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Volume 2 — Templates and Supporting Material

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Patient Care Work Group
Child Health work Group

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Logical Observation Identifiers Names & Codes (LOINC)	Regenstrief Institute
International Classification of Diseases (ICD) codes	World Health Organization (WHO)

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Structure of This Guide

Two volumes comprise this *HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes.* Volume 1 provides narrative introductory and background material pertinent to this implementation guide, including information on how to understand and use the templates in Volume 2. Volume 2 contains the normative Clinical Document Architecture (CDA) templates for this guide along with lists of all templates, code systems, value sets, and changes from the previous version.

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2 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)
- Header constraints (e.g., document type, template id, participants)
- Required and optional section-level templates

Table 1: Required and Optional Sections for Each Document Type

Document Type **Preferred LOINC** **templateId**	**Required Sections**	**Optional Sections**
Care Plan 56447-6 2.16.840.1.113883.10.20.22.1.15	Goals Section Health Concerns Section	Health Status Evaluations and Outcomes Section Interventions Section (V2)

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Document Type Preferred LOINC templateId	Required Sections	Optional Sections
Consultation Note (V2) 11488-4 2.16.840.1.113883.10.20.22.1.4:2014-06-09	Assessment and Plan Section (V2) / Assessment Section /Plan of Treatment Section (V2) History of Past Illness Section (V2) Physical Exam Section (V2) Reason for Visit Section[1] **	Advance Directives Section (entries optional) (V2) Allergies and Intolerances Section (entries required) (V2) Chief Complaint and Reason for Visit Section** Chief Complaint Section** Family History Section (V2) Functional Status Section (V2) General Status Section History of Present Illness Section Immunizations Section (entries optional) (V2) Medical Equipment Section (V2) Medications Section (entries required) (V2) Mental Status Section Nutrition Section Problem Section (entries required) (V2) Procedures Section (entries optional) (V2) Results Section (entries required) (V2) Review of Systems Section Social History Section (V2) Vital Signs Section (entries required) (V2)
Continuity of Care Document (CCD) (V2) (Summarization of Episode Note) 34133-9 (required) 2.16.840.1.113883.10.20.22.1.2:2014-06-09	Allergies and Intolerances Section (entries required) (V2) Medications Section (entries required) (V2) Problem Section (entries required) (V2) Procedures Section (entries required) (V2) Results Section (entries required) (V2) Social History Section (V2) Vital Signs Section (entries required) (V2)	Advance Directives Section (entries optional) (V2) Encounters Section (entries optional) (V2) Family History Section (V2) Functional Status Section (V2) Immunizations Section (entries required) (V2) Medical Equipment Section (V2) Mental Status Section Nutrition Section Payers Section (V2) Plan of Treatment Section (V2)

[1] Either Reason for Referral or Reason for Visit must be present.

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Document Type Preferred LOINC templateId	Required Sections	Optional Sections
Diagnostic Imaging Report (V2) 18748-4 2.16.840.1.113883.10.20.22.1.5:2014-06-09	DICOM Object Catalog Section - DCM 121181 Findings Section (DIR)	Code Observations Fetus Subject Context Observer Context Physician of Record Participant (V2) Physician Reading Study Performer (V2) Procedure Context Quantity Measurement Observation SOP Instance Observation Text Observation
Discharge Summary (V2) (Discharge Summarization Note) 18842-5 2.16.840.1.113883.10.20.22.1.8:2014-06-09	Allergies and Intolerances Section (entries optional) (V2) Hospital Course Section Discharge Diagnosis Section (V2) Discharge Medications Section (entries required) (V2) Plan of Treatment Section (V2)	Admission Diagnosis Section (V2) Admission Medications Section (entries optional) (V2) Chief Complaint and Reason for Visit Section** Chief Complaint Section** Discharge Diet Section (DEPRECATED) Discharge Medications Section (entries optional) (V2) Family History Section (V2) Functional Status Section (V2) History of Past Illness Section (V2) History of Present Illness Section Hospital Consultations Section Hospital Course Section Hospital Discharge Instructions Section Hospital Discharge Physical Section Hospital Discharge Studies Summary Section Immunizations Section (entries optional) (V2) Nutrition Section Problem Section (entries optional) (V2) Procedures Section (entries optional) (V2) Reason for Visit Section** Review of Systems Section Social History Section (V2) Vital Signs Section (entries optional) (V2)

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Document Type **Preferred LOINC** **templateId**	**Required Sections**	**Optional Sections**
History and Physical (V2) 34117-2 2.16.840.1.113883.10.20.22.1.3:2014-06-09	Allergies and Intolerances Section (entries optional) (V2) Assessment Section /Assessment and Plan Section (V2) /Plan of Treatment Section (V2)* Chief Complaint and Reason for Visit Section** Chief Complaint Section** Family History Section (V2) General Status Section History of Past Illness Section (V2) Medications Section (entries optional) (V2) Physical Exam Section (V2) Reason for Visit Section** Results Section (entries optional) (V2) Review of Systems Section Social History Section (V2) Vital Signs Section (entries optional) (V2)	Assessment and Plan Section (V2) Assessment Section History of Present Illness Section Immunizations Section (entries optional) (V2) Instructions Section (V2) Plan of Treatment Section (V2) Problem Section (entries optional) (V2) Procedures Section (entries optional) (V2)
Operative Note (V2) (Surgical Operation Note) 11504-8 2.16.840.1.113883.10.20.22.1.7:2014-06-09	Anesthesia Section (V2) Complications Section (V2) Postoperative Diagnosis Section Preoperative Diagnosis Section (V2) Procedure Description Section Procedure Estimated Blood Loss Section Procedure Findings Section (V2) Procedure Specimens Taken Section	Operative Note Fluids Section Operative Note Surgical Procedure Section Plan of Treatment Section (V2) Planned Procedure Section (V2) Procedure Disposition Section Procedure Implants Section Procedure Indications Section (V2) Surgical Drains Section

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Document Type Preferred LOINC templateId	Required Sections	Optional Sections
Procedure Note (V2) 28570-0 2.16.840.1.113883.10.20.22.1.6:2014-06-09	Assessment Section/Assessment and Plan Section (V2) /Plan of Treatment Section (V2)* Complications Section (V2) Procedure Description Section Postprocedure Diagnosis Section (V2) Procedure Indications Section (V2)	Allergies and Intolerances Section (entries optional) (V2) Anesthesia Section (V2) Assessment and Plan Section (V2) Assessment Section Chief Complaint and Reason for Visit Section Chief Complaint Section Family History Section (V2) History of Past Illness Section (V2) History of Present Illness Section Medical (General) History Section Medications Administered Section (V2) Medications Section (entries optional) (V2) Physical Exam Section (V2) Plan of Treatment Section (V2) Planned Procedure Section (V2) Procedure Disposition Section Procedure Estimated Blood Loss Section Procedure Findings Section (V2) Procedure Implants Section Procedure Specimens Taken Section Procedures Section (entries optional) (V2) Reason for Visit Section Review of Systems Section Social History Section (V2)

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Document Type Preferred LOINC templateId	Required Sections	Optional Sections
Progress Note (V2) (Subsequent Evaluation Note) 11506-3 2.16.840.1.113883.10.20.22.1.9:2014-06-09 (open)]	Assessment Section/Assessment and Plan Section (V2) /Plan of Treatment Section (V2)*	Allergies and Intolerances Section (entries optional) (V2) Assessment and Plan Section (V2) Assessment Section Chief Complaint Section Instructions Section (V2) Interventions Section (V2) Medications Section (entries optional) (V2) Nutrition Section Objective Section Physical Exam Section (V2) Plan of Treatment Section (V2) Problem Section (entries optional) (V2) Results Section (entries optional) (V2) Review of Systems Section Subjective Section Vital Signs Section (entries optional) (V2)
Referral Note 57133-1 2.16.840.1.113883.10.20.22.1.14	Allergies and Intolerances Section (entries required) (V2) Assessment Section/Assessment and Plan Section (V2) /Plan of Treatment Section (V2)* Medications Section (entries required) (V2) Problem Section (entries required) (V2) Reason for Referral Section (V2)	Advance Directives Section (entries optional) (V2) Assessment and Plan Section (V2) Assessment Section Family History Section (V2) Functional Status Section (V2) General Status Section History of Past Illness Section (V2) History of Present Illness Section Immunizations Section (entries required) (V2) Medical Equipment Section (V2) Mental Status Section Nutrition Section Physical Exam Section (V2) Plan of Treatment Section (V2) Procedures Section (entries optional) (V2) Results Section (entries required) (V2) Review of Systems Section Social History Section (V2) Vital Signs Section (entries required) (V2)

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Document Type Preferred LOINC templateId	Required Sections	Optional Sections
Transfer Summary 18761-7 2.16.840.1.113883.10.20.22.1.13	Allergies and Intolerances Section (entries required) (V2) Assessment Section/Assessment and Plan Section (V2) /Plan of Treatment Section (V2)* Medications Section (entries required) (V2) Problem Section (entries required) (V2) Reason for Referral Section (V2) Results Section (entries required) (V2) Vital Signs Section (entries required) (V2)	Admission Diagnosis Section (V2) Admission Medications Section (entries optional) (V2) Advance Directives Section (entries required) (V2) Course of Care Section Discharge Diagnosis Section (V2) Encounters Section (entries required) (V2) Family History Section (V2) Functional Status Section (V2) General Status Section History of Past Illness Section (V2) History of Present Illness Section Immunizations Section (entries optional) (V2) Medical Equipment Section (V2) Mental Status Section Nutrition Section Payers Section (V2) Physical Exam Section (V2) Procedures Section (entries required) (V2) Review of Systems Section Social History Section (V2)
Unstructured Document Non-preferred 2.16.840.1.113883.10.20.22.1.10:2014-06-09	N/A	N/A

* Wherever referenced, intent is that either “Assessment and Plan” is present or both “Assessment” and “Plan of Care”. Only these combinations should be used.

** Wherever referenced, intent is that either Chief Complaint/Reason for Visit Section is present or Chief Complaint Section and/or Reason for Visit unique Sections should be present.

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2.1 US Realm Header (V2)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09 (open)]

Table 2: US Realm Header (V2) Contexts

Contained By:	Contains:
	US Realm Address (AD.US.FIELDED) US Realm Date and Time (DTM.US.FIELDED) US Realm Person Name (PN.US.FIELDED)

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

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Table 3: US Realm Header (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)					
realmCode	1..1	SHALL		1098-16791	US
typeId	1..1	SHALL		1098-5361	
@root	1..1	SHALL		1098-5250	2.16.840.1.113883.1.3
@extension	1..1	SHALL		1098-5251	POCD_HD000040
templateId	1..1	SHALL		1098-5252	
@root	1..1	SHALL		1098-10036	2.16.840.1.113883.10.20.22.1.1
@extension	1..1	SHALL		1098-32503	2014-06-09
id	1..1	SHALL		1098-5363	
code	1..1	SHALL		1098-5253	
title	1..1	SHALL		1098-5254	
effectiveTime	1..1	SHALL		1098-5256	US Realm Date and Time (DTM.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4
confidentialityCode	1..1	SHALL		1098-5259	2.16.840.1.113883.1.11.16926 (HL7 BasicConfidentialityKind)
languageCode	1..1	SHALL		1098-5372	2.16.840.1.113883.1.11.11526 (Language)
setId	0..1	MAY		1098-5261	
versionNumber	0..1	MAY		1098-5264	
recordTarget	1..*	SHALL		1098-5266	
patientRole	1..1	SHALL		1098-5267	
id	1..*	SHALL		1098-5268	
addr	1..*	SHALL		1098-5271	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
telecom	1..*	SHALL		1098-	

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				5280	
@use	0..1	SHOULD		1098-5375	2.16.840.1.113883.11.20.9.20 (Telecom Use (US Realm Header))
patient	1..1	SHALL		1098-5283	
name	1..*	SHALL		1098-5284	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
administrativeGenderCode	1..1	SHALL		1098-6394	2.16.840.1.113883.1.11.1 (Administrative Gender (HL7 V3))
birthTime	1..1	SHALL		1098-5298	
maritalStatusCode	0..1	SHOULD		1098-5303	2.16.840.1.113883.1.11.12212 (Marital Status)
religiousAffiliationCode	0..1	MAY		1098-5317	2.16.840.1.113883.1.11.19185 (Religious Affiliation)
raceCode	1..1	SHALL		1098-5322	2.16.840.1.113883.3.2074.1.1.3 (Race Category Excluding Nulls)
sdtc:raceCode	0..*	MAY		1098-7263	2.16.840.1.113883.1.11.14914 (Race)
ethnicGroupCode	1..1	SHALL		1098-5323	2.16.840.1.114222.4.11.837 (EthnicityGroup)
guardian	0..*	MAY		1098-5325	
code	0..1	SHOULD		1098-5326	2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)
addr	0..*	SHOULD		1098-5359	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
telecom	0..*	SHOULD		1098-5382	
@use	0..1	SHOULD		1098-7993	2.16.840.1.113883.11.20.9.20 (Telecom Use (US Realm Header))
guardianPerson	1..1	SHALL		1098-5385	
name	1..*	SHALL		1098-5386	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
birthplace	0..1	MAY		1098-5395	
place	1..1	SHALL		1098-5396	
addr	1..1	SHALL		1098-5397	

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country	0..1	SHOULD		1098-5404	2.16.840.1.113883.3.88.12.80.63 (Country)
postalCode	0..1	MAY		1098-5403	2.16.840.1.113883.3.88.12.80.2 (PostalCode)
languageCommunication	1..*	SHALL		1098-5406	
languageCode	1..1	SHALL		1098-5407	2.16.840.1.113883.11.20.9.64 (PatientLanguage)
modeCode	0..1	MAY		1098-5409	2.16.840.1.113883.1.11.12249 (LanguageAbilityMode)
proficiencyLevelCode	0..1	SHOULD		1098-9965	2.16.840.1.113883.1.11.12199 (LanguageAbilityProficiency)
preferenceInd	0..1	SHOULD		1098-5414	
providerOrganization	0..1	MAY		1098-5416	
id	1..*	SHALL		1098-5417	
@root	0..1	SHOULD		1098-16820	2.16.840.1.113883.4.6
name	1..*	SHALL		1098-5419	
telecom	1..*	SHALL		1098-5420	
@use	0..1	SHOULD		1098-7994	2.16.840.1.113883.11.20.9.20 (Telecom Use (US Realm Header))
addr	1..*	SHALL		1098-5422	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
author	1..*	SHALL		1098-5444	
time	1..1	SHALL		1098-5445	US Realm Date and Time (DTM.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4
assignedAuthor	1..1	SHALL		1098-5448	
id	1..*	SHALL		1098-5449	
id	0..1	SHOULD		1098-32882	
@nullFlavor	0..1	MAY		1098-32883	2.16.840.1.113883.5.1008 (HL7NullFlavor) = UNK
@root	1..1	SHALL		1098-32884	2.16.840.1.113883.4.6
@extension	0..1	SHOULD		1098-32885	

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code	0..1	SHOULD		1098-16787	
@code	1..1	SHALL		1098-16788	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
addr	1..*	SHALL		1098-5452	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
telecom	1..*	SHALL		1098-5428	
@use	0..1	SHOULD		1098-7995	2.16.840.1.113883.11.20.9.20 (Telecom Use (US Realm Header))
assignedPerson	0..1	SHOULD		1098-5430	
name	1..*	SHALL		1098-16789	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
assignedAuthoringDevice	0..1	SHOULD		1098-16783	
manufacturerModelName	1..1	SHALL		1098-16784	
softwareName	1..1	SHALL		1098-16785	
dataEnterer	0..1	MAY		1098-5441	
assignedEntity	1..1	SHALL		1098-5442	
id	1..*	SHALL		1098-5443	
@root	0..1	SHOULD		1098-16821	2.16.840.1.113883.4.6
code	0..1	MAY		1098-32173	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
addr	1..*	SHALL		1098-5460	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
telecom	1..*	SHALL		1098-5466	
@use	0..1	SHOULD		1098-7996	2.16.840.1.113883.11.20.9.20 (Telecom Use (US Realm Header))
assignedPerson	1..1	SHALL		1098-5469	
name	1..*	SHALL		1098-5470	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.

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					22.5.1.1
informant	0..*	MAY		1098-8001	
assignedEntity	1..1	SHALL		1098-8002	
id	1..*	SHALL		1098-9945	
code	0..1	MAY		1098-32174	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
addr	1..*	SHALL		1098-8220	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
assignedPerson	1..1	SHALL		1098-8221	
name	1..*	SHALL		1098-8222	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
informant	0..*	MAY		1098-31355	
relatedEntity	1..1	SHALL		1098-31356	
custodian	1..1	SHALL		1098-5519	
assignedCustodian	1..1	SHALL		1098-5520	
representedCustodianOrganization	1..1	SHALL		1098-5521	
id	1..*	SHALL		1098-5522	
@root	0..1	SHOULD		1098-16822	2.16.840.1.113883.4.6
name	1..1	SHALL		1098-5524	
telecom	1..1	SHALL		1098-5525	
@use	0..1	SHOULD		1098-7998	2.16.840.1.113883.11.20.9.20 (Telecom Use (US Realm Header))
addr	1..1	SHALL		1098-5559	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
informationRecipient	0..*	MAY		1098-5565	
intendedRecipient	1..1	SHALL		1098-5566	

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id	0..*	MAY		1098-32399	
informationRecipient	0..1	MAY		1098-5567	
name	1..*	SHALL		1098-5568	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
receivedOrganization	0..1	MAY		1098-5577	
name	1..1	SHALL		1098-5578	
legalAuthenticator	0..1	SHOULD		1098-5579	
time	1..1	SHALL		1098-5580	US Realm Date and Time (DTM.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4
signatureCode	1..1	SHALL		1098-5583	
@code	1..1	SHALL		1098-5584	2.16.840.1.113883.5.89 (Participationsignature) = S
sdtc:signatureText	0..1	MAY		1098-30810	
assignedEntity	1..1	SHALL		1098-5585	
id	1..*	SHALL		1098-5586	
@root	0..1	MAY		1098-16823	2.16.840.1.113883.4.6
code	0..1	MAY		1098-17000	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
addr	1..*	SHALL		1098-5589	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
telecom	1..*	SHALL		1098-5595	
@use	0..1	SHOULD		1098-7999	2.16.840.1.113883.11.20.9.20 (Telecom Use (US Realm Header))
assignedPerson	1..1	SHALL		1098-5597	
name	1..*	SHALL		1098-5598	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
authenticator	0..*	MAY		1098-5607	

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time	1..1	SHALL		1098-5608	US Realm Date and Time (DTM.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4
signatureCode	1..1	SHALL		1098-5610	
@code	1..1	SHALL		1098-5611	2.16.840.1.113883.5.89 (Participationsignature) = S
sdtc:signatureText	0..1	MAY		1098-30811	
assignedEntity	1..1	SHALL		1098-5612	
id	1..*	SHALL		1098-5613	
@root	0..1	SHOULD		1098-16824	2.16.840.1.113883.4.6
code	0..1	MAY		1098-16825	
@code	0..1	MAY		1098-16826	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
addr	1..*	SHALL		1098-5616	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
telecom	1..*	SHALL		1098-5622	
@use	0..1	SHOULD		1098-8000	2.16.840.1.113883.11.20.9.20 (Telecom Use (US Realm Header))
assignedPerson	1..1	SHALL		1098-5624	
name	1..*	SHALL		1098-5625	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
participant	0..*	MAY		1098-10003	
time	0..1	MAY		1098-10004	
inFulfillmentOf	0..*	MAY		1098-9952	
order	1..1	SHALL		1098-9953	
id	1..*	SHALL		1098-9954	
documentationOf	0..*	MAY		1098-14835	
serviceEvent	1..1	SHALL		1098-	

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				14836	
effectiveTime	1..1	SHALL		1098-14837	
low	1..1	SHALL		1098-14838	
performer	0..*	SHOULD		1098-14839	
@typeCode	1..1	SHALL		1098-14840	2.16.840.1.113883.1.11.19601 (x_ServiceEventPerformer)
functionCode	0..1	MAY		1098-16818	
@code	0..1	SHOULD		1098-32889	2.16.840.1.113883.1.11.10267 (ParticipationFunction)
assignedEntity	1..1	SHALL		1098-14841	
id	1..*	SHALL		1098-14846	
@root	0..1	SHOULD		1098-14847	2.16.840.1.113883.4.6
code	0..1	SHOULD		1098-14842	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
authorization	0..*	MAY		1098-16792	
consent	1..1	SHALL		1098-16793	
id	0..*	MAY		1098-16794	
code	0..1	MAY		1098-16795	
statusCode	1..1	SHALL		1098-16797	
@code	1..1	SHALL		1098-16798	2.16.840.1.113883.5.6 (HL7ActClass) = completed
componentOf	0..1	MAY		1098-9955	
encompassingEncounter	1..1	SHALL		1098-9956	
id	1..*	SHALL		1098-9959	
effectiveTime	1..1	SHALL		1098-9958	

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2.1.1 Properties

2.1.1.1 realmCode

1. **SHALL** contain exactly one [1..1] **realmCode**="US" (CONF:1098-16791).

Figure 1: US Realm Header (V2) Example

```
<ClinicalDocument>
    <realmCode code="US" />
    <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3" />
    <!-- CCD template -->
    <templateId root="2.16.840.1.113883.10.20.22.1.1" extension="2014-06-09" />
    <!-- Globally unique identifier for the document  -->
    <id extension="TT988" root="2.16.840.1.113883.19.5.99999.1" />
    <code code="34133-9" displayName="Summarization of Episode Note"
codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />
    <!-- Title of the document -->
    <title>Patient Chart Summary</title>
    <effectiveTime value="201209151030-0800" />
    <confidentialityCode code="N" displayName="normal" codeSystem="2.16.840.1.113883.5.25"
codeSystemName="Confidentiality" />
    <languageCode code="en-US" />
    <setId extension="sTT988" root="2.16.840.1.113883.19.5.99999.19" />
    <!-- Version of the document -->
    <versionNumber value="1" />
     . . .
</ClinicalDocument>
```

2. **SHALL** contain exactly one [1..1] **typeId** (CONF:1098-5361).
   a. This typeId **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.1.3" (CONF:1098-5250).
   b. This typeId **SHALL** contain exactly one [1..1] **@extension**="POCD_HD000040" (CONF:1098-5251).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-5252) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.1" (CONF:1098-10036).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32503).
4. **SHALL** contain exactly one [1..1] **id** (CONF:1098-5363).
   a. This id **SHALL** be a globally unique identifier for the document (CONF:1098-9991).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-5253).
   a. This code **SHALL** specify the particular kind of document (e.g., History and Physical, Discharge Summary, Progress Note) (CONF:1098-9992).
6. **SHALL** contain exactly one [1..1] **title** (CONF:1098-5254).
   Note: The title can either be a locally defined name or the displayName corresponding to clinicalDocument/code
7. **SHALL** contain exactly one [1..1] **US Realm Date and Time (DTM.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4) (CONF:1098-5256).

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8. **SHALL** contain exactly one [1..1] **confidentialityCode**, which **SHOULD** be selected from ValueSet **HL7 BasicConfidentialityKind** 2.16.840.1.113883.1.11.16926 **STATIC** 2010-04-21 (CONF:1098-5259).
9. **SHALL** contain exactly one [1..1] **languageCode**, which **SHALL** be selected from ValueSet **Language** 2.16.840.1.113883.1.11.11526 **DYNAMIC** (CONF:1098-5372).
10. **MAY** contain zero or one [0..1] **setId** (CONF:1098-5261).
    a. If setId is present versionNumber **SHALL** be present (CONF:1098-6380).
11. **MAY** contain zero or one [0..1] **versionNumber** (CONF:1098-5264).
    a. If versionNumber is present setId **SHALL** be present (CONF:1098-6387).

2.1.1.2 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

12. **SHALL** contain at least one [1..*] **recordTarget** (CONF:1098-5266).
    a. Such recordTargets **SHALL** contain exactly one [1..1] **patientRole** (CONF:1098-5267).
        i. This patientRole **SHALL** contain at least one [1..*] **id** (CONF:1098-5268).
        ii. This patientRole **SHALL** contain at least one [1..*] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-5271).
        iii. This patientRole **SHALL** contain at least one [1..*] **telecom** (CONF:1098-5280).
            1. Such telecoms **SHOULD** contain zero or one [0..1] **@use**, which **SHALL** be selected from ValueSet **Telecom Use (US Realm Header)** 2.16.840.1.113883.11.20.9.20 **DYNAMIC** (CONF:1098-5375).
        iv. This patientRole **SHALL** contain exactly one [1..1] **patient** (CONF:1098-5283).
            1. This patient **SHALL** contain at least one [1..*] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-5284).
            2. This patient **SHALL** contain exactly one [1..1] **administrativeGenderCode**, which **SHALL** be selected from ValueSet **Administrative Gender (HL7 V3)** 2.16.840.1.113883.1.11.1 **DYNAMIC** (CONF:1098-6394).
            3. This patient **SHALL** contain exactly one [1..1] **birthTime** (CONF:1098-5298).
                a. **SHALL** be precise to year (CONF:1098-5299).
                b. **SHOULD** be precise to day (CONF:1098-5300).

For cases where information about newborn's time of birth needs to be captured.

                c. **MAY** be precise to the minute (CONF:1098-32418).

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4. This patient **SHOULD** contain zero or one [0..1] **maritalStatusCode**, which **SHALL** be selected from ValueSet **Marital Status** 2.16.840.1.113883.1.11.12212 **DYNAMIC** (CONF:1098-5303).
5. This patient **MAY** contain zero or one [0..1] **religiousAffiliationCode**, which **SHALL** be selected from ValueSet **Religious Affiliation** 2.16.840.1.113883.1.11.19185 **DYNAMIC** (CONF:1098-5317).
6. This patient **SHALL** contain exactly one [1..1] **raceCode**, which **SHALL** be selected from ValueSet **Race Category Excluding Nulls** 2.16.840.1.113883.3.2074.1.1.3 **DYNAMIC** (CONF:1098-5322).
7. This patient **MAY** contain zero or more [0..*] **sdtc:raceCode**, which **SHALL** be selected from ValueSet **Race** 2.16.840.1.113883.1.11.14914 **DYNAMIC** (CONF:1098-7263). Note: The sdtc:raceCode is only used to record additional values when the patient has indicated multiple races or additional race detail beyond the five categories required for Meaningful Use Stage 2. 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 additional raceCode elements.
    a. If sdtc:raceCode is present, then the patient **SHALL** contain [1..1] raceCode (CONF:1098-31347).
8. This patient **SHALL** contain exactly one [1..1] **ethnicGroupCode**, which **SHALL** be selected from ValueSet **EthnicityGroup** 2.16.840.1.114222.4.11.837 **DYNAMIC** (CONF:1098-5323).
9. This patient **MAY** contain zero or more [0..*] **guardian** (CONF:1098-5325).
    a. 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:1098-5326).
    b. The guardian, if present, **SHOULD** contain zero or more [0..*] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-5359).
    c. The guardian, if present, **SHOULD** contain zero or more [0..*] **telecom** (CONF:1098-5382).
        i. The telecom, if present, **SHOULD** contain zero or one [0..1] **@use**, which **SHALL** be selected from ValueSet **Telecom Use (US Realm Header)** 2.16.840.1.113883.11.20.9.20 **DYNAMIC** (CONF:1098-7993).
    d. The guardian, if present, **SHALL** contain exactly one [1..1] **guardianPerson** (CONF:1098-5385).
        i. This guardianPerson **SHALL** contain at least one [1..*] **US Realm Person Name (PN.US.FIELDED)**

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(identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-5386).

10. This patient **MAY** contain zero or one [0..1] **birthplace** (CONF:1098-5395).
    a. The birthplace, if present, **SHALL** contain exactly one [1..1] **place** (CONF:1098-5396).
        i. This place **SHALL** contain exactly one [1..1] **addr** (CONF:1098-5397).
        1. This addr **SHOULD** contain zero or one [0..1] **country**, which **SHALL** be selected from ValueSet **Country** 2.16.840.1.113883.3.88.12.80.63 **DYNAMIC** (CONF:1098-5404).
        2. This addr **MAY** contain zero or one [0..1] **postalCode**, which **SHALL** be selected from ValueSet **PostalCode** 2.16.840.1.113883.3.88.12.80.2 **DYNAMIC** (CONF:1098-5403).
        3. If country is US, this addr **SHOULD** contain zero to one [0..1] state, which **SHALL** be selected from ValueSet StateValueSet 2.16.840.1.113883.3.88.12.80.1 **DYNAMIC** (CONF:1098-5402).
11. This patient **SHALL** contain at least one [1..*] **languageCommunication** (CONF:1098-5406).
    a. Such languageCommunications **SHALL** contain exactly one [1..1] **languageCode**, which **SHALL** be selected from ValueSet **PatientLanguage** 2.16.840.1.113883.11.20.9.64 **DYNAMIC** (CONF:1098-5407).
    b. Such languageCommunications **MAY** contain zero or one [0..1] **modeCode**, which **SHALL** be selected from ValueSet **LanguageAbilityMode** 2.16.840.1.113883.1.11.12249 **DYNAMIC** (CONF:1098-5409).
    c. Such languageCommunications **SHOULD** contain zero or one [0..1] **proficiencyLevelCode**, which **SHALL** be selected from ValueSet **LanguageAbilityProficiency** 2.16.840.1.113883.1.11.12199 **DYNAMIC** (CONF:1098-9965).
    d. Such languageCommunications **SHOULD** contain zero or one [0..1] **preferenceInd** (CONF:1098-5414).

v. This patientRole **MAY** contain zero or one [0..1] **providerOrganization** (CONF:1098-5416).
    1. The providerOrganization, if present, **SHALL** contain at least one [1..*] **id** (CONF:1098-5417).
        a. Such ids **SHOULD** contain zero or one [0..1] **@root**="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1098-16820).

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2. The providerOrganization, if present, **SHALL** contain at least one [1..*] **name** (CONF:1098-5419).
3. The providerOrganization, if present, **SHALL** contain at least one [1..*] **telecom** (CONF:1098-5420).
    a. Such telecoms **SHOULD** contain zero or one [0..1] **@use**, which **SHALL** be selected from ValueSet **Telecom Use (US Realm Header)** 2.16.840.1.113883.11.20.9.20 **DYNAMIC** (CONF:1098-7994).
4. The providerOrganization, if present, **SHALL** contain at least one [1..*] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-5422).

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Figure 2: 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>
                <!-- The "SP" is "Spouse" from
                     HL7 Code System EntityNamePartQualifier 2.16.840.1.113883.5.43 -->
                <family qualifier="SP">Betterhalf</family>
            </name>
            <!-- The second name element represents another name
                 associated with the patient -->
            <name>
                <given>Eve</given>
                <!-- The "BR" is "Birth" from
                     HL7 Code System EntityNamePartQualifier 2.16.840.1.113883.5.43 -->
                <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 & 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 & Ethnicity - CDC" />
            <ethnicGroupCode code="2186-5" displayName="Not Hispanic or Latino"
codeSystem="2.16.840.1.113883.6.238" codeSystemName="Race & 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>
```


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```
                    <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>
```

2.1.1.3 author

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

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13. **SHALL** contain at least one [1..*] **author** (CONF:1098-5444).
    a. Such authors **SHALL** contain exactly one [1..1] **US Realm Date and Time (DTM.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4) (CONF:1098-5445).
    b. Such authors **SHALL** contain exactly one [1..1] **assignedAuthor** (CONF:1098-5448).
        i. This assignedAuthor **SHALL** contain at least one [1..*] **id** (CONF:1098-5449).

If this assignedAuthor is an assignedPerson

        ii. This assignedAuthor **SHOULD** contain zero or one [0..1] **id** (CONF:1098-32882) such that it

If id with @root="2.16.840.1.113883.4.6" National Provider Identifier is unknown then

            1. **MAY** contain zero or one [0..1] **@nullFlavor**="UNK" Unknown (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32883).
            2. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1098-32884).
            3. **SHOULD** contain zero or one [0..1] **@extension** (CONF:1098-32885).

Only if this assignedAuthor is an assignedPerson should the assignedAuthor contain a code.

        iii. This assignedAuthor **SHOULD** contain zero or one [0..1] **code** (CONF:1098-16787).
            1. The code, if present, **SHALL** contain exactly one [1..1] **@code**, which **SHOULD** be selected from ValueSet **Healthcare Provider Taxonomy (HIPAA)** 2.16.840.1.114222.4.11.1066 **DYNAMIC** (CONF:1098-16788).
        iv. This assignedAuthor **SHALL** contain at least one [1..*] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-5452).
        v. This assignedAuthor **SHALL** contain at least one [1..*] **telecom** (CONF:1098-5428).
            1. Such telecoms **SHOULD** contain zero or one [0..1] **@use**, which **SHALL** be selected from ValueSet **Telecom Use (US Realm Header)** 2.16.840.1.113883.11.20.9.20 **DYNAMIC** (CONF:1098-7995).
        vi. This assignedAuthor **SHOULD** contain zero or one [0..1] **assignedPerson** (CONF:1098-5430).
            1. The assignedPerson, if present, **SHALL** contain at least one [1..*] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-16789).
        vii. This assignedAuthor **SHOULD** contain zero or one [0..1] **assignedAuthoringDevice** (CONF:1098-16783).
            1. The assignedAuthoringDevice, if present, **SHALL** contain exactly one [1..1] **manufacturerModelName** (CONF:1098-16784).
            2. The assignedAuthoringDevice, if present, **SHALL** contain exactly one [1..1] **softwareName** (CONF:1098-16785).

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viii. There **SHALL** be exactly one assignedAuthor/assignedPerson or exactly one assignedAuthor/assignedAuthoringDevice (CONF:1098-16790).

Figure 3: author Example

```
<author>
    <time value="201209151030-0800" />
    <assignedAuthor>
        <id extension="5555555555" root="2.16.840.1.113883.4.6" />
        <code code="163W00000X" displayName="Registered nurse"
codeSystem="2.16.840.1.113883.5.53" codeSystemName="Health Care Provider Taxonomy" />
        <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>
```

2.1.1.4 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.

14. **MAY** contain zero or one [0..1] **dataEnterer** (CONF:1098-5441).
    a. The dataEnterer, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-5442).
        i. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-5443).
            1. Such ids **SHOULD** contain zero or one [0..1] **@root**="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1098-16821).
        ii. This assignedEntity **MAY** 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:1098-32173).
        iii. This assignedEntity **SHALL** contain at least one [1..*] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-5460).

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iv. This assignedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:1098-5466).

1. Such telecoms **SHOULD** contain zero or one [0..1] **@use**, which **SHALL** be selected from ValueSet **Telecom Use (US Realm Header)** 2.16.840.1.113883.11.20.9.20 **DYNAMIC** (CONF:1098-7996).

v. This assignedEntity **SHALL** contain exactly one [1..1] **assignedPerson** (CONF:1098-5469).

1. This assignedPerson **SHALL** contain at least one [1..*] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-5470).

Figure 4: 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>
```

2.1.1.5 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.

15. **MAY** contain zero or more [0..*] **informant** (CONF:1098-8001) such that it

a. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-8002).

i. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-9945).

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:1098-9946).

ii. This assignedEntity **MAY** 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:1098-32174).

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iii. This assignedEntity **SHALL** contain at least one [1..*] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-8220).

iv. This assignedEntity **SHALL** contain exactly one [1..1] **assignedPerson** (CONF:1098-8221).

1. This assignedPerson **SHALL** contain at least one [1..*] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-8222).

Figure 5: 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>
```

2.1.1.6 informant

The informant element describes an information source (who is not a provider) for any content within the clinical document. This informant would be used when the source of information has a personal relationship with the patient or is the patient.

16. **MAY** contain zero or more [0..*] **informant** (CONF:1098-31355) such that it
    a. **SHALL** contain exactly one [1..1] **relatedEntity** (CONF:1098-31356).

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Figure 6: 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>
```

2.1.1.7 custodian

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

There is only one custodian per CDA document. Allowing that a CDA document 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.

17. **SHALL** contain exactly one [1..1] **custodian** (CONF:1098-5519).
    a. This custodian **SHALL** contain exactly one [1..1] **assignedCustodian** (CONF:1098-5520).
        i. This assignedCustodian **SHALL** contain exactly one [1..1] **representedCustodianOrganization** (CONF:1098-5521).
            1. This representedCustodianOrganization **SHALL** contain at least one [1..*] **id** (CONF:1098-5522).
                a. Such ids **SHOULD** contain zero or one [0..1] **@root**="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1098-16822).
            2. This representedCustodianOrganization **SHALL** contain exactly one [1..1] **name** (CONF:1098-5524).
            3. This representedCustodianOrganization **SHALL** contain exactly one [1..1] **telecom** (CONF:1098-5525).
                a. This telecom **SHOULD** contain zero or one [0..1] **@use**, which **SHALL** be selected from ValueSet **Telecom Use (US Realm Header)** 2.16.840.1.113883.11.20.9.20 **DYNAMIC** (CONF:1098-7998).
            4. This representedCustodianOrganization **SHALL** contain exactly one [1..1] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-5559).

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Figure 7: 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>
```

2.1.1.8 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.

18. **MAY** contain zero or more [0..*] **informationRecipient** (CONF:1098-5565).
    a. The informationRecipient, if present, **SHALL** contain exactly one [1..1] **intendedRecipient** (CONF:1098-5566).
        i. This intendedRecipient **MAY** contain zero or more [0..*] **id** (CONF:1098-32399).
        ii. This intendedRecipient **MAY** contain zero or one [0..1] **informationRecipient** (CONF:1098-5567).
            1. The informationRecipient, if present, **SHALL** contain at least one [1..*] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-5568).
        iii. This intendedRecipient **MAY** contain zero or one [0..1] **receivedOrganization** (CONF:1098-5577).
            1. The receivedOrganization, if present, **SHALL** contain exactly one [1..1] **name** (CONF:1098-5578).

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Figure 8: 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>
```

2.1.1.9 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.

19. **SHOULD** contain zero or one [0..1] **legalAuthenticator** (CONF:1098-5579).
    a. The legalAuthenticator, if present, **SHALL** contain exactly one [1..1] **US Realm Date and Time (DTM.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4) (CONF:1098-5580).
    b. The legalAuthenticator, if present, **SHALL** contain exactly one [1..1] **signatureCode** (CONF:1098-5583).
        i. This signatureCode **SHALL** contain exactly one [1..1] **@code**="S" (CodeSystem: Participationsignature 2.16.840.1.113883.5.89 **STATIC**) (CONF:1098-5584).

2.1.1.10 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.

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c. The legalAuthenticator, if present, **MAY** contain zero or one [0..1] **sdtc:signatureText** (CONF:1098-30810).
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 9: Digital signature Example

```
<sdtc:signatureText mediaType="text/xml"
representation="B64">omSJUEdmde9j44zmMiromSJUEdmde9j44zmMirdMDSsWdIJdksIJR3373jeu83
   6edjzMMIjdMDSsWdIJdksIJR3373jeu83MNYD83jmMdomSJUEdmde9j44zmMir
   ... MNYD83jmMdomSJUEdmde9j44zmMir6edjzMMIjdMDSsWdIJdksIJR3373jeu83
   4zmMir6edjzMMIjdMDSsWdIJdksIJR3373jeu83==</sdtc:signatureText>
```

d. The legalAuthenticator, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-5585).
   i. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-5586).
      1. Such ids **MAY** contain zero or one [0..1] **@root**="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1098-16823).
   ii. This assignedEntity **MAY** 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:1098-17000).
   iii. This assignedEntity **SHALL** contain at least one [1..*] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-5589).
   iv. This assignedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:1098-5595).
      1. Such telecoms **SHOULD** contain zero or one [0..1] **@use**, which **SHALL** be selected from ValueSet **Telecom Use (US Realm Header)** 2.16.840.1.113883.11.20.9.20 **DYNAMIC** (CONF:1098-7999).
   v. This assignedEntity **SHALL** contain exactly one [1..1] **assignedPerson** (CONF:1098-5597).
      1. This assignedPerson **SHALL** contain at least one [1..*] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-5598).

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Figure 10: 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="2.16.840.1.113883.5.53" codeSystemName="Health Care Provider Taxonomy" />
        <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>
```

2.1.1.11 authenticator

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

20. **MAY** contain zero or more [0..*] **authenticator** (CONF:1098-5607) such that it
    a. **SHALL** contain exactly one [1..1] **US Realm Date and Time (DTM.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4) (CONF:1098-5608).
    b. **SHALL** contain exactly one [1..1] **signatureCode** (CONF:1098-5610).
        i. This signatureCode **SHALL** contain exactly one [1..1] **@code**="S" (CodeSystem: Participationsignature 2.16.840.1.113883.5.89 **STATIC**) (CONF:1098-5611).

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.

    c. **MAY** contain zero or one [0..1] **sdtc:signatureText** (CONF:1098-30811).
    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

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signature data block that is constructed in accordance to a digital signature standard, such as XML-DSIG, PKCS#7, PGP, etc.

d. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-5612).
   i. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-5613).
      1. Such ids **SHOULD** contain zero or one [0..1] **@root="**`2.16.840.1.113883.4.6`**"** National Provider Identifier (CONF:1098-16824).
   ii. This assignedEntity **MAY** contain zero or one [0..1] **code** (CONF:1098-16825).
      1. The code, if present, **MAY** 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` **STATIC** (CONF:1098-16826).
   iii. This assignedEntity **SHALL** contain at least one [1..*] **US Realm Address (AD.US.FIELDED)** (identifier: `urn:oid:2.16.840.1.113883.10.20.22.5.2`) (CONF:1098-5616).
   iv. This assignedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:1098-5622).
      1. Such telecoms **SHOULD** contain zero or one [0..1] **@use**, which **SHALL** be selected from ValueSet **Telecom Use (US Realm Header)** `2.16.840.1.113883.11.20.9.20` **DYNAMIC** (CONF:1098-8000).
   v. This assignedEntity **SHALL** contain exactly one [1..1] **assignedPerson** (CONF:1098-5624).
      1. This assignedPerson **SHALL** contain at least one [1..*] **US Realm Person Name (PN.US.FIELDED)** (identifier: `urn:oid:2.16.840.1.113883.10.20.22.5.1.1`) (CONF:1098-5625).

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Figure 11: 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="2.16.840.1.113883.5.53" codeSystemName="Health Care Provider Taxonomy" />
        <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>
```

2.1.1.12 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).

21. **MAY** contain zero or more [0..*] **participant** (CONF:1098-10003) such that it
    a. **MAY** contain zero or one [0..1] **time** (CONF:1098-10004).
    b. **SHALL** contain associatedEntity/associatedPerson **AND/OR** associatedEntity/scopingOrganization (CONF:1098-10006).
    c. 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:1098-10007).

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Figure 12: 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>
```

2.1.1.13 inFulfillmentOf

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

22. **MAY** contain zero or more [0..*] **inFulfillmentOf** (CONF:1098-9952).
    a. The inFulfillmentOf, if present, **SHALL** contain exactly one [1..1] **order** (CONF:1098-9953).
        i. This order **SHALL** contain at least one [1..*] **id** (CONF:1098-9954).

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Figure 13: 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>
```

2.1.1.14 documentationOf

23. **MAY** contain zero or more [0..*] **documentationOf** (CONF:1098-14835).

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.

a. The documentationOf, if present, **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1098-14836).
   i. This serviceEvent **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-14837).
      1. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-14838).

2.1.1.15 performer

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.

   ii. This serviceEvent **SHOULD** contain zero or more [0..*] **performer** (CONF:1098-14839).
      1. The performer, if present, **SHALL** contain exactly one [1..1] **@typeCode**, which **SHALL** be selected from ValueSet **x_ServiceEventPerformer** 2.16.840.1.113883.1.11.19601 **STATIC** 2014-09-01 (CONF:1098-14840).
      2. The performer, if present, **MAY** contain zero or one [0..1] **functionCode** (CONF:1098-16818).
         a. The functionCode, if present, **SHOULD** contain zero or one [0..1] **@code**, which **SHOULD** be selected from ValueSet **ParticipationFunction** 2.16.840.1.113883.1.11.10267 **STATIC** 2014-09-01 (CONF:1098-32889).
      3. The performer, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-14841).

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a. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-14846).
    i. Such ids **SHOULD** contain zero or one [0..1] **@root="**`2.16.840.1.113883.4.6`**"** National Provider Identifier (CONF:1098-14847).
b. This assignedEntity **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:1098-14842).

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Figure 14: performer Example

```
<performer typeCode="PRF">
    <functionCode code="PCP"
              displayName="Primary Care Provider"
              codeSystem="2.16.840.1.113883.5.88"
              codeSystemName="ParticipationFunction">
        <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="2.16.840.1.113883.5.53" codeSystemName="Health Care Provider Taxonomy" />
        <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>
```


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Figure 15: 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="PCP"
                                        displayName="Primary Care Provider"
                                        codeSystem="2.16.840.1.113883.5.88"
                                        codeSystemName="ParticipationFunction">
    <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="2.16.840.1.113883.5.53" codeSystemName="Health Care Provider Taxonomy" />
    <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>
```


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2.1.1.16 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'.

The authorization consent is used for referring to consents that are documented elsewhere in the EHR or medical record for a health condition and/or treatment that is described in the CDA document.

24. **MAY** contain zero or more [0..*] **authorization** (CONF:1098-16792) such that it
    a. **SHALL** contain exactly one [1..1] **consent** (CONF:1098-16793).
        i. This consent **MAY** contain zero or more [0..*] **id** (CONF:1098-16794).
        ii. This consent **MAY** contain zero or one [0..1] **code** (CONF:1098-16795). Note: The type of consent (e.g., a consent to perform the related serviceEvent) is conveyed in consent/code.
        iii. This consent **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-16797).
            1. This statusCode **SHALL** contain exactly one [1..1] **@code**="`completed`" Completed (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-16798).

Figure 16: 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>
```

2.1.1.17 componentOf

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.

25. **MAY** contain zero or one [0..1] **componentOf** (CONF:1098-9955).

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a. The componentOf, if present, **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1098-9956).
    i. This encompassingEncounter **SHALL** contain at least one [1..*] **id** (CONF:1098-9959).
    ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-9958).

Table 4: HL7 BasicConfidentialityKind

Value Set: HL7 BasicConfidentialityKind 2.16.840.1.113883.1.11.16926 A value set of HL7 Code indication the level of confidentiality an act. Value Set Source: http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html			
Code	**Code System**	**Code System OID**	**Print Name**
N	ConfidentialityCode	2.16.840.1.113883.5.25	normal
R	ConfidentialityCode	2.16.840.1.113883.5.25	restricted
V	ConfidentialityCode	2.16.840.1.113883.5.25	very restricted

Table 5: Language

Value Set: Language 2.16.840.1.113883.1.11.11526 A value set of codes defined by Internet RFC 4646 (replacing RFC 3066). Please see ISO 639 language code set maintained by Library of Congress for enumeration of language codes. Value Set Source: http://www.ietf.org/rfc/rfc4646.txt			
Code	**Code System**	**Code System OID**	**Print Name**
aa	Language	2.16.840.1.113883.6.121	Afar
ab	Language	2.16.840.1.113883.6.121	Abkhazian
ace	Language	2.16.840.1.113883.6.121	Achinese
ach	Language	2.16.840.1.113883.6.121	Acoli
ada	Language	2.16.840.1.113883.6.121	Adangme
ady	Language	2.16.840.1.113883.6.121	Adyghe; Adygei
ae	Language	2.16.840.1.113883.6.121	Avestan
af	Language	2.16.840.1.113883.6.121	Afrikaans
afa	Language	2.16.840.1.113883.6.121	Afro-Asiatic (Other)
afh	Language	2.16.840.1.113883.6.121	Afrihili
…			

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Table 6: Telecom Use (US Realm Header)

Value Set: Telecom Use (US Realm Header) 2.16.840.1.113883.11.20.9.20 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
HP	AddressUse	2.16.840.1.113883.5.1119	Primary home
HV	AddressUse	2.16.840.1.113883.5.1119	Vacation home
WP	AddressUse	2.16.840.1.113883.5.1119	Work place
MC	AddressUse	2.16.840.1.113883.5.1119	Mobile contact

Table 7: 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. Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
F	AdministrativeGender	2.16.840.1.113883.5.1	Female
M	AdministrativeGender	2.16.840.1.113883.5.1	Male
UN	AdministrativeGender	2.16.840.1.113883.5.1	Undifferentiated

Table 8: Marital Status

Value Set: Marital Status 2.16.840.1.113883.1.11.12212 Marital Status is the domestic partnership status of a person. Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
A	MaritalStatus	2.16.840.1.113883.5.2	Annulled
D	MaritalStatus	2.16.840.1.113883.5.2	Divorced
T	MaritalStatus	2.16.840.1.113883.5.2	Domestic partner
I	MaritalStatus	2.16.840.1.113883.5.2	Interlocutory
L	MaritalStatus	2.16.840.1.113883.5.2	Legally Separated
M	MaritalStatus	2.16.840.1.113883.5.2	Married
S	MaritalStatus	2.16.840.1.113883.5.2	Never Married
P	MaritalStatus	2.16.840.1.113883.5.2	Polygamous
W	MaritalStatus	2.16.840.1.113883.5.2	Widowed

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Table 9: Religious Affiliation

Value Set: Religious Affiliation 2.16.840.1.113883.1.11.19185 A value set of codes that reflect spiritual faith affiliation. Value Set Source: http://www.hl7.org/v3ballotarchive_temp_16B8D83E-1C23-BA17-0CBFC625BE7BA72F/v3ballot/html/infrastructure/vocabulary/vocabulary.html#voc-sets			
Code	**Code System**	**Code System OID**	**Print Name**
1001	ReligiousAffiliation	2.16.840.1.113883.5.1076	Adventist
1002	ReligiousAffiliation	2.16.840.1.113883.5.1076	African Religions
1003	ReligiousAffiliation	2.16.840.1.113883.5.1076	Afro-Caribbean Religions
1004	ReligiousAffiliation	2.16.840.1.113883.5.1076	Agnosticism
1005	ReligiousAffiliation	2.16.840.1.113883.5.1076	Anglican
1006	ReligiousAffiliation	2.16.840.1.113883.5.1076	Animism
1007	ReligiousAffiliation	2.16.840.1.113883.5.1076	Atheism
1008	ReligiousAffiliation	2.16.840.1.113883.5.1076	Babi & Baha'I faiths
1009	ReligiousAffiliation	2.16.840.1.113883.5.1076	Baptist
1010	ReligiousAffiliation	2.16.840.1.113883.5.1076	Bon
…			

Table 10: Race Category Excluding Nulls

Value Set: Race Category Excluding Nulls 2.16.840.1.113883.3.2074.1.1.3			
Code	**Code System**	**Code System OID**	**Print Name**
1002-5	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	American Indian or Alaska Native
2028-9	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Asian
2054-5	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Black or African American
2076-8	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Native Hawaiian or Other Pacific Islander
2106-3	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	White

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Table 11: EthnicityGroup

Value Set: EthnicityGroup 2.16.840.1.114222.4.11.837 Code System: Race & Ethnicity - CDC 2.16.840.1.113883.6.238 Value Set Source: http://phinvads.cdc.gov/vads/ViewValueSet.action?id=35D34BBC-617F-DD11-B38D-00188B398520			
Code	**Code System**	**Code System OID**	**Print Name**
2135-2	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Hispanic or Latino
2186-5	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Not Hispanic or Latino

Table 12: 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 Value Set Source: http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html			
Code	**Code System**	**Code System OID**	**Print Name**
SELF	RoleCode	2.16.840.1.113883.5.111	self
MTH	RoleCode	2.16.840.1.113883.5.111	mother
FTH	RoleCode	2.16.840.1.113883.5.111	father
DAU	RoleCode	2.16.840.1.113883.5.111	natural daughter
SON	RoleCode	2.16.840.1.113883.5.111	natural son
DAUINLAW	RoleCode	2.16.840.1.113883.5.111	daughter in-law
SONINLAW	RoleCode	2.16.840.1.113883.5.111	son in-law
GUARD	RoleCode	2.16.840.1.113883.5.111	guardian
HPOWATT	RoleCode	2.16.840.1.113883.5.111	healthcare power of attorney
…			

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Table 13: Country

Value Set: Country 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. Value Set Source: http://www.iso.org/iso/country_codes/iso_3166_code_lists.htm			
Code	**Code System**	**Code System OID**	**Print Name**
AW	Country	2.16.840.1.113883.3.88.12.80.63	Aruba
IL	Country	2.16.840.1.113883.3.88.12.80.63	Israel
…			

Table 14: PostalCode

Value Set: PostalCode 2.16.840.1.113883.3.88.12.80.2 A value set of postal (ZIP) Code of an address in the United States Value Set Source: http://ushik.ahrq.gov/ViewItemDetails?system=mdr&itemKey=86671000			
Code	**Code System**	**Code System OID**	**Print Name**
19009	USPostalCodes	2.16.840.1.113883.6.231	Bryn Athyn
92869-1736	USPostalCodes	2.16.840.1.113883.6.231	Orange, CA
32830-8413	USPostalCodes	2.16.840.1.113883.6.231	Lake Buena Vista, FL
…			

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Table 15: PatientLanguage

Value Set: PatientLanguage 2.16.840.1.113883.11.20.9.64 This value set contains codes for the representation of language names as defined by the Library of Congress, the ISO 639-2 registration authority. This value set contains a subset of the ISO 639-2 alpha-3 code set, limited to those that have a corresponding ISO 639-1 alpha-2 code as required for representing a patient's language under Meaningful Use Stage 2. Value Set Source: http://www.loc.gov/standards/iso639-2/php/code_list.php			
Code	**Code System**	**Code System OID**	**Print Name**
aar	Language	2.16.840.1.113883.6.121	Afar
abk	Language	2.16.840.1.113883.6.121	Abkhazian
afr	Language	2.16.840.1.113883.6.121	Afrikaans
aka	Language	2.16.840.1.113883.6.121	Akan
sqi	Language	2.16.840.1.113883.6.121	Albanian
amh	Language	2.16.840.1.113883.6.121	Amharic
ara	Language	2.16.840.1.113883.6.121	Arabic
arg	Language	2.16.840.1.113883.6.121	Aragonese
hye	Language	2.16.840.1.113883.6.121	Armenian
asm	Language	2.16.840.1.113883.6.121	Assamese
…			

Table 16: LanguageAbilityMode

Value Set: LanguageAbilityMode 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. Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
ESGN	LanguageAbilityMode	2.16.840.1.113883.5.60	Expressed signed
ESP	LanguageAbilityMode	2.16.840.1.113883.5.60	Expressed spoken
EWR	LanguageAbilityMode	2.16.840.1.113883.5.60	Expressed written
RSGN	LanguageAbilityMode	2.16.840.1.113883.5.60	Received signed
RSP	LanguageAbilityMode	2.16.840.1.113883.5.60	Received spoken
RWR	LanguageAbilityMode	2.16.840.1.113883.5.60	Received written

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Table 17: LanguageAbilityProficiency

Value Set: LanguageAbilityProficiency 2.16.840.1.113883.1.11.12199 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
E	LanguageAbilityProficiency	2.16.840.1.113883.5.61	Excellent
F	LanguageAbilityProficiency	2.16.840.1.113883.5.61	Fair
G	LanguageAbilityProficiency	2.16.840.1.113883.5.61	Good
P	LanguageAbilityProficiency	2.16.840.1.113883.5.61	Poor

Table 18: Race

Value Set: Race 2.16.840.1.113883.1.11.14914 Concepts in the race value set include the 5 minimum categories for race specified by OMB along with a more detailed set of race categories used by the Bureau of Census. Value Set Source: http://phinvads.cdc.gov/vads/ViewCodeSystemConcept.action?oid=2.16.840.1.113883.6.238&code=1000-9			
Code	**Code System**	**Code System OID**	**Print Name**
1002-5	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	American Indian or Alaska Native
2028-9	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Asian
2054-5	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Black or African American
2076-8	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Native Hawaiian or Other Pacific Islander
2106-3	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	White
1006-6	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Abenaki
1579-2	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Absentee Shawnee
1490-2	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Acoma
2126-1	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Afghanistani
1740-0	Race & Ethnicity - CDC	2.16.840.1.113883.6.238	Ahtna
…			

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Table 19: Healthcare Provider Taxonomy (HIPAA)

Value Set: Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066 The Health Care Provider Taxonomy value 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 values to associate with a provider, the user needs to review the requirements of the trading partner with which the value(s) are being used. Value Set Source: http://www.nucc.org/index.php?option=com_content&view=article&id=14&Itemid=125			
Code	**Code System**	**Code System OID**	**Print Name**
171100000X	Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.113883.6.101	Acupuncturist
363LA2100X	Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.113883.6.101	Nurse Practitioner - Acute Care
364SA2100X	Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.113883.6.101	Clinical Nurse Specialist - Acute Care
101YA0400X	Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.113883.6.101	Counselor - Addiction (Substance Use Disorder)
103TA0400X	Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.113883.6.101	Psychologist - Addiction (Substance Use Disorder)
163WA0400X	Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.113883.6.101	Registered Nurse - Addiction (Substance Use Disorder)
207LA0401X	Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.113883.6.101	Anesthesiology - Addiction Medicine
207QA0401X	Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.113883.6.101	Family Medicine - Addiction Medicine
207RA0401X	Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.113883.6.101	Internal Medicine - Addiction Medicine
2084A0401X	Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.113883.6.101	Psychiatry & Neurology - Addiction Medicine
…			

Table 20: INDRoleclassCodes

Value Set: INDRoleclassCodes 2.16.840.1.113883.11.20.9.33 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
PRS	RoleClass	2.16.840.1.113883.5.110	personal relationship
NOK	RoleClass	2.16.840.1.113883.5.110	next of kin
CAREGIVER	RoleClass	2.16.840.1.113883.5.110	caregiver
AGNT	RoleClass	2.16.840.1.113883.5.110	agent
GUAR	RoleClass	2.16.840.1.113883.5.110	guarantor
ECON	RoleClass	2.16.840.1.113883.5.110	emergency contact

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Table 21: x_ServiceEventPerformer

Value Set: x_ServiceEventPerformer 2.16.840.1.113883.1.11.19601 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
PRF	HL7ParticipationType	2.16.840.1.113883.5.90	performer
SPRF	HL7ParticipationType	2.16.840.1.113883.5.90	secondary performer
PPRF	HL7ParticipationType	2.16.840.1.113883.5.90	primary performer

Table 22: ParticipationFunction

Value Set: ParticipationFunction 2.16.840.1.113883.1.11.10267 This HL7-defined value set can be used to specify the exact function an actor had in a service in all necessary detail. Value Set Source: http://www.hl7.org/			
Code	**Code System**	**Code System OID**	**Print Name**
SNRS	participationFunction	2.16.840.1.113883.5.88	Scrub nurse
SASST	participationFunction	2.16.840.1.113883.5.88	Second assistant surgeon
…			

2.1.2 Care Plan

[ClinicalDocument: identifier urn:oid:2.16.840.1.113883.10.20.22.1.15 (open)]

Table 23: Care Plan Contexts

Contained By:	**Contains:**
	Goals Section Health Concerns Section Health Status Evaluations and Outcomes Section Interventions Section (V2) US Realm Person Name (PN.US.FIELDED)

CARE PLAN FRAMEWORK

A Care Plan (including Home Health Plan of Care (HHPoC)) is a consensus-driven dynamic plan that represents 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, their caregivers and providers), to guide the 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.

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

Key differentiators between a Care Plan CDA and CCD (another "snapshot in time" document):

- Requires relationships between various acts:
  - Health Concerns
  - Problems
  - Interventions
  - Goals
  - Outcomes
- Provides the ability to identify patient and provider priorities with each act
- Provides a header participant to indicate occurrences of Care Plan review

Please see Volume 1 of this guide to view a Care Plan Relationship diagram and story board.

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Table 24: Care Plan Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:oid:2.16.840.1.113883.10.20.22.1.15)					
templateId	1..1	SHALL		1098-28741	
@root	1..1	SHALL		1098-28742	2.16.840.1.113883.10.20.22.1.15
code	1..1	SHALL		1098-28745	
@code	1..1	SHALL		1098-28746	52521-2
@codeSystem	1..1	SHALL		1098-28747	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
setId	0..1	SHOULD		1098-32321	
versionNumber	0..1	SHOULD		1098-32322	
informationRecipient	0..*	SHOULD		1098-31993	
intendedRecipient	1..1	SHALL		1098-31994	
id	1..*	SHALL		1098-31996	
addr	0..*	SHOULD		1098-31997	
telecom	0..*	SHOULD		1098-31998	
informationRecipient	0..1	SHOULD		1098-31999	
name	1..1	SHALL		1098-32320	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
receivedOrganization	0..1	SHOULD		1098-32000	
id	0..*	SHOULD		1098-32001	
name	1..*	SHALL		1098-32002	
standardIndustryClassCode	0..1	SHOULD		1098-32003	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
authenticator	0..1	SHOULD		1098-31910	
time	1..1	SHALL		1098-31911	

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signatureCode	1..1	SHALL		1098-31912	
sdtc:signatureText	0..1	MAY		1098-31913	
assignedEntity	1..1	SHALL		1098-31914	
id	1..*	SHALL		1098-31915	
code	1..1	SHALL		1098-31916	
@code	1..1	SHALL		1098-31917	ONESELF
@codeSystem	1..1	SHALL		1098-31918	2.16.840.1.113883.5.111 (RoleCode) = 2.16.840.1.113883.5.111
participant	0..*	SHOULD		1098-31677	
@typeCode	1..1	SHALL		1098-31678	2.16.840.1.113883.5.90 (HL7ParticipationType) = VRF
functionCode	1..1	SHALL		1098-31679	
@code	1..1	SHALL		1098-31680	425268008
@codeSystem	1..1	SHALL		1098-31681	2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
time	1..1	SHALL		1098-31682	
associatedEntity	1..1	SHALL		1098-31683	
@classCode	1..1	SHALL		1098-31686	2.16.840.1.113883.5.110 (RoleClass) = ASSIGNED
id	1..*	SHALL		1098-31684	
code	0..1	SHOULD		1098-31685	
@code	1..1	SHALL		1098-32367	2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)
participant	0..*	SHOULD		1098-31895	
@typeCode	1..1	SHALL		1098-31896	2.16.840.1.113883.5.90 (HL7ParticipationType) = IND
associatedEntity	1..1	SHALL		1098-31897	
@classCode	1..1	SHALL		1098-31898	2.16.840.1.113883.11.20.9.33 (INDRoleclassCodes)
associatedPerson	1..1	SHALL		1098-	

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				31899	
name	1..*	SHALL		1098-31900	
documentationOf	1..1	SHALL		1098-31901	
serviceEvent	1..1	SHALL		1098-31902	
@classCode	1..1	SHALL		1098-31903	2.16.840.1.113883.5.6 (HL7ActClass) = PCPR
effectiveTime	1..1	SHALL		1098-31904	
low	1..1	SHALL		1098-32330	
high	0..1	MAY		1098-32331	
performer	1..*	SHALL		1098-31905	
assignedEntity	1..1	SHALL		1098-31907	
id	1..*	SHALL		1098-31908	
code	0..1	MAY		1098-31909	
assignedPerson	1..1	SHALL		1098-32328	
name	1..1	SHALL		1098-32329	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
relatedDocument	0..*	MAY		1098-29893	
@typeCode	1..1	SHALL		1098-31889	2.16.840.1.113883.11.20.9.62 (Related Document (append/replace))
parentDocument	1..1	SHALL		1098-29894	
setId	1..1	SHALL		1098-29895	
versionNumber	1..1	SHALL		1098-29896	
componentOf	0..1	SHOULD		1098-32004	
encompassingEncounter	1..1	SHALL		1098-32005	
effectiveTime	1..1	SHALL		1098-32007	
component	1..1	SHALL		1098-28753	

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structuredBody	1..1	SHALL		1098-28754	
component	1..1	SHALL		1098-28755	
section	1..1	SHALL		1098-28756	Health Concerns Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.58
component	1..1	SHALL		1098-28761	
section	1..1	SHALL		1098-28762	Goals Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.60
component	0..1	SHOULD		1098-28763	
section	1..1	SHALL		1098-28764	Interventions Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2014-06-09
component	0..1	SHOULD		1098-29596	
section	1..1	SHALL		1098-29597	Health Status Evaluations and Outcomes Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.61

2.1.3 Properties

1. Conforms to **US Realm Header (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-28741) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.15" (CONF:1098-28742).
3. **SHALL** contain exactly one [1..1] **code** (CONF:1098-28745).
   a. This code **SHALL** contain exactly one [1..1] **@code**="52521-2" Overall Plan of Care/ Advance Care Directives (CONF:1098-28746).
   b. 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:1098-28747).
4. **SHOULD** contain zero or one [0..1] **setId** (CONF:1098-32321).
5. **SHOULD** contain zero or one [0..1] **versionNumber** (CONF:1098-32322).

2.1.3.1 informationRecipient

6. **SHOULD** contain zero or more [0..*] **informationRecipient** (CONF:1098-31993) such that it
   a. **SHALL** contain exactly one [1..1] **intendedRecipient** (CONF:1098-31994).

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i. This intendedRecipient **SHALL** contain at least one [1..*] **id** (CONF:1098-31996).

ii. This intendedRecipient **SHOULD** contain zero or more [0..*] **addr** (CONF:1098-31997).

iii. This intendedRecipient **SHOULD** contain zero or more [0..*] **telecom** (CONF:1098-31998).

iv. This intendedRecipient **SHOULD** contain zero or one [0..1] **informationRecipient** (CONF:1098-31999).

1. The informationRecipient, if present, **SHALL** contain exactly one [1..1] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-32320).

v. This intendedRecipient **SHOULD** contain zero or one [0..1] **receivedOrganization** (CONF:1098-32000).

1. The receivedOrganization, if present, **SHOULD** contain zero or more [0..*] **id** (CONF:1098-32001).
2. The receivedOrganization, if present, **SHALL** contain at least one [1..*] **name** (CONF:1098-32002).
3. The receivedOrganization, if present, **SHOULD** contain zero or one [0..1] **standardIndustryClassCode**, which **SHALL** be selected from ValueSet **Healthcare Provider Taxonomy (HIPAA)** 2.16.840.1.114222.4.11.1066 **DYNAMIC** (CONF:1098-32003).

2.1.3.2 authenticator

This authenticator represents patient agreement or sign-off of the Care Plan

7. **SHOULD** contain zero or one [0..1] **authenticator** (CONF:1098-31910) such that it
   a. **SHALL** contain exactly one [1..1] **time** (CONF:1098-31911).
   b. **SHALL** contain exactly one [1..1] **signatureCode** (CONF:1098-31912).
   c. **MAY** contain zero or one [0..1] **sdtc:signatureText** (CONF:1098-31913).
   d. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-31914).
      i. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-31915).
      ii. This assignedEntity **SHALL** contain exactly one [1..1] **code** (CONF:1098-31916).
         1. This code **SHALL** contain exactly one [1..1] **@code**="ONESELF" Self (CONF:1098-31917).
         2. This code **SHALL** contain exactly one [1..1] **@codeSystem**="2.16.840.1.113883.5.111" (CodeSystem: RoleCode 2.16.840.1.113883.5.111) (CONF:1098-31918).

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Figure 17: Care Plan Patient authenticator Example

```
<!-- This authenticator represents patient agreement or
  sign-off of the Care Plan-->
<authenticator>
  <time value="20130802" />
  <signatureCode code="S" />
  <sdtc:signatureText mediaType="text/xml"
representation="B64">omSJUEdmde9j44zmMiromSJUEdmde9j44zmMirdMDSsWdIJdksIJR3373jeu83
    6edjzMMIjdMDSsWdIJdksIJR3373jeu83MNYD83jmMdomSJUEdmde9j44zmMir ...
    MNYD83jmMdomSJUEdmde9j44zmMir6edjzMMIjdMDSsWdIJdksIJR3373jeu83
    4zmMir6edjzMMIjdMDSsWdIJdksIJR3373jeu83==</sdtc:signatureText>
  <assignedEntity>
    <id extension="996-756-495" root="2.16.840.1.113883.19.5" />
    <code code="ONESELF" displayName="Self" codeSystem="2.16.840.1.113883.5.111"
codeSystemName="HL7 Role code" />
  </assignedEntity>
</authenticator>
```

2.1.3.3 participant

This participant represents the person who reviewed the Care Plan. 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.

8. **SHOULD** contain zero or more [0..*] **participant** (CONF:1098-31677) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="VRF" Verifier (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:1098-31678).
    b. **SHALL** contain exactly one [1..1] **functionCode** (CONF:1098-31679).
        i. This functionCode **SHALL** contain exactly one [1..1] **@code**="425268008" Review of Care Plan (CONF:1098-31680).
        ii. This functionCode **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:1098-31681).
    c. **SHALL** contain exactly one [1..1] **time** (CONF:1098-31682).
    d. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1098-31683).
        i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode**="ASSIGNED" (CodeSystem: RoleClass 2.16.840.1.113883.5.110) (CONF:1098-31686).
        ii. This associatedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-31684).
        iii. This associatedEntity **SHOULD** contain zero or one [0..1] **code** (CONF:1098-31685).
            1. The code, if present, **SHALL** contain exactly one [1..1] **@code** (ValueSet: **Personal And Legal Relationship Role Type** 2.16.840.1.113883.11.20.12.1) (CONF:1098-32367).

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Figure 18: Care Plan Review Example

```
<!-- 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. -->
<!-- This example shows a Care Plan Review that has already taken place -->
<participant typeCode="IND">
  <functionCode code="425268008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED
CT" displayName="Review of Care Plan" />
  <time value="20130801" />
  <associatedEntity classCode="ASSIGNED">
    <id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c" />
  </associatedEntity>
</participant>
```

2.1.3.4 participant

This participant identifies an individual who supports the patient such as a relative or caregiver.

9. **SHOULD** contain zero or more [0..*] **participant** (CONF:1098-31895) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="IND" Indirect (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:1098-31896).
    b. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1098-31897).
        i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode**, which **SHALL** be selected from ValueSet **INDRoleclassCodes** 2.16.840.1.113883.11.20.9.33 **STATIC** 2011-09-30 (CONF:1098-31898).
        ii. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1098-31899).
            1. This associatedPerson **SHALL** contain at least one [1..*] **name** (CONF:1098-31900).

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Figure 19: Care Plan Caregiver participant Example

```
<participant typeCode="IND">
  <functionCode code="407543004" displayName="Primary Carer"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED-CT" />
  <!-- Caregiver -->
  <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>
```

2.1.3.5 documentationOf

serviceEvent

The serviceEvent describes the provision of healthcare over a period of time. The duration over which care was provided is indicated in serviceEvent/effectiveTime. Additional data from outside this duration may also be included if it is relevant to care provided during that time range (e.g., reviewed during the stated time range).

10. **SHALL** contain exactly one [1..1] **documentationOf** (CONF:1098-31901) such that it
    a. **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1098-31902).
        i. This serviceEvent **SHALL** contain exactly one [1..1] **@classCode**="PCPR" Care Provision (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-31903).
        ii. This serviceEvent **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-31904).
            1. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-32330).
            2. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:1098-32331).

2.1.3.6 performer

The performer(s) represents the healthcare providers involved in the current or historical care of the patient. In Care Plan, the patient's key healthcare providers performing and monitoring

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the overall care plan would be listed here, which would include the primary physician and any active consulting physicians, therapists, counselors, and care team members. A care plan may contain multiple plans of care, care providers performing specific plans of care should be represented as performer underneath each plans of care in the document body.

iii. This serviceEvent **SHALL** contain at least one [1..*] **performer** (CONF:1098-31905) such that it

1. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-31907).
   a. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-31908).
   b. This assignedEntity **MAY** contain zero or one [0..1] **code** (CONF:1098-31909).
   c. This assignedEntity **SHALL** contain exactly one [1..1] **assignedPerson** (CONF:1098-32328).
      i. This assignedPerson **SHALL** contain exactly one [1..1] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-32329).

Figure 20: Care Plan performer Example

```
<performer typeCode="PRF">
  <time value="20130715223615-0800" />
  <assignedEntity>
    <id extension="5555555555" root="2.16.840.1.113883.4.6" />
    <code code="59058001" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
displayName="General Physician" />
    <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)-1004" />
    <assignedPerson>
      <name>
        <given>Patricia</given>
        <given qualifier="CL">Patty</given>
        <family>Primary</family>
        <suffix qualifier="AC">M.D.</suffix>
      </name>
    </assignedPerson>
  </assignedEntity>
</performer>
```


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2.1.3.7 relatedDocument

The Care Plan is continually evolving and dynamic. The Care Plan CDA instance is NOT dynamic. Each time a Care Plan CDA is generated it represents a snapshot in time of the Care Plan at that moment. Whenever a care provider or patient generates a Care Plan, it should be noted through relatedDocument whether the current Care Plan replaces or appends another Care Plan. The relatedDocumentTypeCode indicates whether the current document is an addendum to the ParentDocument (APND (append)) or the current document is a replacement of the ParentDocument (RPLC (replace)).

11. **MAY** contain zero or more [0..*] **relatedDocument** (CONF:1098-29893) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**, which **SHALL** be selected from ValueSet **Related Document (append/replace)** 2.16.840.1.113883.11.20.9.62 **STATIC** 2014-09-01 (CONF:1098-31889).
    b. **SHALL** contain exactly one [1..1] **parentDocument** (CONF:1098-29894).
        i. This parentDocument **SHALL** contain exactly one [1..1] **setId** (CONF:1098-29895).
        ii. This parentDocument **SHALL** contain exactly one [1..1] **versionNumber** (CONF:1098-29896).

Figure 21: Care Plan relatedDocument Example

```
<!-- This document is the second in a set - relatedDocument
  describes the parent document-->
<relatedDocument typeCode="RPLC">
  <parentDocument>
    <id root="223769be-f6ee-4b04-a0ce-b56ae998c880" />
    <code code="CarePlan-x" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Care Plan" />
    <setId root="004bb033-b948-4f4c-b5bf-a8dbd7d8dd40" />
    <versionNumber value="1" />
  </parentDocument>
</relatedDocument>
```

2.1.3.8 componentOf

12. **SHOULD** contain zero or one [0..1] **componentOf** (CONF:1098-32004) such that it
    a. **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1098-32005).
        i. This encompassingEncounter **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-32007).

2.1.3.9 component

13. **SHALL** contain exactly one [1..1] **component** (CONF:1098-28753).
    a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1098-28754).
        i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-28755) such that it

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1. **SHALL** contain exactly one [1..1] **Health Concerns Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.58) (CONF:1098-28756).

ii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-28761) such that it

1. **SHALL** contain exactly one [1..1] **Goals Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.60) (CONF:1098-28762).

iii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-28763) such that it

1. **SHALL** contain exactly one [1..1] **Interventions Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2014-06-09) (CONF:1098-28764).

iv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-29596) such that it

1. **SHALL** contain exactly one [1..1] **Health Status Evaluations and Outcomes Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.61) (CONF:1098-29597).

v. This structuredBody **SHALL NOT** contain a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10.2) (CONF:1098-31044).

Table 25: Related Document (append/replace)

Value Set: Related Document (append/replace) 2.16.840.1.113883.11.20.9.62 The Related Document value set is used to constrain a related document to two concepts - append and replace. Specific URL pending Value Set Source: **http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html**			
Code	**Code System**	**Code System OID**	**Print Name**
APND	HL7ActRelationshipType	2.16.840.1.113883.5.1002	Append
RPLC	HL7ActRelationshipType	2.16.840.1.113883.5.1002	Replace

2.1.4 Consultation Note (V2)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.4:2014-06-09 (open)]

Table 26: Consultation Note (V2) Contexts

Contained By:	Contains:
	Advance Directives Section (entries optional) (V2) Allergies and Intolerances Section (entries required)

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Contained By:	Contains:
	(V2) Assessment and Plan Section (V2) Assessment Section Chief Complaint and Reason for Visit Section Chief Complaint Section Family History Section (V2) Functional Status Section (V2) General Status Section History of Past Illness Section (V2) History of Present Illness Section Immunizations Section (entries optional) (V2) Medical Equipment Section (V2) Medications Section (entries required) (V2) Mental Status Section Nutrition Section Physical Exam Section (V2) Plan of Treatment Section (V2) Problem Section (entries required) (V2) Procedures Section (entries optional) (V2) Reason for Visit Section Results Section (entries required) (V2) Review of Systems Section Social History Section (V2) US Realm Date and Time (DT.US.FIELDED) Vital Signs Section (entries required) (V2)

The Consultation Note is generated by a request from a clinician for an opinion or advice from another clinician. Consultations may involve face-to-face time with the patient or may fall under the auspices of telemedicine visits. Consultations may occur while the patient is inpatient or ambulatory. The Consultation Note should also be used to summarize an Emergency Room or Urgent Care encounter.

A Consultation Note includes the reason for the referral, history of present illness, physical examination, and decision-making components (Assessment and Plan).

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Table 27: Consultation Note (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.4:2014-06-09)					
templateId	1..1	SHALL		1098-8375	
@root	1..1	SHALL		1098-10040	2.16.840.1.113883.10.20.22.1.4
@extension	1..1	SHALL		1098-32502	2014-06-09
code	1..1	SHALL		1098-17176	2.16.840.1.113883.11.20.9.31 (ConsultDocumentType)
participant	0..*	SHOULD		1098-31656	
@typeCode	1..1	SHALL		1098-31657	2.16.840.1.113883.5.90 (HL7ParticipationType) = CALLBCK
associatedEntity	1..1	SHALL		1098-31658	
@classCode	1..1	SHALL		1098-31659	2.16.840.1.113883.5.110 (RoleClass) = ASSIGNED
id	1..*	SHALL		1098-31660	
addr	0..*	SHOULD		1098-31661	
telecom	1..*	SHALL		1098-31662	
associatedPerson	1..1	SHALL		1098-31663	
name	1..*	SHALL		1098-31664	
scopingOrganization	0..1	MAY		1098-31665	
inFulfillmentOf	1..*	SHALL		1098-8382	
order	1..1	SHALL		1098-29923	
id	1..*	SHALL		1098-29924	
componentOf	1..1	SHALL		1098-8386	
encompassingEncounter	1..1	SHALL		1098-8387	
id	1..*	SHALL		1098-8388	
effectiveTime	1..1	SHALL		1098-8389	US Realm Date and Time (DT.US.FIELDED) (identifier:

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					urn:oid:2.16.840.1.113883.10.20.22.5.3
responsibleParty	0..1	MAY		1098-8391	
encounterParticipant	0..*	MAY		1098-8392	
component	1..1	SHALL		1098-8397	
structuredBody	1..1	SHALL		1098-28895	
component	0..1	MAY		1098-28896	
section	1..1	SHALL		1098-28897	Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8
component	0..1	MAY		1098-28898	
section	1..1	SHALL		1098-28899	Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09
component	0..1	MAY		1098-28900	
section	1..1	SHALL		1098-28901	Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
component	0..1	MAY		1098-28904	
section	1..1	SHALL		1098-28905	Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12
component	1..1	SHALL		1098-28906	
section	1..1	SHALL		1098-28907	History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4
component	0..1	SHOULD		1098-28908	
section	1..1	SHALL		1098-28909	Physical Exam Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09
component	1..1	SHALL		1098-28910	
section	1..1	SHALL		1098-28911	Allergies and Intolerances Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.2

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					0.22.2.6.1:2014-06-09
component	0..1	MAY		1098-28912	
section	1..1	SHALL		1098-28913	Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1
component	0..1	MAY		1098-28915	
section	1..1	SHALL		1098-28916	Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13
component	0..1	MAY		1098-28917	
section	1..1	SHALL		1098-28918	Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09
component	0..1	MAY		1098-28919	
section	1..1	SHALL		1098-28920	General Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.5
component	0..1	MAY		1098-28921	
section	1..1	SHALL		1098-28922	History of Past Illness Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09
component	0..1	MAY		1098-28923	
section	1..1	SHALL		1098-28924	Immunizations Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09
component	0..1	SHOULD		1098-28925	
section	1..1	SHALL		1098-28926	Medications Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09
component	1..1	SHALL		1098-28928	
section	1..1	SHALL		1098-28929	Problem Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09
component	0..1	MAY		1098-28930	

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section	1..1	SHALL		1098-28931	Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09
component	0..1	SHOULD		1098-28932	
section	1..1	SHALL		1098-28933	Results Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09
component	0..1	MAY		1098-28934	
section	1..1	SHALL		1098-28935	Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09
component	0..1	MAY		1098-28936	
section	1..1	SHALL		1098-28937	Vital Signs Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09
component	0..1	MAY		1098-28942	
section	1..1	SHALL		1098-28943	Advance Directives Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09
component	0..1	MAY		1098-28944	
section	1..1	SHALL		1098-28945	Functional Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09
component	0..1	MAY		1098-30237	
section	1..1	SHALL		1098-30238	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18
component	0..1	MAY		1098-30904	
section	1..1	SHALL		1098-30905	Medical Equipment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09
component	0..1	MAY		1098-30906	
section	1..1	SHALL		1098-30907	Mental Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.

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					22.2.56
component	0..1	MAY		1098-30909	
section	1..1	SHALL		1098-30910	Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57

2.1.5 Properties

1. Conforms to **US Realm Header (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8375) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.4" (CONF:1098-10040).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32502).

The Consultation Note recommends use of the document type code 11488-4 "Consult 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.

3. **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:1098-17176).

2.1.5.1 participant

This participant represents the person to contact for questions about the consult summary. This call back contact individual may be a different person than the individual(s) identified in the author or legalAuthenticator participant.

4. **SHOULD** contain zero or more [0..*] **participant** (CONF:1098-31656) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="CALLBCK" call back contact (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **DYNAMIC**) (CONF:1098-31657).
   b. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1098-31658).
      i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode**="ASSIGNED" assigned entity (CodeSystem: RoleClass 2.16.840.1.113883.5.110 **DYNAMIC**) (CONF:1098-31659).
      ii. This associatedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-31660).
      iii. This associatedEntity **SHOULD** contain zero or more [0..*] **addr** (CONF:1098-31661).
      iv. This associatedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:1098-31662).
      v. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1098-31663).
         1. This associatedPerson **SHALL** contain at least one [1..*] **name** (CONF:1098-31664).

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vi. This associatedEntity **MAY** contain zero or one [0..1] **scopingOrganization** (CONF:1098-31665).

Figure 22: Consultation Note Callback participant Example

```
<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 & 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>
                <suffix>DO</suffix>
            </name>
        </associatedPerson>
    </associatedEntity>
</participant>
```

2.1.5.2 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 consultation that is being reported in the note.

5. **SHALL** contain at least one [1..*] **inFulfillmentOf** (CONF:1098-8382).
    a. Such inFulfillmentOfs **SHALL** contain exactly one [1..1] **order** (CONF:1098-29923).

Where a referral is being fulfilled by this consultation, this id would be the same as the id in the Patient Referral Act template.

i. This order **SHALL** contain at least one [1..*] **id** (CONF:1098-29924).

Figure 23: Consultation Note (V2) 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>
```


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2.1.5.3 componentOf

A Consultation Note is always associated with an encounter; the id element of the encompassingEncounter is required to be present and represents the identifier for the encounter.

6. **SHALL** contain exactly one [1..1] **componentOf** (CONF:1098-8386).
    a. This componentOf **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1098-8387).
        i. This encompassingEncounter **SHALL** contain at least one [1..*] **id** (CONF:1098-8388).
        ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **US Realm Date and Time (DT.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1098-8389).
        iii. This encompassingEncounter **MAY** contain zero or one [0..1] **responsibleParty** (CONF:1098-8391).

The responsibleParty element records only the party responsible for the encounter, not necessarily the entire episode of care.

1. The responsibleParty element, if present, **SHALL** contain an assignedEntity element which **SHALL** contain an assignedPerson element, a representedOrganization element, or both (CONF:1098-8394).

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

iv. This encompassingEncounter **MAY** contain zero or more [0..*] **encounterParticipant** (CONF:1098-8392).
Note: If present, SHALL contain an assignedEntity element which SHALL contain an assignedPerson element, a representedOrganization element, or both.

2.1.5.4 component

7. **SHALL** contain exactly one [1..1] **component** (CONF:1098-8397).
    a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1098-28895).
        i. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28896) such that it
            1. **SHALL** contain exactly one [1..1] **Assessment Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1098-28897).
        ii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28898) such that it
            1. **SHALL** contain exactly one [1..1] **Assessment and Plan Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1098-28899).

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iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28900) such that it
    1. **SHALL** contain exactly one [1..1] **Plan of Treatment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-28901).

iv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28904) such that it
    1. **SHALL** contain exactly one [1..1] **Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:1098-28905).

v. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-28906) such that it
    1. **SHALL** contain exactly one [1..1] **History of Present Illness Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1098-28907).

vi. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-28908) such that it
    1. **SHALL** contain exactly one [1..1] **Physical Exam Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09) (CONF:1098-28909).

vii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-28910) such that it
    1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09) (CONF:1098-28911).

viii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28912) such that it
    1. **SHALL** contain exactly one [1..1] **Chief Complaint Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1098-28913).

ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28915) such that it
    1. **SHALL** contain exactly one [1..1] **Chief Complaint and Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:1098-28916).

x. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28917) such that it
    1. **SHALL** contain exactly one [1..1] **Family History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-28918).

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xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28919) such that it

1. **SHALL** contain exactly one [1..1] **General Status Section** (identifier: urn:oid:2.16.840.1.113883.10.20.2.5) (CONF:1098-28920).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28921) such that it

1. **SHALL** contain exactly one [1..1] **History of Past Illness Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09) (CONF:1098-28922).

xiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28923) such that it

1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09) (CONF:1098-28924).

xiv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-28925) such that it

1. **SHALL** contain exactly one [1..1] **Medications Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09) (CONF:1098-28926).

xv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-28928) such that it

1. **SHALL** contain exactly one [1..1] **Problem Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09) (CONF:1098-28929).

xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28930) such that it

1. **SHALL** contain exactly one [1..1] **Procedures Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09) (CONF:1098-28931).

xvii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-28932) such that it

1. **SHALL** contain exactly one [1..1] **Results Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09) (CONF:1098-28933).

xviii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28934) such that it

1. **SHALL** contain exactly one [1..1] **Social History Section (V2)** (identifier:

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urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-28935).

xix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28936) such that it

1. **SHALL** contain exactly one [1..1] **Vital Signs Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09) (CONF:1098-28937).

xx. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28942) such that it

1. **SHALL** contain exactly one [1..1] **Advance Directives Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09) (CONF:1098-28943).

xxi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28944) such that it

1. **SHALL** contain exactly one [1..1] **Functional Status Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09) (CONF:1098-28945).

xxii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30237) such that it

1. **SHALL** contain exactly one [1..1] **Review of Systems Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-30238).

xxiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30904) such that it

1. **SHALL** contain exactly one [1..1] **Medical Equipment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09) (CONF:1098-30905).

xxiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30906) such that it

1. **SHALL** contain exactly one [1..1] **Mental Status Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.56) (CONF:1098-30907).

xxv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30909) such that it

1. **SHALL** contain exactly one [1..1] **Nutrition Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1098-30910).

xxvi. This structuredBody **MAY** contain either an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09), or an Assessment Section (2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-28938).

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xxvii. This structuredBody **SHALL NOT** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1098-28939).

xxviii. This structuredBody **SHALL NOT** contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) is present (CONF:1098-28940).

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Figure 24: Consultation Note structuredBody Example

```
<component>
    <structuredBody>
        <component>
            <section>
                <templateId root="2.16.840.1.113883.10.20.22.2.6.1"
                    extension="2014-06-09" />
                <!-- Allergies 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" extension="2014-06-09"
/>
                <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" extension="2014-06-09" />
                <!-- 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>
```


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```
        <component>
            <section>
                <templateId root="2.16.840.1.113883.10.20.22.2.10"
                    extension="2014-06-09" />
                <!--  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" extension="2014-06-09"
/>
                <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"
                    extension="2014-06-09" />
                <!-- 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"
                    extension="2014-06-09" />
                <!-- 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" extension="2014-06-09"
/>
                <!-- 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>
```


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```
                <templateId root="2.16.840.1.113883.10.20.22.2.17" extension="2014-06-09"
/>
                <!-- 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" extension="2014-06-09"
/>
                <!-- 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>
```

Table 28: ConsultDocumentType

Value Set: ConsultDocumentType 2.16.840.1.113883.11.20.9.31 Specific URL Pending Value Set Source: http://www.loinc.org/			
Code	**Code System**	**Code System OID**	**Print Name**
11488-4	LOINC	2.16.840.1.113883.6.1	Consult note
34099-2	LOINC	2.16.840.1.113883.6.1	Cardiology Consult note
34756-7	LOINC	2.16.840.1.113883.6.1	Dentistry Consult note
34758-3	LOINC	2.16.840.1.113883.6.1	Dermatology Consult note
34760-9	LOINC	2.16.840.1.113883.6.1	Diabetology Consult note
34879-7	LOINC	2.16.840.1.113883.6.1	Endocrinology Consult note
34761-7	LOINC	2.16.840.1.113883.6.1	Gastroenterology Consult note
34764-1	LOINC	2.16.840.1.113883.6.1	General medicine Consult note
34776-5	LOINC	2.16.840.1.113883.6.1	Gerontology Consult note
34779-9	LOINC	2.16.840.1.113883.6.1	Hematology + Medical Oncology Consult note
…			

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2.1.6 Continuity of Care Document (CCD) (V2)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.2:2014-06-09 (open)]

Table 29: Continuity of Care Document (CCD) (V2) Contexts

Contained By:	Contains:
	Advance Directives Section (entries optional) (V2) Allergies and Intolerances Section (entries required) (V2) Encounters Section (entries optional) (V2) Family History Section (V2) Functional Status Section (V2) Immunizations Section (entries required) (V2) Medical Equipment Section (V2) Medications Section (entries required) (V2) Mental Status Section Nutrition Section Payers Section (V2) Plan of Treatment Section (V2) Problem Section (entries required) (V2) Procedures Section (entries required) (V2) Results Section (entries required) (V2) Social History Section (V2) Vital Signs Section (entries required) (V2)

This document type was originally based on the Continuity of Care Document (CCD) Release 1.1 which itself was derived from HITSP C32 and CCD Release 1.0.

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. The key characteristic of a CCD is that the ServiceEvent is constrained to "PCPR". This means it does not function to report new ServiceEvents associated with performing care. It reports on care that has already been provided. The CCD provides a historical tally of the care over a range of time and is not a record of new services delivered.

More specific use cases, such as a Discharge Summary, Transfer Summary, Referral Note, Consultation Note, or Progress Note, are available as alternative documents in this guide.

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Table 30: Continuity of Care Document (CCD) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.2:2014-06-09)					
templateId	1..1	SHALL		1098-8450	
@root	1..1	SHALL		1098-10038	2.16.840.1.113883.10.20.22.1.2
@extension	1..1	SHALL		1098-32516	2014-06-09
code	1..1	SHALL		1098-17180	
@code	1..1	SHALL		1098-17181	34133-9
@codeSystem	1..1	SHALL		1098-32138	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
author	1..*	SHALL		1098-9442	
assignedAuthor	1..1	SHALL		1098-9443	
documentationOf	1..1	SHALL		1098-8452	
serviceEvent	1..1	SHALL		1098-8480	
@classCode	1..1	SHALL		1098-8453	2.16.840.1.113883.5.6 (HL7ActClass) = PCPR
effectiveTime	1..1	SHALL		1098-8481	
low	1..1	SHALL		1098-8454	
high	1..1	SHALL		1098-8455	
performer	0..*	SHOULD		1098-8482	
@typeCode	1..1	SHALL		1098-8458	2.16.840.1.113883.5.90 (HL7ParticipationType) = PRF
assignedEntity	0..1	MAY		1098-8459	
id	1..1	SHALL		1098-30882	
assignedPerson	0..1	MAY		1098-32467	
component	1..1	SHALL		1098-30659	
structuredBody	1..1	SHALL		1098-30660	

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component	1..1	SHALL		1098-30661	
section	1..1	SHALL		1098-30662	Allergies and Intolerances Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09
component	1..1	SHALL		1098-30663	
section	1..1	SHALL		1098-30664	Medications Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09
component	1..1	SHALL		1098-30665	
section	1..1	SHALL		1098-30666	Problem Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09
component	0..1	SHOULD		1098-30667	
section	1..1	SHALL		1098-30668	Procedures Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7.1:2014-06-09
component	1..1	SHALL		1098-30669	
section	1..1	SHALL		1098-30670	Results Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09
component	0..1	MAY		1098-30671	
section	1..1	SHALL		1098-30672	Advance Directives Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09
component	0..1	MAY		1098-30673	
section	1..1	SHALL		1098-30674	Encounters Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.22:2014-06-09
component	0..1	MAY		1098-30675	
section	1..1	SHALL		1098-30676	Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09
component	0..1	MAY		1098-30677	

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section	1..1	SHALL		1098-30678	Functional Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09
component	0..1	MAY		1098-30679	
section	1..1	SHALL		1098-30680	Immunizations Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2014-06-09
component	0..1	MAY		1098-30681	
section	1..1	SHALL		1098-30682	Medical Equipment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09
component	0..1	MAY		1098-30683	
section	1..1	SHALL		1098-30684	Payers Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.18:2014-06-09
component	0..1	SHOULD		1098-30685	
section	1..1	SHALL		1098-30686	Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
component	1..1	SHALL		1098-30687	
section	1..1	SHALL		1098-30688	Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09
component	1..1	SHALL		1098-30689	
section	1..1	SHALL		1098-30690	Vital Signs Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09
component	0..1	MAY		1098-32143	
section	1..1	SHALL		1098-32144	Mental Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.56
component	0..1	MAY		1098-32624	
section	1..1	SHALL		1098-32625	Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57

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2.1.7 Properties

1. Conforms to **US Realm Header (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8450) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.2" (CONF:1098-10038).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32516).
3. **SHALL** contain exactly one [1..1] **code** (CONF:1098-17180).
   a. This code **SHALL** contain exactly one [1..1] **@code**="34133-9" Summarization of Episode Note (CONF:1098-17181).
   b. 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:1098-32138).

2.1.7.1 author

4. **SHALL** contain at least one [1..*] **author** (CONF:1098-9442).
   a. Such authors **SHALL** contain exactly one [1..1] **assignedAuthor** (CONF:1098-9443).
      i. Such assignedAuthors **SHALL** contain exactly one [1..1] assignedPerson and/or exactly one [1..1] representedOrganization (CONF:1098-8456).
      ii. 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:1098-8457).

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Figure 25: CCD (V2) 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="Healthcare Provider Taxonomy" />
        <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>
```

2.1.7.2 documentationOf

The documentationOf relationship in a Continuity Care Document contains the representation of providers who are wholly or partially responsible for the safety and well-being of a subject of care.

5. **SHALL** contain exactly one [1..1] **documentationOf** (CONF:1098-8452).

The main activity being described by a CCD is the provision of healthcare over a period of time. This is shown by setting the value of serviceEvent/@classCode to “PCPR” (care provision) and indicating the duration over which care was provided in serviceEvent/effectiveTime. Additional data from outside this duration may also be included if it is relevant to care provided during that time range (e.g., reviewed during the stated time range).

NOTE: Implementations originating a CCD should take care to discover what the episode of care being summarized is. For example, when a patient fills out a form providing relevant health history, the episode of care being documented might be from birth to the present.

a. This documentationOf **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1098-8480).
    i. This serviceEvent **SHALL** contain exactly one [1..1] **@classCode**="PCPR" Care Provision (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8453).
    ii. This serviceEvent **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-8481).

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1. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-8454).
2. This effectiveTime **SHALL** contain exactly one [1..1] **high** (CONF:1098-8455).

2.1.7.3 performer

The 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.

iii. This serviceEvent **SHOULD** contain zero or more [0..*] **performer** (CONF:1098-8482).
   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:1098-8458).
   2. The performer, if present, **MAY** contain zero or one [0..1] **assignedEntity** (CONF:1098-8459).
      a. The assignedEntity, if present, **SHALL** contain exactly one [1..1] **id** (CONF:1098-30882) such that it
         i. If this assignedEntity is an assignedPerson, the assignedEntity **SHOULD** contain zero or one [0..1] id such that it (CONF:1098-32466).
            1. **SHALL** contain exactly one [1..1] **@root="2.16.840.1.113883.4.6"** National Provider Identifier (CONF:1098-32484).
      b. The assignedEntity, if present, **MAY** contain zero or one [0..1] **assignedPerson** (CONF:1098-32467).

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Figure 26: CCD (V2) Performer Example

```
<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>
            ...
        </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>
           ...
        </representedOrganization>
    </assignedEntity>
</performer>
```

Figure 27: CCD (V2) serviceEvent 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">
           ....
        </performer>
    </serviceEvent>
</documentationOf>
```

2.1.7.4 component

6. **SHALL** contain exactly one [1..1] **component** (CONF:1098-30659).

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a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1098-30660).
   i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30661) such that it
      1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09) (CONF:1098-30662).
   ii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30663) such that it
      1. **SHALL** contain exactly one [1..1] **Medications Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09) (CONF:1098-30664).
   iii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30665) such that it
      1. **SHALL** contain exactly one [1..1] **Problem Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09) (CONF:1098-30666).
   iv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-30667) such that it
      1. **SHALL** contain exactly one [1..1] **Procedures Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7.1:2014-06-09) (CONF:1098-30668).
   v. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30669) such that it
      1. **SHALL** contain exactly one [1..1] **Results Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09) (CONF:1098-30670).
   vi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30671) such that it
      1. **SHALL** contain exactly one [1..1] **Advance Directives Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09) (CONF:1098-30672).
   vii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30673) such that it
      1. **SHALL** contain exactly one [1..1] **Encounters Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.22:2014-06-09) (CONF:1098-30674).
   viii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30675) such that it

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1. **SHALL** contain exactly one [1..1] **Family History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-30676).

ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30677) such that it

1. **SHALL** contain exactly one [1..1] **Functional Status Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09) (CONF:1098-30678).

x. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30679) such that it

1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2014-06-09) (CONF:1098-30680).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30681) such that it

1. **SHALL** contain exactly one [1..1] **Medical Equipment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09) (CONF:1098-30682).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30683) such that it

1. **SHALL** contain exactly one [1..1] **Payers Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.18:2014-06-09) (CONF:1098-30684).

xiii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-30685) such that it

1. **SHALL** contain exactly one [1..1] **Plan of Treatment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30686).

xiv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30687) such that it

1. **SHALL** contain exactly one [1..1] **Social History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-30688).

xv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30689) such that it

1. **SHALL** contain exactly one [1..1] **Vital Signs Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09) (CONF:1098-30690).

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xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-32143) such that it

1. **SHALL** contain exactly one [1..1] **Mental Status Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.56) (CONF:1098-32144).

xvii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-32624) such that it

1. **SHALL** contain exactly one [1..1] **Nutrition Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1098-32625).

2.1.8 Diagnostic Imaging Report (V2)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.5:2014-06-09 (open)]

Table 31: Diagnostic Imaging Report (V2) Contexts

Contained By:	Contains:
	Code Observations DICOM Object Catalog Section - DCM 121181 Fetus Subject Context Findings Section (DIR) Observer Context Physician of Record Participant (V2) Physician Reading Study Performer (V2) Procedure Context Quantity Measurement Observation SOP Instance Observation Text Observation US Realm Date and Time (DT.US.FIELDED) US Realm Person Name (PN.US.FIELDED)

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.

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Table 32: Diagnostic Imaging Report (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.5:2014-06-09)					
templateId	1..1	SHALL		1098-8404	
@root	1..1	SHALL		1098-10042	2.16.840.1.113883.10.20.22.1.5
@extension	1..1	SHALL		1098-32515	2014-06-09
id	1..1	SHALL		1098-30932	
@root	1..1	SHALL		1098-30933	
code	1..1	SHALL		1098-14833	
@code	1..1	SHALL		1098-14834	1.3.6.1.4.1.12009.10.2.5 (LOINC Imaging Document Codes)
informant	0..0	SHALL NOT		1098-8410	
informationRecipient	0..*	MAY		1098-8411	
participant	0..1	MAY		1098-8414	
associatedEntity	1..1	SHALL		1098-31198	
associatedPerson	1..1	SHALL		1098-31199	
name	1..1	SHALL		1098-31200	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
inFulfillmentOf	0..*	MAY		1098-30936	
order	1..1	SHALL		1098-30937	
id	1..*	SHALL		1098-30938	
documentationOf	1..1	SHALL		1098-8416	
serviceEvent	1..1	SHALL		1098-8431	
@classCode	1..1	SHALL		1098-8430	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
id	0..*	SHOULD		1098-8418	
code	1..1	SHALL		1098-	

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				8419	
performer	0..*	SHOULD		1098-8422	Physician Reading Study Performer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.1:2014-06-09
relatedDocument	0..1	MAY		1098-8432	
parentDocument	1..1	SHALL		1098-32089	
id	1..1	SHALL		1098-32090	
componentOf	0..1	MAY		1098-30939	
encompassingEncounter	1..1	SHALL		1098-30940	
id	1..*	SHALL		1098-30941	
effectiveTime	1..1	SHALL		1098-30943	US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3
responsibleParty	0..1	MAY		1098-30945	
assignedEntity	1..1	SHALL		1098-30946	
encounterParticipant	0..1	SHOULD		1098-30948	Physician of Record Participant (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.2:2014-06-09
component	1..1	SHALL		1098-14907	
structuredBody	1..1	SHALL		1098-30695	
component	1..1	SHALL		1098-30696	
section	1..1	SHALL		1098-30697	Findings Section (DIR) (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.2
component	0..1	SHOULD		1098-30698	
section	1..1	SHALL		1098-30699	DICOM Object Catalog Section - DCM 121181 (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.1
component	0..*	MAY		1098-31055	
section	1..1	SHALL		1098-31056	
code	1..1	SHALL		1098-	

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				31057	
@code	1..1	SHALL		1098-31207	2.16.840.1.113883.11.20.9.59 (DIRSectionTypeCodes)
title	0..1	SHOULD		1098-31058	
text	0..1	SHOULD		1098-31059	
subject	0..*	MAY		1098-31215	
relatedSubject	1..1	SHALL		1098-31216	Fetus Subject Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.3
author	0..*	MAY		1098-31217	
assignedAuthor	1..1	SHALL		1098-31218	Observer Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.4
entry	0..*	MAY		1098-31213	
act	1..1	SHALL		1098-31214	Procedure Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.5
entry	0..*	MAY		1098-31357	
observation	1..1	SHALL		1098-31358	Text Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.12
entry	0..*	MAY		1098-31359	
observation	1..1	SHALL		1098-31360	Code Observations (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.13
entry	0..*	MAY		1098-31361	
observation	1..1	SHALL		1098-31362	Quantity Measurement Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.14
entry	0..*	MAY		1098-31363	
observation	1..1	SHALL		1098-31364	SOP Instance Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8
component	0..*	MAY		1098-31208	

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2.1.9 Properties

1. Conforms to **US Realm Header (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8404) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.5" (CONF:1098-10042).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32515).
3. **SHALL** contain exactly one [1..1] **id** (CONF:1098-30932).
   a. This id **SHALL** contain exactly one [1..1] **@root** (CONF:1098-30933).

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 of the regular expression: (0-2])(.(1-9]0-9]*|0))+

   i. The ClinicalDocument/id/@root attribute **SHALL** be a syntactically correct OID, and **SHALL NOT** be a UUID (CONF:1098-30934).
   ii. OIDs **SHALL** be no more than 64 characters in length (CONF:1098-30935).

Preferred code is 18748-4 LOINC Diagnostic Imaging Report

4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-14833).
   a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHOULD** be selected from ValueSet **LOINC Imaging Document Codes** 1.3.6.1.4.1.12009.10.2.5 **DYNAMIC** (CONF:1098-14834).
5. **SHALL NOT** contain [0..0] **informant** (CONF:1098-8410).

2.1.9.1 informationRecipient

6. **MAY** contain zero or more [0..*] **informationRecipient** (CONF:1098-8411).
   a. The physician requesting the imaging procedure (ClinicalDocument/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:1098-8412).
   b. 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:1098-8413).

2.1.9.2 participant

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).

7. **MAY** contain zero or one [0..1] **participant** (CONF:1098-8414) such that it
   a. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1098-31198).

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i. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1098-31199).

1. This associatedPerson **SHALL** contain exactly one [1..1] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-31200).

Figure 28: DIR Participant Example

```
<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>
```

2.1.9.3 inFulfillmentOf

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.

8. **MAY** contain zero or more [0..*] **inFulfillmentOf** (CONF:1098-30936).
   a. The inFulfillmentOf, if present, **SHALL** contain exactly one [1..1] **order** (CONF:1098-30937).
      i. This order **SHALL** contain at least one [1..*] **id** (CONF:1098-30938).
      Note: DICOM Accession Number in the DICOM imaging and report data

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Figure 29: DIR inFulfillmentOf Example

```
<inFulfillmentOf>
    <order>
      <id extension="10523475" root="2.16.840.1.113883.19.4.27" />
      <!--  {root}.27= accession number list *-->
    </order>
</inFulfillmentOf>
```

2.1.9.4 documentationOf

Each 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, serviceEvent/id is the ID of the Requested Procedure.

9. **SHALL** contain exactly one [1..1] **documentationOf** (CONF:1098-8416) such that it
    a. **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1098-8431) such that it
        i. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8430).
        ii. **SHOULD** contain zero or more [0..*] **id** (CONF:1098-8418).
        iii. **SHALL** contain exactly one [1..1] **code** (CONF:1098-8419).
            1. The value of serviceEvent/code **SHALL NOT** conflict with the CliniicalDocument/code. When transforming from DICOM SR documents that do not contain a procedure code, an appropriate nullFlavor **SHALL** be used on serviceEvent/code (CONF:1098-8420).
        iv. **SHOULD** contain zero or more [0..*] **Physician Reading Study Performer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.1:2014-06-09) (CONF:1098-8422).

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Figure 30: Physician of Reading Study Performer Example

```
<performer typeCode="PRF">
  <templateId root="2.16.840.1.113883.10.20.6.2.1" />
  <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>
```

Figure 31: DIR documentationOf/serviceEvent Example

```
<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" />
    <!-- DICOM Requested Procedure ID -->
    <code code="71020"
          displayName="Radiologic examination, chest, two views, frontal and lateral"
          codeSystem="2.16.840.1.113883.6.12"
          codeSystemName="CPT4" />
    <effectiveTime value="20060823222400" />
    <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>
```


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2.1.9.5 relatedDocument

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.

10. **MAY** contain zero or one [0..1] **relatedDocument** (CONF:1098-8432).
    a. The relatedDocument, if present, **SHALL** contain exactly one [1..1] **parentDocument** (CONF:1098-32089).
        i. This parentDocument **SHALL** contain exactly one [1..1] **id** (CONF:1098-32090).
            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 of the regular expression: ([0-2])(.([1-9][0-9]*|0))+ (CONF:1098-10031).
            2. OIDs **SHALL** be no more than 64 characters in length (CONF:1098-10032).
    b. 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:1098-8433).

Figure 32: DIR relatedDocument Example

```
<!-- 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>
```

2.1.9.6 componentOf

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

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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.

11. **MAY** contain zero or one [0..1] **componentOf** (CONF:1098-30939).

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.

a. The componentOf, if present, **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1098-30940).
    i. This encompassingEncounter **SHALL** contain at least one [1..*] **id** (CONF:1098-30941).
        1. In the case of transformed DICOM SR documents, an appropriate null flavor **MAY** be used if the id is unavailable (CONF:1098-30942).
    ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **US Realm Date and Time (DT.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1098-30943).
    iii. This encompassingEncounter **MAY** contain zero or one [0..1] **responsibleParty** (CONF:1098-30945).
        1. The responsibleParty, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-30946).
            a. **SHOULD** contain zero or one [0..1] assignedPerson **OR** contain zero or one [0..1] representedOrganization (CONF:1098-30947).
    iv. This encompassingEncounter **SHOULD** contain zero or one [0..1] **Physician of Record Participant (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.2:2014-06-09) (CONF:1098-30948).

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Figure 33: DIR componentOf Example

```
<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="4" root="2.16.840.1.113883.19" />
        <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>
```

2.1.9.7 component

12. **SHALL** contain exactly one [1..1] **component** (CONF:1098-14907).
    a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1098-30695).
        i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30696) such that it
            1. **SHALL** contain exactly one [1..1] **Findings Section (DIR)** (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.2) (CONF:1098-30697).
        ii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-30698) such that it
            1. **SHALL** contain exactly one [1..1] **DICOM Object Catalog Section - DCM 121181** (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.1) (CONF:1098-30699).
                a. 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:1098-31206).
        iii. This structuredBody **MAY** contain zero or more [0..*] **component** (CONF:1098-31055) such that it
            1. **SHALL** contain exactly one [1..1] **section** (CONF:1098-31056).
                a. This section **SHALL** contain exactly one [1..1] **code** (CONF:1098-31057).

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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

i. 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:1098-31207).
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.

b. This section **SHOULD** contain zero or one [0..1] **title** (CONF:1098-31058).

c. This section **SHOULD** contain zero or one [0..1] **text** (CONF:1098-31059).

i. If clinical statements are present, the section/text **SHALL** represent faithfully all such statements and **MAY** contain additional text (CONF:1098-31060).

ii. All text elements **SHALL** contain content. Text elements **SHALL** contain PCDATA or child elements (CONF:1098-31061).

iii. 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:1098-31062).

Figure 34: WADO Reference Using linkHtml Example

```
<text>
  ...
  <paragraph>
    <caption>Source of Measurement</caption>
    <linkHtml
href="http://www.example.org/wado?requestType=WADO&studyUID=1.2.840.113619.2.62.99404478552
8.114289542805&seriesUID=1.2.840.113619.2.62.994044785528.20060823223142485051&objectUID=1.
2.840.113619.2.62.994044785528.20060823.200608232232322.3&contentType=application/dicom">Ch
est_PA</linkHtml>
  </paragraph>
  ...
</text>
```

d. This section **MAY** contain zero or more [0..*] **subject** (CONF:1098-31215) such that it

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i. **SHALL** contain exactly one [1..1] **Fetus Subject Context** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.3) (CONF:1098-31216).

Figure 35: Fetus Subject Context Example

```
<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>
```

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

e. This section **MAY** contain zero or more [0..*] **author** (CONF:1098-31217) such that it
   i. **SHALL** contain exactly one [1..1] **Observer Context** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.4) (CONF:1098-31218).

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

f. This section **MAY** contain zero or more [0..*] **entry** (CONF:1098-31213) such that it
   i. **SHALL** contain exactly one [1..1] **Procedure Context** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.5) (CONF:1098-31214).
g. This section **MAY** contain zero or more [0..*] **entry** (CONF:1098-31357) such that it
   i. **SHALL** contain exactly one [1..1] **Text Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.12) (CONF:1098-31358).
h. This section **MAY** contain zero or more [0..*] **entry** (CONF:1098-31359) such that it
   i. **SHALL** contain exactly one [1..1] **Code Observations** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.13) (CONF:1098-31360).

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i. This section **MAY** contain zero or more [0..*] **entry** (CONF:1098-31361) such that it
   i. **SHALL** contain exactly one [1..1] **Quantity Measurement Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.14) (CONF:1098-31362).

j. This section **MAY** contain zero or more [0..*] **entry** (CONF:1098-31363) such that it
   i. **SHALL** contain exactly one [1..1] **SOP Instance Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8) (CONF:1098-31364).

k. This section **MAY** contain zero or more [0..*] **component** (CONF:1098-31208).
   i. **SHALL** contain child elements (CONF:1098-31210).

l. All sections defined in the DIR Section Type Codes table **SHALL** be top-level sections (CONF:1098-31211).

m. **SHALL** contain at least one text element or one or more component elements (CONF:1098-31212).

Table 33: 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.

Value Set Source: **http://www.loinc.org/**

Code	Code System	Code System OID	Print Name
121181	DCM	1.2.840.10008.2.16.4	DICOM Object Catalog
121060	DCM	1.2.840.10008.2.16.4	History
121062	DCM	1.2.840.10008.2.16.4	Request
121064	DCM	1.2.840.10008.2.16.4	Current Procedure Descriptions
121066	DCM	1.2.840.10008.2.16.4	Prior Procedure Descriptions
121068	DCM	1.2.840.10008.2.16.4	Previous Findings
121070	DCM	1.2.840.10008.2.16.4	Findings (DIR)
121072	DCM	1.2.840.10008.2.16.4	Impressions
121074	DCM	1.2.840.10008.2.16.4	Recommendations
121076	DCM	1.2.840.10008.2.16.4	Conclusions
…			

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Table 34: LOINC Imaging Document Codes

Value Set: LOINC Imaging Document Codes 1.3.6.1.4.1.12009.10.2.5 Value Set Source: http://search.loinc.org			
Code	**Code System**	**Code System OID**	**Print Name**
24754-4	LOINC	2.16.840.1.113883.6.1	Administration of vasodilator into catheter of Vein
26376-4	LOINC	2.16.840.1.113883.6.1	Administration of vasodilator into catheter of Vein - bilateral
26377-2	LOINC	2.16.840.1.113883.6.1	Administration of vasodilator into catheter of Vein - left
26378-0	LOINC	2.16.840.1.113883.6.1	Administration of vasodilator into catheter of Vein - right
30649-8	LOINC	2.16.840.1.113883.6.1	Peripheral artery Fluoroscopic angiogram Additional angioplasty W contrast IA
30641-5	LOINC	2.16.840.1.113883.6.1	Vein Fluoroscopic angiogram Additional angioplasty W contrast IV
36760-7	LOINC	2.16.840.1.113883.6.1	AV shunt Fluoroscopic angiogram Angioplasty W contrast
36762-3	LOINC	2.16.840.1.113883.6.1	Extremity vessel Fluoroscopic angiogram Angioplasty W contrast
69067-7	LOINC	2.16.840.1.113883.6.1	Unspecified body region Fluoroscopic angiogram Angioplasty W contrast
24543-1	LOINC	2.16.840.1.113883.6.1	Aorta Fluoroscopic angiogram Angioplasty W contrast IA
…			

2.1.10 Discharge Summary (V2)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.8:2014-06-09 (open)]`

Table 35: Discharge Summary (V2) Contexts

Contained By:	**Contains:**
	Admission Diagnosis Section (V2) Admission Medications Section (entries optional) (V2) Allergies and Intolerances Section (entries optional)

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Contained By:	Contains:
	(V2) Chief Complaint and Reason for Visit Section Chief Complaint Section Discharge Diagnosis Section (V2) Discharge Diet Section (DEPRECATED) Discharge Medications Section (entries optional) (V2) Discharge Medications Section (entries required) (V2) Family History Section (V2) Functional Status Section (V2) History of Past Illness Section (V2) History of Present Illness Section Hospital Consultations Section Hospital Course Section Hospital Discharge Instructions Section Hospital Discharge Physical Section Hospital Discharge Studies Summary Section Immunizations Section (entries optional) (V2) Nutrition Section Plan of Treatment Section (V2) Problem Section (entries optional) (V2) Procedures Section (entries optional) (V2) Reason for Visit Section Review of Systems Section Social History Section (V2) Vital Signs Section (entries optional) (V2)

The Discharge Summary is a document which synopsizes a patient's admission to a hospital, LTPAC provider, or other setting. It provides information for the continuation of care following discharge. The Joint Commission requires the following information to be included in the Discharge Summary (http://www.jointcommission.org/):

- The reason for hospitalization (the admission)
- The procedures performed, as applicable
- 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 best practice for a Discharge Summary is to include the discharge disposition in the display of the header.

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Table 36: Discharge Summary (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.8:2014-06-09)					
templateId	1..1	SHALL		1098-8463	
@root	1..1	SHALL		1098-10044	2.16.840.1.113883.10.20.22.1.8
@extension	1..1	SHALL		1098-32517	2014-06-09
code	1..1	SHALL		1098-17178	
@code	1..1	SHALL		1098-17179	2.16.840.1.113883.11.20.4.1 (DischargeSummaryDocumentTypeCode)
participant	0..*	MAY		1098-8467	
componentOf	1..1	SHALL		1098-8471	
encompassingEncounter	1..1	SHALL		1098-8472	
effectiveTime	1..1	SHALL		1098-32611	
low	1..1	SHALL		1098-8473	
high	1..1	SHALL		1098-8475	
dischargeDispositionCode	1..1	SHALL		1098-8476	2.16.840.1.113883.3.88.12.80.33 (NUBC UB-04 FL17 Patient Status)
responsibleParty	0..1	MAY		1098-8479	
assignedEntity	1..1	SHALL		1098-32613	
assignedPerson	0..1	SHOULD		1098-32619	
representedOrganization	0..1	SHOULD		1098-32620	
encounterParticipant	0..*	MAY		1098-8478	
assignedEntity	1..1	SHALL		1098-32615	
assignedPerson	0..1	SHOULD		1098-32621	
representedOrganization	0..1	SHOULD		1098-32622	
component	1..1	SHALL		1098-	

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				9539	
structuredBody	1..1	SHALL		1098-30518	
component	1..1	SHALL		1098-30519	
section	1..1	SHALL		1098-30520	Allergies and Intolerances Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09
component	1..1	SHALL		1098-30521	
section	1..1	SHALL		1098-30522	Hospital Course Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.5
component	1..1	SHALL		1098-30523	
section	1..1	SHALL		1098-30524	Discharge Diagnosis Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2014-06-09
component	0..1	SHOULD		1098-30525	
section	1..1	SHALL		1098-30526	Discharge Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2014-06-09
component	1..1	SHALL		1098-30527	
section	1..1	SHALL		1098-30528	Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
component	0..1	MAY		1098-30529	
section	1..1	SHALL		1098-30530	Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1
component	0..1	MAY		1098-30531	
section	1..1	SHALL		1098-30532	Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13
component	0..1	MAY		1098-30533	
section	1..1	SHALL		1098-30534	Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57

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component	0..1	MAY		1098-30535	
section	1..1	SHALL		1098-30536	Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09
component	0..1	MAY		1098-30537	
section	1..1	SHALL		1098-30538	Functional Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09
component	0..1	MAY		1098-30539	
section	1..1	SHALL		1098-30540	History of Past Illness Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09
component	0..1	MAY		1098-30541	
section	1..1	SHALL		1098-30542	History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4
component	0..1	MAY		1098-30543	
section	1..1	SHALL		1098-30544	Admission Diagnosis Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2014-06-09
component	0..1	MAY		1098-30545	
section	1..1	SHALL		1098-30546	Admission Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2014-06-09
component	0..1	MAY		1098-30547	
section	1..1	SHALL		1098-30548	Hospital Consultations Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.42
component	0..1	MAY		1098-30549	
section	1..1	SHALL		1098-30550	Hospital Discharge Instructions Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.41
component	0..1	MAY		1098-30551	

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section	1..1	SHALL		1098-30552	Hospital Discharge Physical Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.26
component	0..1	MAY		1098-30553	
section	1..1	SHALL		1098-30554	Hospital Discharge Studies Summary Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.16
component	0..1	MAY		1098-30555	
section	1..1	SHALL		1098-30556	Immunizations Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09
component	0..1	MAY		1098-30557	
section	1..1	SHALL		1098-30558	Problem Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09
component	0..1	MAY		1098-30559	
section	1..1	SHALL		1098-30560	Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09
component	0..1	MAY		1098-30561	
section	1..1	SHALL		1098-30562	Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12
component	0..1	MAY		1098-30563	
section	1..1	SHALL		1098-30564	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18
component	0..1	MAY		1098-30565	
section	1..1	SHALL		1098-30566	Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09
component	0..1	MAY		1098-30567	
section	1..1	SHALL		1098-30568	Vital Signs Section (entries optional) (V2) (identifier:

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					urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09
component	0..1	MAY		1098-31586	
section	1..1	SHALL		1098-31587	Discharge Medications Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11.1:2014-06-09
component	0..1	MAY		1098-32790	
section	1..1	SHALL		1098-32791	Discharge Diet Section (DEPRECATED) (identifier: urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.33:2014-06-09

2.1.11 Properties

1. Conforms to **US Realm Header (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8463) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.8" (CONF:1098-10044).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32517).

The Discharge Summary recommends use of a single document type code, 18842-5 "Discharge summary", 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.

3. **SHALL** contain exactly one [1..1] **code** (CONF:1098-17178).
   a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **DischargeSummaryDocumentTypeCode** 2.16.840.1.113883.11.20.4.1 **DYNAMIC** (CONF:1098-17179).

2.1.11.1 participant

The participant element in the Discharge Summary header follows the General Header Constraints for participants. Discharge Summary does not specify any use for functionCode for participants. Local policies will determine how this element should be used in implementations.

4. **MAY** contain zero or more [0..*] **participant** (CONF:1098-8467).
   a. 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:1098-8469).

2.1.11.2 componentOf

The Discharge Summary is always associated with a Hospital Admission using the encompassingEncounter element in the header.

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5. **SHALL** contain exactly one [1..1] **componentOf** (CONF:1098-8471).
    a. This componentOf **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1098-8472).
        i. This encompassingEncounter **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-32611).

The admission date is recorded in the componentOf/encompassingEncounter/effectiveTime/low.

1. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-8473).

The discharge date is recorded in the componentOf/encompassingEncounter/effectiveTime/high.

2. This effectiveTime **SHALL** contain exactly one [1..1] **high** (CONF:1098-8475).

The dischargeDispositionCode records the disposition of the patient at time of discharge. Access to the National Uniform Billing Committee (NUBC) code system requires a membership. The following conformance statement aligns with HITSP C80 requirements.

The dischargeDispositionCode, @displayName, or NUBC UB-04 Print Name, must be displayed when the document is rendered.

ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **dischargeDispositionCode**, which **SHOULD** be selected from ValueSet **NUBC UB-04 FL17 Patient Status** 2.16.840.1.113883.3.88.12.80.33 **DYNAMIC** (CONF:1098-8476).

The responsibleParty element represents only the party responsible for the encounter, not necessarily the entire episode of care.

iii. This encompassingEncounter **MAY** contain zero or one [0..1] **responsibleParty** (CONF:1098-8479).

If present, the responsibleParty/assignedEntity element **SHALL** have at least one assignedPerson or representedOrganization element present

1. The responsibleParty, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-32613).
    a. This assignedEntity **SHOULD** contain zero or one [0..1] **assignedPerson** (CONF:1098-32619).
    b. This assignedEntity **SHOULD** contain zero or one [0..1] **representedOrganization** (CONF:1098-32620).

The encounterParticipant elements represent only those participants in the encounter, not necessarily the entire episode of care.

iv. This encompassingEncounter **MAY** contain zero or more [0..*] **encounterParticipant** (CONF:1098-8478).

If present, the encounterParticipant/assignedEntity element **SHALL** have at least one assignedPerson or representedOrganization element present.

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1. The encounterParticipant, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-32615).
    a. This assignedEntity **SHOULD** contain zero or one [0..1] **assignedPerson** (CONF:1098-32621).
    b. This assignedEntity **SHOULD** contain zero or one [0..1] **representedOrganization** (CONF:1098-32622).

Figure 36: Discharge Summary encompassingEncounter Example

```
<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="20090227130000+0500" />
            <high value="20090227130000+0500" />
         </effectiveTime>
         <dischargeDispositionCode code="01" codeSystem="2.16.840.1.113883.12.112"
displayName="Routine Discharge" codeSystemName="HL7 Discharge Disposition" />
         <location>
            <healthCareFacility>
               <id root="2.16.540.1.113883.19.2" />
            </healthCareFacility>
         </location>
      </encompassingEncounter>
</componentOf>
```

2.1.11.3 component

6. **SHALL** contain exactly one [1..1] **component** (CONF:1098-9539).

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

a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1098-30518).
    i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30519) such that it
        1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09) (CONF:1098-30520).
    ii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30521) such that it
        1. **SHALL** contain exactly one [1..1] **Hospital Course Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.5) (CONF:1098-30522).
    iii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30523) such that it

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1. **SHALL** contain exactly one [1..1] **Discharge Diagnosis Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2014-06-09) (CONF:1098-30524).

iv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-30525) such that it

1. **SHALL** contain exactly one [1..1] **Discharge Medications Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2014-06-09) (CONF:1098-30526).

v. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30527) such that it

1. **SHALL** contain exactly one [1..1] **Plan of Treatment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30528).

vi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30529) such that it

1. **SHALL** contain exactly one [1..1] **Chief Complaint Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1098-30530).

vii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30531) such that it

1. **SHALL** contain exactly one [1..1] **Chief Complaint and Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:1098-30532).

viii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30533) such that it

1. **SHALL** contain exactly one [1..1] **Nutrition Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1098-30534).

ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30535) such that it

1. **SHALL** contain exactly one [1..1] **Family History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-30536).

x. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30537) such that it

1. **SHALL** contain exactly one [1..1] **Functional Status Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09) (CONF:1098-30538).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30539) such that it

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1. **SHALL** contain exactly one [1..1] **History of Past Illness Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09) (CONF:1098-30540).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30541) such that it

1. **SHALL** contain exactly one [1..1] **History of Present Illness Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1098-30542).

xiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30543) such that it

1. **SHALL** contain exactly one [1..1] **Admission Diagnosis Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2014-06-09) (CONF:1098-30544).

xiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30545) such that it

1. **SHALL** contain exactly one [1..1] **Admission Medications Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2014-06-09) (CONF:1098-30546).

xv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30547) such that it

1. **SHALL** contain exactly one [1..1] **Hospital Consultations Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.42) (CONF:1098-30548).

xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30549) such that it

1. **SHALL** contain exactly one [1..1] **Hospital Discharge Instructions Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.41) (CONF:1098-30550).

xvii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30551) such that it

1. **SHALL** contain exactly one [1..1] **Hospital Discharge Physical Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.26) (CONF:1098-30552).

xviii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30553) such that it

1. **SHALL** contain exactly one [1..1] **Hospital Discharge Studies Summary Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.16) (CONF:1098-30554).

xix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30555) such that it

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1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09) (CONF:1098-30556).

xx. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30557) such that it

1. **SHALL** contain exactly one [1..1] **Problem Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09) (CONF:1098-30558).

xxi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30559) such that it

1. **SHALL** contain exactly one [1..1] **Procedures Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09) (CONF:1098-30560).

xxii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30561) such that it

1. **SHALL** contain exactly one [1..1] **Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:1098-30562).

xxiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30563) such that it

1. **SHALL** contain exactly one [1..1] **Review of Systems Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-30564).

xxiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30565) such that it

1. **SHALL** contain exactly one [1..1] **Social History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-30566).

xxv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30567) such that it

1. **SHALL** contain exactly one [1..1] **Vital Signs Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09) (CONF:1098-30568).

xxvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-31586) such that it

1. **SHALL** contain exactly one [1..1] **Discharge Medications Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11.1:2014-06-09) (CONF:1098-31587).

xxvii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-32790) such that it

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1. **SHALL** contain exactly one [1..1] **Discharge Diet Section (DEPRECATED)** (identifier: urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.33:2014-06-09) (CONF:1098-32791).

xxviii. This structuredBody **SHALL NOT** contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) is present (CONF:1098-30569).

Table 37: DischargeSummaryDocumentTypeCode

Value Set: DischargeSummaryDocumentTypeCode 2.16.840.1.113883.11.20.4.1
A value set of LOINC document codes for discharge summaries.

Specific URL Pending
Value Set Source: http://www.loinc.org/

Code	Code System	Code System OID	Print Name
18842-5	LOINC	2.16.840.1.113883.6.1	Discharge summary
11490-0	LOINC	2.16.840.1.113883.6.1	Physician Discharge summary
28655-9	LOINC	2.16.840.1.113883.6.1	Physician attending Discharge summary
29761-4	LOINC	2.16.840.1.113883.6.1	Dentist Discharge summary
34745-0	LOINC	2.16.840.1.113883.6.1	Nurse Discharge summary
34105-7	LOINC	2.16.840.1.113883.6.1	Hospital Discharge summary
34106-5	LOINC	2.16.840.1.113883.6.1	Physician Hospital Discharge summary
…			

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Table 38: NUBC UB-04 FL17 Patient Status

Value Set: NUBC UB-04 FL17 Patient Status 2.16.840.1.113883.3.88.12.80.33 National Uniform Billing Committee (NUBC) code system. Value Set Source: http://www.nubc.org			
Code	**Code System**	**Code System OID**	**Print Name**
01	nubc-UB-04-Manual-code set	2.16.840.1.113883.6.301	Discharged to Home or Self Care (Routine Discharge)
01	nubc-UB-04-Manual-code set	2.16.840.1.113883.6.301	Discharged/transferred to a Short-Term General Hospital for Inpatient Care
03	nubc-UB-04-Manual-code set	2.16.840.1.113883.6.301	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care
04	nubc-UB-04-Manual-code set	2.16.840.1.113883.6.301	Discharged/transferred to a Facility that Provides Custodial or Supportive Care
05	nubc-UB-04-Manual-code set	2.16.840.1.113883.6.301	Discharged/transferred to a Designated Cancer Center or Children's Hospital
05	nubc-UB-04-Manual-code set	2.16.840.1.113883.6.301	Discharged/transferred to Home Under Care of an Organized Home Health Service Organization in Anticipation of Covered Skilled Care
06	nubc-UB-04-Manual-code set	2.16.840.1.113883.6.301	Discharged/transferred to Home Under Care of an Organized Home Health Service Organization in Anticipation of Covered Skilled Care
07	nubc-UB-04-Manual-code set	2.16.840.1.113883.6.301	Left Against Medical Advice or Discontinued Care
08	nubc-UB-04-Manual-code set	2.16.840.1.113883.6.301	Reserved for Assignment by the NUBC
09	nubc-UB-04-Manual-code set	2.16.840.1.113883.6.301	Admitted as an Inpatient to this Hospital
…			

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2.1.12 History and Physical (V2)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.3:2014-06-09 (open)]

Table 39: History and Physical (V2) Contexts

Contained By:	Contains:
	Allergies and Intolerances Section (entries optional) (V2) Assessment and Plan Section (V2) Assessment Section Chief Complaint and Reason for Visit Section Chief Complaint Section Family History Section (V2) General Status Section History of Past Illness Section (V2) History of Present Illness Section Immunizations Section (entries optional) (V2) Instructions Section (V2) Medications Section (entries optional) (V2) Physical Exam Section (V2) Plan of Treatment Section (V2) Problem Section (entries optional) (V2) Procedures Section (entries optional) (V2) Reason for Visit Section Results Section (entries optional) (V2) Review of Systems Section Social History Section (V2) US Realm Date and Time (DT.US.FIELDED) 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 the 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.

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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.

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Table 40: History and Physical (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.3:2014-06-09)					
templateId	1..1	SHALL		1098-8283	
@root	1..1	SHALL		1098-10046	2.16.840.1.113883.10.20.22.1.3
@extension	1..1	SHALL		1098-32518	2014-06-09
code	1..1	SHALL		1098-17185	
@code	1..1	SHALL		1098-17186	2.16.840.1.113883.1.11.20.22 (HPDocumentType)
informationRecipient	0..*	MAY		1098-32482	
intendedRecipient	1..1	SHALL		1098-32483	
participant	0..*	MAY		1098-8286	
inFulfillmentOf	0..*	MAY		1098-8336	
componentOf	1..1	SHALL		1098-8338	
encompassingEncounter	1..1	SHALL		1098-8339	
id	1..*	SHALL		1098-8340	
effectiveTime	1..1	SHALL		1098-8341	US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3
responsibleParty	0..1	MAY		1098-8345	
encounterParticipant	0..*	MAY		1098-8342	
location	0..1	MAY		1098-8344	
component	1..1	SHALL		1098-8349	
structuredBody	1..1	SHALL		1098-30570	
component	1..1	SHALL		1098-30571	
section	1..1	SHALL		1098-30572	Allergies and Intolerances Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.2

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					0.22.2.6:2014-06-09
component	0..1	MAY		1098-30573	
section	1..1	SHALL		1098-30574	Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8
component	0..1	MAY		1098-30575	
section	1..1	SHALL		1098-30576	Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
component	0..1	MAY		1098-30577	
section	1..1	SHALL		1098-30578	Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09
component	0..1	MAY		1098-30579	
section	1..1	SHALL		1098-30580	Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1
component	0..1	MAY		1098-30581	
section	1..1	SHALL		1098-30582	Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13
component	1..1	SHALL		1098-30583	
section	1..1	SHALL		1098-30584	Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09
component	1..1	SHALL		1098-30585	
section	1..1	SHALL		1098-30586	General Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.5
component	1..1	SHALL		1098-30587	
section	1..1	SHALL		1098-30588	History of Past Illness Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09
component	0..1	SHOULD		1098-30589	

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section	1..1	SHALL		1098-30590	History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4
component	0..1	MAY		1098-30591	
section	1..1	SHALL		1098-30592	Immunizations Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09
component	0..1	MAY		1098-30593	
section	1..1	SHALL		1098-31385	Instructions Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09
component	1..1	SHALL		1098-30595	
section	1..1	SHALL		1098-30596	Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09
component	1..1	SHALL		1098-30597	
section	1..1	SHALL		1098-30598	Physical Exam Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09
component	0..1	MAY		1098-30599	
section	1..1	SHALL		1098-30600	Problem Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09
component	0..1	MAY		1098-30601	
section	1..1	SHALL		1098-30602	Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09
component	0..1	MAY		1098-30603	
section	1..1	SHALL		1098-30604	Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12
component	1..1	SHALL		1098-30605	
section	1..1	SHALL		1098-30606	Results Section (entries optional) (V2) (identifier:

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					urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09
component	1..1	SHALL		1098-30607	
section	1..1	SHALL		1098-30608	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18
component	1..1	SHALL		1098-30609	
section	1..1	SHALL		1098-30610	Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09
component	1..1	SHALL		1098-30611	
section	1..1	SHALL		1098-30612	Vital Signs Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09

2.1.13 Properties

1. Conforms to **US Realm Header (V2)** template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)`.
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8283) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.1.3`" (CONF:1098-10046).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32518).

The H&P Note recommends use of a single document type code, 34117-2

3. **SHALL** contain exactly one [1..1] **code** (CONF:1098-17185).
   a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **HPDocumentType** `2.16.840.1.113883.1.11.20.22` **DYNAMIC** (CONF:1098-17186).
4. **MAY** contain zero or more [0..*] **informationRecipient** (CONF:1098-32482).
   a. The informationRecipient, if present, **SHALL** contain exactly one [1..1] **intendedRecipient** (CONF:1098-32483).

2.1.13.1 participant

The participant element in the H&P header follows the General Header Constraints for participants. H&P Note does not specify any use for functionCode for participants. Local policies will determine how this element should be used in implementations.

5. **MAY** contain zero or more [0..*] **participant** (CONF:1098-8286).

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,

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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.

a. 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:1098-8333).

2.1.13.2 inFulfillmentOf

inFulfillmentOf elements describe 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 the H&P Note may be in partial fulfillment of that referral.

6. **MAY** contain zero or more [0..*] **inFulfillmentOf** (CONF:1098-8336).

2.1.13.3 componentOf

The H&P Note is always associated with an encounter.

7. **SHALL** contain exactly one [1..1] **componentOf** (CONF:1098-8338).
   a. This componentOf **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1098-8339).
      i. This encompassingEncounter **SHALL** contain at least one [1..*] **id** (CONF:1098-8340).

The effectiveTime represents the time interval or point in time in which the encounter took place.

      ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **US Realm Date and Time (DT.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1098-8341).

The responsibleParty element records only the party responsible for the encounter, not necessarily the entire episode of care.

      iii. This encompassingEncounter **MAY** contain zero or one [0..1] **responsibleParty** (CONF:1098-8345).
         1. The responsibleParty element, if present, **SHALL** contain an assignedEntity element, which **SHALL** contain an assignedPerson element, a representedOrganization element, or both (CONF:1098-8348).

The encounterParticipant elements represent only those participants in the encounter, not necessarily the entire episode of care.

      iv. This encompassingEncounter **MAY** contain zero or more [0..*] **encounterParticipant** (CONF:1098-8342).
         1. An encounterParticipant element, if present, **SHALL** contain an assignedEntity element, which **SHALL** contain an assignedPerson element, a representedOrganization element, or both (CONF:1098-8343).

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v. This encompassingEncounter **MAY** contain zero or one [0..1] **location** (CONF:1098-8344).

Figure 37: H&P encompassingEncounter Example

```
<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="20090227130000+0500" />
            <high value="20090227130000+0500" />
         </effectiveTime>
         <location>
            <healthCareFacility>
               <id root="2.16.540.1.113883.19.2" />
            </healthCareFacility>
         </location>
      </encompassingEncounter>
</componentOf>
```

2.1.13.4 component

8. **SHALL** contain exactly one [1..1] **component** (CONF:1098-8349).

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

a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1098-30570).

i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30571) such that it

1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09) (CONF:1098-30572).

ii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30573) such that it

1. **SHALL** contain exactly one [1..1] **Assessment Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1098-30574).

iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30575) such that it

1. **SHALL** contain exactly one [1..1] **Plan of Treatment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30576).

iv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30577) such that it

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1. **SHALL** contain exactly one [1..1] **Assessment and Plan Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1098-30578).

v. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30579) such that it

1. **SHALL** contain exactly one [1..1] **Chief Complaint Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1098-30580).

vi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30581) such that it

1. **SHALL** contain exactly one [1..1] **Chief Complaint and Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:1098-30582).

vii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30583) such that it

1. **SHALL** contain exactly one [1..1] **Family History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-30584).

viii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30585) such that it

1. **SHALL** contain exactly one [1..1] **General Status Section** (identifier: urn:oid:2.16.840.1.113883.10.20.2.5) (CONF:1098-30586).

ix. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30587) such that it

1. **SHALL** contain exactly one [1..1] **History of Past Illness Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09) (CONF:1098-30588).

x. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-30589) such that it

1. **SHALL** contain exactly one [1..1] **History of Present Illness Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1098-30590).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30591) such that it

1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09) (CONF:1098-30592).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30593) such that it

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1. **SHALL** contain exactly one [1..1] **Instructions Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09) (CONF:1098-31385).

xiii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30595) such that it

1. **SHALL** contain exactly one [1..1] **Medications Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09) (CONF:1098-30596).

xiv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30597) such that it

1. **SHALL** contain exactly one [1..1] **Physical Exam Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09) (CONF:1098-30598).

xv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30599) such that it

1. **SHALL** contain exactly one [1..1] **Problem Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09) (CONF:1098-30600).

xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30601) such that it

1. **SHALL** contain exactly one [1..1] **Procedures Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09) (CONF:1098-30602).

xvii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30603) such that it

1. **SHALL** contain exactly one [1..1] **Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:1098-30604).

xviii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30605) such that it

1. **SHALL** contain exactly one [1..1] **Results Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09) (CONF:1098-30606).

xix. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30607) such that it

1. **SHALL** contain exactly one [1..1] **Review of Systems Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-30608).

xx. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30609) such that it

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1. **SHALL** contain exactly one [1..1] **Social History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-30610).

xxi. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30611) such that it

1. **SHALL** contain exactly one [1..1] **Vital Signs Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09) (CONF:1098-30612).

xxii. This structuredBody **SHALL** contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) or a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) (CONF:1098-30613).

xxiii. This structuredBody **SHALL** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09), or an Assessment Section (2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30614).

xxiv. This structuredBody **SHALL NOT** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1098-30615).

xxv. This structuredBody **SHALL NOT** contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) is present (CONF:1098-30616).

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Table 41: HPDocumentType

Value Set: HPDocumentType 2.16.840.1.113883.1.11.20.22 Specific URL Pending Value Set Source: http://www.loinc.org/			
Code	**Code System**	**Code System OID**	**Print Name**
34117-2	LOINC	2.16.840.1.113883.6.1	History and physical note
11492-6	LOINC	2.16.840.1.113883.6.1	Provider-unspecified, History and physical note
28626-0	LOINC	2.16.840.1.113883.6.1	Physician History and physical note
34774-0	LOINC	2.16.840.1.113883.6.1	Surgery History and physical note
34115-6	LOINC	2.16.840.1.113883.6.1	Medical student Hospital History and physical note
34116-4	LOINC	2.16.840.1.113883.6.1	Physician Nursing facility History and physical note
34095-0	LOINC	2.16.840.1.113883.6.1	Comprehensive history and physical note
34096-8	LOINC	2.16.840.1.113883.6.1	Nursing facility Comprehensive history and physical note
51849-8	LOINC	2.16.840.1.113883.6.1	Admission history and physical note
47039-3	LOINC	2.16.840.1.113883.6.1	Hospital Admission history and physical note
…			

2.1.14 Operative Note (V2)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.7:2014-06-09 (open)]`

Table 42: Operative Note (V2) Contexts

Contained By:	**Contains:**
	Anesthesia Section (V2) Complications Section (V2) Operative Note Fluids Section Operative Note Surgical Procedure Section Plan of Treatment Section (V2) Planned Procedure Section (V2) Postoperative Diagnosis Section Preoperative Diagnosis Section (V2) Procedure Description Section Procedure Disposition Section Procedure Estimated Blood Loss Section

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Contained By:	Contains:
	Procedure Findings Section (V2) Procedure Implants Section Procedure Indications Section (V2) Procedure Specimens Taken Section Surgical Drains Section US Realm Date and Time (DT.US.FIELDED)

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.

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Table 43: Operative Note (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.7:2014-06-09)					
templateId	1..1	SHALL		1098-8483	
@root	1..1	SHALL		1098-10048	2.16.840.1.113883.10.20.22.1.7
@extension	1..1	SHALL		1098-32519	2014-06-09
code	1..1	SHALL		1098-17187	
@code	1..1	SHALL		1098-17188	2.16.840.1.113883.11.20.1.1 (SurgicalOperationNoteDocumentTypeCode)
documentationOf	1..*	SHALL		1098-8486	
serviceEvent	1..1	SHALL		1098-8493	
effectiveTime	1..1	SHALL		1098-8494	US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3
performer	1..*	SHALL		1098-8489	
@typeCode	1..1	SHALL		1098-8495	2.16.840.1.113883.5.90 (HL7ParticipationType) = PPRF
assignedEntity	1..1	SHALL		1098-10917	
code	1..1	SHALL		1098-8490	2.16.840.1.113883.3.88.12.3221.4.2 (Provider Role)
performer	0..*	MAY		1098-32736	
@typeCode	1..1	SHALL		1098-32738	2.16.840.1.113883.5.90 (HL7ParticipationType) = SPRF
assignedEntity	1..1	SHALL		1098-32737	
code	1..1	SHALL		1098-32739	2.16.840.1.113883.3.88.12.3221.4.2 (Provider Role)
authorization	0..1	MAY		1098-32404	
@typeCode	1..1	SHALL		1098-32408	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = AUTH
consent	1..1	SHALL		1098-32405	
@classCode	1..1	SHALL		1098-	2.16.840.1.113883.5.6

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				32409	(HL7ActClass) = CONS
@moodCode	1..1	SHALL		1098-32410	2.16.840.1.113883.5.1001 (ActMood) = EVN
statusCode	1..1	SHALL		1098-32411	
component	1..1	SHALL		1098-9585	
structuredBody	1..1	SHALL		1098-30485	
component	1..1	SHALL		1098-30486	
section	1..1	SHALL		1098-30487	Anesthesia Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.25:2014-06-09
component	1..1	SHALL		1098-30488	
section	1..1	SHALL		1098-30489	Complications Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09
component	1..1	SHALL		1098-30490	
section	1..1	SHALL		1098-30491	Preoperative Diagnosis Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.34:2014-06-09
component	1..1	SHALL		1098-30492	
section	1..1	SHALL		1098-30493	Procedure Estimated Blood Loss Section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.9
component	1..1	SHALL		1098-30494	
section	1..1	SHALL		1098-30495	Procedure Findings Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.28:2014-06-09
component	1..1	SHALL		1098-30496	
section	1..1	SHALL		1098-30497	Procedure Specimens Taken Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.31
component	1..1	SHALL		1098-30498	
section	1..1	SHALL		1098-30499	Procedure Description Section (identifier: urn:oid:2.16.840.1.113883.10.20.

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					22.2.27
component	1..1	SHALL		1098-30500	
section	1..1	SHALL		1098-30501	Postoperative Diagnosis Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.35
component	0..1	MAY		1098-30502	
section	1..1	SHALL		1098-30503	Procedure Implants Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.40
component	0..1	MAY		1098-30504	
section	1..1	SHALL		1098-30505	Operative Note Fluids Section (identifier: urn:oid:2.16.840.1.113883.10.20.7.12
component	0..1	MAY		1098-30506	
section	1..1	SHALL		1098-30507	Operative Note Surgical Procedure Section (identifier: urn:oid:2.16.840.1.113883.10.20.7.14
component	0..1	MAY		1098-30508	
section	1..1	SHALL		1098-30509	Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
component	0..1	MAY		1098-30510	
section	1..1	SHALL		1098-30511	Planned Procedure Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.30:2014-06-09
component	0..1	MAY		1098-30512	
section	1..1	SHALL		1098-30513	Procedure Disposition Section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.12
component	0..1	MAY		1098-30514	
section	1..1	SHALL		1098-30515	Procedure Indications Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.29:2014-06-09
component	0..1	MAY		1098-	

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				30516	
section	1..1	SHALL		1098-30517	Surgical Drains Section (identifier: urn:oid:2.16.840.1.113883.10.20.7.13

2.1.15 Properties

1. Conforms to **US Realm Header (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8483) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.7" (CONF:1098-10048).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32519).

The Operative Note recommends use of a single document type code, 11504-8 "Provider-unspecified Operation Note", with further specification provided by author or performer, setting, or specialty data in the CDA header. Some of the LOINC codes in the Surgical Operation Note Document Type Code table are pre-coordinated with the practice setting or the training or professional level of the author. Use of pre-coordinated codes is not recommended because of potential conflict with other information in the header. When these 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.

3. **SHALL** contain exactly one [1..1] **code** (CONF:1098-17187).
   a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **SurgicalOperationNoteDocumentTypeCode** 2.16.840.1.113883.11.20.1.1 **DYNAMIC** (CONF:1098-17188).

2.1.15.1 documentationOf

A serviceEvent represents the main act, such as a colonoscopy or an appendectomy, being documented. A serviceEvent can further specialize the act inherent in the ClinicalDocument/code, such as where the ClinicalDocument/code is simply "Surgical Operation Note" and the procedure is "Appendectomy." serviceEvent is required in the Operative Note and it must be equivalent to or further specialize the value inherent in the ClinicalDocument/code; it shall not conflict with the value inherent in the ClinicalDocument/code, as such a conflict would create ambiguity. serviceEvent/effectiveTime can be used to indicate the time the actual event (as opposed to the encounter surrounding the event) took place.

If the date and the duration of the procedure is known, serviceEvent/effectiveTime/low is used with a width element that describes the duration; no high element is used. However, if only the date is known, the date is placed in both the low and high elements.

4. **SHALL** contain at least one [1..*] **documentationOf** (CONF:1098-8486).
   a. Such documentationOfs **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1098-8493).

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i. This serviceEvent **SHALL** contain exactly one [1..1] **US Realm Date and Time (DT.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1098-8494).
   1. The serviceEvent/effectiveTime **SHALL** be present with effectiveTime/low (CONF:1098-8488).
   2. If a width is not present, the serviceEvent/effectiveTime **SHALL** include effectiveTime/high (CONF:1098-10058).
   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:1098-10060).

2.1.15.2 performer

This performer represents a clinicians who actually and principally carry out the serviceEvent. Typically, these are clinicians who have surgical privileges in their institutions such as Surgeons, Obstetrician/Gynecologists, and Family Practice Physicians. The performer may also be non-physician providers (NPPs) who have surgical privileges. There may be more than one primary performer in the case of complicated surgeries. There are occasionally co-surgeons. Usually they will be billing separately and will each dictate their own notes. An example may be spinal surgery , where a general surgeon and an orthopedic surgeon both are present and billing off the same Current Procedural Terminology (CPT) codes. Typically two Operative Notes are generated; however, each will list the other as a co-surgeon.

ii. This serviceEvent **SHALL** contain at least one [1..*] **performer** (CONF:1098-8489) 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:1098-8495).
   2. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-10917).
      a. This assignedEntity **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet **Provider Role** 2.16.840.1.113883.3.88.12.3221.4.2 **DYNAMIC** (CONF:1098-8490).

