Data Requirement Specification
For
Encounter Record

[S17]

Version 1.4.3

Aug 2022

The Government of the Hong Kong Special Administrative Region

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DOCUMENT SUMMARY

Document Item	Current Value
Document Title	Data Requirement Specification eHR Encounter Record
Creation Date	20 Jul 2012
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Document Description	The document describes the data requirement specification for Encounter Record for Hong Kong Special Administrative Region eHR. The document should be read in conjunction with other related documents suggested by the eHR Information Standards Office.
Author	SM(EHP)10
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AMENDMENT HISTORY

Version No.	Approval Date	Effective Date	Summary of Changes
1.0.0	20 Jul 2012	20 Jul 2012	Original version
1.1.0	13 Mar 2013	13 Mar 2013	Enhanced according to the -dataset as of Feb 2013 defined by eHR Information Standards Office
1.2.0	19 Jun 2014	19 Jun 2014	• Updated the definition of data fields: 'Record creation institution name' and 'Record update institution name' • Added remarks in data field 'Transaction type' • Updated definition and notes of 'Death before arrival indicator' • Add the notes of 'Record Key' in section 9.2 • Updated the checking rule of the following data fields: o Encounter type o Last update datetime • Aligned the terms used in eHR Sharing System (eHRSS) Bill: o Participant -> eHR Healthcare Recipient o Enroll -> Register o Re-join -> Re-register • Remove "CDA" components in: o section 'DOCUMENT MAP'
1.3.0	30 Jun 2015	30 Jun 2015	• Jun 2015 Release
1.4.0	13 Oct 2016	31 Oct 2016	• Updated Document Summary - Changed from 'Current Document Issue' to 'Latest Version Number' - Changed from 'Prepared by' to 'Author' - Added 'Document Owner' and Subject Officer' - Updated Contact Information • Updated Amendment History

			- Replaced 'Date' with 'Approval Date' and 'Effective Date' • Changed from 'conditional mandatory' to 'optional' a. 'Episode start specialty remarks' b. 'Episode end specialty remarks' c. 'Visit specialty remarks' d. 'Referral specialty remarks'
1.4.1	19 Jul 2017	31 Jul 2017	• Update data requirement on following data fields, which are retained for backward compatibility, to N/A - Encounter service type - Encounter service type details
1.4.2	02 Aug 2021	02 Aug 2021	• Updated field definition for "HKIC number" in order to support Consular Corps ID Card holders
1.4.3	15 Aug 2022	31 Aug 2022	• Updated bureau name from Food and Health Bureau (FHB) to Health Bureau (HHB)

1 PURPOSE

1.1 OBJECTIVE

This document describes the data requirement and data compliance level of Encounter Record uploaded from trusted HCP to eHR system.

1.2 INTENDED READERS

This document is intended for health informatics experts and business analysts involving the interface development of EMR and eHR of Hong Kong for data exchange of Encounter Record.

2 SCOPE

This reference describes the data exchange requirements between EMR applications and eHR system through Health Level Seven (HL7) message. Both eHR Healthcare Recipient (HCR) personal identity data and related Encounter records will be covered. Specifically, this document contains:

- Trigger event descriptions
- Data definition and reference documents
- Data compliance level

The Encounter data requirements defined in this document are for appointment, admission and discharge records. Besides, the sharable dataset domain 'Encounter' supports eHR Data Compliance Level 3 only.

This document is referring to the health data defined in the eHR sharable dataset domain Encounter mentioned in **eHR Content Standards Guidebook** in eHR Office website. It provides the data elements that are mandatory (required), optional, or conditional (required, based on a condition), and gives relevant usage notes for interfacing to eHR system.

3 REFERENCES

- Data Interface Requirement Document
  - Technical Interface Specification for eHR Encounter Record
  - BLS Technical Interface Specification for eHR Encounter Record

- eHR Information Standards Document
  - eHR Content Standards Guidebook
  - eHR Data Interoperability Standards
  - eHR Contents
  - eHR Codex

4 DOCUMENT MAP

The following table describes the reference documents related to the eHR sharable data domain 'Encounter'.

	Document ID	Document Name	Description
Basic Information	N/A	eHR Content Standards Guidebook	It defines the initial set of content and information standards for Hong Kong eHR.
	S01	Data Interoperability Standards	It defines the data requirements and messaging standards to support standards-compliant interoperability.
Data Requirement	N/A	eHR Contents Code Set	It defines the data requirements of each sharable dataset domain. The updated code set will be posted in eHR office website for reference.
	N/A	eHR Codex List	It defines a list of code tables which eHR data should be conformed to. The updated code tables will be posted in eHR office website for reference.

	Document ID	Document Name	Description
	S17	Data Requirement Specification For eHR Encounter Record	It describes the data requirements for implementing Health Level Seven (HL7) Version 2.5 standards messaging for "Encounter" data upload. The document should be read in conjunction with other related documents suggested by the eHR Information Standards Office.
Technical Requirement	S19	Technical Interface Specification for eHR Encounter Record	It describes the technical interface for implementing Health Level Seven (HL7) version 2.5 standards messaging for transferring eHR Encounter record from healthcare providers (HCP) to eHR system.
	S18	BLS Technical Interface Specification for eHR Encounter Record	It describes the detail technical requirements for implementing HL7-HK Localised Bulk Load Standards (BLS) to upload "Encounter" data. The document should be read in conjunction with other related documents suggested by the eHR Information Standards Office.

	Document ID	Document Name	Description
	S55	Communication Protocol Specification	It defines the communication protocols supported by eHR-HK clinical data exchanges. Related technical issues will be included.

5 DEFINITIONS AND CONVENTIONS

5.1 MESSAGE STANDARDS

There are two message standards supported for uploading Encounter Record from HCP to eHR system:

- HL7-HK Message Standards
- HL7-HK Localised Bulk Load Standards

The Health Level Seven (HL7) messages are used to exchange electronic data between different healthcare systems. HL7 provides a framework and related standards for the exchange, integration, sharing and retrieval of electronic health-related information. Each HL7 message contains information about a particular event such as a patient admission, laboratory result records, etc.

5.2 HL7-HK MESSAGE STANDARDS

Health Level Seven (HL7) version 2.5 message standards will be adopted for uploading event-based Encounter Record from HCP to eHR system.

According to the recommendation of the Hong Kong Special Administrative Region (HKSAR) Interoperability Framework, ebXML Message Service (ebMS) v2 will be adopted. Each HL7 message in ebXML format will only carry the clinical records of an eHR Healthcare Recipient (HCR) within the corresponding sharable dataset domain. Data requirements of different sharable dataset domains will be diverse.

To learn more about the HL7 organization and standards, please refer to the official HL7 website.

5.3 HL7-HK LOCALISED BULK LOAD STANDARDS

HL7-HK Bulk Load Standards use HL7 version 2.5 message standards as the framework. The standards allow HCP to upload large transaction volume of clinical records of eHR Healthcare Recipients (HCR). There are two types of file upload modes: incremental mode and materialisation mode:

i. **Incremental mode** is the format for HCP to upload sharable data in ONE batch.
ii. **Materialisation mode** is the format for HCP to upload new registered eHR Healthcare Recipient (HCR) and re-registered eHR Healthcare Recipient (HCR).

5.4 ABBREVIATIONS

Term	Description
ENCTR	Encounter
CDR	Clinical Data Repository
eHR	Electronic Health Record
EMR	Electronic Medical Record
HCP	Healthcare Provider
HL7	Health Level Seven
ADT	HL7 message type of "Person Administration"
SIU	HL7 message type of "Scheduling"
ORU	HL7 message type of "Unsolicited Observation Message"
HCR	eHR Healthcare Recipient

5.5 NOTATIONS

Code	Description
A01 - A99	HL7 event code of "Person Administration"
S01 - S99	HL7 event code of "Scheduling"
SCN1 – SCN99	Scenario numbering
"quoted"	Fixed Value
N/A	Not Applicable

6 ASSUMPTIONS

- HCP is responsible for ensuring the integrity, accuracy and completeness of structured data and the image report when sending data to eHR.

- It is recommended HCP should send the updated clinical record to eHR as soon as possible when there are any changes or new records of the eHR Healthcare Recipient (HCR).

- To ensure the integrity of the Encounter Record, the complete set of structured data of an encounter record should be sent for any amendment.

