BLS Technical Interface Specification
For
eHR Encounter Record

Version 1.4.4

Jul 2022

Intellectual Property Rights Notice

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DOCUMENT SUMMARY

Document Item	Current Value
Document Title	BLS Technical Interface Specification For eHR Encounter Record
Creation Date	20 Jul 2012
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Document Description	The document describes the interface specification for bulk upload standards of 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.
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AMENDMENT HISTORY

<table>
<tr><th>Version No.</th><th>Summary of Changes</th><th>Date</th></tr>
<tr><td>1.0.0</td><td>Original version</td><td>20 Jul 2012</td></tr>
<tr><td>1.1.0</td><td>Enhanced according to the -dataset as of Feb 2013 defined by eHR Information Standards Office</td><td>13 Mar 2013</td></tr>
<tr><td>1.2.0</td><td>• Updated the definition of data fields: 'Record creation institution name' and 'Record update institution name'
• Added section ‘XML PREDEFINED ENTITIES’
• Added remarks in section ‘Data Upload Requirements’ and updated notes of data field ‘Transaction type’
• Updated definition and notes of ‘Death before arrival indicator’
• Updated the checking rule of the following data fields:
o Encounter type
o Last update datetime
• Add remarks to ‘Record Key’
• Aligned the terms used in eHR Sharing System (eHRSS) Bill:
o Participant -> eHR Healthcare Recipient
o Enroll -> Register
o Re-join -> Re-register
• Update the template of cover page and descriptions in footer
• Update the contents in section 'Intellectual Property Rights Notice'</td><td>19 Jun 2014</td></tr>
<tr><td>1.2.1</td><td>In section 10.2.2 ‘Admission or attendance data component’, update the requirement of column 'Delete (SCN20, 21)' of the following data fields:
<table><tr><th>#</th><th>Data Field</th><th>From</th><th>To</th></tr><tr><td>6</td><td>Transaction profile type</td><td>(for SCN12, 16)</td><td>(for SCN20)</td></tr><tr><td>7</td><td>Episode number</td><td rowspan="2">(for SCN13, 17)</td><td rowspan="2">(for SCN21)</td></tr><tr><td>16</td><td>Episode urgency</td></tr></table></td><td>30 Dec 2014</td></tr>
</table>

Version No.	Summary of Changes	Date
	19 | Episode attendance indicator | |	
1.3.0	Jun 2015 Release	30 Jun 2015
1.4.0	• Changed from 'conditional mandatory' to 'optional' a. 'Episode start specialty remarks' b. 'Episode end specialty remarks' c. 'Visit specialty remarks' d. 'Referral specialty remarks'	13 Oct 2016
1.4.1	• Update data requirement on following data fields, which are retained for backward compatibility, to N/A a. Encounter service type b. Encounter service type details	19 Jul 2017
1.4.2	• Revise Figure 1 (update 'ORU^O01' to 'ORU^R01')	21 Sep 2018
1.4.3	• Updated field definition for "HKIC number" in order to support Consular Corps ID Card holders	02 Aug 2021
1.4.4	• Updated bureau name from Food and Health Bureau (FHB) to Health Bureau (HHB)	26 Jul 2022

1 PURPOSE

1.1 OBJECTIVE

This document describes the technical interface requirements for implementing Health Level Seven (HL7) version 2.5 standards messaging for transferring Encounter record in bulk upload standards from trusted healthcare providers to eHR system.

There are TWO data exchange standards for uploading clinical records to eHR system:

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

HL7-HK Localised Bulk Load Standards will be described in detail in this document. For the HL7-HK Message Standards, please refer to 'Technical Interface Specification for eHR Record'.

1.2 INTENDED READERS

This document is intended for all parties involving the interface development of eHR in Hong Kong.

2 SCOPE

This reference defines the interface format, interface name for different upload mode and the message of the HL7 version 2.5 messaging. Specifically, this document contains:

- Data File Naming Convention
- Data File Content with delimiter
- Data definition and mapping

The Encounter data requirements defined in this document are for appointment, admission and discharge records.

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 interpretation and guidance to which HL7 trigger event and data elements are required for interfacing to eHR system.

For details of scenarios, please refer to Data Requirement Specification for Encounter Record.

3 REFERENCES

- Data Interface Requirement Document
  - Data Requirement Specification for eHR Encounter Record
  - Communication Protocol Specification

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

4 DEFINITIONS AND CONVENTIONS

4.1 ABBREVIATIONS

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

4.2 NOTATIONS

Value	Description
"quoted"	Fixed Value
#	HL7 Mandatory Field
N/A	Not Applicable
SCN1 - SCN99	Scenario numbering
RP/#	Repeatable Indicator [Y:Yes N: No] of HL7 element
TBL#	HL7 Table Reference Number
[ ]	Optional
{ }	Repeatable
YYYY	Year
MM	Month
DD	Day
hh	Hour (24-Hour)
mm	Minute
ss	Second
.sss	Millisecond

5 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.

6 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.

7 DATA UPLOAD REQUIREMENTS

7.1 TYPES OF FILE UPLOAD MODE

There are two types of file upload mode: incremental mode and materialisation mode

1. **Incremental batch mode** is the format for HCP to upload sharable data in ONE batch.
2. **Materialisation mode** is the format for HCP to upload a HCR's specific sharable dataset that exists in EMR, e.g. new registered HCR and re-registered HCR.