2.1.15.3 performer

This performer represents any assistants.

iii. This serviceEvent **MAY** contain zero or more [0..*] **performer** (CONF:1098-32736) such that it
   1. **SHALL** contain exactly one [1..1] **@typeCode**="SPRF" Secondary performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:1098-32738).
   2. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-32737).

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a. This assignedEntity **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet **Provider Role** 2.16.840.1.113883.3.88.12.3221.4.2 **DYNAMIC** (CONF:1098-32739).

iv. The value of 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:1098-8487).

Figure 38: Operative Note performer Example

```
 <performer typeCode="PPRF">
    <assignedEntity>
       <id extension="1" root="2.16.840.1.113883.19" />
       <code code="2086S0120X" codeSystem="2.16.840.1.113883.6.101" codeSystemName="NUCC"
displayName="Pediatric Surgeon" />
       <addr>
          <streetAddressLine>1013 Healthcare Drive</streetAddressLine>
          <city>Ann Arbor</city>
          <state>MI</state>
          <postalCode>99999</postalCode>
          <country>US</country>
       </addr>
       <telecom value="tel:(555)555-1013" />
       <assignedPerson>
          <name>
             <prefix>Dr.</prefix>
             <given>Carl</given>
             <family>Cutter</family>
          </name>
       </assignedPerson>
    </assignedEntity>
 </performer>
```

Figure 39: Operative Note serviceEvent Example

```
 <serviceEvent classCode="PROC">
   <code code="801460020" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
displayName="Laparoscopic Appendectomy" />
      <effectiveTime>
      <low value="201003292240" />
      <width value="15" unit="m" />
      </effectiveTime>
   ...
 </serviceEvent>
```

Authorization represents consent. Consent, if present, shall be represented by authorization/consent.

5. **MAY** contain zero or one [0..1] **authorization** (CONF:1098-32404).

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a. The authorization, if present, **SHALL** contain exactly one [1..1] **@typeCode**="AUTH" authorized by (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32408).
b. The authorization, if present, **SHALL** contain exactly one [1..1] **consent** (CONF:1098-32405).
    i. This consent **SHALL** contain exactly one [1..1] **@classCode**="CONS" consent (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-32409).
    ii. This consent **SHALL** contain exactly one [1..1] **@moodCode**="EVN" event (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-32410).
    iii. This consent **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-32411).

2.1.15.4 component

6. **SHALL** contain exactly one [1..1] **component** (CONF:1098-9585).
    a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1098-30485).
        i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30486) such that it
            1. **SHALL** contain exactly one [1..1] **Anesthesia Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.25:2014-06-09) (CONF:1098-30487).
        ii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30488) such that it
            1. **SHALL** contain exactly one [1..1] **Complications Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09) (CONF:1098-30489).
        iii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30490) such that it
            1. **SHALL** contain exactly one [1..1] **Preoperative Diagnosis Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.34:2014-06-09) (CONF:1098-30491).
        iv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30492) such that it
            1. **SHALL** contain exactly one [1..1] **Procedure Estimated Blood Loss Section** (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.9) (CONF:1098-30493).
        v. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30494) such that it
            1. **SHALL** contain exactly one [1..1] **Procedure Findings Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.28:2014-06-09) (CONF:1098-30495).

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vi. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30496) such that it
    1. **SHALL** contain exactly one [1..1] **Procedure Specimens Taken Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.31) (CONF:1098-30497).

vii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30498) such that it
    1. **SHALL** contain exactly one [1..1] **Procedure Description Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.27) (CONF:1098-30499).

viii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30500) such that it
    1. **SHALL** contain exactly one [1..1] **Postoperative Diagnosis Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.35) (CONF:1098-30501).

ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30502) such that it
    1. **SHALL** contain exactly one [1..1] **Procedure Implants Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.40) (CONF:1098-30503).

x. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30504) such that it
    1. **SHALL** contain exactly one [1..1] **Operative Note Fluids Section** (identifier: urn:oid:2.16.840.1.113883.10.20.7.12) (CONF:1098-30505).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30506) such that it
    1. **SHALL** contain exactly one [1..1] **Operative Note Surgical Procedure Section** (identifier: urn:oid:2.16.840.1.113883.10.20.7.14) (CONF:1098-30507).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30508) such that it
    1. **SHALL** contain exactly one [1..1] **Plan of Treatment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30509).

xiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30510) such that it
    1. **SHALL** contain exactly one [1..1] **Planned Procedure Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.30:2014-06-09) (CONF:1098-30511).

xiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30512) such that it

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1. **SHALL** contain exactly one [1..1] **Procedure Disposition Section** (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.12) (CONF:1098-30513).

xv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30514) such that it

1. **SHALL** contain exactly one [1..1] **Procedure Indications Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.29:2014-06-09) (CONF:1098-30515).

xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30516) such that it

1. **SHALL** contain exactly one [1..1] **Surgical Drains Section** (identifier: urn:oid:2.16.840.1.113883.10.20.7.13) (CONF:1098-30517).

Table 44: SurgicalOperationNoteDocumentTypeCode

Value Set: SurgicalOperationNoteDocumentTypeCode 2.16.840.1.113883.11.20.1.1 Specific URL Pending Value Set Source: **http://www.loinc.org/**			
Code	**Code System**	**Code System OID**	**Print Name**
11504-8	LOINC	2.16.840.1.113883.6.1	Provider-unspecified Operation note
34137-0	LOINC	2.16.840.1.113883.6.1	Outpatient Surgical operation note
28583-3	LOINC	2.16.840.1.113883.6.1	Dentist Operation note
28624-5	LOINC	2.16.840.1.113883.6.1	Podiatry Operation note
28573-4	LOINC	2.16.840.1.113883.6.1	Physician, Operation note
34877-1	LOINC	2.16.840.1.113883.6.1	Urology Surgical operation note
34874-8	LOINC	2.16.840.1.113883.6.1	Surgery Surgical operation note
34870-6	LOINC	2.16.840.1.113883.6.1	Plastic surgery Surgical operation note
34868-0	LOINC	2.16.840.1.113883.6.1	Orthopaedic surgery Surgical operation note
34818-5	LOINC	2.16.840.1.113883.6.1	Otolaryngology Surgical operation note

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Table 45: Provider Role

Value Set: Provider Role 2.16.840.1.113883.3.88.12.3221.4.2 The Provider type vocabulary classifies providers according to the type of license or accreditation they hold or the service they provide. Value Set Source: http://www.nucc.org/index.php?option=com_content&view=article&id=14&Itemid=125			
Code	**Code System**	**Code System OID**	**Print Name**
CP	Provider Role (HL7)	2.16.840.1.113883.3.88.12.3221.4	Consulting Provider
PP	Provider Role (HL7)	2.16.840.1.113883.3.88.12.3221.4	Primary Care Provider
RP	Provider Role (HL7)	2.16.840.1.113883.3.88.12.3221.4	Referring Provider

2.1.16 Procedure Note (V2)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.6:2014-06-09 (open)]`

Table 46: Procedure Note (V2) Contexts

Contained By:	Contains:
	Allergies and Intolerances Section (entries optional) (V2) Anesthesia Section (V2) Assessment and Plan Section (V2) Assessment Section Chief Complaint and Reason for Visit Section Chief Complaint Section Complications Section (V2) Family History Section (V2) History of Past Illness Section (V2) History of Present Illness Section Medical (General) History Section Medications Administered Section (V2) Medications Section (entries optional) (V2) Physical Exam Section (V2) Plan of Treatment Section (V2) Planned Procedure Section (V2) Postprocedure Diagnosis Section (V2) Procedure Description Section Procedure Disposition Section Procedure Estimated Blood Loss Section Procedure Findings Section (V2) Procedure Implants Section Procedure Indications Section (V2)

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Contained By:	Contains:
	Procedure Specimens Taken Section Procedures Section (entries optional) (V2) Reason for Visit Section Review of Systems Section Social History Section (V2) US Realm Date and Time (DT.US.FIELDED)

A 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, postprocedure 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.

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Table 47: Procedure Note (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.6:2014-06-09)					
templateId	1..1	SHALL		1098-8496	
@root	1..1	SHALL		1098-10050	2.16.840.1.113883.10.20.22.1.6
@extension	1..1	SHALL		1098-32520	2014-06-09
code	1..1	SHALL		1098-17182	
@code	1..1	SHALL		1098-17183	2.16.840.1.113883.11.20.6.1 (ProcedureNoteDocumentTypeCodes)
participant	0..*	MAY		1098-8504	
@typeCode	1..1	SHALL		1098-8505	2.16.840.1.113883.5.88 (participationFunction) = IND
functionCode	1..1	SHALL		1098-8506	2.16.840.1.113883.5.88 (participationFunction) = PCP
associatedEntity/@classCode	1..1	SHALL		1098-8507	2.16.840.1.113883.5.90 (HL7ParticipationType) = PROV
associatedPerson	1..1	SHALL		1098-8508	
documentationOf	1..*	SHALL		1098-8510	
serviceEvent	1..1	SHALL		1098-10061	
effectiveTime	1..1	SHALL		1098-10062	US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3
low	1..1	SHALL		1098-26449	
performer	1..*	SHALL		1098-8520	
@typeCode	1..1	SHALL		1098-8521	2.16.840.1.113883.5.90 (HL7ParticipationType) = PPRF
assignedEntity	1..1	SHALL		1098-14911	
code	0..1	SHOULD		1098-14912	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
performer	0..*	MAY		1098-32732	
@typeCode	1..1	SHALL		1098-	2.16.840.1.113883.5.90

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				32734	(HL7ParticipationType) = SPRF
assignedEntity	1..1	SHALL		1098-32733	
code	0..1	SHOULD		1098-32735	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
authorization	0..1	MAY		1098-32412	
@typeCode	1..1	SHALL		1098-32413	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = AUTH
consent	1..1	SHALL		1098-32414	
@classCode	1..1	SHALL		1098-32415	2.16.840.1.113883.5.6 (HL7ActClass) = CONS
@moodCode	1..1	SHALL		1098-32416	2.16.840.1.113883.5.1001 (ActMood) = EVN
statusCode	1..1	SHALL		1098-32417	
componentOf	0..1	SHOULD		1098-30871	
encompassingEncounter	1..1	SHALL		1098-30872	
id	0..*	SHOULD		1098-32395	
code	1..1	SHALL		1098-30873	
encounterParticipant	0..1	MAY		1098-30874	
@typeCode	1..1	SHALL		1098-30875	REF
location	1..*	SHALL		1098-30876	
healthCareFacility	1..1	SHALL		1098-30877	
id	1..*	SHALL		1098-30878	
component	1..1	SHALL		1098-9588	
structuredBody	1..1	SHALL		1098-30352	
component	1..1	SHALL		1098-30353	
section	1..1	SHALL		1098-30387	Complications Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09
component	1..1	SHALL		1098-	

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				30355	
section	1..1	SHALL		1098-30356	Procedure Description Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.27
component	1..1	SHALL		1098-30357	
section	1..1	SHALL		1098-30358	Procedure Indications Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.29:2014-06-09
component	1..1	SHALL		1098-30359	
section	1..1	SHALL		1098-30360	Postprocedure Diagnosis Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.36:2014-06-09
component	0..1	MAY		1098-30361	
section	1..1	SHALL		1098-30362	Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8
component	0..1	MAY		1098-30363	
section	1..1	SHALL		1098-30364	Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09
component	0..1	MAY		1098-30365	
section	1..1	SHALL		1098-30366	Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
component	0..1	MAY		1098-30367	
section	1..1	SHALL		1098-30368	Allergies and Intolerances Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09
component	0..1	MAY		1098-30369	
section	1..1	SHALL		1098-30370	Anesthesia Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.25:2014-06-09
component	0..1	MAY		1098-30371	
section	1..1	SHALL		1098-30372	Chief Complaint Section (identifier:

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					urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1
component	0..1	MAY		1098-30373	
section	1..1	SHALL		1098-30374	Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13
component	0..1	MAY		1098-30375	
section	1..1	SHALL		1098-30376	Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09
component	0..1	MAY		1098-30377	
section	1..1	SHALL		1098-30378	History of Past Illness Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09
component	0..1	MAY		1098-30379	
section	1..1	SHALL		1098-30380	History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4
component	0..1	MAY		1098-30381	
section	1..1	SHALL		1098-30382	Medical (General) History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.39
component	0..1	MAY		1098-30383	
section	1..1	SHALL		1098-30384	Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09
component	0..1	MAY		1098-30388	
section	1..1	SHALL		1098-30389	Medications Administered Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.38:2014-06-09
component	0..1	MAY		1098-30390	
section	1..1	SHALL		1098-30391	Physical Exam Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09

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component	0..1	MAY		1098-30392	
section	1..1	SHALL		1098-30393	Planned Procedure Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.30:2014-06-09
component	0..1	MAY		1098-30394	
section	1..1	SHALL		1098-30395	Procedure Disposition Section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.12
component	0..1	MAY		1098-30396	
section	1..1	SHALL		1098-30397	Procedure Estimated Blood Loss Section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.9
component	0..1	MAY		1098-30398	
section	1..1	SHALL		1098-30399	Procedure Findings Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.28:2014-06-09
component	0..1	MAY		1098-30400	
section	1..1	SHALL		1098-30401	Procedure Implants Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.40
component	0..1	MAY		1098-30402	
section	1..1	SHALL		1098-30403	Procedure Specimens Taken Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.31
component	0..1	MAY		1098-30404	
section	1..1	SHALL		1098-30405	Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09
component	0..1	MAY		1098-30406	
section	1..1	SHALL		1098-30407	Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12
component	0..1	MAY		1098-30408	

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section	1..1	SHALL		1098-30409	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18
component	0..1	MAY		1098-30410	
section	1..1	SHALL		1098-30411	Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09

2.1.17 Properties

1. Conforms to **US Realm Header (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8496) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.6" (CONF:1098-10050).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32520).

The Procedure Note recommends use of a single document type code, 28570-0 "Procedure 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.

3. **SHALL** contain exactly one [1..1] **code** (CONF:1098-17182).
   a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ProcedureNoteDocumentTypeCodes** 2.16.840.1.113883.11.20.6.1 **DYNAMIC** (CONF:1098-17183).

2.1.17.1 participant

The participant element in the Procedure Note header follows the General Header Constraints for participants.

4. **MAY** contain zero or more [0..*] **participant** (CONF:1098-8504) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="IND" Individual (CodeSystem: participationFunction 2.16.840.1.113883.5.88 **STATIC**) (CONF:1098-8505).
   b. **SHALL** contain exactly one [1..1] **functionCode**="PCP" Primary Care Physician (CodeSystem: participationFunction 2.16.840.1.113883.5.88 **STATIC**) (CONF:1098-8506).
   c. **SHALL** contain exactly one [1..1] **associatedEntity/@classCode**="PROV" Provider (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-8507).
      i. This associatedEntity/@classCode **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1098-8508).

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2.1.17.2 documentationOf

A serviceEvent is required in the Procedure Note to represent the main act, such as a colonoscopy or a cardiac stress study, being documented. It must be equivalent to or further specialize the value inherent in the ClinicalDocument/@code (such as where the ClinicalDocument/@code is simply "Procedure Note" and the procedure is "colonoscopy"), and it shall not conflict with the value inherent in the ClinicalDocument/@code, as such a conflict would create ambiguity. A serviceEvent/effectiveTime element indicates the time the actual event (as opposed to the encounter surrounding the event) took place.

serviceEvent/effectiveTime may be represented two different ways in the Procedure Note. For accuracy to the second, the best method is effectiveTime/low together with effectiveTime/high. If a more general time, such as minutes or hours, is acceptable OR if the duration is unknown, an effectiveTime/low with a width element may be used. If the duration is unknown, the appropriate HL7 null value such as "NI" or "NA" must be used for the width element.

5. **SHALL** contain at least one [1..*] **documentationOf** (CONF:1098-8510) such that it
    a. **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1098-10061).
        i. This serviceEvent **SHALL** contain exactly one [1..1] **US Realm Date and Time (DT.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1098-10062).
            1. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-26449).
            2. The serviceEvent/effectiveTime **SHALL** be present with effectiveTime/low (CONF:1098-8513).
            3. If a width is not present, the serviceEvent/effectiveTime **SHALL** include effectiveTime/high (CONF:1098-8514).
            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:1098-8515).

2.1.17.3 performer

This performer participant represents clinicians who actually and principally carry out the serviceEvent. Typically, these are clinicians who have the appropriate privileges in their institutions such as gastroenterologists, interventional radiologists, and family practice physicians. Performers may also be non-physician providers (NPPs) who have other significant roles in the procedure such as a radiology technician, dental assistant, or nurse.

        ii. This serviceEvent **SHALL** contain at least one [1..*] **performer** (CONF:1098-8520) 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:1098-8521).
            2. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-14911).
                a. This assignedEntity **SHOULD** contain zero or one [0..1] **code**, which **SHALL** be selected from ValueSet **Healthcare**

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Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066 **DYNAMIC** (CONF:1098-14912).

Figure 40: Procedure Note performer Example

```
<performer typeCode="PPRF">
    <assignedEntity>
      <id extension="IO00017" root="2.16.840.1.113883.19.5" />
      <code code="207RG0100X" codeSystem="2.16.840.1.113883.6.96" codeSystemName="NUCC"
displayName="Gastroenterologist" />
      <addr>
        <streetAddressLine>1001 Hospital Lane</streetAddressLine>
        <city>Ann Arbor</city>
        <state>MI</state>
        <postalCode>99999</postalCode>
        <country>US</country>
      </addr>
      <telecom value="tel:(999)555-1212" />
      <assignedPerson>
        <name>
          <prefix>Dr.</prefix>
          <given>Tony</given>
          <family>Tum</family>
        </name>
      </assignedPerson>
     </assignedEntity>
</performer>
```

2.1.17.4 performer

This performer identifies any assistants.

iii. This serviceEvent **MAY** contain zero or more [0..*] **performer** (CONF:1098-32732) such that it
   1. **SHALL** contain exactly one [1..1] **@typeCode**="SPRF" Secondary Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:1098-32734).
   2. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-32733).
      a. This assignedEntity **SHOULD** contain zero or one [0..1] **code**, which **SHALL** be selected from ValueSet **Healthcare Provider Taxonomy (HIPAA)** 2.16.840.1.114222.4.11.1066 **DYNAMIC** (CONF:1098-32735).

iv. 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:1098-8511).

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Figure 41: Procedure Note serviceEvent Example

```
<documentationOf>
    <serviceEvent classCode="PROC">
       <code code="118155006" codeSystem="2.16.840.1.113883.6.96"
             codeSystemName="SNOMED CT" displayName="Gastrointestinal tract endoscopy" />
       <effectiveTime>
         <low value="201003292240" />
         <width value="15" unit="m" />
       </effectiveTime>
       ...
    </serviceEvent>
</documentationOf>
```

Authorization represents consent. Consent, if present, shall be represented by authorization/consent.

6. **MAY** contain zero or one [0..1] **authorization** (CONF:1098-32412).
    a. The authorization, if present, **SHALL** contain exactly one [1..1] **@typeCode**="AUTH" authorized by (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32413).
    b. The authorization, if present, **SHALL** contain exactly one [1..1] **consent** (CONF:1098-32414).
        i. This consent **SHALL** contain exactly one [1..1] **@classCode**="CONS" consent (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-32415).
        ii. This consent **SHALL** contain exactly one [1..1] **@moodCode**="EVN" event (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-32416).
        iii. This consent **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-32417).

2.1.17.5 componentOf

7. **SHOULD** contain zero or one [0..1] **componentOf** (CONF:1098-30871).
    a. The componentOf, if present, **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1098-30872).
        i. This encompassingEncounter **SHOULD** contain zero or more [0..*] **id** (CONF:1098-32395).
        ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **code** (CONF:1098-30873).
        iii. This encompassingEncounter **MAY** contain zero or one [0..1] **encounterParticipant** (CONF:1098-30874) such that it
            1. **SHALL** contain exactly one [1..1] **@typeCode**="REF" Referrer (CONF:1098-30875).
        iv. This encompassingEncounter **SHALL** contain at least one [1..*] **location** (CONF:1098-30876).
            1. Such locations **SHALL** contain exactly one [1..1] **healthCareFacility** (CONF:1098-30877).

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a. This healthCareFacility **SHALL** contain at least one [1..*] **id** (CONF:1098-30878).

2.1.17.6 component

8. **SHALL** contain exactly one [1..1] **component** (CONF:1098-9588).
    a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1098-30352).
        i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30353) such that it
            1. **SHALL** contain exactly one [1..1] **Complications Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09) (CONF:1098-30387).
        ii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30355) such that it
            1. **SHALL** contain exactly one [1..1] **Procedure Description Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.27) (CONF:1098-30356).
        iii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30357) such that it
            1. **SHALL** contain exactly one [1..1] **Procedure Indications Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.29:2014-06-09) (CONF:1098-30358).
        iv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30359) such that it
            1. **SHALL** contain exactly one [1..1] **Postprocedure Diagnosis Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.36:2014-06-09) (CONF:1098-30360).
        v. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30361) such that it
            1. **SHALL** contain exactly one [1..1] **Assessment Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1098-30362).
        vi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30363) such that it
            1. **SHALL** contain exactly one [1..1] **Assessment and Plan Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1098-30364).
        vii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30365) such that it
            1. **SHALL** contain exactly one [1..1] **Plan of Treatment Section (V2)** (identifier:

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urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30366).

viii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30367) such that it

1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09) (CONF:1098-30368).

ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30369) such that it

1. **SHALL** contain exactly one [1..1] **Anesthesia Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.25:2014-06-09) (CONF:1098-30370).

x. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30371) such that it

1. **SHALL** contain exactly one [1..1] **Chief Complaint Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1098-30372).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30373) such that it

1. **SHALL** contain exactly one [1..1] **Chief Complaint and Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:1098-30374).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30375) such that it

1. **SHALL** contain exactly one [1..1] **Family History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-30376).

xiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30377) such that it

1. **SHALL** contain exactly one [1..1] **History of Past Illness Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09) (CONF:1098-30378).

xiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30379) such that it

1. **SHALL** contain exactly one [1..1] **History of Present Illness Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1098-30380).

xv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30381) such that it

1. **SHALL** contain exactly one [1..1] **Medical (General) History Section** (identifier:

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urn:oid:2.16.840.1.113883.10.20.22.2.39) (CONF:1098-30382).

xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30383) such that it

1. **SHALL** contain exactly one [1..1] **Medications Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09) (CONF:1098-30384).

xvii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30388) such that it

1. **SHALL** contain exactly one [1..1] **Medications Administered Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.38:2014-06-09) (CONF:1098-30389).

xviii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30390) such that it

1. **SHALL** contain exactly one [1..1] **Physical Exam Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09) (CONF:1098-30391).

xix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30392) such that it

1. **SHALL** contain exactly one [1..1] **Planned Procedure Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.30:2014-06-09) (CONF:1098-30393).

xx. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30394) such that it

1. **SHALL** contain exactly one [1..1] **Procedure Disposition Section** (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.12) (CONF:1098-30395).

xxi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30396) such that it

1. **SHALL** contain exactly one [1..1] **Procedure Estimated Blood Loss Section** (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.9) (CONF:1098-30397).

xxii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30398) such that it

1. **SHALL** contain exactly one [1..1] **Procedure Findings Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.28:2014-06-09) (CONF:1098-30399).

xxiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30400) such that it

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1. **SHALL** contain exactly one [1..1] **Procedure Implants Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.40) (CONF:1098-30401).

xxiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30402) such that it

1. **SHALL** contain exactly one [1..1] **Procedure Specimens Taken Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.31) (CONF:1098-30403).

xxv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30404) such that it

1. **SHALL** contain exactly one [1..1] **Procedures Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09) (CONF:1098-30405).

xxvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30406) such that it

1. **SHALL** contain exactly one [1..1] **Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:1098-30407).

xxvii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30408) such that it

1. **SHALL** contain exactly one [1..1] **Review of Systems Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-30409).

xxviii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30410) such that it

1. **SHALL** contain exactly one [1..1] **Social History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-30411).

xxix. This structuredBody **SHALL** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09), or an Assessment Section (2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30412).

xxx. This structuredBody **SHALL NOT** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1098-30414).

xxxi. This structuredBody **SHALL NOT** contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) is present (CONF:1098-30415).

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Table 48: ProcedureNoteDocumentTypeCodes

Value Set: ProcedureNoteDocumentTypeCodes 2.16.840.1.113883.11.20.6.1 A value set of LOINC document codes for Procedure Notes. Specific URL Pending Value Set Source: http://search.loinc.org			
Code	**Code System**	**Code System OID**	**Print Name**
28570-0	LOINC	2.16.840.1.113883.6.1	Provider-unspecified Procedure note
11505-5	LOINC	2.16.840.1.113883.6.1	Physician procedure note
18744-3	LOINC	2.16.840.1.113883.6.1	Bronchoscopy study
18745-0	LOINC	2.16.840.1.113883.6.1	Cardiac catheterization study
18746-8	LOINC	2.16.840.1.113883.6.1	Colonoscopy study
18751-8	LOINC	2.16.840.1.113883.6.1	Endoscopy study
18753-4	LOINC	2.16.840.1.113883.6.1	Flexible sigmoidoscopy study
18836-7	LOINC	2.16.840.1.113883.6.1	Cardiac stress study Procedure
28577-5	LOINC	2.16.840.1.113883.6.1	Dentist procedure note
28625-2	LOINC	2.16.840.1.113883.6.1	Podiatry procedure note
…			

2.1.18 Progress Note (V2)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.9:2014-06-09 (open)]`

Table 49: Progress Note (V2) Contexts

Contained By:	**Contains:**
	Allergies and Intolerances Section (entries optional) (V2) Assessment and Plan Section (V2) Assessment Section Chief Complaint Section Instructions Section (V2) Interventions Section (V2) Medications Section (entries optional) (V2) Nutrition Section Objective Section Physical Exam Section (V2) Plan of Treatment Section (V2) Problem Section (entries optional) (V2) Results Section (entries optional) (V2) Review of Systems Section

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Contained By:	Contains:
	Subjective Section US Realm Date and Time (DT.US.FIELDED) Vital Signs Section (entries optional) (V2)

This template represents a patient's clinical status during a hospitalization, outpatient visit, treatment with a LTPAC provider, or other healthcare 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.

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Table 50: Progress Note (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.9:2014-06-09)					
templateId	1..1	SHALL		1098-7588	
@root	1..1	SHALL		1098-10052	2.16.840.1.113883.10.20.22.1.9
@extension	1..1	SHALL		1098-32521	2014-06-09
code	1..1	SHALL		1098-17189	
@code	1..1	SHALL		1098-17190	2.16.840.1.113883.11.20.8.1 (ProgressNoteDocumentTypeCode)
documentationOf	0..1	SHOULD		1098-7603	
serviceEvent	1..1	SHALL		1098-7604	
@classCode	1..1	SHALL		1098-26420	2.16.840.1.113883.5.6 (HL7ActClass) = PCPR
templateId	1..1	SHALL		1098-9480	
@root	1..1	SHALL		1098-10068	2.16.840.1.113883.10.20.21.3.1
effectiveTime	0..1	SHOULD		1098-9481	US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3
componentOf	1..1	SHALL		1098-7595	
encompassingEncounter	1..1	SHALL		1098-7596	
id	1..*	SHALL		1098-7597	
effectiveTime	1..1	SHALL		1098-7598	US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3
low	1..1	SHALL		1098-7599	
location	1..1	SHALL		1098-30879	
healthCareFacility	1..1	SHALL		1098-30880	
id	1..*	SHALL		1098-30881	

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component	1..1	SHALL		1098-9591	
structuredBody	1..1	SHALL		1098-30617	
component	0..1	MAY		1098-30618	
section	1..1	SHALL		1098-30619	Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8
component	0..1	MAY		1098-30620	
section	1..1	SHALL		1098-30621	Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
component	0..1	MAY		1098-30622	
section	1..1	SHALL		1098-30623	Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09
component	0..1	MAY		1098-30624	
section	1..1	SHALL		1098-30625	Allergies and Intolerances Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09
component	0..1	MAY		1098-30626	
section	1..1	SHALL		1098-30627	Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1
component	0..1	MAY		1098-30628	
section	1..1	SHALL		1098-30629	Interventions Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2014-06-09
component	0..1	MAY		1098-30639	
section	1..1	SHALL		1098-31386	Instructions Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09
component	0..1	MAY		1098-30641	
section	1..1	SHALL		1098-30642	Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.2

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					0.22.2.1:2014-06-09
component	0..1	MAY		1098-30643	
section	1..1	SHALL		1098-30644	Objective Section (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.1
component	0..1	MAY		1098-30645	
section	1..1	SHALL		1098-30646	Physical Exam Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09
component	0..1	MAY		1098-30647	
section	1..1	SHALL		1098-30648	Problem Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09
component	0..1	MAY		1098-30649	
section	1..1	SHALL		1098-30650	Results Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09
component	0..1	MAY		1098-30651	
section	1..1	SHALL		1098-30652	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18
component	0..1	MAY		1098-30653	
section	1..1	SHALL		1098-30654	Subjective Section (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.2
component	0..1	MAY		1098-30655	
section	1..1	SHALL		1098-30656	Vital Signs Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09
component	0..1	MAY		1098-32626	
section	1..1	SHALL		1098-32627	Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57

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2.1.19 Properties

1. Conforms to **US Realm Header (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7588) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.9" (CONF:1098-10052).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32521).

The Progress Note recommends use of a single document type code, 11506-3 "Subsequent evaluation 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.

3. **SHALL** contain exactly one [1..1] **code** (CONF:1098-17189).
   a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ProgressNoteDocumentTypeCode** 2.16.840.1.113883.11.20.8.1 **DYNAMIC** (CONF:1098-17190).

2.1.19.1 documentationOf

A documentationOf can contain a serviceEvent to further specialize the act inherent in the ClinicalDocument/code.

In a Progress Note, a serviceEvent can represent the event of writing the Progress Note. The serviceEvent/effectiveTime is the time period the note documents.

4. **SHOULD** contain zero or one [0..1] **documentationOf** (CONF:1098-7603).
   a. The documentationOf, if present, **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1098-7604).
      i. This serviceEvent **SHALL** contain exactly one [1..1] **@classCode**="PCPR" Care Provision (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-26420).
      ii. This serviceEvent **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-9480) such that it
         1. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.21.3.1" (CONF:1098-10068).
      iii. This serviceEvent **SHOULD** contain zero or one [0..1] **US Realm Date and Time (DT.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1098-9481).
         1. The serviceEvent/effectiveTime element **SHOULD** be present with effectiveTime/low element (CONF:1098-9482).
         2. If a width element is not present, the serviceEvent **SHALL** include effectiveTime/high (CONF:1098-10066).

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Figure 42: Progress Note serviceEvent Example

```
<documentationOf>
  <serviceEvent classCode="PCPR">
    <templateId root="2.16.840.1.113883.10.20.21.3.1" />
    <effectiveTime>
      <low value="200503291200" />
      <high value="200503291400" />
    </effectiveTime>
   ...
  </serviceEvent>
</documentationOf>
```

2.1.19.2 componentOf

The Progress Note is always associated with an encounter by the componentOf/encompassingEncounter element in the header.

The effectiveTime element for an encompassingEncounter represents the time or time interval in which the encounter took place. A single encounter may contain multiple Progress Notes; hence the effectiveTime elements for a Progress Note (recorded in serviceEvent) and for an encounter (recorded in encompassingEncounter) represent different time intervals.

All visits take place at a specific location. When available, the location ID is included in the encompassingEncounter/location/healthCareFacility/id element.

5. **SHALL** contain exactly one [1..1] **componentOf** (CONF:1098-7595).
    a. This componentOf **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1098-7596).
        i. This encompassingEncounter **SHALL** contain at least one [1..*] **id** (CONF:1098-7597).
        ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **US Realm Date and Time (DT.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1098-7598).
            1. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-7599).
        iii. This encompassingEncounter **SHALL** contain exactly one [1..1] **location** (CONF:1098-30879).
            1. This location **SHALL** contain exactly one [1..1] **healthCareFacility** (CONF:1098-30880).
                a. This healthCareFacility **SHALL** contain at least one [1..*] **id** (CONF:1098-30881).

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Figure 43: Progress Note encompassingEncounter Example

```
<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="20090227130000+0500" />
            <high value="20090227130000+0500" />
         </effectiveTime>
         <location>
            <healthCareFacility>
               <id root="2.16.540.1.113883.19.2" />
            </healthCareFacility>
         </location>
      </encompassingEncounter>
</componentOf>
```

2.1.19.3 component

6. **SHALL** contain exactly one [1..1] **component** (CONF:1098-9591).

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

a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1098-30617).
   i. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30618) such that it
      1. **SHALL** contain exactly one [1..1] **Assessment Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1098-30619).
   ii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30620) such that it
      1. **SHALL** contain exactly one [1..1] **Plan of Treatment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30621).
   iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30622) such that it
      1. **SHALL** contain exactly one [1..1] **Assessment and Plan Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1098-30623).
   iv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30624) such that it
      1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09) (CONF:1098-30625).

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v. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30626) such that it
    1. **SHALL** contain exactly one [1..1] **Chief Complaint Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1098-30627).

vi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30628) such that it
    1. **SHALL** contain exactly one [1..1] **Interventions Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2014-06-09) (CONF:1098-30629).

vii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30639) such that it
    1. **SHALL** contain exactly one [1..1] **Instructions Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09) (CONF:1098-31386).

viii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30641) such that it
    1. **SHALL** contain exactly one [1..1] **Medications Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09) (CONF:1098-30642).

ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30643) such that it
    1. **SHALL** contain exactly one [1..1] **Objective Section** (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.1) (CONF:1098-30644).

x. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30645) such that it
    1. **SHALL** contain exactly one [1..1] **Physical Exam Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09) (CONF:1098-30646).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30647) such that it
    1. **SHALL** contain exactly one [1..1] **Problem Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09) (CONF:1098-30648).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30649) such that it
    1. **SHALL** contain exactly one [1..1] **Results Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09) (CONF:1098-30650).

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xiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30651) such that it

1. **SHALL** contain exactly one [1..1] **Review of Systems Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-30652).

xiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30653) such that it

1. **SHALL** contain exactly one [1..1] **Subjective Section** (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.2) (CONF:1098-30654).

xv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30655) such that it

1. **SHALL** contain exactly one [1..1] **Vital Signs Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09) (CONF:1098-30656).

xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-32626) such that it

1. **SHALL** contain exactly one [1..1] **Nutrition Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1098-32627).

xvii. This structuredBody **SHALL** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09), or an Assessment Section (2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30657).

xviii. This structuredBody **SHALL NOT** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1098-30658).

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Table 51: ProgressNoteDocumentTypeCode

Value Set: ProgressNoteDocumentTypeCode 2.16.840.1.113883.11.20.8.1 Specific URL Pending Value Set Source: http://www.loinc.org/			
Code	**Code System**	**Code System OID**	**Print Name**
11506-3	LOINC	2.16.840.1.113883.6.1	Provider-unspecified Progress note
18733-6	LOINC	2.16.840.1.113883.6.1	Physician attending Progress note
28569-2	LOINC	2.16.840.1.113883.6.1	Physician consulting Progress note
28617-9	LOINC	2.16.840.1.113883.6.1	Dentistry Progress note
34900-1	LOINC	2.16.840.1.113883.6.1	General medicine Progress note
34904-3	LOINC	2.16.840.1.113883.6.1	Mental health Progress note
28623-7	LOINC	2.16.840.1.113883.6.1	Nurse Progress note
11507-1	LOINC	2.16.840.1.113883.6.1	Occupational therapy Progress note
11508-9	LOINC	2.16.840.1.113883.6.1	Physical therapy Progress note
11509-7	LOINC	2.16.840.1.113883.6.1	Podiatry Progress note
…			

2.1.20 Referral Note

```
[ClinicalDocument: identifier urn:oid:2.16.840.1.113883.10.20.22.1.14 (open)]
```

Table 52: Referral Note Contexts

Contained By:	**Contains:**
	Advance Directives Section (entries optional) (V2) Allergies and Intolerances Section (entries required) (V2) Assessment and Plan Section (V2) Assessment Section Family History Section (V2) Functional Status Section (V2) General Status Section History of Past Illness Section (V2) History of Present Illness Section Immunizations Section (entries required) (V2) Medical Equipment Section (V2) Medications Section (entries required) (V2) Mental Status Section Nutrition Section

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Contained By:	Contains:
	Physical Exam Section (V2) Plan of Treatment Section (V2) Problem Section (entries required) (V2) Procedures Section (entries optional) (V2) Reason for Referral Section (V2) Results Section (entries required) (V2) Review of Systems Section Social History Section (V2) US Realm Patient Name (PTN.US.FIELDED) US Realm Person Name (PN.US.FIELDED) Vital Signs Section (entries required) (V2)

A Referral Note communicates pertinent information from a provider who is requesting services of another provider of clinical or non-clinical services. The information in this document includes the reason for the referral and additional information that would augment decision making and care delivery.

Examples of referral situations are when a patient is referred from a family physician to a cardiologist for cardiac evaluation or when patient is sent by a cardiologist to an emergency department for angina or when a patient is referred by a nurse practitioner to an audiologist for hearing screening or when a patient is referred by a hospitalist to social services.

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Table 53: Referral Note Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:oid:2.16.840.1.113883.10.20.22.1.14)					
templateId	1..1	SHALL		1098-28947	
@root	1..1	SHALL		1098-28948	2.16.840.1.113883.10.20.22.1.14
code	1..1	SHALL		1098-28949	2.16.840.1.113883.1.11.20.2.3 (ReferralDocumentType)
informationRecipient	1..1	SHALL		1098-31589	
intendedRecipient	1..1	SHALL		1098-31590	
addr	0..*	SHOULD		1098-31591	
telecom	0..*	SHOULD		1098-31592	
informationRecipient	1..1	SHALL		1098-31593	
name	1..*	SHALL		1098-31594	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
participant	0..*	SHOULD		1098-31642	
@typeCode	1..1	SHALL		1098-31924	2.16.840.1.113883.5.90 (HL7ParticipationType) = IND
associatedEntity	1..1	SHALL		1098-31643	
@classCode	1..1	SHALL		1098-31925	2.16.840.1.113883.11.20.9.33 (INDRoleclassCodes)
associatedPerson	1..1	SHALL		1098-31644	
name	1..*	SHALL		1098-31645	US Realm Patient Name (PTN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1
participant	0..*	SHOULD		1098-31647	
@typeCode	1..1	SHALL		1098-31648	2.16.840.1.113883.5.90 (HL7ParticipationType) = CALLBCK
associatedEntity	1..1	SHALL		1098-31649	
@classCode	1..1	SHALL		1098-32419	2.16.840.1.113883.5.110 (RoleClass) = ASSIGNED

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id	1..*	SHALL		1098-31650	
addr	0..*	SHOULD		1098-31651	
telecom	1..*	SHALL		1098-31652	
associatedPerson	1..1	SHALL		1098-31653	
name	1..*	SHALL		1098-31654	
scopingOrganization	0..1	MAY		1098-31655	
component	1..1	SHALL		1098-29062	
structuredBody	1..1	SHALL		1098-29063	
component	0..1	SHOULD		1098-29066	
section	1..1	SHALL		1098-29067	Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
component	0..1	MAY		1098-29068	
section	1..1	SHALL		1098-29069	Advance Directives Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09
component	0..1	MAY		1098-29074	
section	1..1	SHALL		1098-29075	History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4
component	0..1	MAY		1098-29076	
section	1..1	SHALL		1098-29077	Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09
component	0..1	MAY		1098-29082	
section	1..1	SHALL		1098-29083	Immunizations Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2014-06-09
component	1..1	SHALL		1098-29086	
section	1..1	SHALL		1098-	Problem Section (entries required)

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				29087	(V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09
component	0..1	MAY		1098-29088	
section	1..1	SHALL		1098-29089	Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09
component	0..1	SHOULD		1098-29090	
section	1..1	SHALL		1098-29091	Results Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09
component	0..1	MAY		1098-29092	
section	1..1	SHALL		1098-29093	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18
component	0..1	MAY		1098-29094	
section	1..1	SHALL		1098-29095	Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09
component	0..1	MAY		1098-29096	
section	1..1	SHALL		1098-29097	Vital Signs Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09
component	0..1	SHOULD		1098-29098	
section	1..1	SHALL		1098-29099	Functional Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09
component	0..1	MAY		1098-29100	
section	1..1	SHALL		1098-29101	Physical Exam Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09
component	0..1	MAY		1098-29564	
section	1..1	SHALL		1098-29565	Advance Directives Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.2

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					0.22.2.21:2014-06-09
component	0..1	SHOULD		1098-30780	
section	1..1	SHALL		1098-30781	Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57
component	0..1	SHOULD		1098-30796	
section	1..1	SHALL		1098-30926	Mental Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.56
component	0..1	MAY		1098-30798	
section	1..1	SHALL		1098-30799	Medical Equipment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09
component	1..1	SHALL		1098-30911	
section	1..1	SHALL		1098-30912	Allergies and Intolerances Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09
component	0..1	MAY		1098-30913	
section	1..1	SHALL		1098-30914	Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8
component	0..1	MAY		1098-30915	
section	1..1	SHALL		1098-30916	Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09
component	0..1	MAY		1098-30917	
section	1..1	SHALL		1098-30918	History of Past Illness Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09
component	0..1	MAY		1098-30919	
section	1..1	SHALL		1098-30920	General Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.5
component	1..1	SHALL		1098-30922	
section	1..1	SHALL		1098-30923	Medications Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.2

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					0.22.2.1.1:2014-06-09
component	1..1	SHALL		1098-30924	
section	1..1	SHALL		1098-30925	Reason for Referral Section (V2) (identifier: urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.1:2014-06-09

2.1.21 Properties

1. Conforms to **US Realm Header (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-28947) such that it
   a. **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.10.20.22.1.14" (CONF:1098-28948).

The Referral Note recommends use of the document type code 57133-1 "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. The type of referral and the target of the referral are specified via the participant (and not via the author).

3. **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet **ReferralDocumentType** 2.16.840.1.113883.1.11.20.2.3 **DYNAMIC** (CONF:1098-28949).

2.1.21.1 informationRecipient

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

4. **SHALL** contain exactly one [1..1] **informationRecipient** (CONF:1098-31589).
   a. This informationRecipient **SHALL** contain exactly one [1..1] **intendedRecipient** (CONF:1098-31590).
      i. This intendedRecipient **SHOULD** contain zero or more [0..*] **addr** (CONF:1098-31591).
      ii. This intendedRecipient **SHOULD** contain zero or more [0..*] **telecom** (CONF:1098-31592).
      iii. This intendedRecipient **SHALL** contain exactly one [1..1] **informationRecipient** (CONF:1098-31593).
         1. This informationRecipient **SHALL** contain at least one [1..*] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-31594).

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Figure 44: Referral Note informationRecipient Example

```
<informationRecipient>
    <intendedRecipient>
        <informationRecipient>
            <name>
                <given>Nancy</given>
                <family>Nightingale</family>
                <suffix qualifier="AC">RN</suffix>
            </name>
        </informationRecipient>
        <receivedOrganization>
            <name>Community Health and Hospitals</name>
            <telecom value="tel:+1(555)-555-1002" use="WP" />
            <addr use="WP">
                <streetAddressLine>Cardiac Stepdown Unit, 4B </streetAddressLine>
                <streetAddressLine>1002 Healthcare Drive </streetAddressLine>
                <city>Ann Arbor</city>
                <state>MI</state>
                <postalCode>97857</postalCode>
                <country>US</country>
            </addr>
        </receivedOrganization>
    </intendedRecipient>
</informationRecipient>
```

2.1.21.2 participant

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

5. **SHOULD** contain zero or more [0..*] **participant** (CONF:1098-31642) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="IND" Indirect (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:1098-31924).
    b. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1098-31643).
        i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode**, which **SHALL** be selected from ValueSet **INDRoleclassCodes** 2.16.840.1.113883.11.20.9.33 **DYNAMIC** (CONF:1098-31925).
        ii. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1098-31644).
            1. This associatedPerson **SHALL** contain at least one [1..*] **US Realm Patient Name (PTN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1) (CONF:1098-31645).

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Figure 45: Referral Note Caregiver Example

```
<participant typeCode="IND">
    <functionCode code="407543004" displayName="Primary Carer"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED-CT" />
    <!-- Caregiver -->
    <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: 1+(555)555-1212" use="WP" />
        <associatedPerson>
            <name>
                <prefix>Mrs.</prefix>
                <given>Martha</given>
                <family>Jones</family>
            </name>
        </associatedPerson>
    </associatedEntity>
</participant>
```

2.1.21.3 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.

This participant represents the clinician to contact for questions about the referral note. This call back contact individual may be a different person than the individual(s) identified in the author or legalAuthenticator participant.

6. **SHOULD** contain zero or more [0..*] **participant** (CONF:1098-31647) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="CALLBCK" call back contact (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **DYNAMIC**) (CONF:1098-31648).
    b. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1098-31649).
        i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode**="ASSIGNED" assigned entity (CodeSystem: RoleClass 2.16.840.1.113883.5.110) (CONF:1098-32419).
        ii. This associatedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-31650).
        iii. This associatedEntity **SHOULD** contain zero or more [0..*] **addr** (CONF:1098-31651).
        iv. This associatedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:1098-31652).
        v. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1098-31653).

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1. This associatedPerson **SHALL** contain at least one [1..*] **name** (CONF:1098-31654).

vi. This associatedEntity **MAY** contain zero or one [0..1] **scopingOrganization** (CONF:1098-31655).

Figure 46: Referral Note Callback Contact Example

```
<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 & 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>
                <suffix>DO</suffix>
            </name>
        </associatedPerson>
    </associatedEntity>
</participant>
```

2.1.21.4 component

7. **SHALL** contain exactly one [1..1] **component** (CONF:1098-29062).
   a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1098-29063).
      i. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-29066) such that it
         1. **SHALL** contain exactly one [1..1] **Plan of Treatment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-29067).
      ii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-29068) such that it
         1. **SHALL** contain exactly one [1..1] **Advance Directives Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09) (CONF:1098-29069).
      iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-29074) such that it

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1. **SHALL** contain exactly one [1..1] **History of Present Illness Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1098-29075).

iv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-29076) such that it

1. **SHALL** contain exactly one [1..1] **Family History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-29077).

v. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-29082) such that it

1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2014-06-09) (CONF:1098-29083).

vi. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-29086) such that it

1. **SHALL** contain exactly one [1..1] **Problem Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09) (CONF:1098-29087).

vii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-29088) such that it

1. **SHALL** contain exactly one [1..1] **Procedures Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09) (CONF:1098-29089).

viii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-29090) such that it

1. **SHALL** contain exactly one [1..1] **Results Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09) (CONF:1098-29091).

ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-29092) such that it

1. **SHALL** contain exactly one [1..1] **Review of Systems Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-29093).

x. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-29094) such that it

1. **SHALL** contain exactly one [1..1] **Social History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-29095).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-29096) such that it

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1. **SHALL** contain exactly one [1..1] **Vital Signs Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09) (CONF:1098-29097).

xii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-29098) such that it

1. **SHALL** contain exactly one [1..1] **Functional Status Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09) (CONF:1098-29099).

xiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-29100) such that it

1. **SHALL** contain exactly one [1..1] **Physical Exam Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09) (CONF:1098-29101).

xiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-29564) such that it

1. **SHALL** contain exactly one [1..1] **Advance Directives Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09) (CONF:1098-29565).

xv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-30780) such that it

1. **SHALL** contain exactly one [1..1] **Nutrition Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1098-30781).

xvi. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-30796) such that it

1. **SHALL** contain exactly one [1..1] **Mental Status Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.56) (CONF:1098-30926).

xvii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30798) such that it

1. **SHALL** contain exactly one [1..1] **Medical Equipment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09) (CONF:1098-30799).

xviii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30911) such that it

1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09) (CONF:1098-30912).

xix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30913) such that it

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1. **SHALL** contain exactly one [1..1] **Assessment Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1098-30914).

xx. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30915) such that it

1. **SHALL** contain exactly one [1..1] **Assessment and Plan Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1098-30916).

xxi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30917) such that it

1. **SHALL** contain exactly one [1..1] **History of Past Illness Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09) (CONF:1098-30918).

xxii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30919) such that it

1. **SHALL** contain exactly one [1..1] **General Status Section** (identifier: urn:oid:2.16.840.1.113883.10.20.2.5) (CONF:1098-30920).

xxiii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30922) such that it

1. **SHALL** contain exactly one [1..1] **Medications Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09) (CONF:1098-30923).

xxiv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-30924) such that it

1. **SHALL** contain exactly one [1..1] **Reason for Referral Section (V2)** (identifier: urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.1:2014-06-09) (CONF:1098-30925).

xxv. This structuredBody **SHALL** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09), or an Assessment Section (2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-29102).

xxvi. This structuredBody **SHALL NOT** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1098-29103).

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Table 54: 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. Specific URL Pending Value Set Source: http://www.loinc.org/			
Code	**Code System**	**Code System OID**	**Print Name**
57133-1	LOINC	2.16.840.1.113883.6.1	Referral note
57170-3	LOINC	2.16.840.1.113883.6.1	Cardiovascular disease Referral note
57178-6	LOINC	2.16.840.1.113883.6.1	Critical Care Medicine Referral note
57134-9	LOINC	2.16.840.1.113883.6.1	Dentistry Referral note
57135-6	LOINC	2.16.840.1.113883.6.1	Dermatology Referral note
57136-4	LOINC	2.16.840.1.113883.6.1	Diabetology Referral note
57137-2	LOINC	2.16.840.1.113883.6.1	Endocrinology Referral note
57138-0	LOINC	2.16.840.1.113883.6.1	Gastroenterology Referral note
57139-8	LOINC	2.16.840.1.113883.6.1	General medicine Referral note
57171-1	LOINC	2.16.840.1.113883.6.1	Geriatric medicine Referral note
…			

2.1.22 Transfer Summary

```
[ClinicalDocument: identifier urn:oid:2.16.840.1.113883.10.20.22.1.13 (open)]
```

Table 55: Transfer Summary Contexts

Contained By:	**Contains:**
	Admission Diagnosis Section (V2) Admission Medications Section (entries optional) (V2) Advance Directives Section (entries required) (V2) Allergies and Intolerances Section (entries required) (V2) Assessment and Plan Section (V2) Assessment Section Course of Care Section Discharge Diagnosis Section (V2) Encounters Section (entries required) (V2) Family History Section (V2) Functional Status Section (V2) General Status Section History of Past Illness Section (V2) History of Present Illness Section

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Contained By:	Contains:
	Immunizations Section (entries optional) (V2) Medical Equipment Section (V2) Medications Section (entries required) (V2) Mental Status Section Nutrition Section Payers Section (V2) Physical Exam Section (V2) Plan of Treatment Section (V2) Problem Section (entries required) (V2) Procedures Section (entries required) (V2) Reason for Referral Section (V2) Results Section (entries required) (V2) Review of Systems Section Social History Section (V2) Vital Signs Section (entries required) (V2)

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.

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Table 56: Transfer Summary Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:oid:2.16.840.1.113883.10.20.22.1.13)					
templateId	1..1	SHALL		1098-28239	
@root	1..1	SHALL		1098-28240	2.16.840.1.113883.10.20.22.1.13
code	1..1	SHALL		1098-28243	2.16.840.1.113883.1.11.20.2.4 (TransferDocumentType)
title	1..1	SHALL		1098-29838	
participant	0..*	SHOULD		1098-31599	
@typeCode	1..1	SHALL		1098-31872	2.16.840.1.113883.5.90 (HL7ParticipationType) = IND
associatedEntity	1..1	SHALL		1098-31600	
@classCode	1..1	SHALL		1098-31873	2.16.840.1.113883.11.20.9.33 (INDRoleclassCodes)
associatedPerson	1..1	SHALL		1098-31601	
name	1..*	SHALL		1098-31602	
participant	0..*	SHOULD		1098-31626	
@typeCode	1..1	SHALL		1098-31627	2.16.840.1.113883.5.90 (HL7ParticipationType) = CALLBCK
associatedEntity	1..1	SHALL		1098-31628	
@classCode	1..1	SHALL		1098-31641	2.16.840.1.113883.5.110 (RoleClass) = ASSIGNED
id	1..*	SHALL		1098-31629	
addr	0..*	SHOULD		1098-31630	
telecom	1..*	SHALL		1098-31631	
associatedPerson	1..1	SHALL		1098-31632	
name	1..*	SHALL		1098-31633	
scopingOrganization	0..1	MAY		1098-31634	
documentationOf	1..1	SHALL		1098-31570	

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serviceEvent	1..1	SHALL		1098-31571	
@classCode	1..1	SHALL		1098-31572	2.16.840.1.113883.5.6 (HL7ActClass) = PCPR
code	0..1	MAY		1098-32650	
performer	1..*	SHALL		1098-31574	
@typeCode	1..1	SHALL		1098-31575	2.16.840.1.113883.5.90 (HL7ParticipationType) = PRF
functionCode	0..1	MAY		1098-32651	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
component	1..1	SHALL		1098-28251	
structuredBody	1..1	SHALL		1098-28252	
component	0..1	SHOULD		1098-28253	
section	1..1	SHALL		1098-28254	Advance Directives Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21.1:2014-06-09
component	1..1	SHALL		1098-28255	
section	1..1	SHALL		1098-28256	Allergies and Intolerances Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09
component	0..1	MAY		1098-28257	
section	1..1	SHALL		1098-28258	Physical Exam Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09
component	0..1	MAY		1098-28261	
section	1..1	SHALL		1098-28262	Encounters Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.22.1:2014-06-09
component	0..1	MAY		1098-28263	
section	1..1	SHALL		1098-28264	Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09
component	0..1	SHOULD		1098-28265	

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section	1..1	SHALL		1098-28266	Functional Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09
component	0..1	SHOULD		1098-28271	
section	1..1	SHALL		1098-28272	Discharge Diagnosis Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2014-06-09
component	0..1	MAY		1098-28273	
section	1..1	SHALL		1098-28274	Immunizations Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09
component	0..1	MAY		1098-28275	
section	1..1	SHALL		1098-28276	Medical Equipment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09
component	1..1	SHALL		1098-28277	
section	1..1	SHALL		1098-28278	Medications Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09
component	0..1	MAY		1098-28279	
section	1..1	SHALL		1098-28280	Payers Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.18:2014-06-09
component	0..1	MAY		1098-28281	
section	1..1	SHALL		1098-28282	Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
component	1..1	SHALL		1098-28283	
section	1..1	SHALL		1098-28284	Problem Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09
component	0..1	SHOULD		1098-28285	
section	1..1	SHALL		1098-28286	Procedures Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.2

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					0.22.2.7.1:2014-06-09
component	1..1	SHALL		1098-28287	
section	1..1	SHALL		1098-28288	Results Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09
component	0..1	SHOULD		1098-28289	
section	1..1	SHALL		1098-28290	Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09
component	1..1	SHALL		1098-28291	
section	1..1	SHALL		1098-28292	Vital Signs Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09
component	0..1	SHOULD		1098-28327	
section	1..1	SHALL		1098-28328	Mental Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.56
component	0..1	MAY		1098-28838	
section	1..1	SHALL		1098-28839	General Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.5
component	0..1	MAY		1098-30239	
section	1..1	SHALL		1098-30240	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18
component	0..1	SHOULD		1098-30776	
section	1..1	SHALL		1098-30777	Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57
component	1..1	SHALL		1098-31342	
section	1..1	SHALL		1098-31343	Reason for Referral Section (V2) (identifier: urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.1:2014-06-09
component	0..1	MAY		1098-31561	
section	1..1	SHALL		1098-	History of Past Illness Section (V2) (identifier:

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				31562	urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09
component	0..1	SHOULD		1098-31563	
section	1..1	SHALL		1098-31564	History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4
component	0..1	MAY		1098-31565	
section	1..1	SHALL		1098-31566	Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09
component	0..1	MAY		1098-31567	
section	1..1	SHALL		1098-31568	Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8
component	0..1	MAY		1098-32445	
section	1..1	SHALL		1098-32446	Admission Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2014-06-09
component	0..1	MAY		1098-32447	
section	1..1	SHALL		1098-32448	Admission Diagnosis Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2014-06-09
component	0..1	MAY		1098-32648	
section	1..1	SHALL		1098-32649	Course of Care Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.64

2.1.23 Properties

1. Conforms to **US Realm Header (V2)** template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)`.
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-28239) such that it
   a. **SHALL** contain exactly one [1..1] **@root="**`2.16.840.1.113883.10.20.22.1.13`**"** (CONF:1098-28240).

The Transfer Summary recommends use of the document type code 18761-7 "Provider Unspecified Transfer Summary", 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

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document type. For example, an Obstetrics and Gynecology Transfer Summary note would not be authored by a Pediatric Cardiologist.

Pre-coordinated codes are those that indicate the specialty or service provided in the LOINC Long Common Name (Print Name in the TransferDocumentType valueSet table).

When using a generic type of code such as 18761-7 (Provider - Unspecified Transfer Summary), the types of services involved in the care are handled in documentationOf/serviceEvent with the use of serviceEvent/code (e.g., use a SNOMED CT procedure code such as 69031006 (Excision of breast tissue) while performers/providers involved in the care can be identified using the functionCode (bound to Healthcare Provider Taxonomy role codes).

3. **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet **TransferDocumentType** `2.16.840.1.113883.1.11.20.2.4` **DYNAMIC** (CONF:1098-28243).
4. **SHALL** contain exactly one [1..1] **title** (CONF:1098-29838).

2.1.23.1 participant

This participant identifies individuals who support the patient such as a relative or caregiver.

5. **SHOULD** contain zero or more [0..*] **participant** (CONF:1098-31599) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="`IND`" indirect (CodeSystem: `HL7ParticipationType 2.16.840.1.113883.5.90`) (CONF:1098-31872).
    b. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1098-31600).
        i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode** (ValueSet: **INDRoleclassCodes** `2.16.840.1.113883.11.20.9.33` **DYNAMIC**) (CONF:1098-31873).
        ii. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1098-31601).
            1. This associatedPerson **SHALL** contain at least one [1..*] **name** (CONF:1098-31602).

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Figure 47: Transfer Summary participant (Support) Example

```
<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>
```


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2.1.23.2 participant

This participant represents the clinician to contact for questions about the transfer summary. This call back contact individual may be a different person than the individual(s) identified in the author or legalAuthenticator participant.

6. **SHOULD** contain zero or more [0..*] **participant** (CONF:1098-31626) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="CALLBCK" Call back contact (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:1098-31627).
    b. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1098-31628).
        i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode**="ASSIGNED" assigned entity (CodeSystem: RoleClass 2.16.840.1.113883.5.110) (CONF:1098-31641).
        ii. This associatedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-31629).
        iii. This associatedEntity **SHOULD** contain zero or more [0..*] **addr** (CONF:1098-31630).
        iv. This associatedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:1098-31631).
        v. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1098-31632).
            1. This associatedPerson **SHALL** contain at least one [1..*] **name** (CONF:1098-31633).
        vi. This associatedEntity **MAY** contain zero or one [0..1] **scopingOrganization** (CONF:1098-31634).

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Figure 48: Transfer Summary Callback Contact Example

```
<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 & 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>
```

2.1.23.3 documentationOf

7. **SHALL** contain exactly one [1..1] **documentationOf** (CONF:1098-31570).

The serviceEvent in a Transfer Note contains the representation of providers who are wholly or partially responsible for the safety and well-being of a subject of care.

a. This documentationOf **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1098-31571).

i. This serviceEvent **SHALL** contain exactly one [1..1] **@classCode**="`PCPR`" Care Provision (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6`) (CONF:1098-31572).

Use serviceEvent/code when using a generic document type code such as 18761-7 (Provider-Unspecified Transfer Summary) to represent the service.

ii. This serviceEvent **MAY** contain zero or one [0..1] **code** (CONF:1098-32650).

2.1.23.4 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.

iii. This serviceEvent **SHALL** contain at least one [1..*] **performer** (CONF:1098-31574) such that it

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1. **SHALL** contain exactly one [1..1] **@typeCode**="PRF" Participation of Physical Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **DYNAMIC**) (CONF:1098-31575).

Use performer/functionCode when using a generic document type code such as 18761-7 (Provider-Unspecified Transfer Summary) to represent the provider.

2. **MAY** contain zero or one [0..1] **functionCode**, which **SHOULD** be selected from ValueSet **Healthcare Provider Taxonomy (HIPAA)** 2.16.840.1.114222.4.11.1066 **DYNAMIC** (CONF:1098-32651).

2.1.23.5 component

8. **SHALL** contain exactly one [1..1] **component** (CONF:1098-28251).
   a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1098-28252).
      i. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-28253) such that it
         1. **SHALL** contain exactly one [1..1] **Advance Directives Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21.1:2014-06-09) (CONF:1098-28254).
      ii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-28255) such that it
         1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09) (CONF:1098-28256).
      iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28257) such that it
         1. **SHALL** contain exactly one [1..1] **Physical Exam Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09) (CONF:1098-28258).
      iv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28261) such that it
         1. **SHALL** contain exactly one [1..1] **Encounters Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.22.1:2014-06-09) (CONF:1098-28262).
      v. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28263) such that it
         1. **SHALL** contain exactly one [1..1] **Family History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-28264).
      vi. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-28265) such that it

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1. **SHALL** contain exactly one [1..1] **Functional Status Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09) (CONF:1098-28266).

vii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-28271) such that it

1. **SHALL** contain exactly one [1..1] **Discharge Diagnosis Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2014-06-09) (CONF:1098-28272).

viii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28273) such that it

1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09) (CONF:1098-28274).

ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28275) such that it

1. **SHALL** contain exactly one [1..1] **Medical Equipment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09) (CONF:1098-28276).

x. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-28277) such that it

1. **SHALL** contain exactly one [1..1] **Medications Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09) (CONF:1098-28278).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28279) such that it

1. **SHALL** contain exactly one [1..1] **Payers Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.18:2014-06-09) (CONF:1098-28280).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28281) such that it

1. **SHALL** contain exactly one [1..1] **Plan of Treatment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-28282).

xiii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-28283) such that it

1. **SHALL** contain exactly one [1..1] **Problem Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09) (CONF:1098-28284).

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xiv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-28285) such that it

1. **SHALL** contain exactly one [1..1] **Procedures Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7.1:2014-06-09) (CONF:1098-28286).

xv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-28287) such that it

1. **SHALL** contain exactly one [1..1] **Results Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09) (CONF:1098-28288).

xvi. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-28289) such that it

1. **SHALL** contain exactly one [1..1] **Social History Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-28290).

xvii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-28291) such that it

1. **SHALL** contain exactly one [1..1] **Vital Signs Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09) (CONF:1098-28292).

xviii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-28327) such that it

1. **SHALL** contain exactly one [1..1] **Mental Status Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.56) (CONF:1098-28328).

xix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-28838) such that it

1. **SHALL** contain exactly one [1..1] **General Status Section** (identifier: urn:oid:2.16.840.1.113883.10.20.2.5) (CONF:1098-28839).

xx. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-30239) such that it

1. **SHALL** contain exactly one [1..1] **Review of Systems Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-30240).

xxi. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-30776) such that it

1. **SHALL** contain exactly one [1..1] **Nutrition Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1098-30777).

xxii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1098-31342) such that it

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1. **SHALL** contain exactly one [1..1] **Reason for Referral Section (V2)** (identifier: urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.1:2014-06-09) (CONF:1098-31343).

xxiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-31561) such that it

1. **SHALL** contain exactly one [1..1] **History of Past Illness Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09) (CONF:1098-31562).

xxiv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1098-31563) such that it

1. **SHALL** contain exactly one [1..1] **History of Present Illness Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1098-31564).

xxv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-31565) such that it

1. **SHALL** contain exactly one [1..1] **Assessment and Plan Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1098-31566).

xxvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-31567) such that it

1. **SHALL** contain exactly one [1..1] **Assessment Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1098-31568).

xxvii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-32445) such that it

1. **SHALL** contain exactly one [1..1] **Admission Medications Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2014-06-09) (CONF:1098-32446).

xxviii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-32447) such that it

1. **SHALL** contain exactly one [1..1] **Admission Diagnosis Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2014-06-09) (CONF:1098-32448).

xxix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1098-32648) such that it

1. **SHALL** contain exactly one [1..1] **Course of Care Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.64) (CONF:1098-32649).

xxx. This structuredBody **SHALL** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09), or an Assessment Section

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(2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-31582).

xxxi. This structuredBody **SHALL NOT** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1098-31583).

Table 57: 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.

This value set includes all LOINC codes whose Component = Transfer Summary Note* and SCALE_TYPE = Doc.

Value Set Source: http://search.loinc.org/search.zul?query=transfer+summary+note

Code	Code System	Code System OID	Print Name
18761-7	LOINC	2.16.840.1.113883.6.1	Provider-unspecified Transfer summary
68618-8	LOINC	2.16.840.1.113883.6.1	Adolescent medicine Transfer summarization note
68632-9	LOINC	2.16.840.1.113883.6.1	Allergy and immunology Transfer summarization note
68647-7	LOINC	2.16.840.1.113883.6.1	Child and adolescent psychiatry Transfer summarization note
68660-0	LOINC	2.16.840.1.113883.6.1	Clinical genetics Transfer summarization note
34755-9	LOINC	2.16.840.1.113883.6.1	Critical Care Medicine Transfer summarization note
68669-1	LOINC	2.16.840.1.113883.6.1	Developmental-behavioral pediatrics Transfer summarization note
34770-8	LOINC	2.16.840.1.113883.6.1	General medicine Transfer summarization note
68680-8	LOINC	2.16.840.1.113883.6.1	Multi-specialty program Transfer summarization note
68704-6	LOINC	2.16.840.1.113883.6.1	Neurology with special qualifications in child neurology Transfer summary note
…			

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2.1.24 Unstructured Document (V2)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.10:2014-06-09 (open)]

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 examples that 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 template 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, implementers need to ensure that their documents at a minimum conform with the SHALL constraints from either specification.

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Table 58: Unstructured Document (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.10:2014-06-09)					
templateId	1..1	SHALL		1098-7710	
@root	1..1	SHALL		1098-10054	2.16.840.1.113883.10.20.22.1.10
@extension	1..1	SHALL		1098-32522	2014-06-09
recordTarget	1..*	SHALL		1098-31089	
patientRole	1..1	SHALL		1098-31090	
id	1..*	SHALL		1098-31091	
custodian	1..1	SHALL		1098-31096	
assignedCustodian	1..1	SHALL		1098-31097	
representedCustodianOrganization	1..1	SHALL		1098-31098	
component	1..1	SHALL		1098-31085	
nonXMLBody	1..1	SHALL		1098-31086	
text	1..1	SHALL		1098-31087	
@mediaType	0..1	MAY		1098-31088	2.16.840.1.113883.11.20.7.1 (SupportedFileFormats)

2.1.25 Properties

1. Conforms to **US Realm Header (V2)** template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)`.
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7710) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.1.10`" (CONF:1098-10054).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32522).

2.1.25.1 recordTarget

3. **SHALL** contain at least one [1..*] **recordTarget** (CONF:1098-31089).
   a. Such recordTargets **SHALL** contain exactly one [1..1] **patientRole** (CONF:1098-31090).
      i. This patientRole **SHALL** contain at least one [1..*] **id** (CONF:1098-31091).

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2.1.25.2 custodian

4. **SHALL** contain exactly one [1..1] **custodian** (CONF:1098-31096).
    a. This custodian **SHALL** contain exactly one [1..1] **assignedCustodian** (CONF:1098-31097).
        i. This assignedCustodian **SHALL** contain exactly one [1..1] **representedCustodianOrganization** (CONF:1098-31098).
5. **SHALL** contain exactly one [1..1] **component** (CONF:1098-31085).

2.1.25.3 nonXMLBody

An Unstructured Document must include a nonXMLBody component with a single text element. The text element can reference an external file using a reference element, or include unstructured content directly with a mediaType attribute.

The nonXMLBody/text element also has a "compression" attribute that can be used to indicate that the unstructured content was compressed before being Base64Encoded. At a minimum, a compression value of "DF" for the deflate compression algorithm (RFC 1951 **http://www.ietf.org/rfc/rfc1951.txt**) must be supported although it is not required that content be compressed.

a. This component **SHALL** contain exactly one [1..1] **nonXMLBody** (CONF:1098-31086).
    i. This nonXMLBody **SHALL** contain exactly one [1..1] **text** (CONF:1098-31087).
        1. 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 **DYNAMIC** (CONF:1098-31088).
        2. If the text element does not contain a reference element with a value attribute, then it **SHALL** contain exactly one [1..1] @representation="B64" and exactly one [1..1] @mediaType (CONF:1098-31103).

Figure 49: nonXMLBody Example with Embedded Content

```
<component>
  <nonXMLBody>
    <text mediaType="text/rtf" representation="B64">e1xydGY...</text>
  </nonXMLBody>
</component>
```

Figure 50: nonXMLBody Example with Referenced Content

```
<component>
  <nonXMLBody>
    <text>
      <reference value="UD_sample.pdf" />
    </text>
  </nonXMLBody>
</component>
```


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Figure 51: nonXMLBody Example with Compressed Content

```
<component>
  <nonXMLBody>
    <text mediaType="text/rtf" representation="B64"
compression="DF">dhUhkasd437hbjfQS7…</text>
  </nonXMLBody>
</component>
```

Table 59: 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. Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
application/msword	Media Type	2.16.840.1.113883.5.79	MSWORD
application/pdf	Media Type	2.16.840.1.113883.5.79	PDF
text/plain	Media Type	2.16.840.1.113883.5.79	Plain Text
text/rtf	Media Type	2.16.840.1.113883.5.79	RTF Text
text/html	Media Type	2.16.840.1.113883.5.79	HTML Text
image/gif	Media Type	2.16.840.1.113883.5.79	GIF Image
image/tiff	Media Type	2.16.840.1.113883.5.79	TIF Image
image/jpeg	Media Type	2.16.840.1.113883.5.79	JPEG Image
image/png	Media Type	2.16.840.1.113883.5.79	PNG Image

2.1.26 US Realm Header for Patient Generated Document

`[ClinicalDocument: identifier urn:oid:2.16.840.1.113883.10.20.29.1 (open)]`

This template is designed to be used in conjunction with the US Realm Header (V2). It includes additional conformances which further constrain the US Realm Header (V2).

The Patient Generated Document Header template is not a separate document type. The document body may contain any structured or unstructured content from C-CDA.

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Table 60: US Realm Header for Patient Generated Document Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:oid:2.16.840.1.113883.10.20.29.1)					
templateId	1..1	SHALL		1098-28458	
@root	1..1	SHALL		1098-28459	2.16.840.1.113883.10.20.29.1
recordTarget	1..1	SHALL		1098-28460	
patientRole	1..1	SHALL		1098-28461	
id	1..*	SHALL		1098-28462	
patient	1..1	SHALL		1098-28465	
guardian	0..*	MAY		1098-28469	
id	0..*	SHOULD		1098-28470	
code	0..1	SHOULD		1098-28473	2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)
languageCommunication	0..*	SHOULD		1098-28474	
preferenceInd	0..1	MAY		1098-28475	
providerOrganization	0..1	MAY		1098-28476	
author	1..*	SHALL		1098-28477	
assignedAuthor	1..1	SHALL		1098-28478	
id	1..*	SHALL		1098-28479	
code	0..1	SHOULD		1098-28481	
@code	1..1	SHALL		1098-28676	2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)
dataEnterer	0..1	MAY		1098-28678	
assignedEntity	1..1	SHALL		1098-28679	
code	0..1	MAY		1098-28680	2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)

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informant	0..*	MAY		1098-28681	
relatedEntity	1..1	SHALL		1098-28682	
code	0..1	MAY		1098-28683	
@code	0..1	SHOULD		1098-28684	2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)
custodian	1..1	SHALL		1098-28685	
assignedCustodian	1..1	SHALL		1098-28686	
representedCustodianOrganization	1..1	SHALL		1098-28687	
id	1..*	SHALL		1098-28688	
informationRecipient	0..*	MAY		1098-28690	
intendedRecipient	1..1	SHALL		1098-28691	
id	0..*	SHOULD		1098-28692	
@root	0..1	SHOULD		1098-28693	
legalAuthenticator	0..1	MAY		1098-28694	
assignedEntity	1..1	SHALL		1098-28695	
id	1..*	SHALL		1098-28696	
code	0..1	MAY		1098-28697	
@code	0..1	MAY		1098-28698	2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)
authenticator	0..*	MAY		1098-28699	
assignedEntity	1..1	SHALL		1098-28700	
id	1..*	SHALL		1098-28701	
code	0..1	SHOULD		1098-28702	2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)
participant	0..*	MAY		1098-28703	
@typeCode	1..1	SHALL		1098-	

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				28704	
associatedEntity	1..1	SHALL		1098-28705	
code	0..1	SHOULD		1098-28706	2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)
inFulfillmentOf	0..*	MAY		1098-28707	
order	1..1	SHALL		1098-28708	
id	1..*	SHALL		1098-28709	
documentationOf	0..*	MAY		1098-28710	
serviceEvent	1..1	SHALL		1098-28711	
code	0..1	SHOULD		1098-28712	
performer	0..*	SHOULD		1098-28713	
functionCode	0..1	MAY		1098-28714	
assignedEntity	1..1	SHALL		1098-28715	
id	1..*	SHALL		1098-28716	
code	0..1	MAY		1098-28718	2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)

2.1.27 Properties

1. Conforms to **US Realm Header (V2)** template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)`.
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-28458) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.29.1`" (CONF:1098-28459).

2.1.27.1 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 patient's language of preference and the predominant language used by the organization receiving the CDA.

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HL7 Vocabulary simply describes guardian as a relationship to a ward. This need not be a formal legal relationship. When a guardian relationship exists for the patient, it can be represented, regardless of who is present at the time the document is generated. This need not be a formal legal relationship. A child's parent can 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 can 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.

3. **SHALL** contain exactly one [1..1] **recordTarget** (CONF:1098-28460).
    a. This recordTarget **SHALL** contain exactly one [1..1] **patientRole** (CONF:1098-28461).
        i. This patientRole **SHALL** contain at least one [1..*] **id** (CONF:1098-28462).
        ii. This patientRole **SHALL** contain exactly one [1..1] **patient** (CONF:1098-28465).
            1. This patient **MAY** contain zero or more [0..*] **guardian** (CONF:1098-28469).
                a. The guardian, if present, **SHOULD** contain zero or more [0..*] **id** (CONF:1098-28470).
                b. 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:1098-28473).
            2. This patient **SHOULD** contain zero or more [0..*] **languageCommunication** (CONF:1098-28474).
                a. The languageCommunication, if present, **MAY** contain zero or one [0..1] **preferenceInd** (CONF:1098-28475).
                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.

        iii. This patientRole **MAY** contain zero or one [0..1] **providerOrganization** (CONF:1098-28476).
        Note: If present, this organization represents the provider organization where the person is claiming to be a patient.

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Figure 52: Patient Generated Document 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>
                <!-- The "SP" is "Spouse" from
                     HL7 Code System EntityNamePartQualifier 2.16.840.1.113883.5.43 -->
                <family qualifier="SP">Betterhalf</family>
            </name>
            <!-- The second name element represents another name
                 associated with the patient -->
            <name>
                <given>Eve</given>
                <!-- The "BR" is "Birth" from
                     HL7 Code System EntityNamePartQualifier 2.16.840.1.113883.5.43 -->
                <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 & 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 & Ethnicity - CDC" />
            <ethnicGroupCode code="2186-5" displayName="Not Hispanic or Latino"
codeSystem="2.16.840.1.113883.6.238" codeSystemName="Race & Ethnicity - CDC" />
            <guardian>
                <id root="2.16.840.1.113883.4.1" extension="111-22-3333" />
                <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>
```


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```
                    <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>
```


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2.1.27.2 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.

4. **SHALL** contain at least one [1..*] **author** (CONF:1098-28477).
    a. Such authors **SHALL** contain exactly one [1..1] **assignedAuthor** (CONF:1098-28478).
        i. This assignedAuthor **SHALL** contain at least one [1..*] **id** (CONF:1098-28479).

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.

        ii. This assignedAuthor **SHOULD** contain zero or one [0..1] **code** (CONF:1098-28481).
            1. The code, if present, **SHALL** contain exactly one [1..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:1098-28676).

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Figure 53: Patient Generated Document 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="Self" 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>
```


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Figure 54: Patient Generated Document 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>
```

2.1.27.3 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.

5. **MAY** contain zero or one [0..1] **dataEnterer** (CONF:1098-28678).
    a. The dataEnterer, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-28679).
        i. This assignedEntity **MAY** 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:1098-28680).

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Figure 55: Patient Generated Document 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="Self" 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>
```

2.1.27.4 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 a 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.

6. **MAY** contain zero or more [0..*] **informant** (CONF:1098-28681).
    a. The informant, if present, **SHALL** contain exactly one [1..1] **relatedEntity** (CONF:1098-28682).
    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).
        i. This relatedEntity **MAY** contain zero or one [0..1] **code** (CONF:1098-28683).
            1. The code, if present, **SHOULD** contain zero or one [0..1] **@code**, which **SHOULD** be selected from ValueSet **Personal And Legal**

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Relationship Role Type 2.16.840.1.113883.11.20.12.1 **DYNAMIC** (CONF:1098-28684).

Figure 56: Patient Generated Document informant Example

```
<informant>
 <assignedEntity>
  <!-- id using HL7 example OID. -->
  <id extension="999.1" root="2.16.840.1.113883.19" />
  <code code="ONESELF" displayName="Self" 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>
```


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Figure 57: Patient Generated Document 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>
```

2.1.27.5 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.

7. **SHALL** contain exactly one [1..1] **custodian** (CONF:1098-28685).
    a. This custodian **SHALL** contain exactly one [1..1] **assignedCustodian** (CONF:1098-28686).

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

i. This assignedCustodian **SHALL** contain exactly one [1..1] **representedCustodianOrganization** (CONF:1098-28687).

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

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1. This representedCustodianOrganization **SHALL** contain at least one [1..*] **id** (CONF:1098-28688).

Figure 58: Patient Generated Document 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>
```

2.1.27.6 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.

8. **MAY** contain zero or more [0..*] **informationRecipient** (CONF:1098-28690).
   a. The informationRecipient, if present, **SHALL** contain exactly one [1..1] **intendedRecipient** (CONF:1098-28691).

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

i. This intendedRecipient **SHOULD** contain zero or more [0..*] **id** (CONF:1098-28692).

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:1098-28693).

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Figure 59: Patient Generated Document 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>
```


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```
    </addr>
   </receivedOrganization>
  </intendedRecipient>
</informationRecipient>
```

2.1.27.7 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.

9. **MAY** contain zero or one [0..1] **legalAuthenticator** (CONF:1098-28694).
    a. The legalAuthenticator, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-28695).

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

i. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-28696).
ii. This assignedEntity **MAY** contain zero or one [0..1] **code** (CONF:1098-28697).
    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** 2.16.840.1.113883.11.20.12.1 **DYNAMIC** (CONF:1098-28698).

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Figure 60: Patient Generated Document legalAuthenticator Example

```
<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>
```

2.1.27.8 authenticator

10. **MAY** contain zero or more [0..*] **authenticator** (CONF:1098-28699).
    a. The authenticator, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-28700).

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

i. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-28701).
ii. This assignedEntity **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:1098-28702).

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Figure 61: Patient Generated Document 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>
```

2.1.27.9 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)

11. **MAY** contain zero or more [0..*] **participant** (CONF:1098-28703).

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

a. The participant, if present, **SHALL** contain exactly one [1..1] **@typeCode** (CONF:1098-28704).
b. The participant, if present, **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1098-28705).
    i. This associatedEntity **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:1098-28706).

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Figure 62: Patient Generated Document 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>
```

2.1.27.10 inFulfillmentOf

12. **MAY** contain zero or more [0..*] **inFulfillmentOf** (CONF:1098-28707).
    a. The inFulfillmentOf, if present, **SHALL** contain exactly one [1..1] **order** (CONF:1098-28708).

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

i. This order **SHALL** contain at least one [1..*] **id** (CONF:1098-28709).

Figure 63: Patient Generated Document 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>
```

2.1.27.11 documentationOf

13. **MAY** contain zero or more [0..*] **documentationOf** (CONF:1098-28710).
    a. The documentationOf, if present, **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1098-28711).

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

i. This serviceEvent **SHOULD** contain zero or one [0..1] **code** (CONF:1098-28712).

2.1.27.12 performer

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.

ii. This serviceEvent **SHOULD** contain zero or more [0..*] **performer** (CONF:1098-28713).

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:1098-28714).
2. The performer, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-28715).

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

a. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-28716).

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

b. This assignedEntity **MAY** 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:1098-28718).

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3 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 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 handcrafted 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.

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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.

3.1 Admission Diagnosis Section (V2)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2014-06-09 (open)]`

Table 61: Admission Diagnosis Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Discharge Summary (V2) (optional)	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.

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Table 62: Admission Diagnosis Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2014-06-09)					
templateId	1..1	SHALL		1098-9930	
@root	1..1	SHALL		1098-10391	2.16.840.1.113883.10.20.22.2.43
@extension	1..1	SHALL		1098-32563	2014-06-09
code	1..1	SHALL		1098-15479	
@code	1..1	SHALL		1098-15480	42347-5
@codeSystem	1..1	SHALL		1098-30865	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-9932	
text	1..1	SHALL		1098-9933	
entry	0..1	SHOULD		1098-9934	
act	1..1	SHALL		1098-15481	Hospital Admission Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-9930) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.43" (CONF:1098-10391).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32563).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15479).
    a. This code **SHALL** contain exactly one [1..1] **@code**="42347-5" Admission diagnosis (CONF:1098-15480).
    b. 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:1098-30865).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-9932).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-9933).
5. **SHOULD** contain zero or one [0..1] **entry** (CONF:1098-9934).
    a. The entry, if present, **SHALL** contain exactly one [1..1] **Hospital Admission Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09) (CONF:1098-15481).

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Figure 64: Admission Diagnosis Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.43" extension="2014-06-09" />
    <code code="42347-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Admission diagnosis" />
    <title>HOSPITAL ADMISSION DIAGNOSIS</title>
    <text>Appendicitis</text>
    <entry>
        <act classCode="ACT" moodCode="EVN">
            <!--Admission Diagnosis template -->
            ...
        </act>
    </entry>
</section>
```

3.2 Admission Medications Section (entries optional) (V2)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2014-06-09 (open)]`

Table 63: Admission Medications Section (entries optional) (V2) Contexts

Contained By:	**Contains:**
Transfer Summary (optional) Discharge Summary (V2) (optional)	Admission Medication (V2)

The section contains the medications taken by the patient prior to and at the time of admission to the facility.

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Table 64: Admission Medications Section (entries optional) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2014-06-09)					
templateId	1..1	SHALL		1098-10098	
@root	1..1	SHALL		1098-10392	2.16.840.1.113883.10.20.22.2.44
@extension	1..1	SHALL		1098-32560	2014-06-09
code	1..1	SHALL		1098-15482	
@code	1..1	SHALL		1098-15483	42346-7
@codeSystem	1..1	SHALL		1098-32142	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-10100	
text	1..1	SHALL		1098-10101	
entry	0..*	SHOULD		1098-10102	
act	1..1	SHALL		1098-15484	Admission Medication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.36:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-10098) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.44" (CONF:1098-10392).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32560).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15482).
    a. This code **SHALL** contain exactly one [1..1] **@code**="42346-7" Medications on Admission (CONF:1098-15483).
    b. 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:1098-32142).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-10100).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-10101).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-10102) such that it
    a. **SHALL** contain exactly one [1..1] **Admission Medication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.36:2014-06-09) (CONF:1098-15484).

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3.3 Advance Directives Section (entries optional) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09 (open)]

Table 65: Advance Directives Section (entries optional) (V2) Contexts

Contained By:	Contains:
Consultation Note (V2) (optional) Referral Note (optional) Continuity of Care Document (CCD) (V2) (optional)	Advance Directive Observation (V2) Advance Directive Organizer

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.

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Table 66: Advance Directives Section (entries optional) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09)					
templateId	1..1	SHALL		1098-7928	
@root	1..1	SHALL		1098-10376	2.16.840.1.113883.10.20.22.2.21
@extension	1..1	SHALL		1098-32497	2014-06-09
code	1..1	SHALL		1098-15340	
@code	1..1	SHALL		1098-15342	42348-3
@codeSystem	1..1	SHALL		1098-30812	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7930	
text	1..1	SHALL		1098-7931	
entry	0..*	MAY		1098-7957	
observation	1..1	SHALL		1098-15443	Advance Directive Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09
entry	0..*	MAY		1098-32891	
organizer	1..1	SHALL		1098-32892	Advance Directive Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.108

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7928) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.21" (CONF:1098-10376).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32497).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15340).
    a. This code **SHALL** contain exactly one [1..1] **@code**="42348-3" Advance Directives (CONF:1098-15342).
    b. 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:1098-30812).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7930).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7931).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-7957) such that it

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a. **SHALL** contain exactly one [1..1] **Advance Directive Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09) (CONF:1098-15443).

6. **MAY** contain zero or more [0..*] **entry** (CONF:1098-32891) such that it
   a. **SHALL** contain exactly one [1..1] **Advance Directive Organizer** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.108) (CONF:1098-32892).

3.3.1 Advance Directives Section (entries required) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.21.1:2014-06-09 (open)]

Table 67: Advance Directives Section (entries required) (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional)	Advance Directive Observation (V2) Advance Directive Organizer

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.

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Table 68: Advance Directives Section (entries required) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21.1:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32800	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-30227	
@root	1..1	SHALL		1098-30228	2.16.840.1.113883.10.20.22.2.21.1
@extension	1..1	SHALL		1098-32512	2014-06-09
entry	1..*	SHALL		1098-30235	
observation	0..1	MAY		1098-30236	Advance Directive Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09
organizer	0..1	MAY		1098-32420	Advance Directive Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.108

1. Conforms to **Advance Directives Section (entries optional) (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09).
2. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32800).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30227) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.21.1" (CONF:1098-30228).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32512).

If section/@nullFlavor is not present **SHALL** contain an Advance Directive Observation (V2) **OR** an Advance Directive Organizer (NEW):

4. **SHALL** contain at least one [1..*] **entry** (CONF:1098-30235) such that it
   a. **MAY** contain zero or one [0..1] **Advance Directive Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09) (CONF:1098-30236).
   b. **MAY** contain zero or one [0..1] **Advance Directive Organizer** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.108) (CONF:1098-32420).
   c. This entry **SHALL** contain **EITHER** an Advance Directive Observation (V2) **OR** an Advance Directive Organizer (CONF:1098-32881).

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Figure 65: Advance Directives Section (V2) Example

```
<section>
    <!-- C-CDA Advance Directives Section (required entries)template id -->
    <templateId root="2.16.840.1.113883.10.20.22.2.21.1" extension="2014-06-09" />
    <code code="42348-3" codeSystem="2.16.840.1.113883.6.1" />
    <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>
```

3.4 Allergies and Intolerances Section (entries optional) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09 (open)]

Table 69: Allergies and Intolerances Section (entries optional) (V2) Contexts

Contained By:	Contains:
Discharge Summary (V2) (required) History and Physical (V2) (required) Procedure Note (V2) (optional) Progress Note (V2) (optional)	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.

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Table 70: Allergies and Intolerances Section (entries optional) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09)					
templateId	1..1	SHALL		1098-7800	
@root	1..1	SHALL		1098-10378	2.16.840.1.113883.10.20.22.2.6
@extension	1..1	SHALL		1098-32544	2014-06-09
code	1..1	SHALL		1098-15345	
@code	1..1	SHALL		1098-15346	48765-2
@codeSystem	1..1	SHALL		1098-32139	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7802	
text	1..1	SHALL		1098-7803	
entry	0..*	SHOULD		1098-7804	
act	1..1	SHALL		1098-15444	Allergy Concern Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.30:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7800) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.6" (CONF:1098-10378).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32544).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15345).
    a. This code **SHALL** contain exactly one [1..1] **@code**="48765-2" Allergies, adverse reactions, alerts (CONF:1098-15346).
    b. 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:1098-32139).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7802).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7803).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-7804) such that it
    a. **SHALL** contain exactly one [1..1] **Allergy Concern Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.30:2014-06-09) (CONF:1098-15444).

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3.4.1 Allergies and Intolerances Section (entries required) (V2)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09 (open)]`

Table 71: Allergies and Intolerances Section (entries required) (V2) Contexts

Contained By:	Contains:
Transfer Summary (required) Consultation Note (V2) (required) Referral Note (required) Continuity of Care Document (CCD) (V2) (required)	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.

Table 72: Allergies and Intolerances Section (entries required) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32824	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-7527	
@root	1..1	SHALL		1098-10379	2.16.840.1.113883.10.20.22.2.6.1
@extension	1..1	SHALL		1098-32545	2014-06-09
code	1..1	SHALL		1098-15349	
@code	1..1	SHALL		1098-15350	48765-2
@codeSystem	1..1	SHALL		1098-32140	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7534	
text	1..1	SHALL		1098-7530	
entry	1..*	SHALL		1098-7531	
act	1..1	SHALL		1098-15446	Allergy Concern Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.30:2014-06-09

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1. Conforms to **Allergies and Intolerances Section (entries optional) (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09).
2. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32824).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7527) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.6.1" (CONF:1098-10379).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32545).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15349).
    a. This code **SHALL** contain exactly one [1..1] **@code**="48765-2" Allergies, adverse reactions, alerts (CONF:1098-15350).
    b. 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:1098-32140).
5. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7534).
6. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7530).

If section/@nullFlavor is not present:

7. **SHALL** contain at least one [1..*] **entry** (CONF:1098-7531) such that it
    a. **SHALL** contain exactly one [1..1] **Allergy Concern Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.30:2014-06-09) (CONF:1098-15446).

Figure 66: Allergies and Intolerances Section (entries required) (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.6.1" extension="2014-06-09" />
    <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" extension="2014-06-09" />
            <!--   Allergy Concern Act template   -->
        ...

        </act>
    </entry>
</section>
```


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3.5 Anesthesia Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.25:2014-06-09 (open)]

Table 73: Anesthesia Section (V2) Contexts

Contained By:	Contains:
Operative Note (V2) (required) Procedure Note (V2) (optional)	Medication Activity (V2) 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.

Table 74: Anesthesia Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.25:2014-06-09)					
templateId	1..1	SHALL		1098-8066	
@root	1..1	SHALL		1098-10380	2.16.840.1.113883.10.20.22.2.25
@extension	1..1	SHALL		1098-32531	2014-06-09
code	1..1	SHALL		1098-15351	
@code	1..1	SHALL		1098-15352	59774-0
@codeSystem	1..1	SHALL		1098-30830	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8068	
text	1..1	SHALL		1098-8069	
entry	0..*	MAY		1098-8092	
procedure	1..1	SHALL		1098-15447	Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09
entry	0..*	MAY		1098-8094	
substanceAdministration	1..1	SHALL		1098-31127	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09

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1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8066) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.25" (CONF:1098-10380).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32531).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15351).
    a. This code **SHALL** contain exactly one [1..1] **@code**="59774-0" Anesthesia (CONF:1098-15352).
    b. 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:1098-30830).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8068).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8069).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8092) such that it
    a. **SHALL** contain exactly one [1..1] **Procedure Activity Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09) (CONF:1098-15447).
6. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8094) such that it
    a. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-31127).

Figure 67: Anesthesia Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.25" extension="2014-06-09" />
    <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" extension="2014-06-09" />
        ...


        </procedure>
    </entry>
    <entry>
        <substanceAdministration classCode="SBADM" moodCode="EVN">
            <!-- Medication activity template -->
            <templateId root="2.16.840.1.113883.10.20.22.4.16" extension="2014-06-09" />
        ...


        </substanceAdministration>
    </entry>
</section>
```


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3.6 Assessment and Plan Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09 (open)]

Table 75: Assessment and Plan Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) History and Physical (V2) (optional) Procedure Note (V2) (optional) Progress Note (V2) (optional)	Planned Act (V2)

This section represents the clinician's conclusions and working assumptions that will guide treatment of the patient. The Assessment and Plan Section 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 2.16.840.1.113883.10.20.22.2.10:2014-06-09

Table 76: Assessment and Plan Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09)					
templateId	1..1	SHALL		1098-7705	
@root	1..1	SHALL		1098-10381	2.16.840.1.113883.10.20.22.2.9
@extension	1..1	SHALL		1098-32583	2014-06-09
code	1..1	SHALL		1098-15353	
@code	1..1	SHALL		1098-15354	51847-2
@codeSystem	1..1	SHALL		1098-32141	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
text	1..1	SHALL		1098-7707	
entry	0..*	MAY		1098-7708	
act	1..1	SHALL		1098-15448	Planned Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7705) such that it

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a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.9" (CONF:1098-10381).
b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32583).

2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15353).
   a. This code **SHALL** contain exactly one [1..1] **@code**="51847-2" Assessment and Plan (CONF:1098-15354).
   b. 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:1098-32141).
3. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7707).
4. **MAY** contain zero or more [0..*] **entry** (CONF:1098-7708) such that it
   a. **SHALL** contain exactly one [1..1] **Planned Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09) (CONF:1098-15448).

Figure 68: Assessment and Plan Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.9" extension="2014-06-09" />
    <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>
```

3.7 Assessment Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.8 (open)]

Table 77: Assessment Section Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) History and Physical (V2) (optional) Procedure Note (V2) (optional) Progress Note (V2) (optional)	

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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.

Table 78: Assessment Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8)					
templateId	1..1	SHALL		81-7711	
@root	1..1	SHALL		81-10382	2.16.840.1.113883.10.20.22.2.8
code	1..1	SHALL		81-14757	
@code	1..1	SHALL		81-14758	51848-0
@codeSystem	1..1	SHALL		81-26472	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-16774	
text	1..1	SHALL		81-7713	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7711) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.8" (CONF:81-10382).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-14757).
    a. This code **SHALL** contain exactly one [1..1] **@code**="51848-0" Assessments (CONF:81-14758).
    b. 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:81-26472).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-16774).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7713).

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Figure 69: 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>
```

3.8 Chief Complaint and Reason for Visit Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.13 (open)]

Table 79: Chief Complaint and Reason for Visit Section Contexts

Contained By:	Contains:
Consultation Note (V2) (optional) Discharge Summary (V2) (optional) History and Physical (V2) (optional) 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.

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Table 80: Chief Complaint and Reason for Visit Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13)					
templateId	1..1	SHALL		81-7840	
@root	1..1	SHALL		81-10383	2.16.840.1.113883.10.20.22.2.13
code	1..1	SHALL		81-15449	
@code	1..1	SHALL		81-15450	46239-0
@codeSystem	1..1	SHALL		81-26473	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-7842	
text	1..1	SHALL		81-7843	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7840) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.13" (CONF:81-10383).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15449).
    a. This code **SHALL** contain exactly one [1..1] **@code**="46239-0" Chief Complaint and Reason for Visit (CONF:81-15450).
    b. 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:81-26473).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7842).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7843).

Figure 70: 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>
```


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3.9 Chief Complaint Section

[section: identifier urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1 (open)]

Table 81: Chief Complaint Section Contexts

Contained By:	Contains:
Consultation Note (V2) (optional) Discharge Summary (V2) (optional) History and Physical (V2) (optional) Procedure Note (V2) (optional) Progress Note (V2) (optional)	

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

Table 82: Chief Complaint Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1)					
templateId	1..1	SHALL		81-7832	
@root	1..1	SHALL	UID	81-10453	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1
code	1..1	SHALL		81-15451	
@code	1..1	SHALL		81-15452	10154-3
@codeSystem	1..1	SHALL		81-26474	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-7834	
text	1..1	SHALL		81-7835	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7832) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1" (CONF:81-10453).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15451).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10154-3" Chief Complaint (CONF:81-15452).
    b. 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:81-26474).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7834).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7835).

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Figure 71: 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>
```

3.10 Complications Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09 (open)]

Table 83: Complications Section (V2) Contexts

Contained By:	Contains:
Operative Note (V2) (required) Procedure Note (V2) (required)	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.

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Table 84: Complications Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09)					
templateId	1..1	SHALL		1098-8174	
@root	1..1	SHALL		1098-10384	2.16.840.1.113883.10.20.22.2.37
@extension	1..1	SHALL		1098-32538	2014-06-09
code	1..1	SHALL		1098-15453	
@code	1..1	SHALL		1098-15454	55109-3
@codeSystem	1..1	SHALL		1098-30860	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8176	
text	1..1	SHALL		1098-8177	
entry	0..*	MAY		1098-8795	
observation	1..1	SHALL		1098-15455	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8174) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.37" (CONF:1098-10384).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32538).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15453).
    a. This code **SHALL** contain exactly one [1..1] **@code**="55109-3" Complications (CONF:1098-15454).
    b. 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:1098-30860).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8176).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8177).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8795) such that it
    a. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-15455).
    Note: When no coded entries or negation of entries are present, narrative

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section/text will be provided containing details of the complication(s) or that there were no complications.

Figure 72: Complications Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.37" extension="2014-06-09" />
    <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>
```

3.11 Course of Care Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.64 (open)]

Table 85: Course of Care Section Contexts

Contained By:	Contains:
Transfer Summary (optional)	

The Course of Care section describes what happened during the course of an encounter.

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Table 86: Course of Care Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.64)					
templateId	1..1	SHALL		1098-32640	
@root	1..1	SHALL		1098-32642	2.16.840.1.113883.10.20.22.2.64
code	1..1	SHALL		1098-32641	
@code	1..1	SHALL		1098-32645	8648-8
@codeSystem	1..1	SHALL		1098-32646	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-32643	
text	1..1	SHALL		1098-32644	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-32640) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.64" (CONF:1098-32642).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-32641).
    a. This code **SHALL** contain exactly one [1..1] **@code**="8648-8" Hospital Course Narrative (CONF:1098-32645).
    b. 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:1098-32646).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-32643).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-32644).

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Figure 73: Course of Care Section Example

```
<section>
  <templateId root="2.16.840.1.113883.10.20.22.2.64"
             extension="2014-06-09" />
  <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
          code="8648-8" displayName="Hospital Course Narrative" />
  <title>Hospital Course of Care</title>
  <text>
    <paragraph>This patient was only recently transferred after 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>
```

3.12 DICOM Object Catalog Section - DCM 121181

[section: identifier urn:oid:2.16.840.1.113883.10.20.6.1.1 (open)]

Table 87: DICOM Object Catalog Section - DCM 121181 Contexts

Contained By:	**Contains:**
Diagnostic Imaging Report (V2) (optional)	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.

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Table 88: DICOM Object Catalog Section - DCM 121181 Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.1)					
templateId	1..1	SHALL		81-8525	
@root	1..1	SHALL	UID	81-10454	2.16.840.1.113883.10.20.6.1.1
code	1..1	SHALL		81-15456	
@code	1..1	SHALL		81-15457	121181
@codeSystem	1..1	SHALL		81-26475	1.2.840.10008.2.16.4 (DCM) = 1.2.840.10008.2.16.4
entry	1..*	SHALL		81-8530	
act	1..1	SHALL		81-15458	Study Act (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.6

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8525) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.6.1.1" (CONF:81-10454).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15456).
    a. This code **SHALL** contain exactly one [1..1] **@code**="121181" Dicom Object Catalog (CONF:81-15457).
    b. This code **SHALL** contain exactly one [1..1] **@codeSystem**="1.2.840.10008.2.16.4" (CodeSystem: DCM 1.2.840.10008.2.16.4) (CONF:81-26475).
3. **SHALL** contain at least one [1..*] **entry** (CONF:81-8530).
    a. Such entries **SHALL** contain exactly one [1..1] **Study Act** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.6) (CONF:81-15458).
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:81-8527).

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Figure 74: DICOM Object Catalog Section - DCM 121181 Example

```
<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>
```


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3.13 Discharge Diagnosis Section (V2)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2014-06-09 (open)]`

Table 89: Discharge Diagnosis Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Discharge Summary (V2) (required)	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.

Table 90: Discharge Diagnosis Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2014-06-09)					
templateId	1..1	SHALL		1098-7979	
@root	1..1	SHALL		1098-10394	2.16.840.1.113883.10.20.22.2.24
@extension	1..1	SHALL		1098-32549	2014-06-09
code	1..1	SHALL		1098-15355	
@code	1..1	SHALL		1098-15356	2.16.840.1.113883.6.1 (LOINC) = C-CDAV2-DDN
@codeSystem	1..1	SHALL		1098-30861	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7981	
text	1..1	SHALL		1098-7982	
entry	0..1	SHOULD		1098-7983	
act	1..1	SHALL		1098-15489	Hospital Discharge Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.33:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7979) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.24" (CONF:1098-10394).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32549).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15355).

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a. This code **SHALL** contain exactly one [1..1] **@code**="C-CDAV2-DDN" Prognosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 **STATIC**) (CONF:1098-15356).
b. 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:1098-30861).

3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7981).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7982).
5. **SHOULD** contain zero or one [0..1] **entry** (CONF:1098-7983).
   a. The entry, if present, **SHALL** contain exactly one [1..1] **Hospital Discharge Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.33:2014-06-09) (CONF:1098-15489).

Figure 75: Discharge Diagnosis Section (V2) Example

```
<section>
    <!-- Discharge Diagnosis Section Template Id -->
    <templateId root="2.16.840.1.113883.10.20.22.2.24" extension="2014-06-09" />
    <code code="75328-5" displayName="Prognosis" codeSystem="2.16.840.1.113883.6.1"
codeSystemName="LOINC" />
    <title>Discharge Diagnosis</title>
    <text>Diverticula of intestine</text>
    <entry>
        <act classCode="ACT" moodCode="EVN">
            <!-- Hospital discharge Diagnosis act -->
            ...
        </act>
    </entry>
</section>
```

3.14 Discharge Diet Section (DEPRECATED)

[section: identifier urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.33:2014-06-09 (open)]

Table 91: Discharge Diet Section (DEPRECATED) Contexts

Contained By:	Contains:
Discharge Summary (V2) (optional)	

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 TEMPLATE HAS BEEN DEPRECATED IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED.

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Reason for deprecation: This template has been replaced by the Nutrition Section (2.16.840.1.113883.10.20.22.2.57).

Table 92: Discharge Diet Section (DEPRECATED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.33:2014-06-09)					
templateId	1..1	SHALL		1098-7975	
@root	1..1	SHALL	UID	1098-10455	1.3.6.1.4.1.19376.1.5.3.1.3.33
@extension	1..1	SHALL		1098-32593	2014-06-09
code	1..1	SHALL		1098-15459	
@code	1..1	SHALL		1098-15460	42344-2
@codeSystem	1..1	SHALL		1098-31140	
title	1..1	SHALL		1098-7977	
text	1..1	SHALL		1098-7978	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7975) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.3.33" (CONF:1098-10455).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32593).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15459).
    a. This code **SHALL** contain exactly one [1..1] **@code**="42344-2" Discharge Diet (CONF:1098-15460).
    b. This code **SHALL** contain exactly one [1..1] **@codeSystem** (CONF:1098-31140).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7977).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7978).

3.15 Discharge Medications Section (entries optional) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2014-06-09 (open)]

Table 93: Discharge Medications Section (entries optional) (V2) Contexts

Contained By:	Contains:
Discharge Summary (V2) (optional)	Discharge Medication (V2)

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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.

Table 94: Discharge Medications Section (entries optional) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2014-06-09)					
templateId	1..1	SHALL		1098-7816	
@root	1..1	SHALL		1098-10396	2.16.840.1.113883.10.20.22.2.11
@extension	1..1	SHALL		1098-32561	2014-06-09
code	1..1	SHALL		1098-15359	
@code	1..1	SHALL		1098-15360	2.16.840.1.113883.6.1 (LOINC) = 75311-1
@codeSystem	1..1	SHALL		1098-32480	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7818	
text	1..1	SHALL		1098-7819	
entry	0..*	SHOULD		1098-7820	
act	1..1	SHALL		1098-15490	Discharge Medication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.35:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7816) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.11" (CONF:1098-10396).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32561).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15359).
    a. This code **SHALL** contain exactly one [1..1] **@code**="75311-1" Discharge medications (CodeSystem: LOINC 2.16.840.1.113883.6.1 **STATIC**) (CONF:1098-15360).
    b. 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:1098-32480).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7818).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7819).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-7820) such that it

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a. **SHALL** contain exactly one [1..1] **Discharge Medication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.35:2014-06-09) (CONF:1098-15490).

3.15.1 Discharge Medications Section (entries required) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.11.1:2014-06-09 (open)]

Table 95: Discharge Medications Section (entries required) (V2) Contexts

Contained By:	Contains:
Discharge Summary (V2) (optional)	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.

Table 96: Discharge Medications Section (entries required) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11.1:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32812	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-7822	
@root	1..1	SHALL		1098-10397	2.16.840.1.113883.10.20.22.2.11.1
@extension	1..1	SHALL		1098-32562	2014-06-09
code	1..1	SHALL		1098-15361	
@code	1..1	SHALL		1098-15362	75311-1
@codeSystem	1..1	SHALL		1098-32145	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7824	
text	1..1	SHALL		1098-7825	
entry	1..*	SHALL		1098-7826	
act	1..1	SHALL		1098-15491	Discharge Medication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.35:2014-06-09

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1. Conforms to **Discharge Medications Section (entries optional) (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2014-06-09).
2. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32812).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7822) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.11.1" (CONF:1098-10397).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32562).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15361).
    a. This code **SHALL** contain exactly one [1..1] **@code**="75311-1" Discharge Medications (CONF:1098-15362).
    b. 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:1098-32145).
5. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7824).
6. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7825).

If section/@nullFlavor is not present:

7. **SHALL** contain at least one [1..*] **entry** (CONF:1098-7826) such that it
    a. **SHALL** contain exactly one [1..1] **Discharge Medication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.35:2014-06-09) (CONF:1098-15491).

Figure 76: Discharge Medication Section (V2) (entries required) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.11.1" extension="2014-06-09" />
    <code code="75311-1" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="DISCHARGE MEDICATIONS" />
    <title>Discharge Medications</title>
    <text>
       ...
    </text>
    <entry typeCode="DRIV">
        <act classCode="ACT" moodCode="EVN">
            <!-- Discharge Medication Entry -->
            ...


        </act>
    </entry>
    ...
</section>
```


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3.16 Encounters Section (entries optional) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.22:2014-06-09 (open)]

Table 97: Encounters Section (entries optional) (V2) Contexts

Contained By:	Contains:
Continuity of Care Document (CCD) (V2) (optional)	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, or non-face-to-face interactions. It is also a contact between a patient and a practitioner who has primary responsibility (exercising independent judgment) for assessing and treating the patient at a given contact. This section may contain all encounters for the time period being summarized, but should include notable encounters.

Table 98: Encounters Section (entries optional) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.22:2014-06-09)					
templateId	1..1	SHALL		1098-7940	
@root	1..1	SHALL		1098-10386	2.16.840.1.113883.10.20.22.2.22
@extension	1..1	SHALL		1098-32547	2014-06-09
code	1..1	SHALL		1098-15461	
@code	1..1	SHALL		1098-15462	46240-8
@codeSystem	1..1	SHALL		1098-31136	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7942	
text	1..1	SHALL		1098-7943	
entry	0..*	SHOULD		1098-7951	
encounter	1..1	SHALL		1098-15465	Encounter Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7940) such that it

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a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.22" (CONF:1098-10386).
b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32547).

2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15461).
   a. This code **SHALL** contain exactly one [1..1] **@code**="46240-8" Encounters (CONF:1098-15462).
   b. 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:1098-31136).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7942).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7943).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-7951) such that it
   a. **SHALL** contain exactly one [1..1] **Encounter Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09) (CONF:1098-15465).

3.16.1 Encounters Section (entries required) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.22.1:2014-06-09 (open)]

Table 99: Encounters Section (entries required) (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional)	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 (exercising independent judgment) for assessing and treating the patient at a given contact. This section may contain all encounters for the time period being summarized, but should include notable encounters.

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Table 100: Encounters Section (entries required) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.22.1:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32815	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-8705	
@root	1..1	SHALL		1098-10387	2.16.840.1.113883.10.20.22.2.22.1
@extension	1..1	SHALL		1098-32548	2014-06-09
code	1..1	SHALL		1098-15466	
@code	1..1	SHALL		1098-15467	46240-8
@codeSystem	1..1	SHALL		1098-31137	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8707	
text	1..1	SHALL		1098-8708	
entry	1..*	SHALL		1098-8709	
encounter	1..1	SHALL		1098-15468	Encounter Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09

1. Conforms to **Encounters Section (entries optional) (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.22:2014-06-09).
2. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32815).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8705) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.22.1" (CONF:1098-10387).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32548).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15466).
   a. This code **SHALL** contain exactly one [1..1] **@code**="46240-8" Encounters (CONF:1098-15467).
   b. 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:1098-31137).
5. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8707).
6. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8708).

If section/@nullFlavor is not present:

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7. **SHALL** contain at least one [1..*] **entry** (CONF:1098-8709) such that it
    a. **SHALL** contain exactly one [1..1] **Encounter Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09) (CONF:1098-15468).

Figure 77: Encounters Section (entries required) (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.22.1" extension="2014-06-09" />
    <!-- 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>
```

3.17 Family History Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09 (open)]

Table 101: Family History Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) Continuity of Care Document (CCD) (V2) (optional) Discharge Summary (V2) (optional) History and Physical (V2) (required) Procedure Note (V2) (optional)	Family History Organizer (V2)

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.

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Table 102: Family History Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09)					
templateId	1..1	SHALL		1098-7932	
@root	1..1	SHALL		1098-10388	2.16.840.1.113883.10.20.22.2.15
@extension	1..1	SHALL		1098-32607	2014-06-09
code	1..1	SHALL		1098-15469	
@code	1..1	SHALL		1098-15470	10157-6
@codeSystem	1..1	SHALL		1098-32481	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7934	
text	1..1	SHALL		1098-7935	
entry	0..*	MAY		1098-32430	
organizer	1..1	SHALL		1098-32431	Family History Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7932) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.15" (CONF:1098-10388).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32607).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15469).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10157-6" Family History (CONF:1098-15470).
    b. 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:1098-32481).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7934).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7935).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-32430) such that it
    a. **SHALL** contain exactly one [1..1] **Family History Organizer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09) (CONF:1098-32431).

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Figure 78: Family History Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.15" extension="2014-06-09" />
    <!--  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>
```

3.18 Fetus Subject Context

[relatedSubject: identifier urn:oid:2.16.840.1.113883.10.20.6.2.3 (open)]

Table 103: Fetus Subject Context Contexts

Contained By:	Contains:
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.

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Table 104: Fetus Subject Context Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
relatedSubject (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.3)					
templateId	1..1	SHALL		81-9189	
@root	1..1	SHALL		81-10535	2.16.840.1.113883.10.20.6.2.3
code	1..1	SHALL		81-9190	
@code	1..1	SHALL		81-26455	121026
@codeSystem	1..1	SHALL		81-26476	1.2.840.10008.2.16.4 (DCM) = 1.2.840.10008.2.16.4
subject	1..1	SHALL		81-9191	
name	1..1	SHALL		81-15347	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-9189) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.6.2.3" (CONF:81-10535).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-9190).
    a. This code **SHALL** contain exactly one [1..1] **@code**="121026" (CONF:81-26455).
    b. This code **SHALL** contain exactly one [1..1] **@codeSystem**="1.2.840.10008.2.16.4" (CodeSystem: DCM 1.2.840.10008.2.16.4) (CONF:81-26476).
3. **SHALL** contain exactly one [1..1] **subject** (CONF:81-9191).

The name element is used to store the DICOM fetus ID, typically a pseudonym such as fetus_1.

a. This subject **SHALL** contain exactly one [1..1] **name** (CONF:81-15347).

Figure 79: Fetus Subject Context Example

```
<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>
```


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3.19 Findings Section (DIR)

`[section: identifier urn:oid:2.16.840.1.113883.10.20.6.1.2 (open)]`

Table 105: Findings Section (DIR) Contexts

Contained By:	Contains:
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.

Table 106: Findings Section (DIR) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.2)					
templateId	1..1	SHALL		81-8531	
@root	1..1	SHALL	UID	81-10456	2.16.840.1.113883.10.20.6.1.2

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8531) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.6.1.2" (CONF:81-10456).
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:81-8532).

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Figure 80: Findings Section (DIR) Example

```
<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>
```

3.20 Functional Status Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09 (open)]

Table 107: Functional Status Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) Continuity of Care Document (CCD) (V2) (optional) Discharge Summary (V2) (optional)	Assessment Scale Observation Caregiver Characteristics Cognitive Status Problem Observation (DEPRECATED) Functional Status Observation (V2) Functional Status Organizer (V2) Functional Status Problem Observation (DEPRECATED) Non-Medicinal Supply Activity (V2) Pressure Ulcer Observation (DEPRECATED) Self-Care Activities (ADL and IADL) Sensory Status

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 ability to perform Activities of Daily Living (ADLs) in areas such as Mobility (e.g., ambulation), Self-Care

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(e.g., bathing, dressing, feeding, grooming) or 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.

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Table 108: Functional Status Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09)					
templateId	1..1	SHALL		1098-7920	
@root	1..1	SHALL		1098-10389	2.16.840.1.113883.10.20.22.2.14
@extension	1..1	SHALL		1098-32567	2014-06-09
code	1..1	SHALL		1098-14578	
@code	1..1	SHALL		1098-14579	47420-5
@codeSystem	1..1	SHALL		1098-30866	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7922	
text	1..1	SHALL		1098-7923	
entry	0..*	MAY		1098-14414	
organizer	1..1	SHALL		1098-14415	Functional Status Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.66:2014-06-09
entry	0..*	MAY		1098-14418	
observation	1..1	SHALL		1098-14419	Functional Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09
entry	0..*	MAY		1098-14426	
observation	1..1	SHALL		1098-14427	Caregiver Characteristics (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72
entry	0..*	MAY		1098-14580	
observation	1..1	SHALL		1098-14581	Assessment Scale Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69
entry	0..*	MAY		1098-14582	
supply	1..1	SHALL		1098-30783	Non-Medicinal Supply Activity (V2) (identifier:

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					urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09
entry	0..*	MAY		1098-32792	
observation	1..1	SHALL		1098-31009	Self-Care Activities (ADL and IADL) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.128
entry	0..*	MAY		1098-16779	
observation	1..1	SHALL		1098-31011	Sensory Status (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.127
entry	0..*	MAY		1098-14424	
observation	1..1	SHALL		1098-14425	Cognitive Status Problem Observation (DEPRECATED) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.73:2014-06-09
entry	0..*	MAY		1098-14422	
observation	1..1	SHALL		1098-14423	Functional Status Problem Observation (DEPRECATED) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.68:2014-06-09
entry	0..*	MAY		1098-16777	
observation	1..1	SHALL		1098-16778	Pressure Ulcer Observation (DEPRECATED) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.70:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7920) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.14" (CONF:1098-10389).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32567).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-14578).
   a. This code **SHALL** contain exactly one [1..1] **@code**="47420-5" Functional Status (CONF:1098-14579).
   b. 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:1098-30866).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7922).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7923).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-14414) such that it

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a. **SHALL** contain exactly one [1..1] **Functional Status Organizer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.66:2014-06-09) (CONF:1098-14415).

6. **MAY** contain zero or more [0..*] **entry** (CONF:1098-14418) such that it
   a. **SHALL** contain exactly one [1..1] **Functional Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09) (CONF:1098-14419).
7. **MAY** contain zero or more [0..*] **entry** (CONF:1098-14426) such that it
   a. **SHALL** contain exactly one [1..1] **Caregiver Characteristics** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72) (CONF:1098-14427).
8. **MAY** contain zero or more [0..*] **entry** (CONF:1098-14580) such that it
   a. **SHALL** contain exactly one [1..1] **Assessment Scale Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69) (CONF:1098-14581).
9. **MAY** contain zero or more [0..*] **entry** (CONF:1098-14582) such that it
   a. **SHALL** contain exactly one [1..1] **Non-Medicinal Supply Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09) (CONF:1098-30783).
10. **MAY** contain zero or more [0..*] **entry** (CONF:1098-32792) such that it
    a. **SHALL** contain exactly one [1..1] **Self-Care Activities (ADL and IADL)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.128) (CONF:1098-31009).
11. **MAY** contain zero or more [0..*] **entry** (CONF:1098-16779) such that it
    a. **SHALL** contain exactly one [1..1] **Sensory Status** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.127) (CONF:1098-31011).
12. **MAY** contain zero or more [0..*] **entry** (CONF:1098-14424) such that it
    a. **SHALL** contain exactly one [1..1] **Cognitive Status Problem Observation (DEPRECATED)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.73:2014-06-09) (CONF:1098-14425).
13. **MAY** contain zero or more [0..*] **entry** (CONF:1098-14422) such that it
    a. **SHALL** contain exactly one [1..1] **Functional Status Problem Observation (DEPRECATED)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.68:2014-06-09) (CONF:1098-14423).
14. **MAY** contain zero or more [0..*] **entry** (CONF:1098-16777) such that it
    a. **SHALL** contain exactly one [1..1] **Pressure Ulcer Observation (DEPRECATED)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.70:2014-06-09) (CONF:1098-16778).

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Figure 81: Functional Status Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.14" extension="2014-06-09" />
    <!-- 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" extension="2014-06-09" />
            ....
        </organizer>
    </entry>
    <entry>
        <observation classCode="OBS" moodCode="EVN">
            <!-- Functional Status  Observation V2-->
            <templateId root="2.16.840.1.113883.10.20.22.4.67" extension="2014-06-09" />
            ...
        </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>
```


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3.21 General Status Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.2.5 (open)]

Table 109: General Status Section Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) 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.

Table 110: General Status Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.2.5)					
templateId	1..1	SHALL		81-7985	
@root	1..1	SHALL	UID	81-10457	2.16.840.1.113883.10.20.2.5
code	1..1	SHALL		81-15472	
@code	1..1	SHALL		81-15473	10210-3
@codeSystem	1..1	SHALL		81-26477	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-7987	
text	1..1	SHALL		81-7988	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7985) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.2.5" (CONF:81-10457).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15472).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10210-3" General Status (CONF:81-15473).
    b. 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:81-26477).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7987).

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4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7988).

Figure 82: 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>
```

3.22 Goals Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.60 (open)]

Table 111: Goals Section Contexts

Contained By:	Contains:
Care Plan (required)	Goal Observation

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 over-arching goals (e.g., alleviation of health concerns, desired/intended positive outcomes from interventions, longevity, function, symptom management, comfort) and health concern-specific or intervention-specific goals to achieve desired outcomes.

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Table 112: Goals Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.60)					
@nullFlavor	0..1	MAY		1098-32819	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-29584	
@root	1..1	SHALL		1098-29585	2.16.840.1.113883.10.20.22.2.60
code	1..1	SHALL		1098-29586	
@code	1..1	SHALL		1098-29587	61146-7
@codeSystem	1..1	SHALL		1098-29588	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-30721	
text	1..1	SHALL		1098-30722	
entry	1..*	SHALL		1098-30719	
observation	1..1	SHALL		1098-30720	Goal Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.121

1. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32819).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-29584) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.60" (CONF:1098-29585).
3. **SHALL** contain exactly one [1..1] **code** (CONF:1098-29586).
   a. This code **SHALL** contain exactly one [1..1] **@code**="61146-7" Goals (CONF:1098-29587).
   b. 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:1098-29588).
4. **SHALL** contain exactly one [1..1] **title** (CONF:1098-30721).
5. **SHALL** contain exactly one [1..1] **text** (CONF:1098-30722).

If section/@nullFlavor is not present:

6. **SHALL** contain at least one [1..*] **entry** (CONF:1098-30719) such that it
   a. **SHALL** contain exactly one [1..1] **Goal Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.121) (CONF:1098-30720).

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Figure 83: 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>
```

3.23 Health Concerns Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.58 (open)]

Table 113: Health Concerns Section Contexts

Contained By:	Contains:
Care Plan (required)	Health Concern Act Health Status Observation (V2) Risk Concern Act

This section contains data describing an interest or worry about a health state or process that could possibly require attention, intervention, or management. A Health Concern is a health related matter that is of interest, importance or worry to someone, who may be the patient, patient's family or patient's health care provider. Health concerns are derived from a variety of sources within an EHR (such as Problem List, Family History, Social History, Social Worker Note, etc.). Health concerns can be medical, surgical, nursing, allied health or patient-reported concerns.

Problem Concerns are a subset of Health Concerns that have risen to the level of importance that they typically would belong on a classic “Problem List”, such as “Diabetes Mellitus” or “Family History of Melanoma” or “Tobacco abuse”. These are of broad interest to multiple members of the care team. Examples of other Health Concerns that might not typically be considered a Problem Concern include “Risk of Hyperkalemia” for a patient taking an ACE-inhibitor medication, or “Transportation difficulties” for someone who doesn't drive and has trouble getting to appointments, or “Under-insured” for someone who doesn't have sufficient insurance to properly cover their medical needs such as medications. These are typically most important to just a limited number of care team members.

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Table 114: Health Concerns Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.58)					
@nullFlavor	0..1	MAY		1098-32802	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-28804	
@root	1..1	SHALL		1098-28805	2.16.840.1.113883.10.20.22.2.58
code	1..1	SHALL		1098-28806	
@code	1..1	SHALL		1098-28807	75310-3
@codeSystem	1..1	SHALL		1098-28808	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-28809	
text	1..1	SHALL		1098-28810	
entry	0..*	SHOULD		1098-30483	
observation	1..1	SHALL		1098-30484	Health Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09
entry	1..*	SHALL		1098-30768	
act	1..1	SHALL		1098-30769	Health Concern Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.132
entry	0..*	MAY		1098-32308	
act	1..1	SHALL		1098-32309	Risk Concern Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.136

1. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32802).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-28804) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.58" (CONF:1098-28805).
3. **SHALL** contain exactly one [1..1] **code** (CONF:1098-28806).
   a. This code **SHALL** contain exactly one [1..1] **@code**="75310-3" Health concerns document (CONF:1098-28807).

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b. 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:1098-28808).

4. **SHALL** contain exactly one [1..1] **title** (CONF:1098-28809).
5. **SHALL** contain exactly one [1..1] **text** (CONF:1098-28810).
6. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-30483) such that it
   a. **SHALL** contain exactly one [1..1] **Health Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09) (CONF:1098-30484).

If section/@nullFlavor is not present:

7. **SHALL** contain at least one [1..*] **entry** (CONF:1098-30768) such that it
   a. **SHALL** contain exactly one [1..1] **Health Concern Act** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.132) (CONF:1098-30769).
8. **MAY** contain zero or more [0..*] **entry** (CONF:1098-32308) such that it
   a. **SHALL** contain exactly one [1..1] **Risk Concern Act** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.136) (CONF:1098-32309).

Figure 84: Health Concerns Section Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.58" />
    <code code="75310-3" displayName="Health Concerns Document"
codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />
    <title>Health Concerns Section</title>
    <text>
      ...
    </text>
    <entry>
        <!-- Health Status Observation -->
    </entry>
    <entry>
        <!-- Health Concern Act -->
    </entry>
</section>
```

3.24 Health Status Evaluations and Outcomes Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.61 (open)]

Table 115: Health Status Evaluations and Outcomes Section Contexts

Contained By:	Contains:
Care Plan (optional)	Outcome Observation

This template represents observations regarding the outcome of care from the interventions used to treat the patient. These observations represent status, at points in time, related to established care plan goals and/or interventions.

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Table 116: Health Status Evaluations and Outcomes Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.61)					
@nullFlavor	0..1	MAY		1098-32821	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-29578	
@root	1..1	SHALL		1098-29579	2.16.840.1.113883.10.20.22.2.61
code	1..1	SHALL		1098-29580	
@code	1..1	SHALL		1098-29581	11383-7
@codeSystem	1..1	SHALL		1098-29582	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-29589	
text	1..1	SHALL		1098-29590	
entry	1..*	SHALL		1098-31227	
observation	1..1	SHALL		1098-31228	Outcome Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.144

1. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32821).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-29578) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.61" (CONF:1098-29579).
3. **SHALL** contain exactly one [1..1] **code** (CONF:1098-29580).
   a. This code **SHALL** contain exactly one [1..1] **@code**="11383-7" Patient Problem Outcome (CONF:1098-29581).
   b. 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:1098-29582).
4. **SHALL** contain exactly one [1..1] **title** (CONF:1098-29589).
5. **SHALL** contain exactly one [1..1] **text** (CONF:1098-29590).

If section/@nullFlavor is not present:

6. **SHALL** contain at least one [1..*] **entry** (CONF:1098-31227) such that it
   a. **SHALL** contain exactly one [1..1] **Outcome Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.144) (CONF:1098-31228).

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Figure 85: Health Status Evaluations and 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>
```


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3.25 History of Past Illness Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09 (open)]

Table 117: History of Past Illness Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) Discharge Summary (V2) (optional) History and Physical (V2) (required) Procedure Note (V2) (optional)	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.

Table 118: History of Past Illness Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09)					
templateId	1..1	SHALL		1098-7828	
@root	1..1	SHALL		1098-10390	2.16.840.1.113883.10.20.22.2.20
@extension	1..1	SHALL		1098-32536	2014-06-09
code	1..1	SHALL		1098-15474	
@code	1..1	SHALL		1098-15475	11348-0
@codeSystem	1..1	SHALL		1098-30831	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7830	
text	1..1	SHALL		1098-7831	
entry	0..*	MAY		1098-8791	
observation	1..1	SHALL		1098-15476	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7828) such that it

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a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.20" (CONF:1098-10390).
b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32536).

2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15474).
   a. This code **SHALL** contain exactly one [1..1] **@code**="11348-0" History of Past Illness (CONF:1098-15475).
   b. 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:1098-30831).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7830).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7831).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8791) such that it
   a. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-15476).

Figure 86: History of Past Illness Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.20" extension="2014-06-09" />
    <!-- ** 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>
```


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3.26 History of Present Illness Section

`[section: identifier urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4 (open)]`

Table 119: History of Present Illness Section Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (required) Referral Note (optional) Discharge Summary (V2) (optional) History and Physical (V2) (optional) 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.

Table 120: History of Present Illness Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4)					
templateId	1..1	SHALL		81-7848	
@root	1..1	SHALL	UID	81-10458	1.3.6.1.4.1.19376.1.5.3.1.3.4
code	1..1	SHALL		81-15477	
@code	1..1	SHALL		81-15478	10164-2
@codeSystem	1..1	SHALL		81-26478	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-7850	
text	1..1	SHALL		81-7851	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7848) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.3.4" (CONF:81-10458).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15477).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10164-2" (CONF:81-15478).
    b. 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:81-26478).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7850).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7851).

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Figure 87: 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>
```

3.27 Hospital Consultations Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.42 (open)]

Table 121: Hospital Consultations Section Contexts

Contained By:	Contains:
Discharge Summary (V2) (optional)	

The Hospital Consultations Section records consultations that occurred during the admission.

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Table 122: Hospital Consultations Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.42)					
templateId	1..1	SHALL		81-9915	
@root	1..1	SHALL		81-10393	2.16.840.1.113883.10.20.22.2.42
code	1..1	SHALL		81-15485	
@code	1..1	SHALL		81-15486	18841-7
@codeSystem	1..1	SHALL		81-26479	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-9917	
text	1..1	SHALL		81-9918	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-9915) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.42" (CONF:81-10393).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15485).
    a. This code **SHALL** contain exactly one [1..1] **@code**="18841-7" Hospital Consultations Section (CONF:81-15486).
    b. 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:81-26479).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-9917).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-9918).

Figure 88: 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>
```


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3.28 Hospital Course Section

`[section: identifier urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.5 (open)]`

Table 123: Hospital Course Section Contexts

Contained By:	Contains:
Discharge Summary (V2) (required)	

The Hospital Course Section describes the sequence of events from admission to discharge in a hospital facility.

Table 124: Hospital Course Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.5)					
templateId	1..1	SHALL		81-7852	
@root	1..1	SHALL	UID	81-10459	1.3.6.1.4.1.19376.1.5.3.1.3.5
code	1..1	SHALL		81-15487	
@code	1..1	SHALL		81-15488	8648-8
@codeSystem	1..1	SHALL		81-26480	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-7854	
text	1..1	SHALL		81-7855	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7852) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.3.5" (CONF:81-10459).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15487).
    a. This code **SHALL** contain exactly one [1..1] **@code**="8648-8" Hospital Course (CONF:81-15488).
    b. 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:81-26480).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7854).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7855).

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Figure 89: 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>
```

3.29 Hospital Discharge Instructions Section

`[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.41 (open)]`

Table 125: Hospital Discharge Instructions Section Contexts

Contained By:	Contains:
Discharge Summary (V2) (optional)	

The Hospital Discharge Instructions Section records instructions at discharge.

Table 126: Hospital Discharge Instructions Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.41)					
templateId	1..1	SHALL		81-9919	
@root	1..1	SHALL		81-10395	2.16.840.1.113883.10.20.22.2.41
code	1..1	SHALL		81-15357	
@code	1..1	SHALL		81-15358	8653-8
@codeSystem	1..1	SHALL		81-26481	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-9921	
text	1..1	SHALL		81-9922	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-9919) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.41" (CONF:81-10395).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15357).

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a. This code **SHALL** contain exactly one [1..1] **@code**="8653-8" Hospital Discharge Instructions (CONF:81-15358).
b. 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:81-26481).

3. **SHALL** contain exactly one [1..1] **title** (CONF:81-9921).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-9922).

Figure 90: 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>
```


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3.30 Hospital Discharge Physical Section

`[section: identifier urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.26 (open)]`

Table 127: Hospital Discharge Physical Section Contexts

Contained By:	Contains:
Discharge Summary (V2) (optional)	

The Hospital Discharge Physical Section records a narrative description of the patient's physical findings.

Table 128: Hospital Discharge Physical Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.26)					
templateId	1..1	SHALL		81-7971	
@root	1..1	SHALL	UID	81-10460	1.3.6.1.4.1.19376.1.5.3.1.3.26
code	1..1	SHALL		81-15363	
@code	1..1	SHALL		81-15364	10184-0
@codeSystem	1..1	SHALL		81-26482	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-7973	
text	1..1	SHALL		81-7974	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7971) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.3.26" (CONF:81-10460).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15363).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10184-0" Hospital Discharge Physical (CONF:81-15364).
    b. 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:81-26482).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7973).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7974).

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Figure 91: 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>
```

3.31 Hospital Discharge Studies Summary Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.16 (open)]

Table 129: Hospital Discharge Studies Summary Section Contexts

Contained By:	Contains:
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 when 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.

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Note that there are discrepancies between CCD and the lab domain model, such as the effectiveTime in specimen collection.

Table 130: Hospital Discharge Studies Summary Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.16)					
templateId	1..1	SHALL		81-7910	
@root	1..1	SHALL		81-10398	2.16.840.1.113883.10.20.22.2.16
code	1..1	SHALL		81-15365	
@code	1..1	SHALL		81-15366	11493-4
@codeSystem	1..1	SHALL		81-26483	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-7912	
text	1..1	SHALL		81-7913	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7910) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.16" (CONF:81-10398).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15365).
    a. This code **SHALL** contain exactly one [1..1] **@code**="11493-4" Hospital Discharge Studies Summary (CONF:81-15366).
    b. 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:81-26483).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7912).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7913).

Figure 92: 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>
```


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3.32 Immunizations Section (entries optional) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09 (open)]

Table 131: Immunizations Section (entries optional) (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Discharge Summary (V2) (optional) History and Physical (V2) (optional)	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.

Table 132: Immunizations Section (entries optional) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09)					
templateId	1..1	SHALL		1098-7965	
@root	1..1	SHALL		1098-10399	2.16.840.1.113883.10.20.22.2.2
@extension	1..1	SHALL		1098-32529	2014-06-09
code	1..1	SHALL		1098-15367	
@code	1..1	SHALL		1098-15368	11369-6
@codeSystem	1..1	SHALL		1098-32146	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7967	
text	1..1	SHALL		1098-7968	
entry	0..*	SHOULD		1098-7969	
substanceAdministration	1..1	SHALL		1098-15494	Immunization Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7965) such that it

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a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.2" (CONF:1098-10399).
b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32529).

2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15367).
   a. This code **SHALL** contain exactly one [1..1] **@code**="11369-6" Immunizations (CONF:1098-15368).
   b. 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:1098-32146).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7967).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7968).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-7969) such that it
   a. **SHALL** contain exactly one [1..1] **Immunization Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09) (CONF:1098-15494).

3.32.1 Immunizations Section (entries required) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2014-06-09 (open)]

Table 133: Immunizations Section (entries required) (V2) Contexts

Contained By:	Contains:
Referral Note (optional) Continuity of Care Document (CCD) (V2) (optional)	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.

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Table 134: Immunizations Section (entries required) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32833	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-9015	
@root	1..1	SHALL		1098-10400	2.16.840.1.113883.10.20.22.2.2.1
@extension	1..1	SHALL		1098-32530	2014-06-09
code	1..1	SHALL		1098-15369	
@code	1..1	SHALL		1098-15370	11369-6
@codeSystem	1..1	SHALL		1098-32147	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-9017	
text	1..1	SHALL		1098-9018	
entry	1..*	SHALL		1098-9019	
substanceAdministration	1..1	SHALL		1098-15495	Immunization Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09

1. Conforms to **Immunizations Section (entries optional) (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09).
2. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32833).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-9015) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.2.1" (CONF:1098-10400).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32530).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15369).
    a. This code **SHALL** contain exactly one [1..1] **@code**="11369-6" Immunizations (CONF:1098-15370).
    b. 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:1098-32147).
5. **SHALL** contain exactly one [1..1] **title** (CONF:1098-9017).
6. **SHALL** contain exactly one [1..1] **text** (CONF:1098-9018).

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If section/@nullFlavor is not present:

7. **SHALL** contain at least one [1..*] **entry** (CONF:1098-9019) such that it
    a. **SHALL** contain exactly one [1..1] **Immunization Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09) (CONF:1098-15495).

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Figure 93: Immunizations Section (entries required) (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.1" extension="2014-06-09" />
    <!--  ********  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>
```


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```
    </entry>
  ...
</section>
```

3.33 Implants Section (DEPRECATED)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.33:2014-06-09 (open)]

THIS TEMPLATE HAS BEEN DEPRECATED IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED.

Reason for Deprecation: Replaced by the Procedure Implants Section (2.16.840.1.113883.10.20.22.2.40)

Table 135: Implants Section (DEPRECATED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.33:2014-06-09)					
templateId	1..1	SHALL		1098-8042	
@root	1..1	SHALL		1098-32608	2.16.840.1.113883.10.20.22.2.33
@extension	1..1	SHALL		1098-32609	2014-06-09
code	1..1	SHALL		1098-15371	
@code	1..1	SHALL		1098-15372	55122-6
@codeSystem	1..1	SHALL		1098-26471	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8044	
text	1..1	SHALL		1098-8045	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8042) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.33" (CONF:1098-32608).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32609).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15371).
    a. This code **SHALL** contain exactly one [1..1] **@code**="55122-6" Implants (CONF:1098-15372).

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b. 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:1098-26471).

3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8044).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8045).

3.34 Instructions Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09 (open)]

Table 136: Instructions Section (V2) Contexts

Contained By:	Contains:
History and Physical (V2) (optional) Progress Note (V2) (optional)	Instruction (V2)

The Instructions Section records instructions given to a patient. List patient decision aids here.

Table 137: Instructions Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32835	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-10112	
@root	1..1	SHALL		1098-31384	2.16.840.1.113883.10.20.22.2.45
@extension	1..1	SHALL		1098-32599	2014-06-09
code	1..1	SHALL		1098-15375	
@code	1..1	SHALL		1098-15376	69730-0
@codeSystem	1..1	SHALL		1098-32148	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-10114	
text	1..1	SHALL		1098-10115	
entry	1..*	SHALL		1098-10116	
act	1..1	SHALL		1098-31398	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09

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1. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32835).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-10112) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.45" (CONF:1098-31384).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32599).
3. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15375).
    a. This code **SHALL** contain exactly one [1..1] **@code**="69730-0" Instructions (CONF:1098-15376).
    b. 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:1098-32148).
4. **SHALL** contain exactly one [1..1] **title** (CONF:1098-10114).
5. **SHALL** contain exactly one [1..1] **text** (CONF:1098-10115).

If section/@nullFlavor is not present:

6. **SHALL** contain at least one [1..*] **entry** (CONF:1098-10116).
    a. Such entries **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31398).

Figure 94: Instructions Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.21.2.45"
         extension="2014-06-09" />
    <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 ***  -->
       ...

        </act>
    </entry>
  </section>
```


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3.35 Interventions Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2014-06-09 (open)]

Table 138: Interventions Section (V2) Contexts

Contained By:	Contains:
Care Plan (optional) Progress Note (V2) (optional)	Handoff Communication Participants Intervention Act Planned Intervention Act

This template represents Interventions. Interventions are actions taken to maximize the prospects of the goals of care for the patient, 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 nested within 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.

Instructions are information or directions to the patient. Use the Instructions Section when instructions are included as part of a document that is not a Care Plan. Use the Interventions Section, containing the Intervention Act containing the Instruction entry, when instructions are part of a structured care plan.

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Table 139: Interventions Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2014-06-09)					
templateId	1..1	SHALL		1098-8680	
@root	1..1	SHALL	UID	1098-10461	2.16.840.1.113883.10.20.21.2.3
@extension	1..1	SHALL		1098-32559	2014-06-09
code	1..1	SHALL		1098-15377	
@code	1..1	SHALL		1098-15378	62387-6
@codeSystem	1..1	SHALL		1098-30864	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8682	
text	1..1	SHALL		1098-8683	
entry	0..*	SHOULD		1098-30996	
act	1..1	SHALL		1098-30997	Intervention Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.131
entry	0..*	SHOULD		1098-32730	
act	1..1	SHALL		1098-32731	Planned Intervention Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.146
entry	0..*	MAY	Entry	1098-32402	
act	1..1	SHALL		1098-32403	Handoff Communication Participants (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8680) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.21.2.3" (CONF:1098-10461).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32559).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15377).
    a. This code **SHALL** contain exactly one [1..1] **@code**="62387-6" Interventions Provided (CONF:1098-15378).

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b. 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:1098-30864).

3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8682).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8683).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-30996) such that it
   a. **SHALL** contain exactly one [1..1] **Intervention Act** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.131) (CONF:1098-30997).
6. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-32730) such that it
   a. **SHALL** contain exactly one [1..1] **Planned Intervention Act** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.146) (CONF:1098-32731).
7. **MAY** contain zero or more [0..*] **entry** (CONF:1098-32402) such that it
   a. **SHALL** contain exactly one [1..1] **Handoff Communication Participants** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141) (CONF:1098-32403).

Figure 95: Interventions Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.21.2.3" extension="2014-06-09" />
    <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>
```

3.36 Medical (General) History Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.39 (open)]

Table 140: Medical (General) History Section Contexts

Contained By:	Contains:
Procedure Note (V2) (optional)	

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.

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Table 141: Medical (General) History Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.39)					
templateId	1..1	SHALL		81-8160	
@root	1..1	SHALL		81-10403	2.16.840.1.113883.10.20.22.2.39
code	1..1	SHALL		81-15379	
@code	1..1	SHALL		81-15380	11329-0
@codeSystem	1..1	SHALL		81-26484	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-8162	
text	1..1	SHALL		81-8163	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8160) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.39" (CONF:81-10403).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15379).
    a. This code **SHALL** contain exactly one [1..1] **@code**="11329-0" Medical (General) History (CONF:81-15380).
    b. 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:81-26484).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-8162).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-8163).

3.37 Medical Equipment Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09 (open)]

Table 142: Medical Equipment Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) Continuity of Care Document (CCD) (V2) (optional)	Medical Equipment Organizer Non-Medicinal Supply Activity (V2) Procedure Activity Procedure (V2)

This section defines a patient's implanted and external health and medical devices and equipment. This section lists any pertinent durable medical equipment (DME) used to help

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maintain the patient's health status. All equipment relevant to the diagnosis, care, or treatment of a patient should be included.

Devices applied to, or placed in, the patient are represented with the Procedure Activity Procedure (V2) template. Equipment supplied to the patient (e.g., pumps, inhalers, wheelchairs) is represented by the Non-Medicinal Supply Activity V2 template.

These devices may be grouped together within a Medical Equipment Organizer. The organizer would probably not be used with devices applied in or on the patient but rather to organize a group of medical supplies the patient has been supplied with.

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Table 143: Medical Equipment Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09)					
templateId	1..1	SHALL		1098-7944	
@root	1..1	SHALL		1098-10404	2.16.840.1.113883.10.20.22.2.23
@extension	1..1	SHALL		1098-32523	2014-06-09
code	1..1	SHALL		1098-15381	
@code	1..1	SHALL		1098-15382	46264-8
@codeSystem	1..1	SHALL		1098-30828	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7946	
text	1..1	SHALL		1098-7947	
entry	0..*	MAY		1098-7948	
organizer	1..1	SHALL		1098-30351	Medical Equipment Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.135
entry	0..*	SHOULD		1098-31125	
supply	1..1	SHALL		1098-31861	Non-Medicinal Supply Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09
entry	0..*	SHOULD		1098-31885	
procedure	1..1	SHALL		1098-31886	Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7944) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.23" (CONF:1098-10404).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32523).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15381).
    a. This code **SHALL** contain exactly one [1..1] **@code**="46264-8" Medical Equipment (CONF:1098-15382).

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   b. 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:1098-30828).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7946).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7947).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-7948) such that it
   a. **SHALL** contain exactly one [1..1] **Medical Equipment Organizer** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.135) (CONF:1098-30351).
6. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-31125) such that it
   a. **SHALL** contain exactly one [1..1] **Non-Medicinal Supply Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09) (CONF:1098-31861).
7. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-31885) such that it
   a. **SHALL** contain exactly one [1..1] **Procedure Activity Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09) (CONF:1098-31886).

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Figure 96: Medical Equipment Section (V2) Example

```
<component>
    <section>
        <!-- Medical equipment section -->
        <templateId root="2.16.840.1.113883.10.20.22.2.23" extension="2014-06-09" />
        <code code="46264-8" codeSystem="2.16.840.1.113883.6.1" />
        <title>MEDICAL EQUIPMENT</title>
        <text>
            <content styleCode="Bold">Medical Equipment</content>
            <list>
                <item>Implanted Devices: Cardiac Pacemaker July 3, 2013</item>
                <item>Implanted Devices: Upper GI Prosthesis, January 3, 2013</item>
                <item>Cane, February 2, 2003</item>
                <item>Biliary Stent, May 5, 2013</item>
            </list>
        </text>
        <entry>
            <organizer classCode="CLUSTER" moodCode="EVN">
                <!-- Medical Equipment Organizer template -->
                <templateId root="2.16.840.1.113883.10.20.22.4.135" />
                ...
            </organizer>
        </entry>
        <entry>
            <supply classCode="SPLY" moodCode="EVN">
                <!-- Non-medicinal supply activity V2 template ******* -->
                <templateId root="2.16.840.1.113883.10.20.22.4.50" extension="2014-06-09"
/>
                ...
            </supply>
        </entry>
        <entry>
            <procedure classCode="PROC" moodCode="EVN">
                <!-- Procedure Activity Procedure V2-->
                <templateId root="2.16.840.1.113883.10.20.22.4.14" extension="2014-06-09"
/>
                ...
            </procedure>
        </entry>
    </section>
</component>
```

3.38 Medications Administered Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.38:2014-06-09 (open)]

Table 144: Medications Administered Section (V2) Contexts

Contained By:	Contains:
Procedure Note (V2) (optional)	Medication Activity (V2)

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The Medications Administered Section usually resides inside a Procedure Note describing a procedure. This section defines medications and fluids administered during the procedure, its related encounter, or other procedure related activity excluding anesthetic medications. Anesthesia medications should be documented as described in the Anesthesia Section

templateId 2.16.840.1.113883.10.20.22.2.25.

Table 145: Medications Administered Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.38:2014-06-09)					
templateId	1..1	SHALL		1098-8152	
@root	1..1	SHALL		1098-10405	2.16.840.1.113883.10.20.22.2.38
@extension	1..1	SHALL		1098-32525	2014-06-09
code	1..1	SHALL		1098-15383	
@code	1..1	SHALL		1098-15384	29549-3
@codeSystem	1..1	SHALL		1098-30829	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8154	
text	1..1	SHALL		1098-8155	
entry	0..*	MAY		1098-8156	
substanceAdministration	1..1	SHALL		1098-15499	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8152) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.38" (CONF:1098-10405).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32525).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15383).
    a. This code **SHALL** contain exactly one [1..1] **@code**="29549-3" Medications Administered (CONF:1098-15384).
    b. 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:1098-30829).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8154).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8155).

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5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8156).
    a. The entry, if present, **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-15499).

Figure 97: Medications Administered Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.38" extension="2014-06-09" />
    <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 Substitution 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" extension="2014-06-09" />
            <!-- ** MEDICATION ACTIVITY V2 ** -->
                ...
        </substanceAdministration>
    </entry>
</section>
```


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3.39 Medications Section (entries optional) (V2)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09 (open)]`

Table 146: Medications Section (entries optional) (V2) Contexts

Contained By:	Contains:
History and Physical (V2) (required) Procedure Note (V2) (optional) Progress Note (V2) (optional)	Medication Activity (V2)

The Medications Section contains a patient's current medications and pertinent medication history. At a minimum, the currently active medications are listed. An entire medication history is an option. The section can describe a patient's prescription and dispense history and information about intended drug monitoring.

Table 147: Medications Section (entries optional) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09)					
templateId	1..1	SHALL		1098-7791	
@root	1..1	SHALL		1098-10432	2.16.840.1.113883.10.20.22.2.1
@extension	1..1	SHALL		1098-32500	2014-06-09
code	1..1	SHALL		1098-15385	
@code	1..1	SHALL		1098-15386	10160-0
@codeSystem	1..1	SHALL		1098-30824	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7793	
text	1..1	SHALL		1098-7794	
entry	0..*	SHOULD		1098-7795	
substanceAdministration	1..1	SHALL		1098-10076	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7791) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.1" (CONF:1098-10432).

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b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32500).

2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15385).
   a. This code **SHALL** contain exactly one [1..1] **@code**="10160-0" History of medication use (CONF:1098-15386).
   b. 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:1098-30824).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7793).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7794).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-7795) such that it
   a. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-10076).

3.39.1 Medications Section (entries required) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09 (open)]

Table 148: Medications Section (entries required) (V2) Contexts

Contained By:	Contains:
Transfer Summary (required) Consultation Note (V2) (optional) Referral Note (required) Continuity of Care Document (CCD) (V2) (required)	Medication Activity (V2)

The Medications Section contains a patient's current medications and pertinent medication history. At a minimum, the currently active medications are listed. An entire medication history is an option. The section can describe a patient's prescription and dispense history and information about intended drug monitoring.

This section requires either an entry indicating the subject is not known to be on any medications or entries summarizing the subject's medications.

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Table 149: Medications Section (entries required) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32845	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-7568	
@root	1..1	SHALL		1098-10433	2.16.840.1.113883.10.20.22.2.1.1
@extension	1..1	SHALL		1098-32499	2014-06-09
code	1..1	SHALL		1098-15387	
@code	1..1	SHALL		1098-15388	10160-0
@codeSystem	1..1	SHALL		1098-30825	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7570	
text	1..1	SHALL		1098-7571	
entry	1..*	SHALL		1098-7572	
substanceAdministration	1..1	SHALL		1098-10077	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09

1. Conforms to **Medications Section (entries optional) (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09).
2. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32845).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7568) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.1.1" (CONF:1098-10433).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32499).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15387).
   a. This code **SHALL** contain exactly one [1..1] **@code**="10160-0" History of medication use (CONF:1098-15388).
   b. 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:1098-30825).
5. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7570).
6. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7571).

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If section/@nullFlavor is not present:

7. **SHALL** contain at least one [1..*] **entry** (CONF:1098-7572) such that it
    a. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-10077).