7 DELIVERY REQUIREMENTS

- HL7 version 2.5 message standards in XML format will be implemented for delivering all ‘Encounter’ event messages defined by eHR.

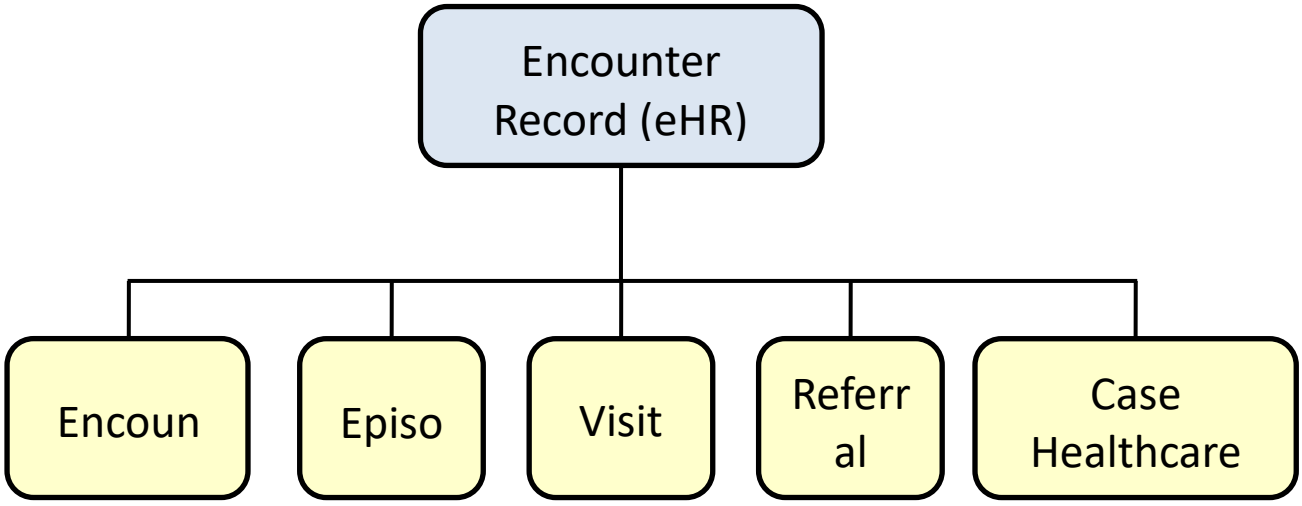
- The sharable dataset domain ‘Encounter’ supports eHR Data Compliance Level 3 only. Before sending clinical record to eHR, Healthcare Provider (HCP) has to register which data compliance levels she can comply to.

- A complete set of updated Encounter data with an unique record key of the record is expected to be uploaded to eHR. eHR will use the HCP unique record key for subsequent data amendments in eHR repository.

- HCP must ensure the data submitted to eHR is complied with the compliance levels declared in the message. The detail definition of the Data Compliance Level is stated in eHR Content Standard Guidebook posted in eHR Office website.

8 DATA REQUIREMENTS OVERVIEW

There are five data components required in eHR Encounter record, the components include, 'Encounter', 'Episode', 'Visit', 'Referral Source' and 'Case Healthcare Professional'. The elements included in each of the data components will be described in '*Section 9 – Data Requirements Details*'. The following picture depicts the five data components required,



Descriptions of Data Components

Encounter
A list of booked appointments and attended healthcare encounters (face-to-face or electronic contact between a person and the healthcare practitioner who will access, evaluate and treat a person).

Episode
An episode is composed of one or more encounter(s).

Visit
A visit is composed of one encounter (i.e. outpatient service). Multiple outpatient visits can be grouped under an episode.

Referral Source
It includes information about the source of a referral, such as Referral number, Refer-from-institution identifier, etc.

Case Healthcare Professional
It includes the information of the healthcare professional who is in charge of the episode.

9 DATA REQUIREMENTS DETAILS

For preparing a complete Encounter record, three major data sets are required:

- Healthcare Recipient Information
- Detail Information

9.1 HEALTHCARE RECIPIENT INFORMATION

The following table shows the data requirements for HCR information required by eHR.

9.1.1 HCR Data [Repeatable = 'N'] (Y:Yes; N:No)

Data Field	Definition	Maximum Length	Repeatable Y: Yes N: No	Notes
eHR number	A unique eHR healthcare recipient identifier assigned to each patient for each participation in the Hong Kong eHR	string(12)	N	Fixed length
HKIC number	The Hong Kong Identity Card number or the Registration Number printed on Hong Kong Birth Certificate (post-1981) or the Consular Corps Identity Card number issued by HKSAR Immigration Department, include the check digit	string(12)	N	
Type of identity document	[eHR value] of the "Type of identity document" code table. It is the type of patient's identity / travel document presented during registration / enrolment / update of the patient's identity / demographic data.	string(6)	N	Refer to the code set of "Type of identity document" in eHR Office website
Identity document number	The document number of the [Type of identity document - patient]	string(30)	N	
English surname	Patient's surname in English	string(40)	N	
English given name	Patient's given name in English	string(40)	N	
English full name	Patient's full name in English	string(100)	N	

Sex	[eHR value] of the "Sex" code table. It is used to identify the sex of the patient.	string(1)	N	• Fixed length • Refer to the code set of "Sex" in eHR Office website
Date of birth	The patient's date of birth	string(23)	N	

9.1.2 Record Type Data [Repeatable = 'N'] (Y:Yes; N:No)

Data Field	**Definition**	**Maximum Length**	**Repeatable** Y: Yes N: No	**Notes**
eHR record type	eHR record type	string(20)	N	Fixed value: "ENCTR"

9.2 DETAIL INFORMATION

Each encounter record should have a unique record key provided by HCP for identifying the encounter record.

Data Field	**Definition**	**Maximum Length**	**Repeatable** Y: Yes N: No	**Notes**
Record key	A unique identifier for each Encounter record within HCP	string(50)	N	Same record key should be used for same episode.

The following sections describe the specific data requirements for 'Encounter' domain:

9.2.1 General Encounter Data [Repeatable = 'N'] (Y:Yes; N:No)

Data Field	Definition	Maximum Length	Repeatable Y: Yes N: No	Notes
Episode number	A unique reference number assigned by the healthcare institution to an episode of care. An episode is composed of one or more encounter(s). The episode of care can be of inpatient or outpatient nature.	string(20)	N	
Attendance institution identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution for participant attendance	string(10)	N	

9.2.2 Encounter [Repeatable = 'N'] (Y:Yes; N:No)

Data Field	Definition	Maximum Length	Repeatable Y: Yes N: No	Notes
Encounter healthcare provider identifier	[Healthcare provider identifier] in the Healthcare Provider Index for the healthcare provider who created the encounter	string(10)	N	Fixed length
Encounter healthcare institution identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution who created the encounter	string(10)	N	Fixed length
Encounter type	[eHR value] of the "Encounter type" code table which is used to identify the type of the encounter received / to be received by the patient	string(1)	N	Refer to the code set of "Encounter Type" in eHR Office website
Encounter service type *(Retained for backward compatibility to v1.0.0)*	[eHR value] of the "Service type" code table which is used to identify the type of encounter service received / to be received by the patient	string(10)	N	

Encounter service type details *(Retained for backward compatibility to v1.0.0)*	Details on the outpatient service type received / to be received by the patient	string(255)	N	
Appointment number	A unique reference number assigned by the healthcare institution to an appointment (a scheduled encounter)	string(20)	N	

9.2.3 Episode [Repeatable = 'N'] (Y:Yes; N:No)

Data Field	Definition	Maximum Length	Repeatable Y: Yes N: No	Notes
Episode start datetime	The date and time when the episode of care is started. If it is a future date or time, it represents a scheduled episode.	string(23)	N	
Episode urgency	[eHR value] of the "Urgency" code table. [Episode urgency] refers to the urgency of the care when the episode was started.	string(1)	N	Refer to the code set of "Urgency" in eHR Office website
Episode start specialty	[eHR value] of the "Specialty" code table. [Episode start specialty] refers to the specialty of the patient upon commencement of an episode.	string(10)	N	Refer to the code set of "Specialty" in eHR Office website
Episode start specialty remarks	Details on specialty of the patient upon commencement of an episode	string(255)	N	
Episode attendance indicator	[eHR value] of the "Attendance indicator" code table. [Episode attendance indicator] is an indicator to identify whether the episode has been attended in relation to inpatient or emergency service.	string(1)	N	Refer to the code set of "Attendance Indicator" in eHR Office website
Episode end datetime	The date and time when the episode of care was ended	string(23)	N	
Episode end specialty	[eHR value] of the "Specialty" code table. [Episode end specialty] refers to the specialty of the patient upon completion of an episode.	string(10)	N	Refer to the code set of "Specialty" in eHR Office website