The following table shows the files required for different upload mode and its schedule:

	HCR List File	**Data File**	**Schedule**
Incremental Mode	Required	Required	Within agreed period
Materialisation Mode	Required	Required	Within agreed period

Remarks:
For Materialisation Mode, 'Update' and 'Delete' transaction types are not accepted. If 'Update' or 'Delete' transaction type is uploaded using materialisation mode, the record will be rejected by eHR.

7.2 SHARABLE DATASET CODE

Sharable dataset code is a standardised short term to distinguish the sharable dataset. Please refer to the Interoperability Guide for details in eHR Office website.

For Encounter Record, the sharable dataset code is "**ENCTR"**.

7.3 COMPLIANCE LEVEL

eHR partner's applications must be certified for three levels of inter-operability: data inter-operability, security compliance and system inter-operability. Data inter-operability will focus on the EMR system's capability to send and receive messages in the defined standards.

A partner's systems will be certified as a compliance level, according to the message structure, format, content and coding validity for the type of message. Only the certified types of interfaces of partner's systems are permitted for on-going information exchange with the eHR Core.

The general definition of data compliance level is explained in Content Guidebook in eHR Office website.

7.4 MESSAGE COMPONENTS

There are three main data file types used to carry the clinical information of 'Encounter' domain:

File Type	Usage
HL7 Message (ORU^R01)	It serves as delivery list which records the list of file names of 'HCR list' and 'Structured Data File'.
HCR list	It contains the HCR identity of those HCRs whose clinical data records are updated and already included in the 'Structured Data File'.
Structured Data File	It contains the eHR required data fields defined in the 'Data Requirement Specification for eHR Encounter Record'. The data mapping format must follow the requirements described in this document.

The details of the above file types will be further explained in subsequent sections.

8 HL7 MESSAGE

HL7 message 'ORU^R01' will be applied in exchanging of eHR clinical records. In the segment of OBX of 'ORU^R01', OBX.4 in HL7 message is used to indicate the file upload mode, whether it is in incremental and materialisation.

- The major components are used to carry the bulk clinical information when exchanging data in HL7 v2.5 standard. The components are:

  - HL7 version 2.5 ORU – Unsolicited Observation Message (Event R01):

  ORU^R01 event includes 3 mandatory segments
    - MSH – Message Header Segment
    - OBR – Observation Request Segment
    - OBX – Observation related to OBRs

  - The file upload mode will be assigned to the fourth field of OBX. For the <OBX.4> tag, the fields can either be "BL" and "BL-M" which represents whether it is in incremental or materialisation. For the data mapping of OBX in HL7 message, please refer to *Section 8.4.3 - OBX - Observation/Result Segment*.

  - The batch file name will be assigned to the <OBX.5> tag. The detail will be described in following section.

  - XML digital signature:

  In order to ensure the integrity, reputation and authenticity of the message exchange, a XML digital signature is required to digitally sign the whole HL7 document. The eHR system will not accept messages that are not digitally signed.

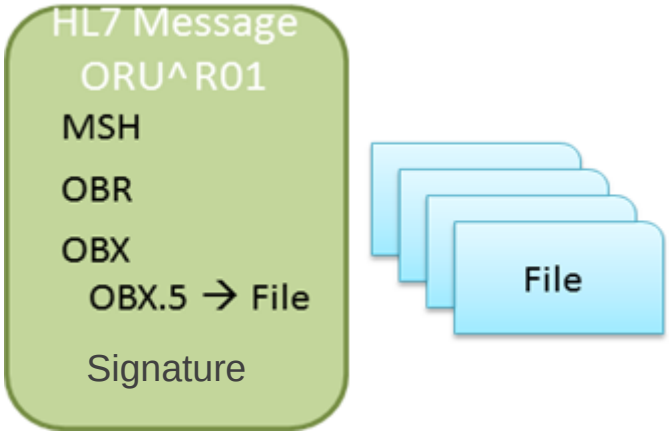

Figure 1 describes the overview structure of BLS in HL7 standards.
(Please refer to HL7 official website for HL7 standards details.)

8.1 FILE NAME

The naming convention of the file which is carrying the HL7 message is specified as below:

Format

With Sending Location Code,

<HCP ID>.<Sending Location code>.<Record Type>.HL7.<Message Control ID>

Example
e.g. 8088450656.BRANCHA.ENCTR.HL7.20110701230000

Naming Convention

1. The file name should be in capital letters.
2. The value of each file name component should not contain dot "."
3. Message Control ID refers to the value MSH.10.
4. If the **<*Sending Location code*>** cannot be provided, its value can be set as same as **<*HCP ID*>**.
5. The value of the **<*Sending Location code*>** can be in any combination of alphanumeric characters i.e. [A-Z][0-9][-_]

8.2 CHARACTER SET AND ENCODING

A Unicode Transformation Format (UTF) is an algorithmic mapping from every Unicode code point to a unique byte sequence. Among the several UTF scheme, UTF-8 is the most common Unicode encoding used and it has become the main storage encoding on most Unix-like operating systems since it is a relatively easy replacement of traditional extended ASCII character sets.

Therefore, UTF-8 will be used in eHR Clinical Data Sharing data exchange. HCP is required to ensure the file that sent to eHR should use UTF-8 encoding.