Figure 98: Medications Section (entries required) (V2) Example

```
<section>
    <!--**MEDICATION SECTION (coded entries required) ** -->
    <templateId root="2.16.840.1.113883.10.20.22.2.1.1" extension="2014-06-09" />
    <!-- Medications Section (entries optional) -->
    <templateId root="2.16.840.1.113883.10.20.22.2.1" extension="2014-06-09" />

    <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" extension="2014-06-09" />
            ....
        </substanceAdministration>
    </entry>
</section>
```

3.40 Mental Status Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.56 (open)]

Table 150: Mental Status Section Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) Continuity of Care Document (CCD) (V2) (optional)	Assessment Scale Observation Mental Status Observation (V2) Mental Status Organizer (V2)

The Mental Status Section contains observations and evaluations related to a patient's psychological and mental competency and deficits including, but not limited to any of the following types of information:

- Appearance (e.g., unusual grooming, clothing or body modifications)
- Attitude (e.g., cooperative, guarded, hostile)
- Behavior/psychomotor (e.g., abnormal movements, eye contact, tics)

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- Mood and affect (e.g., anxious, angry, euphoric)
- Speech and Language (e.g., pressured speech, perseveration)
- Thought process (e.g., logic, coherence)
- Thought content (e.g., delusions, phobias)
- Perception (e.g., voices, hallucinations)
- Cognition (e.g., memory, alertness/consciousness, attention, orientation) – which were included in Cognitive Status Observation in earlier publications of C-CDA.
- Insight and judgment (e.g., understanding of condition, decision making)

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Table 151: Mental Status Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.56)					
templateId	1..1	SHALL		1098-28293	
@root	1..1	SHALL		1098-28294	2.16.840.1.113883.10.20.22.2.56
code	1..1	SHALL		1098-28295	
@code	1..1	SHALL		1098-28296	10190-7
@codeSystem	1..1	SHALL		1098-30826	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-28297	
text	1..1	SHALL		1098-28298	
entry	0..*	MAY		1098-28301	
organizer	1..1	SHALL		1098-28302	Mental Status Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.75:2014-06-09
entry	0..*	MAY		1098-28305	
observation	1..1	SHALL		1098-28306	Mental Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09
entry	0..*	MAY		1098-28313	
observation	1..1	SHALL		1098-28314	Assessment Scale Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-28293) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.56" (CONF:1098-28294).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-28295).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10190-7" Mental Status (CONF:1098-28296).
    b. 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:1098-30826).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-28297).

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4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-28298).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-28301) such that it
    a. **SHALL** contain exactly one [1..1] **Mental Status Organizer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.75:2014-06-09) (CONF:1098-28302).
6. **MAY** contain zero or more [0..*] **entry** (CONF:1098-28305) such that it
    a. **SHALL** contain exactly one [1..1] **Mental Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09) (CONF:1098-28306).
7. **MAY** contain zero or more [0..*] **entry** (CONF:1098-28313) such that it
    a. **SHALL** contain exactly one [1..1] **Assessment Scale Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69) (CONF:1098-28314).

Figure 99: Mental Status Section Example

```
<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" />
               ...


        </observation>
    </entry>
    <entry>
        <observation classCode="OBS" moodCode="EVN">
            <!-- Mental Status Observation V2 -->
            <templateId root="2.16.840.1.113883.10.20.22.4.74" extension="2014-06-09" />
            ...

        </observation>
    </entry>
    <entry>
        <organizer classCode="CLUSTER" moodCode="EVN">
            <!-- Mental Status Organizer V2-->
            <templateId root="2.16.840.1.113883.10.20.22.4.75" extension="2014-06-09" />
            <id root="a7bc1062-8649-42a0-833d-ekd65bd013c9" />
             ...

        </organizer>
    </entry>
</section>
```


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3.41 MG Test

[section: identifier urn:oid:1.2.3.4.5.6.7.8.9.10 (open)]

Table 152: MG Test Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:1.2.3.4.5.6.7.8.9.10)					

3.42 Nutrition Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.57 (open)]

Table 153: Nutrition Section Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) Continuity of Care Document (CCD) (V2) (optional) Discharge Summary (V2) (optional) Progress Note (V2) (optional)	Nutritional Status Observation

The Nutrition Section represents diet and nutrition information including special diet requirements and restrictions (e.g., texture modified diet, liquids only, enteral feeding). It also represents the overall nutritional status of the patient and nutrition assessment findings.

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Table 154: Nutrition Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57)					
templateId	1..1	SHALL		1098-30477	
@root	1..1	SHALL	UID	1098-30478	2.16.840.1.113883.10.20.22.2.57
code	1..1	SHALL		1098-30318	
@code	1..1	SHALL		1098-30319	61144-2
@codeSystem	1..1	SHALL		1098-30320	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-31042	
text	1..1	SHALL		1098-31043	
entry	0..*	SHOULD		1098-30321	
observation	1..1	SHALL		1098-30322	Nutritional Status Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.124

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30477) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.57" (CONF:1098-30478).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-30318).
    a. This code **SHALL** contain exactly one [1..1] **@code**="61144-2" Diet and nutrition (CONF:1098-30319).
    b. 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:1098-30320).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-31042).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-31043).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-30321) such that it
    a. **SHALL** contain exactly one [1..1] **Nutritional Status Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.124) (CONF:1098-30322).

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Figure 100: Nutrition Section Example

```
    <section>
        <!--  Nutrition Section  -->
        <templateId root="2.16.840.1.113883.10.20.22.2.57" />
        <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>
              </observation>
        </entry>
    </section>
```

3.43 Objective Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.21.2.1 (open)]

Table 155: Objective Section Contexts

Contained By:	**Contains:**
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.

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Table 156: Objective Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.1)					
templateId	1..1	SHALL		81-7869	
@root	1..1	SHALL	UID	81-10462	2.16.840.1.113883.10.20.21.2.1
code	1..1	SHALL		81-15389	
@code	1..1	SHALL		81-15390	61149-1
@codeSystem	1..1	SHALL		81-26485	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-7871	
text	1..1	SHALL		81-7872	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7869) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.21.2.1" (CONF:81-10462).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15389).
    a. This code **SHALL** contain exactly one [1..1] **@code**="61149-1" Objective (CONF:81-15390).
    b. 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:81-26485).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7871).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7872).

Figure 101: 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>
```


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3.44 Observer Context

[assignedAuthor: identifier urn:oid:2.16.840.1.113883.10.20.6.2.4 (open)]

Table 157: Observer Context Contexts

Contained By:	Contains:
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.

Table 158: Observer Context Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
assignedAuthor (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.4)					
templateId	1..1	SHALL		81-9194	
@root	1..1	SHALL		81-10536	2.16.840.1.113883.10.20.6.2.4
id	1..*	SHALL		81-9196	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-9194) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.6.2.4" (CONF:81-10536).

The id element contains the author's id or the DICOM device observer UID

2. **SHALL** contain at least one [1..*] **id** (CONF:81-9196).
3. Either assignedPerson or assignedAuthoringDevice **SHALL** be present (CONF:81-9198).

Figure 102: Observer Context 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>
```


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3.45 Operative Note Fluids Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.7.12 (open)]

Table 159: Operative Note Fluids Section Contexts

Contained By:	Contains:
Operative Note (V2) (optional)	

The Operative Note Fluids Section may be used to record fluids administered during the surgical procedure.

Table 160: Operative Note Fluids Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.7.12)					
templateId	1..1	SHALL		81-8030	
@root	1..1	SHALL	UID	81-10463	2.16.840.1.113883.10.20.7.12
code	1..1	SHALL		81-15391	
@code	1..1	SHALL		81-15392	10216-0
@codeSystem	1..1	SHALL		81-26486	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-8032	
text	1..1	SHALL		81-8033	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8030) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.7.12" (CONF:81-10463).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15391).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10216-0" Operative Note Fluids (CONF:81-15392).
    b. 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:81-26486).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-8032).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-8033).
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:81-8052).

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Figure 103: 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>
```

3.46 Operative Note Surgical Procedure Section

`[section: identifier urn:oid:2.16.840.1.113883.10.20.7.14 (open)]`

Table 161: Operative Note Surgical Procedure Section Contexts

Contained By:	Contains:
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.

Table 162: Operative Note Surgical Procedure Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.7.14)					
templateId	1..1	SHALL		81-8034	
@root	1..1	SHALL	UID	81-10464	2.16.840.1.113883.10.20.7.14
code	1..1	SHALL		81-15393	
@code	1..1	SHALL		81-15394	10223-6
@codeSystem	1..1	SHALL		81-26487	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-8036	
text	1..1	SHALL		81-8037	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8034) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.7.14" (CONF:81-10464).

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2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15393).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10223-6" Operative Note Surgical Procedure (CONF:81-15394).
    b. 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:81-26487).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-8036).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-8037).
5. If the surgical procedure section is present there **SHALL** be text indicating the procedure performed (CONF:81-8054).

Figure 104: 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>
```

3.47 Payers Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.18:2014-06-09 (open)]

Table 163: Payers Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Continuity of Care Document (CCD) (V2) (optional)	Coverage Activity (V2)

The Payers Section contains data on the patient's payers, whether "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.

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Table 164: Payers Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.18:2014-06-09)					
templateId	1..1	SHALL		1098-7924	
@root	1..1	SHALL		1098-10434	2.16.840.1.113883.10.20.22.2.18
@extension	1..1	SHALL		1098-32597	2014-06-09
code	1..1	SHALL		1098-15395	
@code	1..1	SHALL		1098-15396	48768-6
@codeSystem	1..1	SHALL		1098-32149	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7926	
text	1..1	SHALL		1098-7927	
entry	0..*	SHOULD		1098-7959	
act	1..1	SHALL		1098-15501	Coverage Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.60:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7924) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.18" (CONF:1098-10434).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32597).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15395).
    a. This code **SHALL** contain exactly one [1..1] **@code**="48768-6" Payers (CONF:1098-15396).
    b. 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:1098-32149).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7926).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7927).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-7959) such that it
    a. **SHALL** contain exactly one [1..1] **Coverage Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.60:2014-06-09) (CONF:1098-15501).

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Figure 105: Payers Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.18" extension="2014-06-09" />
    <!--  ******** 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" extension="2014-06-09" />
            <!--  ****  Coverage entry template  **** -->
      ...

        </act>
    </entry>
</section>
```

3.48 Physical Exam Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09 (open)]

Table 165: Physical Exam Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) History and Physical (V2) (required) Procedure Note (V2) (optional) Progress Note (V2) (optional)	Longitudinal Care Wound Observation

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.

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Table 166: Physical Exam Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09)					
templateId	1..1	SHALL		1098-7806	
@root	1..1	SHALL	UID	1098-10465	2.16.840.1.113883.10.20.2.10
@extension	1..1	SHALL		1098-32587	2014-06-09
code	1..1	SHALL		1098-15397	
@code	1..1	SHALL		1098-15398	29545-1
@codeSystem	1..1	SHALL		1098-30931	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7808	
text	1..1	SHALL		1098-7809	
entry	0..*	MAY		1098-31926	
observation	1..1	SHALL		1098-31927	Longitudinal Care Wound Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.114
component	0..*	MAY		1098-32434	
section	1..1	SHALL		1098-32435	
code	1..1	SHALL		1098-32436	2.16.840.1.113883.11.20.9.65 (Physical Exam Type)
title	1..1	SHALL		1098-32437	
text	1..1	SHALL		1098-32438	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7806) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.2.10" (CONF:1098-10465).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32587).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15397).
    a. This code **SHALL** contain exactly one [1..1] **@code**="29545-1" Physical Findings (CONF:1098-15398).

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b. 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:1098-30931).

3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7808).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7809).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-31926) such that it
   a. **SHALL** contain exactly one [1..1] **Longitudinal Care Wound Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.114) (CONF:1098-31927).
6. **MAY** contain zero or more [0..*] **component** (CONF:1098-32434) such that it
   a. **SHALL** contain exactly one [1..1] **section** (CONF:1098-32435).
      i. This section **SHALL** contain exactly one [1..1] **code** (ValueSet: **Physical Exam Type** 2.16.840.1.113883.11.20.9.65 **STATIC** 2014-05-15) (CONF:1098-32436).
      ii. This section **SHALL** contain exactly one [1..1] **title** (CONF:1098-32437).
      iii. This section **SHALL** contain exactly one [1..1] **text** (CONF:1098-32438).

Table 167: Physical Exam Type

Value Set: Physical Exam Type 2.16.840.1.113883.11.20.9.65 Additional section types that may be used under the Physical Examination section. Value Set Source: **http://www.search.loinc.org**			
Code	**Code System**	**Code System OID**	**Print Name**
10199-8	LOINC	2.16.840.1.113883.6.1	Head, physical findings
10197-2	LOINC	2.16.840.1.113883.6.1	Eye, physical findings
10195-6	LOINC	2.16.840.1.113883.6.1	Ear, physical Findings
10203-8	LOINC	2.16.840.1.113883.6.1	Nose, physical findings
11393-6	LOINC	2.16.840.1.113883.6.1	Ears & nose & mouth & throat, physical findings
10201-2	LOINC	2.16.840.1.113883.6.1	Mouth & throat & teeth, physical findings
51850-6	LOINC	2.16.840.1.113883.6.1	Head & ears & eyes & nose & throat, physical findings
11411-6	LOINC	2.16.840.1.113883.6.1	Neck, physical findings
10207-9	LOINC	2.16.840.1.113883.6.1	Thorax & lungs, physical findings
11391-0	LOINC	2.16.840.1.113883.6.1	Chest, physical findings
…			

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Figure 106: Physical Exam Section (V2) Example

```
<component>
    <section>
        <templateId root="2.16.840.1.113883.10.20.2.10" extension="2014-06-09" />
        <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 -->
        <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>
```

3.49 Plan of Treatment Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09 (open)]

Table 168: Plan of Treatment Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) Continuity of Care Document (CCD) (V2) (optional) Discharge Summary (V2) (required) History and Physical (V2) (optional) Operative Note (V2) (optional) Procedure Note (V2) (optional) Progress Note (V2) (optional)	Goal Observation Handoff Communication Participants Instruction (V2) Nutrition Recommendation Planned Act (V2) Planned Encounter (V2) Planned Immunization Activity Planned Medication Activity (V2) Planned Observation (V2) Planned Procedure (V2) Planned Supply (V2)

This section, formerly known as "Plan of Care", contains data that define pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only. These 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.

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This section may also contain information about ongoing care of the patient, clinical reminders, patient's values, beliefs, preferences, care expectations, and overarching care goals.

Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and healthcare 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 may range from being treated only 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.

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Table 169: Plan of Treatment Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09)					
templateId	1..1	SHALL		1098-7723	
@root	1..1	SHALL		1098-10435	2.16.840.1.113883.10.20.22.2.10
@extension	1..1	SHALL		1098-32501	2014-06-09
code	1..1	SHALL		1098-14749	
@code	1..1	SHALL		1098-14750	18776-5
@codeSystem	1..1	SHALL		1098-30813	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-16986	
text	1..1	SHALL		1098-7725	
entry	0..*	MAY		1098-7726	
observation	1..1	SHALL		1098-14751	Planned Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09
entry	0..*	MAY		1098-8805	
encounter	1..1	SHALL		1098-30472	Planned Encounter (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09
entry	0..*	MAY		1098-8807	
act	1..1	SHALL		1098-30473	Planned Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09
entry	0..*	MAY		1098-8809	
procedure	1..1	SHALL		1098-30474	Planned Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09
entry	0..*	MAY		1098-8811	
substanceAdministration	1..1	SHALL		1098-30475	Planned Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.2

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					0.22.4.42:2014-06-09
entry	0..*	MAY		1098-8813	
supply	1..1	SHALL		1098-30476	Planned Supply (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09
entry	0..*	MAY		1098-14695	
act	1..1	SHALL		1098-31397	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
entry	0..*	MAY		1098-29621	
act	1..1	SHALL		1098-30868	Handoff Communication Participants (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141
entry	0..*	MAY		1098-31841	
act	1..1	SHALL		1098-31864	Nutrition Recommendation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.130
entry	0..*	MAY		1098-32353	
substanceAdministration	1..1	SHALL		1098-32354	Planned Immunization Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.120
entry	0..*	MAY		1098-32887	
observation	1..1	SHALL		1098-32888	Goal Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.121

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7723) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.2.10`" (CONF:1098-10435).
    b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32501).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-14749).
    a. This code **SHALL** contain exactly one [1..1] **@code**="`18776-5`" Plan of Treatment (CONF:1098-14750).
    b. 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:1098-30813).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-16986).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7725).

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5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-7726) such that it
    a. **SHALL** contain exactly one [1..1] **Planned Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09) (CONF:1098-14751).
6. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8805) such that it
    a. **SHALL** contain exactly one [1..1] **Planned Encounter (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09) (CONF:1098-30472).
7. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8807) such that it
    a. **SHALL** contain exactly one [1..1] **Planned Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09) (CONF:1098-30473).
8. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8809) such that it
    a. **SHALL** contain exactly one [1..1] **Planned Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09) (CONF:1098-30474).
9. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8811) such that it
    a. **SHALL** contain exactly one [1..1] **Planned Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09) (CONF:1098-30475).
10. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8813) such that it
    a. **SHALL** contain exactly one [1..1] **Planned Supply (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09) (CONF:1098-30476).
11. **MAY** contain zero or more [0..*] **entry** (CONF:1098-14695) such that it
    a. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31397).
12. **MAY** contain zero or more [0..*] **entry** (CONF:1098-29621) such that it
    a. **SHALL** contain exactly one [1..1] **Handoff Communication Participants** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141) (CONF:1098-30868).
13. **MAY** contain zero or more [0..*] **entry** (CONF:1098-31841) such that it
    a. **SHALL** contain exactly one [1..1] **Nutrition Recommendation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.130) (CONF:1098-31864).
14. **MAY** contain zero or more [0..*] **entry** (CONF:1098-32353) such that it
    a. **SHALL** contain exactly one [1..1] **Planned Immunization Activity** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.120) (CONF:1098-32354).
15. **MAY** contain zero or more [0..*] **entry** (CONF:1098-32887) such that it
    a. **SHALL** contain exactly one [1..1] **Goal Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.121) (CONF:1098-32888).

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Figure 107: Plan of Treatment Section (V2) Example

```
<component>
    <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.10" extension="2014-06-09" />
        <!--  **** 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" />
              ...

            </act>
        </entry>
        <entry>
            <encounter moodCode="INT" classCode="ENC">
                <templateId root="2.16.840.1.113883.10.20.22.4.40" extension="2014-06-09"
/>
                <!-- Plan Activity Encounter V2 template -->
              ...


            </encounter>
        </entry>
    </section>
</component>
```

3.50 Planned Procedure Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.30:2014-06-09 (open)]

Table 170: Planned Procedure Section (V2) Contexts

Contained By:	**Contains:**
Operative Note (V2) (optional) Procedure Note (V2) (optional)	Planned Procedure (V2)

This section contains the procedure(s) that a clinician planned based on the preoperative assessment.

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Table 171: Planned Procedure Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.30:2014-06-09)					
templateId	1..1	SHALL		1098-8082	
@root	1..1	SHALL		1098-10436	2.16.840.1.113883.10.20.22.2.30
@extension	1..1	SHALL		1098-32590	2014-06-09
code	1..1	SHALL		1098-15399	
@code	1..1	SHALL		1098-15400	59772-4
@codeSystem	1..1	SHALL		1098-32151	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8084	
text	1..1	SHALL		1098-8085	
entry	0..*	MAY		1098-8744	
procedure	1..1	SHALL		1098-15502	Planned Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8082) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.30" (CONF:1098-10436).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32590).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15399).
    a. This code **SHALL** contain exactly one [1..1] **@code**="59772-4" Planned Procedure (CONF:1098-15400).
    b. 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:1098-32151).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8084).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8085).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8744) such that it
    a. **SHALL** contain exactly one [1..1] **Planned Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09) (CONF:1098-15502).

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Figure 108: Planned Procedure Section (V2) Example

```
<section>
   <templateId root="2.16.840.1.113883.10.20.22.2.30" extension="2014-06-09" />
   <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" extension="2014-06-09" />
         <!-- ** Planned Procedure ** -->
         ...
      </procedure>
   </entry>
</section>
```

3.51 Postoperative Diagnosis Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.35 (open)]

Table 172: Postoperative Diagnosis Section Contexts

Contained By:	Contains:
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.

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Table 173: Postoperative Diagnosis Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.35)					
templateId	1..1	SHALL		81-8101	
@root	1..1	SHALL		81-10437	2.16.840.1.113883.10.20.22.2.35
code	1..1	SHALL		81-15401	
@code	1..1	SHALL		81-15402	10218-6
@codeSystem	1..1	SHALL		81-26488	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-8103	
text	1..1	SHALL		81-8104	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8101) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.35" (CONF:81-10437).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15401).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10218-6" Postoperative Diagnosis (CONF:81-15402).
    b. 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:81-26488).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-8103).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-8104).

Figure 109: 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>
```


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3.52 Postprocedure Diagnosis Section (V2)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.36:2014-06-09 (open)]`

Table 174: Postprocedure Diagnosis Section (V2) Contexts

Contained By:	Contains:
Procedure Note (V2) (required)	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 preprocedure diagnosis or indication.

Table 175: Postprocedure Diagnosis Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.36:2014-06-09)					
templateId	1..1	SHALL		1098-8167	
@root	1..1	SHALL		1098-10438	2.16.840.1.113883.10.20.22.2.36
@extension	1..1	SHALL		1098-32550	2014-06-09
code	1..1	SHALL		1098-15403	
@code	1..1	SHALL		1098-15404	59769-0
@codeSystem	1..1	SHALL		1098-30862	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8170	
text	1..1	SHALL		1098-8171	
entry	0..1	SHOULD		1098-8762	
act	1..1	SHALL		1098-15503	Postprocedure Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8167) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.36" (CONF:1098-10438).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32550).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15403).

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a. This code **SHALL** contain exactly one [1..1] **@code**="59769-0" Postprocedure Diagnosis (CONF:1098-15404).
b. 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:1098-30862).

3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8170).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8171).
5. **SHOULD** contain zero or one [0..1] **entry** (CONF:1098-8762) such that it
   a. **SHALL** contain exactly one [1..1] **Postprocedure Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09) (CONF:1098-15503).

Figure 110: Postprocedure Diagnosis Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.36" extension="2014-06-09" />
    <code code="59769-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="POSTPROCEDURE DIAGNOSIS" />
    <title>Postprocedure Diagnosis</title>
    <text>
      ...
   </text>
    <entry>
        <act moodCode="EVN" classCode="ACT">
            <templateId root="2.16.840.1.113883.10.20.22.4.51" extension="2014-06-09" />
            <!-- ** Postprocedure Diagnosis ** -->

          ...

        </act>
    </entry>
</section>
```

3.53 Preoperative Diagnosis Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.34:2014-06-09 (open)]

Table 176: Preoperative Diagnosis Section (V2) Contexts

Contained By:	Contains:
Operative Note (V2) (required)	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.

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Table 177: Preoperative Diagnosis Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.34:2014-06-09)					
templateId	1..1	SHALL		1098-8097	
@root	1..1	SHALL		1098-10439	2.16.840.1.113883.10.20.22.2.34
@extension	1..1	SHALL		1098-32551	2014-06-09
code	1..1	SHALL		1098-15405	
@code	1..1	SHALL		1098-15406	10219-4
@codeSystem	1..1	SHALL		1098-30863	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8099	
text	1..1	SHALL		1098-8100	
entry	0..1	SHOULD		1098-10096	
act	1..1	SHALL		1098-15504	Preoperative Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8097) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.34" (CONF:1098-10439).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32551).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15405).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10219-4" Preoperative Diagnosis (CONF:1098-15406).
    b. 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:1098-30863).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8099).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8100).
5. **SHOULD** contain zero or one [0..1] **entry** (CONF:1098-10096) such that it
    a. **SHALL** contain exactly one [1..1] **Preoperative Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09) (CONF:1098-15504).

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Figure 111: Preoperative Diagnosis Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.34" extension="2014-06-09" />
    <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" extension="2014-06-09" />
            <!-- ** Preoperative Diagnosis ** -->
         ...


        </act>
    </entry>
</section>
```

3.54 Problem Section (entries optional) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09 (open)]

Table 178: Problem Section (entries optional) (V2) Contexts

Contained By:	Contains:
Discharge Summary (V2) (optional) History and Physical (V2) (optional) Progress Note (V2) (optional)	Health Status Observation (V2) Problem Concern Act (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.

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Table 179: Problem Section (entries optional) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09)					
templateId	1..1	SHALL		1098-7877	
@root	1..1	SHALL		1098-10440	2.16.840.1.113883.10.20.22.2.5
@extension	1..1	SHALL		1098-32511	2014-06-09
code	1..1	SHALL		1098-15407	
@code	1..1	SHALL		1098-15408	11450-4
@codeSystem	1..1	SHALL		1098-31141	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7879	
text	1..1	SHALL		1098-7880	
entry	0..*	SHOULD		1098-7881	
act	1..1	SHALL		1098-15505	Problem Concern Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09
entry	0..1	MAY		1098-30481	
observation	1..1	SHALL		1098-30482	Health Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7877) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.5" (CONF:1098-10440).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32511).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15407).
    a. This code **SHALL** contain exactly one [1..1] **@code**="11450-4" Problem List (CONF:1098-15408).
    b. 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:1098-31141).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7879).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7880).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-7881) such that it

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a. **SHALL** contain exactly one [1..1] **Problem Concern Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09) (CONF:1098-15505).

6. **MAY** contain zero or one [0..1] **entry** (CONF:1098-30481) such that it
   a. **SHALL** contain exactly one [1..1] **Health Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09) (CONF:1098-30482).

3.54.1 Problem Section (entries required) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09 (open)]

Table 180: Problem Section (entries required) (V2) Contexts

Contained By:	Contains:
Transfer Summary (required) Consultation Note (V2) (required) Referral Note (required) Continuity of Care Document (CCD) (V2) (required)	Health Status Observation (V2) Problem Concern Act (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.

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Table 181: Problem Section (entries required) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32864	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-9179	
@root	1..1	SHALL		1098-10441	2.16.840.1.113883.10.20.22.2.5.1
@extension	1..1	SHALL		1098-32510	2014-06-09
code	1..1	SHALL		1098-15409	
@code	1..1	SHALL		1098-15410	11450-4
@codeSystem	1..1	SHALL		1098-31142	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-9181	
text	1..1	SHALL		1098-9182	
entry	1..*	SHALL		1098-9183	
act	1..1	SHALL		1098-15506	Problem Concern Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09
entry	0..1	MAY		1098-30479	
observation	1..1	SHALL		1098-30480	Health Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09

1. Conforms to **Problem Section (entries optional) (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09).
2. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32864).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-9179) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.5.1" (CONF:1098-10441).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32510).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15409).
   a. This code **SHALL** contain exactly one [1..1] **@code**="11450-4" Problem List (CONF:1098-15410).

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b. 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:1098-31142).

5. **SHALL** contain exactly one [1..1] **title** (CONF:1098-9181).
6. **SHALL** contain exactly one [1..1] **text** (CONF:1098-9182).

If section/@nullFlavor is not present:

7. **SHALL** contain at least one [1..*] **entry** (CONF:1098-9183) such that it
   a. **SHALL** contain exactly one [1..1] **Problem Concern Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09) (CONF:1098-15506).
8. **MAY** contain zero or one [0..1] **entry** (CONF:1098-30479) such that it
   a. **SHALL** contain exactly one [1..1] **Health Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09) (CONF:1098-30480).

Figure 112: Problem Section (entries required) (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.5.1"
            extension="2014-06-09" />
    <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" extension="2014-06-09" />
            <!-- Problem Concern Act template -->
        ...


        </act>
    </entry>
</section>
```


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Figure 113: No Known Problems Section Example

```
<section>
  <templateId root="2.16.840.1.113883.10.20.22.2.5"
        extension="2014-06-09" />
  <!-- Problem Section with Coded Entries Optional -->
  <templateId root="2.16.840.1.113883.10.20.22.2.5.1"
        extension="2014-06-09" />
  <!-- Problem Section with Coded Entries Required -->
  <code code="11450-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Problem List" />
  <title>PROBLEMS</title>
  <text ID="Concern_1"> Problem Concern:<br /> Concern Tracker Start Date: 06/07/2013
16:05:06<br /> Concern Tracker End Date: <br /> Concern Status: Active<br />
    <content ID="problems1">No known <content
ID="problemType1">problems.</content></content>
  </text>
  <entry typeCode="DRIV">
    <!-- Problem Concern Act -->
    <act classCode="ACT" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.3.2" />
      <id root="36e3e930-7b14-11db-9fe1-0800200c9a66" />
      <!-- C-CDA R1.1 supports 48765-2 or CONC. C-CDA R2 only supports CONC in the code
element -->
      <code code="CONC" codeSystem="2.16.840.1.113883.5.6" />
      <text>
        <reference value="#Concern_1" />
      </text>
      <statusCode code="active" />
      <!-- The concern is not active, in terms of there being an active condition to be
managed.-->
      <effectiveTime>
        <low value="20130607160506" />
        <!-- Time at which THIS "concern" began being tracked.-->
      </effectiveTime>
      <!-- status is active so high is not applicable. If high is present it should have
nullFlavor of NA-->
      <!-- Optional Author Element-->
      <author>
        <templateId root="2.16.840.1.113883.10.20.22.4.119" />
        <time value="20130607160506" />
        <assignedAuthor>
          <id extension="66666" root="2.16.840.1.113883.4.6" />
          <code code="207RC0000X" codeSystem="2.16.840.1.113883.6.101"
codeSystemName="NUCC" displayName="Cardiovascular Disease" />
          <addr>
            <streetAddressLine>6666 StreetName St.</streetAddressLine>
            <city>Silver Spring</city>
            <state>MD</state>
            <postalCode>20901</postalCode>
            <country>US</country>
          </addr>
          <telecom value="tel:+1(301)666-6666" use="WP" />
          <assignedPerson>
            <name>
              <given>Heartly</given>
              <family>Sixer</family>
```


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```
              <suffix>MD</suffix>
            </name>
          </assignedPerson>
        </assignedAuthor>
      </author>
      <entryRelationship typeCode="SUBJ">
        <observation classCode="OBS" moodCode="EVN" negationInd="true">
          <!-- Model of Meaning for No Problems -->
          <!-- This is more consistent with how we did no known allergies. -->
          <!-- The use of negationInd corresponds with the newer
Observation.ValueNegationInd -->
          <!-- The negationInd = true negates the value element. -->
          <!-- problem observation template -->
          <templateId root="2.16.840.1.113883.10.20.22.4.4.2" />
          <id root="4adc1021-7b14-11db-9fe1-0800200c9a67" />
          <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />
          <text>
            <reference value="#problems1" />
          </text>
          <statusCode code="completed" />
          <effectiveTime>
            <low value="20130607160506" />
          </effectiveTime>
          <!-- The time when this was biologically relevant, i.e., true for the patient. --
>
          <!-- As a minimum time interval over which this is true, populate the
effectiveTime/low with the current time. -->
          <!-- It would be equally valid to have a longer range of time over which this
statement was represented as being true. -->
          <!-- As a maximum, you would never indicate an effectiveTime/high that was
greater than the current point in time. -->
          <!-- This idea assumes that the value element could come from the Problem value
set, or-->
          <!-- when negationInd was true, is could also come from the ProblemType value set
(and code would be ASSERTION). -->
          <value xsi:type="CD" code="55607006" displayName="Problem"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT">
            <originalText>
              <reference value="#problemType1" />
            </originalText>
          </value>
        </observation>
      </entryRelationship>
    </act>
  </entry>
</section>
```


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3.55 Procedure Description Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.27 (open)]

Table 182: Procedure Description Section Contexts

Contained By:	Contains:
Operative Note (V2) (required) 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.

Table 183: Procedure Description Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.27)					
templateId	1..1	SHALL		81-8062	
@root	1..1	SHALL		81-10442	2.16.840.1.113883.10.20.22.2.27
code	1..1	SHALL		81-15411	
@code	1..1	SHALL		81-15412	29554-3
@codeSystem	1..1	SHALL		81-26489	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-8064	
text	1..1	SHALL		81-8065	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8062) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.27" (CONF:81-10442).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15411).
    a. This code **SHALL** contain exactly one [1..1] **@code**="29554-3" Procedure Description (CONF:81-15412).
    b. 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:81-26489).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-8064).

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4. **SHALL** contain exactly one [1..1] **text** (CONF:81-8065).

Figure 114: 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>
```

3.56 Procedure Disposition Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.18.2.12 (open)]

Table 184: Procedure Disposition Section Contexts

Contained By:	Contains:
Operative Note (V2) (optional) 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 patient was transferred to for the next level of care.

Table 185: Procedure Disposition Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.12)					
templateId	1..1	SHALL		81-8070	
@root	1..1	SHALL	UID	81-10466	2.16.840.1.113883.10.20.18.2.12
code	1..1	SHALL		81-15413	
@code	1..1	SHALL		81-15414	59775-7
@codeSystem	1..1	SHALL		81-26490	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-8072	
text	1..1	SHALL		81-8073	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8070) such that it

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a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.18.2.12" (CONF:81-10466).

2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15413).
   a. This code **SHALL** contain exactly one [1..1] **@code**="59775-7" Procedure Disposition (CONF:81-15414).
   b. 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:81-26490).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-8072).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-8073).

Figure 115: 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>
```

3.57 Procedure Estimated Blood Loss Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.18.2.9 (open)]

Table 186: Procedure Estimated Blood Loss Section Contexts

Contained By:	Contains:
Operative Note (V2) (required) Procedure Note (V2) (optional)	

The Procedure Estimated Blood Loss Section may be a subsection of another section such as the Procedure Description Section. The Procedure 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”.

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Table 187: Procedure Estimated Blood Loss Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.9)					
templateId	1..1	SHALL		81-8074	
@root	1..1	SHALL	UID	81-10467	2.16.840.1.113883.10.20.18.2.9
code	1..1	SHALL		81-15415	
@code	1..1	SHALL		81-15416	59770-8
@codeSystem	1..1	SHALL		81-26491	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-8076	
text	1..1	SHALL		81-8077	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8074) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.18.2.9" (CONF:81-10467).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15415).
    a. This code **SHALL** contain exactly one [1..1] **@code**="59770-8" Procedure Estimated Blood Loss (CONF:81-15416).
    b. 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:81-26491).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-8076).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-8077).
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:81-8741).

Figure 116: 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>
```


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3.58 Procedure Findings Section (V2)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.28:2014-06-09 (open)]`

Table 188: Procedure Findings Section (V2) Contexts

Contained By:	Contains:
Operative Note (V2) (required) Procedure Note (V2) (optional)	Problem Observation (V2)

The Procedure Findings Section records clinically significant observations confirmed or discovered during a procedure or surgery.

Table 189: Procedure Findings Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.28:2014-06-09)					
templateId	1..1	SHALL		1098-8078	
@root	1..1	SHALL		1098-10443	2.16.840.1.113883.10.20.22.2.28
@extension	1..1	SHALL		1098-32537	2014-06-09
code	1..1	SHALL		1098-15417	
@code	1..1	SHALL		1098-15418	59776-5
@codeSystem	1..1	SHALL		1098-30859	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8080	
text	1..1	SHALL		1098-8081	
entry	0..*	MAY		1098-8090	
observation	1..1	SHALL		1098-15507	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8078) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.28" (CONF:1098-10443).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32537).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15417).

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a. This code **SHALL** contain exactly one [1..1] **@code**="59776-5" Procedure Findings (CONF:1098-15418).
b. 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:1098-30859).

3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8080).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8081).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8090) such that it
   a. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-15507).

Figure 117: Procedure Findings Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.28" extension="2014-06-09" />
    <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" extension="2014-06-09" />
            <!-- Problem Observation -->
        ...

        </observation>
    </entry>
</section>
```

3.59 Procedure Implants Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.40 (open)]

Table 190: Procedure Implants Section Contexts

Contained By:	Contains:
Operative Note (V2) (optional) Procedure Note (V2) (optional)	

The Procedure Implants Section records any materials placed during the procedure including stents, tubes, and drains.

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Table 191: Procedure Implants Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.40)					
templateId	1..1	SHALL		81-8178	
@root	1..1	SHALL		81-10444	2.16.840.1.113883.10.20.22.2.40
code	1..1	SHALL		81-15373	
@code	1..1	SHALL		81-15374	59771-6
@codeSystem	1..1	SHALL		81-26492	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-8180	
text	1..1	SHALL		81-8181	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8178) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.40" (CONF:81-10444).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15373).
    a. This code **SHALL** contain exactly one [1..1] **@code**="59771-6" Procedure Implants (CONF:81-15374).
    b. 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:81-26492).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-8180).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-8181).
5. The Procedure Implants section **SHALL** include a statement providing details of the implants placed, or assert no implants were placed (CONF:81-8769).

Figure 118: 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>
```


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3.60 Procedure Indications Section (V2)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.29:2014-06-09 (open)]`

Table 192: Procedure Indications Section (V2) Contexts

Contained By:	Contains:
Operative Note (V2) (optional) Procedure Note (V2) (required)	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.

Table 193: Procedure Indications Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.29:2014-06-09)					
templateId	1..1	SHALL		1098-8058	
@root	1..1	SHALL		1098-10445	2.16.840.1.113883.10.20.22.2.29
@extension	1..1	SHALL		1098-32572	2014-06-09
code	1..1	SHALL		1098-15419	
@code	1..1	SHALL		1098-15420	59768-2
@codeSystem	1..1	SHALL		1098-30827	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8060	
text	1..1	SHALL		1098-8061	
entry	0..*	MAY		1098-8743	
observation	1..1	SHALL		1098-15508	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8058) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.29" (CONF:1098-10445).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32572).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15419).
    a. This code **SHALL** contain exactly one [1..1] **@code**="59768-2" Procedure Indications (CONF:1098-15420).

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b. 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:1098-30827).

3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8060).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8061).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8743) such that it
   a. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-15508).

Figure 119: Procedure Indications Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.29" extension="2014-06-09" />
    <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" extension="2014-06-09" />
         ...

        </observation>
    </entry>
</section>
```

3.61 Procedure Specimens Taken Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.31 (open)]

Table 194: Procedure Specimens Taken Section Contexts

Contained By:	Contains:
Operative Note (V2) (required) 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.

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Table 195: Procedure Specimens Taken Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.31)					
templateId	1..1	SHALL		81-8086	
@root	1..1	SHALL		81-10446	2.16.840.1.113883.10.20.22.2.31
code	1..1	SHALL		81-15421	
@code	1..1	SHALL		81-15422	59773-2
@codeSystem	1..1	SHALL		81-26493	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-8088	
text	1..1	SHALL		81-8089	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8086) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.31" (CONF:81-10446).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15421).
    a. This code **SHALL** contain exactly one [1..1] **@code**="59773-2" Procedure Specimens Taken (CONF:81-15422).
    b. 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:81-26493).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-8088).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-8089).
5. The Procedure Specimens Taken section **SHALL** list all specimens removed or **SHALL** explicitly state that no specimens were taken (CONF:81-8742).

Figure 120: Procedure Specimens Taken Section Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.31"/>
    <code code="59773-2"
         codeSystem="2.16.840.1.113883.6.1"
         codeSystemName="LOINC"
         displayName="PROCEDURE SPECIMENS TAKEN"/>
    <title>Procedure Specimens Taken</title>
    <text>Ascending colon polyp</text>
</section>
```


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3.62 Procedures Section (entries optional) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09 (open)]

Table 196: Procedures Section (entries optional) (V2) Contexts

Contained By:	Contains:
Consultation Note (V2) (optional) Referral Note (optional) Discharge Summary (V2) (optional) History and Physical (V2) (optional) Procedure Note (V2) (optional)	Procedure Activity Act (V2) Procedure Activity Observation (V2) Procedure Activity Procedure (V2)

This section describes all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section should 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 Activity Procedure (V2) is for procedures that alter the physical condition of a patient (e.g., splenectomy). Procedure Activity Observation (V2) is for procedures that result in new information about a patient but do not cause physical alteration (e.g., EEG). Procedure Activity Act (V2) is for all other types of procedures (e.g., dressing change).

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Table 197: Procedures Section (entries optional) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09)					
templateId	1..1	SHALL		1098-6270	
@root	1..1	SHALL		1098-6271	2.16.840.1.113883.10.20.22.2.7
@extension	1..1	SHALL		1098-32532	2014-06-09
code	1..1	SHALL		1098-15423	
@code	1..1	SHALL		1098-15424	47519-4
@codeSystem	1..1	SHALL		1098-31139	2.16.840.1.113883.6.1 (LOINC)
title	1..1	SHALL		1098-17184	
text	1..1	SHALL		1098-6273	
entry	0..*	MAY		1098-6274	
procedure	1..1	SHALL		1098-15509	Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09
entry	0..*	MAY		1098-6278	
observation	1..1	SHALL		1098-15510	Procedure Activity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09
entry	0..*	MAY		1098-8533	
act	1..1	SHALL		1098-15511	Procedure Activity Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-6270) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.7" (CONF:1098-6271).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32532).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15423).
    a. This code **SHALL** contain exactly one [1..1] **@code**="47519-4" History of Procedures (CONF:1098-15424).

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b. This code **SHALL** contain exactly one [1..1] **@codeSystem** (CodeSystem: `LOINC 2.16.840.1.113883.6.1`) (CONF:1098-31139).

3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-17184).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-6273).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-6274) such that it
   a. **SHALL** contain exactly one [1..1] **Procedure Activity Procedure (V2)** `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09)` (CONF:1098-15509).
6. **MAY** contain zero or more [0..*] **entry** (CONF:1098-6278) such that it
   a. **SHALL** contain exactly one [1..1] **Procedure Activity Observation (V2)** `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09)` (CONF:1098-15510).
7. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8533) such that it
   a. **SHALL** contain exactly one [1..1] **Procedure Activity Act (V2)** `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09)` (CONF:1098-15511).

3.62.1 Procedures Section (entries required) (V2)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.7.1:2014-06-09 (open)]`

Table 198: Procedures Section (entries required) (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Continuity of Care Document (CCD) (V2) (optional)	Procedure Activity Act (V2) Procedure Activity Observation (V2) Procedure Activity Procedure (V2)

This section describes all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section should 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 that alter the physical condition of a patient (e.g., splenectomy). Observation act is for procedures that result in new information about a patient but do not cause physical alteration (e.g., EEG). Act is for all other types of procedures (e.g., dressing change).

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Table 199: Procedures Section (entries required) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7.1:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32876	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-7891	
@root	1..1	SHALL		1098-10447	2.16.840.1.113883.10.20.22.2.7.1
@extension	1..1	SHALL		1098-32533	2014-06-09
code	1..1	SHALL		1098-15425	
@code	1..1	SHALL		1098-15426	47519-4
@codeSystem	1..1	SHALL		1098-31138	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7893	
text	1..1	SHALL		1098-7894	
entry	1..*	SHALL		1098-7895	
act	0..1	MAY		1098-32877	Procedure Activity Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09
observation	0..1	MAY		1098-32878	Procedure Activity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09
procedure	0..1	MAY		1098-15512	Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09

1. Conforms to **Procedures Section (entries optional) (V2)** template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09)`.
2. **MAY** contain zero or one [0..1] **`@nullFlavor`**`="NI"` No information (CodeSystem: `HL7NullFlavor 2.16.840.1.113883.5.1008`) (CONF:1098-32876).
3. **SHALL** contain exactly one [1..1] **`templateId`** (CONF:1098-7891) such that it
   a. **SHALL** contain exactly one [1..1] **`@root`**`="2.16.840.1.113883.10.20.22.2.7.1"` (CONF:1098-10447).
   b. **SHALL** contain exactly one [1..1] **`@extension`**`="2014-06-09"` (CONF:1098-32533).
4. **SHALL** contain exactly one [1..1] **`code`** (CONF:1098-15425).

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a. This code **SHALL** contain exactly one [1..1] **@code**="47519-4" History of Procedures (CONF:1098-15426).
b. 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:1098-31138).

5. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7893).
6. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7894).

If section/@nullFlavor is not present there **SHALL** be at least one entry conformant to Procedure Activity Act (V2) (templateId 2.16.840.1.113883.10.20.22.4.12:2014-06-09) **OR** Procedure Activity Observation (V2) (templateId: 2.16.840.1.113883.10.20.22.4.13:2014-06-09) **OR** Procedure Activity Procedure (V2) (templateId: 2.16.840.1.113883.10.20.22.4.14:2014-06-09)

7. **SHALL** contain at least one [1..*] **entry** (CONF:1098-7895) such that it
   a. **MAY** contain zero or one [0..1] **Procedure Activity Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09) (CONF:1098-32877).
   b. **MAY** contain zero or one [0..1] **Procedure Activity Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09) (CONF:1098-32878).
   c. **MAY** contain zero or one [0..1] **Procedure Activity Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09) (CONF:1098-15512).

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Figure 121: Procedures Section (entries required) (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.7" extension="2014-06-09" />
    <!-- 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" extension="2014-06-09" />
          ...
        </procedure>
    </entry>
    <observation classCode="OBS" moodCode="EVN">
        <templateId root="2.16.840.1.113883.10.20.22.4.13" extension="2014-06-09" />
        <!-- Procedure Activity Observation template -->
        ...
    </observation>
    <entry>
        <act classCode="ACT" moodCode="INT">
        <templateId root="2.16.840.1.113883.10.20.22.4.12" extension="2014-06-09" />
        <!-- Procedure Activity Act template -->
         ...
        </act>
    </entry>
</section>
```

3.63 Reason for Referral Section (V2)

[section: identifier urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.1:2014-06-09 (open)]

Table 200: Reason for Referral Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (required) Referral Note (required)	Patient Referral Act

This section describes the clinical reason why a provider is sending a patient to another provider for care. The reason for referral may become the reason for visit documented by the receiving provider.

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Table 201: Reason for Referral Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.1:2014-06-09)					
templateId	1..1	SHALL		1098-7844	
@root	1..1	SHALL	UID	1098-10468	1.3.6.1.4.1.19376.1.5.3.1.3.1
@extension	1..1	SHALL		1098-32571	2014-06-09
code	1..1	SHALL		1098-15427	
@code	1..1	SHALL		1098-15428	42349-1
@codeSystem	1..1	SHALL		1098-30867	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7846	
text	1..1	SHALL		1098-7847	
entry	0..*	MAY		1098-30808	
observation	1..1	SHALL		1098-30897	Patient Referral Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.140

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7844) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="`1.3.6.1.4.1.19376.1.5.3.1.3.1`" (CONF:1098-10468).
    b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32571).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15427).
    a. This code **SHALL** contain exactly one [1..1] **@code**="`42349-1`" Reason for Referral (CONF:1098-15428).
    b. 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:1098-30867).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7846).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7847).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-30808) such that it
    a. **SHALL** contain exactly one [1..1] **Patient Referral Act** `(identifier: urn:oid:2.16.840.1.113883.10.20.22.4.140)` (CONF:1098-30897).

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Figure 122: Reason for Referral Section (V2) Example

```
<component>
    <section>
        <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.1" extension="2014-06-09" />
        <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>
```

3.64 Reason for Visit Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.12 (open)]

Table 202: Reason for Visit Section Contexts

Contained By:	**Contains:**
Consultation Note (V2) (optional) Discharge Summary (V2) (optional) History and Physical (V2) (optional) 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.

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Table 203: Reason for Visit Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12)					
templateId	1..1	SHALL		81-7836	
@root	1..1	SHALL		81-10448	2.16.840.1.113883.10.20.22.2.12
code	1..1	SHALL		81-15429	
@code	1..1	SHALL		81-15430	29299-5
@codeSystem	1..1	SHALL		81-26494	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-7838	
text	1..1	SHALL		81-7839	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7836) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.12" (CONF:81-10448).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15429).
    a. This code **SHALL** contain exactly one [1..1] **@code**="29299-5" Reason for Visit (CONF:81-15430).
    b. 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:81-26494).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7838).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7839).

Figure 123: 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>
```


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3.65 Results Section (entries optional) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09 (open)]

Table 204: Results Section (entries optional) (V2) Contexts

Contained By:	Contains:
History and Physical (V2) (required) Progress Note (V2) (optional)	Result Organizer (V2)

This section contains the results of observations generated by laboratories, imaging and other procedures. The scope includes observations of 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. It can 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.

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Table 205: Results Section (entries optional) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09)					
templateId	1..1	SHALL		1098-7116	
@root	1..1	SHALL		1098-9136	2.16.840.1.113883.10.20.22.2.3
@extension	1..1	SHALL		1098-32591	2014-06-09
code	1..1	SHALL		1098-15431	
@code	1..1	SHALL		1098-15432	30954-2
@codeSystem	1..1	SHALL		1098-31041	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8891	
text	1..1	SHALL		1098-7118	
entry	0..*	SHOULD		1098-7119	
organizer	1..1	SHALL		1098-15515	Result Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7116) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.3" (CONF:1098-9136).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32591).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15431).
    a. This code **SHALL** contain exactly one [1..1] **@code**="30954-2" Relevant diagnostic tests and/or laboratory data (CONF:1098-15432).
    b. 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:1098-31041).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8891).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7118).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-7119) such that it
    a. **SHALL** contain exactly one [1..1] **Result Organizer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09) (CONF:1098-15515).

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3.65.1 Results Section (entries required) (V2)

```
[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09
(open)]
```

Table 206: Results Section (entries required) (V2) Contexts

Contained By:	Contains:
Transfer Summary (required) Consultation Note (V2) (optional) Referral Note (optional) Continuity of Care Document (CCD) (V2) (required)	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.

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Table 207: Results Section (entries required) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32875	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-7108	
@root	1..1	SHALL		1098-9137	2.16.840.1.113883.10.20.22.2.3.1
@extension	1..1	SHALL		1098-32592	2014-06-09
code	1..1	SHALL		1098-15433	
@code	1..1	SHALL		1098-15434	30954-2
@codeSystem	1..1	SHALL		1098-31040	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8892	
text	1..1	SHALL		1098-7111	
entry	1..*	SHALL		1098-7112	
organizer	1..1	SHALL		1098-15516	Result Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09

1. Conforms to **Results Section (entries optional) (V2)** template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09)`.
2. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: `HL7NullFlavor 2.16.840.1.113883.5.1008`) (CONF:1098-32875).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7108) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.3.1" (CONF:1098-9137).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32592).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15433).
   a. This code **SHALL** contain exactly one [1..1] **@code**="30954-2" Relevant diagnostic tests and/or laboratory data (CONF:1098-15434).
   b. 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:1098-31040).
5. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8892).
6. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7111).

If section/@nullFlavor is not present:

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7. **SHALL** contain at least one [1..*] **entry** (CONF:1098-7112) such that it
    a. **SHALL** contain exactly one [1..1] **Result Organizer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09) (CONF:1098-15516).

Figure 124: Results Section (entries required) (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.3.1" extension="2014-06-09" />
    <code code="30954-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="RELEVANT DIAGNOSTIC TESTS AND/OR LABORATORY DATA" />
    <title>Results</title>
    <text />
    <entry typeCode="DRIV">
        <organizer classCode="BATTERY" moodCode="EVN">
            <templateId root="2.16.840.1.113883.10.20.22.4.1" extension="2014-06-09" />
      ...



            <organizer>
                <component>
                    <observation classCode="OBS" moodCode="EVN">
                        <templateId root="2.16.840.1.113883.10.20.22.4.2" extension="2014-
06-09" />
                        . . .

                    </observation>
                </component>
            </organizer>
        </organizer>
    </entry>
</section>
```

3.66 Review of Systems Section

[section: identifier urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18 (open)]

Table 208: Review of Systems Section Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) Discharge Summary (V2) (optional) History and Physical (V2) (required) Procedure Note (V2) (optional) 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

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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.

Table 209: Review of Systems Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18)					
templateId	1..1	SHALL		81-7812	
@root	1..1	SHALL	UID	81-10469	1.3.6.1.4.1.19376.1.5.3.1.3.18
code	1..1	SHALL		81-15435	
@code	1..1	SHALL		81-15436	10187-3
@codeSystem	1..1	SHALL		81-26495	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-7814	
text	1..1	SHALL		81-7815	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7812) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.3.18" (CONF:81-10469).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15435).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10187-3" Review of Systems (CONF:81-15436).
    b. 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:81-26495).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7814).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7815).

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Figure 125: 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>
```

3.67 Social History Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09 (open)]

Table 210: Social History Section (V2) Contexts

Contained By:	Contains:
Transfer Summary (optional) Consultation Note (V2) (optional) Referral Note (optional) Continuity of Care Document (CCD) (V2) (required) Discharge Summary (V2) (optional) History and Physical (V2) (required) Procedure Note (V2) (optional)	Caregiver Characteristics Characteristics of Home Environment Cultural and Religious Observation Pregnancy Observation Smoking Status - Meaningful Use (V2) Social History Observation (V2) Tobacco Use (V2)

This section contains social history data that influence 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.

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Table 211: Social History Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09)					
templateId	1..1	SHALL		1098-7936	
@root	1..1	SHALL		1098-10449	2.16.840.1.113883.10.20.22.2.17
@extension	1..1	SHALL		1098-32494	2014-06-09
code	1..1	SHALL		1098-14819	
@code	1..1	SHALL		1098-14820	29762-2
@codeSystem	1..1	SHALL		1098-30814	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7938	
text	1..1	SHALL		1098-7939	
entry	0..*	MAY		1098-7953	
observation	1..1	SHALL		1098-14821	Social History Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09
entry	0..*	MAY		1098-9132	
observation	1..1	SHALL		1098-14822	Pregnancy Observation (identifier: urn:oid:2.16.840.1.113883.10.20.15.3.8
entry	0..*	SHOULD		1098-14823	
observation	1..1	SHALL		1098-14824	Smoking Status - Meaningful Use (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09
entry	0..*	MAY		1098-16816	
observation	1..1	SHALL		1098-16817	Tobacco Use (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09
entry	0..*	MAY		1098-28361	
observation	1..1	SHALL		1098-28362	Caregiver Characteristics (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72

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entry	0..*	MAY		1098-28366	
observation	1..1	SHALL		1098-28367	Cultural and Religious Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.111
entry	0..*	MAY		1098-28825	
observation	1..1	SHALL		1098-28826	Characteristics of Home Environment (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.109

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7936) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.17" (CONF:1098-10449).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32494).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-14819).
    a. This code **SHALL** contain exactly one [1..1] **@code**="29762-2" Social History (CONF:1098-14820).
    b. 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:1098-30814).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7938).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7939).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1098-7953) such that it
    a. **SHALL** contain exactly one [1..1] **Social History Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09) (CONF:1098-14821).
6. **MAY** contain zero or more [0..*] **entry** (CONF:1098-9132) such that it
    a. **SHALL** contain exactly one [1..1] **Pregnancy Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.15.3.8) (CONF:1098-14822).
7. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-14823) such that it
    a. **SHALL** contain exactly one [1..1] **Smoking Status - Meaningful Use (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09) (CONF:1098-14824).
8. **MAY** contain zero or more [0..*] **entry** (CONF:1098-16816) such that it
    a. **SHALL** contain exactly one [1..1] **Tobacco Use (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09) (CONF:1098-16817).
9. **MAY** contain zero or more [0..*] **entry** (CONF:1098-28361) such that it
    a. **SHALL** contain exactly one [1..1] **Caregiver Characteristics** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72) (CONF:1098-28362).
10. **MAY** contain zero or more [0..*] **entry** (CONF:1098-28366) such that it

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a. **SHALL** contain exactly one [1..1] **Cultural and Religious Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.111) (CONF:1098-28367).

11. **MAY** contain zero or more [0..*] **entry** (CONF:1098-28825) such that it

a. **SHALL** contain exactly one [1..1] **Characteristics of Home Environment** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.109) (CONF:1098-28826).

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Figure 126: Social History Section (V2) Example

```
<component>
    <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.17" extension="2014-06-09" />
        <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" extension="2014-06-09"
/>
       ...

            </observation>
        </entry>
        <entry>
            <observation classCode="OBS" moodCode="EVN">
                <!-- ** Current smoking status observation ** -->
                <templateId root="2.16.840.1.113883.10.20.22.4.78" extension="2014-06-09"
/>
 ...


            </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>
```


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```
    </section></component>
```

3.68 Subjective Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.21.2.2 (open)]

Table 212: Subjective Section Contexts

Contained By:	Contains:
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.

Table 213: Subjective Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.2)					
templateId	1..1	SHALL		81-7873	
@root	1..1	SHALL	UID	81-10470	2.16.840.1.113883.10.20.21.2.2
code	1..1	SHALL		81-15437	
@code	1..1	SHALL		81-15438	61150-9
@codeSystem	1..1	SHALL		81-26496	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-7875	
text	1..1	SHALL		81-7876	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7873) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.21.2.2" (CONF:81-10470).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15437).
    a. This code **SHALL** contain exactly one [1..1] **@code**="61150-9" Subjective (CONF:81-15438).
    b. 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:81-26496).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7875).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7876).

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Figure 127: 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>
```

3.69 Surgery Description Section (DEPRECATED)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.26:2014-06-09 (open)]

THIS TEMPLATE HAS BEEN DEPRECATED IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED.

Reason for deprecation: This template has been replaced by the Procedure Description Section (2.16.840.1.113883.10.20.22.2.27).

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Table 214: Surgery Description Section (DEPRECATED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.26:2014-06-09)					
templateId	1..1	SHALL		1098-8022	
@root	1..1	SHALL		1098-10450	2.16.840.1.113883.10.20.22.2.26
@extension	1..1	SHALL		1098-32893	2014-06-09
code	1..1	SHALL		1098-15439	
@code	1..1	SHALL		1098-15440	29554-3
@codeSystem	1..1	SHALL		1098-26497	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-8024	
text	1..1	SHALL		1098-8025	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8022) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.26" (CONF:1098-10450).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32893).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15439).
   a. This code **SHALL** contain exactly one [1..1] **@code**="29554-3" Surgery Description (CONF:1098-15440).
   b. 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:1098-26497).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-8024).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-8025).

3.70 Surgical Drains Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.7.13 (open)]

Table 215: Surgical Drains Section Contexts

Contained By:	Contains:
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.

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Table 216: Surgical Drains Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:oid:2.16.840.1.113883.10.20.7.13)					
templateId	1..1	SHALL		81-8038	
@root	1..1	SHALL	UID	81-10473	2.16.840.1.113883.10.20.7.13
code	1..1	SHALL		81-15441	
@code	1..1	SHALL		81-15442	11537-8
@codeSystem	1..1	SHALL		81-26498	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		81-8040	
text	1..1	SHALL		81-8041	

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8038) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.7.13" (CONF:81-10473).
2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15441).
    a. This code **SHALL** contain exactly one [1..1] **@code**="11537-8" Surgical Drains (CONF:81-15442).
    b. 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:81-26498).
3. **SHALL** contain exactly one [1..1] **title** (CONF:81-8040).
4. **SHALL** contain exactly one [1..1] **text** (CONF:81-8041).
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:81-8056).

Figure 128: 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>
```


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3.71 Vital Signs Section (entries optional) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09 (open)]

Table 217: Vital Signs Section (entries optional) (V2) Contexts

Contained By:	Contains:
Discharge Summary (V2) (optional) History and Physical (V2) (required) Progress Note (V2) (optional)	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.

Table 218: Vital Signs Section (entries optional) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09)					
templateId	1..1	SHALL		1098-7268	
@root	1..1	SHALL		1098-10451	2.16.840.1.113883.10.20.22.2.4
@extension	1..1	SHALL		1098-32584	2014-06-09
code	1..1	SHALL		1098-15242	
@code	1..1	SHALL		1098-15243	8716-3
@codeSystem	1..1	SHALL		1098-30902	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-9966	
text	1..1	SHALL		1098-7270	
entry	0..*	SHOULD		1098-7271	
organizer	1..1	SHALL		1098-15517	Vital Signs Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.26:2014-06-09

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1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7268) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.4" (CONF:1098-10451).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32584).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15242).
    a. This code **SHALL** contain exactly one [1..1] **@code**="8716-3" Vital Signs (CONF:1098-15243).
    b. 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:1098-30902).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-9966).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7270).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-7271) such that it
    a. **SHALL** contain exactly one [1..1] **Vital Signs Organizer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.26:2014-06-09) (CONF:1098-15517).

3.71.1 Vital Signs Section (entries required) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09 (open)]

Table 219: Vital Signs Section (entries required) (V2) Contexts

Contained By:	Contains:
Transfer Summary (required) Consultation Note (V2) (optional) Referral Note (optional) Continuity of Care Document (CCD) (V2) (required)	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.

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Table 220: Vital Signs Section (entries required) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32874	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-7273	
@root	1..1	SHALL		1098-10452	2.16.840.1.113883.10.20.22.2.4.1
@extension	1..1	SHALL		1098-32585	2014-06-09
code	1..1	SHALL		1098-15962	
@code	1..1	SHALL		1098-15963	8716-3
@codeSystem	1..1	SHALL		1098-30903	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-9967	
text	1..1	SHALL		1098-7275	
entry	1..*	SHALL		1098-7276	
organizer	1..1	SHALL		1098-15964	Vital Signs Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.26:2014-06-09

1. Conforms to **Vital Signs Section (entries optional) (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09).
2. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32874).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7273) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.4.1" (CONF:1098-10452).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32585).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15962).
   a. This code **SHALL** contain exactly one [1..1] **@code**="8716-3" Vital Signs (CONF:1098-15963).
   b. 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:1098-30903).
5. **SHALL** contain exactly one [1..1] **title** (CONF:1098-9967).
6. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7275).

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If section/@nullFlavor is not present:

7. **SHALL** contain at least one [1..*] **entry** (CONF:1098-7276) such that it
    a. **SHALL** contain exactly one [1..1] **Vital Signs Organizer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.26:2014-06-09) (CONF:1098-15964).

Figure 129: Vital Signs Section (entries required) (V2) Example

```
<component>
    <section>
        <!-- ** Vital Signs section with entries required ** -->
        <templateId root="2.16.840.1.113883.10.20.22.2.4.1" extension="2014-06-09" />
        <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" extension="2014-06-09"
/>
                . . .
            </organizer>
        </entry>
    </section>
</component>
```


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4 ENTRY-LEVEL TEMPLATES

This chapter describes the clinical statement entry templates used within the sections of the document types of this consolidated guide. 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., template identifier, 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), this guide constrains 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 (C-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.

4.1 Admission Medication (V2)

`[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.36:2014-06-09 (open)]`

Table 221: Admission Medication (V2) Contexts

Contained By:	Contains:
Admission Medications Section (entries optional) (V2) (optional)	Medication Activity (V2)

This template represents the medications taken by the patient prior to and at the time of admission.

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Table 222: Admission Medication (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.36:2014-06-09)					
@classCode	1..1	SHALL		1098-7698	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-7699	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-16758	
@root	1..1	SHALL		1098-16759	2.16.840.1.113883.10.20.22.4.36
@extension	1..1	SHALL		1098-32524	2014-06-09
code	1..1	SHALL		1098-15518	
@code	1..1	SHALL		1098-15519	42346-7
@codeSystem	1..1	SHALL		1098-32152	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
entryRelationship	1..*	SHALL		1098-7701	
@typeCode	1..1	SHALL		1098-7702	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
substanceAdministration	1..1	SHALL		1098-15520	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="`ACT`" (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-7698).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-7699).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16758) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.36`" (CONF:1098-16759).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32524).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15518).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`42346-7`" Medications on Admission (CONF:1098-15519).
   b. 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:1098-32152).
5. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-7701) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7702).

b. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-15520).

Figure 130: Admission Medication (V2) Example

```
<act classCode="ACT" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.22.4.36" extension="2014-06-09" />
  <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" extension="2014-06-09" />
        ...
    </substanceAdministration>
  </entryRelationship>
</act>
```

4.2 Advance Directive Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09 (open)]

Table 223: Advance Directive Observation (V2) Contexts

Contained By:	Contains:
Advance Directive Organizer (required) Advance Directives Section (entries optional) (V2) (optional) Advance Directives Section (entries required) (V2) (optional) Intervention Act (optional) Planned Intervention Act (optional)	Author Participation US Realm Address (AD.US.FIELDED) US Realm Person Name (PN.US.FIELDED)

This clinical statement represents Advance Directive Observation findings (e.g., "resuscitation status is Full Code") rather than orders. It should not be considered a legal document or a substitute for the actual Advance Directive document. 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

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- 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.

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Table 224: Advance Directive Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09)					
@classCode	1..1	SHALL		1098-8648	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-8649	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-8655	
@root	1..1	SHALL		1098-10485	2.16.840.1.113883.10.20.22.4.48
@extension	1..1	SHALL		1098-32496	2014-06-09
id	1..*	SHALL		1098-8654	
code	1..1	SHALL		1098-8651	
@code	1..1	SHALL		1098-32786	75278-2
@codeSystem	1..1	SHALL		1098-32787	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-8652	
@code	1..1	SHALL		1098-19082	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-8656	
low	1..1	SHALL		1098-28719	
high	1..1	SHALL		1098-15521	
value	1..1	SHALL		1098-30804	
author	0..*	SHOULD		1098-32406	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	0..*	SHOULD		1098-8662	
@typeCode	1..1	SHALL		1098-8663	2.16.840.1.113883.5.90 (HL7ParticipationType) = VRF
time	0..1	SHOULD		1098-8665	
participantRole	1..1	SHALL		1098-8825	
code	0..1	SHOULD		1098-28446	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy

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					(HIPAA))
addr	0..*	MAY		1098-28451	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
playingEntity	0..1	MAY		1098-28428	
code	0..1	SHOULD		1098-28429	2.16.840.1.113883.11.20.9.51 (Healthcare Agent Qualifier)
name	0..*	MAY		1098-28454	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
participant	0..*	SHOULD		1098-8667	
@typeCode	1..1	SHALL		1098-8668	2.16.840.1.113883.5.90 (HL7ParticipationType) = CST
participantRole	1..1	SHALL		1098-8669	
@classCode	1..1	SHALL		1098-8670	2.16.840.1.113883.5.110 (RoleClass) = AGNT
code	0..1	SHOULD		1098-28440	2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)
addr	0..1	SHOULD		1098-8671	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
telecom	0..*	SHOULD		1098-8672	
playingEntity	1..1	SHALL		1098-8824	
code	0..1	SHOULD		1098-28444	2.16.840.1.113883.11.20.9.51 (Healthcare Agent Qualifier)
name	1..1	SHALL		1098-8673	
reference	1..*	SHOULD		1098-8692	
@typeCode	1..1	SHALL		1098-8694	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
externalDocument	1..1	SHALL		1098-8693	
id	1..*	SHALL		1098-8695	
text	0..1	MAY		1098-8696	
reference	0..1	MAY		1098-8697	

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1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8648).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-8649).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8655) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.48" (CONF:1098-10485).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32496).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8654).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-8651).
    a. This code **SHALL** contain exactly one [1..1] **@code**="75278-2" Advance directive status (CONF:1098-32786).
    b. 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:1098-32787).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-8652).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19082).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-8656).
    a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-28719).
    b. This effectiveTime **SHALL** contain exactly one [1..1] **high** (CONF:1098-15521).
        i. If the Advance Directive does not have a specified ending time, the <high> element **SHALL** have the nullFlavor attribute set to **NA** (CONF:1098-32449).
8. **SHALL** contain exactly one [1..1] **value** (CONF:1098-30804) such that it
    a. If type CD, then value will be SNOMED-CT (CONF:1098-32493).
9. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32406).

The participant "VRF" represents the clinician(s) who verified the patient advance directive observation.

10. **SHOULD** contain zero or more [0..*] **participant** (CONF:1098-8662) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="VRF" Verifier (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-8663).
    b. **SHOULD** contain zero or one [0..1] **time** (CONF:1098-8665).
        i. The data type of Observation/participant/time in a verification **SHALL** be **TS** (time stamp) (CONF:1098-8666).
    c. **SHALL** contain exactly one [1..1] **participantRole** (CONF:1098-8825).
        i. 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:1098-28446).

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ii. This participantRole **MAY** contain zero or more [0..*] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-28451).

iii. This participantRole **MAY** contain zero or one [0..1] **playingEntity** (CONF:1098-28428).

1. The playingEntity, if present, **SHOULD** contain zero or one [0..1] **code**, which **SHOULD** be selected from ValueSet **Healthcare Agent Qualifier** 2.16.840.1.113883.11.20.9.51 **DYNAMIC** (CONF:1098-28429).
2. The playingEntity, if present, **MAY** contain zero or more [0..*] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-28454).

This custodian (CST) participant identifies a legal representative for the patient's advance directive. Examples of such individuals are called health care agents, substitute decision makers and/or health care proxies. If there is more than one legal representative, a qualifier may be used to designate the legal representative as primary or secondary.

11. **SHOULD** contain zero or more [0..*] **participant** (CONF:1098-8667) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="CST" Custodian (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-8668).

b. **SHALL** contain exactly one [1..1] **participantRole** (CONF:1098-8669).

i. This participantRole **SHALL** contain exactly one [1..1] **@classCode**="AGNT" Agent (CodeSystem: RoleClass 2.16.840.1.113883.5.110 **STATIC**) (CONF:1098-8670).

ii. 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:1098-28440).

iii. This participantRole **SHOULD** contain zero or one [0..1] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-8671).

iv. This participantRole **SHOULD** contain zero or more [0..*] **telecom** (CONF:1098-8672).

v. This participantRole **SHALL** contain exactly one [1..1] **playingEntity** (CONF:1098-8824).

1. This playingEntity **SHOULD** contain zero or one [0..1] **code**, which **SHOULD** be selected from ValueSet **Healthcare Agent Qualifier** 2.16.840.1.113883.11.20.9.51 **DYNAMIC** (CONF:1098-28444).

Record the name of the agent who can provide a copy of the Advance Directive in the name element.

2. This playingEntity **SHALL** contain exactly one [1..1] **name** (CONF:1098-8673).

12. **SHOULD** contain at least one [1..*] **reference** (CONF:1098-8692) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8694).

b. **SHALL** contain exactly one [1..1] **externalDocument** (CONF:1098-8693).

   i. This externalDocument **SHALL** contain at least one [1..*] **id** (CONF:1098-8695).

   ii. This externalDocument **MAY** contain zero or one [0..1] **text** (CONF:1098-8696).

      1. The text, if present, **MAY** contain zero or one [0..1] **reference** (CONF:1098-8697).

         a. The URL of a referenced advance directive document **MAY** be present, and **SHALL** be represented in Observation/reference/ExternalDocument/text/reference (CONF:1098-8698).

         b. If a URL is referenced, then it **SHOULD** have a corresponding linkHTML element in narrative block (CONF:1098-8699).

Table 225: Healthcare Agent Qualifier

Value Set: Healthcare Agent Qualifier 2.16.840.1.113883.11.20.9.51 A value set SNOMED-CT qualifier codes for representing principal and secondary. Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
63161005	SNOMED CT	2.16.840.1.113883.6.96	Principal
2603003	SNOMED CT	2.16.840.1.113883.6.96	Secondary

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Figure 131: Advance Directive Observation (V2) Example

```
<entry>
  <observation classCode="OBS" moodCode="EVN">
    <!-- ** Advance Directive Observation V2** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.48"
        extension="2014-06-09" />
    <id root="9b54c3c9-1673-49c7-aef9-b037ed72ed27" />
    <code code="75278-2"
      codeSystem="2.16.840.1.113883.6.1"
      displayName="Advance directive status">
    </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>
    <author>
      <templateId root="2.16.840.1.113883.10.20.22.4.119" />
      <time value="201308011235-0800" />
      <assignedAuthor>
        <id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c" />
        <code code="163W00000X"
            displayName="Registered nurse"
            codeSystem="2.16.840.1.113883.6.101"
            codeSystemName="Health Care Provider Taxonomy (HIPAA)" />
        <assignedPerson>
          <name>
            <given>Nurse</given>
            <family>Nightingale</family>
            <suffix>RN</suffix>
          </name>
        </assignedPerson>
        <representedOrganization classCode="ORG">
          <id root="2.16.840.1.113883.19.5" />
          <name>Good Health Hospital</name>
        </representedOrganization>
      </assignedAuthor>
    </author>
    <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 (HIPAA)"
             displayName="Registered nurse" />
        <addr>
          ...
```


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```
        </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>
```


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4.3 Advance Directive Organizer

[organizer: identifier urn:oid:2.16.840.1.113883.10.20.22.4.108 (open)]

Table 226: Advance Directive Organizer Contexts

Contained By:	Contains:
Advance Directives Section (entries optional) (V2) (optional) Advance Directives Section (entries required) (V2) (optional)	Advance Directive Observation (V2) Author Participation

This clinical statement groups a set of advance directive observations.

Table 227: Advance Directive Organizer Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.108)					
@classCode	1..1	SHALL		1098-28410	2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER
@moodCode	1..1	SHALL		1098-28411	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-28412	
@root	1..1	SHALL		1098-28413	2.16.840.1.113883.10.20.22.4.108
id	1..*	SHALL		1098-28414	
code	1..1	SHALL		1098-28415	
@code	1..1	SHALL		1098-31230	45473-6
@codeSystem	1..1	SHALL		1098-31231	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-28418	
@code	1..1	SHALL		1098-31346	2.16.840.1.113883.5.14 (ActStatus) = completed
author	0..*	SHOULD		1098-32407	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
component	1..*	SHALL		1098-28420	
observation	1..1	SHALL		1098-28421	Advance Directive Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09

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1. **SHALL** contain exactly one [1..1] **@classCode**="CLUSTER" Cluster (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-28410).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-28411).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-28412) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.108" (CONF:1098-28413).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-28414).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-28415).
    a. This code **SHALL** contain exactly one [1..1] **@code**="45473-6" Advance directive - living will (CONF:1098-31230).
    b. 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:1098-31231).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-28418).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31346).
7. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32407).
8. **SHALL** contain at least one [1..*] **component** (CONF:1098-28420) such that it
    a. **SHALL** contain exactly one [1..1] **Advance Directive Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09) (CONF:1098-28421).

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Figure 132: 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="45473-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="advance directive - living will" />
    <statusCode code="completed" />
    <author>
       <templateId root="2.16.840.1.113883.10.20.22.4.119" />
       <time value="201308011235-0800" />
       <assignedAuthor>
           <id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c" />
           <code code="163W00000X" displayName="Registered nurse"
codeSystem="2.16.840.1.113883.5.53" codeSystemName="Health Care Provider Taxonomy" />
           <assignedPerson>
               <name>
                   <given>Nurse</given>
                   <family>Nightingale</family>
                   <suffix>RN</suffix>
               </name>
           </assignedPerson>
           <representedOrganization classCode="ORG">
               <id root="2.16.840.1.113883.19.5" />
               <name>Good Health Hospital</name>
           </representedOrganization>
       </assignedAuthor>
    </author>
    <component>
        <observation classCode="OBS" moodCode="EVN">
            <!-- ** Advance Directive Observation V2** -->
            <templateId root="2.16.840.1.113883.10.20.22.4.48" extension="2014-06-09" />
            ...
        </observation>
    </component>
    <component>
        <observation classCode="OBS" moodCode="EVN">
             <!-- ** Advance Directive Observation V2** -->
            <templateId root="2.16.840.1.113883.10.20.22.4.48" extension="2014-06-09" />
            <id root="9b54c3c9-1673-49c7-aef9-b037ed72ed27" />
            ...
        </observation>
    </component>

    <component>
        <observation classCode="OBS" moodCode="EVN">
             <!-- ** Advance Directive Observation V2** -->
            <templateId root="2.16.840.1.113883.10.20.22.4.48" extension="2014-06-09" />
            ...
        </observation>
    </component>
</organizer>
```


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4.4 Age Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.31 (open)]

Table 228: Age Observation Contexts

Contained By:	Contains:
Problem Observation (V2) (optional) Family History 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").

Table 229: Age Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.31)					
@classCode	1..1	SHALL		81-7613	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-7614	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-7899	
@root	1..1	SHALL		81-10487	2.16.840.1.113883.10.20.22.4.31
code	1..1	SHALL		81-7615	
@code	1..1	SHALL		81-16776	445518008
@codeSystem	1..1	SHALL		81-26499	2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
statusCode	1..1	SHALL		81-15965	
@code	1..1	SHALL		81-15966	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..1	SHALL	PQ	81-7617	
@unit	1..1	SHALL	CS	81-7618	2.16.840.1.113883.11.20.9.21 (AgePQ_UCUM)

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1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-7613).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-7614).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7899) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.31" (CONF:81-10487).
4. **SHALL** contain exactly one [1..1] **code** (CONF:81-7615).
    a. This code **SHALL** contain exactly one [1..1] **@code**="445518008" Age At Onset (CONF:81-16776).
    b. 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:81-26499).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:81-15965).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:81-15966).
6. **SHALL** contain exactly one [1..1] **value** with @xsi:type="PQ" (CONF:81-7617).
    a. This value **SHALL** contain exactly one [1..1] **@unit**, which **SHALL** be selected from ValueSet **AgePQ_UCUM** 2.16.840.1.113883.11.20.9.21 **DYNAMIC** (CONF:81-7618).

Table 230: 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. Specific URL Pending Value Set Source: **http://unitsofmeasure.org/ucum.html**			
Code	**Code System**	**Code System OID**	**Print Name**
min	UCUM	2.16.840.1.113883.6.8	Minute
h	UCUM	2.16.840.1.113883.6.8	Hour
d	UCUM	2.16.840.1.113883.6.8	Day
wk	UCUM	2.16.840.1.113883.6.8	Week
mo	UCUM	2.16.840.1.113883.6.8	Month
a	UCUM	2.16.840.1.113883.6.8	Year

Figure 133: 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>
```


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4.5 Allergy Concern Act (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.30:2014-06-09 (open)]

Table 231: Allergy Concern Act (V2) Contexts

Contained By:	Contains:
Allergies and Intolerances Section (entries optional) (V2) (optional) Allergies and Intolerances Section (entries required) (V2) (required)	Allergy - Intolerance Observation (V2) Author Participation

This template reflects an ongoing concern on behalf of the provider that placed the allergy on a patient's allergy list. As long as the underlying condition is of concern to the provider (i.e., as 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 Concern 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 Concern 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).

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Table 232: Allergy Concern Act (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.30:2014-06-09)					
@classCode	1..1	SHALL		1098-7469	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-7470	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7471	
@root	1..1	SHALL		1098-10489	2.16.840.1.113883.10.20.22.4.30
@extension	1..1	SHALL		1098-32543	2014-06-09
id	1..*	SHALL		1098-7472	
code	1..1	SHALL		1098-7477	
@code	1..1	SHALL		1098-19158	CONC
@codeSystem	1..1	SHALL		1098-32154	2.16.840.1.113883.5.6 (HL7ActClass) = 2.16.840.1.113883.5.6
statusCode	1..1	SHALL		1098-7485	
@code	1..1	SHALL		1098-19086	2.16.840.1.113883.11.20.9.19 (ProblemAct statusCode)
effectiveTime	1..1	SHALL		1098-7498	
low	1..1	SHALL		1098-31534	
high	0..1	MAY		1098-31535	
author	0..*	SHOULD		1098-31145	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	1..*	SHALL		1098-7509	
@typeCode	1..1	SHALL		1098-7915	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
observation	1..1	SHALL		1098-14925	Allergy - Intolerance Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7469).

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2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7470).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7471) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.30" (CONF:1098-10489).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32543).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-7472).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-7477).
    a. This code **SHALL** contain exactly one [1..1] **@code**="CONC" Concern (CONF:1098-19158).
    b. This code **SHALL** contain exactly one [1..1] **@codeSystem**="2.16.840.1.113883.5.6" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-32154).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7485).
    a. 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** 2011-09-09 (CONF:1098-19086).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-7498).
    a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-31534).
    Note: The effectiveTime/low asserts when the allergy was noted. This equates to the time the allergy was authored in the patient's chart.
    b. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:1098-31535).
    Note: It is clinically rare for an allergy to be "resolved", and therefore for the Concern 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** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31145).
9. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-7509) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7915).
    b. **SHALL** contain exactly one [1..1] **Allergy - Intolerance Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09) (CONF:1098-14925).

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Table 233: 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 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
completed	ActStatus	2.16.840.1.113883.5.14	Completed
aborted	ActStatus	2.16.840.1.113883.5.14	Aborted
active	ActStatus	2.16.840.1.113883.5.14	Active
suspended	ActStatus	2.16.840.1.113883.5.14	Suspended

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Figure 134: Allergy Concern Act (V2) Example

```
<act classCode="ACT" moodCode="EVN">
    <!-- ** Allergy Concern Act ** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.30" extension="2014-06-09" />
    <id root="36e3e930-7b14-11db-9fe1-0800200c9a66" />
    <code code="CONC" codeSystem="2.16.840.1.113883.5.6" />
    <!-- The statusCode represents the need to continue tracking the allergy -->
    <!-- This is of ongoing concern to the provider -->
    <statusCode code="active" />
    <effectiveTime>
        <!-- The low value represents when the allergy was first recorded in the
             patient's chart -->
        <!-- Concern was documented on May 1, 1998 -->
        <low value="199805011145-0800" />
    </effectiveTime>
    <author typeCode="AUT">
        <!-- Same as Concern effectiveTime/low -->
        <time value="199805011145-0800" />
        <assignedAuthor>
            <id extension="555555555" root="1.1.1.1.1.1.1.2" />
        </assignedAuthor>
    </author>
    <entryRelationship typeCode="SUBJ">
        <observation classCode="OBS" moodCode="EVN">
            <!-- ** Allergy observation ** -->
            <templateId root="2.16.840.1.113883.10.20.22.4.7" extension="2014-06-09" />
            <id root="4adc1020-7b14-11db-9fe1-0800200c9a66" />
            <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />
            <!-- Observation statusCode represents the status of the act of observing -->
            <statusCode code="completed" />
            <effectiveTime>
                <!-- The low value reflects the date of onset of the allergy -->
                <!-- Based on patient symptoms, presumed onset is May 1, 1998 -->
                <low value="19980501" />
                <!-- The high value reflects when the allergy was known to be resolved
                     (and will generally be absent) -->
            </effectiveTime>
            <value xsi:type="CD" code="419199007" displayName="Allergy to substance"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" />
            <author typeCode="AUT">
                <time value="199805011145-0800" />
                <assignedAuthor>
                    <id extension="222223333" root="1.1.1.1.1.1.1.3" />
                </assignedAuthor>
            </author>
            <participant typeCode="CSM">
                <participantRole classCode="MANU">
                    <playingEntity classCode="MMAT">
                        <code code="70618" displayName="Penicillin"
codeSystem="2.16.840.1.113883.6.88" codeSystemName="RxNorm" />
                    </playingEntity>
                </participantRole>
            </participant>
            <entryRelationship typeCode="MFST" inversionInd="true">
                <observation classCode="OBS" moodCode="EVN">
                    <!-- ** Reaction observation ** -->
```


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```
                    <templateId root="2.16.840.1.113883.10.20.22.4.9" extension="2014-06-
09" />
                    <id root="4adc1020-7b14-11db-9fe1-0800200c9a64" />
                    <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />
                    <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" />
                </observation>
            </entryRelationship>
        </observation>
    </entryRelationship>
</act>
```


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Figure 135: No Known Drug Allergies Example

```
<act classCode="ACT" moodCode="EVN">
    <!-- ** Allergy concern act ** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.30" extension="2014-06-09" />
    <id root="b18d084d-0fb9-4cc3-ba95-07acc8d48d26" />
    <code code="CONC" codeSystem="2.16.840.1.113883.5.6" />
    <!-- The statusCode represents the need to continue tracking the problem -->
    <!-- This is of ongoing concern to the provider -->
    <statusCode code="active" />
    <effectiveTime>
        <!-- The low value represents when the problem was first recorded in the
            patient's chart -->
        <!-- Concern was documented on May 01, 1998 -->
        <low value="199805011145-0800" />
    </effectiveTime>
    <author typeCode="AUT">
        <!-- Same as Concern effectiveTime/low -->
        <time value="199805011145-0800" />
        <assignedAuthor>
            <id extension="555555555" root="1.1.1.1.1.1.1.2" />
        </assignedAuthor>
    </author>
    <entryRelationship typeCode="SUBJ">
        <observation classCode="OBS" moodCode="EVN" negationInd="true">
            <!-- ** Allergy observation ** -->
            <templateId root="2.16.840.1.113883.10.20.22.4.7" extension="2014-06-09" />
            <id root="8beb9ba4-f76a-4c78-92a9-1364f579f733" />
            <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />
            <!-- The statusCode reflects the status of the act of observing -->
            <statusCode code="completed" />
            <!-- The low value reflects the date of onset -->
            <!-- This patient has never had any allergies,
                so effectiveTime/low = date of birth -->
            <effectiveTime>
                <low value="19750501" />
            </effectiveTime>
            <value xsi:type="CD" code="419199007" displayName="Allergy to substance"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" />
            <author typeCode="AUT">
                <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" />
                </assignedAuthor>
            </author>
            <participant typeCode="CSM">
                <participantRole classCode="MANU">
                    <playingEntity classCode="MMAT">
                        <code code="410942007" displayName="drug or medication"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" />
                    </playingEntity>
                </participantRole>
            </participant>
        </observation>
    </entryRelationship>
```


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```
</act>
```

4.6 Allergy Status Observation (DEPRECATED)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.28:2014-06-09 (open)]

Table 234: Allergy Status Observation (DEPRECATED) Contexts

Contained By:	Contains:
Substance or Device Allergy - Intolerance Observation (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 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED.

Reason for deprecation: 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.

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Table 235: Allergy Status Observation (DEPRECATED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.28:2014-06-09)					
@classCode	1..1	SHALL		1098-7318	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-7319	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7317	
@root	1..1	SHALL		1098-10490	2.16.840.1.113883.10.20.22.4.28
@extension	1..1	SHALL		1098-32576	2014-06-09
code	1..1	SHALL		1098-7320	
@code	1..1	SHALL		1098-19131	33999-4
@codeSystem	1..1	SHALL		1098-32155	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-7321	
@code	1..1	SHALL		1098-19087	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..1	SHALL	CD	1098-7322	2.16.840.1.113883.3.88.12.80.68 (Problem Status)

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" Observation (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-7318).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-7319).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7317) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.28`" (CONF:1098-10490).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32576).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-7320).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`33999-4`" Status (CONF:1098-19131).
   b. 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:1098-32155).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7321).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="`completed`" Completed (CodeSystem: `ActStatus 2.16.840.1.113883.5.14` **STATIC**) (CONF:1098-19087).

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6. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHALL** be selected from ValueSet **Problem Status** 2.16.840.1.113883.3.88.12.80.68 **DYNAMIC** (CONF:1098-7322).

Table 236: Problem Status

Value Set: Problem Status 2.16.840.1.113883.3.88.12.80.68 A value set of SNOMED-CT codes reflecting state of existence. Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
55561003	SNOMED CT	2.16.840.1.113883.6.96	Active
73425007	SNOMED CT	2.16.840.1.113883.6.96	Inactive
413322009	SNOMED CT	2.16.840.1.113883.6.96	Resolved

4.7 Assessment Scale Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.69 (open)]

Table 237: Assessment Scale Observation Contexts

Contained By:	Contains:
Sensory Status (optional) Mental Status Section (optional) Health Concern Act (optional) Mental Status Observation (V2) (optional) Functional Status Section (V2) (optional) Functional Status Observation (V2) (optional) Risk Concern Act (optional)	Assessment Scale Supporting Observation

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.)

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Table 238: Assessment Scale Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69)					
@classCode	1..1	SHALL		81-14434	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-14435	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-14436	
@root	1..1	SHALL		81-14437	2.16.840.1.113883.10.20.22.4.69
id	1..*	SHALL		81-14438	
code	1..1	SHALL		81-14439	
derivationExpr	0..1	MAY		81-14637	
statusCode	1..1	SHALL		81-14444	
@code	1..1	SHALL		81-19088	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		81-14445	
value	1..1	SHALL		81-14450	
interpretationCode	0..*	MAY		81-14459	
translation	0..*	MAY		81-14888	
author	0..*	MAY		81-14460	
entryRelationship	0..*	SHOULD		81-14451	
@typeCode	1..1	SHALL		81-16741	COMP
observation	1..1	SHALL		81-16742	Assessment Scale Supporting Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.86
referenceRange	0..*	MAY		81-16799	
observationRange	1..1	SHALL		81-16800	
text	0..1	SHOULD		81-16801	
reference	0..1	SHOUL		81-	

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		D		16802	
@value	0..1	MAY		81-16803	

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-14434).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-14435).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-14436) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.69" (CONF:81-14437).
4. **SHALL** contain at least one [1..*] **id** (CONF:81-14438).
5. **SHALL** contain exactly one [1..1] **code** (CONF:81-14439).
    a. 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:81-14440).

Such derivation expression can contain a text calculation of how the components total up to the summed score

6. **MAY** contain zero or one [0..1] **derivationExpr** (CONF:81-14637).
7. **SHALL** contain exactly one [1..1] **statusCode** (CONF:81-14444).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:81-19088).

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)

8. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:81-14445).
9. **SHALL** contain exactly one [1..1] **value** (CONF:81-14450).
10. **MAY** contain zero or more [0..*] **interpretationCode** (CONF:81-14459).
    a. The interpretationCode, if present, **MAY** contain zero or more [0..*] **translation** (CONF:81-14888).
11. **MAY** contain zero or more [0..*] **author** (CONF:81-14460).
12. **SHOULD** contain zero or more [0..*] **entryRelationship** (CONF:81-14451) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" has component (CONF:81-16741).
    b. **SHALL** contain exactly one [1..1] **Assessment Scale Supporting Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.86) (CONF:81-16742).

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)

13. **MAY** contain zero or more [0..*] **referenceRange** (CONF:81-16799).
    a. The referenceRange, if present, **SHALL** contain exactly one [1..1] **observationRange** (CONF:81-16800).

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The text 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)

i. This observationRange **SHOULD** contain zero or one [0..1] **text** (CONF:81-16801).
   1. The text, if present, **SHOULD** contain zero or one [0..1] **reference** (CONF:81-16802).
      a. The reference, if present, **MAY** contain zero or one [0..1] **@value** (CONF:81-16803).
         i. 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:81-16804).

Figure 136: 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>
```

4.8 Assessment Scale Supporting Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.86 (open)]

Table 239: Assessment Scale Supporting Observation Contexts

Contained By:	Contains:
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.

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Table 240: Assessment Scale Supporting Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.86)					
@classCode	1..1	SHALL		81-16715	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-16716	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-16722	
@root	1..1	SHALL		81-16723	2.16.840.1.113883.10.20.22.4.86
id	1..*	SHALL		81-16724	
code	1..1	SHALL		81-19178	
@code	1..1	SHALL		81-19179	
statusCode	1..1	SHALL		81-16720	
@code	1..1	SHALL		81-19089	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..*	SHALL		81-16754	

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-16715).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-16716).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-16722) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.86" (CONF:81-16723).
4. **SHALL** contain at least one [1..*] **id** (CONF:81-16724).
5. **SHALL** contain exactly one [1..1] **code** (CONF:81-19178).
    a. This code **SHALL** contain exactly one [1..1] **@code** (CONF:81-19179).
        i. 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:81-19180).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:81-16720).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:81-19089).
7. **SHALL** contain at least one [1..*] **value** (CONF:81-16754).

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a. If xsi:type="CD", **MAY** have a translation code to further specify the source if the instrument has an applicable code system and value set for the integer (CONF:14639) (CONF:81-16755).

Figure 137: Assessment Scale Supporting Observation Example

```
 <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>
```

4.9 Authorization Activity

`[act: identifier urn:oid:2.16.840.1.113883.10.20.1.19 (open)]`

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.

Table 241: Authorization Activity Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.1.19)					
@classCode	1..1	SHALL		81-8944	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		81-8945	2.16.840.1.113883.5.6 (HL7ActClass) = EVN
templateId	1..1	SHALL		81-8946	
@root	1..1	SHALL		81-10529	2.16.840.1.113883.10.20.1.19
id	1..1	SHALL		81-8947	
entryRelationship	1..*	SHALL		81-8948	
@typeCode	1..1	SHALL		81-8949	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:81-8944).

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2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-8945).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8946) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.1.19" (CONF:81-10529).
4. **SHALL** contain exactly one [1..1] **id** (CONF:81-8947).
5. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:81-8948) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-8949).
    b. The target of an authorization activity with act/entryRelationship/@typeCode="SUBJ" **SHALL** be a clinical statement with moodCode="PRMS" Promise (CONF:81-8951).
    c. The target of an authorization activity **MAY** contain one or more performer, to indicate the providers that have been authorized to provide treatment (CONF:81-8952).

Figure 138: 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>
```

4.10 Boundary Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.6.2.11 (open)]

Table 242: Boundary Observation Contexts

Contained By:	Contains:
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.

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Table 243: Boundary Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.11)					
@classCode	1..1	SHALL		81-9282	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-9283	2.16.840.1.113883.5.6 (HL7ActClass) = EVN
code	1..1	SHALL		81-9284	
@code	1..1	SHALL		81-19157	1.2.840.10008.2.16.4 (DCM) = 113036
value	1..*	SHALL	INT	81-9285	

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-9282).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-9283).
3. **SHALL** contain exactly one [1..1] **code** (CONF:81-9284).
    a. This code **SHALL** contain exactly one [1..1] **@code**="113036" Frames for Display (CodeSystem: DCM 1.2.840.10008.2.16.4 **STATIC**) (CONF:81-19157).

Each number represents a frame for display.

4. **SHALL** contain at least one [1..*] **value** with @xsi:type="INT" (CONF:81-9285).

Figure 139: 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>
```


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4.11 Caregiver Characteristics

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.72 (open)]

Table 244: Caregiver Characteristics Contexts

Contained By:	Contains:
Social History Section (V2) (optional) Health Concern Act (optional) Functional Status Section (V2) (optional) Functional Status Observation (V2) (optional) Risk Concern Act (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.

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Table 245: Caregiver Characteristics Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72)					
@classCode	1..1	SHALL		81-14219	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-14220	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-14221	
@root	1..1	SHALL		81-14222	2.16.840.1.113883.10.20.22.4.72
id	1..*	SHALL		81-14223	
code	1..1	SHALL		81-14230	
statusCode	1..1	SHALL		81-14233	
@code	1..1	SHALL		81-19090	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..1	SHALL	CD	81-14599	
participant	1..*	SHALL		81-14227	
@typeCode	1..1	SHALL		81-26451	IND
time	0..1	MAY		81-14830	
low	1..1	SHALL		81-14831	
high	0..1	MAY		81-14832	
participantRole	1..1	SHALL		81-14228	
@classCode	1..1	SHALL		81-14229	CAREGIVER

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-14219).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-14220).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-14221) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.72" (CONF:81-14222).
4. **SHALL** contain at least one [1..*] **id** (CONF:81-14223).
5. **SHALL** contain exactly one [1..1] **code** (CONF:81-14230).

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a. This code **MAY** be drawn from LOINC (CodeSystem: LOINC 2.16.840.1.113883.6.1) or **MAY** be bound to ASSERTION (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:81-26513).

6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:81-14233).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:81-19090).
7. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD" (CONF:81-14599).
   a. The code **SHALL** be selected from LOINC (codeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:81-14600).
8. **SHALL** contain at least one [1..*] **participant** (CONF:81-14227).
   a. Such participants **SHALL** contain exactly one [1..1] **@typeCode**="IND" (CONF:81-26451).
   b. Such participants **MAY** contain zero or one [0..1] **time** (CONF:81-14830).
      i. The time, if present, **SHALL** contain exactly one [1..1] **low** (CONF:81-14831).
      ii. The time, if present, **MAY** contain zero or one [0..1] **high** (CONF:81-14832).
   c. Such participants **SHALL** contain exactly one [1..1] **participantRole** (CONF:81-14228).
      i. This participantRole **SHALL** contain exactly one [1..1] **@classCode**="CAREGIVER" (CONF:81-14229).

Figure 140: 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>
```


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4.12 Characteristics of Home Environment

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.109 (open)]

Table 246: Characteristics of Home Environment Contexts

Contained By:	Contains:
Social History Section (V2) (optional) Health Concern Act (optional) Risk Concern Act (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).

Table 247: Characteristics of Home Environment Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.109)					
@classCode	1..1	SHALL		1098-27890	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-27891	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-27892	
@root	1..1	SHALL		1098-27893	2.16.840.1.113883.10.20.22.4.109
id	1..*	SHALL		1098-27894	
code	1..1	SHALL		1098-31352	
@code	1..1	SHALL		1098-31353	75274-1
@codeSystem	1..1	SHALL		1098-31354	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-27901	
@code	1..1	SHALL		1098-27902	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..1	SHALL	CD	1098-28823	2.16.840.1.113883.11.20.9.49 (Residence and Accommodation Type)

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-27890).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-27891).

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3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-27892) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.109" (CONF:1098-27893).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-27894).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-31352).
    a. This code **SHALL** contain exactly one [1..1] **@code**="75274-1" Characteristics of residence (CONF:1098-31353).
    b. 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:1098-31354).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-27901).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-27902).
7. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **Residence and Accommodation Type** 2.16.840.1.113883.11.20.9.49 **DYNAMIC** (CONF:1098-28823).

Table 248: 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

Value Set Source: **https://vsac.nlm.nih.gov**

Code	Code System	Code System OID	Print Name
424661000	SNOMED CT	2.16.840.1.113883.6.96	cluttered living space (finding)
160708008	SNOMED CT	2.16.840.1.113883.6.96	stairs in house (finding)
160751007	SNOMED CT	2.16.840.1.113883.6.96	eviction from dwelling (finding)
423859003	SNOMED CT	2.16.840.1.113883.6.96	crowded living space (finding)
160720000	SNOMED CT	2.16.840.1.113883.6.96	harassment by landlord (finding)
105529008	SNOMED CT	2.16.840.1.113883.6.96	lives alone (finding)
60585007	SNOMED CT	2.16.840.1.113883.6.96	slum area living (finding)
365508006	SNOMED CT	2.16.840.1.113883.6.96	unsatisfactory living conditions (finding)
422491004	SNOMED CT	2.16.840.1.113883.6.96	housing contains exposed wiring (finding)
…			

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Figure 141: 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="75274-1" codeSystem="2.16.840.1.113883.6.1"
          displayName="Characteristics of residence" />
    <statusCode code="completed" />
    <effectiveTime value="20130312" />
    <value xsi:type="CD" code="308899009" displayName="unsatisfactory living conditions
(finding)" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" />
</observation>
```

4.13 Code Observations

[observation: identifier urn:oid:2.16.840.1.113883.10.20.6.2.13 (open)]

Table 249: Code Observations Contexts

Contained By:	**Contains:**
Diagnostic Imaging Report (V2) (optional)	Quantity Measurement Observation 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.

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Table 250: Code Observations Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.13)					
@classCode	1..1	SHALL		81-9304	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-9305	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-15523	
@root	1..1	SHALL		81-15524	2.16.840.1.113883.10.20.6.2.13
code	1..1	SHALL		81-19181	
effectiveTime	0..1	SHOULD		81-9309	
value	1..1	SHALL		81-9308	
entryRelationship	0..*	MAY		81-9311	
@typeCode	1..1	SHALL		81-9312	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT
observation	1..1	SHALL		81-16083	SOP Instance Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8
entryRelationship	0..*	MAY		81-9314	
@typeCode	1..1	SHALL		81-9315	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT
observation	1..1	SHALL		81-16084	Quantity Measurement Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.14

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" Observation (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:81-9304).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:81-9305).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-15523).
   a. This templateId **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.6.2.13`" (CONF:81-15524).
4. **SHALL** contain exactly one [1..1] **code** (CONF:81-19181).
5. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:81-9309).
6. **SHALL** contain exactly one [1..1] **value** (CONF:81-9308).
7. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:81-9311) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-9312).

b. **SHALL** contain exactly one [1..1] **SOP Instance Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8) (CONF:81-16083).

8. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:81-9314) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-9315).

b. **SHALL** contain exactly one [1..1] **Quantity Measurement Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.14) (CONF:81-16084).

9. Code Observations **SHALL** be rendered into section/text in separate paragraphs (CONF:81-9310).

Figure 142: 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>
```

4.14 Cognitive Status Problem Observation (DEPRECATED)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.73:2014-06-09 (open)]

Table 251: Cognitive Status Problem Observation (DEPRECATED) Contexts

Contained By:	Contains:
Functional Status Section (V2) (optional)	

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, judgement, comprehension ability, or response speed.

THIS TEMPLATE HAS BEEN DEPRECATED AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED.

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Reason for deprecation: Cognitive Status Problem Observation has been merged, without loss of expressivity, into Mental Status Observation (2.16.840.1.113883.10.20.22.4.74:2014-06-09).

Table 252: Cognitive Status Problem Observation (DEPRECATED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.73:2014-06-09)					
@classCode	1..1	SHALL		1098-14319	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-14320	2.16.840.1.113883.5.1001 (ActMood) = EVN
@negationInd	0..1	MAY		1098-14344	
templateId	1..1	SHALL		1098-14346	
@root	1..1	SHALL		1098-14347	2.16.840.1.113883.10.20.22.4.73
@extension	1..1	SHALL		1098-32600	2014-06-09
id	1..*	SHALL		1098-14321	
code	1..1	SHALL		1098-14804	
@code	0..1	SHOULD		1098-14805	2.16.840.1.113883.6.96 (SNOMED CT) = 373930000
text	0..1	SHOULD		1098-14341	
reference	0..1	SHOULD		1098-15532	
@value	0..1	SHOULD		1098-15533	
statusCode	1..1	SHALL		1098-14323	
@code	1..1	SHALL		1098-19091	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	0..1	SHOULD		1098-14324	
low	1..1	SHALL		1098-26458	
high	0..1	MAY		1098-26459	
value	1..1	SHALL	CD	1098-14349	2.16.840.1.113883.3.88.12.3221.7.4 (Problem)
methodCode	0..*	MAY		1098-14693	

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1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-14319).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-14320).

Use negationInd="true" to indicate that the problem was not observed.

3. **MAY** contain zero or one [0..1] **@negationInd** (CONF:1098-14344).
4. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-14346) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.73" (CONF:1098-14347).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32600).
5. **SHALL** contain at least one [1..*] **id** (CONF:1098-14321).
6. **SHALL** contain exactly one [1..1] **code** (CONF:1098-14804).
    a. 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:1098-14805).
7. **SHOULD** contain zero or one [0..1] **text** (CONF:1098-14341).
    a. The text, if present, **SHOULD** contain zero or one [0..1] **reference** (CONF:1098-15532).
        i. The reference, if present, **SHOULD** contain zero or one [0..1] **@value** (CONF:1098-15533).
            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:1098-15534).
8. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-14323).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19091).
9. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-14324).

The value of effectiveTime/low represents onset date.

    a. The effectiveTime, if present, **SHALL** contain exactly one [1..1] **low** (CONF:1098-26458).

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.

    b. The effectiveTime, if present, **MAY** contain zero or one [0..1] **high** (CONF:1098-26459).
10. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **Problem** 2.16.840.1.113883.3.88.12.3221.7.4 **DYNAMIC** (CONF:1098-14349).
11. **MAY** contain zero or more [0..*] **methodCode** (CONF:1098-14693).

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Table 253: Problem

Value Set: Problem 2.16.840.1.113883.3.88.12.3221.7.4 A value set of SNOMED-CT codes limited to terms descending from the Clinical Findings (404684003) or Situation with Explicit Context (243796009) hierarchies. Specific URL Pending Value Set Source: https://vsac.nlm.nih.gov			
Code	**Code System**	**Code System OID**	**Print Name**
46635009	SNOMED CT	2.16.840.1.113883.6.96	diabetes mellitus type 1
234422006	SNOMED CT	2.16.840.1.113883.6.96	acute intermittent porphyria
31712002	SNOMED CT	2.16.840.1.113883.6.96	primary biliary cirrhosis
302002000	SNOMED CT	2.16.840.1.113883.6.96	difficulty moving
15188001	SNOMED CT	2.16.840.1.113883.6.96	hearing loss
129851009	SNOMED CT	2.16.840.1.113883.6.96	alteration in bowel elimination
247472004	SNOMED CT	2.16.840.1.113883.6.96	hives
39579001	SNOMED CT	2.16.840.1.113883.6.96	anaphylaxis
274945004	SNOMED CT	2.16.840.1.113883.6.96	AA amyloidosis (disorder)
129851009	SNOMED CT	2.16.840.1.113883.6.96	alteration in comfort: pain
…			

4.15 Comment Activity

`[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.64 (open)]`

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.

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Table 254: Comment Activity Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.64)					
@classCode	1..1	SHALL		81-9425	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		81-9426	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-9427	
@root	1..1	SHALL		81-10491	2.16.840.1.113883.10.20.22.4.64
code	1..1	SHALL		81-9428	
@code	1..1	SHALL		81-19159	48767-8
@codeSystem	1..1	SHALL		81-26501	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
text	1..1	SHALL		81-9430	
reference	1..1	SHALL		81-15967	
@value	1..1	SHALL		81-15968	
reference/@value	1..1	SHALL		81-9431	
author	0..1	MAY		81-9433	
time	1..1	SHALL		81-9434	
assignedAuthor	1..1	SHALL		81-9435	
id	1..1	SHALL		81-9436	
addr	1..1	SHALL		81-9437	

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-9425).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-9426).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-9427) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.64" (CONF:81-10491).
4. **SHALL** contain exactly one [1..1] **code** (CONF:81-9428).

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a. This code **SHALL** contain exactly one [1..1] **@code**="48767-8" Annotation Comment (CONF:81-19159).
b. 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:81-26501).

5. **SHALL** contain exactly one [1..1] **text** (CONF:81-9430).
   a. This text **SHALL** contain exactly one [1..1] **reference** (CONF:81-15967).
      i. This reference **SHALL** contain exactly one [1..1] **@value** (CONF:81-15968).
         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:81-15969).
   b. This text **SHALL** contain exactly one [1..1] **reference/@value** (CONF:81-9431).
6. **MAY** contain zero or one [0..1] **author** (CONF:81-9433).
   a. The author, if present, **SHALL** contain exactly one [1..1] **time** (CONF:81-9434).
   b. The author, if present, **SHALL** contain exactly one [1..1] **assignedAuthor** (CONF:81-9435).
      i. This assignedAuthor **SHALL** contain exactly one [1..1] **id** (CONF:81-9436).
      ii. This assignedAuthor **SHALL** contain exactly one [1..1] **addr** (CONF:81-9437).
         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:81-10480).
      iii. SHALL include assignedPerson/name or representedOrganization/name (CONF:81-9438).
      iv. 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:81-9439).
7. Data elements defined elsewhere in the specification **SHALL NOT** be recorded using the Comment Activity (CONF:81-9429).

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Figure 143: 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>
```

4.16 Coverage Activity (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.60:2014-06-09 (open)]

Table 255: Coverage Activity (V2) Contexts

Contained By:	**Contains:**
Payers Section (V2) (optional)	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.

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Table 256: Coverage Activity (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.60:2014-06-09)					
@classCode	1..1	SHALL		1098-8872	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-8873	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-8897	
@root	1..1	SHALL		1098-10492	2.16.840.1.113883.10.20.22.4.60
@extension	1..1	SHALL		1098-32596	2014-06-09
id	1..*	SHALL		1098-8874	
code	1..1	SHALL		1098-8876	
@code	1..1	SHALL		1098-19160	48768-6
@codeSystem	1..1	SHALL		1098-32156	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-8875	
@code	1..1	SHALL		1098-19094	2.16.840.1.113883.5.14 (ActStatus) = completed
entryRelationship	1..*	SHALL		1098-8878	
@typeCode	1..1	SHALL		1098-8879	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
sequenceNumber	0..1	MAY		1098-17174	
@value	1..1	SHALL		1098-17175	
act	1..1	SHALL		1098-15528	Policy Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.61:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8872).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-8873).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8897) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.60" (CONF:1098-10492).

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b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32596).

4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8874).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-8876).
   a. This code **SHALL** contain exactly one [1..1] **@code**="48768-6" Payment sources (CONF:1098-19160).
   b. 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:1098-32156).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-8875).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19094).
7. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-8878) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8879).
   b. **MAY** contain zero or one [0..1] **sequenceNumber** (CONF:1098-17174).
      i. The sequenceNumber, if present, **SHALL** contain exactly one [1..1] **@value** (CONF:1098-17175).
   c. **SHALL** contain exactly one [1..1] **Policy Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.61:2014-06-09) (CONF:1098-15528).

Figure 144: Coverage Activity (V2) Example

```
<act classCode="ACT" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.60" extension="2014-06-09" />
    <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">
            <sequenceNumber value="2" />
            <templateId root="2.16.840.1.113883.10.20.22.4.61" extension="2014-06-09" />
            . . .
        </act>
    </entryRelationship>
</act>
```


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4.17 Cultural and Religious Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.111 (open)]

Table 257: Cultural and Religious Observation Contexts

Contained By:	Contains:
Social History Section (V2) (optional) Health Concern Act (optional) Risk Concern Act (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.

Table 258: Cultural and Religious Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.111)					
@classCode	1..1	SHALL		1098-27924	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-27925	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-27926	
@root	1..1	SHALL		1098-27927	2.16.840.1.113883.10.20.22.4.111
id	1..*	SHALL		1098-27928	
code	1..1	SHALL		1098-27929	
@code	1..1	SHALL		1098-27930	75281-6
@codeSystem	1..1	SHALL		1098-27931	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-27936	
@code	1..1	SHALL		1098-27937	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..1	SHALL		1098-28442	

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-27924).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-27925).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-27926) such that it

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a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.111" (CONF:1098-27927).

4. **SHALL** contain at least one [1..*] **id** (CONF:1098-27928).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-27929).
   a. This code **SHALL** contain exactly one [1..1] **@code**="75281-6" Personal belief (CONF:1098-27930).
   b. 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:1098-27931).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-27936).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-27937).
7. **SHALL** contain exactly one [1..1] **value** (CONF:1098-28442).
   a. If value is CD, it **SHALL** be SNOMED-CT (CONF:1098-32487).

Figure 145: Cultural and Religious Observation Example

```
<entry>
    <observation classCode="OBS" moodCode="EVN">
        <!-- **Cultural and Religious Observation **-->
        <templateId root="2.16.840.1.113883.10.20.22.4.111" />
        <id root="37f76c51-6411-4e1d-8a37-957fd49d2cef" />
        <code code="75281-6" codeSystem="2.16.840.1.113883.6.1"
                   displayName="Personal belief" />
        <statusCode code="completed" />
        <effectiveTime>
            <low value="20130312" />
        </effectiveTime>
        <value xsi:type="ST">Does not accept blood transfusions, or donates, or
            stores blood for transfusion.</value>
    </observation>
</entry>
```

4.18 Deceased Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.79:2014-06-09 (open)]

Table 259: Deceased Observation (V2) Contexts

Contained By:	Contains:
	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.

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Table 260: Deceased Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.79:2014-06-09)					
@classCode	1..1	SHALL		1098-14851	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-14852	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-14871	
@root	1..1	SHALL		1098-14872	2.16.840.1.113883.10.20.22.4.79
@extension	1..1	SHALL		1098-32541	2014-06-09
id	1..*	SHALL		1098-14873	
code	1..1	SHALL		1098-14853	
@code	1..1	SHALL		1098-19135	ASSERTION
@codeSystem	1..1	SHALL		1098-32158	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
statusCode	1..1	SHALL		1098-14854	
@code	1..1	SHALL		1098-19095	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-14855	
low	1..1	SHALL		1098-14874	
value	1..1	SHALL	CD	1098-14857	
@code	1..1	SHALL		1098-15142	2.16.840.1.113883.6.96 (SNOMED CT) = 419099009
entryRelationship	0..1	SHOULD		1098-14868	
@typeCode	1..1	SHALL		1098-14875	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = CAUS
observation	1..1	SHALL		1098-14870	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-14851).

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2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-14852).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-14871) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.79" (CONF:1098-14872).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32541).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-14873).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-14853).
    a. This code **SHALL** contain exactly one [1..1] **@code**="ASSERTION" Assertion (CONF:1098-19135).
    b. 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:1098-32158).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-14854).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19095).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-14855).
    a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-14874).
8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD" (CONF:1098-14857).
    a. This value **SHALL** contain exactly one [1..1] **@code**="419099009" Dead (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 **STATIC**) (CONF:1098-15142).
9. **SHOULD** contain zero or one [0..1] **entryRelationship** (CONF:1098-14868) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="CAUS" Is etiology for (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-14875).
    b. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-14870).

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Figure 146: Deceased Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.79" extension="2014-06-09"/>
    <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>
```

4.19 Discharge Medication (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.35:2014-06-09 (open)]

Table 261: Discharge Medication (V2) Contexts

Contained By:	**Contains:**
Discharge Medications Section (entries optional) (V2) (optional) Discharge Medications Section (entries required) (V2) (required)	Medication Activity (V2)

This template represents medications that the patient is intended to take (or stop) after discharge.

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Table 262: Discharge Medication (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.35:2014-06-09)					
@classCode	1..1	SHALL		1098-7689	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-7690	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-16760	
@root	1..1	SHALL		1098-16761	2.16.840.1.113883.10.20.22.4.35
@extension	1..1	SHALL		1098-32513	2014-06-09
code	1..1	SHALL		1098-7691	
@code	1..1	SHALL		1098-19161	10183-2
@codeSystem	1..1	SHALL		1098-32159	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-32779	
@code	1..1	SHALL		1098-32780	2.16.840.1.113883.5.14 (ActStatus) = completed
entryRelationship	1..*	SHALL		1098-7692	
@typeCode	1..1	SHALL		1098-7693	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
substanceAdministration	1..1	SHALL		1098-15525	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="`ACT`" (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-7689).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-7690).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16760) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.35`" (CONF:1098-16761).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32513).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-7691).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`10183-2`" Discharge medication (CONF:1098-19161).

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b. 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:1098-32159).

5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-32779).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-32780).
6. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-7692) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7693).
   b. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-15525).

Figure 147: Discharge Medication (V2) Example

```
<act classCode="ACT" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.22.4.35" extension="2014-06-09" />
  <code code="10183-2" />
  <statusCode code="completed" />
  <entryRelationship typeCode="SUBJ">
    <substanceAdministration classCode="SBADM" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.16" extension="2014-06-09" />
        ...
    </substanceAdministration>
  </entryRelationship>
</act>
```

4.20 Drug Monitoring Act

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.123 (open)]

Table 263: Drug Monitoring Act Contexts

Contained By:	Contains:
Medication Activity (V2) (optional)	US Realm Patient Name (PTN.US.FIELDED)

This template represents the act of monitoring the patient's medication and includes a participation to record the person responsible for monitoring the medication. The prescriber of the medication is not necessarily the same person or persons monitoring the drug. The effectiveTime indicates the time when the activity is intended to take place.

For example, a cardiologist may prescribe a patient Warfarin. The patient's primary care provider may monitor the patient's INR and adjust the dosing of the Warfarin based on these lab results. Here the person designated to monitor the drug is the primary care provider.

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Table 264: Drug Monitoring Act Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.123)					
@classCode	1..1	SHALL		1098-30823	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-28656	INT
templateId	1..1	SHALL		1098-28657	
@root	1..1	SHALL		1098-28658	2.16.840.1.113883.10.20.22.4.123
id	1..*	SHALL		1098-31920	
code	1..1	SHALL		1098-28660	
@code	1..1	SHALL		1098-30818	395170001
@codeSystem	1..1	SHALL		1098-30819	2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
statusCode	1..1	SHALL		1098-31921	
@code	1..1	SHALL		1098-32358	2.16.840.1.113883.1.11.159331 (ActStatus)
effectiveTime	1..1	SHALL		1098-31922	
participant	1..*	SHALL		1098-28661	
@typeCode	1..1	SHALL		1098-28663	RESP
participantRole	1..1	SHALL		1098-28662	
@classCode	1..1	SHALL		1098-28664	ASSIGNED
id	1..*	SHALL		1098-28665	
playingEntity	1..1	SHALL		1098-28667	
@classCode	1..1	SHALL		1098-28668	PSN
name	1..1	SHALL		1098-28669	US Realm Patient Name (PTN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1

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1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-30823).
2. **SHALL** contain exactly one [1..1] **@moodCode**="INT" (CONF:1098-28656).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-28657) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.123" (CONF:1098-28658).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-31920).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-28660).
    a. This code **SHALL** contain exactly one [1..1] **@code**="395170001" medication monitoring (regime/therapy) (CONF:1098-30818).
    b. 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:1098-30819).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-31921).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ActStatus** 2.16.840.1.113883.1.11.159331 **DYNAMIC** (CONF:1098-32358).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-31922).
8. **SHALL** contain at least one [1..*] **participant** (CONF:1098-28661) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RESP" (CONF:1098-28663).
    b. **SHALL** contain exactly one [1..1] **participantRole** (CONF:1098-28662).
        i. This participantRole **SHALL** contain exactly one [1..1] **@classCode**="ASSIGNED" (CONF:1098-28664).
        ii. This participantRole **SHALL** contain at least one [1..*] **id** (CONF:1098-28665).
        iii. This participantRole **SHALL** contain exactly one [1..1] **playingEntity** (CONF:1098-28667).
            1. This playingEntity **SHALL** contain exactly one [1..1] **@classCode**="PSN" (CONF:1098-28668).
            2. This playingEntity **SHALL** contain exactly one [1..1] **US Realm Patient Name (PTN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1) (CONF:1098-28669).

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Table 265: 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. Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
normal	ActStatus	2.16.840.1.113883.5.14	normal
aborted	ActStatus	2.16.840.1.113883.5.14	aborted
active	ActStatus	2.16.840.1.113883.5.14	active
cancelled	ActStatus	2.16.840.1.113883.5.14	cancelled
completed	ActStatus	2.16.840.1.113883.5.14	completed
held	ActStatus	2.16.840.1.113883.5.14	held
new	ActStatus	2.16.840.1.113883.5.14	new
suspended	ActStatus	2.16.840.1.113883.5.14	suspended
nullified	ActStatus	2.16.840.1.113883.5.14	nullified
obsolete	ActStatus	2.16.840.1.113883.5.14	obsolete

Figure 148: 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(regime/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>
```


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4.21 Drug Vehicle

[participantRole: identifier urn:oid:2.16.840.1.113883.10.20.22.4.24 (open)]

Table 266: Drug Vehicle Contexts

Contained By:	Contains:
Medication Activity (V2) (optional) Immunization Activity (V2) (optional)	

This template represents the vehicle (e.g., saline, dextrose) for administering a medication.

Table 267: Drug Vehicle Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
participantRole (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.24)					
@classCode	1..1	SHALL		81-7490	2.16.840.1.113883.5.110 (RoleClass) = MANU
templateId	1..1	SHALL		81-7495	
@root	1..1	SHALL		81-10493	2.16.840.1.113883.10.20.22.4.24
code	1..1	SHALL		81-19137	
@code	1..1	SHALL		81-19138	412307009
@codeSystem	1..1	SHALL		81-26502	2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
playingEntity	1..1	SHALL		81-7492	
code	1..1	SHALL		81-7493	
name	0..1	MAY		81-7494	

1. **SHALL** contain exactly one [1..1] **@classCode**="MANU" (CodeSystem: RoleClass 2.16.840.1.113883.5.110 **STATIC**) (CONF:81-7490).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7495) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.24" (CONF:81-10493).
3. **SHALL** contain exactly one [1..1] **code** (CONF:81-19137).
   a. This code **SHALL** contain exactly one [1..1] **@code**="412307009" Drug Vehicle (CONF:81-19138).
   b. 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:81-26502).

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4. **SHALL** contain exactly one [1..1] **playingEntity** (CONF:81-7492).

This playingEntity/code is used to supply a coded term for the drug vehicle.

a. This playingEntity **SHALL** contain exactly one [1..1] **code** (CONF:81-7493).
b. This playingEntity **MAY** contain zero or one [0..1] **name** (CONF:81-7494).
   i. This playingEntity/name **MAY** be used for the vehicle name in text, such as Normal Saline (CONF:81-10087).

Figure 149: 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>
```

4.22 Encounter Activity (V2)

[encounter: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09 (open)]

Table 268: Encounter Activity (V2) Contexts

Contained By:	Contains:
Encounters Section (entries optional) (V2) (optional) Encounters Section (entries required) (V2) (required) Intervention Act (optional) Planned Intervention Act (optional)	Encounter Diagnosis (V2) Indication (V2) 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.

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Table 269: Encounter Activity (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
encounter (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09)					
@classCode	1..1	SHALL		1098-8710	2.16.840.1.113883.5.6 (HL7ActClass) = ENC
@moodCode	1..1	SHALL		1098-8711	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-8712	
@root	1..1	SHALL		1098-26353	2.16.840.1.113883.10.20.22.4.49
@extension	1..1	SHALL		1098-32546	2014-06-09
id	1..*	SHALL		1098-8713	
code	1..1	SHALL		1098-8714	2.16.840.1.113883.3.88.12.80.32 (EncounterTypeCode)
originalText	0..1	SHOULD		1098-8719	
reference	0..1	SHOULD		1098-15970	
@value	0..1	SHOULD		1098-15971	
translation	0..1	MAY		1098-32323	
effectiveTime	1..1	SHALL		1098-8715	
sdtc:dischargeDispositionCode	0..1	MAY		1098-32176	
performer	0..*	MAY		1098-8725	
assignedEntity	1..1	SHALL		1098-8726	
code	0..1	MAY		1098-8727	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
participant	0..*	SHOULD		1098-8738	
@typeCode	1..1	SHALL		1098-8740	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = LOC
participantRole	1..1	SHALL		1098-14903	Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32
entryRelationship	0..*	MAY		1098-8722	

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@typeCode	1..1	SHALL		1098-8723	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-14899	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
entryRelationship	0..*	MAY		1098-15492	
act	1..1	SHALL		1098-15973	Encounter Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ENC" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8710).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-8711).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8712) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.49" (CONF:1098-26353).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32546).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8713).
5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **EncounterTypeCode** 2.16.840.1.113883.3.88.12.80.32 **DYNAMIC** (CONF:1098-8714).
    a. This code **SHOULD** contain zero or one [0..1] **originalText** (CONF:1098-8719).
        i. The originalText, if present, **SHOULD** contain zero or one [0..1] **reference** (CONF:1098-15970).
            1. The reference, if present, **SHOULD** contain zero or one [0..1] **@value** (CONF:1098-15971).
                a. 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:1098-15972).

The translation may exist to map the code of EncounterTypeCode (2.16.840.1.113883.3.88.12.80.32) valueset to the code of Encounter Planned (2.16.840.1.113883.11.20.9.52) valueset.

    b. This code **MAY** contain zero or one [0..1] **translation** (CONF:1098-32323).
6. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-8715).
7. **MAY** contain zero or one [0..1] **sdtc:dischargeDispositionCode** (CONF:1098-32176). Note: 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
    a. This sdtc:dischargeDispositionCode **SHALL** contain exactly [1..1] **@code**, which **SHALL** be selected from ValueSet 2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status (code system 2.16.840.1.113883.6.301.5) **DYNAMIC** or, if

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access to NUBC is unavailable, from CodeSystem 2.16.840.1.113883.12.112 HL7 Discharge Disposition (CONF:1098-32177).

b. This sdtc:dischargeDispositionCode **SHALL** contain exactly [1..1] **@codeSystem**, which **SHALL** be either CodeSystem: NUBC 2.16.840.1.113883.6.301.5 **OR** CodeSystem: HL7 Discharge Disposition 2.16.840.1.113883.12.112 (CONF:1098-32377).

8. **MAY** contain zero or more [0..*] **performer** (CONF:1098-8725).
   a. The performer, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-8726).
      i. This assignedEntity **MAY** 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:1098-8727).
9. **SHOULD** contain zero or more [0..*] **participant** (CONF:1098-8738) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode="**LOC**"** Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8740).
   b. **SHALL** contain exactly one [1..1] **Service Delivery Location** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32) (CONF:1098-14903).
10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-8722) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode="**RSON**"** Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8723).
    b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-14899).
11. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-15492) such that it
    a. **SHALL** contain exactly one [1..1] **Encounter Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09) (CONF:1098-15973).

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Table 270: EncounterTypeCode

Value Set: EncounterTypeCode 2.16.840.1.113883.3.88.12.80.32 This value set includes only the codes of the Current Procedure and Terminology designated for Evaluation and Management (99200 – 99607) (subscription to AMA Required Value Set Source: http://www.amacodingonline.com/			
Code	**Code System**	**Code System OID**	**Print Name**
99201	CPT4	2.16.840.1.113883.6.12	Office or other outpatient visit (problem focused)
99202	CPT4	2.16.840.1.113883.6.12	Office or other outpatient visit (expanded problem (expanded)
99203	CPT4	2.16.840.1.113883.6.12	Office or other outpatient visit (detailed)
99204	CPT4	2.16.840.1.113883.6.12	Office or other outpatient visit (comprehensive, (comprehensive - moderate)
99205	CPT4	2.16.840.1.113883.6.12	Office or other outpatient visit (comprehensive, comprehensive-high)
…			

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Figure 150: Encounter Activity (V2) Example

```
<encounter classCode="ENC" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.49" extension="2014-06-09" />
    <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>
        . . .
        </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" extension="2014-06-09" />

            . . .
        </observation>
    </entryRelationship>
</encounter>
```

4.23 Encounter Diagnosis (V2)

`[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09 (open)]`

Table 271: Encounter Diagnosis (V2) Contexts

Contained By:	**Contains:**
Encounter Activity (V2) (optional) Health Concern Act (optional) Risk Concern Act (optional)	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.

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Table 272: Encounter Diagnosis (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09)					
@classCode	1..1	SHALL		1098-14889	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-14890	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-14895	
@root	1..1	SHALL		1098-14896	2.16.840.1.113883.10.20.22.4.80
@extension	1..1	SHALL		1098-32542	2014-06-09
code	1..1	SHALL		1098-19182	
@code	1..1	SHALL		1098-19183	29308-4
@codeSystem	1..1	SHALL		1098-32160	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
entryRelationship	1..*	SHALL		1098-14892	
@typeCode	1..1	SHALL		1098-14893	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
observation	1..1	SHALL		1098-14898	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="`ACT`" (CodeSystem: `HL7ActClass` `2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-14889).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" (CodeSystem: `ActMood` `2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-14890).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-14895) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.80`" (CONF:1098-14896).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32542).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-19182).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`29308-4`" Diagnosis (CONF:1098-19183).
   b. 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:1098-32160).
5. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-14892) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-14893).

b. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-14898).

Figure 151: Encounter Diagnosis (V2) Example

```
<act classCode="ACT" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.80" extension="2014-06-09" />
    <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" extension="2014-06-09" />
            <!-- Problem Observation -->
          ...

        </observation>
    </entryRelationship>
</act>
```

4.24 Entry Reference

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.122 (open)]

Table 273: Entry Reference Contexts

Contained By:	Contains:
Goal Observation (optional) Health Concern Act (optional) Intervention Act (optional) Outcome Observation (optional) Risk Concern Act (optional) Planned Intervention Act (required)	

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. This template can be used to reference many types of Act class derivations, such as encounters, observations, procedures etc., as it is often necessary when authoring CDA documents to repeatedly reference other Acts of these types. For example, in a Care Plan it is necessary to repeatedly relate Health Concerns, Goals, Interventions and Outcomes.

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The id is required and must be the same id as the entry/id it is referencing. The id cannot be a null value. Act/Code is set to nullFlavor="NP" (Not Present). This means the value is not present in the message (in act/Code).

Table 274: Entry Reference Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122)					
@classCode	1..1	SHALL		1098-31485	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-31486	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-31487	
@root	1..1	SHALL		1098-31488	2.16.840.1.113883.10.20.22.4.122
id	1..*	SHALL		1098-31489	
code	1..1	SHALL		1098-31490	
@nullFlavor	1..1	SHALL		1098-31491	2.16.840.1.113883.5.1008 (HL7NullFlavor) = NP
statusCode	1..1	SHALL		1098-31498	
@code	0..1	MAY		1098-31499	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:1098-31485).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" (CodeSystem: `ActMood 2.16.840.1.113883.5.1001`) (CONF:1098-31486).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-31487) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.122`" (CONF:1098-31488).

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. The ID cannot have Null value (e.g., nullFlavor is not allowed).

4. **SHALL** contain at least one [1..*] **id** (CONF:1098-31489).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-31490).
    a. This code **SHALL** contain exactly one [1..1] **@nullFlavor**="`NP`" Not Present (CodeSystem: `HL7NullFlavor 2.16.840.1.113883.5.1008`) (CONF:1098-31491).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-31498).
    a. This statusCode **MAY** contain zero or one [0..1] **@code**="`completed`" (CodeSystem: `ActStatus 2.16.840.1.113883.5.14`) (CONF:1098-31499).

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Figure 152: Entry 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="75310-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Health Concern" />
  <statusCode code="active" />
  <effectiveTime value="20130616" />
  <entryRelationship typeCode="REFR">
    <!-- Problem Observation (V2) -->
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.4" extension="2014-06-09" />
      <id root="8dfacd73-1682-4cc4-9351-e54ccea83612" />
      <code code="29308-4"
            codeSystem="2.16.840.1.113883.6.1"
            codeSystemName="LOINC"
            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"
            displayName="Pneumonia" />
      <!-- This Entry Reference 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>
```


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```
  <!-- 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="71850-2"
          codeSystem="2.16.840.1.113883.6.1"
          codeSystemName="LOINC"
          displayName="Oxygen saturation [Pure mass fraction] in Capillary blood by
Oximetry"/>
    <statusCode code="active" />
    <value xsi:type="IVL_PQ">
      <low value="92" unit="%" />
    </value>
    <!-- There could be another Entry Reference here referring to the
            related health concern, actual outcome, or intervention -->
    ...

  </observation>
</entry>
...
```

Figure 153: Diagnosis Reference Example

```
<!-- Show how an encounter can include a discharge diagnosis which references an
       item on the problem list using the Entry 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" extension="2014-06-09" />
            <!-- 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 Entry Reference template. -->
            <entryRelationship typeCode="SUBJ">
                <act classCode="ACT" moodCode="XXX">
                    <templateId root="2.16.840.1.113883.10.20.22.4.122" />
                    <id root="1234567" />
                    <code nullFlavor="NP" />
                </act>
            </entryRelationship>
        </act>
    </entryRelationship>
</encounter>
```


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4.25 Estimated Date of Delivery

`[observation: identifier urn:oid:2.16.840.1.113883.10.20.15.3.1 (closed)]`

Table 275: Estimated Date of Delivery Contexts

Contained By:	Contains:
Pregnancy Observation (optional)	

This clinical statement represents the anticipated date when a woman will give birth.

Table 276: Estimated Date of Delivery Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.15.3.1)					
@classCode	1..1	SHALL		81-444	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-445	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-16762	
@root	1..1	SHALL		81-16763	2.16.840.1.113883.10.20.15.3.1
code	1..1	SHALL		81-19139	
@code	1..1	SHALL		81-19140	11778-8
@codeSystem	1..1	SHALL		81-26503	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		81-448	
@code	1..1	SHALL		81-19096	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..1	SHALL	TS	81-450	

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" Observation (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:81-444).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:81-445).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-16762) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.15.3.1`" (CONF:81-16763).
4. **SHALL** contain exactly one [1..1] **code** (CONF:81-19139).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`11778-8`" Estimated date of delivery (CONF:81-19140).

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b. 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:81-26503).

5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:81-448).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:81-19096).
6. **SHALL** contain exactly one [1..1] **value** with @xsi:type="TS" (CONF:81-450).

Figure 154: 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" value="20110919" />
</observation>
```

4.26 External Document Reference

[externalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09 (open)]

Table 277: External Document Reference Contexts

Contained By:	Contains:
Goal Observation (optional) Health Concern Act (optional) Intervention Act (optional) Outcome Observation (optional) Risk Concern Act (optional) Planned Intervention Act (optional)	

Where it is necessary to reference an external clinical document, the External Document Reference template can be used to reference this external document. However, if the containing document is replacing or appending to another document in the same set, that relationship is set in the header, using ClinicalDocument/relatedDocument.

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Table 278: External Document Reference Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
externalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09)					
@classCode	1..1	SHALL		1098-31931	2.16.840.1.113883.5.6 (HL7ActClass) = DOCCLIN
@moodCode	1..1	SHALL		1098-31932	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-32748	
@root	1..1	SHALL		1098-32750	2.16.840.1.113883.10.20.22.4.115
@extension	1..1	SHALL		1098-32749	2014-06-09
id	1..1	SHALL		1098-32751	
code	1..1	SHALL		1098-31933	
setId	0..1	SHOULD		1098-32752	
versionNumber	0..1	SHOULD		1098-32753	

1. **SHALL** contain exactly one [1..1] **@classCode**="DOCCLIN" Clinical Document (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-31931).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-31932).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-32748) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.115" (CONF:1098-32750).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32749).
4. **SHALL** contain exactly one [1..1] **id** (CONF:1098-32751).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-31933).
6. **SHOULD** contain zero or one [0..1] **setId** (CONF:1098-32752).
7. **SHOULD** contain zero or one [0..1] **versionNumber** (CONF:1098-32753).

4.27 Family History Death Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.47 (open)]

Table 279: Family History Death Observation Contexts

Contained By:	Contains:
Family History Observation (V2) (optional)	

This clinical statement records whether the family member is deceased.

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Table 280: Family History Death Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.47)					
@classCode	1..1	SHALL		81-8621	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-8622	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-8623	
@root	1..1	SHALL		81-10495	2.16.840.1.113883.10.20.22.4.47
code	1..1	SHALL		81-19141	
@code	1..1	SHALL		81-19142	ASSERTION
@codeSystem	1..1	SHALL		81-26504	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
statusCode	1..1	SHALL		81-8625	
@code	1..1	SHALL		81-19097	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..1	SHALL	CD	81-8626	
@code	1..1	SHALL		81-26470	2.16.840.1.113883.6.96 (SNOMED CT) = 419099009

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" Observation (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:81-8621).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:81-8622).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8623) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.47`" (CONF:81-10495).
4. **SHALL** contain exactly one [1..1] **code** (CONF:81-19141).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`ASSERTION`" Assertion (CONF:81-19142).
   b. 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:81-26504).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:81-8625).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="`completed`" Completed (CodeSystem: `ActStatus 2.16.840.1.113883.5.14` **STATIC**) (CONF:81-19097).
6. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD" (CONF:81-8626).

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a. This value **SHALL** contain exactly one [1..1] **@code**="419099009" Dead (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 **STATIC**) (CONF:81-26470).

Figure 155: 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>
```

4.28 Family History Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.46:2014-06-09 (open)]

Table 281: Family History Observation (V2) Contexts

Contained By:	Contains:
Family History Organizer (V2) (required)	Age Observation 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).

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Table 282: Family History Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.46:2014-06-09)					
@classCode	1..1	SHALL		1098-8586	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-8587	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-8599	
@root	1..1	SHALL		1098-10496	2.16.840.1.113883.10.20.22.4.46
@extension	1..1	SHALL		1098-32605	2014-06-09
id	1..*	SHALL		1098-8592	
code	1..1	SHALL		1098-32427	2.16.840.1.113883.3.88.12.3221.7.2 (Problem Type)
statusCode	1..1	SHALL		1098-8590	
@code	1..1	SHALL		1098-19098	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	0..1	SHOULD		1098-8593	
value	1..1	SHALL	CD	1098-8591	2.16.840.1.113883.3.88.12.3221.7.4 (Problem)
entryRelationship	0..1	MAY		1098-8675	
@typeCode	1..1	SHALL		1098-8676	2.16.840.1.113883.5.90 (HL7ParticipationType) = SUBJ
@inversionInd	1..1	SHALL		1098-8677	true
observation	1..1	SHALL		1098-15526	Age Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.31
entryRelationship	0..1	MAY		1098-8678	
@typeCode	1..1	SHALL		1098-8679	2.16.840.1.113883.5.90 (HL7ParticipationType) = CAUS
observation	1..1	SHALL		1098-15527	Family History Death Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.47

1. **SHALL** contain exactly one [1..1] `@classCode="OBS"` Observation (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-8586).

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2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-8587).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8599) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.46" (CONF:1098-10496).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32605).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8592).
5. **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** 2014-09-02 (CONF:1098-32427).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-8590).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19098).
7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-8593).
8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHALL** be selected from ValueSet **Problem** 2.16.840.1.113883.3.88.12.3221.7.4 **DYNAMIC** (CONF:1098-8591).
9. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-8675) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Subject (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-8676).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-8677).
    c. **SHALL** contain exactly one [1..1] **Age Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.31) (CONF:1098-15526).
10. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-8678) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="CAUS" Causal or Contributory (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-8679).
    b. **SHALL** contain exactly one [1..1] **Family History Death Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.47) (CONF:1098-15527).

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Table 283: Problem Type

Value Set: Problem Type 2.16.840.1.113883.3.88.12.3221.7.2 This value set indicates the level of medical judgment used to determine the existence of a problem. Value Set Source: http://www.loinc.org/			
Code	**Code System**	**Code System OID**	**Print Name**
75326-9	LOINC	2.16.840.1.113883.6.1	Problem HL7.CCDAR2
75325-1	LOINC	2.16.840.1.113883.6.1	Symptom HL7.CCDAR2
75324-4	LOINC	2.16.840.1.113883.6.1	Functional performance HL7.CCDAR2
75323-6	LOINC	2.16.840.1.113883.6.1	Functional performance HL7.CCDAR2
75323-6	LOINC	2.16.840.1.113883.6.1	Condition HL7.CCDAR2
29308-4	LOINC	2.16.840.1.113883.6.1	Diagnosis
75322-8	LOINC	2.16.840.1.113883.6.1	Complaint HL7.CCDAR2
75321-0	LOINC	2.16.840.1.113883.6.1	Clinical finding HL7.CCDAR2
75319-4	LOINC	2.16.840.1.113883.6.1	Cognitive function family member HL7.CCDAR2
75319-4	LOINC	2.16.840.1.113883.6.1	Cognitive function family member HL7.CCDAR2
…			

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Figure 156: Family History Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.46" extension="2014-06-09" />
    <!-- Family History Observation template -->
    <id root="d42ebf70-5c89-11db-b0de-0800200c9a66" />
    <code code="75315-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Condition Family Member"/>
    <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" />
             ....

        </observation>
    </entryRelationship>
</observation>
```

4.29 Family History Organizer (V2)

[organizer: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09 (open)]

Table 284: Family History Organizer (V2) Contexts

Contained By:	Contains:
Health Concern Act (optional) Risk Concern Act (optional) Family History Section (V2) (optional)	Family History Observation (V2)

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.

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Table 285: Family History Organizer (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
organizer (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09)					
@classCode	1..1	SHALL		1098-8600	2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER
@moodCode	1..1	SHALL		1098-8601	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-8604	
@root	1..1	SHALL		1098-10497	2.16.840.1.113883.10.20.22.4.45
@extension	1..1	SHALL		1098-32606	2014-06-09
id	1..*	SHALL		1098-32485	
statusCode	1..1	SHALL		1098-8602	
@code	1..1	SHALL		1098-19099	2.16.840.1.113883.5.14 (ActStatus) = completed
subject	1..1	SHALL		1098-8609	
relatedSubject	1..1	SHALL		1098-15244	
@classCode	1..1	SHALL		1098-15245	2.16.840.1.113883.5.41 (EntityClass) = PRS
code	1..1	SHALL		1098-15246	
@code	1..1	SHALL		1098-15247	2.16.840.1.113883.1.11.19579 (Family Member Value Set)
subject	0..1	SHOULD		1098-15248	
administrativeGenderCode	1..1	SHALL		1098-15974	
@code	1..1	SHALL		1098-15975	2.16.840.1.113883.1.11.1 (Administrative Gender (HL7 V3))
birthTime	0..1	SHOULD		1098-15976	
component	1..*	SHALL		1098-32428	
observation	1..1	SHALL		1098-32429	Family History Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.46:2014-06-09

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1. **SHALL** contain exactly one [1..1] **@classCode**="CLUSTER" Cluster (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8600).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-8601).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8604) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.45" (CONF:1098-10497).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32606).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-32485).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-8602).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19099).
6. **SHALL** contain exactly one [1..1] **subject** (CONF:1098-8609).
    a. This subject **SHALL** contain exactly one [1..1] **relatedSubject** (CONF:1098-15244).
        i. This relatedSubject **SHALL** contain exactly one [1..1] **@classCode**="PRS" Person (CodeSystem: EntityClass 2.16.840.1.113883.5.41 **STATIC**) (CONF:1098-15245).
        ii. This relatedSubject **SHALL** contain exactly one [1..1] **code** (CONF:1098-15246).
            1. This code **SHALL** contain exactly one [1..1] **@code**, which **SHOULD** be selected from ValueSet **Family Member Value Set** 2.16.840.1.113883.1.11.19579 **DYNAMIC** (CONF:1098-15247).
        iii. This relatedSubject **SHOULD** contain zero or one [0..1] **subject** (CONF:1098-15248).
            1. The subject, if present, **SHALL** contain exactly one [1..1] **administrativeGenderCode** (CONF:1098-15974).
                a. This administrativeGenderCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **Administrative Gender (HL7 V3)** 2.16.840.1.113883.1.11.1 **DYNAMIC** (CONF:1098-15975).
            2. The subject, if present, **SHOULD** contain zero or one [0..1] **birthTime** (CONF:1098-15976).
            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:1098-15249).
            4. The subject **MAY** contain zero or one [0..1] **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:1098-15981).
            5. The subject **MAY** contain zero or one [0..1] **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:1098-15982).

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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:1098-15983).

7. **SHALL** contain at least one [1..*] **component** (CONF:1098-32428).
   a. Such components **SHALL** contain exactly one [1..1] **Family History Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.46:2014-06-09) (CONF:1098-32429).

Table 286: 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 Value Set Source: **http://www.hl7.org**			
Code	**Code System**	**Code System OID**	**Print Name**
ADOPT	RoleCode	2.16.840.1.113883.5.111	adopted child
AUNT	RoleCode	2.16.840.1.113883.5.111	aunt
CHILD	RoleCode	2.16.840.1.113883.5.111	Child
CHLDINLAW	RoleCode	2.16.840.1.113883.5.111	child in-law
COUSN	RoleCode	2.16.840.1.113883.5.111	cousin
DOMPART	RoleCode	2.16.840.1.113883.5.111	domestic partner
FAMMEMB	RoleCode	2.16.840.1.113883.5.111	Family Member
CHLDFOST	RoleCode	2.16.840.1.113883.5.111	foster child
GRNDCHILD	RoleCode	2.16.840.1.113883.5.111	grandchild
GRPRN	RoleCode	2.16.840.1.113883.5.111	Grandparent
…			

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Figure 157: Family History Organizer (V2) Example

```
<organizer moodCode="EVN" classCode="CLUSTER">
    <templateId root="2.16.840.1.113883.10.20.22.4.45" extension="2014-06-09" />
    <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 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>
```

4.30 Functional Status Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09 (open)]

Table 287: Functional Status Observation (V2) Contexts

Contained By:	Contains:
Health Concern Act (optional) Functional Status Section (V2) (optional) Functional Status Organizer (V2) (required) Risk Concern Act (optional)	Assessment Scale Observation Author Participation Caregiver Characteristics Non-Medicinal Supply Activity (V2)

This template represents the patient's physical function (e.g., mobility status, instrumental 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.

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Table 288: Functional Status Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09)					
@classCode	1..1	SHALL		1098-13905	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-13906	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-13889	
@root	1..1	SHALL		1098-13890	2.16.840.1.113883.10.20.22.4.67
@extension	1..1	SHALL		1098-32568	2014-06-09
id	1..*	SHALL		1098-13907	
code	1..1	SHALL		1098-13908	
@code	1..1	SHALL		1098-31522	54522-8
@codeSystem	1..1	SHALL		1098-31523	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-13929	
@code	1..1	SHALL		1098-19101	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-13930	
value	1..1	SHALL		1098-13932	
author	0..*	SHOULD		1098-13936	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..1	MAY		1098-13892	
@typeCode	1..1	SHALL		1098-14596	REFR
supply	1..1	SHALL		1098-14218	Non-Medicinal Supply Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09
entryRelationship	0..1	MAY		1098-13895	
@typeCode	1..1	SHALL		1098-14597	REFR
observation	1..1	SHALL		1098-13897	Caregiver Characteristics (identifier:

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					urn:oid:2.16.840.1.113883.10.20.22.4.72
entryRelationship	0..1	MAY		1098-14465	
@typeCode	1..1	SHALL		1098-14598	COMP
observation	1..1	SHALL		1098-14466	Assessment Scale Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69
referenceRange	0..*	MAY		1098-13937	

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-13905).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-13906).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-13889) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.67" (CONF:1098-13890).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32568).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-13907).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-13908).
   a. This code **SHALL** contain exactly one [1..1] **@code**="54522-8" Functional status (CONF:1098-31522).
   b. 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:1098-31523).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-13929).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19101).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-13930).
8. **SHALL** contain exactly one [1..1] **value** (CONF:1098-13932).
   a. If xsi:type="CD", **SHOULD** contain a code from SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:1098-14234).
9. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-13936).
10. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-13892) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" refers to (CONF:1098-14596).
    b. **SHALL** contain exactly one [1..1] **Non-Medicinal Supply Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09) (CONF:1098-14218).
11. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-13895) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" refers to (CONF:1098-14597).

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b. **SHALL** contain exactly one [1..1] **Caregiver Characteristics** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72) (CONF:1098-13897).

12. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-14465) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" has component (CONF:1098-14598).
    b. **SHALL** contain exactly one [1..1] **Assessment Scale Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69) (CONF:1098-14466).

referenceRange could be used to represent normal or expected capability for the function being evaluated.

13. **MAY** contain zero or more [0..*] **referenceRange** (CONF:1098-13937).

Figure 158: Functional Status Observation (V2) Example

```
<entry>
    <observation classCode="OBS" moodCode="EVN">
        <!-- Functional Status Observation V2-->
        <templateId root="2.16.840.1.113883.10.20.22.4.67" extension="2014-06-09" />
        <id root="ce7cfb78-bd16-467e-8bcf-859a3034108e" />
        <code code="54522-8" displayName="Functional status"
codeSystem="2.16.840.1.113883.6.1" 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" />
    </observation>
</entry>
```

4.31 Functional Status Organizer (V2)

[organizer: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.66:2014-06-09 (open)]

Table 289: Functional Status Organizer (V2) Contexts

Contained By:	Contains:
Functional Status Section (V2) (optional)	Author Participation Functional Status Observation (V2) Self-Care Activities (ADL and IADL)

This template groups related functional status observations into categories (e.g., mobility, self-care).

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Table 290: Functional Status Organizer (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
organizer (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.66:2014-06-09)					
@classCode	1..1	SHALL		1098-14355	2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER
@moodCode	1..1	SHALL		1098-14357	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-14361	
@root	1..1	SHALL		1098-14362	2.16.840.1.113883.10.20.22.4.66
@extension	1..1	SHALL		1098-32569	2014-06-09
id	1..*	SHALL		1098-14363	
code	1..1	SHALL		1098-14364	
statusCode	1..1	SHALL		1098-14358	
@code	1..1	SHALL		1098-31434	2.16.840.1.113883.5.14 (ActStatus) = completed
author	0..*	SHOULD		1098-31585	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
component	1..*	SHALL		1098-14359	
observation	1..1	SHALL		1098-14368	Functional Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09
component	1..*	SHALL		1098-31432	
observation	1..1	SHALL		1098-31433	Self-Care Activities (ADL and IADL) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.128

1. **SHALL** contain exactly one [1..1] **@classCode**="`CLUSTER`" Cluster (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6`) (CONF:1098-14355).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-14357).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-14361) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.66`" (CONF:1098-14362).
    b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32569).

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4. **SHALL** contain at least one [1..*] **id** (CONF:1098-14363).

The code selected should indicate the category that groups the contained functional status evaluation observations (e.g., mobility, self-care, communication).

5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-14364).
    a. **SHOULD** be selected from ICF (codeSystem 2.16.840.1.113883.6.254) **OR** LOINC (2.16.840.1.113883.6.1) (CONF:1098-31417).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-14358).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="`completed`" (CodeSystem: `ActStatus 2.16.840.1.113883.5.14`) (CONF:1098-31434).
7. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: `urn:oid:2.16.840.1.113883.10.20.22.4.119`) (CONF:1098-31585).
8. **SHALL** contain at least one [1..*] **component** (CONF:1098-14359) such that it
    a. **SHALL** contain exactly one [1..1] **Functional Status Observation (V2)** (identifier: `urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09`) (CONF:1098-14368).
9. **SHALL** contain at least one [1..*] **component** (CONF:1098-31432) such that it
    a. **SHALL** contain exactly one [1..1] **Self-Care Activities (ADL and IADL)** (identifier: `urn:oid:2.16.840.1.113883.10.20.22.4.128`) (CONF:1098-31433).

