 1. The effectiveTime, if present, SHALL contain exactly one [1..1] low (CONF:26458).

If the problem is resolved, record the resolution date in effectiveTime/high. If the problem is known to be resolved but the resolution date is not known, use @nullFlavor="UNK". If the problem is not resolved, do not include the high element.

* 1. The effectiveTime, if present, MAY contain zero or one [0..1] high (CONF:26459).

1. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [Problem Value Set](#Problem_Value_Set) 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:14349).
2. MAY contain zero or more [0..\*] methodCode (CONF:14693).

267: Problem Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 | | |
| Code | Code System | Print Name |
| 50992006 | SNOMED CT | 22q partial trisomy syndrome (disorder) |
| 237931009 | SNOMED CT | 2-Ketoadipic acidemia (disorder) |
| 54470008 | SNOMED CT | 3 beta-Hydroxysteroid dehydrogenase deficiency (disorder) |
| 237950009 | SNOMED CT | 3-Methylglutaconic aciduria (disorder) |
| 296646009 | SNOMED CT | 4-quinolones overdose (disorder) |
| 41797007 | SNOMED CT | 5 10-Methylenetetrahydrofolate reductase deficiency (disorder) |
| 413380004 | SNOMED CT | A pattern strabismus (disorder) |
| 425879009 | SNOMED CT | AA amyloid nephropathy (disorder) |
| 274945004 | SNOMED CT | AA amyloidosis (disorder) |
| 75100008 | SNOMED CT | Abdominal abscess (disorder) |
| ... | | |

Comment Activity

[act: templateId 2.16.840.1.113883.10.20.22.4.64 (open)]

268: Comment Activity Contexts

| Contained By: | Contains: |
| --- | --- |

Comments are free text data that cannot otherwise be recorded using data elements already defined by this specification. They are not to be used to record information that can be recorded elsewhere. For example, a free text description of the severity of an allergic reaction would not be recorded in a comment.

269: Comment Activity Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.64'] | | | | | |
| @classCode | 1..1 | SHALL |  | [9425](#C_9425) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [9426](#C_9426) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [9427](#C_9427) |  |
| @root | 1..1 | SHALL |  | [10491](#C_10491) | 2.16.840.1.113883.10.20.22.4.64 |
| code | 1..1 | SHALL |  | [9428](#C_9428) |  |
| @code | 1..1 | SHALL |  | [19159](#C_19159) | 2.16.840.1.113883.6.1 (LOINC) = 48767-8 |
| text | 1..1 | SHALL |  | [9430](#C_9430) |  |
| reference | 1..1 | SHALL |  | [15967](#C_15967) |  |
| @value | 1..1 | SHALL |  | [15968](#C_15968) |  |
| reference/@value | 1..1 | SHALL |  | [9431](#C_9431) |  |
| author | 0..1 | MAY |  | [9433](#C_9433) |  |
| time | 1..1 | SHALL |  | [9434](#C_9434) |  |
| assignedAuthor | 1..1 | SHALL |  | [9435](#C_9435) |  |
| id | 1..1 | SHALL |  | [9436](#C_9436) |  |
| addr | 1..1 | SHALL |  | [9437](#C_9437) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9425).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9426).
3. SHALL contain exactly one [1..1] templateId (CONF:9427) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.64" (CONF:10491).
4. SHALL contain exactly one [1..1] code (CONF:9428).
   1. This code SHALL contain exactly one [1..1] @code="48767-8" Annotation Comment (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19159).
5. SHALL contain exactly one [1..1] text (CONF:9430).
   1. This text SHALL contain exactly one [1..1] reference (CONF:15967).
      1. This reference SHALL contain exactly one [1..1] @value (CONF:15968).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15969).
   2. This text SHALL contain exactly one [1..1] reference/@value (CONF:9431).
6. MAY contain zero or one [0..1] author (CONF:9433).
   1. The author, if present, SHALL contain exactly one [1..1] time (CONF:9434).
   2. The author, if present, SHALL contain exactly one [1..1] assignedAuthor (CONF:9435).
      1. This assignedAuthor SHALL contain exactly one [1..1] id (CONF:9436).
      2. This assignedAuthor SHALL contain exactly one [1..1] addr (CONF:9437).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10480).
      3. SHALL include assignedPerson/name or representedOrganization/name (CONF:9438).
      4. An  assignedPerson/name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:9439).
7. Data elements defined elsewhere in the specification SHALL NOT be recorded using the Comment Activity (CONF:9429).

Figure 117: Comment Activity Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.64" />

<code code="48767-8" displayName="Annotation Comment" codeSystemName="LOINC" codeSystem="2.16.840.1.113883.6.1" />

<text>The patient stated that he was looking forward to an upcoming

vacation to New York with his family. He was concerned that he may

not have enough medication for the trip. An additional prescription

was provided to cover that period of time.

<reference value="#PntrtoSectionText" /></text>

<author>

<time value="20050329224411+0500" />

<assignedAuthor>

<id extension="KP00017" root="2.16.840.1.113883.19.5" />

<addr>

<streetAddressLine>21 North Ave.</streetAddressLine>

<city>Burlington</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:(555)555-1003" />

<assignedPerson>

<name>

<given>Henry</given>

<family>Seven</family>

</name>

</assignedPerson>

</assignedAuthor>

</author>

</act>

Coverage Activity (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.60.2 (open)]

270: Coverage Activity (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Payers Section (V2)](#S_Payers_Section_V2) (optional) | [Policy Activity (V2)](#Policy_Activity_V2) |

A Coverage Activity groups the policy and authorization acts within a Payers Section to order the payment sources. A Coverage Activity contains one or more policy activities, each of which contains zero or more authorization activities. The Coverage Activity id is the Id from the patient's insurance card.  The sequenceNumber/@value shows the policy order of preference.

271: Coverage Activity (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.60.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [8872](#C_8872) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [8873](#C_8873) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [8897](#C_8897) |  |
| @root | 1..1 | SHALL |  | [10492](#C_10492) | 2.16.840.1.113883.10.20.22.4.60.2 |
| id | 1..\* | SHALL |  | [8874](#C_8874) |  |
| code | 1..1 | SHALL |  | [8876](#C_8876) |  |
| @code | 1..1 | SHALL |  | [19160](#C_19160) | 2.16.840.1.113883.6.1 (LOINC) = 48768-6 |
| statusCode | 1..1 | SHALL |  | [8875](#C_8875) |  |
| @code | 1..1 | SHALL |  | [19094](#C_19094) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| entryRelationship | 1..\* | SHALL |  | [8878](#C_8878) |  |
| @typeCode | 1..1 | SHALL |  | [8879](#C_8879) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| sequenceNumber | 0..1 | MAY |  | [17174](#C_17174) |  |
| @value | 1..1 | SHALL |  | [17175](#C_17175) |  |
| act | 1..1 | SHALL |  | [15528](#C_15528) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8872).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8873).
3. SHALL contain exactly one [1..1] templateId (CONF:8897) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.60.2" (CONF:10492).
4. SHALL contain at least one [1..\*] id (CONF:8874).
5. SHALL contain exactly one [1..1] code (CONF:8876).
   1. This code SHALL contain exactly one [1..1] @code="48768-6" Payment sources (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19160).
6. SHALL contain exactly one [1..1] statusCode (CONF:8875).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19094).
7. SHALL contain at least one [1..\*] entryRelationship (CONF:8878) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8879).
   2. MAY contain zero or one [0..1] sequenceNumber (CONF:17174).
      1. The sequenceNumber, if present, SHALL contain exactly one [1..1] @value (CONF:17175).
   3. SHALL contain exactly one [1..1] [Policy Activity (V2)](#Policy_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.61.2) (CONF:15528).

Figure 118: Coverage Activity Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.60.2"/>

<id root="1fe2cdd0-7aad-11db-9fe1-0800200c9a66"/>

<code code="48768-6" codeSystem="2.16.840.1.113883.6.1"

codeSystemName="LOINC" displayName="Payment sources"/>

<statusCode code="completed"/>

<entryRelationship typeCode="COMP">

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.61.2"/>

. . .

</entryRelationship>

</act>

Cultural and Religious Observation (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.111 (open)]

272: Cultural and Religious Observation (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Social History Section (V2)](#S_Social_History_Section_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) |  |

This template represents a patient’s spiritual, religious, and cultural belief practices, such as a kosher diet or fasting ritual. religiousAffiliationCode in the document header captures only the patient’s religious affiliation.

273: Cultural and Religious Observation (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.111'] | | | | | |
| @classCode | 1..1 | SHALL |  | [27924](#C_27924) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [27925](#C_27925) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [27926](#C_27926) |  |
| @root | 1..1 | SHALL |  | [27927](#C_27927) | 2.16.840.1.113883.10.20.22.4.111 |
| id | 1..\* | SHALL |  | [27928](#C_27928) |  |
| code | 1..1 | SHALL |  | [27929](#C_27929) |  |
| @code | 1..1 | SHALL |  | [27930](#C_27930) | 406198009 |
| @codeSystem | 1..1 | SHALL |  | [27931](#C_27931) | 2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96 |
| statusCode | 1..1 | SHALL |  | [27936](#C_27936) |  |
| @code | 1..1 | SHALL |  | [27937](#C_27937) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL |  | [28442](#C_28442) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:27924).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:27925).
3. SHALL contain exactly one [1..1] templateId (CONF:27926) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.111" (CONF:27927).
4. SHALL contain at least one [1..\*] id (CONF:27928).
5. SHALL contain exactly one [1..1] code (CONF:27929).
   1. This code SHALL contain exactly one [1..1] @code="406198009" personal belief pattern (observable entity) (CONF:27930).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:27931).
6. SHALL contain exactly one [1..1] statusCode (CONF:27936).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:27937).
7. SHALL contain exactly one [1..1] value (CONF:28442).

Figure 119: Cultural and Religious Observations Example

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- \*\*Cultural and Religious Observations(NEW)\*\*-->

<templateId root="2.16.840.1.113883.10.20.22.4.111"/>

<id root="37f76c51-6411-4e1d-8a37-957fd49d2cef"/>

<code code="406198009" codeSystem="2.16.840.1.113883.6.96"

displayName="personal belief pattern"/>

<statusCode code="completed"/>

<effectiveTime>

<low value="20130312"/>

</effectiveTime>

<value xsi:type="ST">Does not accept blood tranfusions, or donates,or

stores blood for transfusion.</value>

</observation>

</entry>

Deceased Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.79.2 (open)]

274: Deceased Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
|  | [Problem Observation (V2)](#E_Problem_Observation_V2) |

This template represents the observation that a patient has died. It also represents the cause of death, indicated by an entryRelationship type of ‘CAUS’. This template allows for more specific representation of data than is available with the use of dischargeDispositionCode.

275: Deceased Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.79.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [14851](#C_14851) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14852](#C_14852) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [14871](#C_14871) |  |
| @root | 1..1 | SHALL |  | [14872](#C_14872) | 2.16.840.1.113883.10.20.22.4.79.2 |
| id | 1..\* | SHALL |  | [14873](#C_14873) |  |
| code | 1..1 | SHALL |  | [14853](#C_14853) |  |
| @code | 1..1 | SHALL |  | [19135](#C_19135) | 2.16.840.1.113883.5.4 (ActCode) = ASSERTION |
| statusCode | 1..1 | SHALL |  | [14854](#C_14854) |  |
| @code | 1..1 | SHALL |  | [19095](#C_19095) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [14855](#C_14855) |  |
| low | 1..1 | SHALL |  | [14874](#C_14874) |  |
| value | 1..1 | SHALL | CD | [14857](#C_14857) |  |
| @code | 1..1 | SHALL |  | [15142](#C_15142) | 2.16.840.1.113883.6.96 (SNOMED CT) = 419099009 |
| entryRelationship | 0..1 | SHOULD |  | [14868](#C_14868) |  |
| @typeCode | 1..1 | SHALL |  | [14875](#C_14875) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = CAUS |
| observation | 1..1 | SHALL |  | [14870](#C_14870) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14851).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14852).
3. SHALL contain exactly one [1..1] templateId (CONF:14871) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.79.2" (CONF:14872).
4. SHALL contain at least one [1..\*] id (CONF:14873).
5. SHALL contain exactly one [1..1] code (CONF:14853).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19135).
6. SHALL contain exactly one [1..1] statusCode (CONF:14854).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19095).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:14855).
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:14874).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:14857).
   1. This value SHALL contain exactly one [1..1] @code="419099009" Dead (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:15142).
9. SHOULD contain zero or one [0..1] entryRelationship (CONF:14868) such that it
   1. SHALL contain exactly one [1..1] @typeCode="CAUS" Is etiology for (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14875).
   2. SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:14870).

Figure 120: Deceased Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.79"/>

<id root="6898fae0-5c8a-11db-b0de-0800200c9a77"/>

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<statusCode code="completed"/>

<effectiveTime>

<low value="20100303"/>

</effectiveTime>

<value xsi:type="CD" code="419099009"

codeSystem="2.16.840.1.113883.6.96"

displayName="Dead"/>

<entry typeCode="DRIV">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.4" />

...

</observation>

</entry>

</observation>

Discharge Medication (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.35.2 (open)]

276: Discharge Medication (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Hospital Discharge Medications Section (entries optional) (V2)](#S_Hospital_Discharge_Medications_Sectio) (optional)  [Hospital Discharge Medications Section (entries required) (V2)](#S_Hospital_Discharge_Medications_reqd_v2) (required) | [Medication Activity (V2)](#Medication_Activity_V2) |

This template represents medications that the patient is intended to take (or stop) after discharge.

277: Discharge Medication (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.35.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7689](#C_7689) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [7690](#C_7690) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [16760](#C_16760) |  |
| @root | 1..1 | SHALL |  | [16761](#C_16761) | 2.16.840.1.113883.10.20.22.4.35.2 |
| code | 1..1 | SHALL |  | [7691](#C_7691) |  |
| @code | 1..1 | SHALL |  | [19161](#C_19161) | 2.16.840.1.113883.6.1 (LOINC) = 10183-2 |
| entryRelationship | 1..\* | SHALL |  | [7692](#C_7692) |  |
| @typeCode | 1..1 | SHALL |  | [7693](#C_7693) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| substanceAdministration | 1..1 | SHALL |  | [15525](#C_15525) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7689).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7690).
3. SHALL contain exactly one [1..1] templateId (CONF:16760) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.35.2" (CONF:16761).
4. SHALL contain exactly one [1..1] code (CONF:7691).
   1. This code SHALL contain exactly one [1..1] @code="10183-2" Discharge medication (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19161).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:7692) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7693).
   2. SHALL contain exactly one [1..1] [Medication Activity (V2)](#Medication_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15525).

Figure 121: Discharge Medication Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.35.2" />

<code code="10183-2" />

<entryRelationship typeCode="SUBJ">

<substanceAdministration classCode="SBADM" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.16.2" />

...

</substanceAdministration>

</entryRelationship>

</act>

Drug Vehicle

[participantRole: templateId 2.16.840.1.113883.10.20.22.4.24 (open)]

278: Drug Vehicle Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medication Activity (V2)](#Medication_Activity_V2) (optional)  [Immunization Activity (V2)](#E_Immunization_Activity_V2) (optional) |  |

This template represents the vehicle (e.g. saline, dextrose) for administering a medication.

279: Drug Vehicle Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| participantRole[templateId/@root = '2.16.840.1.113883.10.20.22.4.24'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7490](#C_7490) | 2.16.840.1.113883.5.110 (RoleClass) = MANU |
| playingEntity | 1..1 | SHALL |  | [7492](#C_7492) |  |
| code | 1..1 | SHALL |  | [7493](#C_7493) |  |
| name | 0..1 | MAY |  | [7494](#C_7494) |  |
| templateId | 1..1 | SHALL |  | [7495](#C_7495) |  |
| @root | 1..1 | SHALL |  | [10493](#C_10493) | 2.16.840.1.113883.10.20.22.4.24 |
| code | 1..1 | SHALL |  | [19137](#C_19137) |  |
| @code | 1..1 | SHALL |  | [19138](#C_19138) | 2.16.840.1.113883.6.96 (SNOMED CT) = 412307009 |

1. SHALL contain exactly one [1..1] @classCode="MANU" (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:7490).
2. SHALL contain exactly one [1..1] templateId (CONF:7495) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.24" (CONF:10493).
3. SHALL contain exactly one [1..1] code (CONF:19137).
   1. This code SHALL contain exactly one [1..1] @code="412307009" Drug Vehicle (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:19138).
4. SHALL contain exactly one [1..1] playingEntity (CONF:7492).

This playingEntity/code is used to supply a coded term for the drug vehicle.

* 1. This playingEntity SHALL contain exactly one [1..1] code (CONF:7493).
  2. This playingEntity MAY contain zero or one [0..1] name (CONF:7494).
     1. This playingEntity/name MAY be used for the vehicle name in text, such as Normal Saline (CONF:10087).

Figure 122: Drug Vehicle Example

<participantRole classCode="MANU">

<templateId root="2.16.840.1.113883.10.20.22.4.24" />

<code code="412307009" displayName="drug vehicle" codeSystem="2.16.840.1.113883.6.96" />

<playingEntity classCode="MMAT">

<code code="324049" displayName="Aerosol" codeSystem="2.16.840.1.113883.6.88" codeSystemName="RxNorm" />

<name>Aerosol</name>

</playingEntity>

</participantRole>

Encounter Activity (V2)

[encounter: templateId 2.16.840.1.113883.10.20.22.4.49.2 (open)]

280: Encounter Activity (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Encounters Section (entries optional) (V2)](#S_Encounters_Section_entries_optional_V) (optional)  [Encounters Section (entries required) (V2)](#S_Encounters_Section_entries_required_V) (required)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Encounter Diagnosis (V2)](#E_Encounter_Diagnosis_V2)  [Indication (V2)](#Indication_V2)  [Service Delivery Location](#E_Service_Delivery_Location) |

This clinical statement describes an interaction between a patient and clinician. Interactions may include in-person encounters, telephone conversations, and email exchanges.

281: Encounter Activity (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| encounter[templateId/@root = '2.16.840.1.113883.10.20.22.4.49.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [8710](#C_8710) | 2.16.840.1.113883.5.6 (HL7ActClass) = ENC |
| @moodCode | 1..1 | SHALL |  | [8711](#C_8711) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [8712](#C_8712) |  |
| @root | 1..1 | SHALL |  | [26353](#C_26353) | 2.16.840.1.113883.10.20.22.4.49.2 |
| id | 1..\* | SHALL |  | [8713](#C_8713) |  |
| code | 0..1 | SHOULD |  | [8714](#C_8714) | 2.16.840.1.113883.3.88.12.80.32 (EncounterTypeCode) |
| originalText | 0..1 | SHOULD |  | [8719](#C_8719) |  |
| reference | 0..1 | SHOULD |  | [15970](#C_15970) |  |
| @value | 0..1 | SHOULD |  | [15971](#C_15971) |  |
| reference/@value | 0..1 | SHOULD |  | [8720](#C_8720) |  |
| effectiveTime | 1..1 | SHALL |  | [8715](#C_8715) |  |
| performer | 0..\* | MAY |  | [8725](#C_8725) |  |
| assignedEntity | 1..1 | SHALL |  | [8726](#C_8726) |  |
| code | 0..1 | MAY |  | [8727](#C_8727) |  |
| participant | 0..\* | MAY |  | [8738](#C_8738) |  |
| @typeCode | 1..1 | SHALL |  | [8740](#C_8740) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = LOC |
| participantRole | 1..1 | SHALL |  | [14903](#C_14903) |  |
| entryRelationship | 0..\* | MAY |  | [8722](#C_8722) |  |
| @typeCode | 1..1 | SHALL |  | [8723](#C_8723) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| observation | 1..1 | SHALL |  | [14899](#C_14899) |  |
| entryRelationship | 0..\* | MAY |  | [15492](#C_15492) |  |
| act | 1..1 | SHALL |  | [15973](#C_15973) |  |

1. SHALL contain exactly one [1..1] @classCode="ENC" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8710).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8711).
3. SHALL contain exactly one [1..1] templateId (CONF:8712) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.49.2" (CONF:26353).
4. SHALL contain at least one [1..\*] id (CONF:8713).
5. SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet [EncounterTypeCode](#EncounterTypeCode) 2.16.840.1.113883.3.88.12.80.32 DYNAMIC (CONF:8714).
   1. The code, if present, SHOULD contain zero or one [0..1] originalText (CONF:8719).
      1. The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:15970).
         1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15971).
            1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15972).
      2. The originalText, if present, SHOULD contain zero or one [0..1] reference/@value (CONF:8720).
6. SHALL contain exactly one [1..1] effectiveTime (CONF:8715).
7. MAY contain zero or more [0..\*] performer (CONF:8725).
   1. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:8726).
      1. This assignedEntity MAY contain zero or one [0..1] code (CONF:8727).
8. MAY contain zero or more [0..\*] participant (CONF:8738) such that it
   1. SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8740).
   2. SHALL contain exactly one [1..1] [Service Delivery Location](#E_Service_Delivery_Location) (templateId:2.16.840.1.113883.10.20.22.4.32) (CONF:14903).
9. MAY contain zero or more [0..\*] entryRelationship (CONF:8722) such that it
   1. SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8723).
   2. SHALL contain exactly one [1..1] [Indication (V2)](#Indication_V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:14899).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:15492) such that it
    1. SHALL contain exactly one [1..1] [Encounter Diagnosis (V2)](#E_Encounter_Diagnosis_V2) (templateId:2.16.840.1.113883.10.20.22.4.80.2) (CONF:15973).
11. MAY contain zero or one 0..1] sdtc:dischargeDispositionCode, which SHALL be selected from ValueSet 2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status DYNAMIC or, if access to NUBC is unavailable, from CodeSystem 2.16.840.1.113883.12.112 HL7 Discharge Disposition (CONF:9929).

282: EncounterTypeCode

|  |  |  |
| --- | --- | --- |
| Value Set: EncounterTypeCode 2.16.840.1.113883.3.88.12.80.32  HITSP C80 Encounter Type Value Set | | |
| Code | Code System | Print Name |

Figure 123: Encounter Activity Example

<encounter classCode="ENC" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.49.2"/>

<id root="2a620155-9d11-439e-92b3-5d9815ff4de8"/>

<code code="99213" displayName="Office outpatient visit 15 minutes"

codeSystemName="CPT-4" codeSystem="2.16.840.1.113883.6.12">

<originalText>

<reference value="#Encounter1"/>

</originalText>

<translation code="AMB" codeSystem="2.16.840.1.113883.5.4"

displayName="Ambulatory" codeSystemName="HL7 ActEncounterCode"/>

</code>

<effectiveTime value="201209271300+0500"/>

<performer>

<assignedEntity>

. . .

</performer>

<participant typeCode="LOC">

<participantRole classCode="SDLOC">

<templateId root="2.16.840.1.113883.10.20.22.4.32"/>

. . .

</participantRole>

</participant>

<entryRelationship typeCode="RSON">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.19.2"/>

. . .

</encounter>

Encounter Diagnosis (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.80.2 (open)]

283: Encounter Diagnosis (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Encounter Activity (V2)](#E_Encounter_Activity_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Problem Observation (V2)](#E_Problem_Observation_V2) |

This template wraps relevant problems or diagnoses at the close of a visit or that need to be followed after the visit. If the encounter is associated with a Hospital Discharge, the Hospital Discharge Diagnosis must be used. This entry requires at least one Problem Observation entry.

284: Encounter Diagnosis (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.80.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [14889](#C_14889) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [14890](#C_14890) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [14895](#C_14895) |  |
| @root | 1..1 | SHALL |  | [14896](#C_14896) | 2.16.840.1.113883.10.20.22.4.80.2 |
| code | 1..1 | SHALL |  | [19182](#C_19182) |  |
| @code | 1..1 | SHALL |  | [19183](#C_19183) | 2.16.840.1.113883.6.1 (LOINC) = 29308-4 |
| entryRelationship | 1..\* | SHALL |  | [14892](#C_14892) |  |
| @typeCode | 1..1 | SHALL |  | [14893](#C_14893) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| observation | 1..1 | SHALL |  | [14898](#C_14898) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14889).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14890).
3. SHALL contain exactly one [1..1] templateId (CONF:14895) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.80.2" (CONF:14896).
4. SHALL contain exactly one [1..1] code (CONF:19182).
   1. This code SHALL contain exactly one [1..1] @code="29308-4" Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19183).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:14892) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14893).
   2. SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:14898).

Figure 124: Encounter Diagnosis Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.80.2" />

<code code="29308-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName=" DIAGNOSIS" />

<statusCode code="active" />

<effectiveTime>

<low value="20903003" />

</effectiveTime>

<entryRelationship typeCode="SUBJ">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.4.2" />

<!-- Problem Observation -->

...

</observation>

</entryRelationship>

</act>

Estimated Date of Delivery

[observation: templateId 2.16.840.1.113883.10.20.15.3.1 (closed)]

285: Estimated Date of Delivery Contexts

| Contained By: | Contains: |
| --- | --- |
| [Pregnancy Observation](#E_Pregnancy_Observation) (optional) |  |

This clinical statement represents the anticipated date when a woman will give birth.

286: Estimated Date of Delivery Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.15.3.1'] | | | | | |
| @classCode | 1..1 | SHALL |  | [444](#C_444) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [445](#C_445) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| statusCode | 1..1 | SHALL |  | [448](#C_448) |  |
| @code | 1..1 | SHALL |  | [19096](#C_19096) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL | TS | [450](#C_450) |  |
| templateId | 1..1 | SHALL |  | [16762](#C_16762) |  |
| @root | 1..1 | SHALL |  | [16763](#C_16763) | 2.16.840.1.113883.10.20.15.3.1 |
| code | 1..1 | SHALL |  | [19139](#C_19139) |  |
| @code | 1..1 | SHALL |  | [19140](#C_19140) | 2.16.840.1.113883.6.1 (LOINC) = 11778-8 |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:444).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:445).
3. SHALL contain exactly one [1..1] templateId (CONF:16762) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.15.3.1" (CONF:16763).
4. SHALL contain exactly one [1..1] code (CONF:19139).
   1. This code SHALL contain exactly one [1..1] @code="11778-8" Estimated date of delivery (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19140).
5. SHALL contain exactly one [1..1] statusCode (CONF:448).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19096).
6. SHALL contain exactly one [1..1] value with @xsi:type="TS" (CONF:450).

Figure 125: Estimated Date of Delivery Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.15.3.1"/>

<id extension="123456789" root="2.16.840.1.113883.19"/>

<code code="11778-8" codeSystem="2.16.840.1.113883.6.1"

displayName="Estimated date of delivery"/>

<statusCode code="completed"/>

<value xsi:type="TS">20110919</value>

</observation>

Family History Death Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.47 (open)]

287: Family History Death Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [Family History Observation](#E_Family_History_Observation) (optional) |  |

This clinical statement records whether the family member is deceased.

288: Family History Death Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.47'] | | | | | |
| @classCode | 1..1 | SHALL |  | [8621](#C_8621) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [8622](#C_8622) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [8623](#C_8623) |  |
| @root | 1..1 | SHALL |  | [10495](#C_10495) | 2.16.840.1.113883.10.20.22.4.47 |
| statusCode | 1..1 | SHALL |  | [8625](#C_8625) |  |
| @code | 1..1 | SHALL |  | [19097](#C_19097) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL | CD | [8626](#C_8626) |  |
| @code | 1..1 | SHALL |  | [26470](#C_26470) | 2.16.840.1.113883.6.96 (SNOMED CT) = 419099009 |
| code | 1..1 | SHALL |  | [19141](#C_19141) |  |
| @code | 1..1 | SHALL |  | [19142](#C_19142) | 2.16.840.1.113883.5.4 (ActCode) = ASSERTION |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8621).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8622).
3. SHALL contain exactly one [1..1] templateId (CONF:8623) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.47" (CONF:10495).
4. SHALL contain exactly one [1..1] code (CONF:19141).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19142).
5. SHALL contain exactly one [1..1] statusCode (CONF:8625).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19097).
6. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:8626).
   1. This value SHALL contain exactly one [1..1] @code="419099009" Dead (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:26470).

Figure 126: Family History Death Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.47"/>

<id root="6898fae0-5c8a-11db-b0de-0800200c9a66"/>

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<statusCode code="completed"/>

<value xsi:type="CD"

code="419099009"

codeSystem="2.16.840.1.113883.6.96"

displayName="Dead"/>

</observation>

Family History Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.46 (open)]

289: Family History Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [Family History Organizer](#E_Family_History_Organizer) (required) | [Age Observation](#E_Age_Observation)  [Family History Death Observation](#E_Family_History_Death_Observation) |

Family History Observations related to a particular family member are contained within a Family History Organizer. The effectiveTime in the Family History Observation is the biologically or clinically relevant time of the observation. The biologically or clinically relevant time is the time at which the observation holds (is effective) for the family member (the subject of the observation).

290: Family History Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.46'] | | | | | |
| entryRelationship | 0..1 | MAY |  | [8675](#C_8675) |  |
| @typeCode | 1..1 | SHALL |  | [8676](#C_8676) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [8677](#C_8677) | true |
| observation | 1..1 | SHALL |  | [15526](#C_15526) |  |
| entryRelationship | 0..1 | MAY |  | [8678](#C_8678) |  |
| @typeCode | 1..1 | SHALL |  | [8679](#C_8679) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = CAUS |
| observation | 1..1 | SHALL |  | [15527](#C_15527) |  |
| @classCode | 1..1 | SHALL |  | [8586](#C_8586) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [8587](#C_8587) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| code | 1..1 | SHALL |  | [8589](#C_8589) | 2.16.840.1.113883.3.88.12.3221.7.2 (Problem Type) |
| statusCode | 1..1 | SHALL |  | [8590](#C_8590) |  |
| @code | 1..1 | SHALL |  | [19098](#C_19098) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL | CD | [8591](#C_8591) | 2.16.840.1.113883.3.88.12.3221.7.4 (Problem Value Set) |
| id | 1..\* | SHALL |  | [8592](#C_8592) |  |
| effectiveTime | 0..1 | SHOULD |  | [8593](#C_8593) |  |
| templateId | 1..1 | SHALL |  | [8599](#C_8599) |  |
| @root | 1..1 | SHALL |  | [10496](#C_10496) | 2.16.840.1.113883.10.20.22.4.46 |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8586).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8587).
3. SHALL contain exactly one [1..1] templateId (CONF:8599) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.46" (CONF:10496).
4. SHALL contain at least one [1..\*] id (CONF:8592).
5. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet [Problem Type](#Problem_Type) 2.16.840.1.113883.3.88.12.3221.7.2 STATIC 2012-06-01 (CONF:8589).
6. SHALL contain exactly one [1..1] statusCode (CONF:8590).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19098).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:8593).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [Problem Value Set](#Problem_Value_Set) 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:8591).
9. MAY contain zero or one [0..1] entryRelationship (CONF:8675) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Subject (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8676).
   2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:8677).
   3. SHALL contain exactly one [1..1] [Age Observation](#E_Age_Observation) (templateId:2.16.840.1.113883.10.20.22.4.31) (CONF:15526).
10. MAY contain zero or one [0..1] entryRelationship (CONF:8678) such that it
    1. SHALL contain exactly one [1..1] @typeCode="CAUS" Causal or Contributory (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8679).
    2. SHALL contain exactly one [1..1] [Family History Death Observation](#E_Family_History_Death_Observation) (templateId:2.16.840.1.113883.10.20.22.4.47) (CONF:15527).

291: Problem Type

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Type 2.16.840.1.113883.3.88.12.3221.7.2 | | |
| Code | Code System | Print Name |
| 404684003 | SNOMED CT | Finding |
| 409586006 | SNOMED CT | Complaint |
| 282291009 | SNOMED CT | Diagnosis |
| 64572001 | SNOMED CT | Condition |
| 248536006 | SNOMED CT | Finding of functional performance and activity |
| 418799008 | SNOMED CT | Symptom |
| 55607006 | SNOMED CT | Problem |
| 373930000 | SNOMED CT | Cognitive function finding |

292: Problem Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 | | |
| Code | Code System | Print Name |
| 50992006 | SNOMED CT | 22q partial trisomy syndrome (disorder) |
| 237931009 | SNOMED CT | 2-Ketoadipic acidemia (disorder) |
| 54470008 | SNOMED CT | 3 beta-Hydroxysteroid dehydrogenase deficiency (disorder) |
| 237950009 | SNOMED CT | 3-Methylglutaconic aciduria (disorder) |
| 296646009 | SNOMED CT | 4-quinolones overdose (disorder) |
| 41797007 | SNOMED CT | 5 10-Methylenetetrahydrofolate reductase deficiency (disorder) |
| 413380004 | SNOMED CT | A pattern strabismus (disorder) |
| 425879009 | SNOMED CT | AA amyloid nephropathy (disorder) |
| 274945004 | SNOMED CT | AA amyloidosis (disorder) |
| 75100008 | SNOMED CT | Abdominal abscess (disorder) |
| ... | | |

Figure 127: Family History Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.46"/>

<!-- Family History Observation template -->

<id root="d42ebf70-5c89-11db-b0de-0800200c9a66"/>

<code code="64572001"

displayName="Condition"

codeSystemName="SNOMED CT"

codeSystem="2.16.840.1.113883.6.96"/>

<statusCode code="completed"/>

<effectiveTime value="1967"/>

<value xsi:type="CD" code="22298006"

codeSystem="2.16.840.1.113883.6.96"

displayName="Myocardial infarction"/>

<entryRelationship typeCode="CAUS">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.47"/>

...

</observation>

</entryRelationship>

<entryRelationship typeCode="SUBJ" inversionInd="true">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.31"/>

<code code="445518008" codeSystem="2.16.840.1.113883.6.96"/>

....

</entryRelationship>

</observation>

Family History Organizer

[organizer: templateId 2.16.840.1.113883.10.20.22.4.45 (open)]

293: Family History Organizer Contexts

| Contained By: | Contains: |
| --- | --- |
| [Family History Section](#S_Family_History_Section) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Family History Observation](#E_Family_History_Observation) |

The Family History Organizer associates a set of observations with a family member. For example, the Family History Organizer can group a set of observations about the patient’s father.

294: Family History Organizer Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| organizer[templateId/@root = '2.16.840.1.113883.10.20.22.4.45'] | | | | | |
| component | 1..\* | SHALL |  | [8607](#C_8607) |  |
| observation | 1..1 | SHALL |  | [16888](#C_16888) |  |
| @classCode | 1..1 | SHALL |  | [8600](#C_8600) | 2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER |
| @moodCode | 1..1 | SHALL |  | [8601](#C_8601) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| statusCode | 1..1 | SHALL |  | [8602](#C_8602) |  |
| @code | 1..1 | SHALL |  | [19099](#C_19099) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| templateId | 1..1 | SHALL |  | [8604](#C_8604) |  |
| @root | 1..1 | SHALL |  | [10497](#C_10497) | 2.16.840.1.113883.10.20.22.4.45 |
| subject | 1..1 | SHALL |  | [8609](#C_8609) |  |
| relatedSubject | 1..1 | SHALL |  | [15244](#C_15244) |  |
| @classCode | 1..1 | SHALL |  | [15245](#C_15245) | 2.16.840.1.113883.5.41 (EntityClass) = PRS |
| code | 1..1 | SHALL |  | [15246](#C_15246) |  |
| @code | 1..1 | SHALL |  | [15247](#C_15247) | 2.16.840.1.113883.1.11.19579 (Family Member Value Set) |
| subject | 0..1 | SHOULD |  | [15248](#C_15248) |  |
| administrativeGenderCode | 1..1 | SHALL |  | [15974](#C_15974) |  |
| @code | 1..1 | SHALL |  | [15975](#C_15975) | 2.16.840.1.113883.1.11.1 (Administrative Gender (HL7 V3)) |
| birthTime | 0..1 | SHOULD |  | [15976](#C_15976) |  |

1. SHALL contain exactly one [1..1] @classCode="CLUSTER" Cluster (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8600).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8601).
3. SHALL contain exactly one [1..1] templateId (CONF:8604) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.45" (CONF:10497).
4. SHALL contain exactly one [1..1] statusCode (CONF:8602).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19099).
5. SHALL contain exactly one [1..1] subject (CONF:8609).
   1. This subject SHALL contain exactly one [1..1] relatedSubject (CONF:15244).
      1. This relatedSubject SHALL contain exactly one [1..1] @classCode="PRS" Person (CodeSystem: EntityClass 2.16.840.1.113883.5.41 STATIC) (CONF:15245).
      2. This relatedSubject SHALL contain exactly one [1..1] code (CONF:15246).
         1. This code SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet [Family Member Value Set](#Family_Member_Value_Set) 2.16.840.1.113883.1.11.19579 DYNAMIC (CONF:15247).
      3. This relatedSubject SHOULD contain zero or one [0..1] subject (CONF:15248).
         1. The subject, if present, SHALL contain exactly one [1..1] administrativeGenderCode (CONF:15974).
            1. This administrativeGenderCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [Administrative Gender (HL7 V3)](#Administrative_Gender_HL7_V3) 2.16.840.1.113883.1.11.1 STATIC (CONF:15975).
         2. The subject, if present, SHOULD contain zero or one [0..1] birthTime (CONF:15976).
         3. The subject SHOULD contain zero or more 0..**] sdtc:id. The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the id element** (CONF:15249).
         4. The subject MAY contain zero or one sdtc:deceasedInd. The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the deceasedInd element (CONF:15981).
         5. The subject MAY contain zero or one sdtc:deceasedTime. The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the deceasedTime element (CONF:15982).
         6. The age of a relative at the time of a family history observation SHOULD be inferred by comparing RelatedSubject/subject/birthTime with Observation/effectiveTime (CONF:15983).
6. SHALL contain at least one [1..\*] component (CONF:8607).
   1. Such components SHALL contain exactly one [1..1] [Family History Observation](#E_Family_History_Observation) (templateId:2.16.840.1.113883.10.20.22.4.46) (CONF:16888).

295: Family Member Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Family Member Value Set 2.16.840.1.113883.1.11.19579  Family Relationships record the familial relationship of a person to another person. This value set is to be used when it is necessary to record family relationships (e.g., next of kin, or blood relations). This is a subset of the value set used for personal relationships | | |
| Code | Code System | Print Name |
| ADOPT | RoleCode | adopted child |
| AUNT | RoleCode | aunt |
| CHILD | RoleCode | Child |
| CHLDINLAW | RoleCode | child in-law |
| COUSN | RoleCode | cousin |
| DOMPART | RoleCode | domestic partner |
| FAMMEMB | RoleCode | Family Member |
| CHLDFOST | RoleCode | foster child |
| GRNDCHILD | RoleCode | grandchild |
| GRPRN | RoleCode | Grandparent |
| ... | | |

296: Administrative Gender (HL7 V3)

|  |  |  |
| --- | --- | --- |
| Value Set: Administrative Gender (HL7 V3) 2.16.840.1.113883.1.11.1  Administrative Gender based upon HL7 V3 vocabulary. This value set contains only male, female and undifferentiated concepts. | | |
| Code | Code System | Print Name |
| F | AdministrativeGender | Female |
| M | AdministrativeGender | Male |
| UN | AdministrativeGender | Undifferentiated |

Figure 128: Family History Organizer Example

<organizer moodCode="EVN" classCode="CLUSTER">

<templateId root="2.16.840.1.113883.10.20.22.4.45"/>

<statusCode code="completed"/>

<subject>

<relatedSubject classCode="PRS">

<code code="FTH" displayName="Father" codeSystemName="HL7 FamilyMember"

codeSystem="2.16.840.1.113883.5.111">

<translation code="9947008" displayName="Natural father"

codeSystemName="SNOMED" codeSystem="2.16.840.1.113883.6.96"/>

</code>

<subject>

<sdtc:id root="2.16.840.1.113883.19.5.99999.2" extension="99999999"/>

<id xmlns="urn:hl7-org:sdtc" root="2.16.840.1.113883.19.5.99999.2" extension="1234"/>

<administrativeGenderCode code="M"/>

<birthTime value="1910"/>

<!-- Example use of sdtc extensions :-->

<!-- <sdtc:deceasedInd value="true"/><sdtc:deceasedTime value="1967"/> -->

</subject>

</relatedSubject>

</subject>

<component>

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.46"/>

. . .

</observation>

</component>

</organizer>

Functional Status Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.67.2 (open)]

297: Functional Status Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (optional)  [Functional Status Organizer (V2)](#E_Functional_Status_Organizer_V2) (required) | [Assessment Scale Observation](#E_Assessment_Scale_Observation)  [Author Participation (NEW)](#U_Author_Participation_NEW)  [Caregiver Characteristics](#E_Caregiver_Characteristics)  [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2) |

This template represents the patient's physical function (e.g. mobility status, activities of daily living, self-care status) and problems that limit function (dyspnea, dysphagia). The template may include assessment scale observations, identify supporting caregivers and provide information about non-medicinal supplies. This template is used to represent physical or developmental function of all patient populations and is not limited to the long-term care population.

298: Functional Status Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.67.2'] | | | | | |
| entryRelationship | 0..1 | MAY |  | [14465](#C_14465) |  |
| @typeCode | 1..1 | SHALL |  | [14598](#C_14598) | COMP |
| observation | 1..1 | SHALL |  | [14466](#C_14466) |  |
| entryRelationship | 0..1 | MAY |  | [13895](#C_13895) |  |
| @typeCode | 1..1 | SHALL |  | [14597](#C_14597) | REFR |
| observation | 1..1 | SHALL |  | [13897](#C_13897) |  |
| @classCode | 1..1 | SHALL |  | [13905](#C_13905) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [13906](#C_13906) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [13889](#C_13889) |  |
| @root | 1..1 | SHALL |  | [13890](#C_13890) | 2.16.840.1.113883.10.20.22.4.67.2 |
| id | 1..\* | SHALL |  | [13907](#C_13907) |  |
| code | 1..1 | SHALL |  | [13908](#C_13908) |  |
| @code | 1..1 | SHALL |  | [31522](#C_31522) | 364644000 |
| @codeSystem | 1..1 | SHALL |  | [31523](#C_31523) | 2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96 |
| text | 0..1 | SHOULD |  | [13926](#C_13926) |  |
| statusCode | 1..1 | SHALL |  | [13929](#C_13929) |  |
| @code | 1..1 | SHALL |  | [19101](#C_19101) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [13930](#C_13930) |  |
| value | 1..1 | SHALL |  | [13932](#C_13932) |  |
| author | 0..\* | SHOULD |  | [13936](#C_13936) |  |
| entryRelationship | 0..1 | MAY |  | [13892](#C_13892) |  |
| @typeCode | 1..1 | SHALL |  | [14596](#C_14596) | REFR |
| supply | 1..1 | SHALL |  | [14218](#C_14218) |  |
| referenceRange | 0..\* | MAY |  | [13937](#C_13937) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:13905).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:13906).
3. SHALL contain exactly one [1..1] templateId (CONF:13889) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.67.2" (CONF:13890).
4. SHALL contain at least one [1..\*] id (CONF:13907).
5. SHALL contain exactly one [1..1] code (CONF:13908).
   1. This code SHALL contain exactly one [1..1] @code="364644000" functional observable (CONF:31522).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:31523).
6. SHOULD contain zero or one [0..1] text (CONF:13926).
7. SHALL contain exactly one [1..1] statusCode (CONF:13929).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19101).
8. SHALL contain exactly one [1..1] effectiveTime (CONF:13930).
9. SHALL contain exactly one [1..1] value (CONF:13932).
   1. If xsi:type=“CD”, SHOULD contain a code from SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:14234).
10. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:13936).
11. MAY contain zero or one [0..1] entryRelationship (CONF:13892) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CONF:14596).
    2. SHALL contain exactly one [1..1] [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.50.2) (CONF:14218).
12. MAY contain zero or one [0..1] entryRelationship (CONF:13895) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CONF:14597).
    2. SHALL contain exactly one [1..1] [Caregiver Characteristics](#E_Caregiver_Characteristics) (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:13897).
13. MAY contain zero or one [0..1] entryRelationship (CONF:14465) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" has component (CONF:14598).
    2. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:14466).

referenceRange could be used to represent normal or expected capability for the function being evaluated.

1. MAY contain zero or more [0..\*] referenceRange (CONF:13937).

Figure 129: Functional Status Observation Example

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Functional Status Observation V2-->

<templateId root="2.16.840.1.113883.10.20.22.4.67.2"/>

<id root="ce7cfb78-bd16-467e-8bcf-859a3034108e"/>

<code code="364644000" displayName="functional observable"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"/>

<text>

<reference value="#FUNC1"/>

</text>

<statusCode code="completed"/>

<effectiveTime value="200130311"/>

<value xsi:type="CD" code="129035000"

displayName="independent with dressing"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"/>

</entry>

Functional Status Organizer (V2)

[organizer: templateId 2.16.840.1.113883.10.20.22.4.66.2 (open)]

299: Functional Status Organizer (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (optional) | [Author Participation (NEW)](#U_Author_Participation_NEW)  [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2)  [Self-Care Activities (ADL and IADL) (NEW)](#E_SelfCare_Activities_ADL_and_IADL_NEW) |

This template groups related functional status observations into categories (e.g ambulation, self-care).

300: Functional Status Organizer (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| organizer[templateId/@root = '2.16.840.1.113883.10.20.22.4.66.2'] | | | | | |
| component | 1..\* | SHALL |  | [14359](#C_14359) |  |
| observation | 1..1 | SHALL |  | [14368](#C_14368) |  |
| @classCode | 1..1 | SHALL |  | [14355](#C_14355) | 2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER |
| @moodCode | 1..1 | SHALL |  | [14357](#C_14357) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [14361](#C_14361) |  |
| @root | 1..1 | SHALL |  | [14362](#C_14362) | 2.16.840.1.113883.10.20.22.4.66.2 |
| id | 1..\* | SHALL |  | [14363](#C_14363) |  |
| code | 1..1 | SHALL |  | [14364](#C_14364) |  |
| statusCode | 1..1 | SHALL |  | [14358](#C_14358) |  |
| @code | 1..1 | SHALL |  | [31434](#C_31434) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| component | 1..\* | SHALL |  | [31432](#C_31432) |  |
| observation | 1..1 | SHALL |  | [31433](#C_31433) |  |
| author | 0..\* | SHOULD |  | [31585](#C_31585) |  |

1. SHALL contain exactly one [1..1] @classCode="CLUSTER", which SHALL be selected from CodeSystem HL7ActClass (2.16.840.1.113883.5.6) STATIC (CONF:14355).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14357).
3. SHALL contain exactly one [1..1] templateId (CONF:14361) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.66.2" (CONF:14362).
4. SHALL contain at least one [1..\*] id (CONF:14363).

The code selected should indicate the category that groups the contained functional status evaluation observations (e.g. mobility, self-care, communication).

1. SHALL contain exactly one [1..1] code (CONF:14364).
   1. SHOULD be selected from ICF (codeSystem 2.16.840.1.113883.6.254) or SNOMED CT (codeSystem 2.16.840.1.113883.6.96) (CONF:31417).
2. SHALL contain exactly one [1..1] statusCode (CONF:14358).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31434).
3. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31585).
4. SHALL contain at least one [1..\*] component (CONF:14359) such that it
   1. SHALL contain exactly one [1..1] [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.67.2) (CONF:14368).
5. SHALL contain at least one [1..\*] component (CONF:31432) such that it
   1. SHALL contain exactly one [1..1] [Self-Care Activities (ADL and IADL) (NEW)](#E_SelfCare_Activities_ADL_and_IADL_NEW) (templateId:2.16.840.1.113883.10.20.22.4.128) (CONF:31433).

Figure 130: Functional Status Organizer Example

<organizer classCode="CLUSTER" moodCode="EVN">

<!-- Functional Status Organizer V2-->

<templateId root="2.16.840.1.113883.10.20.22.4.66.2"/>

<id root="a7bc1062-8649-42a0-833d-eed65bd017c9"/>

<code code="d5" displayName="Self-Care"

codeSystem="2.16.840.1.113883.6.254" codeSystemName="ICF"/>

<statusCode code="completed"/>

<author>

<time value="200130311"/>

<assignedAuthor>

<id extension="KP00017" root="2.16.840.1.113883.19.5"/>

<addr>

<streetAddressLine>1003 Health Care

Drive</streetAddressLine>

<city>Ann Arbor</city>

<state>MI</state>

<postalCode>02368</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:(555)555-1003"/>

<assignedPerson>

<name>

<given>Assigned</given>

<family>Amanda</family>

</name>

</assignedPerson>

</assignedAuthor>

</author>

<component>

<observation classCode="OBS" moodCode="EVN">

<!-- Functional Status Observation V2-->

<templateId root="2.16.840.1.113883.10.20.22.4.67.2"/>

...

</component>

<component>

<observation classCode="OBS" moodCode="EVN">

<!-- Functional Status Observation V2-->

<templateId root="2.16.840.1.113883.10.20.22.4.67.2"/>

...

</component>

<component>

<observation classCode="OBS" moodCode="EVN">

<!-- Self-Care Activities (ADL and IADL)-->

<templateId root="2.16.840.1.113883.10.20.22.4.128"/>

...

</component>

</organizer>

Functional Status Problem Observation (DEPRECATED)

[observation: templateId 2.16.840.1.113883.10.20.22.4.68.2 (open)]

301: Functional Status Problem Observation (DEPRECATED) Contexts

| Contained By: | Contains: |
| --- | --- |

USE OF FUNCTIONAL STATUS PROBLEM OBSERVATION IS NOT RECOMMENDED. FUNCTIONAL STATUS PROBLEM OBSERVATION AND FUNCTIONAL STATUS RESULT OBSERVATION HAVE BEEN MERGED TOGETHER WITHOUT LOSS OF EXPRESSIVITY INTO FUNCTIONAL STATUS OBSERVATION (TEMPLATE ID: 2.16.840.1.113883.10.20.22.4.67.2)

302: Functional Status Problem Observation (DEPRECATED) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.68.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [14282](#C_14282) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14283](#C_14283) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| @negationInd | 0..1 | MAY |  | [14307](#C_14307) |  |
| templateId | 1..1 | SHALL |  | [14312](#C_14312) |  |
| @root | 1..1 | SHALL |  | [14313](#C_14313) | 2.16.840.1.113883.10.20.22.4.68 |
| id | 1..\* | SHALL |  | [14284](#C_14284) |  |
| code | 1..1 | SHALL |  | [14314](#C_14314) |  |
| @code | 0..1 | SHOULD |  | [14315](#C_14315) | 2.16.840.1.113883.6.96 (SNOMED CT) = 248536006 |
| text | 0..1 | SHOULD |  | [14304](#C_14304) |  |
| reference | 0..1 | SHOULD |  | [15552](#C_15552) |  |
| @value | 0..1 | SHOULD |  | [15553](#C_15553) |  |
| statusCode | 1..1 | SHALL |  | [14286](#C_14286) |  |
| @code | 1..1 | SHALL |  | [19100](#C_19100) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 0..1 | SHOULD |  | [14287](#C_14287) |  |
| low | 1..1 | SHALL |  | [26456](#C_26456) |  |
| high | 0..1 | MAY |  | [26457](#C_26457) |  |
| value | 1..1 | SHALL | CD | [14291](#C_14291) | 2.16.840.1.113883.3.88.12.3221.7.4 (Problem Value Set) |
| @nullFlavor | 0..1 | MAY |  | [14292](#C_14292) |  |
| methodCode | 0..1 | MAY |  | [14316](#C_14316) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14282).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14283).

Use negationInd="true" to indicate that the problem was not observed.

1. MAY contain zero or one [0..1] @negationInd (CONF:14307).
2. SHALL contain exactly one [1..1] templateId (CONF:14312) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.68" (CONF:14313).
3. SHALL contain at least one [1..\*] id (CONF:14284).
4. SHALL contain exactly one [1..1] code (CONF:14314).
   1. This code SHOULD contain zero or one [0..1] @code="248536006" finding of functional performance and activity (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:14315).
5. SHOULD contain zero or one [0..1] text (CONF:14304).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15552).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15553).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15554).
6. SHALL contain exactly one [1..1] statusCode (CONF:14286).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19100).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:14287).

The value of effectiveTime/low represents onset date.

* 1. The effectiveTime, if present, SHALL contain exactly one [1..1] low (CONF:26456).

If the problem is resolved, record the resolution date in effectiveTime/high. If the problem is known to be resolved but the resolution date is not known, use @nullFlavor="UNK". If the problem is not resolved, do not include the high element.

* 1. The effectiveTime, if present, MAY contain zero or one [0..1] high (CONF:26457).

1. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [Problem Value Set](#Problem_Value_Set) 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:14291).
   1. This value MAY contain zero or one [0..1] @nullFlavor (CONF:14292).
      1. If the diagnosis is unknown or the SNOMED code is unknown, @nullFlavor SHOULD be “UNK”.  If the code is something other than SNOMED, @nullFlavor SHOULD be “OTH” and the other code SHOULD be placed in the translation element (CONF:14293).
2. MAY contain zero or one [0..1] methodCode (CONF:14316).

303: Problem Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 | | |
| Code | Code System | Print Name |
| 50992006 | SNOMED CT | 22q partial trisomy syndrome (disorder) |
| 237931009 | SNOMED CT | 2-Ketoadipic acidemia (disorder) |
| 54470008 | SNOMED CT | 3 beta-Hydroxysteroid dehydrogenase deficiency (disorder) |
| 237950009 | SNOMED CT | 3-Methylglutaconic aciduria (disorder) |
| 296646009 | SNOMED CT | 4-quinolones overdose (disorder) |
| 41797007 | SNOMED CT | 5 10-Methylenetetrahydrofolate reductase deficiency (disorder) |
| 413380004 | SNOMED CT | A pattern strabismus (disorder) |
| 425879009 | SNOMED CT | AA amyloid nephropathy (disorder) |
| 274945004 | SNOMED CT | AA amyloidosis (disorder) |
| 75100008 | SNOMED CT | Abdominal abscess (disorder) |
| ... | | |

Handoff Communication (NEW)

[act: templateId 2.16.840.1.113883.10.20.22.4.141 (open)]

304: Handoff Communication (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (optional) | [Author Participation (NEW)](#U_Author_Participation_NEW) |

This template represents provider hand-off communication. The 'hand-off' process involves senders, those transmitting the patient's information and releasing the care of that patient to the next clinician, and receivers, those who accept the patient information and care of that patient.

305: Handoff Communication (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.141'] | | | | | |
| @classCode | 1..1 | SHALL |  | [30832](#C_30832) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [30833](#C_30833) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [30834](#C_30834) |  |
| @root | 1..1 | SHALL |  | [30835](#C_30835) | 2.16.840.1.113883.10.20.22.4.141 |
| code | 1..1 | SHALL |  | [30836](#C_30836) |  |
| @code | 1..1 | SHALL |  | [30837](#C_30837) | 432138007 |
| @codeSystem | 1..1 | SHALL |  | [30838](#C_30838) | 2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96 |
| statusCode | 1..1 | SHALL |  | [31668](#C_31668) |  |
| @code | 1..1 | SHALL |  | [31669](#C_31669) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [31670](#C_31670) |  |
| author | 1..\* | SHALL |  | [31672](#C_31672) |  |
| participant | 1..\* | SHALL |  | [31673](#C_31673) |  |
| @typeCode | 1..1 | SHALL |  | [31674](#C_31674) | 2.16.840.1.113883.5.110 (RoleClass) = IRCP |
| participantRole | 1..1 | SHALL |  | [31675](#C_31675) |  |
| code | 0..1 | SHOULD |  | [31676](#C_31676) | 2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA)) |

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:30832).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:30833).
3. SHALL contain exactly one [1..1] templateId (CONF:30834) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.141" (CONF:30835).
4. SHALL contain exactly one [1..1] code (CONF:30836).
   1. This code SHALL contain exactly one [1..1] @code="432138007" handoff communication (procedure) (CONF:30837).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:30838).
5. SHALL contain exactly one [1..1] statusCode (CONF:31668).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31669).
6. SHALL contain exactly one [1..1] effectiveTime (CONF:31670).
7. SHALL contain at least one [1..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31672).
8. SHALL contain at least one [1..\*] participant (CONF:31673) such that it
   1. SHALL contain exactly one [1..1] @typeCode="IRCP" Information Recipient (CodeSystem: RoleClass 2.16.840.1.113883.5.110) (CONF:31674).
   2. SHALL contain exactly one [1..1] participantRole (CONF:31675).
      1. This participantRole SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet [Healthcare Provider Taxonomy (HIPAA)](#Healthcare_Provider_Taxonomy_HIPAA) 2.16.840.1.114222.4.11.1066 (CONF:31676).

306: Healthcare Provider Taxonomy (HIPAA)

|  |  |  |
| --- | --- | --- |
| Value Set: Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066  The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct Levels including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category. Providers may have one or more than one value associated to them. When determining what value or valuess to associate with a provider, the user needs to review the requirements of the trading partner with which the value(s) are being used. | | |
| Code | Code System | Print Name |
| 171100000X | Healthcare Provider Taxonomy (HIPAA) | Acupuncturist |
| 363LA2100X | Healthcare Provider Taxonomy (HIPAA) | Acute Care |
| 364SA2100X | Healthcare Provider Taxonomy (HIPAA) | Acute Care |
| 101YA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 103TA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 163WA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 207LA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 207QA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 207RA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 2084A0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| ... | | |

Figure 131: Handoff Communication Example

<entry>

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.141"/>

<code code="432138007" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"

displayName="handoff communication (procedure)"/>

<statusCode code="completed"/>

<effectiveTime value="20130712"/>

<author typeCode="AUT">

<templateId root="2.16.840.1.113883.10.20.22.4.119"/>

<time value="20130730" />

<assignedAuthor>

<id root="d839038b-7171-4165-a760-467925b43857" />

...

</author>

<participant typeCode="IRCP">

<participantRole>

<code code="163W00000X" codeSystem="2.16.840.1.113883.6.101"

codeSystemName="NUCC Health Care Provider Taxonomy"

displayName="Registered Nurse"/>

...

</participantRole>

</participant>

</act>

</entry>

Health Concern Act (NEW)

[act: templateId 2.16.840.1.113883.10.20.22.4.132 (open)]

307: Health Concern Act (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concerns Section (NEW)](#S_Health_Concerns_Section_NEW) (required)  [Goal Observation (NEW)](#E_Goal_Observation_NEW) (optional) | [Act Reference (NEW)](#E_Act_Reference_NEW)  [Allergy - Intolerance Observation (V2)](#E_Allergy__Intolerance_Observation_V2)  [Assessment Scale Observation](#E_Assessment_Scale_Observation)  [Author Participation (NEW)](#U_Author_Participation_NEW)  [Caregiver Characteristics](#E_Caregiver_Characteristics)  [Characteristics of Home Environment (NEW)](#E_Characteristics_of_Home_Environment_N)  [Cognitive Abilities Observation (NEW)](#E_Cognitive_Abilities_Observation_NEW)  [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2)  [Cultural and Religious Observation (NEW)](#E_Cultural_and_Religious_Observation_NE)  [Current Smoking Status (V2)](#E_Current_Smoking_Status_V2)  [Encounter Diagnosis (V2)](#E_Encounter_Diagnosis_V2)  [Family History Organizer](#E_Family_History_Organizer)  [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2)  [Highest Pressure Ulcer Stage](#E_Highest_Pressure_Ulcer_Stage)  [Hospital Admission Diagnosis (V2)](#E_Hospital_Admission_Diagnosis_V2)  [Mental Status Observation (NEW)](#E_Mental_Status_Observation_NEW)  [Number of Pressure Ulcers Observation](#E_Number_of_Pressure_Ulcers_Observation)  [Nutrition Assessment (NEW)](#E_Nutrition_Assessment_NEW)  [Nutritional Status Observation (NEW)](#E_Nutritional_Status_Observation_NEW)  [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW)  [Postprocedure Diagnosis (V2)](#E_Postprocedure_Diagnosis_V2)  [Pregnancy Observation](#E_Pregnancy_Observation)  [Preoperative Diagnosis (V2)](#E_Preoperative_Diagnosis_V2)  [Problem Concern Act (Condition) (V2)](#E_Problem_Concern_Act_Condition_V2)  [Problem Observation (V2)](#E_Problem_Observation_V2)  [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW)  [Reaction Observation (V2)](#Reaction_Observation_V2)  [Result Observation (V2)](#E_Result_Observation_V2)  [Result Organizer (V2)](#Result_Organizer_V2)  [Self-Care Activities (ADL and IADL) (NEW)](#E_SelfCare_Activities_ADL_and_IADL_NEW)  [Sensory and Speech Status (NEW)](#E_Sensory_and_Speech_Status_NEW)  [Social History Observation (V2)](#E_Social_History_Observation_V2)  [Substance or Device Allergy - Intolerance Observation (V2)](#E_Substance_or_Device_Allergy__V2)  [Tobacco Use (V2)](#Tobacco_Use_V2)  [Vital Sign Observation (V2)](#E_Vital_Sign_Observation_V2)  [Wound Observation (NEW)](#E_Wound_Observation_NEW) |

This template represents a health concern.

It is a wrapper for health concerns derived from a variety of sources within an EHR (such as Problem List, Family History, Social History, Social Worker Note, etc.).

A Health Concern Act can represent a health concern that a patient currently has. Health concerns require intervention(s) to increase the likelihood of achieving the patient’s or providers’ goals of care.

A Health Concern Act can also represent a health concern that is a risk. A risk is a clinical or socioeconomic condition that the patient doesn't currently have, but the risk for developing that condition rises to the level of concern such that an intervention and/or monitoring are needed.

The code on the Health Concern Act is set to differentiate between the two types of health concerns.

308: Health Concern Act (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.132'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [31549](#C_31549) |  |
| @typeCode | 1..1 | SHALL |  | [31550](#C_31550) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [31551](#C_31551) |  |
| entryRelationship | 0..\* | MAY |  | [31190](#C_31190) |  |
| @typeCode | 1..1 | SHALL |  | [31191](#C_31191) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31192](#C_31192) |  |
| entryRelationship | 0..\* | MAY |  | [31368](#C_31368) |  |
| @typeCode | 1..1 | SHALL |  | [31369](#C_31369) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31370](#C_31370) |  |
| entryRelationship | 0..\* | MAY |  | [31374](#C_31374) |  |
| @typeCode | 1..1 | SHALL |  | [31375](#C_31375) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31376](#C_31376) |  |
| entryRelationship | 0..\* | MAY |  | [31193](#C_31193) |  |
| @typeCode | 1..1 | SHALL |  | [31194](#C_31194) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31195](#C_31195) |  |
| entryRelationship | 0..\* | MAY |  | [31234](#C_31234) |  |
| @typeCode | 1..1 | SHALL |  | [31268](#C_31268) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31273](#C_31273) |  |
| entryRelationship | 0..\* | MAY |  | [31233](#C_31233) |  |
| @typeCode | 1..1 | SHALL |  | [31267](#C_31267) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31271](#C_31271) |  |
| entryRelationship | 0..\* | MAY |  | [31371](#C_31371) |  |
| @typeCode | 1..1 | SHALL |  | [31372](#C_31372) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31373](#C_31373) |  |
| entryRelationship | 0..\* | MAY |  | [31236](#C_31236) |  |
| @typeCode | 1..1 | SHALL |  | [31270](#C_31270) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [31277](#C_31277) |  |
| entryRelationship | 0..\* | MAY |  | [31237](#C_31237) |  |
| @typeCode | 1..1 | SHALL |  | [31279](#C_31279) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| organizer | 1..1 | SHALL |  | [31280](#C_31280) |  |
| entryRelationship | 0..\* | MAY |  | [31238](#C_31238) |  |
| @typeCode | 1..1 | SHALL |  | [31282](#C_31282) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31283](#C_31283) |  |
| entryRelationship | 0..\* | MAY |  | [31239](#C_31239) |  |
| @typeCode | 1..1 | SHALL |  | [31285](#C_31285) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31286](#C_31286) |  |
| @classCode | 1..1 | SHALL |  | [30750](#C_30750) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [30751](#C_30751) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [30752](#C_30752) |  |
| @root | 1..1 | SHALL |  | [30753](#C_30753) | 2.16.840.1.113883.10.20.22.4.132 |
| id | 1..1 | SHALL |  | [30754](#C_30754) |  |
| code | 1..1 | SHALL |  | [30755](#C_30755) | 2.16.840.1.113883.11.20.9.53 (Health Concern Type) |
| statusCode | 1..1 | SHALL |  | [30758](#C_30758) |  |
| effectiveTime | 0..1 | MAY |  | [30759](#C_30759) |  |
| entryRelationship | 0..\* | MAY |  | [30761](#C_30761) |  |
| @typeCode | 1..1 | SHALL |  | [30762](#C_30762) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31001](#C_31001) |  |
| entryRelationship | 0..\* | MAY |  | [31007](#C_31007) |  |
| @typeCode | 1..1 | SHALL |  | [31008](#C_31008) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31186](#C_31186) |  |
| entryRelationship | 0..\* | MAY |  | [31157](#C_31157) |  |
| @typeCode | 1..1 | SHALL |  | [31158](#C_31158) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| entryRelationship | 0..\* | MAY |  | [31160](#C_31160) |  |
| @typeCode | 1..1 | SHALL |  | [31161](#C_31161) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| entryRelationship | 0..\* | MAY |  | [31232](#C_31232) |  |
| @typeCode | 1..1 | SHALL |  | [31264](#C_31264) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31265](#C_31265) |  |
| entryRelationship | 0..\* | MAY |  | [31235](#C_31235) |  |
| @typeCode | 1..1 | SHALL |  | [31269](#C_31269) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31275](#C_31275) |  |
| entryRelationship | 0..\* | MAY |  | [31240](#C_31240) |  |
| @typeCode | 1..1 | SHALL |  | [31288](#C_31288) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31289](#C_31289) |  |
| entryRelationship | 0..\* | MAY |  | [31241](#C_31241) |  |
| @typeCode | 1..1 | SHALL |  | [31291](#C_31291) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [31292](#C_31292) |  |
| entryRelationship | 0..\* | MAY |  | [31242](#C_31242) |  |
| @typeCode | 1..1 | SHALL |  | [31294](#C_31294) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31295](#C_31295) |  |
| entryRelationship | 0..\* | MAY |  | [31243](#C_31243) |  |
| @typeCode | 1..1 | SHALL |  | [31297](#C_31297) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31298](#C_31298) |  |
| entryRelationship | 0..\* | MAY |  | [31244](#C_31244) |  |
| @typeCode | 1..1 | SHALL |  | [31300](#C_31300) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31301](#C_31301) |  |
| entryRelationship | 0..\* | MAY |  | [31245](#C_31245) |  |
| @typeCode | 1..1 | SHALL |  | [31303](#C_31303) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31304](#C_31304) |  |
| entryRelationship | 0..\* | MAY |  | [31246](#C_31246) |  |
| @typeCode | 1..1 | SHALL |  | [31306](#C_31306) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [31307](#C_31307) |  |
| entryRelationship | 0..\* | MAY |  | [31247](#C_31247) |  |
| @typeCode | 1..1 | SHALL |  | [31309](#C_31309) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31310](#C_31310) |  |
| entryRelationship | 0..\* | MAY |  | [31248](#C_31248) |  |
| @typeCode | 1..1 | SHALL |  | [31312](#C_31312) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [31313](#C_31313) |  |
| entryRelationship | 0..\* | MAY |  | [31250](#C_31250) |  |
| @typeCode | 1..1 | SHALL |  | [31318](#C_31318) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31319](#C_31319) |  |
| entryRelationship | 0..\* | MAY |  | [31251](#C_31251) |  |
| @typeCode | 1..1 | SHALL |  | [31321](#C_31321) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31322](#C_31322) |  |
| entryRelationship | 0..\* | MAY |  | [31252](#C_31252) |  |
| @typeCode | 1..1 | SHALL |  | [31324](#C_31324) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31325](#C_31325) |  |
| entryRelationship | 0..\* | MAY |  | [31253](#C_31253) |  |
| @typeCode | 1..1 | SHALL |  | [31327](#C_31327) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31328](#C_31328) |  |
| entryRelationship | 0..\* | MAY |  | [31254](#C_31254) |  |
| typeId | 0..1 | MAY |  | [31330](#C_31330) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31331](#C_31331) |  |
| entryRelationship | 0..\* | MAY |  | [31255](#C_31255) |  |
| @typeCode | 1..1 | SHALL |  | [31333](#C_31333) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31334](#C_31334) |  |
| entryRelationship | 0..\* | MAY |  | [31256](#C_31256) |  |
| @typeCode | 1..1 | SHALL |  | [31336](#C_31336) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31337](#C_31337) |  |
| entryRelationship | 0..\* | MAY |  | [31257](#C_31257) |  |
| @typeCode | 1..1 | SHALL |  | [31339](#C_31339) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31340](#C_31340) |  |
| entryRelationship | 0..\* | MAY |  | [31365](#C_31365) |  |
| @typeCode | 1..1 | SHALL |  | [31366](#C_31366) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT |
| observation | 1..1 | SHALL |  | [31367](#C_31367) |  |
| entryRelationship | 0..\* | MAY |  | [31377](#C_31377) |  |
| @typeCode | 1..1 | SHALL |  | [31378](#C_31378) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31379](#C_31379) |  |
| entryRelationship | 0..\* | MAY |  | [31380](#C_31380) |  |
| @typeCode | 1..1 | SHALL |  | [31381](#C_31381) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| organizer | 1..1 | SHALL |  | [31382](#C_31382) |  |
| entryRelationship | 0..\* | MAY |  | [31442](#C_31442) |  |
| @typeCode | 1..1 | SHALL |  | [31443](#C_31443) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31444](#C_31444) |  |
| entryRelationship | 0..\* | MAY |  | [31445](#C_31445) |  |
| @typeCode | 1..1 | SHALL |  | [31446](#C_31446) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31447](#C_31447) |  |
| entryRelationship | 0..\* | MAY |  | [31544](#C_31544) |  |
| @typeCode | 1..1 | SHALL |  | [31547](#C_31547) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [31548](#C_31548) |  |
| author | 0..\* | SHOULD |  | [31546](#C_31546) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:30750).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:30751).
3. SHALL contain exactly one [1..1] templateId (CONF:30752) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.132" (CONF:30753).
4. SHALL contain exactly one [1..1] id (CONF:30754).
5. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [Health Concern Type](#Health_Concern_Type) 2.16.840.1.113883.11.20.9.53 (CONF:30755).
6. SHALL contain exactly one [1..1] statusCode (CONF:30758).
7. MAY contain zero or one [0..1] effectiveTime (CONF:30759).
8. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31546).
9. MAY contain zero or more [0..\*] entryRelationship (CONF:30761) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30762).
   2. SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:31001).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:31007) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31008).
    2. SHALL contain exactly one [1..1] [Allergy - Intolerance Observation (V2)](#E_Allergy__Intolerance_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.7.2) (CONF:31186).

This entryRelationship represents the relationship between two Health Concern Acts where there is a general relationship between the source and the target (Health Concern RELATES TO Health Concern).

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31157) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31158).
   2. SHALL contain exactly one 1..1] Health Concern Act (NEW) (templateId: 2.16.840.1.113883.10.20.22.4.132] (CONF:31159).

This entryRelationship represents the relationship between two Health Concern Acts where the target is a component of the source (Health Concern HAS COMPONENT Health Concern).

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31160) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31161).
   2. SHALL contain exactly one 1..1] Health Concern Act (NEW) (templateId:2.16.840.1.113883.10.20.22.4.132) (CONF:31162).
2. MAY contain zero or more [0..\*] entryRelationship (CONF:31190) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31191).
   2. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:31192).
3. MAY contain zero or more [0..\*] entryRelationship (CONF:31193) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31194).
   2. SHALL contain exactly one [1..1] [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.74.2) (CONF:31195).
4. MAY contain zero or more [0..\*] entryRelationship (CONF:31232) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31264).
   2. SHALL contain exactly one [1..1] [Self-Care Activities (ADL and IADL) (NEW)](#E_SelfCare_Activities_ADL_and_IADL_NEW) (templateId:2.16.840.1.113883.10.20.22.4.128) (CONF:31265).
5. MAY contain zero or more [0..\*] entryRelationship (CONF:31233) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31267).
   2. SHALL contain exactly one [1..1] [Cognitive Abilities Observation (NEW)](#E_Cognitive_Abilities_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.126) (CONF:31271).
6. MAY contain zero or more [0..\*] entryRelationship (CONF:31234) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31268).
   2. SHALL contain exactly one [1..1] [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.74.2) (CONF:31273).
7. MAY contain zero or more [0..\*] entryRelationship (CONF:31235) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31269).
   2. SHALL contain exactly one [1..1] [Current Smoking Status (V2)](#E_Current_Smoking_Status_V2) (templateId:2.16.840.1.113883.10.20.22.4.78.2) (CONF:31275).
8. MAY contain zero or more [0..\*] entryRelationship (CONF:31236) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31270).
   2. SHALL contain exactly one [1..1] [Encounter Diagnosis (V2)](#E_Encounter_Diagnosis_V2) (templateId:2.16.840.1.113883.10.20.22.4.80.2) (CONF:31277).
9. MAY contain zero or more [0..\*] entryRelationship (CONF:31237) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers To (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31279).
   2. SHALL contain exactly one [1..1] [Family History Organizer](#E_Family_History_Organizer) (templateId:2.16.840.1.113883.10.20.22.4.45) (CONF:31280).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:31238) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31282).
    2. SHALL contain exactly one [1..1] [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.67.2) (CONF:31283).
11. MAY contain zero or more [0..\*] entryRelationship (CONF:31239) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31285).
    2. SHALL contain exactly one [1..1] [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.67.2) (CONF:31286).
12. MAY contain zero or more [0..\*] entryRelationship (CONF:31240) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31288).
    2. SHALL contain exactly one [1..1] [Highest Pressure Ulcer Stage](#E_Highest_Pressure_Ulcer_Stage) (templateId:2.16.840.1.113883.10.20.22.4.77) (CONF:31289).
13. MAY contain zero or more [0..\*] entryRelationship (CONF:31241) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31291).
    2. SHALL contain exactly one [1..1] [Hospital Admission Diagnosis (V2)](#E_Hospital_Admission_Diagnosis_V2) (templateId:2.16.840.1.113883.10.20.22.4.34.2) (CONF:31292).
14. MAY contain zero or more [0..\*] entryRelationship (CONF:31242) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31294).
    2. SHALL contain exactly one [1..1] [Mental Status Observation (NEW)](#E_Mental_Status_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.125) (CONF:31295).
15. MAY contain zero or more [0..\*] entryRelationship (CONF:31243) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31297).
    2. SHALL contain exactly one [1..1] [Number of Pressure Ulcers Observation](#E_Number_of_Pressure_Ulcers_Observation) (templateId:2.16.840.1.113883.10.20.22.4.76) (CONF:31298).
16. MAY contain zero or more [0..\*] entryRelationship (CONF:31244) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31300).
    2. SHALL contain exactly one [1..1] [Nutrition Assessment (NEW)](#E_Nutrition_Assessment_NEW) (templateId:2.16.840.1.113883.10.20.22.4.138) (CONF:31301).
17. MAY contain zero or more [0..\*] entryRelationship (CONF:31245) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31303).
    2. SHALL contain exactly one [1..1] [Nutrition Assessment (NEW)](#E_Nutrition_Assessment_NEW) (templateId:2.16.840.1.113883.10.20.22.4.138) (CONF:31304).
18. MAY contain zero or more [0..\*] entryRelationship (CONF:31246) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31306).
    2. SHALL contain exactly one [1..1] [Postprocedure Diagnosis (V2)](#E_Postprocedure_Diagnosis_V2) (templateId:2.16.840.1.113883.10.20.22.4.51.2) (CONF:31307).
19. MAY contain zero or more [0..\*] entryRelationship (CONF:31247) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31309).
    2. SHALL contain exactly one [1..1] [Pregnancy Observation](#E_Pregnancy_Observation) (templateId:2.16.840.1.113883.10.20.15.3.8) (CONF:31310).
20. MAY contain zero or more [0..\*] entryRelationship (CONF:31248) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31312).
    2. SHALL contain exactly one [1..1] [Preoperative Diagnosis (V2)](#E_Preoperative_Diagnosis_V2) (templateId:2.16.840.1.113883.10.20.22.4.65.2) (CONF:31313).
21. MAY contain zero or more [0..\*] entryRelationship (CONF:31250) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31318).
    2. SHALL contain exactly one [1..1] [Reaction Observation (V2)](#Reaction_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.9.2) (CONF:31319).
22. MAY contain zero or more [0..\*] entryRelationship (CONF:31251) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31321).
    2. SHALL contain exactly one [1..1] [Result Observation (V2)](#E_Result_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.2.2) (CONF:31322).
23. MAY contain zero or more [0..\*] entryRelationship (CONF:31252) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31324).
    2. SHALL contain exactly one [1..1] [Sensory and Speech Status (NEW)](#E_Sensory_and_Speech_Status_NEW) (templateId:2.16.840.1.113883.10.20.22.4.127) (CONF:31325).
24. MAY contain zero or more [0..\*] entryRelationship (CONF:31253) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31327).
    2. SHALL contain exactly one [1..1] [Social History Observation (V2)](#E_Social_History_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.38.2) (CONF:31328).
25. MAY contain zero or more [0..\*] entryRelationship (CONF:31254) such that it
    1. MAY contain zero or one [0..1] typeId="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31330).
    2. SHALL contain exactly one [1..1] [Substance or Device Allergy - Intolerance Observation (V2)](#E_Substance_or_Device_Allergy__V2) (templateId:2.16.840.1.113883.10.20.24.3.90.2) (CONF:31331).
26. MAY contain zero or more [0..\*] entryRelationship (CONF:31255) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31333).
    2. SHALL contain exactly one [1..1] [Tobacco Use (V2)](#Tobacco_Use_V2) (templateId:2.16.840.1.113883.10.20.22.4.85.2) (CONF:31334).
27. MAY contain zero or more [0..\*] entryRelationship (CONF:31256) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31336).
    2. SHALL contain exactly one [1..1] [Vital Sign Observation (V2)](#E_Vital_Sign_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.27.2) (CONF:31337).
28. MAY contain zero or more [0..\*] entryRelationship (CONF:31257) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31339).
    2. SHALL contain exactly one [1..1] [Wound Observation (NEW)](#E_Wound_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.114) (CONF:31340).

This entryRelationship represents the relationship Health Concern HAS SUPPORT Observation.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31365) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31366).
   2. SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:31367).
2. MAY contain zero or more [0..\*] entryRelationship (CONF:31368) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31369).
   2. SHALL contain exactly one [1..1] [Caregiver Characteristics](#E_Caregiver_Characteristics) (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:31370).
3. MAY contain zero or more [0..\*] entryRelationship (CONF:31371) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31372).
   2. SHALL contain exactly one [1..1] [Cultural and Religious Observation (NEW)](#E_Cultural_and_Religious_Observation_NE) (templateId:2.16.840.1.113883.10.20.22.4.111) (CONF:31373).
4. MAY contain zero or more [0..\*] entryRelationship (CONF:31374) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31375).
   2. SHALL contain exactly one [1..1] [Characteristics of Home Environment (NEW)](#E_Characteristics_of_Home_Environment_N) (templateId:2.16.840.1.113883.10.20.22.4.109) (CONF:31376).
5. MAY contain zero or more [0..\*] entryRelationship (CONF:31377) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31378).
   2. SHALL contain exactly one [1..1] [Nutritional Status Observation (NEW)](#E_Nutritional_Status_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.124) (CONF:31379).
6. MAY contain zero or more [0..\*] entryRelationship (CONF:31380) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31381).
   2. SHALL contain exactly one [1..1] [Result Organizer (V2)](#Result_Organizer_V2) (templateId:2.16.840.1.113883.10.20.22.4.1.2) (CONF:31382).

This entryRelationship represents the priority that the patient puts on the health concern.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31442) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31443).
   2. SHALL contain exactly one [1..1] [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31444).

This entryRelationship represents the priority that the provider puts on the health concern.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31445) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31446).
   2. SHALL contain exactly one [1..1] [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31447).
2. MAY contain zero or more [0..\*] entryRelationship (CONF:31544) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31547).
   2. SHALL contain exactly one [1..1] [Problem Concern Act (Condition) (V2)](#E_Problem_Concern_Act_Condition_V2) (templateId:2.16.840.1.113883.10.20.22.4.3.2) (CONF:31548).

Where a Health Concern needs to reference another entry already described in the CDA document instance, rather than repeating the full content of the entry, the Act Reference template may be used to reference this entry.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31549) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31550).
   2. SHALL contain exactly one [1..1] [Act Reference (NEW)](#E_Act_Reference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.122) (CONF:31551).

309: Health Concern Type

|  |  |  |
| --- | --- | --- |
| Value Set: Health Concern Type 2.16.840.1.113883.11.20.9.53 | | |
| Code | Code System | Print Name |
| CONC | HL7ActClass | Concern |
| 80943009 | SNOMED CT | Risk factor |

Figure 132: Health Concern Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.132" />

<id root="4eab0e52-dd7d-4285-99eb-72d32ddb195c" />

<code code="CONC" codeSystem="2.16.840.1.113883.5.6" codeSystemName="HL7ActClass" displayName="Concern" />

<!-- This Health Concern has a statuCode of active because it is an active concern -->

<statusCode code="active" />

<!-- The effective time is the date that the Health Concern started being followed -

this does not necessarily correlate to the onset date of the contained health issues-->

<effectiveTime value="20130616" />

<!-- Health Concern: Current every day smoker-->

<entryRelationship typeCode="REFR">

<!-- Tobacco Use -->

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.85.2" />

<id root="031b375e-e1aa-4602-9855-f65ec3bbee50" />

<code code="229819007" codeSystem="2.16.840.1.113883.6.96" displayName="Tobacco use and exposure" />

<statusCode code="completed" />

<effectiveTime>

<!-- The low value reflects the start date of the current or

past tobacco use observation -->

<low value="20090214" />

</effectiveTime>

<value xsi:type="CD" code="449868002" displayName="Current every day smoker"

codeSystem="2.16.840.1.113883.6.96" />

</observation>

</entryRelationship>

<!-- Health Concern Problem: Respiratory insufficiency -->

<entryRelationship typeCode="REFR">

<!-- Problem Observation -->

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.4.2" />

<id root="8dfacd73-1682-4cc4-9351-e54ccea83612" />

<code code="55607006" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Problem" />

<statusCode code="completed" />

<effectiveTime>

<!-- Onset date of the problem -->

<low value="20130613" />

</effectiveTime>

<value xsi:type="CD" code="409623005" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT" displayName="Respiratory insufficiency" />

</observation>

</entryRelationship>

<!-- Health Concern Diagnosis: Pneumonia -->

<entryRelationship typeCode="REFR">

<!-- Problem Observation -->

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.4.2" />

<id root="8dfacd73-1682-4cc4-9351-e54ccea83612" />

<code code="282291009" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Diagnosis" />

<statusCode code="completed" />

<effectiveTime>

<!-- Date of diagnosis -->

<low value="20130616" />

</effectiveTime>

<value xsi:type="CD" code="233604007" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT" displayName="Pneumonia" />

</observation>

</entryRelationship>

<!--

This is an entry relationship of the SPRT (support) type which shows t

hat the productive cough supports the Health Concern (Problem: Respiratory

Insufficiency and Diagnosis: Pneumonia

This entryRelationship represents the relationship:

Health Concern HAS SUPPORT Observation

-->

<entryRelationship typeCode="SPRT">

<!-- Problem Observation -->

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.4.2" />

<id root="01cb0d7a-46e2-4367-b38b-9465ffbf64e3" />

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />

<statusCode code="completed" />

<effectiveTime>

<!-- Onset date -->

<low value="20130615" />

</effectiveTime>

<value xsi:type="CD" code="28743005" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT" displayName="Productive cough" />

</observation>

</entryRelationship>

<!-- Patient Prioirty Preference - this is the preference that the

patient places on the Health Concern -->

<entryRelationship typeCode="RSON">

<!-- Patient Priority Preference -->

...

</entryRelationship>

<!-- Provider Prioirty Preference - this is the preference that the

patient places on the Health Concern -->

<entryRelationship typeCode="RSON">

<!-- Provider Priority Preference -->

...

</entryRelationship>

</act>

Figure 133: Health Risk Example

<!-- Health Concern Act (RISK) -->

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.132" />

<id root="cbcbf20a-d011-449f-87d1-a23cc3e5f7cf" />

<!-- The following code indicates that this is a RISK -->

<code code="80943009" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Risk factor" />

<!-- This Health Risk has a statuCode of active because it is an active risk -->

<statusCode code="active" />

<!-- The effective time is the date that the Health Risk started being followed -

this does not necessarily correlate to the onset date of the contained health issues-->

<effectiveTime value="20130616" />

<!-- Health Risk: Malignant neoplastic disease -->

<entryRelationship typeCode="REFR">

<!-- Problem Observation -->

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.4.2" />

<id root="8dfacd73-1682-4cc4-9351-e54ccea83612" />

<code code="80943009" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Risk factor" />

<statusCode code="completed" />

<effectiveTime>

<low value="20130613" />

</effectiveTime>

<value xsi:type="CD" code="409623005" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT" displayName="Malignant neoplastic disease" />

</observation>

</entryRelationship>

...

<!--

This entryRelationship represents the relationship "Health Risk REFERS TO Health Concern"

-->

<entryRelationship typeCode="REFR">

<!-- Act Reference Concern Act -->

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.122" />

<!-- This id points to an already defined Health Concern -->

<id root="4eab0e52-dd7d-4285-99eb-72d32ddb195c" />

<code nullFlavor="NP" />

<statusCode code="completed" />

</act>

</entryRelationship>

</act>

Health Status Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.5.2 (open)]

310: Health Status Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concerns Section (NEW)](#S_Health_Concerns_Section_NEW) (optional)  [Problem Section (entries required) (V2)](#S_Problem_Section_entries_required_V2) (optional)  [Problem Section (entries optional) (V2)](#S_Problem_Section_entries_optional_V2) (optional) |  |

This template represents  information about the overall health status of the patient. To represent the impact of a specific problem or concern related to the patient's expected health outcome use the Prognosis Observation Template 2.16.840.1.113883.10.20.22.4.113.

311: Health Status Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.5.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [9057](#C_9057) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [9072](#C_9072) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [16756](#C_16756) |  |
| @root | 1..1 | SHALL |  | [16757](#C_16757) | 2.16.840.1.113883.10.20.22.4.5.2 |
| code | 1..1 | SHALL |  | [19143](#C_19143) |  |
| @code | 1..1 | SHALL |  | [19144](#C_19144) | 2.16.840.1.113883.6.1 (LOINC) = 11323-3 |
| text | 0..1 | SHOULD |  | [9270](#C_9270) |  |
| reference | 0..1 | SHOULD |  | [15529](#C_15529) |  |
| @value | 0..1 | SHOULD |  | [15530](#C_15530) |  |
| statusCode | 1..1 | SHALL |  | [9074](#C_9074) |  |
| @code | 1..1 | SHALL |  | [19103](#C_19103) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL | CD | [9075](#C_9075) | 2.16.840.1.113883.1.11.20.12.2 (HealthStatus (V2)) |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9057).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9072).
3. SHALL contain exactly one [1..1] templateId (CONF:16756) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.5.2" (CONF:16757).
4. SHALL contain exactly one [1..1] code (CONF:19143).
   1. This code SHALL contain exactly one [1..1] @code="11323-3" Health status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19144).
5. SHOULD contain zero or one [0..1] text (CONF:9270).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15529).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15530).
         1. SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15531).
6. SHALL contain exactly one [1..1] statusCode (CONF:9074).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19103).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [HealthStatus (V2)](#HealthStatus_V2) 2.16.840.1.113883.1.11.20.12.2 DYNAMIC (CONF:9075).

312: HealthStatus (V2)

|  |  |  |
| --- | --- | --- |
| Value Set: HealthStatus (V2) 2.16.840.1.113883.1.11.20.12.2  Represents the general health status of the patient. | | |
| Code | Code System | Print Name |
| 81323004 | SNOMED CT | Alive and well |
| 313386006 | SNOMED CT | In remission |
| 162467007 | SNOMED CT | Symptom free |
| 161901003 | SNOMED CT | Chronically ill |
| 271593001 | SNOMED CT | Severely ill |
| 21134002 | SNOMED CT | Disabled |
| 161045001 | SNOMED CT | Severely disabled |
| 135818000 | SNOMED CT | General health poor |
| 135815002 | SNOMED CT | General health good |
| 135816001 | SNOMED CT | General health excellent |

Figure 134: Health Status Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.5"/>

<code code="11323-3" codeSystem="2.16.840.1.113883.6.1"

codeSystemName="LOINC" displayName="Health status"/>

<text>

<reference value="#healthstatus"/>

</text>

<statusCode code="completed"/>

<value xsi:type="CD" code="81323004" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT" displayName="Alive and well"/>

</observation>

Highest Pressure Ulcer Stage

[observation: templateId 2.16.840.1.113883.10.20.22.4.77 (open)]

313: Highest Pressure Ulcer Stage Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2) (optional) |  |

This observation contains a description of the wound tissue of the most severe or highest staged pressure ulcer observed on a patient.

314: Highest Pressure Ulcer Stage Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.77'] | | | | | |
| @classCode | 1..1 | SHALL |  | [14726](#C_14726) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14727](#C_14727) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [14728](#C_14728) |  |
| @root | 1..1 | SHALL |  | [14729](#C_14729) | 2.16.840.1.113883.10.20.22.4.77 |
| id | 1..\* | SHALL |  | [14730](#C_14730) |  |
| code | 1..1 | SHALL |  | [14731](#C_14731) |  |
| @code | 1..1 | SHALL |  | [14732](#C_14732) | 2.16.840.1.113883.6.96 (SNOMED CT) = 420905001 |
| value | 1..1 | SHALL |  | [14733](#C_14733) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14726).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14727).
3. SHALL contain exactly one [1..1] templateId (CONF:14728) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.77" (CONF:14729).
4. SHALL contain at least one [1..\*] id (CONF:14730).
5. SHALL contain exactly one [1..1] code (CONF:14731).
   1. This code SHALL contain exactly one [1..1] @code="420905001" Highest Pressure Ulcer Stage (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:14732).
6. SHALL contain exactly one [1..1] value (CONF:14733).

Figure 135: Highest Pressure Ulcer Stage Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.77"/>

<id root="08edb7c0-2111-43f2-a784-9a5fdfaa67f0"/>

<code code="420905001" codeSystem="2.16.840.1.113883.6.96"

displayName=" Highest Pressure Ulcer Stage"/>

<statusCode code="completed"/>

<value xsi:type="CD" code="421306004"

codeSystem="2.16.840.1.113883.6.96"

displayName="necrotic eschar"/>

</observation>

Hospital Admission Diagnosis (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.34.2 (open)]

315: Hospital Admission Diagnosis (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Hospital Admission Diagnosis Section (V2)](#S_Hospital_Admission_Diagnosis_Section_) (optional) | [Problem Observation (V2)](#E_Problem_Observation_V2) |

This template represents problems or diagnoses identified by the clinician at the time of the patient’s admission.

316: Hospital Admission Diagnosis (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.34.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7671](#C_7671) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [7672](#C_7672) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [16747](#C_16747) |  |
| @root | 1..1 | SHALL |  | [16748](#C_16748) | 2.16.840.1.113883.10.20.22.4.34.2 |
| code | 1..1 | SHALL |  | [19145](#C_19145) |  |
| @code | 1..1 | SHALL |  | [19146](#C_19146) | 2.16.840.1.113883.6.1 (LOINC) = 46241-6 |
| entryRelationship | 1..\* | SHALL |  | [7674](#C_7674) |  |
| @typeCode | 1..1 | SHALL |  | [7675](#C_7675) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| observation | 1..1 | SHALL |  | [15535](#C_15535) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7671).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7672).
3. SHALL contain exactly one [1..1] templateId (CONF:16747) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.34.2" (CONF:16748).
4. SHALL contain exactly one [1..1] code (CONF:19145).
   1. This code SHALL contain exactly one [1..1] @code="46241-6" Admission diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19146).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:7674) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7675).
   2. SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15535).

Figure 136: Hospital Admission Diagnosis Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.34" />

<id root="5a784260-6856-4f38-9638-80c751aff2fb" />

<code code="46241-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Hospital Admission Diagnosis" />

<statusCode code="active" />

<effectiveTime>

<low value="20090303" />

</effectiveTime>

<entryRelationship typeCode="SUBJ" inversionInd="false">

<observation classCode="OBS" moodCode="EVN">

<!-- Problem observation template -->

<templateId root="2.16.840.1.113883.10.20.22.4.4" />

...

</observation>

</entryRelationship>

</act>

Hospital Discharge Diagnosis (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.33.2 (open)]

317: Hospital Discharge Diagnosis (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Hospital Discharge Diagnosis Section (V2)](#Hospital_Discharge_Diagnosis_Section_V2) (optional) | [Problem Observation (V2)](#E_Problem_Observation_V2) |

This template represents problems or diagnoses present at the time of discharge which occurred during the hospitalization or need to be monitored after hospitalization. It requires at least one Problem Observation entry.

318: Hospital Discharge Diagnosis (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.33.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7663](#C_7663) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [7664](#C_7664) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [16764](#C_16764) |  |
| @root | 1..1 | SHALL |  | [16765](#C_16765) | 2.16.840.1.113883.10.20.22.4.33.2 |
| code | 1..1 | SHALL |  | [19147](#C_19147) |  |
| @code | 1..1 | SHALL |  | [19148](#C_19148) | 2.16.840.1.113883.6.1 (LOINC) = 11535-2 |
| entryRelationship | 1..\* | SHALL |  | [7666](#C_7666) |  |
| @typeCode | 1..1 | SHALL |  | [7667](#C_7667) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| observation | 1..1 | SHALL |  | [15536](#C_15536) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7663).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7664).
3. SHALL contain exactly one [1..1] templateId (CONF:16764) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.33.2" (CONF:16765).
4. SHALL contain exactly one [1..1] code (CONF:19147).
   1. This code SHALL contain exactly one [1..1] @code="11535-2" Hospital discharge diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19148).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:7666) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7667).
   2. SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15536).

Figure 137: Hospital Discharge Diagnosis Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.33" />

<id root="5a784260-6856-4f38-9638-80c751aff2fb" />

<code code="11535-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="HOSPITAL DISCHARGE DIAGNOSIS" />

<statusCode code="active" />

<effectiveTime>

<low value="201209091904-0400" />

</effectiveTime>

<entryRelationship typeCode="SUBJ" inversionInd="false">

<observation classCode="OBS" moodCode="EVN">

<!-- Problem observation template -->

<templateId root="2.16.840.1.113883.10.20.22.4.4" />

...

</observation>

</entryRelationship>

</act>

Immunization Activity (V2)

[substanceAdministration: templateId 2.16.840.1.113883.10.20.22.4.52.2 (open)]

319: Immunization Activity (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Immunizations Section (entries optional) (V2)](#S_Immunizations_Section_entries_optiona) (optional)  [Immunizations Section (entries required) (V2)](#S_Immunizations_Section_entries_require) (required)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Author Participation (NEW)](#U_Author_Participation_NEW)  [Drug Vehicle](#E_Drug_Vehicle)  [Immunization Medication Information (V2)](#Immunization_Medication_Information_V2)  [Immunization Refusal Reason](#E_Immunization_Refusal_Reason)  [Indication (V2)](#Indication_V2)  [Instruction (V2)](#Instruction_V2)  [Medication Dispense (V2)](#E_Medication_Dispense_V2)  [Medication Supply Order (V2)](#E_Medication_Supply_Order_V2)  [Precondition for Substance Administration](#E_Precondition_for_Substance_Administrat)  [Reaction Observation (V2)](#Reaction_Observation_V2)  [Substance Administered Act (NEW)](#E_Substance_Administered_Act_NEW) |

An Immunization Activity describes immunization substance administrations that have actually occurred or are intended to occur. Immunization Activities in "INT" mood are reflections of immunizations a clinician intends a patient to receive. Immunization Activities in "EVN" mood reflect immunizations actually received.

An Immunization Activity is very similar to a Medication Activity with some key differentiators. The drug code system is constrained to CVX codes. Administration timing is less complex. Patient refusal reasons should be captured. All vaccines administered should be fully documented in the patient's permanent medical record. Healthcare providers who administer vaccines covered by the National Childhood Vaccine Injury Act are required to ensure that the permanent medical record of the recipient indicates:

1) Date of administration

2) Vaccine manufacturer

3) Vaccine lot number

4) Name and title of the person who administered the vaccine and the address of the clinic or facility where the permanent record will reside

5) Vaccine information statement (VIS)

a. date printed on the VIS

b. date VIS given to patient or parent/guardian.

This information should be included in an Immunization Activity when available.

Notes: reference: http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/D/vacc\_admin.pdf

320: Immunization Activity (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| substanceAdministration[templateId/@root = '2.16.840.1.113883.10.20.22.4.52.2'] | | | | | |
| participant | 0..\* | MAY |  | [8850](#C_8850) |  |
| @typeCode | 1..1 | SHALL |  | [8851](#C_8851) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = CSM |
| participantRole | 1..1 | SHALL |  | [15547](#C_15547) |  |
| @classCode | 1..1 | SHALL |  | [8826](#C_8826) | 2.16.840.1.113883.5.6 (HL7ActClass) = SBADM |
| @moodCode | 1..1 | SHALL |  | [8827](#C_8827) | 2.16.840.1.113883.11.20.9.18 (MoodCodeEvnInt) |
| @negationInd | 1..1 | SHALL |  | [8985](#C_8985) |  |
| templateId | 1..1 | SHALL |  | [8828](#C_8828) |  |
| @root | 1..1 | SHALL |  | [10498](#C_10498) | 2.16.840.1.113883.10.20.22.4.52.2 |
| id | 1..\* | SHALL |  | [8829](#C_8829) |  |
| code | 0..1 | MAY |  | [8830](#C_8830) |  |
| text | 0..1 | SHOULD |  | [8831](#C_8831) |  |
| reference | 0..1 | SHOULD |  | [15543](#C_15543) |  |
| @value | 0..1 | SHOULD |  | [15544](#C_15544) |  |
| statusCode | 1..1 | SHALL |  | [8833](#C_8833) | 2.16.840.1.113883.1.11.159331 (ActStatus) |
| effectiveTime | 1..1 | SHALL |  | [8834](#C_8834) |  |
| repeatNumber | 0..1 | MAY |  | [8838](#C_8838) |  |
| routeCode | 0..1 | MAY |  | [8839](#C_8839) | 2.16.840.1.113883.3.88.12.3221.8.7 (Medication Route FDA Value Set) |
| approachSiteCode | 0..1 | MAY | SET<CD> | [8840](#C_8840) | 2.16.840.1.113883.3.88.12.3221.8.9 (Body Site Value Set) |
| doseQuantity | 0..1 | SHOULD |  | [8841](#C_8841) |  |
| @unit | 0..1 | SHOULD |  | [8842](#C_8842) | 2.16.840.1.113883.1.11.12839 (UnitsOfMeasureCaseSensitive) |
| administrationUnitCode | 0..1 | MAY |  | [8846](#C_8846) | 2.16.840.1.113883.3.88.12.3221.8.11 (Medication Product Form Value Set) |
| consumable | 1..1 | SHALL |  | [8847](#C_8847) |  |
| manufacturedProduct | 1..1 | SHALL |  | [15546](#C_15546) |  |
| performer | 0..1 | SHOULD |  | [8849](#C_8849) |  |
| entryRelationship | 0..\* | MAY |  | [8853](#C_8853) |  |
| @typeCode | 1..1 | SHALL |  | [8854](#C_8854) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| observation | 1..1 | SHALL |  | [15537](#C_15537) |  |
| entryRelationship | 0..1 | MAY |  | [8856](#C_8856) |  |
| @typeCode | 1..1 | SHALL |  | [8857](#C_8857) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [8858](#C_8858) | true |
| act | 1..1 | SHALL |  | [31392](#C_31392) |  |
| entryRelationship | 0..1 | MAY |  | [8860](#C_8860) |  |
| @typeCode | 1..1 | SHALL |  | [8861](#C_8861) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| supply | 1..1 | SHALL |  | [15539](#C_15539) |  |
| entryRelationship | 0..1 | MAY |  | [8863](#C_8863) |  |
| @typeCode | 1..1 | SHALL |  | [8864](#C_8864) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| supply | 1..1 | SHALL |  | [15540](#C_15540) |  |
| entryRelationship | 0..1 | MAY |  | [8866](#C_8866) |  |
| @typeCode | 1..1 | SHALL |  | [8867](#C_8867) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = CAUS |
| observation | 1..1 | SHALL |  | [15541](#C_15541) |  |
| entryRelationship | 0..1 | MAY |  | [8988](#C_8988) |  |
| @typeCode | 1..1 | SHALL |  | [8989](#C_8989) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| observation | 1..1 | SHALL |  | [15542](#C_15542) |  |
| precondition | 0..\* | MAY |  | [8869](#C_8869) |  |
| @typeCode | 1..1 | SHALL |  | [8870](#C_8870) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = PRCN |
| criterion | 1..1 | SHALL |  | [15548](#C_15548) |  |
| author | 0..\* | SHOULD |  | [31151](#C_31151) |  |
| entryRelationship | 0..\* | MAY |  | [31510](#C_31510) |  |
| @typeCode | 1..1 | SHALL |  | [31511](#C_31511) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| @inversionInd | 1..1 | SHALL |  | [31512](#C_31512) | true |
| sequenceNumber | 0..1 | MAY |  | [31513](#C_31513) |  |
| act | 1..1 | SHALL |  | [31514](#C_31514) |  |

1. SHALL contain exactly one [1..1] @classCode="SBADM" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8826).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [MoodCodeEvnInt](#MoodCodeEvnInt) 2.16.840.1.113883.11.20.9.18 STATIC (CONF:8827).

Use negationInd="true" to indicate that the immunization was not given.

1. SHALL contain exactly one [1..1] @negationInd (CONF:8985).
2. SHALL contain exactly one [1..1] templateId (CONF:8828) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.52.2" (CONF:10498).
3. SHALL contain at least one [1..\*] id (CONF:8829).

SubstanceAdministration.code is an optional field. Per HL7 Pharmacy Committee, "this is intended to further specify the nature of the substance administration act. To date the committee has made no use of this attribute". Because the type of substance administration is generally implicit in the routeCode, in the consumable participant, etc, the field is generally not used, and there is no defined value set.

1. MAY contain zero or one [0..1] code (CONF:8830).
2. SHOULD contain zero or one [0..1] text (CONF:8831).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15543).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15544).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1 (CONF:15545).
3. SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet [ActStatus](#ActStatus) 2.16.840.1.113883.1.11.159331 DYNAMIC (CONF:8833).
4. SHALL contain exactly one [1..1] effectiveTime (CONF:8834).

In "INT" (intent) mood, the repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times. To indicate a given immunization's ordering in a series, use the nested Substance Administered Act.

1. MAY contain zero or one [0..1] repeatNumber (CONF:8838).
2. MAY contain zero or one [0..1] routeCode, which SHALL be selected from ValueSet [Medication Route FDA Value Set](#Medication_Route_FDA_Value_Set) 2.16.840.1.113883.3.88.12.3221.8.7 DYNAMIC (CONF:8839).
3. MAY contain zero or one [0..1] approachSiteCode, where the code SHALL be selected from ValueSet [Body Site Value Set](#Body_Site_Value_Set) 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:8840).
4. SHOULD contain zero or one [0..1] doseQuantity (CONF:8841).
   1. The doseQuantity, if present, SHOULD contain zero or one [0..1] @unit, which SHALL be selected from ValueSet [UnitsOfMeasureCaseSensitive](#UnitsOfMeasureCaseSensitive) 2.16.840.1.113883.1.11.12839 DYNAMIC (CONF:8842).
5. MAY contain zero or one [0..1] administrationUnitCode, which SHALL be selected from ValueSet [Medication Product Form Value Set](#Medication_Product_Form_Value_Set) 2.16.840.1.113883.3.88.12.3221.8.11 DYNAMIC (CONF:8846).
6. SHALL contain exactly one [1..1] consumable (CONF:8847).
   1. This consumable SHALL contain exactly one [1..1] [Immunization Medication Information (V2)](#Immunization_Medication_Information_V2) (templateId:2.16.840.1.113883.10.20.22.4.54.2) (CONF:15546).
7. SHOULD contain zero or one [0..1] performer (CONF:8849).
8. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31151).
9. MAY contain zero or more [0..\*] participant (CONF:8850) such that it
   1. SHALL contain exactly one [1..1] @typeCode="CSM" (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8851).
   2. SHALL contain exactly one [1..1] [Drug Vehicle](#E_Drug_Vehicle) (templateId:2.16.840.1.113883.10.20.22.4.24) (CONF:15547).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:8853) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8854).
    2. SHALL contain exactly one [1..1] [Indication (V2)](#Indication_V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:15537).
11. MAY contain zero or one [0..1] entryRelationship (CONF:8856) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8857).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:8858).
    3. SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31392).
12. MAY contain zero or one [0..1] entryRelationship (CONF:8860) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8861).
    2. SHALL contain exactly one [1..1] [Medication Supply Order (V2)](#E_Medication_Supply_Order_V2) (templateId:2.16.840.1.113883.10.20.22.4.17.2) (CONF:15539).
13. MAY contain zero or one [0..1] entryRelationship (CONF:8863) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8864).
    2. SHALL contain exactly one [1..1] [Medication Dispense (V2)](#E_Medication_Dispense_V2) (templateId:2.16.840.1.113883.10.20.22.4.18.2) (CONF:15540).
14. MAY contain zero or one [0..1] entryRelationship (CONF:8866) such that it
    1. SHALL contain exactly one [1..1] @typeCode="CAUS" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8867).
    2. SHALL contain exactly one [1..1] [Reaction Observation (V2)](#Reaction_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.9.2) (CONF:15541).
15. MAY contain zero or one [0..1] entryRelationship (CONF:8988) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8989).
    2. SHALL contain exactly one [1..1] [Immunization Refusal Reason](#E_Immunization_Refusal_Reason) (templateId:2.16.840.1.113883.10.20.22.4.53) (CONF:15542).
16. MAY contain zero or more [0..\*] entryRelationship (CONF:31510) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31511).
    2. SHALL contain exactly one [1..1] @inversionInd="true" (CONF:31512).
    3. MAY contain zero or one [0..1] sequenceNumber (CONF:31513).
    4. SHALL contain exactly one [1..1] [Substance Administered Act (NEW)](#E_Substance_Administered_Act_NEW) (templateId:2.16.840.1.113883.10.20.22.4.118) (CONF:31514).
17. MAY contain zero or more [0..\*] precondition (CONF:8869) such that it
    1. SHALL contain exactly one [1..1] @typeCode="PRCN" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8870).
    2. SHALL contain exactly one [1..1] [Precondition for Substance Administration](#E_Precondition_for_Substance_Administrat) (templateId:2.16.840.1.113883.10.20.22.4.25) (CONF:15548).

321: MoodCodeEvnInt

|  |  |  |
| --- | --- | --- |
| Value Set: MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18  Contains moodCode EVN and INT | | |
| Code | Code System | Print Name |
| EVN | ActMood | Event |
| INT | ActMood | Intent |

322: ActStatus

|  |  |  |
| --- | --- | --- |
| Value Set: ActStatus 2.16.840.1.113883.1.11.159331  Contains the names (codes) for each of the states in the state-machine of the RIM Act class. | | |
| Code | Code System | Print Name |
| normal | ActStatus | normal |
| aborted | ActStatus | aborted |
| active | ActStatus | active |
| cancelled | ActStatus | cancelled |
| completed | ActStatus | completed |
| held | ActStatus | held |
| new | ActStatus | new |
| suspended | ActStatus | suspended |
| nullified | ActStatus | nullified |
| obsolete | ActStatus | obsolete |

323: Medication Route FDA Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Medication Route FDA Value Set 2.16.840.1.113883.3.88.12.3221.8.7  Route of Administration value set is based upon FDA Drug Registration and Listing Database (FDA Orange Book) which are used in FDA structured product and labelling (SPL). | | |
| Code | Code System | Print Name |
| C38192 | FDA RouteOfAdministration | AURICULAR (OTIC) |
| C38193 | FDA RouteOfAdministration | BUCCAL |
| C38194 | FDA RouteOfAdministration | CONJUNCTIVAL |
| C38675 | FDA RouteOfAdministration | CUTANEOUS |
| C38197 | FDA RouteOfAdministration | DENTAL |
| C38633 | FDA RouteOfAdministration | ELECTRO-OSMOSIS |
| C38205 | FDA RouteOfAdministration | ENDOCERVICAL |
| C38206 | FDA RouteOfAdministration | ENDOSINUSIAL |
| C38208 | FDA RouteOfAdministration | ENDOTRACHEAL |
| C38209 | FDA RouteOfAdministration | ENTERAL |
| ... | | |

324: Body Site Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Body Site Value Set 2.16.840.1.113883.3.88.12.3221.8.9  Body site value set is based upon the concepts descending from the SNOMED CT Anatomical Structure (91723000) hierarchy. | | |
| Code | Code System | Print Name |
| 56244007 | SNOMED CT | 10 to 19 percent of body surface (body structure) |
| 37491003 | SNOMED CT | 12 nm filaments (cell structure) |
| 78777002 | SNOMED CT | 20 to 29 percent of body surface (body structure) |
| 12423009 | SNOMED CT | 30 to 39 percent of body surface (body structure) |
| 36849000 | SNOMED CT | 40 to 49 percent of body surface (body structure) |
| 305024009 | SNOMED CT | 5/6 interchondral joint (body structure) |
| 76152003 | SNOMED CT | 50 to 59 percent of body surface (body structure) |
| 305005006 | SNOMED CT | 6/7 interchondral joint (body structure) |
| 91551007 | SNOMED CT | 60 to 69 percent of body surface (body structure) |
| 64700008 | SNOMED CT | 7 nm filaments (cell structure) |
| ... | | |

325: UnitsOfMeasureCaseSensitive

|  |  |  |
| --- | --- | --- |
| Value Set: UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 | | |
| Code | Code System | Print Name |
| 10\* | UCUM | the number ten for arbitrary powers |
| 10^ | UCUM | the number ten for arbitrary powers |
| [pi] | UCUM | the number pi |
| % | UCUM | percent |
| [ppth] | UCUM | parts per thousand |
| [ppm] | UCUM | parts per million |
| [ppb] | UCUM | parts per billion |
| [pptr] | UCUM | parts per trillion |
| mol | UCUM | mole |
| sr | UCUM | steradian |
| ... | | |

326: Medication Product Form Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Medication Product Form Value Set 2.16.840.1.113883.3.88.12.3221.8.11  This is the physical form of the product as presented to the individual. For example: tablet, capsule, liquid or ointment. NCI concept code for pharmaceutical dosage form: C42636 | | |
| Code | Code System | Print Name |
| C42887 | FDA RouteOfAdministration | AEROSOL |
| C42888 | FDA RouteOfAdministration | AEROSOL, FOAM |
| C42960 | FDA RouteOfAdministration | AEROSOL, METERED |
| C42971 | FDA RouteOfAdministration | AEROSOL, POWDER |
| C42889 | FDA RouteOfAdministration | AEROSOL, SPRAY |
| C42892 | FDA RouteOfAdministration | BAR, CHEWABLE |
| C42890 | FDA RouteOfAdministration | BEAD |
| C43451 | FDA RouteOfAdministration | BEAD, IMPLANT, EXTENDED RELEASE |
| C42891 | FDA RouteOfAdministration | BLOCK |
| C25158 | FDA RouteOfAdministration | CAPSULE |
| ... | | |

Figure 138: Immunization Activity Example

<substanceAdministration classCode="SBADM" moodCode="EVN" negationInd="false">

<templateId root="2.16.840.1.113883.10.20.22.4.52.2"/>

<id root="e6f1ba43-c0ed-4b9b-9f12-f435d8ad8f92"/>

<text>

<reference value="#immun1"/>

</text>

<statusCode code="completed"/>

<effectiveTime value="199911"/>

<routeCode code="C28161" codeSystem="2.16.840.1.113883.3.26.1.1"

codeSystemName="National Cancer Institute (NCI) Thesaurus"

displayName="Intramuscular injection"/>

<doseQuantity value="50" unit="mcg"/>

<consumable>

<manufacturedProduct classCode="MANU">

<templateId root="2.16.840.1.113883.10.20.22.4.54"/>

</manufacturedProduct>

</consumable>

<performer>

<assignedEntity>

. . .