8.3 XML PREDEFINED ENTITIES

Extensible Markup Language (XML) is adopted in eHR Clinical Data Sharing data exchange using HL7 messages. The XML specification defines five "predefined entities" representing special characters, and requires that all XML processors honor them. To render the character, the format `&name;` must be used. For example, `&` renders as the character `&` . The table below lists the 5 predefined entities in XML:

Name	Character	Entity Reference	Description
Gt	>	>	Greater than
Lt	<	<	Less than
Amp	&	&	Ampersand
Apos	‘	'	Apostrophe
Quot	“	"	Quotation mark

The prefix of namespace in XML in HL7 message is not expected.

8.4 DATA MAPPING

8.4.1 MSH - Message Header Segment

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
#<MSH.1>	1	ST			Field Separator	"|"	Fixed value
#<MSH.2>	4	ST			Encoding Characters	"^~\&"	Fixed value
<MSH.3> <HD.1>	227	HD		0361	Sending Application Namespace ID	System Version	HCP's system name and version for data exchange
<MSH.4> <HD.1>	227	HD		0362	Sending Facility Namespace ID	Healthcare provider identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution for participation in eHR Sharing System
<MSH.5> <HD.1>	227	HD		0361	Receiving Application Namespace ID	"EIF"	Fixed value
<MSH.6> <HD.1>	227	HD		0362	Receiving Facility Namespace ID	"eHR"	Fixed value

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
#<MSH.7> <TS.1>	26	TS DTM			Date/Time Of Message Time	Message generation datetime	In format: YYYYMMDDhhmmss
<MSH.8>	40	ST			Security	"3"	Data Compliance Level Fixed value **3**: Level 3
#<MSH.9> <MSG.1> <MSG.2> <MSG.3>	15	MSG			Message Type Message Type Trigger Event Message Structure	 "ORU" "R01" "ORU_R01"	 Fixed value Fixed value Fixed value
#<MSH.10>	20	ST			Message Control ID	Unique message identifier in sending application	Values can be in any combination of alphanumeric characters i.e. [A-Z][0-9][-_]
#<MSH. 11> <PT. 1>	3	PT			Processing ID Processing ID	"P"	Fixed value **P**: Production
#<MSH .12> <VID .1>	60	VID			Version ID Version ID	"2.5"	Fixed value
<MSH .13>	15	NM			Sequence Number	NOT USE	
<MSH .14>	180	ST			Continuation Pointer	NOT USE	

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<MSH .15>	2	ID		0155	Accept Acknowledgment Type	"NE"	Fixed value **NE**: Never
<MSH .16>	2	ID		0155	Application Acknowledgment Type	NOT USE	
<MSH .17>	3	ID		0399	Country Code	NOT USE	
<MSH .18>	16	ID	Y	0211	Character Set	NOT USE	
<MSH .19>	250	CE			Principal Language Of Message	NOT USE	
<MSH .20>	20	ID		0356	Alternate Character Set Handling Scheme	NOT USE	
<MSH .21>	427	EI	Y		Message Profile Identity	NOT USE	

8.4.2 OBR - Observation Request Segment

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBR.1>	4	SI			Set ID – OBR	NOT USE	
<OBR.2>	22	EI			Placer Order Number	NOT USE	
<OBR.3>	22	EI			Filler Order Number	NOT USE	
#<OBR.4> <CE.1>	250	CE			Universal Service Identifier Identifier	"ENCTR"	Fixed value Sharable Dataset Code (eHR Record Type)
<OBR.5>	2	ID			Priority – OBR	NOT USE	
<OBR.6>	26	TS			Requested Date/Time	NOT USE	
<OBR.7>	26	TS			Observation Date/Time #	NOT USE	
<OBR.8>	26	TS			Observation End Date/Time #	NOT USE	

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBR.9>	20	CQ			Collection Volume *	NOT USE	
<OBR .10>	250	XCN	Y		Collector Identifier *	NOT USE	
<OBR. 11>	1	ID		0065	Specimen Action Code *	NOT USE	
<OBR .12>	250	CE			Danger Code	NOT USE	
<OBR .13>	300	ST			Relevant Clinical Information	NOT USE	
<OBR .14>	26	TS			Specimen Received Date/Time *	NOT USE	
<OBR .15>	300	SPS			Specimen Source	NOT USE	
<OBR .16>	250	XCN	Y		Ordering Provider	NOT USE	
<OBR .17>	250	XTN	Y/2		Order Callback Phone	NOT USE	
<OBR .18>	60	ST			Placer Field 1	NOT USE	
<OBR .19>	60	ST			Placer Field 2	NOT USE	
<OBR .20>	60	ST			Filler Field 1 +	NOT USE	
<OBR .21>	60	ST			Filler Field 2 +	NOT USE	
<OBR .22>	26	TS			Results Rpt/Status Chng –	NOT USE	
<OBR .23>	40	MOC			Charge to Practice +	NOT USE	
<OBR .24>	10	ID		0074	Diagnostic Serv Sect ID	NOT USE	
<OBR .25>	1	ID		0123	Result Status +	NOT USE	
<OBR .26>	400	PRL			Parent Result +	NOT USE	
<OBR .27>	200	TQ	Y		Quantity/Timing	NOT USE	
<OBR .28>	250	XCN	Y		Result Copies To	NOT USE	
<OBR .29>	200	EIP			Parent	NOT USE	
<OBR .30>	20	ID		0124	Transportation Mode	NOT USE	
<OBR .31>	250	CE	Y		Reason for Study	NOT USE	
<OBR .32>	200	NDL			Principal Result Interpreter +	NOT USE	
<OBR .33>	200	NDL	Y		Assistant Result Interpreter +	NOT USE	
<OBR .34>	200	NDL	Y		Technician +	NOT USE	
<OBR .35>	200	NDL	Y		Transcriptionist +	NOT USE	