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Figure 159: Functional Status Organizer (V2) Example

```
<organizer classCode="CLUSTER" moodCode="EVN">
    <!-- Functional Status Organizer V2-->
    <templateId root="2.16.840.1.113883.10.20.22.4.66" extension="2014-06-09" />
    <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" extension="2014-06-09" />
            ...
        </observation>
    </component>
    <component>
        <observation classCode="OBS" moodCode="EVN">
            <!-- Functional Status Observation V2-->
            <templateId root="2.16.840.1.113883.10.20.22.4.67" extension="2014-06-09" />
            ...
        </observation>
    </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" />
            ...
        </observation>
    </component>
</organizer>
```


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4.32 Functional Status Problem Observation (DEPRECATED)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.68:2014-06-09 (open)]

Table 291: Functional Status Problem Observation (DEPRECATED) Contexts

Contained By:	Contains:
Functional Status Section (V2) (optional)	

A functional status problem observation is a clinical statement that represents a patient's functional perfomance and ability.

THIS TEMPLATE HAS BEEN DEPRECATED IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED.

Reason for deprecation: Functional Status Problem Observation has been merged, without loss of expressivity, into Functional Status Observation (2.16.840.1.113883.10.20.22.4.67:2014-06-09).

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Table 292: Functional Status Problem Observation (DEPRECATED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.68:2014-06-09)					
@classCode	1..1	SHALL		1098-14282	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-14283	2.16.840.1.113883.5.1001 (ActMood) = EVN
@negationInd	0..1	MAY		1098-14307	
templateId	1..1	SHALL		1098-14312	
@root	1..1	SHALL		1098-14313	2.16.840.1.113883.10.20.22.4.68
@extension	1..1	SHALL		1098-32601	2014-06-09
id	1..*	SHALL		1098-14284	
code	1..1	SHALL		1098-14314	
@code	0..1	SHOULD		1098-14315	2.16.840.1.113883.6.96 (SNOMED CT) = 248536006
text	0..1	SHOULD		1098-14304	
reference	0..1	SHOULD		1098-15552	
@value	0..1	SHOULD		1098-15553	
statusCode	1..1	SHALL		1098-14286	
@code	1..1	SHALL		1098-19100	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	0..1	SHOULD		1098-14287	
low	1..1	SHALL		1098-26456	
high	0..1	MAY		1098-26457	
value	1..1	SHALL	CD	1098-14291	2.16.840.1.113883.3.88.12.3221.7.4 (Problem)
@nullFlavor	0..1	MAY		1098-14292	
methodCode	0..1	MAY		1098-14316	

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1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-14282).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-14283).

Use negationInd="true" to indicate that the problem was not observed.

3. **MAY** contain zero or one [0..1] **@negationInd** (CONF:1098-14307).
4. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-14312) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.68" (CONF:1098-14313).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32601).
5. **SHALL** contain at least one [1..*] **id** (CONF:1098-14284).
6. **SHALL** contain exactly one [1..1] **code** (CONF:1098-14314).
    a. 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:1098-14315).
7. **SHOULD** contain zero or one [0..1] **text** (CONF:1098-14304).
    a. The text, if present, **SHOULD** contain zero or one [0..1] **reference** (CONF:1098-15552).
        i. The reference, if present, **SHOULD** contain zero or one [0..1] **@value** (CONF:1098-15553).
            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:1098-15554).
8. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-14286).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19100).
9. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-14287).

The value of effectiveTime/low represents onset date.

    a. The effectiveTime, if present, **SHALL** contain exactly one [1..1] **low** (CONF:1098-26456).

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.

    b. The effectiveTime, if present, **MAY** contain zero or one [0..1] **high** (CONF:1098-26457).
10. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **Problem** 2.16.840.1.113883.3.88.12.3221.7.4 **DYNAMIC** (CONF:1098-14291).
    a. This value **MAY** contain zero or one [0..1] **@nullFlavor** (CONF:1098-14292).
        i. If the diagnosis is unknown or the SNOMED code is unknown, @nullFlavor **SHOULD** be “UNK”. If the diagnosis is known but the code cannot be found in the Value Set, @nullFlavor **SHOULD** be “OTH” and the known diagnosis code **SHOULD** be placed in the translation element (CONF:1098-14293).

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11. **MAY** contain zero or one [0..1] **methodCode** (CONF:1098-14316).

4.33 Goal Observation

`[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.121 (open)]`

Table 293: Goal Observation Contexts

Contained By:	Contains:
Plan of Treatment Section (V2) (optional) Goals Section (required)	Author Participation Entry Reference External Document Reference Goal Observation Priority Preference

This template represents a patient health 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 may have components consisting of other goals (milestones). These milestones are related to the overall goal through entryRelationships.

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Table 294: Goal Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.121)					
@classCode	1..1	SHALL		1098-30418	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-30419	2.16.840.1.113883.5.1001 (ActMood) = GOL
templateId	1..1	SHALL		1098-8583	
@root	1..1	SHALL		1098-10512	2.16.840.1.113883.10.20.22.4.121
id	1..*	SHALL		1098-32332	
code	1..1	SHALL		1098-30784	2.16.840.1.113883.6.1 (LOINC)
statusCode	1..1	SHALL		1098-32333	
@code	1..1	SHALL		1098-32334	2.16.840.1.113883.5.14 (ActStatus) = active
effectiveTime	0..1	SHOULD		1098-32335	
value	0..1	MAY		1098-32743	
author	1..*	SHALL		1098-30995	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-30701	
@typeCode	1..1	SHALL		1098-30702	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-30703	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
entryRelationship	0..*	MAY		1098-30704	
@typeCode	1..1	SHALL		1098-30705	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
act	1..1	SHALL		1098-32879	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
entryRelationship	0..1	SHOULD		1098-30785	
@typeCode	1..1	SHALL		1098-30786	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-	Priority Preference (identifier:

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				30787	urn:oid:2.16.840.1.113883.10.20.22.4.143
entryRelationship	0..*	MAY		1098-31448	
@typeCode	1..1	SHALL		1098-31449	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
observation	1..1	SHALL		1098-32880	Goal Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.121
entryRelationship	0..*	MAY		1098-31559	
@typeCode	1..1	SHALL		1098-31560	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-31588	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
reference	0..*	MAY		1098-32754	
@typeCode	1..1	SHALL		1098-32755	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
externalDocument	1..1	SHALL		1098-32756	External Document Reference (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-30418).
2. **SHALL** contain exactly one [1..1] **@moodCode**="GOL" Goal (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-30419).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8583) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.121" (CONF:1098-10512).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-32332).
5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from CodeSystem LOINC (2.16.840.1.113883.6.1) (CONF:1098-30784).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-32333).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="active" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-32334).
7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-32335).
8. **MAY** contain zero or one [0..1] **value** (CONF:1098-32743).

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.

9. **SHALL** contain at least one [1..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-30995).

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The following entryRelationship represents the relationship between a Goal Observation and a Health Concern Act (Goal Observation REFERS TO Health Concern Act). As Health Concern Act is already defined in Health Concerns Section, rather than clone the whole Health Concern Act template, an Entry Reference may be used in entryRelationship to refer the template.

10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-30701) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-30702).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-30703).

The following entryRelationship represents a planned component of the goal such as Planned Encounter (V2), Planned Observation (V2), Planned Procedure (V2), Planned Medication Activity (V2), Planned Supply (V2), Planned Act (V2) or Planned Immunization Activity. Because these entries are already described in the Interventions Section of the CDA document instance, rather than repeating the full content of the entries, the Entry Reference template may be used to reference the entries.

11. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-30704) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-30705).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-32879).

The following entryRelationship represents the priority that the patient or a provider puts on the goal.

12. **SHOULD** contain zero or one [0..1] **entryRelationship** (CONF:1098-30785) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-30786).
    b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-30787).

The following 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.

13. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31448) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31449).
    b. **SHALL** contain exactly one [1..1] **Goal Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.121) (CONF:1098-32880).

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 Entry Reference template may be used to reference this entry.

14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31559) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31560).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-31588).

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Where it is necessary to reference an external clinical document such a Referral document, Discharge Summary document etc., the External Document Reference template can be used to reference this document. However, if this Care Plan document is replacing or appending another Care Plan document in the same set, that relationship is set in the header, using ClinicalDocument/relatedDocument.

15. **MAY** contain zero or more [0..*] **reference** (CONF:1098-32754).
    a. The reference, if present, **SHALL** contain exactly one [1..1] `@typeCode="REFR"` Refers to (CodeSystem: `HL7ActRelationshipType 2.16.840.1.113883.5.1002`) (CONF:1098-32755).
    b. The reference, if present, **SHALL** contain exactly one [1..1] **External Document Reference** (identifier: `urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09`) (CONF:1098-32756).

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Figure 160: Goal Observation Example

```
<observation classCode="OBS" moodCode="GOL">
  <templateId root="2.16.840.1.113883.10.20.22.4.121" />
  <id root="3700b3b0-fbed-11e2-b778-0800200c9a66" />
  <code code="44616-1"
        codeSystem="2.16.840.1.113883.6.1"
        codeSystemName="LOINC"
        displayName="Pulse oximetry panel" />
  <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>
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    ...
  </author>
  <!-- Patient Author -->
  <author typeCode="AUT">
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    ...
  </author>
  <!-- This entryRelationship represents the relationship "Goal REFERS TO Health Concern" -
->
  <entryRelationship typeCode="REFR">
    <!-- Entry 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" />
      ...
    </act>
  </entryRelationship>
  <!-- Priority Preference -->
  <entryRelationship typeCode="RSON">
    <!-- Priority Preference - this is the preference that the patient
      (specified by the Author Participation template)
                  places on the Goal -->
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.143" />
      ...
    </observation>
  </entryRelationship>
  <!--  Priority Preference - this is the preference that the provider
    (specified by the Author Participation template)
     places on the Goal -->
  <entryRelationship typeCode="RSON">
    <!--  Priority Preference -->
    <observation classCode="OBS" moodCode="EVN">
```


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```
      <templateId root="2.16.840.1.113883.10.20.22.4.143" />
      ...
    </observation>
  </entryRelationship>
</observation>
```

4.34 Handoff Communication Participants

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.141 (open)]

Table 295: Handoff Communication Participants Contexts

Contained By:	Contains:
Plan of Treatment Section (V2) (optional) Interventions Section (V2) (optional) Intervention Act (optional) Planned Intervention Act (optional)	Author Participation

This template represents the sender (author) and receivers (participants) of a handoff communication in a plan of treatment. It does not convey details about the communication. The "handoff" 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.

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Table 296: Handoff Communication Participants Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141)					
@classCode	1..1	SHALL		1098-30832	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-30833	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-30834	
@root	1..1	SHALL		1098-30835	2.16.840.1.113883.10.20.22.4.141
code	1..1	SHALL		1098-30836	
@code	1..1	SHALL		1098-30837	432138007
@codeSystem	1..1	SHALL		1098-30838	2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
statusCode	1..1	SHALL		1098-31668	
@code	1..1	SHALL		1098-31669	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-31670	
author	1..*	SHALL		1098-31672	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	1..*	SHALL		1098-31673	
@typeCode	1..1	SHALL		1098-31674	2.16.840.1.113883.5.110 (RoleClass) = IRCP
participantRole	1..1	SHALL		1098-31675	
id	1..*	SHALL		1098-32422	
code	0..1	SHOULD		1098-31676	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
addr	1..*	SHALL		1098-32392	
playingEntity	0..1	MAY		1098-32393	
name	1..*	SHALL		1098-32394	

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1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-30832).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-30833).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30834) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.141" (CONF:1098-30835).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-30836).
    a. This code **SHALL** contain exactly one [1..1] **@code**="432138007" handoff communication (procedure) (CONF:1098-30837).
    b. 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:1098-30838).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-31668).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31669).

The effective time is the time when the handoff process took place between the sender and receiver of the patient information. This could be the time the information was transmitted, released, or verbally communicated to the next clinician.

6. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-31670).

The Author Participant contains the sender's contact information and is a resource for the Information Recipient for any follow-up questions.

7. **SHALL** contain at least one [1..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31672).

Documentation of the Information Recipient's name and address verifies that the information was exchanged.

8. **SHALL** contain at least one [1..*] **participant** (CONF:1098-31673) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="IRCP" Information Recipient (CodeSystem: RoleClass 2.16.840.1.113883.5.110) (CONF:1098-31674).
    b. **SHALL** contain exactly one [1..1] **participantRole** (CONF:1098-31675).
        i. This participantRole **SHALL** contain at least one [1..*] **id** (CONF:1098-32422).
        ii. 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:1098-31676).
        iii. This participantRole **SHALL** contain at least one [1..*] **addr** (CONF:1098-32392).
        iv. This participantRole **MAY** contain zero or one [0..1] **playingEntity** (CONF:1098-32393).
            1. The playingEntity, if present, **SHALL** contain at least one [1..*] **name** (CONF:1098-32394).

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Figure 161: 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" />
              ...
            </assignedAuthor>
        </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>
```


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4.35 Health Concern Act

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.132 (open)]

Table 297: Health Concern Act Contexts

Contained By:	Contains:
Health Concerns Section (required)	Allergy - Intolerance Observation (V2) Assessment Scale Observation Author Participation Caregiver Characteristics Characteristics of Home Environment Cultural and Religious Observation Encounter Diagnosis (V2) Entry Reference External Document Reference Family History Organizer (V2) Functional Status Observation (V2) Hospital Admission Diagnosis (V2) Longitudinal Care Wound Observation Mental Status Observation (V2) Nutrition Assessment Nutritional Status Observation Postprocedure Diagnosis (V2) Pregnancy Observation Preoperative Diagnosis (V2) Priority Preference Problem Concern Act (V2) Problem Observation (V2) Reaction Observation (V2) Result Observation (V2) Result Organizer (V2) Self-Care Activities (ADL and IADL) Sensory Status Smoking Status - Meaningful Use (V2) Social History Observation (V2) Substance or Device Allergy - Intolerance Observation (V2) Tobacco Use (V2) Vital Sign Observation (V2)

This template represents a health concern.

It is a wrapper for a single health concern which may be 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 is used to track non-optimal physical or psychological situations drawing the patient to the healthcare system. These may be from the perspective of the care team or from the perspective of the patient.

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When the underlying condition is of concern (i.e., as long as the condition, whether active or resolved, is of ongoing concern and interest), 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, a prior heart attack may remain a concern).

Health concerns require intervention(s) to increase the likelihood of achieving the goals of care for the patient and they specify the condition oriented reasons for creating the plan.

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Table 298: Health Concern Act Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.132)					
@classCode	1..1	SHALL		1098-30750	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-30751	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-30752	
@root	1..1	SHALL		1098-30753	2.16.840.1.113883.10.20.22.4.132
id	1..*	SHALL		1098-30754	
code	1..1	SHALL		1098-32310	
@code	1..1	SHALL		1098-32311	75310-3
@codeSystem	1..1	SHALL		1098-32312	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-30758	
@code	1..1	SHALL		1098-32313	2.16.840.1.113883.11.20.9.19 (ProblemAct statusCode)
effectiveTime	0..1	MAY		1098-30759	
author	0..*	SHOULD		1098-31546	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-30761	
@typeCode	1..1	SHALL		1098-30762	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31001	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09
entryRelationship	0..*	MAY		1098-31007	
@typeCode	1..1	SHALL		1098-31008	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31186	Allergy - Intolerance Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09
entryRelationship	0..*	MAY		1098-31157	

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@typeCode	1..1	SHALL		1098-31158	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32106	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
entryRelationship	0..*	MAY		1098-31160	
@typeCode	1..1	SHALL		1098-31161	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
act	1..1	SHALL		1098-32107	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
entryRelationship	0..*	MAY		1098-31190	
@typeCode	1..1	SHALL		1098-31191	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31192	Assessment Scale Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69
entryRelationship	0..*	MAY		1098-31232	
@typeCode	1..1	SHALL		1098-31264	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31265	Self-Care Activities (ADL and IADL) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.128
entryRelationship	0..*	MAY		1098-31234	
@typeCode	1..1	SHALL		1098-31268	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31273	Mental Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09
entryRelationship	0..*	MAY		1098-31235	
@typeCode	1..1	SHALL		1098-31269	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31275	Smoking Status - Meaningful Use (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09
entryRelationship	0..*	MAY		1098-31236	
@typeCode	1..1	SHALL		1098-31270	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR

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act	1..1	SHALL		1098-31277	Encounter Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09
entryRelationship	0..*	MAY		1098-31237	
@typeCode	1..1	SHALL		1098-31279	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
organizer	1..1	SHALL		1098-31280	Family History Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09
entryRelationship	0..*	MAY		1098-31238	
@typeCode	1..1	SHALL		1098-31282	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31283	Functional Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09
entryRelationship	0..*	MAY		1098-31241	
@typeCode	1..1	SHALL		1098-31291	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-31292	Hospital Admission Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09
entryRelationship	0..*	MAY		1098-31244	
@typeCode	1..1	SHALL		1098-31300	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31301	Nutrition Assessment (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.138
entryRelationship	0..*	MAY		1098-31246	
@typeCode	1..1	SHALL		1098-31306	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-31307	Postprocedure Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09
entryRelationship	0..*	MAY		1098-31247	
@typeCode	1..1	SHALL		1098-31309	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31310	Pregnancy Observation (identifier: urn:oid:2.16.840.1.113883.10.20.

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					15.3.8
entryRelationship	0..*	MAY		1098-31248	
@typeCode	1..1	SHALL		1098-31312	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-31313	Preoperative Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09
entryRelationship	0..*	MAY		1098-31250	
@typeCode	1..1	SHALL		1098-31318	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31319	Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09
entryRelationship	0..*	MAY		1098-31251	
@typeCode	1..1	SHALL		1098-31321	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31322	Result Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09
entryRelationship	0..*	MAY		1098-31252	
@typeCode	1..1	SHALL		1098-31324	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31325	Sensory Status (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.127
entryRelationship	0..*	MAY		1098-31253	
@typeCode	1..1	SHALL		1098-31327	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31328	Social History Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09
entryRelationship	0..*	MAY		1098-31254	
typeId	0..1	MAY		1098-31330	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31331	Substance or Device Allergy - Intolerance Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.3.90:2014-06-09

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entryRelationship	0..*	MAY		1098-31255	
@typeCode	1..1	SHALL		1098-31333	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31334	Tobacco Use (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09
entryRelationship	0..*	MAY		1098-31256	
@typeCode	1..1	SHALL		1098-31336	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31337	Vital Sign Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09
entryRelationship	0..*	MAY		1098-31257	
@typeCode	1..1	SHALL		1098-31339	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31340	Longitudinal Care Wound Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.114
entryRelationship	0..*	MAY		1098-31365	
@typeCode	1..1	SHALL		1098-31366	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT
observation	1..1	SHALL		1098-31367	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09
entryRelationship	0..*	MAY		1098-31368	
@typeCode	1..1	SHALL		1098-31369	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31370	Caregiver Characteristics (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72
entryRelationship	0..*	MAY		1098-31371	
@typeCode	1..1	SHALL		1098-31372	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31373	Cultural and Religious Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.111
entryRelationship	0..*	MAY		1098-31374	

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@typeCode	1..1	SHALL		1098-31375	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31376	Characteristics of Home Environment (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.109
entryRelationship	0..*	MAY		1098-31377	
@typeCode	1..1	SHALL		1098-31378	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31379	Nutritional Status Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.124
entryRelationship	0..*	MAY		1098-31380	
@typeCode	1..1	SHALL		1098-31381	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
organizer	1..1	SHALL		1098-31382	Result Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09
entryRelationship	0..*	MAY		1098-31442	
@typeCode	1..1	SHALL		1098-31443	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31444	Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143
entryRelationship	0..*	MAY		1098-31544	
@typeCode	1..1	SHALL		1098-31547	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-31548	Problem Concern Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09
entryRelationship	0..*	MAY		1098-31549	
@typeCode	1..1	SHALL		1098-31550	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-31551	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
reference	0..*	MAY		1098-32757	
@typeCode	1..1	SHALL		1098-32758	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
externalDocument	1..1	SHALL		1098-32759	External Document Reference (identifier:

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					urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-30750).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-30751).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30752) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.132" (CONF:1098-30753).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-30754).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-32310).
    a. This code **SHALL** contain exactly one [1..1] **@code**="75310-3" Health Concern (CONF:1098-32311).
    b. 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:1098-32312).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-30758).
    a. 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** 2014-03-24 (CONF:1098-32313).
7. **MAY** contain zero or one [0..1] **effectiveTime** (CONF:1098-30759).

A health concern may be a patient or provider concern. If the author is set to the recordTarget (patient), this is a patient concern. If the author is set to a provider, this is a provider concern. If both patient and provider are set as authors, this is a concern of both the patient and the provider.

8. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31546).
9. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-30761) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-30762).
    b. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-31001).
10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31007) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31008).
    b. **SHALL** contain exactly one [1..1] **Allergy - Intolerance Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09) (CONF:1098-31186).

The following entryRelationship represents the relationship between two Health Concern Acts where there is a general relationship between the source and the target (Health Concern REFERS TO Health Concern). For example, a patient has 2 health concerns identified in a CARE Plan: Failure to Thrive and Poor Feeding, while it could be that one may have caused the

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other, at the time of care planning and documentation it is not necessary, nor desirable to have to assert what caused what. The Entry Reference template is used here because the target Health Concern Act will be defined elsewhere in the Health Concerns Section and thus a reference to that template is all that is required.

11. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31157) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31158).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-32106).
        i. The Entry Reference template **SHALL** contain an id that references a Health Concern Act (CONF:1098-32744).

The following entryRelationship represents the relationship between two Health Concern Acts where the target is a component of the source (Health Concern HAS COMPONENT Health Concern). For example, a patient has an Impaired Mobility Health Concern. There may then be the need to document several component health concerns, such as "Unable to Transfer Bed to Chair", "Unable to Rise from Commode", "Short of Breath Walking with Walker". The Entry Reference template is used here because the target Health Concern Act will be defined elsewhere in the Health Concerns Section and thus a reference to that template is all that is required.

12. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31160) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31161).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-32107).
        i. The Entry Reference template **SHALL** contain an id that references a Health Concern Act (CONF:1098-32745).

13. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31190) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31191).
    b. **SHALL** contain exactly one [1..1] **Assessment Scale Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69) (CONF:1098-31192).
14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31232) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31264).
    b. **SHALL** contain exactly one [1..1] **Self-Care Activities (ADL and IADL)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.128) (CONF:1098-31265).
15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31234) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31268).
    b. **SHALL** contain exactly one [1..1] **Mental Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09) (CONF:1098-31273).
16. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31235) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31269).
b. **SHALL** contain exactly one [1..1] **Smoking Status - Meaningful Use (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09) (CONF:1098-31275).

17. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31236) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31270).
    b. **SHALL** contain exactly one [1..1] **Encounter Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09) (CONF:1098-31277).
18. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31237) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers To (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31279).
    b. **SHALL** contain exactly one [1..1] **Family History Organizer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09) (CONF:1098-31280).
19. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31238) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31282).
    b. **SHALL** contain exactly one [1..1] **Functional Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09) (CONF:1098-31283).
20. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31241) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31291).
    b. **SHALL** contain exactly one [1..1] **Hospital Admission Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09) (CONF:1098-31292).
21. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31244) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31300).
    b. **SHALL** contain exactly one [1..1] **Nutrition Assessment** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.138) (CONF:1098-31301).
22. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31246) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31306).
    b. **SHALL** contain exactly one [1..1] **Postprocedure Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09) (CONF:1098-31307).
23. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31247) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31309).
    b. **SHALL** contain exactly one [1..1] **Pregnancy Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.15.3.8) (CONF:1098-31310).

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24. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31248) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31312).
    b. **SHALL** contain exactly one [1..1] **Preoperative Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09) (CONF:1098-31313).
25. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31250) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31318).
    b. **SHALL** contain exactly one [1..1] **Reaction Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09) (CONF:1098-31319).
26. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31251) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31321).
    b. **SHALL** contain exactly one [1..1] **Result Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09) (CONF:1098-31322).
27. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31252) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31324).
    b. **SHALL** contain exactly one [1..1] **Sensory Status** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.127) (CONF:1098-31325).
28. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31253) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31327).
    b. **SHALL** contain exactly one [1..1] **Social History Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09) (CONF:1098-31328).
29. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31254) such that it
    a. **MAY** contain zero or one [0..1] **typeId**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31330).
    b. **SHALL** contain exactly one [1..1] **Substance or Device Allergy - Intolerance Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.3.90:2014-06-09) (CONF:1098-31331).
30. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31255) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31333).
    b. **SHALL** contain exactly one [1..1] **Tobacco Use (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09) (CONF:1098-31334).
31. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31256) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31336).

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b. **SHALL** contain exactly one [1..1] **Vital Sign Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09) (CONF:1098-31337).

32. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31257) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31339).
    b. **SHALL** contain exactly one [1..1] **Longitudinal Care Wound Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.114) (CONF:1098-31340).

The following entryRelationship represents the relationship Health Concern HAS SUPPORT Observation.

33. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31365) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SPRT" Has support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31366).
    b. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-31367).
34. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31368) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31369).
    b. **SHALL** contain exactly one [1..1] **Caregiver Characteristics** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72) (CONF:1098-31370).
35. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31371) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31372).
    b. **SHALL** contain exactly one [1..1] **Cultural and Religious Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.111) (CONF:1098-31373).
36. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31374) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31375).
    b. **SHALL** contain exactly one [1..1] **Characteristics of Home Environment** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.109) (CONF:1098-31376).
37. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31377) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31378).
    b. **SHALL** contain exactly one [1..1] **Nutritional Status Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.124) (CONF:1098-31379).
38. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31380) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31381).

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b. **SHALL** contain exactly one [1..1] **Result Organizer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09) (CONF:1098-31382).

The following entryRelationship represents the priority that the patient or a provider puts on the health concern.

39. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31442) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31443).
    b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31444).
40. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31544) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31547).
    b. **SHALL** contain exactly one [1..1] **Problem Concern Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09) (CONF:1098-31548).

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 Entry Reference template may be used to reference this entry.

41. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31549) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31550).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-31551).

Where it is necessary to reference an external clinical document such a Referral document, Discharge Summary document etc., the External Document Reference template can be used to reference this document. However, if this Care Plan document is replacing or appending another Care Plan document in the same set, that relationship is set in the header, using ClinicalDocument/relatedDocument.

42. **MAY** contain zero or more [0..*] **reference** (CONF:1098-32757).
    a. The reference, if present, **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32758).
    b. The reference, if present, **SHALL** contain exactly one [1..1] **External Document Reference** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09) (CONF:1098-32759).

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Figure 162: Health Concern Act 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="75310-3"
        codeSystem="2.16.840.1.113883.6.1"
        codeSystemName="LOINC"
        displayName="Health Concern" />
  <!-- This Health Concern has a statusCode 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 (V2) -->
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.85" extension="2014-06-09" />
      ...
    </observation>
  </entryRelationship>
  <!-- Health Concern Problem: Respiratory insufficiency -->
  <entryRelationship typeCode="REFR">
    <!-- Problem Observation (V2) -->
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.4" extension="2014-06-09" />
      ...
    </observation>
  </entryRelationship>
  <!-- Health Concern Diagnosis: Pneumonia -->
  <entryRelationship typeCode="REFR">
    <!-- Problem Observation (V2) -->
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.4" extension="2014-06-09" />
      ...
    </observation>
  </entryRelationship>
  <!--
        This is an entry relationship of the SPRT (support) type which shows
        that 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 (V2) -->
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.4" extension="2014-06-09" />
      ...
    </observation>
  </entryRelationship>
  <!-- Priority Preference -->
  <entryRelationship typeCode="RSON">
    <!-- Priority Preference - this is the preference that the patient
      (specified by the Author Participation template)
```


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```
       places on the Health Concern -->
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.143" />
      ...
    </observation>
  </entryRelationship>
  <!--  Priority Preference - this is the preference that the provider
    (specified by the Author Participation template)
     places on the Health Concern -->
  <entryRelationship typeCode="RSON">
    <!--  Priority Preference -->
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.143" />
      ...
    </observation>
  </entryRelationship>
</act>
```

4.36 Health Status Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09 (open)]

Table 299: Health Status Observation (V2) Contexts

Contained By:	Contains:
Health Concerns Section (optional) Problem Section (entries required) (V2) (optional) 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.

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Table 300: Health Status Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09)					
@classCode	1..1	SHALL		1098-9057	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-9072	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-16756	
@root	1..1	SHALL		1098-16757	2.16.840.1.113883.10.20.22.4.5
@extension	1..1	SHALL		1098-32558	2014-06-09
id	1..*	SHALL		1098-32486	
code	1..1	SHALL		1098-19143	
@code	1..1	SHALL		1098-19144	11323-3
@codeSystem	1..1	SHALL		1098-32161	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-9074	
@code	1..1	SHALL		1098-19103	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..1	SHALL	CD	1098-9075	2.16.840.1.113883.1.11.20.12 (HealthStatus)

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-9057).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-9072).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16756) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.5" (CONF:1098-16757).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32558).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-32486).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-19143).
   a. This code **SHALL** contain exactly one [1..1] **@code**="11323-3" Health status (CONF:1098-19144).
   b. 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:1098-32161).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-9074).

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a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19103).

7. **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:1098-9075).

Table 301: HealthStatus

Value Set: HealthStatus 2.16.840.1.113883.1.11.20.12 Represents the general health status of the patient. Value Set Source: **https://www.hl7.org/**			
Code	**Code System**	**Code System OID**	**Print Name**
81323004	SNOMED CT	2.16.840.1.113883.6.96	Alive and well
313386006	SNOMED CT	2.16.840.1.113883.6.96	In remission
162467007	SNOMED CT	2.16.840.1.113883.6.96	Symptom free
161901003	SNOMED CT	2.16.840.1.113883.6.96	Chronically ill
271593001	SNOMED CT	2.16.840.1.113883.6.96	Severely ill
21134002	SNOMED CT	2.16.840.1.113883.6.96	Disabled
161045001	SNOMED CT	2.16.840.1.113883.6.96	Severely disabled
419099009	SNOMED CT	2.16.840.1.113883.6.96	Deceased
135818000	SNOMED CT	2.16.840.1.113883.6.96	General health poor
135815002	SNOMED CT	2.16.840.1.113883.6.96	General health good
…			

Figure 163: Health Status Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.5" extension="2014-06-09"/>
    <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>
```

4.37 Highest Pressure Ulcer Stage

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.77 (open)]

Table 302: Highest Pressure Ulcer Stage Contexts

Contained By:	**Contains:**
Longitudinal Care Wound Observation (optional)	

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This observation contains a description of the wound tissue of the most severe or highest staged pressure ulcer observed on a patient.

Table 303: Highest Pressure Ulcer Stage Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.77)					
@classCode	1..1	SHALL		81-14726	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-14727	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-14728	
@root	1..1	SHALL		81-14729	2.16.840.1.113883.10.20.22.4.77
id	1..*	SHALL		81-14730	
code	1..1	SHALL		81-14731	
@code	1..1	SHALL		81-14732	2.16.840.1.113883.6.96 (SNOMED CT) = 420905001
value	1..1	SHALL		81-14733	

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-14726).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-14727).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-14728) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.77" (CONF:81-14729).
4. **SHALL** contain at least one [1..*] **id** (CONF:81-14730).
5. **SHALL** contain exactly one [1..1] **code** (CONF:81-14731).
    a. 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:81-14732).
6. **SHALL** contain exactly one [1..1] **value** (CONF:81-14733).

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Figure 164: 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>
```

4.38 Hospital Admission Diagnosis (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09 (open)]

Table 304: Hospital Admission Diagnosis (V2) Contexts

Contained By:	Contains:
Health Concern Act (optional) Admission Diagnosis Section (V2) (optional) Risk Concern Act (optional)	Problem Observation (V2)

This template represents problems or diagnoses identified by the clinician at the time of the patient's admission.

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Table 305: Hospital Admission Diagnosis (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09)					
@classCode	1..1	SHALL		1098-7671	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-7672	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-16747	
@root	1..1	SHALL		1098-16748	2.16.840.1.113883.10.20.22.4.34
@extension	1..1	SHALL		1098-32535	2014-06-09
code	1..1	SHALL		1098-19145	
@code	1..1	SHALL		1098-19146	46241-6
@codeSystem	1..1	SHALL		1098-32162	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
entryRelationship	1..*	SHALL		1098-7674	
@typeCode	1..1	SHALL		1098-7675	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
observation	1..1	SHALL		1098-15535	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7671).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7672).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16747) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.34" (CONF:1098-16748).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32535).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-19145).
   a. This code **SHALL** contain exactly one [1..1] **@code**="46241-6" Admission diagnosis (CONF:1098-19146).
   b. 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:1098-32162).
5. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-7674) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7675).

b. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-15535).

Figure 165: Hospital Admission Diagnosis (V2) Example

```
<act classCode="ACT" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.34" extension="2014-06-09"/>
    <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>
```

4.39 Hospital Discharge Diagnosis (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.33:2014-06-09 (open)]

Table 306: Hospital Discharge Diagnosis (V2) Contexts

Contained By:	Contains:
Discharge Diagnosis Section (V2) (optional)	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.

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Table 307: Hospital Discharge Diagnosis (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.33:2014-06-09)					
@classCode	1..1	SHALL		1098-7663	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-7664	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-16764	
@root	1..1	SHALL		1098-16765	2.16.840.1.113883.10.20.22.4.33
@extension	1..1	SHALL		1098-32534	2014-06-09
code	1..1	SHALL		1098-19147	
@code	1..1	SHALL		1098-19148	11535-2
@codeSystem	1..1	SHALL		1098-32163	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
entryRelationship	1..*	SHALL		1098-7666	
@typeCode	1..1	SHALL		1098-7667	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
observation	1..1	SHALL		1098-15536	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7663).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7664).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16764) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.33" (CONF:1098-16765).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32534).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-19147).
   a. This code **SHALL** contain exactly one [1..1] **@code**="11535-2" Hospital discharge diagnosis (CONF:1098-19148).
   b. 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:1098-32163).
5. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-7666) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7667).

b. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-15536).

Figure 166: Hospital Discharge Diagnosis (V2) Example

```
<act classCode="ACT" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.33" extension="2014-06-09"/>
    <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>
```

4.40 Immunization Activity (V2)

[substanceAdministration: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09 (open)]

Table 308: Immunization Activity (V2) Contexts

Contained By:	Contains:
Immunizations Section (entries optional) (V2) (optional) Immunizations Section (entries required) (V2) (required) Intervention Act (optional) Planned Intervention Act (optional)	Author Participation Drug Vehicle Immunization Medication Information (V2) Immunization Refusal Reason Indication (V2) Instruction (V2) Medication Dispense (V2) Medication Supply Order (V2) Precondition for Substance Administration (V2) Reaction Observation (V2) Substance Administered Act

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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. (Reference: **http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/D/vacc_admin.pdf**)

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Table 309: Immunization Activity (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
substanceAdministration (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09)					
@classCode	1..1	SHALL		1098-8826	2.16.840.1.113883.5.6 (HL7ActClass) = SBADM
@moodCode	1..1	SHALL		1098-8827	2.16.840.1.113883.11.20.9.18 (MoodCodeEvnInt)
@negationInd	0..1	MAY		1098-8985	
templateId	1..1	SHALL		1098-8828	
@root	1..1	SHALL		1098-10498	2.16.840.1.113883.10.20.22.4.52
@extension	1..1	SHALL		1098-32528	2014-06-09
id	1..*	SHALL		1098-8829	
code	0..1	MAY		1098-8830	
statusCode	1..1	SHALL		1098-8833	
@code	1..1	SHALL		1098-32359	2.16.840.1.113883.1.11.159331 (ActStatus)
effectiveTime	1..1	SHALL		1098-8834	
repeatNumber	0..1	MAY		1098-8838	
routeCode	0..1	MAY		1098-8839	2.16.840.1.113883.3.88.12.3221.8.7 (Medication Route FDA)
approachSiteCode	0..1	MAY	SET<CD>	1098-8840	2.16.840.1.113883.3.88.12.3221.8.9 (Body Site)
doseQuantity	0..1	SHOULD		1098-8841	
@unit	0..1	SHOULD		1098-8842	2.16.840.1.113883.1.11.12839 (UnitsOfMeasureCaseSensitive)
administrationUnitCode	0..1	MAY		1098-8846	2.16.840.1.113883.1.11.14570 (AdministrableDrugForm)
consumable	1..1	SHALL		1098-8847	
manufacturedProduct	1..1	SHALL		1098-15546	Immunization Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09
performer	0..1	SHOULD		1098-8849	
author	0..*	SHOUL		1098-	Author Participation (identifier:

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		D		31151	urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	0..*	MAY		1098-8850	
@typeCode	1..1	SHALL		1098-8851	2.16.840.1.113883.5.90 (HL7ParticipationType) = CSM
participantRole	1..1	SHALL		1098-15547	Drug Vehicle (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.24
entryRelationship	0..*	MAY		1098-8853	
@typeCode	1..1	SHALL		1098-8854	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-15537	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
entryRelationship	0..1	MAY		1098-8856	
@typeCode	1..1	SHALL		1098-8857	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
@inversionInd	1..1	SHALL		1098-8858	true
act	1..1	SHALL		1098-31392	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
entryRelationship	0..1	MAY		1098-8860	
@typeCode	1..1	SHALL		1098-8861	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
supply	1..1	SHALL		1098-15539	Medication Supply Order (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09
entryRelationship	0..1	MAY		1098-8863	
@typeCode	1..1	SHALL		1098-8864	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
supply	1..1	SHALL		1098-15540	Medication Dispense (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.18:2014-06-09
entryRelationship	0..1	MAY		1098-8866	
@typeCode	1..1	SHALL		1098-8867	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = CAUS
observation	1..1	SHALL		1098-15541	Reaction Observation (V2) (identifier:

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					urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09
entryRelationship	0..1	MAY		1098-8988	
@typeCode	1..1	SHALL		1098-8989	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-15542	Immunization Refusal Reason (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.53
entryRelationship	0..*	SHOULD		1098-31510	
@typeCode	1..1	SHALL		1098-31511	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
@inversionInd	1..1	SHALL		1098-31512	true
sequenceNumber	0..1	MAY		1098-31513	
act	1..1	SHALL		1098-31514	Substance Administered Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.118
precondition	0..*	MAY		1098-8869	
@typeCode	1..1	SHALL		1098-8870	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = PRCN
criterion	1..1	SHALL		1098-15548	Precondition for Substance Administration (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="SBADM" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8826).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **MoodCodeEvnInt** 2.16.840.1.113883.11.20.9.18 **STATIC** 2014-09-01 (CONF:1098-8827).
3. **MAY** contain zero or one [0..1] **@negationInd** (CONF:1098-8985).
   Note: Use negationInd="true" to indicate that the immunization was not given.
4. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8828) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.52" (CONF:1098-10498).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32528).
5. **SHALL** contain at least one [1..*] **id** (CONF:1098-8829).
6. **MAY** contain zero or one [0..1] **code** (CONF:1098-8830).
   Note: 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

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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.

7. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-8833).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ActStatus** 2.16.840.1.113883.1.11.159331 **DYNAMIC** (CONF:1098-32359).
8. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-8834).

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. 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.

9. **MAY** contain zero or one [0..1] **repeatNumber** (CONF:1098-8838).
10. **MAY** contain zero or one [0..1] **routeCode**, which **SHALL** be selected from ValueSet **Medication Route FDA** 2.16.840.1.113883.3.88.12.3221.8.7 **DYNAMIC** (CONF:1098-8839).
11. **MAY** contain zero or one [0..1] **approachSiteCode**, where the code **SHALL** be selected from ValueSet **Body Site** 2.16.840.1.113883.3.88.12.3221.8.9 **DYNAMIC** (CONF:1098-8840).
12. **SHOULD** contain zero or one [0..1] **doseQuantity** (CONF:1098-8841).
    a. The doseQuantity, if present, **SHOULD** contain zero or one [0..1] **@unit**, which **SHALL** be selected from ValueSet **UnitsOfMeasureCaseSensitive** 2.16.840.1.113883.1.11.12839 **DYNAMIC** (CONF:1098-8842).
13. **MAY** contain zero or one [0..1] **administrationUnitCode**, which **SHALL** be selected from ValueSet **AdministrableDrugForm** 2.16.840.1.113883.1.11.14570 **DYNAMIC** (CONF:1098-8846).
14. **SHALL** contain exactly one [1..1] **consumable** (CONF:1098-8847).
    a. This consumable **SHALL** contain exactly one [1..1] **Immunization Medication Information (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09) (CONF:1098-15546).
15. **SHOULD** contain zero or one [0..1] **performer** (CONF:1098-8849).
16. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31151).
17. **MAY** contain zero or more [0..*] **participant** (CONF:1098-8850) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="CSM" (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-8851).
    b. **SHALL** contain exactly one [1..1] **Drug Vehicle** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.24) (CONF:1098-15547).
18. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-8853) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8854).

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b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-15537).

19. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-8856) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8857).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-8858).
    c. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31392).
20. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-8860) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8861).
    b. **SHALL** contain exactly one [1..1] **Medication Supply Order (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09) (CONF:1098-15539).
21. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-8863) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8864).
    b. **SHALL** contain exactly one [1..1] **Medication Dispense (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.18:2014-06-09) (CONF:1098-15540).
22. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-8866) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="CAUS" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8867).
    b. **SHALL** contain exactly one [1..1] **Reaction Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09) (CONF:1098-15541).
23. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-8988) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8989).
    b. **SHALL** contain exactly one [1..1] **Immunization Refusal Reason** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.53) (CONF:1098-15542).

The following entryRelationship is used to indicate a given immunization's order in a series. The nested Substance Administered Act identifies an administration in the series. The entryRelationship/sequenceNumber shows the order of this particular administration in that series.

24. **SHOULD** contain zero or more [0..*] **entryRelationship** (CONF:1098-31510) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31511).

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b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" (CONF:1098-31512).

c. **MAY** contain zero or one [0..1] **sequenceNumber** (CONF:1098-31513).

d. **SHALL** contain exactly one [1..1] **Substance Administered Act** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.118) (CONF:1098-31514).

25. **MAY** contain zero or more [0..*] **precondition** (CONF:1098-8869) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="PRCN" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8870).

b. **SHALL** contain exactly one [1..1] **Precondition for Substance Administration (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09) (CONF:1098-15548).

Table 310: MoodCodeEvnInt

Value Set: MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 Contains moodCode EVN and INT Value Set Source: **http://www.hl7.org**			
Code	**Code System**	**Code System OID**	**Print Name**
EVN	ActMood	2.16.840.1.113883.5.1001	Event
INT	ActMood	2.16.840.1.113883.5.1001	Intent

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Table 311: Medication Route FDA

Value Set: Medication Route FDA 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). Specific URL Pending Value Set Source: http://ushik.ahrq.gov/ViewItemDetails?system=mdr&itemKey=84244000			
Code	**Code System**	**Code System OID**	**Print Name**
C38192	FDA RouteOfAdministration	2.16.840.1.113883.3.26.1.1	AURICULAR (OTIC)
C38193	FDA RouteOfAdministration	2.16.840.1.113883.3.26.1.1	BUCCAL
C38194	FDA RouteOfAdministration	2.16.840.1.113883.3.26.1.1	CONJUNCTIVAL
C38675	FDA RouteOfAdministration	2.16.840.1.113883.3.26.1.1	CUTANEOUS
C38197	FDA RouteOfAdministration	2.16.840.1.113883.3.26.1.1	DENTAL
C38633	FDA RouteOfAdministration	2.16.840.1.113883.3.26.1.1	ELECTRO-OSMOSIS
C38205	FDA RouteOfAdministration	2.16.840.1.113883.3.26.1.1	ENDOCERVICAL
C38206	FDA RouteOfAdministration	2.16.840.1.113883.3.26.1.1	ENDOSINUSIAL
C38208	FDA RouteOfAdministration	2.16.840.1.113883.3.26.1.1	ENDOTRACHEAL
C38209	FDA RouteOfAdministration	2.16.840.1.113883.3.26.1.1	ENTERAL
…			

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Table 312: Body Site

Value Set: Body Site 2.16.840.1.113883.3.88.12.3221.8.9 Contains values descending from the SNOMED CT® Anatomical Structure (91723000) hierarchy or Acquired body structure (body structure) (280115004) or Anatomical site notations for tumor staging (body structure) (258331007) or Body structure, altered from its original anatomical structure (morphologic abnormality) (118956008) or Physical anatomical entity (body structure) (91722005) This indicates the anatomical site. Specific URL Pending Value Set Source: https://vsac.nlm.nih.gov			
Code	**Code System**	**Code System OID**	**Print Name**
362783006	SNOMED CT	2.16.840.1.113883.6.96	entire medial surface of lower extremity (body structure)
302539009	SNOMED CT	2.16.840.1.113883.6.96	entire hand (body structure)
287679003	SNOMED CT	2.16.840.1.113883.6.96	left hip region structure (body structure)
3341006	SNOMED CT	2.16.840.1.113883.6.96	right lung structure (body structure)
87878005	SNOMED CT	2.16.840.1.113883.6.96	left ventricular structure (body structure)
49848007	SNOMED CT	2.16.840.1.113883.6.96	structure of myocardium of left ventricle (body structure)
38033009	SNOMED CT	2.16.840.1.113883.6.96	amputation stump (body structure)
305005006	SNOMED CT	2.16.840.1.113883.6.96	6/7 interchondral joint (body structure)
28726007	SNOMED CT	2.16.840.1.113883.6.96	corneal structure (body structure)
75324005	SNOMED CT	2.16.840.1.113883.6.96	70 to 79 percent of body surface (body structure)
…			

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Table 313: UnitsOfMeasureCaseSensitive

Value Set: UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 The UCUM code system provides a set of structural units from which working codes are built. There is an unlimited number of possible valid UCUM codes. Value Set Source: http://unitsofmeasure.org/ucum.html			
Code	**Code System**	**Code System OID**	**Print Name**
min	UCUM	2.16.840.1.113883.6.8	minute
hour	UCUM	2.16.840.1.113883.6.8	hr
%	UCUM	2.16.840.1.113883.6.8	percent
cm	UCUM	2.16.840.1.113883.6.8	centimeter
g	UCUM	2.16.840.1.113883.6.8	gram
g/(12.h)	UCUM	2.16.840.1.113883.6.8	gram per 12 hour
g/L	UCUM	2.16.840.1.113883.6.8	gram per liter
mol	UCUM	2.16.840.1.113883.6.8	mole
[IU]	UCUM	2.16.840.1.113883.6.8	international unit
Hz	UCUM	2.16.840.1.113883.6.8	Hertz
…			

Table 314: AdministrableDrugForm

Value Set: AdministrableDrugForm 2.16.840.1.113883.1.11.14570 Indicates the form in which the drug product should be administered. Value Set Source: http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html			
Code	**Code System**	**Code System OID**	**Print Name**
PUFF	orderableDrugForm	2.16.840.1.113883.5.85	Puff
SCOOP	orderableDrugForm	2.16.840.1.113883.5.85	Scoops
APPFUL	orderableDrugForm	2.16.840.1.113883.5.85	Applicatorful
DROP	orderableDrugForm	2.16.840.1.113883.5.85	Drops
SPRY	orderableDrugForm	2.16.840.1.113883.5.85	Sprays
…			

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Figure 167: Immunization Activity (V2) Example

```
<substanceAdministration classCode="SBADM" moodCode="EVN">
    <!-- ** Immunization activity ** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.52" extension="2014-06-09" />
    <id root="e6f1ba43-c0ed-4b9b-9f12-f435d8ad8f92" />
    <statusCode code="completed" />
    <effectiveTime value="19981215" />
    <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="ug" />
    <consumable>
        <manufacturedProduct classCode="MANU">
            <!-- ** Immunization medication information ** -->
            <templateId root="2.16.840.1.113883.10.20.22.4.54" extension="2014-06-09" />
            <manufacturedMaterial>
                <code code="33" codeSystem="2.16.840.1.113883.6.59"
displayName="Pneumococcal polysaccharide vaccine" codeSystemName="CVX">
                <translation code="854981" displayName="Pneumovax 23 (Pneumococcal vaccine
polyvalent) Injectable Solution" codeSystemName="RxNORM"
codeSystem="2.16.840.1.113883.6.88" />
                </code>
                <lotNumberText>1</lotNumberText>
            </manufacturedMaterial>
            <manufacturerOrganization>
                <name>Health LS - Immuno Inc.</name>
            </manufacturerOrganization>
        </manufacturedProduct>
    </consumable>
    <performer>
        <assignedEntity>
            <id root="2.16.840.1.113883.19.5.9999.456" extension="2981824" />
            <addr>
                <streetAddressLine>1007 Health Drive</streetAddressLine>
                <city>Portland</city>
                <state>OR</state>
                <postalCode>99123</postalCode>
                <country>US</country>
            </addr>
            <telecom use="WP" value="tel: +(555)-555-1030" />
            <assignedPerson>
                <name>
                    <given>Harold</given>
                    <family>Hippocrates</family>
                </name>
            </assignedPerson>
            <representedOrganization>
                <id root="2.16.840.1.113883.19.5.9999.1394" />
                <name>Good Health Clinic</name>
                <telecom use="WP" value="tel: +(555)-555-1030" />
                <addr>
                    <streetAddressLine>1007 Health Drive</streetAddressLine>
                    <city>Portland</city>
                    <state>OR</state>
                    <postalCode>99123</postalCode>
                    <country>US</country>
```


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```
                </addr>
            </representedOrganization>
        </assignedEntity>
    </performer>
</substanceAdministration>
```

4.41 Immunization Medication Information (V2)

```
[manufacturedProduct: identifier
urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09 (open)]
```

Table 315: Immunization Medication Information (V2) Contexts

Contained By:	Contains:
Immunization Activity (V2) (required) Planned Supply (V2) (optional) Medication Supply Order (V2) (optional) Medication Dispense (V2) (optional) Planned Immunization Activity (required)	

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.

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Table 316: Immunization Medication Information (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
manufacturedProduct (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09)					
@classCode	1..1	SHALL		1098-9002	2.16.840.1.113883.5.110 (RoleClass) = MANU
templateId	1..1	SHALL		1098-9004	
@root	1..1	SHALL		1098-10499	2.16.840.1.113883.10.20.22.4.54
@extension	1..1	SHALL		1098-32602	2014-06-09
id	0..*	MAY		1098-9005	
manufacturedMaterial	1..1	SHALL		1098-9006	
code	1..1	SHALL		1098-9007	2.16.840.1.113762.1.4.1010.6 (CVX Vaccines Administered - Vaccine Set)
translation	0..*	MAY		1098-31543	2.16.840.1.113762.1.4.1010.8 (Vaccine Clinical Drug)
translation	0..*	MAY		1098-31881	2.16.840.1.113762.1.4.1010.10 (Specific Vaccine Clinical Drug)
lotNumberText	1..1	SHALL		1098-9014	
manufacturerOrganization	0..1	SHOULD		1098-9012	

1. **SHALL** contain exactly one [1..1] **@classCode**="MANU" (CodeSystem: RoleClass 2.16.840.1.113883.5.110 **STATIC**) (CONF:1098-9002).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-9004) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.54" (CONF:1098-10499).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32602).
3. **MAY** contain zero or more [0..*] **id** (CONF:1098-9005).
4. **SHALL** contain exactly one [1..1] **manufacturedMaterial** (CONF:1098-9006).
   a. This manufacturedMaterial **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet **CVX Vaccines Administered - Vaccine Set** 2.16.840.1.113762.1.4.1010.6 **DYNAMIC** (CONF:1098-9007).
      i. This code **MAY** contain zero or more [0..*] **translation**, which **MAY** be selected from ValueSet **Vaccine Clinical Drug** 2.16.840.1.113762.1.4.1010.8 **DYNAMIC** (CONF:1098-31543).
      ii. This code **MAY** contain zero or more [0..*] **translation**, which **MAY** be selected from ValueSet **Specific Vaccine Clinical Drug** 2.16.840.1.113762.1.4.1010.10 **DYNAMIC** (CONF:1098-31881).

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b. This manufacturedMaterial **SHALL** contain exactly one [1..1] **lotNumberText** (CONF:1098-9014).

5. **SHOULD** contain zero or one [0..1] **manufacturerOrganization** (CONF:1098-9012).

Table 317: CVX Vaccines Administered - Vaccine Set

Value Set: CVX Vaccines Administered - Vaccine Set 2.16.840.1.113762.1.4.1010.6 CVX vaccine concepts that represent actual vaccines types. This does not include the identifiers for CVX codes that do not represent vaccines. Value set intensionally defined from CVX (OID: 2.16.840.1.113883.12.292) FilterOnProperty(nonvaccine,FALSE). Value Set Source: https://vsac.nlm.nih.gov/			
Code	**Code System**	**Code System OID**	**Print Name**
19	CDC Vaccine Code (CVX)	2.16.840.1.113883.12.292	BCG
26	CDC Vaccine Code (CVX)	2.16.840.1.113883.12.292	Cholera
24	CDC Vaccine Code (CVX)	2.16.840.1.113883.12.292	Anthrax
27	CDC Vaccine Code (CVX)	2.16.840.1.113883.12.292	Botulinum antitoxin
…			

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Table 318: Vaccine Clinical Drug

Value Set: Vaccine Clinical Drug 2.16.840.1.113762.1.4.1010.8 Administrable vaccine medication formulations represented using either a "generic" or "brand-specific" concept. Value set intensionally defined from RXNORM (OID: 2.16.840.1.113883.6.88), comprised of those codes whose ingredients map to NDC codes that the CDC associates with CVX codes. Value Set Source: https://vsac.nlm.nih.gov/			
Code	**Code System**	**Code System OID**	**Print Name**
898572	RxNorm	2.16.840.1.113883.6.88	0.17 ML Rho(D) Immune Globulin 0.3 MG/ML Prefilled Syringe [HyperRHO]
807276	RxNorm	2.16.840.1.113883.6.88	0.5 ML diphtheria toxoid vaccine, inactivated 4 UNT/ML / tetanus toxoid vaccine, inactivated 10 UNT/ML Prefilled Syringe [Decavac]
798482	RxNorm	2.16.840.1.113883.6.88	0.5 ML Hepatitis A Vaccine (Inactivated) Strain HM175 1440 UNT/ML Prefilled Syringe [Havrix]
836636	RxNorm	2.16.840.1.113883.6.88	0.5 ML Hepatitis A Vaccine, Inactivated 50 UNT/ML Prefilled Syringe [Vaqta]
…			

Table 319: Specific Vaccine Clinical Drug

Value Set: Specific Vaccine Clinical Drug 2.16.840.1.113762.1.4.1010.10 This value set contains extensionally identified RxNorm vaccine codes. It should be used to supplement the Vaccine Clinical Drug Value Set (Value Set OID 2.16.840.1.113762.1.4.1010.8). Intensional rules for the latter value set are being refined, but at this time lack complete sensitivity, and as a result can miss including relevant codes. This Specific Vaccine Clinical Drug Value Set is used to manually provide for these other RxNorm codes. (At the time of Consolidated CDA R2 publication, the value set has no members) Value Set Source: https://vsac.nlm.nih.gov/			
Code	**Code System**	**Code System OID**	**Print Name**
NA	RxNorm	2.16.840.1.113883.6.88	At the time of Consolidated CDA R2 publication, the value set has no members
…			

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Figure 168: Immunization Medication Information (V2) Example

```
<manufacturedProduct classCode="MANU">
    <!-- ** Immunization medication information ** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.54" extension="2014-06-09" />
    <manufacturedMaterial>
        <code code="33" codeSystem="2.16.840.1.113883.6.59" displayName="Pneumococcal
polysaccharide vaccine" codeSystemName="CVX">
            <translation code="854981" displayName="Pneumovax 23 (Pneumococcal vaccine
polyvalent) Injectable Solution" codeSystemName="RxNORM"
codeSystem="2.16.840.1.113883.6.88" />
        </code>
        <lotNumberText>1</lotNumberText>
    </manufacturedMaterial>
    <manufacturerOrganization>
        <name>Health LS - Immuno Inc.</name>
    </manufacturerOrganization>
</manufacturedProduct>
```

4.42 Immunization Refusal Reason

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.53 (open)]

Table 320: Immunization Refusal Reason Contexts

Contained By:	**Contains:**
Immunization Activity (V2) (optional)	

The Immunization Refusal Reason documents the rationale for the patient declining an immunization.

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Table 321: Immunization Refusal Reason Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.53)					
@classCode	1..1	SHALL		81-8991	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-8992	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-8993	
@root	1..1	SHALL		81-10500	2.16.840.1.113883.10.20.22.4.53
id	1..*	SHALL		81-8994	
code	1..1	SHALL		81-8995	2.16.840.1.113883.1.11.19717 (No Immunization Reason Value Set)
statusCode	1..1	SHALL		81-8996	
@code	1..1	SHALL		81-19104	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:81-8991).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-8992).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-8993) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.53" (CONF:81-10500).
4. **SHALL** contain at least one [1..*] **id** (CONF:81-8994).
5. **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet **No Immunization Reason Value Set** 2.16.840.1.113883.1.11.19717 **DYNAMIC** (CONF:81-8995).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:81-8996).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:81-19104).

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Table 322: No Immunization Reason Value Set

Value Set: No Immunization Reason Value Set 2.16.840.1.113883.1.11.19717 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
IMMUNE	ActReason	2.16.840.1.113883.5.8	Immunity
MEDPREC	ActReason	2.16.840.1.113883.5.8	Medical precaution
OSTOCK	ActReason	2.16.840.1.113883.5.8	Out of stock
PATOBJ	ActReason	2.16.840.1.113883.5.8	Patient objection
PHILISOP	ActReason	2.16.840.1.113883.5.8	Philosophical objection
RELIG	ActReason	2.16.840.1.113883.5.8	Religious objection
VACEFF	ActReason	2.16.840.1.113883.5.8	Vaccine efficacy concerns
VACSAF	ActReason	2.16.840.1.113883.5.8	Vaccine safety concerns

Figure 169: 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>
```


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4.43 Indication (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09 (open)]

Table 323: Indication (V2) Contexts

Contained By:	Contains:
Medication Activity (V2) (optional) Procedure Activity Act (V2) (optional) Procedure Activity Procedure (V2) (optional) Procedure Activity Observation (V2) (optional) Immunization Activity (V2) (optional) Encounter Activity (V2) (optional) Planned Act (V2) (optional) Planned Encounter (V2) (optional) Planned Procedure (V2) (optional) Planned Observation (V2) (optional) Planned Supply (V2) (optional) Planned Medication Activity (V2) (optional) Procedure Indications Section (V2) (optional) Patient Referral Act (optional) Planned Immunization Activity (optional)	

This template represents the rationale for an action such as an encounter, a medication administration, or a procedure. The id element can be used to reference a problem recorded elsewhere in the document, or can be used with a code and value to record the problem. Indications for treatment are not laboratory results; rather the problem associated with the laboratory result should be sited (e.g., hypokalemia instead of a laboratory 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 (V2) [templateId 2.16.840.1.113883.10.20.22.4.25.2] to represent that a medication is to be administered only when the associated criteria are met.

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Table 324: Indication (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09)					
@classCode	1..1	SHALL		1098-7480	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-7481	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7482	
@root	1..1	SHALL		1098-10502	2.16.840.1.113883.10.20.22.4.19
@extension	1..1	SHALL		1098-32570	2014-06-09
id	1..*	SHALL		1098-7483	
code	1..1	SHALL		1098-31229	2.16.840.1.113883.3.88.12.3221.7.2 (Problem Type)
statusCode	1..1	SHALL		1098-7487	
@code	1..1	SHALL		1098-19105	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	0..1	SHOULD		1098-7488	
value	0..1	MAY	CD	1098-7489	2.16.840.1.113883.3.88.12.3221.7.4 (Problem)

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7480).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7481).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7482) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.19" (CONF:1098-10502).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32570).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-7483).
   Note: If the id element is used to reference a problem recorded else where in the document then this 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.
5. **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 **STATIC** 2014-09-02 (CONF:1098-31229).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7487).

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a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19105).

7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-7488).
8. **MAY** contain zero or one [0..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **Problem** 2.16.840.1.113883.3.88.12.3221.7.4 **DYNAMIC** (CONF:1098-7489).

Figure 170: Indication (V2) Example

```
<entry typeCode="DRIV">
    <substanceAdministration classCode="SBADM" moodCode="EVN">
        <templateId root="2.16.840.1.113883.10.20.22.4.16" extension="2014-06-09" />
        <!-- ** 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" extension="2014-06-09"
/>
<!-- 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>
    ...
    </substanceAdministration>
</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"/> -->
```


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4.44 Instruction (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09 (open)]

Table 325: Instruction (V2) Contexts

Contained By:	Contains:
Medication Activity (V2) (optional) Plan of Treatment Section (V2) (optional) Procedure Activity Act (V2) (optional) Procedure Activity Procedure (V2) (optional) Procedure Activity Observation (V2) (optional) Non-Medicinal Supply Activity (V2) (optional) Immunization Activity (V2) (optional) Planned Act (V2) (optional) Planned Procedure (V2) (optional) Planned Observation (V2) (optional) Planned Supply (V2) (optional) Planned Medication Activity (V2) (optional) Medication Supply Order (V2) (optional) Intervention Act (optional) Instructions Section (V2) (required) Planned Immunization Activity (optional) Planned Intervention Act (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 template's moodCode can only be INT. If an instruction was already be given, the Procedure Activity Act template (instead of this template) should be used to represent the already occurred instruction. 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.

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Table 326: Instruction (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09)					
@classCode	1..1	SHALL		1098-7391	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-7392	2.16.840.1.113883.5.1001 (ActMood) = INT
templateId	1..1	SHALL		1098-7393	
@root	1..1	SHALL		1098-10503	2.16.840.1.113883.10.20.22.4.20
@extension	1..1	SHALL		1098-32598	2014-06-09
code	1..1	SHALL		1098-16884	2.16.840.1.113883.11.20.9.34 (Patient Education)
statusCode	1..1	SHALL		1098-7396	
@code	1..1	SHALL		1098-19106	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:1098-7391).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`INT`" (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-7392).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7393) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.20`" (CONF:1098-10503).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32598).
4. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **Patient Education** `2.16.840.1.113883.11.20.9.34` **DYNAMIC** (CONF:1098-16884).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7396).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="`completed`" Completed (CodeSystem: `ActStatus 2.16.840.1.113883.5.14` **STATIC**) (CONF:1098-19106).

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Table 327: Patient Education

Value Set: Patient Education 2.16.840.1.113883.11.20.9.34 Limited to terms descending from the Education (409073007) hierarchy. Specific URL Pending Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
311401005	SNOMED CT	2.16.840.1.113883.6.96	Patient Education
171044003	SNOMED CT	2.16.840.1.113883.6.96	Immunization Education
243072006	SNOMED CT	2.16.840.1.113883.6.96	Cancer Education
…			

Figure 171: Instruction (V2) Example

```
<act classCode="ACT" moodCode="INT">
<templateId root="2.16.840.1.113883.10.20.22.4.20" extension="2014-06-09" />
<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>
```

4.45 Intervention Act

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.131 (open)]

Table 328: Intervention Act Contexts

Contained By:	**Contains:**
Interventions Section (V2) (optional) Planned Intervention Act (optional)	Advance Directive Observation (V2) Author Participation Encounter Activity (V2) Entry Reference External Document Reference Handoff Communication Participants Immunization Activity (V2) Instruction (V2) Intervention Act Medication Activity (V2) Non-Medicinal Supply Activity (V2) Nutrition Recommendation Planned Intervention Act Procedure Activity Act (V2) Procedure Activity Observation (V2) Procedure Activity Procedure (V2)

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This template represents an Intervention Act. It is a wrapper for intervention-type activities considered to be parts of the same intervention. For example, an activity such as "elevate head of bed" combined with "provide humidified O2 per nasal cannula" may be the interventions performed for a health concern of "respiratory insufficiency" 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 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, or to Planned Intervention Acts. (E.g., a Planned 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.)

All interventions referenced in an Intervention Act must have a moodCode of EVN, indicating that they have occurred.

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Table 329: Intervention Act Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.131)					
@classCode	1..1	SHALL		1098-30971	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-30972	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-30973	
@root	1..1	SHALL		1098-30974	2.16.840.1.113883.10.20.22.4.131
id	1..*	SHALL		1098-30975	
code	1..1	SHALL		1098-30976	
@code	1..1	SHALL		1098-30977	362956003
@codeSystem	1..1	SHALL		1098-30978	2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
statusCode	1..1	SHALL		1098-30979	
@code	1..1	SHALL		1098-32316	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	0..1	SHOULD		1098-31624	
author	0..*	SHOULD		1098-31552	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-30980	
@typeCode	1..1	SHALL		1098-30981	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-30982	Advance Directive Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09
entryRelationship	0..*	MAY		1098-30984	
@typeCode	1..1	SHALL		1098-30985	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
substanceAdministration	1..1	SHALL		1098-30986	Immunization Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09
entryRelationship	0..*	MAY		1098-30988	

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@typeCode	1..1	SHALL		1098-30989	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
substanceAdministration	1..1	SHALL		1098-30990	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09
entryRelationship	0..*	MAY		1098-30991	
@typeCode	1..1	SHALL		1098-30992	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-30993	Procedure Activity Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09
entryRelationship	0..*	MAY		1098-31154	
@typeCode	1..1	SHALL		1098-31155	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32460	Intervention Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.131
entryRelationship	0..*	MAY		1098-31164	
@typeCode	1..1	SHALL		1098-31165	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31166	Procedure Activity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09
entryRelationship	0..*	MAY		1098-31168	
@typeCode	1..1	SHALL		1098-31169	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
procedure	1..1	SHALL		1098-31170	Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09
entryRelationship	0..*	MAY		1098-31171	
@typeCode	1..1	SHALL		1098-31172	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
encounter	1..1	SHALL		1098-31173	Encounter Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09
entryRelationship	0..*	MAY		1098-31174	
typeId	0..1	MAY		1098-31175	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-	Instruction (V2) (identifier:

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				31176	urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
entryRelationship	0..*	MAY		1098-31177	
@typeCode	1..1	SHALL		1098-31178	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
supply	1..1	SHALL		1098-31179	Non-Medicinal Supply Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09
entryRelationship	0..*	MAY		1098-31413	
procedure	1..1	SHALL		1098-31414	Nutrition Recommendation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.130
entryRelationship	0..*	MAY		1098-31545	
@typeCode	1..1	SHALL		1098-31554	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-31555	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
entryRelationship	0..*	SHOULD		1098-31621	
@typeCode	1..1	SHALL		1098-31622	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
act	1..1	SHALL		1098-31623	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
entryRelationship	0..*	MAY		1098-32317	
@typeCode	1..1	SHALL		1098-32318	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32319	Handoff Communication Participants (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141
entryRelationship	0..*	MAY		1098-32772	
@typeCode	1..1	SHALL		1098-32773	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32774	Planned Intervention Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.146
reference	0..*	MAY		1098-32760	

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@typeCode	1..1	SHALL		1098-32761	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
externalDocument	1..1	SHALL		1098-32762	External Document Reference (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-30971).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-30972).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30973).
   a. This templateId **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.131" (CONF:1098-30974).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-30975).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-30976).
   a. This code **SHALL** contain exactly one [1..1] **@code**="362956003" procedure / intervention (navigational concept) (CONF:1098-30977).
   b. 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:1098-30978).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-30979).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-32316).
7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-31624).
8. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31552).
9. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-30980) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-30981).
   b. **SHALL** contain exactly one [1..1] **Advance Directive Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09) (CONF:1098-30982).
10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-30984) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-30985).
    b. **SHALL** contain exactly one [1..1] **Immunization Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09) (CONF:1098-30986).
11. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-30988) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-30989).
    b. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-30990).

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12. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-30991) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-30992).
    b. **SHALL** contain exactly one [1..1] **Procedure Activity Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09) (CONF:1098-30993).

The following entryRelationship represents the relationship between two Intervention Acts (Intervention RELATES TO Intervention).

13. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31154) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31155).
    b. **SHALL** contain exactly one [1..1] **Intervention Act** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.131) (CONF:1098-32460).
14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31164) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31165).
    b. **SHALL** contain exactly one [1..1] **Procedure Activity Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09) (CONF:1098-31166).
15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31168) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31169).
    b. **SHALL** contain exactly one [1..1] **Procedure Activity Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09) (CONF:1098-31170).
16. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31171) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31172).
    b. **SHALL** contain exactly one [1..1] **Encounter Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09) (CONF:1098-31173).
17. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31174) such that it
    a. **MAY** contain zero or one [0..1] **typeId**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31175).
    b. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31176).
18. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31177) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31178).
    b. **SHALL** contain exactly one [1..1] **Non-Medicinal Supply Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09) (CONF:1098-31179).
19. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31413) such that it

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a. **SHALL** contain exactly one [1..1] **Nutrition Recommendation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.130) (CONF:1098-31414).

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 Entry Reference template may be used to reference this entry.

20. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31545) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31554).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-31555).

An Intervention Act should reference a Goal Observation. Because the Goal Observation is already described in the CDA document instance's Goals section, rather than repeating the full content of the Goal Observation, the Entry Reference template can be used to reference this entry. The following entryRelationship represents an Entry Reference to Goal Observation.

21. **SHOULD** contain zero or more [0..*] **entryRelationship** (CONF:1098-31621) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31622).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-31623).
    c. This entryReference template **SHALL** reference an instance of a Goal Observation template (CONF:1098-32459).

22. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32317) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32318).
    b. **SHALL** contain exactly one [1..1] **Handoff Communication Participants** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141) (CONF:1098-32319).
23. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32772) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32773).
    b. **SHALL** contain exactly one [1..1] **Planned Intervention Act** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.146) (CONF:1098-32774).
24. **MAY** contain zero or more [0..*] **reference** (CONF:1098-32760).
    a. The reference, if present, **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32761).
    b. The reference, if present, **SHALL** contain exactly one [1..1] **External Document Reference** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09) (CONF:1098-32762).

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Figure 172: 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" -->
        <!-- Procedure Activity Act -->
        <act classCode="ACT" moodCode="INT">
            <templateId root="2.16.840.1.113883.10.20.22.4.12" extension="2014-06-09" />
            <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" extension="2014-06-09" />
            <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 Entry Reference template is being used here as this Goal is
    defined elsewhere in the CDA document -->
    <entryRelationship typeCode="RSON">
        <!-- Entry 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>
```


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Figure 173: 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 intervention -
        "Elevate head of bed" -->
        <!-- Procedure Activity Act -->
        <act classCode="ACT" moodCode="EVN">
            <templateId root="2.16.840.1.113883.10.20.22.4.12" extension="2014-06-09" />
            <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">
        <!-- Entry 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">
        <!-- Entry 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>
    <entryRelationship typeCode="REFR">
       <act classCode="ACT" moodCode="EVN">
            <!-- Handoff Communication template -->
            <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" />
```


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```
            <effectiveTime value="20130712" />
            <author typeCode="AUT">
                   <templateId root="2.16.840.1.113883.10.20.22.4.119" />
                    <time value="20130731" />
                    <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>
                <participant typeCode="IRCP">
                       <participantRole>
                        <code code="163W00000X" codeSystem="2.16.840.1.113883.6.101"
codeSystemName="NUCC Health Care Provider Taxonomy" displayName="Registered Nurse" />
                         <addr>
                                              <streetAddressLine>1006 Health
Drive</streetAddressLine>
                                              <city>Ann Arbor</city>
                                              <state>MI</state>
                                              <postalCode>97867</postalCode>
                                              <country>US</country>
                                          </addr>

                                          <telecom value="tel:+1(555)555-1014" use="WP" />
                                     <playingEntity>
                                              <name>
                                                  <family>Nancy</family>
                                                  <given>Nightingale</given>
                                                  <suffix>RN</suffix>
                                              </name>
                                     </playingEntity>
                          </participantRole>
                  </participant>
            </act>
     </entryRelationship>
</act>
```

4.46 Medical Equipment Organizer

[organizer: identifier urn:oid:2.16.840.1.113883.10.20.22.4.135 (open)]

Table 330: Medical Equipment Organizer Contexts

Contained By:	Contains:
Medical Equipment Section (V2) (optional)	Non-Medicinal Supply Activity (V2) Procedure Activity Procedure (V2)

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This template represents a set of current or historical medical devices, supplies, aids and equipment used by the patient. Examples are hearing aids, orthotic devices, ostomy supplies, visual aids, diabetic supplies such as syringes and pumps, and wheelchairs.

Devices that are applied during a procedure (e.g., cardiac pacemaker, gastrosomy tube, port catheter), whether permanent or temporary, are represented within the Procedure Activity Procedure (V2) template (templateId: 2.16.840.1.113883.10.20.22.4.14.2).

Table 331: Medical Equipment Organizer Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.135)					
@classCode	1..1	SHALL		1098-31020	2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER
@moodCode	1..1	SHALL		1098-31021	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-31022	
@root	1..1	SHALL		1098-31023	2.16.840.1.113883.10.20.22.4.135
id	1..*	SHALL		1098-31024	
code	0..1	MAY		1098-31025	
statusCode	1..1	SHALL		1098-31026	
@code	1..1	SHALL		1098-31029	2.16.840.1.113883.11.20.9.39 (Result Status)
effectiveTime	1..1	SHALL		1098-32136	
low	1..1	SHALL		1098-32378	
high	1..1	SHALL		1098-32379	
component	0..*	MAY		1098-31027	
supply	1..1	SHALL		1098-31862	Non-Medicinal Supply Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09
component	0..*	MAY		1098-31887	
procedure	1..1	SHALL		1098-31888	Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09

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1. **SHALL** contain exactly one [1..1] **@classCode**="CLUSTER" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-31020).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-31021).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-31022) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.135" (CONF:1098-31023).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-31024).

This code can represent a category of devices. The code is strictly optional, and is not currently limited to any value set or code system. Implementers may use it if they wish to provide optional coded information about this grouping of medical equipment.

5. **MAY** contain zero or one [0..1] **code** (CONF:1098-31025).

The organizer is a collection of statuses for contained entries. The organizer remains active until all contained entries are done.

6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-31026).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **Result Status** 2.16.840.1.113883.11.20.9.39 **STATIC** 2014-09-01 (CONF:1098-31029).

The effectiveTime can be used to show the time period over which the patient will be using the set of equipment. The organizer would probably not be used with devices applied in or on the patient.

7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-32136).
    a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-32378).
    b. This effectiveTime **SHALL** contain exactly one [1..1] **high** (CONF:1098-32379).
8. **MAY** contain zero or more [0..*] **component** (CONF:1098-31027) such that it
    a. **SHALL** contain exactly one [1..1] **Non-Medicinal Supply Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09) (CONF:1098-31862).
9. **MAY** contain zero or more [0..*] **component** (CONF:1098-31887) such that it
    a. **SHALL** contain exactly one [1..1] **Procedure Activity Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09) (CONF:1098-31888).
10. Either Non-Medicinal Supply Activity (V2) (templateId:2.16.840.1.113883.10.20.22.4.50:2014-06-09) **OR** Procedure Activity Procedure (V2) (templateId:2.16.840.1.113883.10.20.22.4.14:2014-06-09) **SHALL** be present (CONF:1098-32380).

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Table 332: Result Status

Value Set: Result Status 2.16.840.1.113883.11.20.9.39 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
aborted	ActStatus	2.16.840.1.113883.5.14	aborted
active	ActStatus	2.16.840.1.113883.5.14	active
cancelled	ActStatus	2.16.840.1.113883.5.14	cancelled
completed	ActStatus	2.16.840.1.113883.5.14	completed
held	ActStatus	2.16.840.1.113883.5.14	held
suspended	ActStatus	2.16.840.1.113883.5.14	suspended

Figure 174: 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 root="3e414708-0e61-4d48-8863-484a2d473a02" />
    <code code="337588003" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
displayName="Incontinence appliances">
        <originalText>Incontinence appliances</originalText>
    </code>
    <statusCode code="completed" />
    <effectiveTime xsi:type="IVL_TS">
        <low value="20070103" />
        <high nullFlavor="UNK" />
    </effectiveTime>
    <component>
        <supply classCode="SPLY" moodCode="EVN">
            <templateId root="2.16.840.1.113883.10.20.22.4.50" extension="2014-06-09" />
            <!-- Non-medicinal supply activity V2 template ******* -->
            ...
        </supply>
    </component>
    <component>
        <supply classCode="SPLY" moodCode="EVN">
        <templateId root="2.16.840.1.113883.10.20.22.4.50" extension="2014-06-09" />
                <!-- Non-medicinal supply activity V2 template ******* -->
            ...
        </supply>
    </component>
</organizer>
```


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4.47 Medication Activity (V2)

```
[substanceAdministration: identifier
urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09 (open)]
```

Table 333: Medication Activity (V2) Contexts

Contained By:	Contains:
Medications Section (entries required) (V2) (required) Medications Section (entries optional) (V2) (optional) Reaction Observation (V2) (optional) Procedure Activity Act (V2) (optional) Procedure Activity Procedure (V2) (optional) Procedure Activity Observation (V2) (optional) Discharge Medication (V2) (required) Admission Medication (V2) (required) Medications Administered Section (V2) (optional) Anesthesia Section (V2) (optional) Intervention Act (optional) Planned Intervention Act (optional)	Author Participation Drug Monitoring Act Drug Vehicle Indication (V2) Instruction (V2) Medication Dispense (V2) Medication Information (V2) Medication Supply Order (V2) Precondition for Substance Administration (V2) Reaction Observation (V2) Substance Administered Act

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 that a patient to be administered Lisinopril 20 mg PO for blood pressure control. If what was actually administered was Lisinopril 10 mg., then the Medication activities in the "EVN" mood would reflect actual use.

A moodCode of INT is allowed, but it is recommended that the Planned Medication Activity (V2) template be used for moodCodes other than EVN if the document type contains a section that includes Planned Medication Activity (V2) (for example a Care Plan document with Plan of Treatment, Intervention, or Goal sections).

At a minimum, a Medication Activity shall include an effectiveTime indicating the duration of the administration (or single-administration timestamp). 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 will have 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".

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Table 334: Medication Activity (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
substanceAdministration (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09)					
@classCode	1..1	SHALL		1098-7496	2.16.840.1.113883.5.6 (HL7ActClass) = SBADM
@moodCode	1..1	SHALL		1098-7497	2.16.840.1.113883.11.20.9.18 (MoodCodeEvnInt)
templateId	1..1	SHALL		1098-7499	
@root	1..1	SHALL		1098-10504	2.16.840.1.113883.10.20.22.4.16
@extension	1..1	SHALL		1098-32498	2014-06-09
id	1..*	SHALL		1098-7500	
code	0..1	MAY		1098-7506	
statusCode	1..1	SHALL		1098-7507	
@code	1..1	SHALL		1098-32360	2.16.840.1.113883.1.11.159331 (ActStatus)
effectiveTime	1..1	SHALL	IVL_TS	1098-7508	
@value	0..1	SHOULD		1098-32775	
low	0..1	SHOULD		1098-32776	
high	0..1	MAY		1098-32777	
effectiveTime	0..1	SHOULD		1098-7513	
@operator	1..1	SHALL		1098-9106	A
repeatNumber	0..1	MAY		1098-7555	
routeCode	0..1	SHOULD		1098-7514	2.16.840.1.113883.3.88.12.3221.8.7 (Medication Route FDA)
approachSiteCode	0..1	MAY	SET<CD>	1098-7515	2.16.840.1.113883.3.88.12.3221.8.9 (Body Site)
doseQuantity	1..1	SHALL		1098-7516	
@unit	0..1	SHOULD		1098-7526	2.16.840.1.113883.1.11.12839 (UnitsOfMeasureCaseSensitive)
rateQuantity	0..1	MAY		1098-7517	

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@unit	1..1	SHALL		1098-7525	2.16.840.1.113883.1.11.12839 (UnitsOfMeasureCaseSensitive)
maxDoseQuantity	0..1	MAY	RTO<PQ, PQ>	1098-7518	
administrationUnitCode	0..1	MAY		1098-7519	2.16.840.1.113883.1.11.14570 (AdministrableDrugForm)
consumable	1..1	SHALL		1098-7520	
manufacturedProduct	1..1	SHALL		1098-16085	Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09
performer	0..1	MAY		1098-7522	
author	0..*	SHOULD		1098-31150	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	0..*	MAY		1098-7523	
@typeCode	1..1	SHALL		1098-7524	2.16.840.1.113883.5.90 (HL7ParticipationType) = CSM
participantRole	1..1	SHALL		1098-16086	Drug Vehicle (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.24
entryRelationship	0..*	MAY		1098-7536	
@typeCode	1..1	SHALL		1098-7537	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-16087	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
entryRelationship	0..1	MAY		1098-7539	
@typeCode	1..1	SHALL		1098-7540	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
@inversionInd	1..1	SHALL		1098-7542	true
act	1..1	SHALL		1098-31387	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
entryRelationship	0..1	MAY		1098-7543	
@typeCode	1..1	SHALL		1098-7547	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
supply	1..1	SHALL		1098-16089	Medication Supply Order (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09

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entryRelationship	0..*	MAY		1098-7549	
@typeCode	1..1	SHALL		1098-7553	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
supply	1..1	SHALL		1098-16090	Medication Dispense (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.18:2014-06-09
entryRelationship	0..1	MAY		1098-7552	
@typeCode	1..1	SHALL		1098-7544	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = CAUS
observation	1..1	SHALL		1098-16091	Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09
entryRelationship	0..1	MAY		1098-30820	
@typeCode	1..1	SHALL		1098-30821	COMP
act	1..1	SHALL		1098-30822	Drug Monitoring Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.123
entryRelationship	0..*	MAY		1098-31515	
@typeCode	1..1	SHALL		1098-31516	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
@inversionInd	1..1	SHALL		1098-31517	true
sequenceNumber	0..1	MAY		1098-31518	
act	1..1	SHALL		1098-31519	Substance Administered Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.118
precondition	0..*	MAY		1098-31520	
@typeCode	1..1	SHALL		1098-31882	PRCN
criterion	1..1	SHALL		1098-31883	Precondition for Substance Administration (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="SBADM" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7496).

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2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **MoodCodeEvnInt** 2.16.840.1.113883.11.20.9.18 **STATIC** 2011-04-03 (CONF:1098-7497).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7499) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.16" (CONF:1098-10504).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32498).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-7500).
5. **MAY** contain zero or one [0..1] **code** (CONF:1098-7506).
   Note: 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.
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7507).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ActStatus** 2.16.840.1.113883.1.11.159331 **DYNAMIC** (CONF:1098-32360).

The substance administration effectiveTime field can repeat, in order to represent varying levels of complex dosing. effectiveTime can be used to represent the duration of administration (e.g., "10 days"), the frequency of administration (e.g., "every 8 hours"), and more. Here, we require that there SHALL be an effectiveTime documentation of the duration (or single-administration timestamp), and that there SHOULD be an effectiveTime documentation of the frequency. Other timing nuances, supported by the base CDA R2 standard, may also be included.

7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-7508) such that it
   Note: his effectiveTime represents either the medication duration (i.e., the time the medication was started and stopped) or the single-administration timestamp.
    a. **SHOULD** contain zero or one [0..1] **@value** (CONF:1098-32775).
       Note: indicates a single-administration timestamp
    b. **SHOULD** contain zero or one [0..1] **low** (CONF:1098-32776).
       Note: indicates when medication started
    c. **MAY** contain zero or one [0..1] **high** (CONF:1098-32777).
       Note: indicates when medication stopped
    d. This effectiveTime **SHALL** contain either a low or a @value but not both (CONF:1098-32890).

8. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-7513) such that it
   Note: This effectiveTime represents the medication frequency (e.g., administration times per day).
    a. **SHALL** contain exactly one [1..1] **@operator**="A" (CONF:1098-9106).
    b. **SHALL** contain exactly one [1..1] @xsi:type="PIVL_TS" or "EIVL_TS" (CONF:1098-28499).

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. In "EVN" (event) mood, the repeatNumber is the number of occurrences. For example, a

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repeatNumber of "3" in a substance administration event means that the current administration is the 3rd in a series.

9. **MAY** contain zero or one [0..1] **repeatNumber** (CONF:1098-7555).
10. **SHOULD** contain zero or one [0..1] **routeCode**, which **SHALL** be selected from ValueSet **Medication Route FDA** 2.16.840.1.113883.3.88.12.3221.8.7 **DYNAMIC** (CONF:1098-7514).
11. **MAY** contain zero or one [0..1] **approachSiteCode**, where the code **SHALL** be selected from ValueSet **Body Site** 2.16.840.1.113883.3.88.12.3221.8.9 **DYNAMIC** (CONF:1098-7515).
12. **SHALL** contain exactly one [1..1] **doseQuantity** (CONF:1098-7516).
    a. This doseQuantity **SHOULD** contain zero or one [0..1] **@unit**, which **SHALL** be selected from ValueSet **UnitsOfMeasureCaseSensitive** 2.16.840.1.113883.1.11.12839 **DYNAMIC** (CONF:1098-7526).
    b. 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:1098-16878).
    c. 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:1098-16879).
13. **MAY** contain zero or one [0..1] **rateQuantity** (CONF:1098-7517).
    a. The rateQuantity, if present, **SHALL** contain exactly one [1..1] **@unit**, which **SHALL** be selected from ValueSet **UnitsOfMeasureCaseSensitive** 2.16.840.1.113883.1.11.12839 **DYNAMIC** (CONF:1098-7525).
14. **MAY** contain zero or one [0..1] **maxDoseQuantity** (CONF:1098-7518).
15. **MAY** contain zero or one [0..1] **administrationUnitCode**, which **SHALL** be selected from ValueSet **AdministrableDrugForm** 2.16.840.1.113883.1.11.14570 **DYNAMIC** (CONF:1098-7519).
16. **SHALL** contain exactly one [1..1] **consumable** (CONF:1098-7520).
    a. This consumable **SHALL** contain exactly one [1..1] **Medication Information (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09) (CONF:1098-16085).
17. **MAY** contain zero or one [0..1] **performer** (CONF:1098-7522).
18. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31150).
19. **MAY** contain zero or more [0..*] **participant** (CONF:1098-7523) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode="CSM"** (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-7524).
    b. **SHALL** contain exactly one [1..1] **Drug Vehicle** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.24) (CONF:1098-16086).
20. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-7536) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7537).

b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-16087).

21. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-7539) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7540).

b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-7542).

c. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31387).

22. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-7543) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7547).

b. **SHALL** contain exactly one [1..1] **Medication Supply Order (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09) (CONF:1098-16089).

23. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-7549) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7553).

b. **SHALL** contain exactly one [1..1] **Medication Dispense (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.18:2014-06-09) (CONF:1098-16090).

24. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-7552) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="CAUS" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7544).

b. **SHALL** contain exactly one [1..1] **Reaction Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09) (CONF:1098-16091).

25. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-30820) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has component (CONF:1098-30821).

b. **SHALL** contain exactly one [1..1] **Drug Monitoring Act** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.123) (CONF:1098-30822).

The following entryRelationship is used to indicate a given medication's order in a series. The nested Substance Administered Act identifies an administration in the series. The entryRelationship/sequenceNumber shows the order of this particular administration in that series.

26. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31515) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31516).
b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" (CONF:1098-31517).
c. **MAY** contain zero or one [0..1] **sequenceNumber** (CONF:1098-31518).
d. **SHALL** contain exactly one [1..1] **Substance Administered Act** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.118) (CONF:1098-31519).

27. **MAY** contain zero or more [0..*] **precondition** (CONF:1098-31520).
    a. The precondition, if present, **SHALL** contain exactly one [1..1] **@typeCode**="PRCN" (CONF:1098-31882).
    b. The precondition, if present, **SHALL** contain exactly one [1..1] **Precondition for Substance Administration (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09) (CONF:1098-31883).
28. Medication Activity **SHOULD** include doseQuantity **OR** rateQuantity (CONF:1098-30800).

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Figure 175: Medication Activity (V2) Example

```
<substanceAdministration classCode="SBADM" moodCode="EVN">
  <!-- ** Medication Activity (V2) ** -->
  <templateId root="2.16.840.1.113883.10.20.22.4.16"
         extension="2014-06-09"/>
  <id root="6c844c75-aa34-411c-b7bd-5e4a9f206e29"/>
  <statusCode code="active"/>
  <effectiveTime xsi:type="IVL_TS">
    <low value="20120318"/>
  </effectiveTime>
  <effectiveTime xsi:type="PIVL_TS" institutionSpecified="true" operator="A">
    <period value="12" unit="h"/>
  </effectiveTime>
  <routeCode code="C38288"
            codeSystem="2.16.840.1.113883.3.26.1.1"
            codeSystemName="NCI Thesaurus"
            displayName="ORAL"/>
  <doseQuantity value="1"/>
  <consumable>
    <manufacturedProduct classCode="MANU">
      <!-- ** Medication information ** -->
      <templateId root="2.16.840.1.113883.10.20.22.4.23"
               extension="2014-06-09"/>
      <id root="2a620155-9d11-439e-92b3-5d9815ff4ee8"/>
      <manufacturedMaterial>
        <code code="197380"
              displayName="Atenolol 25 MG Oral Tablet"
              codeSystem="2.16.840.1.113883.6.88" codeSystemName="RxNorm"/>
      </manufacturedMaterial>
    </manufacturedProduct>
  </consumable>
  <entryRelationship typeCode="RSON">
    <observation classCode="OBS" moodCode="EVN">
      <!-- ** Indication ** -->
      <templateId root="2.16.840.1.113883.10.20.22.4.19"
             extension="2014-06-09"/>
      <id root="e63166c7-6482-4a44-83a1-37ccdbde725b"/>
      <code code="75321-0"
            codeSystem="2.16.840.1.113883.6.1"
            codeSystemName="LOINC"
            displayName="Clinical finding"/>
      <statusCode code="completed"/>
      <value xsi:type="CD"
             code="38341003"
             displayName="Hypertension"
             codeSystem="2.16.840.1.113883.6.96"/>
    </observation>
  </entryRelationship>
</substanceAdministration>
```


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Figure 176: No Known Medications Example

```
<substanceAdministration classCode="SBADM" moodCode="EVN" negationInd="true">
    <!-- ** Medication activity ** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.16" extension="2014-06-09" />
    <id root="072f00fc-4f9d-4516-8d6f-ed00ed523fe0" />
    <statusCode code="active" />
    <effectiveTime xsi:type="IVL_TS">
        <low value="20110103" />
    </effectiveTime>
    <consumable>
        <manufacturedProduct classCode="MANU">
            <!-- ** Medication information ** -->
            <templateId root="2.16.840.1.113883.10.20.22.4.23" extension="2014-06-09" />
            <manufacturedMaterial>
                <code nullFlavor="OTH" codeSystem="2.16.840.1.113883.6.88">
                    <translation code="410942007" displayName="drug or medication"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" />
                </code>
            </manufacturedMaterial>
        </manufacturedProduct>
    </consumable>
</substanceAdministration>
```

4.48 Medication Dispense (V2)

[supply: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.18:2014-06-09 (open)]

Table 335: Medication Dispense (V2) Contexts

Contained By:	**Contains:**
Medication Activity (V2) (optional) Immunization Activity (V2) (optional)	Immunization Medication Information (V2) Medication Information (V2) Medication Supply Order (V2) US Realm Address (AD.US.FIELDED)

This template records the act of supplying medications (i.e., dispensing).

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Table 336: Medication Dispense (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
supply (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.18:2014-06-09)					
@classCode	1..1	SHALL		1098-7451	2.16.840.1.113883.5.6 (HL7ActClass) = SPLY
@moodCode	1..1	SHALL		1098-7452	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7453	
@root	1..1	SHALL		1098-10505	2.16.840.1.113883.10.20.22.4.18
@extension	1..1	SHALL		1098-32580	2014-06-09
id	1..*	SHALL		1098-7454	
statusCode	1..1	SHALL		1098-7455	
@code	1..1	SHALL		1098-32361	2.16.840.1.113883.3.88.12.80.64 (Medication Fill Status)
effectiveTime	0..1	SHOULD		1098-7456	
repeatNumber	0..1	SHOULD		1098-7457	
quantity	0..1	SHOULD		1098-7458	
product	0..1	MAY		1098-7459	
manufacturedProduct	1..1	SHALL		1098-15607	Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09
product	0..1	MAY		1098-9331	
manufacturedProduct	1..1	SHALL		1098-31696	Immunization Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09
performer	0..1	MAY		1098-7461	
assignedEntity	1..1	SHALL		1098-7467	
addr	0..1	SHOULD		1098-7468	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
entryRelationship	0..1	MAY		1098-7473	

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@typeCode	1..1	SHALL		1098-7474	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
supply	1..1	SHALL		1098-15606	Medication Supply Order (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7451).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7452).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7453) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.18" (CONF:1098-10505).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32580).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-7454).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7455).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **Medication Fill Status** 2.16.840.1.113883.3.88.12.80.64 **STATIC** 2014-04-23 (CONF:1098-32361).
6. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-7456).

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.

7. **SHOULD** contain zero or one [0..1] **repeatNumber** (CONF:1098-7457).
8. **SHOULD** contain zero or one [0..1] **quantity** (CONF:1098-7458).
9. **MAY** contain zero or one [0..1] **product** (CONF:1098-7459) such that it
   a. **SHALL** contain exactly one [1..1] **Medication Information (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09) (CONF:1098-15607).
10. **MAY** contain zero or one [0..1] **product** (CONF:1098-9331) such that it
    a. **SHALL** contain exactly one [1..1] **Immunization Medication Information (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09) (CONF:1098-31696).
11. **MAY** contain zero or one [0..1] **performer** (CONF:1098-7461).
    a. The performer, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-7467).
       i. This assignedEntity **SHOULD** contain zero or one [0..1] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-7468).

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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:1098-10565).

12. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-7473) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7474).
    b. **SHALL** contain exactly one [1..1] **Medication Supply Order (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09) (CONF:1098-15606).
13. A supply act **SHALL** contain one product/Medication Information **OR** one product/Immunization Medication Information template (CONF:1098-9333).

Table 337: Medication Fill Status

Value Set: Medication Fill Status 2.16.840.1.113883.3.88.12.80.64 Value Set Source: **https://phinvads.cdc.gov/**			
Code	**Code System**	**Code System OID**	**Print Name**
aborted	ActStatus	2.16.840.1.113883.5.14	Aborted
completed	ActStatus	2.16.840.1.113883.5.14	Completed

Figure 177: Medication Dispense (V2) Example

```
<supply classCode="SPLY" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.18" extension="2014-06-09" />
    <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" extension="2014-06-09" />
            . . .
        </manufacturedProduct>
    </product>
    <performer>
        <assignedEntity>
        . . .
        </assignedEntity>
    </performer>
</supply>
```


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4.49 Medication Information (V2)

[manufacturedProduct: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09 (open)]

Table 338: Medication Information (V2) Contexts

Contained By:	Contains:
Medication Activity (V2) (required) Planned Supply (V2) (optional) Planned Medication Activity (V2) (required) Medication Supply Order (V2) (optional) Medication Dispense (V2) (optional)	

A medication should be recorded as a pre-coordinated ingredient + strength + dose form (e.g., “metoprolol 25mg tablet”, “amoxicillin 400mg/5mL suspension”) where possible. This includes RxNorm codes whose Term Type is SCD (semantic clinical drug), SBD (semantic brand drug), GPCK (generic pack), BPCK (brand pack).

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. 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".

Table 339: Medication Information (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
manufacturedProduct (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09)					
@classCode	1..1	SHALL		1098-7408	2.16.840.1.113883.5.110 (RoleClass) = MANU
templateId	1..1	SHALL		1098-7409	
@root	1..1	SHALL		1098-10506	2.16.840.1.113883.10.20.22.4.23
@extension	1..1	SHALL		1098-32579	2014-06-09
id	0..*	MAY		1098-7410	
manufacturedMaterial	1..1	SHALL		1098-7411	
code	1..1	SHALL		1098-7412	2.16.840.1.113762.1.4.1010.4 (Medication Clinical Drug)
translation	0..*	MAY		1098-31884	2.16.840.1.113762.1.4.1010.2 (Clinical Substance)
manufacturerOrganization	0..1	MAY		1098-7416	

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1. **SHALL** contain exactly one [1..1] **@classCode**="MANU" (CodeSystem: RoleClass 2.16.840.1.113883.5.110 **STATIC**) (CONF:1098-7408).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7409) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.23" (CONF:1098-10506).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32579).
3. **MAY** contain zero or more [0..*] **id** (CONF:1098-7410).
4. **SHALL** contain exactly one [1..1] **manufacturedMaterial** (CONF:1098-7411).
   Note: A medication should be recorded as a pre-coordinated ingredient + strength + dose form (e.g., "metoprolol 25mg tablet", "amoxicillin 400mg/5mL suspension") where possible. This includes RxNorm codes whose Term Type is SCD (semantic clinical drug), SBD (semantic brand drug), GPCK (generic pack), BPCK (brand pack).
   a. This manufacturedMaterial **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet **Medication Clinical Drug** 2.16.840.1.113762.1.4.1010.4 **DYNAMIC** (CONF:1098-7412).
      i. This code **MAY** contain zero or more [0..*] **translation**, which **MAY** be selected from ValueSet **Clinical Substance** 2.16.840.1.113762.1.4.1010.2 **DYNAMIC** (CONF:1098-31884).
5. **MAY** contain zero or one [0..1] **manufacturerOrganization** (CONF:1098-7416).

Table 340: Medication Clinical Drug

Value Set: Medication Clinical Drug 2.16.840.1.113762.1.4.1010.4

All prescribable medication formulations represented using either a "generic" or "brand-specific" concept. This includes RxNorm codes whose 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).
Value set intensionally defined as a GROUPING made up of: Value Set: Medication Clinical General Drug (2.16.840.1.113883.3.88.12.80.17) (RxNorm Generic Drugs); Value Set: Medication Clinical Brand-specific Drug (2.16.840.1.113762.1.4.1010.5) (RxNorm Branded Drugs).

Value Set Source: **https://vsac.nlm.nih.gov/**

Code	Code System	Code System OID	Print Name
978727	RxNorm	2.16.840.1.113883.6.88	0.2 ML Dalteparin Sodium 12500 UNT/ML Prefilled Syringe [Fragmin]
827318	RxNorm	2.16.840.1.113883.6.88	Acetaminophen 250 MG / Aspirin 250 MG / Caffeine 65 MG Oral Capsule
199274	RxNorm	2.16.840.1.113883.6.88	Aspirin 300 MG Oral Capsule
362867	RxNorm	2.16.840.1.113883.6.88	Cefotetan Injectable Solution [Cefotan]
…			

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Table 341: Clinical Substance

Value Set: Clinical Substance 2.16.840.1.113762.1.4.1010.2 All substances that may need to be represented in the context of health care related activities. This value set is quite broad in coverage and includes concepts that may never be needed in a health care activity event, particularly the included SNOMED CT concepts. The code system-specific value sets in this grouping value set are intended to provide broad coverage of all kinds of agents, but the expectation for use is that the chosen concept identifier for a substance should be appropriately specific and drawn from the appropriate code system as noted: prescribable medications should use RXNORM concepts, more specific drugs and chemicals should be represented using UNII concepts, and any substances not found in either of those two code systems, should use the appropriate SNOMED CT concept. This overarching grouping value set is intended to support identification of prescribable medications, foods, general substances and environmental entities. Value set intensionally defined as a GROUPING made up of: Value Set: Medication Clinical Drug (2.16.840.1.113762.1.4.1010.4) (RxNorm generic and brand codes); Value Set: Unique Ingredient Identifier - Complete Set (2.16.840.1.113883.3.88.12.80.20) (UNII codes); Value Set: Substance Other Than Clinical Drug (2.16.840.1.113762.1.4.1010.9) (SNOMED CT codes). Value Set Source: **https://vsac.nlm.nih.gov/**			
Code	**Code System**	**Code System OID**	**Print Name**
369436	RxNorm	2.16.840.1.113883.6.88	6-Aminocaproic Acid Oral Tablet [Amicar]
1116447	RxNorm	2.16.840.1.113883.6.88	Acepromazine Oral Tablet
9042592173	Unique Ingredient Identifier (UNII)	2.16.840.1.113883.4.9	ATROMEPINE
7673326042	Unique Ingredient Identifier (UNII)	2.16.840.1.113883.4.9	IRINOTECAN
413480003	SNOMED CT	2.16.840.1.113883.6.96	Almond product (substance)
256915001	SNOMED CT	2.16.840.1.113883.6.96	Aluminum hydroxide absorbed plasma (substance)
…			

Figure 178: Medication Information (V2) Example

```
<manufacturedProduct classCode="MANU">
    <!-- ** Medication information ** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.23" extension="2014-06-09" />
    <id root="2a620155-9d11-439e-92b3-5d9815ff4ee8" />
    <manufacturedMaterial>
        <code code="573621" displayName="Proventil 0.09 MG/ACTUAT inhalant solution"
codeSystem="2.16.840.1.113883.6.88" codeSystemName="RxNorm" />
    </manufacturedMaterial>
    <manufacturerOrganization>
        <name>Medication Factory Inc.</name>
    </manufacturerOrganization>
</manufacturedProduct>
```


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4.50 Medication Supply Order (V2)

```
[supply: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09
(open)]
```

Table 342: Medication Supply Order (V2) Contexts

Contained By:	Contains:
Medication Activity (V2) (optional) Immunization Activity (V2) (optional) Medication Dispense (V2) (optional)	Immunization Medication Information (V2) Instruction (V2) Medication Information (V2)

This template records the intent to supply a patient with medications.

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Table 343: Medication Supply Order (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
supply (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09)					
@classCode	1..1	SHALL		1098-7427	2.16.840.1.113883.5.6 (HL7ActClass) = SPLY
@moodCode	1..1	SHALL		1098-7428	2.16.840.1.113883.5.1001 (ActMood) = INT
templateId	1..1	SHALL		1098-7429	
@root	1..1	SHALL		1098-10507	2.16.840.1.113883.10.20.22.4.17
@extension	1..1	SHALL		1098-32578	2014-06-09
id	1..*	SHALL		1098-7430	
statusCode	1..1	SHALL		1098-7432	
@code	1..1	SHALL		1098-32362	2.16.840.1.113883.1.11.159331 (ActStatus)
effectiveTime	0..1	SHOULD	IVL_TS	1098-15143	
high	1..1	SHALL		1098-15144	
repeatNumber	0..1	SHOULD		1098-7434	
quantity	0..1	SHOULD		1098-7436	
product	0..1	MAY		1098-7439	
manufacturedProduct	1..1	SHALL		1098-16093	Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09
product	0..1	MAY		1098-9334	
manufacturedProduct	1..1	SHALL		1098-31695	Immunization Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09
author	0..1	MAY		1098-7438	
entryRelationship	0..1	MAY		1098-7442	
@typeCode	1..1	SHALL		1098-7444	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
@inversionInd	1..1	SHALL		1098-	true

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				7445	
act	1..1	SHALL		1098-31391	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7427).
2. **SHALL** contain exactly one [1..1] **@moodCode**="INT" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7428).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7429) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.17" (CONF:1098-10507).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32578).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-7430).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7432).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ActStatus** 2.16.840.1.113883.1.11.159331 **DYNAMIC** (CONF:1098-32362).
6. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-15143) such that it
   a. **SHALL** contain exactly one [1..1] **high** (CONF:1098-15144).

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.

7. **SHOULD** contain zero or one [0..1] **repeatNumber** (CONF:1098-7434).
8. **SHOULD** contain zero or one [0..1] **quantity** (CONF:1098-7436).
9. **MAY** contain zero or one [0..1] **product** (CONF:1098-7439) such that it
   a. **SHALL** contain exactly one [1..1] **Medication Information (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09) (CONF:1098-16093).
10. **MAY** contain zero or one [0..1] **product** (CONF:1098-9334) such that it
    a. **SHALL** contain exactly one [1..1] **Immunization Medication Information (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09) (CONF:1098-31695).
       i. A supply act **SHALL** contain one product/Medication Information **OR** one product/Immunization Medication Information template (CONF:1098-16870).
11. **MAY** contain zero or one [0..1] **author** (CONF:1098-7438).
12. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-7442).
    a. The entryRelationship, if present, **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7444).

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b. The entryRelationship, if present, **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-7445).

c. The entryRelationship, if present, **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31391).

Figure 179: Medication Supply Order (V2) Example

```
<supply classCode="SPLY" moodCode="INT">
    <templateId root="2.16.840.1.113883.10.20.22.4.17" extension="2014-06-09" />
    <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" extension="2014-06-09" />

            . . .
        </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" extension="2014-06-09" />

            . . .
        </act>
    </entryRelationship>
</supply>
```

4.51 Mental Status Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09 (open)]

Table 344: Mental Status Observation (V2) Contexts

Contained By:	Contains:
Mental Status Section (optional) Health Concern Act (optional) Mental Status Organizer (V2) (required) Risk Concern Act (optional)	Assessment Scale Observation Author Participation

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The Mental Status Observation template represents an observation about mental status that can come from a broad range of subjective and objective information (including measured data) to address those categories described in the Mental Status Section. See also Assessment Scale Observation for specific collections of observations that together yield a summary evaluation of a particular condition.

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Table 345: Mental Status Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09)					
@classCode	1..1	SHALL		1098-14249	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-14250	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-14255	
@root	1..1	SHALL		1098-14256	2.16.840.1.113883.10.20.22.4.74
@extension	1..1	SHALL		1098-32565	2014-06-09
id	1..*	SHALL		1098-14257	
code	1..1	SHALL		1098-14591	
@code	1..1	SHALL		1098-32788	75275-8
@codeSystem	1..1	SHALL		1098-32789	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-14254	
@code	1..1	SHALL		1098-19092	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-14261	
value	1..1	SHALL		1098-14263	
author	0..*	SHOULD		1098-14266	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-14469	
@typeCode	1..1	SHALL		1098-14595	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
observation	1..1	SHALL		1098-14470	Assessment Scale Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69
referenceRange	0..*	MAY		1098-14267	

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-14249).

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2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-14250).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-14255) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.74" (CONF:1098-14256).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32565).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-14257).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-14591).
    a. This code **SHALL** contain exactly one [1..1] **@code**="75275-8" Cognitive function (CONF:1098-32788).
    b. 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:1098-32789).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-14254).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19092).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-14261).
8. **SHALL** contain exactly one [1..1] **value** (CONF:1098-14263).
    a. If xsi:type="CD", **SHOULD** contain a code from SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:1098-14271).
9. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-14266).
10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-14469) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-14595).
    b. **SHALL** contain exactly one [1..1] **Assessment Scale Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69) (CONF:1098-14470).

The referenceRange could be used to represent normal or expected capability for the mental function being evaluated.

11. **MAY** contain zero or more [0..*] **referenceRange** (CONF:1098-14267).

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Figure 180: Mental Status Observation (V2) Example

```
<entry>
    <observation classCode="OBS" moodCode="EVN">
        <!-- Mental Status Observation V2 -->
        <templateId root="2.16.840.1.113883.10.20.22.4.74" extension="2014-06-09" />
        <id root="c6b5a04b-2bf4-49d1-8336-636a3813df0a" />
        <code code="75275-8" displayName="Cognitive function"
codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />
        <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" />
        <author>
            <time value="200130311" />
            <assignedAuthor>
               ....
            </assignedAuthor>
        </author>
    </observation>
</entry>
```

4.52 Mental Status Organizer (V2)

[organizer: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.75:2014-06-09 (open)]

Table 346: Mental Status Organizer (V2) Contexts

Contained By:	Contains:
Mental Status Section (optional)	Mental Status Observation (V2)

The Mental Status Organizer template may be used to group related Mental Status Observations (e.g., results of mental tests) and associated Assessment Scale Observations into subcategories and/or groupings by time. Subcategories can be things such as Mood and Affect, Behavior, Thought Process, Perception, Cognition, etc.

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Table 347: Mental Status Organizer (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
organizer (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.75:2014-06-09)					
@classCode	1..1	SHALL		1098-14369	2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER
@moodCode	1..1	SHALL		1098-14371	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-14375	
@root	1..1	SHALL		1098-14376	2.16.840.1.113883.10.20.22.4.75
@extension	1..1	SHALL		1098-32566	2014-06-09
id	1..*	SHALL		1098-14377	
code	0..1	SHOULD		1098-14378	
@code	0..1	SHOULD		1098-14697	
statusCode	1..1	SHALL		1098-14372	
@code	1..1	SHALL		1098-19093	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	0..1	SHOULD		1098-32424	
component	1..*	SHALL		1098-14373	
observation	1..1	SHALL		1098-14381	Mental Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="`CLUSTER`" Cluster (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6`) (CONF:1098-14369).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-14371).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-14375) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.75`" (CONF:1098-14376).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32566).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-14377).

The code selected should indicate the category that groups the contained mental status observations (e.g., communication, learning and applying knowledge).

5. **SHOULD** contain zero or one [0..1] **code** (CONF:1098-14378).

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a. The code, if present, **SHOULD** contain zero or one [0..1] **@code** (CONF:1098-14697).
   i. **SHOULD** be selected from ICF (codeSystem 2.16.840.1.113883.6.254) **OR** LOINC (codeSystem 2.16.840.1.113883.6.96) (CONF:1098-14698).

b. The Organizer **SHALL** contain at least one of **code** or **effectiveTime** (CONF:1098-32425).

6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-14372).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19093).

The effectiveTime is an interval that spans the effectiveTimes of the contained mental status observations. Because all contained mental status observations have a required time stamp, it is not required that this effectiveTime be populated.

7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-32424).
   a. The Organizer **SHALL** have at least one of **code** or **effectiveTime** (CONF:1098-32426).

8. **SHALL** contain at least one [1..*] **component** (CONF:1098-14373) such that it
   a. **SHALL** contain exactly one [1..1] **Mental Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09) (CONF:1098-14381).

Figure 181: Mental Status Organizer (V2) Example

```
<entry>
    <organizer classCode="CLUSTER" moodCode="EVN">
        <!-- Mental Status Organizer V2-->
        <templateId root="2.16.840.1.113883.10.20.22.4.75" extension="2014-06-09" />
        <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">
                <!-- Mental Status Observation V2 -->
                <templateId root="2.16.840.1.113883.10.20.22.4.74" extension="2014-06-09"
/>
              ...

            </observation>
        </component>
            <component>
                <observation classCode="OBS" moodCode="EVN">
                    <!-- Mental Status Oservation V2 -->
                    <templateId root="2.16.840.1.113883.10.20.22.4.74" extension="2014-06-
09" />
              ...

                </observation>
            </component>
    </organizer>
</entry>
```


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4.53 Non-Medicinal Supply Activity (V2)

[supply: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09 (open)]

Table 348: Non-Medicinal Supply Activity (V2) Contexts

Contained By:	Contains:
Medical Equipment Section (V2) (optional) Medical Equipment Organizer (optional) Functional Status Section (V2) (optional) Functional Status Observation (V2) (optional) Intervention Act (optional) Planned Intervention Act (optional)	Instruction (V2) Product Instance

This template represents equipment supplied to the patient (e.g., pumps, inhalers, wheelchairs). Devices applied to, or placed in, the patient are represented with the Product Instance entry contained within a Procedure Activity Procedure (V2) (templateId: 2.16.840.1.113883.10.20.22.4.14.2.)

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Table 349: Non-Medicinal Supply Activity (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
supply (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09)					
@classCode	1..1	SHALL		1098-8745	2.16.840.1.113883.5.6 (HL7ActClass) = SPLY
@moodCode	1..1	SHALL		1098-8746	2.16.840.1.113883.11.20.9.18 (MoodCodeEvnInt)
templateId	1..1	SHALL		1098-8747	
@root	1..1	SHALL		1098-10509	2.16.840.1.113883.10.20.22.4.50
@extension	1..1	SHALL		1098-32514	2014-06-09
id	1..*	SHALL		1098-8748	
statusCode	1..1	SHALL		1098-8749	
@code	1..1	SHALL		1098-32363	2.16.840.1.113883.1.11.159331 (ActStatus)
effectiveTime	0..1	SHOULD	IVL_TS	1098-15498	
quantity	0..1	SHOULD		1098-8751	
participant	0..1	MAY		1098-8752	
@typeCode	1..1	SHALL		1098-8754	2.16.840.1.113883.5.90 (HL7ParticipationType) = PRD
participantRole	1..1	SHALL		1098-15900	Product Instance (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.37
entryRelationship	0..1	MAY		1098-30277	
@typeCode	1..1	SHALL		1098-30278	SUBJ
@inversionInd	1..1	SHALL		1098-30279	TRUE
act	1..1	SHALL		1098-31393	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8745).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **MoodCodeEvnInt** 2.16.840.1.113883.11.20.9.18 **STATIC** 2011-04-03 (CONF:1098-8746).

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3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8747) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.50" (CONF:1098-10509).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32514).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8748).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-8749).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ActStatus** 2.16.840.1.113883.1.11.159331 **DYNAMIC** (CONF:1098-32363).
6. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-15498).
    a. The effectiveTime, if present, **SHOULD** contain zero or one [0..1] **high** (CONF:1098-16867).
7. **SHOULD** contain zero or one [0..1] **quantity** (CONF:1098-8751).
8. **MAY** contain zero or one [0..1] **participant** (CONF:1098-8752) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="PRD" Product (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-8754).
    b. **SHALL** contain exactly one [1..1] **Product Instance** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.37) (CONF:1098-15900).
9. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-30277) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" (CONF:1098-30278).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="TRUE" (CONF:1098-30279).
    c. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31393).

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Figure 182: Non-Medicinal Supply Activity (V2) Example

```
<supply classCode="SPLY" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.50" extension="2014-06-09" />
    <!-- Non-medicinal supply activity V2 template ******* -->
    <id root="39b5f1b4-a8e1-4ad7-8849-0deab10c97b1" />
    <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="24993f33-6222-41ce-add6-37a9d3da6acb" />
            <playingDevice>
                <code code="14106009" displayName="cardiac pacemaker, device (physical
object)" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT">
                    <originalText>Cardiac Pacemaker</originalText>
                </code>
            </playingDevice>
            <scopingEntity>
                <id root="eb936010-7b17-11db-9fe1-0800200c9b65" />
                <desc>Good Health Durable Medical Equipment</desc>
            </scopingEntity>
        </participantRole>
    </participant>
</supply>
```

4.54 Number of Pressure Ulcers Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.76:2014-06-09 (open)]

Table 350: Number of Pressure Ulcers Observation (V2) Contexts

Contained By:	Contains:
Longitudinal Care Wound Observation (optional)	

This template represents the number of pressure ulcers observed at a particular stage.

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Table 351: Number of Pressure Ulcers Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.76:2014-06-09)					
@classCode	1..1	SHALL		1098-14705	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-14706	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-14707	
@root	1..1	SHALL		1098-14708	2.16.840.1.113883.10.20.22.4.76
@extension	1..1	SHALL		1098-32604	2014-06-09
id	1..*	SHALL		1098-14709	
code	1..1	SHALL		1098-14767	
@code	1..1	SHALL		1098-14768	75277-4
@codeSystem	1..1	SHALL		1098-32164	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-14714	
@code	1..1	SHALL		1098-19108	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-14715	
value	1..1	SHALL	INT	1098-14771	
author	0..1	MAY		1098-14717	
entryRelationship	1..1	SHALL		1098-14718	
@typeCode	1..1	SHALL		1098-14719	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
observation	1..1	SHALL		1098-14720	
@classCode	1..1	SHALL		1098-14721	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-14722	2.16.840.1.113883.5.1001 (ActMood) = EVN
code	1..1	SHALL		1098-31930	2.16.840.1.113883.5.4 (ActCode) = ASSERTION
value	1..1	SHALL	CD	1098-14725	2.16.840.1.113883.11.20.9.35 (Pressure Ulcer Stage)

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1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-14705).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-14706).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-14707) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.76" (CONF:1098-14708).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32604).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-14709).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-14767).
    a. This code **SHALL** contain exactly one [1..1] **@code**="75277-4" Number of pressure ulcers (CONF:1098-14768).
    b. 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:1098-32164).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-14714).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19108).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-14715).
8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="INT" (CONF:1098-14771).
9. **MAY** contain zero or one [0..1] **author** (CONF:1098-14717).
10. **SHALL** contain exactly one [1..1] **entryRelationship** (CONF:1098-14718) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-14719).
    b. **SHALL** contain exactly one [1..1] **observation** (CONF:1098-14720).
        i. This observation **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-14721).
        ii. This observation **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-14722).
        iii. This observation **SHALL** contain exactly one [1..1] **code**="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4) (CONF:1098-31930).
        iv. This observation **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **Pressure Ulcer Stage** 2.16.840.1.113883.11.20.9.35 **STATIC** 2014-09-01 (CONF:1098-14725).

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Table 352: Pressure Ulcer Stage

Value Set: Pressure Ulcer Stage 2.16.840.1.113883.11.20.9.35 This value set enumerates the type of a pressure ulcer. Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
421076008	SNOMED CT	2.16.840.1.113883.6.96	Pressure Ulcer Stage 1
420324007	SNOMED CT	2.16.840.1.113883.6.96	Pressure Ulcer Stage 2
421927004	SNOMED CT	2.16.840.1.113883.6.96	Pressure Ulcer Stage 3
420597008	SNOMED CT	2.16.840.1.113883.6.96	Pressure Ulcer Stage 4
421594008	SNOMED CT	2.16.840.1.113883.6.96	Nonstageable pressure

Figure 183: Number of Pressure Ulcers Observation (V2) Example

```
<entryRelationship typeCode="COMP">
    <observation classCode="OBS" moodCode="EVN">
        <!-- Number of Pressure Ulcers -->
        <templateId root="2.16.840.1.113883.10.20.22.4.76" extension="2014-06-09"/>
        <id root="08edb7c0-2111-43f2-a784-9a5fdfaa67f0" />
        <code code="75277-4" codeSystem="2.16.840.1.113883.6.1" displayName="Number of
pressure ulcers" />
        <statusCode code="completed" />
        <value xsi:type="INT" value="3" />
        <entryRelationship typeCode="SUBJ">
            <observation classCode="OBS" moodCode="EVN">
                <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />
                <value xsi:type="CD" code="421927004" codeSystem="2.16.840.1.113883.6.96"
displayName="Pressure ulcer stage 3" />
            </observation>
        </entryRelationship>
    </observation>
</entryRelationship>
```

4.55 Nutrition Assessment

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.138 (open)]

Table 353: Nutrition Assessment Contexts

Contained By:	**Contains:**
Nutritional Status Observation (required) Health Concern Act (optional) Risk Concern Act (optional)	Author Participation

This template represents the patient's nutrition abilities and habits including intake, diet requirements or diet followed.

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Table 354: Nutrition Assessment Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.138)					
@classCode	1..1	SHALL		1098-30324	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-30325	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-30326	
@root	1..1	SHALL		1098-30327	2.16.840.1.113883.10.20.22.4.138
id	1..*	SHALL		1098-30328	
code	1..1	SHALL		1098-30329	
@code	1..1	SHALL		1098-32784	75303-8
@codeSystem	1..1	SHALL		1098-32785	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-30332	
@code	1..1	SHALL		1098-30333	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-31666	
value	1..1	SHALL		1098-30334	
author	0..*	SHOULD		1098-31667	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" Observation (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-30324).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-30325).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30326) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.138`" (CONF:1098-30327).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-30328).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-30329).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`75303-8`" Nutrition assessment (CONF:1098-32784).

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b. 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:1098-32785).

6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-30332).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-30333).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-31666).
8. **SHALL** contain exactly one [1..1] **value** (CONF:1098-30334).
   a. If xsi:type="CD", **SHOULD** contain a code from SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:1098-32433).
9. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31667).

Figure 184: 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 code="75303-8"
              displayName="Nutrition assessment"
              codeSystem="2.16.840.1.113883.6.1"
              codeSystemName="LOINC" />
        <statusCode code="completed" />
        <effectiveTime value="20130512" />
        <value xsi:type="CD" code="437421000124105"
              displayName="Decreased sodium diet (regime/therapy)"
              codeSystem="2.16.840.1.113883.6.96"
              codeSystemName="SNOMED CT" />
        <author typeCode="AUT">
            <templateId root="2.16.840.1.113883.10.20.22.4.119" />
            <time value="201300512" />
        ...
        </author>
    </observation>
</entryRelationship>
```


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4.56 Nutrition Recommendation

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.130 (open)]

Table 355: Nutrition Recommendation Contexts

Contained By:	Contains:
Plan of Treatment Section (V2) (optional) Intervention Act (optional) Planned Intervention Act (optional)	Planned Act (V2) Planned Encounter (V2) Planned Medication Activity (V2) Planned Observation (V2) Planned Procedure (V2) Planned Supply (V2)

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.

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Table 356: Nutrition Recommendation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.130)					
@classCode	1..1	SHALL		1098-30385	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-30386	2.16.840.1.113883.11.20.9.23 (Planned moodCode (Act/Encounter/Procedure))
templateId	1..1	SHALL		1098-30340	
@root	1..1	SHALL		1098-30341	2.16.840.1.113883.10.20.22.4.130
code	1..1	SHALL		1098-30342	2.16.840.1.113883.1.11.20.2.9 (Nutrition Recommendations)
statusCode	1..1	SHALL		1098-31697	
@code	1..1	SHALL		1098-31698	2.16.840.1.113883.5.14 (ActStatus) = active
effectiveTime	0..1	SHOULD		1098-31699	
entryRelationship	0..*	MAY		1098-32382	
encounter	1..1	SHALL		1098-32383	Planned Encounter (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09
entryRelationship	0..*	MAY		1098-32384	
substanceAdministration	1..1	SHALL		1098-32385	Planned Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09
entryRelationship	0..*	MAY		1098-32386	
observation	1..1	SHALL		1098-32387	Planned Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09
entryRelationship	0..*	MAY		1098-32388	
procedure	1..1	SHALL		1098-32389	Planned Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09
entryRelationship	0..*	MAY		1098-32390	
supply	1..1	SHALL		1098-	Planned Supply (V2) (identifier:

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				32391	urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09
entryRelationship	0..*	MAY		1098-32632	
act	1..1	SHALL		1098-32633	Planned Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-30385).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **Planned moodCode (Act/Encounter/Procedure)** 2.16.840.1.113883.11.20.9.23 **STATIC** 2014-09-01 (CONF:1098-30386).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30340) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.130" (CONF:1098-30341).
4. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **Nutrition Recommendations** 2.16.840.1.113883.1.11.20.2.9 **DYNAMIC** (CONF:1098-30342).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-31697).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31698).

The effectiveTime indicates the time when the activity is intended to take place.

6. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-31699).
7. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32382).
   a. The entryRelationship, if present, **SHALL** contain exactly one [1..1] **Planned Encounter (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09) (CONF:1098-32383).
8. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32384).
   a. The entryRelationship, if present, **SHALL** contain exactly one [1..1] **Planned Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09) (CONF:1098-32385).
9. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32386).
   a. The entryRelationship, if present, **SHALL** contain exactly one [1..1] **Planned Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09) (CONF:1098-32387).
10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32388).
    a. The entryRelationship, if present, **SHALL** contain exactly one [1..1] **Planned Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09) (CONF:1098-32389).
11. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32390).

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a. The entryRelationship, if present, **SHALL** contain exactly one [1..1] **Planned Supply (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09) (CONF:1098-32391).

12. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32632).
    a. The entryRelationship, if present, **SHALL** contain exactly one [1..1] **Planned Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09) (CONF:1098-32633).

Table 357: Nutrition Recommendations

Value Set: Nutrition Recommendations 2.16.840.1.113883.1.11.20.2.9 Types of nutritional regimes, therapies or interventions. Specific URL Pending Value Set Source: **http://www.hl7.org**			
Code	**Code System**	**Code System OID**	**Print Name**
61310001	SNOMED CT	2.16.840.1.113883.6.96	nutrition education (procedure)
386373004	SNOMED CT	2.16.840.1.113883.6.96	nutrition therapy (regime/therapy)
418995006	SNOMED CT	2.16.840.1.113883.6.96	feeding regime (regime/therapy)
413315001	SNOMED CT	2.16.840.1.113883.6.96	nutrition / feeding management (regime/therapy)
182922004	SNOMED CT	2.16.840.1.113883.6.96	dietary regime (regime/therapy)
229912004	SNOMED CT	2.16.840.1.113883.6.96	enteral feeding (regime/therapy)
225372007	SNOMED CT	2.16.840.1.113883.6.96	total parenteral nutrition (regime/therapy)
448556005	SNOMED CT	2.16.840.1.113883.6.96	oral nutritional support

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Table 358: Planned moodCode (Act/Encounter/Procedure)

Value Set: Planned moodCode (Act/Encounter/Procedure) 2.16.840.1.113883.11.20.9.23 This value set is used to restrict the moodCode on an act, an encounter or a procedure to future moods Value Set Source: http://hl7.org/implement/standards/fhir/v3/ActMood/			
Code	**Code System**	**Code System OID**	**Print Name**
INT	ActMood	2.16.840.1.113883.5.1001	Intent
ARQ	ActMood	2.16.840.1.113883.5.1001	Appointment Request
PRMS	ActMood	2.16.840.1.113883.5.1001	Promise
PRP	ActMood	2.16.840.1.113883.5.1001	Proposal
RQO	ActMood	2.16.840.1.113883.5.1001	Request
APT	ActMood	2.16.840.1.113883.5.1001	Appointment

Figure 185: Nutrition Recommendation Example

```
<entry>
    <act moodCode="INT" classCode="ACT">
        <!-- Nutrition Recommendation ACT-->
        <templateId root="2.16.840.1.113883.10.20.22.4.130" />
        <id root="9a6d1bac-17d3-4195-89a4-1121bc809a5c" />
        <code code="61310001"
               displayName="nutrition education"
               codeSystem="2.16.840.1.113883.6.96"
               codeSystemName="SNOMED CT" />
        <statusCode code="active" />
        <effectiveTime value="20130512" />
    </act>
</entry>
```

4.57 Nutritional Status Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.124 (open)]

Table 359: Nutritional Status Observation Contexts

Contained By:	Contains:
Nutrition Section (optional) Health Concern Act (optional) Risk Concern Act (optional)	Nutrition Assessment

This template describes the overall nutritional status of the patient including findings related to nutritional status.

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Table 360: Nutritional Status Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.124)					
@classCode	1..1	SHALL		1098-29841	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-29842	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-29843	
@root	1..1	SHALL		1098-29844	2.16.840.1.113883.10.20.22.4.124
id	1..*	SHALL		1098-29845	
code	1..1	SHALL		1098-29846	
@code	1..1	SHALL		1098-29897	75305-3
@codeSystem	1..1	SHALL		1098-29898	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-29852	
@code	1..1	SHALL		1098-29853	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-31867	
value	1..1	SHALL		1098-29854	2.16.840.1.113883.1.11.20.2.7 (Nutritional Status)
entryRelationship	1..*	SHALL		1098-30323	
@typeCode	1..1	SHALL		1098-30335	SUBJ
observation	1..1	SHALL		1098-30336	Nutrition Assessment (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.138

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" Observation (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-29841).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-29842).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-29843) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.124`" (CONF:1098-29844).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-29845).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-29846).

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a. This code **SHALL** contain exactly one [1..1] **@code**="75305-3" Nutrition status (CONF:1098-29897).
b. 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:1098-29898).

6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-29852).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-29853).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-31867).
8. **SHALL** contain exactly one [1..1] **value**, which **SHOULD** be selected from ValueSet **Nutritional Status** 2.16.840.1.113883.1.11.20.2.7 **DYNAMIC** (CONF:1098-29854).
9. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-30323) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has subject (CONF:1098-30335).
   b. **SHALL** contain exactly one [1..1] **Nutrition Assessment** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.138) (CONF:1098-30336).

Table 361: Nutritional Status

Value Set: Nutritional Status 2.16.840.1.113883.1.11.20.2.7 A Value Set of SNOMED-CT codes representing nutrition problems. Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
371597004	SNOMED CT	2.16.840.1.113883.6.96	emaciated (finding)
284670008	SNOMED CT	2.16.840.1.113883.6.96	nutritionally compromised (finding)
248325000	SNOMED CT	2.16.840.1.113883.6.96	undernourished (finding)
248324001	SNOMED CT	2.16.840.1.113883.6.96	well nourished (finding)
75051000	SNOMED CT	2.16.840.1.113883.6.96	Food intolerance (finding)
414285001	SNOMED CT	2.16.840.1.113883.6.96	Food allergy (disorder)
414915002	SNOMED CT	2.16.840.1.113883.6.96	Obese (finding)
288939007	SNOMED CT	2.16.840.1.113883.6.96	Swallowing difficulty (finding)
61578001	SNOMED CT	2.16.840.1.113883.6.96	Altered GI function
95907004	SNOMED CT	2.16.840.1.113883.6.96	drug interaction with food (finding)
…			

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Figure 186: 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 code="75305-3"
          displayName="Nutrition status"
          codeSystem="2.16.840.1.113883.6.1"
          codeSystemName="LOINC">
        <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" />
            ...
        </observation>
    </entryRelationship>
</observation>
```

4.58 Outcome Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.144 (open)]

Table 362: Outcome Observation Contexts

Contained By:	Contains:
Health Status Evaluations and Outcomes Section (required)	Author Participation Entry Reference External Document Reference Progress Toward Goal Observation

This template represents the outcome of care resulting from the interventions used to treat the patient. In the Care Planning workflow, the judgment about how well the person is progressing towards the goal is based on the observations made about the status of the patient with respect to interventions performed in the pursuit of achieving that goal.

Often thought of as an "actual outcome", the Outcome Observation may be related to goals, progression toward goals, and the associated interventions. For example, an observation

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outcome of a blood oxygen saturation level of 95% is related to the goal of "Maintain Pulse Ox greater than 92", which in turn is related to the health concern of respiratory insufficiency and the problem of pneumonia. The template makes use of the Entry Reference (templateId:2.16.840.1.113883.10.20.22.4.122) to reference the interventions and goals defined elsewhere in the Care Plan CDA instance.

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Table 363: Outcome Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.144)					
@classCode	1..1	SHALL		1098-31219	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-31220	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-31221	
@root	1..1	SHALL		1098-31222	2.16.840.1.113883.10.20.22.4.144
id	1..*	SHALL		1098-31223	
code	1..1	SHALL		1098-32746	2.16.840.1.113883.6.1 (LOINC)
value	0..1	SHOULD		1098-32747	
author	0..*	SHOULD		1098-31553	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	SHOULD		1098-31224	
@typeCode	1..1	SHALL		1098-31225	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = GEVL
act	1..1	SHALL		1098-32465	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
entryRelationship	0..1	SHOULD		1098-31427	
@typeCode	1..1	SHALL		1098-31428	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT
@inversionInd	1..1	SHALL		1098-31429	true
observation	1..1	SHALL		1098-31430	Progress Toward Goal Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.110
entryRelationship	0..*	MAY		1098-31688	
@typeCode	1..1	SHALL		1098-31689	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
act	1..1	SHALL		1098-31690	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
reference	0..*	MAY		1098-32763	

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@typeCode	1..1	SHALL		1098-32764	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
externalDocument	1..1	SHALL		1098-32765	External Document Reference (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-31219).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-31220).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-31221) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.144" (CONF:1098-31222).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-31223).
5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from CodeSystem LOINC (2.16.840.1.113883.6.1) (CONF:1098-32746).
6. **SHOULD** contain zero or one [0..1] **value** (CONF:1098-32747).
7. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31553).

The following entryRelationship represents the relationship between an Outcome Observation and a Goal Observation. Because the Goal Observation is already described in the CDA document instance's Goals section, rather than repeating the full content of the Goal Observation, the Entry Reference template can be used to reference this entry.

8. **SHOULD** contain zero or more [0..*] **entryRelationship** (CONF:1098-31224) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="GEVL" Evaluates goal (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31225).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-32465).
    c. This entryReference template **SHALL** reference an instance of a Goal Observation template (CONF:1098-32461).

The following entryRelationship represents the relationship between an Outcome Observation and a Progress Toward Goal Observation (Outcome Observation SUPPORTS Progress Toward Goal Observation). In the Care Planning workflow, the judgment about how well the person is progressing towards the goal is based on the observations made about the status of the patient with respect to interventions performed in the pursuit of achieving that goal.

9. **SHOULD** contain zero or one [0..1] **entryRelationship** (CONF:1098-31427) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SPRT" Has support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31428).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" (CONF:1098-31429).
    c. **SHALL** contain exactly one [1..1] **Progress Toward Goal Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.110) (CONF:1098-31430).

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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 Entry Reference template may be used to reference this entry.

10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31688) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31689).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-31690).
    c. This entryReference template **SHALL** reference an instance of a Intervention Act template (CONF:1098-32462).
11. **MAY** contain zero or more [0..*] **reference** (CONF:1098-32763).
    a. The reference, if present, **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32764).
    b. The reference, if present, **SHALL** contain exactly one [1..1] **External Document Reference** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09) (CONF:1098-32765).
12. SHALL contain at least one 1..*] entryRelationships (CONF:1098-32782).

Figure 187: 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="44616-1" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Pulse oximetry panel" />
    <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>
```


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4.59 Patient Referral Act

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.140 (open)]

Table 364: Patient Referral Act Contexts

Contained By:	Contains:
Reason for Referral Section (V2) (optional)	Author Participation Indication (V2)

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).

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Table 365: Patient Referral Act Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.140)					
@classCode	1..1	SHALL		1098-30884	2.16.840.1.113883.5.6 (HL7ActClass) = PCPR
@moodCode	1..1	SHALL		1098-30885	2.16.840.1.113883.11.20.9.66 (Patient Referral Act moodCode)
templateId	1..1	SHALL		1098-30886	
@root	1..1	SHALL		1098-30887	2.16.840.1.113883.10.20.22.4.140
id	1..*	SHALL		1098-30888	
code	1..1	SHALL		1098-30889	2.16.840.1.113883.11.20.9.56 (Referral Types)
statusCode	1..1	SHALL		1098-30892	
@code	1..1	SHALL		1098-31598	2.16.840.1.113883.5.14 (ActStatus) = active
effectiveTime	1..1	SHALL		1098-30893	
priorityCode	0..1	SHOULD		1098-32623	
author	0..*	SHOULD		1098-31612	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	0..*	MAY		1098-32635	
@typeCode	1..1	SHALL		1098-32638	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFT
participantRole	1..1	SHALL		1098-32636	
code	0..1	MAY		1098-32637	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
entryRelationship	0..*	MAY		1098-31604	
@typeCode	1..1	SHALL		1098-31613	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
observation	1..1	SHALL		1098-31605	
@classCode	1..1	SHALL		1098-31606	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-31607	2.16.840.1.113883.5.1001 (ActMood) = RQO
code	1..1	SHALL		1098-	

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				31608	
@code	1..1	SHALL		1098-31619	ASSERTION
@codeSystem	1..1	SHALL		1098-31620	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
statusCode	1..1	SHALL		1098-31614	
@code	1..1	SHALL		1098-31615	2.16.840.1.113883.5.14 (ActStatus) = completed
priorityCode	0..1	SHOULD		1098-32443	2.16.840.1.113883.1.11.16866 (Act Priority)
value	1..1	SHALL	CD	1098-31611	2.16.840.1.113883.11.20.9.61 (Care Model)
entryRelationship	0..*	MAY		1098-31635	
@typeCode	1..1	SHALL		1098-31636	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-32634	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="PCPR" provision of care (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-30884).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **Patient Referral Act moodCode** 2.16.840.1.113883.11.20.9.66 **STATIC** 2014-09-01 (CONF:1098-30885).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30886) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.140" (CONF:1098-30887).

In the case of a Consultation Note where this referral is being fulfilled by this consultation, this id would be referenced in the inFullfilmentOf/order/id of the Consultation Note.

4. **SHALL** contain at least one [1..*] **id** (CONF:1098-30888).
5. **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet **Referral Types** 2.16.840.1.113883.11.20.9.56 **DYNAMIC** (CONF:1098-30889).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-30892).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31598).

The effectiveTime represents the time when the future referral is intended to take place.

7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-30893).
8. **SHOULD** contain zero or one [0..1] **priorityCode** (CONF:1098-32623).
9. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31612).
10. **MAY** contain zero or more [0..*] **participant** (CONF:1098-32635).

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a. The participant, if present, **SHALL** contain exactly one [1..1] **@typeCode**="REFT" Referred to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32638).
b. The participant, if present, **SHALL** contain exactly one [1..1] **participantRole** (CONF:1098-32636).
    i. This participantRole **MAY** 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:1098-32637).

The following entryRelationship represents whether the referral is for full or shared care.

11. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31604) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31613).
    b. **SHALL** contain exactly one [1..1] **observation** (CONF:1098-31605).
        i. This observation **SHALL** contain exactly one [1..1] **@classCode**="OBS" observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-31606).
        ii. This observation **SHALL** contain exactly one [1..1] **@moodCode**="RQO" request (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-31607).
        iii. This observation **SHALL** contain exactly one [1..1] **code** (CONF:1098-31608).
            1. This code **SHALL** contain exactly one [1..1] **@code**="ASSERTION" assertion (CONF:1098-31619).
            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:1098-31620).
        iv. This observation **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-31614).
            1. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31615).
        v. This observation **SHOULD** contain zero or one [0..1] **priorityCode** (ValueSet: **Act Priority** 2.16.840.1.113883.1.11.16866 **DYNAMIC**) (CONF:1098-32443).
        vi. This observation **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **Care Model** 2.16.840.1.113883.11.20.9.61 **STATIC** 2014-06-19 (CONF:1098-31611).

The following entryRelationship represents a reference to another act in the document instance representing the clinical reason for the referral (e.g., problem, concern, procedure).

12. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31635) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31636).
    b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-32634).

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Table 366: Patient Referral Act moodCode

Value Set: Patient Referral Act moodCode 2.16.840.1.113883.11.20.9.66 Contains all the moodCode values it is possible to have for an Patient Referral Act. Value Set Source: http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html			
Code	**Code System**	**Code System OID**	**Print Name**
INT	ActMood	2.16.840.1.113883.5.1001	Intent
RQO	ActMood	2.16.840.1.113883.5.1001	Request

Table 367: 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). Value Set Source: http://vtsl.vetmed.vt.edu/TerminologyMgt/RF2Browser/ISA.cfm?SCT_ConceptID=3457005			
Code	**Code System**	**Code System OID**	**Print Name**
44383000	SNOMED CT	2.16.840.1.113883.6.96	Patient referral for consultation
391034007	SNOMED CT	2.16.840.1.113883.6.96	Refer for falls assessment (procedure)
86395003	SNOMED CT	2.16.840.1.113883.6.96	patient referral for family planning (procedure)
306106002	SNOMED CT	2.16.840.1.113883.6.96	referral to intensive care service (procedure)
306140002	SNOMED CT	2.16.840.1.113883.6.96	referral to clinical oncology service (procedure)
396150002	SNOMED CT	2.16.840.1.113883.6.96	Referral for substance abuse (procedure)
…			

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Table 368: 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". Value Set Source: http://vtsl.vetmed.vt.edu/TerminologyMgt/RF2Browser/ISA.cfm?SCT_ConceptID=170932006			
Code	**Code System**	**Code System OID**	**Print Name**
370985002	SNOMED CT	2.16.840.1.113883.6.96	care by local physician (finding)
170941001	SNOMED CT	2.16.840.1.113883.6.96	full care by GP (finding)
170935008	SNOMED CT	2.16.840.1.113883.6.96	full care by hospice (finding)
268528005	SNOMED CT	2.16.840.1.113883.6.96	full care by specialist (finding)
170939002	SNOMED CT	2.16.840.1.113883.6.96	full care: nurse practitioner (finding)
268529002	SNOMED CT	2.16.840.1.113883.6.96	shared care - consultant and GP (finding)
170936009	SNOMED CT	2.16.840.1.113883.6.96	shared care - hospice and GP (finding)
170937000	SNOMED CT	2.16.840.1.113883.6.96	shared care: district nurse and GP (finding)
170940000	SNOMED CT	2.16.840.1.113883.6.96	shared care: practice nurse and GP (finding)

Table 369: Act Priority

Value Set: Act Priority 2.16.840.1.113883.1.11.16866 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
A	ActPriority	2.16.840.1.113883.5.7	ASAP
CR	ActPriority	2.16.840.1.113883.5.7	Callback results
CS	ActPriority	2.16.840.1.113883.5.7	Callback for scheduling
CSP	ActPriority	2.16.840.1.113883.5.7	Callback placer for scheduling
CSR	ActPriority	2.16.840.1.113883.5.7	Contact recipient for scheduling
EL	ActPriority	2.16.840.1.113883.5.7	Elective
EM	ActPriority	2.16.840.1.113883.5.7	Emergency
P	ActPriority	2.16.840.1.113883.5.7	Preoperative
PRN	ActPriority	2.16.840.1.113883.5.7	As needed
R	ActPriority	2.16.840.1.113883.5.7	Routine
…			

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Figure 188: 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" />
        <statusCode code="active" />
        <effectiveTime value="20130311" />
        <priorityCode code="A"
               codeSystem="2.16.840.1.113883.5.7"
               codeSystemName="ActPriority"
               displayName="ASAP"/>
        <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>
```


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4.60 Planned Act (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09 (open)]

Table 370: Planned Act (V2) Contexts

Contained By:	Contains:
Plan of Treatment Section (V2) (optional) Nutrition Recommendation (optional) Assessment and Plan Section (V2) (optional) Planned Intervention Act (optional)	Author Participation Indication (V2) Instruction (V2) Priority Preference

This template represents planned acts that are not classified as an observation or a procedure according to the HL7 RIM. Examples of these acts are a dressing change, the teaching or feeding of a patient or the providing of comfort measures.

The priority of the activity to the patient and provider is communicated through Priority Preference. The effectiveTime indicates the time when the activity is intended to take place.

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Table 371: Planned Act (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09)					
@classCode	1..1	SHALL		1098-8538	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-8539	2.16.840.1.113883.11.20.9.23 (Planned moodCode (Act/Encounter/Procedure))
templateId	1..1	SHALL		1098-30430	
@root	1..1	SHALL		1098-30431	2.16.840.1.113883.10.20.22.4.39
@extension	1..1	SHALL		1098-32552	2014-06-09
id	1..*	SHALL		1098-8546	
code	1..1	SHALL		1098-31687	
statusCode	1..1	SHALL		1098-30432	
@code	1..1	SHALL		1098-32019	2.16.840.1.113883.5.14 (ActStatus) = active
effectiveTime	0..1	SHOULD		1098-30433	
performer	0..*	MAY		1098-30435	
author	0..1	SHOULD		1098-32020	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-31067	
@typeCode	1..1	SHALL		1098-31068	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31069	Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143
entryRelationship	0..*	MAY		1098-32021	
@typeCode	1..1	SHALL		1098-32022	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-32023	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
entryRelationship	0..*	MAY		1098-32024	

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@typeCode	1..1	SHALL		1098-32025	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
act	1..1	SHALL		1098-32026	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8538).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **Planned moodCode (Act/Encounter/Procedure)** 2.16.840.1.113883.11.20.9.23 **STATIC** 2011-09-30 (CONF:1098-8539).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30430) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.39" (CONF:1098-30431).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32552).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8546).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-31687).
   a. This code in a Planned 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:1098-32030).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-30432).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-32019).

The effectiveTime in a planned act represents the time that the act should occur.

7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-30433).

The clinician who is expected to carry out the act could be identified using act/performer.

8. **MAY** contain zero or more [0..*] **performer** (CONF:1098-30435).

The author in a planned act represents the clinician who is requesting or planning the act.

9. **SHOULD** contain zero or one [0..1] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32020).

The following entryRelationship represents the priority that a patient or a provider places on the activity.

10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31067) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31068).
    b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31069).

The following entryRelationship represents the indication for the act.

11. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32021) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32022).

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b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-32023).

The following entryRelationship captures any instructions associated with the planned act.

12. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32024) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32025).
    b. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-32026).

Figure 189: Planned Act (V2) Example

```
<act classCode="ACT" moodCode="INT">
    <templateId root="2.16.840.1.113883.10.20.22.4.39" extension="2014-06-09" />
    <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" />
    <effectiveTime value="20130902" />
    <author typeCode="AUT">
        <!-- Author Participation -->
    </author>
    <entryRelationship typeCode="RSON">
        <!-- Patient Priority Preference -->
    ...

    </entryRelationship>
    <entryRelationship typeCode="RSON">
        <!-- Provider Priority Preference -->
    ...

    </entryRelationship>
    <entryRelationship typeCode="RSON">
        <!-- Indication (V2) -->
    ...

    </entryRelationship>
    <entryRelationship typeCode="SUBJ">
        <!-- Instruction (V2) -->
    ...

    </entryRelationship>
    <entryRelationship typeCode="COMP">
        <!-- Planned Coverage -->
    ...

    </entryRelationship>
</act>
```


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4.61 Planned Coverage

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.129 (open)]

Table 372: Planned Coverage Contexts

Contained By:	Contains:
Planned Procedure (V2) (optional) Planned Observation (V2) (optional) Planned Supply (V2) (optional)	Author Participation

This template represents the insurance coverage intended to cover an act or procedure.

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Table 373: Planned Coverage Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.129)					
@classCode	1..1	SHALL		1098-31945	2.16.840.1.113883.5.4 (ActCode) = ACT
@moodCode	1..1	SHALL		1098-31946	2.16.840.1.113883.5.1001 (ActMood) = INT
templateId	1..1	SHALL		1098-31947	
@root	1..1	SHALL		1098-31948	2.16.840.1.113883.10.20.22.4.129
id	1..*	SHALL		1098-31950	
code	1..1	SHALL		1098-31951	
@code	1..1	SHALL		1098-31952	48768-6
@codeSystem	1..1	SHALL		1098-31953	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-31954	
@code	1..1	SHALL		1098-31955	2.16.840.1.113883.5.4 (ActCode) = active
author	0..*	MAY		1098-32178	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	1..1	SHALL		1098-31967	
@typeCode	1..1	SHALL		1098-31968	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
act	1..1	SHALL		1098-31969	
@classCode	1..1	SHALL		1098-31970	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-31971	2.16.840.1.113883.5.1001 (ActMood) = INT
id	1..*	SHALL		1098-31972	
code	1..1	SHALL		1098-31973	2.16.840.1.114222.4.11.3591 (Source of Payment Typology (PHDSC))
statusCode	1..1	SHALL		1098-31974	
@code	1..1	SHALL		1098-31975	2.16.840.1.113883.5.14 (ActStatus) = active

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1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" act (CodeSystem: ActCode 2.16.840.1.113883.5.4) (CONF:1098-31945).
2. **SHALL** contain exactly one [1..1] **@moodCode**="INT" Intent (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-31946).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-31947) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.129" (CONF:1098-31948).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-31950).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-31951).
    a. This code **SHALL** contain exactly one [1..1] **@code**="48768-6" Payment Sources (CONF:1098-31952).
    b. 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:1098-31953).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-31954).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="active" Active (CodeSystem: ActCode 2.16.840.1.113883.5.4) (CONF:1098-31955).
7. **MAY** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32178).
8. **SHALL** contain exactly one [1..1] **entryRelationship** (CONF:1098-31967) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31968).
    b. **SHALL** contain exactly one [1..1] **act** (CONF:1098-31969).
        i. This act **SHALL** contain exactly one [1..1] **@classCode**="ACT" ACT (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-31970).
        ii. This act **SHALL** contain exactly one [1..1] **@moodCode**="INT" intent (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-31971).