Episode end specialty remarks	Details on specialty of the patient upon completion of an episode.	string(255)	N	
Death before arrival indicator	[eHR value] of the "Yes No Unspecified" code table. [Death before arrival indicator] is an indicator to identify whether the patient was dead before arrival to the healthcare institution.	string(1)	N	Refer to the code set of "Yes No Unspecified" in eHR Office website
Discharge type	[eHR value] of the "Discharge type" code table which is used to indicate category of location where the patient was discharged from an inpatient / accident & emergency episode	string(10)	N	Refer to the code set of "Discharge Type" in eHR Office website
Discharge-to-institution identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution where the patient was discharged to	string(10)	N	Fixed length
Discharge-to-institution long name	[Healthcare institution displayed English long name] or the [Healthcare institution displayed Chinese long name] in the Healthcare Provider Index for the healthcare institution where the patient was discharged to. It should be the corresponding description of the selected [Discharge-to-institution identifier].	string(255)	N	
Discharge-to-institution local name	Local description of the healthcare institution where the patient was discharged to	string(255)	N	
Discharge healthcare professional identifier	eHR identifier of the healthcare professional who discharged the patient	string(10)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'

Discharge healthcare professional name prefix	English name prefix of the healthcare professional who discharged the episode	string(10)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'
Discharge healthcare professional English name	English full name of the healthcare professional who discharged the episode	string(100)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'
Discharge healthcare professional English given name	English given name of the healthcare professional who discharged the episode	string(40)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'
Discharge healthcare professional Chinese name	Chinese full name of the healthcare professional who discharged the episode	string(10)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0' • Maximum 10 Chinese characters
Discharge healthcare professional Chinese name suffix	Chinese name suffix of the healthcare professional who discharged the episode	string(10)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'

9.2.4 Visit [Repeatable = 'N'] (Y:Yes; N:No)

Data Field	Definition	Maximum Length	Repeatable Y: Yes N: No	Notes
Visit number	A unique reference number assigned by the healthcare institution to a particular visit for healthcare service which the patient received / will receive	string(20)	N	
Visit clinic identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution where the patient received / will receive healthcare services	string(10)	N	Fixed length
Visit clinic long name	[Healthcare institution displayed English long name] or [Healthcare institution displayed Chinese long name] in the Healthcare Provider Index for the healthcare institution where the patient received / will receive healthcare services. It should be the corresponding description of the selected [Visit clinic identifier].	string(255)	N	
Visit clinic local name	Local description of the healthcare institution where the patient received / will receive healthcare services	string(255)	N	
Visit datetime	The date and time of the visit. If it is a future date or time, it represents an healthcare service appointment	string(23)	N	
Visit urgency	[eHR value] of the "Urgency" code table. [Visit urgency] refers to the urgency of the care of the visit.	string(1)	N	Refer to the code set of "Urgency" in eHR Office website
Visit specialty	[eHR value] of the "Specialty" code table. [Visit specialty] refers to the specialty for the visit.	string(10)	N	Refer to the code set of "Specialty" in eHR Office website
Visit specialty remarks	Details on specialty of the patient for the visit	string(255)	N	
Visit attendance indicator	[eHR value] of the "Attendance indicator" code table. [Visit	string(1)	N	Refer to the code set of "Attendance

	attendance indicator] is an indicator to identify whether the visit has been attended.			Indicator" in eHR Office website
Attending healthcare professional identifier	eHR identifier of the healthcare professional who attended the visit	string(10)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'
Attending healthcare professional name prefix	English name prefix of the healthcare professional who attended the visit	string(10)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'
Attending healthcare professional English name	English full name of the healthcare professional who attended the visit	string(100)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'
Attending healthcare professional English given name	English given name of the healthcare professional who attended the visit	string(40)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'

Attending healthcare professional Chinese name	Chinese full name of the healthcare professional who attended the visit	string(10)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0' • Maximum 10 Chinese characters
Attending healthcare professional Chinese name suffix	Chinese name suffix of the healthcare professional who attended the visit	string(10)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'

9.2.5 Referral Source [Repeatable = 'N'] (Y:Yes; N:No)

Data field	**Definition**	**Maximum Length**	**Repeatable** Y: Yes N: No	**Notes**
Referral number	A unique number issued by the healthcare institution for each referral	string(20)	N	
Refer-from-institution identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution where the patient is referred from	string(10)	N	Fixed length
Refer-from-institution long name	[Healthcare institution displayed English long name] or [Healthcare institution displayed Chinese long name] in the Healthcare Provider Index for the healthcare institution where the patient is referred from. It should be the corresponding description of the selected [Refer-from-institution identifier].	string(255)	N	

Refer-from-institution local name	Local description of the healthcare institution where the patient is referred from	string(255)	N	
Refer-from-healthcare professional English name	Full English name with prefix of the healthcare professional who referred the episode	string(100)	N	
Refer-from-healthcare professional Chinese name	Full Chinese name with suffix of the healthcare professional who referred the episode	string(10)	N	Maximum 10 Chinese characters
Refer-from-encounter number	A unique reference number assigned by the healthcare institution, e.g. episode number or visit number, to a particular episode / visit under which the referral was made	string(20)	N	
Referral source code	[eHR value] of the "Referral source" code table, to define the referral source for the current episode / visit	string(1)	N	Refer to the code set of “Referral Source” in eHR Office website
Referral source description	[eHR description] of the "Referral source" code table, to indicate the referral source for the current episode / visit. The [Referral source description] should be the corresponding description of the selected [Referral source code].	string(25)	N	Refer to the code set of “Referral Source” in eHR Office website
Referral source local description	Local description of referral source for the current episode / visit, defined by healthcare institution	string(255)	N	
Referral specialty	The specialty of the patient in which the referral was initiated	string(10)	N	Refer to the code set of “Specialty” in eHR Office website
Referral specialty remarks	Details on specialty of the patient in which the referral was initiated	string(255)	N	

9.2.6 Case Healthcare Professional [Repeatable = 'N'] (Y:Yes; N:No)

Data Field	Definition	Maximum Length	Repeatable Y: Yes N: No	Notes
Case healthcare professional identifier	eHR identifier of the healthcare professional who in-charged the care	string(10)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'
Case healthcare professional name prefix	English name prefix of the healthcare professional who was in charge of the care	string(10)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'
Case healthcare professional English name	Full English name with prefix of the healthcare professional who was in-charge of the care	string(100)	N	
Case healthcare professional English given name	English given name of healthcare professional who was in charge of the care	string(40)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'
Case healthcare professional Chinese name	Full Chinese name with suffix of the healthcare professional who was in-charge of the care	string(10)	N	Maximum 10 Chinese characters

Case healthcare professional Chinese name suffix	Chinese name suffix of the healthcare professional who was in charge of the care	string(10)	N	• Not use • Retained for backward compatibility to 'Data requirement specification for eHR encounter record v1.0.0'

9.2.7 Record Creation Data [Repeatable = 'N'] (Y:Yes; N:No)

Data Field	Definition	Maximum Length	Repeatable Y: Yes N: No	Notes
Record creation datetime	Datetime when the record was created in source system of HCP	string(23)	N	
Record creation institution identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution who created the record	string(10)	N	Fixed length
Record creation institution name	Name of healthcare institution who created the record	string(255)	N	

9.2.8 Record Update Data [Repeatable = 'N'] (Y:Yes; N:No)

Data Field	Definition	Maximum Length	Repeatable Y: Yes N: No	Notes
Record last update datetime	Datetime when the record was last updated in source system of HCP	string(23)	N	
Record update institution identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution who updated the record	string(10)	N	Fixed length
Record update institution name	Name of healthcare institution who updated the record	string(255)	N	