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBR .36>	26	TS			Scheduled Date/Time +	NOT USE	
<OBR .37>	4	NM			Number of Sample Containers *	NOT USE	
<OBR .38>	250	CE	Y		Transport Logistics of Collected Sample *	NOT USE	
<OBR .39>	250	CE	Y		Collector's Comment *	NOT USE	
<OBR .40>	250	CE			Transport Arrangement Responsibility	NOT USE	
<OBR .41>	30	ID		0224	Transport Arranged	NOT USE	
<OBR .42>	1	ID		0225	Escort Required	NOT USE	
<OBR .43>	250	CE	Y		Planned Patient Transport Comment	NOT USE	
<OBR .44>	250	CE		0088	Procedure Code	NOT USE	
<OBR .45>	250	CE	Y	0340	Procedure Code Modifier	NOT USE	
<OBR .46>	250	CE	Y	0411	Placer Supplemental Service Information	NOT USE	
<OBR .47>	250	CE	Y	0411	Filler Supplemental Service Information	NOT USE	
<OBR .48>	250	CWE		0476	Medically Necessary Duplicate Procedure Reason	NOT USE	
<OBR .49>	2	IS		0507	Result Handling	NOT USE	

8.4.3 OBX - Observation/Result Segment

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBX.1>	4	SI			Set ID – OBX	NOT USE	
<OBX.2>	2	ID		0125	Value Type	“RP”	Fixed value **RP**: Reference Pointer

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
# <OBX.3> <CE.1>	250	CE			Observation Identifier Identifier	"ENCTR"	Fixed value Sharable Dataset Code (eHR Record Type)
<OBX.4>	20	ST			Observation Sub-Id	e.g. BL	Possible value of data upload format: **BL**: Bulk load; **BL-M**: Bulk load for materialisation *Remarks:* ***Materialisation*** - HCP upload a HCR's specific sharable dataset that exists in EMR.

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBX.5> <RP.1>	99999	Varies	Y		Observation Value Data	Filename of the batch file:checksum (Please refer to Section 10 – File Name Samples for examples of filename)	Colon ":" is used as field delimiter. Filename of three types of files will be included: - HCR list file - Structured data file For filename of the batch file, please see the file format in the related section. Repeat OBX.5 if more than one batch file. For data file checksum value, the checksum algorithm will use SHA-256. For SHA standard document, please refer to "Secure Hash Standard (SHS) of Federal Information Processing Standards Publication" provided by Information Technology Laboratory of National Institute of Standards and Technology in Gaithersburg (MD 20899-8900)
<OBX.6>	250	CE			Units	NOT USE	

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBX.7>	60	ST			References Range	NOT USE	
<OBX.8>	5	IS	Y	0078	Abnormal Flags	NOT USE	
<OBX.9>	5	NM			Probability	NOT USE	
<OBX .10>	2	ID	Y	0080	Nature of Abnormal Test	NOT USE	
#<OBX. 11>	1	ID		0085	Observation Result Status	"F"	Fixed value **F**: Final Result
<OBX .12>	26	TS			Effective Date of Reference Range	NOT USE	
<OBX .13>	20	ST			User Defined Access Checks	NOT USE	
<OBX .14>	26	TS			Date/Time of the Observation	NOT USE	
<OBX .15>	250	CE			Producer's ID	NOT USE	
<OBX .16>	250	XCN	Y		Responsible Observer	NOT USE	
<OBX .17>	250	CE	Y		Observation Method	NOT USE	
<OBX .18>	22	EI	Y		Equipment Instance Identifier	NOT USE	
<OBX .19>	26	TS			Date/Time of the Analysis	NOT USE	