</assignedEntity>

</performer>

<entryRelationship typeCode="SUBJ" inversionInd="false">

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.20"/>

. . .

</act>

</entryRelationship>

</substanceAdministration>

</entry>

Immunization Medication Information (V2)

[manufacturedProduct: templateId 2.16.840.1.113883.10.20.22.4.54.2 (open)]

327: Immunization Medication Information (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Immunization Activity (V2)](#E_Immunization_Activity_V2) (required)  [Medication Supply Order (V2)](#E_Medication_Supply_Order_V2) (optional)  [Medication Dispense (V2)](#E_Medication_Dispense_V2) (optional) |  |

The Immunization Medication Information represents product information about the immunization substance. The vaccine manufacturer and vaccine lot number are typically recorded in the medical record and should be included if known.

Notes: reference: http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/D/vacc\_admin.pdf

328: Immunization Medication Information (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| manufacturedProduct[templateId/@root = '2.16.840.1.113883.10.20.22.4.54.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [9002](#C_9002) | 2.16.840.1.113883.5.110 (RoleClass) = MANU |
| templateId | 1..1 | SHALL |  | [9004](#C_9004) |  |
| @root | 1..1 | SHALL |  | [10499](#C_10499) | 2.16.840.1.113883.10.20.22.4.54 |
| id | 0..\* | MAY |  | [9005](#C_9005) |  |
| manufacturedMaterial | 1..1 | SHALL |  | [9006](#C_9006) |  |
| code | 1..1 | SHALL |  | [9007](#C_9007) | Temp-ValueSet-medications (Medication Consumable) |
| translation | 0..\* | MAY |  | [31543](#C_31543) | 2.16.840.1.113883.3.88.12.80.22 (Vaccine Administered Value Set) |
| lotNumberText | 0..1 | SHOULD |  | [9014](#C_9014) |  |
| manufacturerOrganization | 0..1 | SHOULD |  | [9012](#C_9012) |  |

1. SHALL contain exactly one [1..1] @classCode="MANU" (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:9002).
2. SHALL contain exactly one [1..1] templateId (CONF:9004) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.54" (CONF:10499).
3. MAY contain zero or more [0..\*] id (CONF:9005).
4. SHALL contain exactly one [1..1] manufacturedMaterial (CONF:9006).
   1. This manufacturedMaterial SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [Medication Consumable](#Medication_Consumable) Temp-ValueSet-medications DYNAMIC (CONF:9007).
      1. This code MAY contain zero or more [0..\*] translation, which MAY be selected from ValueSet [Vaccine Administered Value Set](#Vaccine_Administered_Value_Set) 2.16.840.1.113883.3.88.12.80.22 (CONF:31543).
   2. This manufacturedMaterial SHOULD contain zero or one [0..1] lotNumberText (CONF:9014).
5. SHOULD contain zero or one [0..1] manufacturerOrganization (CONF:9012).

329: Medication Consumable

|  |  |  |
| --- | --- | --- |
| Value Set: Medication Consumable Temp-ValueSet-medications  A value set of RxNorm codes, intensionally defined to include those whose RxNorm Term Type is SCD (semantic clinical drug), SBD (semantic brand drug), GPCK (generic pack), BPCK (brand pack), SCDG (semantic clinical drug group), SBDG (semantic brand drug group), SCDF (semantic clinical drug form), or SBDF (semantic brand drug form).  (Final VSAC URL pending)  Valueset Source: <https://vsac.nlm.nih.gov/> | | |
| Code | Code System | Print Name |
| 978727 | RxNorm | 0.2 ML Dalteparin Sodium 12500 UNT/ML Prefilled Syringe [Fragmin] |
| 827318 | RxNorm | Acetaminophen 250 MG / Aspirin 250 MG / Caffeine 65 MG Oral Capsule |
| 199274 | RxNorm | Aspirin 300 MG Oral Capsule |
| 362867 | RxNorm | Cefotetan Injectable Solution [Cefotan] |
| ... | | |

330: Vaccine Administered Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Vaccine Administered Value Set 2.16.840.1.113883.3.88.12.80.22  Valueset Source: <http://phinvads.cdc.gov/vads/ViewCodeSystem.action?id=2.16.840.1.113883.12.292> | | |
| Code | Code System | Print Name |
| 143 | CDC Vaccine Code (CVX) | Adenovirus types 4 and 7 |
| 54 | CDC Vaccine Code (CVX) | adenovirus, type 4 |
| 55 | CDC Vaccine Code (CVX) | adenovirus, type 7 |
| 82 | CDC Vaccine Code (CVX) | adenovirus, unspecified formulation |
| 24 | CDC Vaccine Code (CVX) | anthrax |
| 19 | CDC Vaccine Code (CVX) | BCG |
| 27 | CDC Vaccine Code (CVX) | botulinum antitoxin |
| 26 | CDC Vaccine Code (CVX) | cholera |
| 29 | CDC Vaccine Code (CVX) | CMVIG |
| 56 | CDC Vaccine Code (CVX) | dengue fever |
| ... | | |

Figure 139: Immunization Medication Information Example

<manufacturedProduct classCode="MANU">

<templateId root="2.16.840.1.113883.10.20.22.4.54" />

<manufacturedMaterial>

<code code="88" codeSystem="2.16.840.1.113883.6.59" displayName="Influenza virus vaccine" codeSystemName="CVX">

<originalText>

<reference value="#immunization1" />

</originalText>

<translation code="141" displayName="Influenza, seasonal, injectable" codeSystemName="CVX" codeSystem="2.16.840.1.113883.6.59" />

</code>

<lotNumberText>1</lotNumberText>

</manufacturedMaterial>

<manufacturerOrganization>

<name>Health LS - Immuno Inc.</name>

</manufacturerOrganization>

</manufacturedProduct>

Immunization Refusal Reason

[observation: templateId 2.16.840.1.113883.10.20.22.4.53 (open)]

331: Immunization Refusal Reason Contexts

| Contained By: | Contains: |
| --- | --- |
| [Immunization Activity (V2)](#E_Immunization_Activity_V2) (optional) |  |

The Immunization Refusal Reason Observation documents the rationale for the patient declining an immunization.

332: Immunization Refusal Reason Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.53'] | | | | | |
| @classCode | 1..1 | SHALL |  | [8991](#C_8991) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [8992](#C_8992) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [8993](#C_8993) |  |
| @root | 1..1 | SHALL |  | [10500](#C_10500) | 2.16.840.1.113883.10.20.22.4.53 |
| id | 1..\* | SHALL |  | [8994](#C_8994) |  |
| code | 1..1 | SHALL |  | [8995](#C_8995) | 2.16.840.1.113883.1.11.19717 (No Immunization Reason Value Set) |
| statusCode | 1..1 | SHALL |  | [8996](#C_8996) |  |
| @code | 1..1 | SHALL |  | [19104](#C_19104) | 2.16.840.1.113883.5.14 (ActStatus) = completed |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8991).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8992).
3. SHALL contain exactly one [1..1] templateId (CONF:8993) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.53" (CONF:10500).
4. SHALL contain at least one [1..\*] id (CONF:8994).
5. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [No Immunization Reason Value Set](#No_Immunization_Reason_Value_Set) 2.16.840.1.113883.1.11.19717 DYNAMIC (CONF:8995).
6. SHALL contain exactly one [1..1] statusCode (CONF:8996).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19104).

333: No Immunization Reason Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: No Immunization Reason Value Set 2.16.840.1.113883.1.11.19717 | | |
| Code | Code System | Print Name |
| IMMUNE | ActReason | Immunity |
| MEDPREC | ActReason | Medical precaution |
| OSTOCK | ActReason | Out of stock |
| PATOBJ | ActReason | Patient objection |
| PHILISOP | ActReason | Philosophical objection |
| RELIG | ActReason | Religious objection |
| VACEFF | ActReason | Vaccine efficacy concerns |
| VACSAF | ActReason | Vaccine safety concerns |

Figure 140: Immunization Refusal Reason Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.53" />

<id root="2a620155-9d11-439e-92b3-5d9815ff4dd8" />

<code displayName="Patient Objection" code="PATOBJ" codeSystemName="HL7 ActNoImmunizationReason" codeSystem="2.16.840.1.113883.5.8" />

<statusCode code="completed" />

</observation>

Indication (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.19.2 (open)]

334: Indication (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medication Activity (V2)](#Medication_Activity_V2) (optional)  [Procedure Activity Act (V2)](#E_Procedure_Activity_Act_V2) (optional)  [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) (optional)  [Procedure Activity Observation (V2)](#E_Procedure_Activity_Observation_V2) (optional)  [Immunization Activity (V2)](#E_Immunization_Activity_V2) (optional)  [Encounter Activity (V2)](#E_Encounter_Activity_V2) (optional)  [Procedure Indications Section (V2)](#Procedure_Indications_Section_V2) (optional) |  |

This template represents the rationale for an action such as the reason for an encounter, a medication administration or a procedure. The id element can be used to reference a problem recorded elsewhere in the document or with a code and value to record the problem. Indications for treatment are not lab results, rather the problem associated with the lab result should be sited (e.g such as hypokalemia instead of a lab result of Potassium 2.0 mEq/L). Use the Drug Monitoring Act templateId 2.16.840.1.113883.10.20.22.4.123] to indicate if a particular drug needs special monitoring (e.g. anticoagulant therapy). Use Precondition for Substance Administration templateId 2.16.840.1.113883.10.20.22.4.25 to represent that a medication is to be administered only when the associated criteria are met.

335: Indication (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.19.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7480](#C_7480) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [7481](#C_7481) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7482](#C_7482) |  |
| @root | 1..1 | SHALL |  | [10502](#C_10502) | 2.16.840.1.113883.10.20.22.4.19.2 |
| id | 1..1 | SHALL |  | [7483](#C_7483) |  |
| statusCode | 1..1 | SHALL |  | [7487](#C_7487) |  |
| @code | 1..1 | SHALL |  | [19105](#C_19105) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 0..1 | SHOULD |  | [7488](#C_7488) |  |
| value | 0..1 | MAY | CD | [7489](#C_7489) | 2.16.840.1.113883.3.88.12.3221.7.4 (Problem Value Set) |
| text | 0..1 | SHOULD |  | [30817](#C_30817) |  |
| code | 1..1 | SHALL |  | [31229](#C_31229) | 2.16.840.1.113883.3.88.12.3221.7.2 (Problem Type) |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7480).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7481).
3. SHALL contain exactly one [1..1] templateId (CONF:7482) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.19.2" (CONF:10502).

This observation/id must equal another entry/id in the same document instance. Application Software must be responsible for resolving the identifier back to its original object and then rendering the information in the correct place in the containing section's narrative text. Its purpose is to obviate the need to repeat the complete XML representation of the referred to entry when relating one entry to another.

1. SHALL contain exactly one [1..1] id (CONF:7483).
2. SHALL contain exactly one [1..1] code, which MAY be selected from ValueSet [Problem Type](#Problem_Type) 2.16.840.1.113883.3.88.12.3221.7.2 (CONF:31229).
3. SHOULD contain zero or one [0..1] text (CONF:30817).
4. SHALL contain exactly one [1..1] statusCode (CONF:7487).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19105).
5. SHOULD contain zero or one [0..1] effectiveTime (CONF:7488).
6. MAY contain zero or one [0..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [Problem Value Set](#Problem_Value_Set) 2.16.840.1.113883.3.88.12.3221.7.4 STATIC (CONF:7489).

336: Problem Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 | | |
| Code | Code System | Print Name |
| 50992006 | SNOMED CT | 22q partial trisomy syndrome (disorder) |
| 237931009 | SNOMED CT | 2-Ketoadipic acidemia (disorder) |
| 54470008 | SNOMED CT | 3 beta-Hydroxysteroid dehydrogenase deficiency (disorder) |
| 237950009 | SNOMED CT | 3-Methylglutaconic aciduria (disorder) |
| 296646009 | SNOMED CT | 4-quinolones overdose (disorder) |
| 41797007 | SNOMED CT | 5 10-Methylenetetrahydrofolate reductase deficiency (disorder) |
| 413380004 | SNOMED CT | A pattern strabismus (disorder) |
| 425879009 | SNOMED CT | AA amyloid nephropathy (disorder) |
| 274945004 | SNOMED CT | AA amyloidosis (disorder) |
| 75100008 | SNOMED CT | Abdominal abscess (disorder) |
| ... | | |

337: Problem Type

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Type 2.16.840.1.113883.3.88.12.3221.7.2 | | |
| Code | Code System | Print Name |
| 404684003 | SNOMED CT | Finding |
| 409586006 | SNOMED CT | Complaint |
| 282291009 | SNOMED CT | Diagnosis |
| 64572001 | SNOMED CT | Condition |
| 248536006 | SNOMED CT | Finding of functional performance and activity |
| 418799008 | SNOMED CT | Symptom |
| 55607006 | SNOMED CT | Problem |
| 373930000 | SNOMED CT | Cognitive function finding |

Figure 141: Indication Example

<entry typeCode="DRIV">

<substanceAdministration classCode="SBADM" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.16.2"/>

<!-- \*\* MEDICATION ACTIVITY -->

<id root="cdbd33f0-6cde-11db-9fe1-0800200c9a66"/>

<text>

<reference value="#Med1"/> 0.09 MG/ACTUAT inhalant solution, 2 puffs QID PRN wheezing

</text>

...

<!-- Indication snippet inside a Medication Activity -->

<entryRelationship typeCode="RSON">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.19.2"/>

<!-- Note that this id equals the problem observation/id -->

<id root="db734647-fc99-424c-a864-7e3cda82e703"/>

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<statusCode code="completed"/>

<value xsi:type="CD" code="32398004" displayName="Bronchitis" codeSystem="2.16.840.1.113883.6.96"/>

</observation>

</entryRelationship>

...

<entry/>

<! -- Points to a problem on the problem list -->

<!-- Problem observation template

<templateId root="2.16.840.1.113883.10.20.22.4.4"/>

Note that this id equals the Indication observation/id

<id root="db734647-fc99-424c-a864-7e3cda82e703"/> -->

Instruction (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.20.2 (open)]

338: Instruction (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medication Activity (V2)](#Medication_Activity_V2) (optional)  [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (optional)  [Procedure Activity Act (V2)](#E_Procedure_Activity_Act_V2) (optional)  [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) (optional)  [Procedure Activity Observation (V2)](#E_Procedure_Activity_Observation_V2) (optional)  [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2) (optional)  [Immunization Activity (V2)](#E_Immunization_Activity_V2) (optional)  [Medication Supply Order (V2)](#E_Medication_Supply_Order_V2) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional)  [Instructions Section (V2)](#Instructions_Section_V2) (optional)  [Medical Device (NEW)](#E_Medical_Device_NEW) (optional) |  |

The Instruction template can be used in several ways, such as to record patient instructions within a Medication Activity or to record fill instructions within a supply order. The act/code defines the type of instruction. Though not defined in this template, a Vaccine Information Statement (VIS) document could be referenced through act/reference/externalDocument, and patient awareness of the instructions can be represented with the generic participant and the participant/awarenessCode.

339: Instruction (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.20.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7391](#C_7391) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [7392](#C_7392) | 2.16.840.1.113883.5.1001 (ActMood) = INT |
| templateId | 1..1 | SHALL |  | [7393](#C_7393) |  |
| @root | 1..1 | SHALL |  | [10503](#C_10503) | 2.16.840.1.113883.10.20.22.4.20.2 |
| code | 1..1 | SHALL |  | [16884](#C_16884) | 2.16.840.1.113883.11.20.9.34 (Patient Education) |
| text | 0..1 | SHOULD |  | [7395](#C_7395) |  |
| reference | 0..1 | SHOULD |  | [15577](#C_15577) |  |
| @value | 0..1 | SHOULD |  | [15578](#C_15578) |  |
| statusCode | 1..1 | SHALL |  | [7396](#C_7396) |  |
| @code | 1..1 | SHALL |  | [19106](#C_19106) | 2.16.840.1.113883.5.14 (ActStatus) = completed |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7391).
2. SHALL contain exactly one [1..1] @moodCode="INT" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7392).
3. SHALL contain exactly one [1..1] templateId (CONF:7393) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.20.2" (CONF:10503).
4. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet [Patient Education](#Patient_Education) 2.16.840.1.113883.11.20.9.34 DYNAMIC (CONF:16884).
5. SHOULD contain zero or one [0..1] text (CONF:7395).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15577).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15578).
         1. This @value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15579).
6. SHALL contain exactly one [1..1] statusCode (CONF:7396).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19106).

340: Patient Education

|  |  |  |
| --- | --- | --- |
| Value Set: Patient Education 2.16.840.1.113883.11.20.9.34 | | |
| Code | Code System | Print Name |
| 311401005 | SNOMED CT | Patient Education |
| 171044003 | SNOMED CT | Immunization Education |
| 243072006 | SNOMED CT | Cancer Education |

Figure 142: Instruction Example

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.20.2" />

<code code="171044003" codeSystem="2.16.840.1.113883.6.96" displayName="immunization education" />

<text>

<reference value="#immunSect" />

Possible flu-like symptoms for three days.

</text>

<statusCode code="completed" />

</act>

Intervention Act (NEW)

[act: templateId 2.16.840.1.113883.10.20.22.4.131 (open)]

341: Intervention Act (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Interventions Section (V2)](#Interventions_Section_V2) (optional)  [Outcome Observation (NEW)](#E_Outcome_Observation_NEW) (optional) | [Act Reference (NEW)](#E_Act_Reference_NEW)  [Advance Directive Observation (V2)](#Advance_Directive_Observation_V2)  [Author Participation (NEW)](#U_Author_Participation_NEW)  [Encounter Activity (V2)](#E_Encounter_Activity_V2)  [Goal Observation (NEW)](#E_Goal_Observation_NEW)  [Immunization Activity (V2)](#E_Immunization_Activity_V2)  [Instruction (V2)](#Instruction_V2)  [Medication Activity (V2)](#Medication_Activity_V2)  [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2)  [Nutrition Recommendations (NEW)](#E_Nutrition_Recommendations_NEW)  [Planned Act (V2)](#E_Planned_Act_V2)  [Planned Encounter (V2)](#E_Planned_Encounter_V2)  [Planned Observation (V2)](#E_Planned_Observation_V2)  [Planned Procedure (V2)](#E_Planned_Procedure_V2)  [Planned Substance Administration (V2)](#E_Planned_Substance_Administration_V2)  [Planned Supply (V2)](#E_Planned_Supply_V2)  [Procedure Activity Act (V2)](#E_Procedure_Activity_Act_V2)  [Procedure Activity Observation (V2)](#E_Procedure_Activity_Observation_V2)  [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) |

This template represents an Intervention Act, and is a wrapper for intervention-type activities considered to be parts of the same intervention (eg. an activity such as "elevate head of bed" combined with "provide humidified O2 per nasal cannula" might be the intervention planned for a health concern of "respiratory insufficiency" in order to attempt to achieve a goal of "pulse oximetry greater than 92%"). These intervention activities may be newly described or derived from a variety of sources within an EHR. Interventions are actions taken to address Health Concerns and increase the likelihood of achieving the patient’s or providers’ Goals.

An Intervention Act should contain a reference to a Goal Observation representing the reason for the intervention.

Intervention Acts can be related to each other, eg. an Intervention Act with moodCode of INT could be related to a series of Intervention Acts with moodCode of EVN each having an effectiveTime containing the time of the intervention.

342: Intervention Act (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.131'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [31545](#C_31545) |  |
| @typeCode | 1..1 | SHALL |  | [31554](#C_31554) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [31555](#C_31555) |  |
| entryRelationship | 0..\* | MAY |  | [31621](#C_31621) |  |
| @typeCode | 1..1 | SHALL |  | [31622](#C_31622) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = GEVL |
| act | 1..1 | SHALL |  | [31623](#C_31623) |  |
| entryRelationship | 0..\* | MAY |  | [30980](#C_30980) |  |
| @typeCode | 1..1 | SHALL |  | [30981](#C_30981) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [30982](#C_30982) |  |
| entryRelationship | 0..\* | MAY |  | [31171](#C_31171) |  |
| @typeCode | 1..1 | SHALL |  | [31172](#C_31172) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| encounter | 1..1 | SHALL |  | [31173](#C_31173) |  |
| entryRelationship | 0..\* | MAY |  | [30984](#C_30984) |  |
| @typeCode | 1..1 | SHALL |  | [30985](#C_30985) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| substanceAdministration | 1..1 | SHALL |  | [30986](#C_30986) |  |
| entryRelationship | 0..\* | MAY |  | [31174](#C_31174) |  |
| typeId | 0..1 | MAY |  | [31175](#C_31175) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [31176](#C_31176) |  |
| @classCode | 1..1 | SHALL |  | [30971](#C_30971) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [30972](#C_30972) | 2.16.840.1.113883.11.20.9.54 (Intervention moodCode) |
| templateId | 1..1 | SHALL |  | [30973](#C_30973) |  |
| @root | 1..1 | SHALL |  | [30974](#C_30974) | 2.16.840.1.113883.10.20.22.4.131 |
| id | 1..1 | SHALL |  | [30975](#C_30975) |  |
| code | 1..1 | SHALL |  | [30976](#C_30976) |  |
| @code | 1..1 | SHALL |  | [30977](#C_30977) | CODE\_FOR\_INTERVENTION |
| @codeSystem | 1..1 | SHALL |  | [30978](#C_30978) | CODE\_SYSTEM |
| statusCode | 1..1 | SHALL |  | [30979](#C_30979) |  |
| entryRelationship | 0..\* | MAY |  | [30988](#C_30988) |  |
| @typeCode | 1..1 | SHALL |  | [30989](#C_30989) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| substanceAdministration | 1..1 | SHALL |  | [30990](#C_30990) |  |
| entryRelationship | 0..\* | MAY |  | [30991](#C_30991) |  |
| @typeCode | 1..1 | SHALL |  | [30992](#C_30992) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [30993](#C_30993) |  |
| entryRelationship | 0..\* | SHOULD |  | [30998](#C_30998) |  |
| @typeCode | 1..1 | SHALL |  | [30999](#C_30999) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| observation | 1..1 | SHALL |  | [31000](#C_31000) |  |
| entryRelationship | 0..\* | MAY |  | [31154](#C_31154) |  |
| @typeCode | 1..1 | SHALL |  | [31155](#C_31155) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| entryRelationship | 0..\* | MAY |  | [31164](#C_31164) |  |
| @typeCode | 1..1 | SHALL |  | [31165](#C_31165) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31166](#C_31166) |  |
| entryRelationship | 0..\* | MAY |  | [31168](#C_31168) |  |
| @typeCode | 1..1 | SHALL |  | [31169](#C_31169) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| procedure | 1..1 | SHALL |  | [31170](#C_31170) |  |
| entryRelationship | 0..\* | MAY |  | [31177](#C_31177) |  |
| @typeCode | 1..1 | SHALL |  | [31178](#C_31178) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| supply | 1..1 | SHALL |  | [31179](#C_31179) |  |
| entryRelationship | 0..\* | MAY |  | [31180](#C_31180) |  |
| @typeCode | 1..1 | SHALL |  | [31181](#C_31181) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [31182](#C_31182) |  |
| entryRelationship | 0..\* | MAY |  | [31183](#C_31183) |  |
| @typeCode | 1..1 | SHALL |  | [31184](#C_31184) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| encounter | 1..1 | SHALL |  | [31185](#C_31185) |  |
| entryRelationship | 0..\* | MAY |  | [31399](#C_31399) |  |
| @typeCode | 1..1 | SHALL |  | [31400](#C_31400) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31401](#C_31401) |  |
| entryRelationship | 0..\* | MAY |  | [31402](#C_31402) |  |
| @typeCode | 1..1 | SHALL |  | [31403](#C_31403) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| procedure | 1..1 | SHALL |  | [31404](#C_31404) |  |
| entryRelationship | 0..\* | MAY |  | [31407](#C_31407) |  |
| @typeCode | 1..1 | SHALL |  | [31408](#C_31408) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| substanceAdministration | 1..1 | SHALL |  | [31409](#C_31409) |  |
| entryRelationship | 0..\* | MAY |  | [31410](#C_31410) |  |
| @typeCode | 1..1 | SHALL |  | [31411](#C_31411) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| supply | 1..1 | SHALL |  | [31412](#C_31412) |  |
| entryRelationship | 0..\* | MAY |  | [31413](#C_31413) |  |
| procedure | 1..1 | SHALL |  | [31414](#C_31414) |  |
| author | 0..\* | SHOULD |  | [31552](#C_31552) |  |
| effectiveTime | 0..1 | SHOULD |  | [31624](#C_31624) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:30971).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [Intervention moodCode](#Intervention_moodCode) 2.16.840.1.113883.11.20.9.54 (CONF:30972).
3. SHALL contain exactly one [1..1] templateId (CONF:30973).
   1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.131" (CONF:30974).
4. SHALL contain exactly one [1..1] id (CONF:30975).
5. SHALL contain exactly one [1..1] code (CONF:30976).
   1. This code SHALL contain exactly one [1..1] @code="CODE\_FOR\_INTERVENTION" (CONF:30977).
   2. This code SHALL contain exactly one [1..1] @codeSystem="CODE\_SYSTEM" (CONF:30978).
6. SHALL contain exactly one [1..1] statusCode (CONF:30979).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:31624).
8. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31552).
9. MAY contain zero or more [0..\*] entryRelationship (CONF:30980) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30981).
   2. SHALL contain exactly one [1..1] [Advance Directive Observation (V2)](#Advance_Directive_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.48.2) (CONF:30982).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:30984) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30985).
    2. SHALL contain exactly one [1..1] [Immunization Activity (V2)](#E_Immunization_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.52.2) (CONF:30986).
11. MAY contain zero or more [0..\*] entryRelationship (CONF:30988) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30989).
    2. SHALL contain exactly one [1..1] [Medication Activity (V2)](#Medication_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:30990).
12. MAY contain zero or more [0..\*] entryRelationship (CONF:30991) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30992).
    2. SHALL contain exactly one [1..1] [Procedure Activity Act (V2)](#E_Procedure_Activity_Act_V2) (templateId:2.16.840.1.113883.10.20.22.4.12.2) (CONF:30993).

This entryRelationship represents the relationship between an Intervention Act and a Goal Observation (Intervention HAS REASON Goal).

1. SHOULD contain zero or more [0..\*] entryRelationship (CONF:30998) such that it
   1. SHALL contain exactly one [1..1] @typeCode="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30999).
   2. SHALL contain exactly one [1..1] [Goal Observation (NEW)](#E_Goal_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.121) (CONF:31000).

This entryRelationship represents the relationship between two Intervention Acts (Intervention RELATES TO Intervention).

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31154) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31155).
   2. SHALL contain exactly 1..1] Intervention Act (NEW) (templateId:2.16.840.1.113883.10.20.4.131) (CONF:31156).
2. MAY contain zero or more [0..\*] entryRelationship (CONF:31164) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31165).
   2. SHALL contain exactly one [1..1] [Procedure Activity Observation (V2)](#E_Procedure_Activity_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.13.2) (CONF:31166).
3. MAY contain zero or more [0..\*] entryRelationship (CONF:31168) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31169).
   2. SHALL contain exactly one [1..1] [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) (templateId:2.16.840.1.113883.10.20.22.4.14.2) (CONF:31170).
4. MAY contain zero or more [0..\*] entryRelationship (CONF:31171) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31172).
   2. SHALL contain exactly one [1..1] [Encounter Activity (V2)](#E_Encounter_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.49.2) (CONF:31173).
5. MAY contain zero or more [0..\*] entryRelationship (CONF:31174) such that it
   1. MAY contain zero or one [0..1] typeId="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31175).
   2. SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31176).
6. MAY contain zero or more [0..\*] entryRelationship (CONF:31177) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31178).
   2. SHALL contain exactly one [1..1] [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.50.2) (CONF:31179).
7. MAY contain zero or more [0..\*] entryRelationship (CONF:31180) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31181).
   2. SHALL contain exactly one [1..1] [Planned Act (V2)](#E_Planned_Act_V2) (templateId:2.16.840.1.113883.10.20.22.4.39.2) (CONF:31182).
8. MAY contain zero or more [0..\*] entryRelationship (CONF:31183) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31184).
   2. SHALL contain exactly one [1..1] [Planned Encounter (V2)](#E_Planned_Encounter_V2) (templateId:2.16.840.1.113883.10.20.22.4.40.2) (CONF:31185).
9. MAY contain zero or more [0..\*] entryRelationship (CONF:31399) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31400).
   2. SHALL contain exactly one [1..1] [Planned Observation (V2)](#E_Planned_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.44.2) (CONF:31401).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:31402) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31403).
    2. SHALL contain exactly one [1..1] [Planned Procedure (V2)](#E_Planned_Procedure_V2) (templateId:2.16.840.1.113883.10.20.22.4.41.2) (CONF:31404).
11. MAY contain zero or more [0..\*] entryRelationship (CONF:31407) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31408).
    2. SHALL contain exactly one [1..1] [Planned Substance Administration (V2)](#E_Planned_Substance_Administration_V2) (templateId:2.16.840.1.113883.10.20.22.4.42.2) (CONF:31409).
12. MAY contain zero or more [0..\*] entryRelationship (CONF:31410) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31411).
    2. SHALL contain exactly one [1..1] [Planned Supply (V2)](#E_Planned_Supply_V2) (templateId:2.16.840.1.113883.10.20.22.4.43.2) (CONF:31412).
13. MAY contain zero or more [0..\*] entryRelationship (CONF:31413) such that it
    1. SHALL contain exactly one [1..1] [Nutrition Recommendations (NEW)](#E_Nutrition_Recommendations_NEW) (templateId:2.16.840.1.113883.10.20.22.4.130) (CONF:31414).

Where an Intervention needs to reference another entry already described in the CDA document instance, rather than repeating the full content of the entry, the Act Relationship template may be used to reference this entry.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31545) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31554).
   2. SHALL contain exactly one [1..1] [Act Reference (NEW)](#E_Act_Reference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.122) (CONF:31555).

Where an Intervention needs to reference a Goal Observation entry already described in the CDA document instance, rather than repeating the full content of the Goal Observation, the Act Relationship template may be used to reference this entry.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31621) such that it
   1. SHALL contain exactly one [1..1] @typeCode="GEVL" Evaluates goal (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31622).
   2. SHALL contain exactly one [1..1] [Act Reference (NEW)](#E_Act_Reference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.122) (CONF:31623).

343: Intervention moodCode

|  |  |  |
| --- | --- | --- |
| Value Set: Intervention moodCode 2.16.840.1.113883.11.20.9.54 | | |
| Code | Code System | Print Name |
| APT | ActMood | Appointment |
| ARQ | ActMood | Appointment Request |
| EVN | ActMood | Event |
| INT | ActMood | Intent |
| PRMS | ActMood | Promise |
| PRP | ActMood | Proposal |
| RQO | ActMood | Request |

Figure 143: Intervention Act (moodCode="INT") Example

<!--

This entry shows an act in intent mood (planned intervention-

meaning this is intended to be done), with the reason "RSN" for the act

being the already defined Goal (pulse ox reading > 92)

The intervention contains relationships to different components of

the intervention.

-->

<!-- Intervention Act -->

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.131" />

<id root="85fa4b62-e3a9-4385-b064-fe04cca35adb" />

<code code="code\_for\_intervention" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Intervention" />

<statusCode code="active" />

<entryRelationship typeCode="REFR">

<!-- The following act is one part of the intervention -

"Elevate head of bed" -->

<!-- Procdure Activity Act -->

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.12.2" />

<id root="7658963e-54da-496f-bf18-dea1dddaa3b0" />

<code code="423171007" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Elevate head of bed" />

<statusCode code="active" />

</act>

</entryRelationship>

<entryRelationship typeCode="REFR">

<!-- The following procedure is one part of the intervention -

"Oxygen administration by nasal cannula" -->

<!-- Procedure Activity Procedure -->

<procedure classCode="PROC" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.14.2" />

<id root="6a560f3d-88fd-4292-9415-f9371adaec46" />

<code code="371907003" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Oxygen administration by nasal cannula" />

<statusCode code="active" />

</procedure>

</entryRelationship>

<!-- This entryRelationship represents the relationship between an

Intervention Act and a Goal Observation (Intervention HAS REASON Goal).

The Act Reference template is being used here as this Goal is

defined elsewhere in the CDA document -->

<entryRelationship typeCode="RSON">

<!-- Act Reference template -->

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.122" />

<!-- This id points to an already defined Goal

(pulse ox reading > 92) in the Goals Section -->

<id root="3700b3b0-fbed-11e2-b778-0800200c9a66" />

<code nullFlavor="NP" />

<statusCode code="completed" />

</act>

</entryRelationship>

</act>

Figure 144: Intervention Act (moodCode="EVN") Example

<!-- Intervention Act -->

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.131" />

<id root="b3c091b3-f9a4-41e4-a8e4-2d1b11f2eb22" />

<code code="code\_for\_intervention" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Intervention" />

<statusCode code="active" />

<entryRelationship typeCode="REFR">

<!-- The following act is one part of the intervtion -

"Elevate head of bed" -->

<!-- Procdure Activity Act -->

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.12.2" />

<id root="7658963e-54da-496f-bf18-dea1dddaa3b0" />

<code code="423171007" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Elevate head of bed" />

<statusCode code="completed" />

<!-- When this act took place -->

<effectiveTime value="20130801" />

</act>

</entryRelationship>

<!-- This entryRelationship represents the relationship between an

Intervention Act and a Goal Observation (Intervention HAS REASON Goal). -->

<entryRelationship typeCode="RSON">

<!-- Act Reference template -->

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.122" />

<!-- This id points back to an already defined Goal

(pulse ox reading > 92) in the Goals Section -->

<id root="3700b3b0-fbed-11e2-b778-0800200c9a66" />

<code nullFlavor="NP" />

<statusCode code="completed" />

</act>

</entryRelationship>

<!-- This entryRelationship represents the relationship between two

Intervention Acts (Intervention RELATES TO Intervention).-->

<!-- This intervention it is pointing to an elsewhere defined

planned intervention -->

<entryRelationship typeCode="REFR">

<!-- Act Reference template -->

<act classCode="ACT" moodCode="EVN">

<templateId root="85fa4b62-e3a9-4385-b064-fe04cca35adb" />

<!-- This id points to an already defined Intervention -->

<id root="3700b3b0-fbed-11e2-b778-0800200c9a66" />

<code nullFlavor="NP" />

<statusCode code="completed" />

</act>

</entryRelationship>

</act>

Medical Device (NEW)

[supply: templateId 2.16.840.1.113883.10.20.22.4.115 (open)]

344: Medical Device (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medical Equipment Section (V2)](#S_Medical_Equipment_Section_V2) (optional)  [Medical Equipment Organizer (NEW)](#E_Medical_Equipment_Organizer_NEW) (required) | [Instruction (V2)](#Instruction_V2)  [Product Instance](#E_Product_Instance) |

This template represents a medical device. A medical device is equipment that has been applied (a device in or on the patient's body) to a patient and is designed to treat or monitor a patient's condition.

345: Medical Device (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| supply[templateId/@root = '2.16.840.1.113883.10.20.22.4.115'] | | | | | |
| entryRelationship | 0..1 | MAY |  | [31855](#C_31855) |  |
| @typeCode | 1..1 | SHALL |  | [31856](#C_31856) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [31857](#C_31857) | true |
| act | 1..1 | SHALL |  | [31858](#C_31858) |  |
| @classCode | 1..1 | SHALL |  | [31843](#C_31843) | SPLY |
| @moodCode | 1..1 | SHALL |  | [31844](#C_31844) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [31845](#C_31845) |  |
| @root | 1..1 | SHALL |  | [31846](#C_31846) | 2.16.840.1.113883.10.20.22.4.115 |
| id | 1..\* | SHALL |  | [31847](#C_31847) |  |
| code | 1..1 | SHALL |  | [31848](#C_31848) |  |
| statusCode | 1..1 | SHALL |  | [31849](#C_31849) |  |
| effectiveTime | 1..1 | SHALL |  | [31850](#C_31850) |  |
| quantity | 0..1 | SHOULD |  | [31851](#C_31851) |  |
| participant | 0..\* | MAY |  | [31852](#C_31852) |  |
| @typeCode | 1..1 | SHALL |  | [31853](#C_31853) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = PRD |
| participantRole | 1..1 | SHALL |  | [31854](#C_31854) |  |
| product | 0..1 | MAY |  | [31859](#C_31859) |  |
| manufacturedProduct | 1..1 | SHALL |  | [31860](#C_31860) |  |

1. SHALL contain exactly one [1..1] @classCode="SPLY" Supply (CONF:31843).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:31844).
3. SHALL contain exactly one [1..1] templateId (CONF:31845).
   1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.115" (CONF:31846).
4. SHALL contain at least one [1..\*] id (CONF:31847).
5. SHALL contain exactly one [1..1] code (CONF:31848).
6. SHALL contain exactly one [1..1] statusCode (CONF:31849).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:31850).
8. SHOULD contain zero or one [0..1] quantity (CONF:31851).
9. MAY contain zero or one [0..1] product (CONF:31859).
   1. The product, if present, SHALL contain exactly one [1..1] manufacturedProduct (CONF:31860).
10. MAY contain zero or more [0..\*] participant (CONF:31852).
    1. The participant, if present, SHALL contain exactly one [1..1] @typeCode="PRD" Product (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:31853).
    2. The participant, if present, SHALL contain exactly one [1..1] [Product Instance](#E_Product_Instance) (templateId:2.16.840.1.113883.10.20.22.4.37) (CONF:31854).
11. MAY contain zero or one [0..1] entryRelationship (CONF:31855).
    1. The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31856).
    2. The entryRelationship, if present, SHALL contain exactly one [1..1] @inversionInd="true" (CONF:31857).
    3. The entryRelationship, if present, SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31858).

Figure 145: Medical Device Example

<supply classCode="SPLY" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.115" />

<id />

<code />

<statusCode />

<effectiveTime />

<quantity />

<product>

<manufacturedProduct />

</product>

<participant typeCode="PRD">

<participantRole />

</participant>

<entryRelationship typeCode="SUBJ" inversionInd="true">

<act />

</entryRelationship>

</supply>

Medical Equipment Organizer (NEW)

[organizer: templateId 2.16.840.1.113883.10.20.22.4.135 (open)]

346: Medical Equipment Organizer (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medical Equipment Section (V2)](#S_Medical_Equipment_Section_V2) (optional)  [Medical (General) History Section (V2)](#Medical_General_History_Section_V2) (optional) | [Medical Device (NEW)](#E_Medical_Device_NEW) |

This clinical statement represents a set of current or historical medical devices/equipment in use or ordered. It may contain information applicable to all of the contained devices/equipment over time. For example, all nebulizer applied from 2003 to 2012 represents historical devices, and nebulizer between 2013 to current represents current device(s) in use.

An appropriate nullFlavor can be used when the organizer/code or organizer/id is unknown

The Medical Device template represents Medical Device(s) in or on a patient.

347: Medical Equipment Organizer (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| organizer[templateId/@root = '2.16.840.1.113883.10.20.22.4.135'] | | | | | |
| component | 1..\* | SHALL |  | [31027](#C_31027) |  |
| supply | 1..1 | SHALL |  | [31862](#C_31862) |  |
| @classCode | 1..1 | SHALL |  | [31020](#C_31020) | 2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER |
| @moodCode | 1..1 | SHALL |  | [31021](#C_31021) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [31022](#C_31022) |  |
| @root | 1..1 | SHALL |  | [31023](#C_31023) | 2.16.840.1.113883.10.20.22.4.135 |
| id | 1..\* | SHALL |  | [31024](#C_31024) |  |
| code | 1..1 | SHALL |  | [31025](#C_31025) |  |
| @code | 0..1 | SHOULD |  | [30349](#C_30349) | 2.16.840.1.113883.6.96 (SNOMED CT) |
| statusCode | 1..1 | SHALL |  | [31026](#C_31026) |  |
| @code | 1..1 | SHALL |  | [31029](#C_31029) | 2.16.840.1.113883.11.20.9.39 (Result Status) |

1. SHALL contain exactly one [1..1] @classCode="CLUSTER" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:31020).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:31021).
3. SHALL contain exactly one [1..1] templateId (CONF:31022) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.135" (CONF:31023).
4. SHALL contain at least one [1..\*] id (CONF:31024).
5. SHALL contain exactly one [1..1] code (CONF:31025).
   1. This code SHOULD contain zero or one [0..1] @code (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:30349).
6. SHALL contain exactly one [1..1] statusCode (CONF:31026).
   1. This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [Result Status](#Result_Status) 2.16.840.1.113883.11.20.9.39 STATIC (CONF:31029).
7. SHALL contain at least one [1..\*] component (CONF:31027) such that it
   1. SHALL contain exactly one [1..1] [Medical Device (NEW)](#E_Medical_Device_NEW) (templateId:2.16.840.1.113883.10.20.22.4.115) (CONF:31862).

348: Result Status

|  |  |  |
| --- | --- | --- |
| Value Set: Result Status 2.16.840.1.113883.11.20.9.39 | | |
| Code | Code System | Print Name |
| aborted | ActStatus | aborted |
| active | ActStatus | active |
| cancelled | ActStatus | cancelled |
| completed | ActStatus | completed |
| held | ActStatus | held |
| suspended | ActStatus | suspended |

Figure 146: Medical Equipment Organizer Example

<organizer classCode="CLUSTER" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.135" />

<!-- Medical Equipment Organizer template -->

<id nullFlavor="NA" />

<code nullFlavor="OTH">

<originalText>Medical Equipment History</originalText>

</code>

<statusCode code="completed" />

<!-- Medical Equipment History between 2011-June-06 to current -->

<effectiveTime>

<low value="20110616" />

<high nullFlavor="NA" />

</effectiveTime>

<component>

<procedure classCode="PROC" moodCode="EVN">

<!-- Supporting Medical Device -->

<templateId root="2.16.840.1.113883.10.20.22.4.115" />

<!-- Procedure Activity Procedure -->

<templateId root="2.16.840.1.113883.10.20.22.4.14" />

...

</procedure>

</component>

<component>

<procedure classCode="PROC" moodCode="EVN">

<!-- Supporting Medical Device -->

<templateId root="2.16.840.1.113883.10.20.22.4.115" />

<!-- Procedure Activity Procedure -->

<templateId root="2.16.840.1.113883.10.20.22.4.14" />

...

</procedure>

</component>

</organizer>

Medication Activity (V2)

[substanceAdministration: templateId 2.16.840.1.113883.10.20.22.4.16.2 (open)]

349: Medication Activity (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medications Section (entries required) (V2)](#S_Medications_Section_entries_required_) (required)  [Medications Section (entries optional) (V2)](#S_Medications_Section_entries_optional_) (optional)  [Reaction Observation (V2)](#Reaction_Observation_V2) (optional)  [Procedure Activity Act (V2)](#E_Procedure_Activity_Act_V2) (optional)  [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) (optional)  [Procedure Activity Observation (V2)](#E_Procedure_Activity_Observation_V2) (optional)  [Discharge Medication (V2)](#Discharge_Medication_V2) (required)  [Admission Medication (V2)](#Admission_Medication_V2) (required)  [Medications Administered Section (V2)](#S_Medications_Administered_Section_V2) (optional)  [Anesthesia Section (V2)](#S_Anesthesia_Section_V2) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Author Participation (NEW)](#U_Author_Participation_NEW)  [Drug Monitoring Act (NEW)](#E_Drug_Monitoring_Act_NEW)  [Drug Vehicle](#E_Drug_Vehicle)  [Indication (V2)](#Indication_V2)  [Instruction (V2)](#Instruction_V2)  [Medication Dispense (V2)](#E_Medication_Dispense_V2)  [Medication Information (V2)](#E_Medication_Information_V2)  [Medication Supply Order (V2)](#E_Medication_Supply_Order_V2)  [Reaction Observation (V2)](#Reaction_Observation_V2)  [Substance Administered Act (NEW)](#E_Substance_Administered_Act_NEW) |

A medication activity describes substance administrations that have actually occurred (e.g. pills ingested or injections given) or are intended to occur (e.g. "take 2 tablets twice a day for the next 10 days"). Medication activities in "INT" mood are reflections of what a clinician intends a patient to be taking. For example, a clinician may intend for a  patient to be administered Lisinopril  20 mg PO for blood pressure control.  However, what was actually administered was Lisinopril 10 mg.  In the latter case, the Medication activities in the "EVN" mood would reflect actual use.

At a minimum, a medication activity shall include an effectiveTime indicating the duration of the administration. Ambulatory medication lists generally provide a summary of use for a given medication over time - a medication activity in event mood with the duration reflecting when the medication started and stopped. Ongoing medications will not have a stop date (or a stop date with a suitable NULL value). Ambulatory medication lists will generally also have a frequency (e.g. a medication is being taken twice a day). Inpatient medications generally record each administration as a separate act.

The dose (doseQuantity) represents how many of the consumables are to be administered at each administration event. As a result, the dose is always relative to the consumable and the interval of administration. Thus, a patient consuming a single "metoprolol 25mg tablet" per administration will have a doseQuantity of "1", whereas a patient consuming "metoprolol" will have a dose of "25 mg".

350: Medication Activity (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| substanceAdministration[templateId/@root = '2.16.840.1.113883.10.20.22.4.16.2'] | | | | | |
| participant | 0..\* | MAY |  | [7523](#C_7523) |  |
| @typeCode | 1..1 | SHALL |  | [7524](#C_7524) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = CSM |
| participantRole | 1..1 | SHALL |  | [16086](#C_16086) |  |
| entryRelationship | 0..\* | MAY |  | [7536](#C_7536) |  |
| @typeCode | 1..1 | SHALL |  | [7537](#C_7537) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| observation | 1..1 | SHALL |  | [16087](#C_16087) |  |
| entryRelationship | 0..1 | MAY |  | [7539](#C_7539) |  |
| @typeCode | 1..1 | SHALL |  | [7540](#C_7540) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [7542](#C_7542) | true |
| act | 1..1 | SHALL |  | [31387](#C_31387) |  |
| @classCode | 1..1 | SHALL |  | [7496](#C_7496) | 2.16.840.1.113883.5.6 (HL7ActClass) = SBADM |
| @moodCode | 1..1 | SHALL |  | [7497](#C_7497) | 2.16.840.1.113883.11.20.9.18 (MoodCodeEvnInt) |
| templateId | 1..1 | SHALL |  | [7499](#C_7499) |  |
| @root | 1..1 | SHALL |  | [10504](#C_10504) | 2.16.840.1.113883.10.20.22.4.16.2 |
| id | 1..\* | SHALL |  | [7500](#C_7500) |  |
| code | 0..1 | MAY |  | [7506](#C_7506) |  |
| text | 0..1 | SHOULD |  | [7501](#C_7501) |  |
| reference | 0..1 | SHOULD |  | [15977](#C_15977) |  |
| @value | 0..1 | SHOULD |  | [15978](#C_15978) |  |
| statusCode | 1..1 | SHALL |  | [7507](#C_7507) | 2.16.840.1.113883.1.11.159331 (ActStatus) |
| effectiveTime | 1..1 | SHALL |  | [7508](#C_7508) |  |
| low | 1..1 | SHALL |  | [7511](#C_7511) |  |
| high | 1..1 | SHALL |  | [7512](#C_7512) |  |
| effectiveTime | 0..1 | SHOULD |  | [7513](#C_7513) |  |
| @operator | 1..1 | SHALL |  | [9106](#C_9106) | A |
| repeatNumber | 0..1 | MAY |  | [7555](#C_7555) |  |
| routeCode | 0..1 | MAY |  | [7514](#C_7514) | 2.16.840.1.113883.3.88.12.3221.8.7 (Medication Route FDA Value Set) |
| approachSiteCode | 0..1 | MAY | SET<CD> | [7515](#C_7515) | 2.16.840.1.113883.3.88.12.3221.8.9 (Body Site Value Set) |
| doseQuantity | 0..1 | SHOULD |  | [7516](#C_7516) |  |
| @unit | 0..1 | SHOULD |  | [7526](#C_7526) | 2.16.840.1.113883.1.11.12839 (UnitsOfMeasureCaseSensitive) |
| rateQuantity | 0..1 | MAY |  | [7517](#C_7517) |  |
| @unit | 1..1 | SHALL |  | [7525](#C_7525) | 2.16.840.1.113883.1.11.12839 (UnitsOfMeasureCaseSensitive) |
| maxDoseQuantity | 0..1 | MAY | RTO<PQ, PQ> | [7518](#C_7518) |  |
| administrationUnitCode | 0..1 | MAY |  | [7519](#C_7519) | 2.16.840.1.113883.3.88.12.3221.8.11 (Medication Product Form Value Set) |
| consumable | 1..1 | SHALL |  | [7520](#C_7520) |  |
| manufacturedProduct | 1..1 | SHALL |  | [16085](#C_16085) |  |
| performer | 0..1 | MAY |  | [7522](#C_7522) |  |
| entryRelationship | 0..1 | MAY |  | [7543](#C_7543) |  |
| @typeCode | 1..1 | SHALL |  | [7547](#C_7547) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| supply | 1..1 | SHALL |  | [16089](#C_16089) |  |
| entryRelationship | 0..\* | MAY |  | [7549](#C_7549) |  |
| @typeCode | 1..1 | SHALL |  | [7553](#C_7553) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| supply | 1..1 | SHALL |  | [16090](#C_16090) |  |
| entryRelationship | 0..1 | MAY |  | [7552](#C_7552) |  |
| @typeCode | 1..1 | SHALL |  | [7544](#C_7544) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = CAUS |
| observation | 1..1 | SHALL |  | [16091](#C_16091) |  |
| entryRelationship | 0..1 | MAY |  | [30820](#C_30820) |  |
| @typeCode | 1..1 | SHALL |  | [30821](#C_30821) | COMP |
| act | 1..1 | SHALL |  | [30822](#C_30822) |  |
| author | 0..\* | SHOULD |  | [31150](#C_31150) |  |
| entryRelationship | 0..\* | MAY |  | [31515](#C_31515) |  |
| @typeCode | 1..1 | SHALL |  | [31516](#C_31516) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| @inversionInd | 1..1 | SHALL |  | [31517](#C_31517) | true |
| sequenceNumber | 0..1 | MAY |  | [31518](#C_31518) |  |
| act | 1..1 | SHALL |  | [31519](#C_31519) |  |
| precondition | 0..\* | MAY |  | [31520](#C_31520) |  |

1. SHALL contain exactly one [1..1] @classCode="SBADM" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7496).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [MoodCodeEvnInt](#MoodCodeEvnInt) 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03 (CONF:7497).
3. SHALL contain exactly one [1..1] templateId (CONF:7499) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.16.2" (CONF:10504).
4. SHALL contain at least one [1..\*] id (CONF:7500).

SubstanceAdministration.code is an optional field. Per HL7 Pharmacy Committee, "this is intended to further specify the nature of the substance administration act. To date the committee has made no use of this attribute". Because the type of substance administration is generally implicit in the routeCode, in the consumable participant, etc, the field is generally not used, and there is no defined value set.

1. MAY contain zero or one [0..1] code (CONF:7506).
2. SHOULD contain zero or one [0..1] text (CONF:7501).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15977).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15978).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15979).
3. SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet [ActStatus](#ActStatus) 2.16.840.1.113883.1.11.159331 DYNAMIC (CONF:7507).

This effectiveTime represents the medication duration (i.e. the time the medication was started and stopped).

1. SHALL contain exactly one [1..1] effectiveTime (CONF:7508) such that it
   1. SHALL contain exactly one [1..1] low (CONF:7511).
   2. SHALL contain exactly one [1..1] high (CONF:7512).

This effectiveTime represents the medication frequency (e.g. administration times per day).

1. SHOULD contain zero or one [0..1] effectiveTime (CONF:7513) such that it
   1. SHALL contain exactly one [1..1] @operator="A" (CONF:9106).
   2. SHALL contain exactly one 1..1] @xsi:type=”PIVL*TS” or “EIVL*TS” (CONF:28499).

In "INT" (intent) mood, the repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times. To indicate a given medication's ordering in a series, use the nested Substance Administered Act.

1. MAY contain zero or one [0..1] repeatNumber (CONF:7555).
2. MAY contain zero or one [0..1] routeCode, which SHALL be selected from ValueSet [Medication Route FDA Value Set](#Medication_Route_FDA_Value_Set) 2.16.840.1.113883.3.88.12.3221.8.7 DYNAMIC (CONF:7514).
3. MAY contain zero or one [0..1] approachSiteCode, where the code SHALL be selected from ValueSet [Body Site Value Set](#Body_Site_Value_Set) 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:7515).
4. SHOULD contain zero or one [0..1] doseQuantity (CONF:7516).
   1. The doseQuantity, if present, SHOULD contain zero or one [0..1] @unit, which SHALL be selected from ValueSet [UnitsOfMeasureCaseSensitive](#UnitsOfMeasureCaseSensitive) 2.16.840.1.113883.1.11.12839 DYNAMIC (CONF:7526).
   2. Pre-coordinated consumable: If the consumable code is a pre-coordinated unit dose (e.g. "metoprolol 25mg tablet") then doseQuantity is a unitless number that indicates the number of products given per administration (e.g. "2", meaning 2 x "metoprolol 25mg tablet" per administration) (CONF:16878).
   3. Not pre-coordinated consumable: If the consumable code is not pre-coordinated (e.g. is simply "metoprolol"), then doseQuantity must represent a physical quantity with @unit, e.g. "25" and "mg", specifying the amount of product given per administration (CONF:16879).
5. MAY contain zero or one [0..1] rateQuantity (CONF:7517).
   1. The rateQuantity, if present, SHALL contain exactly one [1..1] @unit, which SHALL be selected from ValueSet [UnitsOfMeasureCaseSensitive](#UnitsOfMeasureCaseSensitive) 2.16.840.1.113883.1.11.12839 DYNAMIC (CONF:7525).
6. MAY contain zero or one [0..1] maxDoseQuantity (CONF:7518).
7. MAY contain zero or one [0..1] administrationUnitCode, which SHALL be selected from ValueSet [Medication Product Form Value Set](#Medication_Product_Form_Value_Set) 2.16.840.1.113883.3.88.12.3221.8.11 DYNAMIC (CONF:7519).
8. SHALL contain exactly one [1..1] consumable (CONF:7520).
   1. This consumable SHALL contain exactly one [1..1] [Medication Information (V2)](#E_Medication_Information_V2) (templateId:2.16.840.1.113883.10.20.22.4.23.2) (CONF:16085).
9. MAY contain zero or one [0..1] performer (CONF:7522).
10. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31150).
11. MAY contain zero or more [0..\*] participant (CONF:7523) such that it
    1. SHALL contain exactly one [1..1] @typeCode="CSM" (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:7524).
    2. SHALL contain exactly one [1..1] [Drug Vehicle](#E_Drug_Vehicle) (templateId:2.16.840.1.113883.10.20.22.4.24) (CONF:16086).
12. MAY contain zero or more [0..\*] entryRelationship (CONF:7536) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7537).
    2. SHALL contain exactly one [1..1] [Indication (V2)](#Indication_V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:16087).
13. MAY contain zero or one [0..1] entryRelationship (CONF:7539) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7540).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7542).
    3. SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31387).
14. MAY contain zero or one [0..1] entryRelationship (CONF:7543) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7547).
    2. SHALL contain exactly one [1..1] [Medication Supply Order (V2)](#E_Medication_Supply_Order_V2) (templateId:2.16.840.1.113883.10.20.22.4.17.2) (CONF:16089).
15. MAY contain zero or more [0..\*] entryRelationship (CONF:7549) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7553).
    2. SHALL contain exactly one [1..1] [Medication Dispense (V2)](#E_Medication_Dispense_V2) (templateId:2.16.840.1.113883.10.20.22.4.18.2) (CONF:16090).
16. MAY contain zero or one [0..1] entryRelationship (CONF:7552) such that it
    1. SHALL contain exactly one [1..1] @typeCode="CAUS" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7544).
    2. SHALL contain exactly one [1..1] [Reaction Observation (V2)](#Reaction_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.9.2) (CONF:16091).
17. MAY contain zero or one [0..1] entryRelationship (CONF:30820) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CONF:30821).
    2. SHALL contain exactly one [1..1] [Drug Monitoring Act (NEW)](#E_Drug_Monitoring_Act_NEW) (templateId:2.16.840.1.113883.10.20.22.4.123) (CONF:30822).
18. MAY contain zero or more [0..\*] entryRelationship (CONF:31515) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31516).
    2. SHALL contain exactly one [1..1] @inversionInd="true" (CONF:31517).
    3. MAY contain zero or one [0..1] sequenceNumber (CONF:31518).
    4. SHALL contain exactly one [1..1] [Substance Administered Act (NEW)](#E_Substance_Administered_Act_NEW) (templateId:2.16.840.1.113883.10.20.22.4.118) (CONF:31519).
19. MAY contain zero or more [0..\*] precondition (CONF:31520).
20. Medication Activity SHOULD include doseQuantity OR rateQuantity (CONF:30800).

351: MoodCodeEvnInt

|  |  |  |
| --- | --- | --- |
| Value Set: MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18  Contains moodCode EVN and INT | | |
| Code | Code System | Print Name |
| EVN | ActMood | Event |
| INT | ActMood | Intent |

352: ActStatus

|  |  |  |
| --- | --- | --- |
| Value Set: ActStatus 2.16.840.1.113883.1.11.159331  Contains the names (codes) for each of the states in the state-machine of the RIM Act class. | | |
| Code | Code System | Print Name |
| normal | ActStatus | normal |
| aborted | ActStatus | aborted |
| active | ActStatus | active |
| cancelled | ActStatus | cancelled |
| completed | ActStatus | completed |
| held | ActStatus | held |
| new | ActStatus | new |
| suspended | ActStatus | suspended |
| nullified | ActStatus | nullified |
| obsolete | ActStatus | obsolete |

353: Medication Route FDA Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Medication Route FDA Value Set 2.16.840.1.113883.3.88.12.3221.8.7  Route of Administration value set is based upon FDA Drug Registration and Listing Database (FDA Orange Book) which are used in FDA structured product and labelling (SPL). | | |
| Code | Code System | Print Name |
| C38192 | FDA RouteOfAdministration | AURICULAR (OTIC) |
| C38193 | FDA RouteOfAdministration | BUCCAL |
| C38194 | FDA RouteOfAdministration | CONJUNCTIVAL |
| C38675 | FDA RouteOfAdministration | CUTANEOUS |
| C38197 | FDA RouteOfAdministration | DENTAL |
| C38633 | FDA RouteOfAdministration | ELECTRO-OSMOSIS |
| C38205 | FDA RouteOfAdministration | ENDOCERVICAL |
| C38206 | FDA RouteOfAdministration | ENDOSINUSIAL |
| C38208 | FDA RouteOfAdministration | ENDOTRACHEAL |
| C38209 | FDA RouteOfAdministration | ENTERAL |
| ... | | |

354: Body Site Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Body Site Value Set 2.16.840.1.113883.3.88.12.3221.8.9  Body site value set is based upon the concepts descending from the SNOMED CT Anatomical Structure (91723000) hierarchy. | | |
| Code | Code System | Print Name |
| 56244007 | SNOMED CT | 10 to 19 percent of body surface (body structure) |
| 37491003 | SNOMED CT | 12 nm filaments (cell structure) |
| 78777002 | SNOMED CT | 20 to 29 percent of body surface (body structure) |
| 12423009 | SNOMED CT | 30 to 39 percent of body surface (body structure) |
| 36849000 | SNOMED CT | 40 to 49 percent of body surface (body structure) |
| 305024009 | SNOMED CT | 5/6 interchondral joint (body structure) |
| 76152003 | SNOMED CT | 50 to 59 percent of body surface (body structure) |
| 305005006 | SNOMED CT | 6/7 interchondral joint (body structure) |
| 91551007 | SNOMED CT | 60 to 69 percent of body surface (body structure) |
| 64700008 | SNOMED CT | 7 nm filaments (cell structure) |
| ... | | |

355: UnitsOfMeasureCaseSensitive

|  |  |  |
| --- | --- | --- |
| Value Set: UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 | | |
| Code | Code System | Print Name |
| 10\* | UCUM | the number ten for arbitrary powers |
| 10^ | UCUM | the number ten for arbitrary powers |
| [pi] | UCUM | the number pi |
| % | UCUM | percent |
| [ppth] | UCUM | parts per thousand |
| [ppm] | UCUM | parts per million |
| [ppb] | UCUM | parts per billion |
| [pptr] | UCUM | parts per trillion |
| mol | UCUM | mole |
| sr | UCUM | steradian |
| ... | | |

356: Medication Product Form Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Medication Product Form Value Set 2.16.840.1.113883.3.88.12.3221.8.11  This is the physical form of the product as presented to the individual. For example: tablet, capsule, liquid or ointment. NCI concept code for pharmaceutical dosage form: C42636 | | |
| Code | Code System | Print Name |
| C42887 | FDA RouteOfAdministration | AEROSOL |
| C42888 | FDA RouteOfAdministration | AEROSOL, FOAM |
| C42960 | FDA RouteOfAdministration | AEROSOL, METERED |
| C42971 | FDA RouteOfAdministration | AEROSOL, POWDER |
| C42889 | FDA RouteOfAdministration | AEROSOL, SPRAY |
| C42892 | FDA RouteOfAdministration | BAR, CHEWABLE |
| C42890 | FDA RouteOfAdministration | BEAD |
| C43451 | FDA RouteOfAdministration | BEAD, IMPLANT, EXTENDED RELEASE |
| C42891 | FDA RouteOfAdministration | BLOCK |
| C25158 | FDA RouteOfAdministration | CAPSULE |
| ... | | |

Figure 147: Medication Activity Example

<entry typeCode="DRIV">

<substanceAdministration classCode="SBADM" moodCode="EVN">

<!-- \*\* Medication activity \*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.16.2"/>

<id root="cdbd33f0-6cde-11db-9fe1-0800200c9a66"/>

<statusCode code="completed"/>

<effectiveTime xsi:type="IVL\_TS">

<low value="20110103"/>

<high value="20120515"/>

</effectiveTime>

<effectiveTime xsi:type="PIVL\_TS" institutionSpecified="true"

operator="A">

<period value="6" unit="h"/>

</effectiveTime>

<routeCode code="C38216" codeSystem="2.16.840.1.113883.3.26.1.1"

codeSystemName="NCI Thesaurus"

displayName="RESPIRATORY (INHALATION)"/>

<doseQuantity value="1" unit="mg/actuat"/>

<rateQuantity value="90" unit="ml/min"/>

<maxDoseQuantity nullFlavor="UNK">

<numerator nullFlavor="UNK"/>

<denominator nullFlavor="UNK"/>

</maxDoseQuantity>

<administrationUnitCode code="C42944" displayName="INHALANT"

codeSystem="2.16.840.1.113883.3.26.1.1"

codeSystemName="NCI Thesaurus"/>

Medication Dispense (V2)

[supply: templateId 2.16.840.1.113883.10.20.22.4.18.2 (open)]

357: Medication Dispense (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medication Activity (V2)](#Medication_Activity_V2) (optional)  [Immunization Activity (V2)](#E_Immunization_Activity_V2) (optional) | [Immunization Medication Information (V2)](#Immunization_Medication_Information_V2)  [Medication Information (V2)](#E_Medication_Information_V2)  [Medication Supply Order (V2)](#E_Medication_Supply_Order_V2) |

This template records the act of supplying medications (i.e., dispensing).

358: Medication Dispense (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| supply[templateId/@root = '2.16.840.1.113883.10.20.22.4.18.2'] | | | | | |
| product | 0..1 | MAY |  | [9331](#C_9331) |  |
| manufacturedProduct | 1..1 | SHALL |  | [31696](#C_31696) |  |
| @classCode | 1..1 | SHALL |  | [7451](#C_7451) | 2.16.840.1.113883.5.6 (HL7ActClass) = SPLY |
| @moodCode | 1..1 | SHALL |  | [7452](#C_7452) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7453](#C_7453) |  |
| @root | 1..1 | SHALL |  | [10505](#C_10505) | 2.16.840.1.113883.10.20.22.4.18.2 |
| id | 1..\* | SHALL |  | [7454](#C_7454) |  |
| statusCode | 1..1 | SHALL |  | [7455](#C_7455) | 2.16.840.1.113883.3.88.12.80.64 (Medication Fill Status) |
| effectiveTime | 0..1 | SHOULD |  | [7456](#C_7456) |  |
| repeatNumber | 0..1 | SHOULD |  | [7457](#C_7457) |  |
| quantity | 0..1 | SHOULD |  | [7458](#C_7458) |  |
| product | 0..1 | MAY |  | [7459](#C_7459) |  |
| manufacturedProduct | 1..1 | SHALL |  | [15607](#C_15607) |  |
| performer | 0..1 | MAY |  | [7461](#C_7461) |  |
| assignedEntity | 1..1 | SHALL |  | [7467](#C_7467) |  |
| addr | 0..1 | SHOULD |  | [7468](#C_7468) |  |
| entryRelationship | 0..1 | MAY |  | [7473](#C_7473) |  |
| @typeCode | 1..1 | SHALL |  | [7474](#C_7474) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| supply | 1..1 | SHALL |  | [15606](#C_15606) |  |

1. SHALL contain exactly one [1..1] @classCode="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7451).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7452).
3. SHALL contain exactly one [1..1] templateId (CONF:7453) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.18.2" (CONF:10505).
4. SHALL contain at least one [1..\*] id (CONF:7454).
5. SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet [Medication Fill Status](#Medication_Fill_Status) 2.16.840.1.113883.3.88.12.80.64 DYNAMIC (CONF:7455).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:7456).
7. SHOULD contain zero or one [0..1] repeatNumber (CONF:7457).
   1. In "EVN" (event) mood, the repeatNumber is the number of occurrences. For example, a repeatNumber of "3" in a dispense act means that the current dispensation is the 3rd (CONF:16876).
8. SHOULD contain zero or one [0..1] quantity (CONF:7458).
9. MAY contain zero or one [0..1] product (CONF:7459) such that it
   1. SHALL contain exactly one [1..1] [Medication Information (V2)](#E_Medication_Information_V2) (templateId:2.16.840.1.113883.10.20.22.4.23.2) (CONF:15607).
10. MAY contain zero or one [0..1] product (CONF:9331) such that it
    1. SHALL contain exactly one [1..1] [Immunization Medication Information (V2)](#Immunization_Medication_Information_V2) (templateId:2.16.840.1.113883.10.20.22.4.54.2) (CONF:31696).
11. MAY contain zero or one [0..1] performer (CONF:7461).
    1. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:7467).
       1. This assignedEntity SHOULD contain zero or one [0..1] addr (CONF:7468).
          1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10565).
12. MAY contain zero or one [0..1] entryRelationship (CONF:7473) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7474).
    2. SHALL contain exactly one [1..1] [Medication Supply Order (V2)](#E_Medication_Supply_Order_V2) (templateId:2.16.840.1.113883.10.20.22.4.17.2) (CONF:15606).
13. A supply act SHALL contain one product/Medication Information or one product/Immunization Medication Information template (CONF:9333).

359: Medication Fill Status

|  |  |  |
| --- | --- | --- |
| Value Set: Medication Fill Status 2.16.840.1.113883.3.88.12.80.64 | | |
| Code | Code System | Print Name |
| aborted | ActStatus | Aborted |
| completed | ActStatus | Completed |

Figure 148: Medication Dispense Example

<supply classCode="SPLY" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.18.2"/>

<id root="1.2.3.4.56789.1"

extension="cb734647-fc99-424c-a864-7e3cda82e704"/>

<statusCode code="completed"/>

<effectiveTime value="201208151450-0800"/>

<repeatNumber value="1"/>

<quantity value="75"/>

<product>

<manufacturedProduct classCode="MANU">

<templateId root="2.16.840.1.113883.10.20.22.4.23.2"/>

. . .

</manufacturedProduct>

</product>

<performer>

<assignedEntity>

. . .

</performer>

</supply>

Medication Information (V2)

[manufacturedProduct: templateId 2.16.840.1.113883.10.20.22.4.23.2 (open)]

360: Medication Information (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medication Activity (V2)](#Medication_Activity_V2) (required)  [Medication Supply Order (V2)](#E_Medication_Supply_Order_V2) (optional)  [Medication Dispense (V2)](#E_Medication_Dispense_V2) (optional) |  |

The medication can be recorded as a pre-coordinated product strength, product form, or product concentration (e.g., “metoprolol 25mg tablet”, “amoxicillin 400mg/5mL suspension”) or not pre-coordinated (e.g., “metoprolol product”).

361: Medication Information (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| manufacturedProduct[templateId/@root = '2.16.840.1.113883.10.20.22.4.23.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7408](#C_7408) | 2.16.840.1.113883.5.110 (RoleClass) = MANU |
| templateId | 1..1 | SHALL |  | [7409](#C_7409) |  |
| @root | 1..1 | SHALL |  | [10506](#C_10506) | 2.16.840.1.113883.10.20.22.4.23.2 |
| id | 0..\* | MAY |  | [7410](#C_7410) |  |
| manufacturedMaterial | 1..1 | SHALL |  | [7411](#C_7411) |  |
| code | 1..1 | SHALL |  | [7412](#C_7412) | Temp-ValueSet-medications (Medication Consumable) |
| manufacturerOrganization | 0..1 | MAY |  | [7416](#C_7416) |  |

1. SHALL contain exactly one [1..1] @classCode="MANU" (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:7408).
2. SHALL contain exactly one [1..1] templateId (CONF:7409) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.23.2" (CONF:10506).
3. MAY contain zero or more [0..\*] id (CONF:7410).
4. SHALL contain exactly one [1..1] manufacturedMaterial (CONF:7411).
   1. This manufacturedMaterial SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [Medication Consumable](#Medication_Consumable) Temp-ValueSet-medications DYNAMIC (CONF:7412).
5. MAY contain zero or one [0..1] manufacturerOrganization (CONF:7416).

362: Medication Consumable

|  |  |  |
| --- | --- | --- |
| Value Set: Medication Consumable Temp-ValueSet-medications  A value set of RxNorm codes, intensionally defined to include those whose RxNorm Term Type is SCD (semantic clinical drug), SBD (semantic brand drug), GPCK (generic pack), BPCK (brand pack), SCDG (semantic clinical drug group), SBDG (semantic brand drug group), SCDF (semantic clinical drug form), or SBDF (semantic brand drug form).  (Final VSAC URL pending)  Valueset Source: <https://vsac.nlm.nih.gov/> | | |
| Code | Code System | Print Name |
| 978727 | RxNorm | 0.2 ML Dalteparin Sodium 12500 UNT/ML Prefilled Syringe [Fragmin] |
| 827318 | RxNorm | Acetaminophen 250 MG / Aspirin 250 MG / Caffeine 65 MG Oral Capsule |
| 199274 | RxNorm | Aspirin 300 MG Oral Capsule |
| 362867 | RxNorm | Cefotetan Injectable Solution [Cefotan] |
| ... | | |

Figure 149: Medication Information Example

<manufacturedProduct classCode="MANU">

<templateId root="2.16.840.1.113883.10.20.22.4.23.2" />

<id root="2a620155-9d11-439e-92b3-5d9815ff4ee8" />

<manufacturedMaterial>

<code code="573621" codeSystem="2.16.840.1.113883.6.88" displayName="Proventil 0.09 MG/ACTUAT inhalant solution">

<originalText>

<reference value="#medication1" />

</originalText>

<translation code="219483" displayName="Proventil HFA" codeSystem="2.16.840.1.113883.6.88" codeSystemName="RxNorm" />

</code>

</manufacturedMaterial>

<manufacturerOrganization>

<name>Medication Factory Inc.</name>

</manufacturerOrganization>

</manufacturedProduct>

Medication Supply Order (V2)

[supply: templateId 2.16.840.1.113883.10.20.22.4.17.2 (open)]

363: Medication Supply Order (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medication Activity (V2)](#Medication_Activity_V2) (optional)  [Immunization Activity (V2)](#E_Immunization_Activity_V2) (optional)  [Medication Dispense (V2)](#E_Medication_Dispense_V2) (optional) | [Immunization Medication Information (V2)](#Immunization_Medication_Information_V2)  [Instruction (V2)](#Instruction_V2)  [Medication Information (V2)](#E_Medication_Information_V2) |

This template records the intent to supply a patient with medications.

364: Medication Supply Order (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| supply[templateId/@root = '2.16.840.1.113883.10.20.22.4.17.2'] | | | | | |
| product | 0..1 | MAY |  | [9334](#C_9334) |  |
| manufacturedProduct | 1..1 | SHALL |  | [31695](#C_31695) |  |
| entryRelationship | 0..1 | MAY |  | [7442](#C_7442) |  |
| @typeCode | 1..1 | SHALL |  | [7444](#C_7444) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [7445](#C_7445) | true |
| act | 1..1 | SHALL |  | [31391](#C_31391) |  |
| product | 0..1 | MAY |  | [7439](#C_7439) |  |
| manufacturedProduct | 1..1 | SHALL |  | [16093](#C_16093) |  |
| @classCode | 1..1 | SHALL |  | [7427](#C_7427) | 2.16.840.1.113883.5.6 (HL7ActClass) = SPLY |
| @moodCode | 1..1 | SHALL |  | [7428](#C_7428) | 2.16.840.1.113883.5.1001 (ActMood) = INT |
| templateId | 1..1 | SHALL |  | [7429](#C_7429) |  |
| @root | 1..1 | SHALL |  | [10507](#C_10507) | 2.16.840.1.113883.10.20.22.4.17.2 |
| id | 1..\* | SHALL |  | [7430](#C_7430) |  |
| statusCode | 1..1 | SHALL |  | [7432](#C_7432) |  |
| effectiveTime | 0..1 | SHOULD | IVL\_TS | [15143](#C_15143) |  |
| high | 1..1 | SHALL |  | [15144](#C_15144) |  |
| repeatNumber | 0..1 | SHOULD |  | [7434](#C_7434) |  |
| quantity | 0..1 | SHOULD |  | [7436](#C_7436) |  |
| author | 0..1 | MAY |  | [7438](#C_7438) |  |

1. SHALL contain exactly one [1..1] @classCode="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7427).
2. SHALL contain exactly one [1..1] @moodCode="INT" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7428).
3. SHALL contain exactly one [1..1] templateId (CONF:7429) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.17.2" (CONF:10507).
4. SHALL contain at least one [1..\*] id (CONF:7430).
5. SHALL contain exactly one [1..1] statusCode (CONF:7432).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:15143) such that it
   1. SHALL contain exactly one [1..1] high (CONF:15144).
7. SHOULD contain zero or one [0..1] repeatNumber (CONF:7434).
   1. In "INT" (intent) mood, the repeatNumber defines the number of allowed fills. For example, a repeatNumber of "3" means that the substance can be supplied up to 3 times (or, can be dispensed, with 2 refills) (CONF:16869).
8. SHOULD contain zero or one [0..1] quantity (CONF:7436).
9. MAY contain zero or one [0..1] product (CONF:7439) such that it
   1. SHALL contain exactly one [1..1] [Medication Information (V2)](#E_Medication_Information_V2) (templateId:2.16.840.1.113883.10.20.22.4.23.2) (CONF:16093).
10. MAY contain zero or one [0..1] product (CONF:9334) such that it
    1. SHALL contain exactly one [1..1] [Immunization Medication Information (V2)](#Immunization_Medication_Information_V2) (templateId:2.16.840.1.113883.10.20.22.4.54.2) (CONF:31695).
       1. A supply act SHALL contain one product/Medication Information or one product/Immunization Medication Information template (CONF:16870).
11. MAY contain zero or one [0..1] author (CONF:7438).
12. MAY contain zero or one [0..1] entryRelationship (CONF:7442).
    1. The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7444).
    2. The entryRelationship, if present, SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7445).
    3. The entryRelationship, if present, SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31391).

Figure 150: Medication Supply Order Example

<supply classCode="SPLY" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.17.2"/>

<id root="aba2fc75-1a43-435f-8309-d24e4be5f1cd"/>

<statusCode code="completed"/>

<effectiveTime xsi:type="IVL\_TS">

<low value="20070103"/>

<high nullFlavor="UNK"/>

</effectiveTime>

<repeatNumber value="1"/>

<quantity value="75"/>

<product>

<manufacturedProduct classCode="MANU">

<templateId root="2.16.840.1.113883.10.20.22.4.23.2"/>

. . .

</manufacturedProduct>

</product>

<author>

. . .

</author>

<entryRelationship typeCode="SUBJ" inversionInd="true">

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.20"/>

. . .

</act>

</entryRelationship>

</supply>

Medication Use - None Known (obsolete)

[observation: templateId 2.16.840.1.113883.10.20.22.4.29.obsolete (open)]

365: Medication Use - None Known (obsolete) Contexts

| Contained By: | Contains: |
| --- | --- |

This template is obsolete and will be deleted completely in the future.

The recommended approach to stating no known medications is to use the appropriate nullFlavor instead of this template.

See ""Unknown Information"" in Section 1.

366: Medication Use - None Known (obsolete) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.29.obsolete'] | | | | | |

Mental Status Observation (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.125 (open)]

367: Mental Status Observation (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Assessment Scale Observation](#E_Assessment_Scale_Observation)  [Author Participation (NEW)](#U_Author_Participation_NEW) |

This template represents observations relating intellectual, mental powers and state of mind. Mental Status observations in a clinical note often have a psychological focus (e.g . level of consciousness, mood, anxiety level, reasoning ability).

368: Mental Status Observation (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.125'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [29207](#C_29207) |  |
| @typeCode | 1..1 | SHALL |  | [29208](#C_29208) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| observation | 1..1 | SHALL |  | [29209](#C_29209) |  |
| @classCode | 1..1 | SHALL |  | [29182](#C_29182) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [29183](#C_29183) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [29186](#C_29186) |  |
| @root | 1..1 | SHALL |  | [29187](#C_29187) | 2.16.840.1.113883.10.20.22.4.125 |
| id | 1..\* | SHALL |  | [29188](#C_29188) |  |
| code | 1..1 | SHALL |  | [29189](#C_29189) | 2.16.840.1.113883.11.20.9.43 (Mental Status Observation Type) |
| statusCode | 1..1 | SHALL |  | [29194](#C_29194) |  |
| @code | 1..1 | SHALL |  | [29195](#C_29195) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [29196](#C_29196) |  |
| value | 1..1 | SHALL | CD | [29202](#C_29202) | 2.16.840.1.113883.11.20.9.44 (Mental and Functional Status Response Value Set) |
| author | 0..\* | SHOULD |  | [31435](#C_31435) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:29182).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:29183).
3. SHALL contain exactly one [1..1] templateId (CONF:29186) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.125" (CONF:29187).
4. SHALL contain at least one [1..\*] id (CONF:29188).
5. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet [Mental Status Observation Type](#Mental_Status_Observation_Type) 2.16.840.1.113883.11.20.9.43 DYNAMIC (CONF:29189).
6. SHALL contain exactly one [1..1] statusCode (CONF:29194).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:29195).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:29196).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [Mental and Functional Status Response Value Set](#Mental_and_Functional_Status_Response_V) 2.16.840.1.113883.11.20.9.44 DYNAMIC (CONF:29202).
9. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31435).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:29207) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:29208).
    2. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:29209).

369: Mental Status Observation Type

|  |  |  |
| --- | --- | --- |
| Value Set: Mental Status Observation Type 2.16.840.1.113883.11.20.9.43  A value set of observable entity codes for types of mental status. | | |
| Code | Code System | Print Name |
| 43173001 | SNOMED CT | orientation, function (observable entity) |
| 405051006 | SNOMED CT | level of anxiety (observable entity) |
| 363871006 | SNOMED CT | mental state (observable entity) |
| 85256008 | SNOMED CT | mood, function (observable entity) |
| 285231000 | SNOMED CT | mental function (observable entity) |
| 6942003 | SNOMED CT | level of consciousness (observable entity) |

370: Mental and Functional Status Response Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Mental and Functional Status Response Value Set 2.16.840.1.113883.11.20.9.44  A value set containing 2 SNOMED-CT qualifier codes that are common responses to mental and functional ability queries. | | |
| Code | Code System | Print Name |
| 11163003 | SNOMED CT | Intact |
| 260379002 | SNOMED CT | Impaired |

Figure 151: Mental Status Observation Example

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Mental Status Observation template -->

<templateId root="2.16.840.1.113883.10.20.22.4.125"/>

<id root="c12ecaaf-53f8-4593-8f79-359aeaa3948b"/>

<code xsi:type="CD" code="285231000" displayName="Mental Function"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"> </code>

<statusCode code="completed"/>

<effectiveTime value="20130311"/>

<value xsi:type="CD" code="11163003" displayName="Intact"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT">

</value>

<author>

<time value="200130311"/>

<assignedAuthor>

<id extension="KP00017" root="2.16.840.1.113883.19.5"/>

<addr>

<streetAddressLine>1003 Health Care

Drive</streetAddressLine>

<city>Ann Arbor</city>

<state>MI</state>

<postalCode>02368</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:(555)555-1003"/>

<assignedPerson>

<name>

<given>Assigned</given>

<family>Amanda</family>

</name>

</assignedPerson>

</assignedAuthor>

</author>

</observation>

</entry>

Non-Medicinal Supply Activity (V2)

[supply: templateId 2.16.840.1.113883.10.20.22.4.50.2 (open)]

371: Non-Medicinal Supply Activity (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW) (optional)  [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2) (optional)  [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (optional)  [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Instruction (V2)](#Instruction_V2)  [Product Instance](#E_Product_Instance) |

This template represents non-medicinal supplies, such as medical equipment. - NOTES: RENT OR OWN EXPIRATION DATE

372: Non-Medicinal Supply Activity (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| supply[templateId/@root = '2.16.840.1.113883.10.20.22.4.50.2'] | | | | | |
| entryRelationship | 0..1 | MAY |  | [30277](#C_30277) |  |
| @typeCode | 1..1 | SHALL |  | [30278](#C_30278) | SUBJ |
| @inversionInd | 1..1 | SHALL |  | [30279](#C_30279) | TRUE |
| act | 1..1 | SHALL |  | [31393](#C_31393) |  |
| @classCode | 1..1 | SHALL |  | [8745](#C_8745) | 2.16.840.1.113883.5.6 (HL7ActClass) = SPLY |
| @moodCode | 1..1 | SHALL |  | [8746](#C_8746) | 2.16.840.1.113883.11.20.9.18 (MoodCodeEvnInt) |
| templateId | 1..1 | SHALL |  | [8747](#C_8747) |  |
| @root | 1..1 | SHALL |  | [10509](#C_10509) | 2.16.840.1.113883.10.20.22.4.50.2 |
| id | 1..\* | SHALL |  | [8748](#C_8748) |  |
| statusCode | 1..1 | SHALL |  | [8749](#C_8749) |  |
| effectiveTime | 0..1 | SHOULD | IVL\_TS | [15498](#C_15498) |  |
| quantity | 0..1 | SHOULD |  | [8751](#C_8751) |  |
| participant | 0..1 | MAY |  | [8752](#C_8752) |  |
| @typeCode | 1..1 | SHALL |  | [8754](#C_8754) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = PRD |
| participantRole | 1..1 | SHALL |  | [15900](#C_15900) |  |

1. SHALL contain exactly one [1..1] @classCode="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8745).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [MoodCodeEvnInt](#MoodCodeEvnInt) 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03 (CONF:8746).
3. SHALL contain exactly one [1..1] templateId (CONF:8747) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.50.2" (CONF:10509).
4. SHALL contain at least one [1..\*] id (CONF:8748).
5. SHALL contain exactly one [1..1] statusCode (CONF:8749).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:15498).
   1. The effectiveTime, if present, SHOULD contain zero or one 0..1] high (CONF:16867).
7. SHOULD contain zero or one [0..1] quantity (CONF:8751).
8. MAY contain zero or one [0..1] participant (CONF:8752) such that it
   1. SHALL contain exactly one [1..1] @typeCode="PRD" Product (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8754).
   2. SHALL contain exactly one [1..1] [Product Instance](#E_Product_Instance) (templateId:2.16.840.1.113883.10.20.22.4.37) (CONF:15900).
9. MAY contain zero or one [0..1] entryRelationship (CONF:30277) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" (CONF:30278).
   2. SHALL contain exactly one [1..1] @inversionInd="TRUE" (CONF:30279).
   3. SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31393).

373: MoodCodeEvnInt

|  |  |  |
| --- | --- | --- |
| Value Set: MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18  Contains moodCode EVN and INT | | |
| Code | Code System | Print Name |
| EVN | ActMood | Event |
| INT | ActMood | Intent |

Figure 152: Non-Medicinal Supply Activity Example

<supply classCode="SPLY" moodCode="RQO">

<templateId root="2.16.840.1.113883.10.20.22.4.50"/>

<!-- Non-medicinal supply activity template \*\*\*\*\*\*\* -->

<id root="2413773c-2372-4299-bbe6-5b0f60664446"/>

<statusCode code="completed"/>

<effectiveTime xsi:type="IVL\_TS">

<high value="20130703"/>

</effectiveTime>

<quantity value="1"/>

<participant typeCode="PRD">

<participantRole classCode="MANU">

<templateId root="2.16.840.1.113883.10.20.22.4.37" />

<!-- Product instance template -->

<id root="742aee30-21c5-11e1-bfc2-0800200c9a66" />

<playingDevice>

<code code="44668000" displayName="Pump"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT">

<originalText>Pumps</originalText>

</code>

</playingDevice>

<scopingEntity>

<id root="eb936010-7b17-11db-9fe1-0800200c9b65" />

<desc>Good Health Durable Medical Equipment</desc>

</scopingEntity>

</participantRole>

</participant>

</supply>

Number of Pressure Ulcers Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.76 (open)]

374: Number of Pressure Ulcers Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2) (optional) |  |

This clinical statement enumerates the number of pressure ulcers observed in a particular stage.

375: Number of Pressure Ulcers Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.76'] | | | | | |
| @classCode | 1..1 | SHALL |  | [14705](#C_14705) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14706](#C_14706) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [14707](#C_14707) |  |
| @root | 1..1 | SHALL |  | [14708](#C_14708) | 2.16.840.1.113883.10.20.22.4.76 |
| id | 1..\* | SHALL |  | [14709](#C_14709) |  |
| statusCode | 1..1 | SHALL |  | [14714](#C_14714) |  |
| @code | 1..1 | SHALL |  | [19108](#C_19108) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [14715](#C_14715) |  |
| author | 0..1 | MAY |  | [14717](#C_14717) |  |
| entryRelationship | 1..1 | SHALL |  | [14718](#C_14718) |  |
| @typeCode | 1..1 | SHALL |  | [14719](#C_14719) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| observation | 1..1 | SHALL |  | [14720](#C_14720) |  |
| @classCode | 1..1 | SHALL |  | [14721](#C_14721) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14722](#C_14722) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| value | 1..1 | SHALL | CD | [14725](#C_14725) | 2.16.840.1.113883.11.20.9.35 (Pressure Ulcer Stage) |
| code | 1..1 | SHALL |  | [14767](#C_14767) |  |
| @code | 1..1 | SHALL |  | [14768](#C_14768) | 2264892003 |
| value | 1..1 | SHALL | INT | [14771](#C_14771) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14705).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14706).
3. SHALL contain exactly one [1..1] templateId (CONF:14707) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.76" (CONF:14708).
4. SHALL contain at least one [1..\*] id (CONF:14709).
5. SHALL contain exactly one [1..1] code (CONF:14767).
   1. This code SHALL contain exactly one [1..1] @code="2264892003" number of pressure ulcers (CONF:14768).
6. SHALL contain exactly one [1..1] statusCode (CONF:14714).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19108).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:14715).
8. SHALL contain exactly one [1..1] value with @xsi:type="INT" (CONF:14771).
9. MAY contain zero or one [0..1] author (CONF:14717).
10. SHALL contain exactly one [1..1] entryRelationship (CONF:14718).
    1. This entryRelationship SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14719).
    2. This entryRelationship SHALL contain exactly one [1..1] observation (CONF:14720).
       1. This observation SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14721).
       2. This observation SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14722).
       3. This observation SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [Pressure Ulcer Stage](#Pressure_Ulcer_Stage) 2.16.840.1.113883.11.20.9.35 STATIC (CONF:14725).

376: Pressure Ulcer Stage

|  |  |  |
| --- | --- | --- |
| Value Set: Pressure Ulcer Stage 2.16.840.1.113883.11.20.9.35 | | |
| Code | Code System | Print Name |
| 421076008 | SNOMED CT | Pressure Ulcer Stage 1 |
| 420324007 | SNOMED CT | Pressure Ulcer Stage 2 |
| 421927004 | SNOMED CT | Pressure Ulcer Stage 3 |
| 420597008 | SNOMED CT | Pressure Ulcer Stage 4 |
| 421594008 | SNOMED CT | Nonstageable pressure |

Figure 153: Number of Pressure Ulcers Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.76"/>

<id root="08edb7c0-2111-43f2-a784-9a5fdfaa67f0"/>

<code code="2264892003"

codeSystem="2.16.840.1.113883.6.96"

displayName="number of pressure ulcers"/>

<statusCode code="completed"/>

<value xsi:type="INT" value="3"/>

<entryRelationship typeCode="SUBJ">

<observation classCode="OBS" moodCode="EVN">

<value xsi:type="CD" code="421927004"

codeSystem="2.16.840.1.113883.6.96"

displayName="Pressure ulcer stage 3"/>

</observation>

</entryRelationship>

</observation>

Nutrition Assessment (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.138 (open)]

377: Nutrition Assessment (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Nutritional Status Observation (NEW)](#E_Nutritional_Status_Observation_NEW) (required)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Author Participation (NEW)](#U_Author_Participation_NEW) |

This template represents the patient's nutrition abilities and habits including intake, diet requirements or diet followed.

378: Nutrition Assessment (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.138'] | | | | | |
| @classCode | 1..1 | SHALL |  | [30324](#C_30324) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [30325](#C_30325) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [30326](#C_30326) |  |
| @root | 1..1 | SHALL |  | [30327](#C_30327) | 2.16.840.1.113883.10.20.22.4.138 |
| id | 1..\* | SHALL |  | [30328](#C_30328) |  |
| code | 1..1 | SHALL |  | [30329](#C_30329) | 2.16.840.1.113883.1.11.20.2.8 (Nutrition Assessment) |
| statusCode | 1..1 | SHALL |  | [30332](#C_30332) |  |
| @code | 1..1 | SHALL |  | [30333](#C_30333) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL |  | [30334](#C_30334) |  |
| effectiveTime | 1..1 | SHALL |  | [31666](#C_31666) |  |
| author | 0..\* | SHOULD |  | [31667](#C_31667) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:30324).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:30325).
3. SHALL contain exactly one [1..1] templateId (CONF:30326) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.138" (CONF:30327).
4. SHALL contain at least one [1..\*] id (CONF:30328).
5. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet [Nutrition Assessment](#Nutrition_Assessment) 2.16.840.1.113883.1.11.20.2.8 DYNAMIC (CONF:30329).
6. SHALL contain exactly one [1..1] statusCode (CONF:30332).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:30333).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:31666).
8. SHALL contain exactly one [1..1] value (CONF:30334).
9. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31667).

379: Nutrition Assessment

|  |  |  |
| --- | --- | --- |
| Value Set: Nutrition Assessment 2.16.840.1.113883.1.11.20.2.8  A value set of SNOMED-CT observable entity codes descending from "364645004" "eating feeding / drinking observable (observable entity)" for diet and nutrition habits and abilities.    Specific URL Pending  Valueset Source: <http://vtsl.vetmed.vt.edu/> | | |
| Code | Code System | Print Name |
| 364395008 | SNOMED CT | dietary intake (observable entity) |
| 364394007 | SNOMED CT | dietary requirements (observable entity) |
| 230125005 | SNOMED CT | diet followed (observable entity) |
| 288929001 | SNOMED CT | ability to clear mouth of residue (observable entity) |
| 288987002 | SNOMED CT | ability to latch on to breast for feeding (observable entity) |
| ... | | |

Figure 154: Nutrition Assessment Example

<entryRelationship typeCode="SUBJ">

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Nutrition Assessment\*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.138"/>

<id root="ab1791b0-5c71-11db-b0de-0800200c9a66"/>

<code xsi:type="CD" code="230125005" displayName="diet followed"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"/>

<statusCode code="completed"/>

<effectiveTime value="20130512"/>

<value xsi:type="CD" code="386619000"

displayName="low sodium diet (finding)"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"> </value>

<author typeCode="AUT">

<templateId root="2.16.840.1.113883.10.20.22.4.119"/>

<time value="201300512" />

...

</author>

</observation>

</entryRelationship>

Nutrition Recommendations (NEW)

[procedure: templateId 2.16.840.1.113883.10.20.22.4.130 (open)]

380: Nutrition Recommendations (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) |  |

This template represents nutrition regimens (e.g. fluid restrictions, calorie minimum), interventions (e.g. NPO, nutritional supplements), and procedures (e.g. G-Tube by bolus, TPN by central line). It may also depict the need for nutrition education.

381: Nutrition Recommendations (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| procedure[templateId/@root = '2.16.840.1.113883.10.20.22.4.130'] | | | | | |
| templateId | 1..1 | SHALL |  | [30340](#C_30340) |  |
| @root | 1..1 | SHALL |  | [30341](#C_30341) | 2.16.840.1.113883.10.20.22.4.130 |
| code | 1..1 | SHALL |  | [30342](#C_30342) | 2.16.840.1.113883.1.11.20.2.9 (Nutrition Recommendations) |
| @classCode | 1..1 | SHALL |  | [30385](#C_30385) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [30386](#C_30386) | 2.16.840.1.113883.11.20.9.23 (Plan of Care moodCode (Act/Encounter/Procedure)) |
| statusCode | 1..1 | SHALL |  | [31697](#C_31697) |  |
| @code | 1..1 | SHALL |  | [31698](#C_31698) | 2.16.840.1.113883.5.14 (ActStatus) = active |
| effectiveTime | 0..1 | SHOULD |  | [31699](#C_31699) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:30385).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [Plan of Care moodCode (Act/Encounter/Procedure)](#Plan_of_Care_moodCode_ActEncounterProce) 2.16.840.1.113883.11.20.9.23 (CONF:30386).
3. SHALL contain exactly one [1..1] templateId (CONF:30340) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.130" (CONF:30341).
4. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet [Nutrition Recommendations](#Nutrition_Recommendations) 2.16.840.1.113883.1.11.20.2.9 DYNAMIC (CONF:30342).
5. SHALL contain exactly one [1..1] statusCode (CONF:31697).
   1. This statusCode SHALL contain exactly one [1..1] @code="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31698).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:31699).

382: Nutrition Recommendations

|  |  |  |
| --- | --- | --- |
| Value Set: Nutrition Recommendations 2.16.840.1.113883.1.11.20.2.9  Types of nutritional regimes, therapies or interventions. | | |
| Code | Code System | Print Name |
| 61310001 | SNOMED CT | nutrition education (procedure) |
| 386373004 | SNOMED CT | nutrition therapy (regime/therapy) |
| 418995006 | SNOMED CT | feeding regime (regime/therapy) |
| 413315001 | SNOMED CT | nutrition / feeding management (regime/therapy) |
| 182922004 | SNOMED CT | dietary regime (regime/therapy) |
| 229912004 | SNOMED CT | enteral feeding (regime/therapy) |
| 225372007 | SNOMED CT | total parenteral nutrition (regime/therapy) |
| 2897151011 | SNOMED CT | oral nutrition support (regime/therapy) |

383: Plan of Care moodCode (Act/Encounter/Procedure)

|  |  |  |
| --- | --- | --- |
| Value Set: Plan of Care moodCode (Act/Encounter/Procedure) 2.16.840.1.113883.11.20.9.23 | | |
| Code | Code System | Print Name |
| INT | ActMood | Intent |
| ARQ | ActMood | Appointment Request |
| PRMS | ActMood | Promise |
| PRP | ActMood | Proposal |
| RQO | ActMood | Request |

Figure 155: Nutrition Recommendations Example

<entry>

<procedure classCode="ACT" moodCode="RQO">

<templateId root="2.16.840.1.113883.10.20.22.4.130" />

<id root="cdbd33f0-6cde-11db-9fe1-0800200c9a66"/>

<code xsi:type="CD" code="61310001"

displayName="nutrition eduction"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"/>

<statusCode code="active" />

<effectiveTime value="20130512"/>

</procedure>

</entry>

Nutritional Status Observation (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.124 (open)]

384: Nutritional Status Observation (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Nutrition Section (NEW)](#S_Nutrition_Section_NEW) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Nutrition Assessment (NEW)](#E_Nutrition_Assessment_NEW) |

This template describes the overall nutritional status of the patient and findings related to nutritional status.

385: Nutritional Status Observation (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.124'] | | | | | |
| entryRelationship | 1..\* | SHALL |  | [30323](#C_30323) |  |
| @typeCode | 1..1 | SHALL |  | [30335](#C_30335) | SUBJ |
| observation | 1..1 | SHALL |  | [30336](#C_30336) |  |
| @classCode | 1..1 | SHALL |  | [29841](#C_29841) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [29842](#C_29842) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [29843](#C_29843) |  |
| @root | 1..1 | SHALL |  | [29844](#C_29844) | 2.16.840.1.113883.10.20.22.4.124 |
| id | 1..\* | SHALL |  | [29845](#C_29845) |  |
| code | 1..1 | SHALL |  | [29846](#C_29846) |  |
| @code | 1..1 | SHALL |  | [29897](#C_29897) | 87276001 |
| @codeSystem | 1..1 | SHALL |  | [29898](#C_29898) | 2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96 |
| statusCode | 1..1 | SHALL |  | [29852](#C_29852) |  |
| @code | 1..1 | SHALL |  | [29853](#C_29853) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL |  | [29854](#C_29854) | 2.16.840.1.113883.1.11.20.2.7 (Nutritional Status) |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:29841).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:29842).
3. SHALL contain exactly one [1..1] templateId (CONF:29843) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.124" (CONF:29844).
4. SHALL contain at least one [1..\*] id (CONF:29845).
5. SHALL contain exactly one [1..1] code (CONF:29846).
   1. This code SHALL contain exactly one [1..1] @code="87276001" nutritional status (observable entity) (CONF:29897).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:29898).
6. SHALL contain exactly one [1..1] statusCode (CONF:29852).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:29853).
7. SHALL contain exactly one [1..1] value, which SHOULD be selected from ValueSet [Nutritional Status](#Nutritional_Status) 2.16.840.1.113883.1.11.20.2.7 DYNAMIC (CONF:29854).
8. SHALL contain at least one [1..\*] entryRelationship (CONF:30323) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CONF:30335).
   2. SHALL contain exactly one [1..1] [Nutrition Assessment (NEW)](#E_Nutrition_Assessment_NEW) (templateId:2.16.840.1.113883.10.20.22.4.138) (CONF:30336).

386: Nutritional Status

|  |  |  |
| --- | --- | --- |
| Value Set: Nutritional Status 2.16.840.1.113883.1.11.20.2.7  A Value Set of codes representing nutrition problems. | | |
| Code | Code System | Print Name |
| 371597004 | SNOMED CT | emaciated (finding) |
| 284670008 | SNOMED CT | nutritionally compromised (finding) |
| 248325000 | SNOMED CT | undernourished (finding) |
| 248324001 | SNOMED CT | well nourished (finding) |
| 75051000 | SNOMED CT | Food intolerance (finding) |
| 414285001 | SNOMED CT | Food allergy (disorder) |
| 414915002 | SNOMED CT | Obese (finding) |
| 288939007 | SNOMED CT | Swallowing difficulty (finding) |
| 175130015 | SNOMED CT | biting/chewing (masticatory) difficulty |
| 2647146015 | SNOMED CT | Breastfeeding difficulty |
| ... | | |

Figure 156: Nutritional Status Observation Example

<observation classCode="OBS" moodCode="EVN">

<!-- Nutritional Status Observation -->

<templateId root="2.16.840.1.113883.10.20.22.4.124"/>

<id root="c12ecaaf-53f8-4593-8f79-359aeaa3948b"/>

<code xsi:type="CD" code="87276001" displayName="nutritional status "

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED-CT">

<originalText>Nutritional Status</originalText>

</code>

<statusCode code="completed"/>

<effectiveTime value="20130512"/>

<value xsi:type="CD" code="248324001"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED-CT"

displayName="well nourished"/>

<entryRelationship typeCode="SUBJ">

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Nutrition Assessment\*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.138"/>

...

</observation>

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Nutrition Assessment\*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.138"/>

...

</entryRelationship>

Outcome Observation (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.144 (open)]

387: Outcome Observation (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Status Evaluations/Outcomes Section (NEW)](#S_Health_Status_EvaluationsOutcomes_Sec) (required) | [Act Reference (NEW)](#E_Act_Reference_NEW)  [Author Participation (NEW)](#U_Author_Participation_NEW)  [Goal Observation (NEW)](#E_Goal_Observation_NEW)  [Intervention Act (NEW)](#E_Intervention_Act_NEW)  [Progress Toward Goal Observation (NEW)](#E_Progress_Toward_Goal_Observation_NEW) |

This template represents an outcome of an intervention. An Outcome Observation evaluates a goal and is the actual outcome of an intervention(s) (eg. interventions "elevate head of bed to 30 degrees" and "provide humidified O2 per nasal cannula" leads to the achievement a goal of "pulse oximetry reading of 92 or greater") or other factors (eg. time - the goal of "pulse oximetry reading of 92 or greater" is achieved without intervention).

The reason for the outcome is the intervention and the Outcome Observation is related to an Intervention Act with a "has reason" entryRelationship.

The outcome evaluates a goal and the Outcome Observation is related to a Goal Observation with a "evaluates goal" entryRelationship.

The actual outcome supports the evaluation of progress toward a goal and the Outcome Observation is related to the Progress Toward Goal Observation with a "supports" entryRelationship.

388: Outcome Observation (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.144'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [31556](#C_31556) |  |
| @typeCode | 1..1 | SHALL |  | [31557](#C_31557) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = GEVL |
| act | 1..1 | SHALL |  | [31558](#C_31558) |  |
| entryRelationship | 0..\* | MAY |  | [31688](#C_31688) |  |
| @typeCode | 1..1 | SHALL |  | [31689](#C_31689) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| act | 1..1 | SHALL |  | [31690](#C_31690) |  |
| entryRelationship | 0..\* | MAY |  | [31691](#C_31691) |  |
| @typeCode | 1..1 | SHALL |  | [31692](#C_31692) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| act | 1..1 | SHALL |  | [31693](#C_31693) |  |
| @classCode | 1..1 | SHALL |  | [31219](#C_31219) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [31220](#C_31220) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [31221](#C_31221) |  |
| @root | 1..1 | SHALL |  | [31222](#C_31222) | 2.16.840.1.113883.10.20.22.4.144 |
| id | 1..1 | SHALL |  | [31223](#C_31223) |  |
| entryRelationship | 0..\* | SHOULD |  | [31224](#C_31224) |  |
| @typeCode | 1..1 | SHALL |  | [31225](#C_31225) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = GEVL |
| observation | 1..1 | SHALL |  | [31226](#C_31226) |  |
| entryRelationship | 0..1 | SHOULD |  | [31427](#C_31427) |  |
| @typeCode | 1..1 | SHALL |  | [31428](#C_31428) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT |
| @inversionInd | 1..1 | SHALL |  | [31429](#C_31429) | true |
| observation | 1..1 | SHALL |  | [31430](#C_31430) |  |
| author | 0..\* | SHOULD |  | [31553](#C_31553) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:31219).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:31220).
3. SHALL contain exactly one [1..1] templateId (CONF:31221) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.144" (CONF:31222).
4. SHALL contain exactly one [1..1] id (CONF:31223).
5. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31553).

This entryRelationship represents the relationship between an Outcome Observation and an Goal Observation (Outcome Observation EVALUATES Goal Observation).

1. SHOULD contain zero or more [0..\*] entryRelationship (CONF:31224) such that it
   1. SHALL contain exactly one [1..1] @typeCode="GEVL" Evaluates goal (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31225).
   2. SHALL contain exactly one [1..1] [Goal Observation (NEW)](#E_Goal_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.121) (CONF:31226).

This entryRelationship represents the relationship between an Outcome Observation and a Progress Toward Goal Observation (Outcome Observation SUPPORTS Outcome Assessment Observation).

1. SHOULD contain zero or one [0..1] entryRelationship (CONF:31427) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31428).
   2. SHALL contain exactly one [1..1] @inversionInd="true" (CONF:31429).
   3. SHALL contain exactly one [1..1] [Progress Toward Goal Observation (NEW)](#E_Progress_Toward_Goal_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.110) (CONF:31430).

Where an Outcome Observation needs to reference a Goal Observation already described in the CDA document instance, rather than repeating the full content of the Goal Observation, the Act Reference template may be used to reference this entry.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31556) such that it
   1. SHALL contain exactly one [1..1] @typeCode="GEVL" Evaluates goal (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31557).
   2. SHALL contain exactly one [1..1] [Act Reference (NEW)](#E_Act_Reference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.122) (CONF:31558).

Where an Outcome Observation needs to reference an Intervention Act already described in the CDA document instance, rather than repeating the full content of the Intervention Act, the Act Reference template may be used to reference this entry.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31688) such that it
   1. SHALL contain exactly one [1..1] @typeCode="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31689).
   2. SHALL contain exactly one [1..1] [Act Reference (NEW)](#E_Act_Reference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.122) (CONF:31690).

This entryRelationship represents the relationship between an Outcome Observation and an Intervention Act (Outcome Observation HAS REASON Intervention Act).

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31691) such that it
   1. SHALL contain exactly one [1..1] @typeCode="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31692).
   2. SHALL contain exactly one [1..1] [Intervention Act (NEW)](#E_Intervention_Act_NEW) (templateId:2.16.840.1.113883.10.20.22.4.131) (CONF:31693).

Figure 157: Outcome Observation Example

<!-- Outcome Observation -->

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.144" />

<id root="0aaaa123-24e2-46b3-9d49-6b753c712dec" />

<code code="252465000"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED"

displayName="Pulse oximetry" />

<statusCode code="completed" />

<effectiveTime value="20130806" />

<value xsi:type="PQ" value="95" unit="%" />

<author>

...

</author>

<!-- This Outcome Observation EVALUATES a Goal

(Pulse ox reading of 95 evaluates the goal of Pulse ox reading > 92)-->

<entryRelationship typeCode="GEVL">

...

</entryRelationship>

<!-- This Outcome Observation SUPPORTS the Progress Toward Goal Observation -->

<entryRelationship typeCode="SPRT" inversionInd="true">

...

</entryRelationship>

</observation>

Patient Priority Preference (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.142 (open)]

389: Patient Priority Preference (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Problem Observation (V2)](#E_Problem_Observation_V2) (optional)  [Goal Observation (NEW)](#E_Goal_Observation_NEW) (optional)  [Planned Act (V2)](#E_Planned_Act_V2) (optional)  [Planned Encounter (V2)](#E_Planned_Encounter_V2) (optional)  [Planned Procedure (V2)](#E_Planned_Procedure_V2) (optional)  [Planned Observation (V2)](#E_Planned_Observation_V2) (optional)  [Planned Supply (V2)](#E_Planned_Supply_V2) (optional)  [Planned Substance Administration (V2)](#E_Planned_Substance_Administration_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) |  |

This template represents patient preferences. Preferences are choices made by patients, independently or together with their caregivers (e.g. family) relative to options for care or treatment (including scheduling, care experience, and meeting of personal health goals) and the sharing and disclosure of their health information. This template does not represent guardianship. The patient’s guardian is represented in the CDA header with recordTarget/PatientRole/Patient/Guardian.