9.2.9 Transaction Data [Repeatable = 'N'] (Y:Yes; N:No)

Data Field	Definition	Maximum Length	Repeatable Y: Yes N: No	Notes
Transaction datetime	The datetime indicates the transaction sequence	string(23)	N	
Transaction type	Insert/Update/Delete	string(1)	N	Possible value: **I**: Insert operation **U**: Update operation **D**: Delete operation ***Remarks:*** ***'U' and 'D' are not accepted in materialisation mode.***
Last update datetime	The last update datetime for HCP system	string(23)	N	In format: YYYY-MM-DD HI24:MI:SS.000
Transaction profile type	The Transaction Profile Type indicates the objective of the message	string(10)	N	Refer to the code table 'Transaction Profile Type' in *Section 11.1 - Transaction Profile Type*

10 SCENARIOS AND MESSAGE EVENTS

There are several scenarios will trigger the transfer of encounter data from HCP to eHR system, HCP should send an event-based message or bulk load message to eHR system if there is any scenario happens with the following objectives:

Scenario Type	**Scenario Description**	**Scenario No.**	**Transaction Profile Type** *(Refer to the code table 'Transaction Profile Type' in Section 11.1 - Transaction Profile Type)*
Create appointment	Create appointment for inpatient	SCN1	APP-IP
	Create appointment for outpatient	SCN2	Without episode number: APP-OP
			With episode number: APP-OP-EP
	Create appointment for other encounter type	SCN3	APP-OTH
Update appointment	Update appointment for inpatient	SCN4	APP-IP
	Update appointment for outpatient	SCN5	Without episode number: APP-OP
			With episode number: APP-OP-EP
	Update appointment for other encounter type	SCN6	APP-OTH
Cancel appointment	Cancel appointment for inpatient	SCN7	APP-IP
	Cancel appointment for outpatient	SCN8	Without episode number: APP-OP
			With episode number: APP-OP-EP
	Cancel appointment for other encounter type	SCN9	APP-OTH
Create admission or attendance	Create admission for inpatient	SCN10	ADM-IP
	Create admission for A&E patient	SCN11	ADM-AE
	Create attendance for outpatient	SCN12	Without episode number: ADM-OP
			With episode number: ADM-OP-EP
	Create attendance for other encounter type	SCN13	ADM-OTH

Scenario Type	**Scenario Description**	**Scenario No.**	**Transaction Profile Type** *(Refer to the code table 'Transaction Profile Type' in Section 11.1 - Transaction Profile Type)*
Update admission or attendance	Update admission for inpatient	SCN14	ADM-IP
	Update admission for A&E patient	SCN15	ADM-AE
	Update attendance for outpatient	SCN16	Without episode number: ADM-OP
			With episode number: ADM-OP-EP
	Update attendance for other encounter type	SCN17	ADM-OTH
Cancel admission or attendance	Cancel admission for inpatient	SCN18	ADM-IP
	Cancel admission for A&E patient	SCN19	ADM-AE
	Cancel attendance for outpatient	SCN20	Without episode number: ADM-OP
			With episode number: ADM-OP-EP
	Cancel attendance for other encounter type	SCN21	ADM-OTH
Create discharge	Discharge of inpatient	SCN22	DIS-IP
	Discharge of A&E patient	SCN23	DIS-AE
Cancel discharge	Cancel discharge of inpatient	SCN24	DIS-IP
	Cancel discharge of A&E patient	SCN25	DIS-AE

10.1 CREATE APPOINTMENT

The following sections describe the scenarios where new appointments created in HCP should be uploaded to eHR.

10.1.1 Create Appointment for Inpatient (SCN1)

Description

When a new appointment record is created for an inpatient in HCP, such appointment record should be submitted to eHR.

10.1.2 Create Appointment for Outpatient (SCN2)

Description

When a new appointment record is created for an outpatient in HCP, such appointment record should be submitted to eHR.

10.1.3 Create Appointment for Other Encounter Type (SCN3)

Description

When a new appointment record is created for other encounter type patient in HCP, such appointment record should be submitted to eHR.

10.1.4 General Workflow

i. HCP creates an appointment record for a patient and stores the record in her local system. The system recognises the record has not been submitted to eHR before.

ii. HCP local system assembles messages representing the new appointment record according to the data requirements based on the HCP declared data compliance level.

iii. If the HCP has ensured the completeness and correctness of the new appointment record, she can submit the record to eHR.

10.1.5 Message Event Details

The following event information is referring to HL7 version 2.5 messaging standards. The details of HL7 segments can be found in HL7 specification. For updated HL7 specifications, please visit the official HL7 websites.

Scenario No.	Description	HL-7-HK Message Standards	HL-7-HK Localised Bulk Load Standards
SCN1	Create appointment for inpatient	Message Event Code SIU^S12 Event Name Notification of New Appointment Booking HL7 Message Structure S12	Message Event Code ORU^R01 Event Name Unsolicited Observation Message HL7 Message Structure R01
SCN2	Create appointment for outpatient		
SCN3	Create appointment for other encounter type		

10.1.6 Assumption of HL7 Message Event "SIU^S12" Usage

- a new appointment record is created in HCP and to be submitted to eHR (with [Transaction type] = "I")

10.1.7 Data Interface Requirements

In this section, the data elements embedded in the trigger event 'S12' will be described.

Data Component Required: Person Identity, Encounter, Episode, Visit, Referral Source and Case Healthcare Professional

Purpose: To uniquely and accurately identify the HCR and create a set of appointment data

HCR Information

Remarks: Same data requirements in "HCR Information" are applied in all scenarios (Inpatient, outpatient, A&E patient, other encounter type and Consultation without patient's physical presence) mentioned in this document.

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
Data Element	**Inpatient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
HCR Data				
eHR number	M			
HKIC number	O if [Identity document number] is given M if [Identity document number] is blank			
Type of identity document	O if [Identity document number] is blank M if [Identity document number] is given			
Identity document number	O if [HKIC number] is given M if [HKIC number] is blank			
English surname	O if [English full name] is not blank M if [English full name] is blank			
English given name	O if [English full name] is not blank M if [English full name] is blank			
English full name	O if [English surname] and [English given name] are not blank M if [English surname] and [English given name] are blank ** If patient has either English surname or given name stored in local EMR system, full name should be filled.*			
Sex	M			
Date of birth	M			
Record Type Data				
eHR record type	M			

Detail Information

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
Data Element	**Inpatient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Record key	M	M	M	M
General Encounter Data				
Episode number	O	N/A	M	O
Attendance institution identifier	O	O	O	O
Encounter				
Encounter healthcare provider identifier	M	M	M	M
Encounter healthcare institution identifier	M	M	M	M
Encounter type	M Fixed value "I" is expected	M Fixed value "O" / "T" is expected	M Fixed value "O" / "T" is expected	M Fixed value "H" is expected
Encounter service type *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Encounter service type details *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Appointment number	M	M	M	M
Episode				
Episode start datetime	M	N/A	O	O

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
Data Element	**Inpatient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Episode urgency	O *(If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'* *If Urgency type is 'S', Encounter type must be 'I' or 'O' or 'T' or 'H'* *If Urgency type is 'W', Encounter type must be 'O' or 'H')*	N/A	N/A	O *(If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'* *If Urgency type is 'S', Encounter type must be 'I' or 'O' or 'T' or 'H'* *If Urgency type is 'W', Encounter type must be 'O' or 'H')*
Episode start specialty	O	N/A	O	O
Episode start specialty remarks	O	N/A	O	O
Episode attendance indicator	O	N/A	N/A	O
Episode end datetime	N/A	N/A	N/A	O
Episode end specialty	N/A	N/A	N/A	O
Episode end specialty remarks	N/A	N/A	N/A	O
Death before arrival indicator	N/A	N/A	N/A	O
Discharge type	N/A	N/A	N/A	O
Discharge-to-institution identifier	N/A	N/A	N/A	O M if [Discharge-to-institution long name] is not blank

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
Data Element	**Inpatient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Discharge-to-institution long name	N/A	N/A	N/A	O M if [Discharge-to-institution identifier] is not blank
Discharge-to-institution local name	N/A	N/A	N/A	O M if [Discharge-to-institution identifier] is not blank
Discharge healthcare professional identifier *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Discharge healthcare professional name prefix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Discharge healthcare professional English name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Discharge healthcare professional English given name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Discharge healthcare professional Chinese name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Discharge healthcare professional Chinese name suffix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Visit				