8.5 HL7 MESSAGE SAMPLE

The following HL7 sample in XML format shows data materialisation case:

```
<?xml version="1.0" encoding="UTF-8"?>
<ORU_R01 xsi:schemaLocation="urn:hl7-org:v2xml ORU_R01.xsd"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance" xmlns="urn:hl7-
org:v2xml">
      <MSH>
            <MSH.1>|</MSH.1>
            <MSH.2>^~\&amp;amp;</MSH.2>
            <MSH.3>
                  <HD.1>CMS 3.0</HD.1>
            </MSH.3>
            <MSH.4>
                  <HD.1>8088450656</HD.1>
            </MSH.4>
            <MSH.5>
                  <HD.1>EIF</HD.1>
            </MSH.5>
            <MSH.6>
                  <HD.1>eHR</HD.1>
            </MSH.6>
            <MSH.7>
                  <TS.1>20120301230001</TS.1>
            </MSH.7>
            <MSH.8>3</MSH.8>
            <MSH.9>
                  <MSG.1>ORU</MSG.1>
                  <MSG.2>R01</MSG.2>
                  <MSG.3>ORU_R01</MSG.3>
            </MSH.9>
            <MSH.10>20120301230001</MSH.10>
            <MSH.11>
                  <PT.1>P</PT.1>
            </MSH.11>
            <MSH.12>
                  <VID.1>2.5</VID.1>
            </MSH.12>
            <MSH.15>NE</MSH.15>
      </MSH>
      <ORU_R01.PATIENT_RESULT>
            <ORU_R01.ORDER_OBSERVATION>
                  <OBR>
                        <OBR.4>
                              <CE.1>ENCTR</CE.1>
                        </OBR.4>
                  </OBR>
                  <ORU_R01.OBSERVATION>
                        <OBX>
                              <OBX.2>RP</OBX.2>
                              <OBX.3>
                                    <CE.1>ENCTR</CE.1>
                              </OBX.3>
                              <OBX.4>BL</OBX.4>
                              <OBX.5>
                                    <RP.1>
      8088450656.BRANCHA.ENCTR.DF.1.20110101020600:332be2c46e1a0a632610e8bf
63bde57851374c583aaf84b3769d7eb2d67f8bcc2b0c356c4972aa49c444860c3e00104b50d
```



```
24907b86a6e3c6927e61bd3ecfc24
                                    </RP.1>
                                </OBX.5>
                                <OBX.5>
                                    <RP.1>
      8088450656.BRANCHA.ENCTR.PL.1.20110101020600:dba2a0463da72f264677ba6e
83fb8eecdce1454e17cea6ec5dcf41a11f1a94e28bbbabbb11e3441de0da7ea741cb175527f
ff41558062c9f0691c7c463a186b6
                                    </RP.1>
                                </OBX.5>
                                <OBX.11>F</OBX.11>
                            </OBX>
                    </ORU_R01.OBSERVATION>
            </ORU_R01.ORDER_OBSERVATION>
      </ORU_R01.PATIENT_RESULT>
</ORU_R01>
```


8.6 XML DIGITAL SIGNATURE ON HL7

XML digital signature is required the components of XML digital signature are listed below:

No.	XML Tag	XPath	Attribute	Element Name	Mandatory (M) / Optional(O)	Remarks
1	Signature	Signature		Signature	M	Sign the HL7 message *(Please refer to "XML Signature Syntax and Processing (Second Edition)" provided by W3C Recommendation 10 June 2008)*
			@xmlns		M	Fixed Value: "http://www.w3.org/2000/09/xmldsig#"
2	SignedInfo	Signature/SignedInfo		Signed Information	M	
2.1	CanonicalizationMethod	Signature/SignedInfo/ CanonicalizationMethod		Canonicalization Method	M	
			@Algorithm	Algorithm	M	Fixed Value: "http://www.w3.org/TR/2001/REC-xml-c14n-20010315"
2.2	SignatureMethod	Signature/SignedInfo/ SignatureMethod		Signature Method	M	
			@Algorithm	Algorithm	M	Fixed Value: "http://www.w3.org/2001/04/xmldsig-more#rsa-sha256"

No.	XML Tag	XPath	Attribute	Element Name	Mandatory (M) / Optional(O)	Remarks
2.3	Reference	Signature/SignedInfo/ Reference		Reference element for the whole HL7 document	M	
			@ URI	URI	M	Fixed Value: “” *(Empty String)*. Apply the signature to the whole HL7 document
2.3.1	Transforms	Signature/SignedInfo/ Reference/Transforms		Transforms	M	
2.3.1.1	Transform	Signature/SignedInfo/ Reference/Transforms/ Transform		Transform	M	
			@Algorithm	Algorithm	M	Fixed Value: “http://www.w3.org/2000/09/xmldsig#enveloped-signature”
2.3.2	DigestMethod	Signature/SignedInfo/ Reference/DigestMethod			M	
			@Algorithm	Algorithm	M	Fixed Value: “http://www.w3.org/2001/04/xmlenc#sha256”
2.3.3	DigestValue	Signature/SignedInfo/ Reference/DigestValue		Digest Value	M	Message’s Digest Value

No.	XML Tag	XPath	Attribute	Element Name	Mandatory (M) / Optional(O)	Remarks
3	SignatureValue	Signature/SignatureValue		Signature value	M	Canonicalize and then calculate the SignatureValue over SignedInfo based on algorithms specified in SignedInfo as specified in XML Signature [XMLDSIG]
4	KeyInfo	Signature/KeyInfo		Key Info	M	
4.1	X509Data	Signature/KeyInfo/ X509Data		X509 Data	M	
4.1.1	X509SubjectName	Signature/KeyInfo/ X509Data/ X509SubjectName		X509 Subject Name	M	Distinguished name (DN) that contains the information for both the owner or requestor of the certificate (called the Subject DN) and the CA that issues the certificate (called the Issuer DN)
4.1.2	X509Certificate	Signature/KeyInfo/ X509Data/ X509Certificate		Certificate	M	base64-encoded [X509v3] certificate *(Please refer to the content of X509Data in "XML Signature Syntax and Processing (Second Edition)" provided by W3C Recommendation 10 June 2008)*