390: Patient Priority Preference (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.142'] | | | | | |
| @classCode | 1..1 | SHALL |  | [30959](#C_30959) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [30960](#C_30960) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [30961](#C_30961) |  |
| @root | 1..1 | SHALL |  | [30962](#C_30962) | 2.16.840.1.113883.10.20.22.4.142 |
| id | 1..1 | SHALL |  | [30963](#C_30963) |  |
| code | 1..1 | SHALL |  | [30964](#C_30964) |  |
| @code | 1..1 | SHALL |  | [30965](#C_30965) | PAT |
| @codeSystem | 0..1 | MAY |  | [30966](#C_30966) | 2.16.840.1.113883.5.8 (ActReason) = 2.16.840.1.113883.5.8 |
| priorityCode | 0..1 | SHOULD |  | [30967](#C_30967) | 2.16.840.1.113883.11.20.9.57 (Priority Order) |
| value | 1..1 | SHALL | CD | [30968](#C_30968) | 2.16.840.1.113883.11.20.9.60 (Priority Level) |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:30959).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:30960).
3. SHALL contain exactly one [1..1] templateId (CONF:30961).
   1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.142" (CONF:30962).
4. SHALL contain exactly one [1..1] id (CONF:30963).
5. SHALL contain exactly one [1..1] code (CONF:30964).
   1. This code SHALL contain exactly one [1..1] @code="PAT" Patient request (CONF:30965).
   2. This code MAY contain zero or one [0..1] @codeSystem="2.16.840.1.113883.5.8" (CodeSystem: ActReason 2.16.840.1.113883.5.8) (CONF:30966).
6. SHOULD contain zero or one [0..1] priorityCode, which SHOULD be selected from ValueSet [Priority Order](#Priority_Order) 2.16.840.1.113883.11.20.9.57 (CONF:30967).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [Priority Level](#Priority_Level) 2.16.840.1.113883.11.20.9.60 (CONF:30968).

391: Priority Order

|  |  |  |
| --- | --- | --- |
| Value Set: Priority Order 2.16.840.1.113883.11.20.9.57 | | |
| Code | Code System | Print Name |
| 255216001 | SNOMED CT | First |
| 81170007 | SNOMED CT | Second |
| 70905002 | SNOMED CT | Third |
| 29970001 | SNOMED CT | Fourth |
| 32088001 | SNOMED CT | Fifth |
| 53046009 | SNOMED CT | Sixth |
| 86777004 | SNOMED CT | Seventh |
| 51601003 | SNOMED CT | Eighth |
| 58584009 | SNOMED CT | Ninth |
| 28226006 | SNOMED CT | Tenth |

392: Priority Level

|  |  |  |
| --- | --- | --- |
| Value Set: Priority Level 2.16.840.1.113883.11.20.9.60 | | |
| Code | Code System | Print Name |
| 394849002 | SNOMED CT | High priority |
| 394848005 | SNOMED CT | Normal priority |
| 441808003 | SNOMED CT | Delayed priority |

Figure 158: Patient Priority Preference Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.142" />

<id root="a5b64706-9438-4d13-8dcf-651da3ef83bf" />

<code code="PAT"

codeSystem="2.16.840.1.113883.5.8"

codeSystemName="ActReason"

displayName="Patient request" />

<priorityCode code="255216001"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"

displayName="First" />

<value xsi:type="CD"

code="394849002"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED"

displayName="High priority" />

</observation>

Patient Referral Act (NEW)

[act: templateId 2.16.840.1.113883.10.20.22.4.140 (open)]

393: Patient Referral Act (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Reason for Referral Section (V2)](#Reason_for_Referral_Section_V2) (optional) | [Act Reference (NEW)](#E_Act_Reference_NEW)  [Author Participation (NEW)](#U_Author_Participation_NEW) |

This template represents the type of referral (e.g. for dental care, to a specialist, for aging problems) and represents whether the referral is for full care or shared care. It may contain a reference to another act in the document instance representing the clinical reason for the referral (e.g. problem, concern, procedure).

394: Patient Referral Act (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.140'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [31635](#C_31635) |  |
| @typeCode | 1..1 | SHALL |  | [31636](#C_31636) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| act | 1..1 | SHALL |  | [31637](#C_31637) |  |
| @classCode | 1..1 | SHALL |  | [30884](#C_30884) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [30885](#C_30885) | 2.16.840.1.113883.5.1001 (ActMood) = INT |
| templateId | 1..1 | SHALL |  | [30886](#C_30886) |  |
| @root | 1..1 | SHALL |  | [30887](#C_30887) | 2.16.840.1.113883.10.20.22.4.140 |
| id | 1..\* | SHALL |  | [30888](#C_30888) |  |
| code | 1..1 | SHALL |  | [30889](#C_30889) | 2.16.840.1.113883.11.20.9.56 (Referral Types) |
| statusCode | 1..1 | SHALL |  | [30892](#C_30892) |  |
| @code | 1..1 | SHALL |  | [31598](#C_31598) | 2.16.840.1.113883.5.14 (ActStatus) = active |
| effectiveTime | 1..1 | SHALL |  | [30893](#C_30893) |  |
| entryRelationship | 0..\* | MAY |  | [31604](#C_31604) |  |
| @typeCode | 1..1 | SHALL |  | [31613](#C_31613) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| observation | 1..1 | SHALL |  | [31605](#C_31605) |  |
| @classCode | 1..1 | SHALL |  | [31606](#C_31606) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [31607](#C_31607) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| code | 1..1 | SHALL |  | [31608](#C_31608) |  |
| @code | 1..1 | SHALL |  | [31619](#C_31619) | ASSERTION |
| @codeSystem | 1..1 | SHALL |  | [31620](#C_31620) | 2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4 |
| statusCode | 1..1 | SHALL |  | [31614](#C_31614) |  |
| @code | 1..1 | SHALL |  | [31615](#C_31615) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL | CD | [31611](#C_31611) | 2.16.840.1.113883.11.20.9.61 (Care Model) |
| author | 0..\* | SHOULD |  | [31612](#C_31612) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:30884).
2. SHALL contain exactly one [1..1] @moodCode="INT" intent (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:30885).
3. SHALL contain exactly one [1..1] templateId (CONF:30886) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.140" (CONF:30887).
4. SHALL contain at least one [1..\*] id (CONF:30888).
5. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [Referral Types](#Referral_Types) 2.16.840.1.113883.11.20.9.56 DYNAMIC (CONF:30889).
6. SHALL contain exactly one [1..1] statusCode (CONF:30892).
   1. This statusCode SHALL contain exactly one [1..1] @code="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31598).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:30893).
8. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31612).

This entryRelationship represents whether the referral is for full or shared care.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31604) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31613).
   2. SHALL contain exactly one [1..1] observation (CONF:31605).
      1. This observation SHALL contain exactly one [1..1] @classCode="OBS" observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:31606).
      2. This observation SHALL contain exactly one [1..1] @moodCode="EVN" event (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:31607).
      3. This observation SHALL contain exactly one [1..1] code (CONF:31608).
         1. This code SHALL contain exactly one [1..1] @code="ASSERTION" assertion (CONF:31619).
         2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.5.4 " (CodeSystem: ActCode 2.16.840.1.113883.5.4) (CONF:31620).
      4. This observation SHALL contain exactly one [1..1] statusCode (CONF:31614).
         1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31615).
      5. This observation SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [Care Model](#Care_Model) 2.16.840.1.113883.11.20.9.61 (CONF:31611).

This entry relationship represents a reference to another act in the document instance representing the clinical reason for the referral (e.g. problem, concern, procedure).

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31635) such that it
   1. SHALL contain exactly one [1..1] @typeCode="RSON" has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31636).
   2. SHALL contain exactly one [1..1] [Act Reference (NEW)](#E_Act_Reference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.122) (CONF:31637).

395: Referral Types

|  |  |  |
| --- | --- | --- |
| Value Set: Referral Types 2.16.840.1.113883.11.20.9.56  A value set of SNOMED-CT codes descending from "3457005" patient referral (procedure).    Specific URL Pending  Valueset Source: <http://vtsl.vetmed.vt.edu/> | | |
| Code | Code System | Print Name |
| 44383000 | SNOMED CT | Patient referral for consultation |
| 391034007 | SNOMED CT | Refer for falls assessment (procedure) |
| 86395003 | SNOMED CT | patient referral for family planning (procedure) |
| 306106002 | SNOMED CT | referral to intensive care service (procedure) |
| 306140002 | SNOMED CT | referral to clinical oncology service (procedure) |
| 396150002 | SNOMED CT | Referral for substance abuse (procedure) |
| ... | | |

396: Care Model

|  |  |  |
| --- | --- | --- |
| Value Set: Care Model 2.16.840.1.113883.11.20.9.61  A value set of SNOMED-CT codes representing care management styles (e.g. shared care, full care) descending from "170932006" "Chronic disease - care arrangement".      Specific URL Pending  Valueset Source: <http://vtsl.vetmed.vt.edu/> | | |
| Code | Code System | Print Name |
| 370985002 | SNOMED CT | care by local physician (finding) |
| 170941001 | SNOMED CT | full care by GP (finding) |
| 170935008 | SNOMED CT | full care by hospice (finding) |
| 268528005 | SNOMED CT | full care by specialist (finding) |
| 170939002 | SNOMED CT | full care: nurse practitioner (finding) |
| 268529002 | SNOMED CT | shared care - consultant and GP (finding) |
| 170936009 | SNOMED CT | shared care - hospice and GP (finding) |
| 170937000 | SNOMED CT | shared care: district nurse and GP (finding) |
| 170940000 | SNOMED CT | shared care: practice nurse and GP (finding) |

Figure 159: Patient Referral Act Example

<entry>

<act classCode="ACT" moodCode="INT">

<!--Patient Referral Act-->

<templateId root="2.16.840.1.113883.10.20.22.4.140"/>

<id root="70bdd7db-e02d-4eff-9829-35e3b7d9e154"/>

<code code="44383000" displayName="Patient referral for consultation"

codeSystemName="SNOMED" codeSystem="2.16.840.1.113883.6.96">

</code>

<statusCode code="active"/>

<effectiveTime value="20130311"/>

<author>

<time value="200130311"/>

<assignedAuthor>

<id extension="KP00017" root="2.16.840.1.113883.19.5"/>

<addr>

<streetAddressLine>1003 Health Care

Drive</streetAddressLine>

<city>Ann Arbor</city>

<state>MI</state>

<postalCode>02368</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:(555)555-1003"/>

<assignedPerson>

<name>

<given>Assigned</given>

<family>Amanda</family>

</name>

</assignedPerson>

</assignedAuthor>

</author>

<entryRelationship typeCode="SUBJ">

<observation classCode="OBS" moodCode="EVN">

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<statusCode code="completed"/>

<value xsi:type="CD" code="268528005" displayName="full care by specialist"

codeSystem="2.16.840.1.113883.6.96"/>

</observation>

</entryRelationship>

</act>

</entry>

Physician of Record Participant (V2)

[entry: templateId 2.16.840.1.113883.10.20.6.2.2.2 (open)]

397: Physician of Record Participant (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (optional) | [US Realm Person Name (PN.US.FIELDED)](#U_US_Realm_Person_Name_PNUSFIELDED) |

This encounterParticipant is the attending physician and is usually different from the Physician Reading Study Performer defined in documentationOf/serviceEvent.

398: Physician of Record Participant (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| entry[templateId/@root = '2.16.840.1.113883.10.20.6.2.2.2'] | | | | | |
| @typeCode | 1..1 | SHALL |  | [8881](#C_8881) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = ATND |
| templateId | 1..1 | SHALL |  | [16072](#C_16072) |  |
| @root | 1..1 | SHALL |  | [16073](#C_16073) | 2.16.840.1.113883.10.20.6.2.2.2 |
| assignedEntity | 1..1 | SHALL |  | [8886](#C_8886) |  |
| id | 1..\* | SHALL |  | [8887](#C_8887) |  |
| @root | 1..1 | SHALL |  | [31204](#C_31204) | 2.16.840.1.113883.4.6 |
| code | 1..1 | SHALL |  | [8888](#C_8888) |  |
| representedOrganization | 0..1 | MAY |  | [16074](#C_16074) |  |
| name | 0..1 | SHOULD |  | [16075](#C_16075) |  |
| assignedPerson | 0..1 | SHOULD |  | [30928](#C_30928) |  |
| name | 1..1 | SHALL |  | [30929](#C_30929) |  |

1. SHALL contain exactly one [1..1] @typeCode="ATND" Attender (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8881).
2. SHALL contain exactly one [1..1] templateId (CONF:16072) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.2.2" (CONF:16073).
3. SHALL contain exactly one [1..1] assignedEntity (CONF:8886).
   1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:8887).
   2. MISSING NARRATIVE FOR PRIMITIVE  (CONF:31203).
      1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:31204).
   3. This assignedEntity SHALL contain exactly one [1..1] code (CONF:8888).
      1. SHALL contain a valid DICOM Organizational Role from DICOM CID 7452  (Value Set 1.2.840.10008.6.1.516)(@codeSystem is 1.2.840.10008.2.16.4) or an appropriate national health care provider coding system (e.g., NUCC in the U.S., where @codeSystem is 2.16.840.1.113883.6.101)Footnote: DICOM Part 16 (NEMA PS3.16), page 631 in the 2011 edition. See ftp://medical.nema.org/medical/dicom/2011/11\_16pu.pdf (CONF:8889).
   4. This assignedEntity MAY contain zero or one [0..1] representedOrganization (CONF:16074).
      1. The representedOrganization, if present, SHOULD contain zero or one [0..1] name (CONF:16075).
   5. This assignedEntity SHOULD contain zero or one [0..1] assignedPerson (CONF:30928).
      1. The assignedPerson, if present, SHALL contain exactly one [1..1] [US Realm Person Name (PN.US.FIELDED)](#U_US_Realm_Person_Name_PNUSFIELDED) (templateId:2.16.840.1.113883.10.20.22.5.1.1) (CONF:30929).

Figure 160: Physician of Record Participant Example

<encounterParticipant typeCode="ATND">

<templateId root="2.16.840.1.113883.10.20.6.2.2.2" />

<assignedEntity>

<id extension="44444444" root="2.16.840.1.113883.4.6" />

<code code="208D00000X" codeSystem="2.16.840.1.113883.6.101" codeSystemName="NUCC" displayName="General Practice" />

<addr nullFlavor="NI" />

<telecom nullFlavor="NI" />

<assignedPerson>

<name>

<prefix>Dr.</prefix>

<given>Fay</given>

<family>Family</family>

</name>

</assignedPerson>

</assignedEntity>

</encounterParticipant>

Planned Act (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.39.2 (open)]

399: Planned Act (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (optional)  [Goal Observation (NEW)](#E_Goal_Observation_NEW) (optional)  [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW)  [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) |

This is the generic template for the Planned Act. The activities in this template represent procedures that are not classified as an observation or a procedure according to the HL7 RIM. Examples of these procedures are a dressing change, teaching or feeding a patient or providing comfort measures. The priority of the activity to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference. The effective time indicates the time when the activity is intended to take place.

400: Planned Act (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.39.2'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [31067](#C_31067) |  |
| @typeCode | 1..1 | SHALL |  | [31068](#C_31068) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31069](#C_31069) |  |
| @classCode | 1..1 | SHALL |  | [8538](#C_8538) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [8539](#C_8539) | 2.16.840.1.113883.11.20.9.23 (Plan of Care moodCode (Act/Encounter/Procedure)) |
| templateId | 1..1 | SHALL |  | [30430](#C_30430) |  |
| @root | 1..1 | SHALL |  | [30431](#C_30431) | 2.16.840.1.113883.10.20.22.4.39.2 |
| id | 1..\* | SHALL |  | [8546](#C_8546) |  |
| statusCode | 1..1 | SHALL |  | [30432](#C_30432) |  |
| effectiveTime | 1..1 | SHALL |  | [30433](#C_30433) |  |
| performer | 0..\* | MAY |  | [30435](#C_30435) |  |
| participant | 0..\* | MAY |  | [30436](#C_30436) |  |
| entryRelationship | 0..\* | MAY |  | [31070](#C_31070) |  |
| @typeCode | 1..1 | SHALL |  | [31071](#C_31071) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31072](#C_31072) |  |
| code | 1..1 | SHALL |  | [31687](#C_31687) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8538).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [Plan of Care moodCode (Act/Encounter/Procedure)](#Plan_of_Care_moodCode_ActEncounterProce) 2.16.840.1.113883.11.20.9.23 STATIC 2011-09-30 (CONF:8539).
3. SHALL contain exactly one [1..1] templateId (CONF:30430) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.39.2" (CONF:30431).
4. SHALL contain at least one [1..\*] id (CONF:8546).
5. SHALL contain exactly one [1..1] code (CONF:31687).
6. SHALL contain exactly one [1..1] statusCode (CONF:30432).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:30433).

Performers represent clinicians who are responsible for assessing and treating the patient.

1. MAY contain zero or more [0..\*] performer (CONF:30435).

Participants represent those in supporting roles such as caregiver, who participate in the patient's care.

1. MAY contain zero or more [0..\*] participant (CONF:30436).

This entryRelationship represents the priority that a patient places on the activity.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31067) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31068).
   2. SHALL contain exactly one [1..1] [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31069).

This entryRelationship represents the priority that a provider places on the activity.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31070) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31071).
   2. SHALL contain exactly one [1..1] [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31072).

401: Plan of Care moodCode (Act/Encounter/Procedure)

|  |  |  |
| --- | --- | --- |
| Value Set: Plan of Care moodCode (Act/Encounter/Procedure) 2.16.840.1.113883.11.20.9.23 | | |
| Code | Code System | Print Name |
| INT | ActMood | Intent |
| ARQ | ActMood | Appointment Request |
| PRMS | ActMood | Promise |
| PRP | ActMood | Proposal |
| RQO | ActMood | Request |

Figure 161: Planned Act Example

<entry>

<act moodCode="INT" classCode="ACT">

<templateId root="2.16.840.1.113883.10.20.22.4.39.2"/>

<!-- Planned Act V2 template -->

<id root="9a6d1bac-17d3-4195-89a4-1121bc809a5c"/>

<code xsi:type="CD" code="225358003"

displayName="wound care (regime/therapy)"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"/>

<statusCode code="new"/>

<effectiveTime value="20130615"/>

<participant typeCode="IND">

<participantRole classCode="IND">

<code code="MTH" codeSystem="2.16.840.1.113883.5.111"

displayName="Mother"/>

</participantRole>

</participant>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Patient Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.142"/>

...

</observation>

</entryRelationship>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Provider Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.143"/>

...

</observation>

</entryRelationship>

</act>

</entry>

Planned Encounter (V2)

[encounter: templateId 2.16.840.1.113883.10.20.22.4.40.2 (open)]

402: Planned Encounter (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (optional)  [Goal Observation (NEW)](#E_Goal_Observation_NEW) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW)  [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) |

The Planned Encounter represents an intent or request for an interaction between a patient and a practitioner who is vested with primary responsibility for diagnosing, evaluating, or treating the patient’s condition. Such encounters may include visits, appointments, and non-face-to-face interactions. The practitioner who has primary responsibility for assessing and treating the patient at a given contact is represented by the performer. The participant would represent a support person or caregiver who participates in the patient's care. The priority of the activity encounter is communicated through Patient Priority Preference and Provider Priority Preference. The effective time indicates the time when this is intended to be fulfilled.

403: Planned Encounter (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| encounter[templateId/@root = '2.16.840.1.113883.10.20.22.4.40.2'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [31033](#C_31033) |  |
| @typeCode | 1..1 | SHALL |  | [31034](#C_31034) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31035](#C_31035) |  |
| @classCode | 1..1 | SHALL |  | [8564](#C_8564) | 2.16.840.1.113883.5.6 (HL7ActClass) = ENC |
| @moodCode | 1..1 | SHALL |  | [8565](#C_8565) | 2.16.840.1.113883.11.20.9.23 (Plan of Care moodCode (Act/Encounter/Procedure)) |
| templateId | 1..1 | SHALL |  | [30437](#C_30437) |  |
| @root | 1..1 | SHALL |  | [30438](#C_30438) | 2.16.840.1.113883.10.20.22.4.40.2 |
| id | 1..\* | SHALL |  | [8567](#C_8567) |  |
| statusCode | 1..1 | SHALL |  | [30439](#C_30439) |  |
| effectiveTime | 1..1 | SHALL |  | [30440](#C_30440) |  |
| performer | 0..\* | MAY |  | [30442](#C_30442) |  |
| participant | 0..\* | MAY |  | [30443](#C_30443) |  |
| code | 1..1 | SHALL |  | [31032](#C_31032) |  |
| entryRelationship | 0..\* | MAY |  | [31036](#C_31036) |  |
| @typeCode | 1..1 | SHALL |  | [31037](#C_31037) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31038](#C_31038) |  |

1. SHALL contain exactly one [1..1] @classCode="ENC" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8564).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [Plan of Care moodCode (Act/Encounter/Procedure)](#Plan_of_Care_moodCode_ActEncounterProce) 2.16.840.1.113883.11.20.9.23 STATIC 2011-09-30 (CONF:8565).
3. SHALL contain exactly one [1..1] templateId (CONF:30437) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.40.2" (CONF:30438).
4. SHALL contain at least one [1..\*] id (CONF:8567).

Records the type of encounter.

1. SHALL contain exactly one [1..1] code (CONF:31032).
2. SHALL contain exactly one [1..1] statusCode (CONF:30439).
3. SHALL contain exactly one [1..1] effectiveTime (CONF:30440).

Performers represent clinicians who are responsible for assessing and treating the patient.

1. MAY contain zero or more [0..\*] performer (CONF:30442).

Participants represent those in supporting roles such as caregiver, who participate in the patient's care.

1. MAY contain zero or more [0..\*] participant (CONF:30443).

This entryRelationship represents the priority that a patient places on the encounter.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31033) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31034).
   2. SHALL contain exactly one [1..1] [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31035).

This entryRelationship represents the priority that a provider places on the encounter.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31036) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31037).
   2. SHALL contain exactly one [1..1] [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31038).

404: Plan of Care moodCode (Act/Encounter/Procedure)

|  |  |  |
| --- | --- | --- |
| Value Set: Plan of Care moodCode (Act/Encounter/Procedure) 2.16.840.1.113883.11.20.9.23 | | |
| Code | Code System | Print Name |
| INT | ActMood | Intent |
| ARQ | ActMood | Appointment Request |
| PRMS | ActMood | Promise |
| PRP | ActMood | Proposal |
| RQO | ActMood | Request |

Figure 162: Planned Encounter Example

<entry>

<encounter moodCode="INT" classCode="ENC">

<templateId root="2.16.840.1.113883.10.20.22.4.40.2" />

<!-- Encounter Plan V2 template -->

<id root="9a6d1bac-17d3-4195-89a4-1121bc809b4d" />

<code code="425604002" displayName="case management follow up (procedure)" codeSystemName="SNOMED CT" codeSystem="2.16.840.1.113883.6.96">

</code>

<statusCode code="new" />

<effectiveTime value="20130615" />

<performer>

<assignedEntity>

<id root="2a620155-9d11-439e-92a3-5d9815ff4de8" />

<code code="59058001" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="General Physician" />

</assignedEntity>

</performer>

<participant typeCode="IRCP">

<participantRole classCode="ASSIGNED">

<code code="158965000" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED-CT" displayName="Medical Practitioner" />

<addr>

<streetAddressLine>1006 Health

Drive</streetAddressLine>

<city>Ann Arbor</city>

<state>MI</state>

<postalCode>97867</postalCode>

<country>US</country>

</addr>

<!-- 8.6.3 Telephone number of verifier -->

<telecom value="tel:(995)555-1006" use="WP" />

<playingEntity>

<name>

<prefix>Dr.</prefix>

<family>James</family>

<given>Case</given>

</name>

</playingEntity>

</participantRole>

</participant>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Patient Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.142" />

...

</observation>

</entryRelationship>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Provider Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.143" />

...

</observation>

</entryRelationship>

</encounter>

</entry>

Planned Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.44.2 (open)]

405: Planned Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (optional)  [Goal Observation (NEW)](#E_Goal_Observation_NEW) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW)  [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) |

This template represents a Planned Observation. The importance of the the planned observation to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference.

406: Planned Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.44.2'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [31073](#C_31073) |  |
| @typeCode | 1..1 | SHALL |  | [31074](#C_31074) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31075](#C_31075) |  |
| @classCode | 1..1 | SHALL |  | [8581](#C_8581) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [8582](#C_8582) | 2.16.840.1.113883.11.20.9.25 (Plan of Care moodCode (Observation)) |
| templateId | 1..1 | SHALL |  | [30451](#C_30451) |  |
| @root | 1..1 | SHALL |  | [30452](#C_30452) | 2.16.840.1.113883.10.20.22.4.44.2 |
| id | 1..\* | SHALL |  | [8584](#C_8584) |  |
| statusCode | 1..1 | SHALL |  | [30453](#C_30453) |  |
| effectiveTime | 1..1 | SHALL |  | [30454](#C_30454) |  |
| performer | 0..\* | MAY |  | [30456](#C_30456) |  |
| participant | 0..\* | MAY |  | [30457](#C_30457) |  |
| code | 1..1 | SHALL |  | [31030](#C_31030) |  |
| value | 0..\* | MAY |  | [31031](#C_31031) |  |
| entryRelationship | 0..\* | MAY |  | [31076](#C_31076) |  |
| @typeCode | 1..1 | SHALL |  | [31077](#C_31077) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31078](#C_31078) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8581).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [Plan of Care moodCode (Observation)](#Plan_of_Care_moodCode_Observation) 2.16.840.1.113883.11.20.9.25 STATIC 2011-09-30 (CONF:8582).
3. SHALL contain exactly one [1..1] templateId (CONF:30451) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.44.2" (CONF:30452).
4. SHALL contain at least one [1..\*] id (CONF:8584).
5. SHALL contain exactly one [1..1] code (CONF:31030).
6. SHALL contain exactly one [1..1] statusCode (CONF:30453).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:30454).
8. MAY contain zero or more [0..\*] value (CONF:31031).

Performers represent clinicians who are responsible for assessing and treating the patient.

1. MAY contain zero or more [0..\*] performer (CONF:30456).

Participants represent those in supporting roles such as caregiver, who participate in the patient's care.

1. MAY contain zero or more [0..\*] participant (CONF:30457).

This entryRelationship represents the priority that the patient places on the observation.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31073) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31074).
   2. SHALL contain exactly one [1..1] [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31075).

This entryRelationship represents the priority that a provider places on the observation.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31076) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31077).
   2. SHALL contain exactly one [1..1] [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31078).

407: Plan of Care moodCode (Observation)

|  |  |  |
| --- | --- | --- |
| Value Set: Plan of Care moodCode (Observation) 2.16.840.1.113883.11.20.9.25 | | |
| Code | Code System | Print Name |
| INT | ActMood | Intent |
| GOL | ActMood | Goal |
| PRMS | ActMood | Promise |
| PRP | ActMood | Proposal |
| RQO | ActMood | Request |

Figure 163: Planned Observation Example

<observation classCode="OBS" moodCode="GOL">

<!-- \*\*Planned Observation V2\*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.44.2"/>

<id root="9b56c25d-9104-45ee-9fa4-e0f3afaa01c1"/>

<!-- \*\*Assertion or observable entity\*\* -->

<code code="252465000"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"

displayName="Pulse oximetry"/>

<text>Care Goal: Pulse Oximetry greater than 92%</text>

<statusCode code="active"/>

<effectiveTime value="20130615"/>

<value xsi:type="IVL\_PQ">

<low value="92" unit="%"/>

</value>

<participant typeCode="IND">

<participantRole classCode="IND">

<code code="MTH" codeSystem="2.16.840.1.113883.5.111"

displayName="Mother"/>

</participantRole>

</participant>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Patient Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.142"/>

...

</observation>

</entryRelationship>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Provider Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.143"/>

<id root="9a6d1bac-17d3-4195-89a4-1121bc809b4d"/>

...

</observation>

</entryRelationship>

</observation>

Goal Observation (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.121 (open)]

408: Goal Observation (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Goals Section (NEW)](#S_Goals_Section_NEW) (required)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional)  [Outcome Observation (NEW)](#E_Outcome_Observation_NEW) (optional) | [Act Reference (NEW)](#E_Act_Reference_NEW)  [Author Participation (NEW)](#U_Author_Participation_NEW)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW)  [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW)  [Planned Act (V2)](#E_Planned_Act_V2)  [Planned Encounter (V2)](#E_Planned_Encounter_V2)  [Planned Observation (V2)](#E_Planned_Observation_V2)  [Planned Procedure (V2)](#E_Planned_Procedure_V2)  [Planned Substance Administration (V2)](#E_Planned_Substance_Administration_V2)  [Planned Supply (V2)](#E_Planned_Supply_V2)  [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) |

This template represents a patient care goal.  A Goal Observation template may have related components that are acts, encounters, observations, procedures, substance administrations or supplies.

A goal may be a patient or provider goal.  If the author is set to the recordTarget (patient), this is a patient goal.  If the author is set to a provider, this is a provider goal. If both patient and provider are set as authors, this is a negotiated goal.

A goal usually has a related health concern and/or risk.

A goal can have components consisting of other goals (milestones), these milestones are related to the overall goal through the "component" entryRelationship.

409: Goal Observation (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.121'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [31559](#C_31559) |  |
| @typeCode | 1..1 | SHALL |  | [31560](#C_31560) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [31588](#C_31588) |  |
| entryRelationship | 0..\* | SHOULD |  | [30701](#C_30701) |  |
| @typeCode | 1..1 | SHALL |  | [30702](#C_30702) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| act | 1..1 | SHALL |  | [30703](#C_30703) |  |
| entryRelationship | 0..1 | SHOULD |  | [30785](#C_30785) |  |
| @typeCode | 1..1 | SHALL |  | [30786](#C_30786) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| observation | 1..1 | SHALL |  | [30787](#C_30787) |  |
| entryRelationship | 0..\* | MAY |  | [30770](#C_30770) |  |
| @typeCode | 1..1 | SHALL |  | [30771](#C_30771) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| act | 1..1 | SHALL |  | [30772](#C_30772) |  |
| entryRelationship | 0..\* | MAY |  | [30704](#C_30704) |  |
| @typeCode | 1..1 | SHALL |  | [30705](#C_30705) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| encounter | 1..1 | SHALL |  | [30706](#C_30706) |  |
| entryRelationship | 0..\* | MAY |  | [30707](#C_30707) |  |
| @typeCode | 1..1 | SHALL |  | [30708](#C_30708) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| observation | 1..1 | SHALL |  | [30709](#C_30709) |  |
| templateId | 1..1 | SHALL |  | [8583](#C_8583) |  |
| @root | 1..1 | SHALL |  | [10512](#C_10512) | 2.16.840.1.113883.10.20.22.4.121 |
| @classCode | 1..1 | SHALL |  | [30418](#C_30418) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [30419](#C_30419) | 2.16.840.1.113883.5.1001 (ActMood) = GOL |
| entryRelationship | 0..\* | MAY |  | [30710](#C_30710) |  |
| @typeCode | 1..1 | SHALL |  | [30711](#C_30711) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| procedure | 1..1 | SHALL |  | [30712](#C_30712) |  |
| entryRelationship | 0..\* | MAY |  | [30713](#C_30713) |  |
| @typeCode | 1..1 | SHALL |  | [30714](#C_30714) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| substanceAdministration | 1..1 | SHALL |  | [30715](#C_30715) |  |
| entryRelationship | 0..\* | MAY |  | [30716](#C_30716) |  |
| @typeCode | 1..1 | SHALL |  | [30717](#C_30717) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| supply | 1..1 | SHALL |  | [30718](#C_30718) |  |
| code | 1..1 | SHALL |  | [30784](#C_30784) |  |
| entryRelationship | 0..\* | SHOULD |  | [30788](#C_30788) |  |
| @typeCode | 1..1 | SHALL |  | [30789](#C_30789) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| observation | 1..1 | SHALL |  | [30790](#C_30790) |  |
| author | 1..\* | SHALL |  | [30995](#C_30995) |  |
| entryRelationship | 0..\* | MAY |  | [31448](#C_31448) |  |
| @typeCode | 1..1 | SHALL |  | [31449](#C_31449) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |

1. Conforms to [Planned Observation (V2)](#E_Planned_Observation_V2) template (2.16.840.1.113883.10.20.22.4.44.2).
2. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:30418).
3. SHALL contain exactly one [1..1] @moodCode="GOL" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:30419).
4. SHALL contain exactly one [1..1] templateId (CONF:8583) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.121" (CONF:10512).
5. SHALL contain exactly one [1..1] code (CONF:30784).

If the author is set to the recordTarget (patient), this is a patient goal.  If the author is set to a provider, this is a provider goal. If both patient and provider are set as authors, this is a negotiated goal.

1. SHALL contain at least one [1..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:30995).

This entryRelationship represents the relationship between a Goal Observation and a Health Concern Act (Goal Observation REFERS TO Health Concern Act).

1. SHOULD contain zero or more [0..\*] entryRelationship (CONF:30701) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30702).
   2. SHALL contain exactly one [1..1] [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (templateId:2.16.840.1.113883.10.20.22.4.132) (CONF:30703).

This entryRelationship represents an encounter component of the goal.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:30704) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30705).
   2. SHALL contain exactly one [1..1] [Planned Encounter (V2)](#E_Planned_Encounter_V2) (templateId:2.16.840.1.113883.10.20.22.4.40.2) (CONF:30706).

This entryRelationship represents an observation component of the goal.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:30707) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30708).
   2. SHALL contain exactly one [1..1] [Planned Observation (V2)](#E_Planned_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.44.2) (CONF:30709).

This entryRelationship represents a procedure component of the goal.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:30710) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30711).
   2. SHALL contain exactly one [1..1] [Planned Procedure (V2)](#E_Planned_Procedure_V2) (templateId:2.16.840.1.113883.10.20.22.4.41.2) (CONF:30712).

This entryRelationship represents an substance administration component of the goal.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:30713) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30714).
   2. SHALL contain exactly one [1..1] [Planned Substance Administration (V2)](#E_Planned_Substance_Administration_V2) (templateId:2.16.840.1.113883.10.20.22.4.42.2) (CONF:30715).

This entryRelationship represents a supply component of the goal.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:30716) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30717).
   2. SHALL contain exactly one [1..1] [Planned Supply (V2)](#E_Planned_Supply_V2) (templateId:2.16.840.1.113883.10.20.22.4.43.2) (CONF:30718).

This entryRelationship represents an act component of the goal.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:30770) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30771).
   2. SHALL contain exactly one [1..1] [Planned Act (V2)](#E_Planned_Act_V2) (templateId:2.16.840.1.113883.10.20.22.4.39.2) (CONF:30772).

This entryRelationship represents the priority that the patient puts on the goal.

1. SHOULD contain zero or one [0..1] entryRelationship (CONF:30785) such that it
   1. SHALL contain exactly one [1..1] @typeCode="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30786).
   2. SHALL contain exactly one [1..1] [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:30787).

This entryRelationship represents the priority that a provider puts on the goal.

1. SHOULD contain zero or more [0..\*] entryRelationship (CONF:30788) such that it
   1. SHALL contain exactly one [1..1] @typeCode="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:30789).
   2. SHALL contain exactly one [1..1] [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:30790).

This entryRelationship represents the relationship between two Goal Observations where the target is a component of the source (Goal Observation HAS COMPONENT Goal Observation). The component goal (target) is a Milestone.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31448) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31449).
   2. SHALL contain exactly one 1..1] Goal Observation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.121) (CONF:31450).

Where a Goal Observation needs to reference another entry already described in the CDA document instance, rather than repeating the full content of the entry, the Act Reference template may be used to reference this entry.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31559) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31560).
   2. SHALL contain exactly one [1..1] [Act Reference (NEW)](#E_Act_Reference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.122) (CONF:31588).

Figure 164: Goal Observation Example

<!-- Goal Observation -->

<!-- Goal is pulse ox reading of 92 or greater. -->

<observation classCode="OBS" moodCode="GOL">

<!-- Observation Plan (V2) templateId -->

<templateId root="2.16.840.1.113883.10.20.22.4.44.2" />

<!-- Goal Observation templateId -->

<templateId root="2.16.840.1.113883.10.20.22.4.121" />

<id root="3700b3b0-fbed-11e2-b778-0800200c9a66" />

<code code="252465000" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Pulse oximetry" />

<statusCode code="active" />

<effectiveTime value="20130902" />

<value xsi:type="IVL\_PQ">

<low value="92" unit="%" />

</value>

<!--

If the author is set to the recordTarget (patient), this is a patient goal.

If the author is set to a provider, this is a provider goal.

If both patient and provider are set as authors, this is a negotiated goal.

-->

<!-- Provider Author -->

<author typeCode="AUT">

<templateId root="2.16.840.1.113883.10.20.22.4.119" />

<time value="20130730" />

<assignedAuthor>

<id root="d839038b-7171-4165-a760-467925b43857" />

<code code="163W00000X" codeSystem="2.16.840.1.113883.6.101" codeSystemName="Health Care Provider Taxonomy" displayName="Registered nurse" />

<assignedPerson>

<name>

<given>Nurse</given>

<family>Florence</family>

<suffix>RN</suffix>

</name>

</assignedPerson>

</assignedAuthor>

</author>

<!-- Patient Author -->

<author typeCode="AUT">

<templateId root="2.16.840.1.113883.10.20.22.4.119" />

<time />

<assignedAuthor>

<!-- This id can point back to the record target already described in the CDA header

(or someone else can be described here)

-->

<!-- This particlar example points back to the record target -->

<id extension="996-756-495" root="2.16.840.1.113883.19.5" />

</assignedAuthor>

</author>

<!--

This entryRelationship represents the relationship "Goal REFERS TO Health Concern"

-->

<entryRelationship typeCode="REFR">

<!-- Act Reference Concern Act -->

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.122" />

<!-- This id points to an already defined Health Concern

in the Health Concerns Section -->

<id root="4eab0e52-dd7d-4285-99eb-72d32ddb195c" />

<code nullFlavor="NP" />

<statusCode code="completed" />

</act>

</entryRelationship>

<entryRelationship typeCode="RSON">

<!-- Patient Priority Preference -->

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.142" />

<id root="a5b64706-9438-4d13-8dcf-651da3ef83bf" />

<code code="PAT" codeSystem="2.16.840.1.113883.5.8" codeSystemName="ActReason" displayName="Patient request" />

<priorityCode code="255216001" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"

displayName="First" />

<value xsi:type="CD" code="394849002" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT" displayName="High priority" />

</observation>

</entryRelationship>

<entryRelationship typeCode="RSON">

<!-- Provider Priority Preference -->

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.143" />

<id root="7d66f448-ba82-4291-a9da-9e5db5e58803" />

<code code="103323008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="ActReason" displayName="Provider preference" />

<priorityCode code="255216001" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"

displayName="First" />

<value xsi:type="CD" code="394849002" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT" displayName="High priority" />

<!--

This author has an id that is the same as the author of the document

However, the author could be a different provider - someone else in the

header, or a new provider not elsewhere specified.

-->

<author>

<time value="20130801" />

<assignedAuthor>

<id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c" />

</assignedAuthor>

</author>

</observation>

</entryRelationship>

</observation>

Planned Procedure (V2)

[procedure: templateId 2.16.840.1.113883.10.20.22.4.41.2 (open)]

410: Planned Procedure (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (optional)  [Goal Observation (NEW)](#E_Goal_Observation_NEW) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional)  [Planned Procedure Section (V2)](#Planned_Procedure_Section_V2) (optional) | [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW)  [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) |

The Planned Procedure represents planned alterations of the physical condition. Examples of such procedures are tracheostomy, knee replacements, and  craniectomy. The priority of the procedure to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference. The effective time indicates the time when the procedure is intended to take place.

411: Planned Procedure (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| procedure[templateId/@root = '2.16.840.1.113883.10.20.22.4.41.2'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [31079](#C_31079) |  |
| @typeCode | 1..1 | SHALL |  | [31080](#C_31080) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31081](#C_31081) |  |
| @classCode | 1..1 | SHALL |  | [8568](#C_8568) | 2.16.840.1.113883.5.6 (HL7ActClass) = PROC |
| @moodCode | 1..1 | SHALL |  | [8569](#C_8569) | 2.16.840.1.113883.11.20.9.23 (Plan of Care moodCode (Act/Encounter/Procedure)) |
| templateId | 1..1 | SHALL |  | [30444](#C_30444) |  |
| @root | 1..1 | SHALL |  | [30445](#C_30445) | 2.16.840.1.113883.10.20.22.4.41.2 |
| id | 1..\* | SHALL |  | [8571](#C_8571) |  |
| statusCode | 1..1 | SHALL |  | [30446](#C_30446) |  |
| effectiveTime | 0..1 | SHOULD |  | [30447](#C_30447) |  |
| performer | 0..\* | MAY |  | [30449](#C_30449) |  |
| participant | 0..\* | MAY |  | [30450](#C_30450) |  |
| entryRelationship | 0..\* | MAY |  | [31082](#C_31082) |  |
| @typeCode | 1..1 | SHALL |  | [31083](#C_31083) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31084](#C_31084) |  |

1. SHALL contain exactly one [1..1] @classCode="PROC" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8568).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [Plan of Care moodCode (Act/Encounter/Procedure)](#Plan_of_Care_moodCode_ActEncounterProce) 2.16.840.1.113883.11.20.9.23 STATIC 2011-09-30 (CONF:8569).
3. SHALL contain exactly one [1..1] templateId (CONF:30444) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.41.2" (CONF:30445).
4. SHALL contain at least one [1..\*] id (CONF:8571).
5. SHALL contain exactly one [1..1] statusCode (CONF:30446).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:30447).

Performers represent clinicians who are responsible for assessing and treating the patient.

1. MAY contain zero or more [0..\*] performer (CONF:30449).

Participants represent those in supporting roles such as caregiver, who participate in the patient's care.

1. MAY contain zero or more [0..\*] participant (CONF:30450).

This entryRelationship represents the priority that a patient places on the procedure.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31079) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31080).
   2. SHALL contain exactly one [1..1] [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31081).

This entryRelationship represents the priority that a provider places on the procedure.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31082) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31083).
   2. SHALL contain exactly one [1..1] [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31084).

412: Plan of Care moodCode (Act/Encounter/Procedure)

|  |  |  |
| --- | --- | --- |
| Value Set: Plan of Care moodCode (Act/Encounter/Procedure) 2.16.840.1.113883.11.20.9.23 | | |
| Code | Code System | Print Name |
| INT | ActMood | Intent |
| ARQ | ActMood | Appointment Request |
| PRMS | ActMood | Promise |
| PRP | ActMood | Proposal |
| RQO | ActMood | Request |

Figure 165: Planned Procedure Example

<entry>

<procedure moodCode="RQO" classCode="PROC">

<templateId root="2.16.840.1.113883.10.20.22.4.41.2"/>

<!-- \*\*Planned Procedure V2 template \*\* -->

<id root="9a6d1bac-17d3-4195-89c4-1121bc809b5a"/>

<code code="73761001" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT" displayName="Colonoscopy"/>

<statusCode code="new"/>

<effectiveTime>

<center value="20130613"/>

</effectiveTime>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Patient Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.142"/>

...

</observation>

</entryRelationship>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Provider Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.143"/>

...

</entryRelationship>

</procedure>

</entry>

Planned Substance Administration (V2)

[substanceAdministration: templateId 2.16.840.1.113883.10.20.22.4.42.2 (open)]

413: Planned Substance Administration (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (optional)  [Goal Observation (NEW)](#E_Goal_Observation_NEW) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW)  [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) |

The Planned Substance Administration describes substance administrations that will occur. The priority of the  substance administration activity to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference. The effective time indicates the time when the substance is intended to be administered.

414: Planned Substance Administration (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| substanceAdministration[templateId/@root = '2.16.840.1.113883.10.20.22.4.42.2'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [31104](#C_31104) |  |
| @typeCode | 1..1 | SHALL |  | [31105](#C_31105) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31106](#C_31106) |  |
| @classCode | 1..1 | SHALL |  | [8572](#C_8572) | 2.16.840.1.113883.5.6 (HL7ActClass) = SBADM |
| @moodCode | 1..1 | SHALL |  | [8573](#C_8573) | 2.16.840.1.113883.11.20.9.24 (Plan of Care moodCode (SubstanceAdministration/Supply)) |
| templateId | 1..1 | SHALL |  | [30465](#C_30465) |  |
| @root | 1..1 | SHALL |  | [30466](#C_30466) | 2.16.840.1.113883.10.20.22.4.42.2 |
| id | 1..\* | SHALL |  | [8575](#C_8575) |  |
| statusCode | 1..1 | SHALL |  | [30467](#C_30467) |  |
| effectiveTime | 1..1 | SHALL |  | [30468](#C_30468) |  |
| performer | 0..\* | MAY |  | [30470](#C_30470) |  |
| participant | 0..\* | MAY |  | [30471](#C_30471) |  |
| entryRelationship | 0..\* | MAY |  | [31107](#C_31107) |  |
| @typeCode | 1..1 | SHALL |  | [31108](#C_31108) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31109](#C_31109) |  |

1. SHALL contain exactly one [1..1] @classCode="SBADM" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8572).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [Plan of Care moodCode (SubstanceAdministration/Supply)](#Plan_of_Care_moodCode_SubstanceAdminist) 2.16.840.1.113883.11.20.9.24 STATIC 2011-09-30 (CONF:8573).
3. SHALL contain exactly one [1..1] templateId (CONF:30465) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.42.2" (CONF:30466).
4. SHALL contain at least one [1..\*] id (CONF:8575).
5. SHALL contain exactly one [1..1] statusCode (CONF:30467).
6. SHALL contain exactly one [1..1] effectiveTime (CONF:30468).

Performers represent clinicians who are responsible for assessing and treating the patient.

1. MAY contain zero or more [0..\*] performer (CONF:30470).

Participants represent those in supporting roles such as caregiver, who participate in the patient's care.

1. MAY contain zero or more [0..\*] participant (CONF:30471).

This entryRelationship represents the priority that a patient places on the substance administration.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31104) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31105).
   2. SHALL contain exactly one [1..1] [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31106).

This entryRelationship represents the priority that a provider places on the substance administration.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31107) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31108).
   2. SHALL contain exactly one [1..1] [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31109).

415: Plan of Care moodCode (SubstanceAdministration/Supply)

|  |  |  |
| --- | --- | --- |
| Value Set: Plan of Care moodCode (SubstanceAdministration/Supply) 2.16.840.1.113883.11.20.9.24 | | |
| Code | Code System | Print Name |
| INT | ActMood | Intent |
| PRMS | ActMood | Promise |
| PRP | ActMood | Proposal |
| RQO | ActMood | Request |

Figure 166: Suststance Administration Plan Example

<entry>

<substanceAdministration moodCode="RQO" classCode="SBADM">

<templateId root="2.16.840.1.113883.10.20.22.4.42.2"/>

<!-- \*\*Substance Administration Plan V2 template \*\*-->

<id root="cdbd33f0-6cde-11db-9fe1-0800200c9a66"/>

<text>Heparin 0.25 ml Prefilled Syringe</text>

<statusCode code="completed"/>

<effectiveTime xsi:type="IVL\_TS">

<low value="20130615"/>

</effectiveTime>

<effectiveTime xsi:type="PIVL\_TS" institutionSpecified="true"

operator="A">

<period value="4" unit="h"/>

</effectiveTime>

<consumable>

...

</consumable>

<participant typeCode="IND">

<participantRole classCode="CAREGIVER">

<code code="MTH" codeSystem="2.16.840.1.113883.5.111"

displayName="Mother"/>

</participantRole>

</participant>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Patient Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.142"/>

<id root="9a6d1bac-17d3-4195-89a4-1121bc809b4d"/>

...

</observation>

</entryRelationship>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Provider Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.143"/>

...

</observation>

</entryRelationship>

</substanceAdministration>

</entry>

<participant typeCode="IND">

...>

</participant>

</substanceAdministration>

</entry>

Drug Monitoring Act (NEW)

[act: templateId 2.16.840.1.113883.10.20.22.4.123 (open)]

416: Drug Monitoring Act (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medication Activity (V2)](#Medication_Activity_V2) (optional) |  |

This template represents the person responsible for monitoring the medication. The prescriber of the medication is not necessarily the same person who is designated to monitor the drug.

417: Drug Monitoring Act (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.123'] | | | | | |
| @moodCode | 1..1 | SHALL |  | [28656](#C_28656) | INT |
| templateId | 1..1 | SHALL |  | [28657](#C_28657) |  |
| @root | 1..1 | SHALL |  | [28658](#C_28658) | 2.16.840.1.113883.10.20.22.4.123 |
| code | 1..1 | SHALL |  | [28660](#C_28660) |  |
| @code | 1..1 | SHALL |  | [30818](#C_30818) | 395170001 |
| @codeSystem | 1..1 | SHALL |  | [30819](#C_30819) | 2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96 |
| participant | 1..\* | SHALL |  | [28661](#C_28661) |  |
| @typeCode | 1..1 | SHALL |  | [28663](#C_28663) | RESP |
| participantRole | 1..1 | SHALL |  | [28662](#C_28662) |  |
| @classCode | 1..1 | SHALL |  | [28664](#C_28664) | ASSIGNED |
| id | 1..\* | SHALL |  | [28665](#C_28665) |  |
| playingEntity | 1..1 | SHALL |  | [28667](#C_28667) |  |
| @classCode | 1..1 | SHALL |  | [28668](#C_28668) | PSN |
| name | 1..1 | SHALL |  | [28669](#C_28669) |  |
| @classCode | 1..1 | SHALL |  | [30823](#C_30823) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |

1. Conforms to [Planned Substance Administration (V2)](#E_Planned_Substance_Administration_V2) template (2.16.840.1.113883.10.20.22.4.42.2).
2. SHALL contain exactly one [1..1] @classCode="ACT" act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:30823).
3. SHALL contain exactly one [1..1] @moodCode="INT" (CONF:28656).
4. SHALL contain exactly one [1..1] templateId (CONF:28657) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.123" (CONF:28658).
5. SHALL contain exactly one [1..1] code (CONF:28660).
   1. This code SHALL contain exactly one [1..1] @code="395170001" medication monitoring (regime/therapy) (CONF:30818).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:30819).
6. SHALL contain at least one [1..\*] participant (CONF:28661).
   1. Such participants SHALL contain exactly one [1..1] @typeCode="RESP" (CONF:28663).
   2. Such participants SHALL contain exactly one [1..1] participantRole (CONF:28662).
      1. This participantRole SHALL contain exactly one [1..1] @classCode="ASSIGNED" (CONF:28664).
      2. This participantRole SHALL contain at least one [1..\*] id (CONF:28665).
      3. This participantRole SHALL contain exactly one [1..1] playingEntity (CONF:28667).
         1. This playingEntity SHALL contain exactly one [1..1] @classCode="PSN" (CONF:28668).
         2. This playingEntity SHALL contain exactly one [1..1] name (CONF:28669).

Figure 167: Drug Monitoring Act Example

<entryRelationship typeCode="COMP">

<!-- \*\*DRUG MONITORING ACT \*\*-->

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.123"/>

<id root="2a620155-9d11-439e-92b3-5d9815ff4ee8"/>

<code code="395170001" displayName="medication monitoring(regine/therapy"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED-CT"/>

<statusCode code="completed"/>

<effectiveTime xsi:type="IVL\_TS">

<low value="20130615"/>

<high value="20130715"/>

</effectiveTime>

<participant typeCode="RESP">

<participantRole classCode="ASSIGNED">

<id root="2a620155-9d11-439e-92b3-5d9815ff4ee5"/>

<playingEntity classCode="PSN">

<name>

<given>Listener</given>

<family>Larry</family>

<prefix>DR</prefix>

</name>

</playingEntity>

</participantRole>

</participant>

</act>

</entryRelationship>

</substanceAdministration>

</entry>

Planned Supply (V2)

[supply: templateId 2.16.840.1.113883.10.20.22.4.43.2 (open)]

418: Planned Supply (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) (optional)  [Goal Observation (NEW)](#E_Goal_Observation_NEW) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW)  [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) |

This template represents both medicinal and non-medicinal supplies ordered, requested or intended for the patient. The importance of the supply order or request to the patient and provider may be indicated in the Patient Priority Preference and Provider Priority Preference. The author/time indicates the time when the planned supply was documented.

419: Planned Supply (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| supply[templateId/@root = '2.16.840.1.113883.10.20.22.4.43.2'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [31110](#C_31110) |  |
| @typeCode | 1..1 | SHALL |  | [31111](#C_31111) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31112](#C_31112) |  |
| @classCode | 1..1 | SHALL |  | [8577](#C_8577) | 2.16.840.1.113883.5.6 (HL7ActClass) = SPLY |
| @moodCode | 1..1 | SHALL |  | [8578](#C_8578) | 2.16.840.1.113883.11.20.9.24 (Plan of Care moodCode (SubstanceAdministration/Supply)) |
| templateId | 1..1 | SHALL |  | [30463](#C_30463) |  |
| @root | 1..1 | SHALL |  | [30464](#C_30464) | 2.16.840.1.113883.10.20.22.4.43.2 |
| id | 1..\* | SHALL |  | [8580](#C_8580) |  |
| statusCode | 1..1 | SHALL |  | [30458](#C_30458) |  |
| effectiveTime | 0..1 | SHOULD |  | [30459](#C_30459) |  |
| entryRelationship | 0..\* | MAY |  | [31113](#C_31113) |  |
| @typeCode | 1..1 | SHALL |  | [31114](#C_31114) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31115](#C_31115) |  |
| author | 0..1 | SHOULD |  | [31129](#C_31129) |  |
| time | 1..1 | SHALL |  | [31130](#C_31130) |  |

1. SHALL contain exactly one [1..1] @classCode="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8577).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [Plan of Care moodCode (SubstanceAdministration/Supply)](#Plan_of_Care_moodCode_SubstanceAdminist) 2.16.840.1.113883.11.20.9.24 STATIC 2011-09-30 (CONF:8578).
3. SHALL contain exactly one [1..1] templateId (CONF:30463) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.43.2" (CONF:30464).
4. SHALL contain at least one [1..\*] id (CONF:8580).
5. SHALL contain exactly one [1..1] statusCode (CONF:30458).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:30459).  
   Note: effectiveTime in a plan template indicates the time frame around which an event should occur.

If the author of a Supply Plan is different then the author of the document, or if there is more than one document author, the supplyAct author must be stated.

1. SHOULD contain zero or one [0..1] author (CONF:31129).
   1. The author, if present, SHALL contain exactly one [1..1] time (CONF:31130).  
      Note: The author/time indicates the time when the supply plan was documented.

This entryRelationship represents the priority that a patient places on the supply.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31110) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31111).
   2. SHALL contain exactly one [1..1] [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31112).

This entryRelationship represents the priority that a provider places on the supply.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31113) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31114).
   2. SHALL contain exactly one [1..1] [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31115).

420: Plan of Care moodCode (SubstanceAdministration/Supply)

|  |  |  |
| --- | --- | --- |
| Value Set: Plan of Care moodCode (SubstanceAdministration/Supply) 2.16.840.1.113883.11.20.9.24 | | |
| Code | Code System | Print Name |
| INT | ActMood | Intent |
| PRMS | ActMood | Promise |
| PRP | ActMood | Proposal |
| RQO | ActMood | Request |

Figure 168: Planned Supply Example

<entry>

<supply moodCode="INT" classCode="SPLY">

<templateId root="2.16.840.1.113883.10.20.22.4.43.2" />

<!-- \*\* Planned Supply V2 \*\* -->

<id root="9a6d1bac-17d3-4195-89c4-1121bc809b5d" />

<statusCode code="completed" />

<effectiveTime value="20130615" />

<repeatNumber value="1" />

<quantity value="3" />

<product>

<manufacturedProduct classCode="MANU">

<templateId root="2.16.840.1.113883.10.20.22.4.23" />

<id root="2a620155-9d11-439e-92b3-5d9815ff4ee8" />

<manufacturedMaterial>

<code code="573621" codeSystem="2.16.840.1.113883.6.88" displayName="Proventil 0.09 MG/ACTUAT inhalant solution">

<originalText>

<reference value="#MedSec\_1" />

</originalText>

<translation code="573621" displayName="Proventil 0.09 MG/ACTUAT inhalant solution" codeSystem="2.16.840.1.113883.6.88" codeSystemName="RxNorm" />

</code>

</manufacturedMaterial>

<manufacturerOrganization>

<name>Medication Factory Inc.</name>

</manufacturerOrganization>

</manufacturedProduct>

</product>

<performer>

....

</performer>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Patient Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.142" />

....

</observation>

</entryRelationship>

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Provider Priority Preference-->

<templateId root="2.16.840.1.113883.10.20.22.4.143" />

....

</observation>

</entryRelationship>

</supply>

</entry>

Policy Activity (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.61.2 (closed)]

421: Policy Activity (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Coverage Activity (V2)](#E_Coverage_Activity_V2) (required) |  |

A policy activity represents the policy or program providing the coverage. The person for whom payment is being provided (i.e., the patient) is the covered party. The subscriber of the policy or program is represented as a participant that is the holder the coverage. The payer is represented as the performer of the policy activity.

422: Policy Activity (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.61.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [8898](#C_8898) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [8899](#C_8899) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [8900](#C_8900) |  |
| @root | 1..1 | SHALL |  | [10516](#C_10516) | 2.16.840.1.113883.10.20.22.4.61.2 |
| id | 1..\* | SHALL |  | [8901](#C_8901) |  |
| code | 1..1 | SHALL |  | [8903](#C_8903) |  |
| @code | 0..1 | SHOULD |  | [19185](#C_19185) | 2.16.840.1.113883.3.88.12.3221.5.2 (Health Insurance Type Value Set) |
| statusCode | 1..1 | SHALL |  | [8902](#C_8902) |  |
| @code | 1..1 | SHALL |  | [19109](#C_19109) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| performer | 1..1 | SHALL |  | [8906](#C_8906) |  |
| @typeCode | 1..1 | SHALL |  | [8907](#C_8907) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = PRF |
| templateId | 1..1 | SHALL |  | [16808](#C_16808) |  |
| @root | 1..1 | SHALL |  | [16809](#C_16809) | 2.16.840.1.113883.10.20.22.4.87 |
| assignedEntity | 1..1 | SHALL |  | [8908](#C_8908) |  |
| id | 1..\* | SHALL |  | [8909](#C_8909) |  |
| code | 0..1 | SHOULD |  | [8914](#C_8914) |  |
| @code | 1..1 | SHALL |  | [15992](#C_15992) | 2.16.840.1.113883.1.11.10416 (HL7FinanciallyResponsiblePartyType) |
| addr | 0..1 | MAY |  | [8910](#C_8910) |  |
| telecom | 0..\* | MAY |  | [8911](#C_8911) |  |
| representedOrganization | 0..1 | SHOULD |  | [8912](#C_8912) |  |
| name | 0..1 | SHOULD |  | [8913](#C_8913) |  |
| performer | 0..1 | SHOULD |  | [8961](#C_8961) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = PRF |
| templateId | 1..1 | SHALL |  | [16810](#C_16810) |  |
| @root | 1..1 | SHALL |  | [16811](#C_16811) | 2.16.840.1.113883.10.20.22.4.88 |
| time | 0..1 | SHOULD |  | [8963](#C_8963) |  |
| assignedEntity | 1..1 | SHALL |  | [8962](#C_8962) |  |
| code | 1..1 | SHALL |  | [8968](#C_8968) |  |
| @code | 1..1 | SHALL |  | [16096](#C_16096) | 2.16.840.1.113883.5.110 (RoleClass) = GUAR |
| addr | 0..1 | SHOULD |  | [8964](#C_8964) |  |
| telecom | 0..\* | SHOULD |  | [8965](#C_8965) |  |
| participant | 1..1 | SHALL |  | [8916](#C_8916) |  |
| @typeCode | 1..1 | SHALL |  | [8917](#C_8917) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = COV |
| templateId | 1..1 | SHALL |  | [16812](#C_16812) |  |
| @root | 1..1 | SHALL |  | [16814](#C_16814) | 2.16.840.1.113883.10.20.22.4.89 |
| time | 0..1 | SHOULD |  | [8918](#C_8918) |  |
| low | 0..1 | SHOULD |  | [8919](#C_8919) |  |
| high | 0..1 | SHOULD |  | [8920](#C_8920) |  |
| participantRole | 1..1 | SHALL |  | [8921](#C_8921) |  |
| id | 1..\* | SHALL |  | [8922](#C_8922) |  |
| code | 1..1 | SHALL |  | [8923](#C_8923) |  |
| @code | 0..1 | SHOULD |  | [16078](#C_16078) | 2.16.840.1.113883.1.11.18877 (Coverage Role Type Value Set) |
| addr | 0..1 | SHOULD |  | [8956](#C_8956) |  |
| playingEntity | 0..1 | SHOULD |  | [8932](#C_8932) |  |
| name | 1..1 | SHALL |  | [8930](#C_8930) |  |
| sdtc:birthTime | 1..1 | SHALL |  | [31344](#C_31344) |  |
| participant | 0..1 | SHOULD |  | [8934](#C_8934) |  |
| @typeCode | 1..1 | SHALL |  | [8935](#C_8935) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = HLD |
| templateId | 1..1 | SHALL |  | [16813](#C_16813) |  |
| @root | 1..1 | SHALL |  | [16815](#C_16815) | 2.16.840.1.113883.10.20.22.4.90 |
| time | 0..1 | MAY |  | [8938](#C_8938) |  |
| participantRole | 1..1 | SHALL |  | [8936](#C_8936) |  |
| id | 1..\* | SHALL |  | [8937](#C_8937) |  |
| addr | 0..1 | SHOULD |  | [8925](#C_8925) |  |
| entryRelationship | 1..\* | SHALL |  | [8939](#C_8939) |  |
| @typeCode | 1..1 | SHALL |  | [8940](#C_8940) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8898).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8899).
3. SHALL contain exactly one [1..1] templateId (CONF:8900) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.61.2" (CONF:10516).

This id is a unique identifier for the policy or program providing the coverage

1. SHALL contain at least one [1..\*] id (CONF:8901).
2. SHALL contain exactly one [1..1] code (CONF:8903).
   1. This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet [Health Insurance Type Value Set](#Health_Insurance_Type_Value_Set) 2.16.840.1.113883.3.88.12.3221.5.2 DYNAMIC (CONF:19185).
3. SHALL contain exactly one [1..1] statusCode (CONF:8902).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19109).

This performer represents the Payer.

1. SHALL contain exactly one [1..1] performer (CONF:8906) such that it
   1. SHALL contain exactly one [1..1] @typeCode="PRF" Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8907).
   2. SHALL contain exactly one [1..1] templateId (CONF:16808).
      1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.87" Payer Performer (CONF:16809).
   3. SHALL contain exactly one [1..1] assignedEntity (CONF:8908).
      1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:8909).
      2. This assignedEntity SHOULD contain zero or one [0..1] code (CONF:8914).
         1. The code, if present, SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet [HL7FinanciallyResponsiblePartyType](#HL7FinanciallyResponsiblePartyType) 2.16.840.1.113883.1.11.10416 DYNAMIC (CONF:15992).
      3. This assignedEntity MAY contain zero or one [0..1] addr (CONF:8910).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10481).
      4. This assignedEntity MAY contain zero or more [0..\*] telecom (CONF:8911).
      5. This assignedEntity SHOULD contain zero or one [0..1] representedOrganization (CONF:8912).
         1. The representedOrganization, if present, SHOULD contain zero or one [0..1] name (CONF:8913).

This performer represents the Guarantor.

1. SHOULD contain zero or one [0..1] performer="PRF" Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8961) such that it
   1. SHALL contain exactly one [1..1] templateId (CONF:16810).
      1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.88" Guarantor Performer (CONF:16811).
   2. SHOULD contain zero or one [0..1] time (CONF:8963).
   3. SHALL contain exactly one [1..1] assignedEntity (CONF:8962).
      1. This assignedEntity SHALL contain exactly one [1..1] code (CONF:8968).
         1. This code SHALL contain exactly one [1..1] @code="GUAR" Guarantor (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:16096).
      2. This assignedEntity SHOULD contain zero or one [0..1] addr (CONF:8964).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10482).
      3. This assignedEntity SHOULD contain zero or more [0..\*] telecom (CONF:8965).
      4. SHOULD include assignedEntity/assignedPerson/name AND/OR assignedEntity/representedOrganization/name (CONF:8967).
2. SHALL contain exactly one [1..1] participant (CONF:8916) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COV" Coverage target (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8917).
   2. SHALL contain exactly one [1..1] templateId (CONF:16812).
      1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.89" Covered Party Participant (CONF:16814).
   3. SHOULD contain zero or one [0..1] time (CONF:8918).
      1. The time, if present, SHOULD contain zero or one [0..1] low (CONF:8919).
      2. The time, if present, SHOULD contain zero or one [0..1] high (CONF:8920).
   4. SHALL contain exactly one [1..1] participantRole (CONF:8921).
      1. This participantRole SHALL contain at least one [1..\*] id (CONF:8922).
         1. This id is a unique identifier for  the covered party member. Implementers SHOULD use the same GUID for each instance of a member identifier from the same health plan (CONF:8984).
      2. This participantRole SHALL contain exactly one [1..1] code (CONF:8923).
         1. This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet [Coverage Role Type Value Set](#Coverage_Role_Type_Value_Set) 2.16.840.1.113883.1.11.18877 DYNAMIC (CONF:16078).
      3. This participantRole SHOULD contain zero or one [0..1] addr (CONF:8956).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10484).
      4. This participantRole SHOULD contain zero or one [0..1] playingEntity (CONF:8932).

If the covered party’s name is recorded differently in the health plan and in the registration/medication summary (due to marriage or for other reasons), use the name as it is recorded in the health plan.

* + - 1. The playingEntity, if present, SHALL contain exactly one [1..1] name (CONF:8930).

If the covered party’s date of birth is recorded differently in the health plan and in the registration/medication summary, use the date of birth as it is recorded in the health plan.

* + - 1. The playingEntity, if present, SHALL contain exactly one [1..1] sdtc:birthTime (CONF:31344).
         1. The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the birthTime element (CONF:31345).

1. SHOULD contain zero or one [0..1] participant (CONF:8934) such that it
   1. SHALL contain exactly one [1..1] @typeCode="HLD" Holder (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8935).
   2. SHALL contain exactly one [1..1] templateId (CONF:16813).
      1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.90" Policy Holder Participant (CONF:16815).
   3. MAY contain zero or one [0..1] time (CONF:8938).
   4. SHALL contain exactly one [1..1] participantRole (CONF:8936).
      1. This participantRole SHALL contain at least one [1..\*] id (CONF:8937).
         1. This id is a unique identifier for the subscriber of the coverage (CONF:10120).
      2. This participantRole SHOULD contain zero or one [0..1] addr (CONF:8925).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10483).
   5. When the Subscriber is the patient, the participant element describing the subscriber SHALL NOT be present. This information will be recorded instead in the data elements used to record member information (CONF:17139).
2. SHALL contain at least one [1..\*] entryRelationship (CONF:8939) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8940).
   2. The target of a policy activity with act/entryRelationship/@typeCode="REFR" SHALL be an authorization activity (templateId 2.16.840.1.113883.10.20.1.19) OR an act, with act@classCode="ACT"] and act@moodCode="DEF"], representing a description of the coverage plan (CONF:8942).
   3. A description of the coverage plan SHALL contain one or more act/id, to represent the plan identifier, and an act/text with the name of the plan (CONF:8943).

423: Health Insurance Type Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Health Insurance Type Value Set 2.16.840.1.113883.3.88.12.3221.5.2 | | |
| Code | Code System | Print Name |
| 12 | Insurance Type Code | Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan |
| 13 | Insurance Type Code | Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan |
| 14 | Insurance Type Code | Medicare Secondary, No-fault Insurance including Auto is Primary |
| 15 | Insurance Type Code | Medicare Secondary Worker's Compensation |
| 16 | Insurance Type Code | Medicare Secondary Public Health Service (PHS)or Other Federal Agency |
| 41 | Insurance Type Code | Medicare Secondary Black Lung |
| 42 | Insurance Type Code | Medicare Secondary Veteran's Administration |
| 43 | Insurance Type Code | Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) |
| 47 | Insurance Type Code | Medicare Secondary, Other Liability Insurance is Primary |
| AP | Insurance Type Code | Auto Insurance Policy |
| ... | | |

424: HL7FinanciallyResponsiblePartyType

|  |  |  |
| --- | --- | --- |
| Value Set: HL7FinanciallyResponsiblePartyType 2.16.840.1.113883.1.11.10416  RoleClass 2.16.840.1.113883.5.110  http://www.hl7.org/memonly/downloads/v3edition.cfm#V32008 | | |
| Code | Code System | Print Name |
| GUAR | RoleClass | Guarantor |
| EMP | RoleClass | Employee |
| INVSBJ | RoleClass | Investigation Subject |

425: Coverage Role Type Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Coverage Role Type Value Set 2.16.840.1.113883.1.11.18877 | | |
| Code | Code System | Print Name |

Figure 169: Policy Activity Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.61.2"/>

<id root="3e676a50-7aac-11db-9fe1-0800200c9a66"/>

<code code="SELF" codeSystemName="HL7 RoleClassRelationship"

codeSystem="2.16.840.1.113883.5.110"/>

<statusCode code="completed"/>

<!-- Insurance company information -->

<performer typeCode="PRF">

<templateId root="2.16.840.1.113883.10.20.22.4.87"/>

<time>

<low nullFlavor="UNK"/>

<high nullFlavor="UNK"/>

</time>

<assignedEntity>

<id root="2.16.840.1.113883.19"/>

<code code="PAYOR" codeSystem="2.16.840.1.113883.5.110"

codeSystemName="HL7 RoleCode"/>

<addr use="WP">

<streetAddressLine>123 Insurance Road</streetAddressLine>

<city>Blue Bell</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>US</country>

<!-- US is "United States" from ISO 3166-1 Country Codes: 1.0.3166.1 -->

</addr>

<telecom value="tel:+(555)555-1515" use="WP"/>

<representedOrganization>

<name>Good Health Insurance</name>

<telecom value="tel:+(555)555-1515" use="WP"/>

<addr use="WP">

<streetAddressLine>123 Insurance Road</streetAddressLine>

<city>Blue Bell</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>US</country>

</addr>

</representedOrganization>

</assignedEntity>

</performer>

<!-- Guarantor information (the person responsible for the final bill) -->

<performer typeCode="PRF">

<templateId root="2.16.840.1.113883.10.20.22.4.88"/>

<time>

<low nullFlavor="UNK"/>

<high nullFlavor="UNK"/>

</time>

<assignedEntity>

<id root="329fcdf0-7ab3-11db-9fe1-0800200c9a66"/>

<code code="GUAR" codeSystem="2.16.840.1.113883.5.111"

codeSystemName="HL7 RoleCode"/>

<addr use="HP">

<streetAddressLine>17 Daws Rd.</streetAddressLine>

<city>Blue Bell</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>US</country>

</addr>

<telecom value="tel:+(781)555-1212" use="HP"/>

<assignedPerson>

<name>

<prefix>Mr.</prefix>

<given>Adam</given>

<given>Frankie</given>

<family>Everyman</family>

</name>

</assignedPerson>

</assignedEntity>

</performer>

<!-- Covered party -->

<participant typeCode="COV">

<templateId root="2.16.840.1.113883.10.20.22.4.89.2"/>

<time>

<low nullFlavor="UNK"/>

<high nullFlavor="UNK"/>

</time>

<participantRole classCode="PAT">

<!-- Health plan ID for patient. -->

<id root="1.1.1.1.1.1.1.1.14" extension="1138345"/>

<code code="SELF" codeSystem="2.16.840.1.113883.5.111"/>

<addr use="HP">

<streetAddressLine>17 Daws Rd.</streetAddressLine>

<city>Blue Bell</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>US</country>

</addr>

<playingEntity>

<name>

<!-- Name is needed if different than name on health plan. -->

<prefix>Mr.</prefix>

<given>Frank</given>

<given>A.</given>

<family>Everyman</family>

</name>

</playingEntity>

</participantRole>

</participant>

<!-- Policy holder -->

<participant typeCode="HLD">

<templateId root="2.16.840.1.113883.10.20.22.4.90.2"/>

<participantRole>

<id extension="1138345" root="2.16.840.1.113883.19"/>

<addr use="HP">

<streetAddressLine>17 Daws Rd.</streetAddressLine>

<city>Blue Bell</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>US</country>

</addr>

</participantRole>

</participant>

<entryRelationship typeCode="REFR">

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.1.19"/>

. . .

</entryRelationship>

</act>

</entryRelationship>

Postprocedure Diagnosis (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.51.2 (open)]

426: Postprocedure Diagnosis (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Postprocedure Diagnosis Section (V2)](#S_Postprocedure_Diagnosis_Section_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Problem Observation (V2)](#E_Problem_Observation_V2) |

This template represents the diagnosis or diagnoses discovered or confirmed during the procedure. They may be the same as preprocedure diagnoses or indications.

427: Postprocedure Diagnosis (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.51.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [8756](#C_8756) | ACT |
| @moodCode | 1..1 | SHALL |  | [8757](#C_8757) | EVN |
| templateId | 1..1 | SHALL |  | [16766](#C_16766) |  |
| @root | 1..1 | SHALL |  | [16767](#C_16767) | 2.16.840.1.113883.10.20.22.4.51.2 |
| code | 1..1 | SHALL |  | [19151](#C_19151) |  |
| @code | 1..1 | SHALL |  | [19152](#C_19152) | 2.16.840.1.113883.6.1 (LOINC) = 59769-0 |
| entryRelationship | 1..\* | SHALL |  | [8759](#C_8759) |  |
| @typeCode | 1..1 | SHALL |  | [8760](#C_8760) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| observation | 1..1 | SHALL |  | [15583](#C_15583) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CONF:8756).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CONF:8757).
3. SHALL contain exactly one [1..1] templateId (CONF:16766) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.51.2" (CONF:16767).
4. SHALL contain exactly one [1..1] code (CONF:19151).
   1. This code SHALL contain exactly one [1..1] @code="59769-0" Postprocedure diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19152).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:8759).
   1. Such entryRelationships SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8760).
   2. Such entryRelationships SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15583).

Figure 170: Postprocedure Diagnosis Section Example

<act moodCode="EVN" classCode="ACT">

<templateId root="2.16.840.1.113883.10.20.22.4.51.2" />

<!-- \*\* Postprocedure Diagnosis Entry \*\* -->

<code code="59769-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Postprocedure Diagnosis" />

<entryRelationship typeCode="SUBJ">

<observation classCode="OBS" moodCode="EVN">

<!-- Problem observation -->

<templateId root="2.16.840.1.113883.10.20.22.4.4.2" />

. . .

</observation>

</entryRelationship>

</act>

Precondition for Substance Administration

[criterion: templateId 2.16.840.1.113883.10.20.22.4.25 (open)]

428: Precondition for Substance Administration Contexts

| Contained By: | Contains: |
| --- | --- |
| [Immunization Activity (V2)](#E_Immunization_Activity_V2) (optional) |  |

A criterion for administration can be used to record that the medication is to be administered only when the associated criteria are met.

429: Precondition for Substance Administration Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| criterion[templateId/@root = '2.16.840.1.113883.10.20.22.4.25'] | | | | | |
| value | 0..1 | SHOULD | CD | [7369](#C_7369) |  |
| templateId | 1..1 | SHALL |  | [7372](#C_7372) |  |
| @root | 1..1 | SHALL |  | [10517](#C_10517) | 2.16.840.1.113883.10.20.22.4.25 |
| text | 0..1 | MAY |  | [7373](#C_7373) |  |
| code | 0..1 | SHOULD |  | [16854](#C_16854) |  |

1. SHALL contain exactly one [1..1] templateId (CONF:7372) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.25" (CONF:10517).
2. SHOULD contain zero or one [0..1] code (CONF:16854).
3. MAY contain zero or one [0..1] text (CONF:7373).
4. SHOULD contain zero or one [0..1] value with @xsi:type="CD" (CONF:7369).

Figure 171: Precondition for Substance Administration Example

<precondition typeCode="PRCN">

<templateId root="2.16.840.1.113883.10.20.22.4.25" />

<criterion>

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />

<value xsi:type="CE" code="56018004" codeSystem="2.16.840.1.113883.6.96"

displayName="Wheezing" />

</criterion>

</precondition>

Pregnancy Observation

[observation: templateId 2.16.840.1.113883.10.20.15.3.8 (open)]

430: Pregnancy Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [Social History Section (V2)](#S_Social_History_Section_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Estimated Date of Delivery](#E_Estimated_Date_of_Delivery) |

This clinical statement represents current and/or prior pregnancy dates enabling investigators to determine if the subject of the case report was pregnant during the course of a condition.

431: Pregnancy Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.15.3.8'] | | | | | |
| entryRelationship | 0..1 | MAY |  | [458](#C_458) |  |
| @typeCode | 1..1 | SHALL |  | [459](#C_459) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [15584](#C_15584) |  |
| @classCode | 1..1 | SHALL |  | [451](#C_451) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [452](#C_452) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| statusCode | 1..1 | SHALL |  | [455](#C_455) |  |
| @code | 1..1 | SHALL |  | [19110](#C_19110) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL | CD | [457](#C_457) |  |
| @code | 1..1 | SHALL |  | [26460](#C_26460) | 2.16.840.1.113883.6.96 (SNOMED CT) = 77386006 |
| effectiveTime | 0..1 | SHOULD |  | [2018](#C_2018) |  |
| templateId | 1..1 | SHALL |  | [16768](#C_16768) |  |
| @root | 1..1 | SHALL |  | [16868](#C_16868) | 2.16.840.1.113883.10.20.15.3.8 |
| code | 1..1 | SHALL |  | [19153](#C_19153) |  |
| @code | 1..1 | SHALL |  | [19154](#C_19154) | 2.16.840.1.113883.5.4 (ActCode) = ASSERTION |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:451).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:452).
3. SHALL contain exactly one [1..1] templateId (CONF:16768) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.15.3.8" (CONF:16868).
4. SHALL contain exactly one [1..1] code (CONF:19153).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19154).
5. SHALL contain exactly one [1..1] statusCode (CONF:455).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19110).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:2018).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:457).
   1. This value SHALL contain exactly one [1..1] @code="77386006" Pregnant (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:26460).
8. MAY contain zero or one [0..1] entryRelationship (CONF:458) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:459).
   2. SHALL contain exactly one [1..1] [Estimated Date of Delivery](#E_Estimated_Date_of_Delivery) (templateId:2.16.840.1.113883.10.20.15.3.1) (CONF:15584).

Figure 172: Pregnancy Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.15.3.8"/>

<id extension="123456789" root="2.16.840.1.113883.19"/>

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<statusCode code="completed"/>

<effectiveTime>

<low value="20110410"/>

</effectiveTime>

<value xsi:type="CD" code="77386006"

displayName="pregnant"

codeSystem="2.16.840.1.113883.6.96"/>

<entryRelationship typeCode="REFR">

<templateId root="2.16.840.1.113883.10.20.15.3.1"/>

. . .

</entryRelationship>

</observation>

Preoperative Diagnosis (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.65.2 (open)]

432: Preoperative Diagnosis (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Preoperative Diagnosis Section (V2)](#S_Preoperative_Diagnosis_Section_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Problem Observation (V2)](#E_Problem_Observation_V2) |

This template represents the surgical diagnosis or diagnoses assigned to the patient before the surgical procedure and is the reason for the surgery. The preoperative diagnosis is, in the opinion of the surgeon, the diagnosis that will be confirmed during surgery.

433: Preoperative Diagnosis (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.65.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [10090](#C_10090) | ACT |
| @moodCode | 1..1 | SHALL |  | [10091](#C_10091) | EVN |
| templateId | 1..1 | SHALL |  | [16770](#C_16770) |  |
| @root | 1..1 | SHALL |  | [16771](#C_16771) | 2.16.840.1.113883.10.20.22.4.65.2 |
| code | 1..1 | SHALL |  | [19155](#C_19155) |  |
| @code | 1..1 | SHALL |  | [19156](#C_19156) | 2.16.840.1.113883.6.1 (LOINC) = 10219-4 |
| entryRelationship | 1..\* | SHALL |  | [10093](#C_10093) |  |
| @typeCode | 1..1 | SHALL |  | [10094](#C_10094) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| observation | 1..1 | SHALL |  | [15605](#C_15605) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CONF:10090).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CONF:10091).
3. SHALL contain exactly one [1..1] templateId (CONF:16770) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.65.2" (CONF:16771).
4. SHALL contain exactly one [1..1] code (CONF:19155).
   1. This code SHALL contain exactly one [1..1] @code="10219-4" Preoperative Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19156).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:10093).
   1. Such entryRelationships SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:10094).
   2. Such entryRelationships SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15605).

Figure 173: Preoperative Diagnosis Example

<act moodCode="EVN" classCode="ACT">

<templateId root="2.16.840.1.113883.10.20.22.4.65" />

<code code="10219-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Preoperative Diagnosis" />

<entryRelationship typeCode="SUBJ">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.4" />

. . .

</observation>

</entryRelationship>

</act>

Pressure Ulcer Observation (DEPRECATED)

[observation: templateId 2.16.840.1.113883.10.20.22.4.70.2 (open)]

434: Pressure Ulcer Observation (DEPRECATED) Contexts

| Contained By: | Contains: |
| --- | --- |

THIS TEMPLATE HAS BEEN DEPRECATED AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE THE WOUND OBSERVATION TEMPLATE INSTEAD.

The pressure ulcer observation contains details about the pressure ulcer such as the stage of the ulcer, location, and dimensions. If the pressure ulcer is a diagnosis, you may find this on the problem list. An example of how this would appear is in the Problem Section.

435: Pressure Ulcer Observation (DEPRECATED) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.70.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [14383](#C_14383) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14384](#C_14384) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| @negationInd | 0..1 | MAY |  | [14385](#C_14385) |  |
| templateId | 1..1 | SHALL |  | [14387](#C_14387) |  |
| @root | 1..1 | SHALL |  | [14388](#C_14388) | 2.16.840.1.113883.10.20.22.4.70.2 |
| id | 1..\* | SHALL |  | [14389](#C_14389) |  |
| code | 1..1 | SHALL |  | [14759](#C_14759) |  |
| @code | 1..1 | SHALL |  | [14760](#C_14760) | 2.16.840.1.113883.5.4 (ActCode) = ASSERTION |
| text | 0..1 | SHOULD |  | [14391](#C_14391) |  |
| reference | 0..1 | SHOULD |  | [14392](#C_14392) |  |
| @value | 1..1 | SHALL |  | [15585](#C_15585) |  |
| statusCode | 1..1 | SHALL |  | [14394](#C_14394) |  |
| @code | 1..1 | SHALL |  | [19111](#C_19111) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [14395](#C_14395) |  |
| value | 1..1 | SHALL | CD | [14396](#C_14396) | 2.16.840.1.113883.11.20.9.35 (Pressure Ulcer Stage) |
| targetSiteCode | 0..\* | SHOULD |  | [14797](#C_14797) |  |
| @code | 1..1 | SHALL |  | [14798](#C_14798) | 2.16.840.1.113883.11.20.9.36 (Pressure Point ) |
| qualifier | 0..1 | SHOULD |  | [14799](#C_14799) |  |
| name | 1..1 | SHALL |  | [14800](#C_14800) |  |
| @code | 0..1 | SHOULD |  | [14801](#C_14801) | 2.16.840.1.113883.6.96 (SNOMED CT) = 272741003 |
| value | 1..1 | SHALL |  | [14802](#C_14802) |  |
| @code | 0..1 | SHOULD |  | [14803](#C_14803) | 2.16.840.1.113883.11.20.9.37 (TargetSite Qualifiers ) |
| entryRelationship | 0..1 | SHOULD |  | [14410](#C_14410) |  |
| @typeCode | 1..1 | SHALL |  | [14411](#C_14411) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| observation | 1..1 | SHALL |  | [14619](#C_14619) |  |
| @classCode | 1..1 | SHALL |  | [14685](#C_14685) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14686](#C_14686) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| code | 1..1 | SHALL |  | [14620](#C_14620) |  |
| @code | 1..1 | SHALL |  | [14621](#C_14621) | 2.16.840.1.113883.6.96 (SNOMED CT) = 401238003 |
| value | 1..1 | SHALL | PQ | [14622](#C_14622) |  |
| entryRelationship | 0..1 | SHOULD |  | [14601](#C_14601) |  |
| @typeCode | 1..1 | SHALL |  | [14602](#C_14602) | COMP |
| observation | 1..1 | SHALL |  | [14623](#C_14623) |  |
| @classCode | 1..1 | SHALL |  | [14687](#C_14687) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14688](#C_14688) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| code | 1..1 | SHALL |  | [14624](#C_14624) |  |
| @code | 1..1 | SHALL |  | [14625](#C_14625) | 2.16.840.1.113883.6.96 (SNOMED CT) = 401239006 |
| value | 1..1 | SHALL | PQ | [14626](#C_14626) |  |
| entryRelationship | 0..1 | SHOULD |  | [14605](#C_14605) |  |
| @typeCode | 1..1 | SHALL |  | [14606](#C_14606) | COMP |
| observation | 1..1 | SHALL |  | [14627](#C_14627) |  |
| @classCode | 1..1 | SHALL |  | [14689](#C_14689) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14690](#C_14690) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| code | 1..1 | SHALL |  | [14628](#C_14628) |  |
| @code | 1..1 | SHALL |  | [14629](#C_14629) | 2.16.840.1.113883.6.96 (SNOMED CT) = 425094009 |
| value | 1..1 | SHALL | PQ | [14630](#C_14630) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14383).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14384).

Use negationInd="true" to indicate that the problem was not observed.

1. MAY contain zero or one [0..1] @negationInd (CONF:14385).
2. SHALL contain exactly one [1..1] templateId (CONF:14387) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.70.2" (CONF:14388).
3. SHALL contain at least one [1..\*] id (CONF:14389).
4. SHALL contain exactly one [1..1] code (CONF:14759).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:14760).
5. SHOULD contain zero or one [0..1] text (CONF:14391).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:14392).
      1. The reference, if present, SHALL contain exactly one [1..1] @value (CONF:15585).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15586).
6. SHALL contain exactly one [1..1] statusCode (CONF:14394).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19111).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:14395).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [Pressure Ulcer Stage](#Pressure_Ulcer_Stage) 2.16.840.1.113883.11.20.9.35 STATIC (CONF:14396).
9. SHOULD contain zero or more [0..\*] targetSiteCode (CONF:14797).
   1. The targetSiteCode, if present, SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet [Pressure Point](#Pressure_Point_) 2.16.840.1.113883.11.20.9.36 STATIC (CONF:14798).
   2. The targetSiteCode, if present, SHOULD contain zero or one [0..1] qualifier (CONF:14799).
      1. The qualifier, if present, SHALL contain exactly one [1..1] name (CONF:14800).
         1. This name SHOULD contain zero or one [0..1] @code="272741003" laterality (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:14801).
      2. The qualifier, if present, SHALL contain exactly one [1..1] value (CONF:14802).
         1. This value SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet [TargetSite Qualifiers](#TargetSite_Qualifiers_) 2.16.840.1.113883.11.20.9.37 STATIC (CONF:14803).
10. SHOULD contain zero or one [0..1] entryRelationship (CONF:14410) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14411).
    2. SHALL contain exactly one [1..1] observation (CONF:14619).
       1. This observation SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14685).
       2. This observation SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14686).
       3. This observation SHALL contain exactly one [1..1] code (CONF:14620).
          1. This code SHALL contain exactly one [1..1] @code="401238003" Length of Wound (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:14621).
       4. This observation SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:14622).
11. SHOULD contain zero or one [0..1] entryRelationship (CONF:14601) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" (CONF:14602).
    2. SHALL contain exactly one [1..1] observation (CONF:14623).
       1. This observation SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14687).
       2. This observation SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14688).
       3. This observation SHALL contain exactly one [1..1] code (CONF:14624).
          1. This code SHALL contain exactly one [1..1] @code="401239006" Width of Wound (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:14625).
       4. This observation SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:14626).
12. SHOULD contain zero or one [0..1] entryRelationship (CONF:14605) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" (CONF:14606).
    2. SHALL contain exactly one [1..1] observation (CONF:14627).
       1. This observation SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14689).
       2. This observation SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14690).
       3. This observation SHALL contain exactly one [1..1] code (CONF:14628).
          1. This code SHALL contain exactly one [1..1] @code="425094009" Depth of Wound (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:14629).
       4. This observation SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:14630).

436: Pressure Ulcer Stage

|  |  |  |
| --- | --- | --- |
| Value Set: Pressure Ulcer Stage 2.16.840.1.113883.11.20.9.35 | | |
| Code | Code System | Print Name |
| 421076008 | SNOMED CT | Pressure Ulcer Stage 1 |
| 420324007 | SNOMED CT | Pressure Ulcer Stage 2 |
| 421927004 | SNOMED CT | Pressure Ulcer Stage 3 |
| 420597008 | SNOMED CT | Pressure Ulcer Stage 4 |
| 421594008 | SNOMED CT | Nonstageable pressure |

437: Pressure Point

|  |  |  |
| --- | --- | --- |
| Value Set: Pressure Point 2.16.840.1.113883.11.20.9.36 | | |
| Code | Code System | Print Name |
| 43631005 | SNOMED CT | occipital region structure |
| 23747009 | SNOMED CT | skin structure of chin |
| 91774008 | SNOMED CT | structure of right shoulder |
| 7874003 | SNOMED CT | structure of scapular region of back; 272741003 = laterality; 24028007 = right (qualifier value) |
| 368149001 | SNOMED CT | right elbow region structure |
| 368148009 | SNOMED CT | left elbow region structure |
| 87141009 | SNOMED CT | sacral vertebra structure |
| 122495006 | SNOMED CT | thoracic spine structure |
| 122496007 | SNOMED CT | lumbar spine structure |
| 287579007 | SNOMED CT | right hip region structure |
| ... | | |

438: TargetSite Qualifiers

|  |  |  |
| --- | --- | --- |
| Value Set: TargetSite Qualifiers 2.16.840.1.113883.11.20.9.37 | | |
| Code | Code System | Print Name |
| 255549009 | SNOMED CT | anterior |
| 7771000 | SNOMED CT | left |
| 255561001 | SNOMED CT | medial |
| 255551008 | SNOMED CT | posterior |
| 24028007 | SNOMED CT | right |

Problem Concern Act (Condition) (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.3.2 (open)]

439: Problem Concern Act (Condition) (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Problem Section (entries required) (V2)](#S_Problem_Section_entries_required_V2) (required)  [Problem Section (entries optional) (V2)](#S_Problem_Section_entries_optional_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Author Participation (NEW)](#U_Author_Participation_NEW)  [Problem Observation (V2)](#E_Problem_Observation_V2)  [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) |

This template reflects an ongoing concern on behalf of the provider that placed the concern on a patient’s problem list. So long as the underlying condition is of concern to the provider (i.e. so long as the condition, whether active or resolved, is of ongoing concern and interest to the provider), the statusCode is “active”. Only when the underlying condition is no longer of concern is the statusCode set to “completed”. The effectiveTime reflects the time that the underlying condition was felt to be a concern – it may or may not correspond to the effectiveTime of the condition (e.g. even five years later, the clinician may remain concerned about a prior heart attack).

The statusCode of the Problem Concern Act (Condition) is the definitive indication of the status of the concern, whereas the effectiveTime of the nested Problem Observation is the definitive indication of whether or not the underlying condition is resolved.

The effectiveTime/low of the Problem Concern Act (Condition) asserts when the concern became active. This equates to the time the concern was authored in the patient's chart. The effectiveTime/high asserts when the concern was completed (e.g. when the clinician deemed there is no longer any need to track the underlying condition).

440: Problem Concern Act (Condition) (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.3.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [9024](#C_9024) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [9025](#C_9025) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [16772](#C_16772) |  |
| @root | 1..1 | SHALL |  | [16773](#C_16773) | 2.16.840.1.113883.10.20.22.4.3.2 |
| id | 1..\* | SHALL |  | [9026](#C_9026) |  |
| code | 1..1 | SHALL |  | [9027](#C_9027) |  |
| @code | 1..1 | SHALL |  | [19184](#C_19184) | 2.16.840.1.113883.5.6 (HL7ActClass) = CONC |
| statusCode | 1..1 | SHALL |  | [9029](#C_9029) |  |
| @code | 1..1 | SHALL |  | [31525](#C_31525) | 2.16.840.1.113883.11.20.9.19 (ProblemAct statusCode) |
| effectiveTime | 1..1 | SHALL |  | [9030](#C_9030) |  |
| low | 1..1 | SHALL |  | [9032](#C_9032) |  |
| high | 0..1 | MAY |  | [9033](#C_9033) |  |
| entryRelationship | 1..\* | SHALL |  | [9034](#C_9034) |  |
| @typeCode | 1..1 | SHALL |  | [9035](#C_9035) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| observation | 1..1 | SHALL |  | [15980](#C_15980) |  |
| author | 0..\* | SHOULD |  | [31146](#C_31146) |  |
| entryRelationship | 0..\* | MAY |  | [31638](#C_31638) |  |
| @typeCode | 1..1 | SHALL |  | [31639](#C_31639) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31640](#C_31640) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9024).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9025).
3. SHALL contain exactly one [1..1] templateId (CONF:16772) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.3.2" (CONF:16773).
4. SHALL contain at least one [1..\*] id (CONF:9026).
5. SHALL contain exactly one [1..1] code (CONF:9027).
   1. This code SHALL contain exactly one [1..1] @code="CONC" Concern (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:19184).
6. SHALL contain exactly one [1..1] statusCode (CONF:9029).
   1. This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [ProblemAct statusCode](#ProblemAct_statusCode) 2.16.840.1.113883.11.20.9.19 STATIC 2011-09-10 (CONF:31525).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:9030).
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:9032).  
      Note: The effectiveTime/low asserts when the concern became active. This equates to the time the concern was authored in the patient's chart.
   2. This effectiveTime MAY contain zero or one [0..1] high (CONF:9033).  
      Note: The effectiveTime/high asserts when the concern was completed (e.g. when the clinician deemed there is no longer any need to track the underlying condition).
8. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31146).
9. SHALL contain at least one [1..\*] entryRelationship (CONF:9034) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9035).
   2. SHALL contain exactly one [1..1] [Problem Observation (V2)](#E_Problem_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15980).

This entryRelationship represents the importance of the concern to a provider.

1. MAY contain zero or more [0..\*] entryRelationship (CONF:31638) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31639).
   2. SHALL contain exactly one [1..1] [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31640).

441: ProblemAct statusCode

|  |  |  |
| --- | --- | --- |
| Value Set: ProblemAct statusCode 2.16.840.1.113883.11.20.9.19  A ValueSet of HL7 actStatus codes for use on the concern act | | |
| Code | Code System | Print Name |
| completed | ActStatus | Completed |
| aborted | ActStatus | Aborted |
| active | ActStatus | Active |
| suspended | ActStatus | Suspended |

Figure 174: Problem Concern Act Example

<act classCode="ACT" moodCode="EVN" negationInd="true">

<templateId root="2.16.840.1.113883.10.20.22.4.3.2" />

<id root="ec8a6ff8-ed4b-4f7e-82c3-e98e58b45de7" />

<code code="CONC" codeSystem="2.16.840.1.113883.5.6" displayName="Concern" />

<!-- The statusCode represents the need to continue tracking the problem -->

<statusCode code="completed" />

<effectiveTime>

<!-- The low value represents when the problem was recorded in the patient's chart -->

<low value="20080103" />

<!-- The high value reflects when there was no longer a need to track the problem -->

<high value="20080106" />

</effectiveTime>

<author>

<templateId root="2.16.840.1.113883.10.20.22.4.119" />

<time value="200801031145-0800" />

. . .

</author>

<entryRelationship typeCode="SUBJ">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.4.2" />

. . .

</observation>

</entryRelationship>

</act>

Problem Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.4.2 (open)]

442: Problem Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Problem Concern Act (Condition) (V2)](#E_Problem_Concern_Act_Condition_V2) (required)  [Hospital Discharge Diagnosis (V2)](#Hospital_Discharge_Diagnosis_V2) (required)  [Hospital Admission Diagnosis (V2)](#E_Hospital_Admission_Diagnosis_V2) (required)  [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2) (optional)  [Procedure Findings Section (V2)](#S_Procedure_Findings_Section_V2) (optional)  [Complications Section (V2)](#S_Complications_Section_V2) (optional)  [Postprocedure Diagnosis (V2)](#E_Postprocedure_Diagnosis_V2) (required)  [Preoperative Diagnosis (V2)](#E_Preoperative_Diagnosis_V2) (required)  [Deceased Observation (V2)](#E_Deceased_Observation_V2) (optional)  [Encounter Diagnosis (V2)](#E_Encounter_Diagnosis_V2) (required)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Age Observation](#E_Age_Observation)  [Author Participation (NEW)](#U_Author_Participation_NEW)  [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW)  [Prognosis Observation (NEW)](#E_Prognosis_Observation_NEW)  [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) |

This template reflects a discrete observation about a patient's problem. Because it is a discrete observation, it will have a statusCode of "completed". The effectiveTime, also referred to as the “biologically relevant time” is the time at which the observation holds for the patient. For a provider seeing a patient in the clinic today, observing a history of heart attack that occurred five years ago, the effectiveTime is five years ago.

The effectiveTime of the Problem Observation is the definitive indication of whether or not the underlying condition is resolved. If the problem is known to be resolved, then an effectiveTime/high would be present. If the date of resolution is not known, then effectiveTime/high will be present with a nullFlavor of "UNK".

443: Problem Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.4.2'] | | | | | |
| entryRelationship | 0..1 | MAY |  | [9059](#C_9059) |  |
| @typeCode | 1..1 | SHALL |  | [9060](#C_9060) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [9069](#C_9069) | true |
| observation | 1..1 | SHALL |  | [15590](#C_15590) |  |
| entryRelationship | 0..\* | MAY |  | [31063](#C_31063) |  |
| @typeCode | 1..1 | SHALL |  | [31532](#C_31532) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31064](#C_31064) |  |
| @classCode | 1..1 | SHALL |  | [9041](#C_9041) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [9042](#C_9042) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| @negationInd | 0..1 | MAY |  | [10139](#C_10139) |  |
| templateId | 1..1 | SHALL |  | [14926](#C_14926) |  |
| @root | 1..1 | SHALL |  | [14927](#C_14927) | 2.16.840.1.113883.10.20.22.4.4.2 |
| id | 1..\* | SHALL |  | [9043](#C_9043) |  |
| code | 1..1 | SHALL |  | [9045](#C_9045) | 2.16.840.1.113883.3.88.12.3221.7.2 (Problem Type) |
| text | 0..1 | SHOULD |  | [9185](#C_9185) |  |
| reference | 0..1 | SHOULD |  | [15587](#C_15587) |  |
| @value | 1..1 | SHALL |  | [15588](#C_15588) |  |
| statusCode | 1..1 | SHALL |  | [9049](#C_9049) |  |
| @code | 1..1 | SHALL |  | [19112](#C_19112) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [9050](#C_9050) |  |
| low | 1..1 | SHALL |  | [15603](#C_15603) |  |
| high | 0..1 | MAY |  | [15604](#C_15604) |  |
| value | 1..1 | SHALL | CD | [9058](#C_9058) | 2.16.840.1.113883.3.88.12.3221.7.4 (Problem Value Set) |
| translation | 0..\* | MAY |  | [16749](#C_16749) |  |
| @code | 0..1 | MAY |  | [16750](#C_16750) | 2.16.840.1.113883.6.90 (ICD10CM) |
| entryRelationship | 0..1 | MAY |  | [29951](#C_29951) |  |
| @typeCode | 1..1 | SHALL |  | [31531](#C_31531) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [29952](#C_29952) |  |
| entryRelationship | 0..\* | MAY |  | [31065](#C_31065) |  |
| @typeCode | 1..1 | SHALL |  | [31533](#C_31533) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| observation | 1..1 | SHALL |  | [31066](#C_31066) |  |
| author | 0..\* | SHOULD |  | [31147](#C_31147) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9041).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9042).
3. MAY contain zero or one [0..1] @negationInd (CONF:10139).  
   Note: Use negationInd="true" to indicate that the problem was not observed.
4. SHALL contain exactly one [1..1] templateId (CONF:14926) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.4.2" (CONF:14927).
5. SHALL contain at least one [1..\*] id (CONF:9043).
6. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet [Problem Type](#Problem_Type) 2.16.840.1.113883.3.88.12.3221.7.2 STATIC 2012-06-01 (CONF:9045).
7. SHOULD contain zero or one [0..1] text (CONF:9185).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15587).
      1. The reference, if present, SHALL contain exactly one [1..1] @value (CONF:15588).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15589).
8. SHALL contain exactly one [1..1] statusCode (CONF:9049).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19112).
9. SHALL contain exactly one [1..1] effectiveTime (CONF:9050).  
   Note: If the problem is known to be resolved, but the date of resolution is not known, then the high element SHALL be present, and the nullFlavor attribute SHALL be set to 'UNK'. Therefore, the existence of an high element within a problem does indicate that the problem has been resolved.
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:15603).  
      Note: The effectiveTime/low (a.k.a. "onset date") asserts when the condition became biologically active.
   2. This effectiveTime MAY contain zero or one [0..1] high (CONF:15604).  
      Note: The effectiveTime/high (a.k.a. "resolution date") asserts when the condition became biologically resolved.
10. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [Problem Value Set](#Problem_Value_Set) 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:9058).
    1. This value MAY contain zero or more [0..\*] translation (CONF:16749).
       1. The translation, if present, MAY contain zero or one [0..1] @code (CodeSystem: ICD10CM 2.16.840.1.113883.6.90 STATIC) (CONF:16750).
11. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31147).
12. MAY contain zero or one [0..1] entryRelationship (CONF:9059) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9060).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:9069).
    3. SHALL contain exactly one [1..1] [Age Observation](#E_Age_Observation) (templateId:2.16.840.1.113883.10.20.22.4.31) (CONF:15590).
13. MAY contain zero or one [0..1] entryRelationship (CONF:29951) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31531).
    2. SHALL contain exactly one [1..1] [Prognosis Observation (NEW)](#E_Prognosis_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.113) (CONF:29952).
14. MAY contain zero or more [0..\*] entryRelationship (CONF:31063) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31532).
    2. SHALL contain exactly one [1..1] [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31064).
15. MAY contain zero or more [0..\*] entryRelationship (CONF:31065) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31533).
    2. SHALL contain exactly one [1..1] [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31066).

444: Problem Type

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Type 2.16.840.1.113883.3.88.12.3221.7.2 | | |
| Code | Code System | Print Name |
| 404684003 | SNOMED CT | Finding |
| 409586006 | SNOMED CT | Complaint |
| 282291009 | SNOMED CT | Diagnosis |
| 64572001 | SNOMED CT | Condition |
| 248536006 | SNOMED CT | Finding of functional performance and activity |
| 418799008 | SNOMED CT | Symptom |
| 55607006 | SNOMED CT | Problem |
| 373930000 | SNOMED CT | Cognitive function finding |

445: Problem Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 | | |
| Code | Code System | Print Name |
| 50992006 | SNOMED CT | 22q partial trisomy syndrome (disorder) |
| 237931009 | SNOMED CT | 2-Ketoadipic acidemia (disorder) |
| 54470008 | SNOMED CT | 3 beta-Hydroxysteroid dehydrogenase deficiency (disorder) |
| 237950009 | SNOMED CT | 3-Methylglutaconic aciduria (disorder) |
| 296646009 | SNOMED CT | 4-quinolones overdose (disorder) |
| 41797007 | SNOMED CT | 5 10-Methylenetetrahydrofolate reductase deficiency (disorder) |
| 413380004 | SNOMED CT | A pattern strabismus (disorder) |
| 425879009 | SNOMED CT | AA amyloid nephropathy (disorder) |
| 274945004 | SNOMED CT | AA amyloidosis (disorder) |
| 75100008 | SNOMED CT | Abdominal abscess (disorder) |
| ... | | |

Figure 175: Problem Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.4.2"/>

<id root="ab1791b0-5c71-11db-b0de-0800200c9a66"/>

<code code="64572001" codeSystem="2.16.840.1.113883.6.96"

displayName="Condition"/>

<text>

<reference value="#problemtype1"/>

</text>

<!-- The statusCode reflects the status of the observation itself -->

<statusCode code="completed"/>

<effectiveTime>

<!-- The low value reflects the date of onset -->

<low value="20080103"/>

<!-- The high value reflects when the problem was known to be resolved -->

<high value="20080106"/>

</effectiveTime>

<value xsi:type="CD" code="233604007"

codeSystem="2.16.840.1.113883.6.96" displayName="Pneumonia">

<originalText>

<reference value="#problem1"/>

</originalText>

</value>

<author>

<templateId root="2.16.840.1.113883.10.20.22.4.119"/>

<time value="200801061030-0800"/>

<assignedAuthor>

. . .

</author>

</observation>

Wound Observation (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.114 (open)]

446: Wound Observation (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Physical Findings of Skin Section (NEW)](#S_Physical_Findings_of_Skin_Section_NEW) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2) (optional) | [Author Participation (NEW)](#U_Author_Participation_NEW)  [Wound Characteristics (NEW)](#E_Wound_Characteristics_NEW)  [Wound Measurement Observation (NEW)](#E_Wound_Measurement_Observation_NEW) |

This template represents acquired or surgical wounds commonly found in the long term care population. It is not intended to encompass all wound types.  The template includes the general type of wound (e.g. pressure ulcers, surgical incisions, deep tissue injury wounds) and can include wound measurements and wound characteristics.

447: Wound Observation (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.114'] | | | | | |
| templateId | 1..1 | SHALL |  | [29473](#C_29473) |  |
| @root | 1..1 | SHALL |  | [29474](#C_29474) | 2.16.840.1.113883.10.20.22.4.114 |
| code | 1..1 | SHALL |  | [29476](#C_29476) |  |
| @code | 1..1 | SHALL |  | [29477](#C_29477) | ASSERTION |
| @codeSystem | 1..1 | SHALL |  | [31010](#C_31010) | 2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4 |
| value | 1..1 | SHALL | CD | [29485](#C_29485) | 2.16.840.1.113883.1.11.20.2.6 (Wound Type) |
| targetSiteCode | 0..1 | SHOULD |  | [29488](#C_29488) | 2.16.840.1.113883.3.88.12.3221.8.9 (Body Site Value Set) |
| qualifier | 0..\* | MAY |  | [29490](#C_29490) |  |
| name | 1..1 | SHALL |  | [29491](#C_29491) |  |
| @code | 1..1 | SHALL |  | [29492](#C_29492) | 272741003 |
| @codeSystem | 1..1 | SHALL |  | [31524](#C_31524) | 2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96 |
| value | 1..1 | SHALL |  | [29493](#C_29493) |  |
| @code | 1..1 | SHALL |  | [29494](#C_29494) | 2.16.840.1.113883.11.20.9.37 (TargetSite Qualifiers ) |
| entryRelationship | 0..\* | SHOULD |  | [29495](#C_29495) |  |
| @typeCode | 1..1 | SHALL |  | [29496](#C_29496) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| observation | 1..1 | SHALL |  | [29497](#C_29497) |  |
| entryRelationship | 0..\* | SHOULD |  | [29503](#C_29503) |  |
| @typeCode | 1..1 | SHALL |  | [29504](#C_29504) | COMP |
| observation | 1..1 | SHALL |  | [29505](#C_29505) |  |
| @classCode | 1..1 | SHALL |  | [31012](#C_31012) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [31013](#C_31013) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| author | 0..\* | SHOULD |  | [31542](#C_31542) |  |

1. Conforms to [Problem Observation (V2)](#E_Problem_Observation_V2) template (2.16.840.1.113883.10.20.22.4.4.2).
2. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:31012).
3. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:31013).
4. SHALL contain exactly one [1..1] templateId (CONF:29473) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.114" (CONF:29474).
5. SHALL contain exactly one [1..1] code (CONF:29476).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" assertion (CONF:29477).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.5.4" (CodeSystem: ActCode 2.16.840.1.113883.5.4) (CONF:31010).
6. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [Wound Type](#Wound_Type) 2.16.840.1.113883.1.11.20.2.6 DYNAMIC (CONF:29485).
7. SHOULD contain zero or one [0..1] targetSiteCode, which SHOULD be selected from ValueSet [Body Site Value Set](#Body_Site_Value_Set) 2.16.840.1.113883.3.88.12.3221.8.9 (CONF:29488) such that it

If targetSite/qualifierCode name/value pairs are used care must be taken to avoid conflict with the SNOMED-CT body structure code used in observation/value.  SNOMED-CT body structure codes are often pre-coordinated with laterality.

* 1. MAY contain zero or more [0..\*] qualifier (CONF:29490).
     1. The qualifier, if present, SHALL contain exactly one [1..1] name (CONF:29491).
        1. This name SHALL contain exactly one [1..1] @code="272741003" laterality (CONF:29492).
        2. This name SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:31524).
     2. The qualifier, if present, SHALL contain exactly one [1..1] value (CONF:29493).
        1. This value SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet [TargetSite Qualifiers](#TargetSite_Qualifiers_) 2.16.840.1.113883.11.20.9.37 STATIC (CONF:29494).

1. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31542).
2. SHOULD contain zero or more [0..\*] entryRelationship (CONF:29495) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:29496).
   2. SHALL contain exactly one [1..1] [Wound Measurement Observation (NEW)](#E_Wound_Measurement_Observation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.133) (CONF:29497).
3. SHOULD contain zero or more [0..\*] entryRelationship (CONF:29503) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" (CONF:29504).
   2. SHALL contain exactly one [1..1] [Wound Characteristics (NEW)](#E_Wound_Characteristics_NEW) (templateId:2.16.840.1.113883.10.20.22.4.134) (CONF:29505).