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
Data Element	**Inpatient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Visit number	N/A	O	O	O
Visit clinic identifier	N/A	O M if [Visit clinic long name] is not blank	O M if [Visit clinic long name] is not blank	O M if [Visit clinic long name] is not blank
Visit clinic long name	N/A	O M if [Visit clinic identifier] is not blank	O M if [Visit clinic identifier] is not blank	O M if [Visit clinic identifier] is not blank
Visit clinic local name	N/A	O M if [Visit clinic identifier] is not blank	O M if [Visit clinic identifier] is not blank	O M if [Visit clinic identifier] is not blank
Visit datetime	N/A	M	M	M
Visit urgency	N/A	O *(If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'* *If Urgency type is 'S', Encounter type must be 'I' or 'O' or 'T' or 'H'* *If Urgency type is 'W', Encounter type must be 'O' or 'H')*	O *(If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'* *If Urgency type is 'S', Encounter type must be 'I' or 'O' or 'T' or 'H'* *If Urgency type is 'W', Encounter type must be 'O' or 'H')*	O *(If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'* *If Urgency type is 'S', Encounter type must be 'I' or 'O' or 'T' or 'H'* *If Urgency type is 'W', Encounter type must be 'O' or 'H')*
Visit specialty	N/A	O	O	O
Visit specialty remarks	N/A	O	O	O
Visit attendance indicator	N/A	O	O	O

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
Data Element	**Inpatient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Attending healthcare professional identifier *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Attending healthcare professional name prefix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Attending healthcare professional English name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Attending healthcare professional English given name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Attending healthcare professional Chinese name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Attending healthcare professional Chinese name suffix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Referral Source				
Referral number	O	O	O	O
Refer-from-institution identifier	O M if [Refer-from-institution long name] is not blank	O M if [Refer-from-institution long name] is not blank	O M if [Refer-from-institution long name] is not blank	O M if [Refer-from-institution long name] is not blank

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
Data Element	**Inpatient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Refer-from-institution long name	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank
Refer-from-institution local name	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank
Refer-from-healthcare professional English name	O	O	O	O
Refer-from-healthcare professional Chinese name	O	O	O	O
Refer-from-encounter number	O	O	O	O
Referral source code	O	O	O	O
Referral source description	O M if [Referral source code] is not blank	O M if [Referral source code] is not blank	O M if [Referral source code] is not blank	O M if [Referral source code] is not blank
Referral source local description	O	O	O	O
Referral specialty	O	O	O	O
Referral specialty remarks	O	O	O	O
Case Healthcare Professional				
Case healthcare professional identifier *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
Data Element	**Inpatient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Case healthcare professional name prefix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Case healthcare professional English name	O	O	O	O
Case healthcare professional English given name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Case healthcare professional Chinese name	O	O	O	O
Case healthcare professional Chinese name suffix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A
Record Creation Data				
Record creation datetime	O	O	O	O
Record creation institution identifier	O	O	O	O
Record creation institution name	O	O	O	O
Record Update Data				
Record last update datetime	O	O	O	O
Record update institution identifier	O	O	O	O
Record update institution name	O	O	O	O
Transaction Data				
Transaction datetime	M	M	M	M

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
Data Element	**Inpatient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Transaction type	M	M	M	M
	Possible value: **I**: Insert operation - Applied when the record identified by HCP's [Record Key] has not been submitted to eHR before **U**: Update operation - Applied when the record identified by HCP's [Record Key] has been submitted to eHR before. The existing record in eHR will be overridden by the new set of data according to the record key provided by HCP **D**: Delete operation - Applied when HCP would like delete the existing record identified by HCP's [Record Key] which has been submitted to eHR before ***Remarks:*** ***'U' and 'D'are not accepted in materialisation mode.***			
Last update datetime	M	M	M	M
Transaction profile type	M Fixed value: "APP-IP"	M Fixed value: "APP-OP"	M Fixed value: "APP-OP-EP"	M Fixed value: "APP-OTH"

10.2 UPDATE APPOINTMENT

The following sections describe the scenarios where updated appointments in HCP should be uploaded to eHR.

10.2.1 Update Appointment for Inpatient (SCN4)

Description

When an inpatient appointment record was sent to eHR, and subsequently a modification on the appointment is made by a HCP, the updated appointment record should be submitted to eHR again.

10.2.2 Update Appointment for Outpatient (SCN5)

Description

When an outpatient appointment record was sent to eHR, and subsequently a modification on the appointment is made by a HCP, the updated appointment record should be submitted to eHR again.

10.2.3 Update Appointment for Other Encounter Type (SCN6)

Description

When other encounter type patient appointment record was sent to eHR, and subsequently a modification on the appointment is made by a HCP, the updated appointment record should be submitted to eHR again.

10.2.4 General Workflow

i. HCP modifies an appointment record in her local system for whatever. The system recognises that the prior version of the appointment has already been submitted to eHR before.

ii. The system constructs a message that contains the complete set of updated appointment record data with the record key of the record to be amended.

iii. HCP sends the message with the latest ‘Encounter’ data to eHR for amendment. The existing appointment record in eHR will then be overridden by the new set of data according to the record key provided by HCP.

10.2.5 Message Event Details

The following event information is referring to HL7 version 2.5 messaging standards. The details of HL7 segments can be found in HL7 specification. For updated HL7 specifications, please visit the official HL7 websites.

Scenario No.	Description	HL-7-HK Message Standards	HL-7-HK Localised Bulk Load Standards
SCN4	Update appointment for inpatient	Message Event Code SIU^S14 Event Name Notification of Appointment Modification HL7 Message Structure S12	Message Event Code ORU^R01 Event Name Unsolicited Observation Message HL7 Message Structure R01
SCN5	Update appointment for outpatient		
SCN6	Update appointment for other encounter type		

10.2.6 Assumption of HL7 Message Event "SIU^S14" Usage

- an existing appointment record in eHR to be updated (with [Transaction type] = "U")

10.2.7 Data Interface Requirements

In this section, the data elements embedded in the trigger event 'S14' will be described.

Data Component Required: Person Identity, Encounter, Episode, Visit, Referral Source and Case Healthcare Professional

Purpose: To uniquely and accurately identify the eHR appointment and update the whole set of appointment data

HCR Information

(Refer to the 'HCR Information' in Section 10.1.7 - Data Interface Requirements)

Detail Information

(Refer to the 'Detail Information' in Section 10.1.7 - Data Interface Requirements)

10.3 CANCEL APPOINTMENT

The following sections describe the scenarios where deleted appointments in HCP should be uploaded to eHR.

10.3.1 Cancel Appointment for Inpatient (SCN7)

Description

When an inpatient appointment record was sent to eHR, and subsequently a deletion of the appointment is made by a HCP, the deleted appointment record should be submitted to eHR again.

10.3.2 Cancel Appointment for Outpatient (SCN8)

Description

When an outpatient appointment record was sent to eHR, and subsequently a deletion of the appointment is made by a HCP, the deleted appointment record should be submitted to eHR again.

10.3.3 Cancel Appointment for Other Encounter Type (SCN9)

Description

When other encounter type patient appointment record was sent to eHR, and subsequently a deletion of the appointment is made by a HCP, the deleted appointment record should be submitted to eHR again.

10.3.4 General Workflow

i. HCP deletes an appointment record in her local system. The system recognises that the appointment has already been submitted to eHR.

ii. The system constructs a message that contains HCR's identity information and the identifying information of the appointment record to be deleted.

iii. HCP sends the message to eHR. The corresponding appointment record will be deleted in eHR by using the record key provided by HCP.

10.3.5 Message Event Details

The following event information is referring to HL7 version 2.5 messaging standards. The details of HL7 segments can be found in HL7 specification. For updated HL7 specifications, please visit the official HL7 websites.

Scenario No.	Description	HL-7-HK Message Standards	HL-7-HK Localised Bulk Load Standards
SCN7	Cancel appointment for inpatient	Message Event Code SIU^S15 Event Name Notification of Appointment Cancellation HL7 Message Structure S12	Message Event Code ORU^R01 Event Name Unsolicited Observation Message HL7 Message Structure R01
SCN8	Cancel appointment for outpatient		
SCN9	Cancel appointment for other encounter type		

10.3.6 Assumption of HL7 Message Event "SIU^S15" Usage

- an existing appointment record in eHR to be deleted (with [Transaction type] = "D")

10.3.7 Data Interface Requirements

In this section, the data elements embedded in the trigger event 'S15' will be described.