These act/identifiers are unique identifiers for the policy or program providing the coverage.

        iii. This act **SHALL** contain at least one [1..*] **id** (CONF:1098-31972).
        iv. This act **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet **Source of Payment Typology (PHDSC)** 2.16.840.1.114222.4.11.3591 **DYNAMIC** (CONF:1098-31973).
        v. This act **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-31974).
            1. This statusCode **SHALL** contain exactly one [1..1] **@code**="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31975).

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Table 374: Source of Payment Typology (PHDSC)

Value Set: Source of Payment Typology (PHDSC) 2.16.840.1.114222.4.11.3591 A value set of Public Health Data Standards Consortium Source of Payment Typology Version 3.0 Codes Value Set Source: http://www.phdsc.org/standards/payer-typology.asp			
Code	**Code System**	**Code System OID**	**Print Name**
1	Source of Payment Typology (PHDSC)	2.16.840.1.113883.3.221.5	Medicare
2	Source of Payment Typology (PHDSC)	2.16.840.1.113883.3.221.5	Medicaid
311	Source of Payment Typology (PHDSC)	2.16.840.1.113883.3.221.5	Tricare (CHAMPUS)
33	Source of Payment Typology (PHDSC)	2.16.840.1.113883.3.221.5	Indian Health Service or Tribe
62	Source of Payment Typology (PHDSC)	2.16.840.1.113883.3.221.5	BC Indemnity
61	Source of Payment Typology (PHDSC)	2.16.840.1.113883.3.221.5	BC Managed Care
611	Source of Payment Typology (PHDSC)	2.16.840.1.113883.3.221.5	BC Managed Care - HMO
619	Source of Payment Typology (PHDSC)	2.16.840.1.113883.3.221.5	BC Managed Care - Other
613	Source of Payment Typology (PHDSC)	2.16.840.1.113883.3.221.5	BC Managed Care - POS
612	Source of Payment Typology (PHDSC)	2.16.840.1.113883.3.221.5	BC Managed Care - PPO
...			

Figure 190: Planned Coverage Example

```
<act classCode="ACT" moodCode="INT">
    <templateId root="2.16.840.1.113883.10.20.22.4.129" />
    <id root="03f5e10b-7e79-4610-9626-d2984ff10cc1" />
    <code code="48768-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Payment Sources" />
    <statusCode code="active" />
    <entryRelationship typeCode="COMP">
        <act classCode="ACT" moodCode="INT">
            <!-- These act/identifiers are unique identifiers
        for the policy or program providing the coverage. -->
            <id root="4c9a3be1-5f09-46dd-88e7-14c8ec612e4c" />
            <code code="111" displayName="Medicare HMO"
                      codeSystemName="Source of Payment Typology (PHDSC)"
                      codeSystem="2.16.840.1.113883.3.221.5" />
            <statusCode code="active" />
        </act>
    </entryRelationship>
</act>
```


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4.62 Planned Encounter (V2)

```
[encounter: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09
(open)]
```

Table 375: Planned Encounter (V2) Contexts

Contained By:	Contains:
Plan of Treatment Section (V2) (optional) Nutrition Recommendation (optional) Planned Intervention Act (optional)	Author Participation Indication (V2) Priority Preference Service Delivery Location

This template represents a planned or ordered encounter. The type of encounter (e.g., comprehensive outpatient visit) is represented. Clinicians participating in the encounter and the location of the planned encounter may be captured. The priority that the patient and providers place on the encounter may be represented.

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Table 376: Planned Encounter (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
encounter (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09)					
@classCode	1..1	SHALL		1098-8564	2.16.840.1.113883.5.6 (HL7ActClass) = ENC
@moodCode	1..1	SHALL		1098-8565	2.16.840.1.113883.11.20.9.23 (Planned moodCode (Act/Encounter/Procedure))
templateId	1..1	SHALL		1098-30437	
@root	1..1	SHALL		1098-30438	2.16.840.1.113883.10.20.22.4.40
@extension	1..1	SHALL		1098-32553	2014-06-09
id	1..*	SHALL		1098-8567	
code	0..1	SHOULD		1098-31032	2.16.840.1.113883.11.20.9.52 (Encounter Planned)
statusCode	1..1	SHALL		1098-30439	
@code	1..1	SHALL		1098-31880	2.16.840.1.113883.5.14 (ActStatus) = active
effectiveTime	0..1	SHOULD		1098-30440	
performer	0..*	MAY		1098-30442	
assignedEntity	1..1	SHALL		1098-31874	
author	0..*	SHOULD		1098-32045	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	0..*	MAY		1098-30443	
@typeCode	1..1	SHALL		1098-31875	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = LOC
participantRole	1..1	SHALL		1098-31876	Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32
entryRelationship	0..1	MAY		1098-31033	
@typeCode	1..1	SHALL		1098-31034	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31035	Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143

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entryRelationship	0..*	MAY		1098-31877	
@typeCode	1..1	SHALL		1098-31878	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-31879	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ENC" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8564).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **Planned moodCode (Act/Encounter/Procedure)** 2.16.840.1.113883.11.20.9.23 **STATIC** 2011-09-30 (CONF:1098-8565).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30437) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.40" (CONF:1098-30438).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32553).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8567).

Records the type of encounter ordered or recommended.

5. **SHOULD** contain zero or one [0..1] **code**, which **SHOULD** be selected from ValueSet **Encounter Planned** 2.16.840.1.113883.11.20.9.52 **DYNAMIC** (CONF:1098-31032).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-30439).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31880).
7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-30440).

Performers represent clinicians who are responsible for assessing and treating the patient.

8. **MAY** contain zero or more [0..*] **performer** (CONF:1098-30442) such that it
   a. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-31874).

The author in a planned encounter represents the clinician who is requesting or planning the encounter.

9. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32045).

This location participation captures where the planned or ordered encounter may take place.

10. **MAY** contain zero or more [0..*] **participant** (CONF:1098-30443) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31875).
    b. **SHALL** contain exactly one [1..1] **Service Delivery Location** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32) (CONF:1098-31876).

The following entryRelationship represents the priority that a patient or a provider places on the encounter.

11. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-31033) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31034).

b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31035).

The following entryRelationship captures the reason for the planned or ordered encounter

12. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31877) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31878).

b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-31879).

Table 377: Encounter Planned

Value Set: Encounter Planned 2.16.840.1.113883.11.20.9.52
A value set of SNOMED-CT codes descending from "308335008" patient encounter procedure (procedure).
Value Set Source:
http://vtsl.vetmed.vt.edu/TerminologyMgt/RF2Browser/ISA.cfm?SCT_ConceptID=308335008

Code	Code System	Code System OID	Print Name
185349003	SNOMED CT	2.16.840.1.113883.6.96	encounter for "check-up" (procedure)
439740005	SNOMED CT	2.16.840.1.113883.6.96	postoperative follow-up visit (procedure)
439708006	SNOMED CT	2.16.840.1.113883.6.96	home visit (procedure)
438515009	SNOMED CT	2.16.840.1.113883.6.96	E-mail encounter from carer (procedure)
14736009	SNOMED CT	2.16.840.1.113883.6.96	patient evaluation and management
4525004	SNOMED CT	2.16.840.1.113883.6.96	emergency department patient visit
12586001	SNOMED CT	2.16.840.1.113883.6.96	physician direction of emergency medical systems
11429006	SNOMED CT	2.16.840.1.113883.6.96	consultation
680007	SNOMED CT	2.16.840.1.113883.6.96	radiation physics consultation
726007	SNOMED CT	2.16.840.1.113883.6.96	pathology consultation, comprehensive, records and specimen with report
…			

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Figure 191: Planned Encounter (V2) Example

```
<entry>
    <encounter moodCode="INT" classCode="ENC">
        <templateId root="2.16.840.1.113883.10.20.22.4.40" extension="2014-06-09" />
        <!-- Planned Encounter V2 template -->
        <id root="9a6d1bac-17d3-4195-89a4-1121bc809b4d" />
        <code code="185349003" displayName="encounter for check-up (procedure)"
codeSystemName="SNOMED CT" codeSystem="2.16.840.1.113883.6.96"> </code>
        <statusCode code="active" />
        <effectiveTime value="20130615" />
        <performer>
            <assignedEntity>
                ...
            </assignedEntity>
        </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-->
               ...
            </observation>
        </entryRelationship>
    </encounter>
</entry>
```

4.63 Planned Immunization Activity

[substanceAdministration: identifier urn:oid:2.16.840.1.113883.10.20.22.4.120 (open)]

Table 378: Planned Immunization Activity Contexts

Contained By:	Contains:
Plan of Treatment Section (V2) (optional) Planned Intervention Act (optional)	Author Participation Immunization Medication Information (V2) Indication (V2) Instruction (V2) Precondition for Substance Administration (V2) Priority Preference

This template represents planned immunizations. Planned Immunization Activity is very similar to Planned Medication Activity with some key differences, for example, the drug code system is constrained to CVX codes.

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The priority of the immunization activity to the patient and provider is communicated through Priority Preference. The effectiveTime indicates the time when the immunization activity is intended to take place and authorTime indicates when the documentation of the plan occurred.

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Table 379: Planned Immunization Activity Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
substanceAdministration (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.120)					
@classCode	1..1	SHALL		1098-32091	SBADM
@moodCode	1..1	SHALL		1098-32097	2.16.840.1.113883.11.20.9.24 (Planned moodCode (SubstanceAdministration/Supply))
templateId	1..1	SHALL		1098-32098	
@root	1..1	SHALL		1098-32099	2.16.840.1.113883.10.20.22.4.120
id	1..*	SHALL		1098-32100	
statusCode	1..1	SHALL		1098-32101	
@code	1..1	SHALL		1098-32102	2.16.840.1.113883.5.14 (ActStatus) = active
effectiveTime	1..1	SHALL		1098-32103	
repeatNumber	0..1	MAY		1098-32126	
routeCode	0..1	MAY		1098-32127	2.16.840.1.113883.3.88.12.3221.8.7 (Medication Route FDA)
approachSiteCode	0..*	MAY		1098-32128	2.16.840.1.113883.3.88.12.3221.8.9 (Body Site)
doseQuantity	0..1	MAY		1098-32129	
@unit	0..1	SHOULD		1098-32130	2.16.840.1.113883.1.11.12839 (UnitsOfMeasureCaseSensitive)
consumable	1..1	SHALL		1098-32131	
manufacturedProduct	1..1	SHALL		1098-32132	Immunization Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09
performer	0..*	MAY		1098-32104	
author	0..*	MAY		1098-32105	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-32108	
@typeCode	1..1	SHALL		1098-32109	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR

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observation	1..1	SHALL		1098-32110	Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143
entryRelationship	0..*	MAY		1098-32114	
@typeCode	1..1	SHALL		1098-32115	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-32116	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
entryRelationship	0..*	MAY		1098-32117	
@typeCode	1..1	SHALL		1098-32118	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
act	1..1	SHALL		1098-32119	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
precondition	0..*	MAY		1098-32123	
@typeCode	1..1	SHALL		1098-32124	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = PRCN
criterion	1..1	SHALL		1098-32125	Precondition for Substance Administration (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="SBADM" (CONF:1098-32091).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **Planned moodCode (SubstanceAdministration/Supply)** 2.16.840.1.113883.11.20.9.24 **STATIC** 2014-09-01 (CONF:1098-32097).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-32098) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.120" (CONF:1098-32099).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-32100).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-32101).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-32102).

The effectiveTime in a planned immunization activity represents the time that the immunization activity should occur.

6. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-32103).

In a Planned Immunization Activity, repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times.

7. **MAY** contain zero or one [0..1] **repeatNumber** (CONF:1098-32126).

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8. **MAY** contain zero or one [0..1] **routeCode**, which **SHALL** be selected from ValueSet **Medication Route FDA** 2.16.840.1.113883.3.88.12.3221.8.7 **DYNAMIC** (CONF:1098-32127).
9. **MAY** contain zero or more [0..*] **approachSiteCode**, which **SHALL** be selected from ValueSet **Body Site** 2.16.840.1.113883.3.88.12.3221.8.9 **DYNAMIC** (CONF:1098-32128).
10. **MAY** contain zero or one [0..1] **doseQuantity** (CONF:1098-32129).
    a. The doseQuantity, if present, **SHOULD** contain zero or one [0..1] **@unit**, which **SHALL** be selected from ValueSet **UnitsOfMeasureCaseSensitive** 2.16.840.1.113883.1.11.12839 **DYNAMIC** (CONF:1098-32130).
11. **SHALL** contain exactly one [1..1] **consumable** (CONF:1098-32131).
    a. This consumable **SHALL** contain exactly one [1..1] **Immunization Medication Information (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09) (CONF:1098-32132).

The clinician who is expected to perform the planned immunization activity could be identified using substanceAdministration/performer.

12. **MAY** contain zero or more [0..*] **performer** (CONF:1098-32104).

The author in a planned immunization activity represents the clinician who is requesting or planning the immunization activity.

13. **MAY** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32105).

The following entryRelationship represents the priority that a patient or a provider places on the immunization activity.

14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32108) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32109).
    b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-32110).

The following entryRelationship represents the indication for the immunization activity.

15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32114) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32115).
    b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-32116).

The following entryRelationship captures any instructions associated with the planned immunization activity.

16. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32117) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32118).

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b. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-32119).

17. **MAY** contain zero or more [0..*] **precondition** (CONF:1098-32123) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="PRCN" Precondition (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32124).
    b. **SHALL** contain exactly one [1..1] **Precondition for Substance Administration (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09) (CONF:1098-32125).

Table 380: Planned moodCode (SubstanceAdministration/Supply)

Value Set: Planned moodCode (SubstanceAdministration/Supply) 2.16.840.1.113883.11.20.9.24 This value set is used to restrict the moodCode on a substance administration or a supply to future moods. Value Set Source: **http://hl7.org/implement/standards/fhir/v3/ActMood/**			
Code	**Code System**	**Code System OID**	**Print Name**
INT	ActMood	2.16.840.1.113883.5.1001	Intent
PRMS	ActMood	2.16.840.1.113883.5.1001	Promise
PRP	ActMood	2.16.840.1.113883.5.1001	Proposal
RQO	ActMood	2.16.840.1.113883.5.1001	Request

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Figure 192: Planned Immunization Activity

```
<substanceAdministration classCode="SBADM" moodCode="INT">
    <!--  Planned Immunization Activity -->
    <templateId root="2.16.840.1.113883.10.20.22.4.120" />
    <id root="81505d5e-2305-42b3-9273-f579d622000d" />
    <statusCode code="active" />
    <effectiveTime xsi:type="IVL_TS" value="20131115" />
    <repeatNumber value="1" />
    <routeCode code="IM" codeSystem="2.16.840.1.113883.5.112"
codeSystemName="RouteOfAdministration" displayName="Intramuscular injection" />
    <consumable>
        <!-- Immunization Medication Information (V2) -->
    </consumable>
    <performer>
        ...
    </performer>
    <author>
        <!-- Author Participation -->
    </author>
    <entryRelationship typeCode="REFR">
        <!-- Patient Priority Preference -->
        ...
    </entryRelationship>
    <entryRelationship typeCode="REFR">
        <!-- Provider Priority Preference -->
        ...
    </entryRelationship>
    <entryRelationship typeCode="RSON">
        <!-- Indication (V2) -->
        ...
    </entryRelationship>
    <entryRelationship typeCode="SUBJ">
        <!-- Instruction (V2) -->
        ...
    </entryRelationship>
    <precondition typeCode="PRCN">
        <!-- Precondition for Substance Administration (V2) -->
        ...
    </precondition>
</substanceAdministration>
```


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4.64 Planned Intervention Act

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.146 (open)]

Table 381: Planned Intervention Act Contexts

Contained By:	Contains:
Interventions Section (V2) (optional) Intervention Act (optional)	Advance Directive Observation (V2) Author Participation Encounter Activity (V2) Entry Reference External Document Reference Handoff Communication Participants Immunization Activity (V2) Instruction (V2) Intervention Act Medication Activity (V2) Non-Medicinal Supply Activity (V2) Nutrition Recommendation Planned Act (V2) Planned Encounter (V2) Planned Immunization Activity Planned Medication Activity (V2) Planned Observation (V2) Planned Procedure (V2) Planned Supply (V2) Procedure Activity Act (V2) Procedure Activity Observation (V2) Procedure Activity Procedure (V2)

This template represents a Planned Intervention Act. It is a wrapper for planned intervention-type activities considered to be parts of the same intervention. For example, an activity such as "elevate head of bed" combined with "provide humidified O2 per nasal cannula" may be the interventions 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 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.

Planned Intervention Acts can be related to each other or to Intervention Acts. (E.g., a Planned 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.)

All interventions referenced in a Planned Intervention Act must have moodCodes indicating that that are planned (have not yet occurred).

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Table 382: Planned Intervention Act Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.146)					
@classCode	1..1	SHALL		1098-32678	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-32679	2.16.840.1.113883.11.20.9.54 (Planned Intervention moodCode)
templateId	1..1	SHALL		1098-32653	
@root	1..1	SHALL		1098-32680	2.16.840.1.113883.10.20.22.4.146
id	1..*	SHALL		1098-32681	
code	1..1	SHALL		1098-32654	
@code	1..1	SHALL		1098-32682	362956003
@codeSystem	1..1	SHALL		1098-32683	2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
statusCode	1..1	SHALL		1098-32655	
@code	1..1	SHALL		1098-32684	2.16.840.1.113883.5.14 (ActStatus) = active
effectiveTime	0..1	SHOULD		1098-32723	
author	0..*	SHOULD		1098-32719	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-32652	
@typeCode	1..1	SHALL		1098-32685	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32677	Advance Directive Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09
entryRelationship	0..*	MAY		1098-32656	
@typeCode	1..1	SHALL		1098-32686	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
substanceAdministration	1..1	SHALL		1098-32687	Immunization Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09
entryRelationship	0..*	MAY		1098-32657	

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@typeCode	1..1	SHALL		1098-32688	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
substanceAdministration	1..1	SHALL		1098-32689	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09
entryRelationship	0..*	MAY		1098-32658	
@typeCode	1..1	SHALL		1098-32690	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32691	Procedure Activity Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09
entryRelationship	0..*	MAY		1098-32659	
@typeCode	1..1	SHALL		1098-32692	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32693	Intervention Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.131
entryRelationship	0..*	MAY		1098-32660	
@typeCode	1..1	SHALL		1098-32694	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32695	Procedure Activity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09
entryRelationship	0..*	MAY		1098-32661	
@typeCode	1..1	SHALL		1098-32696	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
procedure	1..1	SHALL		1098-32697	Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09
entryRelationship	0..*	MAY		1098-32662	
@typeCode	1..1	SHALL		1098-32698	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
encounter	1..1	SHALL		1098-32699	Encounter Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09
entryRelationship	0..*	MAY		1098-32663	
typeId	0..1	MAY		1098-32700	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-	Instruction (V2) (identifier:

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				32701	urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
entryRelationship	0..*	MAY		1098-32664	
@typeCode	1..1	SHALL		1098-32702	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
supply	1..1	SHALL		1098-32703	Non-Medicinal Supply Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09
entryRelationship	0..*	MAY		1098-32665	
@typeCode	1..1	SHALL		1098-32704	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32705	Planned Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09
entryRelationship	0..*	MAY		1098-32666	
@typeCode	1..1	SHALL		1098-32706	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
encounter	1..1	SHALL		1098-32707	Planned Encounter (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09
entryRelationship	0..*	MAY		1098-32667	
@typeCode	1..1	SHALL		1098-32708	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32709	Planned Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09
entryRelationship	0..*	MAY		1098-32668	
@typeCode	1..1	SHALL		1098-32710	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
procedure	1..1	SHALL		1098-32711	Planned Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09
entryRelationship	0..*	MAY		1098-32669	
@typeCode	1..1	SHALL		1098-32712	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
substanceAdministration	1..1	SHALL		1098-32713	Planned Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09

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entryRelationship	0..*	MAY		1098-32670	
@typeCode	1..1	SHALL		1098-32714	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
supply	1..1	SHALL		1098-32715	Planned Supply (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09
entryRelationship	0..*	MAY		1098-32671	
procedure	1..1	SHALL		1098-32716	Nutrition Recommendation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.130
entryRelationship	0..*	MAY		1098-32672	
@typeCode	1..1	SHALL		1098-32717	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32718	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
entryRelationship	1..1	SHALL		1098-32673	
@typeCode	1..1	SHALL		1098-32720	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
act	1..1	SHALL		1098-32721	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
entryRelationship	0..*	MAY		1098-32675	
@typeCode	1..1	SHALL		1098-32726	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32727	Handoff Communication Participants (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141
entryRelationship	0..*	MAY		1098-32676	
@typeCode	1..1	SHALL		1098-32728	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
substanceAdministration	1..1	SHALL		1098-32729	Planned Immunization Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.120
reference	0..*	MAY		1098-32766	
@typeCode	1..1	SHALL		1098-32767	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
externalDocument	1..1	SHALL		1098-	External Document Reference

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				32768	(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-32678).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **Planned Intervention moodCode** 2.16.840.1.113883.11.20.9.54 **DYNAMIC** (CONF:1098-32679).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-32653).
    a. This templateId **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.146" (CONF:1098-32680).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-32681).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-32654).
    a. This code **SHALL** contain exactly one [1..1] **@code**="362956003" procedure / intervention (navigational concept) (CONF:1098-32682).
    b. 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:1098-32683).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-32655).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-32684).
7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-32723).
8. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32719).
9. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32652) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32685).
    b. **SHALL** contain exactly one [1..1] **Advance Directive Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09) (CONF:1098-32677).
10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32656) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32686).
    b. **SHALL** contain exactly one [1..1] **Immunization Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09) (CONF:1098-32687).
11. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32657) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32688).
    b. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-32689).
12. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32658) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32690).
b. **SHALL** contain exactly one [1..1] **Procedure Activity Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09) (CONF:1098-32691).

The following entryRelationship represents the relationship between two Intervention Acts (Intervention RELATES TO Intervention).

13. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32659) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32692).
    b. **SHALL** contain exactly one [1..1] **Intervention Act** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.131) (CONF:1098-32693).
14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32660) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32694).
    b. **SHALL** contain exactly one [1..1] **Procedure Activity Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09) (CONF:1098-32695).
15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32661) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32696).
    b. **SHALL** contain exactly one [1..1] **Procedure Activity Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09) (CONF:1098-32697).
16. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32662) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32698).
    b. **SHALL** contain exactly one [1..1] **Encounter Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09) (CONF:1098-32699).
17. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32663) such that it
    a. **MAY** contain zero or one [0..1] **typeId**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32700).
    b. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-32701).
18. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32664) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32702).
    b. **SHALL** contain exactly one [1..1] **Non-Medicinal Supply Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09) (CONF:1098-32703).
19. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32665) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32704).
b. **SHALL** contain exactly one [1..1] **Planned Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09) (CONF:1098-32705).

20. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32666) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32706).
    b. **SHALL** contain exactly one [1..1] **Planned Encounter (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09) (CONF:1098-32707).
21. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32667) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32708).
    b. **SHALL** contain exactly one [1..1] **Planned Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09) (CONF:1098-32709).
22. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32668) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32710).
    b. **SHALL** contain exactly one [1..1] **Planned Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09) (CONF:1098-32711).
23. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32669) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32712).
    b. **SHALL** contain exactly one [1..1] **Planned Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09) (CONF:1098-32713).
24. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32670) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32714).
    b. **SHALL** contain exactly one [1..1] **Planned Supply (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09) (CONF:1098-32715).
25. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32671) such that it
    a. **SHALL** contain exactly one [1..1] **Nutrition Recommendation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.130) (CONF:1098-32716).

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 Entry Reference template may be used to reference this entry.

26. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32672) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32717).

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b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-32718).

An Intervention Act SHALL reference a Goal Observation. Because the Goal Observation is already described in the CDA document instance's Goals section, rather than repeating the full content of the Goal Observation, the Entry Reference template can be used to reference this entry. The following entryRelationship represents an Entry Reference to Goal Observation.

27. **SHALL** contain exactly one [1..1] **entryRelationship** (CONF:1098-32673) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32720).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-32721).
    c. This entryReference template **SHALL** reference an instance of a Goal Observation template (CONF:1098-32722).
28. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32675) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32726).
    b. **SHALL** contain exactly one [1..1] **Handoff Communication Participants** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141) (CONF:1098-32727).
29. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32676) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32728).
    b. **SHALL** contain exactly one [1..1] **Planned Immunization Activity** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.120) (CONF:1098-32729).
30. **MAY** contain zero or more [0..*] **reference** (CONF:1098-32766).
    a. The reference, if present, **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32767).
    b. The reference, if present, **SHALL** contain exactly one [1..1] **External Document Reference** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09) (CONF:1098-32768).

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Table 383: Planned Intervention moodCode

Value Set: Planned Intervention moodCode 2.16.840.1.113883.11.20.9.54 Contains all the moodCode values it is possible to have for a Planned Intervention. Value Set Source: http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html			
Code	**Code System**	**Code System OID**	**Print Name**
APT	ActMood	2.16.840.1.113883.5.1001	Appointment
ARQ	ActMood	2.16.840.1.113883.5.1001	Appointment Request
INT	ActMood	2.16.840.1.113883.5.1001	Intent
PRMS	ActMood	2.16.840.1.113883.5.1001	Promise
PRP	ActMood	2.16.840.1.113883.5.1001	Proposal
RQO	ActMood	2.16.840.1.113883.5.1001	Request

4.65 Planned Medication Activity (V2)

```
[substanceAdministration: identifier
urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09 (open)]
```

Table 384: Planned Medication Activity (V2) Contexts

Contained By:	Contains:
Plan of Treatment Section (V2) (optional) Nutrition Recommendation (optional) Planned Intervention Act (optional)	Author Participation Indication (V2) Instruction (V2) Medication Information (V2) Precondition for Substance Administration (V2) Priority Preference

This template represents planned medication activities. The priority of the medication activity to the patient and provider is communicated through Priority Preference. The effectiveTime indicates the time when the medication activity is intended to take place. The authorTime indicates when the documentation of the plan occurred.

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Table 385: Planned Medication Activity (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
substanceAdministration (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09)					
@classCode	1..1	SHALL		1098-8572	2.16.840.1.113883.5.6 (HL7ActClass) = SBADM
@moodCode	1..1	SHALL		1098-8573	2.16.840.1.113883.11.20.9.24 (Planned moodCode (SubstanceAdministration/Supply))
templateId	1..1	SHALL		1098-30465	
@root	1..1	SHALL		1098-30466	2.16.840.1.113883.10.20.22.4.42
@extension	1..1	SHALL		1098-32557	2014-06-09
id	1..*	SHALL		1098-8575	
statusCode	1..1	SHALL		1098-32087	
@code	1..1	SHALL		1098-32088	2.16.840.1.113883.5.14 (ActStatus) = active
effectiveTime	1..1	SHALL		1098-30468	
repeatNumber	0..1	MAY		1098-32066	
routeCode	0..1	MAY		1098-32067	2.16.840.1.113883.3.88.12.3221.8.7 (Medication Route FDA)
approachSiteCode	0..*	MAY		1098-32078	2.16.840.1.113883.3.88.12.3221.8.9 (Body Site)
doseQuantity	0..1	MAY		1098-32068	
@unit	0..1	SHOULD		1098-32133	2.16.840.1.113883.1.11.12839 (UnitsOfMeasureCaseSensitive)
rateQuantity	0..1	MAY		1098-32079	
@unit	0..1	SHOULD		1098-32134	2.16.840.1.113883.1.11.12839 (UnitsOfMeasureCaseSensitive)
maxDoseQuantity	0..1	MAY		1098-32080	
administrationUnitCode	0..1	MAY		1098-32081	2.16.840.1.113883.1.11.14570 (AdministrableDrugForm)
consumable	1..1	SHALL		1098-32082	
manufacturedProduct	1..1	SHALL		1098-32083	Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.2

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					0.22.4.23:2014-06-09
performer	0..*	MAY		1098-30470	
author	0..1	SHOULD		1098-32046	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-31104	
@typeCode	1..1	SHALL		1098-31105	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31106	Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143
entryRelationship	0..*	MAY		1098-32069	
@typeCode	1..1	SHALL		1098-32070	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-32071	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
entryRelationship	0..*	MAY		1098-32072	
@typeCode	1..1	SHALL		1098-32073	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
act	1..1	SHALL		1098-32074	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
precondition	0..*	MAY		1098-32084	
@typeCode	1..1	SHALL		1098-32085	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = PRCN
criterion	1..1	SHALL		1098-32086	Precondition for Substance Administration (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="SBADM" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8572).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **Planned moodCode (SubstanceAdministration/Supply)** 2.16.840.1.113883.11.20.9.24 **STATIC** 2011-09-30 (CONF:1098-8573).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30465) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.42" (CONF:1098-30466).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32557).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8575).

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5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-32087).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="`active`" Active (CodeSystem: `ActStatus 2.16.840.1.113883.5.14`) (CONF:1098-32088).

The effectiveTime in a planned medication activity represents the time that the medication activity should occur.

6. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-30468).

In a Planned Medication Activity, repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times.

7. **MAY** contain zero or one [0..1] **repeatNumber** (CONF:1098-32066).
8. **MAY** contain zero or one [0..1] **routeCode**, which **SHALL** be selected from ValueSet **Medication Route FDA** `2.16.840.1.113883.3.88.12.3221.8.7` **DYNAMIC** (CONF:1098-32067).
9. **MAY** contain zero or more [0..*] **approachSiteCode**, which **SHALL** be selected from ValueSet **Body Site** `2.16.840.1.113883.3.88.12.3221.8.9` **DYNAMIC** (CONF:1098-32078).
10. **MAY** contain zero or one [0..1] **doseQuantity** (CONF:1098-32068).
    a. The doseQuantity, if present, **SHOULD** contain zero or one [0..1] **@unit**, which **SHALL** be selected from ValueSet **UnitsOfMeasureCaseSensitive** `2.16.840.1.113883.1.11.12839` **DYNAMIC** (CONF:1098-32133).
11. **MAY** contain zero or one [0..1] **rateQuantity** (CONF:1098-32079).
    a. The rateQuantity, if present, **SHOULD** contain zero or one [0..1] **@unit**, which **SHALL** be selected from ValueSet **UnitsOfMeasureCaseSensitive** `2.16.840.1.113883.1.11.12839` **DYNAMIC** (CONF:1098-32134).
12. **MAY** contain zero or one [0..1] **maxDoseQuantity** (CONF:1098-32080).
13. **MAY** contain zero or one [0..1] **administrationUnitCode**, which **SHALL** be selected from ValueSet **AdministrableDrugForm** `2.16.840.1.113883.1.11.14570` **DYNAMIC** (CONF:1098-32081).
14. **SHALL** contain exactly one [1..1] **consumable** (CONF:1098-32082).
    a. This consumable **SHALL** contain exactly one [1..1] **Medication Information (V2)** `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09)` (CONF:1098-32083).

The clinician who is expected to perform the medication activity could be identified using substanceAdministration/performer.

15. **MAY** contain zero or more [0..*] **performer** (CONF:1098-30470).

The author in a planned medication activity represents the clinician who is requesting or planning the medication activity.

16. **SHOULD** contain zero or one [0..1] **Author Participation** `(identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119)` (CONF:1098-32046).

The following entryRelationship represents the priority that a patient or a provider places on the planned medication activity.

17. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31104) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31105).
b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31106).

The following entryRelationship represents the indication for the planned medication activity.

18. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32069) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32070).
    b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-32071).

The following entryRelationship captures any instructions associated with the planned medication activity.

19. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32072) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32073).
    b. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-32074).
20. **MAY** contain zero or more [0..*] **precondition** (CONF:1098-32084).
    a. The precondition, if present, **SHALL** contain exactly one [1..1] **@typeCode**="PRCN" Precondition (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32085).
    b. The precondition, if present, **SHALL** contain exactly one [1..1] **Precondition for Substance Administration (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09) (CONF:1098-32086).

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Figure 193: Planned Medication Activity (V2) Example

```
<substanceAdministration moodCode="INT" classCode="SBADM">
  <templateId root="2.16.840.1.113883.10.20.22.4.42" extension="2014-06-09" />
  <!-- Planned Medication Activity (V2)-->
  <id root="cdbd33f0-6cde-11db-9fe1-0800200c9a66" />
  <text>Heparin 0.25 ml Prefilled Syringe</text>
  <statusCode code="active" />
  <!-- The effectiveTime in a planned medication activity
    represents the time that the medication activity should occur. -->
  <effectiveTime value="20130905" />
  <consumable>
    <manufacturedProduct classCode="MANU">
      <!-- Medication Information (V2) -->
      ...
    </manufacturedProduct>
  </consumable>
  <entryRelationship typeCode="REFR">
    <observation classCode="OBS" moodCode="EVN">
      <!-- Patient Priority Preference-->
      ...
    </observation>
  </entryRelationship>
  <entryRelationship typeCode="REFR">
    <observation classCode="OBS" moodCode="EVN">
      <!-- Provider Priority Preference-->
      ...
    </observation>
  </entryRelationship>
  <entryRelationship typeCode="RSON">
    <!-- Indication (V2) -->
    ...
  </entryRelationship>
  <entryRelationship typeCode="SUBJ">
    <!-- Instruction (V2) -->
    ...
  </entryRelationship>
</substanceAdministration>
```

4.66 Planned Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09 (open)]

Table 386: Planned Observation (V2) Contexts

Contained By:	Contains:
Plan of Treatment Section (V2) (optional) Nutrition Recommendation (optional) Planned Intervention Act (optional)	Author Participation Indication (V2) Instruction (V2) Planned Coverage Priority Preference

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This template represents planned observations that result in new information about the patient which cannot be classified as a procedure according to the HL7 RIM, i.e., procedures alter the patient's body. Examples of these observations are laboratory tests, diagnostic imaging tests, EEGs, and EKGs.

The importance of the planned observation to the patient and provider is communicated through Priority Preference. The effectiveTime indicates the time when the observation is intended to take place and authorTime indicates when the documentation of the plan occurred.

The Planned Observation template may also indicate the potential insurance coverage for the observation.

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Table 387: Planned Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09)					
@classCode	1..1	SHALL		1098-8581	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-8582	2.16.840.1.113883.11.20.9.25 (Planned moodCode (Observation))
templateId	1..1	SHALL		1098-30451	
@root	1..1	SHALL		1098-30452	2.16.840.1.113883.10.20.22.4.44
@extension	1..1	SHALL		1098-32555	2014-06-09
id	1..*	SHALL		1098-8584	
code	1..1	SHALL		1098-31030	2.16.840.1.113883.6.1 (LOINC)
statusCode	1..1	SHALL		1098-30453	
@code	1..1	SHALL		1098-32032	2.16.840.1.113883.5.14 (ActStatus) = active
effectiveTime	0..1	SHOULD		1098-30454	
value	0..1	MAY		1098-31031	
methodCode	0..1	MAY		1098-32043	
targetSiteCode	0..*	SHOULD		1098-32044	2.16.840.1.113883.3.88.12.3221.8.9 (Body Site)
performer	0..*	MAY		1098-30456	
author	0..*	SHOULD		1098-32033	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-31073	
@typeCode	1..1	SHALL		1098-31074	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31075	Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143
entryRelationship	0..*	MAY		1098-32034	
@typeCode	1..1	SHALL		1098-32035	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) =

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					RSON
observation	1..1	SHALL		1098-32036	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
entryRelationship	0..*	MAY		1098-32037	
@typeCode	1..1	SHALL		1098-32038	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
act	1..1	SHALL		1098-32039	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
entryRelationship	0..*	MAY		1098-32040	
@typeCode	1..1	SHALL		1098-32041	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
act	1..1	SHALL		1098-32042	Planned Coverage (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.129

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8581).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **Planned moodCode (Observation)** 2.16.840.1.113883.11.20.9.25 **STATIC** 2011-09-30 (CONF:1098-8582).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30451) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.44" (CONF:1098-30452).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32555).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8584).
5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from CodeSystem LOINC (2.16.840.1.113883.6.1) (CONF:1098-31030).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-30453).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-32032).

The effectiveTime in a planned observation represents the time that the observation should occur.

7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-30454).
8. **MAY** contain zero or one [0..1] **value** (CONF:1098-31031).

In a planned observation the provider may suggest that an observation should be performed using a particular method.

9. **MAY** contain zero or one [0..1] **methodCode** (CONF:1098-32043).

The targetSiteCode is used to identify the part of the body of concern for the planned observation.

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10. **SHOULD** contain zero or more [0..*] **targetSiteCode**, which **SHALL** be selected from ValueSet **Body Site** 2.16.840.1.113883.3.88.12.3221.8.9 **DYNAMIC** (CONF:1098-32044).

The clinician who is expected to perform the observation could be identified using procedure/performer.

11. **MAY** contain zero or more [0..*] **performer** (CONF:1098-30456).

The author in a planned observation represents the clinician who is requesting or planning the observation.

12. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32033).

The following entryRelationship represents the priority that a patient or a provider places on the observation.

13. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31073) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31074).
    b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31075).

The following entryRelationship represents the indication for the observation.

14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32034) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32035).
    b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-32036).

The following entryRelationship captures any instructions associated with the planned observation.

15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32037) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32038).
    b. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-32039).

The following entryRelationship represents the insurance coverage the patient may have for the observation.

16. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32040) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32041).
    b. **SHALL** contain exactly one [1..1] **Planned Coverage** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.129) (CONF:1098-32042).

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Table 388: Planned moodCode (Observation)

Value Set: Planned moodCode (Observation) 2.16.840.1.113883.11.20.9.25 This value set is used to restrict the moodCode on an to future moods. Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
INT	ActMood	2.16.840.1.113883.5.1001	Intent
PRMS	ActMood	2.16.840.1.113883.5.1001	Promise
PRP	ActMood	2.16.840.1.113883.5.1001	Proposal
RQO	ActMood	2.16.840.1.113883.5.1001	Request
…			

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Figure 194: Planned Observation (V2) Example

```
<observation classCode="OBS" moodCode="INT">
    <templateId root="2.16.840.1.113883.10.20.22.4.44"
        extension="2014-06-09" />
    <id root="b52bee94-c34b-4e2c-8c15-5ad9d6def205" />
    <code code="71850-2"
        codeSystem="2.16.840.1.113883.6.1"
        codeSystemName="LOINC"
        displayName="Oxygen saturation [Pure mass fraction] in Capillary blood by
                             Oximetry" />
    <statusCode code="active" />
    <effectiveTime value="20130903" />
    <author typeCode="AUT">
        <!-- Author Participation -->
    </author>
    <entryRelationship typeCode="REFR">
        <!-- Priority Preference -->
    ...

    </entryRelationship>
    <entryRelationship typeCode="RSON">
        <!-- Indication (V2) -->
    ...

    </entryRelationship>
    <entryRelationship typeCode="SUBJ">
        <!-- Instruction (V2) -->
    ...

    </entryRelationship>
    <entryRelationship typeCode="COMP">
        <!-- Planned Coverage -->
    ...

    </entryRelationship>
</observation>
```

4.67 Planned Procedure (V2)

[procedure: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09 (open)]

Table 389: Planned Procedure (V2) Contexts

Contained By:	Contains:
Plan of Treatment Section (V2) (optional) Nutrition Recommendation (optional) Planned Procedure Section (V2) (optional) Planned Intervention Act (optional)	Author Participation Indication (V2) Instruction (V2) Planned Coverage Priority Preference

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This template represents planned alterations of the patient's physical condition. Examples of such procedures are tracheostomy, knee replacement, and craniectomy. The priority of the procedure to the patient and provider is communicated through Priority Preference. The effectiveTime indicates the time when the procedure is intended to take place and authorTime indicates when the documentation of the plan occurred. The Planned Procedure Template may also indicate the potential insurance coverage for the procedure.

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Table 390: Planned Procedure (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
procedure (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09)					
@classCode	1..1	SHALL		1098-8568	2.16.840.1.113883.5.6 (HL7ActClass) = PROC
@moodCode	1..1	SHALL		1098-8569	2.16.840.1.113883.11.20.9.23 (Planned moodCode (Act/Encounter/Procedure))
templateId	1..1	SHALL		1098-30444	
@root	1..1	SHALL		1098-30445	2.16.840.1.113883.10.20.22.4.41
@extension	1..1	SHALL		1098-32554	2014-06-09
id	1..*	SHALL		1098-8571	
code	1..1	SHALL		1098-31976	
statusCode	1..1	SHALL		1098-30446	
@code	1..1	SHALL		1098-31978	2.16.840.1.113883.5.14 (ActStatus) = active
effectiveTime	0..1	SHOULD		1098-30447	
methodCode	0..*	MAY		1098-31980	
targetSiteCode	0..*	MAY		1098-31981	2.16.840.1.113883.3.88.12.3221.8.9 (Body Site)
performer	0..*	MAY		1098-30449	
author	0..1	SHOULD		1098-31979	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-31079	
@typeCode	1..1	SHALL		1098-31080	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31081	Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143
entryRelationship	0..*	MAY		1098-31982	
@typeCode	1..1	SHALL		1098-31983	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-	Indication (V2) (identifier:

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				31984	urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
entryRelationship	0..*	MAY		1098-31985	
@typeCode	1..1	SHALL		1098-31986	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
@inversionInd	1..1	SHALL		1098-31987	true
act	1..1	SHALL		1098-31989	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
entryRelationship	0..*	MAY		1098-31990	
@typeCode	1..1	SHALL		1098-31991	COMP
act	1..1	SHALL		1098-31992	Planned Coverage (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.129

1. **SHALL** contain exactly one [1..1] **@classCode**="PROC" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8568).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **Planned moodCode (Act/Encounter/Procedure)** 2.16.840.1.113883.11.20.9.23 **STATIC** 2011-09-30 (CONF:1098-8569).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30444) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.41" (CONF:1098-30445).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32554).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8571).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-31976).
   a. The procedure/code in a planned procedure **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:1098-31977).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-30446).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31978).

The effectiveTime in a planned procedure represents the time that the procedure should occur.

7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-30447).

In a planned procedure the provider may suggest that a procedure should be performed using a particular method.

MethodCode **SHALL NOT** conflict with the method inherent in Procedure / code.

8. **MAY** contain zero or more [0..*] **methodCode** (CONF:1098-31980).

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The targetSiteCode is used to identify the part of the body of concern for the planned procedure.

9. **MAY** contain zero or more [0..*] **targetSiteCode**, which **SHALL** be selected from ValueSet **Body Site** 2.16.840.1.113883.3.88.12.3221.8.9 **DYNAMIC** (CONF:1098-31981).

The clinician who is expected to perform the procedure could be identified using procedure/performer.

10. **MAY** contain zero or more [0..*] **performer** (CONF:1098-30449).

The author in a planned procedure represents the clinician who is requesting or planning the procedure.

11. **SHOULD** contain zero or one [0..1] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31979).

The following entryRelationship represents the priority that a patient or a provider places on the procedure.

12. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31079) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31080).
    b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31081).

The following entryRelationship represents the indication for the procedure.

13. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31982) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31983).
    b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-31984).

The following entryRelationship captures any instructions associated with the planned procedure.

14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31985) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31986).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-31987).
    c. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31989).

The following entryRelationship represents the insurance coverage the patient may have for the procedure.

15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31990) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has component (CONF:1098-31991).
    b. **SHALL** contain exactly one [1..1] **Planned Coverage** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.129) (CONF:1098-31992).

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Figure 195: Planned Procedure (V2) Example

```
<entry>
    <procedure moodCode="RQO" classCode="PROC">
        <templateId root="2.16.840.1.113883.10.20.22.4.41" extension="2014-06-09" />
        <!-- **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="active" />
        <effectiveTime value="20130613" />
        <!-- Author Participation -->
        <author typeCode="AUT">
          ...
        </author>
        <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>
        <entryRelationship typeCode="RSON">
            <observation classCode="OBS" moodCode="EVN">
                <!-- Indication-->
                <templateId root="2.16.840.1.113883.10.20.22.4.19" extension="2014-06-09"
/>
               ...
            </observation>
        </entryRelationship>
        <entryRelationship typeCode="SUBJ">
            <act classCode="ACT" moodCode="INT">
                <!-- Instruction-->
                <templateId root="2.16.840.1.113883.10.20.22.4.20" extension="2014-06-09"
/>
               ...
            </act>
        </entryRelationship>
        <entryRelationship typeCode="COMP">
            <observation classCode="ACT" moodCode="INT">
                <!-- Planned Coverage -->
                <templateId root="2.16.840.1.113883.10.20.22.4.129" />
               ...
            </observation>
        </entryRelationship>
    </procedure>
</entry>
```


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4.68 Planned Supply (V2)

```
[supply: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09
(open)]
```

Table 391: Planned Supply (V2) Contexts

Contained By:	Contains:
Plan of Treatment Section (V2) (optional) Nutrition Recommendation (optional) Planned Intervention Act (optional)	Author Participation Immunization Medication Information (V2) Indication (V2) Instruction (V2) Medication Information (V2) Planned Coverage Priority Preference Product Instance

This template represents both medicinal and non-medicinal supplies ordered, requested, or intended for the patient (e.g., medication prescription, order for wheelchair). The importance of the supply order or request to the patient and provider may be indicated in the Priority Preference.

The effective time indicates the time when the supply is intended to take place and author time indicates when the documentation of the plan occurred. The Planned Supply template may also indicate the potential insurance coverage for the procedure.

Depending on the type of supply, the product or participant will be either a Medication Information product (medication), an Immunization Medication Information product (immunization), or a Product Instance participant (device/equipment).

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Table 392: Planned Supply (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
supply (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09)					
@classCode	1..1	SHALL		1098-8577	2.16.840.1.113883.5.6 (HL7ActClass) = SPLY
@moodCode	1..1	SHALL		1098-8578	2.16.840.1.113883.11.20.9.24 (Planned moodCode (SubstanceAdministration/Supply))
templateId	1..1	SHALL		1098-30463	
@root	1..1	SHALL		1098-30464	2.16.840.1.113883.10.20.22.4.43
@extension	1..1	SHALL		1098-32556	2014-06-09
id	1..*	SHALL		1098-8580	
statusCode	1..1	SHALL		1098-30458	
@code	1..1	SHALL		1098-32047	2.16.840.1.113883.5.14 (ActStatus) = active
effectiveTime	0..1	SHOULD		1098-30459	
repeatNumber	0..1	MAY		1098-32063	
quantity	0..1	MAY		1098-32064	
product	0..1	MAY		1098-32049	
manufacturedProduct	1..1	SHALL		1098-32050	Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09
product	0..1	MAY		1098-32051	
manufacturedProduct	1..1	SHALL		1098-32052	Immunization Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09
product	0..1	SHOULD		1098-32325	
performer	0..*	MAY		1098-32048	
author	0..1	SHOULD		1098-31129	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	0..1	MAY		1098-	

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				32094	
participantRole	1..1	SHALL		1098-32095	Product Instance (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.37
entryRelationship	0..*	MAY		1098-31110	
@typeCode	1..1	SHALL		1098-31111	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31112	Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143
entryRelationship	0..*	MAY		1098-32054	
@typeCode	1..1	SHALL		1098-32055	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-32056	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
entryRelationship	0..*	MAY		1098-32057	
@typeCode	1..1	SHALL		1098-32058	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
act	1..1	SHALL		1098-32059	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
entryRelationship	0..*	MAY		1098-32060	
@typeCode	1..1	SHALL		1098-32061	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
act	1..1	SHALL		1098-32062	Planned Coverage (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.129

1. **SHALL** contain exactly one [1..1] **@classCode**="`SPLY`" (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-8577).
2. **SHALL** contain exactly one [1..1] **@moodCode**, which **SHALL** be selected from ValueSet **Planned moodCode (SubstanceAdministration/Supply)** `2.16.840.1.113883.11.20.9.24` **STATIC** 2011-09-30 (CONF:1098-8578).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30463) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.43`" (CONF:1098-30464).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32556).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8580).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-30458).

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a. This statusCode **SHALL** contain exactly one [1..1] **@code**="`active`" Active (CodeSystem: `ActStatus 2.16.840.1.113883.5.14`) (CONF:1098-32047).

The effectiveTime in a planned supply represents the time that the supply should occur.

6. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-30459).

In a Planned Supply, repeatNumber indicates the number of times the supply event can occur. For example, if a medication is filled at a pharmacy and the prescription may be refilled 3 more times, the supply RepeatNumber equals 4.

7. **MAY** contain zero or one [0..1] **repeatNumber** (CONF:1098-32063).
8. **MAY** contain zero or one [0..1] **quantity** (CONF:1098-32064).

This product represents medication that is ordered, requested or intended for the patient.

9. **MAY** contain zero or one [0..1] **product** (CONF:1098-32049) such that it
   a. **SHALL** contain exactly one [1..1] **Medication Information (V2)** (identifier: `urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09`) (CONF:1098-32050).
   b. If the product is Medication Information (V2) (2.16.840.1.113883.10.20.22.4.23.2) then the product **SHALL NOT** be Immunization Medication Information (2.16.840.1.113883.10.20.22.4.54.2) and the participant **SHALL NOT** be Product Instance (CONF:1098-32092).

This product represents immunization medication that is ordered, requested or intended for the patient.

10. **MAY** contain zero or one [0..1] **product** (CONF:1098-32051) such that it
    a. **SHALL** contain exactly one [1..1] **Immunization Medication Information (V2)** (identifier: `urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09`) (CONF:1098-32052).
    b. If the product is Medication Information (V2) (2.16.840.1.113883.10.20.22.4.23.2) then the product **SHALL NOT** be Immunization Medication Information (2.16.840.1.113883.10.20.22.4.54.2) and the participant **SHALL NOT** be Product Instance (CONF:1098-32093).

A product is recommended or even required under certain implementations. This IG makes product as recommended (SHOULD).

11. **SHOULD** contain zero or one [0..1] **product** (CONF:1098-32325).

The clinician who is expected to perform the supply could be identified using supply/performer.

12. **MAY** contain zero or more [0..*] **performer** (CONF:1098-32048).

The author in a supply represents the clinician who is requesting or planning the supply.

13. **SHOULD** contain zero or one [0..1] **Author Participation** (identifier: `urn:oid:2.16.840.1.113883.10.20.22.4.119`) (CONF:1098-31129).

This participant represents a device that is ordered, requested or intended for the patient.

14. **MAY** contain zero or one [0..1] **participant** (CONF:1098-32094) such that it

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a. **SHALL** contain exactly one [1..1] **Product Instance** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.37) (CONF:1098-32095).
b. If the participant is Product Instance then the product **SHALL NOT** be Medication Information (V2) (2.16.840.1.113883.10.20.22.4.23.2) and the product **SHALL NOT** be Immunization Medication Information (V2) (2.16.840.1.113883.10.20.22.4.54.2) (CONF:1098-32096).

The following entryRelationship represents the priority that a patient or a provider places on the supply.

15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31110) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31111).
    b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31112).

The following entryRelationship represents the indication for the supply.

16. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32054) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32055).
    b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-32056).

The following entryRelationship captures any instructions associated with the planned supply.

17. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32057) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32058).
    b. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-32059).

The following entryRelationship represents the insurance coverage the patient may have for the supply.

18. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32060) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32061).
    b. **SHALL** contain exactly one [1..1] **Planned Coverage** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.129) (CONF:1098-32062).

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Figure 196: Planned Supply (V2) Example

```
<supply moodCode="INT" classCode="SPLY">
    <templateId root="2.16.840.1.113883.10.20.22.4.43" extension="2014-06-09" />
    <!-- Planned Supply (V2) -->
    <id root="9a6d1bac-17d3-4195-89c4-1121bc809b5d" />
    <statusCode code="active" />
    <!-- The effectiveTime in a planned supply represents
    the time that the supply should occur. -->
    <effectiveTime value="20130615" />
    <repeatNumber value="1" />
    <quantity value="3" />
    <!-- This product represents medication that is ordered,
    requested or intended for the patient. -->
    <product>
        <manufacturedProduct classCode="MANU">
            <!-- Medication Information (V2) -->
            <templateId root="2.16.840.1.113883.10.20.22.4.23" extension="2014-06-09" />
            <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>
    <!-- The clinician who is expected to perform the supply
    could be identified using supply/performer. -->
    <performer>
    ...

  </performer>
    <!-- The author in a supply represents the clinician
    who is requesting or planning the supply. -->
    <author typeCode="AUT">
    ...

  </author>
    <entryRelationship typeCode="REFR">
        <!-- Patient Priority Preference -->
    ...

    </entryRelationship>
    <entryRelationship typeCode="REFR">
        <!-- Provider Priority Preference -->
    ...

    </entryRelationship>
    <entryRelationship typeCode="RSON">
```


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```
        <!-- Indication (V2) -->
    ...

    </entryRelationship>
    <entryRelationship typeCode="SUBJ">
        <!-- Instruction (V2) -->
    ...

    </entryRelationship>
    <entryRelationship typeCode="COMP">
        <!-- Planned Coverage -->
    ...

    </entryRelationship>
</supply>
```

4.69 Policy Activity (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.61:2014-06-09 (open)]

Table 393: Policy Activity (V2) Contexts

Contained By:	Contains:
Coverage Activity (V2) (required)	US Realm Address (AD.US.FIELDED)

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 of the coverage. The payer is represented as the performer of the policy activity.

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Table 394: Policy Activity (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.61:2014-06-09)					
@classCode	1..1	SHALL		1098-8898	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-8899	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-8900	
@root	1..1	SHALL		1098-10516	2.16.840.1.113883.10.20.22.4.61
@extension	1..1	SHALL		1098-32595	2014-06-09
id	1..*	SHALL		1098-8901	
code	1..1	SHALL		1098-8903	2.16.840.1.114222.4.11.3591 (Source of Payment Typology (PHDSC))
statusCode	1..1	SHALL		1098-8902	
@code	1..1	SHALL		1098-19109	2.16.840.1.113883.5.14 (ActStatus) = completed
performer	1..1	SHALL		1098-8906	
@typeCode	1..1	SHALL		1098-8907	2.16.840.1.113883.5.90 (HL7ParticipationType) = PRF
templateId	1..1	SHALL		1098-16808	
@root	1..1	SHALL		1098-16809	2.16.840.1.113883.10.20.22.4.87
assignedEntity	1..1	SHALL		1098-8908	
id	1..*	SHALL		1098-8909	
code	0..1	SHOULD		1098-8914	
@code	1..1	SHALL		1098-15992	2.16.840.1.113883.1.11.10416 (HL7FinanciallyResponsibleParty Type)
addr	0..1	MAY		1098-8910	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
telecom	0..*	MAY		1098-8911	
representedOrganization	0..1	SHOUL		1098-	

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		D		8912	
name	0..1	SHOULD		1098-8913	
performer	0..1	SHOULD		1098-8961	2.16.840.1.113883.5.90 (HL7ParticipationType) = PRF
templateId	1..1	SHALL		1098-16810	
@root	1..1	SHALL		1098-16811	2.16.840.1.113883.10.20.22.4.88
time	0..1	SHOULD		1098-8963	
assignedEntity	1..1	SHALL		1098-8962	
code	1..1	SHALL		1098-8968	
@code	1..1	SHALL		1098-16096	GUAR
@codeSystem	1..1	SHALL		1098-32165	2.16.840.1.113883.5.110
addr	0..1	SHOULD		1098-8964	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
telecom	0..*	SHOULD		1098-8965	
participant	1..1	SHALL		1098-8916	
@typeCode	1..1	SHALL		1098-8917	2.16.840.1.113883.5.90 (HL7ParticipationType) = COV
templateId	1..1	SHALL		1098-16812	
@root	1..1	SHALL		1098-16814	2.16.840.1.113883.10.20.22.4.89
time	0..1	SHOULD		1098-8918	
low	0..1	SHOULD		1098-8919	
high	0..1	SHOULD		1098-8920	
participantRole	1..1	SHALL		1098-8921	
id	1..*	SHALL		1098-8922	
code	1..1	SHALL		1098-8923	
@code	0..1	SHOULD		1098-16078	2.16.840.1.113883.1.11.18877 (Coverage Role Type)

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addr	0..1	SHOULD		1098-8956	
playingEntity	0..1	SHOULD		1098-8932	
name	1..*	SHALL		1098-8930	
sdtc:birthTime	1..1	SHALL		1098-31344	
participant	0..1	SHOULD		1098-8934	
@typeCode	1..1	SHALL		1098-8935	2.16.840.1.113883.5.90 (HL7ParticipationType) = HLD
templateId	1..1	SHALL		1098-16813	
@root	1..1	SHALL		1098-16815	2.16.840.1.113883.10.20.22.4.90
time	0..1	MAY		1098-8938	
participantRole	1..1	SHALL		1098-8936	
id	1..*	SHALL		1098-8937	
addr	0..1	SHOULD		1098-8925	
entryRelationship	1..*	SHALL		1098-8939	
@typeCode	1..1	SHALL		1098-8940	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:1098-8898).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-8899).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8900) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.61`" (CONF:1098-10516).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32595).

This id is a unique identifier for the policy or program providing the coverage

4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8901).
5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **Source of Payment Typology (PHDSC)** `2.16.840.1.114222.4.11.3591` **DYNAMIC** (CONF:1098-8903).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-8902).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="`completed`" Completed (CodeSystem: `ActStatus 2.16.840.1.113883.5.14` **STATIC**) (CONF:1098-19109).

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This performer represents the Payer.

7. **SHALL** contain exactly one [1..1] **performer** (CONF:1098-8906) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="PRF" Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-8907).
    b. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16808).
        i. This templateId **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.87" Payer Performer (CONF:1098-16809).
    c. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-8908).
        i. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-8909).
        ii. This assignedEntity **SHOULD** contain zero or one [0..1] **code** (CONF:1098-8914).
            1. The code, if present, **SHALL** contain exactly one [1..1] **@code**, which **SHOULD** be selected from ValueSet **HL7FinanciallyResponsiblePartyType** 2.16.840.1.113883.1.11.10416 **DYNAMIC** (CONF:1098-15992).
        iii. This assignedEntity **MAY** contain zero or one [0..1] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-8910).
        iv. This assignedEntity **MAY** contain zero or more [0..*] **telecom** (CONF:1098-8911).
        v. This assignedEntity **SHOULD** contain zero or one [0..1] **representedOrganization** (CONF:1098-8912).
            1. The representedOrganization, if present, **SHOULD** contain zero or one [0..1] **name** (CONF:1098-8913).

This performer represents the Guarantor.

8. **SHOULD** contain zero or one [0..1] **performer**="PRF" Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-8961) such that it
    a. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16810).
        i. This templateId **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.88" Guarantor Performer (CONF:1098-16811).
    b. **SHOULD** contain zero or one [0..1] **time** (CONF:1098-8963).
    c. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-8962).
        i. This assignedEntity **SHALL** contain exactly one [1..1] **code** (CONF:1098-8968).
            1. This code **SHALL** contain exactly one [1..1] **@code**="GUAR" Guarantor (CONF:1098-16096).
            2. This code **SHALL** contain exactly one [1..1] **@codeSystem**="2.16.840.1.113883.5.110" (CONF:1098-32165).
        ii. This assignedEntity **SHOULD** contain zero or one [0..1] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-8964).

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iii. This assignedEntity **SHOULD** contain zero or more [0..*] **telecom** (CONF:1098-8965).

iv. **SHOULD** include assignedEntity/assignedPerson/name AND/OR assignedEntity/representedOrganization/name (CONF:1098-8967).

9. **SHALL** contain exactly one [1..1] **participant** (CONF:1098-8916) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="COV" Coverage target (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-8917).

b. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16812).

i. This templateId **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.89" Covered Party Participant (CONF:1098-16814).

c. **SHOULD** contain zero or one [0..1] **time** (CONF:1098-8918).

i. The time, if present, **SHOULD** contain zero or one [0..1] **low** (CONF:1098-8919).

ii. The time, if present, **SHOULD** contain zero or one [0..1] **high** (CONF:1098-8920).

d. **SHALL** contain exactly one [1..1] **participantRole** (CONF:1098-8921).

i. This participantRole **SHALL** contain at least one [1..*] **id** (CONF:1098-8922).

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:1098-8984).

ii. This participantRole **SHALL** contain exactly one [1..1] **code** (CONF:1098-8923).

1. This code **SHOULD** contain zero or one [0..1] **@code**, which **SHOULD** be selected from ValueSet **Coverage Role Type** 2.16.840.1.113883.1.11.18877 **DYNAMIC** (CONF:1098-16078).

iii. This participantRole **SHOULD** contain zero or one [0..1] **addr** (CONF:1098-8956).

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:1098-10484).

iv. This participantRole **SHOULD** contain zero or one [0..1] **playingEntity** (CONF:1098-8932).

If the covered party's name is recorded differently in the health plan and in the registration/pharmacy benefit 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 at least one [1..*] **name** (CONF:1098-8930).

If the covered party's date of birth is recorded differently in the health plan and in the registration/pharmacy benefit summary, use the date of birth as it is recorded in the health plan.

2. The playingEntity, if present, **SHALL** contain exactly one [1..1] **sdtc:birthTime** (CONF:1098-31344).

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a. 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:1098-31345).

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.

10. **SHOULD** contain zero or one [0..1] **participant** (CONF:1098-8934) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="`HLD`" Holder (CodeSystem: `HL7ParticipationType 2.16.840.1.113883.5.90` **STATIC**) (CONF:1098-8935).
    b. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16813).
        i. This templateId **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.90`" Policy Holder Participant (CONF:1098-16815).
    c. **MAY** contain zero or one [0..1] **time** (CONF:1098-8938).
    d. **SHALL** contain exactly one [1..1] **participantRole** (CONF:1098-8936).
        i. This participantRole **SHALL** contain at least one [1..*] **id** (CONF:1098-8937).
            1. This id is a unique identifier for the subscriber of the coverage (CONF:1098-10120).
        ii. This participantRole **SHOULD** contain zero or one [0..1] **addr** (CONF:1098-8925).
            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:1098-10483).
    e. 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:1098-17139).

11. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-8939) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="`REFR`" Refers to (CodeSystem: `HL7ActRelationshipType 2.16.840.1.113883.5.1002` **STATIC**) (CONF:1098-8940).
    b. 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:1098-8942).
    c. 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:1098-8943).

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Table 395: 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 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
GUAR	RoleClass	2.16.840.1.113883.5.110	Guarantor
EMP	RoleClass	2.16.840.1.113883.5.110	Employee
INVSBJ	RoleClass	2.16.840.1.113883.5.110	Investigation Subject

Table 396: Coverage Role Type

Value Set: Coverage Role Type 2.16.840.1.113883.1.11.18877 A value set of HL7 role Codes for role recognized through the issuance of insurance coverage to an identified covered party who has this relationship with the policy holder such as the policy holder themselves (self), spouse, child, etc. Value Set Source: http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html			
Code	**Code System**	**Code System OID**	**Print Name**
FAMDEP	RoleCode	2.16.840.1.113883.5.111	Family dependent
FSTUD	RoleCode	2.16.840.1.113883.5.111	Full-time student
SELF	RoleCode	2.16.840.1.113883.5.111	Self
…			

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Figure 197: Policy Activity (V2) Example

```
<act classCode="ACT" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.61" extension="2014-06-09" />
    <id root="3e676a50-7aac-11db-9fe1-0800200c9a66" />
    <code code="81" displayName="self-pay"
             codeSystemName="Source of Payment Typology (PHDSC)"
             codeSystem="2.16.840.1.113883.3.221.5" />
    <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>
```


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```
                <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>
```


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```
    <entryRelationship typeCode="REFR">
        <act classCode="ACT" moodCode="EVN">
            <templateId root="2.16.840.1.113883.10.20.1.19" />
             . . .
        </act>
    </entryRelationship>
    </act>
```

4.70 Postprocedure Diagnosis (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09 (open)]

Table 397: Postprocedure Diagnosis (V2) Contexts

Contained By:	Contains:
Postprocedure Diagnosis Section (V2) (optional) Health Concern Act (optional) Risk Concern Act (optional)	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.

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Table 398: Postprocedure Diagnosis (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09)					
@classCode	1..1	SHALL		1098-8756	ACT
@moodCode	1..1	SHALL		1098-8757	EVN
templateId	1..1	SHALL		1098-16766	
@root	1..1	SHALL		1098-16767	2.16.840.1.113883.10.20.22.4.51
@extension	1..1	SHALL		1098-32539	2014-06-09
code	1..1	SHALL		1098-19151	
@code	1..1	SHALL		1098-19152	59769-0
@codeSystem	1..1	SHALL		1098-32166	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
entryRelationship	1..*	SHALL		1098-8759	
@typeCode	1..1	SHALL		1098-8760	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
observation	1..1	SHALL		1098-15583	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CONF:1098-8756).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CONF:1098-8757).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16766) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.51" (CONF:1098-16767).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32539).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-19151).
    a. This code **SHALL** contain exactly one [1..1] **@code**="59769-0" Postprocedure diagnosis (CONF:1098-19152).
    b. 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:1098-32166).
5. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-8759) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8760).

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b. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-15583).

Figure 198: Postprocedure Diagnosis (V2) Example

```
<act moodCode="EVN" classCode="ACT">
    <templateId root="2.16.840.1.113883.10.20.22.4.51" extension="2014-06-09" />
    <!-- ** 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" extension="2014-06-09" />
            . . .
        </observation>
    </entryRelationship>
</act>
```

4.71 Precondition for Substance Administration (V2)

[criterion: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09 (open)]

Table 399: Precondition for Substance Administration (V2) Contexts

Contained By:	Contains:
Medication Activity (V2) (optional) Immunization Activity (V2) (optional) Planned Medication Activity (V2) (optional) Planned Immunization Activity (optional)	

A criterion for administration can be used to record that the medication is to be administered only when the associated criteria are met.

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Table 400: Precondition for Substance Administration (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
criterion (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09)					
templateId	1..1	SHALL		1098-7372	
@root	1..1	SHALL		1098-10517	2.16.840.1.113883.10.20.22.4.25
@extension	1..1	SHALL		1098-32603	2014-06-09
code	1..1	SHALL	CD	1098-32396	
@code	1..1	SHALL		1098-32397	ASSERTION
@codeSystem	1..1	SHALL		1098-32398	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
value	1..1	SHALL	CD	1098-7369	2.16.840.1.113883.3.88.12.3221.7.4 (Problem)

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7372) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.25" (CONF:1098-10517).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32603).
2. **SHALL** contain exactly one [1..1] **code** with @xsi:type="CD" (CONF:1098-32396).
   a. This code **SHALL** contain exactly one [1..1] **@code**="ASSERTION" Assertion (CONF:1098-32397).
   b. 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:1098-32398).
3. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHALL** be selected from ValueSet **Problem** 2.16.840.1.113883.3.88.12.3221.7.4 **DYNAMIC** (CONF:1098-7369).

Figure 199: Precondition for Substance Administration (V2) Example

```
<criterion>
  <templateId root="2.16.840.1.113883.10.20.22.4.25"
    extension="2014-06-09" />
  <code code="ASSERTION"
    codeSystem="2.16.840.1.113883.5.4" />
  <value xsi:type="CD"
    code="56018004"
    codeSystem="2.16.840.1.113883.6.96"
    displayName="Wheezing" />
</criterion>
```


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4.72 Pregnancy Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.15.3.8 (open)]

Table 401: Pregnancy Observation Contexts

Contained By:	Contains:
Social History Section (V2) (optional) Health Concern Act (optional) Risk Concern Act (optional)	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.

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Table 402: Pregnancy Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.15.3.8)					
@classCode	1..1	SHALL		81-451	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-452	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-16768	
@root	1..1	SHALL		81-16868	2.16.840.1.113883.10.20.15.3.8
code	1..1	SHALL		81-19153	
@code	1..1	SHALL		81-19154	ASSERTION
@codeSystem	1..1	SHALL		81-26505	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
statusCode	1..1	SHALL		81-455	
@code	1..1	SHALL		81-19110	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	0..1	SHOULD		81-2018	
value	1..1	SHALL	CD	81-457	
@code	1..1	SHALL		81-26460	2.16.840.1.113883.6.96 (SNOMED CT) = 77386006
entryRelationship	0..1	MAY		81-458	
@typeCode	1..1	SHALL		81-459	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		81-15584	Estimated Date of Delivery (identifier: urn:oid:2.16.840.1.113883.10.20.15.3.1

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" Observation (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:81-451).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:81-452).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-16768) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.15.3.8`" (CONF:81-16868).
4. **SHALL** contain exactly one [1..1] **code** (CONF:81-19153).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`ASSERTION`" Assertion (CONF:81-19154).

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b. 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:81-26505).

5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:81-455).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:81-19110).
6. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:81-2018).
7. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD" (CONF:81-457).
   a. This value **SHALL** contain exactly one [1..1] **@code**="77386006" Pregnant (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF:81-26460).
8. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:81-458) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-459).
   b. **SHALL** contain exactly one [1..1] **Estimated Date of Delivery** (identifier: urn:oid:2.16.840.1.113883.10.20.15.3.1) (CONF:81-15584).

Figure 200: 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>
```

4.73 Preoperative Diagnosis (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09 (open)]

Table 403: Preoperative Diagnosis (V2) Contexts

Contained By:	Contains:
Preoperative Diagnosis Section (V2) (optional) Health Concern Act (optional) Risk Concern Act (optional)	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.

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Table 404: Preoperative Diagnosis (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09)					
@classCode	1..1	SHALL		1098-10090	ACT
@moodCode	1..1	SHALL		1098-10091	EVN
templateId	1..1	SHALL		1098-16770	
@root	1..1	SHALL		1098-16771	2.16.840.1.113883.10.20.22.4.65
@extension	1..1	SHALL		1098-32540	2014-06-09
code	1..1	SHALL		1098-19155	
@code	1..1	SHALL		1098-19156	10219-4
@codeSystem	1..1	SHALL		1098-32167	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
entryRelationship	1..*	SHALL		1098-10093	
@typeCode	1..1	SHALL		1098-10094	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
observation	1..1	SHALL		1098-15605	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CONF:1098-10090).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CONF:1098-10091).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16770) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.65" (CONF:1098-16771).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32540).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-19155).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10219-4" Preoperative Diagnosis (CONF:1098-19156).
    b. 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:1098-32167).
5. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-10093) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-10094).

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b. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-15605).

Figure 201: Preoperative Diagnosis (V2) Example

```
<act moodCode="EVN" classCode="ACT">
    <templateId root="2.16.840.1.113883.10.20.22.4.65" extension="2014-06-09"/>
    <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>
```

4.74 Pressure Ulcer Observation (DEPRECATED)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.70:2014-06-09 (open)]

Table 405: Pressure Ulcer Observation (DEPRECATED) Contexts

Contained By:	Contains:
Functional Status Section (V2) (optional)	

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 IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED.

Reason for deprecation: This template has been replaced by Longitudinal Care Wound Observation (2.16.840.1.113883.10.20.22.4.114).

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Table 406: Pressure Ulcer Observation (DEPRECATED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.70:2014-06-09)					
@classCode	1..1	SHALL		1098-14383	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-14384	2.16.840.1.113883.5.1001 (ActMood) = EVN
@negationInd	0..1	MAY		1098-14385	
templateId	1..1	SHALL		1098-14387	
@root	1..1	SHALL		1098-14388	2.16.840.1.113883.10.20.22.4.70
@extension	1..1	SHALL		1098-32594	2014-06-09
id	1..*	SHALL		1098-14389	
code	1..1	SHALL		1098-14759	
@code	1..1	SHALL		1098-14760	2.16.840.1.113883.5.4 (ActCode) = ASSERTION
text	0..1	SHOULD		1098-14391	
reference	0..1	SHOULD		1098-14392	
@value	1..1	SHALL		1098-15585	
statusCode	1..1	SHALL		1098-14394	
@code	1..1	SHALL		1098-19111	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-14395	
value	1..1	SHALL	CD	1098-14396	2.16.840.1.113883.11.20.9.35 (Pressure Ulcer Stage)
targetSiteCode	0..*	SHOULD		1098-14797	
@code	1..1	SHALL		1098-14798	2.16.840.1.113883.11.20.9.36 (Pressure Point)
qualifier	0..1	SHOULD		1098-14799	
name	1..1	SHALL		1098-14800	
@code	0..1	SHOULD		1098-14801	2.16.840.1.113883.6.96 (SNOMED CT) = 272741003

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value	1..1	SHALL		1098-14802	
@code	0..1	SHOULD		1098-14803	2.16.840.1.113883.11.20.9.37 (TargetSite Qualifiers)
entryRelationship	0..1	SHOULD		1098-14410	
@typeCode	1..1	SHALL		1098-14411	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
observation	1..1	SHALL		1098-14619	
@classCode	1..1	SHALL		1098-14685	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-14686	2.16.840.1.113883.5.1001 (ActMood) = EVN
code	1..1	SHALL		1098-14620	
@code	1..1	SHALL		1098-14621	2.16.840.1.113883.6.96 (SNOMED CT) = 401238003
value	1..1	SHALL	PQ	1098-14622	
entryRelationship	0..1	SHOULD		1098-14601	
@typeCode	1..1	SHALL		1098-14602	COMP
observation	1..1	SHALL		1098-14623	
@classCode	1..1	SHALL		1098-14687	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-14688	2.16.840.1.113883.5.1001 (ActMood) = EVN
code	1..1	SHALL		1098-14624	
@code	1..1	SHALL		1098-14625	2.16.840.1.113883.6.96 (SNOMED CT) = 401239006
value	1..1	SHALL	PQ	1098-14626	
entryRelationship	0..1	SHOULD		1098-14605	
@typeCode	1..1	SHALL		1098-14606	COMP
observation	1..1	SHALL		1098-14627	
@classCode	1..1	SHALL		1098-14689	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-14690	2.16.840.1.113883.5.1001 (ActMood) = EVN

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code	1..1	SHALL		1098-14628	
@code	1..1	SHALL		1098-14629	2.16.840.1.113883.6.96 (SNOMED CT) = 425094009
value	1..1	SHALL	PQ	1098-14630	

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-14383).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-14384).

Use negationInd="true" to indicate that the problem was not observed.

3. **MAY** contain zero or one [0..1] **@negationInd** (CONF:1098-14385).
4. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-14387) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.70" (CONF:1098-14388).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32594).
5. **SHALL** contain at least one [1..*] **id** (CONF:1098-14389).
6. **SHALL** contain exactly one [1..1] **code** (CONF:1098-14759).
    a. This code **SHALL** contain exactly one [1..1] **@code**="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 **STATIC**) (CONF:1098-14760).
7. **SHOULD** contain zero or one [0..1] **text** (CONF:1098-14391).
    a. The text, if present, **SHOULD** contain zero or one [0..1] **reference** (CONF:1098-14392).
        i. The reference, if present, **SHALL** contain exactly one [1..1] **@value** (CONF:1098-15585).
            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:1098-15586).
8. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-14394).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19111).
9. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-14395).
10. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **Pressure Ulcer Stage** 2.16.840.1.113883.11.20.9.35 **STATIC** 2014-09-01 (CONF:1098-14396).
11. **SHOULD** contain zero or more [0..*] **targetSiteCode** (CONF:1098-14797).
    a. The targetSiteCode, if present, **SHALL** contain exactly one [1..1] **@code**, which **SHOULD** be selected from ValueSet **Pressure Point** 2.16.840.1.113883.11.20.9.36 **STATIC** (CONF:1098-14798).
    b. The targetSiteCode, if present, **SHOULD** contain zero or one [0..1] **qualifier** (CONF:1098-14799).

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i. The qualifier, if present, **SHALL** contain exactly one [1..1] **name** (CONF:1098-14800).
    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:1098-14801).
ii. The qualifier, if present, **SHALL** contain exactly one [1..1] **value** (CONF:1098-14802).
    1. This value **SHOULD** contain zero or one [0..1] **@code**, which **SHOULD** be selected from ValueSet **TargetSite Qualifiers** 2.16.840.1.113883.11.20.9.37 **STATIC** 2014-09-01 (CONF:1098-14803).

12. **SHOULD** contain zero or one [0..1] **entryRelationship** (CONF:1098-14410) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-14411).
    b. **SHALL** contain exactly one [1..1] **observation** (CONF:1098-14619).
        i. This observation **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-14685).
        ii. This observation **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-14686).
        iii. This observation **SHALL** contain exactly one [1..1] **code** (CONF:1098-14620).
            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:1098-14621).
        iv. This observation **SHALL** contain exactly one [1..1] **value** with @xsi:type="PQ" (CONF:1098-14622).
13. **SHOULD** contain zero or one [0..1] **entryRelationship** (CONF:1098-14601) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" (CONF:1098-14602).
    b. **SHALL** contain exactly one [1..1] **observation** (CONF:1098-14623).
        i. This observation **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-14687).
        ii. This observation **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-14688).
        iii. This observation **SHALL** contain exactly one [1..1] **code** (CONF:1098-14624).
            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:1098-14625).
        iv. This observation **SHALL** contain exactly one [1..1] **value** with @xsi:type="PQ" (CONF:1098-14626).
14. **SHOULD** contain zero or one [0..1] **entryRelationship** (CONF:1098-14605) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" (CONF:1098-14606).

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b. **SHALL** contain exactly one [1..1] **observation** (CONF:1098-14627).
   i. This observation **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-14689).
   ii. This observation **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-14690).
   iii. This observation **SHALL** contain exactly one [1..1] **code** (CONF:1098-14628).
      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:1098-14629).
   iv. This observation **SHALL** contain exactly one [1..1] **value** with @xsi:type="PQ" (CONF:1098-14630).

Table 407: Pressure Point

Value Set: Pressure Point 2.16.840.1.113883.11.20.9.36 This value set represents points on the body that are susceptible to pressure ulcer development. Specific URL Pending Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
43631005	SNOMED CT	2.16.840.1.113883.6.96	occipital region structure
23747009	SNOMED CT	2.16.840.1.113883.6.96	skin structure of chin
91774008	SNOMED CT	2.16.840.1.113883.6.96	structure of right shoulder
7874003	SNOMED CT	2.16.840.1.113883.6.96	structure of scapular region of back; 272741003 = laterality; 24028007 = right (qualifier value)
368149001	SNOMED CT	2.16.840.1.113883.6.96	right elbow region structure
368148009	SNOMED CT	2.16.840.1.113883.6.96	left elbow region structure
87141009	SNOMED CT	2.16.840.1.113883.6.96	sacral vertebra structure
122495006	SNOMED CT	2.16.840.1.113883.6.96	thoracic spine structure
122496007	SNOMED CT	2.16.840.1.113883.6.96	lumbar spine structure
287579007	SNOMED CT	2.16.840.1.113883.6.96	right hip region structure
…			

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Table 408: TargetSite Qualifiers

Value Set: TargetSite Qualifiers 2.16.840.1.113883.11.20.9.37 Specific URL Pending Value Set Source: https://vsac.nlm.nih.gov			
Code	**Code System**	**Code System OID**	**Print Name**
255549009	SNOMED CT	2.16.840.1.113883.6.96	anterior
7771000	SNOMED CT	2.16.840.1.113883.6.96	left
255561001	SNOMED CT	2.16.840.1.113883.6.96	medial
255551008	SNOMED CT	2.16.840.1.113883.6.96	posterior
24028007	SNOMED CT	2.16.840.1.113883.6.96	right

4.75 Priority Preference

```
[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.143 (open)]
```

Table 409: Priority Preference Contexts

Contained By:	**Contains:**
Problem Observation (V2) (optional) Problem Concern Act (V2) (optional) Goal Observation (optional) Planned Act (V2) (optional) Planned Encounter (V2) (optional) Planned Procedure (V2) (optional) Planned Observation (V2) (optional) Planned Supply (V2) (optional) Planned Medication Activity (V2) (optional) Health Concern Act (optional) Planned Immunization Activity (optional) Risk Concern Act (optional)	Author Participation

This template represents priority preferences chosen by a patient or a care provider. Priority preferences are choices made by care providers or patients or both relative to options for care or treatment (including scheduling, care experience, and meeting of personal health goals), the sharing and disclosure of health information, and the prioritization of concerns and problems.

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Table 410: Priority Preference Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143)					
@classCode	1..1	SHALL		1098-30949	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-30950	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-30951	
@root	1..1	SHALL		1098-30952	2.16.840.1.113883.10.20.22.4.143
id	1..*	SHALL		1098-30953	
code	1..1	SHALL		1098-30954	
@code	1..1	SHALL		1098-30955	225773000
@codeSystem	1..1	SHALL		1098-30956	2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
effectiveTime	0..1	SHOULD		1098-32327	
value	1..1	SHALL	CD	1098-30957	2.16.840.1.113883.11.20.9.60 (Priority Level)
author	0..*	SHOULD		1098-30958	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-30949).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-30950).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30951) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.143" (CONF:1098-30952).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-30953).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-30954).
   a. This code **SHALL** contain exactly one [1..1] **@code**="225773000" Preference (CONF:1098-30955).
   b. 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:1098-30956).
6. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-32327).

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7. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHALL** be selected from ValueSet **Priority Level** 2.16.840.1.113883.11.20.9.60 **STATIC** 2014-06-11 (CONF:1098-30957).
8. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-30958).

Table 411: Priority Level

Value Set: Priority Level 2.16.840.1.113883.11.20.9.60 A value set of SNOMED-CT that contains concepts representing priority. Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
394849002	SNOMED CT	2.16.840.1.113883.6.96	High priority
394848005	SNOMED CT	2.16.840.1.113883.6.96	Normal priority
441808003	SNOMED CT	2.16.840.1.113883.6.96	Delayed priority

Figure 202: 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="225773000"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT"
        displayName="preference" />
  <value xsi:type="CD"
         code="394849002"
         codeSystem="2.16.840.1.113883.6.96"
         codeSystemName="SNOMED"
         displayName="High priority" />
  <!--
      Author Participation Template
      In this case, the author is the same as a participant already described in the
header.
      However, the author could be a the record target (patient), a different provider -
      someone else in the header, or a new provider not elsewhere specified.
    -->
  <author>
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    <time value="20130801" />
    <assignedAuthor>
      <!-- This id points back to a participant in the header -->
      <id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c" />
    </assignedAuthor>
  </author>
</observation>
```


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4.76 Problem Concern Act (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09 (open)]

Table 412: Problem Concern Act (V2) Contexts

Contained By:	Contains:
Problem Section (entries required) (V2) (required) Problem Section (entries optional) (V2) (optional) Health Concern Act (optional) Risk Concern Act (optional)	Author Participation Priority Preference Problem Observation (V2)

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., as 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 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 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).

A Problem Concern Act can contain many Problem Observations (templateId 2.16.840.1.113883.10.20.22.4.4.2). Each Problem Observation is a discrete observation of a condition, and therefore will have a statusCode of "completed". The many Problem Observations nested under a Problem Concern Act reflect the change in the clinical understanding of a condition over time. For instance, a Concern may initially contain a Problem Observation of "chest pain":

- Problem Concern 1

  --- Problem Observation: Chest Pain

Later, a new Problem Observation of "esophagitis" will be added, reflecting a better understanding of the nature of the chest pain. The later problem observation will have a more recent author time stamp.

- Problem Concern 1

  --- Problem Observation (author/time Jan 3, 2012): Chest Pain

  --- Problem Observation (author/time Jan 6, 2012): Esophagitis

Many systems display the nested Problem Observation with the most recent author time stamp, and provide a mechanism for viewing prior observations.

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Table 413: Problem Concern Act (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09)					
@classCode	1..1	SHALL		1098-9024	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-9025	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-16772	
@root	1..1	SHALL		1098-16773	2.16.840.1.113883.10.20.22.4.3
@extension	1..1	SHALL		1098-32509	2014-06-09
id	1..*	SHALL		1098-9026	
code	1..1	SHALL		1098-9027	
@code	1..1	SHALL		1098-19184	CONC
@codeSystem	1..1	SHALL		1098-32168	2.16.840.1.113883.5.6 (HL7ActClass) = 2.16.840.1.113883.5.6
statusCode	1..1	SHALL		1098-9029	
@code	1..1	SHALL		1098-31525	2.16.840.1.113883.11.20.9.19 (ProblemAct statusCode)
effectiveTime	1..1	SHALL		1098-9030	
low	1..1	SHALL		1098-9032	
high	0..1	MAY		1098-9033	
author	0..*	SHOULD		1098-31146	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	1..*	SHALL		1098-9034	
@typeCode	1..1	SHALL		1098-9035	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
observation	1..1	SHALL		1098-15980	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09
entryRelationship	0..*	MAY		1098-31638	
@typeCode	1..1	SHALL		1098-	2.16.840.1.113883.5.1002

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				31639	(HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31640	Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-9024).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-9025).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16772) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.3" (CONF:1098-16773).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32509).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-9026).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-9027).
   a. This code **SHALL** contain exactly one [1..1] **@code**="CONC" Concern (CONF:1098-19184).
   b. This code **SHALL** contain exactly one [1..1] **@codeSystem**="2.16.840.1.113883.5.6" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-32168).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-9029).

The statusCode of the Problem Concern Act 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.

   a. 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:1098-31525).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-9030).
   a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-9032).
   Note: The effectiveTime/low asserts when the concern became active. This equates to the time the concern was authored in the patient's chart.
   b. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:1098-9033).
   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** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31146).
9. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-9034) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-9035).
   b. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-15980).

The following entryRelationship represents the importance of the concern to a provider.

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10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31638) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31639).
    b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31640).

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Figure 203: Problem Concern Act (V2) Example

```
<act classCode="ACT" moodCode="EVN">
  <!-- ** Problem Concern Act (V2) ** -->
  <templateId root="2.16.840.1.113883.10.20.22.4.3"
          extension="2014-06-09" />
  <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 -->
  <!-- This is of ongoing concern to the provider -->
  <statusCode code="active" />
  <effectiveTime>
    <!-- The low value represents when the problem was first recorded in the patient's
chart -->
    <!-- Concern was documented on July 6, 2013 -->
    <low value="201307061145-0800" />
  </effectiveTime>
  <author typeCode="AUT">
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    <!-- Same as Concern effectiveTime/low -->
    <time value="201307061145-0800" />
    <assignedAuthor>
      <id extension="555555555" root="2.16.840.1.113883.4.6" />
      <code code="207QA0505X" displayName="Adult Medicine"
codeSystem="2.16.840.1.113883.6.101"
        codeSystemName="Healthcare Provider Taxonomy (HIPAA)" />
    </assignedAuthor>
  </author>
  <entryRelationship typeCode="SUBJ">
    <observation classCode="OBS" moodCode="EVN">
      <!-- ** Problem Observation (V2) ** -->
      <templateId root="2.16.840.1.113883.10.20.22.4.4" extension="2014-06-09" />
      <id root="ab1791b0-5c71-11db-b0de-0800200c9a66" />
      <code code="75323-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Condition" />
      <!-- The statusCode reflects the status of the observation itself -->
      <statusCode code="completed" />
      <effectiveTime>
        <!-- The low value reflects the date of onset -->
        <!-- Based on patient symptoms, presumed onset is July 3, 2013 -->
        <low value="20130703" />
        <!-- The high value reflects when the problem was known to be resolved -->
        <!-- Based on signs and symptoms, appears to be resolved on Aug 14, 2013 -->
        <high value="20080814" />
      </effectiveTime>
      <value xsi:type="CD"
             code="233604007"
             codeSystem="2.16.840.1.113883.6.96"
             displayName="Pneumonia" />
      <author typeCode="AUT">
        <templateId root="2.16.840.1.113883.10.20.22.4.119" />
        <time value="200808141030-0800" />
        <assignedAuthor>
          <id extension="555555555" root="2.16.840.1.113883.4.6" />
          <code code="207QA0505X"
                displayName="Adult Medicine"
                codeSystem="2.16.840.1.113883.6.101"
```


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```
                codeSystemName="Healthcare Provider Taxonomy (HIPAA)" />
        </assignedAuthor>
      </author>
    </observation>
  </entryRelationship>
</act>
```

4.77 Problem Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09 (open)]

Table 414: Problem Observation (V2) Contexts

Contained By:	Contains:
Problem Concern Act (V2) (required) Hospital Discharge Diagnosis (V2) (required) Hospital Admission Diagnosis (V2) (required) History of Past Illness Section (V2) (optional) Procedure Findings Section (V2) (optional) Complications Section (V2) (optional) Postprocedure Diagnosis (V2) (required) Preoperative Diagnosis (V2) (required) Deceased Observation (V2) (optional) Encounter Diagnosis (V2) (required) Health Concern Act (optional) Risk Concern Act (optional)	Age Observation Author Participation Priority Preference Problem Status (DEPRECATED) Prognosis Observation

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".

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Table 415: Problem Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)					
@classCode	1..1	SHALL		1098-9041	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-9042	2.16.840.1.113883.5.1001 (ActMood) = EVN
@negationInd	0..1	MAY		1098-10139	
templateId	1..1	SHALL		1098-14926	
@root	1..1	SHALL		1098-14927	2.16.840.1.113883.10.20.22.4.4
@extension	1..1	SHALL		1098-32508	2014-06-09
id	1..*	SHALL		1098-9043	
code	1..1	SHALL		1098-9045	2.16.840.1.113883.3.88.12.3221.7.2 (Problem Type)
statusCode	1..1	SHALL		1098-9049	
@code	1..1	SHALL		1098-19112	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-9050	
low	1..1	SHALL		1098-15603	
high	0..1	MAY		1098-15604	
value	1..1	SHALL	CD	1098-9058	2.16.840.1.113883.3.88.12.3221.7.4 (Problem)
qualifier	0..*	MAY		1098-31870	
translation	0..*	MAY		1098-16749	
@code	0..1	MAY		1098-16750	2.16.840.1.113883.6.90 (ICD10CM)
@code	0..1	MAY		1098-31871	
author	0..*	SHOULD		1098-31147	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..1	MAY		1098-9059	
@typeCode	1..1	SHALL		1098-9060	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ

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@inversionInd	1..1	SHALL		1098-9069	true
observation	1..1	SHALL		1098-15590	Age Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.31
entryRelationship	0..1	MAY		1098-29951	
@typeCode	1..1	SHALL		1098-31531	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-29952	Prognosis Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.113
entryRelationship	0..*	MAY		1098-31063	
@typeCode	1..1	SHALL		1098-31532	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-31064	Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143
entryRelationship	0..1	MAY		1098-9063	
@typeCode	1..1	SHALL		1098-9068	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-15591	Problem Status (DEPRECATED) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.6:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-9041).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-9042).

The negationInd is used to indicate the absence of the condition in observation/value. A negationInd of "true" coupled with an observation/value of SNOMED code 64572001 "Disease (disorder)" indicates that the patient has no known conditions.

3. **MAY** contain zero or one [0..1] **@negationInd** (CONF:1098-10139).
4. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-14926) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.4" (CONF:1098-14927).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32508).
5. **SHALL** contain at least one [1..*] **id** (CONF:1098-9043).
6. **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** 2014-09-02 (CONF:1098-9045).
7. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-9049).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19112).

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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.

8. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-9050).

The effectiveTime/low (a.k.a. "onset date") asserts when the condition became biologically active.

   a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-15603).

The effectiveTime/high (a.k.a. "resolution date") asserts when the condition became biologically resolved.

   b. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:1098-15604).

9. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **Problem** `2.16.840.1.113883.3.88.12.3221.7.4` **DYNAMIC** (CONF:1098-9058).

The observation/value and all the qualifiers together (often referred to as a post-coordinated expression) make up one concept. Qualifiers constrain the meaning of the primary code, and cannot negate it or change its meaning. Qualifiers can only be used according to well-defined rules of post-coordination and only if the underlying code system defines the use of such qualifiers or if there is a third code system that specifies how other code systems may be combined.

For example, SNOMED CT allows constructing concepts as a combination of multiple codes. SNOMED CT defines a concept "pneumonia (disorder)" (233604007) an attribute "finding site" (363698007) and another concept "left lower lobe of lung (body structure)" (41224006). SNOMED CT allows one to combine these codes in a code phrase, as shown in the sample XML.

   a. This value **MAY** contain zero or more [0..*] **qualifier** (CONF:1098-31870).
   b. This value **MAY** contain zero or more [0..*] **translation** (CONF:1098-16749) such that it
      i. **MAY** contain zero or one [0..1] **@code** (CodeSystem: `ICD10CM 2.16.840.1.113883.6.90` **STATIC**) (CONF:1098-16750).

A negationInd of "true" coupled with an observation/value/@code of SNOMED code 64572001 "Disease (disorder)" indicates that the patient has no known conditions.

   c. This value **MAY** contain zero or one [0..1] **@code** (CONF:1098-31871).

10. **SHOULD** contain zero or more [0..*] **Author Participation** `(identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119)` (CONF:1098-31147).
11. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-9059) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode="**`SUBJ`**"** Has subject (CodeSystem: `HL7ActRelationshipType 2.16.840.1.113883.5.1002` **STATIC**) (CONF:1098-9060).
    b. **SHALL** contain exactly one [1..1] **@inversionInd="**`true`**"** True (CONF:1098-9069).
    c. **SHALL** contain exactly one [1..1] **Age Observation** `(identifier: urn:oid:2.16.840.1.113883.10.20.22.4.31)` (CONF:1098-15590).

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12. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-29951) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31531).
    b. **SHALL** contain exactly one [1..1] **Prognosis Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.113) (CONF:1098-29952).
13. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31063) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31532).
    b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31064).
14. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-9063) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-9068).
    b. **SHALL** contain exactly one [1..1] **Problem Status (DEPRECATED)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.6:2014-06-09) (CONF:1098-15591).

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Figure 204: Problem Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
  <!-- ** Problem Observation (V2) ** -->
  <templateId root="2.16.840.1.113883.10.20.22.4.4" extension="2014-06-09" />
  <id root="ab1791b0-5c71-11db-b0de-0800200c9a66" />
  <code code="75323-6"
           codeSystem="2.16.840.1.113883.6.1"
           codeSystemName="LOINC"
           displayName="Condition" />
  <!-- The statusCode reflects the status of the observation itself -->
  <statusCode code="completed" />
  <effectiveTime>
    <!-- The low value reflects the date of onset -->
    <!-- Based on patient symptoms, presumed onset is July 3, 2013 -->
    <low value="20130703" />
    <!-- The high value reflects when the problem was known to be resolved -->
    <!-- Based on signs and symptoms, appears to be resolved on Aug 14, 2013 -->
    <high value="20080814" />
  </effectiveTime>
  <value xsi:type="CD"
    code="233604007"
    codeSystem="2.16.840.1.113883.6.96"
    displayName="Pneumonia" />
  <author typeCode="AUT">
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    <time value="200808141030-0800" />
    <assignedAuthor>
      <id extension="555555555" root="2.16.840.1.113883.4.6" />
      <code code="207QA0505X"
        displayName="Adult Medicine"
        codeSystem="2.16.840.1.113883.6.101"
        codeSystemName="Healthcare Provider Taxonomy (HIPAA)" />
    </assignedAuthor>
  </author>
</observation>
```


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Figure 205: No Known Problems Example

```
<observation classCode="OBS" moodCode="EVN" negationInd="true">
  <!-- Model of Meaning for No Problems -->
  <!-- This is more consistent with how we did no known allergies. -->
  <!-- The use of negationInd corresponds with the newer Observation.ValueNegationInd -->
  <!-- The negationInd = true negates the value element. -->
  <!-- problem observation template -->
  <templateId root="2.16.840.1.113883.10.20.22.4.4"
        extension="2014-06-09" />
  <id root="4adc1021-7b14-11db-9fe1-0800200c9a67" />
  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />
  <text>
    <reference value="#problems1" />
  </text>
  <statusCode code="completed" />
  <effectiveTime>
    <low value="20130607160506" />
  </effectiveTime>
  <!-- The time when this was biologically relevant, i.e., true for the patient. -->
  <!-- As a minimum time interval over which this is true, populate the effectiveTime/low
with the current time. -->
  <!-- It would be equally valid to have a longer range of time over which this statement
was represented as being true. -->
  <!-- As a maximum, you would never indicate an effectiveTime/high that was greater than
the current point in time. -->
  <!-- This idea assumes that the value element could come from the Problem value set, or--
>
  <!-- when negationInd was true, is could also come from the ProblemType value set (and
code would be ASSERTION). -->
  <value xsi:type="CD" code="55607006" displayName="Problem"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT">
    <originalText>
      <reference value="#problemType1" />
    </originalText>
  </value>
</observation>
```


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Figure 206: Resolved Problem and Resolved Concern Example

```
<act classCode="ACT" moodCode="EVN">
  <!-- ** Problem concern act (V2) ** -->
  <templateId root="2.16.840.1.113883.10.20.22.4.3"
           extension="2014-06-09" />
  <id root="b5159d48-04aa-4927-b355-00d1dcb7158c" />
  <code code="CONC" codeSystem="2.16.840.1.113883.5.6" displayName="Concern" />
  <!-- The statusCode represents the need to continue tracking the problem -->
  <!-- This is no longer of ongoing concern to the provider -->
  <statusCode code="completed" />
  <effectiveTime>
    <!-- The low value represents when the problem was first recorded in the patient's
chart -->
    <!-- Concern was documented on Mar 10, 1998 -->
    <low value="199803101030-0800" />
    <!-- The high value reflects when there was no longer a need to track the problem -->
    <!-- Concern was closed on May 4, 1998 -->
    <high value="199805041145-0800" />
  </effectiveTime>
  <author typeCode="AUT">
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    <!-- Same as Concern effectiveTime/low -->
    <time value="199803161030-0800" />
    <assignedAuthor>
      <id extension="555555555" root="2.16.840.1.113883.4.6" />
      <code code="207QA0505X"
            displayName="Adult Medicine"
            codeSystem="2.16.840.1.113883.6.101"
            codeSystemName="Healthcare Provider Taxonomy (HIPAA)" />
    </assignedAuthor>
  </author>
  <entryRelationship typeCode="SUBJ">
    <observation classCode="OBS" moodCode="EVN">
      <!-- ** Problem observation (V2) ** -->
      <templateId root="2.16.840.1.113883.10.20.22.4.4"
             extension="2014-06-09" />
      <id root="10506b4d-c30a-4220-8bec-97bff9568fd1" />
      <code code="75323-6"
            codeSystem="2.16.840.1.113883.6.1"
            codeSystemName="LOINC"
            displayName="Condition" />
      <!-- The statusCode reflects the status of the observation itself -->
      <statusCode code="completed" />
      <effectiveTime>
        <!-- The low value reflects the date of onset -->
        <!-- Based on patient symptoms, presumed onset is Mar 10, 1998 -->
        <low value="19980310" />
        <!-- The high value reflects when the problem was known to be resolved -->
        <high value="19980316" />
      </effectiveTime>
      <value xsi:type="CD"
             code="233604007"
             codeSystem="2.16.840.1.113883.6.96"
             displayName="Pneumonia">
        <qualifier>
          <name code="363698007" displayName="Finding site" />
```


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```
          <value code="41224006" displayName="Left lower lobe of lung" />
        </qualifier>
      </value>
      <author typeCode="AUT">
        <templateId root="2.16.840.1.113883.10.20.22.4.119" />
        <time value="199803161030-0800" />
        <assignedAuthor>
          <id extension="555555555" root="2.16.840.1.113883.4.6" />
          <code code="207QA0505X"
                displayName="Adult Medicine"
                codeSystem="2.16.840.1.113883.6.101"
                codeSystemName="Healthcare Provider Taxonomy (HIPAA)" />
        </assignedAuthor>
      </author>
    </observation>
  </entryRelationship>
</act>
```


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Figure 207: Problem with Qualifiers Example

```
<observation classCode="OBS" moodCode="EVN">
  <!-- ** Problem observation (V2) ** -->
  <templateId root="2.16.840.1.113883.10.20.22.4.4"
    extension="2014-06-09" />
  <id root="10506b4d-c30a-4220-8bec-97bff9568fd1" />
  <code code="75323-6"
    codeSystem="2.16.840.1.113883.6.1"
    codeSystemName="LOINC"
    displayName="Condition" />
  <!-- The statusCode reflects the status of the observation itself -->
  <statusCode code="completed" />
  <effectiveTime>
    <!-- The low value reflects the date of onset -->
    <!-- Based on patient symptoms, presumed onset is Mar 10, 1998 -->
    <low value="19980310" />
    <!-- The high value reflects when the problem was known to be resolved -->
    <high value="19980316" />
  </effectiveTime>
  <value xsi:type="CD"
    code="233604007"
    codeSystem="2.16.840.1.113883.6.96"
    displayName="Pneumonia">
    <qualifier>
      <name code="363698007" displayName="Finding site" />
      <value code="41224006" displayName="Left lower lobe of lung" />
    </qualifier>
  </value>
  <author typeCode="AUT">
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    <time value="199803161030-0800" />
    <assignedAuthor>
      <id extension="555555555" root="2.16.840.1.113883.4.6" />
      <code code="207QA0505X"
        displayName="Adult Medicine"
        codeSystem="2.16.840.1.113883.6.101"
        codeSystemName="Healthcare Provider Taxonomy (HIPAA)" />
    </assignedAuthor>
  </author>
</observation>
```


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4.77.1 Longitudinal Care Wound Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.114 (open)]

Table 416: Longitudinal Care Wound Observation Contexts

Contained By:	**Contains:**
Health Concern Act (optional) Physical Exam Section (V2) (optional) Risk Concern Act (optional)	Author Participation Highest Pressure Ulcer Stage Number of Pressure Ulcers Observation (V2) Wound Characteristic Wound Measurement Observation

This template represents acquired or surgical wounds and is not intended to encompass all wound types. The template applies to wounds such as pressure ulcers, surgical incisions, and deep tissue injury wounds. Information in this template may include information about the wound measurements characteristics.

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Table 417: Longitudinal Care Wound Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.114)					
@classCode	1..1	SHALL		1098-31012	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-31013	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-29473	
@root	1..1	SHALL		1098-29474	2.16.840.1.113883.10.20.22.4.114
code	1..1	SHALL		1098-29476	
@code	1..1	SHALL		1098-29477	ASSERTION
@codeSystem	1..1	SHALL		1098-31010	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
value	1..1	SHALL	CD	1098-29485	2.16.840.1.113883.1.11.20.2.6 (Wound Type)
targetSiteCode	0..1	SHOULD		1098-29488	2.16.840.1.113883.3.88.12.3221.8.9 (Body Site)
qualifier	0..*	MAY		1098-29490	
name	1..1	SHALL		1098-29491	
@code	1..1	SHALL		1098-29492	272741003
@codeSystem	1..1	SHALL		1098-31524	2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
value	1..1	SHALL		1098-29493	
@code	1..1	SHALL		1098-29494	2.16.840.1.113883.11.20.9.37 (TargetSite Qualifiers)
author	0..*	SHOULD		1098-31542	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	SHOULD		1098-29495	
@typeCode	1..1	SHALL		1098-29496	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
observation	1..1	SHALL		1098-29497	Wound Measurement Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.133

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entryRelationship	0..*	SHOULD		1098-29503	
@typeCode	1..1	SHALL		1098-29504	COMP
observation	1..1	SHALL		1098-29505	Wound Characteristic (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.134
entryRelationship	0..*	MAY		1098-31890	
@typeCode	1..1	SHALL		1098-31891	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
observation	1..1	SHALL		1098-31892	Number of Pressure Ulcers Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.76:2014-06-09
entryRelationship	0..1	MAY		1098-31893	
@typeCode	1..1	SHALL		1098-31894	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
observation	1..1	SHALL		1098-31919	Highest Pressure Ulcer Stage (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.77

1. Conforms to **Problem Observation (V2)** template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)`.
2. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6`) (CONF:1098-31012).
3. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" (CodeSystem: `ActMood 2.16.840.1.113883.5.1001`) (CONF:1098-31013).
4. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-29473) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.114`" (CONF:1098-29474).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-29476).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`ASSERTION`" assertion (CONF:1098-29477).
   b. 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:1098-31010).
6. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **Wound Type** `2.16.840.1.113883.1.11.20.2.6` **DYNAMIC** (CONF:1098-29485).
7. **SHOULD** contain zero or one [0..1] **targetSiteCode**, which **SHOULD** be selected from ValueSet **Body Site** `2.16.840.1.113883.3.88.12.3221.8.9` **DYNAMIC** (CONF:1098-29488) such that it

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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.

a. **MAY** contain zero or more [0..*] **qualifier** (CONF:1098-29490).
   i. The qualifier, if present, **SHALL** contain exactly one [1..1] **name** (CONF:1098-29491).
      1. This name **SHALL** contain exactly one [1..1] **@code**="272741003" laterality (CONF:1098-29492).
      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:1098-31524).
   ii. The qualifier, if present, **SHALL** contain exactly one [1..1] **value** (CONF:1098-29493).
      1. This value **SHALL** contain exactly one [1..1] **@code**, which **SHOULD** be selected from ValueSet **TargetSite Qualifiers** 2.16.840.1.113883.11.20.9.37 **STATIC** 2014-09-01 (CONF:1098-29494).

8. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31542).
9. **SHOULD** contain zero or more [0..*] **entryRelationship** (CONF:1098-29495) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-29496).
   b. **SHALL** contain exactly one [1..1] **Wound Measurement Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.133) (CONF:1098-29497).
10. **SHOULD** contain zero or more [0..*] **entryRelationship** (CONF:1098-29503) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" (CONF:1098-29504).
   b. **SHALL** contain exactly one [1..1] **Wound Characteristic** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.134) (CONF:1098-29505).

When the wound observed is a type of pressure ulcer, then this template SHOULD contain an entry for the Number of Pressure Ulcers.

11. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-31890) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31891).
   b. **SHALL** contain exactly one [1..1] **Number of Pressure Ulcers Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.76:2014-06-09) (CONF:1098-31892).

When the wound observed is a type of pressure ulcer, then this template SHOULD contain an entry for the Highest Pressure Ulcer Stage.

12. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-31893) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31894).

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b. **SHALL** contain exactly one [1..1] **Highest Pressure Ulcer Stage** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.77) (CONF:1098-31919).

Table 418: 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 Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
420226006	SNOMED CT	2.16.840.1.113883.6.96	Pressure ulcer
46742003	SNOMED CT	2.16.840.1.113883.6.96	Skin ulcer
262557004	SNOMED CT	2.16.840.1.113883.6.96	Deep wound
283396008	SNOMED CT	2.16.840.1.113883.6.96	Incised wound
416886008	SNOMED CT	2.16.840.1.113883.6.96	Closed wound
125643001	SNOMED CT	2.16.840.1.113883.6.96	Open wound
421076008	SNOMED CT	2.16.840.1.113883.6.96	Pressure ulcer stage 1
420324007	SNOMED CT	2.16.840.1.113883.6.96	Pressure Ulcer Stage 2
421927004	SNOMED CT	2.16.840.1.113883.6.96	Pressure Ulcer Stage 3
420597008	SNOMED CT	2.16.840.1.113883.6.96	Pressure Ulcer Stage 4
…			

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Figure 208: Longitudinal Care Wound Observation Example

```
<entry>
    <observation classCode="OBS" moodCode="EVN">
        <!-- Wound Observation template -->
        <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" />
        <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" />
               ...

            </observation>
            </entryRelationship>
            <entryRelationship typeCode="COMP">
                <observation classCode="OBS" moodCode="EVN">
                    <!-- Wound Measurements Observation . -->
                    <templateId root="2.16.840.1.113883.10.20.22.4.133" />
               ...

                </observation>
                </entryRelationship>
                <entryRelationship typeCode="COMP">
                    <observation classCode="OBS" moodCode="EVN">
                        <!-- Wound Characteristic -->
                        <templateId root="2.16.840.1.113883.10.20.22.4.134" />
             ...

                    </observation>
                    </entryRelationship>
                    <entryRelationship typeCode="COMP">
                        <observation classCode="OBS" moodCode="EVN">
                            <!-- Number of Pressure Ulcers -->
                            <templateId root="2.16.840.1.113883.10.20.22.4.76" />
       ...

                        </observation>
                        </entryRelationship>
                        <entryRelationship typeCode="COMP">
                            <observation classCode="OBS" moodCode="EVN">
                                <!-- Highest Pressure  Ulcers Stage -->
                                <templateId root="2.16.840.1.113883.10.20.22.4.77" />
             ...
```


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```
                            </observation>
                            </entryRelationship>
                        </observation>
                    </entry>
```

4.78 Problem Status (DEPRECATED)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.6:2014-06-09 (open)]

Table 419: Problem Status (DEPRECATED) Contexts

Contained By:	Contains:
Problem Observation (V2) (optional)	

The Problem Status records whether the indicated problem is active, inactive, or resolved.

THIS TEMPLATE HAS BEEN DEPRECATED IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED.

Reason for deprecation: 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

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Table 420: Problem Status (DEPRECATED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.6:2014-06-09)					
@classCode	1..1	SHALL		1098-7357	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-7358	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7359	
@root	1..1	SHALL		1098-10518	2.16.840.1.113883.10.20.22.4.6
@extension	1..1	SHALL		1098-32581	2014-06-09
code	1..1	SHALL		1098-19162	
@code	1..1	SHALL		1098-19163	2.16.840.1.113883.6.1 (LOINC) = 33999-4
statusCode	1..1	SHALL		1098-7364	
@code	1..1	SHALL		1098-19113	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..1	SHALL	CD	1098-7365	2.16.840.1.113883.3.88.12.80.68 (Problem Status)

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7357).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7358).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7359) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.6" (CONF:1098-10518).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32581).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-19162).
   a. This code **SHALL** contain exactly one [1..1] **@code**="33999-4" Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 **STATIC**) (CONF:1098-19163).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7364).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19113).
6. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHALL** be selected from ValueSet **Problem Status** 2.16.840.1.113883.3.88.12.80.68 **DYNAMIC** (CONF:1098-7365).

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4.79 Procedure Activity Act (V2)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09 (open)]

Table 421: Procedure Activity Act (V2) Contexts

Contained By:	Contains:
Procedures Section (entries optional) (V2) (optional) Procedures Section (entries required) (V2) (optional) Intervention Act (optional) Planned Intervention Act (optional)	Author Participation Indication (V2) Instruction (V2) Medication Activity (V2) 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).

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Table 422: Procedure Activity Act (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09)					
@classCode	1..1	SHALL		1098-8289	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-8290	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-8291	
@root	1..1	SHALL		1098-10519	2.16.840.1.113883.10.20.22.4.12
@extension	1..1	SHALL		1098-32505	2014-06-09
id	1..*	SHALL		1098-8292	
code	1..1	SHALL		1098-8293	
originalText	0..1	SHOULD		1098-19186	
reference	0..1	MAY		1098-19187	
@value	0..1	MAY		1098-19188	
statusCode	1..1	SHALL		1098-8298	
@code	1..1	SHALL		1098-32364	2.16.840.1.113883.11.20.9.22 (ProcedureAct statusCode)
effectiveTime	1..1	SHALL		1098-8299	
priorityCode	0..1	MAY		1098-8300	2.16.840.1.113883.1.11.16866 (Act Priority)
performer	0..*	SHOULD		1098-8301	
assignedEntity	1..1	SHALL		1098-8302	
id	1..1	SHALL		1098-8303	
addr	1..1	SHALL		1098-8304	
telecom	1..*	SHALL		1098-8305	
representedOrganization	0..1	SHOULD		1098-8306	
id	0..*	SHOULD		1098-8307	

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name	0..*	MAY		1098-8308	
telecom	1..*	SHALL		1098-8310	
addr	1..*	SHALL		1098-8309	
author	1..*	SHOULD		1098-32477	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	0..*	MAY		1098-8311	
@typeCode	1..1	SHALL		1098-8312	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = LOC
participantRole	1..1	SHALL		1098-15599	Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32
entryRelationship	0..*	MAY		1098-8314	
@typeCode	1..1	SHALL		1098-8315	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
@inversionInd	1..1	SHALL		1098-8316	true
encounter	1..1	SHALL		1098-8317	
@classCode	1..1	SHALL		1098-8318	2.16.840.1.113883.5.6 (HL7ActClass) = ENC
@moodCode	1..1	SHALL		1098-8319	2.16.840.1.113883.5.1001 (ActMood) = EVN
id	1..1	SHALL		1098-8320	
entryRelationship	0..1	MAY		1098-8322	
@typeCode	1..1	SHALL		1098-8323	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
@inversionInd	1..1	SHALL		1098-8324	true
act	1..1	SHALL		1098-31396	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
entryRelationship	0..*	MAY		1098-8326	
@typeCode	1..1	SHALL		1098-8327	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-15601	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.2

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					0.22.4.19:2014-06-09
entryRelationship	0..*	MAY		1098-8329	
@typeCode	1..1	SHALL		1098-8330	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
substanceAdministration	1..1	SHALL		1098-15602	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8289).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-8290).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8291) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.12" (CONF:1098-10519).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32505).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8292).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-8293).
    a. This code **SHOULD** contain zero or one [0..1] **originalText** (CONF:1098-19186).
        i. The originalText, if present, **MAY** contain zero or one [0..1] **reference** (CONF:1098-19187).
            1. The reference, if present, **MAY** contain zero or one [0..1] **@value** (CONF:1098-19188).
                a. 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:1098-19189).
    b. 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) or ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) or CDT-2 (Code System: 2.16.840.1.113883.6.13) (CONF:1098-19190).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-8298).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ProcedureAct statusCode** 2.16.840.1.113883.11.20.9.22 **STATIC** 2014-04-23 (CONF:1098-32364).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-8299).
8. **MAY** contain zero or one [0..1] **priorityCode**, which **SHALL** be selected from ValueSet **Act Priority** 2.16.840.1.113883.1.11.16866 **DYNAMIC** (CONF:1098-8300).
9. **SHOULD** contain zero or more [0..*] **performer** (CONF:1098-8301).
    a. The performer, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-8302).

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i. This assignedEntity **SHALL** contain exactly one [1..1] **id** (CONF:1098-8303).
ii. This assignedEntity **SHALL** contain exactly one [1..1] **addr** (CONF:1098-8304).
iii. This assignedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:1098-8305).
iv. This assignedEntity **SHOULD** contain zero or one [0..1] **representedOrganization** (CONF:1098-8306).
    1. The representedOrganization, if present, **SHOULD** contain zero or more [0..*] **id** (CONF:1098-8307).
    2. The representedOrganization, if present, **MAY** contain zero or more [0..*] **name** (CONF:1098-8308).
    3. The representedOrganization, if present, **SHALL** contain at least one [1..*] **telecom** (CONF:1098-8310).
    4. The representedOrganization, if present, **SHALL** contain at least one [1..*] **addr** (CONF:1098-8309).

10. **SHOULD** contain at least one [1..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32477).
11. **MAY** contain zero or more [0..*] **participant** (CONF:1098-8311) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8312).
    b. **SHALL** contain exactly one [1..1] **Service Delivery Location** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32) (CONF:1098-15599).
12. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-8314) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8315).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" true (CONF:1098-8316).
    c. **SHALL** contain exactly one [1..1] **encounter** (CONF:1098-8317).
        i. This encounter **SHALL** contain exactly one [1..1] **@classCode**="ENC" Encounter (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8318).
        ii. This encounter **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-8319).
        iii. This encounter **SHALL** contain exactly one [1..1] **id** (CONF:1098-8320).
            1. Set the encounter ID to the ID of an encounter in another section to signify they are the same encounter (CONF:1098-16849).
13. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-8322) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8323).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" true (CONF:1098-8324).

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c. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31396).

14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-8326) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8327).
    b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-15601).
15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-8329) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8330).
    b. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-15602).

Table 423: ProcedureAct statusCode

Value Set: ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22
Code System: ActStatus 2.16.840.1.113883.5.14

A ValueSet of HL7 actStatus codes for use with a procedure activity
Value Set Source: http://www.hl7.org

Code	Code System	Code System OID	Print Name
completed	ActStatus	2.16.840.1.113883.5.14	Completed
active	ActStatus	2.16.840.1.113883.5.14	Active
aborted	ActStatus	2.16.840.1.113883.5.14	Aborted
cancelled	ActStatus	2.16.840.1.113883.5.14	Cancelled

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Figure 209: Procedure Activity Act Example

```
<act classCode="ACT" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.12" extension="2014-06-09" />
    <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" />
            . . .
        </participantRole>
    </participant>
    <entryRelationship typeCode="RSON">
        <observation classCode="OBS" moodCode="EVN">
            <templateId root="2.16.840.1.113883.10.20.22.4.19" extension="2014-06-09" />
                . . .
        </observation>
    </entryRelationship>
    <entryRelationship typeCode="SUBJ" inversionInd="true">
        <act classCode="ACT" moodCode="INT">
            <templateId root="2.16.840.1.113883.10.20.22.4.20" extension="2014-06-09" />
                . . .
        </act>
```


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```
    </entryRelationship>
</act>
```

4.80 Procedure Activity Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09 (open)]

Table 424: Procedure Activity Observation (V2) Contexts

Contained By:	Contains:
Procedures Section (entries optional) (V2) (optional) Procedures Section (entries required) (V2) (optional) Intervention Act (optional) Planned Intervention Act (optional)	Author Participation Indication (V2) Instruction (V2) Medication Activity (V2) Reaction Observation (V2) 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.

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Table 425: Procedure Activity Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09)					
@classCode	1..1	SHALL		1098-8282	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-8237	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-8238	
@root	1..1	SHALL		1098-10520	2.16.840.1.113883.10.20.22.4.13
@extension	1..1	SHALL		1098-32507	2014-06-09
id	1..*	SHALL		1098-8239	
code	1..1	SHALL		1098-19197	
originalText	0..1	SHOULD		1098-19198	
reference	0..1	SHOULD		1098-19199	
@value	0..1	SHOULD		1098-19200	
statusCode	1..1	SHALL		1098-8245	
@code	1..1	SHALL		1098-32365	2.16.840.1.113883.11.20.9.22 (ProcedureAct statusCode)
effectiveTime	0..1	SHOULD		1098-8246	
priorityCode	0..1	MAY		1098-8247	2.16.840.1.113883.1.11.16866 (Act Priority)
value	1..1	SHALL		1098-16846	
@nullFlavor	0..1	MAY		1098-32778	
methodCode	0..1	MAY		1098-8248	
targetSiteCode	0..*	SHOULD		1098-8250	2.16.840.1.113883.3.88.12.3221.8.9 (Body Site)
performer	0..*	SHOULD		1098-8251	
assignedEntity	1..1	SHALL		1098-8252	
id	1..*	SHALL		1098-8253	

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addr	1..*	SHALL		1098-8254	
telecom	1..*	SHALL		1098-8255	
representedOrganization	0..1	SHOULD		1098-8256	
id	0..*	SHOULD		1098-8257	
name	0..*	MAY		1098-8258	
telecom	1..1	SHALL		1098-8260	
addr	1..1	SHALL		1098-8259	
author	1..*	SHOULD		1098-32478	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	0..*	MAY		1098-8261	
@typeCode	1..1	SHALL		1098-8262	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = LOC
participantRole	1..1	SHALL		1098-15904	Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32
entryRelationship	0..*	MAY		1098-8264	
@typeCode	1..1	SHALL		1098-8265	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
@inversionInd	1..1	SHALL		1098-8266	true
encounter	1..1	SHALL		1098-8267	
@classCode	1..1	SHALL		1098-8268	2.16.840.1.113883.5.6 (HL7ActClass) = ENC
@moodCode	1..1	SHALL		1098-8269	2.16.840.1.113883.5.1001 (ActMood) = EVN
id	1..1	SHALL		1098-8270	
entryRelationship	0..1	MAY		1098-8272	
@typeCode	1..1	SHALL		1098-8273	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
@inversionInd	1..1	SHALL		1098-8274	true
act	1..1	SHALL		1098-31394	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.2

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					0.22.4.20:2014-06-09
entryRelationship	0..*	MAY		1098-8276	
@typeCode	1..1	SHALL		1098-8277	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-15906	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
entryRelationship	0..*	MAY		1098-8279	
@typeCode	1..1	SHALL		1098-8280	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
substanceAdministration	1..1	SHALL		1098-15907	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09
entryRelationship	0..*	MAY		1098-32470	
@typeCode	1..1	SHALL		1098-32471	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
observation	1..1	SHALL		1098-32472	Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8282).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-8237).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8238) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.13" (CONF:1098-10520).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32507).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8239).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-19197).
    a. This code **SHOULD** contain zero or one [0..1] **originalText** (CONF:1098-19198).
        i. The originalText, if present, **SHOULD** contain zero or one [0..1] **reference** (CONF:1098-19199).
            1. The reference, if present, **SHOULD** contain zero or one [0..1] **@value** (CONF:1098-19200).
                a. 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:1098-19201).

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b. 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) or ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) or CDT-2 (Code System: 2.16.840.1.113883.6.13) (CONF:1098-19202).

6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-8245).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ProcedureAct statusCode** 2.16.840.1.113883.11.20.9.22 **STATIC** 2014-04-23 (CONF:1098-32365).
7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-8246).
8. **MAY** contain zero or one [0..1] **priorityCode**, which **SHALL** be selected from ValueSet **Act Priority** 2.16.840.1.113883.1.11.16866 **DYNAMIC** (CONF:1098-8247).
9. **SHALL** contain exactly one [1..1] **value** (CONF:1098-16846).

If nothing is appropriate for value, use an appropriate nullFlavor.

   a. This value **MAY** contain zero or one [0..1] **@nullFlavor** (CONF:1098-32778).
10. **MAY** contain zero or one [0..1] **methodCode** (CONF:1098-8248).
    a. MethodCode **SHALL NOT** conflict with the method inherent in Observation / code (CONF:1098-8249).
11. **SHOULD** contain zero or more [0..*] **targetSiteCode**, which **SHALL** be selected from ValueSet **Body Site** 2.16.840.1.113883.3.88.12.3221.8.9 **DYNAMIC** (CONF:1098-8250).
12. **SHOULD** contain zero or more [0..*] **performer** (CONF:1098-8251).
    a. The performer, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-8252).
       i. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-8253).
       ii. This assignedEntity **SHALL** contain at least one [1..*] **addr** (CONF:1098-8254).
       iii. This assignedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:1098-8255).
       iv. This assignedEntity **SHOULD** contain zero or one [0..1] **representedOrganization** (CONF:1098-8256).
          1. The representedOrganization, if present, **SHOULD** contain zero or more [0..*] **id** (CONF:1098-8257).
          2. The representedOrganization, if present, **MAY** contain zero or more [0..*] **name** (CONF:1098-8258).
          3. The representedOrganization, if present, **SHALL** contain exactly one [1..1] **telecom** (CONF:1098-8260).
          4. The representedOrganization, if present, **SHALL** contain exactly one [1..1] **addr** (CONF:1098-8259).
13. **SHOULD** contain at least one [1..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32478).
14. **MAY** contain zero or more [0..*] **participant** (CONF:1098-8261) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8262).
b. **SHALL** contain exactly one [1..1] **Service Delivery Location** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32) (CONF:1098-15904).

15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-8264) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8265).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" true (CONF:1098-8266).
    c. **SHALL** contain exactly one [1..1] **encounter** (CONF:1098-8267).
        i. This encounter **SHALL** contain exactly one [1..1] **@classCode**="ENC" Encounter (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8268).
        ii. This encounter **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-8269).
        iii. This encounter **SHALL** contain exactly one [1..1] **id** (CONF:1098-8270).
            1. Set encounter/id to the id of an encounter in another section to signify they are the same encounter (CONF:1098-16847).

16. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-8272) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8273).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" true (CONF:1098-8274).
    c. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31394).

17. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-8276) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8277).
    b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-15906).

18. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-8279) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-8280).
    b. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-15907).

19. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32470) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32471).

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b. **SHALL** contain exactly one [1..1] **Reaction Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09) (CONF:1098-32472).

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Figure 210: Procedure Activity Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.13" extension="2014-06-09" />
    <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 nullFlavor="NA" />
    <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" />
            . . .
        </participantRole>
    </participant>
    <entryRelationship typeCode="RSON">
        <observation classCode="OBS" moodCode="EVN">
            <templateId root="2.16.840.1.113883.10.20.22.4.19" extension="2014-06-09" />
             . . .
```


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```
        </observation>
    </entryRelationship>
    <entryRelationship typeCode="SUBJ" inversionInd="true">
        <act classCode="ACT" moodCode="INT">
            <templateId root="2.16.840.1.113883.10.20.22.4.20" extension="2014-06-09" />
            . . .

        </act>
    </entryRelationship>
</observation>
```

4.81 Procedure Activity Procedure (V2)

[procedure: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09 (open)]

Table 426: Procedure Activity Procedure (V2) Contexts

Contained By:	Contains:
Reaction Observation (V2) (optional) Medical Equipment Section (V2) (optional) Anesthesia Section (V2) (optional) Procedures Section (entries optional) (V2) (optional) Procedures Section (entries required) (V2) (optional) Medical Equipment Organizer (optional) Intervention Act (optional) Planned Intervention Act (optional)	Author Participation Indication (V2) Instruction (V2) Medication Activity (V2) Product Instance Reaction Observation (V2) 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.

This template can be used with a contained Product Instance template to represent a device in or on a patient. In this case, targetSiteCode is used to record the location of the device in or on the patient's body. Equipment supplied to the patient (e.g., pumps, inhalers, wheelchairs) is represented by the Non-Medicinal Supply Activity (V2) template.

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Table 427: Procedure Activity Procedure (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
procedure (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09)					
@classCode	1..1	SHALL		1098-7652	2.16.840.1.113883.5.6 (HL7ActClass) = PROC
@moodCode	1..1	SHALL		1098-7653	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7654	
@root	1..1	SHALL		1098-10521	2.16.840.1.113883.10.20.22.4.14
@extension	1..1	SHALL		1098-32506	2014-06-09
id	1..*	SHALL		1098-7655	
code	1..1	SHALL		1098-7656	
originalText	0..1	SHOULD		1098-19203	
reference	0..1	SHOULD		1098-19204	
@value	0..1	SHOULD		1098-19205	
statusCode	1..1	SHALL		1098-7661	
@code	1..1	SHALL		1098-32366	2.16.840.1.113883.11.20.9.22 (ProcedureAct statusCode)
effectiveTime	0..1	SHOULD		1098-7662	
priorityCode	0..1	MAY		1098-7668	2.16.840.1.113883.1.11.16866 (Act Priority)
methodCode	0..1	MAY		1098-7670	
targetSiteCode	0..*	SHOULD		1098-7683	
@code	1..1	SHALL		1098-16082	2.16.840.1.113883.3.88.12.3221.8.9 (Body Site)
specimen	0..*	MAY		1098-7697	
specimenRole	1..1	SHALL		1098-7704	
id	0..*	SHOULD		1098-7716	
performer	0..*	SHOULD		1098-7718	

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assignedEntity	1..1	SHALL		1098-7720	
id	1..*	SHALL		1098-7722	
addr	1..*	SHALL		1098-7731	
telecom	1..*	SHALL		1098-7732	
representedOrganization	0..1	SHOULD		1098-7733	
id	0..*	SHOULD		1098-7734	
name	0..*	MAY		1098-7735	
telecom	1..1	SHALL		1098-7737	
addr	1..1	SHALL		1098-7736	
author	1..*	SHOULD		1098-32479	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	0..*	MAY		1098-7751	
@typeCode	1..1	SHALL		1098-7752	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = DEV
participantRole	1..1	SHALL		1098-15911	Product Instance (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.37
participant	0..*	MAY		1098-7765	
@typeCode	1..1	SHALL		1098-7766	2.16.840.1.113883.5.90 (HL7ParticipationType) = LOC
participantRole	1..1	SHALL		1098-15912	Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32
entryRelationship	0..*	MAY		1098-7768	
@typeCode	1..1	SHALL		1098-7769	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
@inversionInd	1..1	SHALL		1098-8009	true
encounter	1..1	SHALL		1098-7770	
@classCode	1..1	SHALL		1098-7771	2.16.840.1.113883.5.6 (HL7ActClass) = ENC
@moodCode	1..1	SHALL		1098-	2.16.840.1.113883.5.1001

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				7772	(ActMood) = EVN
id	1..1	SHALL		1098-7773	
entryRelationship	0..1	MAY		1098-7775	
@typeCode	1..1	SHALL		1098-7776	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
@inversionInd	1..1	SHALL		1098-7777	true
act	1..1	SHALL		1098-31395	Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
entryRelationship	0..*	MAY		1098-7779	
@typeCode	1..1	SHALL		1098-7780	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		1098-15914	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
entryRelationship	0..*	MAY		1098-7886	
@typeCode	1..1	SHALL		1098-7887	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
substanceAdministration	1..1	SHALL		1098-15915	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09
entryRelationship	0..*	MAY		1098-32473	
@typeCode	1..1	SHALL		1098-32474	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
observation	1..1	SHALL		1098-32475	Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="PROC" Procedure (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7652).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7653).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7654) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.14" (CONF:1098-10521).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32506).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-7655).

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5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-7656).
    a. This code **SHOULD** contain zero or one [0..1] **originalText** (CONF:1098-19203).
        i. The originalText, if present, **SHOULD** contain zero or one [0..1] **reference** (CONF:1098-19204).
            1. The reference, if present, **SHOULD** contain zero or one [0..1] **@value** (CONF:1098-19205).
                a. 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:1098-19206).
    b. 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) or ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) or CDT-2 (Code System: 2.16.840.1.113883.6.13) (CONF:1098-19207).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7661).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ProcedureAct statusCode** 2.16.840.1.113883.11.20.9.22 **STATIC** 2014-04-23 (CONF:1098-32366).
7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-7662).
8. **MAY** contain zero or one [0..1] **priorityCode**, which **SHALL** be selected from ValueSet **Act Priority** 2.16.840.1.113883.1.11.16866 **DYNAMIC** (CONF:1098-7668).
9. **MAY** contain zero or one [0..1] **methodCode** (CONF:1098-7670).
    a. MethodCode **SHALL NOT** conflict with the method inherent in Procedure / code (CONF:1098-7890).

In the case of an implanted medical device, targetSiteCode is used to record the location of the device, in or on the patient's body.

10. **SHOULD** contain zero or more [0..*] **targetSiteCode** (CONF:1098-7683).
    a. The targetSiteCode, if present, **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **Body Site** 2.16.840.1.113883.3.88.12.3221.8.9 **DYNAMIC** (CONF:1098-16082).
11. **MAY** contain zero or more [0..*] **specimen** (CONF:1098-7697).
    a. The specimen, if present, **SHALL** contain exactly one [1..1] **specimenRole** (CONF:1098-7704).
        i. This specimenRole **SHOULD** contain zero or more [0..*] **id** (CONF:1098-7716).
            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:1098-29744).
    b. This specimen is for representing specimens obtained from a procedure (CONF:1098-16842).
12. **SHOULD** contain zero or more [0..*] **performer** (CONF:1098-7718) such that it
    a. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-7720).

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i. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-7722).
ii. This assignedEntity **SHALL** contain at least one [1..*] **addr** (CONF:1098-7731).
iii. This assignedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:1098-7732).
iv. This assignedEntity **SHOULD** contain zero or one [0..1] **representedOrganization** (CONF:1098-7733).
    1. The representedOrganization, if present, **SHOULD** contain zero or more [0..*] **id** (CONF:1098-7734).
    2. The representedOrganization, if present, **MAY** contain zero or more [0..*] **name** (CONF:1098-7735).
    3. The representedOrganization, if present, **SHALL** contain exactly one [1..1] **telecom** (CONF:1098-7737).
    4. The representedOrganization, if present, **SHALL** contain exactly one [1..1] **addr** (CONF:1098-7736).

13. **SHOULD** contain at least one [1..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32479).
14. **MAY** contain zero or more [0..*] **participant** (CONF:1098-7751) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="DEV" Device (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7752).
    b. **SHALL** contain exactly one [1..1] **Product Instance** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.37) (CONF:1098-15911).
15. **MAY** contain zero or more [0..*] **participant** (CONF:1098-7765) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="LOC" Location (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-7766).
    b. **SHALL** contain exactly one [1..1] **Service Delivery Location** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32) (CONF:1098-15912).
16. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-7768) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7769).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" true (CONF:1098-8009).
    c. **SHALL** contain exactly one [1..1] **encounter** (CONF:1098-7770).
        i. This encounter **SHALL** contain exactly one [1..1] **@classCode**="ENC" Encounter (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7771).
        ii. This encounter **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7772).
        iii. This encounter **SHALL** contain exactly one [1..1] **id** (CONF:1098-7773).
            1. Set the encounter ID to the ID of an encounter in another section to signify they are the same encounter (CONF:1098-16843).
17. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-7775) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7776).
b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" true (CONF:1098-7777).
c. **SHALL** contain exactly one [1..1] **Instruction (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31395).

18. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-7779) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7780).
    b. **SHALL** contain exactly one [1..1] **Indication (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-15914).
19. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-7886) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7887).
    b. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-15915).
20. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32473) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32474).
    b. **SHALL** contain exactly one [1..1] **Reaction Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09) (CONF:1098-32475).

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Figure 211: Procedure Activity Procedure (V2) Example

```
<procedure classCode="PROC" moodCode="EVN">
    <!-- Procedure Activity Procedure V2-->
    <templateId root="2.16.840.1.113883.10.20.22.4.14" extension="2014-06-09" />
    <id root="d5b614bd-01ce-410d-8726-e1fd01dcc72a" />
    <code code="103716009" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
displayName="Stent Placement">
        <originalText>
            <reference value="#Proc1" />
        </originalText>
    </code>
    <statusCode code="completed" />
    <effectiveTime value="20130512" />
    <targetSiteCode code="28273000" displayName="bile duct"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" />
    <specimen typeCode="SPC">
        <specimenRole classCode="SPEC">
            <id root="a6d7b927-2b70-43c7-bdf3-0e7c4133062c" />
            <specimenPlayingEntity>
                <code code="57259009" codeSystem="2.16.840.1.113883.6.96"
displayName="gallbladder bile" />
            </specimenPlayingEntity>
        </specimenRole>
    </specimen>
    <performer>
        ...
    </performer>
</procedure>
```

4.82 Procedure Context

[act: identifier urn:oid:2.16.840.1.113883.10.20.6.2.5 (open)]

Table 428: Procedure Context Contexts

Contained By:	Contains:
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 minimally invasive imaging services, whereas the Act entry shall be used for diagnostic imaging services.

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Table 429: Procedure Context Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.5)					
@classCode	1..1	SHALL		81-26452	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		81-26453	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-9200	
@root	1..1	SHALL		81-10530	2.16.840.1.113883.10.20.6.2.5
code	1..1	SHALL		81-9201	
effectiveTime	0..1	SHOULD	TS	81-9203	
@value	1..1	SHALL		81-17173	

1. **SHALL** contain exactly one [1..1] **@classCode**="`ACT`" (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6`) (CONF:81-26452).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" (CodeSystem: `ActMood 2.16.840.1.113883.5.1001`) (CONF:81-26453).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-9200) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.6.2.5`" (CONF:81-10530).
4. **SHALL** contain exactly one [1..1] **code** (CONF:81-9201).
5. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:81-9203).
   a. The effectiveTime, if present, **SHALL** contain exactly one [1..1] **@value** (CONF:81-17173).
6. Procedure Context **SHALL** be represented with the procedure or act elements depending on the nature of the procedure (CONF:81-9199).

Figure 212: 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>
```


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4.83 Product Instance

[participantRole: identifier urn:oid:2.16.840.1.113883.10.20.22.4.37 (open)]

Table 430: Product Instance Contexts

Contained By:	Contains:
Procedure Activity Procedure (V2) (optional) Non-Medicinal Supply Activity (V2) (optional) Planned Supply (V2) (optional)	

This clinical statement represents a particular device that was placed in a patient 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 FDA permits an issuing agency to designate that their Device Identifier (DI) + Production Identifier (PI) format qualifies as a UDI through a process of accreditation. Currently, there are three FDA-accredited issuing agencies that are allowed to call their format a UDI. These organizations are GS1, HIBCC, and ICCBBA. For additional information on technical formats that qualify as UDI from each of the issuing agencies see the UDI Appendix.

When communicating only the issuing agency device identifier (i.e., subcomponent of the UDI), the use of the issuing agency OID is appropriate. However, when communicating the unique device identifier (DI + PI), the FDA OID (2.16.840.1.113883.3.3719) must be used.

When sending a UDI, populate the participantRole/id/@root with the FDA OID (2.16.840.1.113883.3.3719) and participantRole/id/@extension with the UDI.

When sending a DI, populate the participantRole/id/@root with the appropriate assigning agency OID and participantRole/id/@extension with the DI.

The scopingEntity/id should correspond to FDA or the appropriate issuing agency.

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Table 431: Product Instance Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
participantRole (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.37)					
@classCode	1..1	SHALL		81-7900	2.16.840.1.113883.5.110 (RoleClass) = MANU
templateId	1..1	SHALL		81-7901	
@root	1..1	SHALL		81-10522	2.16.840.1.113883.10.20.22.4.37
id	1..*	SHALL		81-7902	
playingDevice	1..1	SHALL		81-7903	
code	0..1	SHOULD		81-16837	
scopingEntity	1..1	SHALL		81-7905	
id	1..*	SHALL		81-7908	

1. **SHALL** contain exactly one [1..1] **@classCode**="MANU" Manufactured Product (CodeSystem: RoleClass 2.16.840.1.113883.5.110 **STATIC**) (CONF:81-7900).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7901) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.37" (CONF:81-10522).
3. **SHALL** contain at least one [1..*] **id** (CONF:81-7902).
4. **SHALL** contain exactly one [1..1] **playingDevice** (CONF:81-7903).
   a. This playingDevice **SHOULD** contain zero or one [0..1] **code** (CONF:81-16837).
5. **SHALL** contain exactly one [1..1] **scopingEntity** (CONF:81-7905).
   a. This scopingEntity **SHALL** contain at least one [1..*] **id** (CONF:81-7908).

Figure 213: Product Instance Example

```
<participantRole classCode="MANU">
  <templateId root="2.16.840.1.113883.10.20.22.4.37"/>
  <id root="2.16.840.1.113883.3.3719"
      extension="(01)51022222233336(11)141231(17)150707(10)A213B1(21)1234"
      assigningAuthorityName="FDA"/>
  <playingDevice>
    <code code="90412006" codeSystem="2.16.840.1.113883.6.96"
          displayName="Colonoscope"/>
  </playingDevice>
  <scopingEntity>
    <id root="2.16.840.1.113883.3.3719"/>
  </scopingEntity>
</participantRole>
```


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4.84 Prognosis Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.113 (open)]

Table 432: Prognosis Observation Contexts

Contained By:	Contains:
Problem Observation (V2) (optional)	

This template represents the patient's prognosis, which must be associated with a problem observation. 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.

Table 433: Prognosis Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.113)					
@classCode	1..1	SHALL		1098-29035	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-29036	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-29037	
@root	1..1	SHALL		1098-29038	2.16.840.1.113883.10.20.22.4.113
code	1..1	SHALL		1098-29039	
@code	1..1	SHALL		1098-29468	75328-5
@codeSystem	1..1	SHALL		1098-31349	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-31350	
@code	1..1	SHALL		1098-31351	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-31123	
value	1..1	SHALL		1098-29469	

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-29035).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-29036).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-29037) such that it

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a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.113" (CONF:1098-29038).

4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-29039).
    a. This code **SHALL** contain exactly one [1..1] **@code**="75328-5" Prognosis (CONF:1098-29468).
    b. 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:1098-31349).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-31350).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31351).
6. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-31123).
7. **SHALL** contain exactly one [1..1] **value** (CONF:1098-29469).

Figure 214: 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="75328-5"
       codeSystem="2.16.840.1.113883.6.1"
       codeSystemName="LOINC"
       displayName="Prognosis" />
    <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>
```


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Figure 215: 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="75328-5"
             codeSystem="2.16.840.1.113883.6.1"
             codeSystemName="LOINC"
             displayName="Prognosis" />
        <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>
```

4.85 Progress Toward Goal Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.110 (open)]

Table 434: Progress Toward Goal Observation Contexts

Contained By:	Contains:
Outcome Observation (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 (e.g., "Goal not achieved - no discernible change", "Goal not achieved - progressing toward goal", "Goal not achieved - declining from goal").

In the Care Planning workflow, the judgment about how well the person is progressing towards the goal is based on the observations made about the status of the patient with respect to interventions performed in the pursuit of achieving that goal.

For example, an observation outcome of a blood oxygen saturation level of 95% is related to the goal of "Maintain Pulse Ox greater than 92" and in this case the Progress Toward Goal Observation template would record that the related goal has been achieved.

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Table 435: Progress Toward Goal Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.110)					
@classCode	1..1	SHALL		1098-31418	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-31419	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-31420	
@root	1..1	SHALL		1098-31421	2.16.840.1.113883.10.20.22.4.110
id	1..*	SHALL		1098-31422	
code	1..1	SHALL		1098-31423	
@code	1..1	SHALL		1098-31424	ASSERTION
@codeSystem	1..1	SHALL		1098-31425	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
statusCode	1..1	SHALL		1098-31609	
@code	1..1	SHALL		1098-31610	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..1	SHALL	CD	1098-31426	2.16.840.1.113883.11.20.9.55 (Goal Achievement)

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6`) (CONF:1098-31418).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" (CodeSystem: `ActMood 2.16.840.1.113883.5.1001`) (CONF:1098-31419).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-31420) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.110`" (CONF:1098-31421).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-31422).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-31423).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`ASSERTION`" Assertion (CONF:1098-31424).
   b. 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:1098-31425).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-31609).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="`completed`" (CodeSystem: `ActStatus 2.16.840.1.113883.5.14`) (CONF:1098-31610).

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7. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHALL** be selected from ValueSet **Goal Achievement** 2.16.840.1.113883.11.20.9.55 **DYNAMIC** (CONF:1098-31426).

Table 436: Goal Achievement

Value Set: Goal Achievement 2.16.840.1.113883.11.20.9.55 The Goal Achievement value set contains concepts that describe a patient's progression (or lack thereof) toward a goal and consists of the following codes from the US Extension of SNOMED CT. 390802008 Goal achieved 390801001 Goal not achieved and all its direct children Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
390802008	SNOMED CT	2.16.840.1.113883.6.96	Goal achieved
390801001	SNOMED CT	2.16.840.1.113883.6.96	Goal not achieved

Figure 216: 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>
```

4.86 Purpose of Reference Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.6.2.9 (open)]

Table 437: Purpose of Reference Observation Contexts

Contained By:	Contains:
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.

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Table 438: Purpose of Reference Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.9)					
@classCode	1..1	SHALL		81-9264	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-9265	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-9266	
@root	1..1	SHALL		81-10531	2.16.840.1.113883.10.20.6.2.9
code	1..1	SHALL		81-9267	
@code	0..1	SHOULD		81-19208	2.16.840.1.113883.5.4 (ActCode) = ASSERTION
value	0..1	SHOULD	CD	81-9273	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:81-9264).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-9265).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-9266) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.6.2.9" (CONF:81-10531).
4. **SHALL** contain exactly one [1..1] **code** (CONF:81-9267).
   a. This code **SHOULD** contain zero or one [0..1] **@code**="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 **STATIC**) (CONF:81-19208).
   b. 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:81-19209).

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.

5. **SHOULD** contain zero or one [0..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **DICOMPurposeOfReference** 2.16.840.1.113883.11.20.9.28 **DYNAMIC** (CONF:81-9273).

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Table 439: DICOMPurposeOfReference

Value Set: DICOMPurposeOfReference 2.16.840.1.113883.11.20.9.28 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
121079	DCM	1.2.840.10008.2.16.4	Baseline
121080	DCM	1.2.840.10008.2.16.4	Best illustration of finding
121112	DCM	1.2.840.10008.2.16.4	Source of Measurement

Figure 217: 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>
```

4.87 Quantity Measurement Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.6.2.14 (open)]

Table 440: Quantity Measurement Observation Contexts

Contained By:	**Contains:**
Text Observation (optional) Code Observations (optional) Diagnostic Imaging Report (V2) (optional)	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.

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Table 441: Quantity Measurement Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.14)					
@classCode	1..1	SHALL		81-9317	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		81-9318	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-9319	
@root	1..1	SHALL		81-10532	2.16.840.1.113883.10.20.6.2.14
code	1..1	SHALL		81-9320	
@code	0..1	SHOULD		81-19210	2.16.840.1.113883.11.20.9.29 (DIRQuantityMeasurementTypeCodes)
effectiveTime	0..1	SHOULD		81-9326	
value	1..1	SHALL	PQ	81-9324	
entryRelationship	0..*	MAY		81-9327	
@typeCode	1..1	SHALL		81-9328	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT
observation	1..1	SHALL		81-15916	SOP Instance Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-9317).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-9318).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-9319) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.6.2.14" (CONF:81-10532).

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).

4. **SHALL** contain exactly one [1..1] **code** (CONF:81-9320).

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a. This code **SHOULD** contain zero or one [0..1] **@code**, which **SHOULD** be selected from ValueSet **DIRQuantityMeasurementTypeCodes** 2.16.840.1.113883.11.20.9.29 **DYNAMIC** (CONF:81-19210).

5. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:81-9326).
6. **SHALL** contain exactly one [1..1] **value** with @xsi:type="PQ" (CONF:81-9324).
7. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:81-9327) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode="SPRT"** Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-9328).
   b. **SHALL** contain exactly one [1..1] **SOP Instance Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8) (CONF:81-15916).

Table 442: 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)
Value Set Source: **http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html**

Code	Code System	Code System OID	Print Name
439932008	SNOMED CT	2.16.840.1.113883.6.96	Length of structure
440357003	SNOMED CT	2.16.840.1.113883.6.96	Width of structure
439934009	SNOMED CT	2.16.840.1.113883.6.96	Depth of structure
439984002	SNOMED CT	2.16.840.1.113883.6.96	Diameter of structure
439933003	SNOMED CT	2.16.840.1.113883.6.96	Long axis length of structure
439428006	SNOMED CT	2.16.840.1.113883.6.96	Short axis length of structure
439982003	SNOMED CT	2.16.840.1.113883.6.96	Major axis length of structure
439983008	SNOMED CT	2.16.840.1.113883.6.96	Minor axis length of structure
440356007	SNOMED CT	2.16.840.1.113883.6.96	Perpendicular axis length of structure
439429003	SNOMED CT	2.16.840.1.113883.6.96	Radius of structure
…			

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Figure 218: 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="200802260805-0800"/>
    <value xsi:type="PQ" value="45" unit="mm"
           codeSystemVersion="1.5"/>
    <!-- entryRelationships to SOP Instance Observations may go here -->
</observation>
```

4.88 Reaction Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09 (open)]

Table 443: Reaction Observation (V2) Contexts

Contained By:	Contains:
Medication Activity (V2) (optional) Procedure Activity Procedure (V2) (optional) Procedure Activity Observation (V2) (optional) Allergy - Intolerance Observation (V2) (optional) Substance or Device Allergy - Intolerance Observation (V2) (optional) Immunization Activity (V2) (optional) Health Concern Act (optional) Risk Concern Act (optional)	Medication Activity (V2) Procedure Activity Procedure (V2) Severity Observation (V2)

This clinical statement represents the response to an undesired symptom, finding, etc. due to administered or exposed substance. This reaction may be an undesired symptom, finding, etc. or it could be a desired response to a treatment. A reaction can be defined with respect to its severity, and can have been treated by one or more interventions.