448: Wound Type

|  |  |  |
| --- | --- | --- |
| Value Set: Wound Type 2.16.840.1.113883.1.11.20.2.6  A value set of SNOMED-CT high level wound codes terms commonly used in long term care.    Specific URL Pending  Valueset Source: <http://vtsl.vetmed.vt.edu/> | | |
| Code | Code System | Print Name |
| 420226006 | SNOMED CT | Pressure ulcer |
| 46742003 | SNOMED CT | Skin ulcer |
| 262557004 | SNOMED CT | Deep wound |
| 283396008 | SNOMED CT | Incised wound |
| 416886008 | SNOMED CT | Closed wound |
| 125643001 | SNOMED CT | Open wound |
| 421076008 | SNOMED CT | Pressure ulcer stage 1 |
| 420324007 | SNOMED CT | Pressure Ulcer Stage 2 |
| 421927004 | SNOMED CT | Pressure Ulcer Stage 3 |
| 420597008 | SNOMED CT | Pressure Ulcer Stage 4 |
| ... | | |

449: Body Site Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Body Site Value Set 2.16.840.1.113883.3.88.12.3221.8.9  Body site value set is based upon the concepts descending from the SNOMED CT Anatomical Structure (91723000) hierarchy. | | |
| Code | Code System | Print Name |
| 56244007 | SNOMED CT | 10 to 19 percent of body surface (body structure) |
| 37491003 | SNOMED CT | 12 nm filaments (cell structure) |
| 78777002 | SNOMED CT | 20 to 29 percent of body surface (body structure) |
| 12423009 | SNOMED CT | 30 to 39 percent of body surface (body structure) |
| 36849000 | SNOMED CT | 40 to 49 percent of body surface (body structure) |
| 305024009 | SNOMED CT | 5/6 interchondral joint (body structure) |
| 76152003 | SNOMED CT | 50 to 59 percent of body surface (body structure) |
| 305005006 | SNOMED CT | 6/7 interchondral joint (body structure) |
| 91551007 | SNOMED CT | 60 to 69 percent of body surface (body structure) |
| 64700008 | SNOMED CT | 7 nm filaments (cell structure) |
| ... | | |

450: TargetSite Qualifiers

|  |  |  |
| --- | --- | --- |
| Value Set: TargetSite Qualifiers 2.16.840.1.113883.11.20.9.37 | | |
| Code | Code System | Print Name |
| 255549009 | SNOMED CT | anterior |
| 7771000 | SNOMED CT | left |
| 255561001 | SNOMED CT | medial |
| 255551008 | SNOMED CT | posterior |
| 24028007 | SNOMED CT | right |

Figure 176: Wound Observation Example

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Wound Observation tempalate -->

<templateId root="2.16.840.1.113883.10.20.22.4.114"/>

<id root="ab1791b0-5c71-11db-b0de-0800200c9a66"/>

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<statusCode code="completed"/>

<effectiveTime>

<low value="20013103"/>

</effectiveTime>

<value xsi:type="CD" code="425144005"

codeSystem="2.16.840.1.113883.6.6"

displayName="Minor open wound"/>

<targetSiteCode code="182295001"

codeSystem="2.16.840.1.113883.6.96"

displayName="anterior aspect of knee">

</targetSiteCode>

<author>

...

</author>

<entryRelationship typeCode="COMP">

<observation classCode="OBS" moodCode="EVN">

<!-- Wound Measurements Observation -->

<templateId root="2.16.840.1.113883.10.20.22.4.133"/>

...

</entryRelationship>

<entryRelationship typeCode="COMP">

<observation classCode="OBS" moodCode="EVN">

<!-- Wound Measurements Observation . -->

<templateId root="2.16.840.1.113883.10.20.22.4.133"/>

...

</entryRelationship>

<entryRelationship typeCode="COMP">

<observation classCode="OBS" moodCode="EVN">

<!-- Wound Characteristics -->

<templateId root="2.16.840.1.113883.10.20.22.4.134"/>

...

</entryRelationship>

</observation>

</entry>

Problem Status (DEPRECATED)

[observation: templateId 2.16.840.1.113883.10.20.22.4.6.2 (open)]

451: Problem Status (DEPRECATED) Contexts

| Contained By: | Contains: |
| --- | --- |

This template has been deprecated in Consolidated CDA Release 2. Per the explanation in Volume 1, section 3.2 "Determining a Clinical Statement's Status", the status of a problem is determined based on attributes of the Problem Observation

452: Problem Status (DEPRECATED) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.6.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7357](#C_7357) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [7358](#C_7358) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7359](#C_7359) |  |
| @root | 1..1 | SHALL |  | [10518](#C_10518) | 2.16.840.1.113883.10.20.22.4.6.2 |
| code | 1..1 | SHALL |  | [19162](#C_19162) |  |
| @code | 1..1 | SHALL |  | [19163](#C_19163) | 2.16.840.1.113883.6.1 (LOINC) = 33999-4 |
| statusCode | 1..1 | SHALL |  | [7364](#C_7364) |  |
| @code | 1..1 | SHALL |  | [19113](#C_19113) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL | CD | [7365](#C_7365) | 2.16.840.1.113883.3.88.12.80.68 (Problem Status Value Set) |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7357).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7358).
3. SHALL contain exactly one [1..1] templateId (CONF:7359) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.6.2" (CONF:10518).
4. SHALL contain exactly one [1..1] code (CONF:19162).
   1. This code SHALL contain exactly one [1..1] @code="33999-4" Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19163).
5. SHALL contain exactly one [1..1] statusCode (CONF:7364).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19113).
6. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [Problem Status Value Set](#Problem_Status_Value_Set) 2.16.840.1.113883.3.88.12.80.68 DYNAMIC (CONF:7365).

453: Problem Status Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Status Value Set 2.16.840.1.113883.3.88.12.80.68 | | |
| Code | Code System | Print Name |
| 55561003 | SNOMED CT | Active |
| 73425007 | SNOMED CT | Inactive |
| 413322009 | SNOMED CT | Resolved |

Procedure Activity Act (V2)

[act: templateId 2.16.840.1.113883.10.20.22.4.12.2 (open)]

454: Procedure Activity Act (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2) (optional)  [Procedures Section (entries required) (V2)](#S_Procedures_Section_entries_required_V) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Indication (V2)](#Indication_V2)  [Instruction (V2)](#Instruction_V2)  [Medication Activity (V2)](#Medication_Activity_V2)  [Service Delivery Location](#E_Service_Delivery_Location) |

This template represents any act that cannot be classified as an observation or procedure according to the HL7 RIM. Examples of these acts are a dressing change, teaching or feeding a patient, or providing comfort measures.

The common notion of "procedure" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g., splenectomy).

455: Procedure Activity Act (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.12.2'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [8326](#C_8326) |  |
| @typeCode | 1..1 | SHALL |  | [8327](#C_8327) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| observation | 1..1 | SHALL |  | [15601](#C_15601) |  |
| entryRelationship | 0..1 | MAY |  | [8322](#C_8322) |  |
| @typeCode | 1..1 | SHALL |  | [8323](#C_8323) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [8324](#C_8324) | true |
| act | 1..1 | SHALL |  | [31396](#C_31396) |  |
| entryRelationship | 0..\* | MAY |  | [8329](#C_8329) |  |
| @typeCode | 1..1 | SHALL |  | [8330](#C_8330) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| substanceAdministration | 1..1 | SHALL |  | [15602](#C_15602) |  |
| @classCode | 1..1 | SHALL |  | [8289](#C_8289) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [8290](#C_8290) | 2.16.840.1.113883.11.20.9.18 (MoodCodeEvnInt) |
| templateId | 1..1 | SHALL |  | [8291](#C_8291) |  |
| @root | 1..1 | SHALL |  | [10519](#C_10519) | 2.16.840.1.113883.10.20.22.4.12.2 |
| id | 1..\* | SHALL |  | [8292](#C_8292) |  |
| code | 1..1 | SHALL |  | [8293](#C_8293) |  |
| originalText | 0..1 | SHOULD |  | [19186](#C_19186) |  |
| reference | 0..1 | MAY |  | [19187](#C_19187) |  |
| @value | 0..1 | MAY |  | [19188](#C_19188) |  |
| statusCode | 1..1 | SHALL |  | [8298](#C_8298) | 2.16.840.1.113883.11.20.9.22 (ProcedureAct statusCode) |
| effectiveTime | 0..1 | SHOULD |  | [8299](#C_8299) |  |
| priorityCode | 0..1 | MAY |  | [8300](#C_8300) | 2.16.840.1.113883.1.11.16866 (Act Priority Value Set) |
| performer | 0..\* | SHOULD |  | [8301](#C_8301) |  |
| assignedEntity | 1..1 | SHALL |  | [8302](#C_8302) |  |
| id | 1..\* | SHALL |  | [8303](#C_8303) |  |
| addr | 1..1 | SHALL |  | [8304](#C_8304) |  |
| telecom | 1..1 | SHALL |  | [8305](#C_8305) |  |
| representedOrganization | 0..1 | SHOULD |  | [8306](#C_8306) |  |
| id | 0..\* | SHOULD |  | [8307](#C_8307) |  |
| name | 0..\* | MAY |  | [8308](#C_8308) |  |
| telecom | 1..1 | SHALL |  | [8310](#C_8310) |  |
| addr | 1..1 | SHALL |  | [8309](#C_8309) |  |
| participant | 0..\* | MAY |  | [8311](#C_8311) |  |
| @typeCode | 1..1 | SHALL |  | [8312](#C_8312) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = LOC |
| participantRole | 1..1 | SHALL |  | [15599](#C_15599) |  |
| entryRelationship | 0..\* | MAY |  | [8314](#C_8314) |  |
| @typeCode | 1..1 | SHALL |  | [8315](#C_8315) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| @inversionInd | 1..1 | SHALL |  | [8316](#C_8316) | true |
| encounter | 1..1 | SHALL |  | [8317](#C_8317) |  |
| @classCode | 1..1 | SHALL |  | [8318](#C_8318) | 2.16.840.1.113883.5.6 (HL7ActClass) = ENC |
| @moodCode | 1..1 | SHALL |  | [8319](#C_8319) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| id | 1..1 | SHALL |  | [8320](#C_8320) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8289).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [MoodCodeEvnInt](#MoodCodeEvnInt) 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03 (CONF:8290).
3. SHALL contain exactly one [1..1] templateId (CONF:8291) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.12.2" (CONF:10519).
4. SHALL contain at least one [1..\*] id (CONF:8292).
5. SHALL contain exactly one [1..1] code (CONF:8293).
   1. This code SHOULD contain zero or one [0..1] originalText (CONF:19186).
      1. The originalText, if present, MAY contain zero or one [0..1] reference (CONF:19187).
         1. The reference, if present, MAY contain zero or one [0..1] @value (CONF:19188).
            1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:19189).
   2. This code in a procedure activity act SHOULD be selected from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:19190).
6. SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet [ProcedureAct statusCode](#ProcedureAct_statusCode) 2.16.840.1.113883.11.20.9.22 DYNAMIC (CONF:8298).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:8299).
8. MAY contain zero or one [0..1] priorityCode, which SHALL be selected from ValueSet [Act Priority Value Set](#Act_Priority_Value_Set) 2.16.840.1.113883.1.11.16866 DYNAMIC (CONF:8300).
9. SHOULD contain zero or more [0..\*] performer (CONF:8301).
   1. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:8302).
      1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:8303).
      2. This assignedEntity SHALL contain exactly one [1..1] addr (CONF:8304).
      3. This assignedEntity SHALL contain exactly one [1..1] telecom (CONF:8305).
      4. This assignedEntity SHOULD contain zero or one [0..1] representedOrganization (CONF:8306).
         1. The representedOrganization, if present, SHOULD contain zero or more [0..\*] id (CONF:8307).
         2. The representedOrganization, if present, MAY contain zero or more [0..\*] name (CONF:8308).
         3. The representedOrganization, if present, SHALL contain exactly one [1..1] telecom (CONF:8310).
         4. The representedOrganization, if present, SHALL contain exactly one [1..1] addr (CONF:8309).
10. MAY contain zero or more [0..\*] participant (CONF:8311) such that it
    1. SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8312).
    2. SHALL contain exactly one [1..1] [Service Delivery Location](#E_Service_Delivery_Location) (templateId:2.16.840.1.113883.10.20.22.4.32) (CONF:15599).
11. MAY contain zero or more [0..\*] entryRelationship (CONF:8314) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8315).
    2. SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8316).
    3. SHALL contain exactly one [1..1] encounter (CONF:8317).
       1. This encounter SHALL contain exactly one [1..1] @classCode="ENC" Encounter (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8318).
       2. This encounter SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8319).
       3. This encounter SHALL contain exactly one [1..1] id (CONF:8320).
          1. Set the encounter ID to the ID of an encounter in another section to signify they are the same encounter (CONF:16849).
12. MAY contain zero or one [0..1] entryRelationship (CONF:8322) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8323).
    2. SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8324).
    3. SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31396).
13. MAY contain zero or more [0..\*] entryRelationship (CONF:8326) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8327).
    2. SHALL contain exactly one [1..1] [Indication (V2)](#Indication_V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:15601).
14. MAY contain zero or more [0..\*] entryRelationship (CONF:8329) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8330).
    2. SHALL contain exactly one [1..1] [Medication Activity (V2)](#Medication_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15602).

456: MoodCodeEvnInt

|  |  |  |
| --- | --- | --- |
| Value Set: MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18  Contains moodCode EVN and INT | | |
| Code | Code System | Print Name |
| EVN | ActMood | Event |
| INT | ActMood | Intent |

457: ProcedureAct statusCode

|  |  |  |
| --- | --- | --- |
| Value Set: ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22  A ValueSet of HL7 actStatus codes for use with a procedure activity | | |
| Code | Code System | Print Name |
| completed | ActStatus | Completed |
| active | ActStatus | Active |
| aborted | ActStatus | Aborted |
| cancelled | ActStatus | Cancelled |

458: Act Priority Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Act Priority Value Set 2.16.840.1.113883.1.11.16866 | | |
| Code | Code System | Print Name |
| A | ActPriority | ASAP |
| CR | ActPriority | Callback results |
| CS | ActPriority | Callback for scheduling |
| CSP | ActPriority | Callback placer for scheduling |
| CSR | ActPriority | Contact recipient for scheduling |
| EL | ActPriority | Elective |
| EM | ActPriority | Emergency |
| P | ActPriority | Preoperative |
| PRN | ActPriority | As needed |
| R | ActPriority | Routine |
| ... | | |

Figure 177: Procedure Activity Act Example

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.12.2"/>

<id root="1.2.3.4.5.6.7.8" extension="1234567"/>

<code code="274025005" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT" displayName="Colonic polypectomy">

<originalText>

<reference value="#Proc1"/>

</originalText>

</code>

<statusCode code="completed"/>

<effectiveTime value="20110203"/>

<priorityCode code="CR" codeSystem="2.16.840.1.113883.5.7"

codeSystemName="ActPriority" displayName="Callback results"/>

<performer>

<assignedEntity>

<id root="2.16.840.1.113883.19" extension="1234"/>

<addr>

<streetAddressLine>1001 Village Avenue</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel: +1(555)-555-5000"/>

<representedOrganization>

<id root="2.16.840.1.113883.19.5"/>

<name>Community Health and Hospitals</name>

<telecom use="WP" value="tel:+1(555)-555-5000"/>

<addr>

<streetAddressLine>1001 Village Avenue</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

</representedOrganization>

</assignedEntity>

</performer>

<participant typeCode="LOC">

<participantRole classCode="SDLOC">

<templateId root="2.16.840.1.113883.10.20.22.4.32"/>

. . .

</participant>

<entryRelationship typeCode="RSON">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.19.2"/>

. . .

</observation>

</entryRelationship>

<entryRelationship typeCode="SUBJ" inversionInd="true">

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.20.2"/>

. . .

</act>

</entryRelationship>

</act>

Procedure Activity Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.13.2 (open)]

459: Procedure Activity Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2) (optional)  [Procedures Section (entries required) (V2)](#S_Procedures_Section_entries_required_V) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Indication (V2)](#Indication_V2)  [Instruction (V2)](#Instruction_V2)  [Medication Activity (V2)](#Medication_Activity_V2)  [Service Delivery Location](#E_Service_Delivery_Location) |

The common notion of procedure is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g. splenectomy).

This template represents procedures that result in new information about the patient that cannot be classified as a procedure according to the HL7 RIM. Examples of these procedures are diagnostic imaging procedures, EEGs, and EKGs.

460: Procedure Activity Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.13.2'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [8276](#C_8276) |  |
| @typeCode | 1..1 | SHALL |  | [8277](#C_8277) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| observation | 1..1 | SHALL |  | [15906](#C_15906) |  |
| entryRelationship | 0..1 | MAY |  | [8272](#C_8272) |  |
| @typeCode | 1..1 | SHALL |  | [8273](#C_8273) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [8274](#C_8274) | true |
| act | 1..1 | SHALL |  | [31394](#C_31394) |  |
| entryRelationship | 0..\* | MAY |  | [8279](#C_8279) |  |
| @typeCode | 1..1 | SHALL |  | [8280](#C_8280) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| substanceAdministration | 1..1 | SHALL |  | [15907](#C_15907) |  |
| @classCode | 1..1 | SHALL |  | [8282](#C_8282) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [8237](#C_8237) | 2.16.840.1.113883.11.20.9.18 (MoodCodeEvnInt) |
| templateId | 1..1 | SHALL |  | [8238](#C_8238) |  |
| @root | 1..1 | SHALL |  | [10520](#C_10520) | 2.16.840.1.113883.10.20.22.4.13.2 |
| id | 1..\* | SHALL |  | [8239](#C_8239) |  |
| code | 1..1 | SHALL |  | [19197](#C_19197) |  |
| originalText | 0..1 | SHOULD |  | [19198](#C_19198) |  |
| reference | 0..1 | SHOULD |  | [19199](#C_19199) |  |
| @value | 0..1 | SHOULD |  | [19200](#C_19200) |  |
| statusCode | 1..1 | SHALL |  | [8245](#C_8245) | 2.16.840.1.113883.11.20.9.22 (ProcedureAct statusCode) |
| effectiveTime | 0..1 | SHOULD |  | [8246](#C_8246) |  |
| priorityCode | 0..1 | MAY |  | [8247](#C_8247) | 2.16.840.1.113883.1.11.16866 (Act Priority Value Set) |
| value | 1..1 | SHALL |  | [16846](#C_16846) |  |
| methodCode | 0..1 | MAY | SET<CE> | [8248](#C_8248) |  |
| targetSiteCode | 0..\* | SHOULD |  | [8250](#C_8250) |  |
| @code | 1..1 | SHALL |  | [16071](#C_16071) | 2.16.840.1.113883.3.88.12.3221.8.9 (Body Site Value Set) |
| performer | 0..\* | SHOULD |  | [8251](#C_8251) |  |
| assignedEntity | 1..1 | SHALL |  | [8252](#C_8252) |  |
| id | 1..\* | SHALL |  | [8253](#C_8253) |  |
| addr | 1..1 | SHALL |  | [8254](#C_8254) |  |
| telecom | 1..1 | SHALL |  | [8255](#C_8255) |  |
| representedOrganization | 0..1 | SHOULD |  | [8256](#C_8256) |  |
| id | 0..\* | SHOULD |  | [8257](#C_8257) |  |
| name | 0..\* | MAY |  | [8258](#C_8258) |  |
| telecom | 1..1 | SHALL |  | [8260](#C_8260) |  |
| addr | 1..1 | SHALL |  | [8259](#C_8259) |  |
| participant | 0..\* | MAY |  | [8261](#C_8261) |  |
| @typeCode | 1..1 | SHALL |  | [8262](#C_8262) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = LOC |
| participantRole | 1..1 | SHALL |  | [15904](#C_15904) |  |
| entryRelationship | 0..\* | MAY |  | [8264](#C_8264) |  |
| @typeCode | 1..1 | SHALL |  | [8265](#C_8265) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| @inversionInd | 1..1 | SHALL |  | [8266](#C_8266) | true |
| encounter | 1..1 | SHALL |  | [8267](#C_8267) |  |
| @classCode | 1..1 | SHALL |  | [8268](#C_8268) | 2.16.840.1.113883.5.6 (HL7ActClass) = ENC |
| @moodCode | 1..1 | SHALL |  | [8269](#C_8269) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| id | 1..1 | SHALL |  | [8270](#C_8270) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8282).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [MoodCodeEvnInt](#MoodCodeEvnInt) 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03 (CONF:8237).
3. SHALL contain exactly one [1..1] templateId (CONF:8238) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.13.2" (CONF:10520).
4. SHALL contain at least one [1..\*] id (CONF:8239).
5. SHALL contain exactly one [1..1] code (CONF:19197).
   1. This code SHOULD contain zero or one [0..1] originalText (CONF:19198).
      1. The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:19199).
         1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:19200).
            1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:19201).
   2. This @code SHOULD be selected from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96), and MAY be selected from CPT-4 (CodeSystem: 2.16.840.1.113883.6.12), ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) (CONF:19202).
6. SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet [ProcedureAct statusCode](#ProcedureAct_statusCode) 2.16.840.1.113883.11.20.9.22 DYNAMIC (CONF:8245).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:8246).
8. MAY contain zero or one [0..1] priorityCode, which SHALL be selected from ValueSet [Act Priority Value Set](#Act_Priority_Value_Set) 2.16.840.1.113883.1.11.16866 DYNAMIC (CONF:8247).
9. SHALL contain exactly one [1..1] value (CONF:16846).
10. MAY contain zero or one [0..1] methodCode (CONF:8248).
    1. MethodCode SHALL NOT conflict with the method inherent in Observation / code (CONF:8249).
11. SHOULD contain zero or more [0..\*] targetSiteCode (CONF:8250).
    1. The targetSiteCode, if present, SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [Body Site Value Set](#Body_Site_Value_Set) 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:16071).
12. SHOULD contain zero or more [0..\*] performer (CONF:8251).
    1. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:8252).
       1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:8253).
       2. This assignedEntity SHALL contain exactly one [1..1] addr (CONF:8254).
       3. This assignedEntity SHALL contain exactly one [1..1] telecom (CONF:8255).
       4. This assignedEntity SHOULD contain zero or one [0..1] representedOrganization (CONF:8256).
          1. The representedOrganization, if present, SHOULD contain zero or more [0..\*] id (CONF:8257).
          2. The representedOrganization, if present, MAY contain zero or more [0..\*] name (CONF:8258).
          3. The representedOrganization, if present, SHALL contain exactly one [1..1] telecom (CONF:8260).
          4. The representedOrganization, if present, SHALL contain exactly one [1..1] addr (CONF:8259).
13. MAY contain zero or more [0..\*] participant (CONF:8261).
    1. The participant, if present, SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8262).
    2. The participant, if present, SHALL contain exactly one [1..1] [Service Delivery Location](#E_Service_Delivery_Location) (templateId:2.16.840.1.113883.10.20.22.4.32) (CONF:15904).
14. MAY contain zero or more [0..\*] entryRelationship (CONF:8264).
    1. The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8265).
    2. The entryRelationship, if present, SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8266).
    3. The entryRelationship, if present, SHALL contain exactly one [1..1] encounter (CONF:8267).
       1. This encounter SHALL contain exactly one [1..1] @classCode="ENC" Encounter (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8268).
       2. This encounter SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8269).
       3. This encounter SHALL contain exactly one [1..1] id (CONF:8270).
          1. Set encounter/id to the id of an encounter in another section to signify they are the same encounter (CONF:16847).
15. MAY contain zero or one [0..1] entryRelationship (CONF:8272) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8273).
    2. SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8274).
    3. SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31394).
16. MAY contain zero or more [0..\*] entryRelationship (CONF:8276) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8277).
    2. SHALL contain exactly one [1..1] [Indication (V2)](#Indication_V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:15906).
17. MAY contain zero or more [0..\*] entryRelationship (CONF:8279) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8280).
    2. SHALL contain exactly one [1..1] [Medication Activity (V2)](#Medication_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15907).

461: MoodCodeEvnInt

|  |  |  |
| --- | --- | --- |
| Value Set: MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18  Contains moodCode EVN and INT | | |
| Code | Code System | Print Name |
| EVN | ActMood | Event |
| INT | ActMood | Intent |

462: ProcedureAct statusCode

|  |  |  |
| --- | --- | --- |
| Value Set: ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22  A ValueSet of HL7 actStatus codes for use with a procedure activity | | |
| Code | Code System | Print Name |
| completed | ActStatus | Completed |
| active | ActStatus | Active |
| aborted | ActStatus | Aborted |
| cancelled | ActStatus | Cancelled |

463: Act Priority Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Act Priority Value Set 2.16.840.1.113883.1.11.16866 | | |
| Code | Code System | Print Name |
| A | ActPriority | ASAP |
| CR | ActPriority | Callback results |
| CS | ActPriority | Callback for scheduling |
| CSP | ActPriority | Callback placer for scheduling |
| CSR | ActPriority | Contact recipient for scheduling |
| EL | ActPriority | Elective |
| EM | ActPriority | Emergency |
| P | ActPriority | Preoperative |
| PRN | ActPriority | As needed |
| R | ActPriority | Routine |
| ... | | |

464: Body Site Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Body Site Value Set 2.16.840.1.113883.3.88.12.3221.8.9  Body site value set is based upon the concepts descending from the SNOMED CT Anatomical Structure (91723000) hierarchy. | | |
| Code | Code System | Print Name |
| 56244007 | SNOMED CT | 10 to 19 percent of body surface (body structure) |
| 37491003 | SNOMED CT | 12 nm filaments (cell structure) |
| 78777002 | SNOMED CT | 20 to 29 percent of body surface (body structure) |
| 12423009 | SNOMED CT | 30 to 39 percent of body surface (body structure) |
| 36849000 | SNOMED CT | 40 to 49 percent of body surface (body structure) |
| 305024009 | SNOMED CT | 5/6 interchondral joint (body structure) |
| 76152003 | SNOMED CT | 50 to 59 percent of body surface (body structure) |
| 305005006 | SNOMED CT | 6/7 interchondral joint (body structure) |
| 91551007 | SNOMED CT | 60 to 69 percent of body surface (body structure) |
| 64700008 | SNOMED CT | 7 nm filaments (cell structure) |
| ... | | |

Figure 178: Procedure Activity Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.13.2"/>

<id extension="123456789" root="2.16.840.1.113883.19"/>

<code code="274025005" codeSystem="2.16.840.1.113883.6.96"

displayName="Colonic polypectomy" codeSystemName="SNOMED-CT">

<originalText>

<reference value="#Proc1"/>

</originalText>

</code>

<statusCode code="aborted"/>

<effectiveTime value="20110203"/>

<priorityCode code="CR" codeSystem="2.16.840.1.113883.5.7"

codeSystemName="ActPriority" displayName="Callback results"/>

<value xsi:type="CD"/>

<methodCode nullFlavor="UNK"/>

<targetSiteCode code="416949008" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT" displayName="Abdomen and pelvis"/>

<performer>

<assignedEntity>

<id root="2.16.840.1.113883.19" extension="1234"/>

<addr>

<streetAddressLine>1001 Village Avenue</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel: +1(555)-555-5000"/>

<representedOrganization>

<id root="2.16.840.1.113883.19.5"/>

<name>Community Health and Hospitals</name>

<telecom use="WP" value="tel:+1(555)-555-5000"/>

<addr>

<streetAddressLine>1001 Village Avenue</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

</representedOrganization>

</assignedEntity>

</performer>

<participant typeCode="LOC">

<participantRole classCode="SDLOC">

<templateId root="2.16.840.1.113883.10.20.22.4.32"/>

. . .

</participant>

<entryRelationship typeCode="RSON">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.19.2"/>

. . .

</observation>

</entryRelationship>

<entryRelationship typeCode="SUBJ" inversionInd="true">

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.20.2"/>

. . .

</act>

</entryRelationship>

</observation>

Procedure Activity Procedure (V2)

[procedure: templateId 2.16.840.1.113883.10.20.22.4.14.2 (open)]

465: Procedure Activity Procedure (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Reaction Observation (V2)](#Reaction_Observation_V2) (optional)  [Anesthesia Section (V2)](#S_Anesthesia_Section_V2) (optional)  [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2) (optional)  [Procedures Section (entries required) (V2)](#S_Procedures_Section_entries_required_V) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional) | [Indication (V2)](#Indication_V2)  [Instruction (V2)](#Instruction_V2)  [Medication Activity (V2)](#Medication_Activity_V2)  [Product Instance](#E_Product_Instance)  [Service Delivery Location](#E_Service_Delivery_Location) |

The common notion of "procedure" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g. splenectomy).

This template represents procedures whose immediate and primary outcome (post-condition) is the alteration of the physical condition of the patient. Examples of these procedures are an appendectomy, hip replacement and a creation of a gastrostomy.

466: Procedure Activity Procedure (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| procedure[templateId/@root = '2.16.840.1.113883.10.20.22.4.14.2'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [7779](#C_7779) |  |
| @typeCode | 1..1 | SHALL |  | [7780](#C_7780) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| observation | 1..1 | SHALL |  | [15914](#C_15914) |  |
| entryRelationship | 0..1 | MAY |  | [7775](#C_7775) |  |
| @typeCode | 1..1 | SHALL |  | [7776](#C_7776) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [7777](#C_7777) | true |
| act | 1..1 | SHALL |  | [31395](#C_31395) |  |
| entryRelationship | 0..\* | MAY |  | [7886](#C_7886) |  |
| @typeCode | 1..1 | SHALL |  | [7887](#C_7887) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| substanceAdministration | 1..1 | SHALL |  | [15915](#C_15915) |  |
| @classCode | 1..1 | SHALL |  | [7652](#C_7652) | 2.16.840.1.113883.5.6 (HL7ActClass) = PROC |
| @moodCode | 1..1 | SHALL |  | [7653](#C_7653) | 2.16.840.1.113883.11.20.9.18 (MoodCodeEvnInt) |
| templateId | 1..1 | SHALL |  | [7654](#C_7654) |  |
| @root | 1..1 | SHALL |  | [10521](#C_10521) | 2.16.840.1.113883.10.20.22.4.14.2 |
| id | 1..\* | SHALL |  | [7655](#C_7655) |  |
| code | 1..1 | SHALL |  | [7656](#C_7656) |  |
| originalText | 0..1 | SHOULD |  | [19203](#C_19203) |  |
| reference | 0..1 | SHOULD |  | [19204](#C_19204) |  |
| @value | 0..1 | SHOULD |  | [19205](#C_19205) |  |
| statusCode | 1..1 | SHALL |  | [7661](#C_7661) | 2.16.840.1.113883.11.20.9.22 (ProcedureAct statusCode) |
| effectiveTime | 0..1 | SHOULD |  | [7662](#C_7662) |  |
| priorityCode | 0..1 | MAY |  | [7668](#C_7668) | 2.16.840.1.113883.1.11.16866 (Act Priority Value Set) |
| methodCode | 0..1 | MAY | SET<CE> | [7670](#C_7670) |  |
| targetSiteCode | 0..\* | SHOULD |  | [7683](#C_7683) |  |
| @code | 1..1 | SHALL |  | [16082](#C_16082) | 2.16.840.1.113883.3.88.12.3221.8.9 (Body Site Value Set) |
| specimen | 0..\* | MAY |  | [7697](#C_7697) |  |
| specimenRole | 1..1 | SHALL |  | [7704](#C_7704) |  |
| id | 0..\* | SHOULD |  | [7716](#C_7716) |  |
| performer | 0..\* | SHOULD |  | [7718](#C_7718) |  |
| assignedEntity | 1..1 | SHALL |  | [7720](#C_7720) |  |
| id | 1..\* | SHALL |  | [7722](#C_7722) |  |
| addr | 1..1 | SHALL |  | [7731](#C_7731) |  |
| telecom | 1..1 | SHALL |  | [7732](#C_7732) |  |
| representedOrganization | 0..1 | SHOULD |  | [7733](#C_7733) |  |
| id | 0..\* | SHOULD |  | [7734](#C_7734) |  |
| name | 0..\* | MAY |  | [7735](#C_7735) |  |
| telecom | 1..1 | SHALL |  | [7737](#C_7737) |  |
| addr | 1..1 | SHALL |  | [7736](#C_7736) |  |
| participant | 0..\* | MAY |  | [7751](#C_7751) |  |
| @typeCode | 1..1 | SHALL |  | [7752](#C_7752) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = DEV |
| participantRole | 1..1 | SHALL |  | [15911](#C_15911) |  |
| participant | 0..\* | MAY |  | [7765](#C_7765) |  |
| @typeCode | 1..1 | SHALL |  | [7766](#C_7766) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = LOC |
| participantRole | 1..1 | SHALL |  | [15912](#C_15912) |  |
| entryRelationship | 0..\* | MAY |  | [7768](#C_7768) |  |
| @typeCode | 1..1 | SHALL |  | [7769](#C_7769) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| @inversionInd | 1..1 | SHALL |  | [8009](#C_8009) | true |
| encounter | 1..1 | SHALL |  | [7770](#C_7770) |  |
| @classCode | 1..1 | SHALL |  | [7771](#C_7771) | 2.16.840.1.113883.5.6 (HL7ActClass) = ENC |
| @moodCode | 1..1 | SHALL |  | [7772](#C_7772) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| id | 1..1 | SHALL |  | [7773](#C_7773) |  |

1. SHALL contain exactly one [1..1] @classCode="PROC" Procedure (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7652).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet [MoodCodeEvnInt](#MoodCodeEvnInt) 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03 (CONF:7653).
3. SHALL contain exactly one [1..1] templateId (CONF:7654) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.14.2" (CONF:10521).
4. SHALL contain at least one [1..\*] id (CONF:7655).
5. SHALL contain exactly one [1..1] code (CONF:7656).
   1. This code SHOULD contain zero or one [0..1] originalText (CONF:19203).
      1. The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:19204).
         1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:19205).
            1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:19206).
   2. This code in a procedure activity SHOULD be selected from LOINC (codeSystem 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96), and MAY be selected from CPT-4 (CodeSystem: 2.16.840.1.113883.6.12) or ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) (CONF:19207).
6. SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet [ProcedureAct statusCode](#ProcedureAct_statusCode) 2.16.840.1.113883.11.20.9.22 DYNAMIC (CONF:7661).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:7662).
8. MAY contain zero or one [0..1] priorityCode, which SHALL be selected from ValueSet [Act Priority Value Set](#Act_Priority_Value_Set) 2.16.840.1.113883.1.11.16866 DYNAMIC (CONF:7668).
9. MAY contain zero or one [0..1] methodCode (CONF:7670).
   1. MethodCode SHALL NOT conflict with the method inherent in Procedure / code (CONF:7890).
10. SHOULD contain zero or more [0..\*] targetSiteCode (CONF:7683).
    1. The targetSiteCode, if present, SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [Body Site Value Set](#Body_Site_Value_Set) 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:16082).
11. MAY contain zero or more [0..\*] specimen (CONF:7697).
    1. The specimen, if present, SHALL contain exactly one [1..1] specimenRole (CONF:7704).
       1. This specimenRole SHOULD contain zero or more [0..\*] id (CONF:7716).
          1. If you want to indicate that the Procedure and the Results are referring to the same specimen, the Procedure/specimen/specimenRole/id SHOULD be set to equal an Organizer/specimen/ specimenRole/id (CONF:29744).
    2. This specimen is for representing specimens obtained from a procedure (CONF:16842).
12. SHOULD contain zero or more [0..\*] performer (CONF:7718) such that it
    1. SHALL contain exactly one [1..1] assignedEntity (CONF:7720).
       1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:7722).
       2. This assignedEntity SHALL contain exactly one [1..1] addr (CONF:7731).
       3. This assignedEntity SHALL contain exactly one [1..1] telecom (CONF:7732).
       4. This assignedEntity SHOULD contain zero or one [0..1] representedOrganization (CONF:7733).
          1. The representedOrganization, if present, SHOULD contain zero or more [0..\*] id (CONF:7734).
          2. The representedOrganization, if present, MAY contain zero or more [0..\*] name (CONF:7735).
          3. The representedOrganization, if present, SHALL contain exactly one [1..1] telecom (CONF:7737).
          4. The representedOrganization, if present, SHALL contain exactly one [1..1] addr (CONF:7736).
13. MAY contain zero or more [0..\*] participant (CONF:7751) such that it
    1. SHALL contain exactly one [1..1] @typeCode="DEV" Device (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7752).
    2. SHALL contain exactly one [1..1] [Product Instance](#E_Product_Instance) (templateId:2.16.840.1.113883.10.20.22.4.37) (CONF:15911).
14. MAY contain zero or more [0..\*] participant (CONF:7765) such that it
    1. SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:7766).
    2. SHALL contain exactly one [1..1] [Service Delivery Location](#E_Service_Delivery_Location) (templateId:2.16.840.1.113883.10.20.22.4.32) (CONF:15912).
15. MAY contain zero or more [0..\*] entryRelationship (CONF:7768) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7769).
    2. SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8009).
    3. SHALL contain exactly one [1..1] encounter (CONF:7770).
       1. This encounter SHALL contain exactly one [1..1] @classCode="ENC" Encounter (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7771).
       2. This encounter SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7772).
       3. This encounter SHALL contain exactly one [1..1] id (CONF:7773).
          1. Set the encounter ID to the ID of an encounter in another section to signify they are the same encounter (CONF:16843).
16. MAY contain zero or one [0..1] entryRelationship (CONF:7775) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7776).
    2. SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:7777).
    3. SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31395).
17. MAY contain zero or more [0..\*] entryRelationship (CONF:7779) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7780).
    2. SHALL contain exactly one [1..1] [Indication (V2)](#Indication_V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:15914).
18. MAY contain zero or more [0..\*] entryRelationship (CONF:7886) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7887).
    2. SHALL contain exactly one [1..1] [Medication Activity (V2)](#Medication_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15915).

467: MoodCodeEvnInt

|  |  |  |
| --- | --- | --- |
| Value Set: MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18  Contains moodCode EVN and INT | | |
| Code | Code System | Print Name |
| EVN | ActMood | Event |
| INT | ActMood | Intent |

468: ProcedureAct statusCode

|  |  |  |
| --- | --- | --- |
| Value Set: ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22  A ValueSet of HL7 actStatus codes for use with a procedure activity | | |
| Code | Code System | Print Name |
| completed | ActStatus | Completed |
| active | ActStatus | Active |
| aborted | ActStatus | Aborted |
| cancelled | ActStatus | Cancelled |

469: Act Priority Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Act Priority Value Set 2.16.840.1.113883.1.11.16866 | | |
| Code | Code System | Print Name |
| A | ActPriority | ASAP |
| CR | ActPriority | Callback results |
| CS | ActPriority | Callback for scheduling |
| CSP | ActPriority | Callback placer for scheduling |
| CSR | ActPriority | Contact recipient for scheduling |
| EL | ActPriority | Elective |
| EM | ActPriority | Emergency |
| P | ActPriority | Preoperative |
| PRN | ActPriority | As needed |
| R | ActPriority | Routine |
| ... | | |

470: Body Site Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Body Site Value Set 2.16.840.1.113883.3.88.12.3221.8.9  Body site value set is based upon the concepts descending from the SNOMED CT Anatomical Structure (91723000) hierarchy. | | |
| Code | Code System | Print Name |
| 56244007 | SNOMED CT | 10 to 19 percent of body surface (body structure) |
| 37491003 | SNOMED CT | 12 nm filaments (cell structure) |
| 78777002 | SNOMED CT | 20 to 29 percent of body surface (body structure) |
| 12423009 | SNOMED CT | 30 to 39 percent of body surface (body structure) |
| 36849000 | SNOMED CT | 40 to 49 percent of body surface (body structure) |
| 305024009 | SNOMED CT | 5/6 interchondral joint (body structure) |
| 76152003 | SNOMED CT | 50 to 59 percent of body surface (body structure) |
| 305005006 | SNOMED CT | 6/7 interchondral joint (body structure) |
| 91551007 | SNOMED CT | 60 to 69 percent of body surface (body structure) |
| 64700008 | SNOMED CT | 7 nm filaments (cell structure) |
| ... | | |

Figure 179: Procedure Activity Procedure Example

<procedure classCode="PROC" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.14.2"/>

<id root="d68b7e32-7810-4f5b-9cc2-acd54b0fd85d"/>

<code code="73761001" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT" displayName="Colonoscopy">

<originalText>

<reference value="#Proc1"/>

</originalText>

</code>

<statusCode code="completed"/>

<effectiveTime value="20120512"/>

<methodCode nullFlavor="UNK"/>

<targetSiteCode code="appropriate\_code" displayName="colon"

codeSystem="2.16.840.1.113883.3.88.12.3221.8.9"

codeSystemName="Body Site Value Set"/>

<specimen typeCode="SPC">

<specimenRole classCode="SPEC">

<id root="c2ee9ee9-ae31-4628-a919-fec1cbb58683"/>

<specimenPlayingEntity>

<code code="309226005" codeSystem="2.16.840.1.113883.6.96"

displayName="colonic polyp sample"/>

</specimenPlayingEntity>

</specimenRole>

</specimen>

<performer>

<assignedEntity>

<id root="2.16.840.1.113883.19" extension="1234"/>

<addr>

<streetAddressLine>1001 Village Avenue</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel: +1(555)-555-5000"/>

<representedOrganization>

<id root="2.16.840.1.113883.19.5"/>

<name>Community Health and Hospitals</name>

<telecom use="WP" value="tel:+1(555)-555-5000"/>

<addr>

<streetAddressLine>1001 Village Avenue</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

</representedOrganization>

</assignedEntity>

</performer>

<participant typeCode="DEV">

<participantRole classCode="MANU">

<templateId root="2.16.840.1.113883.10.20.22.4.37"/>

. . .

</participantRole>

</participant>

<participant typeCode="LOC">

<participantRole classCode="SDLOC">

<templateId root="2.16.840.1.113883.10.20.22.4.32"/>

. . .

</participant>

<entryRelationship typeCode="RSON">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.19.2"/>

. . .

</observation>

</entryRelationship>

<entryRelationship typeCode="SUBJ" inversionInd="true">

<act classCode="ACT" moodCode="INT">

<templateId root="2.16.840.1.113883.10.20.22.4.20.2"/>

. . .

</act>

</entryRelationship>

</procedure>

Procedure Context

[act: templateId 2.16.840.1.113883.10.20.6.2.5 (open)]

471: Procedure Context Contexts

| Contained By: | Contains: |
| --- | --- |
| [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (optional) |  |

The ServiceEvent Procedure Context of the document header may be overridden in the CDA structured body if there is a need to refer to multiple imaging procedures or acts. The selection of the Procedure or Act entry from the clinical statement choice box depends on the nature of the imaging service that has been performed. The Procedure entry shall be used for image-guided interventions and minimal invasive imaging services, whereas the Act entry shall be used for diagnostic imaging services.

472: Procedure Context Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.6.2.5'] | | | | | |
| templateId | 1..1 | SHALL |  | [9200](#C_9200) |  |
| @root | 1..1 | SHALL |  | [10530](#C_10530) | 2.16.840.1.113883.10.20.6.2.5 |
| code | 1..1 | SHALL |  | [9201](#C_9201) |  |
| effectiveTime | 0..1 | SHOULD | TS | [9203](#C_9203) |  |
| @value | 1..1 | SHALL |  | [17173](#C_17173) |  |
| @classCode | 1..1 | SHALL |  | [26452](#C_26452) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [26453](#C_26453) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:26452).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:26453).
3. SHALL contain exactly one [1..1] templateId (CONF:9200) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.5" (CONF:10530).
4. SHALL contain exactly one [1..1] code (CONF:9201).
5. SHOULD contain zero or one [0..1] effectiveTime (CONF:9203).
   1. The effectiveTime, if present, SHALL contain exactly one [1..1] @value (CONF:17173).
6. Procedure Context SHALL be represented with the procedure or act elements depending on the nature of the procedure (CONF:9199).

Figure 180: Procedure Context Example

<act moodCode="EVN" classCode="ACT">

<templateId root="2.16.840.1.113883.10.20.6.2.5" />

<code code="70548" displayName="Magnetic resonance angiography, head; with contrast material(s)" codeSystem="2.16.840.1.113883.6.12" codeSystemName="CPT-4" />

<!-- Note: This code is slightly different from the code used in the header documentationOf and overrides it, which is what this entry is for. -->

<effectiveTime value="20060823123529+0400" />

</act>

Product Instance

[participantRole: templateId 2.16.840.1.113883.10.20.22.4.37 (open)]

473: Product Instance Contexts

| Contained By: | Contains: |
| --- | --- |
| [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) (optional)  [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2) (optional)  [Medical Device (NEW)](#E_Medical_Device_NEW) (optional) |  |

This clinical statement represents a particular device that was placed in or used as part of a procedure or other act. This provides a record of the identifier and other details about the given product that was used. For example, it is important to have a record that indicates not just that a hip prostheses was placed in a patient but that it was a particular hip prostheses number with a unique identifier.

The FDA Amendments Act specifies the creation of a Unique Device Identification (UDI) System that requires the label of devices to bear a unique identifier that will standardize device identification and identify the device through distribution and use.

The UDI should be sent in the participantRole/id.

474: Product Instance Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| participantRole[templateId/@root = '2.16.840.1.113883.10.20.22.4.37'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7900](#C_7900) | 2.16.840.1.113883.5.110 (RoleClass) = MANU |
| templateId | 1..1 | SHALL |  | [7901](#C_7901) |  |
| @root | 1..1 | SHALL |  | [10522](#C_10522) | 2.16.840.1.113883.10.20.22.4.37 |
| id | 1..\* | SHALL |  | [7902](#C_7902) |  |
| playingDevice | 1..1 | SHALL |  | [7903](#C_7903) |  |
| code | 0..1 | SHOULD |  | [16837](#C_16837) |  |
| scopingEntity | 1..1 | SHALL |  | [7905](#C_7905) |  |
| id | 1..\* | SHALL |  | [7908](#C_7908) |  |

1. SHALL contain exactly one [1..1] @classCode="MANU" Manufactured Product (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:7900).
2. SHALL contain exactly one [1..1] templateId (CONF:7901) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.37" (CONF:10522).
3. SHALL contain at least one [1..\*] id (CONF:7902).
4. SHALL contain exactly one [1..1] playingDevice (CONF:7903).
   1. This playingDevice SHOULD contain zero or one [0..1] code (CONF:16837).
5. SHALL contain exactly one [1..1] scopingEntity (CONF:7905).
   1. This scopingEntity SHALL contain at least one [1..\*] id (CONF:7908).

Figure 181: Product Instance Example

<participantRole classCode="MANU">

<templateId root="2.16.840.1.113883.10.20.22.4.37" />

<id root="742aee30-21c5-11e1-bfc2-0800200c9a66" />

<playingDevice>

<code code="90412006" codeSystem="2.16.840.1.113883.6.96" displayName="Colonoscope" />

</playingDevice>

<scopingEntity>

<id root="eb936010-7b17-11db-9fe1-0800200c9b65" />

</scopingEntity>

</participantRole>

Prognosis Observation (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.113 (open)]

475: Prognosis Observation (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Problem Observation (V2)](#E_Problem_Observation_V2) (optional) |  |

This template represents the patient’s prognosis, which must be associated with a problem or concern. It may serve as an alert to scope intervention plans.

The effectiveTime represents the clinically relevant time of the observation. The observation/value is not constrained and can represent the expected life duration in PQ, an anticipated course of the disease in text, or coded term.

476: Prognosis Observation (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.113'] | | | | | |
| @classCode | 1..1 | SHALL |  | [29035](#C_29035) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [29036](#C_29036) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [29037](#C_29037) |  |
| @root | 1..1 | SHALL |  | [29038](#C_29038) | 2.16.840.1.113883.10.20.22.4.113 |
| code | 1..1 | SHALL |  | [29039](#C_29039) |  |
| @code | 1..1 | SHALL |  | [29468](#C_29468) | 170967006 |
| @codeSystem | 1..1 | SHALL |  | [31349](#C_31349) | 2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96 |
| value | 1..1 | SHALL |  | [29469](#C_29469) |  |
| effectiveTime | 1..1 | SHALL |  | [31123](#C_31123) |  |
| statusCode | 1..1 | SHALL |  | [31350](#C_31350) |  |
| @code | 1..1 | SHALL |  | [31351](#C_31351) | 2.16.840.1.113883.5.14 (ActStatus) = completed |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:29035).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:29036).
3. SHALL contain exactly one [1..1] templateId (CONF:29037) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.113" (CONF:29038).
4. SHALL contain exactly one [1..1] code (CONF:29039).
   1. This code SHALL contain exactly one [1..1] @code="170967006" prognosis/outlook (CONF:29468).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:31349).
5. SHALL contain exactly one [1..1] statusCode (CONF:31350).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31351).
6. SHALL contain exactly one [1..1] effectiveTime (CONF:31123).
7. SHALL contain exactly one [1..1] value (CONF:29469).

Figure 182: Prognosis, Free Text Example

<observation classCode="OBS" moodCode="EVN">

<!-- Prognosis -->

<templateId root="2.16.840.1.113883.10.20.22.4.113"/>

<id root="2097c709-291b-4a0f-bef9-ad9b23b3bb43"/>

<code code="170967006" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED-CT" displayName="prognosis/outlook"/>

<text>

Presence of a life limiting condition(>50% possibility of death within 2 year)

</text>

<statusCode code="completed"/>

<effectiveTime value="20130606"/>

<value xsi:type="ST">Presence of a life limiting condition(>50% possibility of death within 2 year</value>

</observation>

Figure 183: Prognosis, Coded Example

<entryRelationship typeCode="REFR">

<observation classCode="OBS" moodCode="EVN">

<!-- Prognosis -->

<templateId root="2.16.840.1.113883.10.20.22.4.113"/>

<id root="2097c709-291b-4a0f-bef9-ad9b23b3bb43"/>

<code code="170967006" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED-CT" displayName="prognosis/outlook"/>

<statusCode code="completed"/>

<effectiveTime>

<low value="20130301"/>

</effectiveTime>

<value xsi:type="CD" code="67334001"

codeSystem="2.16.840.1.113883.6.96"

displayName="guarded prognosis" codeSystemName="SNOMED CT"/>

</observation>

</entryRelationship>>

Progress Toward Goal Observation (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.110 (open)]

477: Progress Toward Goal Observation (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Outcome Observation (NEW)](#E_Outcome_Observation_NEW) (optional) |  |

This template represents a patient's Progress Toward a Goal. It can describe whether a goal has been achieved or not and can also describe movement a patient is making toward the achievement of a goal (eg. "Goal not achieved - no discernible change", "Goal not achieved - progressing toward goal" or "Goal not achieved - declining from goal").

478: Progress Toward Goal Observation (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.110'] | | | | | |
| @classCode | 1..1 | SHALL |  | [31418](#C_31418) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [31419](#C_31419) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [31420](#C_31420) |  |
| @root | 1..1 | SHALL |  | [31421](#C_31421) | 2.16.840.1.113883.10.20.22.4.110 |
| id | 1..1 | SHALL |  | [31422](#C_31422) |  |
| code | 1..1 | SHALL |  | [31423](#C_31423) |  |
| @code | 1..1 | SHALL |  | [31424](#C_31424) | ASSERTION |
| @codeSystem | 1..1 | SHALL |  | [31425](#C_31425) | 2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4 |
| value | 1..1 | SHALL | CD | [31426](#C_31426) | 2.16.840.1.113883.11.20.9.55 (Goal Achievement) |
| statusCode | 1..1 | SHALL |  | [31609](#C_31609) |  |
| @code | 1..1 | SHALL |  | [31610](#C_31610) | 2.16.840.1.113883.5.14 (ActStatus) = completed |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:31418).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:31419).
3. SHALL contain exactly one [1..1] templateId (CONF:31420) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.110" (CONF:31421).
4. SHALL contain exactly one [1..1] id (CONF:31422).
5. SHALL contain exactly one [1..1] code (CONF:31423).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CONF:31424).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.5.4" (CodeSystem: ActCode 2.16.840.1.113883.5.4) (CONF:31425).
6. SHALL contain exactly one [1..1] statusCode (CONF:31609).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31610).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [Goal Achievement](#Goal_Achievement) 2.16.840.1.113883.11.20.9.55 (CONF:31426).

479: Goal Achievement

|  |  |  |
| --- | --- | --- |
| Value Set: Goal Achievement 2.16.840.1.113883.11.20.9.55 | | |
| Code | Code System | Print Name |
| 390802008 | SNOMED CT | Goal achieved |
| 390801001 | SNOMED CT | Goal not achieved |
| CODE\_TO\_BE\_DETERMINED | SNOMED CT | Goal not achieved - no discernible change |
| CODE\_TO\_BE\_DETERMINED | SNOMED CT | Goal not achieved - progressing toward goal |
| CODE\_TO\_BE\_DETERMINED | SNOMED CT | Goal not achieved - declining from goal |

Figure 184: Progress Toward Goal Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.110"/>

<id root="2afcf057-aae4-47cf-bfee-b7498e300424"/>

<code code="ASSERTION"

codeSystem="2.16.840.1.113883.5.4"/>

<value xsi:type="CD"

code="390802008"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"

displayName="Goal achieved"/>

</observation>

Provider Priority Preference (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.143 (open)]

480: Provider Priority Preference (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Problem Observation (V2)](#E_Problem_Observation_V2) (optional)  [Problem Concern Act (Condition) (V2)](#E_Problem_Concern_Act_Condition_V2) (optional)  [Goal Observation (NEW)](#E_Goal_Observation_NEW) (optional)  [Planned Act (V2)](#E_Planned_Act_V2) (optional)  [Planned Encounter (V2)](#E_Planned_Encounter_V2) (optional)  [Planned Procedure (V2)](#E_Planned_Procedure_V2) (optional)  [Planned Observation (V2)](#E_Planned_Observation_V2) (optional)  [Planned Supply (V2)](#E_Planned_Supply_V2) (optional)  [Planned Substance Administration (V2)](#E_Planned_Substance_Administration_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Author Participation (NEW)](#U_Author_Participation_NEW) |

This template represents a provider priority preference. Provider priority preferences are choices made by care providers relative to options for care or treatment and the prioritization of concerns and problems

481: Provider Priority Preference (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.143'] | | | | | |
| @classCode | 1..1 | SHALL |  | [30949](#C_30949) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [30950](#C_30950) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 0..\* | SHALL |  | [30951](#C_30951) |  |
| @root | 1..1 | SHALL |  | [30952](#C_30952) | 2.16.840.1.113883.10.20.22.4.143 |
| id | 1..1 | SHALL |  | [30953](#C_30953) |  |
| code | 1..1 | SHALL |  | [30954](#C_30954) |  |
| @code | 1..1 | SHALL |  | [30955](#C_30955) | 103323008 |
| @codeSystem | 1..1 | SHALL |  | [30956](#C_30956) | 2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96 |
| value | 1..1 | SHALL | CD | [30957](#C_30957) | 2.16.840.1.113883.11.20.9.60 (Priority Level) |
| author | 0..\* | SHOULD |  | [30958](#C_30958) |  |
| priorityCode | 0..1 | SHOULD |  | [30970](#C_30970) | 2.16.840.1.113883.11.20.9.57 (Priority Order) |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:30949).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:30950).
3. SHALL contain zero or more [0..\*] templateId (CONF:30951) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.143" (CONF:30952).
4. SHALL contain exactly one [1..1] id (CONF:30953).
5. SHALL contain exactly one [1..1] code (CONF:30954).
   1. This code SHALL contain exactly one [1..1] @code="103323008" Provider preference (CONF:30955).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:30956).
6. SHOULD contain zero or one [0..1] priorityCode, which SHOULD be selected from ValueSet [Priority Order](#Priority_Order) 2.16.840.1.113883.11.20.9.57 (CONF:30970).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [Priority Level](#Priority_Level) 2.16.840.1.113883.11.20.9.60 (CONF:30957).
8. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:30958).

482: Priority Level

|  |  |  |
| --- | --- | --- |
| Value Set: Priority Level 2.16.840.1.113883.11.20.9.60 | | |
| Code | Code System | Print Name |
| 394849002 | SNOMED CT | High priority |
| 394848005 | SNOMED CT | Normal priority |
| 441808003 | SNOMED CT | Delayed priority |

483: Priority Order

|  |  |  |
| --- | --- | --- |
| Value Set: Priority Order 2.16.840.1.113883.11.20.9.57 | | |
| Code | Code System | Print Name |
| 255216001 | SNOMED CT | First |
| 81170007 | SNOMED CT | Second |
| 70905002 | SNOMED CT | Third |
| 29970001 | SNOMED CT | Fourth |
| 32088001 | SNOMED CT | Fifth |
| 53046009 | SNOMED CT | Sixth |
| 86777004 | SNOMED CT | Seventh |
| 51601003 | SNOMED CT | Eighth |
| 58584009 | SNOMED CT | Ninth |
| 28226006 | SNOMED CT | Tenth |

Figure 185: Provider Priority Preference Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.143" />

<id root="7d66f448-ba82-4291-a9da-9e5db5e58803" />

<code code="103323008"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="ActReason"

displayName="Provider preference" />

<priorityCode code="255216001"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"

displayName="First" />

<value xsi:type="CD"

code="394849002"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED"

displayName="High priority" />

<!--

Author Participant Template

This author has an id that is the same as the author of the document

However, the author could be a different provider - someone else in the

header, or a new provider not elsewhere specified.

-->

<author>

<time value="20130801" />

<assignedAuthor>

<!-- This id points back to a participant in the header -->

<id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c" />

</assignedAuthor>

</author>

</observation>

Purpose of Reference Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.9 (open)]

484: Purpose of Reference Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [SOP Instance Observation](#E_SOP_Instance_Observation) (optional) |  |

A Purpose of Reference Observation describes the purpose of the DICOM composite object reference. Appropriate codes, such as externally defined DICOM codes, may be used to specify the semantics of the purpose of reference. When this observation is absent, it implies that the reason for the reference is unknown.

485: Purpose of Reference Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.6.2.9'] | | | | | |
| @classCode | 1..1 | SHALL |  | [9264](#C_9264) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [9265](#C_9265) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [9266](#C_9266) |  |
| @root | 1..1 | SHALL |  | [10531](#C_10531) | 2.16.840.1.113883.10.20.6.2.9 |
| code | 1..1 | SHALL |  | [9267](#C_9267) |  |
| @code | 0..1 | SHOULD |  | [19208](#C_19208) | 2.16.840.1.113883.5.4 (ActCode) = ASSERTION |
| value | 0..1 | SHOULD | CD | [9273](#C_9273) | 2.16.840.1.113883.11.20.9.28 (DICOMPurposeOfReference) |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9264).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9265).
3. SHALL contain exactly one [1..1] templateId (CONF:9266) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.9" (CONF:10531).
4. SHALL contain exactly one [1..1] code (CONF:9267).
   1. This code SHOULD contain zero or one [0..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19208).
   2. For backwards compatibility with the DICOM CMET, the code MAY be drawn from ValueSet 2.16.840.1.113883.11.20.9.28 DICOMPurposeOfReference DYNAMIC (CONF:19209).

The value element is a SHOULD to allow backwards compatibility with the DICOM CMET.  Note that the use of ASSERTION for the code differs from the DICOM CMET. This is intentional. The DICOM CMET was created before the Term Info guidelines describing the use of the assertion pattern were released. It was determined that this IG should follow the latest Term Info guidelines. Implementers using both this IG and the DICOM CMET should be aware of this difference and apply appropriate transformations.

1. SHOULD contain zero or one [0..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [DICOMPurposeOfReference](#DICOMPurposeOfReference) 2.16.840.1.113883.11.20.9.28 DYNAMIC (CONF:9273).

486: DICOMPurposeOfReference

|  |  |  |
| --- | --- | --- |
| Value Set: DICOMPurposeOfReference 2.16.840.1.113883.11.20.9.28 | | |
| Code | Code System | Print Name |
| 121079 | DCM | Baseline |
| 121080 | DCM | Best illustration of finding |
| 121112 | DCM | Source of Measurement |

Figure 186: Purpose of Reference Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.9"/>

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<value xsi:type="CD" code="121112" codeSystem="1.2.840.10008.2.16.4"

codeSystemName="DCM"

displayName="Source of Measurement"/>

</observation>

Quantity Measurement Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.14 (open)]

487: Quantity Measurement Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [Text Observation](#E_Text_Observation) (optional)  [Code Observations](#E_Code_Observations) (optional)  [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (optional) | [SOP Instance Observation](#E_SOP_Instance_Observation) |

A Quantity Measurement Observation records quantity measurements based on image data such as linear, area, volume, and numeric measurements. The codes in DIRQuantityMeasurementTypeCodes (ValueSet: 2.16.840.1.113883.11.20.9.29) are from the qualifier hierarchy of SNOMED CT and are not valid for observation/code according to the Term Info guidelines. These codes can be used for backwards compatibility, but going forward, codes from the observable entity hierarchy will be requested and used.

488: Quantity Measurement Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.6.2.14'] | | | | | |
| @classCode | 1..1 | SHALL |  | [9317](#C_9317) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [9318](#C_9318) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [9319](#C_9319) |  |
| @root | 1..1 | SHALL |  | [10532](#C_10532) | 2.16.840.1.113883.10.20.6.2.14 |
| code | 1..1 | SHALL |  | [9320](#C_9320) |  |
| @code | 0..1 | SHOULD |  | [19210](#C_19210) | 2.16.840.1.113883.11.20.9.29 (DIRQuantityMeasurementTypeCodes) |
| value | 1..1 | SHALL | PQ | [9324](#C_9324) |  |
| effectiveTime | 0..1 | SHOULD |  | [9326](#C_9326) |  |
| entryRelationship | 0..\* | MAY |  | [9327](#C_9327) |  |
| @typeCode | 1..1 | SHALL |  | [9328](#C_9328) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT |
| observation | 1..1 | SHALL |  | [15916](#C_15916) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9317).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9318).
3. SHALL contain exactly one [1..1] templateId (CONF:9319) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.14" (CONF:10532).

The value set of the observation/code includes numeric measurement types for linear dimensions, areas, volumes, and other numeric measurements. This value set is extensible and comprises the union of SNOMED codes for observable entities as reproduced in DIRQuantityMeasurementTypeCodes (ValueSet: 2.16.840.1.113883.11.20.9.29) and DICOM Codes in DICOMQuantityMeasurementTypeCodes (ValueSet: 2.16.840.1.113883.11.20.9.30).

1. SHALL contain exactly one [1..1] code (CONF:9320).
   1. This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet [DIRQuantityMeasurementTypeCodes](#DIRQuantityMeasurementTypeCodes) 2.16.840.1.113883.11.20.9.29 DYNAMIC (CONF:19210).
2. SHOULD contain zero or one [0..1] effectiveTime (CONF:9326).
3. SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:9324).
4. MAY contain zero or more [0..\*] entryRelationship (CONF:9327) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9328).
   2. SHALL contain exactly one [1..1] [SOP Instance Observation](#E_SOP_Instance_Observation) (templateId:2.16.840.1.113883.10.20.6.2.8) (CONF:15916).

489: DIRQuantityMeasurementTypeCodes

|  |  |  |
| --- | --- | --- |
| Value Set: DIRQuantityMeasurementTypeCodes 2.16.840.1.113883.11.20.9.29  These codes are used for the DIR quantity measurement observation. They are from SNOMED CT (http://www.nlm.nih.gov/research/umls/Snomed/snomed\_main.html)  Valueset Source: <http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html> | | |
| Code | Code System | Print Name |
| 439932008 | SNOMED CT | Length of structure |
| 440357003 | SNOMED CT | Width of structure |
| 439934009 | SNOMED CT | Depth of structure |
| 439984002 | SNOMED CT | Diameter of structure |
| 439933003 | SNOMED CT | Long axis length of structure |
| 439428006 | SNOMED CT | Short axis length of structure |
| 439982003 | SNOMED CT | Major axis length of structure |
| 439983008 | SNOMED CT | Minor axis length of structure |
| 440356007 | SNOMED CT | Perpendicular axis length of structure |
| 439429003 | SNOMED CT | Radius of structure |
| ... | | |

Figure 187: Quantity Measurement Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.14"/>

<code code="439984002" codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNM3"

displayName="Diameter of structure">

<originalText>

<reference value="#Diam2"/>

</originalText>

</code>

<statusCode code="completed"/>

<effectiveTime value="20060823223912"/>

<value xsi:type="PQ" value="45" unit="mm">

codeSystemVersion="1.5"/></value>

<!-- entryRelationships to SOP Instance Observations may go here -->

</observation>

Reaction Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.9.2 (open)]

490: Reaction Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medication Activity (V2)](#Medication_Activity_V2) (optional)  [Allergy - Intolerance Observation (V2)](#E_Allergy__Intolerance_Observation_V2) (optional)  [Substance or Device Allergy - Intolerance Observation (V2)](#E_Substance_or_Device_Allergy__V2) (optional)  [Immunization Activity (V2)](#E_Immunization_Activity_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Medication Activity (V2)](#Medication_Activity_V2)  [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2)  [Severity Observation (V2)](#E_Severity_Observation_V2) |

This clinical statement represents an undesired symptom, finding, etc., due to an administered or exposed substance. A reaction can be defined with respect to its severity, and can have been treated by one or more interventions.

491: Reaction Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.9.2'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [7340](#C_7340) |  |
| @typeCode | 1..1 | SHALL |  | [7341](#C_7341) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| @inversionInd | 1..1 | SHALL |  | [7344](#C_7344) | true |
| substanceAdministration | 1..1 | SHALL |  | [15921](#C_15921) |  |
| entryRelationship | 0..\* | MAY |  | [7337](#C_7337) |  |
| @typeCode | 1..1 | SHALL |  | [7338](#C_7338) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| @inversionInd | 1..1 | SHALL |  | [7343](#C_7343) | true |
| procedure | 1..1 | SHALL |  | [15920](#C_15920) |  |
| @classCode | 1..1 | SHALL |  | [7325](#C_7325) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [7326](#C_7326) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7323](#C_7323) |  |
| @root | 1..1 | SHALL |  | [10523](#C_10523) | 2.16.840.1.113883.10.20.22.4.9.2 |
| id | 1..1 | SHALL |  | [7329](#C_7329) |  |
| code | 1..1 | SHALL |  | [16851](#C_16851) |  |
| @code | 1..1 | SHALL |  | [31124](#C_31124) | 2.16.840.1.113883.5.4 (ActCode) = ASSERTION |
| text | 0..1 | SHOULD |  | [7330](#C_7330) |  |
| reference | 0..1 | SHOULD |  | [15917](#C_15917) |  |
| @value | 0..1 | SHOULD |  | [15918](#C_15918) |  |
| statusCode | 1..1 | SHALL |  | [7328](#C_7328) |  |
| @code | 1..1 | SHALL |  | [19114](#C_19114) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 0..1 | SHOULD |  | [7332](#C_7332) |  |
| low | 0..1 | SHOULD |  | [7333](#C_7333) |  |
| high | 0..1 | SHOULD |  | [7334](#C_7334) |  |
| value | 1..1 | SHALL | CD | [7335](#C_7335) | 2.16.840.1.113883.3.88.12.3221.7.4 (Problem Value Set) |
| entryRelationship | 0..1 | MAY |  | [7580](#C_7580) |  |
| @typeCode | 1..1 | SHALL |  | [7581](#C_7581) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [10375](#C_10375) | true |
| observation | 1..1 | SHALL |  | [15922](#C_15922) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7325).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7326).
3. SHALL contain exactly one [1..1] templateId (CONF:7323) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.9.2" (CONF:10523).
4. SHALL contain exactly one [1..1] id (CONF:7329).
5. SHALL contain exactly one [1..1] code (CONF:16851).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:31124).
6. SHOULD contain zero or one [0..1] text (CONF:7330).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15917).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15918).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15919).
7. SHALL contain exactly one [1..1] statusCode (CONF:7328).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19114).
8. SHOULD contain zero or one [0..1] effectiveTime (CONF:7332).
   1. The effectiveTime, if present, SHOULD contain zero or one [0..1] low (CONF:7333).
   2. The effectiveTime, if present, SHOULD contain zero or one [0..1] high (CONF:7334).
9. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [Problem Value Set](#Problem_Value_Set) 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:7335).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:7337) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7338).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7343).
    3. SHALL contain exactly one [1..1] [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) (templateId:2.16.840.1.113883.10.20.22.4.14.2) (CONF:15920).
       1. This procedure activity is intended to contain information about procedures that were performed in response to an allergy reaction (CONF:16853).
11. MAY contain zero or more [0..\*] entryRelationship (CONF:7340) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7341).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7344).
    3. SHALL contain exactly one [1..1] [Medication Activity (V2)](#Medication_Activity_V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15921).
       1. This medication activity is intended to contain information about medications that were administered in response to an allergy reaction (CONF:16840).
12. MAY contain zero or one [0..1] entryRelationship (CONF:7580) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7581).
    2. SHALL contain exactly one [1..1] @inversionInd="true" TRUE (CONF:10375).
    3. SHALL contain exactly one [1..1] [Severity Observation (V2)](#E_Severity_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.8.2) (CONF:15922).

492: Problem Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 | | |
| Code | Code System | Print Name |
| 50992006 | SNOMED CT | 22q partial trisomy syndrome (disorder) |
| 237931009 | SNOMED CT | 2-Ketoadipic acidemia (disorder) |
| 54470008 | SNOMED CT | 3 beta-Hydroxysteroid dehydrogenase deficiency (disorder) |
| 237950009 | SNOMED CT | 3-Methylglutaconic aciduria (disorder) |
| 296646009 | SNOMED CT | 4-quinolones overdose (disorder) |
| 41797007 | SNOMED CT | 5 10-Methylenetetrahydrofolate reductase deficiency (disorder) |
| 413380004 | SNOMED CT | A pattern strabismus (disorder) |
| 425879009 | SNOMED CT | AA amyloid nephropathy (disorder) |
| 274945004 | SNOMED CT | AA amyloidosis (disorder) |
| 75100008 | SNOMED CT | Abdominal abscess (disorder) |
| ... | | |

Figure 188: Reaction Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.9.2"/>

<id root="4adc1020-7b14-11db-9fe1-0800200c9a64"/>

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<text>

<reference value="#reaction1"/>

</text>

<statusCode code="completed"/>

<effectiveTime>

<low value="200802260800-0800"/>

<high value="2008022801200-0800"/>

</effectiveTime>

<value xsi:type="CD" code="422587007" codeSystem="2.16.840.1.113883.6.96"

displayName="Nausea"/>

<entryRelationship typeCode="SUBJ" inversionInd="true">

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.8.2"/>

. . .

</entryRelationship>

</observation>

Referenced Frames Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.10 (open)]

493: Referenced Frames Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [SOP Instance Observation](#E_SOP_Instance_Observation) (optional) | [Boundary Observation](#E_Boundary_Observation) |

A Referenced Frames Observation is used if the referenced DICOM SOP instance is a multiframe image and the reference does not apply to all frames. The list of integer values for the referenced frames of a DICOM multiframe image SOP instance is contained in a Boundary Observation nested inside this class.

494: Referenced Frames Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.6.2.10'] | | | | | |
| entryRelationship | 1..1 | SHALL |  | [9279](#C_9279) |  |
| @typeCode | 1..1 | SHALL |  | [9280](#C_9280) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| observation | 1..1 | SHALL |  | [15923](#C_15923) |  |
| @classCode | 1..1 | SHALL |  | [9276](#C_9276) | 2.16.840.1.113883.5.6 (HL7ActClass) = ROIBND |
| @moodCode | 1..1 | SHALL |  | [9277](#C_9277) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| code | 1..1 | SHALL |  | [19164](#C_19164) |  |
| @code | 0..1 | MAY |  | [19165](#C_19165) | 1.2.840.10008.2.16.4 (DCM) = 121190 |

1. SHALL contain exactly one [1..1] @classCode="ROIBND" Bounded Region of Interest (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9276).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9277).
3. SHALL contain exactly one [1..1] code (CONF:19164).
   1. This code MAY contain zero or one [0..1] @code="121190" Referenced Frames (CodeSystem: DCM 1.2.840.10008.2.16.4 STATIC) (CONF:19165).
4. SHALL contain exactly one [1..1] entryRelationship (CONF:9279).
   1. This entryRelationship SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9280).
   2. This entryRelationship SHALL contain exactly one [1..1] [Boundary Observation](#E_Boundary_Observation) (templateId:2.16.840.1.113883.10.20.6.2.11) (CONF:15923).

Figure 189: Referenced Frames Observation Example

<observation classCode="ROIBND" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.10"/>

<code code="121190" codeSystem="1.2.840.10008.2.16.4" displayName="Referenced Frames"/>

<entryRelationship typeCode="COMP">

<!-- Boundary Observation -->

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.11"/>

<code code="113036" codeSystem="1.2.840.10008.2.16.4" displayName="Frames for Display"/>

<value xsi:type="INT" value="1"/>

</observation>

</entryRelationship>

</observation>

Result Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.2.2 (open)]

495: Result Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Result Organizer (V2)](#Result_Organizer_V2) (required) | [Author Participation (NEW)](#U_Author_Participation_NEW) |

This clinical statement represents details of a lab, radiology, or other study performed on a patient.

The result observation includes a statusCode to allow recording the status of an observation. If a Result Observation is not completed, the Result Organizer must include corresponding statusCode. “Pending” results (e.g., a test has been run but results have not been reported yet) should be represented as “active” ActStatus.

496: Result Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.2.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7130](#C_7130) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [7131](#C_7131) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7136](#C_7136) |  |
| @root | 1..1 | SHALL |  | [9138](#C_9138) | 2.16.840.1.113883.10.20.22.4.2.2 |
| id | 1..\* | SHALL |  | [7137](#C_7137) |  |
| code | 1..1 | SHALL |  | [7133](#C_7133) |  |
| text | 0..1 | SHOULD |  | [7138](#C_7138) |  |
| reference | 0..1 | SHOULD |  | [15924](#C_15924) |  |
| @value | 0..1 | SHOULD |  | [15925](#C_15925) |  |
| statusCode | 1..1 | SHALL |  | [7134](#C_7134) |  |
| @code | 1..1 | SHALL |  | [14849](#C_14849) | 2.16.840.1.113883.11.20.9.39 (Result Status) |
| effectiveTime | 1..1 | SHALL |  | [7140](#C_7140) |  |
| value | 1..1 | SHALL |  | [7143](#C_7143) |  |
| interpretationCode | 0..\* | SHOULD |  | [7147](#C_7147) |  |
| methodCode | 0..1 | MAY | SET<CE> | [7148](#C_7148) |  |
| targetSiteCode | 0..1 | MAY | SET<CD> | [7153](#C_7153) |  |
| author | 0..\* | SHOULD |  | [7149](#C_7149) |  |
| referenceRange | 0..\* | SHOULD |  | [7150](#C_7150) |  |
| observationRange | 1..1 | SHALL |  | [7151](#C_7151) |  |
| code | 0..0 | SHALL NOT |  | [7152](#C_7152) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7130).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7131).
3. SHALL contain exactly one [1..1] templateId (CONF:7136) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.2.2" (CONF:9138).
4. SHALL contain at least one [1..\*] id (CONF:7137).
5. SHALL contain exactly one [1..1] code (CONF:7133).
   1. SHOULD be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:19211).
   2. Laboratory results SHOULD be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or other constrained terminology named by the US Department of Health and Human Services Office of National Coordinator or other federal agency. Local and/or regional codes for laboratory results are allowed. The Local and/or regional codes SHOULD be sent in the translation element. See the Local code example figure (CONF:19212).
6. SHOULD contain zero or one [0..1] text (CONF:7138).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15924).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15925).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15926).
7. SHALL contain exactly one [1..1] statusCode (CONF:7134).
   1. This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [Result Status](#Result_Status) 2.16.840.1.113883.11.20.9.39 STATIC (CONF:14849).
8. SHALL contain exactly one [1..1] effectiveTime (CONF:7140).
   1. Represents clinically effective time of the measurement, which may be when the measurement was performed (e.g., a BP measurement), or may be when sample was taken (and measured some time afterwards) (CONF:16838).
9. SHALL contain exactly one [1..1] value (CONF:7143).
   1. If Observation/value is a physical quantity, the unit of measure SHALL be expressed using a valid Unified Code for Units of Measure (UCUM) expression (CONF:31484).
10. SHOULD contain zero or more [0..\*] interpretationCode (CONF:7147).
11. MAY contain zero or one [0..1] methodCode (CONF:7148).
12. MAY contain zero or one [0..1] targetSiteCode (CONF:7153).
13. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:7149).
14. SHOULD contain zero or more [0..\*] referenceRange (CONF:7150).
    1. The referenceRange, if present, SHALL contain exactly one [1..1] observationRange (CONF:7151).
       1. This observationRange SHALL NOT contain [0..0] code (CONF:7152).

497: Result Status

|  |  |  |
| --- | --- | --- |
| Value Set: Result Status 2.16.840.1.113883.11.20.9.39 | | |
| Code | Code System | Print Name |
| aborted | ActStatus | aborted |
| active | ActStatus | active |
| cancelled | ActStatus | cancelled |
| completed | ActStatus | completed |
| held | ActStatus | held |
| suspended | ActStatus | suspended |

Figure 190: Result Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.2.2"/>

<id root="7c0704bb-9c40-41b5-9c7d-26b2d59e234f"/>

<code code="4544-3"

displayName="Hematocrit [Volume Fraction] of Blood by Automated count"

codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>

<text>

<reference value="#result4"/>

</text>

<statusCode code="completed"/>

<effectiveTime value="200803190830-0800"/>

<value xsi:type="PQ" value="35.3" unit="%"/>

<interpretationCode code="L" codeSystem="2.16.840.1.113883.5.83"/>

<author>

<templateId root="2.16.840.1.113883.10.20.22.4.119"/>

<time value="200803190830-0800"/>

<assignedAuthor>

<id extension="333444444" root="1.1.1.1.1.1.1.4"/>

<addr>

<streetAddressLine>1017 Health Drive</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:+1(555)555-1017"/>

<assignedPerson>

<name>

<given>William</given>

<given qualifier="CL">Bill</given>

<family>Beaker</family>

</name>

</assignedPerson>

<representedOrganization>

<name>Good Health Laboratory</name>

</representedOrganization>

</assignedAuthor>

</author>

<referenceRange>

<observationRange>

<value xsi:type="IVL\_PQ">

<low value="34.9" unit="%"/>

<high value="44.5" unit="%"/>

</value>

</observationRange>

</referenceRange>

</observation>

Result Organizer (V2)

[organizer: templateId 2.16.840.1.113883.10.20.22.4.1.2 (open)]

498: Result Organizer (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Results Section (entries optional) (V2)](#S_Results_Section_entries_optional_V2) (optional)  [Results Section (entries required) (V2)](#S_Results_Section_entries_required_V2) (required) | [Author Participation (NEW)](#U_Author_Participation_NEW)  [Result Observation (V2)](#E_Result_Observation_V2) |

This clinical statement identifies set of result observations. It contains information applicable to all of the contained result observations. Result type codes categorize a result into one of several commonly accepted values (e.g., “Hematology”, “Chemistry”, “Nuclear Medicine”). These values are often implicit in the Organizer/code (e.g., an Organizer/code of “complete blood count” implies a ResultTypeCode of “Hematology”). This template requires Organizer/code to include a ResultTypeCode either directly or as a translation of a code from some other code system.

An appropriate nullFlavor can be used when the organizer/code or organizer/id is unknown.

If any Result Observation within the organizer has a statusCode of ‘active’, the Result Organizer must also have as statusCode of ‘active.

499: Result Organizer (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| organizer[templateId/@root = '2.16.840.1.113883.10.20.22.4.1.2'] | | | | | |
| component | 1..\* | SHALL |  | [7124](#C_7124) |  |
| observation | 1..1 | SHALL |  | [14850](#C_14850) |  |
| @classCode | 1..1 | SHALL |  | [7121](#C_7121) | 2.16.840.1.113883.5.6 (HL7ActClass) |
| @moodCode | 1..1 | SHALL |  | [7122](#C_7122) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7126](#C_7126) |  |
| @root | 1..1 | SHALL |  | [9134](#C_9134) | 2.16.840.1.113883.10.20.22.4.1.2 |
| id | 1..\* | SHALL |  | [7127](#C_7127) |  |
| code | 1..1 | SHALL |  | [7128](#C_7128) |  |
| statusCode | 1..1 | SHALL |  | [7123](#C_7123) |  |
| @code | 1..1 | SHALL |  | [14848](#C_14848) | 2.16.840.1.113883.11.20.9.39 (Result Status) |
| author | 0..\* | SHOULD |  | [31149](#C_31149) |  |

1. SHALL contain exactly one [1..1] @classCode (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7121).
   1. SHOULD contain zero or one 0..1] @classCode="CLUSTER" Cluster (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass) OR SHOULD contain zero or one 0..1] @classCode="BATTERY" Battery (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass) (CONF:7165).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7122).
3. SHALL contain exactly one [1..1] templateId (CONF:7126) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.1.2" (CONF:9134).
4. SHALL contain at least one [1..\*] id (CONF:7127).
5. SHALL contain exactly one [1..1] code (CONF:7128).
   1. SHOULD be selected from LOINC (codeSystem 2.16.840.1.113883.6.1) or SNOMED CT (codeSystem 2.16.840.1.113883.6.96), and MAY be selected from CPT-4 (codeSystem 2.16.840.1.113883.6.12) (CONF:19218).
   2. Laboratory results SHOULD be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or other constrained terminology named by the US Department of Health and Human Services Office of National Coordinator or other federal agency.  Local and/or regional codes for laboratory results SHOULD also be allowed (CONF:19219).
6. SHALL contain exactly one [1..1] statusCode (CONF:7123).
   1. This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [Result Status](#Result_Status) 2.16.840.1.113883.11.20.9.39 STATIC (CONF:14848).
7. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31149).
8. SHALL contain at least one [1..\*] component (CONF:7124) such that it
   1. SHALL contain exactly one [1..1] [Result Observation (V2)](#E_Result_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.2.2) (CONF:14850).

500: Result Status

|  |  |  |
| --- | --- | --- |
| Value Set: Result Status 2.16.840.1.113883.11.20.9.39 | | |
| Code | Code System | Print Name |
| aborted | ActStatus | aborted |
| active | ActStatus | active |
| cancelled | ActStatus | cancelled |
| completed | ActStatus | completed |
| held | ActStatus | held |
| suspended | ActStatus | suspended |

Figure 191: Result Organizer Example

<organizer classCode="BATTERY" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.1.2" />

<id root="7d5a02b0-67a4-11db-bd13-0800200c9a66" />

<code code="57021-8" displayName="CBC W Auto Differential panel in Blood" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />

<statusCode code="completed" />

<author>

<templateId root="2.16.840.1.113883.10.20.22.4.119" />

. . .

</author>

<component>

<observation classCode="OBS" moodCode="EVN">

<!-- \*\* Result observation \*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.2.2" />

. . .

</observation>

</component>

</organizer>

Self-Care Activities (ADL and IADL) (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.128 (open)]

501: Self-Care Activities (ADL and IADL) (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (optional)  [Functional Status Organizer (V2)](#E_Functional_Status_Organizer_V2) (required) |  |

This template represents an adult patient's daily self-care ability. These activities are called Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).  ADLs involve caring for and moving of the body (e.g. dressing, bathing, eating). IADLs support an independent life style (e.g. cooking, managing medications, driving, shopping).

502: Self-Care Activities (ADL and IADL) (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.128'] | | | | | |
| value | 1..1 | SHALL | CD | [28042](#C_28042) | 2.16.840.1.113883.11.20.9.46 (Ability Value Set) |
| code | 1..1 | SHALL |  | [28153](#C_28153) | 2.16.840.1.113883.11.20.9.47 (ADL Result Type) |
| templateId | 1..1 | SHALL |  | [28190](#C_28190) |  |
| @root | 1..1 | SHALL |  | [28457](#C_28457) | 2.16.840.1.113883.10.20.22.4.128 |
| @classCode | 1..1 | SHALL |  | [31389](#C_31389) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [31390](#C_31390) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:31389).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:31390).
3. SHALL contain exactly one [1..1] templateId (CONF:28190) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.128" (CONF:28457).
4. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [ADL Result Type](#ADL_Result_Type) 2.16.840.1.113883.11.20.9.47 DYNAMIC (CONF:28153).
5. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [Ability Value Set](#Ability_Value_Set) 2.16.840.1.113883.11.20.9.46 STATIC (CONF:28042).

503: Ability Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Ability Value Set 2.16.840.1.113883.11.20.9.46  A value set containing SNOMED-CT codes for dependency. | | |
| Code | Code System | Print Name |
| 371153006 | SNOMED CT | Independent |
| 371154000 | SNOMED CT | Dependent |
| 371152001 | SNOMED CT | Assisted |

504: ADL Result Type

|  |  |  |
| --- | --- | --- |
| Value Set: ADL Result Type 2.16.840.1.113883.11.20.9.47  This value set includes Basic ADL and IADL activities. | | |
| Code | Code System | Print Name |
| 46008-9 | LOINC | Bathing |
| 28409-1 | LOINC | Dressing |
| 28408-3 | LOINC | Toileting |
| 46484-2 | LOINC | Feeding or Eating |
| 46482-6 | LOINC | Transferring |
| 28413-3 | LOINC | Ambulation |
| 45618-6 | LOINC | Bowel continence |
| 45619-4 | LOINC | Bladder continence |

Figure 192: Self-Care Activities (ADL and IADL) Example

<observation classCode="OBS" moodCode="EVN">

<!-- Self Care Activities (NEW)-->

<templateId root="2.16.840.1.113883.10.20.22.4.128"/>

<id root="c6b5a04b-2bf4-49d1-8336-636a3813df0a"/>

<code code="46482-6" displayName="Transferring"

codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>

<statusCode code="completed"/>

<effectiveTime value="200130311"/>

<value xsi:type="CD" code="371153006" displayName="Independent"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"/>

<author>

...

</author>

</observation>

Sensory and Speech Status (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.127 (open)]

505: Sensory and Speech Status (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Functional Status Section (V2)](#S_Functional_Status_Section_V2) (optional) | [Assessment Scale Observation](#E_Assessment_Scale_Observation) |

This template represents a patient’s sensory or speech ability. It may contain an Assessment Scale related to the sensory or speech ability.

506: Sensory and Speech Status (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.127'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [27984](#C_27984) |  |
| @typeCode | 1..1 | SHALL |  | [27985](#C_27985) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| observation | 1..1 | SHALL |  | [27986](#C_27986) |  |
| templateId | 1..1 | SHALL |  | [27959](#C_27959) |  |
| @root | 1..1 | SHALL |  | [27960](#C_27960) | 2.16.840.1.113883.10.20.22.4.127 |
| code | 1..1 | SHALL |  | [27962](#C_27962) | 2.16.840.1.113883.11.20.9.50 (Sensory and Speech Problem Type) |
| value | 1..1 | SHALL | CD | [27974](#C_27974) | 2.16.840.1.113883.11.20.9.44 (Mental and Functional Status Response Value Set) |
| @classCode | 1..1 | SHALL |  | [31017](#C_31017) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [31018](#C_31018) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| statusCode | 1..1 | SHALL |  | [31437](#C_31437) |  |
| @code | 1..1 | SHALL |  | [31438](#C_31438) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| author | 0..1 | SHOULD |  | [31439](#C_31439) |  |
| time | 1..1 | SHALL |  | [31440](#C_31440) |  |
| effectiveTime | 1..1 | SHALL |  | [31441](#C_31441) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:31017).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:31018).
3. SHALL contain exactly one [1..1] templateId (CONF:27959) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.127" (CONF:27960).
4. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet [Sensory and Speech Problem Type](#Sensory_and_Speech_Problem_Type) 2.16.840.1.113883.11.20.9.50 DYNAMIC (CONF:27962).
5. SHALL contain exactly one [1..1] statusCode (CONF:31437).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31438).
6. SHALL contain exactly one [1..1] effectiveTime (CONF:31441).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet [Mental and Functional Status Response Value Set](#Mental_and_Functional_Status_Response_V) 2.16.840.1.113883.11.20.9.44 DYNAMIC (CONF:27974).
8. SHOULD contain zero or one [0..1] author (CONF:31439).
   1. The author, if present, SHALL contain exactly one [1..1] time (CONF:31440).
9. MAY contain zero or more [0..\*] entryRelationship (CONF:27984) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:27985).
   2. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:27986).

507: Sensory and Speech Problem Type

|  |  |  |
| --- | --- | --- |
| Value Set: Sensory and Speech Problem Type 2.16.840.1.113883.11.20.9.50  A value set of SNOMED-CT observable codes to identify sensory and speech problems. | | |
| Code | Code System | Print Name |
| 47078008 | SNOMED CT | Hearing |
| 405183003 | SNOMED CT | Sensory function status: vision |
| 373713005 | SNOMED CT | Sensory perception |
| 397627001 | SNOMED CT | Taste, function |
| 397686008 | SNOMED CT | Sense of smell, function |

508: Mental and Functional Status Response Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Mental and Functional Status Response Value Set 2.16.840.1.113883.11.20.9.44  A value set containing 2 SNOMED-CT qualifier codes that are common responses to mental and functional ability queries. | | |
| Code | Code System | Print Name |
| 11163003 | SNOMED CT | Intact |
| 260379002 | SNOMED CT | Impaired |

Figure 193: Sensory and Speech Status Example

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Sensory and Speech Status(NEW)-->

<templateId root="2.16.840.1.113883.10.20.22.4.127"/>

<id root="c6b5a04b-2bf4-49d1-8336-636a3813df0a"/>

<code code="47078008" displayName="Hearing"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED-CT"/>

<statusCode code="completed"/>

<effectiveTime value="200130311"/>

<value xsi:type="CD" code="260379002" displayName="Impaired"

codeSystemName="SNOMED CT"/>

<entryRelationship typeCode="COMP">

<observation classCode="OBS" moodCode="EVN">

<!--Assessment Scale Observation -->

<templateId root="2.16.840.1.113883.10.20.22.4.69"/>

<id root="c6b5a04b-2bf4-49d1-8336-636a3813df0b"/>

...

</observation>

</entryRelationship>

</observation>

</entry>

Series Act

[act: templateId 2.16.840.1.113883.10.20.22.4.63 (open)]

509: Series Act Contexts

| Contained By: | Contains: |
| --- | --- |
| [Study Act](#E_Study_Act) (required) | [SOP Instance Observation](#E_SOP_Instance_Observation) |

A Series Act contains the DICOM series information for referenced DICOM composite objects. The series information defines the attributes that are used to group composite instances into distinct logical sets. Each series is associated with exactly one study. Series Act clinical statements are only instantiated in the DICOM Object Catalog section inside a Study Act, and thus do not require a separate templateId; in other sections, the SOP Instance Observation is included directly.

510: Series Act Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.63'] | | | | | |
| @classCode | 1..1 | SHALL |  | [9222](#C_9222) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [9223](#C_9223) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| id | 1..\* | SHALL |  | [9224](#C_9224) |  |
| @root | 1..1 | SHALL |  | [9225](#C_9225) |  |
| @extension | 0..0 | SHALL NOT |  | [9226](#C_9226) |  |
| text | 0..1 | MAY |  | [9233](#C_9233) |  |
| effectiveTime | 0..1 | SHOULD |  | [9235](#C_9235) |  |
| entryRelationship | 1..\* | SHALL |  | [9237](#C_9237) |  |
| @typeCode | 1..1 | SHALL |  | [9238](#C_9238) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| observation | 1..1 | SHALL |  | [15927](#C_15927) |  |
| templateId | 1..1 | SHALL |  | [10918](#C_10918) |  |
| @root | 1..1 | SHALL |  | [10919](#C_10919) | 2.16.840.1.113883.10.20.22.4.63 |
| code | 1..1 | SHALL |  | [19166](#C_19166) |  |
| @code | 1..1 | SHALL |  | [19167](#C_19167) | 113015 |
| @codeSystem | 0..1 | MAY |  | [26461](#C_26461) | 1.2.840.10008.2.16.4 (DCM) = 1.2.840.10008.2.16.4 |
| qualifier | 1..1 | SHALL |  | [26462](#C_26462) |  |
| name | 1..1 | SHALL |  | [26463](#C_26463) |  |
| @code | 1..1 | SHALL |  | [26464](#C_26464) | 121139 |
| @codeSystem | 1..1 | SHALL |  | [26465](#C_26465) | 1.2.840.10008.2.16.4 (DCM) = 1.2.840.10008.2.16.4 |
| value | 1..1 | SHALL |  | [26466](#C_26466) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9222).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9223).
3. SHALL contain exactly one [1..1] templateId (CONF:10918) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.63" (CONF:10919).
4. SHALL contain at least one [1..\*] id (CONF:9224).

The @root contains the OID of the study instance UID since DICOM study ids consist only of an OID

* 1. Such ids SHALL contain exactly one [1..1] @root (CONF:9225).
  2. Such ids SHALL NOT contain [0..0] @extension (CONF:9226).

1. SHALL contain exactly one [1..1] code (CONF:19166).
   1. This code SHALL contain exactly one [1..1] @code="113015" (CONF:19167).
   2. This code MAY contain zero or one [0..1] @codeSystem="1.2.840.10008.2.16.4" (CodeSystem: DCM 1.2.840.10008.2.16.4) (CONF:26461).
   3. This code SHALL contain exactly one [1..1] qualifier (CONF:26462).
      1. This qualifier SHALL contain exactly one [1..1] name (CONF:26463).
         1. This name SHALL contain exactly one [1..1] @code="121139" Modality (CONF:26464).
         2. This name SHALL contain exactly one [1..1] @codeSystem="1.2.840.10008.2.16.4" (CodeSystem: DCM 1.2.840.10008.2.16.4) (CONF:26465).
      2. This qualifier SHALL contain exactly one [1..1] value (CONF:26466).

If present, the text element contains the description of the series

1. MAY contain zero or one [0..1] text (CONF:9233).

If present, the effectiveTime contains the time the series was started

1. SHOULD contain zero or one [0..1] effectiveTime (CONF:9235).
2. SHALL contain at least one [1..\*] entryRelationship (CONF:9237) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9238).
   2. SHALL contain exactly one [1..1] [SOP Instance Observation](#E_SOP_Instance_Observation) (templateId:2.16.840.1.113883.10.20.6.2.8) (CONF:15927).

Figure 194: Series Act Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.63" />

<id root="1.2.840.113619.2.62.994044785528.20060823223142485051" />

<code code="113015" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM" displayName="Series">

<qualifier>

<name code="121139" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM" displayName="Modality" />

<value code="CR" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM" displayName="Computed Radiography" />

</qualifier>

</code>

<!-- \*\*\*\* SOP Instance UID \*\*\* -->

<entryRelationship typeCode="COMP">

<observation classCode="DGIMG" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.8" />

...

</observation>

</entryRelationship>

</act>

Service Delivery Location

[participantRole: templateId 2.16.840.1.113883.10.20.22.4.32 (open)]

511: Service Delivery Location Contexts

| Contained By: | Contains: |
| --- | --- |
| [Procedure Activity Act (V2)](#E_Procedure_Activity_Act_V2) (optional)  [Procedure Activity Procedure (V2)](#E_Procedure_Activity_Procedure_V2) (optional)  [Procedure Activity Observation (V2)](#E_Procedure_Activity_Observation_V2) (optional)  [Encounter Activity (V2)](#E_Encounter_Activity_V2) (optional) |  |

This clinical statement represents the location of a service event where an act, observation or procedure took place.

512: Service Delivery Location Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| participantRole[templateId/@root = '2.16.840.1.113883.10.20.22.4.32'] | | | | | |
| templateId | 1..1 | SHALL |  | [7635](#C_7635) |  |
| @root | 1..1 | SHALL |  | [10524](#C_10524) | 2.16.840.1.113883.10.20.22.4.32 |
| @classCode | 1..1 | SHALL |  | [7758](#C_7758) | 2.16.840.1.113883.5.111 (RoleCode) = SDLOC |
| addr | 0..\* | SHOULD |  | [7760](#C_7760) |  |
| telecom | 0..\* | SHOULD |  | [7761](#C_7761) |  |
| playingEntity | 0..1 | MAY |  | [7762](#C_7762) |  |
| @classCode | 1..1 | SHALL |  | [7763](#C_7763) | 2.16.840.1.113883.5.41 (EntityClass) = PLC |
| name | 0..1 | MAY |  | [16037](#C_16037) |  |
| code | 1..1 | SHALL |  | [16850](#C_16850) | 2.16.840.1.113883.1.11.20275 (HealthcareServiceLocation) |

1. SHALL contain exactly one [1..1] @classCode="SDLOC" (CodeSystem: RoleCode 2.16.840.1.113883.5.111 STATIC) (CONF:7758).
2. SHALL contain exactly one [1..1] templateId (CONF:7635) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.32" (CONF:10524).
3. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [HealthcareServiceLocation](#HealthcareServiceLocation) 2.16.840.1.113883.1.11.20275 STATIC (CONF:16850).
4. SHOULD contain zero or more [0..\*] addr (CONF:7760).
5. SHOULD contain zero or more [0..\*] telecom (CONF:7761).
6. MAY contain zero or one [0..1] playingEntity (CONF:7762).
   1. The playingEntity, if present, SHALL contain exactly one [1..1] @classCode="PLC" (CodeSystem: EntityClass 2.16.840.1.113883.5.41 STATIC) (CONF:7763).
   2. The playingEntity, if present, MAY contain zero or one [0..1] name (CONF:16037).

513: HealthcareServiceLocation

|  |  |  |
| --- | --- | --- |
| Value Set: HealthcareServiceLocation 2.16.840.1.113883.1.11.20275 | | |
| Code | Code System | Print Name |
| 1162-7 | HL7 HealthcareServiceLocation | 24-Hour observation area |
| 1184-1 | HL7 HealthcareServiceLocation | Administrative area |
| 1210-4 | HL7 HealthcareServiceLocation | Adult Mixed Acuity Unit |
| 1099-1 | HL7 HealthcareServiceLocation | Adult step down unit [post-critical care] |
| 1110-6 | HL7 HealthcareServiceLocation | Allergy clinic |
| 1166-8 | HL7 HealthcareServiceLocation | Ambulatory surgical setting |
| 1212-0 | HL7 HealthcareServiceLocation | Any Age Mixed Acuity Unit |
| 1106-4 | HL7 HealthcareServiceLocation | Assisted living area |
| 1145-2 | HL7 HealthcareServiceLocation | Behavioral health clinic |
| 1185-8 | HL7 HealthcareServiceLocation | Blood bank |
| ... | | |

Figure 195: Service Delivery Location Example

<participantRole classCode="SDLOC">

<templateId root="2.16.840.1.113883.10.20.22.4.32" />

<code code="1160-1" codeSystem="2.16.840.1.113883.6.259" codeSystemName="HealthcareServiceLocation" displayName="Urgent Care Center" />

<addr>

<streetAddressLine>17 Daws Rd.</streetAddressLine>

<city>Blue Bell</city>

<state>MA</state>

<postalCode>02368</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:+1(555)555-5000" />

<playingEntity classCode="PLC">

<name>Community Health and Hospitals</name>

</playingEntity>

</participantRole>

Severity Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.8.2 (open)]

514: Severity Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Reaction Observation (V2)](#Reaction_Observation_V2) (optional)  [Allergy - Intolerance Observation (V2)](#E_Allergy__Intolerance_Observation_V2) (optional)  [Substance or Device Allergy - Intolerance Observation (V2)](#E_Substance_or_Device_Allergy__V2) (optional) |  |

This clinical statement represents the gravity of the problem, such as allergy or reaction, in terms of its actual or potential impact on the patient. The Severity Observation can be associated with an Allergy - Intolerance Observation, Substance or Device Allergy - Intolerance Observation, Reaction Observation or all. When the Severity Observation is associated directly with an allergy it characterizes the allergy. When the Severity Observation is associated with a Reaction Observation it characterizes a Reaction. A person may manifest many symptoms in a reaction to a single substance, and each reaction to the substance can be represented. However, each reaction observation can have only one severity observation associated with it. For example, someone may have a rash reaction observation as well as an itching reaction observation, but each can have only one level of severity.

515: Severity Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.8.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7345](#C_7345) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [7346](#C_7346) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7347](#C_7347) |  |
| @root | 1..1 | SHALL |  | [10525](#C_10525) | 2.16.840.1.113883.10.20.22.4.8.2 |
| code | 1..1 | SHALL |  | [19168](#C_19168) |  |
| @code | 1..1 | SHALL |  | [19169](#C_19169) | 2.16.840.1.113883.5.4 (ActCode) = SEV |
| text | 0..1 | SHOULD |  | [7350](#C_7350) |  |
| reference | 0..1 | SHOULD |  | [15928](#C_15928) |  |
| @value | 0..1 | SHOULD |  | [15929](#C_15929) |  |
| statusCode | 1..1 | SHALL |  | [7352](#C_7352) |  |
| @code | 1..1 | SHALL |  | [19115](#C_19115) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 1..1 | SHALL | CD | [7356](#C_7356) | 2.16.840.1.113883.3.88.12.3221.6.8 (Problem Severity) |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7345).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7346).
3. SHALL contain exactly one [1..1] templateId (CONF:7347) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.8.2" (CONF:10525).
4. SHALL contain exactly one [1..1] code (CONF:19168).
   1. This code SHALL contain exactly one [1..1] @code="SEV" (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19169).
5. SHOULD contain zero or one [0..1] text (CONF:7350).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15928).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15929).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15930).
6. SHALL contain exactly one [1..1] statusCode (CONF:7352).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19115).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [Problem Severity](#Problem_Severity) 2.16.840.1.113883.3.88.12.3221.6.8 DYNAMIC (CONF:7356).

516: Problem Severity

|  |  |  |
| --- | --- | --- |
| Value Set: Problem Severity 2.16.840.1.113883.3.88.12.3221.6.8 | | |
| Code | Code System | Print Name |
| 255604002 | SNOMED CT | Mild (qualifier value) |
| 371923003 | SNOMED CT | Mild to moderate (qualifier value) |
| 6736007 | SNOMED CT | Moderate (severity modifier) (qualifier value) |
| 371924009 | SNOMED CT | Moderate to severe (qualifier value) |
| 24484000 | SNOMED CT | Severe (severity modifier) (qualifier value) |
| 399166001 | SNOMED CT | Fatal (qualifier value) |

Figure 196: Severity Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.8.2"/>

<code code="SEV" displayName="Severity Observation"

codeSystem="2.16.840.1.113883.5.4" codeSystemName="ActCode"/>

<text>

<reference value="#allergyseverity1"/>

</text>

<statusCode code="completed"/>

<value xsi:type="CD" code="371924009"

displayName="Moderate to severe"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"/>

</observation>

Social History Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.38.2 (open)]

517: Social History Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Social History Section (V2)](#S_Social_History_Section_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) |  |

This template represents a patient's occupations, lifestyle, and environmental health risk factors. Demographic data (e.g. marital status, race, ethnicity, religious affiliation) is captured in the header.

518: Social History Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.38.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [8548](#C_8548) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [8549](#C_8549) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [8550](#C_8550) |  |
| @root | 1..1 | SHALL |  | [10526](#C_10526) | 2.16.840.1.113883.10.20.22.4.38.2 |
| id | 1..\* | SHALL |  | [8551](#C_8551) |  |
| code | 1..1 | SHALL |  | [8558](#C_8558) | 2.16.840.1.113883.3.88.12.80.60 (Social History Type Value Set) |
| originalText | 0..1 | SHOULD |  | [19221](#C_19221) |  |
| reference | 0..1 | SHOULD |  | [19222](#C_19222) |  |
| @value | 0..1 | SHOULD |  | [19223](#C_19223) |  |
| statusCode | 1..1 | SHALL |  | [8553](#C_8553) |  |
| @code | 1..1 | SHALL |  | [19117](#C_19117) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| value | 0..1 | SHOULD |  | [8559](#C_8559) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8548).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8549).
3. SHALL contain exactly one [1..1] templateId (CONF:8550) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.38.2" (CONF:10526).
4. SHALL contain at least one [1..\*] id (CONF:8551).
5. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet [Social History Type Value Set](#Social_History_Type_Value_Set) 2.16.840.1.113883.3.88.12.80.60 DYNAMIC (CONF:8558).
   1. This code SHOULD contain zero or one [0..1] originalText (CONF:19221).
      1. The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:19222).
         1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:19223).
            1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:19224).
6. SHALL contain exactly one [1..1] statusCode (CONF:8553).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19117).
7. SHOULD contain zero or one [0..1] value (CONF:8559).
   1. If Observation/value is a physical quantity, the unit of measure SHALL be expressed using a valid Unified Code for Units of Measure (UCUM) expression (CONF:8555).

519: Social History Type Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Social History Type Value Set 2.16.840.1.113883.3.88.12.80.60  This indicates the type of social history observation | | |
| Code | Code System | Print Name |
| 160573003 | SNOMED CT | Alcohol intake (observable entity) |
| 363908000 | SNOMED CT | Details of drug misuse behavior (observable entity) |
| 364703007 | SNOMED CT | Employment detail (observable entity) |
| 256235009 | SNOMED CT | Exercise (observable entity) |
| 228272008 | SNOMED CT | Health-related behavior (observable entity) |
| 364393001 | SNOMED CT | Nutritional observable (observable entity) |
| 229819007 | SNOMED CT | Tobacco use and exposure (observable entity) |
| 425400000 | SNOMED CT | Toxic exposure status (observable entity) |
| 105421008 | SNOMED CT | Educational achievement (observable entity) |
| 302160007 | SNOMED CT | Household, family and support network detail (observable entity) |
| ... | | |

Figure 197: Social History Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.38.2"/>

<id root="37f76c51-6411-4e1d-8a37-957fd49d2cef"/>

<code code="160573003" codeSystem="2.16.840.1.113883.6.96"

displayName="Alcohol consumption"/>

<statusCode code="completed"/>

<effectiveTime>

<low value="20120215"/>

</effectiveTime>

<value xsi:type="PQ" value="2" unit="d"/>

<author>

<templateId root="2.16.840.1.113883.10.20.22.4.119"/>

<time value="201209101145-0800"/>

. . .

</author>

</observation>

SOP Instance Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.8 (open)]

520: SOP Instance Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [Series Act](#E_Series_Act) (required)  [Text Observation](#E_Text_Observation) (optional)  [Code Observations](#E_Code_Observations) (optional)  [Quantity Measurement Observation](#E_Quantity_Measurement_Observation) (optional)  [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (optional) | [Purpose of Reference Observation](#E_Purpose_of_Reference_Observation)  [Referenced Frames Observation](#E_Referenced_Frames_Observation) |

A SOP Instance Observation contains the DICOM Service Object Pair (SOP) Instance information for referenced DICOM composite objects. The SOP Instance act class is used to reference both image and non-image DICOM instances. The text attribute contains the DICOM WADO reference.

521: SOP Instance Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.6.2.8'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [9257](#C_9257) |  |
| @typeCode | 1..1 | SHALL |  | [9258](#C_9258) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON |
| observation | 1..1 | SHALL |  | [15935](#C_15935) |  |
| entryRelationship | 0..\* | MAY |  | [9260](#C_9260) |  |
| @typeCode | 1..1 | SHALL |  | [9261](#C_9261) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| observation | 1..1 | SHALL |  | [15936](#C_15936) |  |
| @classCode | 1..1 | SHALL |  | [9240](#C_9240) | 2.16.840.1.113883.5.6 (HL7ActClass) = DGIMG |
| @moodCode | 1..1 | SHALL |  | [9241](#C_9241) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| id | 1..\* | SHALL |  | [9242](#C_9242) |  |
| code | 1..1 | SHALL |  | [9244](#C_9244) |  |
| @code | 1..1 | SHALL |  | [19225](#C_19225) |  |
| @codeSystem | 1..1 | SHALL |  | [19227](#C_19227) | 1.2.840.10008.2.6.1 |
| text | 0..1 | SHOULD |  | [9246](#C_9246) |  |
| @mediaType | 1..1 | SHALL |  | [9247](#C_9247) | application/dicom |
| reference | 1..1 | SHALL |  | [9248](#C_9248) |  |
| effectiveTime | 0..1 | SHOULD |  | [9250](#C_9250) |  |
| @value | 1..1 | SHALL |  | [9251](#C_9251) |  |
| low | 0..0 | SHALL NOT |  | [9252](#C_9252) |  |
| high | 0..0 | SHALL NOT |  | [9253](#C_9253) |  |
| entryRelationship | 0..\* | MAY |  | [9254](#C_9254) |  |
| @typeCode | 1..1 | SHALL |  | [9255](#C_9255) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |

1. SHALL contain exactly one [1..1] @classCode="DGIMG" Diagnostic Image (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9240).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9241).

The @root contains an OID representing the DICOM SOP Instance UID

1. SHALL contain at least one [1..\*] id (CONF:9242).
2. SHALL contain exactly one [1..1] code (CONF:9244).
   1. This code SHALL contain exactly one [1..1] @code (CONF:19225).
      1. @code is an OID for a valid SOP class name UID (CONF:19226).
   2. This code SHALL contain exactly one [1..1] @codeSystem="1.2.840.10008.2.6.1" DCMUID (CONF:19227).
3. SHOULD contain zero or one [0..1] text (CONF:9246).
   1. The text, if present, SHALL contain exactly one [1..1] @mediaType="application/dicom" (CONF:9247).
   2. The text, if present, SHALL contain exactly one [1..1] reference (CONF:9248).
      1. SHALL contain a @value that contains a WADO reference as a URI (CONF:9249).
4. SHOULD contain zero or one [0..1] effectiveTime (CONF:9250).
   1. The effectiveTime, if present, SHALL contain exactly one [1..1] @value (CONF:9251).
   2. The effectiveTime, if present, SHALL NOT contain [0..0] low (CONF:9252).
   3. The effectiveTime, if present, SHALL NOT contain [0..0] high (CONF:9253).
5. MAY contain zero or more [0..\*] entryRelationship (CONF:9254) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9255).
6. MAY contain zero or more [0..\*] entryRelationship (CONF:9257) such that it
   1. SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9258).
   2. SHALL contain exactly one [1..1] [Purpose of Reference Observation](#E_Purpose_of_Reference_Observation) (templateId:2.16.840.1.113883.10.20.6.2.9) (CONF:15935).
7. MAY contain zero or more [0..\*] entryRelationship (CONF:9260) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9261).
   2. SHALL contain exactly one [1..1] [Referenced Frames Observation](#E_Referenced_Frames_Observation) (templateId:2.16.840.1.113883.10.20.6.2.10) (CONF:15936).
   3. This entryRelationship SHALL be present if the referenced DICOM object is a multiframe object and the reference does not apply to all frames (CONF:9263).