Data Component Required: Person Identity, Encounter

Purpose: To uniquely and accurately identify the eHR appointment data

HCR Information

(Refer to the 'HCR Information' in Section 10.1.7 - Data Interface Requirements)

Detail Information

(Refer to the 'Detail Information' in Section 10.1.7 - Data Interface Requirements)

10.4 CREATE ADMISSION OR ATTENDANCE

The following sections describe the scenarios where new admission or attendance records created in HCP should be uploaded to eHR.

10.4.1 Create Admission for Inpatient (SCN10)

Description

When a new admission record is created for an inpatient in HCP, such admission record should be submitted to eHR.

10.4.2 Create Admission for A&E Patient (SCN11)

Description

When a new admission record is created for an A&E patient in HCP, such admission record should be submitted to eHR.

10.4.3 Create Attendance for Outpatient (SCN12)

Description

When a new attendance record is created for an outpatient in HCP, such attendance record should be submitted to eHR.

10.4.4 Create Attendance for Other Encounter Type (SCN13)

Description

When a new attendance record is created for other encounter type patient in HCP, such attendance record should be submitted to eHR.

10.4.5 General Workflow

i. HCP creates an admission or attendance record for a patient and stores the record in her local system. The system recognises the record has not been submitted to eHR before.

ii. HCP local system assembles messages representing the new admission or attendance record according to the data requirements based on the HCP declared data compliance level.

iii. If the HCP has ensured the completeness and correctness of the new admission or attendance record, she can submit the record to eHR.

10.4.6 Message Event Details

The following event information is referring to HL7 version 2.5 messaging standards. The details of HL7 segments can be found in HL7 specification. For updated HL7 specifications, please visit the official HL7 websites.

<table>
<tr><th>Scenario No.</th><th>Description</th><th>HL-7-HK Message Standards</th><th>HL-7-HK Localised Bulk Load Standards</th></tr>
<tr><td>SCN10</td><td>Create admission for inpatient</td><td><u>Message Event Code</u>
ADT^A01

<u>Event Name</u>
Admit/Visit Notification

<u>HL7 Message Structure</u>
A01</td><td rowspan="4"><u>Message Event Code</u>
ORU^R01

<u>Event Name</u>
Unsolicited Observation Message

<u>HL7 Message Structure</u>
R01</td></tr>
<tr><td>SCN11</td><td>Create admission for A&E patient</td><td rowspan="3"><u>Message Event Code</u>
ADT^A04

<u>Event Name</u>
Register a Patient

<u>HL7 Message Structure</u>
A01</td></tr>
<tr><td>SCN12</td><td>Create attendance for outpatient</td></tr>
<tr><td>SCN13</td><td>Create attendance for other encounter type</td></tr>
</table>

10.4.7 Assumption of HL7 Message Event “ADT^A01” and “ADT^A04” Usage

- a new admission/ attendance record created in HCP and to be submitted to eHR (with [Transaction type] = “I”)

10.4.8 Data Interface Requirements

In this section, the data elements embedded in the trigger event ‘A01’ and ‘A04’ will be described.

Data Component Required: Person Identity, Encounter, Episode, Visit, Referral Source and Case Healthcare Professional

Purpose: To uniquely and accurately identify the HCR and create a set of admission or attendance data

HCR Information

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)				
Data Element	**Inpatient**	**A&E patient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
HCR Data					
eHR number	*(Refer to the 'HCR Information' in Section 10.1.7 - Data Interface Requirements)*				
HKIC number					
Type of identity document					
Identity document number					
English surname					
English given name					
English full name					
Sex					
Date of birth					
Record Type Data					
eHR record type	*(Refer to the 'HCR Information' in Section 10.1.7 - Data Interface Requirements)*				

Detail Information

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)				
Data Element	**Inpatient**	**A&E patient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Record key	M	M	M	M	M
General Encounter Data					
Episode number	M	M	N/A	M	O
Attendance institution identifier	O	O	O	O	O
Encounter					
Encounter healthcare provider identifier	M	M	M	M	M
Encounter healthcare institution identifier	M	M	M	M	M
Encounter type	M Fixed value "I" is expected	M Fixed value "A" is expected	M Fixed value "O" / "T" is expected	M Fixed value "O" / "T" is expected	M Fixed value "H" is expected
Encounter service type *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Encounter service type details *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Appointment number	O	N/A	O	O	O

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)				
Data Element	**Inpatient**	**A&E patient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Episode					
Episode start datetime	M	M	N/A	O	O
Episode urgency	O *(If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'* *If Urgency type is 'S', Encounter type must be 'I' or 'O' or 'T' or 'H'* *If Urgency type is 'W', Encounter type must be 'O' or 'H')*	N/A	N/A	N/A	O *(If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'* *If Urgency type is 'S', Encounter type must be 'I' or 'O' or 'T' or 'H'* *If Urgency type is 'W', Encounter type must be 'O' or 'H')*
Episode start specialty	O	O	N/A	O	O
Episode start specialty remarks	O	O	N/A	O	O
Episode attendance indicator	O	O	N/A	N/A	O
Episode end datetime	N/A	N/A	N/A	O	O
Episode end specialty	N/A	N/A	N/A	O	O
Episode end specialty remarks	N/A	N/A	N/A	O	O
Death before arrival indicator	N/A	N/A	N/A	O	O
Discharge type	N/A	N/A	N/A	O	O

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)				
Data Element	**Inpatient**	**A&E patient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Discharge-to-institution identifier	N/A	N/A	N/A	O M if [Discharge-to-institution long name] is not blank	O M if [Discharge-to-institution long name] is not blank
Discharge-to-institution long name	N/A	N/A	N/A	O M if [Discharge-to-institution identifier] is not blank	O M if [Discharge-to-institution identifier] is not blank
Discharge-to-institution local name	N/A	N/A	N/A	O M if [Discharge-to-institution identifier] is not blank	O M if [Discharge-to-institution identifier] is not blank
Discharge healthcare professional identifier *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Discharge healthcare professional name prefix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)				
Data Element	**Inpatient**	**A&E patient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Discharge healthcare professional English name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Discharge healthcare professional English given name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Discharge healthcare professional Chinese name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Discharge healthcare professional Chinese name suffix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Visit					
Visit number	N/A	N/A	M	M	M
Visit clinic identifier	N/A	N/A	O M if [Visit clinic long name] is not blank	O M if [Visit clinic long name] is not blank	O M if [Visit clinic long name] is not blank

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)				
Data Element	**Inpatient**	**A&E patient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Visit clinic long name	N/A	N/A	O M if [Visit clinic identifier] is not blank	O M if [Visit clinic identifier] is not blank	O M if [Visit clinic identifier] is not blank
Visit clinic local name	N/A	N/A	O M if [Visit clinic identifier] is not blank	O M if [Visit clinic identifier] is not blank	O M if [Visit clinic identifier] is not blank
Visit datetime	N/A	N/A	M	M	M
Visit urgency	N/A	N/A	O *(If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'* *If Urgency type is 'S', Encounter type must be 'I' or 'O' or 'T' or 'H'* *If Urgency type is 'W', Encounter type must be 'O' or 'H')*	O *(If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'* *If Urgency type is 'S', Encounter type must be 'I' or 'O' or 'T' or 'H'* *If Urgency type is 'W', Encounter type must be 'O' or 'H')*	O *(If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'* *If Urgency type is 'S', Encounter type must be 'I' or 'O' or 'T' or 'H'* *If Urgency type is 'W', Encounter type must be 'O' or 'H')*
Visit specialty	N/A	N/A	O	O	O
Visit specialty remarks	N/A	N/A	O	O	O
Visit attendance indicator	N/A	N/A	O	O	O

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)				
Data Element	**Inpatient**	**A&E patient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Attending healthcare professional identifier *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Attending healthcare professional name prefix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Attending healthcare professional English name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Attending healthcare professional English given name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Attending healthcare professional Chinese name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)				
Data Element	**Inpatient**	**A&E patient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Attending healthcare professional Chinese name suffix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Referral Source					
Referral number	O	O	O	O	O
Refer-from-institution identifier	O M if [Refer-from-institution long name] is not blank	O M if [Refer-from-institution long name] is not blank	O M if [Refer-from-institution long name] is not blank	O M if [Refer-from-institution long name] is not blank	O M if [Refer-from-institution long name] is not blank
Refer-from-institution long name	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank
Refer-from-institution local name	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank
Refer-from-healthcare professional English name	O	O	O	O	O