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Table 444: Reaction Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09)					
@classCode	1..1	SHALL		1098-7325	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-7326	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7323	
@root	1..1	SHALL		1098-10523	2.16.840.1.113883.10.20.22.4.9
@extension	1..1	SHALL		1098-32504	2014-06-09
id	1..*	SHALL		1098-7329	
code	1..1	SHALL		1098-16851	
@code	1..1	SHALL		1098-31124	ASSERTION
@codeSystem	1..1	SHALL		1098-32169	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
statusCode	1..1	SHALL		1098-7328	
@code	1..1	SHALL		1098-19114	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	0..1	SHOULD		1098-7332	
low	0..1	SHOULD		1098-7333	
high	0..1	SHOULD		1098-7334	
value	1..1	SHALL	CD	1098-7335	2.16.840.1.113883.3.88.12.3221.7.4 (Problem)
entryRelationship	0..*	MAY		1098-7337	
@typeCode	1..1	SHALL		1098-7338	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
@inversionInd	1..1	SHALL		1098-7343	true
procedure	1..1	SHALL		1098-15920	Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09
entryRelationship	0..*	MAY		1098-7340	

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@typeCode	1..1	SHALL		1098-7341	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
@inversionInd	1..1	SHALL		1098-7344	true
substanceAdministration	1..1	SHALL		1098-15921	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09
entryRelationship	0..1	MAY		1098-7580	
@typeCode	1..1	SHALL		1098-7581	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
@inversionInd	1..1	SHALL		1098-10375	true
observation	1..1	SHALL		1098-15922	Severity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7325).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7326).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7323) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.9" (CONF:1098-10523).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32504).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-7329).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-16851).
   a. This code **SHALL** contain exactly one [1..1] **@code**="ASSERTION" (CONF:1098-31124).
   b. 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:1098-32169).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7328).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19114).
7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-7332).
   a. The effectiveTime, if present, **SHOULD** contain zero or one [0..1] **low** (CONF:1098-7333).
   b. The effectiveTime, if present, **SHOULD** contain zero or one [0..1] **high** (CONF:1098-7334).
8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHALL** be selected from ValueSet **Problem** 2.16.840.1.113883.3.88.12.3221.7.4 **DYNAMIC** (CONF:1098-7335).
9. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-7337) such that it

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a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7338).

b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-7343).

This procedure activity is intended to contain information about procedures that were performed in response to an allergy reaction.

c. **SHALL** contain exactly one [1..1] **Procedure Activity Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09) (CONF:1098-15920).

10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-7340) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7341).

b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-7344).

This medication activity is intended to contain information about medications that were administered in response to an allergy reaction.

c. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-15921).

11. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-7580) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7581).

b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" TRUE (CONF:1098-10375).

c. **SHALL** contain exactly one [1..1] **Severity Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09) (CONF:1098-15922).

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Figure 219: Reaction Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.9" extension="2014-06-09" />
    <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="200802260805-0800" />
        <high value="200802281205-0800" />
    </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" extension="2014-06-09" />
            . . .
        </observation>
        </entryRelationship>
    </observation>
```

4.89 Referenced Frames Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.6.2.10 (open)]

Table 445: Referenced Frames Observation Contexts

Contained By:	**Contains:**
SOP Instance Observation (optional)	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.

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Table 446: Referenced Frames Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.10)					
@classCode	1..1	SHALL		81-9276	2.16.840.1.113883.5.6 (HL7ActClass) = ROIBND
@moodCode	1..1	SHALL		81-9277	2.16.840.1.113883.5.1001 (ActMood) = EVN
code	1..1	SHALL		81-19164	
@code	0..1	MAY		81-19165	1.2.840.10008.2.16.4 (DCM) = 121190
entryRelationship	1..1	SHALL		81-9279	
@typeCode	1..1	SHALL		81-9280	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
observation	1..1	SHALL		81-15923	Boundary Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.11

1. **SHALL** contain exactly one [1..1] **@classCode**="ROIBND" Bounded Region of Interest (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-9276).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-9277).
3. **SHALL** contain exactly one [1..1] **code** (CONF:81-19164).
    a. This code **MAY** contain zero or one [0..1] **@code**="121190" Referenced Frames (CodeSystem: DCM 1.2.840.10008.2.16.4 **STATIC**) (CONF:81-19165).
4. **SHALL** contain exactly one [1..1] **entryRelationship** (CONF:81-9279).
    a. This entryRelationship **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-9280).
    b. This entryRelationship **SHALL** contain exactly one [1..1] **Boundary Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.11) (CONF:81-15923).

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Figure 220: 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>
```

4.90 Result Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09 (open)]

Table 447: Result Observation (V2) Contexts

Contained By:	**Contains:**
Health Concern Act (optional) Result Organizer (V2) (required) Risk Concern Act (optional)	Author Participation

This template represents the results of a laboratory, radiology, or other study performed on a patient.

The result observation includes a statusCode to allow recording the status of an observation. “Pending” results (e.g., a test has been run but results have not been reported yet) should be represented as “active” ActStatus.

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Table 448: Result Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09)					
@classCode	1..1	SHALL		1098-7130	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-7131	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7136	
@root	1..1	SHALL		1098-9138	2.16.840.1.113883.10.20.22.4.2
@extension	1..1	SHALL		1098-32575	2014-06-09
id	1..*	SHALL		1098-7137	
code	1..1	SHALL		1098-7133	2.16.840.1.113883.6.1 (LOINC)
statusCode	1..1	SHALL		1098-7134	
@code	1..1	SHALL		1098-14849	2.16.840.1.113883.11.20.9.39 (Result Status)
effectiveTime	1..1	SHALL		1098-7140	
value	0..1	SHOULD		1098-7143	2.16.840.1.113883.6.96 (SNOMED CT)
interpretationCode	0..*	SHOULD		1098-7147	
@code	1..1	SHALL		1098-32476	2.16.840.1.113883.1.11.78 (Observation Interpretation (HL7))
methodCode	0..1	MAY	SET<CE>	1098-7148	
targetSiteCode	0..1	MAY	SET<CD>	1098-7153	
author	0..*	SHOULD		1098-7149	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
referenceRange	0..*	SHOULD		1098-7150	
observationRange	1..1	SHALL		1098-7151	
code	0..0	SHALL NOT		1098-7152	
value	1..1	SHALL		1098-32175	

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1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7130).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7131).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7136) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.2" (CONF:1098-9138).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32575).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-7137).
5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from CodeSystem LOINC (2.16.840.1.113883.6.1) (CONF:1098-7133).
    a. This code **SHOULD** be a code from the LOINC that identifies the result observation. If an appropriate LOINC code does not exist, then the local code for this result **SHALL** be sent (CONF:1098-19212).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7134).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **Result Status** 2.16.840.1.113883.11.20.9.39 **STATIC** 2013-08-09 (CONF:1098-14849).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-7140).
   Note: Represents the biologically relevant time of the measurement (e.g., the time a blood pressure reading is obtained, the time the blood sample was obtained for a chemistry test).
8. **SHOULD** contain zero or one [0..1] **value**, which **SHOULD** be selected from CodeSystem SNOMED CT (2.16.840.1.113883.6.96) (CONF:1098-7143).
    a. If Observation/value is a physical quantity (**xsi:type**="**PQ**"), the unit of measure **SHALL** be selected from ValueSet UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 **DYNAMIC** (CONF:1098-31484).
    b. A coded value **MAY** contain zero or more [0..*] translations, which can be used to represent the original results as output by the lab (CONF:1098-31866).
    c. If Observation/value is a CD (**xsi:type**="**CD**") the value **SHOULD** be SNOMED-CT (CONF:1098-32610).
9. **SHOULD** contain zero or more [0..*] **interpretationCode** (CONF:1098-7147).
    a. The interpretationCode, if present, **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **Observation Interpretation (HL7)** 2.16.840.1.113883.1.11.78 **STATIC** 2014-09-01 (CONF:1098-32476).
10. **MAY** contain zero or one [0..1] **methodCode** (CONF:1098-7148).
11. **MAY** contain zero or one [0..1] **targetSiteCode** (CONF:1098-7153).
12. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-7149).
13. **SHOULD** contain zero or more [0..*] **referenceRange** (CONF:1098-7150).
    a. The referenceRange, if present, **SHALL** contain exactly one [1..1] **observationRange** (CONF:1098-7151).
        i. This observationRange **SHALL NOT** contain [0..0] **code** (CONF:1098-7152).

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ii. This observationRange **SHALL** contain exactly one [1..1] **value** (CONF:1098-32175).

Table 449: Observation Interpretation (HL7)

Value Set: Observation Interpretation (HL7) 2.16.840.1.113883.1.11.78 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
A	HITSP-CS-83	2.16.840.1.113883.5.83	abnormal
B	HITSP-CS-83	2.16.840.1.113883.5.83	better
Carrier	HITSP-CS-83	2.16.840.1.113883.5.83	carrier
D	HITSP-CS-83	2.16.840.1.113883.5.83	decreased
HX	HITSP-CS-83	2.16.840.1.113883.5.83	above high threshold
I	HITSP-CS-83	2.16.840.1.113883.5.83	intermediate
IND	HITSP-CS-83	2.16.840.1.113883.5.83	indeterminate
LX	HITSP-CS-83	2.16.840.1.113883.5.83	below low threshold
MS	HITSP-CS-83	2.16.840.1.113883.5.83	moderately susceptible
N	HITSP-CS-83	2.16.840.1.113883.5.83	normal
…			

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Figure 221: Result Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.2" extension="2014-06-09" />
    <id root="7c0704bb-9c40-41b5-9c7d-26b2d59e234f" />
    <code code="4544-3" displayName="Hematocrit" codeSystem="2.16.840.1.113883.6.1"
codeSystemName="LOINC" />
    <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>
        <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>
```


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Figure 222: Pending Result Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <!-- ** Result observation ** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.2" extension="2014-06-09" />
    <id root="aed821af-3330-4138-97f0-e84dfe5f3c35" />
    <code code="3094-0" displayName="Urea nitrogen, Serum"
codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />
    <statusCode code="active" />
    <effectiveTime value="200803200930-0800" />
    <value xsi:type="PQ" nullFlavor="NI" />
</observation>
```

Figure 223: Original Lab Units in <translation> Example

```
<observation classCode="OBS" moodCode="EVN">
    <!-- ** Result observation ** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.2" extension="2014-06-09" />
    <id root="a69b3d60-2ffd-4440-958b-72b3335ff35f" />
    <code code="6690-2" displayName="Leukocytes" codeSystem="2.16.840.1.113883.6.1"
codeSystemName="LOINC" />
    <statusCode code="completed" />
    <effectiveTime value="200803190830-0800" />
    <value xsi:type="PQ" value="6.7" unit="10*9/L">
        <translation>
            <originalText>6.7 billion per liter</originalText>
        </translation>
    </value>
    <interpretationCode code="N" codeSystem="2.16.840.1.113883.5.83" />
    <author typeCode="AUT">
        <time value="200803190830-0800" />
        <assignedAuthor>
            <id extension="333444444" root="1.1.1.1.1.1.1.4" />
        </assignedAuthor>
    </author>
    <referenceRange>
        <observationRange>
            <value xsi:type="IVL_PQ">
                <low value="4.3" unit="10*9/L" />
                <high value="10.8" unit="10*9/L" />
            </value>
        </observationRange>
    </referenceRange>
</observation>
```


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4.91 Result Organizer (V2)

```
[organizer: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09
(open)]
```

Table 450: Result Organizer (V2) Contexts

Contained By:	Contains:
Health Concern Act (optional) Results Section (entries optional) (V2) (optional) Results Section (entries required) (V2) (required) Risk Concern Act (optional)	Author Participation Result Observation (V2)

This template provides a mechanism for grouping result observations. It contains information applicable to all of the contained result observations. The Result Organizer code categorizes the contained results into one of several commonly accepted values (e.g., “Hematology”, “Chemistry”, “Nuclear Medicine”).

If any Result Observation within the organizer has a statusCode of "active", the Result Organizer must also have a statusCode of "active".

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Table 451: Result Organizer (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
organizer (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09)					
@classCode	1..1	SHALL		1098-7121	2.16.840.1.113883.5.6 (HL7ActClass)
@moodCode	1..1	SHALL		1098-7122	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7126	
@root	1..1	SHALL		1098-9134	2.16.840.1.113883.10.20.22.4.1
@extension	1..1	SHALL		1098-32588	2014-06-09
id	1..*	SHALL		1098-7127	
code	1..1	SHALL		1098-7128	
statusCode	1..1	SHALL		1098-7123	
@code	1..1	SHALL		1098-14848	2.16.840.1.113883.11.20.9.39 (Result Status)
effectiveTime	0..1	MAY		1098-31865	
low	1..1	SHALL		1098-32488	
high	1..1	SHALL		1098-32489	
author	0..*	SHOULD		1098-31149	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
component	1..*	SHALL		1098-7124	
observation	1..1	SHALL		1098-14850	Result Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode** (CodeSystem: `HL7ActClass` `2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-7121).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood` `2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-7122).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7126) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.1`" (CONF:1098-9134).
    b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32588).

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4. **SHALL** contain at least one [1..*] **id** (CONF:1098-7127).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-7128).
    a. **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:1098-19218).
    b. 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 (CONF:1098-19219).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7123).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **Result Status** 2.16.840.1.113883.11.20.9.39 **STATIC** 2013-08-09 (CONF:1098-14848).
7. **MAY** contain zero or one [0..1] **effectiveTime** (CONF:1098-31865).
   Note: The effectiveTime is an interval that spans the effectiveTimes of the contained result observations. Because all contained result observations have a required time stamp, it is not required that this effectiveTime be populated.
    a. The effectiveTime, if present, **SHALL** contain exactly one [1..1] **low** (CONF:1098-32488).
    b. The effectiveTime, if present, **SHALL** contain exactly one [1..1] **high** (CONF:1098-32489).
8. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31149).
9. **SHALL** contain at least one [1..*] **component** (CONF:1098-7124) such that it
    a. **SHALL** contain exactly one [1..1] **Result Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09) (CONF:1098-14850).

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Figure 224: Result Organizer (V2) Example

```
<organizer classCode="BATTERY" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.1" extension="2014-06-09" />
    <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" />
    <effectiveTime>
        <low value="200803190830-0800" />
        <high value="200803190830-0800" />
    </effectiveTime>
    <author>
        . . .
  </author>
    <component>
        <observation classCode="OBS" moodCode="EVN">
            <!-- ** Result observation ** -->
            <templateId root="2.16.840.1.113883.10.20.22.4.2" extension="2014-06-09" />
            . . .
        </observation>
    </component>
</organizer>
```


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4.92 Risk Concern Act

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.136 (open)]

Table 452: Risk Concern Act Contexts

Contained By:	Contains:
Health Concerns Section (optional)	Allergy - Intolerance Observation (V2) Assessment Scale Observation Author Participation Caregiver Characteristics Characteristics of Home Environment Cultural and Religious Observation Encounter Diagnosis (V2) Entry Reference External Document Reference Family History Organizer (V2) Functional Status Observation (V2) Hospital Admission Diagnosis (V2) Longitudinal Care Wound Observation Mental Status Observation (V2) Nutrition Assessment Nutritional Status Observation Postprocedure Diagnosis (V2) Pregnancy Observation Preoperative Diagnosis (V2) Priority Preference Problem Concern Act (V2) Problem Observation (V2) Reaction Observation (V2) Result Observation (V2) Result Organizer (V2) Self-Care Activities (ADL and IADL) Sensory Status Smoking Status - Meaningful Use (V2) Social History Observation (V2) Substance or Device Allergy - Intolerance Observation (V2) Tobacco Use (V2) Vital Sign Observation (V2)

This template represents a risk concern.

It is a wrapper for a single risk concern which may be derived from a variety of sources within an EHR (such as Problem List, Family History, Social History, Social Worker Note, etc.).

A Risk Concern Act represents a health concern that is a risk. A risk is a clinical or socioeconomic condition that the patient does not currently have, but the probability of developing that condition rises to the level of concern such that an intervention and/or monitoring is needed.

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Table 453: Risk Concern Act Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.136)					
@classCode	1..1	SHALL		1098-32220	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-32221	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-32180	
@root	1..1	SHALL		1098-32222	2.16.840.1.113883.10.20.22.4.136
id	1..1	SHALL		1098-32223	
code	1..1	SHALL		1098-32305	
@code	1..1	SHALL		1098-32306	281694009
@codeSystem	1..1	SHALL		1098-32307	2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
statusCode	1..1	SHALL		1098-32225	
@code	1..1	SHALL		1098-32314	2.16.840.1.113883.11.20.9.19 (ProblemAct statusCode)
effectiveTime	0..1	MAY		1098-32226	
author	0..*	SHOULD		1098-32300	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-32179	
@typeCode	1..1	SHALL		1098-32227	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32219	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09
entryRelationship	0..*	MAY		1098-32181	
@typeCode	1..1	SHALL		1098-32228	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32229	Allergy - Intolerance Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09
entryRelationship	0..*	MAY		1098-32182	

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@typeCode	1..1	SHALL		1098-32230	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32231	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
entryRelationship	0..*	MAY		1098-32183	
@typeCode	1..1	SHALL		1098-32232	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
act	1..1	SHALL		1098-32233	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
entryRelationship	0..*	MAY		1098-32184	
@typeCode	1..1	SHALL		1098-32234	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32235	Assessment Scale Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69
entryRelationship	0..*	MAY		1098-32185	
@typeCode	1..1	SHALL		1098-32236	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32237	Mental Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09
entryRelationship	0..*	MAY		1098-32186	
@typeCode	1..1	SHALL		1098-32238	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32239	Self-Care Activities (ADL and IADL) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.128
entryRelationship	0..*	MAY		1098-32188	
@typeCode	1..1	SHALL		1098-32242	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32243	Mental Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09
entryRelationship	0..*	MAY		1098-32189	
@typeCode	1..1	SHALL		1098-32244	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR

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observation	1..1	SHALL		1098-32245	Smoking Status - Meaningful Use (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09
entryRelationship	0..*	MAY		1098-32190	
@typeCode	1..1	SHALL		1098-32246	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32247	Encounter Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09
entryRelationship	0..*	MAY		1098-32191	
@typeCode	1..1	SHALL		1098-32248	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
organizer	1..1	SHALL		1098-32249	Family History Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09
entryRelationship	0..*	MAY		1098-32192	
@typeCode	1..1	SHALL		1098-32250	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32251	Functional Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09
entryRelationship	0..*	MAY		1098-32193	
@typeCode	1..1	SHALL		1098-32252	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32253	Hospital Admission Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09
entryRelationship	0..*	MAY		1098-32194	
@typeCode	1..1	SHALL		1098-32254	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32255	Mental Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09
entryRelationship	0..*	MAY		1098-32195	
@typeCode	1..1	SHALL		1098-32256	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-	Nutrition Assessment (identifier:

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				32257	urn:oid:2.16.840.1.113883.10.20.22.4.138
entryRelationship	0..*	MAY		1098-32196	
@typeCode	1..1	SHALL		1098-32258	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32259	Nutrition Assessment (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.138
entryRelationship	0..*	MAY		1098-32197	
@typeCode	1..1	SHALL		1098-32260	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32261	Postprocedure Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09
entryRelationship	0..*	MAY		1098-32198	
@typeCode	1..1	SHALL		1098-32262	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32263	Pregnancy Observation (identifier: urn:oid:2.16.840.1.113883.10.20.15.3.8
entryRelationship	0..*	MAY		1098-32199	
@typeCode	1..1	SHALL		1098-32264	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32265	Preoperative Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09
entryRelationship	0..*	MAY		1098-32200	
@typeCode	1..1	SHALL		1098-32266	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32267	Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09
entryRelationship	0..*	MAY		1098-32201	
@typeCode	1..1	SHALL		1098-32268	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32269	Result Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09
entryRelationship	0..*	MAY		1098-	

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				32202	
@typeCode	1..1	SHALL		1098-32270	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32271	Sensory Status (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.127
entryRelationship	0..*	MAY		1098-32203	
@typeCode	1..1	SHALL		1098-32272	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32273	Social History Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09
entryRelationship	0..*	MAY		1098-32204	
typeId	0..1	MAY		1098-32274	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32275	Substance or Device Allergy - Intolerance Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.3.90:2014-06-09
entryRelationship	0..*	MAY		1098-32205	
@typeCode	1..1	SHALL		1098-32276	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32277	Tobacco Use (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09
entryRelationship	0..*	MAY		1098-32206	
@typeCode	1..1	SHALL		1098-32278	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32279	Vital Sign Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09
entryRelationship	0..*	MAY		1098-32207	
@typeCode	1..1	SHALL		1098-32280	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32281	Longitudinal Care Wound Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.114
entryRelationship	0..*	MAY		1098-32208	
@typeCode	1..1	SHALL		1098-	2.16.840.1.113883.5.1002

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				32282	(HL7ActRelationshipType) = SPRT
observation	1..1	SHALL		1098-32283	Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09
entryRelationship	0..*	MAY		1098-32209	
@typeCode	1..1	SHALL		1098-32284	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32285	Caregiver Characteristics (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72
entryRelationship	0..*	MAY		1098-32210	
@typeCode	1..1	SHALL		1098-32286	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32287	Cultural and Religious Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.111
entryRelationship	0..*	MAY		1098-32211	
@typeCode	1..1	SHALL		1098-32288	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32289	Characteristics of Home Environment (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.109
entryRelationship	0..*	MAY		1098-32212	
@typeCode	1..1	SHALL		1098-32290	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32291	Nutritional Status Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.124
entryRelationship	0..*	MAY		1098-32213	
@typeCode	1..1	SHALL		1098-32292	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
organizer	1..1	SHALL		1098-32293	Result Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09
entryRelationship	0..*	MAY		1098-32214	
@typeCode	1..1	SHALL		1098-32294	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-	Priority Preference (identifier:

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				32295	urn:oid:2.16.840.1.113883.10.20.22.4.143
entryRelationship	0..*	MAY		1098-32215	
@typeCode	1..1	SHALL		1098-32296	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
observation	1..1	SHALL		1098-32297	Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143
entryRelationship	0..*	MAY		1098-32216	
@typeCode	1..1	SHALL		1098-32298	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32299	Problem Concern Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09
entryRelationship	0..*	MAY		1098-32217	
@typeCode	1..1	SHALL		1098-32301	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
act	1..1	SHALL		1098-32302	Entry Reference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122
reference	0..*	MAY		1098-32769	
@typeCode	1..1	SHALL		1098-32770	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
externalDocument	1..1	SHALL		1098-32771	External Document Reference (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="`ACT`" (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6`) (CONF:1098-32220).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" (CodeSystem: `ActMood 2.16.840.1.113883.5.1001`) (CONF:1098-32221).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-32180) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.136`" (CONF:1098-32222).
4. **SHALL** contain exactly one [1..1] **id** (CONF:1098-32223).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-32305).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`281694009`" At risk for (CONF:1098-32306).
   b. 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:1098-32307).

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6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-32225).
    a. 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** 2014-03-24 (CONF:1098-32314).
7. **MAY** contain zero or one [0..1] **effectiveTime** (CONF:1098-32226).
8. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32300).
9. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32179) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32227).
    b. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-32219).
10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32181) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32228).
    b. **SHALL** contain exactly one [1..1] **Allergy - Intolerance Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09) (CONF:1098-32229).

The following 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). The Entry Reference template is used here because the target Health Concern Act will be defined elsewhere in the Health Concerns Section and thus a reference to that template is all that is required.

11. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32182) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32230).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-32231).

The following entryRelationship represents the relationship between two Health Concern Acts where the target is a component of the source (Health Concern HAS COMPONENT Health Concern). The Enry Reference template is used here because the target Health Concern Act will be defined elsewhere in the Health Concerns Section and thus a reference to that template is all that is required.

12. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32183) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32232).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-32233).
13. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32184) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32234).
    b. **SHALL** contain exactly one [1..1] **Assessment Scale Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69) (CONF:1098-32235).

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14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32185) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32236).
    b. **SHALL** contain exactly one [1..1] **Mental Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09) (CONF:1098-32237).
15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32186) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32238).
    b. **SHALL** contain exactly one [1..1] **Self-Care Activities (ADL and IADL)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.128) (CONF:1098-32239).
16. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32188) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32242).
    b. **SHALL** contain exactly one [1..1] **Mental Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09) (CONF:1098-32243).
17. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32189) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32244).
    b. **SHALL** contain exactly one [1..1] **Smoking Status - Meaningful Use (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09) (CONF:1098-32245).
18. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32190) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32246).
    b. **SHALL** contain exactly one [1..1] **Encounter Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09) (CONF:1098-32247).
19. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32191) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers To (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32248).
    b. **SHALL** contain exactly one [1..1] **Family History Organizer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09) (CONF:1098-32249).
20. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32192) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32250).
    b. **SHALL** contain exactly one [1..1] **Functional Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09) (CONF:1098-32251).
21. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32193) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32252).

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b. **SHALL** contain exactly one [1..1] **Hospital Admission Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09) (CONF:1098-32253).

22. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32194) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32254).
    b. **SHALL** contain exactly one [1..1] **Mental Status Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09) (CONF:1098-32255).
23. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32195) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32256).
    b. **SHALL** contain exactly one [1..1] **Nutrition Assessment** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.138) (CONF:1098-32257).
24. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32196) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32258).
    b. **SHALL** contain exactly one [1..1] **Nutrition Assessment** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.138) (CONF:1098-32259).
25. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32197) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32260).
    b. **SHALL** contain exactly one [1..1] **Postprocedure Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09) (CONF:1098-32261).
26. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32198) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32262).
    b. **SHALL** contain exactly one [1..1] **Pregnancy Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.15.3.8) (CONF:1098-32263).
27. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32199) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32264).
    b. **SHALL** contain exactly one [1..1] **Preoperative Diagnosis (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09) (CONF:1098-32265).
28. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32200) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32266).
    b. **SHALL** contain exactly one [1..1] **Reaction Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09) (CONF:1098-32267).
29. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32201) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32268).

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b. **SHALL** contain exactly one [1..1] **Result Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09) (CONF:1098-32269).

30. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32202) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32270).
    b. **SHALL** contain exactly one [1..1] **Sensory Status** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.127) (CONF:1098-32271).
31. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32203) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32272).
    b. **SHALL** contain exactly one [1..1] **Social History Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09) (CONF:1098-32273).
32. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32204) such that it
    a. **MAY** contain zero or one [0..1] **typeId**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32274).
    b. **SHALL** contain exactly one [1..1] **Substance or Device Allergy - Intolerance Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.3.90:2014-06-09) (CONF:1098-32275).
33. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32205) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32276).
    b. **SHALL** contain exactly one [1..1] **Tobacco Use (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09) (CONF:1098-32277).
34. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32206) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32278).
    b. **SHALL** contain exactly one [1..1] **Vital Sign Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09) (CONF:1098-32279).
35. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32207) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32280).
    b. **SHALL** contain exactly one [1..1] **Longitudinal Care Wound Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.114) (CONF:1098-32281).

The following entryRelationship represents the relationship Health Concern HAS SUPPORT Observation.

36. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32208) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SPRT" Has support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32282).

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b. **SHALL** contain exactly one [1..1] **Problem Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09) (CONF:1098-32283).

37. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32209) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32284).
    b. **SHALL** contain exactly one [1..1] **Caregiver Characteristics** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72) (CONF:1098-32285).
38. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32210) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32286).
    b. **SHALL** contain exactly one [1..1] **Cultural and Religious Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.111) (CONF:1098-32287).
39. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32211) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32288).
    b. **SHALL** contain exactly one [1..1] **Characteristics of Home Environment** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.109) (CONF:1098-32289).
40. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32212) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32290).
    b. **SHALL** contain exactly one [1..1] **Nutritional Status Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.124) (CONF:1098-32291).
41. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32213) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32292).
    b. **SHALL** contain exactly one [1..1] **Result Organizer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09) (CONF:1098-32293).

The following entryRelationship represents the priority that the patient puts on the health concern.

42. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32214) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32294).
    b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-32295).

The following entryRelationship represents the priority that the provider puts on the health concern.

43. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32215) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32296).

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b. **SHALL** contain exactly one [1..1] **Priority Preference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-32297).

44. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32216) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32298).
    b. **SHALL** contain exactly one [1..1] **Problem Concern Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09) (CONF:1098-32299).

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 Entry Reference template may be used to reference this entry.

45. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-32217) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32301).
    b. **SHALL** contain exactly one [1..1] **Entry Reference** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.122) (CONF:1098-32302).
46. **MAY** contain zero or more [0..*] **reference** (CONF:1098-32769).
    a. The reference, if present, **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32770).
    b. The reference, if present, **SHALL** contain exactly one [1..1] **External Document Reference** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09) (CONF:1098-32771).

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Figure 225: Risk Concern Act Example

```
<!-- Risk Concern Act -->
<act classCode="ACT" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.136" />
    <id root="cbcbf20a-d011-449f-87d1-a23cc3e5f7cf" />
    <code code="X-RISK-CONCERN-ACT" codeSystem="2.16.840.1.113883.6.1"
codeSystemName="LOINC" displayName="At risk for" />
    <!-- This Health Risk has a statusCode 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" extension="2014-06-09" />
            <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">
        <!-- Entry 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>
```


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4.93 Self-Care Activities (ADL and IADL)

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.128 (open)]

Table 454: Self-Care Activities (ADL and IADL) Contexts

Contained By:	Contains:
Health Concern Act (optional) Functional Status Section (V2) (optional) Functional Status Organizer (V2) (required) Risk Concern Act (optional)	Author Participation

This template represents a 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).

Table 455: Self-Care Activities (ADL and IADL) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.128)					
@classCode	1..1	SHALL		1098-31389	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-31390	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-28190	
@root	1..1	SHALL		1098-28457	2.16.840.1.113883.10.20.22.4.128
code	1..1	SHALL		1098-28153	2.16.840.1.113883.11.20.9.47 (ADL Result Type)
statusCode	1..1	SHALL		1098-32490	2.16.840.1.113883.5.14 (ActStatus)
@code	1..1	SHALL		1098-32491	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-32492	
value	1..1	SHALL	CD	1098-28042	2.16.840.1.113883.11.20.9.46 (Ability)
author	0..*	SHOULD		1098-32469	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-31389).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-31390).

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3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-28190) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.128" (CONF:1098-28457).

If more detailed ADL and IADL activities need to be recorded select the appropriate code from LOINC.

4. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **ADL Result Type** 2.16.840.1.113883.11.20.9.47 **DYNAMIC** (CONF:1098-28153).
5. **SHALL** contain exactly one [1..1] **statusCode** (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-32490).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-32491).
6. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-32492).
7. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **Ability** 2.16.840.1.113883.11.20.9.46 **STATIC** (CONF:1098-28042).
8. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32469).

Table 456: Ability

Value Set: Ability 2.16.840.1.113883.11.20.9.46
A value set containing SNOMED-CT codes for level of dependence.

Specific URL Pending
Value Set Source: **https://vsac.nlm.nih.gov**

Code	Code System	Code System OID	Print Name
371150009	SNOMED CT	2.16.840.1.113883.6.96	able
371153006	SNOMED CT	2.16.840.1.113883.6.96	independent
371155004	SNOMED CT	2.16.840.1.113883.6.96	able to and does
371152001	SNOMED CT	2.16.840.1.113883.6.96	assisted
371154000	SNOMED CT	2.16.840.1.113883.6.96	dependent
371151008	SNOMED CT	2.16.840.1.113883.6.96	unable
371156003	SNOMED CT	2.16.840.1.113883.6.96	does not
371157007	SNOMED CT	2.16.840.1.113883.6.96	difficulty
385640009	SNOMED CT	2.16.840.1.113883.6.96	does

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Table 457: 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. Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
46008-9	LOINC	2.16.840.1.113883.6.1	Bathing
28409-1	LOINC	2.16.840.1.113883.6.1	Dressing
28408-3	LOINC	2.16.840.1.113883.6.1	Toileting
46484-2	LOINC	2.16.840.1.113883.6.1	Feeding or Eating
46482-6	LOINC	2.16.840.1.113883.6.1	Transferring
28413-3	LOINC	2.16.840.1.113883.6.1	Ambulation

Figure 226: 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>
```

4.94 Sensory Status

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.127 (open)]

Table 458: Sensory Status Contexts

Contained By:	Contains:
Health Concern Act (optional) Functional Status Section (V2) (optional) Risk Concern Act (optional)	Assessment Scale Observation Author Participation

This template represents a patient's sensory or speech ability. It may contain an assessment scale observations related to the sensory or speech ability.

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Table 459: Sensory Status Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.127)					
@classCode	1..1	SHALL		1098-31017	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-31018	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-27959	
@root	1..1	SHALL		1098-27960	2.16.840.1.113883.10.20.22.4.127
code	1..1	SHALL		1098-27962	2.16.840.1.113883.11.20.9.50 (Sensory Status Problem Type)
statusCode	1..1	SHALL		1098-31437	
@code	1..1	SHALL		1098-31438	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-31441	
low	1..1	SHALL		1098-32630	
high	0..1	MAY		1098-32631	
value	1..1	SHALL	CD	1098-27974	2.16.840.1.113883.11.20.9.44 (Mental and Functional Status Response)
author	0..1	SHOULD		1098-31439	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
entryRelationship	0..*	MAY		1098-27984	
@typeCode	1..1	SHALL		1098-27985	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
observation	1..1	SHALL		1098-27986	Assessment Scale Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" (CodeSystem: `HL7ActClass` `2.16.840.1.113883.5.6`) (CONF:1098-31017).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" (CodeSystem: `ActMood` `2.16.840.1.113883.5.1001`) (CONF:1098-31018).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-27959) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.127`" (CONF:1098-27960).

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4. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **Sensory Status Problem Type** 2.16.840.1.113883.11.20.9.50 **DYNAMIC** (CONF:1098-27962).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-31437).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31438).
6. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-31441).

The effectiveTime/low (a.k.a. "onset date") asserts when the condition became biologically active.

    a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-32630).

The effectiveTime/high (a.k.a. "resolution date") asserts when the condition became biologically resolved.

    b. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:1098-32631).
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** 2.16.840.1.113883.11.20.9.44 **DYNAMIC** (CONF:1098-27974).
8. **SHOULD** contain zero or one [0..1] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31439).
9. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1098-27984) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-27985).
    b. **SHALL** contain exactly one [1..1] **Assessment Scale Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69) (CONF:1098-27986).

Table 460: Sensory Status Problem Type

Value Set: Sensory Status 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. Specific URL Pending Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
47078008	SNOMED CT	2.16.840.1.113883.6.96	Hearing
405183003	SNOMED CT	2.16.840.1.113883.6.96	Sensory function status: vision
373713005	SNOMED CT	2.16.840.1.113883.6.96	Sensory perception
397627001	SNOMED CT	2.16.840.1.113883.6.96	Taste, function
397686008	SNOMED CT	2.16.840.1.113883.6.96	Sense of smell, function
397624008	SNOMED CT	2.16.840.1.113883.6.96	touch sensation, function
128542002	SNOMED CT	2.16.840.1.113883.6.96	speech hearing function
285567008	SNOMED CT	2.16.840.1.113883.6.96	ability to perform functions for speech

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Table 461: Mental and Functional Status Response

Value Set: Mental and Functional Status Response 2.16.840.1.113883.11.20.9.44 A value set containing SNOMED-CT qualifier codes that are common responses to mental and functional ability queries. Value Set Source: http://vtsl.vetmed.vt.edu/TerminologyMgt/RF2Browser/ISA.cfm?SCT_ConceptID=272520006			
Code	**Code System**	**Code System OID**	**Print Name**
11163003	SNOMED CT	2.16.840.1.113883.6.96	Intact
260379002	SNOMED CT	2.16.840.1.113883.6.96	Impaired
272520006	SNOMED CT	2.16.840.1.113883.6.96	degree findings
1250004	SNOMED CT	2.16.840.1.113883.6.96	decreased
18043004	SNOMED CT	2.16.840.1.113883.6.96	thin
18307000	SNOMED CT	2.16.840.1.113883.6.96	altered
20572008	SNOMED CT	2.16.840.1.113883.6.96	good
30714006	SNOMED CT	2.16.840.1.113883.6.96	resistant
35105006	SNOMED CT	2.16.840.1.113883.6.96	increased
41277001	SNOMED CT	2.16.840.1.113883.6.96	lacking
...			

Figure 227: 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>
```


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4.95 Series Act

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.63 (open)]

Table 462: Series Act Contexts

Contained By:	Contains:
Study Act (required)	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.

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Table 463: Series Act Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.63)					
@classCode	1..1	SHALL		81-9222	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		81-9223	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-10918	
@root	1..1	SHALL		81-10919	2.16.840.1.113883.10.20.22.4.63
id	1..*	SHALL		81-9224	
@root	1..1	SHALL		81-9225	
@extension	0..0	SHALL NOT		81-9226	
code	1..1	SHALL		81-19166	
@code	1..1	SHALL		81-19167	113015
@codeSystem	0..1	MAY		81-26461	1.2.840.10008.2.16.4 (DCM) = 1.2.840.10008.2.16.4
qualifier	1..1	SHALL		81-26462	
name	1..1	SHALL		81-26463	
@code	1..1	SHALL		81-26464	121139
@codeSystem	1..1	SHALL		81-26465	1.2.840.10008.2.16.4 (DCM) = 1.2.840.10008.2.16.4
value	1..1	SHALL		81-26466	
text	0..1	MAY		81-9233	
effectiveTime	0..1	SHOULD		81-9235	
entryRelationship	1..*	SHALL		81-9237	
@typeCode	1..1	SHALL		81-9238	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
observation	1..1	SHALL		81-15927	SOP Instance Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8

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1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-9222).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-9223).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-10918) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.63" (CONF:81-10919).
4. **SHALL** contain at least one [1..*] **id** (CONF:81-9224).

The @root contains the OID of the study instance UID since DICOM study ids consist only of an OID

    a. Such ids **SHALL** contain exactly one [1..1] **@root** (CONF:81-9225).
    b. Such ids **SHALL NOT** contain [0..0] **@extension** (CONF:81-9226).
5. **SHALL** contain exactly one [1..1] **code** (CONF:81-19166).
    a. This code **SHALL** contain exactly one [1..1] **@code**="113015" (CONF:81-19167).
    b. 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:81-26461).
    c. This code **SHALL** contain exactly one [1..1] **qualifier** (CONF:81-26462).
        i. This qualifier **SHALL** contain exactly one [1..1] **name** (CONF:81-26463).
            1. This name **SHALL** contain exactly one [1..1] **@code**="121139" Modality (CONF:81-26464).
            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:81-26465).
        ii. This qualifier **SHALL** contain exactly one [1..1] **value** (CONF:81-26466).

If present, the text element contains the description of the series

6. **MAY** contain zero or one [0..1] **text** (CONF:81-9233).

If present, the effectiveTime contains the time the series was started

7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:81-9235).
8. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:81-9237) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-9238).
    b. **SHALL** contain exactly one [1..1] **SOP Instance Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8) (CONF:81-15927).

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Figure 228: 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>
```

4.96 Service Delivery Location

[participantRole: identifier urn:oid:2.16.840.1.113883.10.20.22.4.32 (open)]

Table 464: Service Delivery Location Contexts

Contained By:	Contains:
Procedure Activity Act (V2) (optional) Procedure Activity Procedure (V2) (optional) Procedure Activity Observation (V2) (optional) Encounter Activity (V2) (optional) Planned Encounter (V2) (optional)	

This clinical statement represents the location of a service event where an act, observation or procedure took place.

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Table 465: Service Delivery Location Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
participantRole (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32)					
@classCode	1..1	SHALL		81-7758	2.16.840.1.113883.5.111 (RoleCode) = SDLOC
templateId	1..1	SHALL		81-7635	
@root	1..1	SHALL		81-10524	2.16.840.1.113883.10.20.22.4.32
code	1..1	SHALL		81-16850	2.16.840.1.113883.1.11.20275 (HealthcareServiceLocation)
addr	0..*	SHOULD		81-7760	
telecom	0..*	SHOULD		81-7761	
playingEntity	0..1	MAY		81-7762	
@classCode	1..1	SHALL		81-7763	2.16.840.1.113883.5.41 (EntityClass) = PLC
name	0..1	MAY		81-16037	

1. **SHALL** contain exactly one [1..1] **@classCode**="`SDLOC`" (CodeSystem: `RoleCode 2.16.840.1.113883.5.111` **STATIC**) (CONF:81-7758).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7635) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.32`" (CONF:81-10524).
3. **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet **HealthcareServiceLocation** `2.16.840.1.113883.1.11.20275` **STATIC** (CONF:81-16850).
4. **SHOULD** contain zero or more [0..*] **addr** (CONF:81-7760).
5. **SHOULD** contain zero or more [0..*] **telecom** (CONF:81-7761).
6. **MAY** contain zero or one [0..1] **playingEntity** (CONF:81-7762).
   a. The playingEntity, if present, **SHALL** contain exactly one [1..1] **@classCode**="`PLC`" (CodeSystem: `EntityClass 2.16.840.1.113883.5.41` **STATIC**) (CONF:81-7763).
   b. The playingEntity, if present, **MAY** contain zero or one [0..1] **name** (CONF:81-16037).

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Table 466: HealthcareServiceLocation

Value Set: HealthcareServiceLocation 2.16.840.1.113883.1.11.20275

A comprehensive classification of locations and settings where healthcare services are provided. This value set is based on the National Healthcare Safety Network (NHSN) location code system that has been developed over a number of years through CDC's interaction with a variety of healthcare facilities and is intended to serve a variety of reporting needs where coding of healthcare service locations is required.

Value Set Source:
http://phinvads.cdc.gov/vads/SearchAllVocab_search.action?searchOptions.searchText=Healthcare+Service+Location+%28NHSN%29

Code	Code System	Code System OID	Print Name
1162-7	HL7 HealthcareServiceLocation	2.16.840.1.113883.6.259	24-Hour observation area
1184-1	HL7 HealthcareServiceLocation	2.16.840.1.113883.6.259	Administrative area
1210-4	HL7 HealthcareServiceLocation	2.16.840.1.113883.6.259	Adult Mixed Acuity Unit
1099-1	HL7 HealthcareServiceLocation	2.16.840.1.113883.6.259	Adult step down unit [post-critical care]
1110-6	HL7 HealthcareServiceLocation	2.16.840.1.113883.6.259	Allergy clinic
1166-8	HL7 HealthcareServiceLocation	2.16.840.1.113883.6.259	Ambulatory surgical setting
1212-0	HL7 HealthcareServiceLocation	2.16.840.1.113883.6.259	Any Age Mixed Acuity Unit
1106-4	HL7 HealthcareServiceLocation	2.16.840.1.113883.6.259	Assisted living area
1145-2	HL7 HealthcareServiceLocation	2.16.840.1.113883.6.259	Behavioral health clinic
1185-8	HL7 HealthcareServiceLocation	2.16.840.1.113883.6.259	Blood bank
…			

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Figure 229: 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>
```

4.97 Severity Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09 (open)]

Table 467: Severity Observation (V2) Contexts

Contained By:	Contains:
Reaction Observation (V2) (optional) Allergy - Intolerance Observation (V2) (optional) Substance or Device Allergy - Intolerance Observation (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.

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Table 468: Severity Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09)					
@classCode	1..1	SHALL		1098-7345	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-7346	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7347	
@root	1..1	SHALL		1098-10525	2.16.840.1.113883.10.20.22.4.8
@extension	1..1	SHALL		1098-32577	2014-06-09
code	1..1	SHALL		1098-19168	
@code	1..1	SHALL		1098-19169	SEV
@codeSystem	1..1	SHALL		1098-32170	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
statusCode	1..1	SHALL		1098-7352	
@code	1..1	SHALL		1098-19115	2.16.840.1.113883.5.14 (ActStatus) = completed
value	1..1	SHALL	CD	1098-7356	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:1098-7345).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7346).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7347) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.8" (CONF:1098-10525).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32577).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-19168).
   a. This code **SHALL** contain exactly one [1..1] **@code**="SEV" Severity (CONF:1098-19169).
   b. 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:1098-32170).
5. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7352).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19115).

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6. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHALL** be selected from ValueSet **Problem Severity** 2.16.840.1.113883.3.88.12.3221.6.8 **DYNAMIC** (CONF:1098-7356).

Table 469: Problem Severity

Value Set: Problem Severity 2.16.840.1.113883.3.88.12.3221.6.8 This is a description of the level of the severity of the problem. Specific URL Pending Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
255604002	SNOMED CT	2.16.840.1.113883.6.96	Mild (qualifier value)
371923003	SNOMED CT	2.16.840.1.113883.6.96	Mild to moderate (qualifier value)
6736007	SNOMED CT	2.16.840.1.113883.6.96	Moderate (severity modifier) (qualifier value)
371924009	SNOMED CT	2.16.840.1.113883.6.96	Moderate to severe (qualifier value)
24484000	SNOMED CT	2.16.840.1.113883.6.96	Severe (severity modifier) (qualifier value)
399166001	SNOMED CT	2.16.840.1.113883.6.96	Fatal (qualifier value)

Figure 230: Severity Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.8" extension="2014-06-09" />
    <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>
```

4.98 Smoking Status - Meaningful Use (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09 (open)]

Table 470: Smoking Status - Meaningful Use (V2) Contexts

Contained By:	Contains:
Social History Section (V2) (optional) Health Concern Act (optional) Risk Concern Act (optional)	Author Participation

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This template represents 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.

This template represents a “snapshot in time” observation, simply reflecting what the patient’s current smoking status is at the time of the observation. As a result, the effectiveTime is constrained to a time stamp, and will approximately correspond with the author/time. 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.

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Table 471: Smoking Status - Meaningful Use (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09)					
@classCode	1..1	SHALL		1098-14806	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-14807	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-14815	
@root	1..1	SHALL		1098-14816	2.16.840.1.113883.10.20.22.4.78
@extension	1..1	SHALL		1098-32573	2014-06-09
id	1..*	SHALL		1098-32401	
code	1..1	SHALL		1098-19170	
@code	1..1	SHALL		1098-31039	72166-2
@codeSystem	1..1	SHALL		1098-32157	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-14809	
@code	1..1	SHALL		1098-19116	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-31928	
value	1..1	SHALL	CD	1098-14810	
@code	1..1	SHALL		1098-14817	2.16.840.1.113883.11.20.9.38 (Current Smoking Status)
author	0..*	SHOULD		1098-31148	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" Observation (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-14806).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-14807).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-14815) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.78`" (CONF:1098-14816).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32573).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-32401).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-19170).

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a. This code **SHALL** contain exactly one [1..1] **@code**="72166-2" Tobacco smoking status NHIS (CONF:1098-31039).
b. 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:1098-32157).

6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-14809).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19116).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-31928).
   Note: This template represents a "snapshot in time" observation, simply reflecting what the patient's current smoking status is at the time of the observation. As a result, the effectiveTime is constrained to just a time stamp, and will approximately correspond with the author/time.
8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD" (CONF:1098-14810).
   a. 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 **STATIC** 2014-09-01 (CONF:1098-14817).
   b. If the patient's current smoking status is unknown, @code **SHALL** contain '266927001' (Unknown if ever smoked) from ValueSet Current Smoking Status (2.16.840.1.113883.11.20.9.38 STATIC 2014-09-01) (CONF:1098-31019).
9. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31148).

Table 472: Current Smoking Status

Value Set: Current Smoking Status 2.16.840.1.113883.11.20.9.38 This value set indicates the current smoking status of a patient. Specific URL Pending Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
449868002	SNOMED CT	2.16.840.1.113883.6.96	Current every day smoker
428041000124106	SNOMED CT	2.16.840.1.113883.6.96	Current some day smoker
8517006	SNOMED CT	2.16.840.1.113883.6.96	Former smoker
266919005	SNOMED CT	2.16.840.1.113883.6.96	Never smoker (Never Smoked)
77176002	SNOMED CT	2.16.840.1.113883.6.96	Smoker, current status unknown
266927001	SNOMED CT	2.16.840.1.113883.6.96	Unknown if ever smoked
428071000124103	SNOMED CT	2.16.840.1.113883.6.96	Heavy tobacco smoker
428061000124105	SNOMED CT	2.16.840.1.113883.6.96	Light tobacco smoker

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Figure 231: Smoking Status - Meaningful Use (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.78" extension="2014-06-09" />
    <id extension="123456789" root="2.16.840.1.113883.19" />
    <code code="72166-2" codeSystem="2.16.840.1.113883.6.1" displayName="Tobacco smoking
status NHIS" />
    <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 typeCode="AUT">
        <time value="199803161030-0800" />
        <assignedAuthor>
            <id extension="555555555" root="1.1.1.1.1.1.1.2" />
        </assignedAuthor>
    </author>
</observation>
```

4.99 Social History Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09 (open)]

Table 473: Social History Observation (V2) Contexts

Contained By:	Contains:
Social History Section (V2) (optional) Health Concern Act (optional) Risk Concern Act (optional)	Author Participation

This template represents a patient's occupations, lifestyle, and environmental health risk factors. Demographic data (e.g., marital status, race, ethnicity, religious affiliation) are captured in the header. Though tobacco use and exposure may be represented with a Social History Observation, it is recommended to use the Current Smoking Status template or the Tobacco Use template instead, to represent smoking or tobacco habits.

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Table 474: Social History Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09)					
@classCode	1..1	SHALL		1098-8548	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-8549	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-8550	
@root	1..1	SHALL		1098-10526	2.16.840.1.113883.10.20.22.4.38
@extension	1..1	SHALL		1098-32495	2014-06-09
id	1..*	SHALL		1098-8551	
code	1..1	SHALL		1098-8558	2.16.840.1.113883.6.1 (LOINC)
originalText	0..1	SHOULD		1098-19221	
reference	0..1	SHOULD		1098-19222	
@value	0..1	SHOULD		1098-19223	
statusCode	1..1	SHALL		1098-8553	
@code	1..1	SHALL		1098-19117	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-31868	
value	0..1	SHOULD		1098-8559	
author	0..*	SHOULD		1098-31869	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8548).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-8549).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-8550) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.38" (CONF:1098-10526).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32495).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-8551).

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5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from CodeSystem `LOINC (2.16.840.1.113883.6.1)` **DYNAMIC** (CONF:1098-8558).
    a. This code **SHOULD** contain zero or one [0..1] **originalText** (CONF:1098-19221).
        i. The originalText, if present, **SHOULD** contain zero or one [0..1] **reference** (CONF:1098-19222).
            1. The reference, if present, **SHOULD** contain zero or one [0..1] **@value** (CONF:1098-19223).
                a. 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:1098-19224).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-8553).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="`completed`" Completed (CodeSystem: `ActStatus 2.16.840.1.113883.5.14` **STATIC**) (CONF:1098-19117).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-31868).
8. **SHOULD** contain zero or one [0..1] **value** (CONF:1098-8559).
    a. If Observation/value is a physical quantity (xsi:type="PQ"), the unit of measure **SHALL** be selected from ValueSet UnitsOfMeasureCaseSensitive (2.16.840.1.113883.1.11.12839) **DYNAMIC** (CONF:1098-8555).
9. **SHOULD** contain zero or more [0..*] **Author Participation** `(identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119)` (CONF:1098-31869).

Figure 232: Social History Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.22.4.38"
        extension="2014-06-09" />
  <id root="37f76c51-6411-4e1d-8a37-957fd49d2cef" />
  <code code="74013-4"
        codeSystem="2.16.840.1.113883.6.1"
        codeSystemName="LOINC"
        displayName="Alcoholic drinks per day" />
  <statusCode code="completed" />
  <effectiveTime>
    <low value="20120215" />
  </effectiveTime>
  <value xsi:type="PQ" value="12" />
  <author typeCode="AUT">
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    ...
  </author>
</observation>
```


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4.100SOP Instance Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.6.2.8 (open)]

Table 475: SOP Instance Observation Contexts

Contained By:	Contains:
Series Act (required) Text Observation (optional) Code Observations (optional) Quantity Measurement Observation (optional) Diagnostic Imaging Report (V2) (optional)	Purpose of Reference Observation 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.

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Table 476: SOP Instance Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8)					
@classCode	1..1	SHALL		81-9240	2.16.840.1.113883.5.6 (HL7ActClass) = DGIMG
@moodCode	1..1	SHALL		81-9241	2.16.840.1.113883.5.1001 (ActMood) = EVN
id	1..*	SHALL		81-9242	
code	1..1	SHALL		81-9244	
@code	1..1	SHALL		81-19225	
@codeSystem	1..1	SHALL		81-19227	1.2.840.10008.2.6.1
text	0..1	SHOULD		81-9246	
@mediaType	1..1	SHALL		81-9247	application/dicom
reference	1..1	SHALL		81-9248	
effectiveTime	0..1	SHOULD		81-9250	
@value	1..1	SHALL		81-9251	
low	0..0	SHALL NOT		81-9252	
high	0..0	SHALL NOT		81-9253	
entryRelationship	0..*	MAY		81-9254	
@typeCode	1..1	SHALL		81-9255	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
entryRelationship	0..*	MAY		81-9257	
@typeCode	1..1	SHALL		81-9258	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON
observation	1..1	SHALL		81-15935	Purpose of Reference Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.9
entryRelationship	0..*	MAY		81-9260	
@typeCode	1..1	SHALL		81-9261	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) =

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					COMP
observation	1..1	SHALL		81-15936	Referenced Frames Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.10

1. **SHALL** contain exactly one [1..1] **@classCode**="DGIMG" Diagnostic Image (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:81-9240).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:81-9241).

The @root contains an OID representing the DICOM SOP Instance UID

3. **SHALL** contain at least one [1..*] **id** (CONF:81-9242).
4. **SHALL** contain exactly one [1..1] **code** (CONF:81-9244).
    a. This code **SHALL** contain exactly one [1..1] **@code** (CONF:81-19225).
        i. @code is an OID for a valid SOP class name UID (CONF:81-19226).
    b. This code **SHALL** contain exactly one [1..1] **@codeSystem**="1.2.840.10008.2.6.1" DCMUID (CONF:81-19227).
5. **SHOULD** contain zero or one [0..1] **text** (CONF:81-9246).
    a. The text, if present, **SHALL** contain exactly one [1..1] **@mediaType**="application/dicom" (CONF:81-9247).
    b. The text, if present, **SHALL** contain exactly one [1..1] **reference** (CONF:81-9248).
        i. SHALL contain a @value that contains a WADO reference as a URI (CONF:81-9249).
6. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:81-9250).
    a. The effectiveTime, if present, **SHALL** contain exactly one [1..1] **@value** (CONF:81-9251).
    b. The effectiveTime, if present, **SHALL NOT** contain [0..0] **low** (CONF:81-9252).
    c. The effectiveTime, if present, **SHALL NOT** contain [0..0] **high** (CONF:81-9253).
7. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:81-9254) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-9255).
8. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:81-9257) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-9258).
    b. **SHALL** contain exactly one [1..1] **Purpose of Reference Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.9) (CONF:81-15935).
9. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:81-9260) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-9261).
    b. **SHALL** contain exactly one [1..1] **Referenced Frames Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.10) (CONF:81-15936).
    c. This entryRelationship **SHALL** be present if the referenced DICOM object is a multiframe object and the reference does not apply to all frames (CONF:81-9263).

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Figure 233: 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=1.2.840.113619.2.62.994044
785528.114289542805&amp;seriesUID=1.2.840.113619.2.62.994044785528.20060823223142485051&amp
;objectUID=1.2.840.113619.2.62.994044785528.20060823.200608232232322.3&amp;contentType=appl
ication/dicom"/>
        <!--reference to image 1 (PA) -->
    </text>
    <effectiveTime value="200608231235-0800"/>
</observation>
```

4.101 Study Act

[act: identifier urn:oid:2.16.840.1.113883.10.20.6.2.6 (open)]

Table 477: Study Act Contexts

Contained By:	Contains:
DICOM Object Catalog Section - DCM 121181 (required)	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.

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Table 478: Study Act Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.6)					
@classCode	1..1	SHALL		81-9207	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		81-9208	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-9209	
@root	1..1	SHALL		81-10533	2.16.840.1.113883.10.20.6.2.6
id	1..*	SHALL		81-9210	
@root	1..1	SHALL		81-9213	
@extension	0..0	SHALL NOT		81-9211	
code	1..1	SHALL		81-19172	
@code	1..1	SHALL		81-19173	113014
@codeSystem	1..1	SHALL		81-26506	1.2.840.10008.2.16.4 (DCM) = 1.2.840.10008.2.16.4
text	0..1	MAY		81-9215	
reference	0..1	SHOULD		81-15995	
@value	0..1	SHOULD		81-15996	
effectiveTime	0..1	SHOULD		81-9216	
entryRelationship	1..*	SHALL		81-9219	
@typeCode	1..1	SHALL		81-9220	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
act	1..1	SHALL		81-15937	Series Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.63

1. **SHALL** contain exactly one [1..1] **@classCode**="`ACT`" (CodeSystem: `HL7ActClass` `2.16.840.1.113883.5.6` **STATIC**) (CONF:81-9207).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" (CodeSystem: `ActMood` `2.16.840.1.113883.5.1001` **STATIC**) (CONF:81-9208).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-9209) such that it

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a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.6.2.6" (CONF:81-10533).

4. **SHALL** contain at least one [1..*] **id** (CONF:81-9210).

The @root contains the OID of the study instance UID since DICOM study ids consist only of an OID

a. Such ids **SHALL** contain exactly one [1..1] **@root** (CONF:81-9213).
b. Such ids **SHALL NOT** contain [0..0] **@extension** (CONF:81-9211).

5. **SHALL** contain exactly one [1..1] **code** (CONF:81-19172).
   a. This code **SHALL** contain exactly one [1..1] **@code**="113014" (CONF:81-19173).
   b. This code **SHALL** contain exactly one [1..1] **@codeSystem**="1.2.840.10008.2.16.4" (CodeSystem: DCM 1.2.840.10008.2.16.4) (CONF:81-26506).

If present, the text element contains the description of the study.

6. **MAY** contain zero or one [0..1] **text** (CONF:81-9215).
   a. The text, if present, **SHOULD** contain zero or one [0..1] **reference** (CONF:81-15995).
      i. The reference, if present, **SHOULD** contain zero or one [0..1] **@value** (CONF:81-15996).
         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:81-15997).

If present, the effectiveTime contains the time the study was started

7. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:81-9216).
8. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:81-9219) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-9220).
   b. **SHALL** contain exactly one [1..1] **Series Act** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.63) (CONF:81-15937).

Figure 234: 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>
```


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4.102 Substance Administered Act

[act: identifier urn:oid:2.16.840.1.113883.10.20.22.4.118 (open)]

Table 479: Substance Administered Act Contexts

Contained By:	Contains:
Medication Activity (V2) (optional) Immunization Activity (V2) (optional)	

This template represents the administration course in a series. The entryRelationship/sequenceNumber in the containing template shows the order of this particular administration in that medication series.

Table 480: Substance Administered Act Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.118)					
@classCode	1..1	SHALL		1098-31500	2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-31501	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-31502	
@root	1..1	SHALL		1098-31503	2.16.840.1.113883.10.20.22.4.118
id	1..*	SHALL		1098-31504	
code	1..1	SHALL		1098-31506	
@code	1..1	SHALL		1098-31507	416118004
@codeSystem	1..1	SHALL		1098-31508	2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
statusCode	1..1	SHALL		1098-31505	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	0..1	MAY		1098-31509	

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-31500).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-31501).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-31502) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.118" (CONF:1098-31503).

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4. **SHALL** contain at least one [1..*] **id** (CONF:1098-31504).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-31506).
    a. This code **SHALL** contain exactly one [1..1] **@code**="416118004" Administration (CONF:1098-31507).
    b. 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:1098-31508).
6. **SHALL** contain exactly one [1..1] **statusCode**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31505).
7. **MAY** contain zero or one [0..1] **effectiveTime** (CONF:1098-31509).

Figure 235: Substance Administered Act Example

```
<substanceAdministration classCode="SBADM" moodCode="EVN">
    ...
    <consumable>
                ...
        <code code="43" codeSystem="2.16.840.1.113883.6.59" displayName="Hepatitis B
Vaccine" codeSystemName="CVX" />
    </consumable>
    <entryRelationship typeCode="COMP">
        <!-- This entryRelationship sequenceNumber indicates this is #2 in the series -->
        <sequenceNumber value="2" />
        <act classCode="ACT" moodCode="EVN">
            <!-- Substance Administered Act Template -->
            <templateId root="2.16.840.1.113883.10.20.22.4.118" />
            <id root="df8908d0-40f2-11e3-aa6e-0800200c9a66" />
            <code code="416118004" displayName="administration"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED-CT" />
            <statusCode code="completed" />
            <effectiveTime value="19991101" />
        </act>
    </entryRelationship>
        ...
</substanceAdministration>
```

4.103 Substance or Device Allergy - Intolerance Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.24.3.90:2014-06-09 (open)]

Table 481: Substance or Device Allergy - Intolerance Observation (V2) Contexts

Contained By:	Contains:
Health Concern Act (optional) Risk Concern Act (optional)	Allergy Status Observation (DEPRECATED) Author Participation Reaction Observation (V2) Severity Observation (V2)

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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".

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Table 482: Substance or Device Allergy - Intolerance Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.3.90:2014-06-09)					
@classCode	1..1	SHALL		1098-16303	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-16304	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-16305	
@root	1..1	SHALL		1098-16306	2.16.840.1.113883.10.20.24.3.90
@extension	1..1	SHALL		1098-32527	2014-06-09
id	1..*	SHALL		1098-16307	
code	1..1	SHALL		1098-16345	
@code	1..1	SHALL		1098-16346	ASSERTION
@codeSystem	1..1	SHALL		1098-32171	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
statusCode	1..1	SHALL		1098-16308	
@code	1..1	SHALL		1098-26354	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-16309	
low	1..1	SHALL		1098-31536	
high	0..1	MAY		1098-31537	
value	1..1	SHALL	CD	1098-16312	
@code	1..1	SHALL	CS	1098-16317	2.16.840.1.113883.3.88.12.3221.6.2 (Allergy/Adverse Event Type)
author	0..*	SHOULD		1098-31144	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	0..*	SHOULD		1098-16318	
@typeCode	1..1	SHALL		1098-16319	2.16.840.1.113883.5.90 (HL7ParticipationType) = CSM
participantRole	1..1	SHALL		1098-16320	
@classCode	1..1	SHALL		1098-16321	2.16.840.1.113883.5.110 (RoleClass) = MANU

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playingEntity	1..1	SHALL		1098-16322	
@classCode	1..1	SHALL		1098-16323	2.16.840.1.113883.5.41 (EntityClass) = MMAT
code	1..1	SHALL		1098-16324	2.16.840.1.113762.1.4.1010.1 (Substance-Reactant for Intolerance)
entryRelationship	0..1	MAY		1098-16333	
@typeCode	1..1	SHALL		1098-16335	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
@inversionInd	1..1	SHALL		1098-16334	true
observation	1..1	SHALL		1098-16336	Allergy Status Observation (DEPRECATED) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.28:2014-06-09
entryRelationship	0..*	SHOULD		1098-16337	
@typeCode	1..1	SHALL		1098-16339	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = MFST
@inversionInd	1..1	SHALL		1098-16338	true
observation	1..1	SHALL		1098-16340	Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09
entryRelationship	0..1	MAY		1098-16341	
@typeCode	1..1	SHALL		1098-16342	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
@inversionInd	1..1	SHALL		1098-16343	true
observation	1..1	SHALL		1098-16344	Severity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-16303).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-16304).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16305) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.24.3.90" (CONF:1098-16306).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32527).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-16307).

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5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-16345).
    a. This code **SHALL** contain exactly one [1..1] **@code**="ASSERTION" Assertion (CONF:1098-16346).
    b. 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:1098-32171).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-16308).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-26354).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-16309).
   Note: 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'.
    a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-31536).
    b. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:1098-31537).
8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD" (CONF:1098-16312).
    a. This value **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **Allergy/Adverse Event Type** 2.16.840.1.113883.3.88.12.3221.6.2 **DYNAMIC** (CONF:1098-16317).
       Note: Many systems will simply assign a fixed value here (e.g., "allergy to substance").
9. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31144).
10. **SHOULD** contain zero or more [0..*] **participant** (CONF:1098-16318).
    a. The participant, if present, **SHALL** contain exactly one [1..1] **@typeCode**="CSM" Consumable (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-16319).
    b. The participant, if present, **SHALL** contain exactly one [1..1] **participantRole** (CONF:1098-16320).
        i. This participantRole **SHALL** contain exactly one [1..1] **@classCode**="MANU" Manufactured Product (CodeSystem: RoleClass 2.16.840.1.113883.5.110 **STATIC**) (CONF:1098-16321).
        ii. This participantRole **SHALL** contain exactly one [1..1] **playingEntity** (CONF:1098-16322).
            1. This playingEntity **SHALL** contain exactly one [1..1] **@classCode**="MMAT" Manufactured Material (CodeSystem: EntityClass 2.16.840.1.113883.5.41 **STATIC**) (CONF:1098-16323).
            2. This playingEntity **SHALL** contain exactly one [1..1] **code**, which **MAY** be selected from ValueSet **Substance-Reactant for Intolerance** 2.16.840.1.113762.1.4.1010.1 **DYNAMIC** (CONF:1098-16324).

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11. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-16333) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-16335).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-16334).
    c. **SHALL** contain exactly one [1..1] **Allergy Status Observation (DEPRECATED)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.28:2014-06-09) (CONF:1098-16336).
12. **SHOULD** contain zero or more [0..*] **entryRelationship** (CONF:1098-16337) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="MFST" Is Manifestation of (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-16339).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-16338).
    c. **SHALL** contain exactly one [1..1] **Reaction Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09) (CONF:1098-16340).
13. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-16341) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-16342).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-16343).
    c. **SHALL** contain exactly one [1..1] **Severity Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09) (CONF:1098-16344).

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Table 483: Allergy/Adverse Event Type

Value Set: Allergy/Adverse Event Type 2.16.840.1.113883.3.88.12.3221.6.2 This describes the type of product and intolerance suffered by the patient. Specific URL Pending Value Set Source: https://vsac.nlm.nih.gov			
Code	**Code System**	**Code System OID**	**Print Name**
419199007	SNOMED CT	2.16.840.1.113883.6.96	Allergy to substance (disorder)
416098002	SNOMED CT	2.16.840.1.113883.6.96	Drug allergy (disorder)
59037007	SNOMED CT	2.16.840.1.113883.6.96	Drug intolerance (disorder)
414285001	SNOMED CT	2.16.840.1.113883.6.96	Food allergy (disorder)
235719002	SNOMED CT	2.16.840.1.113883.6.96	Food intolerance (disorder)
420134006	SNOMED CT	2.16.840.1.113883.6.96	Propensity to adverse reactions (disorder)
419511003	SNOMED CT	2.16.840.1.113883.6.96	Propensity to adverse reactions to drug (disorder)
418471000	SNOMED CT	2.16.840.1.113883.6.96	Propensity to adverse reactions to food (disorder)
418038007	SNOMED CT	2.16.840.1.113883.6.96	Propensity to adverse reactions to substance (disorder)
232347008	SNOMED CT	2.16.840.1.113883.6.96	Dander (animal) allergy
…			

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Table 484: Substance-Reactant for Intolerance

Value Set: Substance-Reactant for Intolerance 2.16.840.1.113762.1.4.1010.1 A substance or other type of agent (e.g., sunshine) that may be associated with an intolerance reaction event or a propensity to such an event. These concepts are expected to be at a more general level of abstraction (ingredients versus more specific formulations). This value set is quite general and includes concepts that may never cause an adverse event, particularly the included SNOMED CT concepts. The code system-specific value sets in this grouping value set are intended to provide broad coverage of all kinds of agents, but the expectation for use is that the chosen concept identifier for a substance should be appropriately specific and drawn from the available code systems in the following priority order: NDFRT, then RXNORM, then UNII, then SNOMED CT. This overarching grouping value set is intended to support identification of drug classes, individual medication ingredients, foods, general substances and environmental entities. Value set intensionally defined as a GROUPING made up of: Value Set: Medication Drug Class (2.16.840.1.113883.3.88.12.80.18) (NDFRT drug class codes); Value Set: Clinical Drug Ingredient (2.16.840.1.113762.1.4.1010.7) (RxNORM ingredient codes); Value Set: Unique Ingredient Identifier - Complete Set (2.16.840.1.113883.3.88.12.80.20) (UNII ingredient codes); Value Set: Substance Other Than Clinical Drug (2.16.840.1.113762.1.4.1010.9) (SNOMED CT substance codes). Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
18867	RxNorm	2.16.840.1.113883.6.88	benazepril
196500	RxNorm	2.16.840.1.113883.6.88	Coversyl
83515	RxNorm	2.16.840.1.113883.6.88	eprosartan
237057	RxNorm	2.16.840.1.113883.6.88	lepirudin
C24814	NDFRT	2.16.840.1.113883.3.26.1.5	Acyclovir
N0000168624	NDFRT	2.16.840.1.113883.3.26.1.5	Azacosterol
N0000006690	NDFRT	2.16.840.1.113883.3.26.1.5	Soybean Oil
QE1QX6B99R	Unique Ingredient Identifier (UNII)	2.16.840.1.113883.4.9	PEANUT
…			

4.103.1 Allergy - Intolerance Observation (V2)

`[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09 (open)]`

Table 485: Allergy - Intolerance Observation (V2) Contexts

Contained By:	**Contains:**
Allergy Concern Act (V2) (required) Health Concern Act (optional) Risk Concern Act (optional)	Author Participation Reaction Observation (V2) 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

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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".

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, i.e., use playingEntity classCode = "MMAT" for all agents, manufactured or not.

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Table 486: Allergy - Intolerance Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09)					
@classCode	1..1	SHALL		1098-7379	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-7380	2.16.840.1.113883.5.1001 (ActMood) = EVN
@negationInd	0..1	MAY		1098-31526	
templateId	1..1	SHALL		1098-7381	
@root	1..1	SHALL		1098-10488	2.16.840.1.113883.10.20.22.4.7
@extension	1..1	SHALL		1098-32526	2014-06-09
id	1..*	SHALL		1098-7382	
code	1..1	SHALL		1098-15947	
@code	1..1	SHALL		1098-15948	ASSERTION
@codeSystem	1..1	SHALL		1098-32153	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
statusCode	1..1	SHALL		1098-19084	
@code	1..1	SHALL		1098-19085	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-7387	
low	1..1	SHALL		1098-31538	
high	0..1	MAY		1098-31539	
value	1..1	SHALL	CD	1098-7390	2.16.840.1.113883.3.88.12.3221.6.2 (Allergy/Adverse Event Type)
author	0..*	SHOULD		1098-31143	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
participant	1..1	SHALL		1098-7402	
@typeCode	1..1	SHALL		1098-7403	2.16.840.1.113883.5.90 (HL7ParticipationType) = CSM
participantRole	1..1	SHALL		1098-7404	
@classCode	1..1	SHALL		1098-7405	2.16.840.1.113883.5.110 (RoleClass) = MANU

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playingEntity	1..1	SHALL		1098-7406	
@classCode	1..1	SHALL		1098-7407	2.16.840.1.113883.5.41 (EntityClass) = MMAT
code	1..1	SHALL		1098-7419	2.16.840.1.113762.1.4.1010.1 (Substance-Reactant for Intolerance)
entryRelationship	0..*	SHOULD		1098-7447	
@typeCode	1..1	SHALL		1098-7907	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = MFST
@inversionInd	1..1	SHALL		1098-7449	true
observation	1..1	SHALL		1098-15955	Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09
entryRelationship	0..1	MAY		1098-9961	
@typeCode	1..1	SHALL		1098-9962	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
@inversionInd	1..1	SHALL		1098-9964	true
observation	1..1	SHALL		1098-15956	Severity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09

1. Conforms to **Substance or Device Allergy - Intolerance Observation (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.3.90:2014-06-09).
2. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7379).
3. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7380).
4. **MAY** contain zero or one [0..1] **@negationInd** (CONF:1098-31526).
   Note: Use negationInd="true" to indicate that the allergy was not observed.
5. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7381) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.7" (CONF:1098-10488).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32526).
6. **SHALL** contain at least one [1..*] **id** (CONF:1098-7382).
7. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15947).
   a. This code **SHALL** contain exactly one [1..1] **@code**="ASSERTION" Assertion (CONF:1098-15948).

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b. 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:1098-32153).

8. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-19084).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19085).
9. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-7387).
   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'.
   a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-31538).
      Note: The effectiveTime/low (a.k.a. "onset date") asserts when the allergy/intolerance became biologically active.
   b. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:1098-31539).
      Note: The effectiveTime/high (a.k.a. "resolution date") asserts when the allergy/intolerance became biologically resolved.
10. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHALL** be selected from ValueSet **Allergy/Adverse Event Type** 2.16.840.1.113883.3.88.12.3221.6.2 **DYNAMIC** (CONF:1098-7390).
    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").
11. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31143).
12. **SHALL** contain exactly one [1..1] **participant** (CONF:1098-7402) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="CSM" Consumable (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-7403).
    b. **SHALL** contain exactly one [1..1] **participantRole** (CONF:1098-7404).
       i. This participantRole **SHALL** contain exactly one [1..1] **@classCode**="MANU" Manufactured Product (CodeSystem: RoleClass 2.16.840.1.113883.5.110 **STATIC**) (CONF:1098-7405).
       ii. This participantRole **SHALL** contain exactly one [1..1] **playingEntity** (CONF:1098-7406).
          1. This playingEntity **SHALL** contain exactly one [1..1] **@classCode**="MMAT" Manufactured Material (CodeSystem: EntityClass 2.16.840.1.113883.5.41 **STATIC**) (CONF:1098-7407).
          2. This playingEntity **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet **Substance-Reactant for Intolerance** 2.16.840.1.113762.1.4.1010.1 **DYNAMIC** (CONF:1098-7419).
13. **SHOULD** contain zero or more [0..*] **entryRelationship** (CONF:1098-7447) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="MFST" Is Manifestation of (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7907).
    b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-7449).

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c. **SHALL** contain exactly one [1..1] **Reaction Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09) (CONF:1098-15955).

14. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1098-9961) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-9962).

b. **SHALL** contain exactly one [1..1] **@inversionInd**="true" True (CONF:1098-9964).

c. **SHALL** contain exactly one [1..1] **Severity Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09) (CONF:1098-15956).

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Figure 236: Allergy - Intolerance Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <!-- ** Allergy observation ** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.7" extension="2014-06-09" />
    <id root="901db0f8-9355-4794-81cd-fd951ef07917" />
    <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />
    <!-- Observation statusCode represents the status of the act of observing -->
    <statusCode code="completed" />
    <effectiveTime>
        <!-- The low value reflects the date of onset of the allergy -->
        <low nullFlavor="UNK" />
        <!-- The high value reflects when the allergy was known to be resolved
            (and will generally be absent) -->
    </effectiveTime>
    <value xsi:type="CD" code="419199007" displayName="Allergy to substance"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" />
    <author>
        <time value="201010110915-0800" />
        <assignedAuthor>
            <id extension="222223333" root="1.1.1.1.1.1.1.3" />
        </assignedAuthor>
    </author>
    <participant typeCode="CSM">
        <participantRole classCode="MANU">
            <playingEntity classCode="MMAT">
                <code code="2670" displayName="Codeine" codeSystem="2.16.840.1.113883.6.88"
codeSystemName="RxNorm" />
            </playingEntity>
        </participantRole>
    </participant>
    <entryRelationship typeCode="MFST" inversionInd="true">
        <observation classCode="OBS" moodCode="EVN">
            <!-- ** Reaction observation ** -->
            <templateId root="2.16.840.1.113883.10.20.22.4.9" extension="2014-06-09" />
            <id root="38c63dea-1a43-4f84-ab71-1ffd04f6a1dd" />
            <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />
            <text>
                <reference value="#reaction2" />
            </text>
            <statusCode code="completed" />
            <effectiveTime>
                <low nullFlavor="UNK" />
            </effectiveTime>
            <value xsi:type="CD" code="56018004" displayName="Wheezing"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" />
        </observation>
    </entryRelationship>
    <entryRelationship typeCode="SUBJ" inversionInd="true">
        <observation classCode="OBS" moodCode="EVN">
            <!-- ** Severity observation ** -->
            <templateId root="2.16.840.1.113883.10.20.22.4.8" extension="2014-06-09" />
            <code code="SEV" displayName="Severity Observation"
codeSystem="2.16.840.1.113883.5.4" codeSystemName="ActCode" />
            <text>
                <reference value="#allergyseverity2" />
            </text>
```


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```
            <statusCode code="completed" />
            <value xsi:type="CD" code="255604002" displayName="Mild"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" />
        </observation>
    </entryRelationship>
</observation>
```

4.104Text Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.6.2.12 (open)]

Table 487: Text Observation Contexts

Contained By:	Contains:
Diagnostic Imaging Report (V2) (optional)	Quantity Measurement Observation 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.

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Table 488: Text Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.12)					
@classCode	1..1	SHALL		81-9288	2.16.840.1.113883.5.4 (ActCode) = OBS
@moodCode	1..1	SHALL		81-9289	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		81-9290	
@root	1..1	SHALL		81-10534	2.16.840.1.113883.10.20.6.2.12
code	1..1	SHALL		81-9291	
text	0..1	MAY		81-9295	
reference	0..1	SHOULD		81-15938	
@value	0..1	SHOULD		81-15939	
effectiveTime	0..1	SHOULD		81-9294	
value	1..1	SHALL	ED	81-9292	
entryRelationship	0..*	MAY		81-9298	
@typeCode	1..1	SHALL		81-9299	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT
observation	1..1	SHALL		81-15941	SOP Instance Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8
entryRelationship	0..*	MAY		81-9301	
@typeCode	1..1	SHALL		81-9302	2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SPRT
observation	1..1	SHALL		81-15942	Quantity Measurement Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.14

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" Observation (CodeSystem: `ActCode` `2.16.840.1.113883.5.4` **STATIC**) (CONF:81-9288).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood` `2.16.840.1.113883.5.1001` **STATIC**) (CONF:81-9289).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-9290) such that it

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   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.6.2.12" (CONF:81-10534).
4. **SHALL** contain exactly one [1..1] **code** (CONF:81-9291).
5. **MAY** contain zero or one [0..1] **text** (CONF:81-9295).
   a. The text, if present, **SHOULD** contain zero or one [0..1] **reference** (CONF:81-15938).
      i. The reference, if present, **SHOULD** contain zero or one [0..1] **@value** (CONF:81-15939).
         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:81-15940).
6. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:81-9294).
7. **SHALL** contain exactly one [1..1] **value** with @xsi:type="ED" (CONF:81-9292).
8. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:81-9298) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-9299).
   b. **SHALL** contain exactly one [1..1] **SOP Instance Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8) (CONF:81-15941).
9. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:81-9301) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**) (CONF:81-9302).
   b. **SHALL** contain exactly one [1..1] **Quantity Measurement Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.14) (CONF:81-15942).

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Figure 237: 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>
```

4.105Tobacco Use (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09 (open)]

Table 489: Tobacco Use (V2) Contexts

Contained By:	Contains:
Social History Section (V2) (optional) Health Concern Act (optional) Risk Concern Act (optional)	Author Participation

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. Whereas the Smoking Status - Meaningful Use (V2) template (2.16.840.1.113883.10.20.22.4.78:2014-06-09) represents a "snapshot in time" observation, simply reflecting what the patient's current smoking status is at the time of the observation, this Tobacco Use template uses effectiveTime to represent the biologically relevant time of the

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observation. Thus, to record a former smoker, an observation of "cigarette smoker" will have an effectiveTime/low defining the time the patient started to smoke cigarettes and an effectiveTime/high defining the time the patient ceased to smoke cigarettes. To record a current smoker, the effectiveTime/low will define the time the patient started smoking and will have no effectiveTime/high to indicated that the patient is still smoking.

Table 490: Tobacco Use (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09)					
@classCode	1..1	SHALL		1098-16558	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-16559	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-16566	
@root	1..1	SHALL		1098-16567	2.16.840.1.113883.10.20.22.4.85
@extension	1..1	SHALL		1098-32589	2014-06-09
id	1..*	SHALL		1098-32400	
code	1..1	SHALL		1098-19174	
@code	1..1	SHALL		1098-19175	11367-0
@codeSystem	1..1	SHALL		1098-32172	2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-16561	
@code	1..1	SHALL		1098-19118	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-16564	
low	1..1	SHALL		1098-16565	
high	0..1	MAY		1098-31431	
value	1..1	SHALL	CD	1098-16562	
@code	1..1	SHALL		1098-16563	2.16.840.1.113883.11.20.9.41 (Tobacco Use)
author	0..*	SHOULD		1098-31152	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119

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1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-16558).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-16559).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16566) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.85" (CONF:1098-16567).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32589).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-32400).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-19174).
    a. This code **SHALL** contain exactly one [1..1] **@code**="11367-0" History of tobacco use (CONF:1098-19175).
    b. 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:1098-32172).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-16561).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19118).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-16564).
   Note: The effectiveTime represents the biologically relevant time of the observation. Thus, an observation of “former smoker” will have an effectiveTime defining the time during which the patient has been a former smoker; an observation of “current smoker” will have an effectiveTime defining the time during which the patient has been a current smoker.
    a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1098-16565).
    b. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:1098-31431).
8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD" (CONF:1098-16562).
    a. This value **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **Tobacco Use** 2.16.840.1.113883.11.20.9.41 **DYNAMIC** (CONF:1098-16563).
9. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31152).

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Table 491: Tobacco Use

Value Set: Tobacco Use 2.16.840.1.113883.11.20.9.41 Contains values descending from the SNOMED CT® Finding of tobacco use and exposure (finding) (365980008) hierarchy. Value Set Source: http://vtsl.vetmed.vt.edu/TerminologyMgt/RF2Browser/ISA.cfm?SCT_ConceptID=365980008			
Code	**Code System**	**Code System OID**	**Print Name**
81703003	SNOMED CT	2.16.840.1.113883.6.96	Chews tobacco
228494002	SNOMED CT	2.16.840.1.113883.6.96	Snuff user
59978006	SNOMED CT	2.16.840.1.113883.6.96	Cigar smoker
43381005	SNOMED CT	2.16.840.1.113883.6.96	Passive smoker
228524006	SNOMED CT	2.16.840.1.113883.6.96	Exposed to tobacco smoke at home
427189007	SNOMED CT	2.16.840.1.113883.6.96	Maternal tobacco use
394871007	SNOMED CT	2.16.840.1.113883.6.96	Thinking about stopping smoking
65568007	SNOMED CT	2.16.840.1.113883.6.96	Cigarette smoker
160619003	SNOMED CT	2.16.840.1.113883.6.96	Rolls own cigarettes
266927001	SNOMED CT	2.16.840.1.113883.6.96	Pipe smoker
…			

Figure 238: Tobacco Use (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <!-- ** Tobacco use ** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.85" extension="2014-06-09" />
    <id root="45efb604-7049-4a2e-ad33-d38556c9636c" />
    <code code="11367-0" codeSystem="2.16.840.1.113883.6.1" displayName="History of tobacco
use" />
    <statusCode code="completed" />
    <effectiveTime>
        <!-- The low value reflects the start date of the observation/value (moderate
smoker) -->
        <low value="20090214" />
        <!-- The high value reflects the end date of the observation/value (moderate
smoker) -->
        <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 typeCode="AUT">
        <time value="201209101145-0800" />
        <assignedAuthor>
            <id extension="555555555" root="1.1.1.1.1.1.1.2" />
        </assignedAuthor>
    </author>
</observation>
```


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4.106 Vital Sign Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09 (open)]

Table 492: Vital Sign Observation (V2) Contexts

Contained By:	Contains:
Health Concern Act (optional) Vital Signs Organizer (V2) (required) Risk Concern Act (optional)	Author Participation

This template represents measurement of common vital signs. Vital signs are represented with additional vocabulary constraints for type of vital sign and unit of measure.

The following is a list of recommended units for common types of vital sign measurements:

Name	Unit
PulseOx	%
Height/Head Circumf	cm
Weight	kg
Temp	Cel
BP	mm[Hg]
Pulse/Resp Rate	/min
BMI	kg/m2
BSA	m2

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Table 493: Vital Sign Observation (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09)					
@classCode	1..1	SHALL		1098-7297	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-7298	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7299	
@root	1..1	SHALL		1098-10527	2.16.840.1.113883.10.20.22.4.27
@extension	1..1	SHALL		1098-32574	2014-06-09
id	1..*	SHALL		1098-7300	
code	1..1	SHALL		1098-7301	2.16.840.1.113883.3.88.12.80.62 (Vital Sign Result)
statusCode	1..1	SHALL		1098-7303	
@code	1..1	SHALL		1098-19119	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-7304	
value	1..1	SHALL	PQ	1098-7305	
@unit	1..1	SHALL		1098-31579	2.16.840.1.113883.1.11.12839 (UnitsOfMeasureCaseSensitive)
interpretationCode	0..1	MAY		1098-7307	
@code	1..1	SHALL		1098-32886	2.16.840.1.113883.1.11.78 (Observation Interpretation (HL7))
methodCode	0..1	MAY	SET<CE>	1098-7308	
targetSiteCode	0..1	MAY	SET<CD>	1098-7309	
author	0..*	SHOULD		1098-7310	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7297).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7298).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7299) such that it

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a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.27" (CONF:1098-10527).

b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32574).

4. **SHALL** contain at least one [1..*] **id** (CONF:1098-7300).
5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **Vital Sign Result** 2.16.840.1.113883.3.88.12.80.62 **DYNAMIC** (CONF:1098-7301).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7303).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19119).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-7304).
8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="PQ" (CONF:1098-7305).
   a. This value **SHALL** contain exactly one [1..1] **@unit**, which **SHALL** be selected from ValueSet **UnitsOfMeasureCaseSensitive** 2.16.840.1.113883.1.11.12839 **DYNAMIC** (CONF:1098-31579).
9. **MAY** contain zero or one [0..1] **interpretationCode** (CONF:1098-7307).
   a. The interpretationCode, if present, **SHALL** contain exactly one [1..1] **@code** (ValueSet: **Observation Interpretation (HL7)** 2.16.840.1.113883.1.11.78 **STATIC** 2014-09-01) (CONF:1098-32886).
10. **MAY** contain zero or one [0..1] **methodCode** (CONF:1098-7308).
11. **MAY** contain zero or one [0..1] **targetSiteCode** (CONF:1098-7309).
12. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-7310).

Table 494: Vital Sign Result

Value Set: Vital Sign Result 2.16.840.1.113883.3.88.12.80.62 This identifies the vital sign result type. Specific URL Pending Value Set Source: **http://www.loinc.org/**			
Code	**Code System**	**Code System OID**	**Print Name**
8310-5	LOINC	2.16.840.1.113883.6.1	Body Temperature
8462-4	LOINC	2.16.840.1.113883.6.1	BP Diastolic
8480-6	LOINC	2.16.840.1.113883.6.1	BP Systolic
8287-5	LOINC	2.16.840.1.113883.6.1	Head Circumference
8867-4	LOINC	2.16.840.1.113883.6.1	Heart Rate
8302-2	LOINC	2.16.840.1.113883.6.1	Height
39156-5	LOINC	2.16.840.1.113883.6.1	BMI (Body Mass Index)
2710-2	LOINC	2.16.840.1.113883.6.1	O2 % BldC Oximetry
9279-1	LOINC	2.16.840.1.113883.6.1	Respiratory Rate
3141-9	LOINC	2.16.840.1.113883.6.1	Weight Measured
…			

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Figure 239: Vital Sign Observation (V2) Example

```
<observation classCode="OBS" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.27" extension="2014-06-09" />
    <!-- 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" />
    ....
</observation>
```

4.107 Vital Signs Organizer (V2)

[organizer: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.26:2014-06-09 (open)]

Table 495: Vital Signs Organizer (V2) Contexts

Contained By:	**Contains:**
Vital Signs Section (entries optional) (V2) (optional) Vital Signs Section (entries required) (V2) (required)	Author Participation Vital Sign Observation (V2)

This template provides a mechanism for grouping vital signs (e.g., grouping systolic blood pressure and diastolic blood pressure).

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Table 496: Vital Signs Organizer (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
organizer (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.26:2014-06-09)					
@classCode	1..1	SHALL		1098-7279	2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER
@moodCode	1..1	SHALL		1098-7280	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-7281	
@root	1..1	SHALL		1098-10528	2.16.840.1.113883.10.20.22.4.26
@extension	1..1	SHALL		1098-32582	2014-06-09
id	1..*	SHALL		1098-7282	
code	0..1	MAY		1098-32740	
@code	1..1	SHALL		1098-32741	2.16.840.1.113883.6.1 (LOINC) = 74728-7
@codeSystem	1..1	SHALL		1098-32742	2.16.840.1.113883.6.1
statusCode	1..1	SHALL		1098-7284	
@code	1..1	SHALL		1098-19120	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	0..1	MAY		1098-7288	
author	0..*	SHOULD		1098-31153	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
component	1..*	SHALL		1098-7285	
observation	1..1	SHALL		1098-15946	Vital Sign Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="`CLUSTER`" CLUSTER (CodeSystem: `HL7ActClass 2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-7279).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-7280).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7281) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.26`" (CONF:1098-10528).
   b. **SHALL** contain exactly one [1..1] **@extension**="`2014-06-09`" (CONF:1098-32582).

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4. **SHALL** contain at least one [1..*] **id** (CONF:1098-7282).
5. **MAY** contain zero or one [0..1] **code** (CONF:1098-32740).
    a. The code, if present, **SHALL** contain exactly one [1..1] **@code**="74728-7" Vital signs, weight, height, head circumference, oximetry, BMI, and BSA panel - HL7.CCDAr1.1 (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:1098-32741).
    b. The code, if present, **SHALL** contain exactly one [1..1] **@codeSystem**="2.16.840.1.113883.6.1 " LOINC (CONF:1098-32742).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7284).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-19120).
7. **MAY** contain zero or one [0..1] **effectiveTime** (CONF:1098-7288).
   Note: The effectiveTime is an interval that spans the effectiveTimes of the contained vital signs observations. Because all contained vital signs observations have a required time stamp, it is not required that this effectiveTime be populated.
8. **SHOULD** contain zero or more [0..*] **Author Participation** (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31153).
9. **SHALL** contain at least one [1..*] **component** (CONF:1098-7285) such that it
    a. **SHALL** contain exactly one [1..1] **Vital Sign Observation (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09) (CONF:1098-15946).

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Figure 240: Vital Signs Organizer (V2) Example

```
<organizer classCode="CLUSTER" moodCode="EVN">
    <!-- ** Vital signs organizer ** -->
    <templateId root="2.16.840.1.113883.10.20.22.4.26" extension="2014-06-09" />
    <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>
        <low value="20120910" />
        <high value="20120910" />
    </effectiveTime>
    <component>
        <observation classCode="OBS" moodCode="EVN">
            <templateId root="2.16.840.1.113883.10.20.22.4.27" extension="2014-06-09" />
            <!-- Vital Sign Observation template -->
            ...
        </observation>
    </component>
    <component>
        <observation classCode="OBS" moodCode="EVN">
            <templateId root="2.16.840.1.113883.10.20.22.4.27" extension="2014-06-09" />
            <!-- Vital Sign Observation template -->
            ...
        </observation>
    </component>
    <component>
        <observation classCode="OBS" moodCode="EVN">
            <templateId root="2.16.840.1.113883.10.20.22.4.27" extension="2014-06-09" />
            <!-- Vital Sign Observation template -->
            ...
        </observation>
    </component>
</organizer>
```

4.108 Wound Characteristic

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.134 (open)]

Table 497: Wound Characteristic Contexts

Contained By:	Contains:
Longitudinal Care Wound Observation (optional)	

This template represents characteristics of a wound (e.g., integrity of suture line, odor, erythema).

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Table 498: Wound Characteristic Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.134)					
@classCode	1..1	SHALL		1098-29938	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-29939	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-29940	
@root	1..1	SHALL		1098-29941	2.16.840.1.113883.10.20.22.4.134
id	1..*	SHALL		1098-29942	
code	1..1	SHALL		1098-29943	
@code	1..1	SHALL		1098-31540	ASSERTION
@codeSystem	1..1	SHALL		1098-31541	2.16.840.1.113883.5.4 (ActCode) = 2.16.840.1.113883.5.4
statusCode	1..1	SHALL		1098-29944	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-29946	
value	1..1	SHALL	CD	1098-29947	2.16.840.1.113883.11.20.9.58 (Wound Characteristic)

1. **SHALL** contain exactly one [1..1] **@classCode**="`OBS`" (CodeSystem: `HL7ActClass` `2.16.840.1.113883.5.6` **STATIC**) (CONF:1098-29938).
2. **SHALL** contain exactly one [1..1] **@moodCode**="`EVN`" (CodeSystem: `ActMood` `2.16.840.1.113883.5.1001` **STATIC**) (CONF:1098-29939).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-29940) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="`2.16.840.1.113883.10.20.22.4.134`" (CONF:1098-29941).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-29942).
5. **SHALL** contain exactly one [1..1] **code** (CONF:1098-29943).
   a. This code **SHALL** contain exactly one [1..1] **@code**="`ASSERTION`" assertion (CONF:1098-31540).
   b. 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:1098-31541).
6. **SHALL** contain exactly one [1..1] **statusCode**="`completed`" (CodeSystem: `ActStatus` `2.16.840.1.113883.5.14` **STATIC**) (CONF:1098-29944).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-29946).

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8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHALL** be selected from ValueSet **Wound Characteristic** 2.16.840.1.113883.11.20.9.58 **DYNAMIC** (CONF:1098-29947).

Table 499: Wound Characteristic

Value Set: Wound Characteristic 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 Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
239165001	SNOMED CT	2.16.840.1.113883.6.96	Wound granuloma
239163008	SNOMED CT	2.16.840.1.113883.6.96	Wound erythema
409590008	SNOMED CT	2.16.840.1.113883.6.96	Skin eschar
449746002	SNOMED CT	2.16.840.1.113883.6.96	Wound slough
445916002	SNOMED CT	2.16.840.1.113883.6.96	Wound odor
239164002	SNOMED CT	2.16.840.1.113883.6.96	Wound discharge
447547000	SNOMED CT	2.16.840.1.113883.6.96	Offensive wound odor
271618001	SNOMED CT	2.16.840.1.113883.6.96	Impaired wound healing
449744004	SNOMED CT	2.16.840.1.113883.6.96	Induration of wound
298008006	SNOMED CT	2.16.840.1.113883.6.96	Wound moist
…			

Figure 241: Wound Characteristic Example

```
<entryRelationship typeCode="COMP">
    <observation classCode="OBS" moodCode="EVN">
        <!-- Wound Characteristic -->
        <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>
```


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4.109 Wound Measurement Observation

[observation: identifier urn:oid:2.16.840.1.113883.10.20.22.4.133 (open)]

Table 500: Wound Measurement Observation Contexts

Contained By:	Contains:
Longitudinal Care Wound Observation (optional)	

This template represents the Wound Measurement Observations of wound width, depth and length.

Table 501: Wound Measurement Observation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.133)					
@classCode	1..1	SHALL		1098-29926	2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		1098-29927	2.16.840.1.113883.5.1001 (ActMood) = EVN
templateId	1..1	SHALL		1098-29928	
@root	1..1	SHALL		1098-29929	2.16.840.1.113883.10.20.22.4.133
id	1..*	SHALL		1098-29930	
code	1..1	SHALL		1098-29931	2.16.840.1.113883.1.11.20.2.5 (Wound Measurements)
statusCode	1..1	SHALL		1098-29933	
@code	1..1	SHALL		1098-29934	2.16.840.1.113883.5.14 (ActStatus) = completed
effectiveTime	1..1	SHALL		1098-29935	
value	1..1	SHALL	PQ	1098-29936	

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-29926).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-29927).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-29928) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.133" (CONF:1098-29929).
4. **SHALL** contain at least one [1..*] **id** (CONF:1098-29930).
5. **SHALL** contain exactly one [1..1] **code** (ValueSet: **Wound Measurements** 2.16.840.1.113883.1.11.20.2.5 **DYNAMIC**) (CONF:1098-29931).

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6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-29933).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 **STATIC**) (CONF:1098-29934).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-29935).
8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="PQ" (CONF:1098-29936).

Table 502: Wound Measurements

Value Set: Wound Measurements 2.16.840.1.113883.1.11.20.2.5 A value set of SNOMED-CT codes to capture the dimensions of a wound. Specific URL Pending Value Set Source: **https://vsac.nlm.nih.gov**			
Code	**Code System**	**Code System OID**	**Print Name**
39125-0	LOINC	2.16.840.1.113883.6.1	Width of Wound
39127-6	LOINC	2.16.840.1.113883.6.1	Depth of Wound
39126-8	LOINC	2.16.840.1.113883.6.1	Length of Wound

Figure 242: 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>
```


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5 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 .

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5.1 Author Participation

[author: identifier urn:oid:2.16.840.1.113883.10.20.22.4.119 (open)]

Table 503: Author Participation Contexts

Contained By:	Contains:
Sensory Status (optional) Self-Care Activities (ADL and IADL) (optional) Social History Observation (V2) (optional) Advance Directive Observation (V2) (optional) Advance Directive Organizer (optional) Medication Activity (V2) (optional) Longitudinal Care Wound Observation (optional) Procedure Activity Act (V2) (optional) Procedure Activity Procedure (V2) (optional) Procedure Activity Observation (V2) (optional) Problem Observation (V2) (optional) Problem Concern Act (V2) (optional) Goal Observation (required) Allergy - Intolerance Observation (V2) (optional) Substance or Device Allergy - Intolerance Observation (V2) (optional) Immunization Activity (V2) (optional) Nutrition Assessment (optional) Allergy Concern Act (V2) (optional) Planned Act (V2) (optional) Planned Encounter (V2) (optional) Planned Procedure (V2) (optional) Planned Observation (V2) (optional) Planned Supply (V2) (optional) Planned Medication Activity (V2) (optional) Health Concern Act (optional) Mental Status Observation (V2) (optional) Functional Status Observation (V2) (optional) Functional Status Organizer (V2) (optional) Handoff Communication Participants (required) Patient Referral Act (optional) Smoking Status - Meaningful Use (V2) (optional) Vital Sign Observation (V2) (optional) Result Observation (V2) (optional) Vital Signs Organizer (V2) (optional) Priority Preference (optional) Intervention Act (optional) Result Organizer (V2) (optional) Tobacco Use (V2) (optional) Outcome Observation (optional) Planned Coverage (optional) Planned Immunization Activity (optional)	

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Contained By:	Contains:
Risk Concern Act (optional) Planned Intervention Act (optional)	

This template represents the Author Participation (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.

The Author Participation template was added to those templates in scope for analysis in R2. Although it is not explicitly stated in all templates the Author Participation template can be used in any template.

Table 504: Author Participation Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
author (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119)					
templateId	1..1	SHALL		1098-32017	
@root	1..1	SHALL		1098-32018	2.16.840.1.113883.10.20.22.4.119
time	1..1	SHALL		1098-31471	
assignedAuthor	1..1	SHALL		1098-31472	
id	1..*	SHALL		1098-31473	
code	0..1	SHOULD		1098-31671	2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy (HIPAA))
assignedPerson	0..1	MAY		1098-31474	
name	0..*	MAY		1098-31475	
representedOrganization	0..1	MAY		1098-31476	
@classCode	1..1	SHALL		1098-31477	ORG
id	0..*	MAY		1098-31478	
name	0..*	MAY		1098-31479	
telecom	0..*	MAY		1098-31480	
addr	0..*	MAY		1098-31481	

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1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-32017) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.119" (CONF:1098-32018).
2. **SHALL** contain exactly one [1..1] **time** (CONF:1098-31471).
3. **SHALL** contain exactly one [1..1] **assignedAuthor** (CONF:1098-31472).
    a. This assignedAuthor **SHALL** contain at least one [1..*] **id** (CONF:1098-31473). Note: 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. This id must be a pointer to another author participant.
        i. If the ID isn't referencing an author described elsewhere in the document, then the author components required in US Realm Header are required here as well (CONF:1098-32628).
    b. This assignedAuthor **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:1098-31671).
        i. If the content is patient authored the code **SHOULD** be selected from Personal And Legal Relationship Role Type (2.16.840.1.113883.11.20.12.1) (CONF:1098-32315).
    c. This assignedAuthor **MAY** contain zero or one [0..1] **assignedPerson** (CONF:1098-31474).
        i. The assignedPerson, if present, **MAY** contain zero or more [0..*] **name** (CONF:1098-31475).
    d. This assignedAuthor **MAY** contain zero or one [0..1] **representedOrganization** (CONF:1098-31476).
        i. The representedOrganization, if present, **SHALL** contain exactly one [1..1] **@classCode**="ORG" (CONF:1098-31477).
        ii. The representedOrganization, if present, **MAY** contain zero or more [0..*] **id** (CONF:1098-31478).
        iii. The representedOrganization, if present, **MAY** contain zero or more [0..*] **name** (CONF:1098-31479).
        iv. The representedOrganization, if present, **MAY** contain zero or more [0..*] **telecom** (CONF:1098-31480).
        v. The representedOrganization, if present, **MAY** contain zero or more [0..*] **addr** (CONF:1098-31481).

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Figure 243: New Author Participant Example

```
<author>
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    <time value="201308011235-0800" />
    <assignedAuthor>
        <id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c" />
        <code code="163W00000X" codeSystem="2.16.840.1.113883.5.53" 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 244: 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>
```

5.2 Physician of Record Participant (V2)

[encounterParticipant: identifier urn:hl7ii:2.16.840.1.113883.10.20.6.2.2:2014-06-09 (open)]

Table 505: Physician of Record Participant (V2) Contexts

Contained By:	Contains:
Diagnostic Imaging Report (V2) (optional)	US Realm Person Name (PN.US.FIELDED)

This encounterParticipant is the attending physician and is usually different from the Physician Reading Study Performer defined in documentationOf/serviceEvent.

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Table 506: Physician of Record Participant (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
encounterParticipant (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.2:2014-06-09)					
@typeCode	1..1	SHALL		1098-8881	2.16.840.1.113883.5.90 (HL7ParticipationType) = ATND
templateId	1..1	SHALL		1098-16072	
@root	1..1	SHALL		1098-16073	2.16.840.1.113883.10.20.6.2.2
@extension	1..1	SHALL		1098-32586	2014-06-09
assignedEntity	1..1	SHALL		1098-8886	
id	1..*	SHALL		1098-8887	
code	1..1	SHALL		1098-8888	
assignedPerson	0..1	SHOULD		1098-30928	
name	1..1	SHALL		1098-30929	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
representedOrganization	0..1	MAY		1098-16074	
name	0..1	SHOULD		1098-16075	

1. **SHALL** contain exactly one [1..1] **@typeCode**="ATND" Attender (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-8881).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16072) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.6.2.2" (CONF:1098-16073).
   b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32586).
3. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-8886).
   a. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-8887).
      i. **SHOULD** contain zero or one [0..1] **id** such that **@root="2.16.840.1.113883.4.6"** National Provider Identifier (CONF:1098-31203).
   b. This assignedEntity **SHALL** contain exactly one [1..1] **code** (CONF:1098-8888).
      i. **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

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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:1098-8889).

c. This assignedEntity **SHOULD** contain zero or one [0..1] **assignedPerson** (CONF:1098-30928).
   i. The assignedPerson, if present, **SHALL** contain exactly one [1..1] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-30929).

d. This assignedEntity **MAY** contain zero or one [0..1] **representedOrganization** (CONF:1098-16074).
   i. The representedOrganization, if present, **SHOULD** contain zero or one [0..1] **name** (CONF:1098-16075).

Figure 245: Physician of Record Participant (V2) Example

```
<encounterParticipant typeCode="ATND">
    <templateId root="2.16.840.1.113883.10.20.6.2.2" extension="2014-06-09" />
    <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>
```

5.3 Physician Reading Study Performer (V2)

[performer: identifier urn:hl7ii:2.16.840.1.113883.10.20.6.2.1:2014-06-09 (open)]

Table 507: Physician Reading Study Performer (V2) Contexts

Contained By:	Contains:
Diagnostic Imaging Report (V2) (optional)	US Realm Date and Time (DT.US.FIELDED)

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).

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Table 508: Physician Reading Study Performer (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
performer (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.1:2014-06-09)					
@typeCode	1..1	SHALL		1098-8424	2.16.840.1.113883.5.6 (HL7ActClass) = PRF
templateId	1..1	SHALL		1098-30773	
@root	1..1	SHALL		1098-30774	2.16.840.1.113883.10.20.6.2.1
@extension	1..1	SHALL		1098-32564	2014-06-09
time	0..1	MAY		1098-8425	US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3
assignedEntity	1..1	SHALL		1098-8426	
id	1..*	SHALL		1098-10033	
code	1..1	SHALL		1098-8427	

1. **SHALL** contain exactly one [1..1] **@typeCode**="PRF" Performer (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-8424).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-30773).
   a. This templateId **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.6.2.1" (CONF:1098-30774).
   b. This templateId **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32564).
3. **MAY** contain zero or one [0..1] **US Realm Date and Time (DT.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1098-8425).
4. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1098-8426).
   a. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1098-10033).
   b. This assignedEntity **SHALL** contain exactly one [1..1] **code** (CONF:1098-8427).
      i. **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:1098-8428).
   c. Every assignedEntity element **SHALL** contain at least one [1..*] assignedPerson or representedOrganization (CONF:1098-8429).
   d. The id **SHOULD** include zero or one [0..1] **id** where id/@root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1098-32135).

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Figure 246: Physician Reading Study Performer (V2) Example

```
<performer typeCode="PRF">
    <templateId root="2.16.840.1.113883.10.20.6.2.1" extension="2014-06-09" />
    <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>
```

5.4 US Realm Address (AD.US.FIELDED)

[addr: identifier urn:oid:2.16.840.1.113883.10.20.22.5.2 (open)]

Table 509: US Realm Address (AD.US.FIELDED) Contexts

Contained By:	Contains:
Advance Directive Observation (V2) (optional) US Realm Header (V2) (required) Medication Dispense (V2) (optional) Policy Activity (V2) (optional)	

Reusable address template, for use in US Realm CDA Header.

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Table 510: US Realm Address (AD.US.FIELDED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
addr (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)					
@use	0..1	SHOULD		81-7290	2.16.840.1.113883.1.11.10637 (PostalAddressUse)
country	0..1	SHOULD		81-7295	2.16.840.1.113883.3.88.12.80.63 (Country)
state	0..1	SHOULD	ST	81-7293	2.16.840.1.113883.3.88.12.80.1 (StateValueSet)
city	1..1	SHALL	ST	81-7292	
postalCode	0..1	SHOULD		81-7294	2.16.840.1.113883.3.88.12.80.2 (PostalCode)
streetAddressLine	1..4	SHALL	ST	81-7291	

1. **SHOULD** contain zero or one [0..1] **@use**, which **SHALL** be selected from ValueSet **PostalAddressUse** 2.16.840.1.113883.1.11.10637 **STATIC** 2005-05-01 (CONF:81-7290).
2. **SHOULD** contain zero or one [0..1] **country**, which **SHALL** be selected from ValueSet **Country** 2.16.840.1.113883.3.88.12.80.63 **DYNAMIC** (CONF:81-7295).
3. **SHOULD** contain zero or one [0..1] **state** (ValueSet: **StateValueSet** 2.16.840.1.113883.3.88.12.80.1 **DYNAMIC**) (CONF:81-7293).
    a. 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:81-10024).
4. **SHALL** contain exactly one [1..1] **city** (CONF:81-7292).
5. **SHOULD** contain zero or one [0..1] **postalCode**, which **SHOULD** be selected from ValueSet **PostalCode** 2.16.840.1.113883.3.88.12.80.2 **DYNAMIC** (CONF:81-7294).
    a. 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:81-10025).
6. **SHALL** contain at least one and not more than 4 **streetAddressLine** (CONF:81-7291).
7. **SHALL NOT** have mixed content except for white space (CONF:81-7296).

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Table 511: PostalAddressUse

Value Set: PostalAddressUse 2.16.840.1.113883.1.11.10637 A value set of HL7 Codes for address use. Value Set Source: http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html			
Code	**Code System**	**Code System OID**	**Print Name**
BAD	AddressUse	2.16.840.1.113883.5.1119	bad address
CONF	AddressUse	2.16.840.1.113883.5.1119	confidential
DIR	AddressUse	2.16.840.1.113883.5.1119	direct
H	AddressUse	2.16.840.1.113883.5.1119	home address
HP	AddressUse	2.16.840.1.113883.5.1119	primary home
HV	AddressUse	2.16.840.1.113883.5.1119	vacation home
PHYS	AddressUse	2.16.840.1.113883.5.1119	physical visit address
PST	AddressUse	2.16.840.1.113883.5.1119	postal address
PUB	AddressUse	2.16.840.1.113883.5.1119	public
TMP	AddressUse	2.16.840.1.113883.5.1119	temporary
…			

Table 512: 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 Value Set Source: http://www.itl.nist.gov/fipspubs/fip5-2.htm			
Code	**Code System**	**Code System OID**	**Print Name**
AL	FIPS 5-2 (State)	2.16.840.1.113883.6.92	Alabama
AK	FIPS 5-2 (State)	2.16.840.1.113883.6.92	Alaska
AZ	FIPS 5-2 (State)	2.16.840.1.113883.6.92	Arizona
…			

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Figure 247: 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>
```

5.5 US Realm Date and Time (DT.US.FIELDED)

[effectiveTime: identifier urn:oid:2.16.840.1.113883.10.20.22.5.3 (open)]

Table 513: US Realm Date and Time (DT.US.FIELDED) Contexts

Contained By:	Contains:
Consultation Note (V2) (required) Diagnostic Imaging Report (V2) (optional) History and Physical (V2) (required) Operative Note (V2) (required) Procedure Note (V2) (required) Progress Note (V2) (required) Physician Reading Study Performer (V2) (optional)	

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 elements having a datatype of IVL_TS.

Table 514: US Realm Date and Time (DT.US.FIELDED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
effectiveTime (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3)					

1. **SHALL** be precise to the day (CONF:81-10078).
2. **SHOULD** be precise to the minute (CONF:81-10079).
3. **MAY** be precise to the second (CONF:81-10080).
4. If more precise than day, **SHOULD** include time-zone offset (CONF:81-10081).

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5.6 US Realm Date and Time (DTM.US.FIELDED)

[effectiveTime: identifier urn:oid:2.16.840.1.113883.10.20.22.5.4 (open)]

Table 515: US Realm Date and Time (DTM.US.FIELDED) Contexts

Contained By:	Contains:
US Realm Header (V2) (required)	

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 (DT.US.FIELDED), but is used with elements having a datatype of TS.

Table 516: US Realm Date and Time (DTM.US.FIELDED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
effectiveTime (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4)					

1. **SHALL** be precise to the day (CONF:81-10127).
2. **SHOULD** be precise to the minute (CONF:81-10128).
3. **MAY** be precise to the second (CONF:81-10129).
4. If more precise than day, **SHOULD** include time-zone offset (CONF:81-10130).

Figure 248: US Realm Date and Time Example

```
<!-- Common values for date/time elements would range in precision to the day YYYYMMDD to
precision to the second with a time zone offset YYYYMMDDHHMMSS - ZZzz -->
<!-- time element with TS data type precise to the day for a birthdate -->
<time value="19800531"/>
<!-- effectiveTime element with IVL<TS> data type precise to the second for an observation
-->
<effectiveTime>
    <low value='20110706122735-0800'/>
    <high value='20110706122815-0800'/>
</effectiveTime>
```


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5.7 US Realm Patient Name (PTN.US.FIELDED)

[name: identifier urn:oid:2.16.840.1.113883.10.20.22.5.1 (open)]

Table 517: US Realm Patient Name (PTN.US.FIELDED) Contexts

Contained By:	Contains:
Drug Monitoring Act (required) Referral Note (optional)	

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/).

Table 518: US Realm Patient Name (PTN.US.FIELDED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
name (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1)					
@use	0..1	MAY		81-7154	2.16.840.1.113883.1.11.15913 (EntityNameUse)
family	1..1	SHALL	ST	81-7159	
@qualifier	0..1	MAY		81-7160	2.16.840.1.113883.11.20.9.26 (EntityPersonNamePartQualifier)
given	1..*	SHALL	ST	81-7157	
@qualifier	0..1	MAY		81-7158	2.16.840.1.113883.11.20.9.26 (EntityPersonNamePartQualifier)
prefix	0..*	MAY	ST	81-7155	
@qualifier	0..1	MAY		81-7156	2.16.840.1.113883.11.20.9.26 (EntityPersonNamePartQualifier)
suffix	0..1	MAY	ST	81-7161	
@qualifier	0..1	MAY		81-7162	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** 2.16.840.1.113883.1.11.15913 **STATIC** 2005-05-01 (CONF:81-7154).
2. **SHALL** contain exactly one [1..1] **family** (CONF:81-7159).
    a. This family **MAY** contain zero or one [0..1] **@qualifier**, which **SHALL** be selected from ValueSet **EntityPersonNamePartQualifier** 2.16.840.1.113883.11.20.9.26 **STATIC** 2011-09-30 (CONF:81-7160).

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3. **SHALL** contain at least one [1..*] **given** (CONF:81-7157).
    a. Such givens **MAY** contain zero or one [0..1] **@qualifier**, which **SHALL** be selected from ValueSet **EntityPersonNamePartQualifier** 2.16.840.1.113883.11.20.9.26 **STATIC** 2011-09-30 (CONF:81-7158).
    b. The second occurrence of given (given2]) if provided, **SHALL** include middle name or middle initial (CONF:81-7163).
4. **MAY** contain zero or more [0..*] **prefix** (CONF:81-7155).
    a. The prefix, if present, **MAY** contain zero or one [0..1] **@qualifier**, which **SHALL** be selected from ValueSet **EntityPersonNamePartQualifier** 2.16.840.1.113883.11.20.9.26 **STATIC** 2011-09-30 (CONF:81-7156).
5. **MAY** contain zero or one [0..1] **suffix** (CONF:81-7161).
    a. The suffix, if present, **MAY** contain zero or one [0..1] **@qualifier**, which **SHALL** be selected from ValueSet **EntityPersonNamePartQualifier** 2.16.840.1.113883.11.20.9.26 **STATIC** 2011-09-30 (CONF:81-7162).
6. **SHALL NOT** have mixed content except for white space (CONF:81-7278).

Table 519: EntityNameUse

Value Set: EntityNameUse 2.16.840.1.113883.1.11.15913 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
A	EntityNameUse	2.16.840.1.113883.5.45	Artist/Stage
ABC	EntityNameUse	2.16.840.1.113883.5.45	Alphabetic
ASGN	EntityNameUse	2.16.840.1.113883.5.45	Assigned
C	EntityNameUse	2.16.840.1.113883.5.45	License
I	EntityNameUse	2.16.840.1.113883.5.45	Indigenous/Tribal
IDE	EntityNameUse	2.16.840.1.113883.5.45	Ideographic
L	EntityNameUse	2.16.840.1.113883.5.45	Legal
P	EntityNameUse	2.16.840.1.113883.5.45	Pseudonym
PHON	EntityNameUse	2.16.840.1.113883.5.45	Phonetic
R	EntityNameUse	2.16.840.1.113883.5.45	Religious
…			

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Table 520: EntityPersonNamePartQualifier

Value Set: EntityPersonNamePartQualifier 2.16.840.1.113883.11.20.9.26 Value Set Source: http://www.hl7.org			
Code	**Code System**	**Code System OID**	**Print Name**
AC	EntityNamePartQualifier	2.16.840.1.113883.5.43	academic
AD	EntityNamePartQualifier	2.16.840.1.113883.5.43	adopted
BR	EntityNamePartQualifier	2.16.840.1.113883.5.43	birth
CL	EntityNamePartQualifier	2.16.840.1.113883.5.43	callme
IN	EntityNamePartQualifier	2.16.840.1.113883.5.43	initial
NB	EntityNamePartQualifier	2.16.840.1.113883.5.43	nobility
PR	EntityNamePartQualifier	2.16.840.1.113883.5.43	professional
SP	EntityNamePartQualifier	2.16.840.1.113883.5.43	spouse
TITLE	EntityNamePartQualifier	2.16.840.1.113883.5.43	title
VV	EntityNamePartQualifier	2.16.840.1.113883.5.43	voorvoegsel

Figure 249: 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>
```

5.8 US Realm Person Name (PN.US.FIELDED)

[name: identifier urn:oid:2.16.840.1.113883.10.20.22.5.1.1 (open)]

Table 521: US Realm Person Name (PN.US.FIELDED) Contexts

Contained By:	**Contains:**
Advance Directive Observation (V2) (optional) Care Plan (required) Referral Note (required) US Realm Header (V2) (required) Diagnostic Imaging Report (V2) (optional) 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.

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Table 522: US Realm Person Name (PN.US.FIELDED) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
name (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)					
name	1..1	SHALL		81-9368	

1. **SHALL** contain exactly one [1..1] **name** (CONF:81-9368).
    a. The content of name **SHALL** be either a conformant Patient Name (PTN.US.FIELDED), or a string (CONF:81-9371).
    b. The string **SHALL NOT** contain name parts (CONF:81-9372).

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6 TEMPLATE IDS IN THIS GUIDE

Table 523: Template List

Template Title	Template Type	templateId
Care Plan	document	urn:oid:2.16.840.1.113883.10.20.22.1.15
Consultation Note (V2)	document	urn:hl7ii:2.16.840.1.113883.10.20.22.1.4:2014-06-09
Continuity of Care Document (CCD) (V2)	document	urn:hl7ii:2.16.840.1.113883.10.20.22.1.2:2014-06-09
Diagnostic Imaging Report (V2)	document	urn:hl7ii:2.16.840.1.113883.10.20.22.1.5:2014-06-09
Discharge Summary (V2)	document	urn:hl7ii:2.16.840.1.113883.10.20.22.1.8:2014-06-09
History and Physical (V2)	document	urn:hl7ii:2.16.840.1.113883.10.20.22.1.3:2014-06-09
Operative Note (V2)	document	urn:hl7ii:2.16.840.1.113883.10.20.22.1.7:2014-06-09
Procedure Note (V2)	document	urn:hl7ii:2.16.840.1.113883.10.20.22.1.6:2014-06-09
Progress Note (V2)	document	urn:hl7ii:2.16.840.1.113883.10.20.22.1.9:2014-06-09
Referral Note	document	urn:oid:2.16.840.1.113883.10.20.22.1.14
Transfer Summary	document	urn:oid:2.16.840.1.113883.10.20.22.1.13
Unstructured Document (V2)	document	urn:hl7ii:2.16.840.1.113883.10.20.22.1.10:2014-06-09
US Realm Header (V2)	document	urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09
US Realm Header for Patient Generated Document	document	urn:oid:2.16.840.1.113883.10.20.29.1
Admission Diagnosis Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2014-06-09
Admission Medications Section (entries optional) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2014-06-09
Advance Directives Section (entries optional) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09
Advance Directives Section (entries required) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.21.1:2014-06-09
Allergies and Intolerances Section (entries optional) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09
Allergies and Intolerances Section (entries required) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09
Anesthesia Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.

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Template Title	Template Type	templateId
		22.2.25:2014-06-09
Assessment and Plan Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09
Assessment Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.8
Chief Complaint and Reason for Visit Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.13
Chief Complaint Section	section	urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1
Complications (OpNote) (RETIRED)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.32:2014-06-09
Complications Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09
Course of Care Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.64
DICOM Object Catalog Section - DCM 121181	section	urn:oid:2.16.840.1.113883.10.20.6.1.1
Discharge Diagnosis Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2014-06-09
Discharge Diet Section (DEPRECATED)	section	urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.33:2014-06-09
Discharge Medications Section (entries optional) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2014-06-09
Discharge Medications Section (entries required) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.11.1:2014-06-09
Encounters Section (entries optional) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.22:2014-06-09
Encounters Section (entries required) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.22.1:2014-06-09
Family History Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09
Fetus Subject Context	section	urn:oid:2.16.840.1.113883.10.20.6.2.3
Findings Section (DIR)	section	urn:oid:2.16.840.1.113883.10.20.6.1.2
Functional Status Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09
General Status Section	section	urn:oid:2.16.840.1.113883.10.20.2.5
Goals Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.60
Health Concerns Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.58
Health Status Evaluations and Outcomes Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.61
History of Past Illness Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.

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Template Title	Template Type	templateId
		22.2.20:2014-06-09
History of Present Illness Section	section	urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4
Hospital Consultations Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.42
Hospital Course Section	section	urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.5
Hospital Discharge Instructions Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.41
Hospital Discharge Physical Section	section	urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.26
Hospital Discharge Studies Summary Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.16
Immunizations Section (entries optional) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09
Immunizations Section (entries required) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2014-06-09
Implants Section (DEPRECATED)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.33:2014-06-09
Instructions Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09
Interventions Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2014-06-09
Medical (General) History Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.39
Medical Equipment Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09
Medications Administered Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.38:2014-06-09
Medications Section (entries optional) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09
Medications Section (entries required) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09
Mental Status Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.56
MG Test	section	urn:oid:1.2.3.4.5.6.7.8.9.10
Nutrition Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.57
Objective Section	section	urn:oid:2.16.840.1.113883.10.20.21.2.1
Observer Context	section	urn:oid:2.16.840.1.113883.10.20.6.2.4
Operative Note Fluids Section	section	urn:oid:2.16.840.1.113883.10.20.7.12
Operative Note Surgical Procedure Section	section	urn:oid:2.16.840.1.113883.10.20.7.14

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Template Title	Template Type	templateId
Payers Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.18:2014-06-09
Physical Exam Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09
Plan of Treatment Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
Planned Procedure Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.30:2014-06-09
Postoperative Diagnosis Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.35
Postprocedure Diagnosis Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.36:2014-06-09
Preoperative Diagnosis Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.34:2014-06-09
Problem Section (entries optional) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09
Problem Section (entries required) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09
Procedure Description Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.27
Procedure Disposition Section	section	urn:oid:2.16.840.1.113883.10.20.18.2.12
Procedure Estimated Blood Loss Section	section	urn:oid:2.16.840.1.113883.10.20.18.2.9
Procedure Findings Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.28:2014-06-09
Procedure Implants Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.40
Procedure Indications Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.29:2014-06-09
Procedure Specimens Taken Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.31
Procedures Section (entries optional) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09
Procedures Section (entries required) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.7.1:2014-06-09
Reason for Referral Section (V2)	section	urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.1:2014-06-09
Reason for Visit Section	section	urn:oid:2.16.840.1.113883.10.20.22.2.12
Results Section (entries optional) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09
Results Section (entries required) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09
Review of Systems Section	section	urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18

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Template Title	Template Type	templateId
Social History Section (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09
Subjective Section	section	urn:oid:2.16.840.1.113883.10.20.21.2.2
Surgery Description Section (DEPRECATED)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.26:2014-06-09
Surgical Drains Section	section	urn:oid:2.16.840.1.113883.10.20.7.13
Vital Signs Section (entries optional) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09
Vital Signs Section (entries required) (V2)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09
Admission Medication (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.36:2014-06-09
Advance Directive Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09
Advance Directive Organizer	entry	urn:oid:2.16.840.1.113883.10.20.22.4.108
Age Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.31
Allergy - Intolerance Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09
Allergy Concern Act (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.30:2014-06-09
Allergy Status Observation (DEPRECATED)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.28:2014-06-09
Assessment Scale Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.69
Assessment Scale Supporting Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.86
Authorization Activity	entry	urn:oid:2.16.840.1.113883.10.20.1.19
Boundary Observation	entry	urn:oid:2.16.840.1.113883.10.20.6.2.11
Caregiver Characteristics	entry	urn:oid:2.16.840.1.113883.10.20.22.4.72
Characteristics of Home Environment	entry	urn:oid:2.16.840.1.113883.10.20.22.4.109
Code Observations	entry	urn:oid:2.16.840.1.113883.10.20.6.2.13
Cognitive Status Problem Observation (DEPRECATED)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.73:2014-06-09
Comment Activity	entry	urn:oid:2.16.840.1.113883.10.20.22.4.64
Coverage Activity (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.60:2014-06-09

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Template Title	Template Type	templateId
Cultural and Religious Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.111
Deceased Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.79:2014-06-09
Discharge Medication (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.35:2014-06-09
Drug Monitoring Act	entry	urn:oid:2.16.840.1.113883.10.20.22.4.123
Drug Vehicle	entry	urn:oid:2.16.840.1.113883.10.20.22.4.24
Encounter Activity (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09
Encounter Diagnosis (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09
Entry Reference	entry	urn:oid:2.16.840.1.113883.10.20.22.4.122
Estimated Date of Delivery	entry	urn:oid:2.16.840.1.113883.10.20.15.3.1
External Document Reference	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.115:2014-06-09
Family History Death Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.47
Family History Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.46:2014-06-09
Family History Organizer (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09
Functional Status Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09
Functional Status Organizer (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.66:2014-06-09
Functional Status Problem Observation (DEPRECATED)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.68:2014-06-09
Goal Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.121
Handoff Communication Participants	entry	urn:oid:2.16.840.1.113883.10.20.22.4.141
Health Concern Act	entry	urn:oid:2.16.840.1.113883.10.20.22.4.132
Health Status Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09
Highest Pressure Ulcer Stage	entry	urn:oid:2.16.840.1.113883.10.20.22.4.77
Hospital Admission Diagnosis (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09
Hospital Discharge Diagnosis (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.33:2014-06-09

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Template Title	Template Type	templateId
Immunization Activity (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09
Immunization Medication Information (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09
Immunization Refusal Reason	entry	urn:oid:2.16.840.1.113883.10.20.22.4.53
Indication (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
Instruction (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
Intervention Act	entry	urn:oid:2.16.840.1.113883.10.20.22.4.131
Longitudinal Care Wound Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.114
Medical Equipment Organizer	entry	urn:oid:2.16.840.1.113883.10.20.22.4.135
Medication Activity (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09
Medication Dispense (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.18:2014-06-09
Medication Information (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09
Medication Supply Order (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09
Medication Use - None Known (RETIRED)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.29:2014-06-09
Mental Status Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09
Mental Status Organizer (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.75:2014-06-09
Non-Medicinal Supply Activity (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09
Number of Pressure Ulcers Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.76:2014-06-09
Nutrition Assessment	entry	urn:oid:2.16.840.1.113883.10.20.22.4.138
Nutrition Recommendation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.130
Nutritional Status Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.124
Outcome Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.144
Patient Referral Act	entry	urn:oid:2.16.840.1.113883.10.20.22.4.140
Planned Act (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09

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Template Title	Template Type	templateId
Planned Coverage	entry	urn:oid:2.16.840.1.113883.10.20.22.4.129
Planned Encounter (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09
Planned Immunization Activity	entry	urn:oid:2.16.840.1.113883.10.20.22.4.120
Planned Intervention Act	entry	urn:oid:2.16.840.1.113883.10.20.22.4.146
Planned Medication Activity (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09
Planned Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09
Planned Procedure (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09
Planned Supply (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09
Policy Activity (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.61:2014-06-09
Postprocedure Diagnosis (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09
Precondition for Substance Administration (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09
Pregnancy Observation	entry	urn:oid:2.16.840.1.113883.10.20.15.3.8
Preoperative Diagnosis (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09
Pressure Ulcer Observation (DEPRECATED)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.70:2014-06-09
Priority Preference	entry	urn:oid:2.16.840.1.113883.10.20.22.4.143
Problem Concern Act (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09
Problem Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09
Problem Status (DEPRECATED)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.6:2014-06-09
Procedure Activity Act (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09
Procedure Activity Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09
Procedure Activity Procedure (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09
Procedure Context	entry	urn:oid:2.16.840.1.113883.10.20.6.2.5
Product Instance	entry	urn:oid:2.16.840.1.113883.10.20.22.4.37

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Template Title	Template Type	templateId
Prognosis Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.113
Progress Toward Goal Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.110
Purpose of Reference Observation	entry	urn:oid:2.16.840.1.113883.10.20.6.2.9
Quantity Measurement Observation	entry	urn:oid:2.16.840.1.113883.10.20.6.2.14
Reaction Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09
Referenced Frames Observation	entry	urn:oid:2.16.840.1.113883.10.20.6.2.10
Result Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09
Result Organizer (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09
Risk Concern Act	entry	urn:oid:2.16.840.1.113883.10.20.22.4.136
Self-Care Activities (ADL and IADL)	entry	urn:oid:2.16.840.1.113883.10.20.22.4.128
Sensory Status	entry	urn:oid:2.16.840.1.113883.10.20.22.4.127
Series Act	entry	urn:oid:2.16.840.1.113883.10.20.22.4.63
Service Delivery Location	entry	urn:oid:2.16.840.1.113883.10.20.22.4.32
Severity Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09
Smoking Status - Meaningful Use (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09
Social History Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09
SOP Instance Observation	entry	urn:oid:2.16.840.1.113883.10.20.6.2.8
Study Act	entry	urn:oid:2.16.840.1.113883.10.20.6.2.6
Substance Administered Act	entry	urn:oid:2.16.840.1.113883.10.20.22.4.118
Substance or Device Allergy - Intolerance Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.24.3.90:2014-06-09
Text Observation	entry	urn:oid:2.16.840.1.113883.10.20.6.2.12
Tobacco Use (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09
Vital Sign Observation (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09

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Template Title	Template Type	templateId
Vital Signs Organizer (V2)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.26:2014-06-09
Wound Characteristic	entry	urn:oid:2.16.840.1.113883.10.20.22.4.134
Wound Measurement Observation	entry	urn:oid:2.16.840.1.113883.10.20.22.4.133
Author Participation	unspecified	urn:oid:2.16.840.1.113883.10.20.22.4.119
Physician of Record Participant (V2)	unspecified	urn:hl7ii:2.16.840.1.113883.10.20.6.2.2:2014-06-09
Physician Reading Study Performer (V2)	unspecified	urn:hl7ii:2.16.840.1.113883.10.20.6.2.1:2014-06-09
US Realm Address (AD.US.FIELDED)	unspecified	urn:oid:2.16.840.1.113883.10.20.22.5.2
US Realm Date and Time (DT.US.FIELDED)	unspecified	urn:oid:2.16.840.1.113883.10.20.22.5.3
US Realm Date and Time (DTM.US.FIELDED)	unspecified	urn:oid:2.16.840.1.113883.10.20.22.5.4
US Realm Patient Name (PTN.US.FIELDED)	unspecified	urn:oid:2.16.840.1.113883.10.20.22.5.1
US Realm Person Name (PN.US.FIELDED)	unspecified	urn:oid:2.16.840.1.113883.10.20.22.5.1.1

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7 VALUE SETS IN THIS GUIDE

Table 524: Value Sets

Name	OID	URL
Ability	2.16.840.1.113883.11.20.9.46	https://vsac.nlm.nih.gov
Act Priority	2.16.840.1.113883.1.11.16866	http://www.hl7.org
ActStatus	2.16.840.1.113883.1.11.159331	http://www.hl7.org
ADL Result Type	2.16.840.1.113883.11.20.9.47	http://www.hl7.org
AdministrableDrugForm	2.16.840.1.113883.1.11.14570	http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html
Administrative Gender (HL7 V3)	2.16.840.1.113883.1.11.1	http://www.hl7.org
AgePQ_UCUM	2.16.840.1.113883.11.20.9.21	http://unitsofmeasure.org/ucum.html
Allergy/Adverse Event Type	2.16.840.1.113883.3.88.12.3221.6.2	https://vsac.nlm.nih.gov
Body Site	2.16.840.1.113883.3.88.12.3221.8.9	https://vsac.nlm.nih.gov
Care Model	2.16.840.1.113883.11.20.9.61	http://vtsl.vetmed.vt.edu/TerminologyMgt/RF2Browser/ISA.cfm?SCT_ConceptID=170932006
Clinical Substance	2.16.840.1.113762.1.4.1010.2	https://vsac.nlm.nih.gov/
ConsultDocumentType	2.16.840.1.113883.11.20.9.31	http://www.loinc.org/
Country	2.16.840.1.113883.3.88.12.80.63	http://www.iso.org/iso/country_codes/iso_3166_code_lists.htm
Coverage Role Type	2.16.840.1.113883.1.11.18877	http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html
Current Smoking Status	2.16.840.1.113883.11.20.9.38	https://vsac.nlm.nih.gov
CVX Vaccines Administered - Vaccine Set	2.16.840.1.113762.1.4.1010.6	https://vsac.nlm.nih.gov/
DICOMPurposeOfReference	2.16.840.1.113883.11.20.9.28	http://www.hl7.org
DIRQuantityMeasurementTypeCodes	2.16.840.1.113883.11.20.9.29	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
DIRSectionTypeCodes	2.16.840.1.113883.11.20.9.59	http://www.loinc.org/
DischargeSummaryDocumentTypeCode	2.16.840.1.113883.11.20.4.1	http://www.loinc.org/
Encounter Planned	2.16.840.1.113883.11.20.9.52	http://vtsl.vetmed.vt.edu/TerminologyMgt/RF2Browser/ISA.cfm?SCT_ConceptID=308335008
EncounterTypeCode	2.16.840.1.113883.3.88.12.80.32	http://www.amacodingonline.com/
EntityNameUse	2.16.840.1.113883.1.11.15913	http://www.hl7.org

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Name	OID	URL
EntityPersonNamePartQualifier	2.16.840.1.113883.11.20.9.26	http://www.hl7.org
EthnicityGroup	2.16.840.1.114222.4.11.837	http://phinvads.cdc.gov/vads/ViewValueSet.action?id=35D34BBC-617F-DD11-B38D-00188B398520
Family Member Value Set	2.16.840.1.113883.1.11.19579	http://www.hl7.org
Goal Achievement	2.16.840.1.113883.11.20.9.55	https://vsac.nlm.nih.gov
Healthcare Agent Qualifier	2.16.840.1.113883.11.20.9.51	https://vsac.nlm.nih.gov
Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.114222.4.11.1066	http://www.nucc.org/index.php?option=com_content&view=article&id=14&Itemid=125
HealthcareServiceLocation	2.16.840.1.113883.1.11.20275	http://phinvads.cdc.gov/vads/SearchAllVocab_search.action?searchOptions.searchText=Healthcare+Service+Location+%28NHSN%29
HealthStatus	2.16.840.1.113883.1.11.20.12	https://www.hl7.org/
HL7 BasicConfidentialityKind	2.16.840.1.113883.1.11.16926	http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html
HL7FinanciallyResponsiblePartyType	2.16.840.1.113883.1.11.10416	http://www.hl7.org
HPDocumentType	2.16.840.1.113883.1.11.20.22	http://www.loinc.org/
INDRoleclassCodes	2.16.840.1.113883.11.20.9.33	http://www.hl7.org
Language	2.16.840.1.113883.1.11.11526	http://www.ietf.org/rfc/rfc4646.txt
LanguageAbilityMode	2.16.840.1.113883.1.11.12249	http://www.hl7.org
LanguageAbilityProficiency	2.16.840.1.113883.1.11.12199	http://www.hl7.org
LOINC Imaging Document Codes	1.3.6.1.4.1.12009.10.2.5	http://search.loinc.org
Marital Status	2.16.840.1.113883.1.11.12212	http://www.hl7.org
Medication Clinical Drug	2.16.840.1.113762.1.4.1010.4	https://vsac.nlm.nih.gov/
Medication Fill Status	2.16.840.1.113883.3.88.12.80.64	https://phinvads.cdc.gov/
Medication Route FDA	2.16.840.1.113883.3.88.12.3221.8.7	http://ushik.ahrq.gov/ViewItemDetails?system=mdr&itemKey=84244000
Mental and Functional Status Response	2.16.840.1.113883.11.20.9.44	http://vtsl.vetmed.vt.edu/TerminologyMgt/RF2Browser/ISA.cfm?SCT_ConceptID=272520006
MoodCodeEvnInt	2.16.840.1.113883.11.20.9.18	http://www.hl7.org
No Immunization Reason Value Set	2.16.840.1.113883.1.11.19717	http://www.hl7.org
NUBC UB-04 FL17 Patient Status	2.16.840.1.113883.3.88.12.80.33	http://www.nubc.org
Nutrition Recommendations	2.16.840.1.113883.1.11.20.2.9	http://www.hl7.org
Nutritional Status	2.16.840.1.113883.1.11.20.2.7	https://vsac.nlm.nih.gov
Observation Interpretation (HL7)	2.16.840.1.113883.1.11.78	http://www.hl7.org
ParticipationFunction	2.16.840.1.113883.1.11.10267	http://www.hl7.org/

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Name	OID	URL
Patient Education	2.16.840.1.113883.11.20.9.34	https://vsac.nlm.nih.gov
Patient Referral Act moodCode	2.16.840.1.113883.11.20.9.66	http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html
PatientLanguage	2.16.840.1.113883.11.20.9.64	http://www.loc.gov/standards/iso639-2/php/code_list.php
Personal And Legal Relationship Role Type	2.16.840.1.113883.11.20.12.1	http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html
Physical Exam Type	2.16.840.1.113883.11.20.9.65	http://www.search.loinc.org
Planned Intervention moodCode	2.16.840.1.113883.11.20.9.54	http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html
Planned moodCode (Act/Encounter/Procedure)	2.16.840.1.113883.11.20.9.23	http://hl7.org/implement/standards/fhir/v3/ActMood/
Planned moodCode (Observation)	2.16.840.1.113883.11.20.9.25	http://www.hl7.org
Planned moodCode (SubstanceAdministration/Supply)	2.16.840.1.113883.11.20.9.24	http://hl7.org/implement/standards/fhir/v3/ActMood/
PostalAddressUse	2.16.840.1.113883.1.11.10637	http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html
PostalCode	2.16.840.1.113883.3.88.12.80.2	http://ushik.ahrq.gov/ViewItemDetails?system=mdr&itemKey=86671000
Pressure Point	2.16.840.1.113883.11.20.9.36	https://vsac.nlm.nih.gov
Pressure Ulcer Stage	2.16.840.1.113883.11.20.9.35	https://vsac.nlm.nih.gov
Priority Level	2.16.840.1.113883.11.20.9.60	https://vsac.nlm.nih.gov
Problem	2.16.840.1.113883.3.88.12.3221.7.4	https://vsac.nlm.nih.gov
Problem Severity	2.16.840.1.113883.3.88.12.3221.6.8	https://vsac.nlm.nih.gov
Problem Status	2.16.840.1.113883.3.88.12.80.68	https://vsac.nlm.nih.gov
Problem Type	2.16.840.1.113883.3.88.12.3221.7.2	http://www.loinc.org/
ProblemAct statusCode	2.16.840.1.113883.11.20.9.19	http://www.hl7.org
ProcedureAct statusCode	2.16.840.1.113883.11.20.9.22	http://www.hl7.org
ProcedureNoteDocumentTypeCodes	2.16.840.1.113883.11.20.6.1	http://search.loinc.org
ProgressNoteDocumentTypeCode	2.16.840.1.113883.11.20.8.1	http://www.loinc.org/
Provider Role	2.16.840.1.113883.3.88.12.3221.4.2	http://www.nucc.org/index.php?option=com_content&view=article&id=14&Itemid=125
Race	2.16.840.1.113883.1.11.14914	http://phinvads.cdc.gov/vads/Vie

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Name	OID	URL
		wCodeSystemConcept.action?oid=2.16.840.1.113883.6.238&code=1000-9
Race Category Excluding Nulls	2.16.840.1.113883.3.2074.1.1.3	N/A
Referral Types	2.16.840.1.113883.11.20.9.56	http://vtsl.vetmed.vt.edu/TerminologyMgt/RF2Browser/ISA.cfm?SCT_ConceptID=3457005
ReferralDocumentType	2.16.840.1.113883.1.11.20.2.3	http://www.loinc.org/
Related Document (append/replace)	2.16.840.1.113883.11.20.9.62	http://www.hl7.org/documentcenter/public/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vocabulary.html
Religious Affiliation	2.16.840.1.113883.1.11.19185	http://www.hl7.org/v3ballotarchive_temp_16B8D83E-1C23-BA17-0CBFC625BE7BA72F/v3ballot/html/infrastructure/vocabulary/vocabulary.html#voc-sets
Residence and Accommodation Type	2.16.840.1.113883.11.20.9.49	https://vsac.nlm.nih.gov
Result Status	2.16.840.1.113883.11.20.9.39	http://www.hl7.org
Sensory Status Problem Type	2.16.840.1.113883.11.20.9.50	https://vsac.nlm.nih.gov
Source of Payment Typology (PHDSC)	2.16.840.1.114222.4.11.3591	http://www.phdsc.org/standards/payer-typology.asp
Specific Vaccine Clinical Drug	2.16.840.1.113762.1.4.1010.10	https://vsac.nlm.nih.gov/
StateValueSet	2.16.840.1.113883.3.88.12.80.1	http://www.itl.nist.gov/fipspubs/fip5-2.htm
Substance-Reactant for Intolerance	2.16.840.1.113762.1.4.1010.1	http://www.hl7.org
SupportedFileFormats	2.16.840.1.113883.11.20.7.1	http://www.hl7.org
SurgicalOperationNoteDocumentTypeCode	2.16.840.1.113883.11.20.1.1	http://www.loinc.org/
TargetSite Qualifiers	2.16.840.1.113883.11.20.9.37	https://vsac.nlm.nih.gov
Telecom Use (US Realm Header)	2.16.840.1.113883.11.20.9.20	http://www.hl7.org
Tobacco Use	2.16.840.1.113883.11.20.9.41	http://vtsl.vetmed.vt.edu/TerminologyMgt/RF2Browser/ISA.cfm?SCT_ConceptID=365980008
TransferDocumentType	2.16.840.1.113883.1.11.20.2.4	http://search.loinc.org/search.zul?query=transfer+summary+note
UnitsOfMeasureCaseSensitive	2.16.840.1.113883.1.11.12839	http://unitsofmeasure.org/ucum.html
Vaccine Clinical Drug	2.16.840.1.113762.1.4.1010.8	https://vsac.nlm.nih.gov/
Vital Sign Result	2.16.840.1.113883.3.88.12.80.62	http://www.loinc.org/
Wound Characteristic	2.16.840.1.113883.11.20.9.58	https://vsac.nlm.nih.gov
Wound Measurements	2.16.840.1.113883.1.11.20.2.5	https://vsac.nlm.nih.gov
Wound Type	2.16.840.1.113883.1.11.20.2.6	https://vsac.nlm.nih.gov
x_ServiceEventPerformer	2.16.840.1.113883.1.11.19601	http://www.hl7.org

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8 CODE SYSTEMS IN THIS GUIDE

Table 525: Code Systems

Name	OID
ActCode	2.16.840.1.113883.5.4
ActMood	2.16.840.1.113883.5.1001
ActPriority	2.16.840.1.113883.5.7
ActReason	2.16.840.1.113883.5.8
ActStatus	2.16.840.1.113883.5.14
AddressUse	2.16.840.1.113883.5.1119
AdministrativeGender	2.16.840.1.113883.5.1
CDC Vaccine Code (CVX)	2.16.840.1.113883.12.292
ConfidentialityCode	2.16.840.1.113883.5.25
Country	2.16.840.1.113883.3.88.12.80.63
CPT4	2.16.840.1.113883.6.12
DCM	1.2.840.10008.2.16.4
EntityClass	2.16.840.1.113883.5.41
EntityNamePartQualifier	2.16.840.1.113883.5.43
EntityNameUse	2.16.840.1.113883.5.45
FDA RouteOfAdministration	2.16.840.1.113883.3.26.1.1
FIPS 5-2 (State)	2.16.840.1.113883.6.92
Healthcare Provider Taxonomy (HIPAA)	2.16.840.1.113883.6.101
HITSP-CS-83	2.16.840.1.113883.5.83
HL7 HealthcareServiceLocation	2.16.840.1.113883.6.259
HL7ActClass	2.16.840.1.113883.5.6
HL7ActRelationshipType	2.16.840.1.113883.5.1002
HL7NullFlavor	2.16.840.1.113883.5.1008
HL7ParticipationType	2.16.840.1.113883.5.90
ICD10CM	2.16.840.1.113883.6.90
Language	2.16.840.1.113883.6.121
LanguageAbilityMode	2.16.840.1.113883.5.60
LanguageAbilityProficiency	2.16.840.1.113883.5.61
LOINC	2.16.840.1.113883.6.1
MaritalStatus	2.16.840.1.113883.5.2
Media Type	2.16.840.1.113883.5.79
NDFRT	2.16.840.1.113883.3.26.1.5
nubc-UB-04-Manual-code set	2.16.840.1.113883.6.301
orderableDrugForm	2.16.840.1.113883.5.85
participationFunction	2.16.840.1.113883.5.88

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Name	OID
Participationsignature	2.16.840.1.113883.5.89
Provider Role (HL7)	2.16.840.1.113883.3.88.12.3221.4
Race & Ethnicity - CDC	2.16.840.1.113883.6.238
ReligiousAffiliation	2.16.840.1.113883.5.1076
RoleClass	2.16.840.1.113883.5.110
RoleCode	2.16.840.1.113883.5.111
RxNorm	2.16.840.1.113883.6.88
SNOMED CT	2.16.840.1.113883.6.96
Source of Payment Typology (PHDSC)	2.16.840.1.113883.3.221.5
UCUM	2.16.840.1.113883.6.8
Unique Ingredient Identifier (UNII)	2.16.840.1.113883.4.9
USPostalCodes	2.16.840.1.113883.6.231

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9 RETIRED TEMPLATES

Table 526: Retired Templates

Name	OID	Description
Medication Use - None Known (RETIRED)	urn:hl7ii:2.16.840.1.113883.10.20.22.4.29:2014-06-09	THIS TEMPLATE HAS BEEN RETIRED IN C-CDA R2. USE OF THIS TEMPLATE IS NOT ALLOWED. *Reason for retirement*: The recommended approach to stating no known medications is to use the appropriate nullFlavor instead of this template. See "Unknown Information" in Volume 1.
Complications (OpNote) (RETIRED)	urn:hl7ii:2.16.840.1.113883.10.20.22.2.32:2014-06-09	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 HAS BEEN RETIRED IN C-CDA R2. USE OF THIS TEMPLATE IS NOT ALLOWED. *Reason for retirement*: This template has been replaced by the Complications Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09).

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10 CHANGES FROM PREVIOUS VERSION

10.1 Consultation Note (V2)

Consultation Note (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.4:2014-06-09)

Change	Old	New
Name	Consultation Note	Consultation Note (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.1.4	urn:hl7ii:2.16.840.1.113883.10.20.22.1.4:2014-06-09
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	The Consultation Note is generated by a request from a clinician for an opinion or advice from another clinician. Consultations may involve face-to-face time with the patient or may fall under the auspices of telemedicine visits. Consultations may occur while the patient is inpatient or ambulatory. The Consultation Note should also be used to summarize an Emergency Room or Urgent Care encounter. A Consultation Note includes the reason for the referral, history of present illness, physical examination, and decision-making components (Assessment and Plan).