Figure 198: SOP Instance Observation Example

<observation classCode="DGIMG" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.8" />

<id root="1.2.840.113619.2.62.994044785528.20060823.200608232232322.3" />

<code code="1.2.840.10008.5.1.4.1.1.1" codeSystem="1.2.840.10008.2.6.1" codeSystemName="DCMUID" displayName="Computed Radiography Image Storage">

</code>

<text mediaType="application/dicom">

<reference value="http://www.example.org/wado?requestType=WADO&amp;studyUID=1.2.840.113619.2.62.994044785528.114289542805&amp;seriesUID=1.2.840.113619.2.62.994044785528.20060823223142485051&amp;objectUID=1.2.840.113619.2.62.994044785528.20060823.200608232232322.3&amp;contentType=application/dicom" />

<!--reference to image 1 (PA) -->

</text>

<effectiveTime value="200608231235-0800" />

</observation>

Study Act

[act: templateId 2.16.840.1.113883.10.20.6.2.6 (open)]

522: Study Act Contexts

| Contained By: | Contains: |
| --- | --- |
| [DICOM Object Catalog Section - DCM 121181](#S_DICOM_Object_Catalog_Section__DCM_121) (required) | [Series Act](#E_Series_Act) |

A Study Act contains the DICOM study information that defines the characteristics of a referenced medical study performed on a patient. A study is a collection of one or more series of medical images, presentation states, SR documents, overlays, and/or curves that are logically related for the purpose of diagnosing a patient. Each study is associated with exactly one patient. A study may include composite instances that are created by a single modality, multiple modalities, or by multiple devices of the same modality. The study information is modality-independent. Study Act clinical statements are only instantiated in the DICOM Object Catalog section; in other sections, the SOP Instance Observation is included directly.

523: Study Act Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.6.2.6'] | | | | | |
| entryRelationship | 1..\* | SHALL |  | [9219](#C_9219) |  |
| @typeCode | 1..1 | SHALL |  | [9220](#C_9220) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP |
| act | 1..1 | SHALL |  | [15937](#C_15937) |  |
| @classCode | 1..1 | SHALL |  | [9207](#C_9207) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [9208](#C_9208) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [9209](#C_9209) |  |
| @root | 1..1 | SHALL |  | [10533](#C_10533) | 2.16.840.1.113883.10.20.6.2.6 |
| id | 1..\* | SHALL |  | [9210](#C_9210) |  |
| @root | 1..1 | SHALL |  | [9213](#C_9213) |  |
| @extension | 0..0 | SHALL NOT |  | [9211](#C_9211) |  |
| text | 0..1 | MAY |  | [9215](#C_9215) |  |
| reference | 0..1 | SHOULD |  | [15995](#C_15995) |  |
| @value | 0..1 | SHOULD |  | [15996](#C_15996) |  |
| effectiveTime | 0..1 | SHOULD |  | [9216](#C_9216) |  |
| code | 1..1 | SHALL |  | [19172](#C_19172) |  |
| @code | 1..1 | SHALL |  | [19173](#C_19173) | 1.2.840.10008.2.16.4 (DCM) = 113014 |

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9207).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9208).
3. SHALL contain exactly one [1..1] templateId (CONF:9209) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.6" (CONF:10533).
4. SHALL contain at least one [1..\*] id (CONF:9210).

The @root contains the OID of the study instance UID since DICOM study ids consist only of an OID

* 1. Such ids SHALL contain exactly one [1..1] @root (CONF:9213).
  2. Such ids SHALL NOT contain [0..0] @extension (CONF:9211).

1. SHALL contain exactly one [1..1] code (CONF:19172).
   1. This code SHALL contain exactly one [1..1] @code="113014" (CodeSystem: DCM 1.2.840.10008.2.16.4 STATIC) (CONF:19173).

If present, the text element contains the description of the study.

1. MAY contain zero or one [0..1] text (CONF:9215).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15995).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15996).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15997).

If present, the effectiveTime contains the time the study was started

1. SHOULD contain zero or one [0..1] effectiveTime (CONF:9216).
2. SHALL contain at least one [1..\*] entryRelationship (CONF:9219) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9220).
   2. SHALL contain exactly one [1..1] [Series Act](#E_Series_Act) (templateId:2.16.840.1.113883.10.20.22.4.63) (CONF:15937).

Figure 199: Study Act Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.6.2.6" />

<id root="1.2.840.113619.2.62.994044785528.114289542805" />

<code code="113014" codeSystem="1.2.840.10008.2.16.4" codeSystemName="DCM" displayName="Study" />

<!-- \*\*\*\* Series \*\*\*\*-->

<entryRelationship typeCode="COMP">

<act classCode="ACT" moodCode="EVN">

. . .

</act>

</entryRelationship>

</act>

Substance Administered Act (NEW)

[act: templateId 2.16.840.1.113883.10.20.22.4.118 (open)]

524: Substance Administered Act (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medication Activity (V2)](#Medication_Activity_V2) (optional)  [Immunization Activity (V2)](#E_Immunization_Activity_V2) (optional) |  |

This template, like the Medication Administered template in QRDA, is used where there is a need to group a number of administrations into a larger act (e.g. to group all of the immunizations that are part of a series). The relationship between this template and component substance administrations can include a sequenceNumber, to indicate the component administration's ordering in the series.

525: Substance Administered Act (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| act[templateId/@root = '2.16.840.1.113883.10.20.22.4.118'] | | | | | |
| @classCode | 1..1 | SHALL |  | [31500](#C_31500) | 2.16.840.1.113883.5.6 (HL7ActClass) = ACT |
| @moodCode | 1..1 | SHALL |  | [31501](#C_31501) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [31502](#C_31502) |  |
| @root | 1..1 | SHALL |  | [31503](#C_31503) | 2.16.840.1.113883.10.20.22.4.118 |
| id | 1..\* | SHALL |  | [31504](#C_31504) |  |
| statusCode | 1..1 | SHALL |  | [31505](#C_31505) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| code | 1..1 | SHALL |  | [31506](#C_31506) |  |
| @code | 1..1 | SHALL |  | [31507](#C_31507) | 2.16.840.1.113883.6.96 (SNOMED CT) = 416118004 |
| @codeSystem | 1..1 | SHALL |  | [31508](#C_31508) | 2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96 |
| effectiveTime | 0..1 | MAY |  | [31509](#C_31509) |  |

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:31500).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:31501).
3. SHALL contain exactly one [1..1] templateId (CONF:31502) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.118" (CONF:31503).
4. SHALL contain at least one [1..\*] id (CONF:31504).
5. SHALL contain exactly one [1..1] code (CONF:31506).
   1. This code SHALL contain exactly one [1..1] @code="416118004" Administration (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:31507).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:31508).
6. SHALL contain exactly one [1..1] statusCode="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31505).
7. MAY contain zero or one [0..1] effectiveTime (CONF:31509).

Figure 200: Substance Administered Act Example

<act classCode="ACT" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.118" />

<id />

<code code="416118004" codeSystem="2.16.840.1.113883.6.96" />

<statusCode />

<effectiveTime />

</act>

Substance or Device Allergy - Intolerance Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.24.3.90.2 (open)]

526: Substance or Device Allergy - Intolerance Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Allergy Status Observation (DEPRECATED)](#E_Allergy_Status_Observation_DEPRECATED)  [Author Participation (NEW)](#U_Author_Participation_NEW)  [Reaction Observation (V2)](#Reaction_Observation_V2)  [Severity Observation (V2)](#E_Severity_Observation_V2) |

This template reflects a discrete observation about a patient's allergy or intolerance to a substance or device. Because it is a discrete observation, it will have a statusCode of "completed". The effectiveTime, also referred to as the “biologically relevant time” is the time at which the observation holds for the patient. For a provider seeing a patient in the clinic today, observing a history of penicillin allergy that developed five years ago, the effectiveTime is five years ago.

The effectiveTime of the Substance or Device Allergy - Intolerance Observation is the definitive indication of whether or not the underlying allergy/intolerance is resolved. If known to be resolved, then an effectiveTime/high would be present. If the date of resolution is not known, then effectiveTime/high will be present with a nullFlavor of "UNK".

527: Substance or Device Allergy - Intolerance Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.24.3.90.2'] | | | | | |
| entryRelationship | 0..1 | MAY |  | [16333](#C_16333) |  |
| @typeCode | 1..1 | SHALL |  | [16335](#C_16335) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [16334](#C_16334) | true |
| observation | 1..1 | SHALL |  | [16336](#C_16336) |  |
| entryRelationship | 0..\* | SHOULD |  | [16337](#C_16337) |  |
| @typeCode | 1..1 | SHALL |  | [16339](#C_16339) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = MFST |
| @inversionInd | 1..1 | SHALL |  | [16338](#C_16338) | true |
| observation | 1..1 | SHALL |  | [16340](#C_16340) |  |
| entryRelationship | 0..1 | MAY |  | [16341](#C_16341) |  |
| @typeCode | 1..1 | SHALL |  | [16342](#C_16342) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [16343](#C_16343) | true |
| observation | 1..1 | SHALL |  | [16344](#C_16344) |  |
| @classCode | 1..1 | SHALL |  | [16303](#C_16303) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [16304](#C_16304) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [16305](#C_16305) |  |
| @root | 1..1 | SHALL |  | [16306](#C_16306) | 2.16.840.1.113883.10.20.24.3.90.2 |
| id | 1..\* | SHALL |  | [16307](#C_16307) |  |
| code | 1..1 | SHALL |  | [16345](#C_16345) |  |
| @code | 1..1 | SHALL |  | [16346](#C_16346) | 2.16.840.1.113883.5.4 (ActCode) = ASSERTION |
| statusCode | 1..1 | SHALL |  | [16308](#C_16308) |  |
| @code | 1..1 | SHALL |  | [26354](#C_26354) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [16309](#C_16309) |  |
| low | 1..1 | SHALL |  | [31536](#C_31536) |  |
| high | 0..1 | MAY |  | [31537](#C_31537) |  |
| value | 1..1 | SHALL | CD | [16312](#C_16312) |  |
| @code | 1..1 | SHALL | CS | [16317](#C_16317) | 2.16.840.1.113883.3.88.12.3221.6.2 (Allergy/Adverse Event Type Value Set) |
| participant | 0..\* | SHOULD |  | [16318](#C_16318) |  |
| @typeCode | 1..1 | SHALL |  | [16319](#C_16319) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = CSM |
| participantRole | 1..1 | SHALL |  | [16320](#C_16320) |  |
| @classCode | 1..1 | SHALL |  | [16321](#C_16321) | 2.16.840.1.113883.5.110 (RoleClass) = MANU |
| playingEntity | 1..1 | SHALL |  | [16322](#C_16322) |  |
| @classCode | 1..1 | SHALL |  | [16323](#C_16323) | 2.16.840.1.113883.5.41 (EntityClass) = MMAT |
| code | 1..1 | SHALL |  | [16324](#C_16324) | Temp-ValueSet-substanceReactantForIntolerance (Substance / Reactant for Intolerance) |
| author | 0..\* | SHOULD |  | [31144](#C_31144) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:16303).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:16304).
3. SHALL contain exactly one [1..1] templateId (CONF:16305) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.24.3.90.2" (CONF:16306).
4. SHALL contain at least one [1..\*] id (CONF:16307).
5. SHALL contain exactly one [1..1] code (CONF:16345).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:16346).
6. SHALL contain exactly one [1..1] statusCode (CONF:16308).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:26354).

The effectiveTime/low (a.k.a. "onset date") asserts when the allergy/intolerance became biologically active. The effectiveTime/high (a.k.a. "resolution date") asserts when the allergy/intolerance became biologically resolved.

If the allergy/intolerance is known to be resolved, but the date of resolution is not known, then the high element SHALL be present, and the nullFlavor attribute SHALL be set to 'UNK'. Therefore, the existence of an high element within an allergy/intolerance does indicate that the allergy/intolerance has been resolved

1. SHALL contain exactly one [1..1] effectiveTime (CONF:16309).
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:31536).
   2. This effectiveTime MAY contain zero or one [0..1] high (CONF:31537).
2. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:16312).

The consumable participant points to the precise allergen or substance of intolerance. Because the consumable and the reaction are more clinically relevant than a categorization of the allergy/adverse event type, many systems will simply assign a fixed value here (e.g. "allergy to substance").

* 1. This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [Allergy/Adverse Event Type Value Set](#AllergyAdverse_Event_Type_Value_Set) 2.16.840.1.113883.3.88.12.3221.6.2 DYNAMIC (CONF:16317).

1. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31144).
2. SHOULD contain zero or more [0..\*] participant (CONF:16318).
   1. The participant, if present, SHALL contain exactly one [1..1] @typeCode="CSM" Consumable (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:16319).
   2. The participant, if present, SHALL contain exactly one [1..1] participantRole (CONF:16320).
      1. This participantRole SHALL contain exactly one [1..1] @classCode="MANU" Manufactured Product (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:16321).
      2. This participantRole SHALL contain exactly one [1..1] playingEntity (CONF:16322).
         1. This playingEntity SHALL contain exactly one [1..1] @classCode="MMAT" Manufactured Material (CodeSystem: EntityClass 2.16.840.1.113883.5.41 STATIC) (CONF:16323).
         2. This playingEntity SHALL contain exactly one [1..1] code, which MAY be selected from ValueSet [Substance / Reactant for Intolerance](#Substance__Reactant_for_Intolerance) Temp-ValueSet-substanceReactantForIntolerance DYNAMIC (CONF:16324).
3. MAY contain zero or one [0..1] entryRelationship (CONF:16333) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:16335).
   2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:16334).
   3. SHALL contain exactly one [1..1] [Allergy Status Observation (DEPRECATED)](#E_Allergy_Status_Observation_DEPRECATED) (templateId:2.16.840.1.113883.10.20.22.4.28.2) (CONF:16336).
4. SHOULD contain zero or more [0..\*] entryRelationship (CONF:16337) such that it
   1. SHALL contain exactly one [1..1] @typeCode="MFST" Is Manifestation of (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:16339).
   2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:16338).
   3. SHALL contain exactly one [1..1] [Reaction Observation (V2)](#Reaction_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.9.2) (CONF:16340).
5. MAY contain zero or one [0..1] entryRelationship (CONF:16341) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:16342).
   2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:16343).
   3. SHALL contain exactly one [1..1] [Severity Observation (V2)](#E_Severity_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.8.2) (CONF:16344).

528: Allergy/Adverse Event Type Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Allergy/Adverse Event Type Value Set 2.16.840.1.113883.3.88.12.3221.6.2  This describes the type of product and intolerance suffered by the patient | | |
| Code | Code System | Print Name |
| 419199007 | SNOMED CT | Allergy to substance (disorder) |
| 416098002 | SNOMED CT | Drug allergy (disorder) |
| 59037007 | SNOMED CT | Drug intolerance (disorder) |
| 414285001 | SNOMED CT | Food allergy (disorder) |
| 235719002 | SNOMED CT | Food intolerance (disorder) |
| 420134006 | SNOMED CT | Propensity to adverse reactions (disorder) |
| 419511003 | SNOMED CT | Propensity to adverse reactions to drug (disorder) |
| 418471000 | SNOMED CT | Propensity to adverse reactions to food (disorder) |
| 418038007 | SNOMED CT | Propensity to adverse reactions to substance (disorder) |
| 232347008 | SNOMED CT | Dander (animal) allergy |
| ... | | |

529: Substance / Reactant for Intolerance

|  |  |  |
| --- | --- | --- |
| Value Set: Substance / Reactant for Intolerance Temp-ValueSet-substanceReactantForIntolerance  A grouping value set consisting of the following value sets derived from NDFRT, RXNORM, UNII, SNOMED CT. The intention is that instance content will be determined from the concepts in this grouping value set but values will be determined by searching through the grouped value sets in priority order, and when a concept matching the intension (by preferred name or any synonym), only that particular concept identifier will be included, and not any additional similar or matching identifiers. In this way overlaps in concept representation will be resolved. NDFRT value set will only have drug class identifiers to be defined by work of PCVSC that is expected to include concepts that are commonly associated with intolerances. This will not be a full list of all drug classes. Until this is completed, the existing value set is included. At some point the UNII value set , which is intended to represent mostly non-active drug ingredients, may be restricted to only identifiers that do not have exact maps in RXNORM.  Priority order for concept determination is: NDFRT, RXNORM, UNII, SNOMED CT.  (Final VSAC URL pending)  Valueset Source: <https://vsac.nlm.nih.gov/> | | |
| Code | Code System | Print Name |
| 18867 | RxNorm | benazepril |
| 196500 | RxNorm | Coversyl |
| 83515 | RxNorm | eprosartan |
| 237057 | RxNorm | lepirudin |
| ... | | |

Figure 201: Substance or Device Allergy - Intolerance

<entry>

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.24.3.90.2" />

<id root="4adc1020-7b14-11db-9fe1-0800200c9a63"/>

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<statusCode code="completed"/>

<effectiveTime>

<low value="20060501"/>

<high value="20060503" />

</effectiveTime>

<value xsi:type="CD" code="419511003"

displayName="Propensity to adverse reactions to drug"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"/>

<participant typeCode="CSM">

<participantRole classCode="MANU">

<playingEntity classCode="MMAT">

<code code="763049" displayName="Codeine 30mg/ml"

codeSystem="2.16.840.1.113883.6.88" codeSystemName="RxNorm"/>

</playingEntity>

</participantRole>

</participant>

</observation>

</entry>

Allergy - Intolerance Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.7.2 (open)]

530: Allergy - Intolerance Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Allergy Concern Act (V2)](#E_Allergy_Concern_Act_V2) (required)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Author Participation (NEW)](#U_Author_Participation_NEW)  [Reaction Observation (V2)](#Reaction_Observation_V2)  [Severity Observation (V2)](#E_Severity_Observation_V2) |

This template reflects a discrete observation about a patient's allergy or intolerance. Because it is a discrete observation, it will have a statusCode of "completed". The effectiveTime, also referred to as the “biologically relevant time” is the time at which the observation holds for the patient. For a provider seeing a patient in the clinic today, observing a history of penicillin allergy that developed five years ago, the effectiveTime is five years ago.

The effectiveTime of the Allergy - Intolerance Observation is the definitive indication of whether or not the underlying allergy/intolerance is resolved. If known to be resolved, then an effectiveTime/high would be present. If the date of resolution is not known, then effectiveTime/high will be present with a nullFlavor of "UNK".

NOTE: The agent responsible for an allergy or adverse reaction is not always a manufactured material (for example, food allergies), nor is it necessarily consumed. The following constraints reflect limitations in the base CDA R2 specification, and should be used to represent any type of responsible agent.

531: Allergy - Intolerance Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.7.2'] | | | | | |
| entryRelationship | 0..\* | SHOULD |  | [7447](#C_7447) |  |
| @typeCode | 1..1 | SHALL |  | [7907](#C_7907) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = MFST |
| @inversionInd | 1..1 | SHALL |  | [7449](#C_7449) | true |
| observation | 1..1 | SHALL |  | [15955](#C_15955) |  |
| entryRelationship | 0..1 | MAY |  | [9961](#C_9961) |  |
| @typeCode | 1..1 | SHALL |  | [9962](#C_9962) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ |
| @inversionInd | 1..1 | SHALL |  | [9964](#C_9964) | true |
| observation | 1..1 | SHALL |  | [15956](#C_15956) |  |
| @classCode | 1..1 | SHALL |  | [7379](#C_7379) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [7380](#C_7380) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7381](#C_7381) |  |
| @root | 1..1 | SHALL |  | [10488](#C_10488) | 2.16.840.1.113883.10.20.22.4.7.2 |
| id | 1..\* | SHALL |  | [7382](#C_7382) |  |
| code | 1..1 | SHALL |  | [15947](#C_15947) |  |
| @code | 1..1 | SHALL |  | [15948](#C_15948) | 2.16.840.1.113883.5.4 (ActCode) = ASSERTION |
| statusCode | 1..1 | SHALL |  | [19084](#C_19084) |  |
| @code | 1..1 | SHALL |  | [19085](#C_19085) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [7387](#C_7387) |  |
| low | 1..1 | SHALL |  | [31538](#C_31538) |  |
| high | 0..1 | MAY |  | [31539](#C_31539) |  |
| value | 1..1 | SHALL | CD | [7390](#C_7390) | 2.16.840.1.113883.3.88.12.3221.6.2 (Allergy/Adverse Event Type Value Set) |
| participant | 1..1 | SHALL |  | [7402](#C_7402) |  |
| @typeCode | 1..1 | SHALL |  | [7403](#C_7403) | 2.16.840.1.113883.5.90 (HL7ParticipationType) = CSM |
| participantRole | 1..1 | SHALL |  | [7404](#C_7404) |  |
| @classCode | 1..1 | SHALL |  | [7405](#C_7405) | 2.16.840.1.113883.5.110 (RoleClass) = MANU |
| playingEntity | 1..1 | SHALL |  | [7406](#C_7406) |  |
| @classCode | 1..1 | SHALL |  | [7407](#C_7407) | 2.16.840.1.113883.5.41 (EntityClass) = MMAT |
| code | 1..1 | SHALL |  | [7419](#C_7419) | Temp-ValueSet-substanceReactantForIntolerance (Substance / Reactant for Intolerance) |
| author | 0..\* | SHOULD |  | [31143](#C_31143) |  |
| @negationInd | 0..1 | MAY |  | [31526](#C_31526) |  |
| text | 0..1 | SHOULD |  | [31527](#C_31527) |  |
| reference | 0..1 | SHOULD |  | [31528](#C_31528) |  |
| @value | 1..1 | SHALL |  | [31529](#C_31529) |  |

1. Conforms to [Substance or Device Allergy - Intolerance Observation (V2)](#E_Substance_or_Device_Allergy__V2) template (2.16.840.1.113883.10.20.24.3.90.2).
2. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7379).
3. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7380).

Use negationInd="true" to indicate that the allergy was not observed.

1. MAY contain zero or one [0..1] @negationInd (CONF:31526).
2. SHALL contain exactly one [1..1] templateId (CONF:7381) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.7.2" (CONF:10488).
3. SHALL contain at least one [1..\*] id (CONF:7382).
4. SHALL contain exactly one [1..1] code (CONF:15947).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:15948).
5. SHOULD contain zero or one [0..1] text (CONF:31527).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:31528).
      1. The reference, if present, SHALL contain exactly one [1..1] @value (CONF:31529).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:31530).
6. SHALL contain exactly one [1..1] statusCode (CONF:19084).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19085).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:7387).  
   Note: If the allergy/intolerance is known to be resolved, but the date of resolution is not known, then the high element SHALL be present, and the nullFlavor attribute SHALL be set to 'UNK'. Therefore, the existence of an high element within an allergy/intolerance does indicate that the allergy/intolerance has been resolved.
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:31538).  
      Note: The effectiveTime/low (a.k.a. "onset date") asserts when the allergy/intolerance became biologically active.
   2. This effectiveTime MAY contain zero or one [0..1] high (CONF:31539).  
      Note: The effectiveTime/high (a.k.a. "resolution date") asserts when the allergy/intolerance became biologically resolved.
8. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [Allergy/Adverse Event Type Value Set](#AllergyAdverse_Event_Type_Value_Set) 2.16.840.1.113883.3.88.12.3221.6.2 DYNAMIC (CONF:7390).  
   Note: The consumable participant points to the precise allergen or substance of intolerance. Because the consumable and the reaction are more clinically relevant than a categorization of the allergy/adverse event type, many systems will simply assign a fixed value here (e.g. "allergy to substance").
9. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31143).
10. SHALL contain exactly one [1..1] participant (CONF:7402) such that it
    1. SHALL contain exactly one [1..1] @typeCode="CSM" Consumable (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:7403).
    2. SHALL contain exactly one [1..1] participantRole (CONF:7404).
       1. This participantRole SHALL contain exactly one [1..1] @classCode="MANU" Manufactured Product (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:7405).
       2. This participantRole SHALL contain exactly one [1..1] playingEntity (CONF:7406).
          1. This playingEntity SHALL contain exactly one [1..1] @classCode="MMAT" Manufactured Material (CodeSystem: EntityClass 2.16.840.1.113883.5.41 STATIC) (CONF:7407).
          2. This playingEntity SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet [Substance / Reactant for Intolerance](#Substance__Reactant_for_Intolerance) Temp-ValueSet-substanceReactantForIntolerance DYNAMIC (CONF:7419).
11. SHOULD contain zero or more [0..\*] entryRelationship (CONF:7447) such that it
    1. SHALL contain exactly one [1..1] @typeCode="MFST" Is Manifestation of (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7907).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7449).
    3. SHALL contain exactly one [1..1] [Reaction Observation (V2)](#Reaction_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.9.2) (CONF:15955).
12. MAY contain zero or one [0..1] entryRelationship (CONF:9961) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9962).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:9964).
    3. SHALL contain exactly one [1..1] [Severity Observation (V2)](#E_Severity_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.8.2) (CONF:15956).

532: Allergy/Adverse Event Type Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Allergy/Adverse Event Type Value Set 2.16.840.1.113883.3.88.12.3221.6.2  This describes the type of product and intolerance suffered by the patient | | |
| Code | Code System | Print Name |
| 419199007 | SNOMED CT | Allergy to substance (disorder) |
| 416098002 | SNOMED CT | Drug allergy (disorder) |
| 59037007 | SNOMED CT | Drug intolerance (disorder) |
| 414285001 | SNOMED CT | Food allergy (disorder) |
| 235719002 | SNOMED CT | Food intolerance (disorder) |
| 420134006 | SNOMED CT | Propensity to adverse reactions (disorder) |
| 419511003 | SNOMED CT | Propensity to adverse reactions to drug (disorder) |
| 418471000 | SNOMED CT | Propensity to adverse reactions to food (disorder) |
| 418038007 | SNOMED CT | Propensity to adverse reactions to substance (disorder) |
| 232347008 | SNOMED CT | Dander (animal) allergy |
| ... | | |

533: Substance / Reactant for Intolerance

|  |  |  |
| --- | --- | --- |
| Value Set: Substance / Reactant for Intolerance Temp-ValueSet-substanceReactantForIntolerance  A grouping value set consisting of the following value sets derived from NDFRT, RXNORM, UNII, SNOMED CT. The intention is that instance content will be determined from the concepts in this grouping value set but values will be determined by searching through the grouped value sets in priority order, and when a concept matching the intension (by preferred name or any synonym), only that particular concept identifier will be included, and not any additional similar or matching identifiers. In this way overlaps in concept representation will be resolved. NDFRT value set will only have drug class identifiers to be defined by work of PCVSC that is expected to include concepts that are commonly associated with intolerances. This will not be a full list of all drug classes. Until this is completed, the existing value set is included. At some point the UNII value set , which is intended to represent mostly non-active drug ingredients, may be restricted to only identifiers that do not have exact maps in RXNORM.  Priority order for concept determination is: NDFRT, RXNORM, UNII, SNOMED CT.  (Final VSAC URL pending)  Valueset Source: <https://vsac.nlm.nih.gov/> | | |
| Code | Code System | Print Name |
| 18867 | RxNorm | benazepril |
| 196500 | RxNorm | Coversyl |
| 83515 | RxNorm | eprosartan |
| 237057 | RxNorm | lepirudin |
| ... | | |

Figure 202: Allergy - Intolerance Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.7.2" />

<id root="4adc1020-7b14-11db-9fe1-0800200c9a66" />

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<statusCode code="completed" />

<effectiveTime>

<!-- If it is unknown when the allergy began, this effectiveTime SHALL contain low/@nullFLavor="UNK"-->

<low value="20070501" />

<!-- If the allergy is no longer a concern, this effectiveTime MAY contain zero or one [0..1] high-->

</effectiveTime>

<value xsi:type="CD" code="419511003"

displayName="Propensity to adverse reactions to drug"

codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT">

<originalText>

<!--This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1)-->

<reference value="#reaction1" />

</originalText>

</value>

<participant typeCode="CSM">

<participantRole classCode="MANU">

<playingEntity classCode="MMAT">

<code code="314422" displayName="ALLERGENIC EXTRACT, PENICILLIN"

codeSystem="2.16.840.1.113883.6.88" codeSystemName="RxNorm">

<originalText>

<reference value="#reaction1" />

</originalText>

</code>

</playingEntity>

</participantRole>

</participant>

<entryRelationship typeCode="SUBJ" inversionInd="true">

<observation>

<templateId root="2.16.840.1.113883.10.20.22.4.28" />

<!-- Allergy status observation template -->

...

</observation>

</entryRelationship>

<entryRelationship typeCode="MFST" inversionInd="true">

<observation>

<templateId root="2.16.840.1.113883.10.20.22.4.9.2" />

<!-- Reaction observation template (V2) -->

...

</observation>

</entryRelationship>

<entryRelationship typeCode="SUBJ" inversionInd="true">

<observation>

<templateId root="2.16.840.1.113883.10.20.22.4.8" />

<!-- \*\* Severity observation template \*\* -->

...

</observation>

</entryRelationship>

</observation>

Text Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.12 (open)]

534: Text Observation Contexts

| Contained By: | Contains: |
| --- | --- |
| [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (optional) | [Quantity Measurement Observation](#E_Quantity_Measurement_Observation)  [SOP Instance Observation](#E_SOP_Instance_Observation) |

DICOM Template 2000 specifies that Imaging Report Elements of Value Type Text are contained in sections. The Imaging Report Elements are inferred from Basic Diagnostic Imaging Report Observations that consist of image references and measurements (linear, area, volume, and numeric). Text DICOM Imaging Report Elements in this context are mapped to CDA text observations that are section components and are related to the SOP Instance Observations (templateId 2.16.840.1.113883.10.20.6.2.8) or Quantity Measurement Observations (templateId 2.16.840.1.113883.10.20.6.2.14) by the SPRT (Support) act relationship.

A Text Observation is required if the findings in the section text are represented as inferred from SOP Instance Observations.

535: Text Observation Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.6.2.12'] | | | | | |
| entryRelationship | 0..\* | MAY |  | [9301](#C_9301) |  |
| @typeCode | 1..1 | SHALL |  | [9302](#C_9302) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT |
| observation | 1..1 | SHALL |  | [15942](#C_15942) |  |
| entryRelationship | 0..\* | MAY |  | [9298](#C_9298) |  |
| @typeCode | 1..1 | SHALL |  | [9299](#C_9299) | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT |
| observation | 1..1 | SHALL |  | [15941](#C_15941) |  |
| @classCode | 1..1 | SHALL |  | [9288](#C_9288) | 2.16.840.1.113883.5.4 (ActCode) = OBS |
| @moodCode | 1..1 | SHALL |  | [9289](#C_9289) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [9290](#C_9290) |  |
| @root | 1..1 | SHALL |  | [10534](#C_10534) | 2.16.840.1.113883.10.20.6.2.12 |
| code | 1..1 | SHALL |  | [9291](#C_9291) |  |
| value | 1..1 | SHALL | ED | [9292](#C_9292) |  |
| effectiveTime | 0..1 | SHOULD |  | [9294](#C_9294) |  |
| text | 0..1 | MAY |  | [9295](#C_9295) |  |
| reference | 0..1 | SHOULD |  | [15938](#C_15938) |  |
| @value | 0..1 | SHOULD |  | [15939](#C_15939) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:9288).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9289).
3. SHALL contain exactly one [1..1] templateId (CONF:9290) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.12" (CONF:10534).
4. SHALL contain exactly one [1..1] code (CONF:9291).
5. MAY contain zero or one [0..1] text (CONF:9295).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15938).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15939).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15940).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:9294).
7. SHALL contain exactly one [1..1] value with @xsi:type="ED" (CONF:9292).
8. MAY contain zero or more [0..\*] entryRelationship (CONF:9298) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9299).
   2. SHALL contain exactly one [1..1] [SOP Instance Observation](#E_SOP_Instance_Observation) (templateId:2.16.840.1.113883.10.20.6.2.8) (CONF:15941).
9. MAY contain zero or more [0..\*] entryRelationship (CONF:9301) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9302).
   2. SHALL contain exactly one [1..1] [Quantity Measurement Observation](#E_Quantity_Measurement_Observation) (templateId:2.16.840.1.113883.10.20.6.2.14) (CONF:15942).

Figure 203: Text Observation Example

<text>

<paragraph>

<caption>Finding</caption>

<content ID="Fndng2">The cardiomediastinum is within normal limits. The trachea is midline. The previously described opacity at the medial right lung base has cleared. There are no new infiltrates. There is a new round density at the left hilus, superiorly (diameter about 45mm). A CT scan is recommended for further evaluation. The pleural spaces are clear. The visualized musculoskeletal structures and the upper abdomen are stable and unremarkable.</content>

</paragraph>

...

</text>

<entry>

<observation classCode="OBS" moodCode="EVN">

<!-- Text Observation -->

<templateId root="2.16.840.1.113883.10.20.6.2.12"/>

<code code="121071" codeSystem="1.2.840.10008.2.16.4"

codeSystemName="DCM" displayName="Finding"/>

<value xsi:type="ED">

<reference value="#Fndng2"/>

</value>

...

<!-- entryRelationships to SOP Instance Observations and Quantity

Measurement Observations may go here -->

</observation>

</entry>

Tobacco Use (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.85.2 (open)]

536: Tobacco Use (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Social History Section (V2)](#S_Social_History_Section_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Author Participation (NEW)](#U_Author_Participation_NEW) |

This template represents a patient’s tobacco use.

All the types of tobacco use are represented using the codes from the tobacco use and exposure-finding hierarchy in SNOMED CT, including codes required for recording smoking status in Meaningful Use Stage 2.

The effectiveTime element is used to describe dates associated with the patient's tobacco use.

537: Tobacco Use (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.85.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [16558](#C_16558) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [16559](#C_16559) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [16566](#C_16566) |  |
| @root | 1..1 | SHALL |  | [16567](#C_16567) | 2.16.840.1.113883.10.20.22.4.85.2 |
| code | 1..1 | SHALL |  | [19174](#C_19174) |  |
| @code | 1..1 | SHALL |  | [19175](#C_19175) | 2.16.840.1.113883.6.96 (SNOMED CT) = 229819007 |
| statusCode | 1..1 | SHALL |  | [16561](#C_16561) |  |
| @code | 1..1 | SHALL |  | [19118](#C_19118) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [16564](#C_16564) |  |
| low | 1..1 | SHALL |  | [16565](#C_16565) |  |
| high | 0..1 | MAY |  | [31431](#C_31431) |  |
| value | 1..1 | SHALL | CD | [16562](#C_16562) |  |
| @code | 1..1 | SHALL |  | [16563](#C_16563) | 2.16.840.1.113883.11.20.9.41 (Tobacco Use) |
| author | 0..\* | SHOULD |  | [31152](#C_31152) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:16558).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:16559).
3. SHALL contain exactly one [1..1] templateId (CONF:16566) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.85.2" (CONF:16567).
4. SHALL contain exactly one [1..1] code (CONF:19174).
   1. This code SHALL contain exactly one [1..1] @code="229819007" Tobacco use and exposure (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:19175).
5. SHALL contain exactly one [1..1] statusCode (CONF:16561).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19118).
6. SHALL contain exactly one [1..1] effectiveTime (CONF:16564).
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:16565).  
      Note: The low value represents when the tobacco use or exposure began.
   2. This effectiveTime MAY contain zero or one [0..1] high (CONF:31431).  
      Note: The high value represents when the tobacco use or exposure ended.
7. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:16562).
   1. This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [Tobacco Use](#Tobacco_Use) 2.16.840.1.113883.11.20.9.41 DYNAMIC (CONF:16563).
8. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31152).

538: Tobacco Use

|  |  |  |
| --- | --- | --- |
| Value Set: Tobacco Use 2.16.840.1.113883.11.20.9.41 | | |
| Code | Code System | Print Name |
| 81703003 | SNOMED CT | Chews tobacco |
| 228494002 | SNOMED CT | Snuff user |
| 59978006 | SNOMED CT | Cigar smoker |
| 43381005 | SNOMED CT | Passive smoker |
| 449868002 | SNOMED CT | Current every day smoker |
| 230059006 | SNOMED CT | Current some day smoker |
| 8517006 | SNOMED CT | Former smoker |
| 266919005 | SNOMED CT | Never smoker |
| 77176002 | SNOMED CT | Smoker, current status unknown |
| 266927001 | SNOMED CT | Unknown if ever smoked |
| ... | | |

Figure 204: Tobacco Use Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.85.2"/>

<id root="45efb604-7049-4a2e-ad33-d38556c9636c"/>

<code code="229819007" codeSystem="2.16.840.1.113883.6.96"

displayName="Tobacco use and exposure"/>

<statusCode code="completed"/>

<effectiveTime>

<!-- The low value reflects the start date of the current or

past tobacco use observation -->

<low value="20090214"/>

<!-- The high value reflects the end date of the tobacco use

if not currently observed -->

<high value="20110215"/>

</effectiveTime>

<value xsi:type="CD" code="160604004"

displayName="Moderate cigarette smoker, 10-19/day"

codeSystem="2.16.840.1.113883.6.96"/>

<author>

<templateId root="2.16.840.1.113883.10.20.22.4.119"/>

<time value="201209101145-0800"/>

. . .

</author>

</observation>

Current Smoking Status (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.78.2 (open)]

539: Current Smoking Status (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Social History Section (V2)](#S_Social_History_Section_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional) | [Author Participation (NEW)](#U_Author_Participation_NEW) |

This template constrains the Tobacco Use template to represent the current smoking status of the patient as specified in Meaningful Use (MU) Stage 2 requirements. Historic smoking status observations as well as details about the smoking habit (e.g., how many per day) would be represented in the Tobacco Use template.

The effectiveTime element reflects the date/time when the patient's current smoking status was observed. Details regarding the time period when the patient is/was smoking would be recorded in the Tobacco Use template.

If the patient's current smoking status is unknown, the value element must be populated with SNOMED CT code '266927001' to communicate 'Unknown if ever smoked' from the Current Smoking Status Value Set.

540: Current Smoking Status (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.78.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [14806](#C_14806) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [14807](#C_14807) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [14815](#C_14815) |  |
| @root | 1..1 | SHALL |  | [14816](#C_14816) | 2.16.840.1.113883.10.20.22.4.78.2 |
| code | 1..1 | SHALL |  | [19170](#C_19170) |  |
| @code | 1..1 | SHALL |  | [31039](#C_31039) | 2.16.840.1.113883.6.96 (SNOMED CT) = 229819007 |
| statusCode | 1..1 | SHALL |  | [14809](#C_14809) |  |
| @code | 1..1 | SHALL |  | [19116](#C_19116) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [14814](#C_14814) |  |
| value | 1..1 | SHALL | CD | [14810](#C_14810) |  |
| @code | 1..1 | SHALL |  | [14817](#C_14817) | 2.16.840.1.113883.11.20.9.38.2 (Current Smoking Status) |
| author | 0..\* | SHOULD |  | [31148](#C_31148) |  |

1. Conforms to [Tobacco Use (V2)](#Tobacco_Use_V2) template (2.16.840.1.113883.10.20.22.4.85.2).
2. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14806).
3. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14807).
4. SHALL contain exactly one [1..1] templateId (CONF:14815) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.78.2" (CONF:14816).
5. SHALL contain exactly one [1..1] code (CONF:19170).
   1. This code SHALL contain exactly one [1..1] @code="229819007" Tobacco use and exposure (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:31039).
6. SHALL contain exactly one [1..1] statusCode (CONF:14809).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19116).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:14814).  
   Note: The value for effectiveTime reflects when the patient's current smoking status was observed.
8. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:14810).
   1. This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet [Current Smoking Status](#Current_Smoking_Status) 2.16.840.1.113883.11.20.9.38.2 DYNAMIC 2013-07-25 (CONF:14817).
   2. If the patient's current smoking status is unknown, @code SHALL contain '266927001' (Unknown if ever smoked) from Current Smoking Status Value Set (2.16.840.1.113883.10.22.4.78.2) (CONF:31019).
9. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31148).

541: Current Smoking Status

|  |  |  |
| --- | --- | --- |
| Value Set: Current Smoking Status 2.16.840.1.113883.11.20.9.38.2  This value set indicates the current smoking status of a patient using codes specified for Meaningful Use Stage 2. | | |
| Code | Code System | Print Name |
| 449868002 | SNOMED CT | Current every day smoker |
| 428041000124106 | SNOMED CT | Current some day smoker |
| 8517006 | SNOMED CT | Former smoker |
| 77176002 | SNOMED CT | Smoker, current status unknown |
| 266927001 | SNOMED CT | Unknown if ever smoked |
| 428071000124103 | SNOMED CT | Heavy tobacco smoker |
| 428061000124105 | SNOMED CT | Light tobacco smoker |

Figure 205: Current Smoking Status Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.78.2"/>

<code code="229819007" codeSystem="2.16.840.1.113883.6.96"

displayName="Tobacco use and exposure"/>

<statusCode code="completed"/>

<!-- The effectiveTime reflects when the current smoking status was observed. -->

<effectiveTime value="20120910"/>

<!-- The value represents the patient's smoking status currently observed. -->

<value xsi:type="CD" code="8517006" displayName="Former smoker"

codeSystem="2.16.840.1.113883.6.96"/>

<author>

<templateId root="2.16.840.1.113883.10.20.22.4.119"/>

<time value="201209101145-0800"/>

<assignedAuthor>

<id extension="555555555" root="1.1.1.1.1.1.1.2"/>

<addr>

<streetAddressLine>1004 Health Drive</streetAddressLine>

<city>Portland</city>

<state>OR</state>

<postalCode>99123</postalCode>

<country>US</country>

</addr>

<telecom use="WP" value="tel:+1(555)555-1004"/>

<assignedPerson>

<name>

<given>Patricia</given>

<given qualifier="CL">Patty</given>

<family>Primary</family>

<suffix qualifier="AC">M.D.</suffix>

</name>

</assignedPerson>

<representedOrganization>

<name>The DoctorsTogether Physician Group</name>

</representedOrganization>

</assignedAuthor>

</author>

</observation>

Vital Sign Observation (V2)

[observation: templateId 2.16.840.1.113883.10.20.22.4.27.2 (open)]

542: Vital Sign Observation (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Vital Signs Organizer (V2)](#E_Vital_Signs_Organizer_V2) (required) | [Author Participation (NEW)](#U_Author_Participation_NEW) |

Vital signs are represented as are other results, with additional vocabulary constraints.

543: Vital Sign Observation (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.27.2'] | | | | | |
| @classCode | 1..1 | SHALL |  | [7297](#C_7297) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [7298](#C_7298) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7299](#C_7299) |  |
| @root | 1..1 | SHALL |  | [10527](#C_10527) | 2.16.840.1.113883.10.20.22.4.27.2 |
| id | 1..\* | SHALL |  | [7300](#C_7300) |  |
| code | 1..1 | SHALL |  | [7301](#C_7301) | 2.16.840.1.113883.3.88.12.80.62 (Vital Sign Result Value Set) |
| text | 0..1 | SHOULD |  | [7302](#C_7302) |  |
| reference | 0..1 | SHOULD |  | [15943](#C_15943) |  |
| @value | 0..1 | SHOULD |  | [15944](#C_15944) |  |
| statusCode | 1..1 | SHALL |  | [7303](#C_7303) |  |
| @code | 1..1 | SHALL |  | [19119](#C_19119) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [7304](#C_7304) |  |
| value | 1..1 | SHALL | PQ | [7305](#C_7305) |  |
| @unit | 1..1 | SHALL |  | [31579](#C_31579) | 2.16.840.1.113883.6.8 (UCUM) |
| interpretationCode | 0..1 | MAY |  | [7307](#C_7307) |  |
| methodCode | 0..1 | MAY | SET<CE> | [7308](#C_7308) |  |
| targetSiteCode | 0..1 | MAY | SET<CD> | [7309](#C_7309) |  |
| author | 0..\* | SHOULD |  | [7310](#C_7310) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7297).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7298).
3. SHALL contain exactly one [1..1] templateId (CONF:7299) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.27.2" (CONF:10527).
4. SHALL contain at least one [1..\*] id (CONF:7300).
5. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet [Vital Sign Result Value Set](#Vital_Sign_Result_Value_Set) 2.16.840.1.113883.3.88.12.80.62 DYNAMIC (CONF:7301).
6. SHOULD contain zero or one [0..1] text (CONF:7302).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15943).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15944).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15945).
7. SHALL contain exactly one [1..1] statusCode (CONF:7303).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19119).
8. SHALL contain exactly one [1..1] effectiveTime (CONF:7304).
9. SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:7305).
   1. This value SHALL contain exactly one [1..1] @unit, which SHALL be selected from CodeSystem UCUM (2.16.840.1.113883.6.8) (CONF:31579).
10. MAY contain zero or one [0..1] interpretationCode (CONF:7307).
11. MAY contain zero or one [0..1] methodCode (CONF:7308).
12. MAY contain zero or one [0..1] targetSiteCode (CONF:7309).
13. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:7310).

544: Vital Sign Result Value Set

|  |  |  |
| --- | --- | --- |
| Value Set: Vital Sign Result Value Set 2.16.840.1.113883.3.88.12.80.62  This identifies the vital sign result type | | |
| Code | Code System | Print Name |
| 8310-5 | LOINC | Body Temperature |
| 8462-4 | LOINC | BP Diastolic |
| 8480-6 | LOINC | BP Systolic |
| 8287-5 | LOINC | Head Circumference |
| 8867-4 | LOINC | Heart Rate |
| 8302-2 | LOINC | Height |
| 8306-3 | LOINC | Height (Lying) |
| 2710-2 | LOINC | O2 % BldC Oximetry |
| 9279-1 | LOINC | Respiratory Rate |
| 3141-9 | LOINC | Weight Measured |
| ... | | |

Figure 206: Vital Sign Observation Example

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.27.2" />

<!-- Vital Sign Observation template -->

<id root="c6f88321-67ad-11db-bd13-0800200c9a66" />

<code code="8302-2" codeSystem="2.16.840.1.113883.6.1"

codeSystemName="LOINC" displayName="Height" />

<statusCode code="completed" />

<effectiveTime value="20121114" />

<value xsi:type="PQ" value="177" unit="cm" />

<interpretationCode code="N"

codeSystem="2.16.840.1.113883.5.83" />

....

</observation>

Vital Signs Organizer (V2)

[organizer: templateId 2.16.840.1.113883.10.20.22.4.26.2 (open)]

545: Vital Signs Organizer (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Vital Signs Section (entries optional) (V2)](#Vital_Signs_Section_entries_optional_V2) (optional)  [Vital Signs Section (entries required) (V2)](#S_Vital_Signs_Section_entries_required_) (required) | [Author Participation (NEW)](#U_Author_Participation_NEW)  [Vital Sign Observation (V2)](#E_Vital_Sign_Observation_V2) |

The Vital Signs Organizer groups vital signs, which is similar to the Result Organizer, but with further constraints.

An appropriate nullFlavor can be used when the organizer/code or organizer/id is unknown.

546: Vital Signs Organizer (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| organizer[templateId/@root = '2.16.840.1.113883.10.20.22.4.26.2'] | | | | | |
| component | 1..\* | SHALL |  | [7285](#C_7285) |  |
| observation | 1..1 | SHALL |  | [15946](#C_15946) |  |
| @classCode | 1..1 | SHALL |  | [7279](#C_7279) | 2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER |
| @moodCode | 1..1 | SHALL |  | [7280](#C_7280) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [7281](#C_7281) |  |
| @root | 1..1 | SHALL |  | [10528](#C_10528) | 2.16.840.1.113883.10.20.22.4.26.2 |
| id | 1..\* | SHALL |  | [7282](#C_7282) |  |
| code | 1..1 | SHALL |  | [19176](#C_19176) |  |
| @code | 1..1 | SHALL |  | [19177](#C_19177) | 2.16.840.1.113883.6.96 (SNOMED CT) = 46680005 |
| @codeSystem | 1..1 | SHALL |  | [30901](#C_30901) | 2.16.840.1.113883.6.96 |
| statusCode | 1..1 | SHALL |  | [7284](#C_7284) |  |
| @code | 1..1 | SHALL |  | [19120](#C_19120) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [7288](#C_7288) |  |
| author | 0..\* | SHOULD |  | [31153](#C_31153) |  |

1. SHALL contain exactly one [1..1] @classCode="CLUSTER" CLUSTER (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7279).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7280).
3. SHALL contain exactly one [1..1] templateId (CONF:7281) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.26.2" (CONF:10528).
4. SHALL contain at least one [1..\*] id (CONF:7282).
5. SHALL contain exactly one [1..1] code (CONF:19176).
   1. This code SHALL contain exactly one [1..1] @code="46680005" Vital signs (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:19177).
   2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CONF:30901).
6. SHALL contain exactly one [1..1] statusCode (CONF:7284).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19120).

The effectiveTime represents clinically effective time of the measurement, which is most likely when the measurement was performed (e.g., a BP measurement).

1. SHALL contain exactly one [1..1] effectiveTime (CONF:7288).
2. SHOULD contain zero or more [0..\*] [Author Participation (NEW)](#U_Author_Participation_NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31153).
3. SHALL contain at least one [1..\*] component (CONF:7285) such that it
   1. SHALL contain exactly one [1..1] [Vital Sign Observation (V2)](#E_Vital_Sign_Observation_V2) (templateId:2.16.840.1.113883.10.20.22.4.27.2) (CONF:15946).

Figure 207: Vital Signs Organizer Example

<organizer classCode="CLUSTER" moodCode="EVN">

<!-- \*\* Vital signs organizer \*\* -->

<templateId root="2.16.840.1.113883.10.20.22.4.26.2" />

<id root="24f6ad18-c512-40fc-82bd-1e131aa9e52b" />

<code code="46680005" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED -CT" displayName="Vital signs" />

<statusCode code="completed" />

<effectiveTime value="20110901" />

<component>

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.27.2" />

<!-- Vital Sign Observation template -->

...

</observation>

</component>

<component>

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.27.2" />

<!-- Vital Sign Observation template -->

...

</observation>

</component>

<component>

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.27.2" />

<!-- Vital Sign Observation template -->

...

</observation>

</component>

</organizer>

Wound Characteristics (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.134 (open)]

547: Wound Characteristics (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Wound Observation (NEW)](#E_Wound_Observation_NEW) (optional) |  |

This template represents characteristics of a wound (e.g. integrity of suture line, odor, erythema)

548: Wound Characteristics (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.134'] | | | | | |
| @classCode | 1..1 | SHALL |  | [29938](#C_29938) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [29939](#C_29939) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [29940](#C_29940) |  |
| @root | 1..1 | SHALL |  | [29941](#C_29941) | 2.16.840.1.113883.10.20.22.4.134 |
| id | 1..\* | SHALL |  | [29942](#C_29942) |  |
| code | 1..1 | SHALL |  | [29943](#C_29943) |  |
| @code | 1..1 | SHALL |  | [31540](#C_31540) | ASSERTION |
| @codeSystem | 0..1 | MAY |  | [31541](#C_31541) | 2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4 |
| statusCode | 1..1 | SHALL |  | [29944](#C_29944) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [29946](#C_29946) |  |
| value | 1..1 | SHALL | CD | [29947](#C_29947) | 2.16.840.1.113883.11.20.9.58 (Wound Charactersitic) |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:29938).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:29939).
3. SHALL contain exactly one [1..1] templateId (CONF:29940) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.134" (CONF:29941).
4. SHALL contain at least one [1..\*] id (CONF:29942).
5. SHALL contain exactly one [1..1] code (CONF:29943).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" assertion (CONF:31540).
   2. This code MAY contain zero or one [0..1] @codeSystem="2.16.840.1.113883.5.4" (CodeSystem: ActCode 2.16.840.1.113883.5.4) (CONF:31541).
6. SHALL contain exactly one [1..1] statusCode="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:29944).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:29946).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet [Wound Charactersitic](#Wound_Charactersitic) 2.16.840.1.113883.11.20.9.58 DYNAMIC (CONF:29947).

549: Wound Charactersitic

|  |  |  |
| --- | --- | --- |
| Value Set: Wound Charactersitic 2.16.840.1.113883.11.20.9.58  A value set of SNOMED-CT codes primarily selected from codes descending from 225552003 "Wound finding".    Specific URL Pending  Valueset Source: <http://vtsl.vetmed.vt.edu/> | | |
| Code | Code System | Print Name |
| 239165001 | SNOMED CT | Wound granuloma |
| 239163008 | SNOMED CT | Wound erythema |
| 409590008 | SNOMED CT | Skin eschar |
| 449746002 | SNOMED CT | Wound slough |
| 445916002 | SNOMED CT | Wound odor |
| 239164002 | SNOMED CT | Wound discharge |
| 447547000 | SNOMED CT | Offensive wound odor |
| 271618001 | SNOMED CT | Impaired wound healing |
| 449744004 | SNOMED CT | Induration of wound |
| 298008006 | SNOMED CT | Wound moist |
| ... | | |

Figure 208: Wound Characteristics Example

<entryRelationship typeCode="COMP">

<observation classCode="OBS" moodCode="EVN">

<!-- Wound Characteristics -->

<templateId root="2.16.840.1.113883.10.20.22.4.134"/>

<id root="763428a0-eb35-11e2-91e2-0700200c9a66"/>

<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>

<statusCode code="completed"/>

<effectiveTime value="20013103"/>

<value xsi:type="CD" code="447547000"

displayName="Offensive wound odor"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED-CT"/>

</observation>

</entryRelationship>

Wound Measurement Observation (NEW)

[observation: templateId 2.16.840.1.113883.10.20.22.4.133 (open)]

550: Wound Measurement Observation (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Wound Observation (NEW)](#E_Wound_Observation_NEW) (optional) |  |

This template represents the Wound Measurement Observations of wound width, depth and length.

551: Wound Measurement Observation (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| observation[templateId/@root = '2.16.840.1.113883.10.20.22.4.133'] | | | | | |
| @classCode | 1..1 | SHALL |  | [29926](#C_29926) | 2.16.840.1.113883.5.6 (HL7ActClass) = OBS |
| @moodCode | 1..1 | SHALL |  | [29927](#C_29927) | 2.16.840.1.113883.5.1001 (ActMood) = EVN |
| templateId | 1..1 | SHALL |  | [29928](#C_29928) |  |
| @root | 1..1 | SHALL |  | [29929](#C_29929) | 2.16.840.1.113883.10.20.22.4.133 |
| id | 1..\* | SHALL |  | [29930](#C_29930) |  |
| code | 1..1 | SHALL |  | [29931](#C_29931) | 2.16.840.1.113883.1.11.20.2.5 (Wound Measurements) |
| statusCode | 1..1 | SHALL |  | [29933](#C_29933) |  |
| @code | 1..1 | SHALL |  | [29934](#C_29934) | 2.16.840.1.113883.5.14 (ActStatus) = completed |
| effectiveTime | 1..1 | SHALL |  | [29935](#C_29935) |  |
| value | 1..1 | SHALL | PQ | [29936](#C_29936) |  |

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:29926).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:29927).
3. SHALL contain exactly one [1..1] templateId (CONF:29928) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.133" (CONF:29929).
4. SHALL contain at least one [1..\*] id (CONF:29930).
5. SHALL contain exactly one [1..1] code (ValueSet: [Wound Measurements](#Wound_Measurements) 2.16.840.1.113883.1.11.20.2.5 DYNAMIC) (CONF:29931).
6. SHALL contain exactly one [1..1] statusCode (CONF:29933).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:29934).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:29935).
8. SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:29936).

552: Wound Measurements

|  |  |  |
| --- | --- | --- |
| Value Set: Wound Measurements 2.16.840.1.113883.1.11.20.2.5 | | |
| Code | Code System | Print Name |
| 401239006 | SNOMED CT | width of wound (observable entity) |
| 401238003 | SNOMED CT | length of wound (observable entity) |
| 425094009 | SNOMED CT | depth of wound (observable entity) |

Figure 209: Wound Measurement Observation Example

<entryRelationship typeCode="COMP">

<observation classCode="OBS" moodCode="EVN">

<!-- Wound Measurements Observation . -->

<templateId root="2.16.840.1.113883.10.20.22.4.133"/>

<id root="d2b46280-eb34-11e2-91e2-0800200c9a66"/>

<code code=" 401238003"

codeSystem="2.16.840.1.113883.6.96"

displayName="Length of Wound"/>

<statusCode code="completed"/>

<effectiveTime value="20013103"/>

<value xsi:type="PQ" value="2" unit="[in\_i]"/>

</observation>

</entryRelationship>

# Participation and Other Templates

The participation and other templates chapter contains templates for CDA participations (e.g. author, performer), and other fielded items (e.g. address, name) that cannot stand on their own without being nested in another template .

Author Participation (NEW)

[author: templateId 2.16.840.1.113883.10.20.22.4.119 (open)]

553: Author Participation (NEW) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Medication Activity (V2)](#Medication_Activity_V2) (optional)  [Mental Status Observation (NEW)](#E_Mental_Status_Observation_NEW) (optional)  [Wound Observation (NEW)](#E_Wound_Observation_NEW) (optional)  [Problem Observation (V2)](#E_Problem_Observation_V2) (optional)  [Problem Concern Act (Condition) (V2)](#E_Problem_Concern_Act_Condition_V2) (optional)  [Goal Observation (NEW)](#E_Goal_Observation_NEW) (required)  [Allergy - Intolerance Observation (V2)](#E_Allergy__Intolerance_Observation_V2) (optional)  [Substance or Device Allergy - Intolerance Observation (V2)](#E_Substance_or_Device_Allergy__V2) (optional)  [Immunization Activity (V2)](#E_Immunization_Activity_V2) (optional)  [Nutrition Assessment (NEW)](#E_Nutrition_Assessment_NEW) (optional)  [Allergy Concern Act (V2)](#E_Allergy_Concern_Act_V2) (optional)  [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) (optional)  [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2) (optional)  [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2) (optional)  [Functional Status Organizer (V2)](#E_Functional_Status_Organizer_V2) (optional)  [Handoff Communication (NEW)](#E_Handoff_Communication_NEW) (required)  [Patient Referral Act (NEW)](#E_Patient_Referral_Act_NEW) (optional)  [Current Smoking Status (V2)](#E_Current_Smoking_Status_V2) (optional)  [Vital Sign Observation (V2)](#E_Vital_Sign_Observation_V2) (optional)  [Result Observation (V2)](#E_Result_Observation_V2) (optional)  [Vital Signs Organizer (V2)](#E_Vital_Signs_Organizer_V2) (optional)  [Provider Priority Preference (NEW)](#E_Provider_Priority_Preference_NEW) (optional)  [Intervention Act (NEW)](#E_Intervention_Act_NEW) (optional)  [Result Organizer (V2)](#Result_Organizer_V2) (optional)  [Tobacco Use (V2)](#Tobacco_Use_V2) (optional)  [Outcome Observation (NEW)](#E_Outcome_Observation_NEW) (optional) |  |

This template represents the Author Participant (including the author timestamp). CDA R2 requires that Author and Author timestamp be asserted in the document header. From there, authorship propagates to contained sections and contained entries, unless explicitly overridden.

554: Author Participation (NEW) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| author[templateId/@root = '2.16.840.1.113883.10.20.22.4.119'] | | | | | |
| @typeCode | 1..1 | SHALL |  | [31468](#C_31468) | AUT |
| time | 1..1 | SHALL |  | [31471](#C_31471) |  |
| assignedAuthor | 1..1 | SHALL |  | [31472](#C_31472) |  |
| id | 1..\* | SHALL |  | [31473](#C_31473) |  |
| code | 0..1 | SHOULD |  | [31671](#C_31671) | 2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA)) |
| assignedPerson | 0..1 | MAY |  | [31474](#C_31474) |  |
| name | 0..\* | MAY |  | [31475](#C_31475) |  |
| representedOrganization | 0..1 | MAY |  | [31476](#C_31476) |  |
| @classCode | 1..1 | SHALL |  | [31477](#C_31477) | ORG |
| id | 0..\* | MAY |  | [31478](#C_31478) |  |
| name | 0..\* | MAY |  | [31479](#C_31479) |  |
| telecom | 0..\* | MAY |  | [31480](#C_31480) |  |
| addr | 0..\* | MAY |  | [31481](#C_31481) |  |

1. SHALL contain exactly one [1..1] @typeCode="AUT" (CONF:31468).
2. SHALL contain exactly one [1..1] time (CONF:31471).
3. SHALL contain exactly one [1..1] assignedAuthor (CONF:31472).

This id may be set equal to (a pointer to) an id on a participant elsewhere in the document (header or entries) or a new author participant can be described here. If the id is pointing to a participant already described elsewhere in the document, assignedAuthor/id is sufficient to identify this participant and none of the remaining details of assignedAuthor are required to be set. Application Software must be responsible for resolving the identifier back to its original object and then rendering the information in the correct place in the containing section's narrative text.

* 1. This assignedAuthor SHALL contain at least one [1..\*] id (CONF:31473).
  2. This assignedAuthor SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet [Healthcare Provider Taxonomy (HIPAA)](#Healthcare_Provider_Taxonomy_HIPAA) 2.16.840.1.114222.4.11.1066 (CONF:31671).
  3. This assignedAuthor MAY contain zero or one [0..1] assignedPerson (CONF:31474).
     1. The assignedPerson, if present, MAY contain zero or more [0..\*] name (CONF:31475).
  4. This assignedAuthor MAY contain zero or one [0..1] representedOrganization (CONF:31476).
     1. The representedOrganization, if present, SHALL contain exactly one [1..1] @classCode="ORG" (CONF:31477).
     2. The representedOrganization, if present, MAY contain zero or more [0..\*] id (CONF:31478).
     3. The representedOrganization, if present, MAY contain zero or more [0..\*] name (CONF:31479).
     4. The representedOrganization, if present, MAY contain zero or more [0..\*] telecom (CONF:31480).
     5. The representedOrganization, if present, MAY contain zero or more [0..\*] addr (CONF:31481).

555: Healthcare Provider Taxonomy (HIPAA)

|  |  |  |
| --- | --- | --- |
| Value Set: Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066  The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct Levels including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category. Providers may have one or more than one value associated to them. When determining what value or valuess to associate with a provider, the user needs to review the requirements of the trading partner with which the value(s) are being used. | | |
| Code | Code System | Print Name |
| 171100000X | Healthcare Provider Taxonomy (HIPAA) | Acupuncturist |
| 363LA2100X | Healthcare Provider Taxonomy (HIPAA) | Acute Care |
| 364SA2100X | Healthcare Provider Taxonomy (HIPAA) | Acute Care |
| 101YA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 103TA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 163WA0400X | Healthcare Provider Taxonomy (HIPAA) | Addiction (Substance Use Disorder) |
| 207LA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 207QA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 207RA0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| 2084A0401X | Healthcare Provider Taxonomy (HIPAA) | Addiction Medicine |
| ... | | |

Figure 210: New Author Participant Example

<author>

<time value="201308011235-0800" />

<assignedAuthor>

<id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c" />

<code code="163W00000X" codeSystem="2.16.840.1.113883.6.101" codeSystemName="Health Care Provider Taxonomy" displayName="Registered nurse" />

<assignedPerson>

<name>

<given>Nurse</given>

<family>Nightingale</family>

<suffix>RN</suffix>

</name>

</assignedPerson>

<representedOrganization>

<id root="2.16.840.1.113883.19.5" />

<name>Good Health Hospital</name>

</representedOrganization>

</assignedAuthor>

</author>

Figure 211: Existing Author Reference Example

<author>

<time value="201308011235-0800" />

<assignedAuthor>

<!--

This id points to a participant already described

elsewhere in the document

-->

<id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c" />

</assignedAuthor>

</author>

Physician Reading Study Performer (V2)

[performer: templateId 2.16.840.1.113883.10.20.6.2.1.2 (open)]

556: Physician Reading Study Performer (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (optional) |  |

This participant is the Physician Reading Study Performer defined in documentationOf/serviceEvent. It is usually different from the attending physician. The reading physician interprets the images and evidence of the study (DICOM Definition).

557: Physician Reading Study Performer (V2) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| performer[templateId/@root = '2.16.840.1.113883.10.20.6.2.1.2'] | | | | | |
| @typeCode | 1..1 | SHALL |  | [8424](#C_8424) | 2.16.840.1.113883.5.6 (HL7ActClass) = PRF |
| time | 0..1 | MAY |  | [8425](#C_8425) |  |
| assignedEntity | 1..1 | SHALL |  | [8426](#C_8426) |  |
| id | 1..1 | SHALL |  | [10033](#C_10033) |  |
| @root | 1..1 | SHALL |  | [31584](#C_31584) | 2.16.840.1.113883.4.6 |
| code | 1..1 | SHALL |  | [8427](#C_8427) |  |
| templateId | 1..1 | SHALL |  | [30773](#C_30773) |  |
| @root | 1..1 | SHALL |  | [30774](#C_30774) | 2.16.840.1.113883.10.20.6.2.1.2 |

1. SHALL contain exactly one [1..1] @typeCode="PRF" Performer (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8424).
2. SHALL contain exactly one [1..1] templateId (CONF:30773).
   1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.1.2" (CONF:30774).
3. MAY contain zero or one [0..1] time (CONF:8425).
   1. The content of time SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10134).
4. SHALL contain exactly one [1..1] assignedEntity (CONF:8426).
   1. This assignedEntity SHALL contain exactly one [1..1] id (CONF:10033) such that it
      1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:31584).
   2. This assignedEntity SHALL contain exactly one [1..1] code (CONF:8427).
      1. SHALL contain a valid DICOM personal identification code sequence (@codeSystem is 1.2.840.10008.2.16.4) or an appropriate national health care provider coding system (e.g., NUCC in the U.S., where @codeSystem is 2.16.840.1.113883.6.101) (CONF:8428).
   3. Every assignedEntity element SHALL have at least one assignedPerson or representedOrganization (CONF:8429).

Figure 212: Physician Reading Study Performer Example

<performer typeCode="PRF">

<templateId root="2.16.840.1.113883.10.20.6.2.1.2" />

<assignedEntity>

<id extension="111111111" root="2.16.840.1.113883.4.6" />

<code code="2085R0202X" codeSystem="2.16.840.1.113883.6.101" codeSystemName="NUCC" displayName="Diagnostic Radiology" />

<addr nullFlavor="NI" />

<telecom nullFlavor="NI" />

<assignedPerson>

<name>

<given>Christine</given>

<family>Cure</family>

<suffix>MD</suffix>

</name>

</assignedPerson>

</assignedEntity>

</performer>

US Realm Address (AD.US.FIELDED)

[addr: templateId 2.16.840.1.113883.10.20.22.5.2 (open)]

558: US Realm Address (AD.US.FIELDED) Contexts

| Contained By: | Contains: |
| --- | --- |

Reusable address template, for use in US Realm CDA Header.

559: US Realm Address (AD.US.FIELDED) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| addr[templateId/@root = '2.16.840.1.113883.10.20.22.5.2'] | | | | | |
| @use | 0..1 | SHOULD |  | [7290](#C_7290) | 2.16.840.1.113883.1.11.10637 (PostalAddressUse) |
| streetAddressLine | 1..4 | SHALL | ST | [7291](#C_7291) |  |
| city | 1..1 | SHALL | ST | [7292](#C_7292) |  |
| state | 0..1 | SHOULD | ST | [7293](#C_7293) | 2.16.840.1.113883.3.88.12.80.1 (StateValueSet) |
| postalCode | 0..1 | SHOULD |  | [7294](#C_7294) | 2.16.840.1.113883.3.88.12.80.2 (PostalCodeValueSet) |
| country | 0..1 | SHOULD |  | [7295](#C_7295) | 2.16.840.1.113883.3.88.12.80.63 (CountryValueSet) |

1. SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet [PostalAddressUse](#PostalAddressUse) 2.16.840.1.113883.1.11.10637 STATIC 2005-05-01 (CONF:7290).
2. SHOULD contain zero or one [0..1] country, which SHALL be selected from ValueSet [CountryValueSet](#CountryValueSet) 2.16.840.1.113883.3.88.12.80.63 DYNAMIC (CONF:7295).
3. SHOULD contain zero or one [0..1] state (ValueSet: [StateValueSet](#StateValueSet) 2.16.840.1.113883.3.88.12.80.1 DYNAMIC) (CONF:7293).
   1. State is required if the country is US. If country is not specified, it's assumed to be US. If country is something other than US, the state MAY be present but MAY be bound to different vocabularies (CONF:10024).
4. SHALL contain exactly one [1..1] city (CONF:7292).
5. SHOULD contain zero or one [0..1] postalCode, which SHOULD be selected from ValueSet [PostalCodeValueSet](#PostalCodeValueSet) 2.16.840.1.113883.3.88.12.80.2 DYNAMIC (CONF:7294).
   1. PostalCode is required if the country is US. If country is not specified, it's assumed to be US. If country is something other than US, the postalCode MAY be present but MAY be bound to different vocabularies (CONF:10025).
6. SHALL contain at least one and not more than 4 streetAddressLine (CONF:7291).
7. SHALL NOT have mixed content except for white space (CONF:7296).

560: PostalAddressUse

|  |  |  |
| --- | --- | --- |
| Value Set: PostalAddressUse 2.16.840.1.113883.1.11.10637 | | |
| Code | Code System | Print Name |
| BAD | AddressUse | bad address |
| CONF | AddressUse | confidential |
| DIR | AddressUse | direct |
| H | AddressUse | home address |
| HP | AddressUse | primary home |
| HV | AddressUse | vacation home |
| PHYS | AddressUse | physical visit address |
| PST | AddressUse | postal address |
| PUB | AddressUse | public |
| TMP | AddressUse | temporary |
| ... | | |

561: StateValueSet

|  |  |  |
| --- | --- | --- |
| Value Set: StateValueSet 2.16.840.1.113883.3.88.12.80.1  Identifies addresses within the United States are recorded using the FIPS 5-2 two-letter alphabetic codes for the State, District of Columbia, or an outlying area of the United States or associated area | | |
| Code | Code System | Print Name |

562: PostalCodeValueSet

|  |  |  |
| --- | --- | --- |
| Value Set: PostalCodeValueSet 2.16.840.1.113883.3.88.12.80.2  This identifies the postal (ZIP) Code of an address in the United States | | |
| Code | Code System | Print Name |

563: CountryValueSet

|  |  |  |
| --- | --- | --- |
| Value Set: CountryValueSet 2.16.840.1.113883.3.88.12.80.63  This identifies the codes for the representation of names of countries, territories and areas of geographical interest. | | |
| Code | Code System | Print Name |

Figure 213: US Realm Address Example

<addr use="HP">

<streetAddressLine>22 Sample Street</streetAddressLine>

<city>Beaverton</city>

<state>OR</state>

<postalCode>97867</postalCode>

<country>US</country>

</addr>

US Realm Date and Time (DT.US.FIELDED) (obsolete)

[IVL\_TS: templateId 2.16.840.1.113883.10.20.22.5.3.obsolete (open)]

564: US Realm Date and Time (DT.US.FIELDED) (obsolete) Contexts

| Contained By: | Contains: |
| --- | --- |

This template is obsolete and will be deleted completely in the future. It is a duplicate. Use 2.16.840.1.113883.10.20.22.5.4 instead.

565: US Realm Date and Time (DT.US.FIELDED) (obsolete) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| IVL\_TS[templateId/@root = '2.16.840.1.113883.10.20.22.5.3.obsolete'] | | | | | |

US Realm Date and Time (DTM.US.FIELDED)

[effectiveTime: templateId 2.16.840.1.113883.10.20.22.5.4 (open)]

566: US Realm Date and Time (DTM.US.FIELDED) Contexts

| Contained By: | Contains: |
| --- | --- |

The US Realm Clinical Document Date and Time datatype flavor records date and time information. If no time zone offset is provided, you can make no assumption about time, unless you have made a local exchange agreement.

567: US Realm Date and Time (DTM.US.FIELDED) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| effectiveTime[templateId/@root = '2.16.840.1.113883.10.20.22.5.4'] | | | | | |

1. SHALL be precise to the day (CONF:10127).
2. SHOULD be precise to the minute (CONF:10128).
3. MAY be precise to the second (CONF:10129).
4. If more precise than day, SHOULD include time-zone offset (CONF:10130).

US Realm Patient Name (PTN.US.FIELDED)

[name: templateId 2.16.840.1.113883.10.20.22.5.1 (open)]

568: US Realm Patient Name (PTN.US.FIELDED) Contexts

| Contained By: | Contains: |
| --- | --- |

The US Realm Patient Name datatype flavor is a set of reusable constraints that can be used for the patient or any other person. It requires a first (given) and last (family) name. If a patient or person has only one name part (e.g., patient with first name only) place the name part in the field required by the organization. Use the appropriate nullFlavor, ""Not Applicable"" (NA), in the other field.

For information on mixed content see the Extensible Markup Language reference (http://www.w3c.org/TR/2008/REC-xml-20081126/).

569: US Realm Patient Name (PTN.US.FIELDED) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| name[templateId/@root = '2.16.840.1.113883.10.20.22.5.1'] | | | | | |
| @use | 0..1 | MAY |  | [7154](#C_7154) | 2.16.840.1.113883.1.11.15913 (EntityNameUse) |
| prefix | 0..\* | MAY | ST | [7155](#C_7155) |  |
| @qualifier | 0..1 | MAY |  | [7156](#C_7156) | 2.16.840.1.113883.11.20.9.26 (EntityPersonNamePartQualifier) |
| given | 1..\* | SHALL | ST | [7157](#C_7157) |  |
| @qualifier | 0..1 | MAY |  | [7158](#C_7158) | 2.16.840.1.113883.11.20.9.26 (EntityPersonNamePartQualifier) |
| family | 1..1 | SHALL | ST | [7159](#C_7159) |  |
| @qualifier | 0..1 | MAY |  | [7160](#C_7160) | 2.16.840.1.113883.11.20.9.26 (EntityPersonNamePartQualifier) |
| suffix | 0..1 | MAY | ST | [7161](#C_7161) |  |
| @qualifier | 0..1 | MAY |  | [7162](#C_7162) | 2.16.840.1.113883.11.20.9.26 (EntityPersonNamePartQualifier) |

1. MAY contain zero or one [0..1] @use, which SHALL be selected from ValueSet [EntityNameUse](#EntityNameUse) 2.16.840.1.113883.1.11.15913 STATIC 2005-05-01 (CONF:7154).
2. SHALL contain exactly one [1..1] family (CONF:7159).
   1. This family MAY contain zero or one [0..1] @qualifier, which SHALL be selected from ValueSet [EntityPersonNamePartQualifier](#EntityPersonNamePartQualifier) 2.16.840.1.113883.11.20.9.26 STATIC 2011-09-30 (CONF:7160).
3. SHALL contain at least one [1..\*] given (CONF:7157).
   1. Such givens MAY contain zero or one [0..1] @qualifier, which SHALL be selected from ValueSet [EntityPersonNamePartQualifier](#EntityPersonNamePartQualifier) 2.16.840.1.113883.11.20.9.26 STATIC 2011-09-30 (CONF:7158).
   2. The second occurrence of given (given2]) if provided, SHALL include middle name or middle initial (CONF:7163).
4. MAY contain zero or more [0..\*] prefix (CONF:7155).
   1. The prefix, if present, MAY contain zero or one [0..1] @qualifier, which SHALL be selected from ValueSet [EntityPersonNamePartQualifier](#EntityPersonNamePartQualifier) 2.16.840.1.113883.11.20.9.26 STATIC 2011-09-30 (CONF:7156).
5. MAY contain zero or one [0..1] suffix (CONF:7161).
   1. The suffix, if present, MAY contain zero or one [0..1] @qualifier, which SHALL be selected from ValueSet [EntityPersonNamePartQualifier](#EntityPersonNamePartQualifier) 2.16.840.1.113883.11.20.9.26 STATIC 2011-09-30 (CONF:7162).
6. SHALL NOT have mixed content except for white space (CONF:7278).

570: EntityNameUse

|  |  |  |
| --- | --- | --- |
| Value Set: EntityNameUse 2.16.840.1.113883.1.11.15913 | | |
| Code | Code System | Print Name |
| A | EntityNameUse | Artist/Stage |
| ABC | EntityNameUse | Alphabetic |
| ASGN | EntityNameUse | Assigned |
| C | EntityNameUse | License |
| I | EntityNameUse | Indigenous/Tribal |
| IDE | EntityNameUse | Ideographic |
| L | EntityNameUse | Legal |
| P | EntityNameUse | Pseudonym |
| PHON | EntityNameUse | Phonetic |
| R | EntityNameUse | Religious |
| ... | | |

571: EntityPersonNamePartQualifier

|  |  |  |
| --- | --- | --- |
| Value Set: EntityPersonNamePartQualifier 2.16.840.1.113883.11.20.9.26 | | |
| Code | Code System | Print Name |
| AC | EntityNamePartQualifier | academic |
| AD | EntityNamePartQualifier | adopted |
| BR | EntityNamePartQualifier | birth |
| CL | EntityNamePartQualifier | callme |
| IN | EntityNamePartQualifier | initial |
| NB | EntityNamePartQualifier | nobility |
| PR | EntityNamePartQualifier | professional |
| SP | EntityNamePartQualifier | spouse |
| TITLE | EntityNamePartQualifier | title |
| VV | EntityNamePartQualifier | voorvoegsel |

Figure 214: US Realm Patient Name Example

<name use="L">

<prefix qualifier="TITLE">Rep</suffix>

<given>Evelyn</given>

<given qualifier="CL">Eve</given>

<family qualifier="BR">Everywoman</family>

<suffix qualifier="AC">J.D.</suffix>

</name>

US Realm Person Name (PN.US.FIELDED)

[name: templateId 2.16.840.1.113883.10.20.22.5.1.1 (open)]

572: US Realm Person Name (PN.US.FIELDED) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) (optional)  [Physician of Record Participant (V2)](#E_Physician_of_Record_Participant_V2) (optional) |  |

The US Realm Clinical Document Person Name datatype flavor is a set of reusable constraints that can be used for Persons.

573: US Realm Person Name (PN.US.FIELDED) Constraints Overview

| XPath | Card. | Verb | Data Type | CONF# | Fixed Value |
| --- | --- | --- | --- | --- | --- |
| name[templateId/@root = '2.16.840.1.113883.10.20.22.5.1.1'] | | | | | |
| name | 1..1 | SHALL |  | [9368](#C_9368) |  |

1. SHALL contain exactly one [1..1] name (CONF:9368).
   1. The content of name SHALL be either a conformant Patient Name (PTN.US.FIELDED), or a string (CONF:9371).
   2. The string SHALL NOT contain name parts (CONF:9372).

# Template Ids in This Guide

574: Template List

| Template Title | Template Type | templateId |
| --- | --- | --- |
| [Care Plan (NEW)](#D_Care_Plan_NEW) | document | 2.16.840.1.113883.10.20.22.1.15 |
| [Consultation Note (V2)](#Consultation_Note_V2) | document | 2.16.840.1.113883.10.20.22.1.4.2 |
| [Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) | document | 2.16.840.1.113883.10.20.22.1.2.2 |
| [Diagnostic Imaging Report (V2)](#D_Diagnostic_Imaging_Report_V2) | document | 2.16.840.1.113883.10.20.22.1.5.2 |
| [Discharge Summary (V2)](#D_Discharge_Summary_V2) | document | 2.16.840.1.113883.10.20.22.1.8.2 |
| [History and Physical (V2)](#D_History_and_Physical_V2) | document | 2.16.840.1.113883.10.20.22.1.3.2 |
| [Operative Note (V2)](#D_Operative_Note_V2) | document | 2.16.840.1.113883.10.20.22.1.7.2 |
| [Procedure Note (V2)](#D_Procedure_Note_V2) | document | 2.16.840.1.113883.10.20.22.1.6.2 |
| [Progress Note (V2)](#D_Progress_Note_V2) | document | 2.16.840.1.113883.10.20.22.1.9.2 |
| [Referral Note (NEW)](#D_Referral_Note_NEW) | document | 2.16.840.1.113883.10.20.22.1.14 |
| [Transfer Summary (NEW)](#D_Transfer_Summary_NEW) | document | 2.16.840.1.113883.10.20.22.1.13 |
| [Unstructured Document (V2)](#D_Unstructured_Document_V2) | document | 2.16.840.1.113883.10.20.22.1.10.2 |
| [US Realm Header - Patient Generated Document (NEW)](#D_US_Realm_Header__Patient_Generated_Do) | document | 2.16.840.1.113883.10.20.29.1 |
| [US Realm Header (V2)](#D_US_Realm_Header_V2) | document | 2.16.840.1.113883.10.20.22.1.1.2 |
| [Advance Directives Section (entries optional) (V2)](#Advance_Directives_Section_entries_opti) | section | 2.16.840.1.113883.10.20.22.2.21.2 |
| [Advance Directives Section (entries required) (V2)](#S_Advance_Directives_Section_entries_re) | section | 2.16.840.1.113883.10.20.22.2.21.1.2 |
| [Allergies Section (entries optional) (V2)](#S_Allergies_Section_entries_optional_V2) | section | 2.16.840.1.113883.10.20.22.2.6.2 |
| [Allergies Section (entries required) (V2)](#S_Allergies_Section_entries_required_V2) | section | 2.16.840.1.113883.10.20.22.2.6.1.2 |
| [Anesthesia Section (V2)](#S_Anesthesia_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.25.2 |
| [Assessment and Plan Section (V2)](#S_Assessment_and_Plan_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.9.2 |
| [Assessment Section](#S_Assessment_Section) | section | 2.16.840.1.113883.10.20.22.2.8 |
| [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S) | section | 2.16.840.1.113883.10.20.22.2.13 |
| [Chief Complaint Section](#S_Chief_Complaint_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1 |
| [Complications (OpNote) (obsolete)](#S_Complications_OpNote_obsolete) | section | 2.16.840.1.113883.10.20.22.2.32.obsolete |
| [Complications Section (V2)](#S_Complications_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.37.2 |
| [DICOM Object Catalog Section - DCM 121181](#S_DICOM_Object_Catalog_Section__DCM_121) | section | 2.16.840.1.113883.10.20.6.1.1 |
| [Discharge Diet Section (DEPRECATED)](#S_Discharge_Diet_Section_DEPRECATED) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.33.2 |
| [Encounters Section (entries optional) (V2)](#S_Encounters_Section_entries_optional_V) | section | 2.16.840.1.113883.10.20.22.2.22.2 |
| [Encounters Section (entries required) (V2)](#S_Encounters_Section_entries_required_V) | section | 2.16.840.1.113883.10.20.22.2.22.1.2 |
| [Family History Section](#S_Family_History_Section) | section | 2.16.840.1.113883.10.20.22.2.15 |
| [Fetus Subject Context](#S_Fetus_Subject_Context) | section | 2.16.840.1.113883.10.20.6.2.3 |
| [Findings Section (DIR)](#S_Findings_Section_DIR) | section | 2.16.840.1.113883.10.20.6.1.2 |
| [Functional Status Section (V2)](#S_Functional_Status_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.14.2 |
| [General Status Section](#S_General_Status_Section) | section | 2.16.840.1.113883.10.20.2.5 |
| [Goals Section (NEW)](#S_Goals_Section_NEW) | section | 2.16.840.1.113883.10.20.22.2.60 |
| [Health Concerns Section (NEW)](#S_Health_Concerns_Section_NEW) | section | 2.16.840.1.113883.10.20.22.2.58 |
| [Health Status Evaluations/Outcomes Section (NEW)](#S_Health_Status_EvaluationsOutcomes_Sec) | section | 2.16.840.1.113883.10.20.22.2.61 |
| [History of Past Illness Section (V2)](#S_History_of_Past_Illness_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.20.2 |
| [History of Present Illness Section](#S_History_of_Present_Illness_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.4 |
| [Hospital Admission Diagnosis Section (V2)](#S_Hospital_Admission_Diagnosis_Section_) | section | 2.16.840.1.113883.10.20.22.2.43.2 |
| [Hospital Admission Medications Section (entries optional) (V2)](#S_Hospital_Admission_Medications_Sectio) | section | 2.16.840.1.113883.10.20.22.2.44.2 |
| [Hospital Consultations Section](#S_Hospital_Consultations_Section) | section | 2.16.840.1.113883.10.20.22.2.42 |
| [Hospital Course Section](#S_Hospital_Course_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.5 |
| [Hospital Discharge Diagnosis Section (V2)](#Hospital_Discharge_Diagnosis_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.24.2 |
| [Hospital Discharge Instructions Section](#S_Hospital_Discharge_Instructions_Sectio) | section | 2.16.840.1.113883.10.20.22.2.41 |
| [Hospital Discharge Medications Section (entries optional) (V2)](#S_Hospital_Discharge_Medications_Sectio) | section | 2.16.840.1.113883.10.20.22.2.11.2 |
| [Hospital Discharge Medications Section (entries required) (V2)](#S_Hospital_Discharge_Medications_reqd_v2) | section | 2.16.840.1.113883.10.20.22.2.11.1.2 |
| [Hospital Discharge Physical Section](#S_Hospital_Discharge_Physical_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.26 |
| [Hospital Discharge Studies Summary Section](#S_Hospital_Discharge_Studies_Summary_Sec) | section | 2.16.840.1.113883.10.20.22.2.16 |
| [Immunizations Section (entries optional) (V2)](#S_Immunizations_Section_entries_optiona) | section | 2.16.840.1.113883.10.20.22.2.2.2 |
| [Immunizations Section (entries required) (V2)](#S_Immunizations_Section_entries_require) | section | 2.16.840.1.113883.10.20.22.2.2.1.2 |
| [Implants Section](#S_Implants_Section) | section | 2.16.840.1.113883.10.20.22.2.33 |
| [Instructions Section (V2)](#Instructions_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.45.2 |
| [Interventions Section (V2)](#Interventions_Section_V2) | section | 2.16.840.1.113883.10.20.21.2.3.2 |
| [Medical (General) History Section (V2)](#Medical_General_History_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.39.2 |
| [Medical Equipment Section (V2)](#S_Medical_Equipment_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.23.2 |
| [Medications Administered Section (V2)](#S_Medications_Administered_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.38.2 |
| [Medications Section (entries optional) (V2)](#S_Medications_Section_entries_optional_) | section | 2.16.840.1.113883.10.20.22.2.1.2 |
| [Medications Section (entries required) (V2)](#S_Medications_Section_entries_required_) | section | 2.16.840.1.113883.10.20.22.2.1.1.2 |
| [Mental Status Section (NEW)](#S_Mental_Status_Section_NEW) | section | 2.16.840.1.113883.10.20.22.2.56 |
| [Nutrition Section (NEW)](#S_Nutrition_Section_NEW) | section | 2.16.840.1.113883.10.20.22.2.57 |
| [Objective Section](#S_Objective_Section) | section | 2.16.840.1.113883.10.20.21.2.1 |
| [Observer Context](#S_Observer_Context) | section | 2.16.840.1.113883.10.20.6.2.4 |
| [Operative Note Fluids Section](#S_Operative_Note_Fluids_Section) | section | 2.16.840.1.113883.10.20.7.12 |
| [Operative Note Surgical Procedure Section](#S_Operative_Note_Surgical_Procedure_Sect) | section | 2.16.840.1.113883.10.20.7.14 |
| [Payers Section (V2)](#S_Payers_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.18.2 |
| [Physical Exam Section (V2)](#S_Physical_Exam_Section_V2) | section | 2.16.840.1.113883.10.20.2.10.2 |
| [Physical Findings of Skin Section (NEW)](#S_Physical_Findings_of_Skin_Section_NEW) | section | 2.16.840.1.113883.10.20.22.2.62 |
| [Plan of Treatment Section (V2)](#S_Plan_of_Treatment_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.10.2 |
| [Planned Procedure Section (V2)](#Planned_Procedure_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.30.2 |
| [Postoperative Diagnosis Section](#S_Postoperative_Diagnosis_Section) | section | 2.16.840.1.113883.10.20.22.2.35 |
| [Postprocedure Diagnosis Section (V2)](#S_Postprocedure_Diagnosis_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.36.2 |
| [Preoperative Diagnosis Section (V2)](#S_Preoperative_Diagnosis_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.34.2 |
| [Problem Section (entries optional) (V2)](#S_Problem_Section_entries_optional_V2) | section | 2.16.840.1.113883.10.20.22.2.5.2 |
| [Problem Section (entries required) (V2)](#S_Problem_Section_entries_required_V2) | section | 2.16.840.1.113883.10.20.22.2.5.1.2 |
| [Procedure Description Section](#S_Procedure_Description_Section) | section | 2.16.840.1.113883.10.20.22.2.27 |
| [Procedure Disposition Section](#S_Procedure_Disposition_Section) | section | 2.16.840.1.113883.10.20.18.2.12 |
| [Procedure Estimated Blood Loss Section](#S_Procedure_Estimated_Blood_Loss_Section) | section | 2.16.840.1.113883.10.20.18.2.9 |
| [Procedure Findings Section (V2)](#S_Procedure_Findings_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.28.2 |
| [Procedure Implants Section](#S_Procedure_Implants_Section) | section | 2.16.840.1.113883.10.20.22.2.40 |
| [Procedure Indications Section (V2)](#Procedure_Indications_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.29.2 |
| [Procedure Specimens Taken Section](#S_Procedure_Specimens_Taken_Section) | section | 2.16.840.1.113883.10.20.22.2.31 |
| [Procedures Section (entries optional) (V2)](#Procedures_Section_entries_optional_V2) | section | 2.16.840.1.113883.10.20.22.2.7.2 |
| [Procedures Section (entries required) (V2)](#S_Procedures_Section_entries_required_V) | section | 2.16.840.1.113883.10.20.22.2.7.1.2 |
| [Reason for Referral Section (V2)](#Reason_for_Referral_Section_V2) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.1.2 |
| [Reason for Visit Section](#S_Reason_for_Visit_Section) | section | 2.16.840.1.113883.10.20.22.2.12 |
| [Results Section (entries optional) (V2)](#S_Results_Section_entries_optional_V2) | section | 2.16.840.1.113883.10.20.22.2.3.2 |
| [Results Section (entries required) (V2)](#S_Results_Section_entries_required_V2) | section | 2.16.840.1.113883.10.20.22.2.3.1.2 |
| [Review of Systems Section](#S_Review_of_Systems_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.18 |
| [Social History Section (V2)](#S_Social_History_Section_V2) | section | 2.16.840.1.113883.10.20.22.2.17.2 |
| [Subjective Section](#S_Subjective_Section) | section | 2.16.840.1.113883.10.20.21.2.2 |
| [Surgery Description Section](#S_Surgery_Description_Section) | section | 2.16.840.1.113883.10.20.22.2.26 |
| [Surgical Drains Section](#S_Surgical_Drains_Section) | section | 2.16.840.1.113883.10.20.7.13 |
| [Vital Signs Section (entries optional) (V2)](#Vital_Signs_Section_entries_optional_V2) | section | 2.16.840.1.113883.10.20.22.2.4.2 |
| [Vital Signs Section (entries required) (V2)](#S_Vital_Signs_Section_entries_required_) | section | 2.16.840.1.113883.10.20.22.2.4.1.2 |
| [Act Reference (NEW)](#E_Act_Reference_NEW) | entry | 2.16.840.1.113883.10.20.22.4.122 |
| [Admission Medication (V2)](#Admission_Medication_V2) | entry | 2.16.840.1.113883.10.20.22.4.36.2 |
| [Advance Directive Observation (V2)](#Advance_Directive_Observation_V2) | entry | 2.16.840.1.113883.10.20.22.4.48.2 |
| [Advance Directive Organizer (NEW)](#E_Advance_Directive_Organizer_NEW) | entry | 2.16.840.1.113883.10.20.22.4.108 |
| [Age Observation](#E_Age_Observation) | entry | 2.16.840.1.113883.10.20.22.4.31 |
| [Allergy - Intolerance Observation (V2)](#E_Allergy__Intolerance_Observation_V2) | entry | 2.16.840.1.113883.10.20.22.4.7.2 |
| [Allergy Concern Act (V2)](#E_Allergy_Concern_Act_V2) | entry | 2.16.840.1.113883.10.20.22.4.30.2 |
| [Allergy Status Observation (DEPRECATED)](#E_Allergy_Status_Observation_DEPRECATED) | entry | 2.16.840.1.113883.10.20.22.4.28.2 |
| [Assessment Scale Observation](#E_Assessment_Scale_Observation) | entry | 2.16.840.1.113883.10.20.22.4.69 |
| [Assessment Scale Supporting Observation](#E_Assessment_Scale_Supporting_Observati) | entry | 2.16.840.1.113883.10.20.22.4.86 |
| [Authorization Activity](#E_Authorization_Activity) | entry | 2.16.840.1.113883.10.20.1.19 |
| [Boundary Observation](#E_Boundary_Observation) | entry | 2.16.840.1.113883.10.20.6.2.11 |
| [Caregiver Characteristics](#E_Caregiver_Characteristics) | entry | 2.16.840.1.113883.10.20.22.4.72 |
| [Characteristics of Home Environment (NEW)](#E_Characteristics_of_Home_Environment_N) | entry | 2.16.840.1.113883.10.20.22.4.109 |
| [Code Observations](#E_Code_Observations) | entry | 2.16.840.1.113883.10.20.6.2.13 |
| [Cognitive Abilities Observation (NEW)](#E_Cognitive_Abilities_Observation_NEW) | entry | 2.16.840.1.113883.10.20.22.4.126 |
| [Cognitive Status Observation (V2)](#E_Cognitive_Status_Observation_V2) | entry | 2.16.840.1.113883.10.20.22.4.74.2 |
| [Cognitive Status Organizer (V2)](#E_Cognitive_Status_Organizer_V2) | entry | 2.16.840.1.113883.10.20.22.4.75.2 |
| [Cognitive Status Problem Observation (DEPRECATED)](#E_Cognitive_Status_Problem_ObsDEP) | entry | 2.16.840.1.113883.10.20.22.4.73.2 |
| [Comment Activity](#E_Comment_Activity) | entry | 2.16.840.1.113883.10.20.22.4.64 |
| [Coverage Activity (V2)](#E_Coverage_Activity_V2) | entry | 2.16.840.1.113883.10.20.22.4.60.2 |
| [Cultural and Religious Observation (NEW)](#E_Cultural_and_Religious_Observation_NE) | entry | 2.16.840.1.113883.10.20.22.4.111 |
| [Current Smoking Status (V2)](#E_Current_Smoking_Status_V2) | entry | 2.16.840.1.113883.10.20.22.4.78.2 |
| [Deceased Observation (V2)](#E_Deceased_Observation_V2) | entry | 2.16.840.1.113883.10.20.22.4.79.2 |
| [Discharge Medication (V2)](#Discharge_Medication_V2) | entry | 2.16.840.1.113883.10.20.22.4.35.2 |
| [Drug Monitoring Act (NEW)](#E_Drug_Monitoring_Act_NEW) | entry | 2.16.840.1.113883.10.20.22.4.123 |
| [Drug Vehicle](#E_Drug_Vehicle) | entry | 2.16.840.1.113883.10.20.22.4.24 |
| [Encounter Activity (V2)](#E_Encounter_Activity_V2) | entry | 2.16.840.1.113883.10.20.22.4.49.2 |
| [Encounter Diagnosis (V2)](#E_Encounter_Diagnosis_V2) | entry | 2.16.840.1.113883.10.20.22.4.80.2 |
| [Estimated Date of Delivery](#E_Estimated_Date_of_Delivery) | entry | 2.16.840.1.113883.10.20.15.3.1 |
| [Family History Death Observation](#E_Family_History_Death_Observation) | entry | 2.16.840.1.113883.10.20.22.4.47 |
| [Family History Observation](#E_Family_History_Observation) | entry | 2.16.840.1.113883.10.20.22.4.46 |
| [Family History Organizer](#E_Family_History_Organizer) | entry | 2.16.840.1.113883.10.20.22.4.45 |
| [Functional Status Observation (V2)](#E_Functional_Status_Observation_V2) | entry | 2.16.840.1.113883.10.20.22.4.67.2 |
| [Functional Status Organizer (V2)](#E_Functional_Status_Organizer_V2) | entry | 2.16.840.1.113883.10.20.22.4.66.2 |
| [Functional Status Problem Observation (DEPRECATED)](#E_Functional_Status_Problem_ObsDEP) | entry | 2.16.840.1.113883.10.20.22.4.68.2 |
| [Goal Observation (NEW)](#E_Goal_Observation_NEW) | entry | 2.16.840.1.113883.10.20.22.4.121 |
| [Handoff Communication (NEW)](#E_Handoff_Communication_NEW) | entry | 2.16.840.1.113883.10.20.22.4.141 |
| [Health Concern Act (NEW)](#E_Health_Concern_Act_NEW) | entry | 2.16.840.1.113883.10.20.22.4.132 |
| [Health Status Observation (V2)](#Health_Status_Observation_V2) | entry | 2.16.840.1.113883.10.20.22.4.5.2 |
| [Highest Pressure Ulcer Stage](#E_Highest_Pressure_Ulcer_Stage) | entry | 2.16.840.1.113883.10.20.22.4.77 |
| [Hospital Admission Diagnosis (V2)](#E_Hospital_Admission_Diagnosis_V2) | entry | 2.16.840.1.113883.10.20.22.4.34.2 |
| [Hospital Discharge Diagnosis (V2)](#Hospital_Discharge_Diagnosis_V2) | entry | 2.16.840.1.113883.10.20.22.4.33.2 |
| [Immunization Activity (V2)](#E_Immunization_Activity_V2) | entry | 2.16.840.1.113883.10.20.22.4.52.2 |
| [Immunization Medication Information (V2)](#Immunization_Medication_Information_V2) | entry | 2.16.840.1.113883.10.20.22.4.54.2 |
| [Immunization Refusal Reason](#E_Immunization_Refusal_Reason) | entry | 2.16.840.1.113883.10.20.22.4.53 |
| [Indication (V2)](#Indication_V2) | entry | 2.16.840.1.113883.10.20.22.4.19.2 |
| [Instruction (V2)](#Instruction_V2) | entry | 2.16.840.1.113883.10.20.22.4.20.2 |
| [Intervention Act (NEW)](#E_Intervention_Act_NEW) | entry | 2.16.840.1.113883.10.20.22.4.131 |
| [Medical Device (NEW)](#E_Medical_Device_NEW) | entry | 2.16.840.1.113883.10.20.22.4.115 |
| [Medical Equipment Organizer (NEW)](#E_Medical_Equipment_Organizer_NEW) | entry | 2.16.840.1.113883.10.20.22.4.135 |
| [Medication Activity (V2)](#Medication_Activity_V2) | entry | 2.16.840.1.113883.10.20.22.4.16.2 |
| [Medication Dispense (V2)](#E_Medication_Dispense_V2) | entry | 2.16.840.1.113883.10.20.22.4.18.2 |
| [Medication Information (V2)](#E_Medication_Information_V2) | entry | 2.16.840.1.113883.10.20.22.4.23.2 |
| [Medication Supply Order (V2)](#E_Medication_Supply_Order_V2) | entry | 2.16.840.1.113883.10.20.22.4.17.2 |
| [Medication Use - None Known (obsolete)](#E_Medication_Use__None_Known_obsolete) | entry | 2.16.840.1.113883.10.20.22.4.29.obsolete |
| [Mental Status Observation (NEW)](#E_Mental_Status_Observation_NEW) | entry | 2.16.840.1.113883.10.20.22.4.125 |
| [Non-Medicinal Supply Activity (V2)](#NonMedicinal_Supply_Activity_V2) | entry | 2.16.840.1.113883.10.20.22.4.50.2 |
| [Number of Pressure Ulcers Observation](#E_Number_of_Pressure_Ulcers_Observation) | entry | 2.16.840.1.113883.10.20.22.4.76 |
| [Nutrition Assessment (NEW)](#E_Nutrition_Assessment_NEW) | entry | 2.16.840.1.113883.10.20.22.4.138 |
| [Nutrition Recommendations (NEW)](#E_Nutrition_Recommendations_NEW) | entry | 2.16.840.1.113883.10.20.22.4.130 |
| [Nutritional Status Observation (NEW)](#E_Nutritional_Status_Observation_NEW) | entry | 2.16.840.1.113883.10.20.22.4.124 |
| [Outcome Observation (NEW)](#E_Outcome_Observation_NEW) | entry | 2.16.840.1.113883.10.20.22.4.144 |
| [Patient Priority Preference (NEW)](#E_Patient_Priority_Preference_NEW) | entry | 2.16.840.1.113883.10.20.22.4.142 |
| [Patient Referral Act (NEW)](#E_Patient_Referral_Act_NEW) | entry | 2.16.840.1.113883.10.20.22.4.140 |
| [Physician of Record Participant (V2)](#E_Physician_of_Record_Participant_V2) | entry | 2.16.840.1.113883.10.20.6.2.2.2 |
| [Planned Act (V2)](#E_Planned_Act_V2) | entry | 2.16.840.1.113883.10.20.22.4.39.2 |
| [Planned Encounter (V2)](#E_Planned_Encounter_V2) | entry | 2.16.840.1.113883.10.20.22.4.40.2 |
| [Planned Observation (V2)](#E_Planned_Observation_V2) | entry | 2.16.840.1.113883.10.20.22.4.44.2 |
| [Planned Procedure (V2)](#E_Planned_Procedure_V2) | entry | 2.16.840.1.113883.10.20.22.4.41.2 |
| [Planned Substance Administration (V2)](#E_Planned_Substance_Administration_V2) | entry | 2.16.840.1.113883.10.20.22.4.42.2 |
| [Planned Supply (V2)](#E_Planned_Supply_V2) | entry | 2.16.840.1.113883.10.20.22.4.43.2 |
| [Policy Activity (V2)](#Policy_Activity_V2) | entry | 2.16.840.1.113883.10.20.22.4.61.2 |
| [Postprocedure Diagnosis (V2)](#E_Postprocedure_Diagnosis_V2) | entry | 2.16.840.1.113883.10.20.22.4.51.2 |
| [Precondition for Substance Administration](#E_Precondition_for_Substance_Administrat) | entry | 2.16.840.1.113883.10.20.22.4.25 |
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# Changes from Previous Version