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)				
Data Element	**Inpatient**	**A&E patient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Refer-from-healthcare professional Chinese name	O	O	O	O	O
Refer-from-encounter number	O	O	O	O	O
Referral source code	O	O	O	O	O
Referral source description	O M if [Referral source code] is not blank	O M if [Referral source code] is not blank	O M if [Referral source code] is not blank	O M if [Referral source code] is not blank	O M if [Referral source code] is not blank
Referral source local description	O	O	O	O	O
Referral specialty	O	O	O	O	O
Referral specialty remarks	O	O	O	O	O
Case Healthcare Professional					
Case healthcare professional identifier *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Case healthcare professional name prefix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Case healthcare professional English name	O	O	O	O	O

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)				
Data Element	**Inpatient**	**A&E patient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Case healthcare professional English given name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Case healthcare professional Chinese name	O	O	O	O	O
Case healthcare professional Chinese name suffix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A	N/A	N/A	N/A
Record Creation Data					
Record creation datetime	*(Refer to the 'Detail Information' in Section 10.1.7 - Data Interface Requirements)*				
Record creation institution identifier					
Record creation institution name					
Record Update Data					
Record last update datetime	*(Refer to the 'Detail Information' in Section 10.1.7 - Data Interface Requirements)*				
Record update institution identifier					
Record update institution name					

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)				
Data Element	**Inpatient**	**A&E patient**	**Outpatient without episode number (include Consultation without patient's physical presence)**	**Outpatient with episode number**	**Other encounter type**
Transaction Data					
Transaction datetime	*(Refer to the 'Detail Information' in Section 10.1.7 - Data Interface Requirements)*				
Transaction type					
Last update datetime					
Transaction profile type	M Fixed value: "ADM-IP"	M Fixed value: "ADM-AE"	M Fixed value: "ADM-OP"	M Fixed value: "ADM-OP-EP"	M Fixed value: "ADM-OTH"

10.5 UPDATE ADMISSION OR ATTENDANCE

The following sections describe the scenarios where updated admission or attendance records in HCP should be uploaded to eHR.

10.5.1 Update Admission for Inpatient (SCN14)

Description

When an inpatient admission record was sent to eHR, and subsequently a modification on the admission record is made by a HCP, the updated admission record should be submitted to eHR again.

10.5.2 Update Admission for A&E Patient (SCN15)

Description

When an A&E patient admission record was sent to eHR, and subsequently a modification on the admission record is made by a HCP, the updated admission record should be submitted to eHR again.

10.5.3 Update Attendance for Outpatient (SCN16)

Description

When an outpatient attendance record was sent to eHR, and subsequently a modification on the attendance record is made by a HCP, the updated attendance record should be submitted to eHR again.

10.5.4 Update Attendance for Other Encounter Type (SCN17)

Description

When other encounter type patient attendance record was sent to eHR, and subsequently a modification on the attendance record is made by a HCP, the updated attendance record should be submitted to eHR again.

10.5.5 General Workflow

i. HCP modifies an admission or attendance record in her local system for whatever the system recognises that the prior version of the admission or attendance record has already been submitted to eHR before.

ii. The system constructs a message that contains the complete set of updated admission or attendance record data with the record key of the record to be amended.

iii. HCP sends the message with the latest 'Encounter' data to eHR for amendment. The existing admission or attendance record in eHR will then be overridden by the new set of data according to the record key provided by HCP.

10.5.6 Message Event Details

The following event information is referring to HL7 version 2.5 messaging standards. The details of HL7 segments can be found in HL7 specification. For updated HL7 specifications, please visit the official HL7 websites.

Scenario No.	Description	HL-7-HK Message Standards	HL-7-HK Localised Bulk Load Standards
SCN14	Update admission for inpatient	Message Event Code ADT^A08 Event Name Update Patient Information HL7 Message Structure A01	Message Event Code ORU^R01 Event Name Unsolicited Observation Message HL7 Message Structure R01
SCN15	Update admission for A&E patient		
SCN16	Update attendance for outpatient		
SCN17	Update attendance for other encounter type		

10.5.7 Assumption of HL7 Message Event "ADT^A08" Usage

- an existing admission/ admission record in eHR to be updated (with [Transaction type] = "U")

10.5.8 Data Interface Requirements

In this section, the data elements embedded in the trigger event 'A08' will be described.

Data Component Required: Person Identity, Encounter, Episode, Visit, Referral Source and Case Healthcare Professional

Purpose: To uniquely and accurately identify the eHR admission or attendance data and update whole set of admission or attendance data

HCR Information

(Refer to the 'HCR Information' in Section 10.4.8 - Data Interface Requirements)

Detail Information

(Refer to the 'Detail Information' in Section 10.4.8 - Data Interface Requirements)

10.6 CANCEL ADMISSION OR ATTENDANCE

The following sections describe the scenarios where deleted admission or attendance records in HCP should be uploaded to eHR.

10.6.1 Cancel Admission for Inpatient (SCN18)

Description

When an inpatient admission record was sent to eHR and subsequently a deletion of the admission record is made by a HCP, the deleted admission record should be submitted to eHR again.

10.6.2 Cancel Admission for A&E Patient (SCN19)

Description

When an A&E patient admission record was sent to eHR and subsequently a deletion of the admission record is made by a HCP, the deleted admission record should be submitted to eHR again.

10.6.3 Cancel Attendance for Outpatient (SCN20)

Description

When an outpatient attendance record was sent to eHR and subsequently a deletion of the attendance record is made by a HCP, the deleted attendance record should be submitted to eHR again.

10.6.4 Cancel Attendance for Other Encounter Type (SCN21)

Description

When other encounter type patient attendance record was sent to eHR and subsequently a deletion of the attendance record is made by a HCP, the deleted attendance record should be submitted to eHR again.

10.6.5 General Workflow

i. HCP deletes an admission or attendance record in her local system. The system recognises that the admission or attendance record has already been submitted to eHR.

ii. The system constructs a message that contains HCR's identity information and the identifying information of the admission or attendance record to be deleted.

iii. HCP sends the message to eHR. The corresponding admission or attendance record will be deleted in eHR by using the record key provided by HCP.

10.6.6 Message Event Details

The following event information is referring to HL7 version 2.5 messaging standards. The details of HL7 segments can be found in HL7 specification. For updated HL7 specifications, please visit the official HL7 websites.

Scenario No.	Description	HL-7-HK Message Standards	HL-7-HK Localised Bulk Load Standards
SCN18	Cancel admission for inpatient	Message Event Code ADT^A11 Event Name Cancel Admit / Visit Notification HL7 Message Structure A09	Message Event Code ORU^R01 Event Name Unsolicited Observation Message HL7 Message Structure R01
SCN19	Cancel admission for A&E patient		
SCN20	Cancel attendance for outpatient		
SCN21	Cancel attendance for other encounter type		

10.6.7 Assumption of HL7 Message Event "ADT^A11" Usage

- an existing admission/ attendance record in eHR to be deleted (with [Transaction type] = "D")

10.6.8 Data Interface Requirements

In this section, the data elements embedded in the trigger event 'A11' will be described.

Data Component Required: Person Identity, Encounter, Episode and Visit

Purpose: To uniquely and accurately identify the eHR admission or attendance data

HCR Information

(Refer to the 'HCR Information' in Section 10.4.8 - Data Interface Requirements)

Detail Information

(Refer to the 'Detail Information' in Section 10.4.8 - Data Interface Requirements)

10.7 DISCHARGE

The following sections describe the scenarios where new discharge records created in HCP should be uploaded to eHR.

10.7.1 Discharge of Inpatient (SCN22)

Description

When a new discharge record is created for an inpatient in HCP, such discharge record should be submitted to eHR.

10.7.2 Discharge of A&E Patient (SCN23)

Description

When a new discharge record is created for an A&E patient in HCP, such discharge record should be submitted to eHR.

10.7.3 General Workflow

i. HCP creates a discharge record for a patient and stores the record in her local system. The system recognises the record has not been submitted to eHR before.

ii. HCP local system assembles messages representing the new discharge record according to the data requirements based on the HCP declared data compliance level.

iii. If HCP has ensured the completeness and correctness of the new discharge record, she can submit the record to eHR.