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Change	Old	New
	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.	
Implied Template	US Realm Header (urn:oid:2.16.840.1.113883.10.20.22.1.1)	US Realm Header (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)
CONF #: 1098-28895 Added		This component SHALL contain exactly one [1..1] structuredBody (CONF:1098-28895).
CONF #: 1098-28896 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28896) such that it
CONF #: 1098-28897 Added		SHALL contain exactly one [1..1] Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1098-28897).
CONF #: 1098-28898 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28898) such that it
CONF #: 1098-28899 Added		SHALL contain exactly one [1..1] Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1098-28899).
CONF #: 1098-28900 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28900) such that it
CONF #: 1098-28901 Added		SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-28901).
CONF #: 1098-28904 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28904) such that it
CONF #: 1098-28905 Added		SHALL contain exactly one [1..1] Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:1098-28905).
CONF #: 1098-28906 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-28906) such that it
CONF #: 1098-28907 Added		SHALL contain exactly one [1..1] History of Present Illness Section (identifier:

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Change	Old	New
		urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1098-28907).
CONF #: 1098-28908 Added		This structuredBody SHOULD contain zero or one [0..1] component (CONF:1098-28908) such that it
CONF #: 1098-28909 Added		SHALL contain exactly one [1..1] Physical Exam Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09) (CONF:1098-28909).
CONF #: 1098-28910 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-28910) such that it
CONF #: 1098-28911 Added		SHALL contain exactly one [1..1] Allergies and Intolerances Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09) (CONF:1098-28911).
CONF #: 1098-28912 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28912) such that it
CONF #: 1098-28913 Added		SHALL contain exactly one [1..1] Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1098-28913).
CONF #: 1098-28915 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28915) such that it
CONF #: 1098-28916 Added		SHALL contain exactly one [1..1] Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:1098-28916).
CONF #: 1098-28917 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28917) such that it
CONF #: 1098-28918 Added		SHALL contain exactly one [1..1] Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-28918).
CONF #: 1098-28919 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28919) such that it
CONF #: 1098-28920 Added		SHALL contain exactly one [1..1] General Status Section (identifier:

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Change	Old	New
		urn:oid:2.16.840.1.113883.10.20.2.5) (CONF:1098-28920).
CONF #: 1098-28921 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28921) such that it
CONF #: 1098-28922 Added		SHALL contain exactly one [1..1] History of Past Illness Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09) (CONF:1098-28922).
CONF #: 1098-28923 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28923) such that it
CONF #: 1098-28924 Added		SHALL contain exactly one [1..1] Immunizations Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09) (CONF:1098-28924).
CONF #: 1098-28925 Added		This structuredBody SHOULD contain zero or one [0..1] component (CONF:1098-28925) such that it
CONF #: 1098-28926 Added		SHALL contain exactly one [1..1] Medications Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09) (CONF:1098-28926).
CONF #: 1098-28928 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-28928) such that it
CONF #: 1098-28929 Added		SHALL contain exactly one [1..1] Problem Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09) (CONF:1098-28929).
CONF #: 1098-28930 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28930) such that it
CONF #: 1098-28931 Added		SHALL contain exactly one [1..1] Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09) (CONF:1098-28931).
CONF #: 1098-28932 Added		This structuredBody SHOULD contain zero or one [0..1]

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Change	Old	New
		component (CONF:1098-28932) such that it
CONF #: 1098-28933 Added		SHALL contain exactly one [1..1] Results Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09) (CONF:1098-28933).
CONF #: 1098-28934 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28934) such that it
CONF #: 1098-28935 Added		SHALL contain exactly one [1..1] Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-28935).
CONF #: 1098-28936 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28936) such that it
CONF #: 1098-28937 Added		SHALL contain exactly one [1..1] Vital Signs Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09) (CONF:1098-28937).
CONF #: 1098-28938 Added		This structuredBody *MAY* contain either an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09), or an Assessment Section (2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-28938).
CONF #: 1098-28939 Added		This structuredBody *SHALL NOT* contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1098-28939).
CONF #: 1098-28940 Added		This structuredBody *SHALL NOT* contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13)

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Change	Old	New
		when either a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) is present (CONF:1098-28940).
CONF #: 1098-28942 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28942) such that it
CONF #: 1098-28943 Added		SHALL contain exactly one [1..1] Advance Directives Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09) (CONF:1098-28943).
CONF #: 1098-28944 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-28944) such that it
CONF #: 1098-28945 Added		SHALL contain exactly one [1..1] Functional Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09) (CONF:1098-28945).
CONF #: 1098-29923 Added		Such inFulfillmentOfs SHALL contain exactly one [1..1] order (CONF:1098-29923).
CONF #: 1098-29924 Added		Where a referral is being fulfilled by this consultation, this id would be the same as the id in the Patient Referral Act template. This order SHALL contain at least one [1..*] id (CONF:1098-29924).
CONF #: 1098-30237 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30237) such that it
CONF #: 1098-30238 Added		SHALL contain exactly one [1..1] Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-30238).
CONF #: 1098-30904 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30904) such that it
CONF #: 1098-30905 Added		SHALL contain exactly one [1..1] Medical Equipment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09) (CONF:1098-30905).
CONF #: 1098-30906 Added		This structuredBody MAY contain

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Change	Old	New
		zero or one [0..1] component (CONF:1098-30906) such that it
CONF #: 1098-30907 Added		SHALL contain exactly one [1..1] Mental Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.56) (CONF:1098-30907).
CONF #: 1098-30909 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30909) such that it
CONF #: 1098-30910 Added		SHALL contain exactly one [1..1] Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1098-30910).
CONF #: 1098-31656 Added		Heading: participant (This participant represents the person to contact for questions about the consult summary. This call back contact individual may be a different person than the individual(s) identified in the author or legalAuthenticator participant.) SHOULD contain zero or more [0..*] participant (CONF:1098-31656) such that it
CONF #: 1098-31657 Added		SHALL contain exactly one [1..1] @typeCode="CALLBCK" call back contact (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 DYNAMIC) (CONF:1098-31657).
CONF #: 1098-31658 Added		SHALL contain exactly one [1..1] associatedEntity (CONF:1098-31658).
CONF #: 1098-31659 Added		This associatedEntity SHALL contain exactly one [1..1] @classCode="ASSIGNED" assigned entity (CodeSystem: RoleClass 2.16.840.1.113883.5.110 DYNAMIC) (CONF:1098-31659).
CONF #: 1098-31660 Added		This associatedEntity SHALL contain at least one [1..*] id (CONF:1098-31660).
CONF #: 1098-31661 Added		This associatedEntity SHOULD contain zero or more [0..*] addr (CONF:1098-31661).
CONF #: 1098-31662 Added		This associatedEntity SHALL contain at least one [1..*] telecom (CONF:1098-31662).
CONF #: 1098-31663 Added		This associatedEntity SHALL contain exactly one [1..1]

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Change	Old	New
		associatedPerson (CONF:1098-31663).
CONF #: 1098-31664 Added		This associatedPerson SHALL contain at least one [1..*] name (CONF:1098-31664).
CONF #: 1098-31665 Added		This associatedEntity MAY contain zero or one [0..1] scopingOrganization (CONF:1098-31665).
CONF #: 1098-32502 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32502).
CONF #: 81-9487 Removed	MAY contain zero or one [0..1] Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:81-9487).	
CONF #: 81-9511 Removed	MAY contain zero or one [0..1] Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:81-9511).	
CONF #: 81-9509 Removed	MAY contain zero or one [0..1] Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:81-9509).	
CONF #: 81-9515 Removed	MAY contain zero or one [0..1] General Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.5) (CONF:81-9515).	
CONF #: 81-9493 Removed	SHALL contain exactly one [1..1] History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:81-9493).	
CONF #: 81-9500 Removed	MAY contain zero or one [0..1] Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:81-9500).	
CONF #: 81-9529 Removed	MAY contain zero or one [0..1] Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:81-9529).	
CONF #: 81-8385 Removed	Such inFulfillmentOfs SHALL contain exactly one [1..1] order (CONF:81-8385).	
CONF #: 81-8393 Removed	The responsibleParty element records only the party responsible for the encounter, not necessarily the entire episode of care	

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Change	Old	New
	(CONF:81-8393).	
CONF #: 81-8395 Removed	The encounterParticipant element, if present, records only participants in the encounter, not necessarily in the entire episode of care (CONF:81-8395).	
CONF #: 81-8396 Removed	An encounterParticipant element, if present, SHALL contain an assignedEntity element which SHALL contain an assignedPerson element, a representedOrganization element, or both (CONF:81-8396).	
CONF #: 81-8398 Removed	A Consultation Note can have either a structuredBody or a nonXMLBody (CONF:81-8398).	
CONF #: 81-8399 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:81-8399).	
CONF #: 81-9102 Removed	This order SHALL contain at least one [1..*] id (CONF:81-9102).	
CONF #: 81-9489 Removed	MAY contain zero or one [0..1] Plan of Care Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.10) (CONF:81-9489).	
CONF #: 81-9491 Removed	MAY contain zero or one [0..1] Assessment and Plan Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.9) (CONF:81-9491).	
CONF #: 81-9495 Removed	SHOULD contain zero or one [0..1] Physical Exam Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.10) (CONF:81-9495).	
CONF #: 81-9498 Removed	MAY contain zero or one [0..1] Reason for Referral Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.1) (CONF:81-9498).	
CONF #: 81-9501 Removed	SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan of Care Section	

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Change	Old	New
	(CONF:81-9501).	
CONF #: 81-9503 Removed	If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:81-9503).	
CONF #: 81-9504 Removed	SHALL include a Reason for Referral or Reason for Visit section (CONF:81-9504).	
CONF #: 81-9507 Removed	MAY contain zero or one [0..1] Allergies Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.6) (CONF:81-9507).	
CONF #: 81-9513 Removed	MAY contain zero or one [0..1] Family History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.15) (CONF:81-9513).	
CONF #: 81-9517 Removed	MAY contain zero or one [0..1] History of Past Illness Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.20) (CONF:81-9517).	
CONF #: 81-9519 Removed	MAY contain zero or one [0..1] Immunizations Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.2) (CONF:81-9519).	
CONF #: 81-9521 Removed	MAY contain zero or one [0..1] Medications Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.1) (CONF:81-9521).	
CONF #: 81-9523 Removed	MAY contain zero or one [0..1] Problem Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.5) (CONF:81-9523).	
CONF #: 81-9525 Removed	MAY contain zero or one [0..1] Procedures Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.7) (CONF:81-9525).	
CONF #: 81-9527 Removed	MAY contain zero or one [0..1] Results Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.3) (CONF:81-9527).	
CONF #: 81-9531 Removed	MAY contain zero or one [0..1] Social History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.17) (CONF:81-9531).	

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Change	Old	New
CONF #: 81-9533 Removed	MAY contain zero or one [0..1] Vital Signs Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.4) (CONF:81-9533).	
CONF #: 81-10028 Removed	SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:81-10028).	
CONF #: 81-10029 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:81-10029).	
CONF #: 81-10132 Removed	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:81-10132).	
CONF #: 81-17177 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:81-17177).	
CONF #: 1098-8382 Modified	SHALL contain at least one [1..*] inFulfillmentOf	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 consultation that is being reported in the note.) SHALL contain at least one [1..*] inFulfillmentOf
CONF #: 1098-8386 Modified	SHALL contain exactly one [1..1] componentOf	Heading: componentOf (A Consultation Note is always associated with an encounter; the id element of the encompassingEncounter is required to be present and represents the identifier for the encounter.) SHALL contain exactly one [1..1] componentOf
CONF #: 1098-8388 Modified	This encompassingEncounter SHALL contain exactly one [1..1] id	This encompassingEncounter SHALL contain at least one [1..*] id

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Change	Old	New
CONF #: 1098-8389 Modified	This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime	This encompassingEncounter SHALL contain exactly one [1..1] US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3)
CONF #: 1098-8392 Modified	This encompassingEncounter MAY contain zero or more [0..*] encounterParticipant	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 #: 1098-8394 Modified	The responsibleParty element, if present, SHALL contain an assignedEntity element which SHALL contain an assignedPerson element, a representedOrganization element, or both	The responsibleParty element records only the party responsible for the encounter, not necessarily the entire episode of care. The responsibleParty element, if present, *SHALL* contain an assignedEntity element which *SHALL* contain an assignedPerson element, a representedOrganization element, or both
CONF #: 1098-8397 Modified	SHALL contain exactly one [1..1] component	Heading: component SHALL contain exactly one [1..1] component
CONF #: 1098-10040 Modified	This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.4"	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.4"
CONF #: 1098-17176 Modified	SHALL contain exactly one [1..1] code	The Consultation Note recommends use of the document type code 11488-4 "Consult 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. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet ConsultDocumentType 2.16.840.1.113883.11.20.9.31 DYNAMIC

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10.2 Continuity of Care Document (CCD) (V2)

Continuity of Care Document (CCD) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.2:2014-06-09)

Change	Old	New
Name	Continuity of Care Document (CCD)	Continuity of Care Document (CCD) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.1.2	urn:hl7ii:2.16.840.1.113883.10.20.22.1.2:2014-06-09
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.	This document type was originally based on the Continuity of Care Document (CCD) Release 1.1 which itself was derived from HITSP C32 and CCD Release 1.0. 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. The key characteristic of a CCD is that the ServiceEvent is constrained to "PCPR". This means it does not function to report new ServiceEvents associated with performing care. It reports on care that has already been provided. The CCD provides a historical tally of the care over a range of time and is not a record of new services delivered. More specific use cases, such as a Discharge Summary, Transfer Summary, Referral Note, Consultation Note, or Progress Note, are available as alternative documents in this guide.
Implied Template	US Realm Header (urn:oid:2.16.840.1.113883.10.20.	US Realm Header (V2) (urn:hl7ii:2.16.840.1.113883.10.20

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Change	Old	New
	22.1.1)	.22.1.1:2014-06-09)
CONF #: 1098-30659 Added		Heading: component SHALL contain exactly one [1..1] component (CONF:1098-30659).
CONF #: 1098-30660 Added		This component SHALL contain exactly one [1..1] structuredBody (CONF:1098-30660).
CONF #: 1098-30661 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30661) such that it
CONF #: 1098-30662 Added		SHALL contain exactly one [1..1] Allergies and Intolerances Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09) (CONF:1098-30662).
CONF #: 1098-30663 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30663) such that it
CONF #: 1098-30664 Added		SHALL contain exactly one [1..1] Medications Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09) (CONF:1098-30664).
CONF #: 1098-30665 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30665) such that it
CONF #: 1098-30666 Added		SHALL contain exactly one [1..1] Problem Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09) (CONF:1098-30666).
CONF #: 1098-30667 Added		This structuredBody SHOULD contain zero or one [0..1] component (CONF:1098-30667) such that it
CONF #: 1098-30668 Added		SHALL contain exactly one [1..1] Procedures Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7.1:2014-06-09) (CONF:1098-30668).
CONF #: 1098-30669 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30669) such that it

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Change	Old	New
CONF #: 1098-30670 Added		SHALL contain exactly one [1..1] Results Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09) (CONF:1098-30670).
CONF #: 1098-30671 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30671) such that it
CONF #: 1098-30672 Added		SHALL contain exactly one [1..1] Advance Directives Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09) (CONF:1098-30672).
CONF #: 1098-30673 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30673) such that it
CONF #: 1098-30674 Added		SHALL contain exactly one [1..1] Encounters Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.22:2014-06-09) (CONF:1098-30674).
CONF #: 1098-30675 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30675) such that it
CONF #: 1098-30676 Added		SHALL contain exactly one [1..1] Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-30676).
CONF #: 1098-30677 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30677) such that it
CONF #: 1098-30678 Added		SHALL contain exactly one [1..1] Functional Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09) (CONF:1098-30678).
CONF #: 1098-30679 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30679) such that it
CONF #: 1098-30680 Added		SHALL contain exactly one [1..1] Immunizations Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2014-06-09) (CONF:1098-30680).

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Change	Old	New
CONF #: 1098-30681 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30681) such that it
CONF #: 1098-30682 Added		SHALL contain exactly one [1..1] Medical Equipment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09) (CONF:1098-30682).
CONF #: 1098-30683 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30683) such that it
CONF #: 1098-30684 Added		SHALL contain exactly one [1..1] Payers Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.18:2014-06-09) (CONF:1098-30684).
CONF #: 1098-30685 Added		This structuredBody SHOULD contain zero or one [0..1] component (CONF:1098-30685) such that it
CONF #: 1098-30686 Added		SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30686).
CONF #: 1098-30687 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30687) such that it
CONF #: 1098-30688 Added		SHALL contain exactly one [1..1] Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-30688).
CONF #: 1098-30689 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30689) such that it
CONF #: 1098-30690 Added		SHALL contain exactly one [1..1] Vital Signs Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09) (CONF:1098-30690).
CONF #: 1098-30882 Added		The assignedEntity, if present, SHALL contain exactly one [1..1] id (CONF:1098-30882) such that it
CONF #: 1098-32138 Added		This code SHALL contain exactly

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Change	Old	New
		one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:1098-32138).
CONF #: 1098-32143 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-32143) such that it
CONF #: 1098-32144 Added		SHALL contain exactly one [1..1] Mental Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.56) (CONF:1098-32144).
CONF #: 1098-32466 Added		If this assignedEntity is an assignedPerson, the assignedEntity *SHOULD* contain zero or one [[]0..1[]] id such that it (CONF:1098-32466).
CONF #: 1098-32467 Added		The assignedEntity, if present, MAY contain zero or one [0..1] assignedPerson (CONF:1098-32467).
CONF #: 1098-32484 Added		*SHALL* contain exactly one [[]1..1[]] *@root="2.16.840.1.113883.4.6"* National Provider Identifier (CONF:1098-32484).
CONF #: 1098-32516 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32516).
CONF #: 1098-32624 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-32624) such that it
CONF #: 1098-32625 Added		SHALL contain exactly one [1..1] Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1098-32625).
CONF #: 81-8460 Removed	The assignedEntity, if present, SHALL contain at least one [1..*] id (CONF:81-8460).	
CONF #: 81-8461 Removed	The assignedEntity, if present, MAY contain zero or one [0..1] code (CONF:81-8461).	
CONF #: 81-8462 Removed	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:81-8462).	
CONF #: 81-9445 Removed	SHALL contain exactly one [1..1] Allergies Section (entries required) (identifier:	

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Change	Old	New
	urn:oid:2.16.840.1.113883.10.20.22.2.6.1) (CONF:81-9445).	
CONF #: 81-9447 Removed	SHALL contain exactly one [1..1] Medications Section (entries required) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.1.1) (CONF:81-9447).	
CONF #: 81-9449 Removed	SHALL contain exactly one [1..1] Problem Section (entries required) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.5.1) (CONF:81-9449).	
CONF #: 81-9451 Removed	SHOULD contain zero or one [0..1] Procedures Section (entries required) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.7.1) (CONF:81-9451).	
CONF #: 81-9453 Removed	SHALL contain exactly one [1..1] Results Section (entries required) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.3.1) (CONF:81-9453).	
CONF #: 81-9455 Removed	MAY contain zero or one [0..1] Payers Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.18) (CONF:81-9455).	
CONF #: 81-9536 Removed	The component/structuredBody SHALL conform to the section constraints below (CONF:81-9536).	
CONF #: 81-9974 Removed	MAY contain zero or one [0..1] Social History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.17) (CONF:81-9974).	
CONF #: 81-9975 Removed	MAY contain zero or one [0..1] Medical Equipment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.23) (CONF:81-9975).	
CONF #: 81-9976 Removed	MAY contain zero or one [0..1] Immunizations Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.2) (CONF:81-9976).	
CONF #: 81-9977 Removed	MAY contain zero or one [0..1] Functional Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.14) (CONF:81-9977).	
CONF #: 81-9978 Removed	MAY contain zero or one [0..1] Family History Section (identifier: urn:oid:2.16.840.1.113883.10.20.2	

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Change	Old	New
	2.2.15) (CONF:81-9978).	
CONF #: 81-9979 Removed	MAY contain zero or one [0..1] Encounters Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.22) (CONF:81-9979).	
CONF #: 81-9980 Removed	MAY contain zero or one [0..1] Advance Directives Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.21) (CONF:81-9980).	
CONF #: 81-9981 Removed	MAY contain zero or one [0..1] Plan of Care Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.10) (CONF:81-9981).	
CONF #: 81-9983 Removed	MAY contain zero or one [0..1] Vital Signs Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.4) (CONF:81-9983).	
CONF #: 81-10026 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:81-10026).	
CONF #: 81-10027 Removed	SHOULD include zero or one [0..1] id where id/@root ="2.16.840.1.113883.4.6" National Provider Identifier (CONF:81-10027).	
CONF #: 1098-8452 Modified	SHALL contain exactly one [1..1] documentationOf	Heading: documentationOf (The documentationOf relationship in a Continuity Care Document contains the representation of providers who are wholly or partially responsible for the safety and well-being of a subject of care.) SHALL contain exactly one [1..1] documentationOf
CONF #: 1098-8456 Modified	SHALL contain exactly one [1..1] assignedPerson or exactly one [1..1] representedOrganization	Such assignedAuthors *SHALL* contain exactly one [[]1..1] assignedPerson and/or exactly one [[]1..1] representedOrganization
CONF #: 1098-8457 Modified	If assignedAuthor has an associated representedOrganization with no assignedPerson or	If assignedAuthor has an associated representedOrganization with no assignedPerson or

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Change	Old	New
	assignedAuthoringDevice, then the value for "ClinicalDocument/author/assignedAuthor/id/@NullFlavor" SHALL be "NA" "Not applicable" 2.16.840.1.113883.5.1008 NullFlavor STATIC	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 #: 1098-8480 Modified	This documentationOf SHALL contain exactly one [1..1] serviceEvent	The main activity being described by a CCD is the provision of healthcare over a period of time. This is shown by setting the value of serviceEvent/@classCode to "PCPR" (care provision) and indicating the duration over which care was provided in serviceEvent/effectiveTime. Additional data from outside this duration may also be included if it is relevant to care provided during that time range (e.g., reviewed during the stated time range). NOTE: Implementations originating a CCD should take care to discover what the episode of care being summarized is. For example, when a patient fills out a form providing relevant health history, the episode of care being documented might be from birth to the present. This documentationOf SHALL contain exactly one [1..1] serviceEvent
CONF #: 1098-8482 Modified	This serviceEvent SHOULD contain zero or more [0..*] performer	Heading: performer (The 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 #: 1098-9442 Modified	SHALL contain at least one [1..*] author	Heading: author SHALL contain at least one [1..*] author
CONF #: 1098-17181 Modified	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)	This code SHALL contain exactly one [1..1] @code="34133-9" Summarization of Episode Note

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10.3 Diagnostic Imaging Report (V2)

Diagnostic Imaging Report (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.5:2014-06-09)

Change	Old	New
Name	Diagnostic Imaging Report	Diagnostic Imaging Report (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.1.5	urn:hl7ii:2.16.840.1.113883.10.20.22.1.5:2014-06-09
Description	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.	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.
Implied Template	US Realm Header (urn:oid:2.16.840.1.113883.10.20.22.1.1)	US Realm Header (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)
CONF #: 1098-30695 Added		This component SHALL contain exactly one [1..1] structuredBody (CONF:1098-30695).
CONF #: 1098-30696 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30696) such that it
CONF #: 1098-30697 Added		SHALL contain exactly one [1..1] Findings Section (DIR) (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.2) (CONF:1098-30697).
CONF #: 1098-30698 Added		This structuredBody SHOULD contain zero or one [0..1] component (CONF:1098-30698) such that it
CONF #: 1098-30699 Added		SHALL contain exactly one [1..1] DICOM Object Catalog Section - DCM 121181 (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.1) (CONF:1098-30699).
CONF #: 1098-30932 Added		SHALL contain exactly one [1..1] id (CONF:1098-30932).
CONF #: 1098-30933 Added		This id SHALL contain exactly one [1..1] @root (CONF:1098-30933).
CONF #: 1098-30934 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 of the regular expression: ([0-

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Change	Old	New
		2])(.([1-9][0-9]*|0))+ The ClinicalDocument/id/@root attribute SHALL be a syntactically correct OID, and SHALL NOT be a UUID (CONF:1098-30934).
CONF #: 1098-30935 Added		OIDs SHALL be no more than 64 characters in length (CONF:1098-30935).
CONF #: 1098-30936 Added		Heading: inFulfillmentOf (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

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Change	Old	New
		the requested procedures ordered in this group.) MAY contain zero or more [0..*] inFulfillmentOf (CONF:1098-30936).
CONF #: 1098-30937 Added		The inFulfillmentOf, if present, SHALL contain exactly one [1..1] order (CONF:1098-30937).
CONF #: 1098-30938 Added		This order SHALL contain at least one [1..*] id (CONF:1098-30938). Note: DICOM Accession Number in the DICOM imaging and report data
CONF #: 1098-30939 Added		Heading: componentOf (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:1098-30939).
CONF #: 1098-30940 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

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Change	Old	New
		effective time is unknown, a nullFlavor attribute can be used. The componentOf, if present, SHALL contain exactly one [1..1] encompassingEncounter (CONF:1098-30940).
CONF #: 1098-30941 Added		This encompassingEncounter SHALL contain at least one [1..*] id (CONF:1098-30941).
CONF #: 1098-30942 Added		In the case of transformed DICOM SR documents, an appropriate null flavor *MAY* be used if the id is unavailable (CONF:1098-30942).
CONF #: 1098-30943 Added		This encompassingEncounter SHALL contain exactly one [1..1] US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1098-30943).
CONF #: 1098-30945 Added		This encompassingEncounter MAY contain zero or one [0..1] responsibleParty (CONF:1098-30945).
CONF #: 1098-30946 Added		The responsibleParty, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:1098-30946).
CONF #: 1098-30947 Added		*SHOULD* contain zero or one [[]0..1[]] assignedPerson *OR* contain zero or one [[]0..1[]] representedOrganization (CONF:1098-30947).
CONF #: 1098-30948 Added		This encompassingEncounter SHOULD contain zero or one [0..1] Physician of Record Participant (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.2:2014-06-09) (CONF:1098-30948).
CONF #: 1098-31055 Added		This structuredBody MAY contain zero or more [0..*] component (CONF:1098-31055) such that it
CONF #: 1098-31056 Added		SHALL contain exactly one [1..1] section (CONF:1098-31056).
CONF #: 1098-31057 Added		This section SHALL contain exactly one [1..1] code (CONF:1098-31057).
CONF #: 1098-31058 Added		There is no equivalent to section/title in DICOM SR, so for a CDA to SR transformation, the section/code will be transferred

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Change	Old	New
		and the title element will be dropped. This section SHOULD contain zero or one [0..1] title (CONF:1098-31058).
CONF #: 1098-31059 Added		This section SHOULD contain zero or one [0..1] text (CONF:1098-31059).
CONF #: 1098-31060 Added		If clinical statements are present, the section/text *SHALL* represent faithfully all such statements and *MAY* contain additional text (CONF:1098-31060).
CONF #: 1098-31061 Added		All text elements *SHALL* contain content. Text elements *SHALL* contain PCDATA or child elements (CONF:1098-31061).
CONF #: 1098-31062 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:1098-31062).
CONF #: 1098-31198 Added		SHALL contain exactly one [1..1] associatedEntity (CONF:1098-31198).
CONF #: 1098-31199 Added		This associatedEntity SHALL contain exactly one [1..1] associatedPerson (CONF:1098-31199).
CONF #: 1098-31200 Added		This associatedPerson SHALL contain exactly one [1..1] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-31200).
CONF #: 1098-31206 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:1098-31206).
CONF #: 1098-31207 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

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Change	Old	New
		be selected from ValueSet DIRSectionTypeCodes 2.16.840.1.113883.11.20.9.59 DYNAMIC (CONF:1098-31207). Note: The section/code SHOULD be selected from LOINC or DICOM for sections not listed in the DIR Section Type Codes table
CONF #: 1098-31208 Added		This section MAY contain zero or more [0..*] component (CONF:1098-31208).
CONF #: 1098-31210 Added		*SHALL* contain child elements (CONF:1098-31210).
CONF #: 1098-31211 Added		All sections defined in the DIR Section Type Codes table *SHALL* be top-level sections (CONF:1098-31211).
CONF #: 1098-31212 Added		*SHALL* contain at least one text element or one or more component elements (CONF:1098-31212).
CONF #: 1098-31213 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:1098-31213) such that it
CONF #: 1098-31214 Added		SHALL contain exactly one [1..1] Procedure Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.5) (CONF:1098-31214).
CONF #: 1098-31215 Added		This section MAY contain zero or more [0..*] subject (CONF:1098-31215) such that it
CONF #: 1098-31216 Added		SHALL contain exactly one [1..1] Fetus Subject Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.3) (CONF:1098-31216).
CONF #: 1098-31217 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:1098-31217) such that it

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Change	Old	New
CONF #: 1098-31218 Added		SHALL contain exactly one [1..1] Observer Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.4) (CONF:1098-31218).
CONF #: 1098-31357 Added		This section MAY contain zero or more [0..*] entry (CONF:1098-31357) such that it
CONF #: 1098-31358 Added		SHALL contain exactly one [1..1] Text Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.12) (CONF:1098-31358).
CONF #: 1098-31359 Added		This section MAY contain zero or more [0..*] entry (CONF:1098-31359) such that it
CONF #: 1098-31360 Added		SHALL contain exactly one [1..1] Code Observations (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.13) (CONF:1098-31360).
CONF #: 1098-31361 Added		This section MAY contain zero or more [0..*] entry (CONF:1098-31361) such that it
CONF #: 1098-31362 Added		SHALL contain exactly one [1..1] Quantity Measurement Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.14) (CONF:1098-31362).
CONF #: 1098-31363 Added		This section MAY contain zero or more [0..*] entry (CONF:1098-31363) such that it
CONF #: 1098-31364 Added		SHALL contain exactly one [1..1] SOP Instance Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8) (CONF:1098-31364).
CONF #: 1098-32089 Added		The relatedDocument, if present, SHALL contain exactly one [1..1] parentDocument (CONF:1098-32089).
CONF #: 1098-32090 Added		This parentDocument SHALL contain exactly one [1..1] id (CONF:1098-32090).
CONF #: 1098-32515 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32515).
CONF #: 81-9417 Removed	MAY contain zero or more [0..*] Procedure Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.5) (CONF:81-9417).	
CONF #: 81-15141 Removed	SHOULD contain zero or one [0..1] DICOM Object Catalog Section -	

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Change	Old	New
	DCM 121181 (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.1) (CONF:81-15141).	
CONF #: 81-9419 Removed	MAY contain zero or more [0..*] Fetus Subject Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.3) (CONF:81-9419).	
CONF #: 81-9484 Removed	SHALL contain exactly one [1..1] Findings Section (DIR) (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.2) (CONF:81-9484).	
CONF #: 81-9421 Removed	MAY contain zero or more [0..*] Observer Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.4) (CONF:81-9421).	
CONF #: 81-8405 Removed	The ClinicalDocument/id/@root attribute SHALL be a syntactically correct OID, and SHALL NOT be a UUID (CONF:81-8405).	
CONF #: 81-8406 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:81-8406).	
CONF #: 81-8407 Removed	OIDs SHALL be no more than 64 characters in length (CONF:81-8407).	
CONF #: 81-8408 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:81-8408).	
CONF #: 81-8415 Removed	SHALL contain exactly one [1..1] assignedPerson (CONF:81-8415).	
CONF #: 81-8434 Removed	This id MAY contain zero or one [0..1] componentOf (CONF:81-8434).	
CONF #: 81-8435 Removed	This encompassingEncounter SHALL contain at least one [1..*] id (CONF:81-8435).	
CONF #: 81-8436 Removed	In the case of transformed DICOM SR documents, an appropriate null flavor MAY be used if the id is unavailable (CONF:81-8436).	
CONF #: 81-8437 Removed	This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:81-8437).	

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Change	Old	New
CONF #: 81-8438 Removed	This encompassingEncounter MAY contain zero or one [0..1] responsibleParty (CONF:81-8438).	
CONF #: 81-8439 Removed	SHOULD contain zero or one [0..1] assignedPerson OR SHOULD contain zero or one [0..1] representedOrganization (CONF:81-8439).	
CONF #: 81-8448 Removed	This encompassingEncounter SHOULD contain zero or one [0..1] Physician of Record Participant (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.2) (CONF:81-8448).	
CONF #: 81-8449 Removed	The componentOf, if present, SHALL contain exactly one [1..1] encompassingEncounter (CONF:81-8449).	
CONF #: 81-9406 Removed	This assignedPerson SHALL contain exactly one [1..1] name (CONF:81-9406).	
CONF #: 81-9407 Removed	The responsibleParty, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:81-9407).	
CONF #: 81-9408 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:81-9408).	
CONF #: 81-9409 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:81-9409).	
CONF #: 81-9410 Removed	The section/code SHOULD be selected from LOINC® or DICOM for sections not listed in the DIR Section Type Codes table (CONF:81-9410).	
CONF #: 81-9411 Removed	All sections defined in the DIR Section Type Codes table SHALL be top-level sections (CONF:81-9411).	
CONF #: 81-9412 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	

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Change	Old	New
	DIR Section Type Codes table (CONF:81-9412).	
CONF #: 81-9413 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:81-9413).	
CONF #: 81-9414 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:81-9414).	
CONF #: 81-9415 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:81-9415).	
CONF #: 81-9416 Removed	If clinical statements are present, the section/text SHALL represent faithfully all such statements and MAY contain additional text (CONF:81-9416).	
CONF #: 81-9418 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:81-9418).	
CONF #: 81-9420 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:81-9420).	
CONF #: 81-9422 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:81-9422).	

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Change	Old	New
CONF #: 81-9423 Removed	Descriptions for sections is under development in DICOM in cooperation with the RSNA reporting initiative (CONF:81-9423).	
CONF #: 81-10030 Removed	SHALL contain exactly one [1..1] id (CONF:81-10030).	
CONF #: 81-10133 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:81-10133).	
CONF #: 81-10478 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:81-10478).	
CONF #: 81-14908 Removed	A Diagnostic Imaging Report can have either a structuredBody or a nonXMLBody (CONF:81-14908).	
CONF #: 81-14910 Removed	If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:81-14910).	
CONF #: 1098-8411 Modified	MAY contain zero or more [0..*] informationRecipient	Heading: informationRecipient MAY contain zero or more [0..*] informationRecipient
CONF #: 1098-8412 Modified	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	The physician requesting the imaging procedure (ClinicalDocument/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 #: 1098-8413 Modified	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	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 #: 1098-8414 Modified	MAY contain zero or one [0..1] participant	Heading: participant (If participant is present, the associatedEntity/associatedPerson

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Change	Old	New
		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 #: 1098-8416 Modified	SHALL contain exactly one [1..1] documentationOf	Heading: documentationOf (Each 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.

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Change	Old	New
		Service events map to DICOM Requested Procedures. That is, serviceEvent/id is the ID of the Requested Procedure.) SHALL contain exactly one [1..1] documentationOf
CONF #: 1098-8418 Modified	This serviceEvent SHOULD contain zero or more [0..*] id	SHOULD contain zero or more [0..*] id
CONF #: 1098-8419 Modified	This serviceEvent SHALL contain exactly one [1..1] code	SHALL contain exactly one [1..1] code
CONF #: 1098-8420 Modified	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	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 #: 1098-8422 Modified	This serviceEvent SHOULD contain zero or more [0..*] Physician Reading Study Performer (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.1)	SHOULD contain zero or more [0..*] Physician Reading Study Performer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.1:2014-06-09)
CONF #: 1098-8430 Modified	This serviceEvent SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC)	SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC)
CONF #: 1098-8432 Modified	MAY contain zero or one [0..1] relatedDocument	Heading: relatedDocument (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

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Change	Old	New
		(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 #: 1098-8433 Modified	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	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 #: 1098-10031 Modified	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))+	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 of the regular expression: ([[]0-2[]])(.([[]1-9[]][[]0-9[]][*]|0))+
CONF #: 1098-10032 Modified	OIDs SHALL be no more than 64 characters in length	OIDs *SHALL* be no more than 64 characters in length
CONF #: 1098-14833 Modified	SHALL contain exactly one [1..1] code	Preferred code is 18748-4 LOINC Diagnostic Imaging Report SHALL contain exactly one [1..1] code
CONF #: 1098-14834 Modified	This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet DIRDocumentTypeCodes 2.16.840.1.113883.11.20.9.32 DYNAMIC	This code SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet LOINC Imaging Document Codes 1.3.6.1.4.1.12009.10.2.5 DYNAMIC
CONF #: 1098-14907 Modified	SHALL contain exactly one [1..1] component	Heading: component SHALL contain exactly one [1..1] component

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10.4 Discharge Summary (V2)

Discharge Summary (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.8:2014-06-09)

Change	Old	New
Name	Discharge Summary	Discharge Summary (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.1.8	urn:hl7ii:2.16.840.1.113883.10.20.22.1.8:2014-06-09
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, LTPAC provider, or other setting. It provides information for the continuation of care following discharge. The Joint Commission requires the following information to be included in the Discharge Summary (http://www.jointcommission.org/) : • The reason for hospitalization (the admission) • The procedures performed, as applicable • 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 best practice for a Discharge Summary is to include the discharge disposition in the display of the header.
Implied Template	US Realm Header (urn:oid:2.16.840.1.113883.10.20.22.1.1)	US Realm Header (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)
CONF #: 1098-30518 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:1098-30518).
CONF #: 1098-30519 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30519) such that it
CONF #: 1098-30520 Added		SHALL contain exactly one [1..1] Allergies and Intolerances Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09) (CONF:1098-

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Change	Old	New
		30520).
CONF #: 1098-30521 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30521) such that it
CONF #: 1098-30522 Added		SHALL contain exactly one [1..1] Hospital Course Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.5) (CONF:1098-30522).
CONF #: 1098-30523 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30523) such that it
CONF #: 1098-30524 Added		SHALL contain exactly one [1..1] Discharge Diagnosis Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2014-06-09) (CONF:1098-30524).
CONF #: 1098-30525 Added		This structuredBody SHOULD contain zero or one [0..1] component (CONF:1098-30525) such that it
CONF #: 1098-30526 Added		SHALL contain exactly one [1..1] Discharge Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2014-06-09) (CONF:1098-30526).
CONF #: 1098-30527 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30527) such that it
CONF #: 1098-30528 Added		SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30528).
CONF #: 1098-30529 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30529) such that it
CONF #: 1098-30530 Added		SHALL contain exactly one [1..1] Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1098-30530).
CONF #: 1098-30531 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30531) such that it
CONF #: 1098-30532 Added		SHALL contain exactly one [1..1] Chief Complaint and Reason for

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Change	Old	New
		Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:1098-30532).
CONF #: 1098-30533 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30533) such that it
CONF #: 1098-30534 Added		SHALL contain exactly one [1..1] Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1098-30534).
CONF #: 1098-30535 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30535) such that it
CONF #: 1098-30536 Added		SHALL contain exactly one [1..1] Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-30536).
CONF #: 1098-30537 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30537) such that it
CONF #: 1098-30538 Added		SHALL contain exactly one [1..1] Functional Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09) (CONF:1098-30538).
CONF #: 1098-30539 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30539) such that it
CONF #: 1098-30540 Added		SHALL contain exactly one [1..1] History of Past Illness Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09) (CONF:1098-30540).
CONF #: 1098-30541 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30541) such that it
CONF #: 1098-30542 Added		SHALL contain exactly one [1..1] History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1098-30542).
CONF #: 1098-30543 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30543) such that it
CONF #: 1098-30544 Added		SHALL contain exactly one [1..1] Admission Diagnosis Section (V2) (identifier:

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Change	Old	New
		urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2014-06-09) (CONF:1098-30544).
CONF #: 1098-30545 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30545) such that it
CONF #: 1098-30546 Added		SHALL contain exactly one [1..1] Admission Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2014-06-09) (CONF:1098-30546).
CONF #: 1098-30547 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30547) such that it
CONF #: 1098-30548 Added		SHALL contain exactly one [1..1] Hospital Consultations Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.42) (CONF:1098-30548).
CONF #: 1098-30549 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30549) such that it
CONF #: 1098-30550 Added		SHALL contain exactly one [1..1] Hospital Discharge Instructions Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.41) (CONF:1098-30550).
CONF #: 1098-30551 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30551) such that it
CONF #: 1098-30552 Added		SHALL contain exactly one [1..1] Hospital Discharge Physical Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.26) (CONF:1098-30552).
CONF #: 1098-30553 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30553) such that it
CONF #: 1098-30554 Added		SHALL contain exactly one [1..1] Hospital Discharge Studies Summary Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.16) (CONF:1098-30554).
CONF #: 1098-30555 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30555) such that it
CONF #: 1098-30556 Added		SHALL contain exactly one [1..1] Immunizations Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.

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Change	Old	New
		22.2.2:2014-06-09) (CONF:1098-30556).
CONF #: 1098-30557 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30557) such that it
CONF #: 1098-30558 Added		SHALL contain exactly one [1..1] Problem Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09) (CONF:1098-30558).
CONF #: 1098-30559 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30559) such that it
CONF #: 1098-30560 Added		SHALL contain exactly one [1..1] Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09) (CONF:1098-30560).
CONF #: 1098-30561 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30561) such that it
CONF #: 1098-30562 Added		SHALL contain exactly one [1..1] Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:1098-30562).
CONF #: 1098-30563 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30563) such that it
CONF #: 1098-30564 Added		SHALL contain exactly one [1..1] Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-30564).
CONF #: 1098-30565 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30565) such that it
CONF #: 1098-30566 Added		SHALL contain exactly one [1..1] Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-30566).
CONF #: 1098-30567 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30567) such that it
CONF #: 1098-30568 Added		SHALL contain exactly one [1..1] Vital Signs Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.

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Change	Old	New
		22.2.4:2014-06-09) (CONF:1098-30568).
CONF #: 1098-30569 Added		This structuredBody *SHALL NOT* contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) is present (CONF:1098-30569).
CONF #: 1098-31586 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-31586) such that it
CONF #: 1098-31587 Added		SHALL contain exactly one [1..1] Discharge Medications Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11.1:2014-06-09) (CONF:1098-31587).
CONF #: 1098-32517 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32517).
CONF #: 1098-32611 Added		This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:1098-32611).
CONF #: 1098-32613 Added		If present, the responsibleParty/assignedEntity element *SHALL* have at least one assignedPerson or representedOrganization element present The responsibleParty, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:1098-32613).
CONF #: 1098-32615 Added		If present, the encounterParticipant/assignedEntity element *SHALL* have at least one assignedPerson or representedOrganization element present. The encounterParticipant, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:1098-32615).
CONF #: 1098-32619 Added		This assignedEntity SHOULD contain zero or one [0..1] assignedPerson (CONF:1098-32619).
CONF #: 1098-32620 Added		This assignedEntity SHOULD

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Change	Old	New
		contain zero or one [0..1] representedOrganization (CONF:1098-32620).
CONF #: 1098-32621 Added		This assignedEntity SHOULD contain zero or one [0..1] assignedPerson (CONF:1098-32621).
CONF #: 1098-32622 Added		This assignedEntity SHOULD contain zero or one [0..1] representedOrganization (CONF:1098-32622).
CONF #: 1098-32790 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-32790) such that it
CONF #: 1098-32791 Added		SHALL contain exactly one [1..1] Discharge Diet Section (DEPRECATED) (identifier: urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.33:2014-06-09) (CONF:1098-32791).
CONF #: 81-9556 Removed	MAY contain zero or one [0..1] Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:81-9556).	
CONF #: 81-9554 Removed	MAY contain zero or one [0..1] Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:81-9554).	
CONF #: 81-9566 Removed	MAY contain zero or one [0..1] History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:81-9566).	
CONF #: 81-9924 Removed	MAY contain zero or one [0..1] Hospital Consultations Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.42) (CONF:81-9924).	
CONF #: 81-9544 Removed	SHALL contain exactly one [1..1] Hospital Course Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.5) (CONF:81-9544).	
CONF #: 81-9926 Removed	MAY contain zero or one [0..1] Hospital Discharge Instructions Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.41) (CONF:81-9926).	
CONF #: 81-9568 Removed	MAY contain zero or one [0..1] Hospital Discharge Physical Section (identifier:	

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Change	Old	New
	urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.26) (CONF:81-9568).	
CONF #: 81-9570 Removed	MAY contain zero or one [0..1] Hospital Discharge Studies Summary Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.16) (CONF:81-9570).	
CONF #: 81-9578 Removed	MAY contain zero or one [0..1] Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:81-9578).	
CONF #: 81-9580 Removed	MAY contain zero or one [0..1] Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:81-9580).	
CONF #: 81-8468 Removed	If present, the participant/associatedEntity element SHALL have an associatedPerson or scopingOrganization element (CONF:81-8468).	
CONF #: 81-8477 Removed	The dischargeDispositionCode, @displayName, or NUBC UB-04 Print Name, SHALL be displayed when the document is rendered (CONF:81-8477).	
CONF #: 81-9537 Removed	A Discharge Summary can have either a structuredBody or a nonXMLBody (CONF:81-9537).	
CONF #: 81-9538 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:81-9538).	
CONF #: 81-9540 Removed	If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:81-9540).	
CONF #: 81-9542 Removed	SHALL contain exactly one [1..1] Allergies Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.6) (CONF:81-9542).	

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Change	Old	New
CONF #: 81-9546 Removed	SHALL contain exactly one [1..1] Hospital Discharge Diagnosis Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.24) (CONF:81-9546).	
CONF #: 81-9548 Removed	SHALL contain exactly one [1..1] Hospital Discharge Medications Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.11) (CONF:81-9548).	
CONF #: 81-9550 Removed	SHALL contain exactly one [1..1] Plan of Care Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.10) (CONF:81-9550).	
CONF #: 81-9558 Removed	MAY contain zero or one [0..1] Discharge Diet Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.33) (CONF:81-9558).	
CONF #: 81-9560 Removed	MAY contain zero or one [0..1] Family History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.15) (CONF:81-9560).	
CONF #: 81-9562 Removed	MAY contain zero or one [0..1] Functional Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.14) (CONF:81-9562).	
CONF #: 81-9564 Removed	MAY contain zero or one [0..1] History of Past Illness Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.20) (CONF:81-9564).	
CONF #: 81-9572 Removed	MAY contain zero or one [0..1] Immunizations Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.2) (CONF:81-9572).	
CONF #: 81-9574 Removed	MAY contain zero or one [0..1] Problem Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.5) (CONF:81-9574).	
CONF #: 81-9576 Removed	MAY contain zero or one [0..1] Procedures Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.7) (CONF:81-9576).	
CONF #: 81-9582 Removed	MAY contain zero or one [0..1] Social History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.17) (CONF:81-9582).	

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Change	Old	New
CONF #: 81-9584 Removed	MAY contain zero or one [0..1] Vital Signs Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.4) (CONF:81-9584).	
CONF #: 81-9928 Removed	MAY contain zero or one [0..1] Hospital Admission Diagnosis Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.43) (CONF:81-9928).	
CONF #: 81-10055 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:81-10055).	
CONF #: 81-10111 Removed	MAY contain zero or one [0..1] Hospital Admission Medications Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.44) (CONF:81-10111).	
CONF #: 1098-8467 Modified	MAY contain zero or more [0..*] participant	Heading: participant (The participant element in the Discharge Summary header follows the General Header Constraints for participants. Discharge Summary does not specify any use for functionCode for participants. Local policies will determine how this element should be used in implementations.) MAY contain zero or more [0..*] participant
CONF #: 1098-8469 Modified	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	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 #: 1098-8471 Modified	SHALL contain exactly one [1..1] componentOf	Heading: componentOf (The Discharge Summary is always associated with a Hospital Admission using the encompassingEncounter element in the header.) SHALL contain exactly one [1..1] componentOf
CONF #: 1098-8473 Modified	This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime/low	The admission date is recorded in the componentOf/encompassingEncounter/effectiveTime/low. This effectiveTime SHALL contain

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Change	Old	New
		exactly one [1..1] low
CONF #: 1098-8475 Modified	This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime/high	The discharge date is recorded in the componentOf/encompassingEncounter/effectiveTime/high. This effectiveTime SHALL contain exactly one [1..1] high
CONF #: 1098-8476 Modified	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)	The dischargeDispositionCode records the disposition of the patient at time of discharge. Access to the National Uniform Billing Committee (NUBC) code system requires a membership. The following conformance statement aligns with HITSP C80 requirements. The dischargeDispositionCode, @displayName, or NUBC UB-04 Print Name, must be displayed when the document is rendered. This encompassingEncounter SHALL contain exactly one [1..1] dischargeDispositionCode, which SHOULD be selected from ValueSet NUBC UB-04 FL17 Patient Status 2.16.840.1.113883.3.88.12.80.33 DYNAMIC
CONF #: 1098-8478 Modified	The encounterParticipant elements MAY be present. If present, the encounterParticipant/assignedEntity element SHALL have at least one assignedPerson or representedOrganization element present	The encounterParticipant elements represent only those participants in the encounter, not necessarily the entire episode of care. This encompassingEncounter MAY contain zero or more [0..*] encounterParticipant
CONF #: 1098-8479 Modified	The responsibleParty element MAY be present. If present, the responsibleParty/assignedEntity element SHALL have at least one assignedPerson or representedOrganization element present	The responsibleParty element represents only the party responsible for the encounter, not necessarily the entire episode of care. This encompassingEncounter MAY contain zero or one [0..1] responsibleParty
CONF #: 1098-9539 Modified	SHALL contain exactly one [1..1] component	Heading: component SHALL contain exactly one [1..1] component
CONF #: 1098-17178 Modified	SHALL contain exactly one [1..1] code	The Discharge Summary recommends use of a single document type code, 18842-5 "Discharge summary", with further specification provided by author or performer, setting, or specialty. When pre-coordinated codes are used, any coded values describing

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Change	Old	New
		the author or performer of the service act or the practice setting must be consistent with the LOINC document type. SHALL contain exactly one [1..1] code

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10.5 History and Physical (V2)

History and Physical (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.3:2014-06-09)

Change	Old	New
Name	History and Physical	History and Physical (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.1.3	urn:hl7ii:2.16.840.1.113883.10.20.22.1.3:2014-06-09
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 the 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.
Implied Template	US Realm Header (urn:oid:2.16.840.1.113883.10.20.22.1.1)	US Realm Header (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)
CONF #: 1098-30570 Added		In this template (templateId 2.16.840.1.113883.10.20.22.1.3.2),

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Change	Old	New
		coded entries are optional. This component SHALL contain exactly one [1..1] structuredBody (CONF:1098-30570).
CONF #: 1098-30571 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30571) such that it
CONF #: 1098-30572 Added		SHALL contain exactly one [1..1] Allergies and Intolerances Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09) (CONF:1098-30572).
CONF #: 1098-30573 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30573) such that it
CONF #: 1098-30574 Added		SHALL contain exactly one [1..1] Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1098-30574).
CONF #: 1098-30575 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30575) such that it
CONF #: 1098-30576 Added		SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30576).
CONF #: 1098-30577 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30577) such that it
CONF #: 1098-30578 Added		SHALL contain exactly one [1..1] Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1098-30578).
CONF #: 1098-30579 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30579) such that it
CONF #: 1098-30580 Added		SHALL contain exactly one [1..1] Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1098-30580).
CONF #: 1098-30581 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30581) such that it
CONF #: 1098-30582 Added		SHALL contain exactly one [1..1] Chief Complaint and Reason for

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Change	Old	New
		Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:1098-30582).
CONF #: 1098-30583 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30583) such that it
CONF #: 1098-30584 Added		SHALL contain exactly one [1..1] Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-30584).
CONF #: 1098-30585 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30585) such that it
CONF #: 1098-30586 Added		SHALL contain exactly one [1..1] General Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.5) (CONF:1098-30586).
CONF #: 1098-30587 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30587) such that it
CONF #: 1098-30588 Added		SHALL contain exactly one [1..1] History of Past Illness Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09) (CONF:1098-30588).
CONF #: 1098-30589 Added		This structuredBody SHOULD contain zero or one [0..1] component (CONF:1098-30589) such that it
CONF #: 1098-30590 Added		SHALL contain exactly one [1..1] History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1098-30590).
CONF #: 1098-30591 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30591) such that it
CONF #: 1098-30592 Added		SHALL contain exactly one [1..1] Immunizations Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09) (CONF:1098-30592).
CONF #: 1098-30593 Added		This structuredBody MAY contain zero or one [0..1] component

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Change	Old	New
		(CONF:1098-30593) such that it
CONF #: 1098-31385 Added		SHALL contain exactly one [1..1] Instructions Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09) (CONF:1098-31385).
CONF #: 1098-30595 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30595) such that it
CONF #: 1098-30596 Added		SHALL contain exactly one [1..1] Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09) (CONF:1098-30596).
CONF #: 1098-30597 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30597) such that it
CONF #: 1098-30598 Added		SHALL contain exactly one [1..1] Physical Exam Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09) (CONF:1098-30598).
CONF #: 1098-30599 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30599) such that it
CONF #: 1098-30600 Added		SHALL contain exactly one [1..1] Problem Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09) (CONF:1098-30600).
CONF #: 1098-30601 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30601) such that it
CONF #: 1098-30602 Added		SHALL contain exactly one [1..1] Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09) (CONF:1098-30602).
CONF #: 1098-30603 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30603) such that it
CONF #: 1098-30604 Added		SHALL contain exactly one [1..1] Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:1098-30604).

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Change	Old	New
CONF #: 1098-30605 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30605) such that it
CONF #: 1098-30606 Added		SHALL contain exactly one [1..1] Results Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09) (CONF:1098-30606).
CONF #: 1098-30607 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30607) such that it
CONF #: 1098-30608 Added		SHALL contain exactly one [1..1] Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-30608).
CONF #: 1098-30609 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30609) such that it
CONF #: 1098-30610 Added		SHALL contain exactly one [1..1] Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-30610).
CONF #: 1098-30611 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30611) such that it
CONF #: 1098-30612 Added		SHALL contain exactly one [1..1] Vital Signs Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09) (CONF:1098-30612).
CONF #: 1098-30613 Added		This structuredBody *SHALL* contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) or a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) (CONF:1098-30613).
CONF #: 1098-30614 Added		This structuredBody *SHALL* contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2

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Change	Old	New
		014-06-09), or an Assessment Section (2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10: 2014-06-09) (CONF:1098-30614).
CONF #: 1098-30615 Added		This structuredBody *SHALL NOT* contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10: 2014-06-09) is present (CONF:1098-30615).
CONF #: 1098-30616 Added		This structuredBody *SHALL NOT* contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) is present (CONF:1098-30616).
CONF #: 1098-32482 Added		MAY contain zero or more [0..*] informationRecipient (CONF:1098-32482).
CONF #: 1098-32483 Added		The informationRecipient, if present, SHALL contain exactly one [1..1] intendedRecipient (CONF:1098-32483).
CONF #: 1098-32518 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32518).
CONF #: 81-9605 Removed	MAY contain zero or one [0..1] Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:81-9605).	
CONF #: 81-9613 Removed	MAY contain zero or one [0..1] Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:81-9613).	
CONF #: 81-9611 Removed	MAY contain zero or one [0..1] Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:81-9611).	
CONF #: 81-9617 Removed	SHALL contain exactly one [1..1]	

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Change	Old	New
	General Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.5) (CONF:81-9617).	
CONF #: 81-9621 Removed	SHOULD contain zero or one [0..1] History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:81-9621).	
CONF #: 81-9627 Removed	MAY contain [] Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:81-9627).	
CONF #: 81-9631 Removed	SHALL contain exactly one [1..1] Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:81-9631).	
CONF #: 81-8287 Removed	A participant element, if present, SHALL contain an associatedEntity element which SHALL contain either an associatedPerson or scopingOrganization element (CONF:81-8287).	
CONF #: 81-8288 Removed	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:81-8288).	
CONF #: 81-8337 Removed	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:81-8337).	
CONF #: 81-8346 Removed	The encounterParticipant element, if present, records only participants in the encounter, not necessarily in the entire episode of care (CONF:81-8346).	
CONF #: 81-8347 Removed	The responsibleParty element records only the party responsible for the encounter, not necessarily the entire episode of care	

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Change	Old	New
	(CONF:81-8347).	
CONF #: 81-8350 Removed	A History and Physical document can have either a structuredBody or a nonXMLBody (CONF:81-8350).	
CONF #: 81-8352 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:81-8352).	
CONF #: 81-9597 Removed	If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:81-9597).	
CONF #: 81-9602 Removed	SHALL contain exactly one [1..1] Allergies Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.6) (CONF:81-9602).	
CONF #: 81-9607 Removed	MAY contain zero or one [0..1] Plan of Care Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.10) (CONF:81-9607).	
CONF #: 81-9615 Removed	SHALL contain exactly one [1..1] Family History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.15) (CONF:81-9615).	
CONF #: 81-9619 Removed	SHALL contain exactly one [1..1] History of Past Illness Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.20) (CONF:81-9619).	
CONF #: 81-9623 Removed	SHALL contain exactly one [1..1] Medications Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.1) (CONF:81-9623).	
CONF #: 81-9625 Removed	SHALL contain exactly one [1..1] Physical Exam Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.10) (CONF:81-9625).	
CONF #: 81-9629 Removed	SHALL contain exactly one [1..1] Results Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.2	

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Change	Old	New
	2.2.3) (CONF:81-9629).	
CONF #: 81-9633 Removed	SHALL contain exactly one [1..1] Social History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.17) (CONF:81-9633).	
CONF #: 81-9635 Removed	SHALL contain exactly one [1..1] Vital Signs Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.4) (CONF:81-9635).	
CONF #: 81-9642 Removed	SHALL include a Chief Complaint and Reason for Visit Section, Chief Complaint Section, or a Reason for Visit Section (CONF:81-9642).	
CONF #: 81-9986 Removed	SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan Section (CONF:81-9986).	
CONF #: 81-9987 Removed	MAY contain zero or one [0..1] Assessment and Plan Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.9) (CONF:81-9987).	
CONF #: 81-9988 Removed	MAY contain zero or one [0..1] Immunizations Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.2) (CONF:81-9988).	
CONF #: 81-9989 Removed	MAY contain zero or one [0..1] Problem Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.5) (CONF:81-9989).	
CONF #: 81-9990 Removed	MAY contain zero or one [0..1] Procedures Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.7) (CONF:81-9990).	
CONF #: 81-10056 Removed	SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:81-10056).	
CONF #: 81-10057 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:81-10057).	
CONF #: 81-10135 Removed	The content of effectiveTime SHALL be a conformant US Realm Date	

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Change	Old	New
	and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:81-10135).	
CONF #: 81-16807 Removed	MAY contain zero or one [0..1] Instructions Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.45) (CONF:81-16807).	
CONF #: 1098-8286 Modified	MAY contain zero or more [0..*] participant	Heading: participant (The participant element in the H&P header follows the General Header Constraints for participants. H&P Note does not specify any use for functionCode for participants. Local policies will determine how this element should be used in implementations.) MAY contain zero or more [0..*] participant
CONF #: 1098-8333 Modified	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	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. 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 #: 1098-8336 Modified	MAY contain zero or more [0..*] inFulfillmentOf	Heading: inFulfillmentOf (inFulfillmentOf elements describe 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 the H&P Note may be in partial fulfillment of that referral.) MAY contain zero or more [0..*] inFulfillmentOf
CONF #: 1098-8338 Modified	SHALL contain exactly one [1..1] componentOf	Heading: componentOf (The H&P Note is always associated with an encounter.) SHALL contain exactly one [1..1] componentOf
CONF #: 1098-8340 Modified	This encompassingEncounter	This encompassingEncounter

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Change	Old	New
	SHALL contain exactly one [1..1] id	SHALL contain at least one [1..*] id
CONF #: 1098-8341 Modified	This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime	The effectiveTime represents the time interval or point in time in which the encounter took place. This encompassingEncounter SHALL contain exactly one [1..1] US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3)
CONF #: 1098-8342 Modified	This encompassingEncounter MAY contain zero or more [0..*] encounterParticipant	The encounterParticipant elements represent only those participants in the encounter, not necessarily the entire episode of care. This encompassingEncounter MAY contain zero or more [0..*] encounterParticipant
CONF #: 1098-8345 Modified	This encompassingEncounter MAY contain zero or one [0..1] responsibleParty	The responsibleParty element records only the party responsible for the encounter, not necessarily the entire episode of care. This encompassingEncounter MAY contain zero or one [0..1] responsibleParty
CONF #: 1098-8348 Modified	The responsibleParty element, if present, SHALL contain an assignedEntity element, which SHALL contain an assignedPerson element, a representedOrganization element, or both	The responsibleParty element, if present, *SHALL* contain an assignedEntity element, which *SHALL* contain an assignedPerson element, a representedOrganization element, or both
CONF #: 1098-8349 Modified	SHALL contain exactly one [1..1] component	Heading: component SHALL contain exactly one [1..1] component
CONF #: 1098-17185 Modified	SHALL contain exactly one [1..1] code	The H&P Note recommends use of a single document type code, 34117-2 "History and physical 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. SHALL contain exactly one [1..1] code

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10.6 Operative Note (V2)

Operative Note (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.7:2014-06-09)

Change	Old	New
Name	Operative Note	Operative Note (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.1.7	urn:hl7ii:2.16.840.1.113883.10.20.22.1.7:2014-06-09
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.
Implied Template	US Realm Header (urn:oid:2.16.840.1.113883.10.20.22.1.1)	US Realm Header (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)
CONF #: 1098-30485 Added		This component SHALL contain exactly one [1..1] structuredBody (CONF:1098-30485).
CONF #: 1098-30486 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30486) such that it
CONF #: 1098-30487 Added		SHALL contain exactly one [1..1] Anesthesia Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.25:2014-06-09) (CONF:1098-30487).
CONF #: 1098-30488 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30488) such that it
CONF #: 1098-30489 Added		SHALL contain exactly one [1..1] Complications Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09) (CONF:1098-30489).
CONF #: 1098-30490 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30490)

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Change	Old	New
		such that it
CONF #: 1098-30491 Added		SHALL contain exactly one [1..1] Preoperative Diagnosis Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.34:2014-06-09) (CONF:1098-30491).
CONF #: 1098-30492 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30492) such that it
CONF #: 1098-30493 Added		SHALL contain exactly one [1..1] Procedure Estimated Blood Loss Section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.9) (CONF:1098-30493).
CONF #: 1098-30494 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30494) such that it
CONF #: 1098-30495 Added		SHALL contain exactly one [1..1] Procedure Findings Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.28:2014-06-09) (CONF:1098-30495).
CONF #: 1098-30496 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30496) such that it
CONF #: 1098-30497 Added		SHALL contain exactly one [1..1] Procedure Specimens Taken Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.31) (CONF:1098-30497).
CONF #: 1098-30498 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30498) such that it
CONF #: 1098-30499 Added		SHALL contain exactly one [1..1] Procedure Description Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.27) (CONF:1098-30499).
CONF #: 1098-30500 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30500) such that it
CONF #: 1098-30501 Added		SHALL contain exactly one [1..1] Postoperative Diagnosis Section (identifier:

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Change	Old	New
		urn:oid:2.16.840.1.113883.10.20.22.2.35) (CONF:1098-30501).
CONF #: 1098-30502 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30502) such that it
CONF #: 1098-30503 Added		SHALL contain exactly one [1..1] Procedure Implants Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.40) (CONF:1098-30503).
CONF #: 1098-30504 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30504) such that it
CONF #: 1098-30505 Added		SHALL contain exactly one [1..1] Operative Note Fluids Section (identifier: urn:oid:2.16.840.1.113883.10.20.7.12) (CONF:1098-30505).
CONF #: 1098-30506 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30506) such that it
CONF #: 1098-30507 Added		SHALL contain exactly one [1..1] Operative Note Surgical Procedure Section (identifier: urn:oid:2.16.840.1.113883.10.20.7.14) (CONF:1098-30507).
CONF #: 1098-30508 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30508) such that it
CONF #: 1098-30509 Added		SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30509).
CONF #: 1098-30510 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30510) such that it
CONF #: 1098-30511 Added		SHALL contain exactly one [1..1] Planned Procedure Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.30:2014-06-09) (CONF:1098-30511).
CONF #: 1098-30512 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30512) such that it
CONF #: 1098-30513 Added		SHALL contain exactly one [1..1] Procedure Disposition Section (identifier: urn:oid:2.16.840.1.113883.10.20.1

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Change	Old	New
		8.2.12) (CONF:1098-30513).
CONF #: 1098-30514 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30514) such that it
CONF #: 1098-30515 Added		SHALL contain exactly one [1..1] Procedure Indications Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.29:2014-06-09) (CONF:1098-30515).
CONF #: 1098-30516 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30516) such that it
CONF #: 1098-30517 Added		SHALL contain exactly one [1..1] Surgical Drains Section (identifier: urn:oid:2.16.840.1.113883.10.20.7.13) (CONF:1098-30517).
CONF #: 1098-32404 Added		Authorization represents consent. Consent, if present, shall be represented by authorization/consent. MAY contain zero or one [0..1] authorization (CONF:1098-32404).
CONF #: 1098-32405 Added		The authorization, if present, SHALL contain exactly one [1..1] consent (CONF:1098-32405).
CONF #: 1098-32408 Added		The authorization, if present, SHALL contain exactly one [1..1] @typeCode="AUTH" authorized by (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32408).
CONF #: 1098-32409 Added		This consent SHALL contain exactly one [1..1] @classCode="CONS" consent (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-32409).
CONF #: 1098-32410 Added		This consent SHALL contain exactly one [1..1] @moodCode="EVN" event (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-32410).
CONF #: 1098-32411 Added		This consent SHALL contain exactly one [1..1] statusCode (CONF:1098-32411).
CONF #: 1098-32519 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32519).

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Change	Old	New
CONF #: 1098-32736 Added		Heading: performer (This performer represents any assistants.) This serviceEvent MAY contain zero or more [0..*] performer (CONF:1098-32736) such that it
CONF #: 1098-32737 Added		SHALL contain exactly one [1..1] assignedEntity (CONF:1098-32737).
CONF #: 1098-32738 Added		SHALL contain exactly one [1..1] @typeCode="SPRF" Secondary performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:1098-32738).
CONF #: 1098-32739 Added		This assignedEntity SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Provider Role 2.16.840.1.113883.3.88.12.3221.4.2 DYNAMIC (CONF:1098-32739).
CONF #: 81-9900 Removed	MAY contain zero or one [0..1] Operative Note Fluids Section (identifier: urn:oid:2.16.840.1.113883.10.20.7.12) (CONF:81-9900).	
CONF #: 81-9902 Removed	MAY contain zero or one [0..1] Operative Note Surgical Procedure Section (identifier: urn:oid:2.16.840.1.113883.10.20.7.14) (CONF:81-9902).	
CONF #: 81-9913 Removed	SHALL contain exactly one [1..1] Postoperative Diagnosis Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.35) (CONF:81-9913).	
CONF #: 81-9896 Removed	SHALL contain exactly one [1..1] Procedure Description Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.27) (CONF:81-9896).	
CONF #: 81-9908 Removed	MAY contain zero or one [0..1] Procedure Disposition Section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.12) (CONF:81-9908).	
CONF #: 81-9890 Removed	SHALL contain exactly one [1..1] Procedure Estimated Blood Loss Section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.9) (CONF:81-9890).	
CONF #: 81-9898 Removed	MAY contain zero or one [0..1]	

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Change	Old	New
	Procedure Implants Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.40) (CONF:81-9898).	
CONF #: 81-9894 Removed	SHALL contain exactly one [1..1] Procedure Specimens Taken Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.31) (CONF:81-9894).	
CONF #: 81-9912 Removed	MAY contain zero or one [0..1] Surgical Drains Section (identifier: urn:oid:2.16.840.1.113883.10.20.7.13) (CONF:81-9912).	
CONF #: 81-8485 Removed	A consent, if present, SHALL be represented as ClinicalDocument/authorization/consent (CONF:81-8485).	
CONF #: 81-8491 Removed	This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Provider Role 2.16.840.1.113883.3.88.12.3221.4.2 DYNAMIC (CONF:81-8491).	
CONF #: 81-8512 Removed	Any assistants SHALL be identified and SHALL be identified as secondary performers (SPRF) (CONF:81-8512).	
CONF #: 81-9586 Removed	An Operative Note can have either a structuredBody or a nonXMLBody (CONF:81-9586).	
CONF #: 81-9587 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:81-9587).	
CONF #: 81-9596 Removed	If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:81-9596).	
CONF #: 81-9883 Removed	SHALL contain exactly one [1..1] Anesthesia Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.25) (CONF:81-9883).	
CONF #: 81-9885 Removed	SHALL contain exactly one [1..1]	

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Change	Old	New
	Complications Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.37) (CONF:81-9885).	
CONF #: 81-9888 Removed	SHALL contain exactly one [1..1] Preoperative Diagnosis Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.34) (CONF:81-9888).	
CONF #: 81-9892 Removed	SHALL contain exactly one [1..1] Procedure Findings Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.28) (CONF:81-9892).	
CONF #: 81-9904 Removed	MAY contain zero or one [0..1] Plan of Care Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.10) (CONF:81-9904).	
CONF #: 81-9906 Removed	MAY contain zero or one [0..1] Planned Procedure Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.30) (CONF:81-9906).	
CONF #: 81-9910 Removed	MAY contain zero or one [0..1] Procedure Indications Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.29) (CONF:81-9910).	
CONF #: 81-10136 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:81-10136).	
CONF #: 1098-8486 Modified	SHALL contain at least one [1..*] documentationOf	Heading: documentationOf (A serviceEvent represents the main act, such as a colonoscopy or an appendectomy, being documented. A serviceEvent can further specialize the act inherent in the ClinicalDocument/code, such as where the ClinicalDocument/code is simply "Surgical Operation Note" and the procedure is "Appendectomy." serviceEvent is required in the Operative Note and it must be equivalent to or further specialize the value inherent in the ClinicalDocument/code; it shall not conflict with the value inherent in the ClinicalDocument/code, as such a conflict would create ambiguity. serviceEvent/effectiveTime can be used to indicate the time the actual

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Change	Old	New
		event (as opposed to the encounter surrounding the event) took place. If the date and the duration of the procedure is known, serviceEvent/effectiveTime/low is used with a width element that describes the duration; no high element is used. However, if only the date is known, the date is placed in both the low and high elements.) SHALL contain at least one [1..*] documentationOf
CONF #: 1098-8487 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	The value of 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 #: 1098-8488 Modified	The serviceEvent/effectiveTime SHALL be present with effectiveTime/low	The serviceEvent/effectiveTime *SHALL* be present with effectiveTime/low
CONF #: 1098-8489 Modified	This serviceEvent SHALL contain exactly one [1..1] performer	Heading: performer (This performer represents a clinicians who actually and principally carry out the serviceEvent. Typically, these are clinicians who have surgical privileges in their institutions such as Surgeons, Obstetrician/Gynecologists, and Family Practice Physicians. The performer may also be non-physician providers (NPPs) who have surgical privileges. There may be more than one primary performer in the case of complicated surgeries. There are occasionally co-surgeons. Usually they will be billing separately and will each dictate their own notes. An example may be spinal surgery , where a general surgeon and an orthopedic surgeon both are present and billing off the same Current Procedural Terminology (CPT) codes. Typically two

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Change	Old	New
		Operative Notes are generated; however, each will list the other as a co-surgeon.) This serviceEvent SHALL contain at least one [1..*] performer
CONF #: 1098-8490 Modified	This assignedEntity SHALL contain exactly one [1..1] code	This assignedEntity SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Provider Role 2.16.840.1.113883.3.88.12.3221.4.2 DYNAMIC
CONF #: 1098-8494 Modified	This serviceEvent SHALL contain exactly one [1..1] effectiveTime	This serviceEvent SHALL contain exactly one [1..1] US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3)
CONF #: 1098-9585 Modified	SHALL contain exactly one [1..1] component	Heading: component SHALL contain exactly one [1..1] component
CONF #: 1098-10058 Modified	If a width is not present, the serviceEvent/effectiveTime SHALL include effectiveTime/high	If a width is not present, the serviceEvent/effectiveTime *SHALL* include effectiveTime/high
CONF #: 1098-10060 Modified	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	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 #: 1098-17187 Modified	SHALL contain exactly one [1..1] code	The Operative Note recommends use of a single document type code, 11504-8 "Provider-unspecified Operation Note", with further specification provided by author or performer, setting, or specialty data in the CDA header. Some of the LOINC codes in the Surgical Operation Note Document Type Code table are pre-coordinated with the practice setting or the training or professional level of the author. Use of pre-coordinated codes is not recommended because of potential conflict with other information in the header. When these 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. SHALL contain exactly one [1..1] code

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10.7 Procedure Note (V2)

Procedure Note (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.6:2014-06-09)

Change	Old	New
Name	Procedure Note	Procedure Note (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.1.6	urn:hl7ii:2.16.840.1.113883.10.20.22.1.6:2014-06-09
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.	A 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, postprocedure 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.
Implied Template	US Realm Header (urn:oid:2.16.840.1.113883.10.20.22.1.1)	US Realm Header (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)
CONF #: 1098-30352 Added		This component SHALL contain exactly one [1..1] structuredBody (CONF:1098-30352).
CONF #: 1098-30353 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30353) such that it
CONF #: 1098-30355 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30355) such that it
CONF #: 1098-30356 Added		SHALL contain exactly one [1..1] Procedure Description Section (identifier: urn:oid:2.16.840.1.113883.10.20.2

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Change	Old	New
		2.2.27) (CONF:1098-30356).
CONF #: 1098-30357 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30357) such that it
CONF #: 1098-30358 Added		SHALL contain exactly one [1..1] Procedure Indications Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.29:2014-06-09) (CONF:1098-30358).
CONF #: 1098-30359 Added		This structuredBody SHALL contain exactly one [1..1] component (CONF:1098-30359) such that it
CONF #: 1098-30360 Added		SHALL contain exactly one [1..1] Postprocedure Diagnosis Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.36:2014-06-09) (CONF:1098-30360).
CONF #: 1098-30361 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30361) such that it
CONF #: 1098-30362 Added		SHALL contain exactly one [1..1] Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1098-30362).
CONF #: 1098-30363 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30363) such that it
CONF #: 1098-30364 Added		SHALL contain exactly one [1..1] Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1098-30364).
CONF #: 1098-30365 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30365) such that it
CONF #: 1098-30366 Added		SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30366).
CONF #: 1098-30367 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30367) such that it
CONF #: 1098-30368 Added		SHALL contain exactly one [1..1] Allergies and Intolerances Section

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Change	Old	New
		(entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09) (CONF:1098-30368).
CONF #: 1098-30369 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30369) such that it
CONF #: 1098-30370 Added		SHALL contain exactly one [1..1] Anesthesia Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.25:2014-06-09) (CONF:1098-30370).
CONF #: 1098-30371 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30371) such that it
CONF #: 1098-30372 Added		SHALL contain exactly one [1..1] Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1098-30372).
CONF #: 1098-30373 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30373) such that it
CONF #: 1098-30374 Added		SHALL contain exactly one [1..1] Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:1098-30374).
CONF #: 1098-30375 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30375) such that it
CONF #: 1098-30376 Added		SHALL contain exactly one [1..1] Family History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09) (CONF:1098-30376).
CONF #: 1098-30377 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30377) such that it
CONF #: 1098-30378 Added		SHALL contain exactly one [1..1] History of Past Illness Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09) (CONF:1098-30378).
CONF #: 1098-30379 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30379) such that it
CONF #: 1098-30380 Added		SHALL contain exactly one [1..1] History of Present Illness Section (identifier:

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Change	Old	New
		urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1098-30380).
CONF #: 1098-30381 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30381) such that it
CONF #: 1098-30382 Added		SHALL contain exactly one [1..1] Medical (General) History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.39) (CONF:1098-30382).
CONF #: 1098-30383 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30383) such that it
CONF #: 1098-30384 Added		SHALL contain exactly one [1..1] Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09) (CONF:1098-30384).
CONF #: 1098-30387 Added		SHALL contain exactly one [1..1] Complications Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09) (CONF:1098-30387).
CONF #: 1098-30388 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30388) such that it
CONF #: 1098-30389 Added		SHALL contain exactly one [1..1] Medications Administered Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.38:2014-06-09) (CONF:1098-30389).
CONF #: 1098-30390 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30390) such that it
CONF #: 1098-30391 Added		SHALL contain exactly one [1..1] Physical Exam Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09) (CONF:1098-30391).
CONF #: 1098-30392 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30392) such that it
CONF #: 1098-30393 Added		SHALL contain exactly one [1..1] Planned Procedure Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.30:2014-06-09) (CONF:1098-

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Change	Old	New
		30393).
CONF #: 1098-30394 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30394) such that it
CONF #: 1098-30395 Added		SHALL contain exactly one [1..1] Procedure Disposition Section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.12) (CONF:1098-30395).
CONF #: 1098-30396 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30396) such that it
CONF #: 1098-30397 Added		SHALL contain exactly one [1..1] Procedure Estimated Blood Loss Section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.9) (CONF:1098-30397).
CONF #: 1098-30398 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30398) such that it
CONF #: 1098-30399 Added		SHALL contain exactly one [1..1] Procedure Findings Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.28:2014-06-09) (CONF:1098-30399).
CONF #: 1098-30400 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30400) such that it
CONF #: 1098-30401 Added		SHALL contain exactly one [1..1] Procedure Implants Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.40) (CONF:1098-30401).
CONF #: 1098-30402 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30402) such that it
CONF #: 1098-30403 Added		SHALL contain exactly one [1..1] Procedure Specimens Taken Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.31) (CONF:1098-30403).
CONF #: 1098-30404 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30404) such that it
CONF #: 1098-30405 Added		SHALL contain exactly one [1..1] Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09) (CONF:1098-

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Change	Old	New
		30405).
CONF #: 1098-30406 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30406) such that it
CONF #: 1098-30407 Added		SHALL contain exactly one [1..1] Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:1098-30407).
CONF #: 1098-30408 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30408) such that it
CONF #: 1098-30409 Added		SHALL contain exactly one [1..1] Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-30409).
CONF #: 1098-30410 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30410) such that it
CONF #: 1098-30411 Added		SHALL contain exactly one [1..1] Social History Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09) (CONF:1098-30411).
CONF #: 1098-30412 Added		This structuredBody *SHALL* contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09), or an Assessment Section (2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30412).
CONF #: 1098-30414 Added		This structuredBody *SHALL NOT* contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1098-30414).
CONF #: 1098-30415 Added		This structuredBody *SHALL NOT* contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint

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Change	Old	New
		Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) is present (CONF:1098-30415).
CONF #: 1098-30871 Added		Heading: componentOf SHOULD contain zero or one [0..1] componentOf (CONF:1098-30871).
CONF #: 1098-30872 Added		The componentOf, if present, SHALL contain exactly one [1..1] encompassingEncounter (CONF:1098-30872).
CONF #: 1098-30873 Added		This encompassingEncounter SHALL contain exactly one [1..1] code (CONF:1098-30873).
CONF #: 1098-30874 Added		This encompassingEncounter MAY contain zero or one [0..1] encounterParticipant (CONF:1098-30874) such that it
CONF #: 1098-30875 Added		SHALL contain exactly one [1..1] @typeCode="REF" Referrer (CONF:1098-30875).
CONF #: 1098-30876 Added		This encompassingEncounter SHALL contain at least one [1..*] location (CONF:1098-30876).
CONF #: 1098-30877 Added		Such locations SHALL contain exactly one [1..1] healthCareFacility (CONF:1098-30877).
CONF #: 1098-30878 Added		This healthCareFacility SHALL contain at least one [1..*] id (CONF:1098-30878).
CONF #: 1098-32395 Added		This encompassingEncounter SHOULD contain zero or more [0..*] id (CONF:1098-32395).
CONF #: 1098-32412 Added		Authorization represents consent. Consent, if present, shall be represented by authorization/consent. MAY contain zero or one [0..1] authorization (CONF:1098-32412).
CONF #: 1098-32413 Added		The authorization, if present, SHALL contain exactly one [1..1] @typeCode="AUTH" authorized by (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32413).
CONF #: 1098-32414 Added		The authorization, if present, SHALL contain exactly one [1..1]

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Change	Old	New
		consent (CONF:1098-32414).
CONF #: 1098-32415 Added		This consent SHALL contain exactly one [1..1] @classCode="CONS" consent (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-32415).
CONF #: 1098-32416 Added		This consent SHALL contain exactly one [1..1] @moodCode="EVN" event (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:1098-32416).
CONF #: 1098-32417 Added		This consent SHALL contain exactly one [1..1] statusCode (CONF:1098-32417).
CONF #: 1098-32520 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32520).
CONF #: 1098-32732 Added		Heading: performer (This performer identifies any assistants.) This serviceEvent MAY contain zero or more [0..*] performer (CONF:1098-32732) such that it
CONF #: 1098-32733 Added		SHALL contain exactly one [1..1] assignedEntity (CONF:1098-32733).
CONF #: 1098-32734 Added		SHALL contain exactly one [1..1] @typeCode="SPRF" Secondary Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:1098-32734).
CONF #: 1098-32735 Added		This assignedEntity SHOULD contain zero or one [0..1] code, which SHALL be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:1098-32735).
CONF #: 81-9645 Removed	MAY contain zero or one [0..1] Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:81-9645).	
CONF #: 81-9815 Removed	MAY contain zero or one [0..1] Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:81-9815).	
CONF #: 81-9813 Removed	MAY contain zero or one [0..1] Chief Complaint Section (identifier:	

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Change	Old	New
	urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:81-9813).	
CONF #: 81-9821 Removed	MAY contain zero or one [0..1] History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:81-9821).	
CONF #: 81-9823 Removed	MAY contain zero or one [0..1] Medical (General) History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.39) (CONF:81-9823).	
CONF #: 81-9805 Removed	SHALL contain exactly one [1..1] Procedure Description Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.27) (CONF:81-9805).	
CONF #: 81-9833 Removed	MAY contain zero or one [0..1] Procedure Disposition Section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.12) (CONF:81-9833).	
CONF #: 81-9835 Removed	MAY contain zero or one [0..1] Procedure Estimated Blood Loss Section (identifier: urn:oid:2.16.840.1.113883.10.20.18.2.9) (CONF:81-9835).	
CONF #: 81-9839 Removed	MAY contain zero or one [0..1] Procedure Implants Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.40) (CONF:81-9839).	
CONF #: 81-9841 Removed	MAY contain zero or one [0..1] Procedure Specimens Taken Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.31) (CONF:81-9841).	
CONF #: 81-9845 Removed	MAY contain zero or one [0..1] Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:81-9845).	
CONF #: 81-9847 Removed	MAY contain zero or one [0..1] Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:81-9847).	
CONF #: 81-8499 Removed	SHOULD contain zero or one [0..1] componentOf/encompassingEncounter (CONF:81-8499).	
CONF #: 81-8500 Removed	The componentOf/encompassingEncou	

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Change	Old	New
	nter, if present, SHALL contain at least one [1..*] location/healthCareFacility/id (CONF:81-8500).	
CONF #: 81-8501 Removed	The componentOf/encompassingEncounter, if present, SHALL contain exactly one [1..1] code (CONF:81-8501).	
CONF #: 81-8502 Removed	The componentOf/encompassingEncounter, if present, MAY contain zero or one [0..1] encounterParticipant (CONF:81-8502) such that it	
CONF #: 81-8503 Removed	SHALL contain exactly one [1..1] @typeCode="REF" Referrer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:81-8503).	
CONF #: 81-8509 Removed	A consent, if present, SHALL be represented as ClinicalDocument/authorization/consent (CONF:81-8509).	
CONF #: 81-8524 Removed	Any assistants SHALL be identified and SHALL be identified as secondary performers (SPRF) (CONF:81-8524).	
CONF #: 81-9589 Removed	A Procedure Note can have either a structuredBody or a nonXMLBody (CONF:81-9589).	
CONF #: 81-9590 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:81-9590).	
CONF #: 81-9595 Removed	If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:81-9595).	
CONF #: 81-9643 Removed	SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan Section (CONF:81-9643).	

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Change	Old	New
CONF #: 81-9647 Removed	MAY contain zero or one [0..1] Plan of Care Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.10) (CONF:81-9647).	
CONF #: 81-9649 Removed	MAY contain zero or one [0..1] Assessment and Plan Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.9) (CONF:81-9649).	
CONF #: 81-9802 Removed	SHALL contain exactly one [1..1] Complications Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.37) (CONF:81-9802).	
CONF #: 81-9807 Removed	SHALL contain exactly one [1..1] Procedure Indications Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.29) (CONF:81-9807).	
CONF #: 81-9809 Removed	MAY contain zero or one [0..1] Allergies Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.6) (CONF:81-9809).	
CONF #: 81-9811 Removed	MAY contain zero or one [0..1] Anesthesia Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.25) (CONF:81-9811).	
CONF #: 81-9817 Removed	MAY contain zero or one [0..1] Family History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.15) (CONF:81-9817).	
CONF #: 81-9819 Removed	MAY contain zero or one [0..1] History of Past Illness Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.20) (CONF:81-9819).	
CONF #: 81-9825 Removed	MAY contain zero or one [0..1] Medications Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.1) (CONF:81-9825).	
CONF #: 81-9827 Removed	MAY contain zero or one [0..1] Medications Administered Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.38) (CONF:81-9827).	
CONF #: 81-9829 Removed	MAY contain zero or one [0..1] Physical Exam Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.10) (CONF:81-9829).	
CONF #: 81-9831 Removed	MAY contain zero or one [0..1]	

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Change	Old	New
	Planned Procedure Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.30) (CONF:81-9831).	
CONF #: 81-9837 Removed	MAY contain zero or one [0..1] Procedure Findings Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.28) (CONF:81-9837).	
CONF #: 81-9843 Removed	MAY contain zero or one [0..1] Procedures Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.7) (CONF:81-9843).	
CONF #: 81-9849 Removed	MAY contain zero or one [0..1] Social History Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.17) (CONF:81-9849).	
CONF #: 81-9850 Removed	SHALL contain exactly one [1..1] Postprocedure Diagnosis Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.36) (CONF:81-9850).	
CONF #: 81-9937 Removed	Each section SHALL have a title and the title SHALL NOT be empty (CONF:81-9937).	
CONF #: 81-10063 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:81-10063).	
CONF #: 81-10064 Removed	SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:81-10064).	
CONF #: 81-10065 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:81-10065).	
CONF #: 81-14913 Removed	The code, if present, SHOULD contain zero or one [0..1] @code, which SHALL be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:81-14913).	
CONF #: 1098-8504 Modified	MAY contain zero or more [0..*] participant	Heading: participant (The participant element in the Procedure Note header follows the

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Change	Old	New
		General Header Constraints for participants.) MAY contain zero or more [0..*] participant
CONF #: 1098-8510 Modified	SHALL contain at least one [1..*] documentationOf	Heading: documentationOf (A serviceEvent is required in the Procedure Note to represent the main act, such as a colonoscopy or a cardiac stress study, being documented. It must be equivalent to or further specialize the value inherent in the ClinicalDocument/@code (such as where the ClinicalDocument/@code is simply "Procedure Note" and the procedure is "colonoscopy"), and it shall not conflict with the value inherent in the ClinicalDocument/@code, as such a conflict would create ambiguity. A serviceEvent/effectiveTime element indicates the time the actual event (as opposed to the encounter surrounding the event) took place. serviceEvent/effectiveTime may be represented two different ways in the Procedure Note. For accuracy to the second, the best method is effectiveTime/low together with effectiveTime/high. If a more general time, such as minutes or hours, is acceptable OR if the duration is unknown, an effectiveTime/low with a width element may be used. If the duration is unknown, the appropriate HL7 null value such as "NI" or "NA" must be used for the width element.) SHALL contain at least one [1..*] documentationOf
CONF #: 1098-8511 Modified	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	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

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Change	Old	New
	2.16.840.1.113883.3.88.12.80.28 Procedure DYNAMIC	2.16.840.1.113883.3.88.12.80.28 Procedure *DYNAMIC*
CONF #: 1098-8513 Modified	The serviceEvent/effectiveTime SHALL be present with effectiveTime/low	The serviceEvent/effectiveTime *SHALL* be present with effectiveTime/low
CONF #: 1098-8514 Modified	If a width is not present, the serviceEvent/effectiveTime SHALL include effectiveTime/high	If a width is not present, the serviceEvent/effectiveTime *SHALL* include effectiveTime/high
CONF #: 1098-8515 Modified	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	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 #: 1098-8520 Modified	This serviceEvent SHALL contain exactly one [1..1] performer	Heading: performer (This performer participant represents clinicians who actually and principally carry out the serviceEvent. Typically, these are clinicians who have the appropriate privileges in their institutions such as gastroenterologists, interventional radiologists, and family practice physicians. Performers may also be non-physician providers (NPPs) who have other significant roles in the procedure such as a radiology technician, dental assistant, or nurse.) This serviceEvent SHALL contain at least one [1..*] performer
CONF #: 1098-8521 Modified	This performer SHALL contain exactly one [1..1] @typeCode="PPRF" Primary Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC)	SHALL contain exactly one [1..1] @typeCode="PPRF" Primary Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC)
CONF #: 1098-9588 Modified	SHALL contain exactly one [1..1] component	Heading: component SHALL contain exactly one [1..1] component
CONF #: 1098-10062 Modified	This serviceEvent SHALL contain exactly one [1..1] effectiveTime	This serviceEvent SHALL contain exactly one [1..1] US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3)
CONF #: 1098-14911 Modified	This performer SHALL contain exactly one [1..1] assignedEntity	SHALL contain exactly one [1..1] assignedEntity
CONF #: 1098-14912 Modified	This assignedEntity SHOULD contain zero or one [0..1] code	This assignedEntity SHOULD contain zero or one [0..1] code, which SHALL be selected from

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Change	Old	New
		ValueSet Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066 DYNAMIC
CONF #: 1098-17182 Modified	SHALL contain exactly one [1..1] code	The Procedure Note recommends use of a single document type code, 28570-0 "Procedure 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. SHALL contain exactly one [1..1] code

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10.8 Progress Note (V2)

Progress Note (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.9:2014-06-09)

Change	Old	New
Name	Progress Note	Progress Note (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.1.9	urn:hl7ii:2.16.840.1.113883.10.20.22.1.9:2014-06-09
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, outpatient visit, treatment with a LTPAC provider, or other healthcare 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.
Implied Template	US Realm Header (urn:oid:2.16.840.1.113883.10.20.22.1.1)	US Realm Header (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)
CONF #: 1098-30617 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:1098-30617).
CONF #: 1098-30618 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30618) such that it
CONF #: 1098-30619 Added		SHALL contain exactly one [1..1]

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Change	Old	New
		Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1098-30619).
CONF #: 1098-30620 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30620) such that it
CONF #: 1098-30621 Added		SHALL contain exactly one [1..1] Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30621).
CONF #: 1098-30622 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30622) such that it
CONF #: 1098-30623 Added		SHALL contain exactly one [1..1] Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1098-30623).
CONF #: 1098-30624 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30624) such that it
CONF #: 1098-30625 Added		SHALL contain exactly one [1..1] Allergies and Intolerances Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09) (CONF:1098-30625).
CONF #: 1098-30626 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30626) such that it
CONF #: 1098-30627 Added		SHALL contain exactly one [1..1] Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1098-30627).
CONF #: 1098-30628 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30628) such that it
CONF #: 1098-30629 Added		SHALL contain exactly one [1..1] Interventions Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2014-06-09) (CONF:1098-30629).
CONF #: 1098-30639 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30639) such that it
CONF #: 1098-31386 Added		SHALL contain exactly one [1..1] Instructions Section (V2) (identifier:

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Change	Old	New
		urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09) (CONF:1098-31386).
CONF #: 1098-30641 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30641) such that it
CONF #: 1098-30642 Added		SHALL contain exactly one [1..1] Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09) (CONF:1098-30642).
CONF #: 1098-30643 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30643) such that it
CONF #: 1098-30644 Added		SHALL contain exactly one [1..1] Objective Section (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.1) (CONF:1098-30644).
CONF #: 1098-30645 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30645) such that it
CONF #: 1098-30646 Added		SHALL contain exactly one [1..1] Physical Exam Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09) (CONF:1098-30646).
CONF #: 1098-30647 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30647) such that it
CONF #: 1098-30648 Added		SHALL contain exactly one [1..1] Problem Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09) (CONF:1098-30648).
CONF #: 1098-30649 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30649) such that it
CONF #: 1098-30650 Added		SHALL contain exactly one [1..1] Results Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09) (CONF:1098-30650).
CONF #: 1098-30651 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30651) such that it
CONF #: 1098-30652 Added		SHALL contain exactly one [1..1] Review of Systems Section

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Change	Old	New
		(identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1098-30652).
CONF #: 1098-30653 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30653) such that it
CONF #: 1098-30654 Added		SHALL contain exactly one [1..1] Subjective Section (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.2) (CONF:1098-30654).
CONF #: 1098-30655 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-30655) such that it
CONF #: 1098-30656 Added		SHALL contain exactly one [1..1] Vital Signs Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09) (CONF:1098-30656).
CONF #: 1098-30657 Added		This structuredBody *SHALL* contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09), or an Assessment Section (2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1098-30657).
CONF #: 1098-30658 Added		This structuredBody *SHALL NOT* contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1098-30658).
CONF #: 1098-30879 Added		This encompassingEncounter SHALL contain exactly one [1..1] location (CONF:1098-30879).
CONF #: 1098-30880 Added		This location SHALL contain exactly one [1..1] healthCareFacility (CONF:1098-30880).
CONF #: 1098-30881 Added		This healthCareFacility SHALL contain at least one [1..*] id (CONF:1098-30881).

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Change	Old	New
CONF #: 1098-32521 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32521).
CONF #: 1098-32626 Added		This structuredBody MAY contain zero or one [0..1] component (CONF:1098-32626) such that it
CONF #: 1098-32627 Added		SHALL contain exactly one [1..1] Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1098-32627).
CONF #: 81-8776 Removed	MAY contain zero or one [0..1] Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:81-8776).	
CONF #: 81-8772 Removed	MAY contain zero or one [0..1] Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:81-8772).	
CONF #: 81-8770 Removed	MAY contain zero or one [0..1] Objective Section (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.1) (CONF:81-8770).	
CONF #: 81-8788 Removed	MAY contain zero or one [0..1] Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:81-8788).	
CONF #: 81-8790 Removed	MAY contain zero or one [0..1] Subjective Section (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.2) (CONF:81-8790).	
CONF #: 81-7589 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:81-7589).	
CONF #: 81-7611 Removed	This encompassingEncounter SHALL contain exactly one [1..1] location/healthCareFacility/id (CONF:81-7611).	
CONF #: 81-8704 Removed	SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan Section (CONF:81-8704).	
CONF #: 81-8771 Removed	MAY contain zero or one [0..1] Medications Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.1) (CONF:81-8771).	

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Change	Old	New
CONF #: 81-8773 Removed	MAY contain zero or one [0..1] Allergies Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.6) (CONF:81-8773).	
CONF #: 81-8774 Removed	MAY contain zero or one [0..1] Assessment and Plan Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.9) (CONF:81-8774).	
CONF #: 81-8775 Removed	MAY contain zero or one [0..1] Plan of Care Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.10) (CONF:81-8775).	
CONF #: 81-8778 Removed	MAY contain zero or one [0..1] Interventions Section (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.3) (CONF:81-8778).	
CONF #: 81-8780 Removed	MAY contain zero or one [0..1] Physical Exam Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.10) (CONF:81-8780).	
CONF #: 81-8782 Removed	MAY contain zero or one [0..1] Results Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.3) (CONF:81-8782).	
CONF #: 81-8784 Removed	MAY contain zero or one [0..1] Vital Signs Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.4) (CONF:81-8784).	
CONF #: 81-8786 Removed	MAY contain zero or one [0..1] Problem Section (entries optional) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.5) (CONF:81-8786).	
CONF #: 81-9592 Removed	A Progress Note can have either a structuredBody or a nonXMLBody (CONF:81-9592).	
CONF #: 81-9593 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	

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Change	Old	New
	(CONF:81-9593).	
CONF #: 81-9594 Removed	If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:81-9594).	
CONF #: 81-10069 Removed	SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:81-10069).	
CONF #: 81-10137 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:81-10137).	
CONF #: 81-10138 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:81-10138).	
CONF #: 81-16806 Removed	MAY contain zero or one [0..1] Instructions Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.45) (CONF:81-16806).	
CONF #: 1098-7595 Modified	SHALL contain exactly one [1..1] componentOf	Heading: componentOf (The Progress Note is always associated with an encounter by the componentOf/encompassingEncounter element in the header. The effectiveTime element for an encompassingEncounter represents the time or time interval in which the encounter took place. A single encounter may contain multiple Progress Notes; hence the effectiveTime elements for a Progress Note (recorded in serviceEvent) and for an encounter (recorded in encompassingEncounter) represent different time intervals. All visits take place at a specific location. When available, the location ID is included in the encompassingEncounter/location/healthCareFacility/id element.) SHALL contain exactly one [1..1] componentOf
CONF #: 1098-7598 Modified	This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime	This encompassingEncounter SHALL contain exactly one [1..1] US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.2

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Change	Old	New
		2.5.3)
CONF #: 1098-7603 Modified	SHOULD contain zero or one [0..1] documentationOf	Heading: documentationOf (A documentationOf can contain a serviceEvent to further specialize the act inherent in the ClinicalDocument/code. In a Progress Note, a serviceEvent can represent the event of writing the Progress Note. The serviceEvent/effectiveTime is the time period the note documents.) SHOULD contain zero or one [0..1] documentationOf
CONF #: 1098-9481 Modified	This serviceEvent SHOULD contain zero or one [0..1] effectiveTime	This serviceEvent SHOULD contain zero or one [0..1] US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3)
CONF #: 1098-9482 Modified	The serviceEvent/effectiveTime element SHOULD be present with effectiveTime/low element	The serviceEvent/effectiveTime element *SHOULD* be present with effectiveTime/low element
CONF #: 1098-9591 Modified	SHALL contain exactly one [1..1] component	Heading: component SHALL contain exactly one [1..1] component
CONF #: 1098-10066 Modified	If a width element is not present, the serviceEvent SHALL include effectiveTime/high	If a width element is not present, the serviceEvent *SHALL* include effectiveTime/high
CONF #: 1098-17189 Modified	SHALL contain exactly one [1..1] code	The Progress Note recommends use of a single document type code, 11506-3 "Subsequent evaluation 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. SHALL contain exactly one [1..1] code

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10.9 Unstructured Document (V2)

Unstructured Document (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.10:2014-06-09)

Change	Old	New
Name	Unstructured Document	Unstructured Document (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.1.10	urn:hl7ii:2.16.840.1.113883.10.20.22.1.10:2014-06-09
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 examples that 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 template 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, implementers need to ensure that their documents at a minimum conform with the SHALL constraints from either specification.
Implied Template	US Realm Header (urn:oid:2.16.840.1.113883.10.20.22.1.1)	US Realm Header (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)
CONF #: 1098-31085 Added		SHALL contain exactly one [1..1] component (CONF:1098-31085).
CONF #: 1098-31086 Added		Heading: nonXMLBody (An Unstructured Document must include a nonXMLBody component with a single text element. The text

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Change	Old	New
		element can reference an external file using a reference element, or include unstructured content directly with a mediaType attribute. The nonXMLBody/text element also has a "compression" attribute that can be used to indicate that the unstructured content was compressed before being Base64Encoded. At a minimum, a compression value of "DF" for the deflate compression algorithm (RFC 1951 [URL:http://www.ietf.org/rfc/rfc1951.txt]) must be supported although it is not required that content be compressed.) This component SHALL contain exactly one [1..1] nonXMLBody (CONF:1098-31086).
CONF #: 1098-31087 Added		This nonXMLBody SHALL contain exactly one [1..1] text (CONF:1098-31087).
CONF #: 1098-31088 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 DYNAMIC (CONF:1098-31088).
CONF #: 1098-31089 Added		Heading: recordTarget SHALL contain at least one [1..*] recordTarget (CONF:1098-31089).
CONF #: 1098-31090 Added		Such recordTargets SHALL contain exactly one [1..1] patientRole (CONF:1098-31090).
CONF #: 1098-31091 Added		This patientRole SHALL contain at least one [1..*] id (CONF:1098-31091).
CONF #: 1098-31096 Added		Heading: custodian SHALL contain exactly one [1..1] custodian (CONF:1098-31096).
CONF #: 1098-31097 Added		This custodian SHALL contain exactly one [1..1] assignedCustodian (CONF:1098-31097).
CONF #: 1098-31098 Added		This assignedCustodian SHALL contain exactly one [1..1] representedCustodianOrganization (CONF:1098-31098).
CONF #: 1098-31103 Added		If the text element does not contain a reference element with a value

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Change	Old	New
		attribute, then it *SHALL* contain exactly one [[]1..1[]] @representation="B64" and exactly one [[]1..1[]] @mediaType (CONF:1098-31103).
CONF #: 1098-32522 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32522).
CONF #: 81-7620 Removed	SHALL contain exactly one [1..1] component/nonXMLBody (CONF:81-7620).	
CONF #: 81-7622 Removed	This component/nonXMLBody SHALL contain exactly one [1..1] text (CONF:81-7622).	
CONF #: 81-7623 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:81-7623).	
CONF #: 81-7624 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:81-7624).	
CONF #: 81-7640 Removed	SHALL contain exactly one [1..1] author/assignedAuthor (CONF:81-7640).	
CONF #: 81-7641 Removed	This author/assignedAuthor SHALL contain exactly one [1..1] addr (CONF:81-7641).	
CONF #: 81-7642 Removed	This author/assignedAuthor SHALL contain exactly one [1..1] telecom (CONF:81-7642).	
CONF #: 81-7643 Removed	SHALL contain exactly one [1..1] recordTarget/patientRole/id (CONF:81-7643).	
CONF #: 81-7645 Removed	SHALL contain exactly one [1..1] custodian/assignedCustodian/representedCustodianOrganization (CONF:81-7645).	
CONF #: 81-7648 Removed	This custodian/assignedCustodian/representedCustodianOrganization SHALL contain exactly one [1..1] id (CONF:81-7648).	
CONF #: 81-7649 Removed	This custodian/assignedCustodian/representedCustodianOrganization	

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Change	Old	New
	SHALL contain exactly one [1..1] name (CONF:81-7649).	
CONF #: 81-7650 Removed	This custodian/assignedCustodian/representedCustodianOrganization SHALL contain exactly one [1..1] telecom (CONF:81-7650).	
CONF #: 81-7651 Removed	This custodian/assignedCustodian/representedCustodianOrganization SHALL contain exactly one [1..1] addr (CONF:81-7651).	

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10.10US Realm Header (V2)

US Realm Header (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09)

Change	Old	New
Name	US Realm Header	US Realm Header (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.1.1	urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2014-06-09
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 ClinicalDocument/code, are provided in document templates that conform to this template.
CONF #: 1098-30810 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:1098-30810). 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.
CONF #: 1098-30811 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

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Change	Old	New
		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. MAY contain zero or one [0..1] sdtc:signatureText (CONF:1098-30811). 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.
CONF #: 1098-31347 Added		If sdtc:raceCode is present, then the patient *SHALL* contain [[]1..1[]] raceCode (CONF:1098-31347).
CONF #: 1098-31355 Added		Heading: informant The informant element describes an information source (who is not a provider) for any content within the clinical document. This informant would be used when the source of information has a personal relationship with the patient or is the patient. MAY contain zero or more [0..*] informant (CONF:1098-31355) such that it
CONF #: 1098-31356 Added		SHALL contain exactly one [1..1] relatedEntity (CONF:1098-31356).
CONF #: 1098-32173 Added		This assignedEntity MAY 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:1098-32173).
CONF #: 1098-32174 Added		This assignedEntity MAY contain zero or one [0..1] code, which

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Change	Old	New
		SHOULD be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:1098-32174).
CONF #: 1098-32399 Added		This intendedRecipient MAY contain zero or more [0..*] id (CONF:1098-32399).
CONF #: 1098-32418 Added		For cases where information about newborn's time of birth needs to be captured. *MAY* be precise to the minute (CONF:1098-32418).
CONF #: 1098-32503 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32503).
CONF #: 1098-32882 Added		If this assignedAuthor is an assignedPerson This assignedAuthor SHOULD contain zero or one [0..1] id (CONF:1098-32882) such that it
CONF #: 1098-32883 Added		If id with @root="2.16.840.1.113883.4.6" National Provider Identifier is unknown then MAY contain zero or one [0..1] @nullFlavor="UNK" Unknown (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32883).
CONF #: 1098-32884 Added		SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1098-32884).
CONF #: 1098-32885 Added		SHOULD contain zero or one [0..1] @extension (CONF:1098-32885).
CONF #: 1098-32889 Added		The functionCode, if present, SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet ParticipationFunction 2.16.840.1.113883.1.11.10267 STATIC 2014-09-01 (CONF:1098-32889).
CONF #: 81-5255 Removed	Can either be a locally defined name or the display name corresponding to clinicalDocument/code (CONF:81-5255).	
CONF #: 81-9944 Removed	This assignedEntity MAY contain zero or one [0..1] code which	

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Change	Old	New
	SHOULD be selected from coding system NUCC Health Care Provider Taxonomy 2.16.840.1.113883.6.101 (CONF:81-9944).	
CONF #: 81-9947 Removed	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:81-9947).	
CONF #: 81-10411 Removed	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:81-10411).	
CONF #: 81-10412 Removed	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:81-10412).	
CONF #: 81-10413 Removed	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:81-10413).	
CONF #: 81-10414 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:81-10414).	
CONF #: 81-10415 Removed	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:81-10415).	
CONF #: 81-10417 Removed	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:81-10417).	
CONF #: 81-10418 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:81-10418).	
CONF #: 81-10419 Removed	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:81-10419).	

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Change	Old	New
CONF #: 81-10420 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:81-10420).	
CONF #: 81-10421 Removed	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:81-10421).	
CONF #: 81-10424 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:81-10424).	
CONF #: 81-10425 Removed	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:81-10425).	
CONF #: 81-10427 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:81-10427).	
CONF #: 81-10429 Removed	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:81-10429).	
CONF #: 81-10430 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:81-10430).	
CONF #: 81-14843 Removed	The code, if present, SHALL contain exactly one [1..1] @code, which SHOULD be selected from CodeSystem Healthcare Provider Taxonomy (HIPAA) (2.16.840.1.113883.6.101) STATIC (CONF:81-14843).	
CONF #: 81-16753 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	

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Change	Old	New
	primary physician and any active consulting physicians, therapists, and counselors (CONF:81-16753).	
CONF #: 81-16796 Removed	The type of consent (e.g., a consent to perform the related serviceEvent) is conveyed in consent/code (CONF:81-16796).	
CONF #: 81-16819 Removed	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:81-16819).	
CONF #: 81-16865 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:81-16865).	
CONF #: 81-16866 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:81-16866).	
CONF #: 81-16871 Removed	The content SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:81-16871).	
CONF #: 81-16872 Removed	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:81-16872).	
CONF #: 81-16873 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:81-16873).	
CONF #: 81-16874 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:81-16874).	
CONF #: 81-26467 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:81-26467) such that it	

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Change	Old	New
CONF #: 81-26468 Removed	SHALL contain exactly one [1..1] relatedEntity (CONF:81-26468).	
CONF #: 81-26469 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:81-26469).	
CONF #: 1098-5256 Modified	SHALL contain exactly one [1..1] effectiveTime	SHALL contain exactly one [1..1] US Realm Date and Time (DTM.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4)
CONF #: 1098-5266 Modified	SHALL contain at least one [1..*] recordTarget	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 #: 1098-5271 Modified	This patientRole SHALL contain at least one [1..*] addr	This patientRole SHALL contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-5284 Modified	This patient SHALL contain at least one [1..*] name	This patient SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)
CONF #: 1098-5299 Modified	SHALL be precise to year	*SHALL* be precise to year
CONF #: 1098-5300 Modified	SHOULD be precise to day	*SHOULD* be precise to day
CONF #: 1098-5322 Modified	This patient MAY contain zero or one [0..1] raceCode, which SHALL be selected from ValueSet Race 2.16.840.1.113883.1.11.14914 DYNAMIC	This patient SHALL contain exactly one [1..1] raceCode, which SHALL be selected from ValueSet Race Category Excluding Nulls 2.16.840.1.113883.3.2074.1.1.3 DYNAMIC
CONF #: 1098-5323 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	This patient SHALL contain exactly one [1..1] ethnicGroupCode, which SHALL be selected from ValueSet EthnicityGroup 2.16.840.1.114222.4.11.837 DYNAMIC
CONF #: 1098-5326 Modified	The guardian, if present, SHOULD contain zero or one [0..1] code, which SHALL be selected from ValueSet ResponsibleParty	The guardian, if present, SHOULD contain zero or one [0..1] code, which SHALL be selected from ValueSet Personal And Legal

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Change	Old	New
	2.16.840.1.113883.1.11.19830 DYNAMIC	Relationship Role Type 2.16.840.1.113883.11.20.12.1 DYNAMIC
CONF #: 1098-5359 Modified	The guardian, if present, SHOULD contain zero or more [0..*] addr	The guardian, if present, SHOULD contain zero or more [0..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-5382 Modified	The guardian, if present, MAY contain zero or more [0..*] telecom	The guardian, if present, SHOULD contain zero or more [0..*] telecom
CONF #: 1098-5386 Modified	This guardianPerson SHALL contain at least one [1..*] name	This guardianPerson SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)
CONF #: 1098-5402 Modified	If country is US, this addr SHOULD contain zero or 1 [[]0..1] state, which SHALL be selected from ValueSet 2.16.840.1.113883.3.88.12.80.1 StateValueSet DYNAMIC	If country is US, this addr *SHOULD* contain zero to one [[]0..1[]] state, which *SHALL* be selected from ValueSet StateValueSet 2.16.840.1.113883.3.88.12.80.1 *DYNAMIC*
CONF #: 1098-5406 Modified	This patient SHOULD contain zero or more [0..*] languageCommunication	This patient SHALL contain at least one [1..*] languageCommunication
CONF #: 1098-5407 Modified	The languageCommunication, if present, SHALL contain exactly one [1..1] languageCode, which SHALL be selected from ValueSet Language 2.16.840.1.113883.1.11.11526 DYNAMIC	Such languageCommunications SHALL contain exactly one [1..1] languageCode, which SHALL be selected from ValueSet PatientLanguage 2.16.840.1.113883.11.20.9.64 DYNAMIC
CONF #: 1098-5409 Modified	The languageCommunication, if present, MAY contain zero or one [0..1] modeCode, which SHALL be selected from ValueSet LanguageAbilityMode 2.16.840.1.113883.1.11.12249 DYNAMIC	Such languageCommunications MAY contain zero or one [0..1] modeCode, which SHALL be selected from ValueSet LanguageAbilityMode 2.16.840.1.113883.1.11.12249 DYNAMIC
CONF #: 1098-5414 Modified	The languageCommunication, if present, MAY contain zero or one [0..1] preferenceInd	Such languageCommunications SHOULD contain zero or one [0..1] preferenceInd
CONF #: 1098-5422 Modified	The providerOrganization, if present, SHALL contain at least one [1..*] addr	The providerOrganization, if present, SHALL contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-5441 Modified	MAY contain zero or one [0..1]	Heading: dataEnterer

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Change	Old	New
	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 #: 1098-5444 Modified	SHALL contain at least one [1..*] author	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 #: 1098-5445 Modified	Such authors SHALL contain exactly one [1..1] time	Such authors SHALL contain exactly one [1..1] US Realm Date and Time (DTM.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4)
CONF #: 1098-5452 Modified	This assignedAuthor SHALL contain at least one [1..*] addr	This assignedAuthor SHALL contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-5460 Modified	This assignedEntity SHALL contain at least one [1..*] addr	This assignedEntity SHALL contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-5470 Modified	This assignedPerson SHALL contain at least one [1..*] name	This assignedPerson SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)
CONF #: 1098-5519 Modified	SHALL contain exactly one [1..1] custodian	Heading: custodian The custodian element represents the organization that is in charge of maintaining and is entrusted with the care of the document. There is only one custodian per CDA document. Allowing that a CDA document may not represent the original form of the

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Change	Old	New
		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 #: 1098-5559 Modified	This representedCustodianOrganization SHALL contain exactly one [1..1] addr	This representedCustodianOrganization SHALL contain exactly one [1..1] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-5565 Modified	MAY contain zero or more [0..*] informationRecipient	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 #: 1098-5568 Modified	The informationRecipient, if present, SHALL contain at least one [1..*] name	The informationRecipient, if present, SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)
CONF #: 1098-5579 Modified	SHOULD contain zero or one [0..1] legalAuthenticator	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

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Change	Old	New
		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 #: 1098-5580 Modified	The legalAuthenticator, if present, SHALL contain exactly one [1..1] time	The legalAuthenticator, if present, SHALL contain exactly one [1..1] US Realm Date and Time (DTM.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4)
CONF #: 1098-5589 Modified	This assignedEntity SHALL contain at least one [1..*] addr	This assignedEntity SHALL contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-5598 Modified	This assignedPerson SHALL contain at least one [1..*] name	This assignedPerson SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)
CONF #: 1098-5607 Modified	MAY contain zero or more [0..*] authenticator	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 #: 1098-5608 Modified	The authenticator, if present, SHALL contain exactly one [1..1] time	SHALL contain exactly one [1..1] US Realm Date and Time (DTM.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4)
CONF #: 1098-5610 Modified	The authenticator, if present, SHALL contain exactly one [1..1] signatureCode	SHALL contain exactly one [1..1] signatureCode
CONF #: 1098-5612 Modified	The authenticator, if present, SHALL contain exactly one [1..1] assignedEntity	SHALL contain exactly one [1..1] assignedEntity
CONF #: 1098-5616 Modified	This assignedEntity SHALL contain at least one [1..*] addr	This assignedEntity SHALL contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier:

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Change	Old	New
		urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-5625 Modified	This assignedPerson SHALL contain at least one [1..*] name	This assignedPerson SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)
CONF #: 1098-6380 Modified	If setId is present versionNumber SHALL be present	If setId is present versionNumber *SHALL* be present
CONF #: 1098-6387 Modified	If versionNumber is present setId SHALL be present	If versionNumber is present setId *SHALL* be present
CONF #: 1098-8001 Modified	An informant can contain either an assignedEntity or a relatedEntity. The constraints here apply to assignedEntity. MAY contain zero or more [0..*] informant	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 #: 1098-8220 Modified	This assignedEntity SHALL contain at least one [1..*] addr	This assignedEntity SHALL contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-8222 Modified	This assignedPerson SHALL contain at least one [1..*] name	This assignedPerson SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)
CONF #: 1098-9946 Modified	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	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 #: 1098-9952 Modified	MAY contain zero or more [0..*] inFulfillmentOf	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 #: 1098-9955 Modified	MAY contain zero or one [0..1] componentOf	Heading: componentOf (The encompassing encounter represents the setting of the

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Change	Old	New
		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 #: 1098-9965 Modified	The languageCommunication, if present, SHOULD contain zero or one [0..1] proficiencyLevelCode, which SHALL be selected from ValueSet LanguageAbilityProficiency 2.16.840.1.113883.1.11.12199 DYNAMIC	Such languageCommunications SHOULD contain zero or one [0..1] proficiencyLevelCode, which SHALL be selected from ValueSet LanguageAbilityProficiency 2.16.840.1.113883.1.11.12199 DYNAMIC
CONF #: 1098-9991 Modified	This id SHALL be a globally unique identifier for the document	This id *SHALL* be a globally unique identifier for the document
CONF #: 1098-9992 Modified	This code SHALL specify the particular kind of document (e.g., History and Physical, Discharge Summary, Progress Note)	This code *SHALL* specify the particular kind of document (e.g., History and Physical, Discharge Summary, Progress Note)
CONF #: 1098-10003 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	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 #: 1098-10006 Modified	Such participants, if present, SHALL contain associatedEntity/associatedPerson or associatedEntity/scopingOrganizati	*SHALL* contain associatedEntity/associatedPerson *AND/OR* associatedEntity/scopingOrganization

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Change	Old	New
	on	
CONF #: 1098-10007 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	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 #: 1098-14835 Modified	MAY contain zero or more [0..*] documentationOf	Heading: documentationOf MAY contain zero or more [0..*] documentationOf
CONF #: 1098-14836 Modified	The documentationOf, if present, SHALL contain exactly one [1..1] serviceEvent	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. The documentationOf, if present, SHALL contain exactly one [1..1] serviceEvent
CONF #: 1098-14839 Modified	This serviceEvent SHOULD contain zero or more [0..*] performer	Heading: performer (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.) This serviceEvent SHOULD contain zero or more [0..*] performer
CONF #: 1098-14840 Modified	The performer, if present, SHALL contain exactly one [1..1] @typeCode (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC)	The performer, if present, SHALL contain exactly one [1..1] @typeCode, which SHALL be selected from ValueSet x_ServiceEventPerformer 2.16.840.1.113883.1.11.19601 STATIC 2014-09-01
CONF #: 1098-14842 Modified	This assignedEntity SHOULD	This assignedEntity SHOULD

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Change	Old	New
	contain zero or one [0..1] code	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 #: 1098-16787 Modified	This assignedAuthor SHOULD contain zero or one [0..1] code	Only if this assignedAuthor is an assignedPerson should the assignedAuthor contain a code. This assignedAuthor SHOULD contain zero or one [0..1] code
CONF #: 1098-16789 Modified	The assignedPerson, if present, SHALL contain at least one [1..*] name	The assignedPerson, if present, SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)
CONF #: 1098-16790 Modified	There SHALL be exactly one assignedAuthor/assignedPerson or exactly one assignedAuthor/assignedAuthoring Device	There *SHALL* be exactly one assignedAuthor/assignedPerson or exactly one assignedAuthor/assignedAuthoring Device
CONF #: 1098-16791 Modified	SHALL contain exactly one [1..1] realmCode="US"	Heading: realmCode SHALL contain exactly one [1..1] realmCode="US"
CONF #: 1098-16792 Modified	MAY contain zero or more [0..*] authorization	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'. The authorization consent is used for referring to consents that are documented elsewhere in the EHR or medical record for a health condition and/or treatment that is described in the CDA document. MAY contain zero or more [0..*] authorization
CONF #: 1098-17000 Modified	This assignedEntity MAY 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	This assignedEntity MAY 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

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Change	Old	New
	STATIC	DYNAMIC

10.11 Admission Medication (V2)

Admission Medication (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.36:2014-06-09)

Change	Old	New
Name	Admission Medication	Admission Medication (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.36	urn:hl7ii:2.16.840.1.113883.10.20.22.4.36:2014-06-09
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.
CONF #: 1098-32152 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:1098-32152).
CONF #: 1098-32524 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32524).
CONF #: 1098-15519 Modified	This code SHALL contain exactly one [1..1] @code="42346-7" Medications on Admission (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="42346-7" Medications on Admission
CONF #: 1098-15520 Modified	SHALL contain exactly one [1..1] Medication Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.16)	SHALL contain exactly one [1..1] Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09)

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10.12 Advance Directive Observation (V2)

Advance Directive Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09)

Change	Old	New
Name	Advance Directive Observation	Advance Directive Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.48	urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09
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 Directive Observation findings (e.g., "resuscitation status is Full Code") rather than orders. It should not be considered a legal document or a substitute for the actual Advance Directive document. 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.
CONF #: 1098-28428 Added		This participantRole MAY contain zero or one [0..1] playingEntity (CONF:1098-28428).
CONF #: 1098-28429 Added		The playingEntity, if present, SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Agent Qualifier 2.16.840.1.113883.11.20.9.51 DYNAMIC (CONF:1098-28429).
CONF #: 1098-28440 Added		This participantRole SHOULD contain zero or one [0..1] code,

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Change	Old	New
		which SHOULD be selected from ValueSet Personal And Legal Relationship Role Type 2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:1098-28440).
CONF #: 1098-28444 Added		This playingEntity SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Agent Qualifier 2.16.840.1.113883.11.20.9.51 DYNAMIC (CONF:1098-28444).
CONF #: 1098-28446 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:1098-28446).
CONF #: 1098-28451 Added		This participantRole MAY contain zero or more [0..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1098-28451).
CONF #: 1098-28454 Added		The playingEntity, if present, MAY contain zero or more [0..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-28454).
CONF #: 1098-28719 Added		This effectiveTime SHALL contain exactly one [1..1] low (CONF:1098-28719).
CONF #: 1098-30804 Added		SHALL contain exactly one [1..1] value (CONF:1098-30804) such that it
CONF #: 1098-32406 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32406).
CONF #: 1098-32449 Added		If the Advance Directive does not have a specified ending time, the <high> element *SHALL* have the nullFlavor attribute set to *NA* (CONF:1098-32449).
CONF #: 1098-32493 Added		If type CD, then value will be SNOMED-CT (CONF:1098-32493).
CONF #: 1098-32496 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32496).

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Change	Old	New
CONF #: 1098-32786 Added		This code SHALL contain exactly one [1..1] @code="75278-2" Advance directive status (CONF:1098-32786).
CONF #: 1098-32787 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:1098-32787).
CONF #: 81-8664 Removed	SHALL contain exactly one [1..1] templateId (CONF:81-8664).	
CONF #: 81-8674 Removed	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:81-8674).	
CONF #: 81-8703 Removed	The text, if present, MAY contain zero or one [0..1] @mediaType="text/plain" (CONF:81-8703).	
CONF #: 81-10486 Removed	This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.1.58" (CONF:81-10486).	
CONF #: 1098-8651 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	SHALL contain exactly one [1..1] code
CONF #: 1098-8662 Modified	SHOULD contain zero or more [0..*] participant	The participant "VRF" represents the clinician(s) who verified the patient advance directive observation. SHOULD contain zero or more [0..*] participant
CONF #: 1098-8666 Modified	The data type of Observation/participant/time in a verification SHALL be TS (time stamp)	The data type of Observation/participant/time in a verification *SHALL* be *TS* (time stamp)
CONF #: 1098-8667 Modified	SHOULD contain zero or one [0..1] participant	This custodian (CST) participant identifies a legal representative for the patient's advance directive. Examples of such individuals are called health care agents, substitute decision makers and/or health care proxies. If there is more than one legal representative, a qualifier may be used to designate the legal

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Change	Old	New
		representative as primary or secondary. SHOULD contain zero or more [0..*] participant
CONF #: 1098-8671 Modified	This participantRole SHOULD contain zero or one [0..1] addr	This participantRole SHOULD contain zero or one [0..1] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-8672 Modified	This participantRole SHOULD contain zero or one [0..1] telecom	This participantRole SHOULD contain zero or more [0..*] telecom
CONF #: 1098-8673 Modified	This playingEntity SHALL contain exactly one [1..1] name	Record the name of the agent who can provide a copy of the Advance Directive in the name element. This playingEntity SHALL contain exactly one [1..1] name
CONF #: 1098-8692 Modified	SHOULD contain zero or more [0..*] reference	SHOULD contain at least one [1..*] reference
CONF #: 1098-8698 Modified	The URL of a referenced advance directive document MAY be present, and SHALL be represented in Observation/reference/ExternalDocument/text/reference	The URL of a referenced advance directive document *MAY* be present, and *SHALL* be represented in Observation/reference/ExternalDocument/text/reference
CONF #: 1098-8699 Modified	If a URL is referenced, then it SHOULD have a corresponding linkHtml element in narrative block	If a URL is referenced, then it *SHOULD* have a corresponding linkHTML element in narrative block

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10.13 Allergy - Intolerance Observation (V2)

Allergy - Intolerance Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09)

Change	Old	New
Name	Allergy - Intolerance Observation	Allergy - Intolerance Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.7	urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09
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". 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, i.e., use playingEntity classCode = "MMAT" for all agents, manufactured or not.
Implied Template	Substance or Device Allergy - Intolerance Observation (urn:oid:2.16.840.1.113883.10.20.24.3.90)	Substance or Device Allergy - Intolerance Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.24.3.90:2014-06-09)
CONF #: 1098-31143 Added		SHOULD contain zero or more [0..*] Author Participation (identifier:

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Change	Old	New
		urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31143).
CONF #: 1098-31526 Added		MAY contain zero or one [0..1] @negationInd (CONF:1098-31526). Note: Use negationInd="true" to indicate that the allergy was not observed.
CONF #: 1098-31538 Added		This effectiveTime SHALL contain exactly one [1..1] low (CONF:1098-31538). Note: The effectiveTime/low (a.k.a. "onset date") asserts when the allergy/intolerance became biologically active.
CONF #: 1098-31539 Added		This effectiveTime MAY contain zero or one [0..1] high (CONF:1098-31539). Note: The effectiveTime/high (a.k.a. "resolution date") asserts when the allergy/intolerance became biologically resolved.
CONF #: 1098-32153 Added		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:1098-32153).
CONF #: 1098-32526 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32526).
CONF #: 81-7421 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:81-7421).	
CONF #: 81-7422 Removed	This value SHOULD contain zero or one [0..1] originalText (CONF:81-7422).	
CONF #: 81-7424 Removed	This code SHOULD contain zero or one [0..1] originalText (CONF:81-7424).	
CONF #: 81-7425 Removed	The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:81-7425).	
CONF #: 81-7431 Removed	This code MAY contain zero or more [0..*] translation (CONF:81-7431).	

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Change	Old	New
CONF #: 81-7440 Removed	MAY contain zero or one [0..1] entryRelationship (CONF:81-7440) such that it	
CONF #: 81-7446 Removed	SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:81-7446).	
CONF #: 81-7906 Removed	SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-7906).	
CONF #: 81-9103 Removed	If it is unknown when the allergy began, this effectiveTime SHALL contain low/@nullFLavor="UNK" (CONF:81-9103).	
CONF #: 81-9139 Removed	This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Allergy/Adverse Event Type 2.16.840.1.113883.3.88.12.3221.6.2 DYNAMIC (CONF:81-9139).	
CONF #: 81-10082 Removed	If the allergy is no longer a concern, this effectiveTime MAY contain zero or one [0..1] high (CONF:81-10082).	
CONF #: 81-10083 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:81-10083).	
CONF #: 81-10084 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:81-10084).	
CONF #: 81-15949 Removed	The originalText, if present, MAY contain zero or one [0..1] reference (CONF:81-15949).	
CONF #: 81-15950 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15950).	
CONF #: 81-15951 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:81-15951).	
CONF #: 81-15952 Removed	The reference, if present, SHOULD	

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Change	Old	New
	contain zero or one [0..1] @value (CONF:81-15952).	
CONF #: 81-15953 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:81-15953).	
CONF #: 81-15954 Removed	SHALL contain exactly one [1..1] Allergy Status Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.28) (CONF:81-15954).	
CONF #: 1098-7390 Modified	SHALL contain exactly one [1..1] value with @xsi:type="CD"	SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet Allergy/Adverse Event Type 2.16.840.1.113883.3.88.12.3221.6.2 DYNAMIC
CONF #: 1098-7402 Modified	SHOULD contain zero or one [0..1] participant	SHALL contain exactly one [1..1] participant
CONF #: 1098-7419 Modified	This playingEntity SHALL contain exactly one [1..1] code	This playingEntity SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Substance-Reactant for Intolerance 2.16.840.1.113762.1.4.1010.1 DYNAMIC
CONF #: 1098-15948 Modified	This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC)	This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion
CONF #: 1098-15955 Modified	SHALL contain exactly one [1..1] Reaction Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.9)	SHALL contain exactly one [1..1] Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09)
CONF #: 1098-15956 Modified	SHALL contain exactly one [1..1] Severity Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.8)	SHALL contain exactly one [1..1] Severity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09)

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10.14 Allergy Concern Act (V2)

Allergy Concern Act (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.30:2014-06-09)

Change	Old	New
Name	Allergy Problem Act	Allergy Concern Act (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.30	urn:hl7ii:2.16.840.1.113883.10.20.22.4.30:2014-06-09
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. As long as the underlying condition is of concern to the provider (i.e., as 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 Concern 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 Concern 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).
CONF #: 1098-31145 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31145).
CONF #: 1098-31534 Added		This effectiveTime SHALL contain exactly one [1..1] low (CONF:1098-31534). Note: The effectiveTime/low asserts when the allergy was noted. This equates to the time the allergy was authored in the patient's chart.

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Change	Old	New
CONF #: 1098-31535 Added		This effectiveTime MAY contain zero or one [0..1] high (CONF:1098-31535). Note: It is clinically rare for an allergy to be "resolved", and therefore for the Concern to be resolved, even for patients undergoing allergy desensitization. As a result, effectiveTime/high will generally not be present.
CONF #: 1098-32154 Added		This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.5.6" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-32154).
CONF #: 1098-32543 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32543).
CONF #: 81-7504 Removed	If statusCode/@code="active" Active, then effectiveTime SHALL contain [1..1] low (CONF:81-7504).	
CONF #: 81-10085 Removed	If statusCode/@code="completed" Completed, then effectiveTime SHALL contain [1..1] high (CONF:81-10085).	
CONF #: 1098-14925 Modified	SHALL contain exactly one [1..1] Allergy - Intolerance Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.7)	SHALL contain exactly one [1..1] Allergy - Intolerance Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.7:2014-06-09)
CONF #: 1098-19158 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)	This code SHALL contain exactly one [1..1] @code="CONC" Concern

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10.15 Allergy Status Observation (DEPRECATED)

Allergy Status Observation (DEPRECATED) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.28:2014-06-09)

Change	Old	New
Name	Allergy Status Observation	Allergy Status Observation (DEPRECATED)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.28	urn:hl7ii:2.16.840.1.113883.10.20.22.4.28:2014-06-09
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 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED. *Reason for deprecation*: 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.
CONF #: 1098-32155 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:1098-32155).
CONF #: 1098-32576 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32576).
CONF #: 81-26500 Removed	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:81-26500).	
CONF #: 1098-7322 Modified	SHALL contain exactly one [1..1] value with @xsi:type="CE", where the code SHALL be selected from ValueSet Problem Status 2.16.840.1.113883.3.88.12.80.68 DYNAMIC	SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet Problem Status 2.16.840.1.113883.3.88.12.80.68 DYNAMIC

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10.16 Cognitive Status Problem Observation (DEPRECATED)

Cognitive Status Problem Observation (DEPRECATED) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.73:2014-06-09)

Change	Old	New
Name	Cognitive Status Problem Observation	Cognitive Status Problem Observation (DEPRECATED)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.73	urn:hl7ii:2.16.840.1.113883.10.20.22.4.73:2014-06-09
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.	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, judgement, comprehension ability, or response speed. THIS TEMPLATE HAS BEEN DEPRECATED AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED. *Reason for deprecation*: Cognitive Status Problem Observation has been merged, without loss of expressivity, into Mental Status Observation (2.16.840.1.113883.10.20.22.4.74:2014-06-09).
Implied Template	Problem Observation (urn:oid:2.16.840.1.113883.10.20.22.4.4)	
CONF #: 1098-32600 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32600).
CONF #: 81-14468 Removed	SHALL contain exactly one [1..1] Assessment Scale Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69) (CONF:81-14468).	

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Change	Old	New
CONF #: 81-14352 Removed	SHALL contain exactly one [1..1] Caregiver Characteristics (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72) (CONF:81-14352).	
CONF #: 81-14331 Removed	MAY contain zero or more [0..*] entryRelationship (CONF:81-14331) such that it	
CONF #: 81-14335 Removed	MAY contain zero or more [0..*] entryRelationship (CONF:81-14335) such that it	
CONF #: 81-14351 Removed	SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.50) (CONF:81-14351).	
CONF #: 81-14467 Removed	MAY contain zero or more [0..*] entryRelationship (CONF:81-14467) such that it	
CONF #: 81-14588 Removed	SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-14588).	
CONF #: 81-14589 Removed	SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-14589).	
CONF #: 81-14590 Removed	SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-14590).	

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10.17Coverage Activity (V2)

Coverage Activity (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.60:2014-06-09)

Change	Old	New
Name	Coverage Activity	Coverage Activity (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.60	urn:hl7ii:2.16.840.1.113883.10.20.22.4.60:2014-06-09
Description	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.	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.
CONF #: 1098-32156 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:1098-32156).
CONF #: 1098-32596 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32596).
CONF #: 1098-15528 Modified	SHALL contain exactly one [1..1] Policy Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.61)	SHALL contain exactly one [1..1] Policy Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.61:2014-06-09)
CONF #: 1098-19160 Modified	This code SHALL contain exactly one [1..1] @code="48768-6" Payment sources (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="48768-6" Payment sources

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10.18 Deceased Observation (V2)

Deceased Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.79:2014-06-09)

Change	Old	New
Name	Deceased Observation	Deceased Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.79	urn:hl7ii:2.16.840.1.113883.10.20.22.4.79:2014-06-09
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.
CONF #: 1098-32158 Added		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:1098-32158).
CONF #: 1098-32541 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32541).
CONF #: 1098-14870 Modified	SHALL contain exactly one [1..1] Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.4)	SHALL contain exactly one [1..1] Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)
CONF #: 1098-19135 Modified	This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC)	This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion

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10.19 Discharge Medication (V2)

Discharge Medication (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.35:2014-06-09)

Change	Old	New
Name	Discharge Medication	Discharge Medication (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.35	urn:hl7ii:2.16.840.1.113883.10.20.22.4.35:2014-06-09
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.
CONF #: 1098-32159 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:1098-32159).
CONF #: 1098-32513 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32513).
CONF #: 1098-32779 Added		SHALL contain exactly one [1..1] statusCode (CONF:1098-32779).
CONF #: 1098-32780 Added		This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:1098-32780).
CONF #: 1098-15525 Modified	SHALL contain exactly one [1..1] Medication Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.16)	SHALL contain exactly one [1..1] Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09)
CONF #: 1098-19161 Modified	This code SHALL contain exactly one [1..1] @code="10183-2" Discharge medication (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="10183-2" Discharge medication

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10.20 Encounter Activity (V2)

Encounter Activity (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09)

Change	Old	New
Name	Encounter Activities	Encounter Activity (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.49	urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09
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.
CONF #: 1098-32176 Added		MAY contain zero or one [0..1] sdtc:dischargeDispositionCode (CONF:1098-32176). Note: 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 #: 1098-32177 Added		This sdtc:dischargeDispositionCode *SHALL* contain exactly [[]1..1[]] *@code*, which *SHALL* be selected from ValueSet 2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status (code system 2.16.840.1.113883.6.301.5) *DYNAMIC* or, if access to NUBC is unavailable, from CodeSystem 2.16.840.1.113883.12.112 HL7 Discharge Disposition (CONF:1098-32177).
CONF #: 1098-32323 Added		The translation may exist to map the code of EncounterTypeCode (2.16.840.1.113883.3.88.12.80.32) valueset to the code of Encounter Planned (2.16.840.1.113883.11.20.9.52) valueset. This code MAY contain zero or one [0..1] translation (CONF:1098-32323).
CONF #: 1098-32377 Added		This sdtc:dischargeDispositionCode *SHALL* contain exactly [[]1..1[]] *@codeSystem*, which *SHALL* be either CodeSystem: NUBC 2.16.840.1.113883.6.301.5 *OR* CodeSystem: HL7 Discharge Disposition

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Change	Old	New
		2.16.840.1.113883.12.112 (CONF:1098-32377).
CONF #: 1098-32546 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32546).
CONF #: 81-8720 Removed	The originalText, if present, SHOULD contain zero or one [0..1] reference/@value (CONF:81-8720).	
CONF #: 81-26508 Removed	MAY contain zero or one [0..1] sdtc:dischargeDispositionCode, which SHOULD be selected from ValueSet NUBC UB-04 FL17 Patient Status 2.16.840.1.113883.3.88.12.80.33 DYNAMIC (CONF:81-26508).	
CONF #: 81-26509 Removed	If access to NUBC is unavailable, the value of code *SHOULD* be selected from CodeSystem 2.16.840.1.113883.12.112 HL7 Discharge Disposition DYNAMIC (CONF:81-26509).	
CONF #: 81-26511 Removed	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:81-26511).	
CONF #: 1098-8714 Modified	SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet EncounterTypeCode 2.16.840.1.113883.3.88.12.80.32 DYNAMIC	SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet EncounterTypeCode 2.16.840.1.113883.3.88.12.80.32 DYNAMIC
CONF #: 1098-8719 Modified	The code, if present, SHOULD contain zero or one [0..1] originalText	This code SHOULD contain zero or one [0..1] originalText
CONF #: 1098-8727 Modified	This assignedEntity MAY contain zero or one [0..1] code	This assignedEntity MAY 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 #: 1098-8738 Modified	MAY contain zero or more [0..*] participant	SHOULD contain zero or more [0..*] participant
CONF #: 1098-14899 Modified	SHALL contain exactly one [1..1] Indication (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.19)	SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09)
CONF #: 1098-15972 Modified	This reference/@value SHALL begin with a '#' and SHALL point to	This reference/@value *SHALL* begin with a '#' and *SHALL* point

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Change	Old	New
	its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1)	to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1)
CONF #: 1098-15973 Modified	SHALL contain exactly one [1..1] Encounter Diagnosis (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.80)	SHALL contain exactly one [1..1] Encounter Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09)

10.21 Encounter Diagnosis (V2)

Encounter Diagnosis (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09)

Change	Old	New
Name	Encounter Diagnosis	Encounter Diagnosis (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.80	urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2014-06-09
CONF #: 1098-32160 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:1098-32160).
CONF #: 1098-32542 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32542).
CONF #: 1098-14898 Modified	SHALL contain exactly one [1..1] Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.4)	SHALL contain exactly one [1..1] Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)
CONF #: 1098-19183 Modified	This code SHALL contain exactly one [1..1] @code="29308-4" Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="29308-4" Diagnosis

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10.22 Family History Observation (V2)

Family History Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.46:2014-06-09)

Change	Old	New
Name	Family History Observation	Family History Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.46	urn:hl7ii:2.16.840.1.113883.10.20.22.4.46:2014-06-09
CONF #: 1098-32427 Added		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 2014-09-02 (CONF:1098-32427).
CONF #: 1098-32605 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32605).
CONF #: 81-8589 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:81-8589).	

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10.23 Family History Organizer (V2)

Family History Organizer (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09)

Change	Old	New
Name	Family History Organizer	Family History Organizer (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.45	urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09
CONF #: 1098-32429 Added		Such components SHALL contain exactly one [1..1] Family History Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.46:2014-06-09) (CONF:1098-32429).
CONF #: 1098-32428 Added		SHALL contain at least one [1..*] component (CONF:1098-32428).
CONF #: 1098-32485 Added		SHALL contain at least one [1..*] id (CONF:1098-32485).
CONF #: 1098-32606 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32606).
CONF #: 81-8607 Removed	SHALL contain at least one [1..*] component (CONF:81-8607).	
CONF #: 81-16888 Removed	Such components SHALL contain exactly one [1..1] Family History Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.46) (CONF:81-16888).	
CONF #: 1098-15249 Modified	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	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 #: 1098-15975 Modified	This administrativeGenderCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Administrative Gender (HL7 V3) 2.16.840.1.113883.1.11.1 STATIC	This administrativeGenderCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Administrative Gender (HL7 V3) 2.16.840.1.113883.1.11.1 DYNAMIC
CONF #: 1098-15981 Modified	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	The subject *MAY* contain zero or one [[]0..1[]] *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 #: 1098-15982 Modified	The subject MAY contain zero or	The subject *MAY* contain zero or

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Change	Old	New
	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	one [[]0..1[]] *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 #: 1098-15983 Modified	The age of a relative at the time of a family history observation SHOULD be inferred by comparing RelatedSubject/subject/birthTime with Observation/effectiveTime	The age of a relative at the time of a family history observation *SHOULD* be inferred by comparing RelatedSubject/subject/birthTime with Observation/effectiveTime

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10.24 Functional Status Observation (V2)

Functional Status Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09)

Change	Old	New
Name	Functional Status Result Observation	Functional Status Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.67	urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09
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, instrumental 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.
Implied Template	Result Observation (urn:oid:2.16.840.1.113883.10.20.22.4.2)	
CONF #: 1098-31522 Added		This code SHALL contain exactly one [1..1] @code="54522-8" Functional status (CONF:1098-31522).
CONF #: 1098-31523 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:1098-31523).
CONF #: 1098-32568 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32568).
CONF #: 81-13926 Removed	SHOULD contain zero or one [0..1] text (CONF:81-13926).	
CONF #: 81-13927 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-13927).	
CONF #: 81-13928 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:81-13928).	
CONF #: 81-13933 Removed	SHOULD contain zero or more [0..*]	

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Change	Old	New
	interpretationCode (CONF:81-13933).	
CONF #: 81-13934 Removed	MAY contain zero or one [0..1] methodCode (CONF:81-13934).	
CONF #: 81-13935 Removed	MAY contain zero or one [0..1] targetSiteCode (CONF:81-13935).	
CONF #: 81-13938 Removed	The referenceRange, if present, SHALL contain exactly one [1..1] observationRange (CONF:81-13938).	
CONF #: 81-13939 Removed	This observationRange SHALL NOT contain [0..0] code (CONF:81-13939).	
CONF #: 81-26448 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:81-26448).	
CONF #: 1098-13908 Modified	SHALL contain exactly one [1..1] code (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	SHALL contain exactly one [1..1] code
CONF #: 1098-13930 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	SHALL contain exactly one [1..1] effectiveTime
CONF #: 1098-13936 Modified	MAY contain zero or one [0..1] author	SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119)
CONF #: 1098-13937 Modified	SHOULD contain zero or more [0..*] referenceRange	referenceRange could be used to represent normal or expected capability for the function being evaluated. MAY contain zero or more [0..*] referenceRange
CONF #: 1098-14218 Modified	SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.50)	SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09)
CONF #: 1098-14234 Modified	If xsi:type="CD", SHOULD contain a code from SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96)	If xsi:type="CD", *SHOULD* contain a code from SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96)

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10.25 Functional Status Organizer (V2)

Functional Status Organizer (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.66:2014-06-09)

Change	Old	New
Name	Functional Status Result Organizer	Functional Status Organizer (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.66	urn:hl7ii:2.16.840.1.113883.10.20.22.4.66:2014-06-09
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., mobility, self-care).
Implied Template	Result Organizer (urn:oid:2.16.840.1.113883.10.20.22.4.1)	
CONF #: 1098-31417 Added		*SHOULD* be selected from ICF (codeSystem 2.16.840.1.113883.6.254) *OR* LOINC (2.16.840.1.113883.6.1) (CONF:1098-31417).
CONF #: 1098-31432 Added		SHALL contain at least one [1..*] component (CONF:1098-31432) such that it
CONF #: 1098-31433 Added		SHALL contain exactly one [1..1] Self-Care Activities (ADL and IADL) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.128) (CONF:1098-31433).
CONF #: 1098-31434 Added		This statusCode SHALL contain exactly one [1..1] @code="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31434).
CONF #: 1098-31585 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31585).
CONF #: 1098-32569 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32569).
CONF #: 81-14747 Removed	This code SHOULD contain zero or one [0..1] @code (CONF:81-14747).	

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Change	Old	New
CONF #: 81-14748 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:81-14748).	
CONF #: 81-19102 Removed	This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:81-19102).	
CONF #: 1098-14355 Modified	SHALL contain exactly one [1..1] @classCode="CLUSTER", which SHALL be selected from CodeSystem HL7ActClass (2.16.840.1.113883.5.6) STATIC	SHALL contain exactly one [1..1] @classCode="CLUSTER" Cluster (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6)
CONF #: 1098-14364 Modified	SHALL contain exactly one [1..1] code	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 #: 1098-14368 Modified	SHALL contain exactly one [1..1] Functional Status Result Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.67)	SHALL contain exactly one [1..1] Functional Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.67:2014-06-09)

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10.26 Functional Status Problem Observation (DEPRECATED)

Functional Status Problem Observation (DEPRECATED) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.68:2014-06-09)

Change	Old	New
Name	Functional Status Problem Observation	Functional Status Problem Observation (DEPRECATED)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.68	urn:hl7ii:2.16.840.1.113883.10.20.22.4.68:2014-06-09
Description	A functional status problem observation is a clinical statement that represents a patient's functional performance and ability.	A functional status problem observation is a clinical statement that represents a patient's functional perfomance and ability. THIS TEMPLATE HAS BEEN DEPRECATED IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED. *Reason for deprecation*: Functional Status Problem Observation has been merged, without loss of expressivity, into Functional Status Observation (2.16.840.1.113883.10.20.22.4.67: 2014-06-09).
Implied Template	Problem Observation (urn:oid:2.16.840.1.113883.10.20.22.4.4)	
CONF #: 1098-32601 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32601).
CONF #: 81-14464 Removed	SHALL contain exactly one [1..1] Assessment Scale Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.69) (CONF:81-14464).	
CONF #: 81-14318 Removed	SHALL contain exactly one [1..1] Caregiver Characteristics (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72) (CONF:81-14318).	
CONF #: 81-14294 Removed	MAY contain zero or more [0..*] entryRelationship (CONF:81-14294) such that it	
CONF #: 81-14298 Removed	MAY contain zero or more [0..*] entryRelationship (CONF:81-14298) such that it	

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Change	Old	New
CONF #: 81-14317 Removed	SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.50) (CONF:81-14317).	
CONF #: 81-14463 Removed	MAY contain zero or more [0..*] entryRelationship (CONF:81-14463) such that it	
CONF #: 81-14584 Removed	SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-14584).	
CONF #: 81-14586 Removed	SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-14586).	
CONF #: 81-14587 Removed	SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-14587).	
CONF #: 1098-14293 Modified	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	If the diagnosis is unknown or the SNOMED code is unknown, @nullFlavor SHOULD be “UNK”. If the diagnosis is known but the code cannot be found in the Value Set, @nullFlavor SHOULD be “OTH” and the known diagnosis code SHOULD be placed in the translation element

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10.27Health Status Observation (V2)

Health Status Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09)

Change	Old	New
Name	Health Status Observation	Health Status Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.5	urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09
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.
Open/Closed	Closed	Open
CONF #: 1098-32161 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:1098-32161).
CONF #: 1098-32486 Added		SHALL contain at least one [1..*] id (CONF:1098-32486).
CONF #: 1098-32558 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32558).
CONF #: 81-9270 Removed	SHOULD contain zero or one [0..1] text (CONF:81-9270).	
CONF #: 81-15529 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15529).	
CONF #: 81-15530 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15530).	
CONF #: 81-15531 Removed	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:81-15531).	
CONF #: 1098-19144 Modified	This code SHALL contain exactly one [1..1] @code="11323-3" Health status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="11323-3" Health status

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10.28 Hospital Admission Diagnosis (V2)

Hospital Admission Diagnosis (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09)

Change	Old	New
Name	Hospital Admission Diagnosis	Hospital Admission Diagnosis (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.34	urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09
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.
CONF #: 1098-32162 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:1098-32162).
CONF #: 1098-32535 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32535).
CONF #: 1098-15535 Modified	SHALL contain exactly one [1..1] Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.4)	SHALL contain exactly one [1..1] Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)
CONF #: 1098-19146 Modified	This code SHALL contain exactly one [1..1] @code="46241-6" Admission diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="46241-6" Admission diagnosis

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10.29 Hospital Discharge Diagnosis (V2)

Hospital Discharge Diagnosis (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.33:2014-06-09)

Change	Old	New
Name	Hospital Discharge Diagnosis	Hospital Discharge Diagnosis (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.33	urn:hl7ii:2.16.840.1.113883.10.20.22.4.33:2014-06-09
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.
CONF #: 1098-32163 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:1098-32163).
CONF #: 1098-32534 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32534).
CONF #: 1098-15536 Modified	SHALL contain exactly one [1..1] Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.4)	SHALL contain exactly one [1..1] Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)
CONF #: 1098-19148 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)	This code SHALL contain exactly one [1..1] @code="11535-2" Hospital discharge diagnosis

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10.30Immunization Activity (V2)

Immunization Activity (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09)

Change	Old	New
Name	Immunization Activity	Immunization Activity (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.52	urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09
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. (Reference: [URL:http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/D/vacc_admin.pdf])

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Change	Old	New
CONF #: 1098-31392 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31392).
CONF #: 1098-31151 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31151).
CONF #: 1098-31510 Added		The following entryRelationship is used to indicate a given immunization's order in a series. The nested Substance Administered Act identifies an administration in the series. The entryRelationship/sequenceNumber shows the order of this particular administration in that series. SHOULD contain zero or more [0..*] entryRelationship (CONF:1098-31510) such that it
CONF #: 1098-31511 Added		SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31511).
CONF #: 1098-31512 Added		SHALL contain exactly one [1..1] @inversionInd="true" (CONF:1098-31512).
CONF #: 1098-31513 Added		MAY contain zero or one [0..1] sequenceNumber (CONF:1098-31513).
CONF #: 1098-31514 Added		SHALL contain exactly one [1..1] Substance Administered Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.118) (CONF:1098-31514).
CONF #: 1098-32359 Added		This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ActStatus 2.16.840.1.113883.1.11.159331 DYNAMIC (CONF:1098-32359).
CONF #: 1098-32528 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32528).
CONF #: 81-8831 Removed	SHOULD contain zero or one [0..1] text (CONF:81-8831).	
CONF #: 81-15538 Removed	SHALL contain exactly one [1..1] Instructions (identifier:	

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Change	Old	New
	urn:oid:2.16.840.1.113883.10.20.22.4.20) (CONF:81-15538).	
CONF #: 81-15543 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15543).	
CONF #: 81-15544 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15544).	
CONF #: 81-15545 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:81-15545).	
CONF #: 1098-15547 Modified	The participant, if present, SHALL contain exactly one [1..1] Drug Vehicle (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.24)	SHALL contain exactly one [1..1] Drug Vehicle (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.24)
CONF #: 1098-8827 Modified	SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 STATIC	SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 STATIC 2014-09-01
CONF #: 1098-8838 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	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. MAY contain zero or one [0..1] repeatNumber
CONF #: 1098-8846 Modified	MAY contain zero or one [0..1] administrationUnitCode, which SHALL be selected from ValueSet Medication Product Form Value Set 2.16.840.1.113883.3.88.12.3221.8.11 DYNAMIC	MAY contain zero or one [0..1] administrationUnitCode, which SHALL be selected from ValueSet AdministrableDrugForm 2.16.840.1.113883.1.11.14570 DYNAMIC
CONF #: 1098-8851 Modified	The participant, if present, SHALL contain exactly one [1..1] @typeCode="CSM" (CodeSystem:	SHALL contain exactly one [1..1] @typeCode="CSM" (CodeSystem: HL7ParticipationType

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Change	Old	New
	HL7ParticipationType 2.16.840.1.113883.5.90 STATIC)	2.16.840.1.113883.5.90 STATIC)
CONF #: 1098-8985 Modified	Use negationInd="true" to indicate that the immunization was not given. SHALL contain exactly one [1..1] @negationInd	MAY contain zero or one [0..1] @negationInd
CONF #: 1098-15537 Modified	SHALL contain exactly one [1..1] Indication (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.19)	SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09)
CONF #: 1098-15539 Modified	SHALL contain exactly one [1..1] Medication Supply Order (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.17)	SHALL contain exactly one [1..1] Medication Supply Order (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09)
CONF #: 1098-15540 Modified	SHALL contain exactly one [1..1] Medication Dispense (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.18)	SHALL contain exactly one [1..1] Medication Dispense (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.18:2014-06-09)
CONF #: 1098-15541 Modified	SHALL contain exactly one [1..1] Reaction Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.9)	SHALL contain exactly one [1..1] Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09)
CONF #: 1098-15546 Modified	This consumable SHALL contain exactly one [1..1] Immunization Medication Information (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.54)	This consumable SHALL contain exactly one [1..1] Immunization Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09)
CONF #: 1098-15548 Modified	SHALL contain exactly one [1..1] Precondition for Substance Administration (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.25)	SHALL contain exactly one [1..1] Precondition for Substance Administration (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09)

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10.31 Immunization Medication Information (V2)

Immunization Medication Information (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09)

Change	Old	New
Name	Immunization Medication Information	Immunization Medication Information (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.54	urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09
CONF #: 1098-31543 Added		This code MAY contain zero or more [0..*] translation, which MAY be selected from ValueSet Vaccine Clinical Drug 2.16.840.1.113762.1.4.1010.8 DYNAMIC (CONF:1098-31543).
CONF #: 1098-31881 Added		This code MAY contain zero or more [0..*] translation, which MAY be selected from ValueSet Specific Vaccine Clinical Drug 2.16.840.1.113762.1.4.1010.10 DYNAMIC (CONF:1098-31881).
CONF #: 1098-32602 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32602).
CONF #: 81-9008 Removed	This code SHOULD contain zero or one [0..1] originalText (CONF:81-9008).	
CONF #: 81-9011 Removed	This code MAY contain zero or more [0..*] translation (CONF:81-9011).	
CONF #: 81-15555 Removed	The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15555).	
CONF #: 81-15556 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15556).	
CONF #: 81-15557 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:81-15557).	
CONF #: 81-16887 Removed	Translations can be used to represent generic product name, packaged product code, etc (CONF:81-16887).	
CONF #: 1098-9007 Modified	This manufacturedMaterial SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Vaccine Administered Value Set	This manufacturedMaterial SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet CVX Vaccines Administered - Vaccine Set

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Change	Old	New
	2.16.840.1.113883.3.88.12.80.22 DYNAMIC	2.16.840.1.113762.1.4.1010.6 DYNAMIC
CONF #: 1098-9014 Modified	This manufacturedMaterial SHOULD contain zero or one [0..1] lotNumberText	This manufacturedMaterial SHALL contain exactly one [1..1] lotNumberText

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10.32 Indication (V2)

Indication (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09)

Change	Old	New
Name	Indication	Indication (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.19	urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09
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 an encounter, a medication administration, or a procedure. The id element can be used to reference a problem recorded elsewhere in the document, or can be used with a code and value to record the problem. Indications for treatment are not laboratory results; rather the problem associated with the laboratory result should be sited (e.g., hypokalemia instead of a laboratory 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 (V2) [[]templateId 2.16.840.1.113883.10.20.22.4.25.2] to represent that a medication is to be administered only when the associated criteria are met.
CONF #: 1098-31229 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 STATIC 2014-09-02 (CONF:1098-31229).
CONF #: 1098-32570 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32570).
CONF #: 81-15985 Removed	The value, if present, SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Problem 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:81-15985).	
CONF #: 81-15990 Removed	The value, if present, MAY contain zero or one [0..1] @nullFlavor (CONF:81-15990).	
CONF #: 81-15991 Removed	If the diagnosis is unknown or the SNOMED code is unknown,	

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Change	Old	New
	@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:81-15991).	
CONF #: 81-16885 Removed	Set the observation/id equal to an ID on the problem list to signify that problem as an indication (CONF:81-16885).	
CONF #: 81-16886 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:81-16886).	
CONF #: 1098-7483 Modified	SHALL contain exactly one [1..1] id	SHALL contain at least one [1..*] id
CONF #: 1098-7489 Modified	SHOULD contain zero or one [0..1] value with @xsi:type="CD"	MAY contain zero or one [0..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet Problem 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC

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10.33 Instruction (V2)

Instruction (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09)

Change	Old	New
Name	Instructions	Instruction (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.20	urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09
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 template's moodCode can only be INT. If an instruction was already be given, the Procedure Activity Act template (instead of this template) should be used to represent the already occurred instruction. 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.
CONF #: 1098-32598 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32598).
CONF #: 81-7395 Removed	SHOULD contain zero or one [0..1] text (CONF:81-7395).	
CONF #: 81-15577 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15577).	
CONF #: 81-15578 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15578).	
CONF #: 81-15579 Removed	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:81-15579).	