| Template Name | Change | Old | New |
| --- | --- | --- | --- |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28895 Added |  | Heading: structuredBody  This component SHALL contain exactly one [1..1] structuredBody (CONF:28895). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28896 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28896) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28897 Added |  | SHALL contain exactly one [1..1] Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:28897). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28898 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28898) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28899 Added |  | SHALL contain exactly one [1..1] Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) (CONF:28899). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28900 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28900) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28901 Added |  | SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:28901). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28902 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28902) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28903 Added |  | SHALL contain exactly one [1..1] Reason for Referral Section (V2) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.1.2) (CONF:28903). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28904 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28904) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28905 Added |  | SHALL contain exactly one [1..1] Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:28905). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28906 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:28906) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28907 Added |  | SHALL contain exactly one [1..1] History of Present Illness Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:28907). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28908 Added |  | This structuredBody SHOULD contain zero or one [0..1] component (CONF:28908) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28909 Added |  | SHALL contain exactly one [1..1] Physical Exam Section (V2) (templateId:2.16.840.1.113883.10.20.2.10.2) (CONF:28909). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28910 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:28910) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28911 Added |  | SHALL contain exactly one [1..1] Allergies Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.6.1.2) (CONF:28911). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28912 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28912) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28913 Added |  | SHALL contain exactly one [1..1] Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:28913). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28915 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28915) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28916 Added |  | SHALL contain exactly one [1..1] Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:28916). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28917 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28917) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28918 Added |  | SHALL contain exactly one [1..1] Family History Section (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:28918). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28919 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28919) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28920 Added |  | SHALL contain exactly one [1..1] General Status Section (templateId:2.16.840.1.113883.10.20.2.5) (CONF:28920). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28921 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28921) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28922 Added |  | SHALL contain exactly one [1..1] History of Past Illness Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.20.2) (CONF:28922). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28923 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28923) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28924 Added |  | SHALL contain exactly one [1..1] Immunizations Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.2.2) (CONF:28924). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28925 Added |  | This structuredBody SHOULD contain zero or one [0..1] component (CONF:28925) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28926 Added |  | SHALL contain exactly one [1..1] Medications Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.1.1.2) (CONF:28926). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28928 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:28928) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28929 Added |  | SHALL contain exactly one [1..1] Problem Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.5.1.2) (CONF:28929). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28930 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28930) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28931 Added |  | SHALL contain exactly one [1..1] Procedures Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.7.2) (CONF:28931). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28932 Added |  | This structuredBody SHOULD contain zero or one [0..1] component (CONF:28932) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28933 Added |  | SHALL contain exactly one [1..1] Results Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.3.1.2) (CONF:28933). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28934 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28934) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28935 Added |  | SHALL contain exactly one [1..1] Social History Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:28935). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28936 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28936) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28937 Added |  | SHALL contain exactly one [1..1] Vital Signs Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.4.1.2) (CONF:28937). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28938 Added |  | MAY include an Assessment and Plan Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.9.2) OR both an Assessment Section (templateId: 2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.10.2) (CONF:28938). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28939 Added |  | SHALL NOT include an Assessment and Plan Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId: 2.16.840.1.113883.10.20.22.2.8) and a Plan of Care Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.10.2) are present (CONF:28939). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28940 Added |  | SHALL NOT include a Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) with a Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:28940). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28941 Added |  | SHALL NOT include Reason for Referral Section V2 (templateId: 1.3.6.1.4.1.19376.1.5.3.1.3.1.2) when a Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) is present (CONF:28941). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28942 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28942) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28943 Added |  | SHALL contain exactly one [1..1] Advance Directives Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.21.2) (CONF:28943). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28944 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:28944) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 28945 Added |  | SHALL contain exactly one [1..1] Functional Status Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.14.2) (CONF:28945). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 29837 Added |  | SHALL contain exactly one [1..1] title (CONF:29837). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 29923 Added |  | Such inFulfillmentOfs SHALL contain exactly one [1..1] order (CONF:29923). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 29924 Added |  | This order SHALL contain at least one [1..\*] id (CONF:29924). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 30237 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30237) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 30238 Added |  | SHALL contain exactly one [1..1] Review of Systems Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:30238). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 30904 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30904) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 30905 Added |  | SHALL contain exactly one [1..1] Medical Equipment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.23.2) (CONF:30905). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 30906 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30906) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 30907 Added |  | SHALL contain exactly one [1..1] Mental Status Section (NEW) (templateId:2.16.840.1.113883.10.20.22.2.56) (CONF:30907). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 30909 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30909) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 30910 Added |  | SHALL contain exactly one [1..1] Nutrition Section (NEW) (templateId:2.16.840.1.113883.10.20.22.2.57) (CONF:30910). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 31656 Added |  | Heading: participant (The participants (contact) represent the clinician to contact for questions about the consultation note. The primary clinician(s) involved in the consultation are included here as contacts.)  SHOULD contain zero or more [0..\*] participant (CONF:31656). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 31657 Added |  | The participant, if present, SHALL contain exactly one [1..1] @typeCode="CALLBACK" call back contact (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 DYNAMIC) (CONF:31657). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 31658 Added |  | The participant, if present, SHALL contain exactly one [1..1] associatedEntity (CONF:31658). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 31659 Added |  | This associatedEntity SHALL contain exactly one [1..1] @classCode="ASSIGNED" assigned entity (CodeSystem: RoleClass 2.16.840.1.113883.5.110 DYNAMIC) (CONF:31659). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 31660 Added |  | This associatedEntity SHALL contain at least one [1..\*] id (CONF:31660). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 31661 Added |  | This associatedEntity SHOULD contain zero or more [0..\*] addr (CONF:31661). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 31662 Added |  | This associatedEntity SHALL contain at least one [1..\*] telecom (CONF:31662). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 31663 Added |  | This associatedEntity SHALL contain exactly one [1..1] associatedPerson (CONF:31663). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 31664 Added |  | This associatedPerson SHALL contain at least one [1..\*] name (CONF:31664). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 31665 Added |  | This associatedEntity MAY contain zero or one [0..1] scopingOrganization (CONF:31665). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 8385 Removed | Such inFulfillmentOfs SHALL contain exactly one [1..1] order (CONF:8385). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 8398 Removed | A Consultation Note can have either a structuredBody or a nonXMLBody (CONF:8398). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 8399 Removed | A Consultation Note can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.4), coded entries are optional (CONF:8399). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9102 Removed | This order SHALL contain at least one [1..\*] id (CONF:9102). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9487 Removed | MAY contain zero or one [0..1] Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:9487). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9489 Removed | MAY contain zero or one [0..1] Plan of Care Section (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9489). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9491 Removed | MAY contain zero or one [0..1] Assessment and Plan Section (templateId:2.16.840.1.113883.10.20.22.2.9) (CONF:9491). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9493 Removed | SHALL contain exactly one [1..1] History of Present Illness Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:9493). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9495 Removed | SHOULD contain zero or one [0..1] Physical Exam Section (templateId:2.16.840.1.113883.10.20.2.10) (CONF:9495). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9498 Removed | MAY contain zero or one [0..1] Reason for Referral Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.1) (CONF:9498). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9500 Removed | MAY contain zero or one [0..1] Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:9500). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9501 Removed | SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan of Care Section (CONF:9501). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9503 Removed | If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9503). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9504 Removed | SHALL include a Reason for Referral or Reason for Visit section (CONF:9504). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9507 Removed | MAY contain zero or one [0..1] Allergies Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.6) (CONF:9507). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9509 Removed | MAY contain zero or one [0..1] Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:9509). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9511 Removed | MAY contain zero or one [0..1] Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:9511). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9513 Removed | MAY contain zero or one [0..1] Family History Section (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:9513). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9515 Removed | MAY contain zero or one [0..1] General Status Section (templateId:2.16.840.1.113883.10.20.2.5) (CONF:9515). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9517 Removed | MAY contain zero or one [0..1] History of Past Illness Section (templateId:2.16.840.1.113883.10.20.22.2.20) (CONF:9517). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9519 Removed | MAY contain zero or one [0..1] Immunizations Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.2) (CONF:9519). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9521 Removed | MAY contain zero or one [0..1] Medications Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.1) (CONF:9521). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9523 Removed | MAY contain zero or one [0..1] Problem Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.5) (CONF:9523). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9525 Removed | MAY contain zero or one [0..1] Procedures Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.7) (CONF:9525). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9527 Removed | MAY contain zero or one [0..1] Results Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.3) (CONF:9527). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9529 Removed | MAY contain zero or one [0..1] Review of Systems Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:9529). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9531 Removed | MAY contain zero or one [0..1] Social History Section (templateId:2.16.840.1.113883.10.20.22.2.17) (CONF:9531). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 9533 Removed | MAY contain zero or one [0..1] Vital Signs Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.4) (CONF:9533). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 10028 Removed | SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:10028). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 10029 Removed | SHALL NOT include a combined Chief Complaint and Reason for Visit Section with either a Chief Complaint Section or a Reason for Visit Section (CONF:10029). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 17177 Removed | This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ConsultDocumentType 2.16.840.1.113883.11.20.9.31 DYNAMIC (CONF:17177). |  |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 8375 Modified | SHALL contain exactly one [1..1] templateId (CONF:8375). | SHALL contain exactly one [1..1] templateId (CONF:8375) such that it |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 8382 Modified | SHALL contain at least one [1..\*] inFulfillmentOf (CONF:8382). | Heading: inFulfillmentOf (The inFulfillmentOf element describes prior orders that are fulfilled (in whole or part) by the service events described in the Consultation Note. For example, a prior order might be the the consultation that is being reported in the note.)  SHALL contain at least one [1..\*] inFulfillmentOf (CONF:8382). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 8386 Modified | SHALL contain exactly one [1..1] componentOf (CONF:8386). | Heading: componentOf (A Consultation Note is always associated with an encounter; the componentOf element must be present and the encounter must be identified.)       SHALL contain exactly one [1..1] componentOf (CONF:8386). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 8387 Modified | This componentOf SHALL contain exactly one [1..1] encompassingEncounter (CONF:8387). | CDA R2 requires encompasingEncounter and the id element of the encompassingEncounter is required to be present and represents the identifier for the encounter.  This componentOf SHALL contain exactly one [1..1] encompassingEncounter (CONF:8387). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 8392 Modified | This encompassingEncounter MAY contain zero or more [0..\*] encounterParticipant (CONF:8392). | The encounterParticipant element represents persons who participated in the encounter and not necessarily the entire episode of care.  This encompassingEncounter MAY contain zero or more [0..\*] encounterParticipant (CONF:8392). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 10040 Modified | This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.4" (CONF:10040). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.4.2" (CONF:10040). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 10132 Modified | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10132). | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10132). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | CONF #: 17176 Modified | SHALL contain exactly one [1..1] code (CONF:17176). | SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet ConsultDocumentType 2.16.840.1.113883.11.20.9.31 DYNAMIC (CONF:17176). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | Name | Consultation Note | Consultation Note (V2) |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | Oid | 2.16.840.1.113883.10.20.22.1.4 | 2.16.840.1.113883.10.20.22.1.4.2 |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | Description | For the purpose of this Implementation Guide, a consultation visit is defined by the evaluation and management guidelines for a consultation established by the Centers for Medicare and Medicaid Services (CMS). According to those guidelines, a Consultation Note must be generated as a result of a physician or non-physician practitioner's (NPP) request for an opinion or advice from another physician or NPP. Consultations must involve face-to-face time with the patient or fall under guidelines for telemedicine visits.    A Consultation Note must be provided to the referring physician or NPP and must include the reason for the referral, history of present illness, physical examination, and decision-making component (Assessment and Plan).    An NPP is defined as any licensed medical professional as recognized by the state in which the professional practices, including, but not limited to, physician assistants, nurse practitioners, clinical nurse specialists, social workers, registered dietitians, physical therapists, and speech therapists.    Reports on visits requested by a patient, family member, or other third party are not covered by this specification. Second opinions, sometimes called ""confirmatory consultations,"" also are not covered here. Any question on use of the Consultation Note defined here should be resolved by reference to CMS or American Medical Association (AMA) guidelines. | Consultation Note is generated as a result of a request from a clinician for an opinion or advice from another clinician. Consultations involve face-to-face time with the patient or may fall under the guidelines for tele-medicine visits. A consultation note includes the reason for the referral, history of present illness, physical examination, and decision-making component (Assessment and Plan). |
| [Consultation Note (V2) 2.16.840.1.113883.10.20.22.1.4.2](#Consultation_Note_V2) | Implied Template | US Realm Header (2.16.840.1.113883.10.20.22.1.1) | US Realm Header (V2) (2.16.840.1.113883.10.20.22.1.1.2) |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30659 Added |  | SHALL contain exactly one [1..1] component (CONF:30659). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30660 Added |  | This component SHALL contain exactly one [1..1] structuredBody (CONF:30660). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30661 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30661) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30662 Added |  | SHALL contain exactly one [1..1] Allergies Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.6.1.2) (CONF:30662). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30663 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30663) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30664 Added |  | SHALL contain exactly one [1..1] Medications Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.1.1.2) (CONF:30664). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30665 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30665) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30666 Added |  | SHALL contain exactly one [1..1] Problem Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.5.1.2) (CONF:30666). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30667 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30667) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30668 Added |  | SHALL contain exactly one [1..1] Procedures Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.7.1.2) (CONF:30668). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30669 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30669) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30670 Added |  | SHALL contain exactly one [1..1] Results Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.3.1.2) (CONF:30670). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30671 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30671) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30672 Added |  | SHALL contain exactly one [1..1] Advance Directives Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.21.2) (CONF:30672). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30673 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30673) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30674 Added |  | SHALL contain exactly one [1..1] Encounters Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.22.2) (CONF:30674). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30675 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30675) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30676 Added |  | SHALL contain exactly one [1..1] Family History Section (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:30676). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30677 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30677) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30678 Added |  | SHALL contain exactly one [1..1] Functional Status Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.14.2) (CONF:30678). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30679 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30679) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30680 Added |  | SHALL contain exactly one [1..1] Immunizations Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.2.1.2) (CONF:30680). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30681 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30681) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30682 Added |  | SHALL contain exactly one [1..1] Medical Equipment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.23.2) (CONF:30682). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30683 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30683) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30684 Added |  | SHALL contain exactly one [1..1] Payers Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.18.2) (CONF:30684). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30685 Added |  | This structuredBody SHOULD contain zero or one [0..1] component (CONF:30685) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30686 Added |  | SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30686). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30687 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30687) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30688 Added |  | SHALL contain exactly one [1..1] Social History Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:30688). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30689 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30689) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30690 Added |  | SHALL contain exactly one [1..1] Vital Signs Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.4.1.2) (CONF:30690). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30882 Added |  | The assignedEntity, if present, SHOULD contain zero or one [0..1] id (CONF:30882) such that it |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 30883 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:30883). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9445 Removed | SHALL contain exactly one [1..1] Allergies Section (entries required) (templateId:2.16.840.1.113883.10.20.22.2.6.1) (CONF:9445). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9447 Removed | SHALL contain exactly one [1..1] Medications Section (entries required) (templateId:2.16.840.1.113883.10.20.22.2.1.1) (CONF:9447). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9449 Removed | SHALL contain exactly one [1..1] Problem Section (entries required) (templateId:2.16.840.1.113883.10.20.22.2.5.1) (CONF:9449). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9451 Removed | SHOULD contain zero or one [0..1] Procedures Section (entries required) (templateId:2.16.840.1.113883.10.20.22.2.7.1) (CONF:9451). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9453 Removed | SHALL contain exactly one [1..1] Results Section (entries required) (templateId:2.16.840.1.113883.10.20.22.2.3.1) (CONF:9453). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9455 Removed | MAY contain zero or one [0..1] Payers Section (templateId:2.16.840.1.113883.10.20.22.2.18) (CONF:9455). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9536 Removed | The component/structuredBody SHALL conform to the section constraints below (CONF:9536). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9974 Removed | MAY contain zero or one [0..1] Social History Section (templateId:2.16.840.1.113883.10.20.22.2.17) (CONF:9974). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9975 Removed | MAY contain zero or one [0..1] Medical Equipment Section (templateId:2.16.840.1.113883.10.20.22.2.23) (CONF:9975). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9976 Removed | MAY contain zero or one [0..1] Immunizations Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.2) (CONF:9976). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9977 Removed | MAY contain zero or one [0..1] Functional Status Section (templateId:2.16.840.1.113883.10.20.22.2.14) (CONF:9977). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9978 Removed | MAY contain zero or one [0..1] Family History Section (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:9978). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9979 Removed | MAY contain zero or one [0..1] Encounters Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.22) (CONF:9979). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9980 Removed | MAY contain zero or one [0..1] Advance Directives Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.21) (CONF:9980). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9981 Removed | MAY contain zero or one [0..1] Plan of Care Section (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9981). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 9983 Removed | MAY contain zero or one [0..1] Vital Signs Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.4) (CONF:9983). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 10026 Removed | ServiceEvent/performer represents the healthcare providers involved in the current or pertinent historical care of the patient. Preferably, the patient’s key healthcare providers would be listed, particularly their primary physician and any active consulting physicians, therapists, and counselors (CONF:10026). |  |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 8482 Modified | This serviceEvent SHOULD contain zero or more [0..\*] performer (CONF:8482). | serviceEvent/performer represents the healthcare providers involved in the current or pertinent historical care of the patient. Preferably, the patient’s key healthcare providers would be listed, particularly their primary physician and any active consulting physicians, therapists, and counselors  This serviceEvent SHOULD contain zero or more [0..\*] performer (CONF:8482). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 10038 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.2" (CONF:10038). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.2.2" (CONF:10038). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | CONF #: 17180 Modified | SHALL contain exactly one [1..1] code (CONF:17180). | In accordance with the CDA specification, the ClinicalDocument/code element must be present and specify the type of the clinical document. CCD requires the document type code 34133-9 "Summarization of Episode Note".  SHALL contain exactly one [1..1] code (CONF:17180). |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | Name | Continuity of Care Document (CCD) | Continuity of Care Document (CCD) (V2) |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | Oid | 2.16.840.1.113883.10.20.22.1.2 | 2.16.840.1.113883.10.20.22.1.2.2 |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | Description | This section—Continuity of Care Document (CCD) Release 1.1—describes CDA constraints in accordance with Stage 1 Meaningful Use. The CCD requirements in this guide supersede CCD Release 1; in the near future, this guide could supersede HITSP C32.    The CCD is a core data set of the most relevant administrative, demographic, and clinical information facts about a patient's healthcare, covering one or more healthcare encounters. It provides a means for one healthcare practitioner, system, or setting to aggregate all of the pertinent data about a patient and forward it to another practitioner, system, or setting to support the continuity of care. The primary use case for the CCD is to provide a snapshot in time containing the pertinent clinical, demographic, and administrative data for a specific patient . More specific use cases, such as a Discharge Summary or Progress Note, are available as alternative documents in this guide. | The Continuity of Care Document (CCD) represents a core data set of the most relevant administrative, demographic, and clinical information facts about a patient's healthcare, covering one or more healthcare encounters. It provides a means for one healthcare practitioner, system, or setting to aggregate all of the pertinent data about a patient and forward it to another to support the continuity of care.  The primary use case for the CCD is to provide a snapshot in time containing the germane clinical, demographic, and administrative data for a specific patient. More specific use cases, such as a Discharge Summary or Progress Note, are available as alternative documents in this guide. |
| [Continuity of Care Document (CCD) (V2) 2.16.840.1.113883.10.20.22.1.2.2](#D_Continuity_of_Care_Document_CCD_V2) | Implied Template | US Realm Header (2.16.840.1.113883.10.20.22.1.1) | US Realm Header (V2) (2.16.840.1.113883.10.20.22.1.1.2) |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30695 Added |  | This component SHALL contain exactly one [1..1] structuredBody (CONF:30695). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30696 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30696) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30697 Added |  | SHALL contain exactly one [1..1] Findings Section (DIR) (templateId:2.16.840.1.113883.10.20.6.1.2) (CONF:30697). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30698 Added |  | This structuredBody SHOULD contain zero or one [0..1] component (CONF:30698) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30699 Added |  | SHALL contain exactly one [1..1] DICOM Object Catalog Section - DCM 121181 (templateId:2.16.840.1.113883.10.20.6.1.1) (CONF:30699). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30932 Added |  | SHALL contain exactly one [1..1] id (CONF:30932). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30933 Added |  | This id SHALL contain exactly one [1..1] @root (CONF:30933). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30934 Added |  | OIDs SHALL be represented in dotted decimal notation, where each decimal number is either 0 or starts with a nonzero digit. More formally, an OID SHALL be in the form ([0-2])(.([1-9][0-9]\*|0))+  The ClinicalDocument/id/@root attribute SHALL be a syntactically correct OID, and SHALL NOT be a UUID (CONF:30934). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30935 Added |  | OIDs SHALL be no more than 64 characters in length (CONF:30935). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30936 Added |  | An inFulfillmentOf element represents the Placer Order that is either a group of orders (modeled as PlacerGroup in the Placer Order RMIM of the Orders & Observations domain) or a single order item (modeled as ObservationRequest in the same RMIM). This optionality reflects two major approaches to the grouping of procedures as implemented in the installed base of imaging information systems. These approaches differ in their handling of grouped procedures and how they are mapped to identifiers in the Digital Imaging and Communications in Medicine (DICOM) image and structured reporting data. The example of a CT examination covering chest, abdomen, and pelvis will be used in the discussion below.  In the IHE Scheduled Workflow model, the Chest CT, Abdomen CT, and Pelvis CT each represent a Requested Procedure, and all three procedures are grouped under a single Filler Order. The Filler Order number maps directly to the DICOM Accession Number in the DICOM imaging and report data.  A widely deployed alternative approach maps the requested procedure identifiers directly to the DICOM Accession Number. The Requested Procedure ID in such implementations may or may not be different from the Accession Number, but is of little identifying importance because there is only one Requested Procedure per Accession Number. There is no identifier that formally connects the requested procedures ordered in this group.  MAY contain zero or more [0..\*] inFulfillmentOf (CONF:30936). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30937 Added |  | The inFulfillmentOf, if present, SHALL contain exactly one [1..1] order (CONF:30937). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30938 Added |  | inFulfillmentOf/order/id is mapped to the DICOM Accession Number in the imaging data.  This order SHALL contain at least one [1..\*] id (CONF:30938). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30939 Added |  | The id element of the encompassingEncounter represents the identifier for the encounter. When the diagnostic imaging procedure is performed in the context of a hospital stay or an outpatient visit for which there is an Encounter Number, that number should be present as the ID of the encompassingEncounter.  The effectiveTime represents the time interval or point in time in which the encounter took place. The encompassing encounter might be that of the hospital or office visit in which the diagnostic imaging procedure was performed. If the effective time is unknown, a nullFlavor attribute can be used.  MAY contain zero or one [0..1] componentOf (CONF:30939). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30940 Added |  | The componentOf, if present, SHALL contain exactly one [1..1] encompassingEncounter (CONF:30940). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30941 Added |  | This encompassingEncounter SHALL contain at least one [1..\*] id (CONF:30941). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30942 Added |  | In the case of transformed DICOM SR documents, an appropriate null flavor MAY be used if the id is unavailable (CONF:30942). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30943 Added |  | This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:30943). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30944 Added |  | This effectiveTime SHALL contain exactly one [1..1] US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:30944). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30945 Added |  | This encompassingEncounter MAY contain zero or one [0..1] responsibleParty (CONF:30945). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30946 Added |  | The responsibleParty, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:30946). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30947 Added |  | SHOULD contain zero or one [0..1] assignedPerson OR contain zero or one [0..1] representedOrganization (CONF:30947). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 30948 Added |  | This encompassingEncounter SHOULD contain zero or one [0..1] Physician of Record Participant (V2) (templateId:2.16.840.1.113883.10.20.6.2.2.2) (CONF:30948). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31055 Added |  | A Diagnostic Imaging Report may contain CDA entries that represent, in coded form findings, image references, annotation, and numeric measurements based on DICOM Basic Diagnostic Imaging Report (Template 2000) and Transcribed Diagnostic Imaging Report (Template 2005). Most of the constraints for this document have been inherited from the DICOM PS 3.20 “Transformation of DICOM to and from HL7 Standards”.   This document type and the companion DICOM PS 3.20 “Transformation of DICOM to and from HL7 Standards guidefurther constrain the transformation because image Spatial Coordinates region of interest (SCOORD) for linear, area, and volume measurements are not encoded in the CDA document. If it is desired to show images with such graphical annotations, the annotations should be encoded in DICOM Softcopy Presentation State objects that reference the image. Report applications that display referenced images and annotation should retrieve a rendered image using a WADO reference, including the image and Presentation State, or other DICOM retrieval and rendering methods. This approach avoids the risks of errors in registering a region of interest annotation with DICOM images.  DICOM Template 2000 defines imaging report documents that are comprised of a number of optional sections.   This structuredBody MAY contain zero or more [0..\*] component (CONF:31055) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31056 Added |  | SHALL contain exactly one [1..1] section (CONF:31056). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31057 Added |  | This section SHALL contain exactly one [1..1] code (CONF:31057). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31058 Added |  | There is no equivalent to section/title in DICOM SR, so for a CDA to SR transformation, the section/code will be transferred and the title element will be dropped.  This section SHOULD contain zero or one [0..1] title (CONF:31058). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31059 Added |  | This section SHOULD contain zero or one [0..1] text (CONF:31059). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31060 Added |  | If clinical statements are present, the section/text SHALL represent faithfully all such statements and MAY contain additional text (CONF:31060). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31061 Added |  | All text elements SHALL contain content. Text elements SHALL contain PCDATA or child elements (CONF:31061). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31062 Added |  | The text elements (and their children) MAY contain Web Access to DICOM Persistent Object (WADO) references to DICOM objects by including a linkHtml element where @href is a valid WADO URL and the text content of linkHtml is the visible text of the hyperlink (CONF:31062). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31198 Added |  | SHALL contain exactly one [1..1] associatedEntity (CONF:31198). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31199 Added |  | This associatedEntity SHALL contain exactly one [1..1] associatedPerson (CONF:31199). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31200 Added |  | This associatedPerson SHALL contain exactly one [1..1] US Realm Person Name (PN.US.FIELDED) (templateId:2.16.840.1.113883.10.20.22.5.1.1) (CONF:31200). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31206 Added |  | The DICOM Object Catalog section (templateId 2.16.840.1.113883.10.20.6.1.1), if present, SHALL be the first section in the document Body (CONF:31206). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31207 Added |  | For sections listed in the DIR Section Type Codes table, the code element must contain a LOINC code or DCM code for sections that have no LOINC equivalent  This code SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet DIRSectionTypeCodes 2.16.840.1.113883.11.20.9.59 DYNAMIC (CONF:31207).  Note: The section/code SHOULD be selected from LOINC or DICOM for sections not listed in the DIR Section Type Codes table |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31208 Added |  | This section MAY contain zero or more [0..\*] component (CONF:31208). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31210 Added |  | SHALL contain child elements (CONF:31210). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31211 Added |  | All sections defined in the DIR Section Type Codes table SHALL be top-level sections (CONF:31211). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31212 Added |  | SHALL contain at least one text element or one or more component elements (CONF:31212). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31213 Added |  | If the service context of a section is different from the value specified in documentationOf/serviceEvent, then the section SHALL contain one or more entries containing Procedure Context (templateId 2.16.840.1.113883.10.20.6.2.5), which will reset the context for any clinical statements nested within those elements  This section MAY contain zero or more [0..\*] entry (CONF:31213) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31214 Added |  | SHALL contain exactly one [1..1] Procedure Context (templateId:2.16.840.1.113883.10.20.6.2.5) (CONF:31214). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31215 Added |  | This subject is used if the subject of a section is a fetus. The information on the mother is in the CDA header.  This section MAY contain zero or more [0..\*] subject (CONF:31215) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31216 Added |  | SHALL contain exactly one [1..1] Fetus Subject Context (templateId:2.16.840.1.113883.10.20.6.2.3) (CONF:31216). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31217 Added |  | This author element is used when the author of a section is different from the author(s) listed in the Header  This section MAY contain zero or more [0..\*] author (CONF:31217) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31218 Added |  | SHALL contain exactly one [1..1] Observer Context (templateId:2.16.840.1.113883.10.20.6.2.4) (CONF:31218). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31357 Added |  | This section MAY contain zero or more [0..\*] entry (CONF:31357) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31358 Added |  | SHALL contain exactly one [1..1] Text Observation (templateId:2.16.840.1.113883.10.20.6.2.12) (CONF:31358). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31359 Added |  | This section MAY contain zero or more [0..\*] entry (CONF:31359) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31360 Added |  | SHALL contain exactly one [1..1] Code Observations (templateId:2.16.840.1.113883.10.20.6.2.13) (CONF:31360). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31361 Added |  | This section MAY contain zero or more [0..\*] entry (CONF:31361) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31362 Added |  | SHALL contain exactly one [1..1] Quantity Measurement Observation (templateId:2.16.840.1.113883.10.20.6.2.14) (CONF:31362). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31363 Added |  | This section MAY contain zero or more [0..\*] entry (CONF:31363) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 31364 Added |  | SHALL contain exactly one [1..1] SOP Instance Observation (templateId:2.16.840.1.113883.10.20.6.2.8) (CONF:31364). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8405 Removed | The ClinicalDocument/id/@root attribute SHALL be a syntactically correct OID, and SHALL NOT be a UUID (CONF:8405). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8406 Removed | OIDs SHALL be represented in dotted decimal notation, where each decimal number is either 0 or starts with a nonzero digit. More formally, an OID SHALL be in the form ([0-2])(.([1-9][0-9]\*|0))+ (CONF:8406). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8407 Removed | OIDs SHALL be no more than 64 characters in length (CONF:8407). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8408 Removed | SHALL contain exactly one [1..1] code/@code, which SHALL be selected from ValueSet DIRDocumentTypeCodes 2.16.840.1.113883.11.20.9.32 DYNAMIC (CONF:8408). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8415 Removed | SHALL contain exactly one [1..1] assignedPerson (CONF:8415). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8434 Removed | This id MAY contain zero or one [0..1] componentOf (CONF:8434). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8435 Removed | This encompassingEncounter SHALL contain at least one [1..\*] id (CONF:8435). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8436 Removed | In the case of transformed DICOM SR documents, an appropriate null flavor MAY be used if the id is unavailable (CONF:8436). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8437 Removed | This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:8437). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8438 Removed | This encompassingEncounter MAY contain zero or one [0..1] responsibleParty (CONF:8438). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8439 Removed | SHOULD contain zero or one [0..1] assignedPerson OR SHOULD contain zero or one [0..1] representedOrganization (CONF:8439). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8448 Removed | This encompassingEncounter SHOULD contain zero or one [0..1] Physician of Record Participant (templateId:2.16.840.1.113883.10.20.6.2.2) (CONF:8448). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8449 Removed | The componentOf, if present, SHALL contain exactly one [1..1] encompassingEncounter (CONF:8449). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9406 Removed | This assignedPerson SHALL contain exactly one [1..1] name (CONF:9406). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9407 Removed | The responsibleParty, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:9407). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9408 Removed | The DICOM Object Catalog section (templateId 2.16.840.1.113883.10.20.6.1.1), if present, SHALL be the first section in the document Body (CONF:9408). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9409 Removed | With the exception of the DICOM Object Catalog (templateId 2.16.840.1.113883.10.20.6.1.1), all sections within the Diagnostic Imaging Report content SHOULD contain a title element (CONF:9409). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9410 Removed | The section/code SHOULD be selected from LOINC® or DICOM for sections not listed in the DIR Section Type Codes table (CONF:9410). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9411 Removed | All sections defined in the DIR Section Type Codes table SHALL be top-level sections (CONF:9411). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9412 Removed | A section element SHALL have a code element, which SHALL contain a LOINC code or DCM code for sections that have no LOINC equivalent. This only applies to sections described in the DIR Section Type Codes table (CONF:9412). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9413 Removed | Apart from the DICOM Object Catalog (templateId 2.16.840.1.113883.10.20.6.1.1), all other instances of section SHALL contain at least one text element or one or more component elements (CONF:9413). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9414 Removed | All text or component elements SHALL contain content. Text elements SHALL contain PCDATA or child elements, and component elements SHALL contain child elements (CONF:9414). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9415 Removed | The text elements (and their children) MAY contain Web Access to DICOM Persistent Object (WADO) references to DICOM objects by including a linkHtml element where @href is a valid WADO URL and the text content of linkHtml is the visible text of the hyperlink (CONF:9415). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9416 Removed | If clinical statements are present, the section/text SHALL represent faithfully all such statements and MAY contain additional text (CONF:9416). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9417 Removed | MAY contain zero or more [0..\*] Procedure Context (templateId:2.16.840.1.113883.10.20.6.2.5) (CONF:9417). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9418 Removed | If the service context of a section is different from the value specified in documentationOf/serviceEvent, then the section SHALL contain one or more entries containing Procedure Context (templateId 2.16.840.1.113883.10.20.6.2.5), which will reset the context for any clinical statements nested within those elements (CONF:9418). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9419 Removed | MAY contain zero or more [0..\*] Fetus Subject Context (templateId:2.16.840.1.113883.10.20.6.2.3) (CONF:9419). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9420 Removed | If the subject of a section is a fetus, the section SHALL contain a subject element containing a Fetus Subject Context (templateId 2.16.840.1.113883.10.20.6.2.3) (CONF:9420). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9421 Removed | MAY contain zero or more [0..\*] Observer Context (templateId:2.16.840.1.113883.10.20.6.2.4) (CONF:9421). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9422 Removed | : If the author of a section is different from the author(s) listed in the Header, an author element SHALL be present containing Observer Context (templateId 2.16.840.1.113883.10.20.6.2.4) (CONF:9422). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9423 Removed | Descriptions for sections is under development in DICOM in cooperation with the RSNA reporting initiative (CONF:9423). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 9484 Removed | SHALL contain exactly one [1..1] Findings Section (DIR) (templateId:2.16.840.1.113883.10.20.6.1.2) (CONF:9484). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 10133 Removed | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10133). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 10478 Removed | The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10478). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 14908 Removed | A Diagnostic Imaging Report can have either a structuredBody or a nonXMLBody (CONF:14908). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 14910 Removed | If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:14910). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 15141 Removed | SHOULD contain zero or one [0..1] DICOM Object Catalog Section - DCM 121181 (templateId:2.16.840.1.113883.10.20.6.1.1) (CONF:15141). |  |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8414 Modified | MAY contain zero or one [0..1] participant (CONF:8414) such that it | If participant is present, the associatedEntity/associatedPerson element SHALL be present and SHALL represent the physician requesting the imaging procedure (the referring physician AssociatedEntity that is the target of ClincalDocument/participant@typeCode=REF).  MAY contain zero or one [0..1] participant (CONF:8414) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8416 Modified | SHALL contain exactly one [1..1] documentationOf (CONF:8416) such that it | Each documentationOf/serviceEvent indicates an imaging procedure that the provider describes and interprets in the content of the DIR. The main activity being described by this document is the interpretation of the imaging procedure. This is shown by setting the value of the @classCode attribute of the serviceEvent element to ACT, and indicating the duration over which care was provided in the effectiveTime element. Within each documentationOf element, there is one serviceEvent element. This event is the unit imaging procedure corresponding to a billable item. The type of imaging procedure may be further described in the serviceEvent/code element. This guide makes no specific recommendations about the vocabulary to use for describing this event.  In IHE Scheduled Workflow environments, one serviceEvent/id element contains the DICOM Study Instance UID from the Modality Worklist, and the second serviceEvent/id element contains the DICOM Requested Procedure ID from the Modality Worklist. These two ids are in a single serviceEvent.  The effectiveTime for the serviceEvent covers the duration of the imaging procedure being reported. This event should have one or more performers, which may participate at the same or different periods of time.  Service events map to DICOM Requested Procedures. That is, documentationOf/serviceEvent/id is the ID of the Requested Procedure.  SHALL contain exactly one [1..1] documentationOf (CONF:8416) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8422 Modified | This serviceEvent SHOULD contain zero or more [0..\*] Physician Reading Study Performer (templateId:2.16.840.1.113883.10.20.6.2.1) (CONF:8422). | This serviceEvent SHOULD contain zero or more [0..\*] Physician Reading Study Performer (V2) (templateId:2.16.840.1.113883.10.20.6.2.1.2) (CONF:8422). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 8432 Modified | MAY contain zero or one [0..1] relatedDocument (CONF:8432) such that it | A DIR may have three types of parent document:  • A superseded version that the present document wholly replaces (typeCode = RPLC). DIRs may go through stages of revision prior to being legally authenticated. Such early stages may be drafts from transcription, those created by residents, or other preliminary versions. Policies not covered by this specification may govern requirements for retention of such earlier versions. Except for forensic purposes, the latest version in a chain of revisions represents the complete and current report.  • An original version that the present document appends (typeCode = APND). When a DIR is legally authenticated, it can be amended by a separate addendum document that references the original.  • A source document from which the present document is transformed (typeCode = XFRM). A DIR may be created by transformation from a DICOM Structured Report (SR) document or from another DIR. An example of the latter case is the creation of a derived document for inclusion of imaging results in a clinical document.  MAY contain zero or one [0..1] relatedDocument (CONF:8432) such that it |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 10042 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.5" (CONF:10042). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.5.2" (CONF:10042). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | CONF #: 14833 Modified | SHALL contain exactly one [1..1] code (CONF:14833). | Given that DIR documents may be transformed from established collections of imaging reports already stored with their own type codes, there is no static set of Document Type codes. The set of LOINC codes listed in the DIR LOINC Document Type Codes table may be extended by additions to LOINC and supplemented by local codes as translations.  The DIR document recommends use of a single document type code, 18748-4 "Diagnostic Imaging Report", with further specification provided by author or performer, setting, or specialty. Some of these codes in the DIR LOINC Document Type Codes table are pre-coordinated with either the imaging modality, body part examined, or specific imaging method such as the view. Use of these codes is not recommended, as this duplicates information potentially present with the header. When pre-coordinated codes are used, any coded values describing the author or performer of the service act or the practice setting must be consistent with the LOINC document type. This table is drawn from LOINC Version 2.36, June 30, 2011, and consists of codes whose scale is DOC and that refer to reports for diagnostic imaging procedures.  SHALL contain exactly one [1..1] code (CONF:14833). |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | Name | Diagnostic Imaging Report | Diagnostic Imaging Report (V2) |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | Oid | 2.16.840.1.113883.10.20.22.1.5 | 2.16.840.1.113883.10.20.22.1.5.2 |
| [Diagnostic Imaging Report (V2) 2.16.840.1.113883.10.20.22.1.5.2](#D_Diagnostic_Imaging_Report_V2) | Implied Template | US Realm Header (2.16.840.1.113883.10.20.22.1.1) | US Realm Header (V2) (2.16.840.1.113883.10.20.22.1.1.2) |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30518 Added |  | In this template (templateId 2.16.840.1.113883.10.20.22.1.8.2), coded entries are optional.  This component SHALL contain exactly one [1..1] structuredBody (CONF:30518). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30519 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30519) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30520 Added |  | SHALL contain exactly one [1..1] Allergies Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.6.2) (CONF:30520). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30521 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30521) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30522 Added |  | SHALL contain exactly one [1..1] Hospital Course Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.5) (CONF:30522). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30523 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30523) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30524 Added |  | SHALL contain exactly one [1..1] Hospital Discharge Diagnosis Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.24.2) (CONF:30524). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30525 Added |  | This structuredBody SHOULD contain zero or one [0..1] component (CONF:30525) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30526 Added |  | SHALL contain exactly one [1..1] Hospital Discharge Medications Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.11.2) (CONF:30526). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30527 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30527) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30528 Added |  | SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30528). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30529 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30529) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30530 Added |  | SHALL contain exactly one [1..1] Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:30530). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30531 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30531) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30532 Added |  | SHALL contain exactly one [1..1] Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:30532). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30533 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30533) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30534 Added |  | SHALL contain exactly one [1..1] Nutrition Section (NEW) (templateId:2.16.840.1.113883.10.20.22.2.57) (CONF:30534). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30535 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30535) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30536 Added |  | SHALL contain exactly one [1..1] Family History Section (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:30536). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30537 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30537) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30538 Added |  | SHALL contain exactly one [1..1] Functional Status Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.14.2) (CONF:30538). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30539 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30539) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30540 Added |  | SHALL contain exactly one [1..1] History of Past Illness Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.20.2) (CONF:30540). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30541 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30541) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30542 Added |  | SHALL contain exactly one [1..1] History of Present Illness Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:30542). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30543 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30543) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30544 Added |  | SHALL contain exactly one [1..1] Hospital Admission Diagnosis Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.43.2) (CONF:30544). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30545 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30545) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30546 Added |  | SHALL contain exactly one [1..1] Hospital Admission Medications Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.44.2) (CONF:30546). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30547 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30547) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30548 Added |  | SHALL contain exactly one [1..1] Hospital Consultations Section (templateId:2.16.840.1.113883.10.20.22.2.42) (CONF:30548). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30549 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30549) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30550 Added |  | SHALL contain exactly one [1..1] Hospital Discharge Instructions Section (templateId:2.16.840.1.113883.10.20.22.2.41) (CONF:30550). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30551 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30551) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30552 Added |  | SHALL contain exactly one [1..1] Hospital Discharge Physical Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.26) (CONF:30552). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30553 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30553) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30554 Added |  | SHALL contain exactly one [1..1] Hospital Discharge Studies Summary Section (templateId:2.16.840.1.113883.10.20.22.2.16) (CONF:30554). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30555 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30555) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30556 Added |  | SHALL contain exactly one [1..1] Immunizations Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.2.2) (CONF:30556). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30557 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30557) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30558 Added |  | SHALL contain exactly one [1..1] Problem Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.5.2) (CONF:30558). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30559 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30559) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30560 Added |  | SHALL contain exactly one [1..1] Procedures Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.7.2) (CONF:30560). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30561 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30561) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30562 Added |  | SHALL contain exactly one [1..1] Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:30562). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30563 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30563) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30564 Added |  | SHALL contain exactly one [1..1] Review of Systems Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:30564). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30565 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30565) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30566 Added |  | SHALL contain exactly one [1..1] Social History Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:30566). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30567 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30567) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30568 Added |  | SHALL contain exactly one [1..1] Vital Signs Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.4.2) (CONF:30568). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 30569 Added |  | SHALL NOT include a Chief Complaint and Reason for Visit Section with either a Chief Complaint Section or a Reason for Visit Section (CONF:30569). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 31586 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:31586) such that it |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 31587 Added |  | SHALL contain exactly one [1..1] Hospital Discharge Medications Section (entries required) (V2) (templateId:2.16.840.1.113883.10.20.22.2.11.1.2) (CONF:31587). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9537 Removed | A Discharge Summary can have either a structuredBody or a nonXMLBody (CONF:9537). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9538 Removed | A Discharge Summary can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.8), coded entries are optional (CONF:9538). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9540 Removed | If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9540). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9542 Removed | SHALL contain exactly one [1..1] Allergies Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.6) (CONF:9542). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9544 Removed | SHALL contain exactly one [1..1] Hospital Course Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.5) (CONF:9544). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9546 Removed | SHALL contain exactly one [1..1] Hospital Discharge Diagnosis Section (templateId:2.16.840.1.113883.10.20.22.2.24) (CONF:9546). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9548 Removed | SHALL contain exactly one [1..1] Hospital Discharge Medications Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.11) (CONF:9548). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9550 Removed | SHALL contain exactly one [1..1] Plan of Care Section (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9550). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9554 Removed | MAY contain zero or one [0..1] Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:9554). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9556 Removed | MAY contain zero or one [0..1] Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:9556). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9558 Removed | MAY contain zero or one [0..1] Discharge Diet Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.33) (CONF:9558). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9560 Removed | MAY contain zero or one [0..1] Family History Section (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:9560). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9562 Removed | MAY contain zero or one [0..1] Functional Status Section (templateId:2.16.840.1.113883.10.20.22.2.14) (CONF:9562). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9564 Removed | MAY contain zero or one [0..1] History of Past Illness Section (templateId:2.16.840.1.113883.10.20.22.2.20) (CONF:9564). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9566 Removed | MAY contain zero or one [0..1] History of Present Illness Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:9566). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9568 Removed | MAY contain zero or one [0..1] Hospital Discharge Physical Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.26) (CONF:9568). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9570 Removed | MAY contain zero or one [0..1] Hospital Discharge Studies Summary Section (templateId:2.16.840.1.113883.10.20.22.2.16) (CONF:9570). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9572 Removed | MAY contain zero or one [0..1] Immunizations Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.2) (CONF:9572). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9574 Removed | MAY contain zero or one [0..1] Problem Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.5) (CONF:9574). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9576 Removed | MAY contain zero or one [0..1] Procedures Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.7) (CONF:9576). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9578 Removed | MAY contain zero or one [0..1] Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:9578). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9580 Removed | MAY contain zero or one [0..1] Review of Systems Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:9580). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9582 Removed | MAY contain zero or one [0..1] Social History Section (templateId:2.16.840.1.113883.10.20.22.2.17) (CONF:9582). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9584 Removed | MAY contain zero or one [0..1] Vital Signs Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.4) (CONF:9584). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9924 Removed | MAY contain zero or one [0..1] Hospital Consultations Section (templateId:2.16.840.1.113883.10.20.22.2.42) (CONF:9924). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9926 Removed | MAY contain zero or one [0..1] Hospital Discharge Instructions Section (templateId:2.16.840.1.113883.10.20.22.2.41) (CONF:9926). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 9928 Removed | MAY contain zero or one [0..1] Hospital Admission Diagnosis Section (templateId:2.16.840.1.113883.10.20.22.2.43) (CONF:9928). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 10055 Removed | SHALL NOT include a Chief Complaint and Reason for Visit Section with either a Chief Complaint Section or a Reason for Visit Section (CONF:10055). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 10111 Removed | MAY contain zero or one [0..1] Hospital Admission Medications Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.44) (CONF:10111). |  |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | CONF #: 10044 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.8" (CONF:10044). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.8.2" (CONF:10044). |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | Name | Discharge Summary | Discharge Summary (V2) |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | Oid | 2.16.840.1.113883.10.20.22.1.8 | 2.16.840.1.113883.10.20.22.1.8.2 |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | Description | The Discharge Summary is a document that is a synopsis of a patient's admission to a hospital; it provides pertinent information for the continuation of care following discharge. The Joint Commission requires the following information to be included in the Discharge Summary:  • The reason for hospitalization  • The procedures performed  • The care, treatment, and services provided  • The patient’s condition and disposition at discharge  • Information provided to the patient and family  • Provisions for follow-up care | The Discharge Summary is a document which synopsizes a patient's admission to a hospital; it provides pertinent information for the continuation of care following discharge. The Joint Commission requires the following information to be included in the Discharge Summary:  • The reason for hospitalization  • The procedures performed  • The care, treatment, and services provided  • The patient’s condition and disposition at discharge  • Information provided to the patient and family  • Provisions for follow-up care |
| [Discharge Summary (V2) 2.16.840.1.113883.10.20.22.1.8.2](#D_Discharge_Summary_V2) | Implied Template | US Realm Header (2.16.840.1.113883.10.20.22.1.1) | US Realm Header (V2) (2.16.840.1.113883.10.20.22.1.1.2) |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30570 Added |  | In this template (templateId 2.16.840.1.113883.10.20.22.1.3.2), coded entries are optional.  This component SHALL contain exactly one [1..1] structuredBody (CONF:30570). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30571 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30571) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30572 Added |  | SHALL contain exactly one [1..1] Allergies Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.6.2) (CONF:30572). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30573 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30573) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30574 Added |  | SHALL contain exactly one [1..1] Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:30574). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30575 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30575) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30576 Added |  | SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30576). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30577 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30577) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30578 Added |  | SHALL contain exactly one [1..1] Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) (CONF:30578). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30579 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30579) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30580 Added |  | SHALL contain exactly one [1..1] Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:30580). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30581 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30581) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30582 Added |  | SHALL contain exactly one [1..1] Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:30582). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30583 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30583) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30584 Added |  | SHALL contain exactly one [1..1] Family History Section (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:30584). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30585 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30585) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30586 Added |  | SHALL contain exactly one [1..1] General Status Section (templateId:2.16.840.1.113883.10.20.2.5) (CONF:30586). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30587 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30587) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30588 Added |  | SHALL contain exactly one [1..1] History of Past Illness Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.20.2) (CONF:30588). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30589 Added |  | This structuredBody SHOULD contain zero or one [0..1] component (CONF:30589) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30590 Added |  | SHALL contain exactly one [1..1] History of Present Illness Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:30590). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30591 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30591) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30592 Added |  | SHALL contain exactly one [1..1] Immunizations Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.2.2) (CONF:30592). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30593 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30593) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 31385 Added |  | SHALL contain exactly one [1..1] Instructions Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.45.2) (CONF:31385). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30595 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30595) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30596 Added |  | SHALL contain exactly one [1..1] Medications Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.1.2) (CONF:30596). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30597 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30597) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30598 Added |  | SHALL contain exactly one [1..1] Physical Exam Section (V2) (templateId:2.16.840.1.113883.10.20.2.10.2) (CONF:30598). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30599 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30599) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30600 Added |  | SHALL contain exactly one [1..1] Problem Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.5.2) (CONF:30600). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30601 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30601) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30602 Added |  | SHALL contain exactly one [1..1] Procedures Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.7.2) (CONF:30602). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30603 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30603) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30604 Added |  | SHALL contain exactly one [1..1] Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:30604). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30605 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30605) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30606 Added |  | SHALL contain exactly one [1..1] Results Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.3.2) (CONF:30606). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30607 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30607) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30608 Added |  | SHALL contain exactly one [1..1] Review of Systems Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:30608). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30609 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30609) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30610 Added |  | SHALL contain exactly one [1..1] Social History Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:30610). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30611 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30611) such that it |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30612 Added |  | SHALL contain exactly one [1..1] Vital Signs Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.4.2) (CONF:30612). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30613 Added |  | SHALL include a Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13), a Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1), or a Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:30613). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30614 Added |  | SHALL include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2), or an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30614). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30615 Added |  | SHALL NOT include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) are present (CONF:30615). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 30616 Added |  | SHALL NOT contain a Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) is present (CONF:30616). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 8350 Removed | A History and Physical document can have either a structuredBody or a nonXMLBody (CONF:8350). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 8352 Removed | A History and Physical document can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.3), coded entries are optional (CONF:8352). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9597 Removed | If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9597). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9602 Removed | SHALL contain exactly one [1..1] Allergies Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.6) (CONF:9602). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9605 Removed | MAY contain zero or one [0..1] Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:9605). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9607 Removed | MAY contain zero or one [0..1] Plan of Care Section (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9607). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9611 Removed | MAY contain zero or one [0..1] Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:9611). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9613 Removed | MAY contain zero or one [0..1] Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:9613). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9615 Removed | SHALL contain exactly one [1..1] Family History Section (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:9615). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9617 Removed | SHALL contain exactly one [1..1] General Status Section (templateId:2.16.840.1.113883.10.20.2.5) (CONF:9617). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9619 Removed | SHALL contain exactly one [1..1] History of Past Illness Section (templateId:2.16.840.1.113883.10.20.22.2.20) (CONF:9619). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9621 Removed | SHOULD contain zero or one [0..1] History of Present Illness Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:9621). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9623 Removed | SHALL contain exactly one [1..1] Medications Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.1) (CONF:9623). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9625 Removed | SHALL contain exactly one [1..1] Physical Exam Section (templateId:2.16.840.1.113883.10.20.2.10) (CONF:9625). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9627 Removed | MAY contain [] Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:9627). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9629 Removed | SHALL contain exactly one [1..1] Results Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.3) (CONF:9629). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9631 Removed | SHALL contain exactly one [1..1] Review of Systems Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:9631). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9633 Removed | SHALL contain exactly one [1..1] Social History Section (templateId:2.16.840.1.113883.10.20.22.2.17) (CONF:9633). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9635 Removed | SHALL contain exactly one [1..1] Vital Signs Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.4) (CONF:9635). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9642 Removed | SHALL include a Chief Complaint and Reason for Visit Section, Chief Complaint Section, or a Reason for Visit Section (CONF:9642). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9986 Removed | SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan Section (CONF:9986). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9987 Removed | MAY contain zero or one [0..1] Assessment and Plan Section (templateId:2.16.840.1.113883.10.20.22.2.9) (CONF:9987). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9988 Removed | MAY contain zero or one [0..1] Immunizations Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.2) (CONF:9988). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9989 Removed | MAY contain zero or one [0..1] Problem Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.5) (CONF:9989). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 9990 Removed | MAY contain zero or one [0..1] Procedures Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.7) (CONF:9990). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 10056 Removed | SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:10056). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 10057 Removed | SHALL NOT contain a Chief Complaint and Reason for Visit Section when either a Chief Complaint Section or a Reason for Visit Section is present (CONF:10057). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 16807 Removed | MAY contain zero or one [0..1] Instructions Section (templateId:2.16.840.1.113883.10.20.22.2.45) (CONF:16807). |  |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 10046 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.3" (CONF:10046). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.3.2" (CONF:10046). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | CONF #: 10135 Modified | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10135). | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10135). |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | Name | History and Physical | History and Physical (V2) |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | Oid | 2.16.840.1.113883.10.20.22.1.3 | 2.16.840.1.113883.10.20.22.1.3.2 |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | Description | A History and Physical (H&P) Note is a medical report that documents the current and past conditions of the patient. It contains essential information that helps determine an individual's health status.    The first portion of the report is a current collection of organized information unique to an individual, typically supplied by the patient or their caregiver, about the current medical problem or the reason for the patient encounter. This information is followed by a description of any past or ongoing medical issues, including current medications and allergies. Information is also obtained about the patient's lifestyle, habits, and diseases among family members.    The next portion of the report contains information obtained by physically examining the patient and gathering diagnostic information in the form of laboratory tests, imaging, or other diagnostic procedures.    The report ends with the clinician's assessment of the patient's situation and the intended plan to address those issues.    A History and Physical Examination is required upon hospital admission as well as before operative procedures. An initial evaluation in an ambulatory setting is often documented in the form of an H&P Note. | A History and Physical (H&P) Note is a medical report that documents the current and past conditions of the patient. It contains essential information that helps determine an individual's health status.  The first portion of the report is a current collection of organized information unique to an individual. This is typically supplied by the patient or their caregiver, concerning the current medical problem or the reason for the patient encounter. This information is followed by a description of any past or ongoing medical issues, including current medications and allergies. Information is also obtained about the patient's lifestyle, habits, and diseases among family members.  The next portion of the report contains information obtained by physically examining the patient and gathering diagnostic information in the form of laboratory tests, imaging, or other diagnostic procedures.  The report ends with the clinician's assessment of the patient's situation and the intended plan to address those issues.  A History and Physical Examination is required upon hospital admission as well as before operative procedures. An initial evaluation in an ambulatory setting is often documented in the form of an H&P note. |
| [History and Physical (V2) 2.16.840.1.113883.10.20.22.1.3.2](#D_History_and_Physical_V2) | Implied Template | US Realm Header (2.16.840.1.113883.10.20.22.1.1) | US Realm Header (V2) (2.16.840.1.113883.10.20.22.1.1.2) |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30485 Added |  | This component SHALL contain exactly one [1..1] structuredBody (CONF:30485). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30486 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30486) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30487 Added |  | SHALL contain exactly one [1..1] Anesthesia Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.25.2) (CONF:30487). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30488 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30488) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30489 Added |  | SHALL contain exactly one [1..1] Complications Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.37.2) (CONF:30489). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30490 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30490) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30491 Added |  | SHALL contain exactly one [1..1] Preoperative Diagnosis Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.34.2) (CONF:30491). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30492 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30492) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30493 Added |  | SHALL contain exactly one [1..1] Procedure Estimated Blood Loss Section (templateId:2.16.840.1.113883.10.20.18.2.9) (CONF:30493). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30494 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30494) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30495 Added |  | SHALL contain exactly one [1..1] Procedure Findings Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.28.2) (CONF:30495). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30496 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30496) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30497 Added |  | SHALL contain exactly one [1..1] Procedure Specimens Taken Section (templateId:2.16.840.1.113883.10.20.22.2.31) (CONF:30497). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30498 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30498) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30499 Added |  | SHALL contain exactly one [1..1] Procedure Description Section (templateId:2.16.840.1.113883.10.20.22.2.27) (CONF:30499). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30500 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30500) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30501 Added |  | SHALL contain exactly one [1..1] Postoperative Diagnosis Section (templateId:2.16.840.1.113883.10.20.22.2.35) (CONF:30501). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30502 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30502) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30503 Added |  | SHALL contain exactly one [1..1] Procedure Implants Section (templateId:2.16.840.1.113883.10.20.22.2.40) (CONF:30503). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30504 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30504) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30505 Added |  | SHALL contain exactly one [1..1] Operative Note Fluids Section (templateId:2.16.840.1.113883.10.20.7.12) (CONF:30505). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30506 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30506) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30507 Added |  | SHALL contain exactly one [1..1] Operative Note Surgical Procedure Section (templateId:2.16.840.1.113883.10.20.7.14) (CONF:30507). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30508 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30508) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30509 Added |  | SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30509). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30510 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30510) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30511 Added |  | SHALL contain exactly one [1..1] Planned Procedure Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.30.2) (CONF:30511). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30512 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30512) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30513 Added |  | SHALL contain exactly one [1..1] Procedure Disposition Section (templateId:2.16.840.1.113883.10.20.18.2.12) (CONF:30513). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30514 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30514) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30515 Added |  | SHALL contain exactly one [1..1] Procedure Indications Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.29.2) (CONF:30515). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30516 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30516) such that it |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 30517 Added |  | SHALL contain exactly one [1..1] Surgical Drains Section (templateId:2.16.840.1.113883.10.20.7.13) (CONF:30517). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9586 Removed | An Operative Note can have either a structuredBody or a nonXMLBody (CONF:9586). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9587 Removed | An Operative Note can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.7), coded entries are optional (CONF:9587). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9596 Removed | If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9596). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9883 Removed | SHALL contain exactly one [1..1] Anesthesia Section (templateId:2.16.840.1.113883.10.20.22.2.25) (CONF:9883). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9885 Removed | SHALL contain exactly one [1..1] Complications Section (templateId:2.16.840.1.113883.10.20.22.2.37) (CONF:9885). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9888 Removed | SHALL contain exactly one [1..1] Preoperative Diagnosis Section (templateId:2.16.840.1.113883.10.20.22.2.34) (CONF:9888). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9890 Removed | SHALL contain exactly one [1..1] Procedure Estimated Blood Loss Section (templateId:2.16.840.1.113883.10.20.18.2.9) (CONF:9890). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9892 Removed | SHALL contain exactly one [1..1] Procedure Findings Section (templateId:2.16.840.1.113883.10.20.22.2.28) (CONF:9892). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9894 Removed | SHALL contain exactly one [1..1] Procedure Specimens Taken Section (templateId:2.16.840.1.113883.10.20.22.2.31) (CONF:9894). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9896 Removed | SHALL contain exactly one [1..1] Procedure Description Section (templateId:2.16.840.1.113883.10.20.22.2.27) (CONF:9896). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9898 Removed | MAY contain zero or one [0..1] Procedure Implants Section (templateId:2.16.840.1.113883.10.20.22.2.40) (CONF:9898). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9900 Removed | MAY contain zero or one [0..1] Operative Note Fluids Section (templateId:2.16.840.1.113883.10.20.7.12) (CONF:9900). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9902 Removed | MAY contain zero or one [0..1] Operative Note Surgical Procedure Section (templateId:2.16.840.1.113883.10.20.7.14) (CONF:9902). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9904 Removed | MAY contain zero or one [0..1] Plan of Care Section (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9904). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9906 Removed | MAY contain zero or one [0..1] Planned Procedure Section (templateId:2.16.840.1.113883.10.20.22.2.30) (CONF:9906). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9908 Removed | MAY contain zero or one [0..1] Procedure Disposition Section (templateId:2.16.840.1.113883.10.20.18.2.12) (CONF:9908). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9910 Removed | MAY contain zero or one [0..1] Procedure Indications Section (templateId:2.16.840.1.113883.10.20.22.2.29) (CONF:9910). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9912 Removed | MAY contain zero or one [0..1] Surgical Drains Section (templateId:2.16.840.1.113883.10.20.7.13) (CONF:9912). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 9913 Removed | SHALL contain exactly one [1..1] Postoperative Diagnosis Section (templateId:2.16.840.1.113883.10.20.22.2.35) (CONF:9913). |  |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 8487 Modified | I. The value of Clinical Document /documentationOf/serviceEvent/code SHALL be from ICD9 CM Procedures (CodeSystem 2.16.840.1.113883.6.104), CPT-4 (CodeSystem 2.16.840.1.113883.6.12), or values descending from 71388002 (Procedure) from the SNOMED CT (CodeSystem 2.16.840.1.113883.6.96) ValueSet Procedure 2.16.840.1.113883.3.88.12.80.28 DYNAMIC (CONF:8487). | The value of Clinical Document /documentationOf/serviceEvent/code SHALL be from ICD9 CM Procedures (CodeSystem 2.16.840.1.113883.6.104), CPT-4 (CodeSystem 2.16.840.1.113883.6.12), or values descending from 71388002 (Procedure) from the SNOMED CT (CodeSystem 2.16.840.1.113883.6.96) ValueSet Procedure 2.16.840.1.113883.3.88.12.80.28 DYNAMIC (CONF:8487). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 10048 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.7" (CONF:10048). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.7.2" (CONF:10048). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | CONF #: 10136 Modified | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10136). | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10136). |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | Name | Operative Note | Operative Note (V2) |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | Oid | 2.16.840.1.113883.10.20.22.1.7 | 2.16.840.1.113883.10.20.22.1.7.2 |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | Description | The Operative Note is a frequently used type of procedure note with specific requirements set forth by regulatory agencies.  The Operative Note or Report is created immediately following a surgical or other high-risk procedure and records the pre- and post-surgical diagnosis, pertinent events of the procedure, as well as the condition of the patient following the procedure. The report should be sufficiently detailed to support the diagnoses, justify the treatment, document the course of the procedure, and provide continuity of care. | The Operative Note is a frequently used type of procedure note with specific requirements set forth by regulatory agencies.  The Operative Note is created immediately following a surgical or other high-risk procedure. It records the pre and post-surgical diagnosis, pertinent events of the procedure, as well as the condition of the patient following the procedure. The report should be sufficiently detailed to support the diagnoses, justify the treatment, document the course of the procedure, and provide continuity of care. |
| [Operative Note (V2) 2.16.840.1.113883.10.20.22.1.7.2](#D_Operative_Note_V2) | Implied Template | US Realm Header (2.16.840.1.113883.10.20.22.1.1) | US Realm Header (V2) (2.16.840.1.113883.10.20.22.1.1.2) |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30352 Added |  | This component SHALL contain exactly one [1..1] structuredBody (CONF:30352). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30353 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30353) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30355 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30355) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30356 Added |  | SHALL contain exactly one [1..1] Procedure Description Section (templateId:2.16.840.1.113883.10.20.22.2.27) (CONF:30356). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30357 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30357) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30358 Added |  | SHALL contain exactly one [1..1] Procedure Indications Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.29.2) (CONF:30358). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30359 Added |  | This structuredBody SHALL contain exactly one [1..1] component (CONF:30359) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30360 Added |  | SHALL contain exactly one [1..1] Postprocedure Diagnosis Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.36.2) (CONF:30360). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30361 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30361) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30362 Added |  | SHALL contain exactly one [1..1] Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:30362). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30363 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30363) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30364 Added |  | SHALL contain exactly one [1..1] Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) (CONF:30364). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30365 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30365) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30366 Added |  | SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30366). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30367 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30367) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30368 Added |  | SHALL contain exactly one [1..1] Allergies Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.6.2) (CONF:30368). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30369 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30369) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30370 Added |  | SHALL contain exactly one [1..1] Anesthesia Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.25.2) (CONF:30370). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30371 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30371) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30372 Added |  | SHALL contain exactly one [1..1] Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:30372). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30373 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30373) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30374 Added |  | SHALL contain exactly one [1..1] Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:30374). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30375 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30375) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30376 Added |  | SHALL contain exactly one [1..1] Family History Section (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:30376). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30377 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30377) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30378 Added |  | SHALL contain exactly one [1..1] History of Past Illness Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.20.2) (CONF:30378). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30379 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30379) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30380 Added |  | SHALL contain exactly one [1..1] History of Present Illness Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:30380). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30381 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30381) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30382 Added |  | SHALL contain exactly one [1..1] Medical (General) History Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.39.2) (CONF:30382). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30383 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30383) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30384 Added |  | SHALL contain exactly one [1..1] Medications Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.1.2) (CONF:30384). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30387 Added |  | SHALL contain exactly one [1..1] Complications Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.37.2) (CONF:30387). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30388 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30388) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30389 Added |  | SHALL contain exactly one [1..1] Medications Administered Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.38.2) (CONF:30389). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30390 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30390) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30391 Added |  | SHALL contain exactly one [1..1] Physical Exam Section (V2) (templateId:2.16.840.1.113883.10.20.2.10.2) (CONF:30391). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30392 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30392) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30393 Added |  | SHALL contain exactly one [1..1] Planned Procedure Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.30.2) (CONF:30393). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30394 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30394) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30395 Added |  | SHALL contain exactly one [1..1] Procedure Disposition Section (templateId:2.16.840.1.113883.10.20.18.2.12) (CONF:30395). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30396 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30396) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30397 Added |  | SHALL contain exactly one [1..1] Procedure Estimated Blood Loss Section (templateId:2.16.840.1.113883.10.20.18.2.9) (CONF:30397). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30398 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30398) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30399 Added |  | SHALL contain exactly one [1..1] Procedure Findings Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.28.2) (CONF:30399). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30400 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30400) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30401 Added |  | SHALL contain exactly one [1..1] Procedure Implants Section (templateId:2.16.840.1.113883.10.20.22.2.40) (CONF:30401). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30402 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30402) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30403 Added |  | SHALL contain exactly one [1..1] Procedure Specimens Taken Section (templateId:2.16.840.1.113883.10.20.22.2.31) (CONF:30403). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30404 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30404) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30405 Added |  | SHALL contain exactly one [1..1] Procedures Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.7.2) (CONF:30405). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30406 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30406) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30407 Added |  | SHALL contain exactly one [1..1] Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:30407). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30408 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30408) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30409 Added |  | SHALL contain exactly one [1..1] Review of Systems Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:30409). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30410 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30410) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30411 Added |  | SHALL contain exactly one [1..1] Social History Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.17.2) (CONF:30411). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30412 Added |  | SHALL include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2), or an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30412). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30413 Added |  | Each section SHALL have a title and the title SHALL NOT be empty (CONF:30413). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30414 Added |  | SHALL NOT include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) are present (CONF:30414). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30415 Added |  | SHALL NOT include a Chief Complaint and Reason for Visit Section with either a Chief Complaint Section or a Reason for Visit Section (CONF:30415). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30871 Added |  | SHOULD contain zero or one [0..1] componentOf (CONF:30871). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30872 Added |  | The componentOf, if present, SHALL contain exactly one [1..1] encompassingEncounter (CONF:30872). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30873 Added |  | This encompassingEncounter SHALL contain exactly one [1..1] code (CONF:30873). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30874 Added |  | This encompassingEncounter MAY contain zero or one [0..1] encounterParticipant (CONF:30874) such that it |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30875 Added |  | SHALL contain exactly one [1..1] @typeCode="REF" Referrer (CONF:30875). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30876 Added |  | This encompassingEncounter SHALL contain at least one [1..\*] location (CONF:30876). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30877 Added |  | Such locations SHALL contain exactly one [1..1] healthCareFacility (CONF:30877). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 30878 Added |  | This healthCareFacility SHALL contain at least one [1..\*] id (CONF:30878). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 8499 Removed | SHOULD contain zero or one [0..1] componentOf/encompassingEncounter (CONF:8499). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 8500 Removed | The componentOf/encompassingEncounter, if present, SHALL contain at least one [1..\*] location/healthCareFacility/id (CONF:8500). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 8501 Removed | The componentOf/encompassingEncounter, if present, SHALL contain exactly one [1..1] code (CONF:8501). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 8502 Removed | The componentOf/encompassingEncounter, if present, MAY contain zero or one [0..1] encounterParticipant (CONF:8502) such that it |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 8503 Removed | SHALL contain exactly one [1..1] @typeCode="REF" Referrer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8503). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9589 Removed | A Procedure Note can have either a structuredBody or a nonXMLBody (CONF:9589). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9590 Removed | A Procedure Note can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.6), coded entries are optional (CONF:9590). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9595 Removed | If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9595). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9643 Removed | SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan Section (CONF:9643). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9645 Removed | MAY contain zero or one [0..1] Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:9645). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9647 Removed | MAY contain zero or one [0..1] Plan of Care Section (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9647). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9649 Removed | MAY contain zero or one [0..1] Assessment and Plan Section (templateId:2.16.840.1.113883.10.20.22.2.9) (CONF:9649). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9802 Removed | SHALL contain exactly one [1..1] Complications Section (templateId:2.16.840.1.113883.10.20.22.2.37) (CONF:9802). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9805 Removed | SHALL contain exactly one [1..1] Procedure Description Section (templateId:2.16.840.1.113883.10.20.22.2.27) (CONF:9805). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9807 Removed | SHALL contain exactly one [1..1] Procedure Indications Section (templateId:2.16.840.1.113883.10.20.22.2.29) (CONF:9807). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9809 Removed | MAY contain zero or one [0..1] Allergies Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.6) (CONF:9809). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9811 Removed | MAY contain zero or one [0..1] Anesthesia Section (templateId:2.16.840.1.113883.10.20.22.2.25) (CONF:9811). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9813 Removed | MAY contain zero or one [0..1] Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:9813). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9815 Removed | MAY contain zero or one [0..1] Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:9815). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9817 Removed | MAY contain zero or one [0..1] Family History Section (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:9817). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9819 Removed | MAY contain zero or one [0..1] History of Past Illness Section (templateId:2.16.840.1.113883.10.20.22.2.20) (CONF:9819). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9821 Removed | MAY contain zero or one [0..1] History of Present Illness Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:9821). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9823 Removed | MAY contain zero or one [0..1] Medical (General) History Section (templateId:2.16.840.1.113883.10.20.22.2.39) (CONF:9823). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9825 Removed | MAY contain zero or one [0..1] Medications Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.1) (CONF:9825). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9827 Removed | MAY contain zero or one [0..1] Medications Administered Section (templateId:2.16.840.1.113883.10.20.22.2.38) (CONF:9827). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9829 Removed | MAY contain zero or one [0..1] Physical Exam Section (templateId:2.16.840.1.113883.10.20.2.10) (CONF:9829). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9831 Removed | MAY contain zero or one [0..1] Planned Procedure Section (templateId:2.16.840.1.113883.10.20.22.2.30) (CONF:9831). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9833 Removed | MAY contain zero or one [0..1] Procedure Disposition Section (templateId:2.16.840.1.113883.10.20.18.2.12) (CONF:9833). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9835 Removed | MAY contain zero or one [0..1] Procedure Estimated Blood Loss Section (templateId:2.16.840.1.113883.10.20.18.2.9) (CONF:9835). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9837 Removed | MAY contain zero or one [0..1] Procedure Findings Section (templateId:2.16.840.1.113883.10.20.22.2.28) (CONF:9837). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9839 Removed | MAY contain zero or one [0..1] Procedure Implants Section (templateId:2.16.840.1.113883.10.20.22.2.40) (CONF:9839). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9841 Removed | MAY contain zero or one [0..1] Procedure Specimens Taken Section (templateId:2.16.840.1.113883.10.20.22.2.31) (CONF:9841). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9843 Removed | MAY contain zero or one [0..1] Procedures Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.7) (CONF:9843). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9845 Removed | MAY contain zero or one [0..1] Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:9845). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9847 Removed | MAY contain zero or one [0..1] Review of Systems Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:9847). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9849 Removed | MAY contain zero or one [0..1] Social History Section (templateId:2.16.840.1.113883.10.20.22.2.17) (CONF:9849). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9850 Removed | SHALL contain exactly one [1..1] Postprocedure Diagnosis Section (templateId:2.16.840.1.113883.10.20.22.2.36) (CONF:9850). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 9937 Removed | Each section SHALL have a title and the title SHALL NOT be empty (CONF:9937). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 10064 Removed | SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:10064). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 10065 Removed | SHALL NOT include a Chief Complaint and Reason for Visit Section with either a Chief Complaint Section or a Reason for Visit Section (CONF:10065). |  |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 10050 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.6" (CONF:10050). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.6.2" (CONF:10050). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | CONF #: 10063 Modified | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10063). | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10063). |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | Name | Procedure Note | Procedure Note (V2) |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | Oid | 2.16.840.1.113883.10.20.22.1.6 | 2.16.840.1.113883.10.20.22.1.6.2 |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | Description | Procedure Note is a broad term that encompasses many specific types of non-operative procedures including interventional cardiology, interventional radiology, gastrointestinal endoscopy, osteopathic manipulation, and many other specialty fields. Procedure Notes are documents that are differentiated from Operative Notes in that the procedures documented do not involve incision or excision as the primary act.    The Procedure Note is created immediately following a non-operative procedure and records the indications for the procedure and, when applicable, post-procedure diagnosis, pertinent events of the procedure, and the patient’s tolerance of the procedure. The document should be sufficiently detailed to justify the procedure, describe the course of the procedure, and provide continuity of care. | Procedure Note encompasses many types of non-operative procedures including interventional cardiology, gastrointestinal endoscopy, osteopathic manipulation, and many other specialty fields. Procedure Notes are differentiated from Operative Notes because they do not involve incision or excision as the primary act.    The Procedure Note is created immediately following a non-operative procedure. It records the indications for the procedure and, when applicable, post-procedure diagnosis, pertinent events of the procedure, and the patient’s tolerance for the procedure. It should be detailed enough to justify the procedure, describe the course of the procedure, and provide continuity of care.    The Procedure Note is created immediately following a non-operative procedure and records the indications for the procedure and, when applicable, post-procedure diagnosis, pertinent events of the procedure, and the patient’s tolerance of the procedure. The document should be sufficiently detailed to justify the procedure, describe the course of the procedure, and provide continuity of care. |
| [Procedure Note (V2) 2.16.840.1.113883.10.20.22.1.6.2](#D_Procedure_Note_V2) | Implied Template | US Realm Header (2.16.840.1.113883.10.20.22.1.1) | US Realm Header (V2) (2.16.840.1.113883.10.20.22.1.1.2) |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30617 Added |  | In this template (templateId 2.16.840.1.113883.10.20.22.1.9.2), coded entries are optional  This component SHALL contain exactly one [1..1] structuredBody (CONF:30617). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30618 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30618) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30619 Added |  | SHALL contain exactly one [1..1] Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:30619). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30620 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30620) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30621 Added |  | SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30621). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30622 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30622) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30623 Added |  | SHALL contain exactly one [1..1] Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) (CONF:30623). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30624 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30624) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30625 Added |  | SHALL contain exactly one [1..1] Allergies Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.6.2) (CONF:30625). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30626 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30626) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30627 Added |  | SHALL contain exactly one [1..1] Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:30627). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30628 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30628) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30629 Added |  | SHALL contain exactly one [1..1] Interventions Section (V2) (templateId:2.16.840.1.113883.10.20.21.2.3.2) (CONF:30629). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30639 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30639) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 31386 Added |  | SHALL contain exactly one [1..1] Instructions Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.45.2) (CONF:31386). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30641 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30641) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30642 Added |  | SHALL contain exactly one [1..1] Medications Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.1.2) (CONF:30642). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30643 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30643) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30644 Added |  | SHALL contain exactly one [1..1] Objective Section (templateId:2.16.840.1.113883.10.20.21.2.1) (CONF:30644). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30645 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30645) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30646 Added |  | SHALL contain exactly one [1..1] Physical Exam Section (V2) (templateId:2.16.840.1.113883.10.20.2.10.2) (CONF:30646). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30647 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30647) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30648 Added |  | SHALL contain exactly one [1..1] Problem Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.5.2) (CONF:30648). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30649 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30649) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30650 Added |  | SHALL contain exactly one [1..1] Results Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.3.2) (CONF:30650). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30651 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30651) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30652 Added |  | SHALL contain exactly one [1..1] Review of Systems Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:30652). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30653 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30653) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30654 Added |  | SHALL contain exactly one [1..1] Subjective Section (templateId:2.16.840.1.113883.10.20.21.2.2) (CONF:30654). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30655 Added |  | This structuredBody MAY contain zero or one [0..1] component (CONF:30655) such that it |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30656 Added |  | SHALL contain exactly one [1..1] Vital Signs Section (entries optional) (V2) (templateId:2.16.840.1.113883.10.20.22.2.4.2) (CONF:30656). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30657 Added |  | SHALL include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2), or an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) (CONF:30657). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30658 Added |  | SHALL NOT include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.10.2) are present (CONF:30658). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30879 Added |  | This encompassingEncounter SHALL contain exactly one [1..1] location (CONF:30879). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30880 Added |  | This location SHALL contain exactly one [1..1] healthCareFacility (CONF:30880). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 30881 Added |  | This healthCareFacility SHALL contain at least one [1..\*] id (CONF:30881). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 7589 Removed | SHALL contain exactly one [1..1] code/@code, which SHALL be selected from ValueSet ProgressNoteDocumentTypeCode 2.16.840.1.113883.11.20.8.1 DYNAMIC (CONF:7589). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 7611 Removed | This encompassingEncounter SHALL contain exactly one [1..1] location/healthCareFacility/id (CONF:7611). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8704 Removed | SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan Section (CONF:8704). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8770 Removed | MAY contain zero or one [0..1] Objective Section (templateId:2.16.840.1.113883.10.20.21.2.1) (CONF:8770). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8771 Removed | MAY contain zero or one [0..1] Medications Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.1) (CONF:8771). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8772 Removed | MAY contain zero or one [0..1] Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:8772). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8773 Removed | MAY contain zero or one [0..1] Allergies Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.6) (CONF:8773). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8774 Removed | MAY contain zero or one [0..1] Assessment and Plan Section (templateId:2.16.840.1.113883.10.20.22.2.9) (CONF:8774). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8775 Removed | MAY contain zero or one [0..1] Plan of Care Section (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:8775). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8776 Removed | MAY contain zero or one [0..1] Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:8776). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8778 Removed | MAY contain zero or one [0..1] Interventions Section (templateId:2.16.840.1.113883.10.20.21.2.3) (CONF:8778). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8780 Removed | MAY contain zero or one [0..1] Physical Exam Section (templateId:2.16.840.1.113883.10.20.2.10) (CONF:8780). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8782 Removed | MAY contain zero or one [0..1] Results Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.3) (CONF:8782). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8784 Removed | MAY contain zero or one [0..1] Vital Signs Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.4) (CONF:8784). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8786 Removed | MAY contain zero or one [0..1] Problem Section (entries optional) (templateId:2.16.840.1.113883.10.20.22.2.5) (CONF:8786). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8788 Removed | MAY contain zero or one [0..1] Review of Systems Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:8788). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 8790 Removed | MAY contain zero or one [0..1] Subjective Section (templateId:2.16.840.1.113883.10.20.21.2.2) (CONF:8790). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 9592 Removed | A Progress Note can have either a structuredBody or a nonXMLBody (CONF:9592). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 9593 Removed | A Progress Note can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.9), coded entries are optional (CONF:9593). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 9594 Removed | If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9594). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 10069 Removed | SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:10069). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 16806 Removed | MAY contain zero or one [0..1] Instructions Section (templateId:2.16.840.1.113883.10.20.22.2.45) (CONF:16806). |  |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 10052 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.9" (CONF:10052). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.9.2" (CONF:10052). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 10137 Modified | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10137). | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10137). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | CONF #: 10138 Modified | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10138). | The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10138). |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | Name | Progress Note | Progress Note (V2) |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | Oid | 2.16.840.1.113883.10.20.22.1.9 | 2.16.840.1.113883.10.20.22.1.9.2 |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | Description | A Progress Note documents a patient’s clinical status during a hospitalization or outpatient visit; thus, it is associated with an encounter.    Taber’s medical dictionary defines a Progress Note as “An ongoing record of a patient's illness and treatment. Physicians, nurses, consultants, and therapists record their notes concerning the progress or lack of progress made by the patient between the time of the previous note and the most recent note.”    Mosby’s medical dictionary defines a Progress Note as “Notes made by a nurse, physician, social worker, physical therapist, and other health care professionals that describe the patient's condition and the treatment given or planned.”    A Progress Note is not a re-evaluation note. A Progress Note is not intended to be a Progress Report for Medicare. Medicare B Section 1833(e) defines the requirements of a Medicare Progress Report. | This template represents a patient’s clinical status during a hospitalization or outpatient visit; thus, it is associated with an encounter.    Taber’s medical dictionary defines a Progress Note as “An ongoing record of a patient's illness and treatment. Physicians, nurses, consultants, and therapists record their notes concerning the progress or lack of progress made by the patient between the time of the previous note and the most recent note.”    Mosby’s medical dictionary defines a Progress Note as “Notes made by a nurse, physician, social worker, physical therapist, and other health care professionals that describe the patient's condition and the treatment given or planned.”    A Progress Note is not a re-evaluation note. A Progress Note is not intended to be a Progress Report for Medicare. Medicare B Section 1833(e) defines the requirements of a Medicare Progress Report. |
| [Progress Note (V2) 2.16.840.1.113883.10.20.22.1.9.2](#D_Progress_Note_V2) | Implied Template | US Realm Header (2.16.840.1.113883.10.20.22.1.1) | US Realm Header (V2) (2.16.840.1.113883.10.20.22.1.1.2) |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31085 Added |  | SHALL contain exactly one [1..1] component (CONF:31085). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31086 Added |  | This component SHALL contain exactly one [1..1] nonXMLBody (CONF:31086). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31087 Added |  | This nonXMLBody SHALL contain exactly one [1..1] text (CONF:31087). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31088 Added |  | This text MAY contain zero or one [0..1] @mediaType, which SHALL be selected from ValueSet SupportedFileFormats 2.16.840.1.113883.11.20.7.1 (CONF:31088). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31089 Added |  | SHALL contain exactly one [1..1] recordTarget (CONF:31089). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31090 Added |  | This recordTarget SHALL contain exactly one [1..1] patientRole (CONF:31090). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31091 Added |  | This patientRole SHALL contain exactly one [1..1] id (CONF:31091). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31092 Added |  | SHALL contain exactly one [1..1] author (CONF:31092). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31093 Added |  | This author SHALL contain exactly one [1..1] assignedAuthor (CONF:31093). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31094 Added |  | This assignedAuthor SHALL contain exactly one [1..1] addr (CONF:31094). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31095 Added |  | This assignedAuthor SHALL contain exactly one [1..1] telecom (CONF:31095). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31096 Added |  | SHALL contain exactly one [1..1] custodian (CONF:31096). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31097 Added |  | This custodian SHALL contain exactly one [1..1] assignedCustodian (CONF:31097). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31098 Added |  | This assignedCustodian SHALL contain exactly one [1..1] representedCustodianOrganization (CONF:31098). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31099 Added |  | This representedCustodianOrganization SHALL contain exactly one [1..1] id (CONF:31099). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31100 Added |  | This representedCustodianOrganization SHALL contain exactly one [1..1] name (CONF:31100). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31101 Added |  | This representedCustodianOrganization SHALL contain exactly one [1..1] telecom (CONF:31101). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31102 Added |  | This representedCustodianOrganization SHALL contain exactly one [1..1] addr (CONF:31102). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 31103 Added |  | The text element SHALL either contain a reference element with a value attribute, or have a representation attribute with the value of B64, a mediaType attribute, and contain the media content (CONF:31103). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7620 Removed | SHALL contain exactly one [1..1] component/nonXMLBody (CONF:7620). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7622 Removed | This component/nonXMLBody SHALL contain exactly one [1..1] text (CONF:7622). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7623 Removed | The text element SHALL either contain a reference element with a value attribute, or have a representation attribute with the value of B64, a mediaType attribute, and contain the media content (CONF:7623). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7624 Removed | The value of @mediaType, if present, SHALL be drawn from the value set 2.16.840.1.113883.11.20.7.1 SupportedFileFormats STATIC 20100512 (CONF:7624). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7640 Removed | SHALL contain exactly one [1..1] author/assignedAuthor (CONF:7640). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7641 Removed | This author/assignedAuthor SHALL contain exactly one [1..1] addr (CONF:7641). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7642 Removed | This author/assignedAuthor SHALL contain exactly one [1..1] telecom (CONF:7642). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7643 Removed | SHALL contain exactly one [1..1] recordTarget/patientRole/id (CONF:7643). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7645 Removed | SHALL contain exactly one [1..1] custodian/assignedCustodian/representedCustodianOrganization (CONF:7645). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7648 Removed | This custodian/assignedCustodian/representedCustodianOrganization SHALL contain exactly one [1..1] id (CONF:7648). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7649 Removed | This custodian/assignedCustodian/representedCustodianOrganization SHALL contain exactly one [1..1] name (CONF:7649). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7650 Removed | This custodian/assignedCustodian/representedCustodianOrganization SHALL contain exactly one [1..1] telecom (CONF:7650). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 7651 Removed | This custodian/assignedCustodian/representedCustodianOrganization SHALL contain exactly one [1..1] addr (CONF:7651). |  |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | CONF #: 10054 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.10" (CONF:10054). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.10.2" (CONF:10054). |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | Name | Unstructured Document | Unstructured Document (V2) |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | Oid | 2.16.840.1.113883.10.20.22.1.10 | 2.16.840.1.113883.10.20.22.1.10.2 |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | Description | An unstructured document is a document which is used when the patient record is captured in an unstructured format that is encapsulated within an image file or as unstructured text in an electronic file such as a word processing or Portable Document Format (PDF) document.    There is a need to raise the level of interoperability for these documents to provide full access to the longitudinal patient record across a continuum of care. Until this gap is addressed, image and multi-media files will continue to be a portion of the patient record that remains difficult to access and share with all participants in a patient’s care. The Unstructured Document type addresses this gap by providing consistent guidance on the use of CDA for such documents.    An Unstructured Document (UD) document type can (1) include unstructured content, such as a graphic, directly in a text element with a mediaType attribute, or (2) reference a single document file, such as a word-processing document, using a text/reference element. | An Unstructured Document (UD) document type can (1) include unstructured content, such as a graphic, directly in a text element with a mediaType attribute, or (2) reference a single document file, such as a word-processing document using a text/reference element.  For guidance on how to handle multiple files, on the selection of media types for this IG, and on the identification of external files, see the subsections which follow the constraints below.  IHE’s XDS-SD (Cross-Transaction Specifications and Content Specifications, Scanned Documents Module) profile addresses a similar, more restricted use case, specifically for scanned documents or documents electronically created from existing text sources, and limits content to PDF-A or text. This Unstructured Documents implementation guide is applicable not only for scanned documents in non-PDF formats, but also for clinical documents produced through word processing applications, etc.  For conformance with both specifications, please review the appendix on XDS-SD and US Realm Clinical Document Header Comparison and ensure that your documents at a minimum conform to all the SHALL constraints from either specification. |