Example

```
<?xml version="1.0" encoding="UTF-8"?>
<ORU_R01 xmlns="..." xmlns:xsi="..." xsi:schemaLocation="...">
  <MSH>...</MSH>
  <ORU_R01.PATIENT_RESULT>
    <ORU_R01.ORDER_OBSERVATION>
      <OBR>...      </OBR>
      <ORU_R01.OBSERVATION>
        <OBX>... </OBX>
      </ORU_R01.OBSERVATION>
    </ORU_R01.ORDER_OBSERVATION>
  </ORU_R01.PATIENT_RESULT>
  <Signature xmlns="http://www.w3.org/2000/09/xmldsig#">
    <SignedInfo>
      <CanonicalizationMethod Algorithm="http://www.w3.org/TR/2001/REC-xml-c14n-20010315"/>
      <SignatureMethod Algorithm="http://www.w3.org/2001/04/xmldsig-more#rsa-sha256"/>
      <Reference URI="">
        <Transforms>
          <Transform Algorithm="http://www.w3.org/2000/09/xmldsig#enveloped-signature"/>
        </Transforms>
        <DigestMethod Algorithm="http://www.w3.org/2001/04/xmlenc#sha256"/>
        <DigestValue>xxxxx</DigestValue>
      </Reference>
    </SignedInfo>
    <SignatureValue>xxxxxxxxxx</SignatureValue>
    <KeyInfo>
      <X509Data>
        <X509SubjectName>xxxxx</X509SubjectName>
        <X509Certificate>xxxxxxxxxx</X509Certificate>
      </X509Data>
    </KeyInfo>
  </Signature>
</ORU_R01>
```

XML Digital Signature

9 HEALTHCARE RECEIPIENT LIST

When HCP upload the sharable data to eHR, it is assumed that a daily HCR identity list will be sent **for each sharable dataset** in advance. The HCR identity list consists of the HCR identity of those HCRs who have clinical data records changes.

There are four major keys: Document ID with Document Type, English Name, Sex and Date of Birth of the HCR which are mandatory. They are used to refer to information that can be uniquely identified as an individual. Therefore, four major keys are needed to verify and match the eHR number which is assigned to HCR when one registered to eHR program during the data upload and verification processing.

A HCR list file is required which contains the four major keys and eHR number for every data batch upload. To standardise the HCR list, the file name, content and trailer should be strictly controlled. Besides, the size of the file should not exceed to the maximum upload file size according to eHR Localised Bulk Load Standard Specification. The data file should be split into smaller files within the file size limit and Sequence ID could be used to specify each smaller file.

9.1 FILE NAME

The naming convention of the file which is carrying the HCR List is specified as below:

Format

With Sending Location Code,

<HCP ID>.<Sending Location Code>.<Record Type>.PL.<Sequence ID>.<Generation Date>

Example

e.g. 8088450656.BRANCHA.ENCTR.PL.1.20110702084530

Naming Convention

1. The file name should be in capital letters.
2. Generation date provided in the file name should be in YYYYMMDDhhmmss format (YYYY:year; MM:month; DD:day; hh:hour; mm:minute; ss:second).
3. The value of each file name component should not contain dot “.”
4. If the ***<Sending Location Code>*** cannot be provided, its value can be set as same as ***<HCP ID>***.
5. The value of the ***<Sending Location Code>*** can be in any combination of alphanumeric characters i.e. [A-Z][0-9][-_]

The following table shows the components of file name and the respective definitions:

Sequence	Component	Definition	Maximum Length	Remarks
1	HCP ID	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution for participation in eHR Sharing System	string(10)	
2	Sending Location Code	An code to indicate the location where the data is sending from. The format should be agreed before the interface is on production.	string(20)	
3	Record Type	A standardised short term to distinguish the sharable dataset	string(20)	e.g. ENCTR stands for Encounter Record
4	PL	HCR List	string(2)	Fixed value
5	Sequence ID	Sequence of the file generated in the same generation date	string(3)	• In format: Numeric: 1-999
6	Generation Date	File generation date	string(14)	In format: YYYYMMDDhhmmss

9.2 FILE CONTENT

Format

```
<eHR Number>|<Sex>|<Date of Birth>|<HKIC Number>|<Type of Identity
Document>|<Identity Document Number>|<English Surname>|<English
Given Name>|<English Full Name>\CR\
<eHR Number>|<Sex>|<Date of Birth>|<HKIC Number>|<Type of Identity
Document>|<Identity Document Number>|<English Surname>|<English
Given Name>|<English Full Name>\CR\
EOF.<#Total Number of HCRs>.<File Name of HCR List>
```

Naming Convention

For file content,

1. Each record should be on a new line. \CR\ should be used as record terminator.
2. Pipe line "|" should be used as field delimiter. If data content contains pipe line, pipe line should be replaced by \F\ before sending to eHR.
3. A trailer is required at the bottom of each data file. The convention is explained in the next paragraph.

For file trailer,

1. A trailer is required at the bottom of each file.
2. Dot "." should be used as field delimiter.
3. Generation date provided in the file name should be in YYYYMMDDhhmmss format (YYYY:year; MM:month; DD:day; hh:hour; mm:minute; ss:second).

The following table shows the components of file content and trailer and the respective definitions:

Sequence	Data Field	Definition	Maximum Length	Remarks
File Content				
1	eHR number	A unique eHR healthcare recipient identifier assigned to each patient for each participation in the Hong Kong eHR	string(12)	Fixed length
2	Sex	[eHR value] of the "Sex" code table. It is used to identify the sex of the patient.	string(1)	Refer to the code set of "Sex" in eHR Office website

Sequence	Data Field	Definition	Maximum Length	Remarks
3	Date of birth	The patient's date of birth	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss Milliseconds should be in ".000" format E.g. 2010-01-31 00:00:00.000 (Birth time is not required.) Remarks: • If date is exact to 'Year' (e.g. 2010), the unknown month and day is suggested to be set as '01-01' E.g. 2010-**01-01** 00:00:00.000 • If date is exact to 'Month'(e.g. 2010-12), the unknown day is suggested to be set as '01' E.g. 2010-12-**01** 00:00:00.000
4	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)	
5	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)	Refer to the code set of "Type of identity document" in eHR Office website
6	Identity document number	The document number of the [Type of identity document - patient]	string(30)	