10.7.4 Message Event Details

The following event information is referring to HL7 version 2.5 messaging standards. The details of HL7 segments can be found in HL7 specification. For updated HL7 specifications, please visit the official HL7 websites.

Scenario No.	Description	HL-7-HK Message Standards	HL-7-HK Localised Bulk Load Standards
SCN22	Discharge of inpatient	Message Event Code ADT^A03 Event Name Discharge / End Visit HL7 Message Structure A03	Message Event Code ORU^R01 Event Name Unsolicited Observation Message HL7 Message Structure R01
SCN23	Discharge of A&E patient		

10.7.5 Assumption of HL7 Message Event "ADT^A03" Usage

- a new discharge record created in HCP and to be submitted to eHR (with [Transaction type] = "I"); or
- an existing discharge record in eHR to be updated (with [Transaction type] = "U")

10.7.6 Data Interface Requirements

In this section, the data elements embedded in the trigger event 'A03' will be described.

Data Component Required: Person Identity, Encounter, Episode, Referral Source and Case Healthcare Professional

Purpose: To uniquely and accurately identify the HCR and create discharge data

HCR Information

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted)	
Data Element	**Inpatient**	**A&E patient**
HCR Data		
eHR number	*(Refer to the 'HCR Information' in Section 10.1.7 - Data Interface Requirements)*	
HKIC number		
Type of identity document		
Identity document number		
English surname		
English given name		
English full name		
Sex		
Date of birth		
Record Type Data		
eHR record type	*(Refer to the 'HCR Information' in Section 10.1.7 - Data Interface Requirements)*	

Detail Information

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)	
Data Element	**Inpatient**	**A&E patient**
Record key	M	M
General Encounter Data		
Episode number	M	M
Attendance institution identifier	O	O
Encounter		
Encounter healthcare provider identifier	M	M
Encounter healthcare institution identifier	M	M
Encounter type	M Fixed value “I” is expected	M Fixed value “A” is expected
Encounter service type *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Encounter service type details *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Appointment number	O	N/A
Episode		
Episode start datetime	M	M
Episode urgency	O *(If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'* *If Urgency type is 'S', Encounter type must be 'I' or 'O' or 'T' or 'H'* *If Urgency type is 'W', Encounter type must be 'O' or 'H')*	N/A
Episode start specialty	O	O
Episode start specialty remarks	O	O

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)	
Data Element	**Inpatient**	**A&E patient**
Episode attendance indicator	O	O
Episode end datetime	M	M
Episode end specialty	O	O
Episode end specialty remarks	O	O
Death before arrival indicator	O	O
Discharge type	M	M
Discharge-to-institution identifier	O M if [Discharge-to-institution long name] is not blank	O M if [Discharge-to-institution long name] is not blank
Discharge-to-institution long name	O M if [Discharge-to-institution identifier] is not blank	O M if [Discharge-to-institution identifier] is not blank
Discharge-to-institution local name	O M if [Discharge-to-institution identifier] is not blank	O M if [Discharge-to-institution identifier] is not blank
Discharge healthcare professional identifier *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Discharge healthcare professional name prefix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Discharge healthcare professional English name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Discharge healthcare professional English given name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)	
Data Element	**Inpatient**	**A&E patient**
Discharge healthcare professional Chinese name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Discharge healthcare professional Chinese name suffix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Visit		
Visit number	N/A	N/A
Visit clinic identifier	N/A	N/A
Visit clinic long name	N/A	N/A
Visit clinic local name	N/A	N/A
Visit datetime	N/A	N/A
Visit urgency	N/A	N/A
Visit specialty	N/A	N/A
Visit specialty remarks	N/A	N/A
Visit attendance indicator	N/A	N/A
Attending healthcare professional identifier *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Attending healthcare professional name prefix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Attending healthcare professional English name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Attending healthcare professional English given name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)	
Data Element	**Inpatient**	**A&E patient**
Attending healthcare professional Chinese name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Attending healthcare professional Chinese name suffix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Referral Source		
Referral number	O	O
Refer-from-institution identifier	O M if [Refer-from-institution long name] is not blank	O M if [Refer-from-institution long name] is not blank
Refer-from-institution long name	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank
Refer-from-institution local name	O M if [Refer-from-institution identifier] is not blank	O M if [Refer-from-institution identifier] is not blank
Refer-from-healthcare professional English name	O	O
Refer-from-healthcare professional Chinese name	O	O
Refer-from-encounter number	O	O
Referral source code	O	O
Referral source description	O M if [Referral source code] is not blank	O M if [Referral source code] is not blank
Referral source local description	O	O
Referral specialty	O	O
Referral specialty remarks	O	O

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)	
Data Element	**Inpatient**	**A&E patient**
Case Healthcare Professional		
Case healthcare professional identifier *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Case healthcare professional name prefix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Case healthcare professional English name	O	O
Case healthcare professional English given name *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Case healthcare professional Chinese name	O	O
Case healthcare professional Chinese name suffix *(Retained for backward compatibility to v1.0.0)*	N/A	N/A
Record Creation Data		
Record creation datetime	*(Refer to the 'Detail Information' in Section 10.1.7 - Data Interface Requirements)*	
Record creation institution identifier		
Record creation institution name		
Record Update Data		
Record last update datetime	*(Refer to the 'Detail Information' in Section 10.1.7 - Data Interface Requirements)*	
Record update institution identifier		
Record update institution name		
Record Update Data		
Transaction datetime	*(Refer to the 'Detail Information' in Section 10.1.7 - Data Interface Requirements)*	

	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)	
Data Element	**Inpatient**	**A&E patient**
Transaction type		
Last update datetime		
Transaction profile type	M Fixed value: "DIS-IP"	M Fixed value: "DIS-AE"

10.8 CANCEL DISCHARGE

The following sections describe the scenarios where deleted discharge records in HCP should be uploaded to eHR.

10.8.1 Cancel Discharge of Inpatient (SCN24)

Description

When an inpatient discharge record was sent to eHR, and subsequently a deletion of the discharge record is made by a HCP, the deleted discharge record should be submitted to eHR again.

10.8.2 Cancel Discharge of A&E Patient (SCN25)

Description

When an A&E patient discharge record was sent to eHR, and subsequently a deletion of the discharge record is made by a HCP, the deleted discharge record should be submitted to eHR again.

10.8.3 General Workflow

i. HCP deletes a discharge record in her local system. The system recognises that the discharge record has already been submitted to eHR.

ii. The system constructs a message that contains HCR's identity information and the identifying information of the discharge record to be deleted.

iii. HCP sends the message to eHR. The corresponding discharge record will be deleted in eHR by using the record key provided by HCP.

10.8.4 Message Event Details

The following event information is referring to HL7 version 2.5 messaging standards. The details of HL7 segments can be found in HL7 specification. For updated HL7 specifications, please visit the official HL7 websites.

Scenario No.	Description	HL-7-HK Message Standards	HL-7-HK Localised Bulk Load Standards
SCN24	Cancel discharge of inpatient	Message Event Code ADT^A13 Event Name Discharge / End Visit HL7 Message Structure A01	Message Event Code ORU^R01 Event Name Unsolicited Observation Message HL7 Message Structure R01
SCN25	Cancel discharge of A&E patient		

10.8.5 Assumption of HL7 Message Event "ADT^A13" Usage

- an existing discharge record in eHR to be deleted (with [Transaction type] = "D")

10.8.6 Data Interface Requirements

In this section, the data elements embedded in the trigger event 'A13' will be described.

Data Component Required: Person Identity, Encounter and Episode

Purpose: To uniquely and accurately identify the eHR discharge data

HCR Information

(Refer to the 'HCR Information' in Section 10.7.6 - Data Interface Requirements)

Detail Information

(Refer to the 'Detail Information' in Section 10.7.6 - Data Interface Requirements)

11 APPENDIX

11.1 TRANSACTION PROFILE TYPE

Code	Description
APP-IP	Inpatient appointment
APP-OP	Outpatient appointment without episode number
APP-OP-EP	Outpatient appointment with episode number
APP-OTH	Other encounter type appointment
ADM-IP	Inpatient admission
ADM-AE	A & E patient admission
ADM-OP	Outpatient attendance without episode number
ADM-OP-EP	Outpatient attendance with episode number
ADM-OTH	Other encounter type attendance
DIS-IP	Inpatient discharge
DIS-AE	A & E patient discharge