| [Unstructured Document (V2) 2.16.840.1.113883.10.20.22.1.10.2](#D_Unstructured_Document_V2) | Implied Template | US Realm Header (2.16.840.1.113883.10.20.22.1.1) | US Realm Header (V2) (2.16.840.1.113883.10.20.22.1.1.2) |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 29287 Added |  | The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:29287). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 29402 Added |  | The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:29402). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 30810 Added |  | Heading: sdtc:signatureText  The sdtc:signatureText extension provides a location in CDA for a textual or multimedia depiction of the signature by which the participant endorses and accepts responsibility for his or her participation in the Act as specified in the Participation.typeCode. Details of what goes in the field are described in the HL7 CDA Digital Signature Standard balloted in Fall of 2013..  The legalAuthenticator, if present, MAY contain zero or one [0..1] sdtc:signatureText (CONF:30810).  Note: The signature can be represented either inline or by reference according to the ED data type. Typical cases for CDA are: 1) Electronic signature: this attribute can represent virtually any electronic signature scheme. 2) Digital signature: this attribute can represent digital signatures by reference to a signature data block that is constructed in accordance to a digital signature standard, such as XML-DSIG, PKCS#7, PGP, etc. |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 30811 Added |  | The sdtc:signatureText extension provides a location in CDA for a textual or multimedia depiction of the signature by which the participant endorses and accepts responsibility for his or her participation in the Act as specified in the Participation.typeCode. Details of what goes in the field are described in the HL7 CDA Digital Signature Standard balloted in Fall of 2013..  The authenticator, if present, MAY contain zero or one [0..1] sdtc:signatureText (CONF:30811).  Note: The signature can be represented either inline or by reference according to the ED data type. Typical cases for CDA are: 1) Electronic signature: this attribute can represent virtually any electronic signature scheme. 2) Digital signature: this attribute can represent digital signatures by reference to a signature data block that is constructed in accordance to a digital signature standard, such as XML-DSIG, PKCS#7, PGP, etc. |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 31135 Added |  | If this assignedAuthor is an assignedPerson, the assignedAuthor SHOULD contain zero to one [0..1] id such that it (CONF:31135). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 31347 Added |  | If sdtc:raceCode is present, then the patient SHALL contain [1..1] raceCode (CONF:31347). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 31355 Added |  | Heading: informant  The informant element describes an information source for any content within the clinical document. This informant would be used when the source of information has a personal relationship with the patient.     MAY contain zero or more [0..\*] informant (CONF:31355) such that it |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 31356 Added |  | SHALL contain exactly one [1..1] relatedEntity (CONF:31356). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 31694 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:31694). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 31839 Added |  | The informant element describes an information source for any content within the clinical document. This informant would be used when the source of information has a personal relationship with the patient.     MAY contain zero or more [0..\*] informant (CONF:31839) such that it |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 31840 Added |  | SHALL contain exactly one [1..1] assignedEntity (CONF:31840). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5255 Removed | Can either be a locally defined name or the display name corresponding to clinicalDocument/code (CONF:5255). |  |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 16753 Removed | The performer participant represents clinicians who actually and principally carry out the serviceEvent. In a transfer of care this represents the healthcare providers involved in the current or pertinent historical care of the patient. Preferably, the patient’s key healthcare care team members would be listed, particularly their primary physician and any active consulting physicians, therapists, and counselors (CONF:16753). |  |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 16796 Removed | The type of consent (e.g., a consent to perform the related serviceEvent) is conveyed in consent/code (CONF:16796). |  |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 16865 Removed | The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:16865). |  |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 16873 Removed | The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:16873). |  |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 26467 Removed | An informant can contain either an assignedEntity or a relatedEntity. This template does not place any constraints on a relatedEntity.  MAY contain zero or more [0..\*] informant (CONF:26467) such that it |  |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 26468 Removed | SHALL contain exactly one [1..1] relatedEntity (CONF:26468). |  |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 26469 Removed | If this assignedAuthor is an assignedPerson, the id SHOULD contain zero to one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:26469). |  |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5254 Modified | SHALL contain exactly one [1..1] title (CONF:5254). | SHALL contain exactly one [1..1] title (CONF:5254).  Note: The title can either be a locally defined name or the displayName corresponding to clinicalDocument/code |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5266 Modified | SHALL contain at least one [1..\*] recordTarget (CONF:5266). | Heading: recordTarget  The recordTarget records the administrative and demographic data of the patient whose health information is described by the clinical document; each recordTarget must contain at least one patientRole element  SHALL contain at least one [1..\*] recordTarget (CONF:5266). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5322 Modified | This patient MAY contain zero or one [0..1] raceCode, which SHALL be selected from ValueSet Race Value Set 2.16.840.1.113883.1.11.14914 DYNAMIC (CONF:5322).  Note: To record additional raceCode, use the extension element sdtc:raceCode. | This patient SHOULD contain zero or one [0..1] raceCode, which SHALL be selected from ValueSet Race Value Set 2.16.840.1.113883.1.11.14914 DYNAMIC (CONF:5322). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5323 Modified | This patient MAY contain zero or one [0..1] ethnicGroupCode, which SHALL be selected from ValueSet EthnicityGroup 2.16.840.1.114222.4.11.837 DYNAMIC (CONF:5323). | This patient SHOULD contain zero or one [0..1] ethnicGroupCode, which SHALL be selected from ValueSet EthnicityGroup 2.16.840.1.114222.4.11.837 DYNAMIC (CONF:5323). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5326 Modified | The guardian, if present, SHOULD contain zero or one [0..1] code, which SHALL be selected from ValueSet ResponsibleParty 2.16.840.1.113883.1.11.19830 DYNAMIC (CONF:5326). | The guardian, if present, SHOULD contain zero or one [0..1] code, which SHALL be selected from ValueSet Personal And Legal Relationship Role Type 2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:5326). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5414 Modified | The languageCommunication, if present, MAY contain zero or one [0..1] preferenceInd (CONF:5414). | The languageCommunication, if present, SHOULD contain zero or one [0..1] preferenceInd (CONF:5414). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5441 Modified | MAY contain zero or one [0..1] dataEnterer (CONF:5441). | Heading: dataEnterer  The dataEnterer element represents the person who transferred the content, written or dictated, into the clinical document. To clarify, an author provides the content found within the header or body of a document, subject to their own interpretation; a dataEnterer adds an author's information to the electronic system.  MAY contain zero or one [0..1] dataEnterer (CONF:5441). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5444 Modified | SHALL contain at least one [1..\*] author (CONF:5444). | Heading: author  The author element represents the creator of the clinical document. The author may be a device or a person.  SHALL contain at least one [1..\*] author (CONF:5444). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5519 Modified | SHALL contain exactly one [1..1] custodian (CONF:5519). | Heading: custodian  The custodian element represents the organization that is in charge of maintaining and is entrusted with the care of the document. There may only be exactly one custodian per CDA document. Allowing that CDA is an exchange standard and may not represent the original form of the authenticated document, the custodian represents the steward of the original source document. The custodian may be the document originator, a health information exchange, or other responsible party.  SHALL contain exactly one [1..1] custodian (CONF:5519). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5565 Modified | MAY contain zero or more [0..\*] informationRecipient (CONF:5565). | Heading: informationRecipient  The informationRecipient element records the intended recipient of the information at the time the document was created. In cases where the intended recipient of the document is the patient's health chart, set the receivedOrganization to the scoping organization for that chart.  MAY contain zero or more [0..\*] informationRecipient (CONF:5565). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5579 Modified | SHOULD contain zero or one [0..1] legalAuthenticator (CONF:5579). | Heading: legalAuthenticator  The legalAuthenticator identifies the single person legally responsible for the document and must be present if the document has been legally authenticated. A clinical document that does not contain this element has not been legally authenticated. The act of legal authentication requires a certain privilege be granted to the legal authenticator depending upon local policy. Based on local practice, clinical documents may be released before legal authentication.  All clinical documents have the potential for legal authentication, given the appropriate credentials. Local policies MAY choose to delegate the function of legal authentication to a device or system that generates the clinical document. In these cases, the legal authenticator is a person accepting responsibility for the document, not the generating device or system. Note that the legal authenticator, if present, must be a person.  SHOULD contain zero or one [0..1] legalAuthenticator (CONF:5579). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 5607 Modified | MAY contain zero or more [0..\*] authenticator (CONF:5607). | Heading: authenticator  The authenticator identifies a participant or participants who attest to the accuracy of the information in the document.  MAY contain zero or more [0..\*] authenticator (CONF:5607). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 7263 Modified | This patient MAY contain zero or more [0..\*] sdtc:raceCode, which SHALL be selected from ValueSet Race Value Set 2.16.840.1.113883.1.11.14914 DYNAMIC (CONF:7263). | The sdtc:raceCode is only used to record additional values when the patient has indicated multiple races.  This patient MAY contain zero or more [0..\*] sdtc:raceCode, which SHALL be selected from ValueSet Race Value Set 2.16.840.1.113883.1.11.14914 DYNAMIC (CONF:7263). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 8001 Modified | An informant can contain either an assignedEntity or a relatedEntity. The constraints here apply to assignedEntity.  MAY contain zero or more [0..\*] informant (CONF:8001) such that it | Heading: informant  The informant element describes an information source for any content within the clinical document. This informant is constrained for use when the source of information is an assigned health care provider for the patient.    MAY contain zero or more [0..\*] informant (CONF:8001) such that it |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 9952 Modified | MAY contain zero or more [0..\*] inFulfillmentOf (CONF:9952). | Heading: inFulfillmentOf  The inFulfillmentOf element represents orders that are fulfilled by this document such as a radiologists’ report of an x-ray.  MAY contain zero or more [0..\*] inFulfillmentOf (CONF:9952). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 9955 Modified | MAY contain zero or one [0..1] componentOf (CONF:9955). | Heading: componentOf  The componentOf element contains the encompassing encounter for the document. The encompassing encounter represents the setting of the clinical encounter during which the document act(s) or ServiceEvent(s) occurred. In order to represent providers associated with a specific encounter, they are recorded within the encompassingEncounter as participants. In a CCD, the encompassingEncounter may be used when documenting a specific encounter and its participants. All relevant encounters in a CCD may be listed in the encounters section.   MAY contain zero or one [0..1] componentOf (CONF:9955). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 10003 Modified | In general, many types of participant are possible. When participant/@typeCode is IND (individual), associatedEntity/@classCode must be from the specified value set, unless this requirement is overridden by the document type's header.  MAY contain zero or more [0..\*] participant (CONF:10003) such that it | Heading: participant  The participant element identifies supporting entities, including parents, relatives, caregivers, insurance policyholders, guarantors, and others related in some way to the patient.  A supporting person or organization is an individual or an organization with a relationship to the patient. A supporting person who is playing multiple roles would be recorded in multiple participants (e.g., emergency contact and next-of-kin).   MAY contain zero or more [0..\*] participant (CONF:10003) such that it |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 10006 Modified | Such participants, if present, SHALL contain associatedEntity/associatedPerson or associatedEntity/scopingOrganization (CONF:10006). | SHALL contain associatedEntity/associatedPerson AND/OR associatedEntity/scopingOrganization (CONF:10006). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 10007 Modified | Unless otherwise specified by the document specific header constraints, when participant/@typeCode is IND, associatedEntity/@classCode SHALL be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:10007). | When participant/@typeCode is IND, associatedEntity/@classCode SHOULD be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:10007). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 10036 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.1" (CONF:10036). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.1.2" (CONF:10036). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 14835 Modified | MAY contain zero or more [0..\*] documentationOf (CONF:14835). | Heading: documentationOf  A serviceEvent represents the main act being documented, such as a colonoscopy or a cardiac stress study. In a provision of healthcare serviceEvent, the care providers, PCP, or other longitudinal providers, are recorded within the serviceEvent. If the document is about a single encounter, the providers associated can be recorded in the componentOf/encompassingEncounter template.  MAY contain zero or more [0..\*] documentationOf (CONF:14835). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 14840 Modified | The performer, if present, SHALL contain exactly one [1..1] @typeCode (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:14840). | The performer participant represents clinicians who actually and principally carry out the serviceEvent. In a transfer of care this represents the healthcare providers involved in the current or pertinent historical care of the patient. Preferably, the patient’s key healthcare care team members would be listed, particularly their primary physician and any active consulting physicians, therapists, and counselors  The performer, if present, SHALL contain exactly one [1..1] @typeCode (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:14840). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 16792 Modified | MAY contain zero or more [0..\*] authorization (CONF:16792) such that it | Heading: authorization  The authorization element represents information about the patient’s consent. The type of consent is conveyed in consent/code. Consents in the header have been finalized (consent/statusCode must equal Completed) and should be on file. This specification does not address how 'Privacy Consent' is represented, but does not preclude the inclusion of ‘Privacy Consent’.   MAY contain zero or more [0..\*] authorization (CONF:16792) such that it |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | CONF #: 16795 Modified | This consent MAY contain zero or one [0..1] code (CONF:16795). | The type of consent (e.g., a consent to perform the related serviceEvent) is conveyed in consent/code  This consent MAY contain zero or one [0..1] code (CONF:16795). |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | Name | US Realm Header | US Realm Header (V2) |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | Oid | 2.16.840.1.113883.10.20.22.1.1 | 2.16.840.1.113883.10.20.22.1.1.2 |
| [US Realm Header (V2) 2.16.840.1.113883.10.20.22.1.1.2](#D_US_Realm_Header_V2) | Description | This section describes constraints that apply to the header for all documents within the scope of this implementation guide. Header constraints specific to each document type are described in the appropriate document-specific section below. | This template defines constraints that represent common administrative and demographic concepts for US Realm CDA documents. Further specification, such as documentCode, are provided in document templates that conform to this template. |
| [Admission Medication (V2) 2.16.840.1.113883.10.20.22.4.36.2](#Admission_Medication_V2) | CONF #: 15520 Modified | SHALL contain exactly one [1..1] Medication Activity (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15520). | SHALL contain exactly one [1..1] Medication Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15520). |
| [Admission Medication (V2) 2.16.840.1.113883.10.20.22.4.36.2](#Admission_Medication_V2) | CONF #: 16759 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.36" (CONF:16759). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.36.2" (CONF:16759). |
| [Admission Medication (V2) 2.16.840.1.113883.10.20.22.4.36.2](#Admission_Medication_V2) | Name | Admission Medication | Admission Medication (V2) |
| [Admission Medication (V2) 2.16.840.1.113883.10.20.22.4.36.2](#Admission_Medication_V2) | Oid | 2.16.840.1.113883.10.20.22.4.36 | 2.16.840.1.113883.10.20.22.4.36.2 |
| [Admission Medication (V2) 2.16.840.1.113883.10.20.22.4.36.2](#Admission_Medication_V2) | Description | The Admission Medications entry codes medications that the patient took prior to admission. | This template represents the medications taken by the patient prior to and at the time of admission. |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28428 Added |  | This participantRole MAY contain zero or one [0..1] playingEntity (CONF:28428). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28429 Added |  | The playingEntity, if present, SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Agent Qualifier Value Set 2.16.840.1.113883.11.20.9.51 DYNAMIC (CONF:28429). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28440 Added |  | This participantRole SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Personal And Legal Relationship Role Type 2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:28440). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28444 Added |  | This playingEntity SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Agent Qualifier Value Set 2.16.840.1.113883.11.20.9.51 DYNAMIC (CONF:28444). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28446 Added |  | This participantRole SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:28446). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28451 Added |  | This participantRole MAY contain zero or more [0..\*] addr (CONF:28451). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28452 Added |  | The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:28452). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28453 Added |  | The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:28453). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28454 Added |  | The playingEntity, if present, MAY contain zero or more [0..\*] name (CONF:28454). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28455 Added |  | The playingEntity/name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:28455). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28456 Added |  | The playingEntity/name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:28456). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 28719 Added |  | This effectiveTime SHALL contain exactly one [1..1] low (CONF:28719). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 30804 Added |  | SHOULD contain zero or one [0..1] value (CONF:30804). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 8651 Modified | SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet AdvanceDirectiveTypeCode 2.16.840.1.113883.1.11.20.2 STATIC 2006-10-17 (CONF:8651). | SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet AdvanceDirectiveTypeCode (V2) 2.16.840.1.113883.1.11.20.2.2 DYNAMIC (CONF:8651). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 8662 Modified | SHOULD contain zero or more [0..\*] participant (CONF:8662) such that it | The participant "VRF" represents the clinician(s) who verified the patient advance directive observation.  SHOULD contain zero or one [0..1] participant (CONF:8662) such that it |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 8667 Modified | SHOULD contain zero or one [0..1] participant (CONF:8667) such that it | This participant identifies a legal representative for the patient. Examples of such individuals are health care agents, substitute decision makers and/or health care proxies. If there is an alternate health care agent, a qualifier identifies may be used to designate one as a primary and secondary agent.  SHOULD contain zero or more [0..\*] participant (CONF:8667) such that it |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 8672 Modified | This participantRole SHOULD contain zero or one [0..1] telecom (CONF:8672). | This participantRole SHOULD contain zero or more [0..\*] telecom (CONF:8672). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 8692 Modified | SHOULD contain zero or more [0..\*] reference (CONF:8692) such that it | SHOULD contain at least one [1..\*] reference (CONF:8692) such that it |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | CONF #: 10485 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.48" (CONF:10485). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.48.2" (CONF:10485). |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | Name | Advance Directive Observation | Advance Directive Observation (V2) |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.48 | 2.16.840.1.113883.10.20.22.4.48.2 |
| [Advance Directive Observation (V2) 2.16.840.1.113883.10.20.22.4.48.2](#Advance_Directive_Observation_V2) | Description | Advance Directives Observations assert findings (e.g., “resuscitation status is Full Code”) rather than orders, and should not be considered legal documents. A legal document can be referenced using the reference/externalReference construct. | This clinical statement represents Advance Directives Observations findings (e.g., “resuscitation status is Full Code”) rather than orders, and should not be considered legal documents. The related legal documents are referenced using the reference/externalReference element.  The Advance Directive Observation describes the patient’s directives, including but not limited to  • Medications  • Transfer of Care to Hospital  • Treatment  • Procedures  • Intubation and Ventilation  • Diagnostic Tests  • Tests    The general category of the patient’s directive is documented in the observation/code element. The observation/value element contains the detailed patient directive which may be coded or text. For example, a category directive may be antibiotics, and the details would be intravenous antibiotics only. |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 31143 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31143). |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 31526 Added |  | Use negationInd="true" to indicate that the allergy was not observed.  MAY contain zero or one [0..1] @negationInd (CONF:31526). |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 31527 Added |  | SHOULD contain zero or one [0..1] text (CONF:31527). |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 31528 Added |  | The text, if present, SHOULD contain zero or one [0..1] reference (CONF:31528). |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 31529 Added |  | The reference, if present, SHALL contain exactly one [1..1] @value (CONF:31529). |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 31530 Added |  | This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:31530). |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 31538 Added |  | This effectiveTime SHALL contain exactly one [1..1] low (CONF:31538).  Note: The effectiveTime/low (a.k.a. "onset date") asserts when the allergy/intolerance became biologically active. |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 31539 Added |  | This effectiveTime MAY contain zero or one [0..1] high (CONF:31539).  Note: The effectiveTime/high (a.k.a. "resolution date") asserts when the allergy/intolerance became biologically resolved. |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7421 Removed | In an allergy to a specific medication the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.16 Medication Brand Name DYNAMIC or the ValueSet 2.16.840.1.113883.3.88.12.80.17 Medication Clinical Drug DYNAMIC (CONF:7421). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7422 Removed | This value SHOULD contain zero or one [0..1] originalText (CONF:7422). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7424 Removed | This code SHOULD contain zero or one [0..1] originalText (CONF:7424). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7425 Removed | The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:7425). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7431 Removed | This code MAY contain zero or more [0..\*] translation (CONF:7431). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7440 Removed | MAY contain zero or one [0..1] entryRelationship (CONF:7440) such that it |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7446 Removed | SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7446). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7906 Removed | SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7906). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 9103 Removed | If it is unknown when the allergy began, this effectiveTime SHALL contain low/@nullFLavor="UNK" (CONF:9103). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 9139 Removed | This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Allergy/Adverse Event Type Value Set 2.16.840.1.113883.3.88.12.3221.6.2 DYNAMIC (CONF:9139). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 10082 Removed | If the allergy is no longer a concern, this effectiveTime MAY contain zero or one [0..1] high (CONF:10082). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 10083 Removed | In an allergy to a class of medications the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.18 Medication Drug Class DYNAMIC (CONF:10083). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 10084 Removed | In an allergy to a food or other substance the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.20 Ingredient Name DYNAMIC (CONF:10084). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 15949 Removed | The originalText, if present, MAY contain zero or one [0..1] reference (CONF:15949). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 15950 Removed | The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15950). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 15951 Removed | This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15951). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 15952 Removed | The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15952). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 15953 Removed | This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15953). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 15954 Removed | SHALL contain exactly one [1..1] Allergy Status Observation (templateId:2.16.840.1.113883.10.20.22.4.28) (CONF:15954). |  |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7387 Modified | SHALL contain exactly one [1..1] effectiveTime (CONF:7387). | SHALL contain exactly one [1..1] effectiveTime (CONF:7387).  Note: If the allergy/intolerance is known to be resolved, but the date of resolution is not known, then the high element SHALL be present, and the nullFlavor attribute SHALL be set to 'UNK'. Therefore, the existence of an high element within an allergy/intolerance does indicate that the allergy/intolerance has been resolved. |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7390 Modified | SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:7390). | SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet Allergy/Adverse Event Type Value Set 2.16.840.1.113883.3.88.12.3221.6.2 DYNAMIC (CONF:7390).  Note: The consumable participant points to the precise allergen or substance of intolerance. Because the consumable and the reaction are more clinically relevant than a categorization of the allergy/adverse event type, many systems will simply assign a fixed value here (e.g. "allergy to substance"). |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7402 Modified | SHOULD contain zero or one [0..1] participant (CONF:7402) such that it | SHALL contain exactly one [1..1] participant (CONF:7402) such that it |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 7419 Modified | This playingEntity SHALL contain exactly one [1..1] code (CONF:7419). | This playingEntity SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Substance / Reactant for Intolerance Temp-ValueSet-substanceReactantForIntolerance DYNAMIC (CONF:7419). |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 10488 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.7" (CONF:10488). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.7.2" (CONF:10488). |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 15955 Modified | SHALL contain exactly one [1..1] Reaction Observation (templateId:2.16.840.1.113883.10.20.22.4.9) (CONF:15955). | SHALL contain exactly one [1..1] Reaction Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.9.2) (CONF:15955). |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | CONF #: 15956 Modified | SHALL contain exactly one [1..1] Severity Observation (templateId:2.16.840.1.113883.10.20.22.4.8) (CONF:15956). | SHALL contain exactly one [1..1] Severity Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.8.2) (CONF:15956). |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | Name | Allergy - Intolerance Observation | Allergy - Intolerance Observation (V2) |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.7 | 2.16.840.1.113883.10.20.22.4.7.2 |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | Description | This clinical statement represents that an allergy or adverse reaction exists or does not exist. The agent that is the cause of the allergy or adverse reaction is represented as a manufactured material participant playing entity in the allergy observation. While the agent is often implicit in the alert observation (e.g. ""allergy to penicillin""), it should also be asserted explicitly as an entity. The manufactured material participant is used to represent natural and non-natural occurring substances.    NOTE: The agent responsible for an allergy or adverse reaction is not always a manufactured material (for example, food allergies), nor is it necessarily consumed. The following constraints reflect limitations in the base CDA R2 specification, and should be used to represent any type of responsible agent. | This template reflects a discrete observation about a patient's allergy or intolerance. Because it is a discrete observation, it will have a statusCode of "completed". The effectiveTime, also referred to as the “biologically relevant time” is the time at which the observation holds for the patient. For a provider seeing a patient in the clinic today, observing a history of penicillin allergy that developed five years ago, the effectiveTime is five years ago.    The effectiveTime of the Allergy - Intolerance Observation is the definitive indication of whether or not the underlying allergy/intolerance is resolved. If known to be resolved, then an effectiveTime/high would be present. If the date of resolution is not known, then effectiveTime/high will be present with a nullFlavor of "UNK".    NOTE: The agent responsible for an allergy or adverse reaction is not always a manufactured material (for example, food allergies), nor is it necessarily consumed. The following constraints reflect limitations in the base CDA R2 specification, and should be used to represent any type of responsible agent. |
| [Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.22.4.7.2](#E_Allergy__Intolerance_Observation_V2) | Implied Template | Substance or Device Allergy - Intolerance Observation (2.16.840.1.113883.10.20.24.3.90) | Substance or Device Allergy - Intolerance Observation (V2) (2.16.840.1.113883.10.20.24.3.90.2) |
| [Allergy Concern Act (V2) 2.16.840.1.113883.10.20.22.4.30.2](#E_Allergy_Concern_Act_V2) | CONF #: 31145 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31145). |
| [Allergy Concern Act (V2) 2.16.840.1.113883.10.20.22.4.30.2](#E_Allergy_Concern_Act_V2) | CONF #: 31534 Added |  | This effectiveTime SHALL contain exactly one [1..1] low (CONF:31534).  Note: The effectiveTime/low asserts when the allergy was noted. This equates to the time the allergy was authored in the patient's chart. |
| [Allergy Concern Act (V2) 2.16.840.1.113883.10.20.22.4.30.2](#E_Allergy_Concern_Act_V2) | CONF #: 31535 Added |  | This effectiveTime MAY contain zero or one [0..1] high (CONF:31535).  Note: It is clinically rare for an allergy to be "resolved", even for patients undergoing allergy desensitization. As a result, effectiveTime/high will generally not be present. |
| [Allergy Concern Act (V2) 2.16.840.1.113883.10.20.22.4.30.2](#E_Allergy_Concern_Act_V2) | CONF #: 7504 Removed | If statusCode/@code="active" Active, then effectiveTime SHALL contain [1..1] low (CONF:7504). |  |
| [Allergy Concern Act (V2) 2.16.840.1.113883.10.20.22.4.30.2](#E_Allergy_Concern_Act_V2) | CONF #: 10085 Removed | If statusCode/@code="completed" Completed, then effectiveTime SHALL contain [1..1] high (CONF:10085). |  |
| [Allergy Concern Act (V2) 2.16.840.1.113883.10.20.22.4.30.2](#E_Allergy_Concern_Act_V2) | CONF #: 10489 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.30" (CONF:10489). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.30.2" (CONF:10489). |
| [Allergy Concern Act (V2) 2.16.840.1.113883.10.20.22.4.30.2](#E_Allergy_Concern_Act_V2) | CONF #: 14925 Modified | SHALL contain exactly one [1..1] Allergy - Intolerance Observation (templateId:2.16.840.1.113883.10.20.22.4.7) (CONF:14925). | SHALL contain exactly one [1..1] Allergy - Intolerance Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.7.2) (CONF:14925). |
| [Allergy Concern Act (V2) 2.16.840.1.113883.10.20.22.4.30.2](#E_Allergy_Concern_Act_V2) | CONF #: 19158 Modified | This code SHALL contain exactly one [1..1] @code="48765-2" Allergies, adverse reactions, alerts (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19158). | This code SHALL contain exactly one [1..1] @code="CONC" Concern (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:19158). |
| [Allergy Concern Act (V2) 2.16.840.1.113883.10.20.22.4.30.2](#E_Allergy_Concern_Act_V2) | Name | Allergy Problem Act | Allergy Concern Act (V2) |
| [Allergy Concern Act (V2) 2.16.840.1.113883.10.20.22.4.30.2](#E_Allergy_Concern_Act_V2) | Oid | 2.16.840.1.113883.10.20.22.4.30 | 2.16.840.1.113883.10.20.22.4.30.2 |
| [Allergy Concern Act (V2) 2.16.840.1.113883.10.20.22.4.30.2](#E_Allergy_Concern_Act_V2) | Description | This clinical statement act represents a concern relating to a patient's allergies or adverse events. A concern is a term used when referring to patient's problems that are related to one another. Observations of problems or other clinical statements captured at a point in time are wrapped in a Allergy Problem Act, or ""Concern"" act, which represents the ongoing process tracked over time. This outer Allergy Problem Act (representing the ""Concern"") can contain nested problem observations or other nested clinical statements relevant to the allergy concern. | This template reflects an ongoing concern on behalf of the provider that placed the allergy on a patient’s allergy list. So long as the underlying condition is of concern to the provider (i.e. so long as the allergy, whether active or resolved, is of ongoing concern and interest to the provider), the statusCode is “active”. Only when the underlying allergy is no longer of concern is the statusCode set to “completed”. The effectiveTime reflects the time that the underlying allergy was felt to be a concern.    The statusCode of the Allergy Problem Act is the definitive indication of the status of the concern, whereas the effectiveTime of the nested Allergy - Intolerance Observation is the definitive indication of whether or not the underlying allergy is resolved.    The effectiveTime/low of the Allergy Problem Act asserts when the concern became active. This equates to the time the concern was authored in the patient's chart. The effectiveTime/high asserts when the concern was completed (e.g. when the clinician deemed there is no longer any need to track the underlying condition). |
| [Allergy Status Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.28.2](#E_Allergy_Status_Observation_DEPRECATED) | CONF #: 7322 Modified | SHALL contain exactly one [1..1] value with @xsi:type="CE", where the code SHALL be selected from ValueSet Problem Status Value Set 2.16.840.1.113883.3.88.12.80.68 DYNAMIC (CONF:7322). | SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet Problem Status Value Set 2.16.840.1.113883.3.88.12.80.68 DYNAMIC (CONF:7322). |
| [Allergy Status Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.28.2](#E_Allergy_Status_Observation_DEPRECATED) | CONF #: 10490 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.28" (CONF:10490). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.28.2" (CONF:10490). |
| [Allergy Status Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.28.2](#E_Allergy_Status_Observation_DEPRECATED) | Name | Allergy Status Observation | Allergy Status Observation (DEPRECATED) |
| [Allergy Status Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.28.2](#E_Allergy_Status_Observation_DEPRECATED) | Oid | 2.16.840.1.113883.10.20.22.4.28 | 2.16.840.1.113883.10.20.22.4.28.2 |
| [Allergy Status Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.28.2](#E_Allergy_Status_Observation_DEPRECATED) | Description | This template represents the status of the allergy indicating whether it is active, no longer active, or is an historic allergy. There can be only one allergy status observation per alert observation. | This template represents the status of the allergy indicating whether it is active, no longer active, or is an historic allergy. There can be only one allergy status observation per alert observation.    This template has been deprecated in Consolidated CDA Release 2. Per the explanation in Volume 1, section 3.2 "Determining a Clinical Statement's Status", the status of an allergy is determined based on attributes of the Allergy Problem Act and Allergy - Intolerance Observation. |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 30870 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:30870). |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 14264 Removed | SHOULD contain zero or more [0..\*] interpretationCode (CONF:14264). |  |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 14265 Removed | MAY contain zero or one [0..1] methodCode (CONF:14265). |  |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 14268 Removed | The referenceRange, if present, SHALL contain exactly one [1..1] observationRange (CONF:14268). |  |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 14269 Removed | This observationRange SHALL NOT contain [0..0] code (CONF:14269). |  |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 14270 Removed | MAY contain zero or one [0..1] targetSiteCode (CONF:14270). |  |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 15549 Removed | The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15549). |  |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 15550 Removed | The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15550). |  |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 15551 Removed | This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15551). |  |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 14256 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.74" (CONF:14256). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.74.2" (CONF:14256). |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 14261 Modified | Represents clinically effective time of the measurement, which may be the time the measurement was performed (e.g., a BP measurement), or may be the time the sample was taken (and measured some time afterwards).  SHALL contain exactly one [1..1] effectiveTime (CONF:14261). | SHALL contain exactly one [1..1] effectiveTime (CONF:14261). |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 14266 Modified | MAY contain zero or one [0..1] author (CONF:14266). | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:14266). |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 14267 Modified | SHOULD contain zero or more [0..\*] referenceRange (CONF:14267). | The referenceRange could be used to represent normal or expected capability for the cognitive function being evaluated.  MAY contain zero or more [0..\*] referenceRange (CONF:14267). |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 14273 Modified | SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:14273). | SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.50.2) (CONF:14273). |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | CONF #: 14592 Modified | This code SHOULD contain zero or one [0..1] @code="373930000" Cognitive function finding (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:14592). | This code SHALL contain exactly one [1..1] @code="311465003" Cognitive functions (CONF:14592). |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | Name | Cognitive Status Result Observation | Cognitive Status Observation (V2) |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.74 | 2.16.840.1.113883.10.20.22.4.74.2 |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | Description | This clinical statement contains details of an evaluation or assessment of a patient’s cognitive status. The evaluation may include assessment of a patient's mood, memory, and ability to make decisions. The statement, if present, will include supporting caregivers, non-medical devices, and the time period for which the evaluation and assessment were performed.  This is different from a cognitive status problem observation, which is a clinical statement that describes a patient's cognitive condition, findings, or symptoms. Examples of cognitive problem observations are inability to recall, amnesia, dementia, and aggressive behavior. | This template represents a patient’s cognitive status (e.g. mood, memory, ability to make decisions) and problems that limit cognition (e.g. amnesia, dementia, aggressive behavior). The template may include assessment scale observations, identify supporting caregivers and provide information about non-medicinal supplies. |
| [Cognitive Status Observation (V2) 2.16.840.1.113883.10.20.22.4.74.2](#E_Cognitive_Status_Observation_V2) | Implied Template | Result Observation (2.16.840.1.113883.10.20.22.4.2) |  |
| [Cognitive Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.75.2](#E_Cognitive_Status_Organizer_V2) | CONF #: 14376 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.75" (CONF:14376). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.75.2" (CONF:14376). |
| [Cognitive Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.75.2](#E_Cognitive_Status_Organizer_V2) | CONF #: 14378 Modified | SHALL contain exactly one [1..1] code (CONF:14378). | The code selected should indicate the category that groups the contained cognitive status observations (e.g. communication,learning and applying knowledge).  SHALL contain exactly one [1..1] code (CONF:14378). |
| [Cognitive Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.75.2](#E_Cognitive_Status_Organizer_V2) | CONF #: 14381 Modified | SHALL contain exactly one [1..1] Cognitive Status Result Observation (templateId:2.16.840.1.113883.10.20.22.4.74) (CONF:14381). | SHALL contain exactly one [1..1] Cognitive Status Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.74.2) (CONF:14381). |
| [Cognitive Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.75.2](#E_Cognitive_Status_Organizer_V2) | Name | Cognitive Status Result Organizer | Cognitive Status Organizer (V2) |
| [Cognitive Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.75.2](#E_Cognitive_Status_Organizer_V2) | Oid | 2.16.840.1.113883.10.20.22.4.75 | 2.16.840.1.113883.10.20.22.4.75.2 |
| [Cognitive Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.75.2](#E_Cognitive_Status_Organizer_V2) | Description | This clinical statement identifies a set of cognitive status result observations. It contains information applicable to all of the contained cognitive status result observations. A result organizer may be used to group questions in a Patient Health Questionnaire (PHQ).    An appropriate nullFlavor can be used when the organizer/code or organizer/id is unknown. | This template groups related cognitive status observations into categories . A result organizer may be used to group questions in a Patient Health Questionnaire (PHQ). |
| [Cognitive Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.75.2](#E_Cognitive_Status_Organizer_V2) | Implied Template | Result Organizer (2.16.840.1.113883.10.20.22.4.1) |  |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | CONF #: 14331 Removed | MAY contain zero or more [0..\*] entryRelationship (CONF:14331) such that it |  |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | CONF #: 14335 Removed | MAY contain zero or more [0..\*] entryRelationship (CONF:14335) such that it |  |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | CONF #: 14351 Removed | SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:14351). |  |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | CONF #: 14352 Removed | SHALL contain exactly one [1..1] Caregiver Characteristics (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:14352). |  |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | CONF #: 14467 Removed | MAY contain zero or more [0..\*] entryRelationship (CONF:14467) such that it |  |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | CONF #: 14468 Removed | SHALL contain exactly one [1..1] Assessment Scale Observation (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:14468). |  |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | CONF #: 14588 Removed | SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14588). |  |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | CONF #: 14589 Removed | SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14589). |  |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | CONF #: 14590 Removed | SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14590). |  |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | Name | Cognitive Status Problem Observation | Cognitive Status Problem Observation (DEPRECATED) |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | Oid | 2.16.840.1.113883.10.20.22.4.73 | 2.16.840.1.113883.10.20.22.4.73.2 |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | Description | A cognitive status problem observation is a clinical statement that describes a patient's cognitive condition, findings, or symptoms. Examples of cognitive problem observations are inability to recall, amnesia, dementia, and aggressive behavior.  A cognitive problem observation is a finding or medical condition. This is different from a cognitive result observation, which is a response to a question that provides insight into the patient's cognitive status, judgment, comprehension ability, or response speed. | USE OF COGNITIVE STATUS PROBLEM OBSERVATION IS NOT RECOMMENDED. COGNITIVE STATUS PROBLEM OBSERVATION AND COGNITIVE STATUS RESULT OBSERVATION HAVE BEEN MERGED TOGETHER WITHOUT LOSS OF EXPRESSIVITY INTO COGNITIVE STATUS OBSERVATION (TEMPLATE ID: 2.16.840.1.113883.10.20.22.4.74.2). |
| [Cognitive Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.73.2](#E_Cognitive_Status_Problem_ObsDEP) | Implied Template | Problem Observation (2.16.840.1.113883.10.20.22.4.4) |  |
| [Coverage Activity (V2) 2.16.840.1.113883.10.20.22.4.60.2](#E_Coverage_Activity_V2) | CONF #: 10492 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.60" (CONF:10492). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.60.2" (CONF:10492). |
| [Coverage Activity (V2) 2.16.840.1.113883.10.20.22.4.60.2](#E_Coverage_Activity_V2) | CONF #: 15528 Modified | SHALL contain exactly one [1..1] Policy Activity (templateId:2.16.840.1.113883.10.20.22.4.61) (CONF:15528). | SHALL contain exactly one [1..1] Policy Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.61.2) (CONF:15528). |
| [Coverage Activity (V2) 2.16.840.1.113883.10.20.22.4.60.2](#E_Coverage_Activity_V2) | Name | Coverage Activity | Coverage Activity (V2) |
| [Coverage Activity (V2) 2.16.840.1.113883.10.20.22.4.60.2](#E_Coverage_Activity_V2) | Oid | 2.16.840.1.113883.10.20.22.4.60 | 2.16.840.1.113883.10.20.22.4.60.2 |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | CONF #: 31019 Added |  | If the patient's current smoking status is unknown, @code SHALL contain '266927001' (Unknown if ever smoked) from Current Smoking Status Value Set (2.16.840.1.113883.10.22.4.78.2) (CONF:31019). |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | CONF #: 31039 Added |  | This code SHALL contain exactly one [1..1] @code="229819007" Tobacco use and exposure (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:31039). |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | CONF #: 31148 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31148). |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | CONF #: 14818 Removed | This effectiveTime SHALL contain exactly one [1..1] low (CONF:14818). |  |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | CONF #: 19171 Removed | This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19171). |  |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | CONF #: 14814 Modified | SHALL contain exactly one [1..1] effectiveTime (CONF:14814). | SHALL contain exactly one [1..1] effectiveTime (CONF:14814).  Note: The value for effectiveTime reflects when the patient's current smoking status was observed. |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | CONF #: 14816 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.78" (CONF:14816). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.78.2" (CONF:14816). |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | CONF #: 14817 Modified | This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Smoking Status 2.16.840.1.113883.11.20.9.38 STATIC 2012-07-01 (CONF:14817). | This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Current Smoking Status 2.16.840.1.113883.11.20.9.38.2 DYNAMIC 2013-07-25 (CONF:14817). |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | Name | Smoking Status Observation | Current Smoking Status (V2) |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | Oid | 2.16.840.1.113883.10.20.22.4.78 | 2.16.840.1.113883.10.20.22.4.78.2 |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | Description | This clinical statement represents a patient’s current smoking status. The vocabulary selected for this clinical statement is the best approximation of the statuses in Meaningful Use (MU) Stage 1.  If the patient is a smoker (77176002), the effectiveTime/low element must be present. If the patient is an ex-smoker (8517006), both the effectiveTime/low and effectiveTime/high element must be present.  The smoking status value set includes a special code to communicate if the smoking status is unknown which is different from how Consolidated CDA generally communicates unknown information. | This template constrains the Tobacco Use template to represent the current smoking status of the patient as specified in Meaningful Use (MU) Stage 2 requirements. Historic smoking status observations as well as details about the smoking habit (e.g., how many per day) would be represented in the Tobacco Use template.  The effectiveTime element reflects the date/time when the patient's current smoking status was observed. Details regarding the time period when the patient is/was smoking would be recorded in the Tobacco Use template.  If the patient's current smoking status is unknown, the value element must be populated with SNOMED CT code '266927001' to communicate 'Unknown if ever smoked' from the Current Smoking Status Value Set. |
| [Current Smoking Status (V2) 2.16.840.1.113883.10.20.22.4.78.2](#E_Current_Smoking_Status_V2) | Implied Template | Tobacco Use (2.16.840.1.113883.10.20.22.4.85) | Tobacco Use (V2) (2.16.840.1.113883.10.20.22.4.85.2) |
| [Deceased Observation (V2) 2.16.840.1.113883.10.20.22.4.79.2](#E_Deceased_Observation_V2) | CONF #: 14870 Modified | SHALL contain exactly one [1..1] Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:14870). | SHALL contain exactly one [1..1] Problem Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:14870). |
| [Deceased Observation (V2) 2.16.840.1.113883.10.20.22.4.79.2](#E_Deceased_Observation_V2) | CONF #: 14872 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.79" (CONF:14872). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.79.2" (CONF:14872). |
| [Deceased Observation (V2) 2.16.840.1.113883.10.20.22.4.79.2](#E_Deceased_Observation_V2) | Name | Deceased Observation | Deceased Observation (V2) |
| [Deceased Observation (V2) 2.16.840.1.113883.10.20.22.4.79.2](#E_Deceased_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.79 | 2.16.840.1.113883.10.20.22.4.79.2 |
| [Deceased Observation (V2) 2.16.840.1.113883.10.20.22.4.79.2](#E_Deceased_Observation_V2) | Description | This clinical statement represents the observation that a patient has expired. It also represents the cause of death, indicated by an entryRelationship type of “CAUS”. | This template represents the observation that a patient has died. It also represents the cause of death, indicated by an entryRelationship type of ‘CAUS’. This template allows for more specific representation of data than is available with the use of dischargeDispositionCode. |
| [Discharge Medication (V2) 2.16.840.1.113883.10.20.22.4.35.2](#Discharge_Medication_V2) | CONF #: 15525 Modified | SHALL contain exactly one [1..1] Medication Activity (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15525). | SHALL contain exactly one [1..1] Medication Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15525). |
| [Discharge Medication (V2) 2.16.840.1.113883.10.20.22.4.35.2](#Discharge_Medication_V2) | CONF #: 16761 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.35" (CONF:16761). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.35.2" (CONF:16761). |
| [Discharge Medication (V2) 2.16.840.1.113883.10.20.22.4.35.2](#Discharge_Medication_V2) | Name | Discharge Medication | Discharge Medication (V2) |
| [Discharge Medication (V2) 2.16.840.1.113883.10.20.22.4.35.2](#Discharge_Medication_V2) | Oid | 2.16.840.1.113883.10.20.22.4.35 | 2.16.840.1.113883.10.20.22.4.35.2 |
| [Discharge Medication (V2) 2.16.840.1.113883.10.20.22.4.35.2](#Discharge_Medication_V2) | Description | The Discharge Medications entry codes medications that the patient is intended to take (or stop) after discharge. | This template represents medications that the patient is intended to take (or stop) after discharge. |
| [Encounter Activity (V2) 2.16.840.1.113883.10.20.22.4.49.2](#E_Encounter_Activity_V2) | CONF #: 9929 Modified | MAY contain zero or one [0..1] sdtc:dischargeDispositionCode, which SHALL be selected from ValueSet 2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status DYNAMIC or, if access to NUBC is unavailable, from CodeSystem 2.16.840.1.113883.12.112 HL7 Discharge Disposition. The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the dischargeDispositionCode element (CONF:9929). | MAY contain zero or one [0..1] sdtc:dischargeDispositionCode, which SHALL be selected from ValueSet 2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status DYNAMIC or, if access to NUBC is unavailable, from CodeSystem 2.16.840.1.113883.12.112 HL7 Discharge Disposition (CONF:9929). |
| [Encounter Activity (V2) 2.16.840.1.113883.10.20.22.4.49.2](#E_Encounter_Activity_V2) | CONF #: 14899 Modified | SHALL contain exactly one [1..1] Indication (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:14899). | SHALL contain exactly one [1..1] Indication (V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:14899). |
| [Encounter Activity (V2) 2.16.840.1.113883.10.20.22.4.49.2](#E_Encounter_Activity_V2) | CONF #: 15973 Modified | SHALL contain exactly one [1..1] Encounter Diagnosis (templateId:2.16.840.1.113883.10.20.22.4.80) (CONF:15973). | SHALL contain exactly one [1..1] Encounter Diagnosis (V2) (templateId:2.16.840.1.113883.10.20.22.4.80.2) (CONF:15973). |
| [Encounter Activity (V2) 2.16.840.1.113883.10.20.22.4.49.2](#E_Encounter_Activity_V2) | CONF #: 26353 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.49" (CONF:26353). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.49.2" (CONF:26353). |
| [Encounter Activity (V2) 2.16.840.1.113883.10.20.22.4.49.2](#E_Encounter_Activity_V2) | Name | Encounter Activities | Encounter Activity (V2) |
| [Encounter Activity (V2) 2.16.840.1.113883.10.20.22.4.49.2](#E_Encounter_Activity_V2) | Oid | 2.16.840.1.113883.10.20.22.4.49 | 2.16.840.1.113883.10.20.22.4.49.2 |
| [Encounter Activity (V2) 2.16.840.1.113883.10.20.22.4.49.2](#E_Encounter_Activity_V2) | Description | This clinical statement describes the interactions between the patient and clinicians. Interactions include in-person encounters, telephone conversations, and email exchanges. | This clinical statement describes an interaction between a patient and clinician. Interactions may include in-person encounters, telephone conversations, and email exchanges. |
| [Encounter Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.80.2](#E_Encounter_Diagnosis_V2) | CONF #: 14896 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.80" (CONF:14896). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.80.2" (CONF:14896). |
| [Encounter Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.80.2](#E_Encounter_Diagnosis_V2) | CONF #: 14898 Modified | SHALL contain exactly one [1..1] Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:14898). | SHALL contain exactly one [1..1] Problem Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:14898). |
| [Encounter Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.80.2](#E_Encounter_Diagnosis_V2) | Name | Encounter Diagnosis | Encounter Diagnosis (V2) |
| [Encounter Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.80.2](#E_Encounter_Diagnosis_V2) | Oid | 2.16.840.1.113883.10.20.22.4.80 | 2.16.840.1.113883.10.20.22.4.80.2 |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 31522 Added |  | This code SHALL contain exactly one [1..1] @code="364644000" functional observable (CONF:31522). |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 31523 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:31523). |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13927 Removed | The text, if present, SHOULD contain zero or one [0..1] reference (CONF:13927). |  |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13928 Removed | This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:13928). |  |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13933 Removed | SHOULD contain zero or more [0..\*] interpretationCode (CONF:13933). |  |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13934 Removed | MAY contain zero or one [0..1] methodCode (CONF:13934). |  |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13935 Removed | MAY contain zero or one [0..1] targetSiteCode (CONF:13935). |  |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13938 Removed | The referenceRange, if present, SHALL contain exactly one [1..1] observationRange (CONF:13938). |  |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13939 Removed | This observationRange SHALL NOT contain [0..0] code (CONF:13939). |  |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 26448 Removed | This code SHALL contain exactly one [1..1] @code, which SHOULD be selected from CodeSystem LOINC (2.16.840.1.113883.6.1) STATIC (CONF:26448). |  |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13890 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.67" (CONF:13890). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.67.2" (CONF:13890). |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13908 Modified | SHALL contain exactly one [1..1] code (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:13908). | SHALL contain exactly one [1..1] code (CONF:13908). |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13930 Modified | Represents clinically effective time of the measurement, which may be when the measurement was performed (e.g., a BP measurement), or may be when sample was taken (and measured some time afterwards)  SHALL contain exactly one [1..1] effectiveTime (CONF:13930). | SHALL contain exactly one [1..1] effectiveTime (CONF:13930). |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13936 Modified | MAY contain zero or one [0..1] author (CONF:13936). | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:13936). |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 13937 Modified | SHOULD contain zero or more [0..\*] referenceRange (CONF:13937). | referenceRange could be used to represent normal or expected capability for the function being evaluated.  MAY contain zero or more [0..\*] referenceRange (CONF:13937). |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | CONF #: 14218 Modified | SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:14218). | SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.50.2) (CONF:14218). |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | Name | Functional Status Result Observation | Functional Status Observation (V2) |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.67 | 2.16.840.1.113883.10.20.22.4.67.2 |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | Description | This clinical statement represents details of an evaluation or assessment of a patient's functional status. The evaluation may include assessment of a patient's language, vision, hearing, activities of daily living, behavior, general function, mobility, and self-care status. The statement, if present, will include supporting caregivers, non-medical devices, and the time period for which the evaluation and assessment were performed | This template represents the patient's physical function (e.g. mobility status, activities of daily living, self-care status) and problems that limit function (dyspnea, dysphagia). The template may include assessment scale observations, identify supporting caregivers and provide information about non-medicinal supplies. This template is used to represent physical or developmental function of all patient populations and is not limited to the long-term care population. |
| [Functional Status Observation (V2) 2.16.840.1.113883.10.20.22.4.67.2](#E_Functional_Status_Observation_V2) | Implied Template | Result Observation (2.16.840.1.113883.10.20.22.4.2) |  |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | CONF #: 31417 Added |  | SHOULD be selected from ICF (codeSystem 2.16.840.1.113883.6.254) or SNOMED CT (codeSystem 2.16.840.1.113883.6.96) (CONF:31417). |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | CONF #: 31432 Added |  | SHALL contain at least one [1..\*] component (CONF:31432) such that it |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | CONF #: 31433 Added |  | SHALL contain exactly one [1..1] Self-Care Activities (ADL and IADL) (NEW) (templateId:2.16.840.1.113883.10.20.22.4.128) (CONF:31433). |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | CONF #: 31434 Added |  | This statusCode SHALL contain exactly one [1..1] @code="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:31434). |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | CONF #: 31585 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31585). |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | CONF #: 14747 Removed | This code SHOULD contain zero or one [0..1] @code (CONF:14747). |  |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | CONF #: 14748 Removed | SHOULD be selected from ICF (codeSystem 2.16.840.1.113883.6.254) or SNOMED CT (codeSystem 2.16.840.1.113883.6.96) (CONF:14748). |  |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | CONF #: 19102 Removed | This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19102). |  |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | CONF #: 14362 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.66" (CONF:14362). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.66.2" (CONF:14362). |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | CONF #: 14364 Modified | SHALL contain exactly one [1..1] code (CONF:14364). | The code selected should indicate the category that groups the contained functional status evaluation observations (e.g. mobility, self-care, communication).  SHALL contain exactly one [1..1] code (CONF:14364). |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | CONF #: 14368 Modified | SHALL contain exactly one [1..1] Functional Status Result Observation (templateId:2.16.840.1.113883.10.20.22.4.67) (CONF:14368). | SHALL contain exactly one [1..1] Functional Status Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.67.2) (CONF:14368). |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | Name | Functional Status Result Organizer | Functional Status Organizer (V2) |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | Oid | 2.16.840.1.113883.10.20.22.4.66 | 2.16.840.1.113883.10.20.22.4.66.2 |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | Description | This clinical statement identifies a set of functional status result observations. It contains information applicable to all of the contained functional status result observations. A functional status organizer may group self-care observations related to a patient's ability to feed, bathe, and dress.    An appropriate nullFlavor can be used when the organizer/code or organizer/id is unknown. | This template groups related functional status observations into categories (e.g ambulation, self-care). |
| [Functional Status Organizer (V2) 2.16.840.1.113883.10.20.22.4.66.2](#E_Functional_Status_Organizer_V2) | Implied Template | Result Organizer (2.16.840.1.113883.10.20.22.4.1) |  |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | CONF #: 14294 Removed | MAY contain zero or more [0..\*] entryRelationship (CONF:14294) such that it |  |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | CONF #: 14298 Removed | MAY contain zero or more [0..\*] entryRelationship (CONF:14298) such that it |  |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | CONF #: 14317 Removed | SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:14317). |  |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | CONF #: 14318 Removed | SHALL contain exactly one [1..1] Caregiver Characteristics (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:14318). |  |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | CONF #: 14463 Removed | MAY contain zero or more [0..\*] entryRelationship (CONF:14463) such that it |  |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | CONF #: 14464 Removed | SHALL contain exactly one [1..1] Assessment Scale Observation (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:14464). |  |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | CONF #: 14584 Removed | SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14584). |  |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | CONF #: 14586 Removed | SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14586). |  |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | CONF #: 14587 Removed | SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14587). |  |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | Name | Functional Status Problem Observation | Functional Status Problem Observation (DEPRECATED) |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | Oid | 2.16.840.1.113883.10.20.22.4.68 | 2.16.840.1.113883.10.20.22.4.68.2 |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | Description | A functional status problem observation is a clinical statement that represents a patient’s functional performance and ability. | USE OF FUNCTIONAL STATUS PROBLEM OBSERVATION IS NOT RECOMMENDED. FUNCTIONAL STATUS PROBLEM OBSERVATION AND FUNCTIONAL STATUS RESULT OBSERVATION HAVE BEEN MERGED TOGETHER WITHOUT LOSS OF EXPRESSIVITY INTO FUNCTIONAL STATUS OBSERVATION (TEMPLATE ID: 2.16.840.1.113883.10.20.22.4.67.2) |
| [Functional Status Problem Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.68.2](#E_Functional_Status_Problem_ObsDEP) | Implied Template | Problem Observation (2.16.840.1.113883.10.20.22.4.4) |  |
| [Health Status Observation (V2) 2.16.840.1.113883.10.20.22.4.5.2](#Health_Status_Observation_V2) | CONF #: 9075 Modified | SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet HealthStatus 2.16.840.1.113883.1.11.20.12 DYNAMIC (CONF:9075). | SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet HealthStatus (V2) 2.16.840.1.113883.1.11.20.12.2 DYNAMIC (CONF:9075). |
| [Health Status Observation (V2) 2.16.840.1.113883.10.20.22.4.5.2](#Health_Status_Observation_V2) | CONF #: 16757 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.5" (CONF:16757). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.5.2" (CONF:16757). |
| [Health Status Observation (V2) 2.16.840.1.113883.10.20.22.4.5.2](#Health_Status_Observation_V2) | Name | Health Status Observation | Health Status Observation (V2) |
| [Health Status Observation (V2) 2.16.840.1.113883.10.20.22.4.5.2](#Health_Status_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.5 | 2.16.840.1.113883.10.20.22.4.5.2 |
| [Health Status Observation (V2) 2.16.840.1.113883.10.20.22.4.5.2](#Health_Status_Observation_V2) | Description | The Health Status Observation records information about the current health status of the patient. | This template represents information about the overall health status of the patient. To represent the impact of a specific problem or concern related to the patient's expected health outcome use the Prognosis Observation Template 2.16.840.1.113883.10.20.22.4.113. |
| [Health Status Observation (V2) 2.16.840.1.113883.10.20.22.4.5.2](#Health_Status_Observation_V2) | Open/Closed | Closed | Open |
| [Hospital Admission Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.34.2](#E_Hospital_Admission_Diagnosis_V2) | CONF #: 15535 Modified | SHALL contain exactly one [1..1] Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15535). | SHALL contain exactly one [1..1] Problem Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15535). |
| [Hospital Admission Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.34.2](#E_Hospital_Admission_Diagnosis_V2) | CONF #: 16748 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.34" (CONF:16748). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.34.2" (CONF:16748). |
| [Hospital Admission Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.34.2](#E_Hospital_Admission_Diagnosis_V2) | Name | Hospital Admission Diagnosis | Hospital Admission Diagnosis (V2) |
| [Hospital Admission Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.34.2](#E_Hospital_Admission_Diagnosis_V2) | Oid | 2.16.840.1.113883.10.20.22.4.34 | 2.16.840.1.113883.10.20.22.4.34.2 |
| [Hospital Admission Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.34.2](#E_Hospital_Admission_Diagnosis_V2) | Description | The Hospital Admission Diagnosis entry describes the relevant problems or diagnoses at the time of admission. | This template represents problems or diagnoses identified by the clinician at the time of the patient’s admission. |
| [Hospital Discharge Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.33.2](#Hospital_Discharge_Diagnosis_V2) | CONF #: 15536 Modified | SHALL contain exactly one [1..1] Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15536). | SHALL contain exactly one [1..1] Problem Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15536). |
| [Hospital Discharge Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.33.2](#Hospital_Discharge_Diagnosis_V2) | CONF #: 16765 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.33" (CONF:16765). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.33.2" (CONF:16765). |
| [Hospital Discharge Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.33.2](#Hospital_Discharge_Diagnosis_V2) | Name | Hospital Discharge Diagnosis | Hospital Discharge Diagnosis (V2) |
| [Hospital Discharge Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.33.2](#Hospital_Discharge_Diagnosis_V2) | Oid | 2.16.840.1.113883.10.20.22.4.33 | 2.16.840.1.113883.10.20.22.4.33.2 |
| [Hospital Discharge Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.33.2](#Hospital_Discharge_Diagnosis_V2) | Description | The Hospital Discharge Diagnosis act wraps relevant problems or diagnoses at the time of discharge that occurred during the hospitalization or that need to be followed after hospitalization. This entry requires at least one Problem Observation entry. | This template represents problems or diagnoses present at the time of discharge which occurred during the hospitalization or need to be monitored after hospitalization. It requires at least one Problem Observation entry. |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 31392 Added |  | SHALL contain exactly one [1..1] Instruction (V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31392). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 31151 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31151). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 31510 Added |  | MAY contain zero or more [0..\*] entryRelationship (CONF:31510) such that it |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 31511 Added |  | SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31511). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 31512 Added |  | SHALL contain exactly one [1..1] @inversionInd="true" (CONF:31512). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 31513 Added |  | MAY contain zero or one [0..1] sequenceNumber (CONF:31513). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 31514 Added |  | SHALL contain exactly one [1..1] Substance Administered Act (NEW) (templateId:2.16.840.1.113883.10.20.22.4.118) (CONF:31514). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 15538 Removed | SHALL contain exactly one [1..1] Instructions (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:15538). |  |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 8830 Modified | MAY contain zero or one [0..1] code (CONF:8830). | SubstanceAdministration.code is an optional field. Per HL7 Pharmacy Committee, "this is intended to further specify the nature of the substance administration act. To date the committee has made no use of this attribute". Because the type of substance administration is generally implicit in the routeCode, in the consumable participant, etc, the field is generally not used, and there is no defined value set.  MAY contain zero or one [0..1] code (CONF:8830). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 8833 Modified | SHALL contain exactly one [1..1] statusCode (CONF:8833). | SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet ActStatus 2.16.840.1.113883.1.11.159331 DYNAMIC (CONF:8833). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 8838 Modified | In "INT" (intent) mood, the repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times. In "EVN" (event) mood, the repeatNumber is the number of occurrences. For example, a repeatNumber of "3" in a dispense act means that the current dispensation is the 3rd. A repeatNumber of "3" in a substance administration event means that the current administration is the 3rd in a series.  MAY contain zero or one [0..1] repeatNumber (CONF:8838). | In "INT" (intent) mood, the repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times. To indicate a given immunization's ordering in a series, use the nested Substance Administered Act.  MAY contain zero or one [0..1] repeatNumber (CONF:8838). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 8850 Modified | MAY contain zero or more [0..\*] participant (CONF:8850). | MAY contain zero or more [0..\*] participant (CONF:8850) such that it |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 8851 Modified | The participant, if present, SHALL contain exactly one [1..1] @typeCode="CSM" (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8851). | SHALL contain exactly one [1..1] @typeCode="CSM" (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8851). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 10498 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.52" (CONF:10498). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.52.2" (CONF:10498). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 15537 Modified | SHALL contain exactly one [1..1] Indication (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:15537). | SHALL contain exactly one [1..1] Indication (V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:15537). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 15539 Modified | SHALL contain exactly one [1..1] Medication Supply Order (templateId:2.16.840.1.113883.10.20.22.4.17) (CONF:15539). | SHALL contain exactly one [1..1] Medication Supply Order (V2) (templateId:2.16.840.1.113883.10.20.22.4.17.2) (CONF:15539). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 15540 Modified | SHALL contain exactly one [1..1] Medication Dispense (templateId:2.16.840.1.113883.10.20.22.4.18) (CONF:15540). | SHALL contain exactly one [1..1] Medication Dispense (V2) (templateId:2.16.840.1.113883.10.20.22.4.18.2) (CONF:15540). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 15541 Modified | SHALL contain exactly one [1..1] Reaction Observation (templateId:2.16.840.1.113883.10.20.22.4.9) (CONF:15541). | SHALL contain exactly one [1..1] Reaction Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.9.2) (CONF:15541). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 15546 Modified | This consumable SHALL contain exactly one [1..1] Immunization Medication Information (templateId:2.16.840.1.113883.10.20.22.4.54) (CONF:15546). | This consumable SHALL contain exactly one [1..1] Immunization Medication Information (V2) (templateId:2.16.840.1.113883.10.20.22.4.54.2) (CONF:15546). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | CONF #: 15547 Modified | The participant, if present, SHALL contain exactly one [1..1] Drug Vehicle (templateId:2.16.840.1.113883.10.20.22.4.24) (CONF:15547). | SHALL contain exactly one [1..1] Drug Vehicle (templateId:2.16.840.1.113883.10.20.22.4.24) (CONF:15547). |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | Name | Immunization Activity | Immunization Activity (V2) |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | Oid | 2.16.840.1.113883.10.20.22.4.52 | 2.16.840.1.113883.10.20.22.4.52.2 |
| [Immunization Activity (V2) 2.16.840.1.113883.10.20.22.4.52.2](#E_Immunization_Activity_V2) | Description | An Immunization Activity describes immunization substance administrations that have actually occurred or are intended to occur. Immunization Activities in ""INT"" mood are reflections of immunizations a clinician intends a patient to receive. Immunization Activities in ""EVN"" mood reflect immunizations actually received.  An Immunization Activity is very similar to a Medication Activity with some key differentiators. The drug code system is constrained to CVX codes. Administration timing is less complex. Patient refusal reasons should be captured. All vaccines administered should be fully documented in the patient's permanent medical record. Healthcare providers who administer vaccines covered by the National Childhood Vaccine Injury Act are required to ensure that the permanent medical record of the recipient indicates:    1) Date of administration  2) Vaccine manufacturer  3) Vaccine lot number  4) Name and title of the person who administered the vaccine and the address of the clinic or facility where the permanent record will reside  5) Vaccine information statement (VIS)  a. date printed on the VIS  b. date VIS given to patient or parent/guardian.    This information should be included in an Immunization Activity when available. | An Immunization Activity describes immunization substance administrations that have actually occurred or are intended to occur. Immunization Activities in "INT" mood are reflections of immunizations a clinician intends a patient to receive. Immunization Activities in "EVN" mood reflect immunizations actually received.  An Immunization Activity is very similar to a Medication Activity with some key differentiators. The drug code system is constrained to CVX codes. Administration timing is less complex. Patient refusal reasons should be captured. All vaccines administered should be fully documented in the patient's permanent medical record. Healthcare providers who administer vaccines covered by the National Childhood Vaccine Injury Act are required to ensure that the permanent medical record of the recipient indicates:    1) Date of administration  2) Vaccine manufacturer  3) Vaccine lot number  4) Name and title of the person who administered the vaccine and the address of the clinic or facility where the permanent record will reside  5) Vaccine information statement (VIS)  a. date printed on the VIS  b. date VIS given to patient or parent/guardian.    This information should be included in an Immunization Activity when available. |
| [Immunization Medication Information (V2) 2.16.840.1.113883.10.20.22.4.54.2](#Immunization_Medication_Information_V2) | CONF #: 31543 Added |  | This code MAY contain zero or more [0..\*] translation, which MAY be selected from ValueSet Vaccine Administered Value Set 2.16.840.1.113883.3.88.12.80.22 (CONF:31543). |
| [Immunization Medication Information (V2) 2.16.840.1.113883.10.20.22.4.54.2](#Immunization_Medication_Information_V2) | CONF #: 9008 Removed | This code SHOULD contain zero or one [0..1] originalText (CONF:9008). |  |
| [Immunization Medication Information (V2) 2.16.840.1.113883.10.20.22.4.54.2](#Immunization_Medication_Information_V2) | CONF #: 9011 Removed | This code MAY contain zero or more [0..\*] translation (CONF:9011). |  |
| [Immunization Medication Information (V2) 2.16.840.1.113883.10.20.22.4.54.2](#Immunization_Medication_Information_V2) | CONF #: 15555 Removed | The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:15555). |  |
| [Immunization Medication Information (V2) 2.16.840.1.113883.10.20.22.4.54.2](#Immunization_Medication_Information_V2) | CONF #: 15556 Removed | The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15556). |  |
| [Immunization Medication Information (V2) 2.16.840.1.113883.10.20.22.4.54.2](#Immunization_Medication_Information_V2) | CONF #: 15557 Removed | This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15557). |  |
| [Immunization Medication Information (V2) 2.16.840.1.113883.10.20.22.4.54.2](#Immunization_Medication_Information_V2) | CONF #: 16887 Removed | Translations can be used to represent generic product name, packaged product code, etc (CONF:16887). |  |
| [Immunization Medication Information (V2) 2.16.840.1.113883.10.20.22.4.54.2](#Immunization_Medication_Information_V2) | CONF #: 9007 Modified | This manufacturedMaterial SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Vaccine Administered Value Set 2.16.840.1.113883.3.88.12.80.22 DYNAMIC (CONF:9007). | This manufacturedMaterial SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Medication Consumable Temp-ValueSet-medications DYNAMIC (CONF:9007). |
| [Immunization Medication Information (V2) 2.16.840.1.113883.10.20.22.4.54.2](#Immunization_Medication_Information_V2) | Name | Immunization Medication Information | Immunization Medication Information (V2) |
| [Immunization Medication Information (V2) 2.16.840.1.113883.10.20.22.4.54.2](#Immunization_Medication_Information_V2) | Oid | 2.16.840.1.113883.10.20.22.4.54 | 2.16.840.1.113883.10.20.22.4.54.2 |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | CONF #: 30817 Added |  | SHOULD contain zero or one [0..1] text (CONF:30817). |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | CONF #: 31229 Added |  | SHALL contain exactly one [1..1] code, which MAY be selected from ValueSet Problem Type 2.16.840.1.113883.3.88.12.3221.7.2 (CONF:31229). |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | CONF #: 15985 Removed | The value, if present, SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:15985). |  |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | CONF #: 15990 Removed | The value, if present, MAY contain zero or one [0..1] @nullFlavor (CONF:15990). |  |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | CONF #: 15991 Removed | If the diagnosis is unknown or the SNOMED code is unknown, @nullFlavor SHOULD be “UNK”. If the code is something other than SNOMED, @nullFlavor SHOULD be “OTH” and the other code SHOULD be placed in the translation element (CONF:15991). |  |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | CONF #: 16885 Removed | Set the observation/id equal to an ID on the problem list to signify that problem as an indication (CONF:16885). |  |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | CONF #: 16886 Removed | SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet Problem Type 2.16.840.1.113883.3.88.12.3221.7.2 STATIC 2012-06-01 (CONF:16886). |  |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | CONF #: 7483 Modified | SHALL contain exactly one [1..1] id (CONF:7483). | This observation/id must equal another entry/id in the same document instance. Application Software must be responsible for resolving the identifier back to its original object and then rendering the information in the correct place in the containing section's narrative text. Its purpose is to obviate the need to repeat the complete XML representation of the referred to entry when relating one entry to another.  SHALL contain exactly one [1..1] id (CONF:7483). |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | CONF #: 7489 Modified | SHOULD contain zero or one [0..1] value with @xsi:type="CD" (CONF:7489). | MAY contain zero or one [0..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 STATIC (CONF:7489). |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | CONF #: 10502 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.19" (CONF:10502). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.19.2" (CONF:10502). |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | Name | Indication | Indication (V2) |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | Oid | 2.16.840.1.113883.10.20.22.4.19 | 2.16.840.1.113883.10.20.22.4.19.2 |
| [Indication (V2) 2.16.840.1.113883.10.20.22.4.19.2](#Indication_V2) | Description | The Indication Observation documents the rationale for an activity. It can do this with the id element to reference a problem recorded elsewhere in the document or with a code and value to record the problem type and problem within the Indication. For example, the indication for a prescription of a painkiller might be a headache that is documented in the Problems Section. | This template represents the rationale for an action such as the reason for an encounter, a medication administration or a procedure. The id element can be used to reference a problem recorded elsewhere in the document or with a code and value to record the problem. Indications for treatment are not lab results, rather the problem associated with the lab result should be sited (e.g such as hypokalemia instead of a lab result of Potassium 2.0 mEq/L). Use the Drug Monitoring Act [templateId 2.16.840.1.113883.10.20.22.4.123] to indicate if a particular drug needs special monitoring (e.g. anticoagulant therapy). Use Precondition for Substance Administration templateId 2.16.840.1.113883.10.20.22.4.25 to represent that a medication is to be administered only when the associated criteria are met. |
| [Instruction (V2) 2.16.840.1.113883.10.20.22.4.20.2](#Instruction_V2) | CONF #: 10503 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.20" (CONF:10503). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.20.2" (CONF:10503). |
| [Instruction (V2) 2.16.840.1.113883.10.20.22.4.20.2](#Instruction_V2) | Name | Instructions | Instruction (V2) |
| [Instruction (V2) 2.16.840.1.113883.10.20.22.4.20.2](#Instruction_V2) | Oid | 2.16.840.1.113883.10.20.22.4.20 | 2.16.840.1.113883.10.20.22.4.20.2 |
| [Instruction (V2) 2.16.840.1.113883.10.20.22.4.20.2](#Instruction_V2) | Description | The Instructions template can be used in several ways, such as to record patient instructions within a Medication Activity or to record fill instructions within a supply order. The act/code defines the type of instruction. Though not defined in this template, a Vaccine Information Statement (VIS) document could be referenced through act/reference/externalDocument, and patient awareness of the instructions can be represented with the generic participant and the participant/awarenessCode. | The Instruction template can be used in several ways, such as to record patient instructions within a Medication Activity or to record fill instructions within a supply order. The act/code defines the type of instruction. Though not defined in this template, a Vaccine Information Statement (VIS) document could be referenced through act/reference/externalDocument, and patient awareness of the instructions can be represented with the generic participant and the participant/awarenessCode. |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 31387 Added |  | SHALL contain exactly one [1..1] Instruction (V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31387). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 28499 Added |  | SHALL contain exactly one [1..1] @xsi:type=”PIVL\_TS” or “EIVL\_TS” (CONF:28499). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 30800 Added |  | Medication Activity SHOULD include doseQuantity OR rateQuantity (CONF:30800). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 30820 Added |  | MAY contain zero or one [0..1] entryRelationship (CONF:30820) such that it |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 30821 Added |  | SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CONF:30821). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 30822 Added |  | SHALL contain exactly one [1..1] Drug Monitoring Act (NEW) (templateId:2.16.840.1.113883.10.20.22.4.123) (CONF:30822). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 31150 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31150). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 31515 Added |  | MAY contain zero or more [0..\*] entryRelationship (CONF:31515) such that it |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 31516 Added |  | SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31516). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 31517 Added |  | SHALL contain exactly one [1..1] @inversionInd="true" (CONF:31517). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 31518 Added |  | MAY contain zero or one [0..1] sequenceNumber (CONF:31518). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 31519 Added |  | SHALL contain exactly one [1..1] Substance Administered Act (NEW) (templateId:2.16.840.1.113883.10.20.22.4.118) (CONF:31519). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 31520 Added |  | MAY contain zero or more [0..\*] precondition (CONF:31520). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 7529 Removed | Medication Activity SHOULD include doseQuantity OR rateQuantity (CONF:7529). |  |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 7546 Removed | MAY contain zero or more [0..\*] precondition (CONF:7546) such that it |  |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 7550 Removed | SHALL contain exactly one [1..1] @typeCode="PRCN" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7550). |  |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 9105 Removed | SHALL contain exactly one [1..1] @xsi:type=”PIVL\_TS” or “EIVL\_TS” (CONF:9105). |  |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 16088 Removed | SHALL contain exactly one [1..1] Instructions (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:16088). |  |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 16092 Removed | SHALL contain exactly one [1..1] Precondition for Substance Administration (templateId:2.16.840.1.113883.10.20.22.4.25) (CONF:16092). |  |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 16877 Removed | In "INT" (intent) mood, the repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times. In "EVN" (event) mood, the repeatNumber is the number of occurrences. For example, a repeatNumber of "3" in a substance administration event means that the current administration is the 3rd in a series (CONF:16877). |  |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 7506 Modified | MAY contain zero or one [0..1] code (CONF:7506). | SubstanceAdministration.code is an optional field. Per HL7 Pharmacy Committee, "this is intended to further specify the nature of the substance administration act. To date the committee has made no use of this attribute". Because the type of substance administration is generally implicit in the routeCode, in the consumable participant, etc, the field is generally not used, and there is no defined value set.  MAY contain zero or one [0..1] code (CONF:7506). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 7507 Modified | SHALL contain exactly one [1..1] statusCode (CONF:7507). | SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet ActStatus 2.16.840.1.113883.1.11.159331 DYNAMIC (CONF:7507). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 7508 Modified | SHALL contain exactly one [1..1] effectiveTime (CONF:7508) such that it | This effectiveTime represents the medication duration (i.e. the time the medication was started and stopped).  SHALL contain exactly one [1..1] effectiveTime (CONF:7508) such that it |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 7513 Modified | SHOULD contain zero or one [0..1] effectiveTime (CONF:7513) such that it | This effectiveTime represents the medication frequency (e.g. administration times per day).  SHOULD contain zero or one [0..1] effectiveTime (CONF:7513) such that it |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 7555 Modified | MAY contain zero or one [0..1] repeatNumber (CONF:7555). | In "INT" (intent) mood, the repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times. To indicate a given medication's ordering in a series, use the nested Substance Administered Act.  MAY contain zero or one [0..1] repeatNumber (CONF:7555). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 10504 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.16" (CONF:10504). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.16.2" (CONF:10504). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 16085 Modified | This consumable SHALL contain exactly one [1..1] Medication Information (templateId:2.16.840.1.113883.10.20.22.4.23) (CONF:16085). | This consumable SHALL contain exactly one [1..1] Medication Information (V2) (templateId:2.16.840.1.113883.10.20.22.4.23.2) (CONF:16085). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 16087 Modified | SHALL contain exactly one [1..1] Indication (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:16087). | SHALL contain exactly one [1..1] Indication (V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:16087). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 16089 Modified | SHALL contain exactly one [1..1] Medication Supply Order (templateId:2.16.840.1.113883.10.20.22.4.17) (CONF:16089). | SHALL contain exactly one [1..1] Medication Supply Order (V2) (templateId:2.16.840.1.113883.10.20.22.4.17.2) (CONF:16089). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 16090 Modified | SHALL contain exactly one [1..1] Medication Dispense (templateId:2.16.840.1.113883.10.20.22.4.18) (CONF:16090). | SHALL contain exactly one [1..1] Medication Dispense (V2) (templateId:2.16.840.1.113883.10.20.22.4.18.2) (CONF:16090). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 16091 Modified | SHALL contain exactly one [1..1] Reaction Observation (templateId:2.16.840.1.113883.10.20.22.4.9) (CONF:16091). | SHALL contain exactly one [1..1] Reaction Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.9.2) (CONF:16091). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | CONF #: 16878 Modified | Pre-coordinated consumable: If the consumable code is a pre-coordinated unit dose (e.g. "metoprolol 25mg tablet") then doseQuantity is a unitless number that indicates the number of products given per administration (e.g. "2", meaning 2 x "metoprolol 25mg tablet") (CONF:16878). | Pre-coordinated consumable: If the consumable code is a pre-coordinated unit dose (e.g. "metoprolol 25mg tablet") then doseQuantity is a unitless number that indicates the number of products given per administration (e.g. "2", meaning 2 x "metoprolol 25mg tablet" per administration) (CONF:16878). |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | Name | Medication Activity | Medication Activity (V2) |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | Oid | 2.16.840.1.113883.10.20.22.4.16 | 2.16.840.1.113883.10.20.22.4.16.2 |
| [Medication Activity (V2) 2.16.840.1.113883.10.20.22.4.16.2](#Medication_Activity_V2) | Description | A medication activity describes substance administrations that have actually occurred (e.g. pills ingested or injections given) or are intended to occur (e.g. "take 2 tablets twice a day for the next 10 days"). Medication activities in "INT" mood are reflections of what a clinician intends a patient to be taking. Medication activities in "EVN" mood reflect actual use.  Medication timing is complex. This template requires that there be a substanceAdministration/effectiveTime valued with a time interval, representing the start and stop dates. Additional effectiveTime elements are optional, and can be used to represent frequency and other aspects of more detailed dosing regimens. | A medication activity describes substance administrations that have actually occurred (e.g. pills ingested or injections given) or are intended to occur (e.g. "take 2 tablets twice a day for the next 10 days"). Medication activities in "INT" mood are reflections of what a clinician intends a patient to be taking. For example, a clinician may intend for a patient to be administered Lisinopril 20 mg PO for blood pressure control. However, what was actually administered was Lisinopril 10 mg. In the latter case, the Medication activities in the "EVN" mood would reflect actual use.    At a minimum, a medication activity shall include an effectiveTime indicating the duration of the administration. Ambulatory medication lists generally provide a summary of use for a given medication over time - a medication activity in event mood with the duration reflecting when the medication started and stopped. Ongoing medications will not have a stop date (or a stop date with a suitable NULL value). Ambulatory medication lists will generally also have a frequency (e.g. a medication is being taken twice a day). Inpatient medications generally record each administration as a separate act.    The dose (doseQuantity) represents how many of the consumables are to be administered at each administration event. As a result, the dose is always relative to the consumable and the interval of administration. Thus, a patient consuming a single "metoprolol 25mg tablet" per administration will have a doseQuantity of "1", whereas a patient consuming "metoprolol" will have a dose of "25 mg". |
| [Medication Dispense (V2) 2.16.840.1.113883.10.20.22.4.18.2](#E_Medication_Dispense_V2) | CONF #: 31696 Added |  | SHALL contain exactly one [1..1] Immunization Medication Information (V2) (templateId:2.16.840.1.113883.10.20.22.4.54.2) (CONF:31696). |
| [Medication Dispense (V2) 2.16.840.1.113883.10.20.22.4.18.2](#E_Medication_Dispense_V2) | CONF #: 15608 Removed | SHALL contain exactly one [1..1] Immunization Medication Information (templateId:2.16.840.1.113883.10.20.22.4.54) (CONF:15608). |  |
| [Medication Dispense (V2) 2.16.840.1.113883.10.20.22.4.18.2](#E_Medication_Dispense_V2) | CONF #: 10505 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.18" (CONF:10505). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.18.2" (CONF:10505). |
| [Medication Dispense (V2) 2.16.840.1.113883.10.20.22.4.18.2](#E_Medication_Dispense_V2) | CONF #: 15606 Modified | SHALL contain exactly one [1..1] Medication Supply Order (templateId:2.16.840.1.113883.10.20.22.4.17) (CONF:15606). | SHALL contain exactly one [1..1] Medication Supply Order (V2) (templateId:2.16.840.1.113883.10.20.22.4.17.2) (CONF:15606). |
| [Medication Dispense (V2) 2.16.840.1.113883.10.20.22.4.18.2](#E_Medication_Dispense_V2) | CONF #: 15607 Modified | SHALL contain exactly one [1..1] Medication Information (templateId:2.16.840.1.113883.10.20.22.4.23) (CONF:15607). | SHALL contain exactly one [1..1] Medication Information (V2) (templateId:2.16.840.1.113883.10.20.22.4.23.2) (CONF:15607). |
| [Medication Dispense (V2) 2.16.840.1.113883.10.20.22.4.18.2](#E_Medication_Dispense_V2) | Name | Medication Dispense | Medication Dispense (V2) |
| [Medication Dispense (V2) 2.16.840.1.113883.10.20.22.4.18.2](#E_Medication_Dispense_V2) | Oid | 2.16.840.1.113883.10.20.22.4.18 | 2.16.840.1.113883.10.20.22.4.18.2 |
| [Medication Information (V2) 2.16.840.1.113883.10.20.22.4.23.2](#E_Medication_Information_V2) | CONF #: 7413 Removed | This code SHOULD contain zero or one [0..1] originalText (CONF:7413). |  |
| [Medication Information (V2) 2.16.840.1.113883.10.20.22.4.23.2](#E_Medication_Information_V2) | CONF #: 7414 Removed | This code MAY contain zero or more [0..\*] translation (CONF:7414). |  |
| [Medication Information (V2) 2.16.840.1.113883.10.20.22.4.23.2](#E_Medication_Information_V2) | CONF #: 15986 Removed | The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:15986). |  |
| [Medication Information (V2) 2.16.840.1.113883.10.20.22.4.23.2](#E_Medication_Information_V2) | CONF #: 15987 Removed | The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15987). |  |
| [Medication Information (V2) 2.16.840.1.113883.10.20.22.4.23.2](#E_Medication_Information_V2) | CONF #: 15988 Removed | This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15988). |  |
| [Medication Information (V2) 2.16.840.1.113883.10.20.22.4.23.2](#E_Medication_Information_V2) | CONF #: 16875 Removed | Translations can be used to represent generic product name, packaged product code, etc (CONF:16875). |  |
| [Medication Information (V2) 2.16.840.1.113883.10.20.22.4.23.2](#E_Medication_Information_V2) | CONF #: 7412 Modified | This manufacturedMaterial SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Medication Clinical Drug Name Value Set 2.16.840.1.113883.3.88.12.80.17 DYNAMIC (CONF:7412). | This manufacturedMaterial SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Medication Consumable Temp-ValueSet-medications DYNAMIC (CONF:7412). |
| [Medication Information (V2) 2.16.840.1.113883.10.20.22.4.23.2](#E_Medication_Information_V2) | CONF #: 10506 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.23" (CONF:10506). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.23.2" (CONF:10506). |
| [Medication Information (V2) 2.16.840.1.113883.10.20.22.4.23.2](#E_Medication_Information_V2) | Name | Medication Information | Medication Information (V2) |
| [Medication Information (V2) 2.16.840.1.113883.10.20.22.4.23.2](#E_Medication_Information_V2) | Oid | 2.16.840.1.113883.10.20.22.4.23 | 2.16.840.1.113883.10.20.22.4.23.2 |
| [Medication Supply Order (V2) 2.16.840.1.113883.10.20.22.4.17.2](#E_Medication_Supply_Order_V2) | CONF #: 31695 Added |  | SHALL contain exactly one [1..1] Immunization Medication Information (V2) (templateId:2.16.840.1.113883.10.20.22.4.54.2) (CONF:31695). |
| [Medication Supply Order (V2) 2.16.840.1.113883.10.20.22.4.17.2](#E_Medication_Supply_Order_V2) | CONF #: 31391 Added |  | The entryRelationship, if present, SHALL contain exactly one [1..1] Instruction (V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31391). |
| [Medication Supply Order (V2) 2.16.840.1.113883.10.20.22.4.17.2](#E_Medication_Supply_Order_V2) | CONF #: 16094 Removed | SHALL contain exactly one [1..1] Immunization Medication Information (templateId:2.16.840.1.113883.10.20.22.4.54) (CONF:16094). |  |
| [Medication Supply Order (V2) 2.16.840.1.113883.10.20.22.4.17.2](#E_Medication_Supply_Order_V2) | CONF #: 16095 Removed | The entryRelationship, if present, SHALL contain exactly one [1..1] Instructions (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:16095). |  |
| [Medication Supply Order (V2) 2.16.840.1.113883.10.20.22.4.17.2](#E_Medication_Supply_Order_V2) | CONF #: 10507 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.17" (CONF:10507). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.17.2" (CONF:10507). |
| [Medication Supply Order (V2) 2.16.840.1.113883.10.20.22.4.17.2](#E_Medication_Supply_Order_V2) | CONF #: 16093 Modified | SHALL contain exactly one [1..1] Medication Information (templateId:2.16.840.1.113883.10.20.22.4.23) (CONF:16093). | SHALL contain exactly one [1..1] Medication Information (V2) (templateId:2.16.840.1.113883.10.20.22.4.23.2) (CONF:16093). |
| [Medication Supply Order (V2) 2.16.840.1.113883.10.20.22.4.17.2](#E_Medication_Supply_Order_V2) | Name | Medication Supply Order | Medication Supply Order (V2) |
| [Medication Supply Order (V2) 2.16.840.1.113883.10.20.22.4.17.2](#E_Medication_Supply_Order_V2) | Oid | 2.16.840.1.113883.10.20.22.4.17 | 2.16.840.1.113883.10.20.22.4.17.2 |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 7557 Removed | SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7557). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 7558 Removed | SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7558). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 7559 Removed | SHALL contain exactly one [1..1] templateId (CONF:7559) such that it |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 7560 Removed | SHALL contain at least one [1..\*] id (CONF:7560). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 7562 Removed | SHALL contain exactly one [1..1] statusCode (CONF:7562). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 7563 Removed | SHOULD contain zero or one [0..1] effectiveTime (CONF:7563). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 7564 Removed | SHALL contain exactly one [1..1] value="182904002" Drug treatment unknown (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:7564). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 7565 Removed | MAY contain zero or one [0..1] text (CONF:7565). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 10508 Removed | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.29" (CONF:10508). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 15580 Removed | The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15580). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 15581 Removed | The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15581). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 15582 Removed | This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15582). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 19107 Removed | This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19107). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 19149 Removed | SHALL contain exactly one [1..1] code (CONF:19149). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | CONF #: 19150 Removed | This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19150). |  |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | Name | Medication Use - None Known (deprecated) | Medication Use - None Known (obsolete) |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | Oid | 2.16.840.1.113883.10.20.22.4.29 | 2.16.840.1.113883.10.20.22.4.29.obsolete |
| [Medication Use - None Known (obsolete) 2.16.840.1.113883.10.20.22.4.29.obsolete](#E_Medication_Use__None_Known_obsolete) | Description | The recommended approach to stating no known medications is to use the appropriate nullFlavor instead of this template.    See ""Unknown Information"" in Section 1. | This template is obsolete and will be deleted completely in the future.    The recommended approach to stating no known medications is to use the appropriate nullFlavor instead of this template.    See ""Unknown Information"" in Section 1. |
| [Non-Medicinal Supply Activity (V2) 2.16.840.1.113883.10.20.22.4.50.2](#NonMedicinal_Supply_Activity_V2) | CONF #: 31393 Added |  | SHALL contain exactly one [1..1] Instruction (V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31393). |
| [Non-Medicinal Supply Activity (V2) 2.16.840.1.113883.10.20.22.4.50.2](#NonMedicinal_Supply_Activity_V2) | CONF #: 30277 Added |  | MAY contain zero or one [0..1] entryRelationship (CONF:30277) such that it |
| [Non-Medicinal Supply Activity (V2) 2.16.840.1.113883.10.20.22.4.50.2](#NonMedicinal_Supply_Activity_V2) | CONF #: 30278 Added |  | SHALL contain exactly one [1..1] @typeCode="SUBJ" (CONF:30278). |
| [Non-Medicinal Supply Activity (V2) 2.16.840.1.113883.10.20.22.4.50.2](#NonMedicinal_Supply_Activity_V2) | CONF #: 30279 Added |  | SHALL contain exactly one [1..1] @inversionInd="TRUE" (CONF:30279). |
| [Non-Medicinal Supply Activity (V2) 2.16.840.1.113883.10.20.22.4.50.2](#NonMedicinal_Supply_Activity_V2) | CONF #: 10509 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.50" (CONF:10509). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.50.2" (CONF:10509). |
| [Non-Medicinal Supply Activity (V2) 2.16.840.1.113883.10.20.22.4.50.2](#NonMedicinal_Supply_Activity_V2) | Name | Non-Medicinal Supply Activity | Non-Medicinal Supply Activity (V2) |
| [Non-Medicinal Supply Activity (V2) 2.16.840.1.113883.10.20.22.4.50.2](#NonMedicinal_Supply_Activity_V2) | Oid | 2.16.840.1.113883.10.20.22.4.50 | 2.16.840.1.113883.10.20.22.4.50.2 |
| [Non-Medicinal Supply Activity (V2) 2.16.840.1.113883.10.20.22.4.50.2](#NonMedicinal_Supply_Activity_V2) | Description | This template records non-medicinal supplies provided, such as medical equipment | This template represents non-medicinal supplies, such as medical equipment. - NOTES: RENT OR OWN EXPIRATION DATE |
| [Physician of Record Participant (V2) 2.16.840.1.113883.10.20.6.2.2.2](#E_Physician_of_Record_Participant_V2) | CONF #: 30928 Added |  | This assignedEntity SHOULD contain zero or one [0..1] assignedPerson (CONF:30928). |
| [Physician of Record Participant (V2) 2.16.840.1.113883.10.20.6.2.2.2](#E_Physician_of_Record_Participant_V2) | CONF #: 30929 Added |  | The assignedPerson, if present, SHALL contain exactly one [1..1] US Realm Person Name (PN.US.FIELDED) (templateId:2.16.840.1.113883.10.20.22.5.1.1) (CONF:30929). |
| [Physician of Record Participant (V2) 2.16.840.1.113883.10.20.6.2.2.2](#E_Physician_of_Record_Participant_V2) | CONF #: 31203 Added |  | MISSING NARRATIVE FOR PRIMITIVE (CONF:31203). |
| [Physician of Record Participant (V2) 2.16.840.1.113883.10.20.6.2.2.2](#E_Physician_of_Record_Participant_V2) | CONF #: 31204 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:31204). |
| [Physician of Record Participant (V2) 2.16.840.1.113883.10.20.6.2.2.2](#E_Physician_of_Record_Participant_V2) | CONF #: 8440 Removed | SHALL contain exactly one [1..1] templateId/@root="2.16.840.1.113883.10.20.6.2.2" (CONF:8440). |  |
| [Physician of Record Participant (V2) 2.16.840.1.113883.10.20.6.2.2.2](#E_Physician_of_Record_Participant_V2) | CONF #: 8890 Removed | This assignedEntity SHOULD contain zero or one [0..1] name (CONF:8890). |  |
| [Physician of Record Participant (V2) 2.16.840.1.113883.10.20.6.2.2.2](#E_Physician_of_Record_Participant_V2) | CONF #: 10035 Removed | The id SHOULD include zero or one [0..1] id where id/@root ="2.16.840.1.113883.4.6" National Provider Identifier (CONF:10035). |  |
| [Physician of Record Participant (V2) 2.16.840.1.113883.10.20.6.2.2.2](#E_Physician_of_Record_Participant_V2) | CONF #: 16072 Modified | MAY contain zero or more [0..\*] templateId (CONF:16072). | SHALL contain exactly one [1..1] templateId (CONF:16072) such that it |
| [Physician of Record Participant (V2) 2.16.840.1.113883.10.20.6.2.2.2](#E_Physician_of_Record_Participant_V2) | CONF #: 16073 Modified | The templateId, if present, MAY contain zero or one [0..1] @root="2.16.840.1.113883.10.20.6.2.2" (CONF:16073). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.2.2" (CONF:16073). |
| [Physician of Record Participant (V2) 2.16.840.1.113883.10.20.6.2.2.2](#E_Physician_of_Record_Participant_V2) | Name | Physician of Record Participant | Physician of Record Participant (V2) |
| [Physician of Record Participant (V2) 2.16.840.1.113883.10.20.6.2.2.2](#E_Physician_of_Record_Participant_V2) | Oid | 2.16.840.1.113883.10.20.6.2.2 | 2.16.840.1.113883.10.20.6.2.2.2 |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 31069 Added |  | SHALL contain exactly one [1..1] Patient Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31069). |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 31067 Added |  | This entryRelationship represents the priority that a patient places on the activity.   MAY contain zero or more [0..\*] entryRelationship (CONF:31067) such that it |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 30430 Added |  | SHALL contain exactly one [1..1] templateId (CONF:30430) such that it |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 30431 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.39.2" (CONF:30431). |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 30432 Added |  | SHALL contain exactly one [1..1] statusCode (CONF:30432). |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 30433 Added |  | SHALL contain exactly one [1..1] effectiveTime (CONF:30433). |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 30435 Added |  | Performers represent clinicians who are responsible for assessing and treating the patient.  MAY contain zero or more [0..\*] performer (CONF:30435). |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 30436 Added |  | Participants represent those in supporting roles such as caregiver, who participate in the patient's care.   MAY contain zero or more [0..\*] participant (CONF:30436). |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 31068 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31068). |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 31070 Added |  | This entryRelationship represents the priority that a provider places on the activity.   MAY contain zero or more [0..\*] entryRelationship (CONF:31070) such that it |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 31071 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31071). |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 31072 Added |  | SHALL contain exactly one [1..1] Provider Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31072). |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 31687 Added |  | SHALL contain exactly one [1..1] code (CONF:31687). |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 8544 Removed | SHALL contain exactly one [1..1] templateId (CONF:8544) such that it |  |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | CONF #: 10510 Removed | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.39" (CONF:10510). |  |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | Name | Plan of Care Activity Act | Planned Act (V2) |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | Oid | 2.16.840.1.113883.10.20.22.4.39 | 2.16.840.1.113883.10.20.22.4.39.2 |
| [Planned Act (V2) 2.16.840.1.113883.10.20.22.4.39.2](#E_Planned_Act_V2) | Description | This is the generic template for the Plan of Care Activity. | This is the generic template for the Planned Act. The activities in this template represent procedures that are not classified as an observation or a procedure according to the HL7 RIM. Examples of these procedures are a dressing change, teaching or feeding a patient or providing comfort measures. The priority of the activity to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference. The effective time indicates the time when the activity is intended to take place. |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 31035 Added |  | SHALL contain exactly one [1..1] Patient Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31035). |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 31033 Added |  | This entryRelationship represents the priority that a patient places on the encounter.  MAY contain zero or more [0..\*] entryRelationship (CONF:31033) such that it |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 30437 Added |  | SHALL contain exactly one [1..1] templateId (CONF:30437) such that it |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 30438 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.40.2" (CONF:30438). |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 30439 Added |  | SHALL contain exactly one [1..1] statusCode (CONF:30439). |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 30440 Added |  | SHALL contain exactly one [1..1] effectiveTime (CONF:30440). |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 30442 Added |  | Performers represent clinicians who are responsible for assessing and treating the patient.  MAY contain zero or more [0..\*] performer (CONF:30442). |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 30443 Added |  | Participants represent those in supporting roles such as caregiver, who participate in the patient's care.  MAY contain zero or more [0..\*] participant (CONF:30443). |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 31032 Added |  | Records the type of encounter.  SHALL contain exactly one [1..1] code (CONF:31032). |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 31034 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31034). |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 31036 Added |  | This entryRelationship represents the priority that a provider places on the encounter.  MAY contain zero or more [0..\*] entryRelationship (CONF:31036) such that it |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 31037 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31037). |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 31038 Added |  | SHALL contain exactly one [1..1] Provider Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31038). |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 8566 Removed | SHALL contain exactly one [1..1] templateId (CONF:8566) such that it |  |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | CONF #: 10511 Removed | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.40" (CONF:10511). |  |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | Name | Plan of Care Activity Encounter | Planned Encounter (V2) |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | Oid | 2.16.840.1.113883.10.20.22.4.40 | 2.16.840.1.113883.10.20.22.4.40.2 |
| [Planned Encounter (V2) 2.16.840.1.113883.10.20.22.4.40.2](#E_Planned_Encounter_V2) | Description | This is the template for the Plan of Care Activity Encounter. | The Planned Encounter represents an intent or request for an interaction between a patient and a practitioner who is vested with primary responsibility for diagnosing, evaluating, or treating the patient’s condition. Such encounters may include visits, appointments, and non-face-to-face interactions. The practitioner who has primary responsibility for assessing and treating the patient at a given contact is represented by the performer. The participant would represent a support person or caregiver who participates in the patient's care. The priority of the activity encounter is communicated through Patient Priority Preference and Provider Priority Preference. The effective time indicates the time when this is intended to be fulfilled. |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 31075 Added |  | SHALL contain exactly one [1..1] Patient Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31075). |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 31073 Added |  | This entryRelationship represents the priority that the patient places on the observation.  MAY contain zero or more [0..\*] entryRelationship (CONF:31073) such that it |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 30451 Added |  | SHALL contain exactly one [1..1] templateId (CONF:30451) such that it |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 30452 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.44.2" (CONF:30452). |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 30453 Added |  | SHALL contain exactly one [1..1] statusCode (CONF:30453). |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 30454 Added |  | SHALL contain exactly one [1..1] effectiveTime (CONF:30454). |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 30456 Added |  | Performers represent clinicians who are responsible for assessing and treating the patient.  MAY contain zero or more [0..\*] performer (CONF:30456). |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 30457 Added |  | Participants represent those in supporting roles such as caregiver, who participate in the patient's care.  MAY contain zero or more [0..\*] participant (CONF:30457). |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 31030 Added |  | SHALL contain exactly one [1..1] code (CONF:31030). |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 31031 Added |  | MAY contain zero or more [0..\*] value (CONF:31031). |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 31074 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31074). |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 31076 Added |  | This entryRelationship represents the priority that a provider places on the observation.  MAY contain zero or more [0..\*] entryRelationship (CONF:31076) such that it |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 31077 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31077). |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 31078 Added |  | SHALL contain exactly one [1..1] Provider Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31078). |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 8583 Removed | SHALL contain exactly one [1..1] templateId (CONF:8583) such that it |  |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | CONF #: 10512 Removed | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.44" (CONF:10512). |  |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | Name | Plan of Care Activity Observation | Planned Observation (V2) |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.44 | 2.16.840.1.113883.10.20.22.4.44.2 |
| [Planned Observation (V2) 2.16.840.1.113883.10.20.22.4.44.2](#E_Planned_Observation_V2) | Description | This is the template for the Plan of Care Activity Observation. | This template represents a Planned Observation. The importance of the the planned observation to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference. |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 31081 Added |  | SHALL contain exactly one [1..1] Patient Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31081). |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 31079 Added |  | This entryRelationship represents the priority that a patient places on the procedure.  MAY contain zero or more [0..\*] entryRelationship (CONF:31079) such that it |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 30444 Added |  | SHALL contain exactly one [1..1] templateId (CONF:30444) such that it |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 30445 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.41.2" (CONF:30445). |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 30446 Added |  | SHALL contain exactly one [1..1] statusCode (CONF:30446). |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 30447 Added |  | SHOULD contain zero or one [0..1] effectiveTime (CONF:30447). |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 30449 Added |  | Performers represent clinicians who are responsible for assessing and treating the patient.  MAY contain zero or more [0..\*] performer (CONF:30449). |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 30450 Added |  | Participants represent those in supporting roles such as caregiver, who participate in the patient's care.  MAY contain zero or more [0..\*] participant (CONF:30450). |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 31080 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31080). |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 31082 Added |  | This entryRelationship represents the priority that a provider places on the procedure.  MAY contain zero or more [0..\*] entryRelationship (CONF:31082) such that it |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 31083 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31083). |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 31084 Added |  | SHALL contain exactly one [1..1] Provider Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31084). |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 8570 Removed | SHALL contain exactly one [1..1] templateId (CONF:8570) such that it |  |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | CONF #: 10513 Removed | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.41" (CONF:10513). |  |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | Name | Plan of Care Activity Procedure | Planned Procedure (V2) |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | Oid | 2.16.840.1.113883.10.20.22.4.41 | 2.16.840.1.113883.10.20.22.4.41.2 |
| [Planned Procedure (V2) 2.16.840.1.113883.10.20.22.4.41.2](#E_Planned_Procedure_V2) | Description | This is the template for the Plan of Care Activity Procedure. | The Planned Procedure represents planned alterations of the physical condition. Examples of such procedures are tracheostomy, knee replacements, and craniectomy. The priority of the procedure to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference. The effective time indicates the time when the procedure is intended to take place. |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 31106 Added |  | SHALL contain exactly one [1..1] Patient Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31106). |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 31104 Added |  | This entryRelationship represents the priority that a patient places on the substance administration.  MAY contain zero or more [0..\*] entryRelationship (CONF:31104) such that it |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 30465 Added |  | SHALL contain exactly one [1..1] templateId (CONF:30465) such that it |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 30466 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.42.2" (CONF:30466). |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 30467 Added |  | SHALL contain exactly one [1..1] statusCode (CONF:30467). |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 30468 Added |  | SHALL contain exactly one [1..1] effectiveTime (CONF:30468). |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 30470 Added |  | Performers represent clinicians who are responsible for assessing and treating the patient.  MAY contain zero or more [0..\*] performer (CONF:30470). |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 30471 Added |  | Participants represent those in supporting roles such as caregiver, who participate in the patient's care.    MAY contain zero or more [0..\*] participant (CONF:30471). |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 31105 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31105). |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 31107 Added |  | This entryRelationship represents the priority that a provider places on the substance administration.  MAY contain zero or more [0..\*] entryRelationship (CONF:31107) such that it |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 31108 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31108). |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 31109 Added |  | SHALL contain exactly one [1..1] Provider Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31109). |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 8574 Removed | SHALL contain exactly one [1..1] templateId (CONF:8574) such that it |  |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | CONF #: 10514 Removed | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.42" (CONF:10514). |  |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | Name | Plan of Care Activity Substance Administration | Planned Substance Administration (V2) |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | Oid | 2.16.840.1.113883.10.20.22.4.42 | 2.16.840.1.113883.10.20.22.4.42.2 |
| [Planned Substance Administration (V2) 2.16.840.1.113883.10.20.22.4.42.2](#E_Planned_Substance_Administration_V2) | Description | This is the template for the Plan of Care Activity Substance Administration | The Planned Substance Administration describes substance administrations that will occur. The priority of the substance administration activity to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference. The effective time indicates the time when the substance is intended to be administered. |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 31112 Added |  | SHALL contain exactly one [1..1] Patient Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31112). |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 31110 Added |  | This entryRelationship represents the priority that a patient places on the supply.  MAY contain zero or more [0..\*] entryRelationship (CONF:31110) such that it |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 30463 Added |  | SHALL contain exactly one [1..1] templateId (CONF:30463) such that it |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 30464 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.43.2" (CONF:30464). |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 30458 Added |  | SHALL contain exactly one [1..1] statusCode (CONF:30458). |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 30459 Added |  | SHOULD contain zero or one [0..1] effectiveTime (CONF:30459).  Note: effectiveTime in a plan template indicates the time frame around which an event should occur. |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 31111 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31111). |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 31113 Added |  | This entryRelationship represents the priority that a provider places on the supply.  MAY contain zero or more [0..\*] entryRelationship (CONF:31113) such that it |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 31114 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31114). |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 31115 Added |  | SHALL contain exactly one [1..1] Provider Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31115). |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 31129 Added |  | If the author of a Supply Plan is different then the author of the document, or if there is more than one document author, the supplyAct author must be stated.  SHOULD contain zero or one [0..1] author (CONF:31129). |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 31130 Added |  | The author, if present, SHALL contain exactly one [1..1] time (CONF:31130).  Note: The author/time indicates the time when the supply plan was documented. |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 8579 Removed | SHALL contain exactly one [1..1] templateId (CONF:8579) such that it |  |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | CONF #: 10515 Removed | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.43" (CONF:10515). |  |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | Name | Plan of Care Activity Supply | Planned Supply (V2) |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | Oid | 2.16.840.1.113883.10.20.22.4.43 | 2.16.840.1.113883.10.20.22.4.43.2 |
| [Planned Supply (V2) 2.16.840.1.113883.10.20.22.4.43.2](#E_Planned_Supply_V2) | Description | This is the template for the Plan of Care Activity Supply. | This template represents both medicinal and non-medicinal supplies ordered, requested or intended for the patient. The importance of the supply order or request to the patient and provider may be indicated in the Patient Priority Preference and Provider Priority Preference. The author/time indicates the time when the planned supply was documented. |
| [Policy Activity (V2) 2.16.840.1.113883.10.20.22.4.61.2](#Policy_Activity_V2) | CONF #: 31344 Added |  | If the covered party’s date of birth is recorded differently in the health plan and in the registration/medication summary, use the date of birth as it is recorded in the health plan.  The playingEntity, if present, SHALL contain exactly one [1..1] sdtc:birthTime (CONF:31344). |
| [Policy Activity (V2) 2.16.840.1.113883.10.20.22.4.61.2](#Policy_Activity_V2) | CONF #: 31345 Added |  | The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the birthTime element (CONF:31345). |
| [Policy Activity (V2) 2.16.840.1.113883.10.20.22.4.61.2](#Policy_Activity_V2) | CONF #: 8933 Removed | If the member date of birth as recorded by the health plan differs from the patient date of birth as recorded in the registration/medication summary, then the member date of birth SHALL be recorded in sdtc:birthTime. The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the birthTime element (CONF:8933). |  |
| [Policy Activity (V2) 2.16.840.1.113883.10.20.22.4.61.2](#Policy_Activity_V2) | CONF #: 8911 Modified | This assignedEntity MAY contain zero or one [0..1] telecom (CONF:8911). | This assignedEntity MAY contain zero or more [0..\*] telecom (CONF:8911). |
| [Policy Activity (V2) 2.16.840.1.113883.10.20.22.4.61.2](#Policy_Activity_V2) | CONF #: 8965 Modified | This assignedEntity SHOULD contain zero or one [0..1] telecom (CONF:8965). | This assignedEntity SHOULD contain zero or more [0..\*] telecom (CONF:8965). |
| [Policy Activity (V2) 2.16.840.1.113883.10.20.22.4.61.2](#Policy_Activity_V2) | CONF #: 10516 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.61" (CONF:10516). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.61.2" (CONF:10516). |
| [Policy Activity (V2) 2.16.840.1.113883.10.20.22.4.61.2](#Policy_Activity_V2) | Name | Policy Activity | Policy Activity (V2) |
| [Policy Activity (V2) 2.16.840.1.113883.10.20.22.4.61.2](#Policy_Activity_V2) | Oid | 2.16.840.1.113883.10.20.22.4.61 | 2.16.840.1.113883.10.20.22.4.61.2 |
| [Postprocedure Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.51.2](#E_Postprocedure_Diagnosis_V2) | CONF #: 15583 Modified | Such entryRelationships SHALL contain exactly one [1..1] Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15583). | Such entryRelationships SHALL contain exactly one [1..1] Problem Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15583). |
| [Postprocedure Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.51.2](#E_Postprocedure_Diagnosis_V2) | CONF #: 16767 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.51" (CONF:16767). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.51.2" (CONF:16767). |
| [Postprocedure Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.51.2](#E_Postprocedure_Diagnosis_V2) | Name | Postprocedure Diagnosis | Postprocedure Diagnosis (V2) |
| [Postprocedure Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.51.2](#E_Postprocedure_Diagnosis_V2) | Oid | 2.16.840.1.113883.10.20.22.4.51 | 2.16.840.1.113883.10.20.22.4.51.2 |
| [Postprocedure Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.51.2](#E_Postprocedure_Diagnosis_V2) | Description | The Postprocedure Diagnosis entry encodes the diagnosis or diagnoses discovered or confirmed during the procedure. Often it is the same as the pre-procedure diagnosis or indication. | This template represents the diagnosis or diagnoses discovered or confirmed during the procedure. They may be the same as preprocedure diagnoses or indications. |
| [Preoperative Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.65.2](#E_Preoperative_Diagnosis_V2) | CONF #: 15605 Modified | Such entryRelationships SHALL contain exactly one [1..1] Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15605). | Such entryRelationships SHALL contain exactly one [1..1] Problem Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15605). |
| [Preoperative Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.65.2](#E_Preoperative_Diagnosis_V2) | CONF #: 16771 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.65" (CONF:16771). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.65.2" (CONF:16771). |
| [Preoperative Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.65.2](#E_Preoperative_Diagnosis_V2) | Name | Preoperative Diagnosis | Preoperative Diagnosis (V2) |
| [Preoperative Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.65.2](#E_Preoperative_Diagnosis_V2) | Oid | 2.16.840.1.113883.10.20.22.4.65 | 2.16.840.1.113883.10.20.22.4.65.2 |
| [Preoperative Diagnosis (V2) 2.16.840.1.113883.10.20.22.4.65.2](#E_Preoperative_Diagnosis_V2) | Description | The Preoperative Diagnosis entry encodes the surgical diagnosis or diagnoses assigned to the patient before the surgical procedure and is the reason for the surgery. The preoperative diagnosis is, in the opinion of the surgeon, the diagnosis that will be confirmed during surgery. | This template represents the surgical diagnosis or diagnoses assigned to the patient before the surgical procedure and is the reason for the surgery. The preoperative diagnosis is, in the opinion of the surgeon, the diagnosis that will be confirmed during surgery. |
| [Pressure Ulcer Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.70.2](#E_Pressure_Ulcer_Observation_DEPRECATED) | CONF #: 14397 Removed | This value MAY contain zero or one [0..1] @nullFlavor (CONF:14397). |  |
| [Pressure Ulcer Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.70.2](#E_Pressure_Ulcer_Observation_DEPRECATED) | CONF #: 14398 Removed | If the stage unknown or the SNOMED code is unknown, @nullFlavor SHOULD be “UNK”. If the code is something other than SNOMED, @nullFlavor SHOULD be “OTH” and the other code SHOULD be placed in the translation element (CONF:14398). |  |
| [Pressure Ulcer Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.70.2](#E_Pressure_Ulcer_Observation_DEPRECATED) | CONF #: 14388 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.70" (CONF:14388). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.70.2" (CONF:14388). |
| [Pressure Ulcer Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.70.2](#E_Pressure_Ulcer_Observation_DEPRECATED) | Name | Pressure Ulcer Observation | Pressure Ulcer Observation (DEPRECATED) |
| [Pressure Ulcer Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.70.2](#E_Pressure_Ulcer_Observation_DEPRECATED) | Oid | 2.16.840.1.113883.10.20.22.4.70 | 2.16.840.1.113883.10.20.22.4.70.2 |
| [Pressure Ulcer Observation (DEPRECATED) 2.16.840.1.113883.10.20.22.4.70.2](#E_Pressure_Ulcer_Observation_DEPRECATED) | Description | The pressure ulcer observation contains details about the pressure ulcer such as the stage of the ulcer, location, and dimensions. If the pressure ulcer is a diagnosis, you may find this on the problem list. An example of how this would appear is in the Problem Section. | THIS TEMPLATE HAS BEEN DEPRECATED AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE THE WOUND OBSERVATION TEMPLATE INSTEAD.    The pressure ulcer observation contains details about the pressure ulcer such as the stage of the ulcer, location, and dimensions. If the pressure ulcer is a diagnosis, you may find this on the problem list. An example of how this would appear is in the Problem Section. |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | CONF #: 31146 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31146). |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | CONF #: 31525 Added |  | This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ProblemAct statusCode 2.16.840.1.113883.11.20.9.19 STATIC 2011-09-10 (CONF:31525). |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | CONF #: 31638 Added |  | This entryRelationship represents the importance of the concern to a provider.  MAY contain zero or more [0..\*] entryRelationship (CONF:31638) such that it |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | CONF #: 31639 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31639). |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | CONF #: 31640 Added |  | SHALL contain exactly one [1..1] Provider Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31640). |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | CONF #: 9029 Modified | SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet ProblemAct statusCode 2.16.840.1.113883.11.20.9.19 STATIC 2011-09-09 (CONF:9029). | SHALL contain exactly one [1..1] statusCode (CONF:9029). |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | CONF #: 9030 Modified | The effectiveTime element records the starting and ending times during which the concern was active on the Problem List.  SHALL contain exactly one [1..1] effectiveTime (CONF:9030). | SHALL contain exactly one [1..1] effectiveTime (CONF:9030). |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | CONF #: 9032 Modified | This effectiveTime SHALL contain exactly one [1..1] low (CONF:9032). | This effectiveTime SHALL contain exactly one [1..1] low (CONF:9032).  Note: The effectiveTime/low asserts when the concern became active. This equates to the time the concern was authored in the patient's chart. |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | CONF #: 9033 Modified | This effectiveTime SHOULD contain zero or one [0..1] high (CONF:9033). | This effectiveTime MAY contain zero or one [0..1] high (CONF:9033).  Note: The effectiveTime/high asserts when the concern was completed (e.g. when the clinician deemed there is no longer any need to track the underlying condition). |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | CONF #: 15980 Modified | SHALL contain exactly one [1..1] Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15980). | SHALL contain exactly one [1..1] Problem Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15980). |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | CONF #: 16773 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.3" (CONF:16773). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.3.2" (CONF:16773). |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | Name | Problem Concern Act (Condition) | Problem Concern Act (Condition) (V2) |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | Oid | 2.16.840.1.113883.10.20.22.4.3 | 2.16.840.1.113883.10.20.22.4.3.2 |
| [Problem Concern Act (Condition) (V2) 2.16.840.1.113883.10.20.22.4.3.2](#E_Problem_Concern_Act_Condition_V2) | Description | Observations of problems or other clinical statements captured at a point in time are wrapped in a ""Concern"" act, which represents the ongoing process tracked over time. This allows for binding related observations of problems. For example, the observation of ""Acute MI"" in 2004 can be related to the observation of ""History of MI"" in 2006 because they are the same concern. The conformance statements in this section define an outer ""problem act"" (representing the ""Concern"") that can contain a nested ""problem observation"" or other nested clinical statements. | This template reflects an ongoing concern on behalf of the provider that placed the concern on a patient’s problem list. So long as the underlying condition is of concern to the provider (i.e. so long as the condition, whether active or resolved, is of ongoing concern and interest to the provider), the statusCode is “active”. Only when the underlying condition is no longer of concern is the statusCode set to “completed”. The effectiveTime reflects the time that the underlying condition was felt to be a concern – it may or may not correspond to the effectiveTime of the condition (e.g. even five years later, the clinician may remain concerned about a prior heart attack).    The statusCode of the Problem Concern Act (Condition) is the definitive indication of the status of the concern, whereas the effectiveTime of the nested Problem Observation is the definitive indication of whether or not the underlying condition is resolved.    The effectiveTime/low of the Problem Concern Act (Condition) asserts when the concern became active. This equates to the time the concern was authored in the patient's chart. The effectiveTime/high asserts when the concern was completed (e.g. when the clinician deemed there is no longer any need to track the underlying condition). |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 31064 Added |  | SHALL contain exactly one [1..1] Patient Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:31064). |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 31063 Added |  | MAY contain zero or more [0..\*] entryRelationship (CONF:31063) such that it |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 29951 Added |  | MAY contain zero or one [0..1] entryRelationship (CONF:29951) such that it |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 29952 Added |  | SHALL contain exactly one [1..1] Prognosis Observation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.113) (CONF:29952). |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 31065 Added |  | MAY contain zero or more [0..\*] entryRelationship (CONF:31065) such that it |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 31066 Added |  | SHALL contain exactly one [1..1] Provider Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:31066). |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 31147 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31147). |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 31531 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31531). |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 31532 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31532). |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 31533 Added |  | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31533). |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 9063 Removed | MAY contain zero or one [0..1] entryRelationship (CONF:9063) such that it |  |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 9064 Removed | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9064). |  |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 9067 Removed | MAY contain zero or one [0..1] entryRelationship (CONF:9067) such that it |  |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 9068 Removed | SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9068). |  |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 10141 Removed | This value MAY contain zero or one [0..1] @nullFlavor (CONF:10141). |  |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 10142 Removed | If the diagnosis is unknown or the SNOMED code is unknown, @nullFlavor SHOULD be “UNK”. If the code is something other than SNOMED, @nullFlavor SHOULD be “OTH” and the other code SHOULD be placed in the translation element (CONF:10142). |  |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 15591 Removed | SHALL contain exactly one [1..1] Problem Status (templateId:2.16.840.1.113883.10.20.22.4.6) (CONF:15591). |  |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 15592 Removed | SHALL contain exactly one [1..1] Health Status Observation (templateId:2.16.840.1.113883.10.20.22.4.5) (CONF:15592). |  |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 16880 Removed | Use negationInd="true" to indicate that the problem was not observed (CONF:16880). |  |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 9050 Modified | SHOULD contain zero or one [0..1] effectiveTime (CONF:9050). | SHALL contain exactly one [1..1] effectiveTime (CONF:9050).  Note: If the problem is known to be resolved, but the date of resolution is not known, then the high element SHALL be present, and the nullFlavor attribute SHALL be set to 'UNK'. Therefore, the existence of an high element within a problem does indicate that the problem has been resolved. |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 10139 Modified | MAY contain zero or one [0..1] @negationInd (CONF:10139). | MAY contain zero or one [0..1] @negationInd (CONF:10139).  Note: Use negationInd="true" to indicate that the problem was not observed. |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 14927 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.4" (CONF:14927). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.4.2" (CONF:14927). |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 15603 Modified | The value of effectiveTime/low represents onset date.  The effectiveTime, if present, SHALL contain exactly one [1..1] low (CONF:15603). | This effectiveTime SHALL contain exactly one [1..1] low (CONF:15603).  Note: The effectiveTime/low (a.k.a. "onset date") asserts when the condition became biologically active. |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | CONF #: 15604 Modified | If the problem is resolved, record the resolution date in effectiveTime/high. If the problem is known to be resolved but the resolution date is not known, use @nullFlavor="UNK". If the problem is not resolved, do not include the high element.  The effectiveTime, if present, MAY contain zero or one [0..1] high (CONF:15604). | This effectiveTime MAY contain zero or one [0..1] high (CONF:15604).  Note: The effectiveTime/high (a.k.a. "resolution date") asserts when the condition became biologically resolved. |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | Name | Problem Observation | Problem Observation (V2) |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.4 | 2.16.840.1.113883.10.20.22.4.4.2 |
| [Problem Observation (V2) 2.16.840.1.113883.10.20.22.4.4.2](#E_Problem_Observation_V2) | Description | A problem is a clinical statement that a clinician has noted. In health care it is a condition that requires monitoring or diagnostic, therapeutic, or educational action. It also refers to any unmet or partially met basic human need.  A Problem Observation is required to be wrapped in an act wrapper in locations such as the Problem Section, Allergies Section, and Hospital Discharge Diagnosis Section, where the type of problem needs to be identified or the condition tracked.  A Problem Observation can be a valid “standalone” template instance in cases where a simple problem observation is to be sent.  The negationInd attribute, if true, specifies that the problem indicated was observed to not have occurred (which is subtly but importantly different from having not been observed). NegationInd='true' is an acceptable way to make a clinical assertion that something did not occur, for example, “no diabetes”. | This template reflects a discrete observation about a patient's problem. Because it is a discrete observation, it will have a statusCode of "completed". The effectiveTime, also referred to as the “biologically relevant time” is the time at which the observation holds for the patient. For a provider seeing a patient in the clinic today, observing a history of heart attack that occurred five years ago, the effectiveTime is five years ago.    The effectiveTime of the Problem Observation is the definitive indication of whether or not the underlying condition is resolved. If the problem is known to be resolved, then an effectiveTime/high would be present. If the date of resolution is not known, then effectiveTime/high will be present with a nullFlavor of "UNK". |
| [Problem Status (DEPRECATED) 2.16.840.1.113883.10.20.22.4.6.2](#E_Problem_Status_DEPRECATED) | CONF #: 7362 Removed | SHOULD contain zero or one [0..1] text (CONF:7362). |  |
| [Problem Status (DEPRECATED) 2.16.840.1.113883.10.20.22.4.6.2](#E_Problem_Status_DEPRECATED) | CONF #: 15593 Removed | The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15593). |  |
| [Problem Status (DEPRECATED) 2.16.840.1.113883.10.20.22.4.6.2](#E_Problem_Status_DEPRECATED) | CONF #: 15594 Removed | The reference, if present, SHALL contain exactly one [1..1] @value (CONF:15594). |  |
| [Problem Status (DEPRECATED) 2.16.840.1.113883.10.20.22.4.6.2](#E_Problem_Status_DEPRECATED) | CONF #: 15595 Removed | This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15595). |  |
| [Problem Status (DEPRECATED) 2.16.840.1.113883.10.20.22.4.6.2](#E_Problem_Status_DEPRECATED) | CONF #: 10518 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.6" (CONF:10518). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.6.2" (CONF:10518). |
| [Problem Status (DEPRECATED) 2.16.840.1.113883.10.20.22.4.6.2](#E_Problem_Status_DEPRECATED) | Name | Problem Status | Problem Status (DEPRECATED) |
| [Problem Status (DEPRECATED) 2.16.840.1.113883.10.20.22.4.6.2](#E_Problem_Status_DEPRECATED) | Oid | 2.16.840.1.113883.10.20.22.4.6 | 2.16.840.1.113883.10.20.22.4.6.2 |