Sequence	Data Field	Definition	Maximum Length	Remarks
7	English surname	Patient's surname in English	string(40)	Surname should be in uppercase letters. Optional if [full name] is not blank Mandatory if [full name] is blank
8	English given name	Patient's given name in English	string(40)	Given name should be in uppercase letters. Optional if [full name] is not blank Mandatory if [full name] is blank
9	English full name	Patient's full name in English	string(100)	Full name should be in uppercase letters. In format: [Surname]+[,]+ 1 white space +[Given Name] e.g CHAN, TAI MAN Optional if [English surname] and [English given name] are not blank Mandatory 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.*
File Trailer				
1	EOF	File trailer indicator	string(3)	Fixed value
2	Total number of HCRs	Total number of records in this batch being processed excluding the trailer	string(10)	Numeric value: 0-9999999999
3	File name of HCR list	File name of HCR list	string(83)	Please refer to Section 9.1 - File Name for naming convention of HCR list file name

Example

The following is a sample file of HCR list:

```
201000000001|M|2009-01-01 00:00:00.000|A1234563|ID|A1234563|CHAN|
TAI MAN|CHAN, TAI MAN\CR\
201000000002|F|2001-01-01 00:00:00.000|A7654321|OC|10234567890|LEE|
HO|LEE, HO\CR\
EOF.2.8088450656.BRANCHA.ENCTR.PL.1.20110702084530
```


10 STRUCTURED DATA FILE

Data loading will use a standardised file naming convention, data content and the trailer. With the standardised format, it takes less time and is easier to interpret the data.

For details of the implementation requirements for transferring clinical records, please refer the 'Communication Protocol Specification'.

10.1 FILE NAME

The naming convention of the file which is carrying the Structured Data File is specified as below:

Format

With Sending Location Code,

<HCP ID>.<Sending Location code>.<Record Type>.DF.<sequence ID>.<Generation Date>

Example

e.g. 8088450656.BRANCHA.ENCTR.DF.1.20110702084530

Naming Convention

1. The file name should be in capital letters.
2. Generation date provided in the file name should be in YYYYMMDDhhmmss format (YYYY:year; MM:month; DD:day; hh:hour; mm:minute; ss:second).
3. The value of each file name component should not contain dot "."
4. If the ***<Sending Location code>*** cannot be provided, its value can be set as same as ***<HCP ID>***.
5. The value of the ***<Sending Location code>*** can be in any combination of alphanumeric characters i.e. [A-Z][0-9][-_]

The following table shows the components of file name and the respective definitions:

Sequence	Component	Definition	Maximum Length	Remarks
1	HCP ID	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution for participation in eHR Sharing System	string(10)	
2	Sending Location Code	An code to indicate the location where the data is sending from. The format should be agreed before the interface is on production.	string(20)	
3	Record Type	A standardised short term to distinguish the sharable dataset	string(20)	e.g. ENCTR stands for Encounter Record
4	DF	Data File	string(2)	Fixed value
5	Sequence ID	Sequence of the file generated in the same generation date	string(3)	In format: Numeric: 1-999
6	Generation Date	File generation date	string(14)	In format: YYYYMMDDhhmmss

10.2 FILE CONTENT

Format

```
<eHR Number>|<Record Key>|<Transaction Datetime>|<Transaction Type>|field
1|field 2|field 3|…|field n\CR\
<eHR Number>|<Record Key>|<Transaction Datetime>|<Transaction Type>|field
1|field 2|field 3|…|field n\CR\
EOF.<#Total Number of Records>.<File Name of Data File>
```

Naming Convention

For file content,

1. Each record should be on a new line. \CR\ should be used as record terminator.
2. Pipe line "|" should be used as field delimiter. If data content contains pipe line, pipe line should be replaced by \F\ before sending to eHR.
3. A trailer is required at the bottom of each data file. The convention is explained in the next paragraph.

For file trailer,

1. A trailer is required at the bottom of each file.
2. Dot "." should be used as field delimiter.
3. Generation date provided in the file name should be in YYYYMMDDhhmmss format (YYYY:year; MM:month; DD:day; hh:hour; mm:minute; ss:second).

Data Component

This section describes the components of file content and trailer and the cardinality for each scenario:

Scenario summary

Scenario No.	Description
SCN1	Create appointment for inpatient
SCN2	Create appointment for outpatient
SCN3	Create appointment for other encounter type
SCN4	Update appointment for inpatient
SCN5	Update appointment for outpatient
SCN6	Update appointment for other encounter type
SCN7	Cancel appointment for inpatient
SCN8	Cancel appointment for outpatient
SCN9	Cancel appointment for other encounter type
SCN10	Create admission for inpatient
SCN11	Create admission for A&E patient
SCN12	Create attendance for outpatient
SCN13	Create attendance for other encounter type
SCN14	Update admission for inpatient
SCN15	Update admission for A&E patient
SCN16	Update attendance for outpatient
SCN17	Update attendance for other encounter type
SCN18	Cancel admission for inpatient
SCN19	Cancel admission for A&E patient
SCN20	Cancel attendance for outpatient
SCN21	Cancel attendance for other encounter type
SCN22	Discharge of inpatient
SCN23	Discharge of A&E patient
SCN24	Cancel discharge of inpatient
SCN25	Cancel discharge of A&E patient