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10.34Medication Activity (V2)

Medication Activity (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09)

Change	Old	New
Name	Medication Activity	Medication Activity (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.16	urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09
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 that a patient to be administered Lisinopril 20 mg PO for blood pressure control. If what was actually administered was Lisinopril 10 mg., then the Medication activities in the "EVN" mood would reflect actual use. A moodCode of INT is allowed, but it is recommended that the Planned Medication Activity (V2) template be used for moodCodes other than EVN if the document type contains a section that includes Planned Medication Activity (V2) (for example a Care Plan document with Plan of Treatment, Intervention, or Goal sections). At a minimum, a Medication Activity shall include an effectiveTime indicating the duration of the administration (or single-administration timestamp). 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 will have 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

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Change	Old	New
		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".
CONF #: 1098-30822 Added		SHALL contain exactly one [1..1] Drug Monitoring Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.123) (CONF:1098-30822).
CONF #: 1098-30820 Added		MAY contain zero or one [0..1] entryRelationship (CONF:1098-30820) such that it
CONF #: 1098-31387 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31387).
CONF #: 1098-28499 Added		*SHALL* contain exactly one [[]1..1[]] @xsi:type="PIVL_TS" or "EIVL_TS" (CONF:1098-28499).
CONF #: 1098-30800 Added		Medication Activity *SHOULD* include doseQuantity *OR* rateQuantity (CONF:1098-30800).
CONF #: 1098-30821 Added		SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CONF:1098-30821).
CONF #: 1098-31150 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31150).
CONF #: 1098-31515 Added		The following entryRelationship is used to indicate a given medication's order in a series. The nested Substance Administered Act identifies an administration in the series. The entryRelationship/sequenceNumber shows the order of this particular administration in that series. MAY contain zero or more [0..*] entryRelationship (CONF:1098-31515) such that it

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Change	Old	New
CONF #: 1098-31516 Added		SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31516).
CONF #: 1098-31517 Added		SHALL contain exactly one [1..1] @inversionInd="true" (CONF:1098-31517).
CONF #: 1098-31518 Added		MAY contain zero or one [0..1] sequenceNumber (CONF:1098-31518).
CONF #: 1098-31519 Added		SHALL contain exactly one [1..1] Substance Administered Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.118) (CONF:1098-31519).
CONF #: 1098-31520 Added		MAY contain zero or more [0..*] precondition (CONF:1098-31520).
CONF #: 1098-31882 Added		The precondition, if present, SHALL contain exactly one [1..1] @typeCode="PRCN" (CONF:1098-31882).
CONF #: 1098-31883 Added		The precondition, if present, SHALL contain exactly one [1..1] Precondition for Substance Administration (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09) (CONF:1098-31883).
CONF #: 1098-32360 Added		This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ActStatus 2.16.840.1.113883.1.11.159331 DYNAMIC (CONF:1098-32360).
CONF #: 1098-32498 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32498).
CONF #: 1098-32775 Added		SHOULD contain zero or one [0..1] @value (CONF:1098-32775). Note: indicates a single-administration timestamp
CONF #: 1098-32776 Added		SHOULD contain zero or one [0..1] low (CONF:1098-32776). Note: indicates when medication started
CONF #: 1098-32777 Added		MAY contain zero or one [0..1] high (CONF:1098-32777). Note: indicates when medication stopped

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Change	Old	New
CONF #: 1098-32890 Added		This effectiveTime *SHALL* contain either a low or a @value but not both (CONF:1098-32890).
CONF #: 81-7501 Removed	SHOULD contain zero or one [0..1] text (CONF:81-7501).	
CONF #: 81-7511 Removed	SHALL contain exactly one [1..1] low (CONF:81-7511).	
CONF #: 81-7512 Removed	SHALL contain exactly one [1..1] high (CONF:81-7512).	
CONF #: 81-7529 Removed	Medication Activity SHOULD include doseQuantity OR rateQuantity (CONF:81-7529).	
CONF #: 81-7546 Removed	MAY contain zero or more [0..*] precondition (CONF:81-7546) such that it	
CONF #: 81-7550 Removed	SHALL contain exactly one [1..1] @typeCode="PRCN" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-7550).	
CONF #: 81-9105 Removed	SHALL contain exactly one [1..1] @xsi:type=”PIVL_TS” or “EIVL_TS” (CONF:81-9105).	
CONF #: 81-15977 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15977).	
CONF #: 81-15978 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15978).	
CONF #: 81-15979 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:81-15979).	
CONF #: 81-16088 Removed	SHALL contain exactly one [1..1] Instructions (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.20) (CONF:81-16088).	
CONF #: 81-16092 Removed	SHALL contain exactly one [1..1] Precondition for Substance Administration (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.25) (CONF:81-16092).	
CONF #: 81-16877 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	

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Change	Old	New
	"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:81-16877).	
CONF #: 1098-7508 Modified	SHALL contain exactly one [1..1] effectiveTime	The substance administration effectiveTime field can repeat, in order to represent varying levels of complex dosing. effectiveTime can be used to represent the duration of administration (e.g., "10 days"), the frequency of administration (e.g., "every 8 hours"), and more. Here, we require that there SHALL be an effectiveTime documentation of the duration (or single-administration timestamp), and that there SHOULD be an effectiveTime documentation of the frequency. Other timing nuances, supported by the base CDA R2 standard, may also be included. SHALL contain exactly one [1..1] effectiveTime
CONF #: 1098-7514 Modified	MAY contain zero or one [0..1] routeCode, which SHALL be selected from ValueSet Medication Route FDA 2.16.840.1.113883.3.88.12.3221.8.7 DYNAMIC	SHOULD contain zero or one [0..1] routeCode, which SHALL be selected from ValueSet Medication Route FDA 2.16.840.1.113883.3.88.12.3221.8.7 DYNAMIC
CONF #: 1098-7516 Modified	SHOULD contain zero or one [0..1] doseQuantity	SHALL contain exactly one [1..1] doseQuantity
CONF #: 1098-7519 Modified	MAY contain zero or one [0..1] administrationUnitCode, which SHALL be selected from ValueSet Medication Product Form Value Set 2.16.840.1.113883.3.88.12.3221.8.11 DYNAMIC	MAY contain zero or one [0..1] administrationUnitCode, which SHALL be selected from ValueSet AdministrableDrugForm 2.16.840.1.113883.1.11.14570 DYNAMIC
CONF #: 1098-7526 Modified	The doseQuantity, if present, SHOULD contain zero or one [0..1] @unit, which SHALL be selected from ValueSet UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 DYNAMIC	This doseQuantity SHOULD contain zero or one [0..1] @unit, which SHALL be selected from ValueSet UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 DYNAMIC
CONF #: 1098-7555 Modified	MAY contain zero or one [0..1] repeatNumber	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

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Change	Old	New
		"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. MAY contain zero or one [0..1] repeatNumber
CONF #: 1098-16085 Modified	This consumable SHALL contain exactly one [1..1] Medication Information (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.23)	This consumable SHALL contain exactly one [1..1] Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09)
CONF #: 1098-16087 Modified	SHALL contain exactly one [1..1] Indication (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.19)	SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09)
CONF #: 1098-16089 Modified	SHALL contain exactly one [1..1] Medication Supply Order (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.17)	SHALL contain exactly one [1..1] Medication Supply Order (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09)
CONF #: 1098-16090 Modified	SHALL contain exactly one [1..1] Medication Dispense (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.18)	SHALL contain exactly one [1..1] Medication Dispense (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.18:2014-06-09)
CONF #: 1098-16091 Modified	SHALL contain exactly one [1..1] Reaction Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.9)	SHALL contain exactly one [1..1] Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09)
CONF #: 1098-16878 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")	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)

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10.35Medication Dispense (V2)

Medication Dispense (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.18:2014-06-09)

Change	Old	New
Name	Medication Dispense	Medication Dispense (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.18	urn:hl7ii:2.16.840.1.113883.10.20.22.4.18:2014-06-09
CONF #: 1098-31696 Added		SHALL contain exactly one [1..1] Immunization Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09) (CONF:1098-31696).
CONF #: 1098-32361 Added		This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Medication Fill Status 2.16.840.1.113883.3.88.12.80.64 STATIC 2014-04-23 (CONF:1098-32361).
CONF #: 1098-32580 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32580).
CONF #: 81-15608 Removed	SHALL contain exactly one [1..1] Immunization Medication Information (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.54) (CONF:81-15608).	
CONF #: 81-16876 Removed	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:81-16876).	
CONF #: 1098-7455 Modified	SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet Medication Fill Status 2.16.840.1.113883.3.88.12.80.64 DYNAMIC	SHALL contain exactly one [1..1] statusCode
CONF #: 1098-7457 Modified	SHOULD contain zero or one [0..1] repeatNumber	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

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Change	Old	New
		the current administration is the 3rd in a series. SHOULD contain zero or one [0..1] repeatNumber
CONF #: 1098-7468 Modified	This assignedEntity SHOULD contain zero or one [0..1] addr	This assignedEntity SHOULD contain zero or one [0..1] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-9333 Modified	A supply act SHALL contain one product/Medication Information or one product/Immunization Medication Information template	A supply act *SHALL* contain one product/Medication Information *OR* one product/Immunization Medication Information template
CONF #: 1098-10565 Modified	The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2)	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 #: 1098-15606 Modified	SHALL contain exactly one [1..1] Medication Supply Order (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.17)	SHALL contain exactly one [1..1] Medication Supply Order (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09)
CONF #: 1098-15607 Modified	SHALL contain exactly one [1..1] Medication Information (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.23)	SHALL contain exactly one [1..1] Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09)

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10.36 Medication Information (V2)

Medication Information (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09)

Change	Old	New
Name	Medication Information	Medication Information (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.23	urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09
Description	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”). To report immunizations administered, the vaccinations are represented using CVX codes instead of RxNorm codes. This should be reported by setting the manufacturedMaterial/code/@nullFlavor="OTH", and the code from the CVX code system should be sent using the manufacturedMaterial/code/translation/code.	A medication should be recorded as a pre-coordinated ingredient + strength + dose form (e.g., “metoprolol 25mg tablet”, “amoxicillin 400mg/5mL suspension”) where possible. This includes RxNorm codes whose Term Type is SCD (semantic clinical drug), SBD (semantic brand drug), GPCK (generic pack), BPCK (brand pack). 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. 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".
CONF #: 1098-31884 Added		This code MAY contain zero or more [0..*] translation, which MAY be selected from ValueSet Clinical Substance 2.16.840.1.113762.1.4.1010.2 DYNAMIC (CONF:1098-31884).
CONF #: 1098-32579 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32579).
CONF #: 81-7413 Removed	This code SHOULD contain zero or one [0..1] originalText (CONF:81-7413).	
CONF #: 81-7414 Removed	This code MAY contain zero or more [0..*] translation (CONF:81-7414).	
CONF #: 81-15986 Removed	The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15986).	
CONF #: 81-15987 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15987).	

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Change	Old	New
CONF #: 81-15988 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:81-15988).	
CONF #: 81-16875 Removed	Translations can be used to represent generic product name, packaged product code, etc (CONF:81-16875).	
CONF #: 1098-7412 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	This manufacturedMaterial SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Medication Clinical Drug 2.16.840.1.113762.1.4.1010.4 DYNAMIC

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10.37Medication Supply Order (V2)

Medication Supply Order (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09)

Change	Old	New
Name	Medication Supply Order	Medication Supply Order (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.17	urn:hl7ii:2.16.840.1.113883.10.20.22.4.17:2014-06-09
CONF #: 1098-31695 Added		SHALL contain exactly one [1..1] Immunization Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09) (CONF:1098-31695).
CONF #: 1098-31391 Added		The entryRelationship, if present, SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31391).
CONF #: 1098-32362 Added		This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ActStatus 2.16.840.1.113883.1.11.159331 DYNAMIC (CONF:1098-32362).
CONF #: 1098-32578 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32578).
CONF #: 81-16094 Removed	SHALL contain exactly one [1..1] Immunization Medication Information (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.54) (CONF:81-16094).	
CONF #: 81-16095 Removed	The entryRelationship, if present, SHALL contain exactly one [1..1] Instructions (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.20) (CONF:81-16095).	
CONF #: 81-16869 Removed	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:81-16869).	
CONF #: 1098-7434 Modified	SHOULD contain zero or one [0..1] repeatNumber	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

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Change	Old	New
		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. SHOULD contain zero or one [0..1] repeatNumber
CONF #: 1098-16093 Modified	SHALL contain exactly one [1..1] Medication Information (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.23)	SHALL contain exactly one [1..1] Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09)
CONF #: 1098-16870 Modified	A supply act SHALL contain one product/Medication Information or one product/Immunization Medication Information template	A supply act *SHALL* contain one product/Medication Information *OR* one product/Immunization Medication Information template

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10.38Medication Use - None Known (RETIRED)

Medication Use - None Known (RETIRED)
(urn:hl7ii:2.16.840.1.113883.10.20.22.4.29:2014-06-09)

Change	Old	New
Name	Medication Use - None Known (deprecated)	Medication Use - None Known (RETIRED)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.29	urn:hl7ii:2.16.840.1.113883.10.20.22.4.29:2014-06-09
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 HAS BEEN RETIRED IN C-CDA R2. USE OF THIS TEMPLATE IS NOT ALLOWED. *Reason for retirement*: The recommended approach to stating no known medications is to use the appropriate nullFlavor instead of this template. See "Unknown Information" in Volume 1.
CONF #: 81-7557 Removed	SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:81-7557).	
CONF #: 81-7558 Removed	SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:81-7558).	
CONF #: 81-7559 Removed	SHALL contain exactly one [1..1] templateId (CONF:81-7559) such that it	
CONF #: 81-7560 Removed	SHALL contain at least one [1..*] id (CONF:81-7560).	
CONF #: 81-7562 Removed	SHALL contain exactly one [1..1] statusCode (CONF:81-7562).	
CONF #: 81-7563 Removed	SHOULD contain zero or one [0..1] effectiveTime (CONF:81-7563).	
CONF #: 81-7564 Removed	SHALL contain exactly one [1..1] value="182904002" Drug treatment unknown (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:81-7564).	
CONF #: 81-7565 Removed	MAY contain zero or one [0..1] text (CONF:81-7565).	
CONF #: 81-10508 Removed	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.29" (CONF:81-10508).	

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Change	Old	New
CONF #: 81-15580 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15580).	
CONF #: 81-15581 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15581).	
CONF #: 81-15582 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:81-15582).	
CONF #: 81-19107 Removed	This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:81-19107).	
CONF #: 81-19149 Removed	SHALL contain exactly one [1..1] code (CONF:81-19149).	
CONF #: 81-19150 Removed	This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:81-19150).	

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10.39 Mental Status Observation (V2)

Mental Status Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09)

Change	Old	New
Name	Cognitive Status Result Observation	Mental Status Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.74	urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09
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.	The Mental Status Observation template represents an observation about mental status that can come from a broad range of subjective and objective information (including measured data) to address those categories described in the Mental Status Section. See also Assessment Scale Observation for specific collections of observations that together yield a summary evaluation of a particular condition.
Implied Template	Result Observation (urn:oid:2.16.840.1.113883.10.20.22.4.2)	
CONF #: 1098-32565 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32565).
CONF #: 1098-32788 Added		This code SHALL contain exactly one [1..1] @code="75275-8" Cognitive function (CONF:1098-32788).
CONF #: 1098-32789 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:1098-32789).
CONF #: 81-14277 Removed	SHALL contain exactly one [1..1] Caregiver Characteristics (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72) (CONF:81-14277).	

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Change	Old	New
CONF #: 81-14258 Removed	SHOULD contain zero or one [0..1] text (CONF:81-14258).	
CONF #: 81-14264 Removed	SHOULD contain zero or more [0..*] interpretationCode (CONF:81-14264).	
CONF #: 81-14265 Removed	MAY contain zero or one [0..1] methodCode (CONF:81-14265).	
CONF #: 81-14268 Removed	The referenceRange, if present, SHALL contain exactly one [1..1] observationRange (CONF:81-14268).	
CONF #: 81-14269 Removed	This observationRange SHALL NOT contain [0..0] code (CONF:81-14269).	
CONF #: 81-14270 Removed	MAY contain zero or one [0..1] targetSiteCode (CONF:81-14270).	
CONF #: 81-14272 Removed	MAY contain zero or more [0..*] entryRelationship (CONF:81-14272) such that it	
CONF #: 81-14273 Removed	SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.50) (CONF:81-14273).	
CONF #: 81-14276 Removed	MAY contain zero or more [0..*] entryRelationship (CONF:81-14276) such that it	
CONF #: 81-14592 Removed	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:81-14592).	
CONF #: 81-14593 Removed	SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-14593).	
CONF #: 81-14594 Removed	SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-14594).	
CONF #: 81-15549 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15549).	
CONF #: 81-15550 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value	

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Change	Old	New
	(CONF:81-15550).	
CONF #: 81-15551 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:81-15551).	
CONF #: 1098-14261 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	SHALL contain exactly one [1..1] effectiveTime
CONF #: 1098-14266 Modified	MAY contain zero or one [0..1] author	SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119)
CONF #: 1098-14267 Modified	SHOULD contain zero or more [0..*] referenceRange	The referenceRange could be used to represent normal or expected capability for the mental function being evaluated. MAY contain zero or more [0..*] referenceRange
CONF #: 1098-14271 Modified	If xsi:type="CD", SHOULD contain a code from SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96)	If xsi:type="CD", *SHOULD* contain a code from SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96)

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10.40 Mental Status Organizer (V2)

Mental Status Organizer (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.75:2014-06-09)

Change	Old	New
Name	Cognitive Status Result Organizer	Mental Status Organizer (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.75	urn:hl7ii:2.16.840.1.113883.10.20.22.4.75:2014-06-09
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.	The Mental Status Organizer template may be used to group related Mental Status Observations (e.g., results of mental tests) and associated Assessment Scale Observations into subcategories and/or groupings by time. Subcategories can be things such as Mood and Affect, Behavior, Thought Process, Perception, Cognition, etc.
Implied Template	Result Organizer (urn:oid:2.16.840.1.113883.10.20.22.4.1)	
CONF #: 1098-32424 Added		The effectiveTime is an interval that spans the effectiveTimes of the contained mental status observations. Because all contained mental status observations have a required time stamp, it is not required that this effectiveTime be populated. SHOULD contain zero or one [0..1] effectiveTime (CONF:1098-32424).
CONF #: 1098-32425 Added		The Organizer *SHALL* contain at least one of *code* or *effectiveTime* (CONF:1098-32425).
CONF #: 1098-32426 Added		The Organizer *SHALL* have at least one of *code* or *effectiveTime* (CONF:1098-32426).
CONF #: 1098-32566 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32566).
CONF #: 1098-14369 Modified	SHALL contain exactly one [1..1] @classCode="CLUSTER", which SHALL be selected from CodeSystem HL7ActClass (2.16.840.1.113883.5.6) STATIC	SHALL contain exactly one [1..1] @classCode="CLUSTER" Cluster (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6)
CONF #: 1098-14378 Modified	SHALL contain exactly one [1..1] code	The code selected should indicate the category that groups the contained mental status

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Change	Old	New
		observations (e.g., communication, learning and applying knowledge). SHOULD contain zero or one [0..1] code
CONF #: 1098-14381 Modified	SHALL contain exactly one [1..1] Cognitive Status Result Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.74)	SHALL contain exactly one [1..1] Mental Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.74:2014-06-09)
CONF #: 1098-14697 Modified	This code SHOULD contain zero or one [0..1] @code	The code, if present, SHOULD contain zero or one [0..1] @code
CONF #: 1098-14698 Modified	Should be selected from ICF (codeSystem 2.16.840.1.113883.6.254) or SNOMED CT (codeSystem 2.16.840.1.113883.6.96)	*SHOULD* be selected from ICF (codeSystem 2.16.840.1.113883.6.254) *OR* LOINC (codeSystem 2.16.840.1.113883.6.96)

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10.41 Non-Medicinal Supply Activity (V2)

Non-Medicinal Supply Activity (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09)

Change	Old	New
Name	Non-Medicinal Supply Activity	Non-Medicinal Supply Activity (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.50	urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09
Description	This template records non-medicinal supplies provided, such as medical equipment	This template represents equipment supplied to the patient (e.g., pumps, inhalers, wheelchairs). Devices applied to, or placed in, the patient are represented with the Product Instance entry contained within a Procedure Activity Procedure (V2) (templateId: 2.16.840.1.113883.10.20.22.4.14.2.)
CONF #: 1098-31393 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31393).
CONF #: 1098-30277 Added		MAY contain zero or one [0..1] entryRelationship (CONF:1098-30277) such that it
CONF #: 1098-30278 Added		SHALL contain exactly one [1..1] @typeCode="SUBJ" (CONF:1098-30278).
CONF #: 1098-30279 Added		SHALL contain exactly one [1..1] @inversionInd="TRUE" (CONF:1098-30279).
CONF #: 1098-32363 Added		This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ActStatus 2.16.840.1.113883.1.11.159331 DYNAMIC (CONF:1098-32363).
CONF #: 1098-32514 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32514).
CONF #: 1098-16867 Modified	The effectiveTime, if present, SHOULD contain zero or one [0..1] high	The effectiveTime, if present, *SHOULD* contain zero or one [[]0..1[]] *high*

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10.42 Number of Pressure Ulcers Observation (V2)

Number of Pressure Ulcers Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.76:2014-06-09)

Change	Old	New
Name	Number of Pressure Ulcers Observation	Number of Pressure Ulcers Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.76	urn:hl7ii:2.16.840.1.113883.10.20.22.4.76:2014-06-09
Description	This clinical statement enumerates the number of pressure ulcers observed in a particular stage.	This template represents the number of pressure ulcers observed at a particular stage.
CONF #: 1098-31930 Added		This observation SHALL contain exactly one [1..1] code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4) (CONF:1098-31930).
CONF #: 1098-32164 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:1098-32164).
CONF #: 1098-32604 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32604).
CONF #: 1098-14719 Modified	This entryRelationship SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC)	SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC)
CONF #: 1098-14720 Modified	This entryRelationship SHALL contain exactly one [1..1] observation	SHALL contain exactly one [1..1] observation
CONF #: 1098-14725 Modified	This observation SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet Pressure Ulcer Stage 2.16.840.1.113883.11.20.9.35 STATIC	This observation SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet Pressure Ulcer Stage 2.16.840.1.113883.11.20.9.35 STATIC 2014-09-01
CONF #: 1098-14768 Modified	This code SHALL contain exactly one [1..1] @code="2264892003" number of pressure ulcers	This code SHALL contain exactly one [1..1] @code="75277-4" Number of pressure ulcers

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10.43 Planned Act (V2)

Planned Act (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09)

Change	Old	New
Name	Plan of Care Activity Act	Planned Act (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.39	urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09
Description	This is the generic template for the Plan of Care Activity.	This template represents planned acts that are not classified as an observation or a procedure according to the HL7 RIM. Examples of these acts are a dressing change, the teaching or feeding of a patient or the providing of comfort measures. The priority of the activity to the patient and provider is communicated through Priority Preference. The effectiveTime indicates the time when the activity is intended to take place.
CONF #: 1098-32023 Added		SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-32023).
CONF #: 1098-32021 Added		The following entryRelationship represents the indication for the act. MAY contain zero or more [0..*] entryRelationship (CONF:1098-32021) such that it
CONF #: 1098-32026 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-32026).
CONF #: 1098-32024 Added		The following entryRelationship captures any instructions associated with the planned act. MAY contain zero or more [0..*] entryRelationship (CONF:1098-32024) such that it
CONF #: 1098-30430 Added		SHALL contain exactly one [1..1] templateId (CONF:1098-30430) such that it
CONF #: 1098-30431 Added		SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.39" (CONF:1098-30431).
CONF #: 1098-30432 Added		SHALL contain exactly one [1..1] statusCode (CONF:1098-30432).

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Change	Old	New
CONF #: 1098-30433 Added		The effectiveTime in a planned act represents the time that the act should occur. SHOULD contain zero or one [0..1] effectiveTime (CONF:1098-30433).
CONF #: 1098-30435 Added		The clinician who is expected to carry out the act could be identified using act/performer. MAY contain zero or more [0..*] performer (CONF:1098-30435).
CONF #: 1098-31067 Added		The following entryRelationship represents the priority that a patient or a provider places on the activity. MAY contain zero or more [0..*] entryRelationship (CONF:1098-31067) such that it
CONF #: 1098-31068 Added		SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31068).
CONF #: 1098-31069 Added		SHALL contain exactly one [1..1] Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31069).
CONF #: 1098-31687 Added		SHALL contain exactly one [1..1] code (CONF:1098-31687).
CONF #: 1098-32019 Added		This statusCode SHALL contain exactly one [1..1] @code="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-32019).
CONF #: 1098-32020 Added		The author in a planned act represents the clinician who is requesting or planning the act. SHOULD contain zero or one [0..1] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32020).
CONF #: 1098-32022 Added		SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32022).
CONF #: 1098-32025 Added		SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType

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Change	Old	New
		2.16.840.1.113883.5.1002) (CONF:1098-32025).
CONF #: 1098-32030 Added		This code in a Planned 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:1098-32030).
CONF #: 1098-32552 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32552).
CONF #: 81-8544 Removed	SHALL contain exactly one [1..1] templateId (CONF:81-8544) such that it	
CONF #: 81-10510 Removed	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.39" (CONF:81-10510).	

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10.44 Planned Encounter (V2)

Planned Encounter (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09)

Change	Old	New
Name	Plan of Care Activity Encounter	Planned Encounter (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.40	urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09
Description	This is the template for the Plan of Care Activity Encounter.	This template represents a planned or ordered encounter. The type of encounter (e.g., comprehensive outpatient visit) is represented. Clinicians participating in the encounter and the location of the planned encounter may be captured. The priority that the patient and providers place on the encounter may be represented.
CONF #: 1098-31879 Added		SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-31879).
CONF #: 1098-31877 Added		The following entryRelationship captures the reason for the planned or ordered encounter MAY contain zero or more [0..*] entryRelationship (CONF:1098-31877) such that it
CONF #: 1098-30437 Added		SHALL contain exactly one [1..1] templateId (CONF:1098-30437) such that it
CONF #: 1098-30438 Added		SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.40" (CONF:1098-30438).
CONF #: 1098-30439 Added		SHALL contain exactly one [1..1] statusCode (CONF:1098-30439).
CONF #: 1098-30440 Added		SHOULD contain zero or one [0..1] effectiveTime (CONF:1098-30440).
CONF #: 1098-30442 Added		Performers represent clinicians who are responsible for assessing and treating the patient. MAY contain zero or more [0..*] performer (CONF:1098-30442) such that it
CONF #: 1098-30443 Added		This location participation captures where the planned or ordered encounter may take place. MAY contain zero or more [0..*] participant (CONF:1098-30443) such that it
CONF #: 1098-31032 Added		Records the type of encounter

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Change	Old	New
		ordered or recommended. SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Encounter Planned 2.16.840.1.113883.11.20.9.52 DYNAMIC (CONF:1098-31032).
CONF #: 1098-31033 Added		The following entryRelationship represents the priority that a patient or a provider places on the encounter. MAY contain zero or one [0..1] entryRelationship (CONF:1098-31033) such that it
CONF #: 1098-31034 Added		SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31034).
CONF #: 1098-31035 Added		SHALL contain exactly one [1..1] Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31035).
CONF #: 1098-31874 Added		SHALL contain exactly one [1..1] assignedEntity (CONF:1098-31874).
CONF #: 1098-31875 Added		SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31875).
CONF #: 1098-31876 Added		SHALL contain exactly one [1..1] Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32) (CONF:1098-31876).
CONF #: 1098-31878 Added		SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31878).
CONF #: 1098-31880 Added		This statusCode SHALL contain exactly one [1..1] @code="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31880).
CONF #: 1098-32045 Added		The author in a planned encounter represents the clinician who is requesting or planning the encounter.

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Change	Old	New
		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32045).
CONF #: 1098-32553 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32553).
CONF #: 81-8566 Removed	SHALL contain exactly one [1..1] templateId (CONF:81-8566) such that it	
CONF #: 81-10511 Removed	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.40" (CONF:81-10511).	

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10.45 Planned Medication Activity (V2)

Planned Medication Activity (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09)

Change	Old	New
Name	Plan of Care Activity Substance Administration	Planned Medication Activity (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.42	urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09
Description	This is the template for the Plan of Care Activity Substance Administration	This template represents planned medication activities. The priority of the medication activity to the patient and provider is communicated through Priority Preference. The effectiveTime indicates the time when the medication activity is intended to take place. The authorTime indicates when the documentation of the plan occurred.
CONF #: 1098-32071 Added		SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-32071).
CONF #: 1098-32069 Added		The following entryRelationship represents the indication for the planned medication activity. MAY contain zero or more [0..*] entryRelationship (CONF:1098-32069) such that it
CONF #: 1098-32074 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-32074).
CONF #: 1098-32072 Added		The following entryRelationship captures any instructions associated with the planned medication activity. MAY contain zero or more [0..*] entryRelationship (CONF:1098-32072) such that it
CONF #: 1098-32083 Added		This consumable SHALL contain exactly one [1..1] Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09) (CONF:1098-32083).
CONF #: 1098-32082 Added		SHALL contain exactly one [1..1] consumable (CONF:1098-32082).

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Change	Old	New
CONF #: 1098-30465 Added		SHALL contain exactly one [1..1] templateId (CONF:1098-30465) such that it
CONF #: 1098-30466 Added		SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.42" (CONF:1098-30466).
CONF #: 1098-30468 Added		The effectiveTime in a planned medication activity represents the time that the medication activity should occur. SHALL contain exactly one [1..1] effectiveTime (CONF:1098-30468).
CONF #: 1098-30470 Added		The clinician who is expected to perform the medication activity could be identified using substanceAdministration/performer. MAY contain zero or more [0..*] performer (CONF:1098-30470).
CONF #: 1098-31104 Added		The following entryRelationship represents the priority that a patient or a provider places on the planned medication activity. MAY contain zero or more [0..*] entryRelationship (CONF:1098-31104) such that it
CONF #: 1098-31105 Added		SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31105).
CONF #: 1098-31106 Added		SHALL contain exactly one [1..1] Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31106).
CONF #: 1098-32046 Added		The author in a planned medication activity represents the clinician who is requesting or planning the medication activity. SHOULD contain zero or one [0..1] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32046).
CONF #: 1098-32066 Added		In a Planned Medication Activity, repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times. MAY contain zero or one [0..1] repeatNumber (CONF:1098-32066).

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Change	Old	New
CONF #: 1098-32067 Added		MAY contain zero or one [0..1] routeCode, which SHALL be selected from ValueSet Medication Route FDA 2.16.840.1.113883.3.88.12.3221.8.7 DYNAMIC (CONF:1098-32067).
CONF #: 1098-32068 Added		MAY contain zero or one [0..1] doseQuantity (CONF:1098-32068).
CONF #: 1098-32070 Added		SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32070).
CONF #: 1098-32073 Added		SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32073).
CONF #: 1098-32078 Added		MAY contain zero or more [0..*] approachSiteCode, which SHALL be selected from ValueSet Body Site 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:1098-32078).
CONF #: 1098-32079 Added		MAY contain zero or one [0..1] rateQuantity (CONF:1098-32079).
CONF #: 1098-32080 Added		MAY contain zero or one [0..1] maxDoseQuantity (CONF:1098-32080).
CONF #: 1098-32081 Added		MAY contain zero or one [0..1] administrationUnitCode, which SHALL be selected from ValueSet AdministrableDrugForm 2.16.840.1.113883.1.11.14570 DYNAMIC (CONF:1098-32081).
CONF #: 1098-32084 Added		MAY contain zero or more [0..*] precondition (CONF:1098-32084).
CONF #: 1098-32085 Added		The precondition, if present, SHALL contain exactly one [1..1] @typeCode="PRCN" Precondition (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32085).
CONF #: 1098-32086 Added		The precondition, if present, SHALL contain exactly one [1..1] Precondition for Substance Administration (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.

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Change	Old	New
		22.4.25:2014-06-09) (CONF:1098-32086).
CONF #: 1098-32087 Added		SHALL contain exactly one [1..1] statusCode (CONF:1098-32087).
CONF #: 1098-32088 Added		This statusCode SHALL contain exactly one [1..1] @code="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-32088).
CONF #: 1098-32133 Added		The doseQuantity, if present, SHOULD contain zero or one [0..1] @unit, which SHALL be selected from ValueSet UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 DYNAMIC (CONF:1098-32133).
CONF #: 1098-32134 Added		The rateQuantity, if present, SHOULD contain zero or one [0..1] @unit, which SHALL be selected from ValueSet UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 DYNAMIC (CONF:1098-32134).
CONF #: 1098-32557 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32557).
CONF #: 81-8574 Removed	SHALL contain exactly one [1..1] templateId (CONF:81-8574) such that it	
CONF #: 81-10514 Removed	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.42" (CONF:81-10514).	

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10.46 Planned Observation (V2)

Planned Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09)

Change	Old	New
Name	Plan of Care Activity Observation	Planned Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.44	urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09
Description	This is the template for the Plan of Care Activity Observation.	This template represents planned observations that result in new information about the patient which cannot be classified as a procedure according to the HL7 RIM, i.e., procedures alter the patient's body. Examples of these observations are laboratory tests, diagnostic imaging tests, EEGs, and EKGs. The importance of the planned observation to the patient and provider is communicated through Priority Preference. The effectiveTime indicates the time when the observation is intended to take place and authorTime indicates when the documentation of the plan occurred. The Planned Observation template may also indicate the potential insurance coverage for the observation.
CONF #: 1098-32036 Added		SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-32036).
CONF #: 1098-32034 Added		The following entryRelationship represents the indication for the observation. MAY contain zero or more [0..*] entryRelationship (CONF:1098-32034) such that it
CONF #: 1098-32039 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-32039).
CONF #: 1098-32037 Added		The following entryRelationship captures any instructions associated with the planned observation.

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Change	Old	New
		MAY contain zero or more [0..*] entryRelationship (CONF:1098-32037) such that it
CONF #: 1098-32042 Added		SHALL contain exactly one [1..1] Planned Coverage (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.129) (CONF:1098-32042).
CONF #: 1098-32040 Added		The following entryRelationship represents the insurance coverage the patient may have for the observation. MAY contain zero or more [0..*] entryRelationship (CONF:1098-32040) such that it
CONF #: 1098-30451 Added		SHALL contain exactly one [1..1] templateId (CONF:1098-30451) such that it
CONF #: 1098-30452 Added		SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.44" (CONF:1098-30452).
CONF #: 1098-30453 Added		SHALL contain exactly one [1..1] statusCode (CONF:1098-30453).
CONF #: 1098-30454 Added		The effectiveTime in a planned observation represents the time that the observation should occur. SHOULD contain zero or one [0..1] effectiveTime (CONF:1098-30454).
CONF #: 1098-30456 Added		The clinician who is expected to perform the observation could be identified using procedure/performer. MAY contain zero or more [0..*] performer (CONF:1098-30456).
CONF #: 1098-31030 Added		SHALL contain exactly one [1..1] code, which SHOULD be selected from CodeSystem LOINC (2.16.840.1.113883.6.1) (CONF:1098-31030).
CONF #: 1098-31031 Added		MAY contain zero or one [0..1] value (CONF:1098-31031).
CONF #: 1098-31073 Added		The following entryRelationship represents the priority that a patient or a provider places on the observation. MAY contain zero or more [0..*] entryRelationship (CONF:1098-31073) such that it
CONF #: 1098-31074 Added		SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType

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Change	Old	New
		2.16.840.1.113883.5.1002) (CONF:1098-31074).
CONF #: 1098-31075 Added		SHALL contain exactly one [1..1] Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31075).
CONF #: 1098-32032 Added		This statusCode SHALL contain exactly one [1..1] @code="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-32032).
CONF #: 1098-32033 Added		The author in a planned observation represents the clinician who is requesting or planning the observation. SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32033).
CONF #: 1098-32035 Added		SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32035).
CONF #: 1098-32038 Added		SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32038).
CONF #: 1098-32041 Added		SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32041).
CONF #: 1098-32043 Added		In a planned observation the provider may suggest that an observation should be performed using a particular method. MAY contain zero or one [0..1] methodCode (CONF:1098-32043).
CONF #: 1098-32044 Added		The targetSiteCode is used to identify the part of the body of concern for the planned observation. SHOULD contain zero or more [0..*] targetSiteCode, which SHALL be selected from ValueSet Body Site 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:1098-32044).

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Change	Old	New
CONF #: 1098-32555 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32555).
CONF #: 81-8583 Removed	SHALL contain exactly one [1..1] templateId (CONF:81-8583) such that it	
CONF #: 81-10512 Removed	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.44" (CONF:81-10512).	

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10.47 Planned Procedure (V2)

Planned Procedure (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09)

Change	Old	New
Name	Plan of Care Activity Procedure	Planned Procedure (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.41	urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09
Description	This is the template for the Plan of Care Activity Procedure.	This template represents planned alterations of the patient's physical condition. Examples of such procedures are tracheostomy, knee replacement, and craniectomy. The priority of the procedure to the patient and provider is communicated through Priority Preference. The effectiveTime indicates the time when the procedure is intended to take place and authorTime indicates when the documentation of the plan occurred. The Planned Procedure Template may also indicate the potential insurance coverage for the procedure.
CONF #: 1098-31984 Added		SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-31984).
CONF #: 1098-31982 Added		The following entryRelationship represents the indication for the procedure. MAY contain zero or more [0..*] entryRelationship (CONF:1098-31982) such that it
CONF #: 1098-31989 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31989).
CONF #: 1098-31985 Added		The following entryRelationship captures any instructions associated with the planned procedure. MAY contain zero or more [0..*] entryRelationship (CONF:1098-31985) such that it
CONF #: 1098-31992 Added		SHALL contain exactly one [1..1] Planned Coverage (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.129) (CONF:1098-31992).
CONF #: 1098-31990 Added		The following entryRelationship

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Change	Old	New
		represents the insurance coverage the patient may have for the procedure. MAY contain zero or more [0..*] entryRelationship (CONF:1098-31990) such that it
CONF #: 1098-30444 Added		SHALL contain exactly one [1..1] templateId (CONF:1098-30444) such that it
CONF #: 1098-30445 Added		SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.41" (CONF:1098-30445).
CONF #: 1098-30446 Added		SHALL contain exactly one [1..1] statusCode (CONF:1098-30446).
CONF #: 1098-30447 Added		The effectiveTime in a planned procedure represents the time that the procedure should occur. SHOULD contain zero or one [0..1] effectiveTime (CONF:1098-30447).
CONF #: 1098-30449 Added		The clinician who is expected to perform the procedure could be identified using procedure/performer. MAY contain zero or more [0..*] performer (CONF:1098-30449).
CONF #: 1098-31079 Added		The following entryRelationship represents the priority that a patient or a provider places on the procedure. MAY contain zero or more [0..*] entryRelationship (CONF:1098-31079) such that it
CONF #: 1098-31080 Added		SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31080).
CONF #: 1098-31081 Added		SHALL contain exactly one [1..1] Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31081).
CONF #: 1098-31976 Added		SHALL contain exactly one [1..1] code (CONF:1098-31976).
CONF #: 1098-31977 Added		The procedure/code in a planned procedure *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

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Change	Old	New
		(CodeSystem: 2.16.840.1.113883.6.12) *OR* ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) (CONF:1098-31977).
CONF #: 1098-31978 Added		This statusCode SHALL contain exactly one [1..1] @code="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-31978).
CONF #: 1098-31979 Added		The author in a planned procedure represents the clinician who is requesting or planning the procedure. SHOULD contain zero or one [0..1] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31979).
CONF #: 1098-31980 Added		In a planned procedure the provider may suggest that a procedure should be performed using a particular method. MethodCode *SHALL NOT* conflict with the method inherent in Procedure / code. MAY contain zero or more [0..*] methodCode (CONF:1098-31980).
CONF #: 1098-31981 Added		The targetSiteCode is used to identify the part of the body of concern for the planned procedure. MAY contain zero or more [0..*] targetSiteCode, which SHALL be selected from ValueSet Body Site 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:1098-31981).
CONF #: 1098-31983 Added		SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31983).
CONF #: 1098-31986 Added		SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31986).
CONF #: 1098-31987 Added		SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:1098-31987).
CONF #: 1098-31991 Added		SHALL contain exactly one [1..1]

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Change	Old	New
		@typeCode="COMP" Has component (CONF:1098-31991).
CONF #: 1098-32554 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32554).
CONF #: 81-8570 Removed	SHALL contain exactly one [1..1] templateId (CONF:81-8570) such that it	
CONF #: 81-10513 Removed	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.41" (CONF:81-10513).	

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10.48 Planned Supply (V2)

Planned Supply (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09)

Change	Old	New
Name	Plan of Care Activity Supply	Planned Supply (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.43	urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09
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 (e.g., medication prescription, order for wheelchair). The importance of the supply order or request to the patient and provider may be indicated in the Priority Preference. The effective time indicates the time when the supply is intended to take place and author time indicates when the documentation of the plan occurred. The Planned Supply template may also indicate the potential insurance coverage for the procedure. Depending on the type of supply, the product or participant will be either a Medication Information product (medication), an Immunization Medication Information product (immunization), or a Product Instance participant (device/equipment).
CONF #: 1098-32052 Added		SHALL contain exactly one [1..1] Immunization Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.54:2014-06-09) (CONF:1098-32052).
CONF #: 1098-32051 Added		This product represents immunization medication that is ordered, requested or intended for the patient. MAY contain zero or one [0..1] product (CONF:1098-32051) such that it
CONF #: 1098-32056 Added		SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1098-32056).
CONF #: 1098-32054 Added		The following entryRelationship represents the indication for the

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Change	Old	New
		supply. MAY contain zero or more [0..*] entryRelationship (CONF:1098-32054) such that it
CONF #: 1098-32059 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-32059).
CONF #: 1098-32057 Added		The following entryRelationship captures any instructions associated with the planned supply. MAY contain zero or more [0..*] entryRelationship (CONF:1098-32057) such that it
CONF #: 1098-32050 Added		SHALL contain exactly one [1..1] Medication Information (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09) (CONF:1098-32050).
CONF #: 1098-32049 Added		This product represents medication that is ordered, requested or intended for the patient. MAY contain zero or one [0..1] product (CONF:1098-32049) such that it
CONF #: 1098-32062 Added		SHALL contain exactly one [1..1] Planned Coverage (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.129) (CONF:1098-32062).
CONF #: 1098-32060 Added		The following entryRelationship represents the insurance coverage the patient may have for the supply. MAY contain zero or more [0..*] entryRelationship (CONF:1098-32060) such that it
CONF #: 1098-30463 Added		SHALL contain exactly one [1..1] templateId (CONF:1098-30463) such that it
CONF #: 1098-30464 Added		SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.43" (CONF:1098-30464).
CONF #: 1098-30458 Added		SHALL contain exactly one [1..1] statusCode (CONF:1098-30458).
CONF #: 1098-30459 Added		The effectiveTime in a planned supply represents the time that the supply should occur. SHOULD contain zero or one [0..1]

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Change	Old	New
		effectiveTime (CONF:1098-30459).
CONF #: 1098-31110 Added		The following entryRelationship represents the priority that a patient or a provider places on the supply. MAY contain zero or more [0..*] entryRelationship (CONF:1098-31110) such that it
CONF #: 1098-31111 Added		SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31111).
CONF #: 1098-31112 Added		SHALL contain exactly one [1..1] Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31112).
CONF #: 1098-31129 Added		The author in a supply represents the clinician who is requesting or planning the supply. SHOULD contain zero or one [0..1] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31129).
CONF #: 1098-32047 Added		This statusCode SHALL contain exactly one [1..1] @code="active" Active (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:1098-32047).
CONF #: 1098-32048 Added		The clinician who is expected to perform the supply could be identified using supply/performer. MAY contain zero or more [0..*] performer (CONF:1098-32048).
CONF #: 1098-32055 Added		SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32055).
CONF #: 1098-32058 Added		SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32058).
CONF #: 1098-32061 Added		SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002)

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Change	Old	New
		(CONF:1098-32061).
CONF #: 1098-32063 Added		In a Planned Supply, repeatNumber indicates the number of times the supply event can occur. For example, if a medication is filled at a pharmacy and the prescription may be refilled 3 more times, the supply RepeatNumber equals 4. MAY contain zero or one [0..1] repeatNumber (CONF:1098-32063).
CONF #: 1098-32064 Added		MAY contain zero or one [0..1] quantity (CONF:1098-32064).
CONF #: 1098-32092 Added		If the product is Medication Information (V2) (2.16.840.1.113883.10.20.22.4.23.2) then the product *SHALL NOT* be Immunization Medication Information (2.16.840.1.113883.10.20.22.4.54.2) and the participant *SHALL NOT* be Product Instance (CONF:1098-32092).
CONF #: 1098-32093 Added		If the product is Medication Information (V2) (2.16.840.1.113883.10.20.22.4.23.2) then the product *SHALL NOT* be Immunization Medication Information (2.16.840.1.113883.10.20.22.4.54.2) and the participant *SHALL NOT* be Product Instance (CONF:1098-32093).
CONF #: 1098-32094 Added		This participant represents a device that is ordered, requested or intended for the patient. MAY contain zero or one [0..1] participant (CONF:1098-32094) such that it
CONF #: 1098-32095 Added		SHALL contain exactly one [1..1] Product Instance (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.37) (CONF:1098-32095).
CONF #: 1098-32096 Added		If the participant is Product Instance then the product *SHALL NOT* be Medication Information (V2) (2.16.840.1.113883.10.20.22.4.23.2) and the product *SHALL NOT* be Immunization Medication Information (V2) (2.16.840.1.113883.10.20.22.4.54.

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Change	Old	New
		2) (CONF:1098-32096).
CONF #: 1098-32325 Added		A product is recommended or even required under certain implementations. This IG makes product as recommended (SHOULD). SHOULD contain zero or one [0..1] product (CONF:1098-32325).
CONF #: 1098-32556 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32556).
CONF #: 81-8579 Removed	SHALL contain exactly one [1..1] templateId (CONF:81-8579) such that it	
CONF #: 81-10515 Removed	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.43" (CONF:81-10515).	

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10.49 Policy Activity (V2)

Policy Activity (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.61:2014-06-09)

Change	Old	New
Name	Policy Activity	Policy Activity (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.61	urn:hl7ii:2.16.840.1.113883.10.20.22.4.61:2014-06-09
Description	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.	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 of the coverage. The payer is represented as the performer of the policy activity.
Open/Closed	Closed	Open
CONF #: 1098-31344 Added		If the covered party's date of birth is recorded differently in the health plan and in the registration/pharmacy benefit 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:1098-31344).
CONF #: 1098-31345 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:1098-31345).
CONF #: 1098-32165 Added		This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.5.110" (CONF:1098-32165).
CONF #: 1098-32595 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32595).
CONF #: 81-8933 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	

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Change	Old	New
	namespace provides a necessary extension to CDA R2 for the use of the birthTime element (CONF:81-8933).	
CONF #: 81-10481 Removed	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:81-10481).	
CONF #: 81-10482 Removed	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:81-10482).	
CONF #: 81-19185 Removed	This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Health Insurance Type 2.16.840.1.113883.3.88.12.3221.5.2 DYNAMIC (CONF:81-19185).	
CONF #: 1098-8903 Modified	SHALL contain exactly one [1..1] code	SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet Source of Payment Typology (PHDSC) 2.16.840.1.114222.4.11.3591 DYNAMIC
CONF #: 1098-8910 Modified	This assignedEntity MAY contain zero or one [0..1] addr	This assignedEntity MAY contain zero or one [0..1] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-8911 Modified	This assignedEntity MAY contain zero or one [0..1] telecom	This assignedEntity MAY contain zero or more [0..*] telecom
CONF #: 1098-8930 Modified	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. The playingEntity, if present, SHALL contain exactly one [1..1] name	If the covered party's name is recorded differently in the health plan and in the registration/pharmacy benefit summary (due to marriage or for other reasons), use the name as it is recorded in the health plan. The playingEntity, if present, SHALL contain at least one [1..*] name
CONF #: 1098-8934 Modified	SHOULD contain zero or one [0..1] participant	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. SHOULD contain zero or one [0..1]

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Change	Old	New
		participant
CONF #: 1098-8942 Modified	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	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 #: 1098-8943 Modified	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	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 #: 1098-8964 Modified	This assignedEntity SHOULD contain zero or one [0..1] addr	This assignedEntity SHOULD contain zero or one [0..1] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)
CONF #: 1098-8965 Modified	This assignedEntity SHOULD contain zero or one [0..1] telecom	This assignedEntity SHOULD contain zero or more [0..*] telecom
CONF #: 1098-8967 Modified	SHOULD include assignedEntity/assignedPerson/name AND/OR assignedEntity/representedOrganization/name	*SHOULD* include assignedEntity/assignedPerson/name AND/OR assignedEntity/representedOrganization/name
CONF #: 1098-8984 Modified	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	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 #: 1098-10483 Modified	The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2)	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 #: 1098-10484 Modified	The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2)	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 #: 1098-16096 Modified	This code SHALL contain exactly one [1..1] @code="GUAR" Guarantor (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC)	This code SHALL contain exactly one [1..1] @code="GUAR" Guarantor
CONF #: 1098-17139 Modified	When the Subscriber is the patient, the participant element describing the subscriber SHALL NOT be present. This information will be	When the Subscriber is the patient, the participant element describing the subscriber *SHALL NOT* be present. This information will be

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Change	Old	New
	recorded instead in the data elements used to record member information	recorded instead in the data elements used to record member information

10.50 Postprocedure Diagnosis (V2)

Postprocedure Diagnosis (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09)

Change	Old	New
Name	Postprocedure Diagnosis	Postprocedure Diagnosis (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.51	urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09
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.
CONF #: 1098-32166 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:1098-32166).
CONF #: 1098-32539 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32539).
CONF #: 1098-8760 Modified	Such entryRelationships SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC)	SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC)
CONF #: 1098-15583 Modified	Such entryRelationships SHALL contain exactly one [1..1] Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.4)	SHALL contain exactly one [1..1] Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)
CONF #: 1098-19152 Modified	This code SHALL contain exactly one [1..1] @code="59769-0" Postprocedure diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="59769-0" Postprocedure diagnosis

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10.51 Precondition for Substance Administration (V2)

Precondition for Substance Administration (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09)

Change	Old	New
Name	Precondition for Substance Administration	Precondition for Substance Administration (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.25	urn:hl7ii:2.16.840.1.113883.10.20.22.4.25:2014-06-09
CONF #: 1098-32396 Added		SHALL contain exactly one [1..1] code with @xsi:type="CD" (CONF:1098-32396).
CONF #: 1098-32397 Added		This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CONF:1098-32397).
CONF #: 1098-32398 Added		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:1098-32398).
CONF #: 1098-32603 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32603).
CONF #: 81-7373 Removed	MAY contain zero or one [0..1] text (CONF:81-7373).	
CONF #: 81-16854 Removed	SHOULD contain zero or one [0..1] code (CONF:81-16854).	
CONF #: 1098-7369 Modified	SHOULD contain zero or one [0..1] value with @xsi:type="CD"	SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHALL be selected from ValueSet Problem 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC

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10.52 Preoperative Diagnosis (V2)

Preoperative Diagnosis (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09)

Change	Old	New
Name	Preoperative Diagnosis	Preoperative Diagnosis (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.65	urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09
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.
CONF #: 1098-32167 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:1098-32167).
CONF #: 1098-32540 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32540).
CONF #: 1098-10094 Modified	Such entryRelationships SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC)	SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC)
CONF #: 1098-15605 Modified	Such entryRelationships SHALL contain exactly one [1..1] Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.4)	SHALL contain exactly one [1..1] Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)
CONF #: 1098-19156 Modified	This code SHALL contain exactly one [1..1] @code="10219-4" Preoperative Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="10219-4" Preoperative Diagnosis

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10.53 Pressure Ulcer Observation (DEPRECATED)

Pressure Ulcer Observation (DEPRECATED) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.70:2014-06-09)

Change	Old	New
Name	Pressure Ulcer Observation	Pressure Ulcer Observation (DEPRECATED)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.70	urn:hl7ii:2.16.840.1.113883.10.20.22.4.70:2014-06-09
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.	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 IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED. *Reason for deprecation*: This template has been replaced by Longitudinal Care Wound Observation (2.16.840.1.113883.10.20.22.4.114).
CONF #: 1098-32594 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32594).
CONF #: 81-14397 Removed	This value MAY contain zero or one [0..1] @nullFlavor (CONF:81-14397).	
CONF #: 81-14398 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:81-14398).	
CONF #: 1098-14396 Modified	SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet Pressure Ulcer Stage 2.16.840.1.113883.11.20.9.35 STATIC	SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet Pressure Ulcer Stage 2.16.840.1.113883.11.20.9.35 STATIC 2014-09-01

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Change	Old	New
CONF #: 1098-14803 Modified	This value SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet TargetSite Qualifiers 2.16.840.1.113883.11.20.9.37 STATIC	This value SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet TargetSite Qualifiers 2.16.840.1.113883.11.20.9.37 STATIC 2014-09-01

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10.54Problem Concern Act (V2)

Problem Concern Act (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09)

Change	Old	New
Name	Problem Concern Act (Condition)	Problem Concern Act (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.3	urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09
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., as 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 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 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). A Problem Concern Act can contain many Problem Observations (templateId 2.16.840.1.113883.10.20.22.4.4.2). Each Problem Observation is a discrete observation of a condition,

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Change	Old	New
		and therefore will have a statusCode of “completed”. The many Problem Observations nested under a Problem Concern Act reflect the change in the clinical understanding of a condition over time. For instance, a Concern may initially contain a Problem Observation of “chest pain”: - Problem Concern 1 --- Problem Observation: Chest Pain Later, a new Problem Observation of “esophagitis” will be added, reflecting a better understanding of the nature of the chest pain. The later problem observation will have a more recent author time stamp. - Problem Concern 1 --- Problem Observation (author/time Jan 3, 2012): Chest Pain --- Problem Observation (author/time Jan 6, 2012): Esophagitis Many systems display the nested Problem Observation with the most recent author time stamp, and provide a mechanism for viewing prior observations.
CONF #: 1098-31640 Added		SHALL contain exactly one [1..1] Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31640).
CONF #: 1098-31638 Added		The following entryRelationship represents the importance of the concern to a provider. MAY contain zero or more [0..*] entryRelationship (CONF:1098-31638) such that it
CONF #: 1098-31146 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31146).
CONF #: 1098-31525 Added		The statusCode of the Problem Concern Act 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. This statusCode SHALL contain exactly one [1..1] @code, which

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Change	Old	New
		SHALL be selected from ValueSet ProblemAct statusCode 2.16.840.1.113883.11.20.9.19 STATIC 2011-09-10 (CONF:1098-31525).
CONF #: 1098-31639 Added		SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31639).
CONF #: 1098-32168 Added		This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.5.6" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:1098-32168).
CONF #: 1098-32509 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32509).
CONF #: 1098-9029 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	SHALL contain exactly one [1..1] statusCode
CONF #: 1098-9030 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	SHALL contain exactly one [1..1] effectiveTime
CONF #: 1098-9033 Modified	This effectiveTime SHOULD contain zero or one [0..1] high	This effectiveTime MAY contain zero or one [0..1] high
CONF #: 1098-15980 Modified	SHALL contain exactly one [1..1] Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.4)	SHALL contain exactly one [1..1] Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)
CONF #: 1098-19184 Modified	This code SHALL contain exactly one [1..1] @code="CONC" Concern (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC)	This code SHALL contain exactly one [1..1] @code="CONC" Concern

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10.55Problem Observation (V2)

Problem Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)

Change	Old	New
Name	Problem Observation	Problem Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.4	urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09
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".
CONF #: 1098-31064 Added		SHALL contain exactly one [1..1] Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1098-31064).
CONF #: 1098-31063 Added		MAY contain zero or more [0..*] entryRelationship (CONF:1098-31063) such that it
CONF #: 1098-29951 Added		MAY contain zero or one [0..1] entryRelationship (CONF:1098-29951) such that it
CONF #: 1098-29952 Added		SHALL contain exactly one [1..1] Prognosis Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.113) (CONF:1098-29952).
CONF #: 1098-31147 Added		SHOULD contain zero or more [0..*] Author Participation (identifier:

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Change	Old	New
		urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31147).
CONF #: 1098-31531 Added		SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31531).
CONF #: 1098-31532 Added		SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-31532).
CONF #: 1098-31870 Added		The observation/value and all the qualifiers together (often referred to as a post-coordinated expression) make up one concept. Qualifiers constrain the meaning of the primary code, and cannot negate it or change its meaning. Qualifiers can only be used according to well-defined rules of post-coordination and only if the underlying code system defines the use of such qualifiers or if there is a third code system that specifies how other code systems may be combined. For example, SNOMED CT allows constructing concepts as a combination of multiple codes. SNOMED CT defines a concept "pneumonia (disorder)" (233604007) an attribute "finding site" (363698007) and another concept "left lower lobe of lung (body structure)" (41224006). SNOMED CT allows one to combine these codes in a code phrase, as shown in the sample XML. This value MAY contain zero or more [0..*] qualifier (CONF:1098-31870).
CONF #: 1098-31871 Added		A negationInd of "true" coupled with an observation/value/@code of SNOMED code 64572001 "Disease (disorder)" indicates that the patient has no known conditions. This value MAY contain zero or one [0..1] @code (CONF:1098-31871).
CONF #: 1098-32508 Added		SHALL contain exactly one [1..1] @extension="2014-06-09"

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Change	Old	New
		(CONF:1098-32508).
CONF #: 81-9064 Removed	SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-9064).	
CONF #: 81-9067 Removed	MAY contain zero or one [0..1] entryRelationship (CONF:81-9067) such that it	
CONF #: 81-9185 Removed	SHOULD contain zero or one [0..1] text (CONF:81-9185).	
CONF #: 81-10141 Removed	This value MAY contain zero or one [0..1] @nullFlavor (CONF:81-10141).	
CONF #: 81-10142 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:81-10142).	
CONF #: 81-15587 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15587).	
CONF #: 81-15588 Removed	The reference, if present, SHALL contain exactly one [1..1] @value (CONF:81-15588).	
CONF #: 81-15589 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:81-15589).	
CONF #: 81-15592 Removed	SHALL contain exactly one [1..1] Health Status Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.5) (CONF:81-15592).	
CONF #: 81-16880 Removed	Use negationInd="true" to indicate that the problem was not observed (CONF:81-16880).	
CONF #: 1098-9045 Modified	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	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 2014-09-02
CONF #: 1098-9050 Modified	SHOULD contain zero or one [0..1] effectiveTime	If the problem is known to be resolved, but the date of resolution is not known, then the high

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Change	Old	New
		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. SHALL contain exactly one [1..1] effectiveTime
CONF #: 1098-9068 Modified	SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC)	SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002)
CONF #: 1098-10139 Modified	MAY contain zero or one [0..1] @negationInd	The negationInd is used to indicate the absence of the condition in observation/value. A negationInd of "true" coupled with an observation/value of SNOMED code 64572001 "Disease (disorder)" indicates that the patient has no known conditions. MAY contain zero or one [0..1] @negationInd
CONF #: 1098-15591 Modified	SHALL contain exactly one [1..1] Problem Status (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.6)	SHALL contain exactly one [1..1] Problem Status (DEPRECATED) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.6:2014-06-09)
CONF #: 1098-15603 Modified	The value of effectiveTime/low represents onset date. The effectiveTime, if present, SHALL contain exactly one [1..1] low	The effectiveTime/low (a.k.a. "onset date") asserts when the condition became biologically active. This effectiveTime SHALL contain exactly one [1..1] low
CONF #: 1098-15604 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	The effectiveTime/high (a.k.a. "resolution date") asserts when the condition became biologically resolved. This effectiveTime MAY contain zero or one [0..1] high
CONF #: 1098-16750 Modified	The translation, if present, MAY contain zero or one [0..1] @code (CodeSystem: ICD10CM 2.16.840.1.113883.6.90 STATIC)	MAY contain zero or one [0..1] @code (CodeSystem: ICD10CM 2.16.840.1.113883.6.90 STATIC)

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10.56 Problem Status (DEPRECATED)

Problem Status (DEPRECATED) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.6:2014-06-09)

Change	Old	New
Name	Problem Status	Problem Status (DEPRECATED)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.6	urn:hl7ii:2.16.840.1.113883.10.20.22.4.6:2014-06-09
Description	The Problem Status records whether the indicated problem is active, inactive, or resolved.	The Problem Status records whether the indicated problem is active, inactive, or resolved. THIS TEMPLATE HAS BEEN DEPRECATED IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED. *Reason for deprecation*: 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
CONF #: 1098-32581 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32581).
CONF #: 81-7362 Removed	SHOULD contain zero or one [0..1] text (CONF:81-7362).	
CONF #: 81-15593 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15593).	
CONF #: 81-15594 Removed	The reference, if present, SHALL contain exactly one [1..1] @value (CONF:81-15594).	
CONF #: 81-15595 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:81-15595).	

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10.57Procedure Activity Act (V2)

Procedure Activity Act (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09)

Change	Old	New
Name	Procedure Activity Act	Procedure Activity Act (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.12	urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09
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).
CONF #: 1098-31396 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31396).
CONF #: 1098-32364 Added		This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22 STATIC 2014-04-23 (CONF:1098-32364).
CONF #: 1098-32477 Added		SHOULD contain at least one [1..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32477).
CONF #: 1098-32505 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32505).
CONF #: 81-15600 Removed	SHALL contain exactly one [1..1] Instructions (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.20) (CONF:81-15600).	
CONF #: 1098-15599 Modified	The participant, if present, SHALL contain exactly one [1..1] Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.2	SHALL contain exactly one [1..1] Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.2

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Change	Old	New
	2.4.32)	2.4.32)
CONF #: 1098-8290 Modified	SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03	SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC)
CONF #: 1098-8298 Modified	SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22 DYNAMIC	SHALL contain exactly one [1..1] statusCode
CONF #: 1098-8299 Modified	SHOULD contain zero or one [0..1] effectiveTime	SHALL contain exactly one [1..1] effectiveTime
CONF #: 1098-8303 Modified	This assignedEntity SHALL contain at least one [1..*] id	This assignedEntity SHALL contain exactly one [1..1] id
CONF #: 1098-8305 Modified	This assignedEntity SHALL contain exactly one [1..1] telecom	This assignedEntity SHALL contain at least one [1..*] telecom
CONF #: 1098-8309 Modified	The representedOrganization, if present, SHALL contain exactly one [1..1] addr	The representedOrganization, if present, SHALL contain at least one [1..*] addr
CONF #: 1098-8310 Modified	The representedOrganization, if present, SHALL contain exactly one [1..1] telecom	The representedOrganization, if present, SHALL contain at least one [1..*] telecom
CONF #: 1098-8312 Modified	The participant, if present, SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC)	SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC)
CONF #: 1098-15601 Modified	SHALL contain exactly one [1..1] Indication (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.19)	SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09)
CONF #: 1098-15602 Modified	SHALL contain exactly one [1..1] Medication Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.16)	SHALL contain exactly one [1..1] Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09)
CONF #: 1098-19189 Modified	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)	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 #: 1098-19190 Modified	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)	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:

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Change	Old	New
		2.16.840.1.113883.6.12) or ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) or CDT-2 (Code System: 2.16.840.1.113883.6.13)

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10.58 Procedure Activity Observation (V2)

Procedure Activity Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09)

Change	Old	New
Name	Procedure Activity Observation	Procedure Activity Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.13	urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09
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.
CONF #: 1098-31394 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31394).
CONF #: 1098-32365 Added		This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22 STATIC 2014-04-23 (CONF:1098-32365).
CONF #: 1098-32470 Added		MAY contain zero or more [0..*] entryRelationship (CONF:1098-32470) such that it
CONF #: 1098-32471 Added		SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32471).
CONF #: 1098-32472 Added		SHALL contain exactly one [1..1] Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09) (CONF:1098-

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Change	Old	New
		32472).
CONF #: 1098-32478 Added		SHOULD contain at least one [1..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32478).
CONF #: 1098-32507 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32507).
CONF #: 1098-32778 Added		If nothing is appropriate for value, use an appropriate nullFlavor. This value MAY contain zero or one [0..1] @nullFlavor (CONF:1098-32778).
CONF #: 81-15905 Removed	SHALL contain exactly one [1..1] Instructions (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.20) (CONF:81-15905).	
CONF #: 81-16071 Removed	The targetSiteCode, if present, SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Body Site 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:81-16071).	
CONF #: 81-26512 Removed	If nothing is appropriate for value, use an appropriate nullFlavor. This value MAY contain zero or one [0..1] @nullFlavor (CONF:81-26512).	
CONF #: 1098-15904 Modified	The participant, if present, SHALL contain exactly one [1..1] Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32)	SHALL contain exactly one [1..1] Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32)
CONF #: 1098-8237 Modified	SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03	SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC)
CONF #: 1098-8245 Modified	SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22 DYNAMIC	SHALL contain exactly one [1..1] statusCode
CONF #: 1098-8249 Modified	MethodCode SHALL NOT conflict with the method inherent in Observation / code	MethodCode *SHALL NOT* conflict with the method inherent in Observation / code
CONF #: 1098-8250 Modified	SHOULD contain zero or more [0..*] targetSiteCode	SHOULD contain zero or more [0..*] targetSiteCode, which SHALL be selected from ValueSet Body Site

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Change	Old	New
		2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC
CONF #: 1098-8254 Modified	This assignedEntity SHALL contain exactly one [1..1] addr	This assignedEntity SHALL contain at least one [1..*] addr
CONF #: 1098-8255 Modified	This assignedEntity SHALL contain exactly one [1..1] telecom	This assignedEntity SHALL contain at least one [1..*] telecom
CONF #: 1098-8262 Modified	The participant, if present, SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC)	SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC)
CONF #: 1098-15906 Modified	SHALL contain exactly one [1..1] Indication (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.19)	SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09)
CONF #: 1098-15907 Modified	SHALL contain exactly one [1..1] Medication Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.16)	SHALL contain exactly one [1..1] Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09)
CONF #: 1098-19201 Modified	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)	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 #: 1098-19202 Modified	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)	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) or ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) or CDT-2 (Code System: 2.16.840.1.113883.6.13)

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10.59 Procedure Activity Procedure (V2)

Procedure Activity Procedure (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09)

Change	Old	New
Name	Procedure Activity Procedure	Procedure Activity Procedure (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.14	urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09
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. This template can be used with a contained Product Instance template to represent a device in or on a patient. In this case, targetSiteCode is used to record the location of the device in or on the patient's body. Equipment supplied to the patient (e.g., pumps, inhalers, wheelchairs) is represented by the Non-Medicinal Supply Activity (V2) template.
CONF #: 1098-31395 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31395).
CONF #: 1098-29744 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:1098-29744).
CONF #: 1098-32366 Added		This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ProcedureAct statusCode

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Change	Old	New
		2.16.840.1.113883.11.20.9.22 STATIC 2014-04-23 (CONF:1098-32366).
CONF #: 1098-32473 Added		MAY contain zero or more [0..*] entryRelationship (CONF:1098-32473) such that it
CONF #: 1098-32474 Added		SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:1098-32474).
CONF #: 1098-32475 Added		SHALL contain exactly one [1..1] Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09) (CONF:1098-32475).
CONF #: 1098-32479 Added		SHOULD contain at least one [1..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-32479).
CONF #: 1098-32506 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32506).
CONF #: 81-7717 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:81-7717).	
CONF #: 81-15913 Removed	SHALL contain exactly one [1..1] Instructions (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.20) (CONF:81-15913).	
CONF #: 1098-7653 Modified	SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03	SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC)
CONF #: 1098-7661 Modified	SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22 DYNAMIC	SHALL contain exactly one [1..1] statusCode
CONF #: 1098-7683 Modified	SHOULD contain zero or more [0..*] targetSiteCode	In the case of an implanted medical device, targetSiteCode is used to record the location of the device, in

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Change	Old	New
		or on the patient's body. SHOULD contain zero or more [0..*] targetSiteCode
CONF #: 1098-7731 Modified	This assignedEntity SHALL contain exactly one [1..1] addr	This assignedEntity SHALL contain at least one [1..*] addr
CONF #: 1098-7732 Modified	This assignedEntity SHALL contain exactly one [1..1] telecom	This assignedEntity SHALL contain at least one [1..*] telecom
CONF #: 1098-7890 Modified	MethodCode SHALL NOT conflict with the method inherent in Procedure / code	MethodCode *SHALL NOT* conflict with the method inherent in Procedure / code
CONF #: 1098-15914 Modified	SHALL contain exactly one [1..1] Indication (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.19)	SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09)
CONF #: 1098-15915 Modified	SHALL contain exactly one [1..1] Medication Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.16)	SHALL contain exactly one [1..1] Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09)
CONF #: 1098-19206 Modified	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)	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 #: 1098-19207 Modified	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)	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) or ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) or CDT-2 (Code System: 2.16.840.1.113883.6.13)

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10.60 Reaction Observation (V2)

Reaction Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09)

Change	Old	New
Name	Reaction Observation	Reaction Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.9	urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09
Description	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.	This clinical statement represents the response to an undesired symptom, finding, etc. due to administered or exposed substance. This reaction may be an undesired symptom, finding, etc. or it could be a desired response to a treatment. A reaction can be defined with respect to its severity, and can have been treated by one or more interventions.
CONF #: 1098-31124 Added		This code SHALL contain exactly one [1..1] @code="ASSERTION" (CONF:1098-31124).
CONF #: 1098-32169 Added		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:1098-32169).
CONF #: 1098-32504 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32504).
CONF #: 81-7330 Removed	SHOULD contain zero or one [0..1] text (CONF:81-7330).	
CONF #: 81-15917 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15917).	
CONF #: 81-15918 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15918).	
CONF #: 81-15919 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:81-15919).	
CONF #: 81-16840 Removed	This medication activity is intended to contain information about medications that were administered in response to an allergy reaction (CONF:81-16840).	
CONF #: 81-16852 Removed	The value set for this code element has not been specified.	

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Change	Old	New
	Implementers are allowed to use any code system, such as SNOMED CT, a locally determined code, or a nullFlavor (CONF:81-16852).	
CONF #: 81-16853 Removed	This procedure activity is intended to contain information about procedures that were performed in response to an allergy reaction (CONF:81-16853).	
CONF #: 1098-7329 Modified	SHALL contain exactly one [1..1] id	SHALL contain at least one [1..*] id
CONF #: 1098-15920 Modified	SHALL contain exactly one [1..1] Procedure Activity Procedure (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.14)	This procedure activity is intended to contain information about procedures that were performed in response to an allergy reaction. SHALL contain exactly one [1..1] Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09)
CONF #: 1098-15921 Modified	SHALL contain exactly one [1..1] Medication Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.16)	This medication activity is intended to contain information about medications that were administered in response to an allergy reaction. SHALL contain exactly one [1..1] Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09)
CONF #: 1098-15922 Modified	SHALL contain exactly one [1..1] Severity Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.8)	SHALL contain exactly one [1..1] Severity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09)

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10.61 Result Observation (V2)

Result Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09)

Change	Old	New
Name	Result Observation	Result Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.2	urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09
Description	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.	This template represents the results of a laboratory, radiology, or other study performed on a patient. The result observation includes a statusCode to allow recording the status of an observation. "Pending" results (e.g., a test has been run but results have not been reported yet) should be represented as "active" ActStatus.
CONF #: 1098-31484 Added		If Observation/value is a physical quantity (*xsi:type*=*"PQ"*), the unit of measure *SHALL* be selected from ValueSet UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 *DYNAMIC* (CONF:1098-31484).
CONF #: 1098-31866 Added		A coded value *MAY* contain zero or more [[]0..[*][]] translations, which can be used to represent the original results as output by the lab (CONF:1098-31866).
CONF #: 1098-32175 Added		This observationRange SHALL contain exactly one [1..1] value (CONF:1098-32175).
CONF #: 1098-32476 Added		The interpretationCode, if present, SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Observation Interpretation (HL7) 2.16.840.1.113883.1.11.78 STATIC 2014-09-01 (CONF:1098-32476).
CONF #: 1098-32575 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32575).
CONF #: 1098-32610 Added		If Observation/value is a CD (*xsi:type*=*"CD"*) the value SHOULD be SNOMED-CT (CONF:1098-32610).
CONF #: 81-7138 Removed	SHOULD contain zero or one [0..1] text (CONF:81-7138).	

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Change	Old	New
CONF #: 81-15924 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15924).	
CONF #: 81-15925 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15925).	
CONF #: 81-15926 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:81-15926).	
CONF #: 81-16838 Removed	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:81-16838).	
CONF #: 81-19211 Removed	SHOULD be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:81-19211).	
CONF #: 1098-7133 Modified	SHALL contain exactly one [1..1] code	SHALL contain exactly one [1..1] code, which SHOULD be selected from CodeSystem LOINC (2.16.840.1.113883.6.1)
CONF #: 1098-7143 Modified	SHALL contain exactly one [1..1] value	SHOULD contain zero or one [0..1] value, which SHOULD be selected from CodeSystem SNOMED CT (2.16.840.1.113883.6.96)
CONF #: 1098-7149 Modified	MAY contain zero or one [0..1] author	SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119)
CONF #: 1098-14849 Modified	This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Result Status 2.16.840.1.113883.11.20.9.39 STATIC	This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Result Status 2.16.840.1.113883.11.20.9.39 STATIC 2013-08-09
CONF #: 1098-19212 Modified	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	This code *SHOULD* be a code from the LOINC that identifies the result observation. If an appropriate LOINC code does not exist, then the local code for this result *SHALL* be sent

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Change	Old	New
	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	

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10.62 Result Organizer (V2)

Result Organizer (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09)

Change	Old	New
Name	Result Organizer	Result Organizer (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.1	urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09
Description	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.	This template provides a mechanism for grouping result observations. It contains information applicable to all of the contained result observations. The Result Organizer code categorizes the contained results into one of several commonly accepted values (e.g., “Hematology”, “Chemistry”, “Nuclear Medicine”). If any Result Observation within the organizer has a statusCode of "active", the Result Organizer must also have a statusCode of "active".
CONF #: 1098-31149 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31149).
CONF #: 1098-31865 Added		MAY contain zero or one [0..1] effectiveTime (CONF:1098-31865). Note: The effectiveTime is an interval that spans the effectiveTimes of the contained result observations. Because all contained result observations have a required time stamp, it is not required that this effectiveTime be populated.
CONF #: 1098-32488 Added		The effectiveTime, if present, SHALL contain exactly one [1..1] low (CONF:1098-32488).
CONF #: 1098-32489 Added		The effectiveTime, if present, SHALL contain exactly one [1..1]

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Change	Old	New
		high (CONF:1098-32489).
CONF #: 1098-32588 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32588).
CONF #: 81-7165 Removed	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:81-7165).	
CONF #: 1098-14848 Modified	This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Result Status 2.16.840.1.113883.11.20.9.39 STATIC	This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Result Status 2.16.840.1.113883.11.20.9.39 STATIC 2013-08-09
CONF #: 1098-14850 Modified	SHALL contain exactly one [1..1] Result Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.2)	SHALL contain exactly one [1..1] Result Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2014-06-09)
CONF #: 1098-19218 Modified	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)	*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 #: 1098-19219 Modified	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	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

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10.63Severity Observation (V2)

Severity Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09)

Change	Old	New
Name	Severity Observation	Severity Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.8	urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09
Description	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.	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.
CONF #: 1098-32170 Added		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:1098-32170).
CONF #: 1098-32577 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32577).
CONF #: 81-7350 Removed	SHOULD contain zero or one [0..1] text (CONF:81-7350).	
CONF #: 81-15928 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15928).	
CONF #: 81-15929 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15929).	
CONF #: 81-15930 Removed	This reference/@value SHALL	

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Change	Old	New
	begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:81-15930).	
CONF #: 1098-19169 Modified	This code SHALL contain exactly one [1..1] @code="SEV" (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC)	This code SHALL contain exactly one [1..1] @code="SEV" Severity

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10.64Smoking Status - Meaningful Use (V2)

Smoking Status - Meaningful Use (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09)

Change	Old	New
Name	Smoking Status Observation	Smoking Status - Meaningful Use (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.78	urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09
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 represents 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. This template represents a "snapshot in time" observation, simply reflecting what the patient's current smoking status is at the time of the observation. As a result, the effectiveTime is constrained to a time stamp, and will approximately correspond with the author/time. 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.
Implied Template	Tobacco Use (urn:oid:2.16.840.1.113883.10.20.22.4.85)	
CONF #: 1098-31019 Added		If the patient's current smoking status is unknown, @code *SHALL* contain '266927001' (Unknown if ever smoked) from ValueSet Current Smoking Status (2.16.840.1.113883.11.20.9.38 STATIC 2014-09-01) (CONF:1098-31019).
CONF #: 1098-31039 Added		This code SHALL contain exactly one [1..1] @code="72166-2"

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Change	Old	New
		Tobacco smoking status NHIS (CONF:1098-31039).
CONF #: 1098-31148 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31148).
CONF #: 1098-31928 Added		SHALL contain exactly one [1..1] effectiveTime (CONF:1098-31928). Note: This template represents a "snapshot in time" observation, simply reflecting what the patient's current smoking status is at the time of the observation. As a result, the effectiveTime is constrained to just a time stamp, and will approximately correspond with the author/time.
CONF #: 1098-32157 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:1098-32157).
CONF #: 1098-32401 Added		SHALL contain at least one [1..*] id (CONF:1098-32401).
CONF #: 1098-32573 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32573).
CONF #: 81-14814 Removed	SHALL contain exactly one [1..1] effectiveTime (CONF:81-14814).	
CONF #: 81-14818 Removed	This effectiveTime SHALL contain exactly one [1..1] low (CONF:81-14818).	
CONF #: 81-19171 Removed	This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:81-19171).	
CONF #: 1098-14817 Modified	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 STATIC 2012-07-01	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 STATIC 2014-09-01

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10.65Social History Observation (V2)

Social History Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09)

Change	Old	New
Name	Social History Observation	Social History Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.38	urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09
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) are captured in the header. Though tobacco use and exposure may be represented with a Social History Observation, it is recommended to use the Current Smoking Status template or the Tobacco Use template instead, to represent smoking or tobacco habits.
CONF #: 1098-31868 Added		SHALL contain exactly one [1..1] effectiveTime (CONF:1098-31868).
CONF #: 1098-31869 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31869).
CONF #: 1098-32495 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32495).
CONF #: 81-9130 Removed	SHALL contain exactly one [1..1] @typeCode="DRIV" Is derived from (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-9130).	
CONF #: 81-19220 Removed	This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Social History Type 2.16.840.1.113883.3.88.12.80.60 STATIC (CONF:81-19220).	
CONF #: 1098-8555 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	If Observation/value is a physical quantity (xsi:type="PQ"), the unit of measure *SHALL* be selected from ValueSet UnitsOfMeasureCaseSensitive (2.16.840.1.113883.1.11.12839) *DYNAMIC*
CONF #: 1098-8558 Modified	SHALL contain exactly one [1..1]	SHALL contain exactly one [1..1] code, which SHOULD be selected

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Change	Old	New
	code	from CodeSystem LOINC (2.16.840.1.113883.6.1) DYNAMIC
CONF #: 1098-19224 Modified	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)	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)

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10.66 Substance or Device Allergy - Intolerance Observation (V2)

Substance or Device Allergy - Intolerance Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.24.3.90:2014-06-09)

Change	Old	New
Name	Substance or Device Allergy - Intolerance Observation	Substance or Device Allergy - Intolerance Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.24.3.90	urn:hl7ii:2.16.840.1.113883.10.20.24.3.90:2014-06-09
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".
CONF #: 1098-31144 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31144).
CONF #: 1098-31536 Added		This effectiveTime SHALL contain exactly one [1..1] low (CONF:1098-31536).
CONF #: 1098-31537 Added		This effectiveTime MAY contain zero or one [0..1] high (CONF:1098-31537).
CONF #: 1098-32171 Added		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:1098-32171).

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Change	Old	New
CONF #: 1098-32527 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32527).
CONF #: 81-16325 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:81-16325).	
CONF #: 81-16326 Removed	This code SHOULD contain zero or one [0..1] originalText (CONF:81-16326).	
CONF #: 81-16327 Removed	The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:81-16327).	
CONF #: 81-16328 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-16328).	
CONF #: 81-16329 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:81-16329).	
CONF #: 81-16330 Removed	This code MAY contain zero or more [0..*] translation (CONF:81-16330).	
CONF #: 81-16331 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:81-16331).	
CONF #: 81-16332 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:81-16332).	
CONF #: 1098-16324 Modified	This playingEntity SHALL contain exactly one [1..1] code	This playingEntity SHALL contain exactly one [1..1] code, which MAY be selected from ValueSet Substance-Reactant for Intolerance 2.16.840.1.113762.1.4.1010.1 DYNAMIC
CONF #: 1098-16336 Modified	SHALL contain exactly one [1..1] Allergy Status Observation (identifier:	SHALL contain exactly one [1..1] Allergy Status Observation (DEPRECATED) (identifier:

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Change	Old	New
	urn:oid:2.16.840.1.113883.10.20.22.4.28)	urn:hl7ii:2.16.840.1.113883.10.20.22.4.28:2014-06-09)
CONF #: 1098-16340 Modified	SHALL contain exactly one [1..1] Reaction Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.9)	SHALL contain exactly one [1..1] Reaction Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.9:2014-06-09)
CONF #: 1098-16344 Modified	SHALL contain exactly one [1..1] Severity Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.8)	SHALL contain exactly one [1..1] Severity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.8:2014-06-09)
CONF #: 1098-16346 Modified	This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC)	This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion

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10.67Tobacco Use (V2)

Tobacco Use (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09)

Change	Old	New
Name	Tobacco Use	Tobacco Use (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.85	urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09
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. Whereas the Smoking Status - Meaningful Use (V2) template (2.16.840.1.113883.10.20.22.4.78: 2014-06-09) represents a "snapshot in time" observation, simply reflecting what the patient's current smoking status is at the time of the observation, this Tobacco Use template uses effectiveTime to represent the biologically relevant time of the observation. Thus, to record a former smoker, an observation of "cigarette smoker" will have an effectiveTime/low defining the time the patient started to smoke cigarettes and an effectiveTime/high defining the time the patient ceased to smoke cigarettes. To record a current smoker, the effectiveTime/low will define the time the patient started smoking and will have no effectiveTime/high to indicated that the patient is still smoking.
CONF #: 1098-31152 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31152).
CONF #: 1098-31431 Added		This effectiveTime MAY contain zero or one [0..1] high (CONF:1098-31431).

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Change	Old	New
CONF #: 1098-32172 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:1098-32172).
CONF #: 1098-32400 Added		SHALL contain at least one [1..*] id (CONF:1098-32400).
CONF #: 1098-32589 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32589).
CONF #: 81-26507 Removed	This effectiveTime MAY contain zero or one [0..1] high (CONF:81-26507).	
CONF #: 1098-19175 Modified	This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC)	This code SHALL contain exactly one [1..1] @code="11367-0" History of tobacco use

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10.68 Vital Sign Observation (V2)

Vital Sign Observation (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09)

Change	Old	New
Name	Vital Sign Observation	Vital Sign Observation (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.27	urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09
Description	Vital signs are represented as are other results, with additional vocabulary constraints.	This template represents measurement of common vital signs. Vital signs are represented with additional vocabulary constraints for type of vital sign and unit of measure. The following is a list of recommended units for common types of vital sign measurements: || Name || Unit | PulseOx | % | Height/Head Circumf | cm | Weight | kg | Temp | Cel | BP | mm[[]Hg[]] | Pulse/Resp Rate | /min | BMI | kg/m2 | BSA | m2
CONF #: 1098-31579 Added		This value SHALL contain exactly one [1..1] @unit, which SHALL be selected from ValueSet UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 DYNAMIC (CONF:1098-31579).
CONF #: 1098-32574 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32574).
CONF #: 1098-32886 Added		The interpretationCode, if present, SHALL contain exactly one [1..1] @code (ValueSet: Observation Interpretation (HL7) 2.16.840.1.113883.1.11.78 STATIC 2014-09-01) (CONF:1098-32886).
CONF #: 81-7302 Removed	SHOULD contain zero or one [0..1] text (CONF:81-7302).	
CONF #: 81-15943 Removed	The text, if present, SHOULD contain zero or one [0..1] reference (CONF:81-15943).	
CONF #: 81-15944 Removed	The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:81-15944).	
CONF #: 81-15945 Removed	This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using	

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Change	Old	New
	the approach defined in CDA Release 2, section 4.3.5.1) (CONF:81-15945).	
CONF #: 1098-7310 Modified	MAY contain zero or one [0..1] author	SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119)

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10.69 Vital Signs Organizer (V2)

Vital Signs Organizer (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.4.26:2014-06-09)

Change	Old	New
Name	Vital Signs Organizer	Vital Signs Organizer (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.4.26	urn:hl7ii:2.16.840.1.113883.10.20.22.4.26:2014-06-09
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.	This template provides a mechanism for grouping vital signs (e.g., grouping systolic blood pressure and diastolic blood pressure).
CONF #: 1098-31153 Added		SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31153).
CONF #: 1098-32582 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32582).
CONF #: 1098-32740 Added		MAY contain zero or one [0..1] code (CONF:1098-32740).
CONF #: 1098-32741 Added		The code, if present, SHALL contain exactly one [1..1] @code="74728-7" Vital signs, weight, height, head circumference, oximetry, BMI, and BSA panel - HL7.CCDAr1.1 (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:1098-32741).
CONF #: 1098-32742 Added		The code, if present, SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1 " LOINC (CONF:1098-32742).
CONF #: 81-19176 Removed	SHALL contain exactly one [1..1] code (CONF:81-19176).	
CONF #: 81-19177 Removed	This code SHALL contain exactly one [1..1] @code="46680005" Vital signs (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96 STATIC) (CONF:81-19177).	
CONF #: 1098-7288 Modified	The effectiveTime represents clinically effective time of the measurement, which is most likely when the measurement was performed (e.g., a BP measurement). SHALL contain exactly one [1..1]	MAY contain zero or one [0..1] effectiveTime

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Change	Old	New
	effectiveTime	
CONF #: 1098-15946 Modified	SHALL contain exactly one [1..1] Vital Sign Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.27)	SHALL contain exactly one [1..1] Vital Sign Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.27:2014-06-09)

10.70 Admission Diagnosis Section (V2)

Admission Diagnosis Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2014-06-09)

Change	Old	New
Name	Hospital Admission Diagnosis Section	Admission Diagnosis Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.43	urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2014-06-09
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.
CONF #: 1098-30865 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) (CONF:1098-30865).
CONF #: 1098-32563 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32563).
CONF #: 1098-15480 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)	This code SHALL contain exactly one [1..1] @code="42347-5" Admission diagnosis
CONF #: 1098-15481 Modified	The entry, if present, SHALL contain exactly one [1..1] Hospital Admission Diagnosis (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.34)	The entry, if present, SHALL contain exactly one [1..1] Hospital Admission Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.34:2014-06-09)

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10.71 Admission Medications Section (entries optional) (V2)

Admission Medications Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2014-06-09)

Change	Old	New
Name	Hospital Admission Medications Section (entries optional)	Admission Medications Section (entries optional) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.44	urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2014-06-09
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 taken by the patient prior to and at the time of admission to the facility.
CONF #: 1098-32142 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:1098-32142).
CONF #: 1098-32560 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32560).
CONF #: 1098-15483 Modified	This code SHALL contain exactly one [1..1] @code="42346-7" Medications on Admission (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="42346-7" Medications on Admission
CONF #: 1098-15484 Modified	SHALL contain exactly one [1..1] Admission Medication (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.36)	SHALL contain exactly one [1..1] Admission Medication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.36:2014-06-09)

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10.72 Advance Directives Section (entries optional) (V2)

Advance Directives Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09)

Change	Old	New
Name	Advance Directives Section (entries optional)	Advance Directives Section (entries optional) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.21	urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09
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.
CONF #: 1098-30812 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:1098-30812).
CONF #: 1098-32497 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32497).
CONF #: 1098-32891 Added		MAY contain zero or more [0..*] entry (CONF:1098-32891) such that it
CONF #: 1098-32892 Added		SHALL contain exactly one [1..1] Advance Directive Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.108) (CONF:1098-32892).

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Change	Old	New
CONF #: 1098-15342 Modified	This code SHALL contain exactly one [1..1] @code="42348-3" Advance Directives (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="42348-3" Advance Directives
CONF #: 1098-15443 Modified	SHALL contain exactly one [1..1] Advance Directive Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.48)	SHALL contain exactly one [1..1] Advance Directive Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09)

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10.73 Advance Directives Section (entries required) (V2)

Advance Directives Section (entries required) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.21.1:2014-06-09)

Change	Old	New
Name	Advance Directives Section (entries required)	Advance Directives Section (entries required) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.21.1	urn:hl7ii:2.16.840.1.113883.10.20.22.2.21.1:2014-06-09
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.
Implied Template	Advance Directives Section (entries optional) (urn:oid:2.16.840.1.113883.10.20.22.2.21)	Advance Directives Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2014-06-09)
CONF #: 1098-30227 Added		SHALL contain exactly one [1..1] templateId (CONF:1098-30227) such that it
CONF #: 1098-30228 Added		SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.21.1" (CONF:1098-30228).
CONF #: 1098-30235 Added		If section/@nullFlavor is not present *SHALL* contain an Advance Directive Observation (V2) *OR* an Advance Directive Organizer (NEW): SHALL contain at least one [1..*] entry (CONF:1098-30235) such

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Change	Old	New
		that it
CONF #: 1098-30236 Added		MAY contain zero or one [0..1] Advance Directive Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2014-06-09) (CONF:1098-30236).
CONF #: 1098-32420 Added		MAY contain zero or one [0..1] Advance Directive Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.108) (CONF:1098-32420).
CONF #: 1098-32512 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32512).
CONF #: 1098-32800 Added		MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32800).
CONF #: 1098-32881 Added		This entry *SHALL* contain *EITHER* an Advance Directive Observation (V2) *OR* an Advance Directive Organizer (CONF:1098-32881).
CONF #: 81-8643 Removed	SHALL contain exactly one [1..1] templateId (CONF:81-8643) such that it	
CONF #: 81-8645 Removed	SHALL contain exactly one [1..1] title (CONF:81-8645).	
CONF #: 81-8646 Removed	SHALL contain exactly one [1..1] text (CONF:81-8646).	
CONF #: 81-8647 Removed	SHALL contain at least one [1..*] entry (CONF:81-8647) such that it	
CONF #: 81-10377 Removed	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.21.1" (CONF:81-10377).	
CONF #: 81-15343 Removed	SHALL contain exactly one [1..1] code (CONF:81-15343).	
CONF #: 81-15344 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:81-15344).	
CONF #: 81-15445 Removed	SHALL contain exactly one [1..1] Advance Directive Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.48) (CONF:81-15445).	

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10.74 Allergies and Intolerances Section (entries optional) (V2)

Allergies and Intolerances Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09)

Change	Old	New
Name	Allergies Section (entries optional)	Allergies and Intolerances Section (entries optional) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.6	urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09
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.
CONF #: 1098-32139 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:1098-32139).
CONF #: 1098-32544 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32544).
CONF #: 1098-15346 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)	This code SHALL contain exactly one [1..1] @code="48765-2" Allergies, adverse reactions, alerts
CONF #: 1098-15444 Modified	SHALL contain exactly one [1..1] Allergy Problem Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.30)	SHALL contain exactly one [1..1] Allergy Concern Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.30:2014-06-09)

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10.75 Allergies and Intolerances Section (entries required) (V2)

Allergies and Intolerances Section (entries required) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09)

Change	Old	New
Name	Allergies Section (entries required)	Allergies and Intolerances Section (entries required) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.6.1	urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2014-06-09
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.
Implied Template	Allergies Section (entries optional) (urn:oid:2.16.840.1.113883.10.20.22.2.6)	Allergies and Intolerances Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2014-06-09)
CONF #: 1098-32140 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:1098-32140).
CONF #: 1098-32545 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32545).
CONF #: 1098-32824 Added		MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32824).
CONF #: 1098-7531 Modified	SHALL contain at least one [1..*] entry	If section/@nullFlavor is not present: SHALL contain at least one [1..*] entry
CONF #: 1098-15350 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)	This code SHALL contain exactly one [1..1] @code="48765-2" Allergies, adverse reactions, alerts
CONF #: 1098-15446 Modified	SHALL contain exactly one [1..1] Allergy Problem Act (identifier: urn:oid:2.16.840.1.113883.10.20.2	SHALL contain exactly one [1..1] Allergy Concern Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.

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Change	Old	New
	2.4.30)	22.4.30:2014-06-09)

10.76 Anesthesia Section (V2)

Anesthesia Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.25:2014-06-09)

Change	Old	New
Name	Anesthesia Section	Anesthesia Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.25	urn:hl7ii:2.16.840.1.113883.10.20.22.2.25:2014-06-09
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.
CONF #: 1098-31127 Added		SHALL contain exactly one [1..1] Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-31127).
CONF #: 1098-30830 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) (CONF:1098-30830).
CONF #: 1098-32531 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32531).
CONF #: 81-26454 Removed	SHALL contain exactly one [1..1] Medication Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.16) (CONF:81-26454).	
CONF #: 1098-15447 Modified	SHALL contain exactly one [1..1] Procedure Activity Procedure (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.14)	SHALL contain exactly one [1..1] Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09)

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10.77 Assessment and Plan Section (V2)

Assessment and Plan Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09)

Change	Old	New
Name	Assessment and Plan Section	Assessment and Plan Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.9	urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09
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 Section 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 2.16.840.1.113883.10.20.22.2.10:2014-06-09
CONF #: 1098-32141 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:1098-32141).
CONF #: 1098-32583 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32583).
CONF #: 1098-15448 Modified	SHALL contain exactly one [1..1] Plan of Care Activity Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.39)	SHALL contain exactly one [1..1] Planned Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09)

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10.78 Complications (OpNote) (RETIRED)

Complications (OpNote) (RETIRED) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.32:2014-06-09)

Change	Old	New
Name	Complications (OpNote)	Complications (OpNote) (RETIRED)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.32	urn:hl7ii:2.16.840.1.113883.10.20.22.2.32:2014-06-09
Description	The Complications section records problems that occurred during the procedure or other activity. The complications may have been known risks or unanticipated problems.	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 HAS BEEN RETIRED IN C-CDA R2. USE OF THIS TEMPLATE IS NOT ALLOWED. *Reason for retirement*: This template has been replaced by the Complications Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09).
CONF #: 81-8026 Removed	SHALL contain exactly one [1..1] templateId (CONF:81-8026) such that it	
CONF #: 81-8027 Removed	SHALL contain exactly one [1..1] code/@code="10830-8" Complications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:81-8027).	
CONF #: 81-8028 Removed	SHALL contain exactly one [1..1] title (CONF:81-8028).	
CONF #: 81-8029 Removed	SHALL contain exactly one [1..1] text (CONF:81-8029).	
CONF #: 81-8048 Removed	There SHALL be a statement providing details of the complication(s) or it SHALL explicitly state there were no complications (CONF:81-8048).	
CONF #: 81-8049 Removed	MAY contain at least one [1..*] entry (CONF:81-8049).	
CONF #: 81-8050 Removed	Such entries SHALL contain exactly one [1..1] Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.4) (CONF:81-8050).	
CONF #: 81-10385 Removed	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.2	

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Change	Old	New
	2.2.32" (CONF:81-10385).	

10.79 Complications Section (V2)

Complications Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09)

Change	Old	New
Name	Complications Section	Complications Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.37	urn:hl7ii:2.16.840.1.113883.10.20.22.2.37:2014-06-09
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.
CONF #: 1098-30860 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) (CONF:1098-30860).
CONF #: 1098-32538 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32538).
CONF #: 81-8797 Removed	There SHALL be a statement providing details of the complication(s) or it SHALL explicitly state there were no complications (CONF:81-8797).	
CONF #: 1098-15454 Modified	This code SHALL contain exactly one [1..1] @code="55109-3" Complications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="55109-3" Complications
CONF #: 1098-15455 Modified	SHALL contain exactly one [1..1] Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.4)	SHALL contain exactly one [1..1] Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)

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10.80 Discharge Diagnosis Section (V2)

Discharge Diagnosis Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2014-06-09)

Change	Old	New
Name	Hospital Discharge Diagnosis Section	Discharge Diagnosis Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.24	urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2014-06-09
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.
CONF #: 1098-30861 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) (CONF:1098-30861).
CONF #: 1098-32549 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32549).
CONF #: 1098-15356 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)	This code SHALL contain exactly one [1..1] @code="C-CDAV2-DDN" Prognosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)
CONF #: 1098-15489 Modified	The entry, if present, SHALL contain exactly one [1..1] Hospital Discharge Diagnosis (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.33)	The entry, if present, SHALL contain exactly one [1..1] Hospital Discharge Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.33:2014-06-09)

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10.81 Discharge Diet Section (DEPRECATED)

Discharge Diet Section (DEPRECATED) (urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.33:2014-06-09)

Change	Old	New
Name	Discharge Diet Section	Discharge Diet Section (DEPRECATED)
Oid	urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.33	urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.33:2014-06-09
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 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 TEMPLATE HAS BEEN DEPRECATED IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED. *Reason for deprecation*: This template has been replaced by the Nutrition Section (2.16.840.1.113883.10.20.22.2.57).
CONF #: 1098-31140 Added		This code SHALL contain exactly one [1..1] @codeSystem (CONF:1098-31140).
CONF #: 1098-32593 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32593).
CONF #: 1098-15460 Modified	This code SHALL contain exactly one [1..1] @code="42344-2" Discharge Diet (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="42344-2" Discharge Diet

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10.82 Discharge Medications Section (entries optional) (V2)

Discharge Medications Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2014-06-09)

Change	Old	New
Name	Hospital Discharge Medications Section (entries optional)	Discharge Medications Section (entries optional) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.11	urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2014-06-09
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.
CONF #: 1098-32480 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:1098-32480).
CONF #: 1098-32561 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32561).
CONF #: 1098-15360 Modified	This code SHALL contain exactly one [1..1] @code="10183-2" Hospital Discharge Medications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="75311-1" Discharge medications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)
CONF #: 1098-15490 Modified	SHALL contain exactly one [1..1] Discharge Medication (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.35)	SHALL contain exactly one [1..1] Discharge Medication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.35:2014-06-09)

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10.83 Discharge Medications Section (entries required) (V2)

Discharge Medications Section (entries required) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.11.1:2014-06-09)

Change	Old	New
Name	Hospital Discharge Medications Section (entries required)	Discharge Medications Section (entries required) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.11.1	urn:hl7ii:2.16.840.1.113883.10.20.22.2.11.1:2014-06-09
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 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.
Implied Template	Hospital Discharge Medications Section (entries optional) (urn:oid:2.16.840.1.113883.10.20.22.2.11)	Discharge Medications Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2014-06-09)
CONF #: 1098-32145 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:1098-32145).
CONF #: 1098-32562 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32562).
CONF #: 1098-32812 Added		MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32812).
CONF #: 1098-7826 Modified	SHALL contain at least one [1..*] entry	If section/@nullFlavor is not present: SHALL contain at least one [1..*] entry
CONF #: 1098-15362 Modified	This code SHALL contain exactly one [1..1] @code="10183-2" Hospital Discharge Medications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="75311-1" Discharge Medications
CONF #: 1098-15491 Modified	SHALL contain exactly one [1..1] Discharge Medication (identifier:	SHALL contain exactly one [1..1] Discharge Medication (V2)

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Change	Old	New
	urn:oid:2.16.840.1.113883.10.20.22.4.35)	(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.35:2014-06-09)

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10.84Encounters Section (entries optional) (V2)

Encounters Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.22:2014-06-09)

Change	Old	New
Name	Encounters Section (entries optional)	Encounters Section (entries optional) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.22	urn:hl7ii:2.16.840.1.113883.10.20.22.2.22:2014-06-09
Description	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.	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, or non-face-to-face interactions. It is also a contact between a patient and a practitioner who has primary responsibility (exercising independent judgment) for assessing and treating the patient at a given contact. This section may contain all encounters for the time period being summarized, but should include notable encounters.
CONF #: 1098-31136 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:1098-31136).
CONF #: 1098-32547 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32547).
CONF #: 81-14901 Removed	SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:81-14901).	
CONF #: 1098-15462 Modified	This code SHALL contain exactly one [1..1] @code="46240-8" Encounters (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="46240-8" Encounters
CONF #: 1098-15465 Modified	SHALL contain exactly one [1..1] Encounter Activities (identifier:	SHALL contain exactly one [1..1] Encounter Activity (V2) (identifier:

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Change	Old	New
	urn:oid:2.16.840.1.113883.10.20.22.4.49)	urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09)

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10.85Encounters Section (entries required) (V2)

Encounters Section (entries required) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.22.1:2014-06-09)

Change	Old	New
Name	Encounters Section (entries required)	Encounters Section (entries required) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.22.1	urn:hl7ii:2.16.840.1.113883.10.20.22.2.22.1:2014-06-09
Description	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.	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 (exercising independent judgment) for assessing and treating the patient at a given contact. This section may contain all encounters for the time period being summarized, but should include notable encounters.
Implied Template	Encounters Section (entries optional) (urn:oid:2.16.840.1.113883.10.20.22.2.22)	Encounters Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.22:2014-06-09)
CONF #: 1098-31137 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:1098-31137).
CONF #: 1098-32548 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32548).
CONF #: 1098-32815 Added		MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32815).
CONF #: 1098-8709 Modified	SHALL contain at least one [1..*] entry	If section/@nullFlavor is not present: SHALL contain at least one [1..*]

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Change	Old	New
		entry
CONF #: 1098-15467 Modified	This code SHALL contain exactly one [1..1] @code="46240-8" Encounters (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="46240-8" Encounters
CONF #: 1098-15468 Modified	SHALL contain exactly one [1..1] Encounter Activities (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.49)	SHALL contain exactly one [1..1] Encounter Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2014-06-09)

10.86 Family History Section (V2)

Family History Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09)

Change	Old	New
Name	Family History Section	Family History Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.15	urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2014-06-09
CONF #: 1098-32430 Added		MAY contain zero or more [0..*] entry (CONF:1098-32430) such that it
CONF #: 1098-32431 Added		SHALL contain exactly one [1..1] Family History Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2014-06-09) (CONF:1098-32431).
CONF #: 1098-32481 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:1098-32481).
CONF #: 1098-32607 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32607).
CONF #: 81-7955 Removed	MAY contain zero or more [0..*] entry (CONF:81-7955) such that it	
CONF #: 81-15471 Removed	SHALL contain exactly one [1..1] Family History Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.45) (CONF:81-15471).	
CONF #: 1098-15470 Modified	This code SHALL contain exactly one [1..1] @code="10157-6" Family History (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="10157-6" Family History

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10.87Functional Status Section (V2)

Functional Status Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09)

Change	Old	New
Name	Functional Status Section	Functional Status Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.14	urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09
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	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 ability to perform Activities of Daily Living (ADLs) in areas such as Mobility (e.g., ambulation), Self-Care (e.g., bathing, dressing, feeding, grooming) or 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.

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Change	Old	New
	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.	
CONF #: 1098-32792 Added		MAY contain zero or more [0..*] entry (CONF:1098-32792) such that it
CONF #: 1098-30783 Added		SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09) (CONF:1098-30783).
CONF #: 1098-31009 Added		SHALL contain exactly one [1..1] Self-Care Activities (ADL and IADL) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.128) (CONF:1098-31009).
CONF #: 1098-31011 Added		SHALL contain exactly one [1..1] Sensory Status (identifier:

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Change	Old	New
		urn:oid:2.16.840.1.113883.10.20.22.4.127) (CONF:1098-31011).
CONF #: 1098-30866 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) (CONF:1098-30866).
CONF #: 1098-32567 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32567).
CONF #: 81-16782 Removed	SHALL contain exactly one [1..1] Highest Pressure Ulcer Stage (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.77) (CONF:81-16782).	
CONF #: 81-14416 Removed	MAY contain zero or more [0..*] entry (CONF:81-14416) such that it	
CONF #: 81-14417 Removed	SHALL contain exactly one [1..1] Cognitive Status Result Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.75) (CONF:81-14417).	
CONF #: 81-14420 Removed	MAY contain zero or more [0..*] entry (CONF:81-14420) such that it	
CONF #: 81-14421 Removed	SHALL contain exactly one [1..1] Cognitive Status Result Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.74) (CONF:81-14421).	
CONF #: 81-14583 Removed	SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.50) (CONF:81-14583).	
CONF #: 81-16780 Removed	SHALL contain exactly one [1..1] Number of Pressure Ulcers Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.76) (CONF:81-16780).	
CONF #: 81-16781 Removed	MAY contain zero or more [0..*] entry (CONF:81-16781) such that it	
CONF #: 1098-14415 Modified	SHALL contain exactly one [1..1] Functional Status Result Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.66)	SHALL contain exactly one [1..1] Functional Status Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.66:2014-06-09)
CONF #: 1098-14419 Modified	SHALL contain exactly one [1..1] Functional Status Result Observation (identifier: urn:oid:2.16.840.1.113883.10.20.2	SHALL contain exactly one [1..1] Functional Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.

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Change	Old	New
	2.4.67)	22.4.67:2014-06-09)
CONF #: 1098-14423 Modified	SHALL contain exactly one [1..1] Functional Status Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.68)	SHALL contain exactly one [1..1] Functional Status Problem Observation (DEPRECATED) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.68:2014-06-09)
CONF #: 1098-14425 Modified	SHALL contain exactly one [1..1] Cognitive Status Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.73)	SHALL contain exactly one [1..1] Cognitive Status Problem Observation (DEPRECATED) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.73:2014-06-09)
CONF #: 1098-14579 Modified	This code SHALL contain exactly one [1..1] @code="47420-5" Functional Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="47420-5" Functional Status
CONF #: 1098-16778 Modified	SHALL contain exactly one [1..1] Pressure Ulcer Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.70)	SHALL contain exactly one [1..1] Pressure Ulcer Observation (DEPRECATED) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.70:2014-06-09)

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10.88 History of Past Illness Section (V2)

History of Past Illness Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09)

Change	Old	New
Name	History of Past Illness Section	History of Past Illness Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.20	urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2014-06-09
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.
CONF #: 1098-30831 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) (CONF:1098-30831).
CONF #: 1098-32536 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32536).
CONF #: 1098-15475 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)	This code SHALL contain exactly one [1..1] @code="11348-0" History of Past Illness
CONF #: 1098-15476 Modified	SHALL contain exactly one [1..1] Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.4)	SHALL contain exactly one [1..1] Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)

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10.89Immunizations Section (entries optional) (V2)

Immunizations Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09)

Change	Old	New
Name	Immunizations Section (entries optional)	Immunizations Section (entries optional) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.2	urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09
Description	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.	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.
CONF #: 1098-32146 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:1098-32146).
CONF #: 1098-32529 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32529).
CONF #: 1098-15368 Modified	This code SHALL contain exactly one [1..1] @code="11369-6" Immunizations (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="11369-6" Immunizations
CONF #: 1098-15494 Modified	SHALL contain exactly one [1..1] Immunization Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.52)	SHALL contain exactly one [1..1] Immunization Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2014-06-09)

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10.90Immunizations Section (entries required) (V2)

Immunizations Section (entries required) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2014-06-09)

Change	Old	New
Name	Immunizations Section (entries required)	Immunizations Section (entries required) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.2.1	urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2014-06-09
Description	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.	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.
Implied Template	Immunizations Section (entries optional) (urn:oid:2.16.840.1.113883.10.20.22.2.2)	Immunizations Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2014-06-09)
CONF #: 1098-32147 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:1098-32147).
CONF #: 1098-32530 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32530).
CONF #: 1098-32833 Added		MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32833).
CONF #: 1098-9019 Modified	SHALL contain at least one [1..*] entry	If section/@nullFlavor is not present: SHALL contain at least one [1..*] entry
CONF #: 1098-15370 Modified	This code SHALL contain exactly one [1..1] @code="11369-6" Immunizations (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="11369-6" Immunizations
CONF #: 1098-15495 Modified	SHALL contain exactly one [1..1] Immunization Activity (identifier: urn:oid:2.16.840.1.113883.10.20.2	SHALL contain exactly one [1..1] Immunization Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.

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Change	Old	New
	2.4.52)	22.4.52:2014-06-09)

10.91 Implants Section (DEPRECATED)

Implants Section (DEPRECATED) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.33:2014-06-09)

Change	Old	New
Name	Implants Section	Implants Section (DEPRECATED)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.33	urn:hl7ii:2.16.840.1.113883.10.20.22.2.33:2014-06-09
Description	Replaced by template: 2.16.840.1.113883.10.20.22.2.40	THIS TEMPLATE HAS BEEN DEPRECATED IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED. *Reason for Deprecation*: Replaced by the Procedure Implants Section (2.16.840.1.113883.10.20.22.2.40)
CONF #: 1098-8042 Added		SHALL contain exactly one [1..1] templateId (CONF:1098-8042) such that it
CONF #: 1098-32608 Added		SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.33" (CONF:1098-32608).
CONF #: 1098-32609 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32609).
CONF #: 81-26510 Removed	SHALL contain exactly one [1..1] templateId (CONF:81-26510) such that it	
CONF #: 81-10401 Removed	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.33" (CONF:81-10401).	

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10.92 Instructions Section (V2)

Instructions Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09)

Change	Old	New
Name	Instructions Section	Instructions Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.45	urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09
Description	The Instructions section records instructions given to a patient. List patient decision aids here.	The Instructions Section records instructions given to a patient. List patient decision aids here.
CONF #: 1098-31384 Added		SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.45" (CONF:1098-31384).
CONF #: 1098-31398 Added		Such entries SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31398).
CONF #: 1098-32148 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:1098-32148).
CONF #: 1098-32599 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32599).
CONF #: 1098-32835 Added		MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32835).
CONF #: 81-10402 Removed	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.45" (CONF:81-10402).	
CONF #: 81-15496 Removed	The entry, if present, SHALL contain exactly one [1..1] Instructions (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.20) (CONF:81-15496).	
CONF #: 1098-10116 Modified	SHOULD contain zero or more [0..*] entry	If section/@nullFlavor is not present: SHALL contain at least one [1..*] entry
CONF #: 1098-15376 Modified	This code SHALL contain exactly one [1..1] @code="69730-0" Instructions (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="69730-0" Instructions

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10.93Interventions Section (V2)

Interventions Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2014-06-09)

Change	Old	New
Name	Interventions Section	Interventions Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.21.2.3	urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2014-06-09
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 the goals of care for the patient, 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 nested within 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. Instructions are information or directions to the patient. Use the Instructions Section when instructions are included as part of a document that is not a Care Plan. Use the Interventions Section, containing the Intervention Act containing the Instruction entry, when instructions are part of a structured care plan.
CONF #: 1098-30996 Added		SHOULD contain zero or more [0..*] entry (CONF:1098-30996) such that it
CONF #: 1098-30997 Added		SHALL contain exactly one [1..1] Intervention Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.131) (CONF:1098-30997).

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Change	Old	New
CONF #: 1098-32402 Added		MAY contain zero or more [0..*] entry (CONF:1098-32402) such that it
CONF #: 1098-32403 Added		SHALL contain exactly one [1..1] Handoff Communication Participants (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141) (CONF:1098-32403).
CONF #: 1098-30864 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) (CONF:1098-30864).
CONF #: 1098-32559 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32559).
CONF #: 1098-32730 Added		SHOULD contain zero or more [0..*] entry (CONF:1098-32730) such that it
CONF #: 1098-32731 Added		SHALL contain exactly one [1..1] Planned Intervention Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.146) (CONF:1098-32731).
CONF #: 1098-15378 Modified	This code SHALL contain exactly one [1..1] @code="62387-6" Interventions Provided (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="62387-6" Interventions Provided

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10.94Medical Equipment Section (V2)

Medical Equipment Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09)

Change	Old	New
Name	Medical Equipment Section	Medical Equipment Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.23	urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09
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 a patient's implanted and external health and 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. Devices applied to, or placed in, the patient are represented with the Procedure Activity Procedure (V2) template. Equipment supplied to the patient (e.g., pumps, inhalers, wheelchairs) is represented by the Non-Medicinal Supply Activity V2 template. These devices may be grouped together within a Medical Equipment Organizer. The organizer would probably not be used with devices applied in or on the patient but rather to organize a group of medical supplies the patient has been supplied with.
CONF #: 1098-30351 Added		SHALL contain exactly one [1..1] Medical Equipment Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.135) (CONF:1098-30351).
CONF #: 1098-31125 Added		SHOULD contain zero or more [0..*] entry (CONF:1098-31125) such that it
CONF #: 1098-31861 Added		SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.50:2014-06-09) (CONF:1098-31861).
CONF #: 1098-31885 Added		SHOULD contain zero or more [0..*] entry (CONF:1098-31885) such that it
CONF #: 1098-31886 Added		SHALL contain exactly one [1..1]

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Change	Old	New
		Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09) (CONF:1098-31886).
CONF #: 1098-30828 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) (CONF:1098-30828).
CONF #: 1098-32523 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32523).
CONF #: 81-15497 Removed	SHALL contain exactly one [1..1] Non-Medicinal Supply Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.50) (CONF:81-15497).	
CONF #: 1098-7948 Modified	SHOULD contain zero or more [0..*] entry	MAY contain zero or more [0..*] entry
CONF #: 1098-15382 Modified	This code SHALL contain exactly one [1..1] @code="46264-8" Medical Equipment (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="46264-8" Medical Equipment

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10.95Medications Administered Section (V2)

Medications Administered Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.38:2014-06-09)

Change	Old	New
Name	Medications Administered Section	Medications Administered Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.38	urn:hl7ii:2.16.840.1.113883.10.20.22.2.38:2014-06-09
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 usually resides inside a Procedure Note describing a procedure. This section defines medications and fluids administered during the procedure, its related encounter, or other procedure related activity excluding anesthetic medications. Anesthesia medications should be documented as described in the Anesthesia Section templateId 2.16.840.1.113883.10.20.22.2.25.
CONF #: 1098-30829 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) (CONF:1098-30829).
CONF #: 1098-32525 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32525).
CONF #: 1098-15384 Modified	This code SHALL contain exactly one [1..1] @code="29549-3" Medications Administered (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="29549-3" Medications Administered
CONF #: 1098-15499 Modified	The entry, if present, SHALL contain exactly one [1..1] Medication Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.16)	The entry, if present, SHALL contain exactly one [1..1] Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09)

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10.96Medications Section (entries optional) (V2)

Medications Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09)

Change	Old	New
Name	Medications Section (entries optional)	Medications Section (entries optional) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.1	urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09
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 listed. An entire medication history is an option. The section can describe a patient's prescription and dispense history and information about intended drug monitoring.
CONF #: 1098-30824 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:1098-30824).
CONF #: 1098-32500 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32500).
CONF #: 81-15984 Removed	SHALL contain exactly one [1..1] Medication Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.16) (CONF:81-15984).	
CONF #: 1098-10076 Modified	If medication use is unknown, the appropriate nullFlavor MAY be present (see unknown information in Section 1)	SHALL contain exactly one [1..1] Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09)
CONF #: 1098-15386 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)	This code SHALL contain exactly one [1..1] @code="10160-0" History of medication use

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10.97Medications Section (entries required) (V2)

Medications Section (entries required) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09)

Change	Old	New
Name	Medications Section (entries required)	Medications Section (entries required) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.1.1	urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09
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 listed. An entire medication history is an option. The section can describe a patient's prescription and dispense history and information about intended drug monitoring. This section requires either an entry indicating the subject is not known to be on any medications or entries summarizing the subject's medications.
Implied Template	Medications Section (entries optional) (urn:oid:2.16.840.1.113883.10.20.22.2.1)	Medications Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09)
CONF #: 1098-30825 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:1098-30825).
CONF #: 1098-32499 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32499).
CONF #: 1098-32845 Added		MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32845).
CONF #: 81-15500 Removed	SHALL contain exactly one [1..1] Medication Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.16) (CONF:81-15500).	
CONF #: 1098-7572 Modified	SHALL contain at least one [1..*] entry	If section/@nullFlavor is not present: SHALL contain at least one [1..*] entry

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Change	Old	New
CONF #: 1098-10077 Modified	If medication use is unknown, the appropriate nullFlavor MAY be present (see unknown information in Section 1)	SHALL contain exactly one [1..1] Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09)
CONF #: 1098-15388 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)	This code SHALL contain exactly one [1..1] @code="10160-0" History of medication use

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10.98 Payers Section (V2)

Payers Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.18:2014-06-09)

Change	Old	New
Name	Payers Section	Payers Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.18	urn:hl7ii:2.16.840.1.113883.10.20.22.2.18:2014-06-09
Description	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.	The Payers Section contains data on the patient's payers, whether "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.
CONF #: 1098-32149 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:1098-32149).
CONF #: 1098-32597 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32597).

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Change	Old	New
CONF #: 1098-15396 Modified	This code SHALL contain exactly one [1..1] @code="48768-6" Payers (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="48768-6" Payers
CONF #: 1098-15501 Modified	SHALL contain exactly one [1..1] Coverage Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.60)	SHALL contain exactly one [1..1] Coverage Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.60:2014-06-09)

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10.99 Physical Exam Section (V2)

Physical Exam Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09)

Change	Old	New
Name	Physical Exam Section	Physical Exam Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.2.10	urn:hl7ii:2.16.840.1.113883.10.20.2.10:2014-06-09
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.
CONF #: 1098-30931 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:1098-30931).
CONF #: 1098-31926 Added		MAY contain zero or more [0..*] entry (CONF:1098-31926) such that it
CONF #: 1098-31927 Added		SHALL contain exactly one [1..1] Longitudinal Care Wound Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.114) (CONF:1098-31927).
CONF #: 1098-32434 Added		MAY contain zero or more [0..*] component (CONF:1098-32434) such that it

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Change	Old	New
CONF #: 1098-32435 Added		SHALL contain exactly one [1..1] section (CONF:1098-32435).
CONF #: 1098-32436 Added		This section SHALL contain exactly one [1..1] code (ValueSet: Physical Exam Type 2.16.840.1.113883.11.20.9.65 STATIC 2014-05-15) (CONF:1098-32436).
CONF #: 1098-32437 Added		This section SHALL contain exactly one [1..1] title (CONF:1098-32437).
CONF #: 1098-32438 Added		This section SHALL contain exactly one [1..1] text (CONF:1098-32438).
CONF #: 1098-32587 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32587).
CONF #: 81-17099 Removed	SHALL contain exactly one [1..1] Highest Pressure Ulcer Stage (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.77) (CONF:81-17099).	
CONF #: 81-17094 Removed	MAY contain zero or more [0..*] entry (CONF:81-17094) such that it	
CONF #: 81-17095 Removed	SHALL contain exactly one [1..1] Pressure Ulcer Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.70) (CONF:81-17095).	
CONF #: 81-17096 Removed	MAY contain zero or more [0..*] entry (CONF:81-17096) such that it	
CONF #: 81-17097 Removed	SHALL contain exactly one [1..1] Number of Pressure Ulcers Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.76) (CONF:81-17097).	
CONF #: 81-17098 Removed	MAY contain zero or more [0..*] entry (CONF:81-17098) such that it	
CONF #: 1098-15398 Modified	This code SHALL contain exactly one [1..1] @code="29545-1" Physical Findings (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="29545-1" Physical Findings

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10.100Plan of Treatment Section (V2)

Plan of Treatment Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09)

Change	Old	New
Name	Plan of Care Section	Plan of Treatment Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.10	urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09
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.	This section, formerly known as "Plan of Care", contains data that define pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only. These 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. This section may also contain information about ongoing care of the patient, clinical reminders, patient's values, beliefs, preferences, care expectations, and overarching care goals. Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and healthcare 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 may range from being treated only 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

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Change	Old	New
		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.
CONF #: 1098-31397 Added		SHALL contain exactly one [1..1] Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31397).
CONF #: 1098-29621 Added		MAY contain zero or more [0..*] entry (CONF:1098-29621) such that it
CONF #: 1098-30472 Added		SHALL contain exactly one [1..1] Planned Encounter (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09) (CONF:1098-30472).
CONF #: 1098-30473 Added		SHALL contain exactly one [1..1] Planned Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09) (CONF:1098-30473).
CONF #: 1098-30474 Added		SHALL contain exactly one [1..1] Planned Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09) (CONF:1098-30474).
CONF #: 1098-30475 Added		SHALL contain exactly one [1..1] Planned Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09) (CONF:1098-30475).
CONF #: 1098-30476 Added		SHALL contain exactly one [1..1] Planned Supply (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09) (CONF:1098-30476).
CONF #: 1098-30813 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:1098-30813).
CONF #: 1098-30868 Added		SHALL contain exactly one [1..1] Handoff Communication Participants (identifier:

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Change	Old	New
		urn:oid:2.16.840.1.113883.10.20.22.4.141) (CONF:1098-30868).
CONF #: 1098-31841 Added		MAY contain zero or more [0..*] entry (CONF:1098-31841) such that it
CONF #: 1098-31864 Added		SHALL contain exactly one [1..1] Nutrition Recommendation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.130) (CONF:1098-31864).
CONF #: 1098-32353 Added		MAY contain zero or more [0..*] entry (CONF:1098-32353) such that it
CONF #: 1098-32354 Added		SHALL contain exactly one [1..1] Planned Immunization Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.120) (CONF:1098-32354).
CONF #: 1098-32501 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32501).
CONF #: 1098-32887 Added		MAY contain zero or more [0..*] entry (CONF:1098-32887) such that it
CONF #: 1098-32888 Added		SHALL contain exactly one [1..1] Goal Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.121) (CONF:1098-32888).
CONF #: 81-14752 Removed	SHALL contain exactly one [1..1] Plan of Care Activity Encounter (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.40) (CONF:81-14752).	
CONF #: 81-14753 Removed	SHALL contain exactly one [1..1] Plan of Care Activity Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.44) (CONF:81-14753).	
CONF #: 81-14754 Removed	SHALL contain exactly one [1..1] Plan of Care Activity Procedure (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.41) (CONF:81-14754).	
CONF #: 81-14755 Removed	SHALL contain exactly one [1..1] Plan of Care Activity Substance Administration (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.42) (CONF:81-14755).	
CONF #: 81-14756 Removed	SHALL contain exactly one [1..1] Plan of Care Activity Supply (identifier:	

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Change	Old	New
	urn:oid:2.16.840.1.113883.10.20.22.4.43) (CONF:81-14756).	
CONF #: 81-16751 Removed	SHALL contain exactly one [1..1] Instructions (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.20) (CONF:81-16751).	
CONF #: 1098-14750 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)	This code SHALL contain exactly one [1..1] @code="18776-5" Plan of Treatment
CONF #: 1098-14751 Modified	SHALL contain exactly one [1..1] Plan of Care Activity Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.39)	SHALL contain exactly one [1..1] Planned Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09)

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10.101 Planned Procedure Section (V2)

Planned Procedure Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.30:2014-06-09)

Change	Old	New
Name	Planned Procedure Section	Planned Procedure Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.30	urn:hl7ii:2.16.840.1.113883.10.20.22.2.30:2014-06-09
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.
CONF #: 1098-32151 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:1098-32151).
CONF #: 1098-32590 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32590).
CONF #: 1098-15400 Modified	This code SHALL contain exactly one [1..1] @code="59772-4" Planned Procedure (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="59772-4" Planned Procedure
CONF #: 1098-15502 Modified	SHALL contain exactly one [1..1] Plan of Care Activity Procedure (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.41)	SHALL contain exactly one [1..1] Planned Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09)

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10.102Postprocedure Diagnosis Section (V2)

Postprocedure Diagnosis Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.36:2014-06-09)

Change	Old	New
Name	Postprocedure Diagnosis Section	Postprocedure Diagnosis Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.36	urn:hl7ii:2.16.840.1.113883.10.20.22.2.36:2014-06-09
Description	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.	The Postprocedure Diagnosis Section records the diagnosis or diagnoses discovered or confirmed during the procedure. Often it is the same as the preprocedure diagnosis or indication.
CONF #: 1098-30862 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) (CONF:1098-30862).
CONF #: 1098-32550 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32550).
CONF #: 1098-15404 Modified	This code SHALL contain exactly one [1..1] @code="59769-0" Postprocedure Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="59769-0" Postprocedure Diagnosis
CONF #: 1098-15503 Modified	SHALL contain exactly one [1..1] Postprocedure Diagnosis (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.51)	SHALL contain exactly one [1..1] Postprocedure Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.51:2014-06-09)

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10.103Preoperative Diagnosis Section (V2)

Preoperative Diagnosis Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.34:2014-06-09)

Change	Old	New
Name	Preoperative Diagnosis Section	Preoperative Diagnosis Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.34	urn:hl7ii:2.16.840.1.113883.10.20.22.2.34:2014-06-09
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.
CONF #: 1098-30863 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) (CONF:1098-30863).
CONF #: 1098-32551 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32551).
CONF #: 1098-15406 Modified	This code SHALL contain exactly one [1..1] @code="10219-4" Preoperative Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="10219-4" Preoperative Diagnosis
CONF #: 1098-15504 Modified	SHALL contain exactly one [1..1] Preoperative Diagnosis (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.65)	SHALL contain exactly one [1..1] Preoperative Diagnosis (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.65:2014-06-09)

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10.104Problem Section (entries optional) (V2)

Problem Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09)

Change	Old	New
Name	Problem Section (entries optional)	Problem Section (entries optional) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.5	urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09
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.
CONF #: 1098-30481 Added		MAY contain zero or one [0..1] entry (CONF:1098-30481) such that it
CONF #: 1098-30482 Added		SHALL contain exactly one [1..1] Health Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09) (CONF:1098-30482).
CONF #: 1098-31141 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:1098-31141).
CONF #: 1098-32511 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32511).
CONF #: 1098-15408 Modified	This code SHALL contain exactly one [1..1] @code="11450-4" Problem List (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="11450-4" Problem List
CONF #: 1098-15505 Modified	The entry, if present, SHALL contain exactly one [1..1] Problem Concern Act (Condition) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.3)	SHALL contain exactly one [1..1] Problem Concern Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09)

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10.105Problem Section (entries required) (V2)

Problem Section (entries required) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09)

Change	Old	New
Name	Problem Section (entries required)	Problem Section (entries required) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.5.1	urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2014-06-09
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.
Implied Template	Problem Section (entries optional) (urn:oid:2.16.840.1.113883.10.20.22.2.5)	Problem Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2014-06-09)
CONF #: 1098-30479 Added		MAY contain zero or one [0..1] entry (CONF:1098-30479) such that it
CONF #: 1098-30480 Added		SHALL contain exactly one [1..1] Health Status Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.5:2014-06-09) (CONF:1098-30480).
CONF #: 1098-31142 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:1098-31142).
CONF #: 1098-32510 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32510).
CONF #: 1098-32864 Added		MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32864).
CONF #: 1098-9183 Modified	SHALL contain at least one [1..*] entry	If section/@nullFlavor is not present: SHALL contain at least one [1..*] entry
CONF #: 1098-15410 Modified	This code SHALL contain exactly one [1..1] @code="11450-4" Problem List (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="11450-4" Problem List

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Change	Old	New
CONF #: 1098-15506 Modified	Such entries SHALL contain exactly one [1..1] Problem Concern Act (Condition) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.3)	SHALL contain exactly one [1..1] Problem Concern Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2014-06-09)

10.106Procedure Findings Section (V2)

Procedure Findings Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.28:2014-06-09)

Change	Old	New
Name	Procedure Findings Section	Procedure Findings Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.28	urn:hl7ii:2.16.840.1.113883.10.20.22.2.28:2014-06-09
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.
CONF #: 1098-30859 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) (CONF:1098-30859).
CONF #: 1098-32537 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32537).
CONF #: 1098-15418 Modified	This code SHALL contain exactly one [1..1] @code="59776-5" Procedure Findings (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="59776-5" Procedure Findings
CONF #: 1098-15507 Modified	SHALL contain exactly one [1..1] Problem Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.4)	SHALL contain exactly one [1..1] Problem Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2014-06-09)

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10.107Procedure Indications Section (V2)

Procedure Indications Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.29:2014-06-09)

Change	Old	New
Name	Procedure Indications Section	Procedure Indications Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.29	urn:hl7ii:2.16.840.1.113883.10.20.22.2.29:2014-06-09
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.
CONF #: 1098-30827 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:1098-30827).
CONF #: 1098-32572 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32572).
CONF #: 1098-15420 Modified	This code SHALL contain exactly one [1..1] @code="59768-2" Procedure Indications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="59768-2" Procedure Indications
CONF #: 1098-15508 Modified	SHALL contain exactly one [1..1] Indication (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.19)	SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09)

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10.108Procedures Section (entries optional) (V2)

Procedures Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09)

Change	Old	New
Name	Procedures Section (entries optional)	Procedures Section (entries optional) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.7	urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09
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 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.	This section describes all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section should 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 Activity Procedure (V2) is for procedures that alter the physical condition of a patient (e.g., splenectomy). Procedure Activity Observation (V2) is for procedures that result in new information about a patient but do not cause physical alteration (e.g., EEG). Procedure Activity Act (V2) is for all other types of procedures (e.g., dressing change).
CONF #: 1098-31139 Added		This code SHALL contain exactly one [1..1] @codeSystem (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:1098-31139).
CONF #: 1098-32532 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32532).
CONF #: 1098-6278 Modified	MAY contain zero or one [0..1] entry	MAY contain zero or more [0..*] entry
CONF #: 1098-8533 Modified	MAY contain zero or one [0..1]	MAY contain zero or more [0..*]

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Change	Old	New
	entry	entry
CONF #: 1098-15424 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)	This code SHALL contain exactly one [1..1] @code="47519-4" History of Procedures
CONF #: 1098-15509 Modified	SHALL contain exactly one [1..1] Procedure Activity Procedure (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.14)	SHALL contain exactly one [1..1] Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09)
CONF #: 1098-15510 Modified	SHALL contain exactly one [1..1] Procedure Activity Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.13)	SHALL contain exactly one [1..1] Procedure Activity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09)
CONF #: 1098-15511 Modified	SHALL contain exactly one [1..1] Procedure Activity Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.12)	SHALL contain exactly one [1..1] Procedure Activity Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09)

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10.109Procedures Section (entries required) (V2)

Procedures Section (entries required) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.7.1:2014-06-09)

Change	Old	New
Name	Procedures Section (entries required)	Procedures Section (entries required) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.7.1	urn:hl7ii:2.16.840.1.113883.10.20.22.2.7.1:2014-06-09
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 describes all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section should 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 that alter the physical condition of a patient (e.g., splenectomy). Observation act is for procedures that result in new information about a patient but do not cause physical alteration (e.g., EEG). Act is for all other types of procedures (e.g., dressing change).
Implied Template	Procedures Section (entries optional) (urn:oid:2.16.840.1.113883.10.20.22.2.7)	Procedures Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09)
CONF #: 1098-31138 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:1098-31138).
CONF #: 1098-32533 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32533).
CONF #: 1098-32876 Added		MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32876).

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Change	Old	New
CONF #: 1098-32877 Added		MAY contain zero or one [0..1] Procedure Activity Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.12:2014-06-09) (CONF:1098-32877).
CONF #: 1098-32878 Added		MAY contain zero or one [0..1] Procedure Activity Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.13:2014-06-09) (CONF:1098-32878).
CONF #: 81-8017 Removed	MAY contain zero or more [0..*] entry (CONF:81-8017) such that it	
CONF #: 81-8019 Removed	MAY contain zero or more [0..*] entry (CONF:81-8019) such that it	
CONF #: 81-8021 Removed	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:81-8021).	
CONF #: 81-15513 Removed	SHALL contain exactly one [1..1] Procedure Activity Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.13) (CONF:81-15513).	
CONF #: 81-15514 Removed	SHALL contain exactly one [1..1] Procedure Activity Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.12) (CONF:81-15514).	
CONF #: 1098-7895 Modified	MAY contain zero or more [0..*] entry	If section/@nullFlavor is not present there *SHALL* be at least one entry conformant to Procedure Activity Act (V2) (templateId 2.16.840.1.113883.10.20.22.4.12:2014-06-09) *OR* Procedure Activity Observation (V2) (templateId: 2.16.840.1.113883.10.20.22.4.13:2014-06-09) *OR* Procedure Activity Procedure (V2) (templateId: 2.16.840.1.113883.10.20.22.4.14:2014-06-09) SHALL contain at least one [1..*] entry
CONF #: 1098-15426 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)	This code SHALL contain exactly one [1..1] @code="47519-4" History of Procedures

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Change	Old	New
CONF #: 1098-15512 Modified	SHALL contain exactly one [1..1] Procedure Activity Procedure (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.14)	MAY contain zero or one [0..1] Procedure Activity Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09)

10.110Reason for Referral Section (V2)

Reason for Referral Section (V2) (urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.1:2014-06-09)

Change	Old	New
Name	Reason for Referral Section	Reason for Referral Section (V2)
Oid	urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.1	urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.1:2014-06-09
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 describes the clinical reason why a provider is sending a patient to another provider for care. The reason for referral may become the reason for visit documented by the receiving provider.
CONF #: 1098-30808 Added		MAY contain zero or more [0..*] entry (CONF:1098-30808) such that it
CONF #: 1098-30897 Added		SHALL contain exactly one [1..1] Patient Referral Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.140) (CONF:1098-30897).
CONF #: 1098-30867 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) (CONF:1098-30867).
CONF #: 1098-32571 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32571).
CONF #: 1098-15428 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)	This code SHALL contain exactly one [1..1] @code="42349-1" Reason for Referral

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10.111Results Section (entries optional) (V2)

Results Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09)

Change	Old	New
Name	Results Section (entries optional)	Results Section (entries optional) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.3	urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09
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	This section contains the results of observations generated by laboratories, imaging and other procedures. The scope includes observations of 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. It can 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.

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Change	Old	New
	colonoscopy.	
CONF #: 1098-31041 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:1098-31041).
CONF #: 1098-32591 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32591).
CONF #: 1098-15432 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)	This code SHALL contain exactly one [1..1] @code="30954-2" Relevant diagnostic tests and/or laboratory data
CONF #: 1098-15515 Modified	SHALL contain exactly one [1..1] Result Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.1)	SHALL contain exactly one [1..1] Result Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09)

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10.112Results Section (entries required) (V2)

Results Section (entries required) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09)

Change	Old	New
Name	Results Section (entries required)	Results Section (entries required) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.3.1	urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2014-06-09
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

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Change	Old	New
		of a polyp observed during a colonoscopy.
Implied Template	Results Section (entries optional) (urn:oid:2.16.840.1.113883.10.20.22.2.3)	Results Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2014-06-09)
CONF #: 1098-31040 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:1098-31040).
CONF #: 1098-32592 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32592).
CONF #: 1098-32875 Added		MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32875).
CONF #: 1098-7112 Modified	SHALL contain at least one [1..*] entry	If section/@nullFlavor is not present: SHALL contain at least one [1..*] entry
CONF #: 1098-15434 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)	This code SHALL contain exactly one [1..1] @code="30954-2" Relevant diagnostic tests and/or laboratory data
CONF #: 1098-15516 Modified	SHALL contain exactly one [1..1] Result Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.1)	SHALL contain exactly one [1..1] Result Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2014-06-09)

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10.113Social History Section (V2)

Social History Section (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09)

Change	Old	New
Name	Social History Section	Social History Section (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.17	urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2014-06-09
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 influence 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.
CONF #: 1098-28361 Added		MAY contain zero or more [0..*] entry (CONF:1098-28361) such that it
CONF #: 1098-28362 Added		SHALL contain exactly one [1..1] Caregiver Characteristics (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72) (CONF:1098-28362).
CONF #: 1098-28366 Added		MAY contain zero or more [0..*] entry (CONF:1098-28366) such that it
CONF #: 1098-28367 Added		SHALL contain exactly one [1..1] Cultural and Religious Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.111) (CONF:1098-28367).
CONF #: 1098-28825 Added		MAY contain zero or more [0..*] entry (CONF:1098-28825) such that it
CONF #: 1098-28826 Added		SHALL contain exactly one [1..1] Characteristics of Home Environment (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.109) (CONF:1098-28826).
CONF #: 1098-30814 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:1098-30814).
CONF #: 1098-32494 Added		SHALL contain exactly one [1..1]

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Change	Old	New
		@extension="2014-06-09" (CONF:1098-32494).
CONF #: 1098-14820 Modified	This code SHALL contain exactly one [1..1] @code="29762-2" Social History (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="29762-2" Social History
CONF #: 1098-14821 Modified	SHALL contain exactly one [1..1] Social History Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.38)	SHALL contain exactly one [1..1] Social History Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2014-06-09)
CONF #: 1098-14824 Modified	SHALL contain exactly one [1..1] Smoking Status Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.78)	SHALL contain exactly one [1..1] Smoking Status - Meaningful Use (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.78:2014-06-09)
CONF #: 1098-16817 Modified	SHALL contain exactly one [1..1] Tobacco Use (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.85)	SHALL contain exactly one [1..1] Tobacco Use (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.85:2014-06-09)

10.114Surgery Description Section (DEPRECATED)

Surgery Description Section (DEPRECATED) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.26:2014-06-09)

Change	Old	New
Name	Surgery Description Section	Surgery Description Section (DEPRECATED)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.26	urn:hl7ii:2.16.840.1.113883.10.20.22.2.26:2014-06-09
Description	replaced by 2.16.840.1.113883.10.20.22.2.27	THIS TEMPLATE HAS BEEN DEPRECATED IN C-CDA R2 AND MAY BE DELETED FROM A FUTURE RELEASE OF THIS IMPLEMENTATION GUIDE. USE OF THIS TEMPLATE IS NOT RECOMMENDED. *Reason for deprecation*: This template has been replaced by the Procedure Description Section (2.16.840.1.113883.10.20.22.2.27).
CONF #: 1098-32893 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32893).

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10.115Vital Signs Section (entries optional) (V2)

Vital Signs Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09)

Change	Old	New
Name	Vital Signs Section (entries optional)	Vital Signs Section (entries optional) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.4	urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09
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.
CONF #: 1098-30902 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:1098-30902).
CONF #: 1098-32584 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32584).
CONF #: 1098-15243 Modified	This code SHALL contain exactly one [1..1] @code="8716-3" Vital Signs (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="8716-3" Vital Signs
CONF #: 1098-15517 Modified	SHALL contain exactly one [1..1] Vital Signs Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.26)	SHALL contain exactly one [1..1] Vital Signs Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.26:2014-06-09)

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10.116 Vital Signs Section (entries required) (V2)

Vital Signs Section (entries required) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09)

Change	Old	New
Name	Vital Signs Section (entries required)	Vital Signs Section (entries required) (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.22.2.4.1	urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2014-06-09
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.
Implied Template	Vital Signs Section (entries optional) (urn:oid:2.16.840.1.113883.10.20.22.2.4)	Vital Signs Section (entries optional) (V2) (urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2014-06-09)
CONF #: 1098-30903 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:1098-30903).
CONF #: 1098-32585 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32585).
CONF #: 1098-32874 Added		MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor 2.16.840.1.113883.5.1008) (CONF:1098-32874).
CONF #: 1098-7276 Modified	SHALL contain at least one [1..*] entry	If section/@nullFlavor is not present: SHALL contain at least one [1..*] entry
CONF #: 1098-15963 Modified	This code SHALL contain exactly one [1..1] @code="8716-3" Vital Signs (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC)	This code SHALL contain exactly one [1..1] @code="8716-3" Vital Signs

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Change	Old	New
CONF #: 1098-15964 Modified	SHALL contain exactly one [1..1] Vital Signs Organizer (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.26)	SHALL contain exactly one [1..1] Vital Signs Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.26:2014-06-09)

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10.117Physician of Record Participant (V2)

Physician of Record Participant (V2) (urn:hl7ii:2.16.840.1.113883.10.20.6.2.2:2014-06-09)

Change	Old	New
Name	Physician of Record Participant	Physician of Record Participant (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.6.2.2	urn:hl7ii:2.16.840.1.113883.10.20.6.2.2:2014-06-09
CONF #: 1098-30928 Added		This assignedEntity SHOULD contain zero or one [0..1] assignedPerson (CONF:1098-30928).
CONF #: 1098-30929 Added		The assignedPerson, if present, SHALL contain exactly one [1..1] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1098-30929).
CONF #: 1098-31203 Added		*SHOULD* contain zero or one [[]0..1[]] *id* such that *@root="2.16.840.1.113883.4.6"* National Provider Identifier (CONF:1098-31203).
CONF #: 1098-32586 Added		SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32586).
CONF #: 81-8440 Removed	SHALL contain exactly one [1..1] templateId/@root="2.16.840.1.113883.10.20.6.2.2" (CONF:81-8440).	
CONF #: 81-8890 Removed	This assignedEntity SHOULD contain zero or one [0..1] name (CONF:81-8890).	
CONF #: 81-10035 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:81-10035).	
CONF #: 1098-8889 Modified	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	*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 [URL:ftp://medical.nema.org/medi

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Change	Old	New
		cal/dicom/2011/11_16pu.pdf]
CONF #: 1098-16072 Modified	MAY contain zero or more [0..*] templateId	SHALL contain exactly one [1..1] templateId
CONF #: 1098-16073 Modified	The templateId, if present, MAY contain zero or one [0..1] @root="2.16.840.1.113883.10.20.6.2.2"	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.2"

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10.118Physician Reading Study Performer (V2)

Physician Reading Study Performer (V2) (urn:hl7ii:2.16.840.1.113883.10.20.6.2.1:2014-06-09)

Change	Old	New
Name	Physician Reading Study Performer	Physician Reading Study Performer (V2)
Oid	urn:oid:2.16.840.1.113883.10.20.6.2.1	urn:hl7ii:2.16.840.1.113883.10.20.6.2.1:2014-06-09
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).
CONF #: 1098-30773 Added		SHALL contain exactly one [1..1] templateId (CONF:1098-30773).
CONF #: 1098-30774 Added		This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.1" (CONF:1098-30774).
CONF #: 1098-32135 Added		The id *SHOULD* include zero or one [[]0..1[]] *id* where id/@root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1098-32135).
CONF #: 1098-32564 Added		This templateId SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32564).
CONF #: 81-8423 Removed	SHALL contain exactly one [1..1] templateId/@root="2.16.840.1.113883.10.20.6.2.1" (CONF:81-8423).	
CONF #: 81-10034 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:81-10034).	
CONF #: 81-10134 Removed	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:81-10134).	
CONF #: 1098-8425 Modified	MAY contain zero or one [0..1] time	MAY contain zero or one [0..1] US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3)
CONF #: 1098-8428 Modified	SHALL contain a valid DICOM	*SHALL* contain a valid DICOM

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Change	Old	New
	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)	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 #: 1098-8429 Modified	Every assignedEntity element SHALL have at least one assignedPerson or representedOrganization	Every assignedEntity element *SHALL* contain at least one [[]1..[*][]] assignedPerson or representedOrganization

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