| [Problem Status (DEPRECATED) 2.16.840.1.113883.10.20.22.4.6.2](#E_Problem_Status_DEPRECATED) | Description | The Problem Status records whether the indicated problem is active, inactive, or resolved. | This template has been deprecated in Consolidated CDA Release 2. Per the explanation in Volume 1, section 3.2 "Determining a Clinical Statement's Status", the status of a problem is determined based on attributes of the Problem Observation |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 31396 Added |  | SHALL contain exactly one [1..1] Instruction (V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31396). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 15600 Removed | The entryRelationship, if present, SHALL contain exactly one [1..1] Instructions (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:15600). |  |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8311 Modified | MAY contain zero or more [0..\*] participant (CONF:8311). | MAY contain zero or more [0..\*] participant (CONF:8311) such that it |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8312 Modified | The participant, if present, SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8312). | SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8312). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8314 Modified | MAY contain zero or more [0..\*] entryRelationship (CONF:8314). | MAY contain zero or more [0..\*] entryRelationship (CONF:8314) such that it |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8315 Modified | The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8315). | SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8315). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8316 Modified | The entryRelationship, if present, SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8316). | SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8316). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8317 Modified | The entryRelationship, if present, SHALL contain exactly one [1..1] encounter (CONF:8317). | SHALL contain exactly one [1..1] encounter (CONF:8317). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8322 Modified | MAY contain zero or one [0..1] entryRelationship (CONF:8322). | MAY contain zero or one [0..1] entryRelationship (CONF:8322) such that it |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8323 Modified | The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8323). | SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8323). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8324 Modified | The entryRelationship, if present, SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8324). | SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8324). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8326 Modified | MAY contain zero or more [0..\*] entryRelationship (CONF:8326). | MAY contain zero or more [0..\*] entryRelationship (CONF:8326) such that it |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8327 Modified | The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8327). | SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8327). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8329 Modified | MAY contain zero or more [0..\*] entryRelationship (CONF:8329). | MAY contain zero or more [0..\*] entryRelationship (CONF:8329) such that it |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 8330 Modified | The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8330). | SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8330). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 10519 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.12" (CONF:10519). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.12.2" (CONF:10519). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 15599 Modified | The participant, if present, SHALL contain exactly one [1..1] Service Delivery Location (templateId:2.16.840.1.113883.10.20.22.4.32) (CONF:15599). | SHALL contain exactly one [1..1] Service Delivery Location (templateId:2.16.840.1.113883.10.20.22.4.32) (CONF:15599). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 15601 Modified | The entryRelationship, if present, SHALL contain exactly one [1..1] Indication (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:15601). | SHALL contain exactly one [1..1] Indication (V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:15601). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | CONF #: 15602 Modified | The entryRelationship, if present, SHALL contain exactly one [1..1] Medication Activity (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15602). | SHALL contain exactly one [1..1] Medication Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15602). |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | Name | Procedure Activity Act | Procedure Activity Act (V2) |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | Oid | 2.16.840.1.113883.10.20.22.4.12 | 2.16.840.1.113883.10.20.22.4.12.2 |
| [Procedure Activity Act (V2) 2.16.840.1.113883.10.20.22.4.12.2](#E_Procedure_Activity_Act_V2) | Description | The common notion of "procedure" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g., splenectomy).    This clinical statement represents any procedure that cannot be classified as an observation or a procedure according to the HL7 RIM. Examples of these procedures are a dressing change, teaching or feeding a patient or providing comfort measures. | This template represents any act that cannot be classified as an observation or procedure according to the HL7 RIM. Examples of these acts are a dressing change, teaching or feeding a patient, or providing comfort measures.  The common notion of "procedure" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g., splenectomy). |
| [Procedure Activity Observation (V2) 2.16.840.1.113883.10.20.22.4.13.2](#E_Procedure_Activity_Observation_V2) | CONF #: 31394 Added |  | SHALL contain exactly one [1..1] Instruction (V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31394). |
| [Procedure Activity Observation (V2) 2.16.840.1.113883.10.20.22.4.13.2](#E_Procedure_Activity_Observation_V2) | CONF #: 15905 Removed | SHALL contain exactly one [1..1] Instructions (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:15905). |  |
| [Procedure Activity Observation (V2) 2.16.840.1.113883.10.20.22.4.13.2](#E_Procedure_Activity_Observation_V2) | CONF #: 10520 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.13" (CONF:10520). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.13.2" (CONF:10520). |
| [Procedure Activity Observation (V2) 2.16.840.1.113883.10.20.22.4.13.2](#E_Procedure_Activity_Observation_V2) | CONF #: 15906 Modified | SHALL contain exactly one [1..1] Indication (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:15906). | SHALL contain exactly one [1..1] Indication (V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:15906). |
| [Procedure Activity Observation (V2) 2.16.840.1.113883.10.20.22.4.13.2](#E_Procedure_Activity_Observation_V2) | CONF #: 15907 Modified | SHALL contain exactly one [1..1] Medication Activity (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15907). | SHALL contain exactly one [1..1] Medication Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15907). |
| [Procedure Activity Observation (V2) 2.16.840.1.113883.10.20.22.4.13.2](#E_Procedure_Activity_Observation_V2) | Name | Procedure Activity Observation | Procedure Activity Observation (V2) |
| [Procedure Activity Observation (V2) 2.16.840.1.113883.10.20.22.4.13.2](#E_Procedure_Activity_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.13 | 2.16.840.1.113883.10.20.22.4.13.2 |
| [Procedure Activity Observation (V2) 2.16.840.1.113883.10.20.22.4.13.2](#E_Procedure_Activity_Observation_V2) | Description | The common notion of ""procedure"" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g. splenectomy).    This clinical statement represents procedures that result in new information about the patient that cannot be classified as a procedure according to the HL7 RIM. Examples of these procedures are diagnostic imaging procedures, EEGs and EKGs. | The common notion of procedure is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g. splenectomy).    This template represents procedures that result in new information about the patient that cannot be classified as a procedure according to the HL7 RIM. Examples of these procedures are diagnostic imaging procedures, EEGs, and EKGs. |
| [Procedure Activity Procedure (V2) 2.16.840.1.113883.10.20.22.4.14.2](#E_Procedure_Activity_Procedure_V2) | CONF #: 31395 Added |  | SHALL contain exactly one [1..1] Instruction (V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31395). |
| [Procedure Activity Procedure (V2) 2.16.840.1.113883.10.20.22.4.14.2](#E_Procedure_Activity_Procedure_V2) | CONF #: 29744 Added |  | If you want to indicate that the Procedure and the Results are referring to the same specimen, the Procedure/specimen/specimenRole/id SHOULD be set to equal an Organizer/specimen/ specimenRole/id (CONF:29744). |
| [Procedure Activity Procedure (V2) 2.16.840.1.113883.10.20.22.4.14.2](#E_Procedure_Activity_Procedure_V2) | CONF #: 7717 Removed | If you want to indicate that the Procedure and the Results are referring to the same specimen, the Procedure/specimen/specimenRole/id SHOULD be set to equal an Organizer/specimen/ specimenRole/id (CONF:7717). |  |
| [Procedure Activity Procedure (V2) 2.16.840.1.113883.10.20.22.4.14.2](#E_Procedure_Activity_Procedure_V2) | CONF #: 15913 Removed | SHALL contain exactly one [1..1] Instructions (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:15913). |  |
| [Procedure Activity Procedure (V2) 2.16.840.1.113883.10.20.22.4.14.2](#E_Procedure_Activity_Procedure_V2) | CONF #: 10521 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.14" (CONF:10521). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.14.2" (CONF:10521). |
| [Procedure Activity Procedure (V2) 2.16.840.1.113883.10.20.22.4.14.2](#E_Procedure_Activity_Procedure_V2) | CONF #: 15914 Modified | SHALL contain exactly one [1..1] Indication (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:15914). | SHALL contain exactly one [1..1] Indication (V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:15914). |
| [Procedure Activity Procedure (V2) 2.16.840.1.113883.10.20.22.4.14.2](#E_Procedure_Activity_Procedure_V2) | CONF #: 15915 Modified | SHALL contain exactly one [1..1] Medication Activity (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15915). | SHALL contain exactly one [1..1] Medication Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15915). |
| [Procedure Activity Procedure (V2) 2.16.840.1.113883.10.20.22.4.14.2](#E_Procedure_Activity_Procedure_V2) | Name | Procedure Activity Procedure | Procedure Activity Procedure (V2) |
| [Procedure Activity Procedure (V2) 2.16.840.1.113883.10.20.22.4.14.2](#E_Procedure_Activity_Procedure_V2) | Oid | 2.16.840.1.113883.10.20.22.4.14 | 2.16.840.1.113883.10.20.22.4.14.2 |
| [Procedure Activity Procedure (V2) 2.16.840.1.113883.10.20.22.4.14.2](#E_Procedure_Activity_Procedure_V2) | Description | The common notion of ""procedure"" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g. splenectomy).    This clinical statement represents procedures whose immediate and primary outcome (post-condition) is the alteration of the physical condition of the patient. Examples of these procedures are an appendectomy, hip replacement and a creation of a gastrostomy. | The common notion of "procedure" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g. splenectomy).    This template represents procedures whose immediate and primary outcome (post-condition) is the alteration of the physical condition of the patient. Examples of these procedures are an appendectomy, hip replacement and a creation of a gastrostomy. |
| [Reaction Observation (V2) 2.16.840.1.113883.10.20.22.4.9.2](#Reaction_Observation_V2) | CONF #: 31124 Added |  | This code SHALL contain exactly one [1..1] @code="ASSERTION" (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:31124). |
| [Reaction Observation (V2) 2.16.840.1.113883.10.20.22.4.9.2](#Reaction_Observation_V2) | CONF #: 16852 Removed | The value set for this code element has not been specified. Implementers are allowed to use any code system, such as SNOMED CT, a locally determined code, or a nullFlavor (CONF:16852). |  |
| [Reaction Observation (V2) 2.16.840.1.113883.10.20.22.4.9.2](#Reaction_Observation_V2) | CONF #: 10523 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.9" (CONF:10523). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.9.2" (CONF:10523). |
| [Reaction Observation (V2) 2.16.840.1.113883.10.20.22.4.9.2](#Reaction_Observation_V2) | CONF #: 15920 Modified | SHALL contain exactly one [1..1] Procedure Activity Procedure (templateId:2.16.840.1.113883.10.20.22.4.14) (CONF:15920). | SHALL contain exactly one [1..1] Procedure Activity Procedure (V2) (templateId:2.16.840.1.113883.10.20.22.4.14.2) (CONF:15920). |
| [Reaction Observation (V2) 2.16.840.1.113883.10.20.22.4.9.2](#Reaction_Observation_V2) | CONF #: 15921 Modified | SHALL contain exactly one [1..1] Medication Activity (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15921). | SHALL contain exactly one [1..1] Medication Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15921). |
| [Reaction Observation (V2) 2.16.840.1.113883.10.20.22.4.9.2](#Reaction_Observation_V2) | CONF #: 15922 Modified | SHALL contain exactly one [1..1] Severity Observation (templateId:2.16.840.1.113883.10.20.22.4.8) (CONF:15922). | SHALL contain exactly one [1..1] Severity Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.8.2) (CONF:15922). |
| [Reaction Observation (V2) 2.16.840.1.113883.10.20.22.4.9.2](#Reaction_Observation_V2) | Name | Reaction Observation | Reaction Observation (V2) |
| [Reaction Observation (V2) 2.16.840.1.113883.10.20.22.4.9.2](#Reaction_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.9 | 2.16.840.1.113883.10.20.22.4.9.2 |
| [Result Observation (V2) 2.16.840.1.113883.10.20.22.4.2.2](#E_Result_Observation_V2) | CONF #: 31484 Added |  | If Observation/value is a physical quantity, the unit of measure SHALL be expressed using a valid Unified Code for Units of Measure (UCUM) expression (CONF:31484). |
| [Result Observation (V2) 2.16.840.1.113883.10.20.22.4.2.2](#E_Result_Observation_V2) | CONF #: 7149 Modified | MAY contain zero or one [0..1] author (CONF:7149). | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:7149). |
| [Result Observation (V2) 2.16.840.1.113883.10.20.22.4.2.2](#E_Result_Observation_V2) | CONF #: 9138 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.2" (CONF:9138). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.2.2" (CONF:9138). |
| [Result Observation (V2) 2.16.840.1.113883.10.20.22.4.2.2](#E_Result_Observation_V2) | Name | Result Observation | Result Observation (V2) |
| [Result Observation (V2) 2.16.840.1.113883.10.20.22.4.2.2](#E_Result_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.2 | 2.16.840.1.113883.10.20.22.4.2.2 |
| [Result Organizer (V2) 2.16.840.1.113883.10.20.22.4.1.2](#Result_Organizer_V2) | CONF #: 31149 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31149). |
| [Result Organizer (V2) 2.16.840.1.113883.10.20.22.4.1.2](#Result_Organizer_V2) | CONF #: 9134 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.1" (CONF:9134). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.1.2" (CONF:9134). |
| [Result Organizer (V2) 2.16.840.1.113883.10.20.22.4.1.2](#Result_Organizer_V2) | CONF #: 14850 Modified | SHALL contain exactly one [1..1] Result Observation (templateId:2.16.840.1.113883.10.20.22.4.2) (CONF:14850). | SHALL contain exactly one [1..1] Result Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.2.2) (CONF:14850). |
| [Result Organizer (V2) 2.16.840.1.113883.10.20.22.4.1.2](#Result_Organizer_V2) | Name | Result Organizer | Result Organizer (V2) |
| [Result Organizer (V2) 2.16.840.1.113883.10.20.22.4.1.2](#Result_Organizer_V2) | Oid | 2.16.840.1.113883.10.20.22.4.1 | 2.16.840.1.113883.10.20.22.4.1.2 |
| [Severity Observation (V2) 2.16.840.1.113883.10.20.22.4.8.2](#E_Severity_Observation_V2) | CONF #: 10525 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.8" (CONF:10525). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.8.2" (CONF:10525). |
| [Severity Observation (V2) 2.16.840.1.113883.10.20.22.4.8.2](#E_Severity_Observation_V2) | Name | Severity Observation | Severity Observation (V2) |
| [Severity Observation (V2) 2.16.840.1.113883.10.20.22.4.8.2](#E_Severity_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.8 | 2.16.840.1.113883.10.20.22.4.8.2 |
| [Social History Observation (V2) 2.16.840.1.113883.10.20.22.4.38.2](#E_Social_History_Observation_V2) | CONF #: 9130 Removed | SHALL contain exactly one [1..1] @typeCode="DRIV" Is derived from (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9130). |  |
| [Social History Observation (V2) 2.16.840.1.113883.10.20.22.4.38.2](#E_Social_History_Observation_V2) | CONF #: 19220 Removed | This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Social History Type Value Set 2.16.840.1.113883.3.88.12.80.60 STATIC (CONF:19220). |  |
| [Social History Observation (V2) 2.16.840.1.113883.10.20.22.4.38.2](#E_Social_History_Observation_V2) | CONF #: 8555 Modified | Observation/value can be any data type. Where Observation/value is a physical quantity, the unit of measure SHALL be expressed using a valid Unified Code for Units of Measure (UCUM) expression (CONF:8555). | If Observation/value is a physical quantity, the unit of measure SHALL be expressed using a valid Unified Code for Units of Measure (UCUM) expression (CONF:8555). |
| [Social History Observation (V2) 2.16.840.1.113883.10.20.22.4.38.2](#E_Social_History_Observation_V2) | CONF #: 8558 Modified | SHALL contain exactly one [1..1] code (CONF:8558). | SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet Social History Type Value Set 2.16.840.1.113883.3.88.12.80.60 DYNAMIC (CONF:8558). |
| [Social History Observation (V2) 2.16.840.1.113883.10.20.22.4.38.2](#E_Social_History_Observation_V2) | CONF #: 10526 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.38" (CONF:10526). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.38.2" (CONF:10526). |
| [Social History Observation (V2) 2.16.840.1.113883.10.20.22.4.38.2](#E_Social_History_Observation_V2) | Name | Social History Observation | Social History Observation (V2) |
| [Social History Observation (V2) 2.16.840.1.113883.10.20.22.4.38.2](#E_Social_History_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.38 | 2.16.840.1.113883.10.20.22.4.38.2 |
| [Social History Observation (V2) 2.16.840.1.113883.10.20.22.4.38.2](#E_Social_History_Observation_V2) | Description | This Social History Observation defines the patient’s occupational, personal (e.g., lifestyle), social, and environmental history and health risk factors, as well as administrative data such as marital status, race, ethnicity, and religious affiliation. | This template represents a patient's occupations, lifestyle, and environmental health risk factors. Demographic data (e.g. marital status, race, ethnicity, religious affiliation) is captured in the header. |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 31144 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31144). |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 31536 Added |  | This effectiveTime SHALL contain exactly one [1..1] low (CONF:31536). |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 31537 Added |  | This effectiveTime MAY contain zero or one [0..1] high (CONF:31537). |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16325 Removed | In an allergy to a specific medication the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.16 Medication Brand Name DYNAMIC or the ValueSet 2.16.840.1.113883.3.88.12.80.17 Medication Clinical Drug DYNAMIC (CONF:16325). |  |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16326 Removed | This code SHOULD contain zero or one [0..1] originalText (CONF:16326). |  |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16327 Removed | The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:16327). |  |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16328 Removed | The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:16328). |  |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16329 Removed | This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:16329). |  |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16330 Removed | This code MAY contain zero or more [0..\*] translation (CONF:16330). |  |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16331 Removed | In an allergy to a class of medications the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.18 Medication Drug Class DYNAMIC (CONF:16331). |  |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16332 Removed | In an allergy to a food or other substance the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.20 Ingredient Name DYNAMIC (CONF:16332). |  |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16306 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.24.3.90" (CONF:16306). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.24.3.90.2" (CONF:16306). |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16309 Modified | SHALL contain exactly one [1..1] effectiveTime (CONF:16309). | The effectiveTime/low (a.k.a. "onset date") asserts when the allergy/intolerance became biologically active. The effectiveTime/high (a.k.a. "resolution date") asserts when the allergy/intolerance became biologically resolved.   If the allergy/intolerance is known to be resolved, but the date of resolution is not known, then the high element SHALL be present, and the nullFlavor attribute SHALL be set to 'UNK'. Therefore, the existence of an high element within an allergy/intolerance does indicate that the allergy/intolerance has been resolved  SHALL contain exactly one [1..1] effectiveTime (CONF:16309). |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16317 Modified | This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Allergy/Adverse Event Type Value Set 2.16.840.1.113883.3.88.12.3221.6.2 DYNAMIC (CONF:16317). | The consumable participant points to the precise allergen or substance of intolerance. Because the consumable and the reaction are more clinically relevant than a categorization of the allergy/adverse event type, many systems will simply assign a fixed value here (e.g. "allergy to substance").  This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Allergy/Adverse Event Type Value Set 2.16.840.1.113883.3.88.12.3221.6.2 DYNAMIC (CONF:16317). |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16324 Modified | This playingEntity SHALL contain exactly one [1..1] code (CONF:16324). | This playingEntity SHALL contain exactly one [1..1] code, which MAY be selected from ValueSet Substance / Reactant for Intolerance Temp-ValueSet-substanceReactantForIntolerance DYNAMIC (CONF:16324). |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16336 Modified | SHALL contain exactly one [1..1] Allergy Status Observation (templateId:2.16.840.1.113883.10.20.22.4.28) (CONF:16336). | SHALL contain exactly one [1..1] Allergy Status Observation (DEPRECATED) (templateId:2.16.840.1.113883.10.20.22.4.28.2) (CONF:16336). |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16340 Modified | SHALL contain exactly one [1..1] Reaction Observation (templateId:2.16.840.1.113883.10.20.22.4.9) (CONF:16340). | SHALL contain exactly one [1..1] Reaction Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.9.2) (CONF:16340). |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | CONF #: 16344 Modified | SHALL contain exactly one [1..1] Severity Observation (templateId:2.16.840.1.113883.10.20.22.4.8) (CONF:16344). | SHALL contain exactly one [1..1] Severity Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.8.2) (CONF:16344). |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | Name | Substance or Device Allergy - Intolerance Observation | Substance or Device Allergy - Intolerance Observation (V2) |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | Oid | 2.16.840.1.113883.10.20.24.3.90 | 2.16.840.1.113883.10.20.24.3.90.2 |
| [Substance or Device Allergy - Intolerance Observation (V2) 2.16.840.1.113883.10.20.24.3.90.2](#E_Substance_or_Device_Allergy__V2) | Description | This clinical statement represents that an allergy or adverse reaction to a substance or device exists or does not exist. The agent that is the cause of the allergy or adverse reaction is represented as a participant in the observation. | This template reflects a discrete observation about a patient's allergy or intolerance to a substance or device. Because it is a discrete observation, it will have a statusCode of "completed". The effectiveTime, also referred to as the “biologically relevant time” is the time at which the observation holds for the patient. For a provider seeing a patient in the clinic today, observing a history of penicillin allergy that developed five years ago, the effectiveTime is five years ago.    The effectiveTime of the Substance or Device Allergy - Intolerance Observation is the definitive indication of whether or not the underlying allergy/intolerance is resolved. If known to be resolved, then an effectiveTime/high would be present. If the date of resolution is not known, then effectiveTime/high will be present with a nullFlavor of "UNK". |
| [Tobacco Use (V2) 2.16.840.1.113883.10.20.22.4.85.2](#Tobacco_Use_V2) | CONF #: 31152 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31152). |
| [Tobacco Use (V2) 2.16.840.1.113883.10.20.22.4.85.2](#Tobacco_Use_V2) | CONF #: 31431 Added |  | This effectiveTime MAY contain zero or one [0..1] high (CONF:31431).  Note: The high value represents when the tobacco use or exposure ended. |
| [Tobacco Use (V2) 2.16.840.1.113883.10.20.22.4.85.2](#Tobacco_Use_V2) | CONF #: 16565 Modified | This effectiveTime SHALL contain exactly one [1..1] low (CONF:16565). | This effectiveTime SHALL contain exactly one [1..1] low (CONF:16565).  Note: The low value represents when the tobacco use or exposure began. |
| [Tobacco Use (V2) 2.16.840.1.113883.10.20.22.4.85.2](#Tobacco_Use_V2) | CONF #: 16567 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.85" (CONF:16567). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.85.2" (CONF:16567). |
| [Tobacco Use (V2) 2.16.840.1.113883.10.20.22.4.85.2](#Tobacco_Use_V2) | CONF #: 19175 Modified | This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19175). | This code SHALL contain exactly one [1..1] @code="229819007" Tobacco use and exposure (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:19175). |
| [Tobacco Use (V2) 2.16.840.1.113883.10.20.22.4.85.2](#Tobacco_Use_V2) | Name | Tobacco Use | Tobacco Use (V2) |
| [Tobacco Use (V2) 2.16.840.1.113883.10.20.22.4.85.2](#Tobacco_Use_V2) | Oid | 2.16.840.1.113883.10.20.22.4.85 | 2.16.840.1.113883.10.20.22.4.85.2 |
| [Tobacco Use (V2) 2.16.840.1.113883.10.20.22.4.85.2](#Tobacco_Use_V2) | Description | This clinical statement represents a patient’s tobacco use. All types of tobacco use are represented using the codes from the tobacco use and exposure - finding hierarchy in SNOMED CT. | This template represents a patient’s tobacco use.  All the types of tobacco use are represented using the codes from the tobacco use and exposure-finding hierarchy in SNOMED CT, including codes required for recording smoking status in Meaningful Use Stage 2.  The effectiveTime element is used to describe dates associated with the patient's tobacco use. |
| [Vital Sign Observation (V2) 2.16.840.1.113883.10.20.22.4.27.2](#E_Vital_Sign_Observation_V2) | CONF #: 31579 Added |  | This value SHALL contain exactly one [1..1] @unit, which SHALL be selected from CodeSystem UCUM (2.16.840.1.113883.6.8) (CONF:31579). |
| [Vital Sign Observation (V2) 2.16.840.1.113883.10.20.22.4.27.2](#E_Vital_Sign_Observation_V2) | CONF #: 7310 Modified | MAY contain zero or one [0..1] author (CONF:7310). | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:7310). |
| [Vital Sign Observation (V2) 2.16.840.1.113883.10.20.22.4.27.2](#E_Vital_Sign_Observation_V2) | CONF #: 10527 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.27" (CONF:10527). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.27.2" (CONF:10527). |
| [Vital Sign Observation (V2) 2.16.840.1.113883.10.20.22.4.27.2](#E_Vital_Sign_Observation_V2) | Name | Vital Sign Observation | Vital Sign Observation (V2) |
| [Vital Sign Observation (V2) 2.16.840.1.113883.10.20.22.4.27.2](#E_Vital_Sign_Observation_V2) | Oid | 2.16.840.1.113883.10.20.22.4.27 | 2.16.840.1.113883.10.20.22.4.27.2 |
| [Vital Signs Organizer (V2) 2.16.840.1.113883.10.20.22.4.26.2](#E_Vital_Signs_Organizer_V2) | CONF #: 30901 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.96" (CONF:30901). |
| [Vital Signs Organizer (V2) 2.16.840.1.113883.10.20.22.4.26.2](#E_Vital_Signs_Organizer_V2) | CONF #: 31153 Added |  | SHOULD contain zero or more [0..\*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:31153). |
| [Vital Signs Organizer (V2) 2.16.840.1.113883.10.20.22.4.26.2](#E_Vital_Signs_Organizer_V2) | CONF #: 10528 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.26" (CONF:10528). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.26.2" (CONF:10528). |
| [Vital Signs Organizer (V2) 2.16.840.1.113883.10.20.22.4.26.2](#E_Vital_Signs_Organizer_V2) | CONF #: 15946 Modified | SHALL contain exactly one [1..1] Vital Sign Observation (templateId:2.16.840.1.113883.10.20.22.4.27) (CONF:15946). | SHALL contain exactly one [1..1] Vital Sign Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.27.2) (CONF:15946). |
| [Vital Signs Organizer (V2) 2.16.840.1.113883.10.20.22.4.26.2](#E_Vital_Signs_Organizer_V2) | Name | Vital Signs Organizer | Vital Signs Organizer (V2) |
| [Vital Signs Organizer (V2) 2.16.840.1.113883.10.20.22.4.26.2](#E_Vital_Signs_Organizer_V2) | Oid | 2.16.840.1.113883.10.20.22.4.26 | 2.16.840.1.113883.10.20.22.4.26.2 |
| [Vital Signs Organizer (V2) 2.16.840.1.113883.10.20.22.4.26.2](#E_Vital_Signs_Organizer_V2) | Description | The Vital Signs Organizer groups vital signs, which is similar to the Result Organizer, but with further constraints.    An appropriate nullFlavor can be used when the organizer/code or organizer/id is unknown. | The Vital Signs Organizer groups vital signs, which is similar to the Result Organizer, but with further constraints.    An appropriate nullFlavor can be used when the organizer/code or organizer/id is unknown. |
| [Advance Directives Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.21.2](#Advance_Directives_Section_entries_opti) | CONF #: 30812 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30812). |
| [Advance Directives Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.21.2](#Advance_Directives_Section_entries_opti) | CONF #: 10376 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.21" (CONF:10376). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.21.2" (CONF:10376). |
| [Advance Directives Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.21.2](#Advance_Directives_Section_entries_opti) | CONF #: 15443 Modified | SHALL contain exactly one [1..1] Advance Directive Observation (templateId:2.16.840.1.113883.10.20.22.4.48) (CONF:15443). | SHALL contain exactly one [1..1] Advance Directive Organizer (NEW) (templateId:2.16.840.1.113883.10.20.22.4.108) (CONF:15443). |
| [Advance Directives Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.21.2](#Advance_Directives_Section_entries_opti) | Name | Advance Directives Section (entries optional) | Advance Directives Section (entries optional) (V2) |
| [Advance Directives Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.21.2](#Advance_Directives_Section_entries_opti) | Oid | 2.16.840.1.113883.10.20.22.2.21 | 2.16.840.1.113883.10.20.22.2.21.2 |
| [Advance Directives Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.21.2](#Advance_Directives_Section_entries_opti) | Description | This section contains data defining the patient’s advance directives and any reference to supporting documentation. The most recent and up-to-date directives are required, if known, and should be listed in as much detail as possible. This section contains data such as the existence of living wills, healthcare proxies, and CPR and resuscitation status. If referenced documents are available, they can be included in the CCD exchange package.    NOTE: The descriptions in this section differentiate between “advance directives” and “advance directive documents”. The former are the directions whereas the latter are legal documents containing those directions. Thus, an advance directive might be “no cardiopulmonary resuscitation”, and this directive might be stated in a legal advance directive document. | This section contains data defining the patient’s advance directives and any reference to supporting documentation, including living wills, healthcare proxies, and CPR and resuscitation status. If the referenced documents are available, they can be included in the exchange package.  The most recent directives are required, if known, and should be listed in as much detail as possible.  This section differentiates between 'advance directives' and 'advance directive documents'. The former is the directions to be followed whereas the latter refers to a legal document containing those directions. |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 30227 Added |  | SHALL contain exactly one [1..1] templateId (CONF:30227) such that it |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 30228 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.21.1.2" (CONF:30228). |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 30235 Added |  | SHALL contain at least one [1..\*] entry (CONF:30235) such that it |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 30236 Added |  | SHALL contain exactly one [1..1] Advance Directive Organizer (NEW) (templateId:2.16.840.1.113883.10.20.22.4.108) (CONF:30236). |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 8643 Removed | SHALL contain exactly one [1..1] templateId (CONF:8643) such that it |  |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 8645 Removed | SHALL contain exactly one [1..1] title (CONF:8645). |  |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 8646 Removed | SHALL contain exactly one [1..1] text (CONF:8646). |  |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 8647 Removed | SHALL contain at least one [1..\*] entry (CONF:8647) such that it |  |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 10377 Removed | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.21.1" (CONF:10377). |  |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 15343 Removed | SHALL contain exactly one [1..1] code (CONF:15343). |  |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 15344 Removed | This code SHALL contain exactly one [1..1] @code="42348-3" Advance Directives (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15344). |  |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | CONF #: 15445 Removed | SHALL contain exactly one [1..1] Advance Directive Observation (templateId:2.16.840.1.113883.10.20.22.4.48) (CONF:15445). |  |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | Name | Advance Directives Section (entries required) | Advance Directives Section (entries required) (V2) |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | Oid | 2.16.840.1.113883.10.20.22.2.21.1 | 2.16.840.1.113883.10.20.22.2.21.1.2 |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | Description | This section contains data defining the patient’s advance directives and any reference to supporting documentation. The most recent and up-to-date directives are required, if known, and should be listed in as much detail as possible. This section contains data such as the existence of living wills, healthcare proxies, and CPR and resuscitation status. If referenced documents are available, they can be included in the CCD exchange package.    NOTE: The descriptions in this section differentiate between “advance directives” and “advance directive documents”. The former are the directions whereas the latter are legal documents containing those directions. Thus, an advance directive might be “no cardiopulmonary resuscitation”, and this directive might be stated in a legal advance directive document. | This section contains data defining the patient’s advance directives and any reference to supporting documentation, including living wills, healthcare proxies, and CPR and resuscitation status. If the referenced documents are available, they can be included in the exchange package.    The most recent directives are required, if known, and should be listed in as much detail as possible.    This section differentiates between 'advance directives' and 'advance directive documents'. The former is the directions to be followed whereas the latter refers to a legal document containing those directions. |
| [Advance Directives Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.21.1.2](#S_Advance_Directives_Section_entries_re) | Implied Template | Advance Directives Section (entries optional) (2.16.840.1.113883.10.20.22.2.21) | Advance Directives Section (entries optional) (V2) (2.16.840.1.113883.10.20.22.2.21.2) |
| [Allergies Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.6.2](#S_Allergies_Section_entries_optional_V2) | CONF #: 10378 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.6" (CONF:10378). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.6.2" (CONF:10378). |
| [Allergies Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.6.2](#S_Allergies_Section_entries_optional_V2) | CONF #: 15444 Modified | SHALL contain exactly one [1..1] Allergy Problem Act (templateId:2.16.840.1.113883.10.20.22.4.30) (CONF:15444). | SHALL contain exactly one [1..1] Allergy Concern Act (V2) (templateId:2.16.840.1.113883.10.20.22.4.30.2) (CONF:15444). |
| [Allergies Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.6.2](#S_Allergies_Section_entries_optional_V2) | Name | Allergies Section (entries optional) | Allergies Section (entries optional) (V2) |
| [Allergies Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.6.2](#S_Allergies_Section_entries_optional_V2) | Oid | 2.16.840.1.113883.10.20.22.2.6 | 2.16.840.1.113883.10.20.22.2.6.2 |
| [Allergies Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.6.2](#S_Allergies_Section_entries_optional_V2) | Description | This section lists and describes any medication allergies, adverse reactions, idiosyncratic reactions, anaphylaxis/anaphylactoid reactions to food items, and metabolic variations or adverse reactions/allergies to other substances (such as latex, iodine, tape adhesives) used to assure the safety of health care delivery. At a minimum, it should list currently active and any relevant historical allergies and adverse reactions. | This section lists and describes any medication allergies, adverse reactions, idiosyncratic reactions, anaphylaxis/anaphylactoid reactions to food items, and metabolic variations or adverse reactions/allergies to other substances (such as latex, iodine, tape adhesives). At a minimum, it should list currently active and any relevant historical allergies and adverse reactions. |
| [Allergies Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.6.1.2](#S_Allergies_Section_entries_required_V2) | CONF #: 10379 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.6.1" (CONF:10379). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.6.1.2" (CONF:10379). |
| [Allergies Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.6.1.2](#S_Allergies_Section_entries_required_V2) | CONF #: 15446 Modified | SHALL contain exactly one [1..1] Allergy Problem Act (templateId:2.16.840.1.113883.10.20.22.4.30) (CONF:15446). | SHALL contain exactly one [1..1] Allergy Concern Act (V2) (templateId:2.16.840.1.113883.10.20.22.4.30.2) (CONF:15446). |
| [Allergies Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.6.1.2](#S_Allergies_Section_entries_required_V2) | Name | Allergies Section (entries required) | Allergies Section (entries required) (V2) |
| [Allergies Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.6.1.2](#S_Allergies_Section_entries_required_V2) | Oid | 2.16.840.1.113883.10.20.22.2.6.1 | 2.16.840.1.113883.10.20.22.2.6.1.2 |
| [Allergies Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.6.1.2](#S_Allergies_Section_entries_required_V2) | Description | This section lists and describes any medication allergies, adverse reactions, idiosyncratic reactions, anaphylaxis/anaphylactoid reactions to food items, and metabolic variations or adverse reactions/allergies to other substances (such as latex, iodine, tape adhesives) used to assure the safety of health care delivery. At a minimum, it should list currently active and any relevant historical allergies and adverse reactions. | This section lists and describes any medication allergies, adverse reactions, idiosyncratic reactions, anaphylaxis/anaphylactoid reactions to food items, and metabolic variations or adverse reactions/allergies to other substances (such as latex, iodine, tape adhesives). At a minimum, it should list currently active and any relevant historical allergies and adverse reactions. |
| [Allergies Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.6.1.2](#S_Allergies_Section_entries_required_V2) | Implied Template | Allergies Section (entries optional) (2.16.840.1.113883.10.20.22.2.6) | Allergies Section (entries optional) (V2) (2.16.840.1.113883.10.20.22.2.6.2) |
| [Anesthesia Section (V2) 2.16.840.1.113883.10.20.22.2.25.2](#S_Anesthesia_Section_V2) | CONF #: 30830 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30830). |
| [Anesthesia Section (V2) 2.16.840.1.113883.10.20.22.2.25.2](#S_Anesthesia_Section_V2) | CONF #: 31127 Added |  | SHALL contain exactly one [1..1] Medication Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:31127). |
| [Anesthesia Section (V2) 2.16.840.1.113883.10.20.22.2.25.2](#S_Anesthesia_Section_V2) | CONF #: 26454 Removed | SHALL contain exactly one [1..1] Medication Activity (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:26454). |  |
| [Anesthesia Section (V2) 2.16.840.1.113883.10.20.22.2.25.2](#S_Anesthesia_Section_V2) | CONF #: 10380 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.25" (CONF:10380). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.25.2" (CONF:10380). |
| [Anesthesia Section (V2) 2.16.840.1.113883.10.20.22.2.25.2](#S_Anesthesia_Section_V2) | CONF #: 15447 Modified | SHALL contain exactly one [1..1] Procedure Activity Procedure (templateId:2.16.840.1.113883.10.20.22.4.14) (CONF:15447). | SHALL contain exactly one [1..1] Procedure Activity Procedure (V2) (templateId:2.16.840.1.113883.10.20.22.4.14.2) (CONF:15447). |
| [Anesthesia Section (V2) 2.16.840.1.113883.10.20.22.2.25.2](#S_Anesthesia_Section_V2) | Name | Anesthesia Section | Anesthesia Section (V2) |
| [Anesthesia Section (V2) 2.16.840.1.113883.10.20.22.2.25.2](#S_Anesthesia_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.25 | 2.16.840.1.113883.10.20.22.2.25.2 |
| [Anesthesia Section (V2) 2.16.840.1.113883.10.20.22.2.25.2](#S_Anesthesia_Section_V2) | Description | The Anesthesia section briefly records the type of anesthesia (e.g., general or local) and may state the actual agent used. This may or may not be a subsection of the Procedure Description section. The full details of anesthesia are usually found in a separate Anesthesia Note. | The Anesthesia section records the type of anesthesia (e.g., general or local) and may state the actual agent used. This may be a subsection of the Procedure Description section. The full details of anesthesia are usually found in a separate Anesthesia Note. |
| [Assessment and Plan Section (V2) 2.16.840.1.113883.10.20.22.2.9.2](#S_Assessment_and_Plan_Section_V2) | CONF #: 10381 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.9" (CONF:10381). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.9.2" (CONF:10381). |
| [Assessment and Plan Section (V2) 2.16.840.1.113883.10.20.22.2.9.2](#S_Assessment_and_Plan_Section_V2) | CONF #: 15448 Modified | SHALL contain exactly one [1..1] Plan of Care Activity Act (templateId:2.16.840.1.113883.10.20.22.4.39) (CONF:15448). | SHALL contain exactly one [1..1] Planned Act (V2) (templateId:2.16.840.1.113883.10.20.22.4.39.2) (CONF:15448). |
| [Assessment and Plan Section (V2) 2.16.840.1.113883.10.20.22.2.9.2](#S_Assessment_and_Plan_Section_V2) | Name | Assessment and Plan Section | Assessment and Plan Section (V2) |
| [Assessment and Plan Section (V2) 2.16.840.1.113883.10.20.22.2.9.2](#S_Assessment_and_Plan_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.9 | 2.16.840.1.113883.10.20.22.2.9.2 |
| [Assessment and Plan Section (V2) 2.16.840.1.113883.10.20.22.2.9.2](#S_Assessment_and_Plan_Section_V2) | Description | The Assessment and Plan sections may be combined or separated to meet local policy requirements.    The Assessment and Plan section represents both the clinician’s conclusions and working assumptions that will guide treatment of the patient (see Assessment Section above) and pending orders, interventions, encounters, services, and procedures for the patient (see Plan of Care Section below). | This section represents the clinician’s conclusions and working assumptions that will guide treatment of the patient. The Assessment and Plan sections may be combined or separated to meet local policy requirements.  See also the Assessment Section: templateId 2.16.840.1.113883.10.20.22.2.8 and Plan of Treatment Section (V2): templateId 2.16.840.1.113883.10.20.22.2.10.2 |
| [Complications (OpNote) (obsolete) 2.16.840.1.113883.10.20.22.2.32.obsolete](#S_Complications_OpNote_obsolete) | CONF #: 8026 Removed | SHALL contain exactly one [1..1] templateId (CONF:8026) such that it |  |
| [Complications (OpNote) (obsolete) 2.16.840.1.113883.10.20.22.2.32.obsolete](#S_Complications_OpNote_obsolete) | CONF #: 8027 Removed | SHALL contain exactly one [1..1] code/@code="10830-8" Complications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:8027). |  |
| [Complications (OpNote) (obsolete) 2.16.840.1.113883.10.20.22.2.32.obsolete](#S_Complications_OpNote_obsolete) | CONF #: 8028 Removed | SHALL contain exactly one [1..1] title (CONF:8028). |  |
| [Complications (OpNote) (obsolete) 2.16.840.1.113883.10.20.22.2.32.obsolete](#S_Complications_OpNote_obsolete) | CONF #: 8029 Removed | SHALL contain exactly one [1..1] text (CONF:8029). |  |
| [Complications (OpNote) (obsolete) 2.16.840.1.113883.10.20.22.2.32.obsolete](#S_Complications_OpNote_obsolete) | CONF #: 8048 Removed | There SHALL be a statement providing details of the complication(s) or it SHALL explicitly state there were no complications (CONF:8048). |  |
| [Complications (OpNote) (obsolete) 2.16.840.1.113883.10.20.22.2.32.obsolete](#S_Complications_OpNote_obsolete) | CONF #: 8049 Removed | MAY contain at least one [1..\*] entry (CONF:8049). |  |
| [Complications (OpNote) (obsolete) 2.16.840.1.113883.10.20.22.2.32.obsolete](#S_Complications_OpNote_obsolete) | CONF #: 8050 Removed | Such entries SHALL contain exactly one [1..1] Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:8050). |  |
| [Complications (OpNote) (obsolete) 2.16.840.1.113883.10.20.22.2.32.obsolete](#S_Complications_OpNote_obsolete) | CONF #: 10385 Removed | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.32" (CONF:10385). |  |
| [Complications (OpNote) (obsolete) 2.16.840.1.113883.10.20.22.2.32.obsolete](#S_Complications_OpNote_obsolete) | Name | Complications (OpNote) | Complications (OpNote) (obsolete) |
| [Complications (OpNote) (obsolete) 2.16.840.1.113883.10.20.22.2.32.obsolete](#S_Complications_OpNote_obsolete) | Oid | 2.16.840.1.113883.10.20.22.2.32 | 2.16.840.1.113883.10.20.22.2.32.obsolete |
| [Complications (OpNote) (obsolete) 2.16.840.1.113883.10.20.22.2.32.obsolete](#S_Complications_OpNote_obsolete) | Description | The Complications section records problems that occurred during the procedure or other activity. The complications may have been known risks or unanticipated problems. | This template is obsolete and will be deleted completely in the future.    This is replaced by the Complications Section. |
| [Complications Section (V2) 2.16.840.1.113883.10.20.22.2.37.2](#S_Complications_Section_V2) | CONF #: 30860 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30860). |
| [Complications Section (V2) 2.16.840.1.113883.10.20.22.2.37.2](#S_Complications_Section_V2) | CONF #: 8797 Removed | There SHALL be a statement providing details of the complication(s) or it SHALL explicitly state there were no complications (CONF:8797). |  |
| [Complications Section (V2) 2.16.840.1.113883.10.20.22.2.37.2](#S_Complications_Section_V2) | CONF #: 10384 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.37" (CONF:10384). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.37.2" (CONF:10384). |
| [Complications Section (V2) 2.16.840.1.113883.10.20.22.2.37.2](#S_Complications_Section_V2) | CONF #: 15454 Modified | This code SHALL contain exactly one [1..1] @code="55109-3" Complications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15454). | This code SHALL contain exactly one [1..1] @code="55109-3" Complications (CONF:15454). |
| [Complications Section (V2) 2.16.840.1.113883.10.20.22.2.37.2](#S_Complications_Section_V2) | CONF #: 15455 Modified | SHALL contain exactly one [1..1] Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15455). | SHALL contain exactly one [1..1] Problem Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15455).  Note: Note: When no coded entries or negation of entries are present, narrative section/text will be provided containing details of the complication(s) or that there were no complications. |
| [Complications Section (V2) 2.16.840.1.113883.10.20.22.2.37.2](#S_Complications_Section_V2) | Name | Complications Section | Complications Section (V2) |
| [Complications Section (V2) 2.16.840.1.113883.10.20.22.2.37.2](#S_Complications_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.37 | 2.16.840.1.113883.10.20.22.2.37.2 |
| [Complications Section (V2) 2.16.840.1.113883.10.20.22.2.37.2](#S_Complications_Section_V2) | Description | The Complications section records problems that occurred during the procedure or other activity. The complications may have been known risks or unanticipated problems. | This section contains problems that occurred during or around the time of a procedure. The complications may be known risks or unanticipated problems. |
| [Discharge Diet Section (DEPRECATED) 1.3.6.1.4.1.19376.1.5.3.1.3.33.2](#S_Discharge_Diet_Section_DEPRECATED) | CONF #: 31140 Added |  | This code SHALL contain exactly one [1..1] @codeSystem (CONF:31140). |
| [Discharge Diet Section (DEPRECATED) 1.3.6.1.4.1.19376.1.5.3.1.3.33.2](#S_Discharge_Diet_Section_DEPRECATED) | CONF #: 10455 Modified | SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.33" (CONF:10455). | SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.33.2" (CONF:10455). |
| [Discharge Diet Section (DEPRECATED) 1.3.6.1.4.1.19376.1.5.3.1.3.33.2](#S_Discharge_Diet_Section_DEPRECATED) | CONF #: 15460 Modified | This code SHALL contain exactly one [1..1] @code="42344-2" Discharge Diet (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15460). | This code SHALL contain exactly one [1..1] @code="42344-2" Discharge Diet (CONF:15460). |
| [Discharge Diet Section (DEPRECATED) 1.3.6.1.4.1.19376.1.5.3.1.3.33.2](#S_Discharge_Diet_Section_DEPRECATED) | Name | Discharge Diet Section | Discharge Diet Section (DEPRECATED) |
| [Discharge Diet Section (DEPRECATED) 1.3.6.1.4.1.19376.1.5.3.1.3.33.2](#S_Discharge_Diet_Section_DEPRECATED) | Oid | 1.3.6.1.4.1.19376.1.5.3.1.3.33 | 1.3.6.1.4.1.19376.1.5.3.1.3.33.2 |
| [Discharge Diet Section (DEPRECATED) 1.3.6.1.4.1.19376.1.5.3.1.3.33.2](#S_Discharge_Diet_Section_DEPRECATED) | Description | This section records a narrative description of the expectations for diet and nutrition, including nutrition prescription, proposals, goals, and order requests for monitoring, tracking, or improving the nutritional status of the patient, used in a discharge from a facility such as an emergency department, hospital, or nursing home. | THIS SECTION IS DEPRECATED AND MAY BE DELETED IN THE FUTURE. USE THE NUTRITION SECTION INSTEAD.    This section records a narrative description of the expectations for diet and nutrition, including nutrition prescription, proposals, goals, and order requests for monitoring, tracking, or improving the nutritional status of the patient, used in a discharge from a facility such as an emergency department, hospital, or nursing home. |
| [Encounters Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.22.2](#S_Encounters_Section_entries_optional_V) | CONF #: 31136 Added |  | This code SHALL contain exactly one [1..1] @codeSystem (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31136). |
| [Encounters Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.22.2](#S_Encounters_Section_entries_optional_V) | CONF #: 10494 Removed | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.49" (CONF:10494). |  |
| [Encounters Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.22.2](#S_Encounters_Section_entries_optional_V) | CONF #: 14901 Removed | SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14901). |  |
| [Encounters Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.22.2](#S_Encounters_Section_entries_optional_V) | CONF #: 10386 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.22" (CONF:10386). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.22.2" (CONF:10386). |
| [Encounters Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.22.2](#S_Encounters_Section_entries_optional_V) | CONF #: 15462 Modified | This code SHALL contain exactly one [1..1] @code="46240-8" Encounters (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15462). | This code SHALL contain exactly one [1..1] @code="46240-8" Encounters (CONF:15462). |
| [Encounters Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.22.2](#S_Encounters_Section_entries_optional_V) | CONF #: 15465 Modified | SHALL contain exactly one [1..1] Encounter Activities (templateId:2.16.840.1.113883.10.20.22.4.49) (CONF:15465). | SHALL contain exactly one [1..1] Encounter Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.49.2) (CONF:15465). |
| [Encounters Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.22.2](#S_Encounters_Section_entries_optional_V) | Name | Encounters Section (entries optional) | Encounters Section (entries optional) (V2) |
| [Encounters Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.22.2](#S_Encounters_Section_entries_optional_V) | Oid | 2.16.840.1.113883.10.20.22.2.22 | 2.16.840.1.113883.10.20.22.2.22.2 |
| [Encounters Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.22.1.2](#S_Encounters_Section_entries_required_V) | CONF #: 31137 Added |  | This code SHALL contain exactly one [1..1] @codeSystem (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31137). |
| [Encounters Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.22.1.2](#S_Encounters_Section_entries_required_V) | CONF #: 10387 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.22.1" (CONF:10387). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.22.1.2" (CONF:10387). |
| [Encounters Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.22.1.2](#S_Encounters_Section_entries_required_V) | CONF #: 15467 Modified | This code SHALL contain exactly one [1..1] @code="46240-8" Encounters (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15467). | This code SHALL contain exactly one [1..1] @code="46240-8" Encounters (CONF:15467). |
| [Encounters Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.22.1.2](#S_Encounters_Section_entries_required_V) | CONF #: 15468 Modified | SHALL contain exactly one [1..1] Encounter Activities (templateId:2.16.840.1.113883.10.20.22.4.49) (CONF:15468). | SHALL contain exactly one [1..1] Encounter Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.49.2) (CONF:15468). |
| [Encounters Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.22.1.2](#S_Encounters_Section_entries_required_V) | Name | Encounters Section (entries required) | Encounters Section (entries required) (V2) |
| [Encounters Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.22.1.2](#S_Encounters_Section_entries_required_V) | Oid | 2.16.840.1.113883.10.20.22.2.22.1 | 2.16.840.1.113883.10.20.22.2.22.1.2 |
| [Encounters Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.22.1.2](#S_Encounters_Section_entries_required_V) | Implied Template | Encounters Section (entries optional) (2.16.840.1.113883.10.20.22.2.22) | Encounters Section (entries optional) (V2) (2.16.840.1.113883.10.20.22.2.22.2) |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 30783 Added |  | SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.50.2) (CONF:30783). |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 30866 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30866). |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 31009 Added |  | SHALL contain exactly one [1..1] Self-Care Activities (ADL and IADL) (NEW) (templateId:2.16.840.1.113883.10.20.22.4.128) (CONF:31009). |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 31011 Added |  | SHALL contain exactly one [1..1] Sensory and Speech Status (NEW) (templateId:2.16.840.1.113883.10.20.22.4.127) (CONF:31011). |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14416 Removed | MAY contain zero or more [0..\*] entry (CONF:14416) such that it |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14417 Removed | SHALL contain exactly one [1..1] Cognitive Status Result Organizer (templateId:2.16.840.1.113883.10.20.22.4.75) (CONF:14417). |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14420 Removed | MAY contain zero or more [0..\*] entry (CONF:14420) such that it |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14421 Removed | SHALL contain exactly one [1..1] Cognitive Status Result Observation (templateId:2.16.840.1.113883.10.20.22.4.74) (CONF:14421). |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14422 Removed | MAY contain zero or more [0..\*] entry (CONF:14422) such that it |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14423 Removed | SHALL contain exactly one [1..1] Functional Status Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.68) (CONF:14423). |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14424 Removed | MAY contain zero or more [0..\*] entry (CONF:14424) such that it |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14425 Removed | SHALL contain exactly one [1..1] Cognitive Status Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.73) (CONF:14425). |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14583 Removed | SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:14583). |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 16778 Removed | SHALL contain exactly one [1..1] Pressure Ulcer Observation (templateId:2.16.840.1.113883.10.20.22.4.70) (CONF:16778). |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 16780 Removed | SHALL contain exactly one [1..1] Number of Pressure Ulcers Observation (templateId:2.16.840.1.113883.10.20.22.4.76) (CONF:16780). |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 16781 Removed | MAY contain zero or more [0..\*] entry (CONF:16781) such that it |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 16782 Removed | SHALL contain exactly one [1..1] Highest Pressure Ulcer Stage (templateId:2.16.840.1.113883.10.20.22.4.77) (CONF:16782). |  |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 10389 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.14" (CONF:10389). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.14.2" (CONF:10389). |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14415 Modified | SHALL contain exactly one [1..1] Functional Status Result Organizer (templateId:2.16.840.1.113883.10.20.22.4.66) (CONF:14415). | SHALL contain exactly one [1..1] Functional Status Organizer (V2) (templateId:2.16.840.1.113883.10.20.22.4.66.2) (CONF:14415). |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14419 Modified | SHALL contain exactly one [1..1] Functional Status Result Observation (templateId:2.16.840.1.113883.10.20.22.4.67) (CONF:14419). | SHALL contain exactly one [1..1] Functional Status Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.67.2) (CONF:14419). |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | CONF #: 14579 Modified | This code SHALL contain exactly one [1..1] @code="47420-5" Functional Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:14579). | This code SHALL contain exactly one [1..1] @code="47420-5" Functional Status (CONF:14579). |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | Name | Functional Status Section | Functional Status Section (V2) |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.14 | 2.16.840.1.113883.10.20.22.2.14.2 |
| [Functional Status Section (V2) 2.16.840.1.113883.10.20.22.2.14.2](#S_Functional_Status_Section_V2) | Description | The Functional Status section describes the patient’s physical state, status of functioning, and environmental status at the time the document was created.  A patient’s physical state may include information regarding the patient’s physical findings as they relate to problems, including but not limited to:  • Pressure Ulcers  • Amputations  • Heart murmur  • Ostomies  A patient’s functional status may include information regarding the patient relative to their general functional and cognitive ability, including:  • Ambulatory ability  • Mental status or competency  • Activities of Daily Living (ADLs), including bathing, dressing, feeding, grooming  • Home or living situation having an effect on the health status of the patient  • Ability to care for self  • Social activity, including issues with social cognition, participation with friends and acquaintances other than family members  • Occupation activity, including activities partly or directly related to working, housework or volunteering, family and home responsibilities or activities related to home and family  • Communication ability, including issues with speech, writing or cognition required for communication  • Perception, including sight, hearing, taste, skin sensation, kinesthetic sense, proprioception, or balance  A patient’s environmental status may include information regarding the patient’s current exposures from their daily environment, including but not limited to:  • Airborne hazards such as second-hand smoke, volatile organic compounds, dust, or other allergens  • Radiation  • Safety hazards in home, such as throw rugs, poor lighting, lack of railings/grab bars, etc.  • Safety hazards at work, such as communicable diseases, excessive heat, excessive noise, etc.  The patient's functional status may be expressed as a problem or as a result observation. A functional or cognitive status problem observation describes a patient’s problem, symptoms or condition. A functional or cognitive status result observation may include observations resulting from an assessment scale, evaluation or question and answer assessment.  Any deviation from normal function displayed by the patient and recorded in the record should be included. Of particular interest are those limitations that would interfere with self-care or the medical therapeutic process in any way. In addition, a note of normal function, an improvement, or a change in functioning status may be included. | The Functional Status section contains observations and assessments of a patient's physical abilities. A patient’s functional status may include information regarding the patient’s general function such as ambulation, ability to perform Activities of Daily Living (ADLs), (e.g. bathing, dressing, feeding, grooming) Instrumental Activities of Daily Living (IADLs) (e.g. shopping, using a telephone, balancing a check book). Problems that impact function (e.g. dyspnea, dysphagia) can be contained in the section. |
| [History of Past Illness Section (V2) 2.16.840.1.113883.10.20.22.2.20.2](#S_History_of_Past_Illness_Section_V2) | CONF #: 30831 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30831). |
| [History of Past Illness Section (V2) 2.16.840.1.113883.10.20.22.2.20.2](#S_History_of_Past_Illness_Section_V2) | CONF #: 10390 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.20" (CONF:10390). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.20.2" (CONF:10390). |
| [History of Past Illness Section (V2) 2.16.840.1.113883.10.20.22.2.20.2](#S_History_of_Past_Illness_Section_V2) | CONF #: 15475 Modified | This code SHALL contain exactly one [1..1] @code="11348-0" History of Past Illness (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15475). | This code SHALL contain exactly one [1..1] @code="11348-0" History of Past Illness (CONF:15475). |
| [History of Past Illness Section (V2) 2.16.840.1.113883.10.20.22.2.20.2](#S_History_of_Past_Illness_Section_V2) | CONF #: 15476 Modified | SHALL contain exactly one [1..1] Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15476). | SHALL contain exactly one [1..1] Problem Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15476). |
| [History of Past Illness Section (V2) 2.16.840.1.113883.10.20.22.2.20.2](#S_History_of_Past_Illness_Section_V2) | Name | History of Past Illness Section | History of Past Illness Section (V2) |
| [History of Past Illness Section (V2) 2.16.840.1.113883.10.20.22.2.20.2](#S_History_of_Past_Illness_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.20 | 2.16.840.1.113883.10.20.22.2.20.2 |
| [History of Past Illness Section (V2) 2.16.840.1.113883.10.20.22.2.20.2](#S_History_of_Past_Illness_Section_V2) | Description | This section describes the history related to the patient’s past complaints, problems, or diagnoses. It records these details up until, and possibly pertinent to, the patient’s current complaint or reason for seeking medical care. | This section contains a record of the patient’s past complaints, problems, and diagnoses. It contains data from the patient’s past up to the patient’s current complaint or reason for seeking medical care. |
| [Hospital Admission Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.43.2](#S_Hospital_Admission_Diagnosis_Section_) | CONF #: 30865 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30865). |
| [Hospital Admission Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.43.2](#S_Hospital_Admission_Diagnosis_Section_) | CONF #: 10391 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.43" (CONF:10391). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.43.2" (CONF:10391). |
| [Hospital Admission Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.43.2](#S_Hospital_Admission_Diagnosis_Section_) | CONF #: 15480 Modified | This code SHALL contain exactly one [1..1] @code="46241-6" Hospital Admission Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15480). | This code SHALL contain exactly one [1..1] @code="46241-6" Hospital Admission Diagnosis (CONF:15480). |
| [Hospital Admission Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.43.2](#S_Hospital_Admission_Diagnosis_Section_) | CONF #: 15481 Modified | The entry, if present, SHALL contain exactly one [1..1] Hospital Admission Diagnosis (templateId:2.16.840.1.113883.10.20.22.4.34) (CONF:15481). | The entry, if present, SHALL contain exactly one [1..1] Hospital Admission Diagnosis (V2) (templateId:2.16.840.1.113883.10.20.22.4.34.2) (CONF:15481). |
| [Hospital Admission Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.43.2](#S_Hospital_Admission_Diagnosis_Section_) | Name | Hospital Admission Diagnosis Section | Hospital Admission Diagnosis Section (V2) |
| [Hospital Admission Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.43.2](#S_Hospital_Admission_Diagnosis_Section_) | Oid | 2.16.840.1.113883.10.20.22.2.43 | 2.16.840.1.113883.10.20.22.2.43.2 |
| [Hospital Admission Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.43.2](#S_Hospital_Admission_Diagnosis_Section_) | Description | The Hospital Admitting Diagnosis section contains a narrative description of the primary reason for admission to a hospital facility. The section includes an optional entry to record patient conditions. | This section contains a narrative description of the problems or diagnoses identified by the clinician at the time of the patient’s admission. This section may contain coded entries representing the admitting diagnoses. |
| [Hospital Admission Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.44.2](#S_Hospital_Admission_Medications_Sectio) | CONF #: 10392 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.44" (CONF:10392). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.44.2" (CONF:10392). |
| [Hospital Admission Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.44.2](#S_Hospital_Admission_Medications_Sectio) | CONF #: 15484 Modified | SHALL contain exactly one [1..1] Admission Medication (templateId:2.16.840.1.113883.10.20.22.4.36) (CONF:15484). | SHALL contain exactly one [1..1] Admission Medication (V2) (templateId:2.16.840.1.113883.10.20.22.4.36.2) (CONF:15484). |
| [Hospital Admission Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.44.2](#S_Hospital_Admission_Medications_Sectio) | Name | Hospital Admission Medications Section (entries optional) | Hospital Admission Medications Section (entries optional) (V2) |
| [Hospital Admission Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.44.2](#S_Hospital_Admission_Medications_Sectio) | Oid | 2.16.840.1.113883.10.20.22.2.44 | 2.16.840.1.113883.10.20.22.2.44.2 |
| [Hospital Admission Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.44.2](#S_Hospital_Admission_Medications_Sectio) | Description | The Hospital Admission Medications section defines the relevant medications administered prior to admission to the facility. The currently active medications must be listed. | The section contains the medications administered prior to admission to the facility. The currently active medications must also be listed. |
| [Hospital Discharge Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.24.2](#Hospital_Discharge_Diagnosis_Section_V2) | CONF #: 30861 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30861). |
| [Hospital Discharge Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.24.2](#Hospital_Discharge_Diagnosis_Section_V2) | CONF #: 10394 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.24" (CONF:10394). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.24.2" (CONF:10394). |
| [Hospital Discharge Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.24.2](#Hospital_Discharge_Diagnosis_Section_V2) | CONF #: 15356 Modified | This code SHALL contain exactly one [1..1] @code="11535-2" Hospital Discharge Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15356). | This code SHALL contain exactly one [1..1] @code="11535-2" Hospital Discharge Diagnosis (CONF:15356). |
| [Hospital Discharge Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.24.2](#Hospital_Discharge_Diagnosis_Section_V2) | CONF #: 15489 Modified | The entry, if present, SHALL contain exactly one [1..1] Hospital Discharge Diagnosis (templateId:2.16.840.1.113883.10.20.22.4.33) (CONF:15489). | The entry, if present, SHALL contain exactly one [1..1] Hospital Discharge Diagnosis (V2) (templateId:2.16.840.1.113883.10.20.22.4.33.2) (CONF:15489). |
| [Hospital Discharge Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.24.2](#Hospital_Discharge_Diagnosis_Section_V2) | Name | Hospital Discharge Diagnosis Section | Hospital Discharge Diagnosis Section (V2) |
| [Hospital Discharge Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.24.2](#Hospital_Discharge_Diagnosis_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.24 | 2.16.840.1.113883.10.20.22.2.24.2 |
| [Hospital Discharge Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.24.2](#Hospital_Discharge_Diagnosis_Section_V2) | Description | The Hospital Discharge Diagnosis section describes the relevant problems or diagnoses at the time of discharge that occurred during the hospitalization or that need to be followed after hospitalization. This section includes an optional entry to record patient conditions. | This template represents problems or diagnoses present at the time of discharge which occurred during the hospitalization or need to be monitored after hospitalization. This section includes an optional entry to record patient conditions. |
| [Hospital Discharge Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.11.2](#S_Hospital_Discharge_Medications_Sectio) | CONF #: 10396 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.11" (CONF:10396). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.11.2" (CONF:10396). |
| [Hospital Discharge Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.11.2](#S_Hospital_Discharge_Medications_Sectio) | CONF #: 15490 Modified | SHALL contain exactly one [1..1] Discharge Medication (templateId:2.16.840.1.113883.10.20.22.4.35) (CONF:15490). | SHALL contain exactly one [1..1] Discharge Medication (V2) (templateId:2.16.840.1.113883.10.20.22.4.35.2) (CONF:15490). |
| [Hospital Discharge Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.11.2](#S_Hospital_Discharge_Medications_Sectio) | Name | Hospital Discharge Medications Section (entries optional) | Hospital Discharge Medications Section (entries optional) (V2) |
| [Hospital Discharge Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.11.2](#S_Hospital_Discharge_Medications_Sectio) | Oid | 2.16.840.1.113883.10.20.22.2.11 | 2.16.840.1.113883.10.20.22.2.11.2 |
| [Hospital Discharge Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.11.2](#S_Hospital_Discharge_Medications_Sectio) | Description | The Hospital Discharge Medications section defines the medications that the patient is intended to take (or stop) after discharge. The currently active medications must be listed. The section may also include a patient’s prescription history and indicate the source of the medication list, for example, from a pharmacy system versus from the patient. | This section contains the medications the patient is intended to take or stop after discharge. Current, active medications must be listed. The section may also include a patient’s prescription history and indicate the source of the medication list. |
| [Hospital Discharge Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.11.1.2](#S_Hospital_Discharge_Medications_reqd_v2) | CONF #: 10397 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.11.1" (CONF:10397). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.11.1.2" (CONF:10397). |
| [Hospital Discharge Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.11.1.2](#S_Hospital_Discharge_Medications_reqd_v2) | CONF #: 15491 Modified | SHALL contain exactly one [1..1] Discharge Medication (templateId:2.16.840.1.113883.10.20.22.4.35) (CONF:15491). | SHALL contain exactly one [1..1] Discharge Medication (V2) (templateId:2.16.840.1.113883.10.20.22.4.35.2) (CONF:15491). |
| [Hospital Discharge Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.11.1.2](#S_Hospital_Discharge_Medications_reqd_v2) | Name | Hospital Discharge Medications Section (entries required) | Hospital Discharge Medications Section (entries required) (V2) |
| [Hospital Discharge Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.11.1.2](#S_Hospital_Discharge_Medications_reqd_v2) | Oid | 2.16.840.1.113883.10.20.22.2.11.1 | 2.16.840.1.113883.10.20.22.2.11.1.2 |
| [Hospital Discharge Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.11.1.2](#S_Hospital_Discharge_Medications_reqd_v2) | Description | The Hospital Discharge Medications section defines the medications that the patient is intended to take (or stop) after discharge. At a minimum, the currently active medications should be listed with an entire medication history as an option. The section may also include a patient’s prescription history and indicate the source of the medication list, for example, from a pharmacy system versus from the patient. | This section defines the medications that the patient is intended to take (or stop) after discharge. At a minimum, the currently active medications should be listed, with an entire medication history as an option.  It may also include a patient’s prescription history and indicate the source of the medication list, (e.g. a pharmacy system, patient). |
| [Hospital Discharge Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.11.1.2](#S_Hospital_Discharge_Medications_reqd_v2) | Implied Template | Hospital Discharge Medications Section (entries optional) (2.16.840.1.113883.10.20.22.2.11) | Hospital Discharge Medications Section (entries optional) (V2) (2.16.840.1.113883.10.20.22.2.11.2) |
| [Immunizations Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.2.2](#S_Immunizations_Section_entries_optiona) | CONF #: 10399 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.2" (CONF:10399). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.2.2" (CONF:10399). |
| [Immunizations Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.2.2](#S_Immunizations_Section_entries_optiona) | CONF #: 15494 Modified | SHALL contain exactly one [1..1] Immunization Activity (templateId:2.16.840.1.113883.10.20.22.4.52) (CONF:15494). | SHALL contain exactly one [1..1] Immunization Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.52.2) (CONF:15494). |
| [Immunizations Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.2.2](#S_Immunizations_Section_entries_optiona) | Name | Immunizations Section (entries optional) | Immunizations Section (entries optional) (V2) |
| [Immunizations Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.2.2](#S_Immunizations_Section_entries_optiona) | Oid | 2.16.840.1.113883.10.20.22.2.2 | 2.16.840.1.113883.10.20.22.2.2.2 |
| [Immunizations Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.2.1.2](#S_Immunizations_Section_entries_require) | CONF #: 10400 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.2.1" (CONF:10400). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.2.1.2" (CONF:10400). |
| [Immunizations Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.2.1.2](#S_Immunizations_Section_entries_require) | CONF #: 15495 Modified | SHALL contain exactly one [1..1] Immunization Activity (templateId:2.16.840.1.113883.10.20.22.4.52) (CONF:15495). | SHALL contain exactly one [1..1] Immunization Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.52.2) (CONF:15495). |
| [Immunizations Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.2.1.2](#S_Immunizations_Section_entries_require) | Name | Immunizations Section (entries required) | Immunizations Section (entries required) (V2) |
| [Immunizations Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.2.1.2](#S_Immunizations_Section_entries_require) | Oid | 2.16.840.1.113883.10.20.22.2.2.1 | 2.16.840.1.113883.10.20.22.2.2.1.2 |
| [Immunizations Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.2.1.2](#S_Immunizations_Section_entries_require) | Implied Template | Immunizations Section (entries optional) (2.16.840.1.113883.10.20.22.2.2) | Immunizations Section (entries optional) (V2) (2.16.840.1.113883.10.20.22.2.2.2) |
| [Instructions Section (V2) 2.16.840.1.113883.10.20.22.2.45.2](#Instructions_Section_V2) | CONF #: 31384 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.45.2" (CONF:31384). |
| [Instructions Section (V2) 2.16.840.1.113883.10.20.22.2.45.2](#Instructions_Section_V2) | CONF #: 31398 Added |  | The entry, if present, SHALL contain exactly one [1..1] Instruction (V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31398). |
| [Instructions Section (V2) 2.16.840.1.113883.10.20.22.2.45.2](#Instructions_Section_V2) | CONF #: 10402 Removed | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.45" (CONF:10402). |  |
| [Instructions Section (V2) 2.16.840.1.113883.10.20.22.2.45.2](#Instructions_Section_V2) | CONF #: 15496 Removed | The entry, if present, SHALL contain exactly one [1..1] Instructions (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:15496). |  |
| [Instructions Section (V2) 2.16.840.1.113883.10.20.22.2.45.2](#Instructions_Section_V2) | Name | Instructions Section | Instructions Section (V2) |
| [Instructions Section (V2) 2.16.840.1.113883.10.20.22.2.45.2](#Instructions_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.45 | 2.16.840.1.113883.10.20.22.2.45.2 |
| [Interventions Section (V2) 2.16.840.1.113883.10.20.21.2.3.2](#Interventions_Section_V2) | CONF #: 30864 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30864). |
| [Interventions Section (V2) 2.16.840.1.113883.10.20.21.2.3.2](#Interventions_Section_V2) | CONF #: 30996 Added |  | SHOULD contain zero or more [0..\*] entry (CONF:30996). |
| [Interventions Section (V2) 2.16.840.1.113883.10.20.21.2.3.2](#Interventions_Section_V2) | CONF #: 30997 Added |  | The entry, if present, SHALL contain exactly one [1..1] Intervention Act (NEW) (templateId:2.16.840.1.113883.10.20.22.4.131) (CONF:30997). |
| [Interventions Section (V2) 2.16.840.1.113883.10.20.21.2.3.2](#Interventions_Section_V2) | CONF #: 10461 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.21.2.3" (CONF:10461). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.21.2.3.2" (CONF:10461). |
| [Interventions Section (V2) 2.16.840.1.113883.10.20.21.2.3.2](#Interventions_Section_V2) | CONF #: 15378 Modified | This code SHALL contain exactly one [1..1] @code="62387-6" Interventions Provided (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15378). | This code SHALL contain exactly one [1..1] @code="62387-6" Interventions Provided (CONF:15378). |
| [Interventions Section (V2) 2.16.840.1.113883.10.20.21.2.3.2](#Interventions_Section_V2) | Name | Interventions Section | Interventions Section (V2) |
| [Interventions Section (V2) 2.16.840.1.113883.10.20.21.2.3.2](#Interventions_Section_V2) | Oid | 2.16.840.1.113883.10.20.21.2.3 | 2.16.840.1.113883.10.20.21.2.3.2 |
| [Interventions Section (V2) 2.16.840.1.113883.10.20.21.2.3.2](#Interventions_Section_V2) | Description | The Interventions section contains information about the specific interventions provided during the healthcare visit. Depending on the type of intervention(s) provided (procedural, education, application of assistive equipment, etc.), the details will vary but may include specification of frequency, intensity, and duration. | This template represents Interventions. Interventions are actions taken to maximize the prospects of achieving the patient’s or provider’s goals of care, including the removal of barriers to success. Interventions can be planned, ordered, historical, etc.    Interventions include actions that may be ongoing (e.g. maintenance medications that the patient is taking, or monitoring the patient’s health status or the status of an intervention).    Instructions are a subset of interventions and may include self-care instructions. Instructions are information or directions to the patient and other providers including how to care for the individual’s condition, what to do at home, when to call for help, any additional appointments, testing, and changes to the medication list or medication instructions, clinical guidelines and a summary of best practice. |
| [Medical (General) History Section (V2) 2.16.840.1.113883.10.20.22.2.39.2](#Medical_General_History_Section_V2) | CONF #: 31196 Added |  | MAY contain zero or more [0..\*] entry (CONF:31196) such that it |
| [Medical (General) History Section (V2) 2.16.840.1.113883.10.20.22.2.39.2](#Medical_General_History_Section_V2) | CONF #: 31197 Added |  | SHALL contain exactly one [1..1] Medical Equipment Organizer (NEW) (templateId:2.16.840.1.113883.10.20.22.4.135) (CONF:31197). |
| [Medical (General) History Section (V2) 2.16.840.1.113883.10.20.22.2.39.2](#Medical_General_History_Section_V2) | CONF #: 10403 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.39" (CONF:10403). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.39.2" (CONF:10403). |
| [Medical (General) History Section (V2) 2.16.840.1.113883.10.20.22.2.39.2](#Medical_General_History_Section_V2) | Name | Medical (General) History Section | Medical (General) History Section (V2) |
| [Medical (General) History Section (V2) 2.16.840.1.113883.10.20.22.2.39.2](#Medical_General_History_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.39 | 2.16.840.1.113883.10.20.22.2.39.2 |
| [Medical (General) History Section (V2) 2.16.840.1.113883.10.20.22.2.39.2](#Medical_General_History_Section_V2) | Description | The Medical History section describes all aspects of the medical history of the patient even if not pertinent to the current procedure, and may include chief complaint, past medical history, social history, family history, surgical or procedure history, medication history, and other history information. The history may be limited to information pertinent to the current procedure or may be more comprehensive. The history may be reported as a collection of random clinical statements or it may be reported categorically. Categorical report formats may be divided into multiple subsections including Past Medical History, Social History. | The Medical History section describes all aspects of the medical history of the patient even if not pertinent to the current procedure, and may include chief complaint, past medical history, social history, family history, surgical or procedure history, medical device history, medication history, and other history information. The history may be limited to information pertinent to the current procedure or may be more comprehensive. The history may be reported as a collection of random clinical statements or it may be reported categorically. Categorical report formats may be divided into multiple subsections including Past Medical History, Social History. |
| [Medical Equipment Section (V2) 2.16.840.1.113883.10.20.22.2.23.2](#S_Medical_Equipment_Section_V2) | CONF #: 30351 Added |  | SHALL contain exactly one [1..1] Medical Equipment Organizer (NEW) (templateId:2.16.840.1.113883.10.20.22.4.135) (CONF:30351). |
| [Medical Equipment Section (V2) 2.16.840.1.113883.10.20.22.2.23.2](#S_Medical_Equipment_Section_V2) | CONF #: 30828 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30828). |
| [Medical Equipment Section (V2) 2.16.840.1.113883.10.20.22.2.23.2](#S_Medical_Equipment_Section_V2) | CONF #: 31125 Added |  | SHOULD contain zero or more [0..\*] entry (CONF:31125) such that it |
| [Medical Equipment Section (V2) 2.16.840.1.113883.10.20.22.2.23.2](#S_Medical_Equipment_Section_V2) | CONF #: 31861 Added |  | SHALL contain exactly one [1..1] Medical Device (NEW) (templateId:2.16.840.1.113883.10.20.22.4.115) (CONF:31861). |
| [Medical Equipment Section (V2) 2.16.840.1.113883.10.20.22.2.23.2](#S_Medical_Equipment_Section_V2) | CONF #: 15497 Removed | SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:15497). |  |
| [Medical Equipment Section (V2) 2.16.840.1.113883.10.20.22.2.23.2](#S_Medical_Equipment_Section_V2) | CONF #: 10404 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.23" (CONF:10404). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.23.2" (CONF:10404). |
| [Medical Equipment Section (V2) 2.16.840.1.113883.10.20.22.2.23.2](#S_Medical_Equipment_Section_V2) | CONF #: 15382 Modified | This code SHALL contain exactly one [1..1] @code="46264-8" Medical Equipment (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15382). | This code SHALL contain exactly one [1..1] @code="46264-8" Medical Equipment (CONF:15382). |
| [Medical Equipment Section (V2) 2.16.840.1.113883.10.20.22.2.23.2](#S_Medical_Equipment_Section_V2) | Name | Medical Equipment Section | Medical Equipment Section (V2) |
| [Medical Equipment Section (V2) 2.16.840.1.113883.10.20.22.2.23.2](#S_Medical_Equipment_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.23 | 2.16.840.1.113883.10.20.22.2.23.2 |
| [Medical Equipment Section (V2) 2.16.840.1.113883.10.20.22.2.23.2](#S_Medical_Equipment_Section_V2) | Description | The Medical Equipment section defines a patient’s implanted and external medical devices and equipment that their health status depends on, as well as any pertinent equipment or device history. This section is also used to itemize any pertinent current or historical durable medical equipment (DME) used to help maintain the patient’s health status. All pertinent equipment relevant to the diagnosis, care, and treatment of a patient should be included. | This section defines supportive health and external medical devices and equipment. This section lists any pertinent durable medical equipment (DME) used to help maintain the patient’s health status. All equipment relevant to the diagnosis, care, or treatment of a patient should be included. Any devices in or on a patient are represented using the Medical Device template. These Medical Devices may be grouped together within a Medical Equipment Organizer. |
| [Medications Administered Section (V2) 2.16.840.1.113883.10.20.22.2.38.2](#S_Medications_Administered_Section_V2) | CONF #: 30829 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30829). |
| [Medications Administered Section (V2) 2.16.840.1.113883.10.20.22.2.38.2](#S_Medications_Administered_Section_V2) | CONF #: 10405 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.38" (CONF:10405). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.38.2" (CONF:10405). |
| [Medications Administered Section (V2) 2.16.840.1.113883.10.20.22.2.38.2](#S_Medications_Administered_Section_V2) | CONF #: 15384 Modified | This code SHALL contain exactly one [1..1] @code="29549-3" Medications Administered (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15384). | This code SHALL contain exactly one [1..1] @code="29549-3" Medications Administered (CONF:15384). |
| [Medications Administered Section (V2) 2.16.840.1.113883.10.20.22.2.38.2](#S_Medications_Administered_Section_V2) | CONF #: 15499 Modified | The entry, if present, SHALL contain exactly one [1..1] Medication Activity (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15499). | The entry, if present, SHALL contain exactly one [1..1] Medication Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:15499). |
| [Medications Administered Section (V2) 2.16.840.1.113883.10.20.22.2.38.2](#S_Medications_Administered_Section_V2) | Name | Medications Administered Section | Medications Administered Section (V2) |
| [Medications Administered Section (V2) 2.16.840.1.113883.10.20.22.2.38.2](#S_Medications_Administered_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.38 | 2.16.840.1.113883.10.20.22.2.38.2 |
| [Medications Administered Section (V2) 2.16.840.1.113883.10.20.22.2.38.2](#S_Medications_Administered_Section_V2) | Description | The Medications Administered section defines medications and fluids administered during the procedure, encounter, or other activity excluding anesthetic medications. This guide recommends anesthesia medications be documented as described in the section on Anesthesia. | The Medications Administered section contains medications and fluids administered during a procedure, the procedure's encounter or other activity excluding anesthetic medications. This section is not intended for ongoing medications and medication history. |
| [Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.1.2](#S_Medications_Section_entries_optional_) | CONF #: 30824 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30824). |
| [Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.1.2](#S_Medications_Section_entries_optional_) | CONF #: 10076 Modified | If medication use is unknown, the appropriate nullFlavor MAY be present (see unknown information in Section 1) (CONF:10076). | SHALL contain exactly one [1..1] Medication Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:10076). |
| [Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.1.2](#S_Medications_Section_entries_optional_) | CONF #: 10432 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.1" (CONF:10432). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.1.2" (CONF:10432). |
| [Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.1.2](#S_Medications_Section_entries_optional_) | CONF #: 15386 Modified | This code SHALL contain exactly one [1..1] @code="10160-0" History of medication use (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15386). | This code SHALL contain exactly one [1..1] @code="10160-0" History of medication use (CONF:15386). |
| [Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.1.2](#S_Medications_Section_entries_optional_) | CONF #: 15984 Modified | SHALL contain exactly one [1..1] Medication Activity (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15984). | MAY contain zero or one [0..1] @nullFlavor (CONF:15984). |
| [Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.1.2](#S_Medications_Section_entries_optional_) | Name | Medications Section (entries optional) | Medications Section (entries optional) (V2) |
| [Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.1.2](#S_Medications_Section_entries_optional_) | Oid | 2.16.840.1.113883.10.20.22.2.1 | 2.16.840.1.113883.10.20.22.2.1.2 |
| [Medications Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.1.2](#S_Medications_Section_entries_optional_) | Description | The Medications section defines a patient's current medications and pertinent medication history. At a minimum, the currently active medications are to be listed, with an entire medication history as an option. The section may also include a patient's prescription and dispense history.    This section requires that there be either an entry indicating the subject is not known to be on any medications, or that there be entries summarizing the subject's medications. | The Medications section contains a patient's current medications and pertinent medication history. At a minimum, the currently active medications are to be listed, with an entire medication history as an option. The section also could describe a patient's prescription and dispense history and information about intended drug monitoring. |
| [Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.1.1.2](#S_Medications_Section_entries_required_) | CONF #: 30825 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CONF:30825). |
| [Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.1.1.2](#S_Medications_Section_entries_required_) | CONF #: 15500 Removed | SHALL contain exactly one [1..1] Medication Activity (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15500). |  |
| [Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.1.1.2](#S_Medications_Section_entries_required_) | CONF #: 10077 Modified | If medication use is unknown, the appropriate nullFlavor MAY be present (see unknown information in Section 1) (CONF:10077). | SHALL contain exactly one [1..1] Medication Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.16.2) (CONF:10077). |
| [Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.1.1.2](#S_Medications_Section_entries_required_) | CONF #: 10433 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.1.1" (CONF:10433). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.1.2" (CONF:10433). |
| [Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.1.1.2](#S_Medications_Section_entries_required_) | CONF #: 15388 Modified | This code SHALL contain exactly one [1..1] @code="10160-0" History of medication use (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15388). | This code SHALL contain exactly one [1..1] @code="10160-0" History of medication use (CONF:15388). |
| [Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.1.1.2](#S_Medications_Section_entries_required_) | Name | Medications Section (entries required) | Medications Section (entries required) (V2) |
| [Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.1.1.2](#S_Medications_Section_entries_required_) | Oid | 2.16.840.1.113883.10.20.22.2.1.1 | 2.16.840.1.113883.10.20.22.2.1.1.2 |
| [Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.1.1.2](#S_Medications_Section_entries_required_) | Description | The Medications section defines a patient's current medications and pertinent medication history. At a minimum, the currently active medications are to be listed, with an entire medication history as an option. The section may also include a patient's prescription and dispense history.    This section requires that there be either an entry indicating the subject is not known to be on any medications, or that there be entries summarizing the subject's medications. | The Medications section contains a patient's current medications and pertinent medication history. At a minimum, the currently active medications are to be listed, with an entire medication history as an option. The section also could describe a patient's prescription and dispense history and information about intended drug monitoring.    This section requires that there be either an entry indicating the subject is not known to be on any medications, or that there be entries summarizing the subject's medications. |
| [Medications Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.1.1.2](#S_Medications_Section_entries_required_) | Implied Template | Medications Section (entries optional) (2.16.840.1.113883.10.20.22.2.1) | Medications Section (entries optional) (V2) (2.16.840.1.113883.10.20.22.2.1.2) |
| [Payers Section (V2) 2.16.840.1.113883.10.20.22.2.18.2](#S_Payers_Section_V2) | CONF #: 10434 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.18" (CONF:10434). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.18.2" (CONF:10434). |
| [Payers Section (V2) 2.16.840.1.113883.10.20.22.2.18.2](#S_Payers_Section_V2) | CONF #: 15501 Modified | SHALL contain exactly one [1..1] Coverage Activity (templateId:2.16.840.1.113883.10.20.22.4.60) (CONF:15501). | SHALL contain exactly one [1..1] Coverage Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.60.2) (CONF:15501). |
| [Payers Section (V2) 2.16.840.1.113883.10.20.22.2.18.2](#S_Payers_Section_V2) | Name | Payers Section | Payers Section (V2) |
| [Payers Section (V2) 2.16.840.1.113883.10.20.22.2.18.2](#S_Payers_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.18 | 2.16.840.1.113883.10.20.22.2.18.2 |
| [Physical Exam Section (V2) 2.16.840.1.113883.10.20.2.10.2](#S_Physical_Exam_Section_V2) | CONF #: 30930 Added |  | SHALL contain exactly one [1..1] Wound Observation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.114) (CONF:30930). |
| [Physical Exam Section (V2) 2.16.840.1.113883.10.20.2.10.2](#S_Physical_Exam_Section_V2) | CONF #: 30931 Added |  | This code MAY contain zero or one [0..1] @codeSystem="2.16.840.1.113883.6.1" (CONF:30931). |
| [Physical Exam Section (V2) 2.16.840.1.113883.10.20.2.10.2](#S_Physical_Exam_Section_V2) | CONF #: 17095 Removed | SHALL contain exactly one [1..1] Pressure Ulcer Observation (templateId:2.16.840.1.113883.10.20.22.4.70) (CONF:17095). |  |
| [Physical Exam Section (V2) 2.16.840.1.113883.10.20.2.10.2](#S_Physical_Exam_Section_V2) | CONF #: 10465 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.2.10" (CONF:10465). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.2.10.2" (CONF:10465). |
| [Physical Exam Section (V2) 2.16.840.1.113883.10.20.2.10.2](#S_Physical_Exam_Section_V2) | CONF #: 15398 Modified | This code SHALL contain exactly one [1..1] @code="29545-1" Physical Findings (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15398). | This code SHALL contain exactly one [1..1] @code="29545-1" Physical Findings (CONF:15398). |
| [Physical Exam Section (V2) 2.16.840.1.113883.10.20.2.10.2](#S_Physical_Exam_Section_V2) | Name | Physical Exam Section | Physical Exam Section (V2) |
| [Physical Exam Section (V2) 2.16.840.1.113883.10.20.2.10.2](#S_Physical_Exam_Section_V2) | Oid | 2.16.840.1.113883.10.20.2.10 | 2.16.840.1.113883.10.20.2.10.2 |
| [Physical Exam Section (V2) 2.16.840.1.113883.10.20.2.10.2](#S_Physical_Exam_Section_V2) | Description | The Physical Exam section includes direct observations made by the clinician. The examination may include the use of simple instruments and may also describe simple maneuvers performed directly on the patient’s body. This section includes only observations made by the examining clinician using inspection, palpation, auscultation, and percussion; it does not include laboratory or imaging findings. The exam may be limited to pertinent body systems based on the patient’s chief complaint or it may include a comprehensive examination. The examination may be reported as a collection of random clinical statements or it may be reported categorically.    The Physical Exam section may contain multiple nested subsections: Vital Signs, General Status, and those listed in the Additional Physical Examination Subsections appendix. | The section includes direct observations made by a clinician. The examination may include the use of simple instruments and may also describe simple maneuvers performed directly on the patient’s body.  It also includes observations made by the examining clinician using only inspection, palpation, auscultation, and percussion. It does not include laboratory or imaging findings.  The exam may be limited to pertinent body systems based on the patient’s chief complaint or it may include a comprehensive examination. The examination may be reported as a collection of random clinical statements or it may be reported categorically.    The Physical Exam section may contain multiple nested subsections; Vital Signs, General Status, and those listed in the Additional Physical Examination Subsections appendix. |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 31397 Added |  | SHALL contain exactly one [1..1] Instruction (V2) (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:31397). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 29621 Added |  | MAY contain zero or more [0..\*] entry (CONF:29621) such that it |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 30472 Added |  | SHALL contain exactly one [1..1] Planned Encounter (V2) (templateId:2.16.840.1.113883.10.20.22.4.40.2) (CONF:30472). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 30473 Added |  | SHALL contain exactly one [1..1] Planned Act (V2) (templateId:2.16.840.1.113883.10.20.22.4.39.2) (CONF:30473). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 30474 Added |  | SHALL contain exactly one [1..1] Planned Procedure (V2) (templateId:2.16.840.1.113883.10.20.22.4.41.2) (CONF:30474). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 30475 Added |  | SHALL contain exactly one [1..1] Planned Substance Administration (V2) (templateId:2.16.840.1.113883.10.20.22.4.42.2) (CONF:30475). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 30476 Added |  | SHALL contain exactly one [1..1] Planned Supply (V2) (templateId:2.16.840.1.113883.10.20.22.4.43.2) (CONF:30476). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 30813 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30813). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 30868 Added |  | SHALL contain exactly one [1..1] Handoff Communication (NEW) (templateId:2.16.840.1.113883.10.20.22.4.141) (CONF:30868). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 31841 Added |  | MAY contain zero or more [0..\*] entry (CONF:31841) such that it |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 31842 Added |  | SHALL contain exactly one [1..1] Nutrition Recommendations (NEW) (templateId:2.16.840.1.113883.10.20.22.4.130) (CONF:31842). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 14752 Removed | SHALL contain exactly one [1..1] Plan of Care Activity Encounter (templateId:2.16.840.1.113883.10.20.22.4.40) (CONF:14752). |  |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 14753 Removed | SHALL contain exactly one [1..1] Plan of Care Activity Observation (templateId:2.16.840.1.113883.10.20.22.4.44) (CONF:14753). |  |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 14754 Removed | SHALL contain exactly one [1..1] Plan of Care Activity Procedure (templateId:2.16.840.1.113883.10.20.22.4.41) (CONF:14754). |  |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 14755 Removed | SHALL contain exactly one [1..1] Plan of Care Activity Substance Administration (templateId:2.16.840.1.113883.10.20.22.4.42) (CONF:14755). |  |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 14756 Removed | SHALL contain exactly one [1..1] Plan of Care Activity Supply (templateId:2.16.840.1.113883.10.20.22.4.43) (CONF:14756). |  |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 16751 Removed | SHALL contain exactly one [1..1] Instructions (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:16751). |  |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 10435 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.10" (CONF:10435). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.10.2" (CONF:10435). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 14750 Modified | This code SHALL contain exactly one [1..1] @code="18776-5" Plan of Care (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:14750). | This code SHALL contain exactly one [1..1] @code="18776-5" Plan of Treatment (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:14750). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | CONF #: 14751 Modified | SHALL contain exactly one [1..1] Plan of Care Activity Act (templateId:2.16.840.1.113883.10.20.22.4.39) (CONF:14751). | SHALL contain exactly one [1..1] Planned Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.44.2) (CONF:14751). |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | Name | Plan of Care Section | Plan of Treatment Section (V2) |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.10 | 2.16.840.1.113883.10.20.22.2.10.2 |
| [Plan of Treatment Section (V2) 2.16.840.1.113883.10.20.22.2.10.2](#S_Plan_of_Treatment_Section_V2) | Description | The Plan of Care section contains data that defines pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only, which are indicated by the @moodCode of the entries within this section. All active, incomplete, or pending orders, appointments, referrals, procedures, services, or any other pending event of clinical significance to the current care of the patient should be listed unless constrained due to privacy issues. The plan may also contain information about ongoing care of the patient and information regarding goals and clinical reminders. Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and health-care quality improvements, including widely accepted performance measures. The plan may also indicate that patient education will be provided. | The Plan of Treatment section contains data that defines pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only, which are indicated by the @moodCode of the entries within this section. All active, incomplete, or pending orders, appointments, referrals, procedures, services, or any other pending event of clinical significance to the current care of the patient should be listed unless constrained due to privacy issues.    The plan may also contain information about ongoing care of the patient, clinical reminders, patient’s values, beliefs, preferences, care expectations and overarching goals of care. Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and health-care quality improvements, including widely accepted performance measures. Values may include the importance of quality of life over longevity. These values are taken into account when prioritizing all problems and their treatments. Beliefs may include comfort with dying or the refusal of blood transfusions because of the patient’s religious convictions. Preferences may include liquid medicines over tablets, or treatment via secure email instead of in person. Care expectations could range from only being treated by female clinicians, to expecting all calls to be returned within 24 hours. Overarching goals described in this section are not tied to a specific condition, problem, health concern, or intervention. Examples of overarching goals could be to minimize pain or dependence on others, or to walk a daughter down the aisle for her marriage. The plan may also indicate that patient education will be provided. |
| [Planned Procedure Section (V2) 2.16.840.1.113883.10.20.22.2.30.2](#Planned_Procedure_Section_V2) | CONF #: 10436 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.30" (CONF:10436). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.30.2" (CONF:10436). |
| [Planned Procedure Section (V2) 2.16.840.1.113883.10.20.22.2.30.2](#Planned_Procedure_Section_V2) | CONF #: 15502 Modified | SHALL contain exactly one [1..1] Plan of Care Activity Procedure (templateId:2.16.840.1.113883.10.20.22.4.41) (CONF:15502). | SHALL contain exactly one [1..1] Planned Procedure (V2) (templateId:2.16.840.1.113883.10.20.22.4.41.2) (CONF:15502). |
| [Planned Procedure Section (V2) 2.16.840.1.113883.10.20.22.2.30.2](#Planned_Procedure_Section_V2) | Name | Planned Procedure Section | Planned Procedure Section (V2) |
| [Planned Procedure Section (V2) 2.16.840.1.113883.10.20.22.2.30.2](#Planned_Procedure_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.30 | 2.16.840.1.113883.10.20.22.2.30.2 |
| [Planned Procedure Section (V2) 2.16.840.1.113883.10.20.22.2.30.2](#Planned_Procedure_Section_V2) | Description | The Planned Procedure section records the procedure(s) that a clinician thought would need to be done based on the preoperative assessment. It may be important to record the procedure(s) that were originally planned for, consented to, and perhaps pre-approved by the payer, particularly if different from the actual procedure(s) and procedure details, to provide evidence to various stakeholders that the providers are aware of the discrepancy and the justification can be found in the procedure details. | This section contains the procedure(s) that a clinician planned based on the preoperative assessment. |
| [Postprocedure Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.36.2](#S_Postprocedure_Diagnosis_Section_V2) | CONF #: 30862 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30862). |
| [Postprocedure Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.36.2](#S_Postprocedure_Diagnosis_Section_V2) | CONF #: 10438 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.36" (CONF:10438). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.36.2" (CONF:10438). |
| [Postprocedure Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.36.2](#S_Postprocedure_Diagnosis_Section_V2) | CONF #: 15404 Modified | This code SHALL contain exactly one [1..1] @code="59769-0" Postprocedure Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15404). | This code SHALL contain exactly one [1..1] @code="59769-0" Postprocedure Diagnosis (CONF:15404). |
| [Postprocedure Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.36.2](#S_Postprocedure_Diagnosis_Section_V2) | CONF #: 15503 Modified | SHALL contain exactly one [1..1] Postprocedure Diagnosis (templateId:2.16.840.1.113883.10.20.22.4.51) (CONF:15503). | SHALL contain exactly one [1..1] Postprocedure Diagnosis (V2) (templateId:2.16.840.1.113883.10.20.22.4.51.2) (CONF:15503). |
| [Postprocedure Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.36.2](#S_Postprocedure_Diagnosis_Section_V2) | Name | Postprocedure Diagnosis Section | Postprocedure Diagnosis Section (V2) |
| [Postprocedure Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.36.2](#S_Postprocedure_Diagnosis_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.36 | 2.16.840.1.113883.10.20.22.2.36.2 |
| [Preoperative Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.34.2](#S_Preoperative_Diagnosis_Section_V2) | CONF #: 30863 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30863). |
| [Preoperative Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.34.2](#S_Preoperative_Diagnosis_Section_V2) | CONF #: 10439 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.34" (CONF:10439). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.34.2" (CONF:10439). |
| [Preoperative Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.34.2](#S_Preoperative_Diagnosis_Section_V2) | CONF #: 15406 Modified | This code SHALL contain exactly one [1..1] @code="10219-4" Preoperative Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15406). | This code SHALL contain exactly one [1..1] @code="10219-4" Preoperative Diagnosis (CONF:15406). |
| [Preoperative Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.34.2](#S_Preoperative_Diagnosis_Section_V2) | CONF #: 15504 Modified | SHALL contain exactly one [1..1] Preoperative Diagnosis (templateId:2.16.840.1.113883.10.20.22.4.65) (CONF:15504). | SHALL contain exactly one [1..1] Preoperative Diagnosis (V2) (templateId:2.16.840.1.113883.10.20.22.4.65.2) (CONF:15504). |
| [Preoperative Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.34.2](#S_Preoperative_Diagnosis_Section_V2) | Name | Preoperative Diagnosis Section | Preoperative Diagnosis Section (V2) |
| [Preoperative Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.34.2](#S_Preoperative_Diagnosis_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.34 | 2.16.840.1.113883.10.20.22.2.34.2 |
| [Preoperative Diagnosis Section (V2) 2.16.840.1.113883.10.20.22.2.34.2](#S_Preoperative_Diagnosis_Section_V2) | Description | The Preoperative Diagnosis section records the surgical diagnosis or diagnoses assigned to the patient before the surgical procedure and is the reason for the surgery. The preoperative diagnosis is, in the opinion of the surgeon, the diagnosis that will be confirmed during surgery. | The Preoperative Diagnosis section records the surgical diagnoses assigned to the patient before the surgical procedure which are the reason for the surgery. The preoperative diagnosis is, in the surgeon's opinion, the diagnosis that will be confirmed during surgery. |
| [Problem Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.5.2](#S_Problem_Section_entries_optional_V2) | CONF #: 30481 Added |  | MAY contain zero or one [0..1] entry (CONF:30481) such that it |
| [Problem Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.5.2](#S_Problem_Section_entries_optional_V2) | CONF #: 30482 Added |  | SHALL contain exactly one [1..1] Health Status Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.5.2) (CONF:30482). |
| [Problem Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.5.2](#S_Problem_Section_entries_optional_V2) | CONF #: 31141 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CONF:31141). |
| [Problem Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.5.2](#S_Problem_Section_entries_optional_V2) | CONF #: 7881 Modified | SHOULD contain zero or more [0..\*] entry (CONF:7881). | SHOULD contain zero or more [0..\*] entry (CONF:7881) such that it |
| [Problem Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.5.2](#S_Problem_Section_entries_optional_V2) | CONF #: 10440 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.5" (CONF:10440). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.5.1.2" (CONF:10440). |
| [Problem Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.5.2](#S_Problem_Section_entries_optional_V2) | CONF #: 15408 Modified | This code SHALL contain exactly one [1..1] @code="11450-4" Problem List (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15408). | This code SHALL contain exactly one [1..1] @code="11450-4" Problem List (CONF:15408). |
| [Problem Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.5.2](#S_Problem_Section_entries_optional_V2) | CONF #: 15505 Modified | The entry, if present, SHALL contain exactly one [1..1] Problem Concern Act (Condition) (templateId:2.16.840.1.113883.10.20.22.4.3) (CONF:15505). | SHALL contain exactly one [1..1] Problem Concern Act (Condition) (V2) (templateId:2.16.840.1.113883.10.20.22.4.3.2) (CONF:15505). |
| [Problem Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.5.2](#S_Problem_Section_entries_optional_V2) | Name | Problem Section (entries optional) | Problem Section (entries optional) (V2) |
| [Problem Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.5.2](#S_Problem_Section_entries_optional_V2) | Oid | 2.16.840.1.113883.10.20.22.2.5 | 2.16.840.1.113883.10.20.22.2.5.2 |
| [Problem Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.5.2](#S_Problem_Section_entries_optional_V2) | Description | This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed. | This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed. Overall health status may be represented in this section. |
| [Problem Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.5.1.2](#S_Problem_Section_entries_required_V2) | CONF #: 30479 Added |  | MAY contain zero or one [0..1] entry (CONF:30479) such that it |
| [Problem Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.5.1.2](#S_Problem_Section_entries_required_V2) | CONF #: 30480 Added |  | SHALL contain exactly one [1..1] Health Status Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.5.2) (CONF:30480). |
| [Problem Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.5.1.2](#S_Problem_Section_entries_required_V2) | CONF #: 31142 Added |  | This code SHALL contain exactly one [1..1] @codeSystem (CONF:31142). |
| [Problem Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.5.1.2](#S_Problem_Section_entries_required_V2) | CONF #: 10441 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.5.1" (CONF:10441). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.5.1.2" (CONF:10441). |
| [Problem Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.5.1.2](#S_Problem_Section_entries_required_V2) | CONF #: 15410 Modified | This code SHALL contain exactly one [1..1] @code="11450-4" Problem List (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15410). | This code SHALL contain exactly one [1..1] @code="11450-4" Problem List (CONF:15410). |
| [Problem Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.5.1.2](#S_Problem_Section_entries_required_V2) | CONF #: 15506 Modified | Such entries SHALL contain exactly one [1..1] Problem Concern Act (Condition) (templateId:2.16.840.1.113883.10.20.22.4.3) (CONF:15506). | Such entries SHALL contain exactly one [1..1] Problem Concern Act (Condition) (V2) (templateId:2.16.840.1.113883.10.20.22.4.3.2) (CONF:15506). |
| [Problem Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.5.1.2](#S_Problem_Section_entries_required_V2) | Name | Problem Section (entries required) | Problem Section (entries required) (V2) |
| [Problem Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.5.1.2](#S_Problem_Section_entries_required_V2) | Oid | 2.16.840.1.113883.10.20.22.2.5.1 | 2.16.840.1.113883.10.20.22.2.5.1.2 |
| [Problem Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.5.1.2](#S_Problem_Section_entries_required_V2) | Description | This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed. | This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed. Overall health status may be represented in this section. |
| [Problem Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.5.1.2](#S_Problem_Section_entries_required_V2) | Implied Template | Problem Section (entries optional) (2.16.840.1.113883.10.20.22.2.5) | Problem Section (entries optional) (V2) (2.16.840.1.113883.10.20.22.2.5.2) |
| [Procedure Findings Section (V2) 2.16.840.1.113883.10.20.22.2.28.2](#S_Procedure_Findings_Section_V2) | CONF #: 30859 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30859). |
| [Procedure Findings Section (V2) 2.16.840.1.113883.10.20.22.2.28.2](#S_Procedure_Findings_Section_V2) | CONF #: 10443 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.28" (CONF:10443). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.28.2" (CONF:10443). |
| [Procedure Findings Section (V2) 2.16.840.1.113883.10.20.22.2.28.2](#S_Procedure_Findings_Section_V2) | CONF #: 15418 Modified | This code SHALL contain exactly one [1..1] @code="59776-5" Procedure Findings (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15418). | This code SHALL contain exactly one [1..1] @code="59776-5" Procedure Findings (CONF:15418). |
| [Procedure Findings Section (V2) 2.16.840.1.113883.10.20.22.2.28.2](#S_Procedure_Findings_Section_V2) | CONF #: 15507 Modified | SHALL contain exactly one [1..1] Problem Observation (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15507). | SHALL contain exactly one [1..1] Problem Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.4.2) (CONF:15507). |
| [Procedure Findings Section (V2) 2.16.840.1.113883.10.20.22.2.28.2](#S_Procedure_Findings_Section_V2) | Name | Procedure Findings Section | Procedure Findings Section (V2) |
| [Procedure Findings Section (V2) 2.16.840.1.113883.10.20.22.2.28.2](#S_Procedure_Findings_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.28 | 2.16.840.1.113883.10.20.22.2.28.2 |
| [Procedure Findings Section (V2) 2.16.840.1.113883.10.20.22.2.28.2](#S_Procedure_Findings_Section_V2) | Description | The Procedure Findings section records clinically significant observations confirmed or discovered during the procedure or surgery. | The Procedure Findings section records clinically significant observations confirmed or discovered during a procedure or surgery. |
| [Procedure Indications Section (V2) 2.16.840.1.113883.10.20.22.2.29.2](#Procedure_Indications_Section_V2) | CONF #: 30827 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30827). |
| [Procedure Indications Section (V2) 2.16.840.1.113883.10.20.22.2.29.2](#Procedure_Indications_Section_V2) | CONF #: 10445 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.29" (CONF:10445). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.29.2" (CONF:10445). |
| [Procedure Indications Section (V2) 2.16.840.1.113883.10.20.22.2.29.2](#Procedure_Indications_Section_V2) | CONF #: 15420 Modified | This code SHALL contain exactly one [1..1] @code="59768-2" Procedure Indications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15420). | This code SHALL contain exactly one [1..1] @code="59768-2" Procedure Indications (CONF:15420). |
| [Procedure Indications Section (V2) 2.16.840.1.113883.10.20.22.2.29.2](#Procedure_Indications_Section_V2) | CONF #: 15508 Modified | SHALL contain exactly one [1..1] Indication (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:15508). | SHALL contain exactly one [1..1] Indication (V2) (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:15508). |
| [Procedure Indications Section (V2) 2.16.840.1.113883.10.20.22.2.29.2](#Procedure_Indications_Section_V2) | Name | Procedure Indications Section | Procedure Indications Section (V2) |
| [Procedure Indications Section (V2) 2.16.840.1.113883.10.20.22.2.29.2](#Procedure_Indications_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.29 | 2.16.840.1.113883.10.20.22.2.29.2 |
| [Procedure Indications Section (V2) 2.16.840.1.113883.10.20.22.2.29.2](#Procedure_Indications_Section_V2) | Description | The Procedure Indications section records details about the reason for the procedure or surgery. This section may include the pre-procedure diagnosis or diagnoses as well as one or more symptoms that contribute to the reason the procedure is being performed. | This section contains the reason(s) for the procedure or surgery. This section may include the preprocedure diagnoses as well as symptoms contributing to the reason for the procedure. |
| [Procedures Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.7.2](#Procedures_Section_entries_optional_V2) | CONF #: 31139 Added |  | This code SHALL contain exactly one [1..1] @codeSystem (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31139). |
| [Procedures Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.7.2](#Procedures_Section_entries_optional_V2) | CONF #: 6271 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.7" (CONF:6271). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.7.2" (CONF:6271). |
| [Procedures Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.7.2](#Procedures_Section_entries_optional_V2) | CONF #: 15424 Modified | This code SHALL contain exactly one [1..1] @code="47519-4" History of Procedures (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15424). | This code SHALL contain exactly one [1..1] @code="47519-4" History of Procedures (CONF:15424). |
| [Procedures Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.7.2](#Procedures_Section_entries_optional_V2) | CONF #: 15509 Modified | SHALL contain exactly one [1..1] Procedure Activity Procedure (templateId:2.16.840.1.113883.10.20.22.4.14) (CONF:15509). | SHALL contain exactly one [1..1] Procedure Activity Procedure (V2) (templateId:2.16.840.1.113883.10.20.22.4.14.2) (CONF:15509). |
| [Procedures Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.7.2](#Procedures_Section_entries_optional_V2) | CONF #: 15510 Modified | SHALL contain exactly one [1..1] Procedure Activity Observation (templateId:2.16.840.1.113883.10.20.22.4.13) (CONF:15510). | SHALL contain exactly one [1..1] Procedure Activity Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.13.2) (CONF:15510). |
| [Procedures Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.7.2](#Procedures_Section_entries_optional_V2) | CONF #: 15511 Modified | SHALL contain exactly one [1..1] Procedure Activity Act (templateId:2.16.840.1.113883.10.20.22.4.12) (CONF:15511). | SHALL contain exactly one [1..1] Procedure Activity Act (V2) (templateId:2.16.840.1.113883.10.20.22.4.12.2) (CONF:15511). |
| [Procedures Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.7.2](#Procedures_Section_entries_optional_V2) | Name | Procedures Section (entries optional) | Procedures Section (entries optional) (V2) |
| [Procedures Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.7.2](#Procedures_Section_entries_optional_V2) | Oid | 2.16.840.1.113883.10.20.22.2.7 | 2.16.840.1.113883.10.20.22.2.7.2 |
| [Procedures Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.7.1.2](#S_Procedures_Section_entries_required_V) | CONF #: 31138 Added |  | This code SHALL contain exactly one [1..1] @codeSystem (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31138). |
| [Procedures Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.7.1.2](#S_Procedures_Section_entries_required_V) | CONF #: 8021 Modified | There SHALL be at least one procedure, observation or act entry conformant to Procedure Activity Procedure template, Procedure Activity Observation template or Procedure Activity Act template in the Procedure Section (CONF:8021). | There SHALL be at least one entry conformant to Procedure Activity Act (V2) (templateId 2.16.840.1.113883.10.20.22.4.12.2) or Procedure Activity Observation (V2) (templateId: 2.16.840.1.113883.10.20.22.4.13.2) or Procedure Activity Procedure (V2) (templateId: 2.16.840.1.113883.10.20.22.4.14.2) (CONF:8021). |
| [Procedures Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.7.1.2](#S_Procedures_Section_entries_required_V) | CONF #: 10447 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.7.1" (CONF:10447). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.7.1.2" (CONF:10447). |
| [Procedures Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.7.1.2](#S_Procedures_Section_entries_required_V) | CONF #: 15426 Modified | This code SHALL contain exactly one [1..1] @code="47519-4" History of Procedures (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15426). | This code SHALL contain exactly one [1..1] @code="47519-4" History of Procedures (CONF:15426). |
| [Procedures Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.7.1.2](#S_Procedures_Section_entries_required_V) | CONF #: 15512 Modified | SHALL contain exactly one [1..1] Procedure Activity Procedure (templateId:2.16.840.1.113883.10.20.22.4.14) (CONF:15512). | SHALL contain exactly one [1..1] Procedure Activity Procedure (V2) (templateId:2.16.840.1.113883.10.20.22.4.14.2) (CONF:15512). |
| [Procedures Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.7.1.2](#S_Procedures_Section_entries_required_V) | CONF #: 15513 Modified | SHALL contain exactly one [1..1] Procedure Activity Observation (templateId:2.16.840.1.113883.10.20.22.4.13) (CONF:15513). | SHALL contain exactly one [1..1] Procedure Activity Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.13.2) (CONF:15513). |
| [Procedures Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.7.1.2](#S_Procedures_Section_entries_required_V) | CONF #: 15514 Modified | SHALL contain exactly one [1..1] Procedure Activity Act (templateId:2.16.840.1.113883.10.20.22.4.12) (CONF:15514). | SHALL contain exactly one [1..1] Procedure Activity Act (V2) (templateId:2.16.840.1.113883.10.20.22.4.12.2) (CONF:15514). |
| [Procedures Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.7.1.2](#S_Procedures_Section_entries_required_V) | Name | Procedures Section (entries required) | Procedures Section (entries required) (V2) |
| [Procedures Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.7.1.2](#S_Procedures_Section_entries_required_V) | Oid | 2.16.840.1.113883.10.20.22.2.7.1 | 2.16.840.1.113883.10.20.22.2.7.1.2 |
| [Procedures Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.7.1.2](#S_Procedures_Section_entries_required_V) | Description | This section defines all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section may contain all procedures for the period of time being summarized, but should include notable procedures. The common notion of ""procedure"" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore this section contains procedure templates represented with three RIM classes: Act. Observation, and Procedure. Procedure act is for procedures the alter that physical condition of a patient (Splenectomy). Observation act is for procedures that result in new information about a patient but do not cause physical alteration (EEG). Act is for all other types of procedures (dressing change). | This section defines all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section may contain all procedures for the period of time being summarized, but should include notable procedures. The common notion of "procedure" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore this section contains procedure templates represented with three RIM classes: Act. Observation, and Procedure. Procedure act is for procedures the alter that physical condition of a patient (Splenectomy). Observation act is for procedures that result in new information about a patient but do not cause physical alteration (EEG). Act is for all other types of procedures (dressing change). |
| [Procedures Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.7.1.2](#S_Procedures_Section_entries_required_V) | Implied Template | Procedures Section (entries optional) (2.16.840.1.113883.10.20.22.2.7) | Procedures Section (entries optional) (V2) (2.16.840.1.113883.10.20.22.2.7.2) |
| [Reason for Referral Section (V2) 1.3.6.1.4.1.19376.1.5.3.1.3.1.2](#Reason_for_Referral_Section_V2) | CONF #: 30808 Added |  | MAY contain zero or more [0..\*] entry (CONF:30808) such that it |
| [Reason for Referral Section (V2) 1.3.6.1.4.1.19376.1.5.3.1.3.1.2](#Reason_for_Referral_Section_V2) | CONF #: 30897 Added |  | SHALL contain exactly one [1..1] Patient Referral Act (NEW) (templateId:2.16.840.1.113883.10.20.22.4.140) (CONF:30897). |
| [Reason for Referral Section (V2) 1.3.6.1.4.1.19376.1.5.3.1.3.1.2](#Reason_for_Referral_Section_V2) | CONF #: 30867 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:30867). |
| [Reason for Referral Section (V2) 1.3.6.1.4.1.19376.1.5.3.1.3.1.2](#Reason_for_Referral_Section_V2) | CONF #: 10468 Modified | SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.1" (CONF:10468). | SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.1.2" (CONF:10468). |
| [Reason for Referral Section (V2) 1.3.6.1.4.1.19376.1.5.3.1.3.1.2](#Reason_for_Referral_Section_V2) | CONF #: 15428 Modified | This code SHALL contain exactly one [1..1] @code="42349-1" Reason for Referral (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15428). | This code SHALL contain exactly one [1..1] @code="42349-1" Reason for Referral (CONF:15428). |
| [Reason for Referral Section (V2) 1.3.6.1.4.1.19376.1.5.3.1.3.1.2](#Reason_for_Referral_Section_V2) | Name | Reason for Referral Section | Reason for Referral Section (V2) |
| [Reason for Referral Section (V2) 1.3.6.1.4.1.19376.1.5.3.1.3.1.2](#Reason_for_Referral_Section_V2) | Oid | 1.3.6.1.4.1.19376.1.5.3.1.3.1 | 1.3.6.1.4.1.19376.1.5.3.1.3.1.2 |
| [Reason for Referral Section (V2) 1.3.6.1.4.1.19376.1.5.3.1.3.1.2](#Reason_for_Referral_Section_V2) | Description | A Reason for Referral section records the reason the patient is being referred for a consultation by a provider. An optional Chief Complaint section may capture the patient’s description of the reason for the consultation. | This section contains the reason(s) for a patient’s referral by a provider to a consulting provider. An optional Chief Complaint section may capture the patient’s description of the reason for the consultation. |
| [Results Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.3.2](#S_Results_Section_entries_optional_V2) | CONF #: 31041 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31041). |
| [Results Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.3.2](#S_Results_Section_entries_optional_V2) | CONF #: 9136 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.3" (CONF:9136). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.3.2" (CONF:9136). |
| [Results Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.3.2](#S_Results_Section_entries_optional_V2) | CONF #: 15432 Modified | This code SHALL contain exactly one [1..1] @code="30954-2" Relevant diagnostic tests and/or laboratory data (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15432). | This code SHALL contain exactly one [1..1] @code="30954-2" Relevant diagnostic tests and/or laboratory data (CONF:15432). |
| [Results Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.3.2](#S_Results_Section_entries_optional_V2) | CONF #: 15515 Modified | SHALL contain exactly one [1..1] Result Organizer (templateId:2.16.840.1.113883.10.20.22.4.1) (CONF:15515). | SHALL contain exactly one [1..1] Result Organizer (V2) (templateId:2.16.840.1.113883.10.20.22.4.1.2) (CONF:15515). |
| [Results Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.3.2](#S_Results_Section_entries_optional_V2) | Name | Results Section (entries optional) | Results Section (entries optional) (V2) |
| [Results Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.3.2](#S_Results_Section_entries_optional_V2) | Oid | 2.16.840.1.113883.10.20.22.2.3 | 2.16.840.1.113883.10.20.22.2.3.2 |
| [Results Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.3.1.2](#S_Results_Section_entries_required_V2) | CONF #: 31040 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:31040). |
| [Results Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.3.1.2](#S_Results_Section_entries_required_V2) | CONF #: 9137 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.3.1" (CONF:9137). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.3.1.2" (CONF:9137). |
| [Results Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.3.1.2](#S_Results_Section_entries_required_V2) | CONF #: 15434 Modified | This code SHALL contain exactly one [1..1] @code="30954-2" Relevant diagnostic tests and/or laboratory data (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15434). | This code SHALL contain exactly one [1..1] @code="30954-2" Relevant diagnostic tests and/or laboratory data (CONF:15434). |
| [Results Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.3.1.2](#S_Results_Section_entries_required_V2) | CONF #: 15516 Modified | SHALL contain exactly one [1..1] Result Organizer (templateId:2.16.840.1.113883.10.20.22.4.1) (CONF:15516). | SHALL contain exactly one [1..1] Result Organizer (V2) (templateId:2.16.840.1.113883.10.20.22.4.1.2) (CONF:15516). |
| [Results Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.3.1.2](#S_Results_Section_entries_required_V2) | Name | Results Section (entries required) | Results Section (entries required) (V2) |
| [Results Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.3.1.2](#S_Results_Section_entries_required_V2) | Oid | 2.16.840.1.113883.10.20.22.2.3.1 | 2.16.840.1.113883.10.20.22.2.3.1.2 |
| [Results Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.3.1.2](#S_Results_Section_entries_required_V2) | Description | The Results section contains the results of observations generated by laboratories, imaging procedures, and other procedures. The scope includes observations such as hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. The section often includes notable results such as abnormal values or relevant trends, and could contain all results for the period of time being documented.    Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory.  Imaging results are typically generated by a clinician reviewing the output of an imaging procedure, such as where a cardiologist reports the left ventricular ejection fraction based on the review of a cardiac echocardiogram.    Procedure results are typically generated by a clinician to provide more granular information about component observations made during a procedure, such as where a gastroenterologist reports the size of a polyp observed during a colonoscopy. | The Results section contains observations of results generated by laboratories, imaging procedures, and other procedures. These coded result observations are contained within a Results Organizer in the Results Section. The scope includes observations such as hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. The section often includes notable results such as abnormal values or relevant trends, and could contain all results for the period of time being documented.    Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory.  Imaging results are typically generated by a clinician reviewing the output of an imaging procedure, such as where a cardiologist reports the left ventricular ejection fraction based on the review of a cardiac echocardiogram.    Procedure results are typically generated by a clinician to provide more granular information about component observations made during a procedure, such as where a gastroenterologist reports the size of a polyp observed during a colonoscopy. |
| [Results Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.3.1.2](#S_Results_Section_entries_required_V2) | Implied Template | Results Section (entries optional) (2.16.840.1.113883.10.20.22.2.3) | Results Section (entries optional) (V2) (2.16.840.1.113883.10.20.22.2.3.2) |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 28361 Added |  | MAY contain zero or more [0..\*] entry (CONF:28361) such that it |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 28362 Added |  | SHALL contain exactly one [1..1] Caregiver Characteristics (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:28362). |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 28366 Added |  | MAY contain zero or more [0..\*] entry (CONF:28366) such that it |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 28367 Added |  | SHALL contain exactly one [1..1] Cultural and Religious Observation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.111) (CONF:28367). |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 28825 Added |  | MAY contain zero or more [0..\*] entry (CONF:28825) such that it |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 28826 Added |  | SHALL contain exactly one [1..1] Characteristics of Home Environment (NEW) (templateId:2.16.840.1.113883.10.20.22.4.109) (CONF:28826). |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 30814 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30814). |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 10449 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.17" (CONF:10449). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.17.2" (CONF:10449). |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 14820 Modified | This code SHALL contain exactly one [1..1] @code="29762-2" Social History (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:14820). | This code SHALL contain exactly one [1..1] @code="29762-2" Social History (CONF:14820). |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 14821 Modified | SHALL contain exactly one [1..1] Social History Observation (templateId:2.16.840.1.113883.10.20.22.4.38) (CONF:14821). | SHALL contain exactly one [1..1] Social History Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.38.2) (CONF:14821). |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 14823 Modified | SHOULD contain zero or more [0..\*] entry (CONF:14823) such that it | SHOULD contain zero or one [0..1] entry (CONF:14823) such that it |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 14824 Modified | SHALL contain exactly one [1..1] Smoking Status Observation (templateId:2.16.840.1.113883.10.20.22.4.78) (CONF:14824). | SHALL contain exactly one [1..1] Current Smoking Status (V2) (templateId:2.16.840.1.113883.10.20.22.4.78.2) (CONF:14824). |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | CONF #: 16817 Modified | SHALL contain exactly one [1..1] Tobacco Use (templateId:2.16.840.1.113883.10.20.22.4.85) (CONF:16817). | SHALL contain exactly one [1..1] Tobacco Use (V2) (templateId:2.16.840.1.113883.10.20.22.4.85.2) (CONF:16817). |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | Name | Social History Section | Social History Section (V2) |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | Oid | 2.16.840.1.113883.10.20.22.2.17 | 2.16.840.1.113883.10.20.22.2.17.2 |
| [Social History Section (V2) 2.16.840.1.113883.10.20.22.2.17.2](#S_Social_History_Section_V2) | Description | This section contains data defining the patient’s occupational, personal (e.g. lifestyle), social, and environmental history and health risk factors, as well as administrative data such as marital status, race, ethnicity and religious affiliation. Social history can have significant influence on a patient’s physical, psychological and emotional health and wellbeing so should be considered in the development of a complete record. | This section contains social history data that influences a patient’s physical, psychological or emotional health (e.g. smoking status, pregnancy). Demographic data, such as marital status, race, ethnicity, and religious affiliation, is captured in the header. |
| [Vital Signs Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.4.2](#Vital_Signs_Section_entries_optional_V2) | CONF #: 30902 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30902). |
| [Vital Signs Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.4.2](#Vital_Signs_Section_entries_optional_V2) | CONF #: 10451 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.4" (CONF:10451). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.4.2" (CONF:10451). |
| [Vital Signs Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.4.2](#Vital_Signs_Section_entries_optional_V2) | CONF #: 15517 Modified | SHALL contain exactly one [1..1] Vital Signs Organizer (templateId:2.16.840.1.113883.10.20.22.4.26) (CONF:15517). | SHALL contain exactly one [1..1] Vital Signs Organizer (V2) (templateId:2.16.840.1.113883.10.20.22.4.26.2) (CONF:15517). |
| [Vital Signs Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.4.2](#Vital_Signs_Section_entries_optional_V2) | Name | Vital Signs Section (entries optional) | Vital Signs Section (entries optional) (V2) |
| [Vital Signs Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.4.2](#Vital_Signs_Section_entries_optional_V2) | Oid | 2.16.840.1.113883.10.20.22.2.4 | 2.16.840.1.113883.10.20.22.2.4.2 |
| [Vital Signs Section (entries optional) (V2) 2.16.840.1.113883.10.20.22.2.4.2](#Vital_Signs_Section_entries_optional_V2) | Description | The Vital Signs section contains relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, and pulse oximetry. The section should include notable vital signs such as the most recent, maximum and/or minimum, baseline, or relevant trends.  Vital signs are represented in the same way as other results, but are aggregated into their own section to follow clinical conventions. | The Vital Signs section contains relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, pulse oximetry, temperature and body surface area. The section should include notable vital signs such as the most recent, maximum and/or minimum, baseline, or relevant trends.  Vital signs are represented in the same way as other results, but are aggregated into their own section to follow clinical conventions. |
| [Vital Signs Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.4.1.2](#S_Vital_Signs_Section_entries_required_) | CONF #: 30903 Added |  | This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:30903). |
| [Vital Signs Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.4.1.2](#S_Vital_Signs_Section_entries_required_) | CONF #: 10452 Modified | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.4.1" (CONF:10452). | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.4.1.2" (CONF:10452). |
| [Vital Signs Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.4.1.2](#S_Vital_Signs_Section_entries_required_) | CONF #: 15963 Modified | This code SHALL contain exactly one [1..1] @code="8716-3" Vital Signs (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15963). | This code SHALL contain exactly one [1..1] @code="8716-3" Vital Signs (CONF:15963). |
| [Vital Signs Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.4.1.2](#S_Vital_Signs_Section_entries_required_) | CONF #: 15964 Modified | SHALL contain exactly one [1..1] Vital Signs Organizer (templateId:2.16.840.1.113883.10.20.22.4.26) (CONF:15964). | SHALL contain exactly one [1..1] Vital Signs Organizer (V2) (templateId:2.16.840.1.113883.10.20.22.4.26.2) (CONF:15964). |
| [Vital Signs Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.4.1.2](#S_Vital_Signs_Section_entries_required_) | Name | Vital Signs Section (entries required) | Vital Signs Section (entries required) (V2) |
| [Vital Signs Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.4.1.2](#S_Vital_Signs_Section_entries_required_) | Oid | 2.16.840.1.113883.10.20.22.2.4.1 | 2.16.840.1.113883.10.20.22.2.4.1.2 |
| [Vital Signs Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.4.1.2](#S_Vital_Signs_Section_entries_required_) | Description | The Vital Signs section contains current and historically relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, and pulse oximetry. The section should include notable vital signs such as the most recent, maximum and/or minimum, baseline, or relevant trends.  Vital signs are represented in the same way as other results, but are aggregated into their own section to follow clinical conventions. | The Vital Signs section contains relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, pulse oximetry, temperature and body surface area. The section should include notable vital signs such as the most recent, maximum and/or minimum, baseline, or relevant trends.  Vital signs are represented in the same way as other results, but are aggregated into their own section to follow clinical conventions. |
| [Vital Signs Section (entries required) (V2) 2.16.840.1.113883.10.20.22.2.4.1.2](#S_Vital_Signs_Section_entries_required_) | Implied Template | Vital Signs Section (entries optional) (2.16.840.1.113883.10.20.22.2.4) | Vital Signs Section (entries optional) (V2) (2.16.840.1.113883.10.20.22.2.4.2) |
| [Physician Reading Study Performer (V2) 2.16.840.1.113883.10.20.6.2.1.2](#U_Physician_Reading_Study_Performer_V2) | CONF #: 30773 Added |  | SHALL contain exactly one [1..1] templateId (CONF:30773). |
| [Physician Reading Study Performer (V2) 2.16.840.1.113883.10.20.6.2.1.2](#U_Physician_Reading_Study_Performer_V2) | CONF #: 30774 Added |  | This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.1.2" (CONF:30774). |
| [Physician Reading Study Performer (V2) 2.16.840.1.113883.10.20.6.2.1.2](#U_Physician_Reading_Study_Performer_V2) | CONF #: 31584 Added |  | SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:31584). |
| [Physician Reading Study Performer (V2) 2.16.840.1.113883.10.20.6.2.1.2](#U_Physician_Reading_Study_Performer_V2) | CONF #: 8423 Removed | SHALL contain exactly one [1..1] templateId/@root="2.16.840.1.113883.10.20.6.2.1" (CONF:8423). |  |
| [Physician Reading Study Performer (V2) 2.16.840.1.113883.10.20.6.2.1.2](#U_Physician_Reading_Study_Performer_V2) | CONF #: 10034 Removed | The id SHOULD include zero or one [0..1] id where id/@root ="2.16.840.1.113883.4.6" National Provider Identifier (CONF:10034). |  |
| [Physician Reading Study Performer (V2) 2.16.840.1.113883.10.20.6.2.1.2](#U_Physician_Reading_Study_Performer_V2) | CONF #: 10033 Modified | This assignedEntity SHALL contain at least one [1..\*] id (CONF:10033). | This assignedEntity SHALL contain exactly one [1..1] id (CONF:10033) such that it |
| [Physician Reading Study Performer (V2) 2.16.840.1.113883.10.20.6.2.1.2](#U_Physician_Reading_Study_Performer_V2) | CONF #: 10134 Modified | The content of time SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.3) (CONF:10134). | The content of time SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10134). |
| [Physician Reading Study Performer (V2) 2.16.840.1.113883.10.20.6.2.1.2](#U_Physician_Reading_Study_Performer_V2) | Name | Physician Reading Study Performer | Physician Reading Study Performer (V2) |
| [Physician Reading Study Performer (V2) 2.16.840.1.113883.10.20.6.2.1.2](#U_Physician_Reading_Study_Performer_V2) | Oid | 2.16.840.1.113883.10.20.6.2.1 | 2.16.840.1.113883.10.20.6.2.1.2 |
| [Physician Reading Study Performer (V2) 2.16.840.1.113883.10.20.6.2.1.2](#U_Physician_Reading_Study_Performer_V2) | Description | This performer is the Physician Reading Study Performer and is usually different from the attending physician (Physician of Record Participant) in componentOf/encompassingEncounter. | This participant is the Physician Reading Study Performer defined in documentationOf/serviceEvent. It is usually different from the attending physician. The reading physician interprets the images and evidence of the study (DICOM Definition). |
| [US Realm Date and Time (DT.US.FIELDED) (obsolete) 2.16.840.1.113883.10.20.22.5.3.obsolete](#U_US_Realm_Date_and_Time_DTUSFIELDED_ob) | CONF #: 10078 Removed | SHALL be precise to the day (CONF:10078). |  |
| [US Realm Date and Time (DT.US.FIELDED) (obsolete) 2.16.840.1.113883.10.20.22.5.3.obsolete](#U_US_Realm_Date_and_Time_DTUSFIELDED_ob) | CONF #: 10079 Removed | SHOULD be precise to the minute (CONF:10079). |  |
| [US Realm Date and Time (DT.US.FIELDED) (obsolete) 2.16.840.1.113883.10.20.22.5.3.obsolete](#U_US_Realm_Date_and_Time_DTUSFIELDED_ob) | CONF #: 10080 Removed | MAY be precise to the second (CONF:10080). |  |
| [US Realm Date and Time (DT.US.FIELDED) (obsolete) 2.16.840.1.113883.10.20.22.5.3.obsolete](#U_US_Realm_Date_and_Time_DTUSFIELDED_ob) | CONF #: 10081 Removed | If more precise than day, SHOULD include time-zone offset (CONF:10081). |  |
| [US Realm Date and Time (DT.US.FIELDED) (obsolete) 2.16.840.1.113883.10.20.22.5.3.obsolete](#U_US_Realm_Date_and_Time_DTUSFIELDED_ob) | Name | US Realm Date and Time (DT.US.FIELDED) [DEPRECATED] | US Realm Date and Time (DT.US.FIELDED) (obsolete) |
| [US Realm Date and Time (DT.US.FIELDED) (obsolete) 2.16.840.1.113883.10.20.22.5.3.obsolete](#U_US_Realm_Date_and_Time_DTUSFIELDED_ob) | Oid | 2.16.840.1.113883.10.20.22.5.3 | 2.16.840.1.113883.10.20.22.5.3.obsolete |
| [US Realm Date and Time (DT.US.FIELDED) (obsolete) 2.16.840.1.113883.10.20.22.5.3.obsolete](#U_US_Realm_Date_and_Time_DTUSFIELDED_ob) | Description | The US Realm Clinical Document Date and Time datatype flavor records date and time information. If no time zone offset is provided, you can make no assumption about time, unless you have made a local exchange agreement.    This data type uses the same rules as US Realm Date and Time (DTM.US.FIELDED), but is used with the effectiveTime element. | This template is obsolete and will be deleted completely in the future. It is a duplicate. Use 2.16.840.1.113883.10.20.22.5.4 instead. |