Data components required in different scenarios:

10.2.1 Appointment transaction data component

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
File Content												
1	eHR number	A unique eHR healthcare recipient identifier assigned to each patient for each participation in the Hong Kong eHR	string(12)	Fixed length	M	M	M	M	M	M	M	M
2	Record key	A unique identifier for each encounter record within HCP	string(50)	Same record key should be used for same episode	M	M	M	M	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
3	Transaction datetime	The datetime indicates the transaction sequence	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	M	M	M	M	M	M	M	M
4	Transaction type	Insert/Update/Delete	string(1)	Possible value: **I**: Insert operation - Applied when the record identified by HCP's [Record Key] has not been submitted to eHR before	M	M	M	M	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
				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								

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
				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.***							

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
5	Last update datetime	The last update datetime for HCP system	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	M	M	M	M	M	M	M	M
6	Transaction profile type	The event type indicates the objective of the message	string(10)	Refer to the code table 'Transaction profile type' in *Section 12.1 - Transaction profile type*	M Fixed value: "APP-IP"	M Fixed value: "APP-IP"	M Fixed value: "APP-OP"	M Fixed value: "APP-OP"	M Fixed value: "APP-OP-EP"	M Fixed value: "APP-OP-EP"	M Fixed value: "APP-OTH"	M Fixed value: "APP-OTH"

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
7	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)		O	O	N/A	N/A	M	M	O	O
8	Attendance institution identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution for participant attendance	string(10)		O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
9	Encounter healthcare provider identifier	[Healthcare provider identifier] in the Healthcare Provider Index for the healthcare provider who created the encounter	string(10)	Fixed length	M	M	M	M	M	M	M	M
10	Encounter healthcare institution identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution who created the encounter	string(10)	Fixed length	M	M	M	M	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
11	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)	Refer to the code set of "Encounter Type" in eHR Office website	M Fixed value "I" is expected	M Fixed value "I" is expected	M Fixed value "O" / "T" is expected	M Fixed value "O" / "T" is expected	M Fixed value "O" / "T" is expected	M Fixed value "O" / "T" is expected	M Fixed value "H" is expected	M Fixed value "H" is expected

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
12	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)	• Refer to the code set of "Service Type" in eHR Office website • Required only for Encounter type = 'O' / 'T' / 'H' • If Encounter type = 'H', Service type must NOT be = 'OPD', 'GOPD', or 'SOPD'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
13	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/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
14	Appointment number	A unique reference number assigned by the healthcare institution to an appointment (a scheduled encounter)	string(20)		M	M	M	M	M	M	M	M
15	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)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	M	M	N/A	N/A	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
16	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)	• Refer to the code set of "Urgency" in eHR Office website • 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	O	N/A	N/A	N/A	N/A	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
17	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)	Refer to the code set of “Specialty” in eHR Office website	O	O	N/A	N/A	O	O	O	O
18	Episode start specialty remarks	Details on specialty of the patient upon commencement of an episode	string(255)		O	O	N/A	N/A	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
19	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)	Refer to the code set of “Attendance Indicator” in eHR Office website	O	O	N/A	N/A	N/A	N/A	O	O
20	Episode end datetime	The date and time when the episode of care was ended	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	N/A	N/A	N/A	N/A	N/A	N/A	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
21	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)	Refer to the code set of “Specialty” in eHR Office website	N/A	N/A	N/A	N/A	N/A	N/A	O	O
22	Episode end specialty remarks	Details on specialty of the patient upon completion of an episode.	string(255)		N/A	N/A	N/A	N/A	N/A	N/A	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
23	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)	Refer to the code set of "Yes No Unspecified" in eHR Office website	N/A	N/A	N/A	N/A	N/A	N/A	O	O
24	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)	Refer to the code set of "Discharge Type" in eHR Office website	N/A	N/A	N/A	N/A	N/A	N/A	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
25	Discharge-to-institution identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution where the patient was discharged to	string(10)	Fixed length	N/A	N/A	N/A	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

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
26	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/A	N/A	N/A	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

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
27	Discharge-to-institution local name	Local description of the healthcare institution where the patient was discharged to	string(255)		N/A	N/A	N/A	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
28	Discharge healthcare professional identifier	eHR identifier of the healthcare professional who discharged the patient	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
29	Discharge healthcare professional name prefix	English name prefix of the healthcare professional who discharged the episode	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
30	Discharge healthcare professional English name	English full name of the healthcare professional who discharged the episode	string(100)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
31	Discharge healthcare professional English given name	English given name of the healthcare professional who discharged the episode	string(40)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
32	Discharge healthcare professional Chinese name	Chinese full name of the healthcare professional who discharged the episode	string(10)	• Maximum 10 Chinese characters • Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
33	Discharge healthcare professional Chinese name suffix	Chinese name suffix of the healthcare professional who discharged the episode	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
34	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/A	N/A	O	O	O	O	O	O
35	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)	Fixed Length	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	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

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
36	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/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	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

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
37	Visit clinic local name	Local description of the healthcare institution where the patient received / will receive healthcare services	string(255)		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	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
38	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)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	N/A	N/A	M	M	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
39	Visit urgency	[eHR value] of the "Urgency" code table. [Visit urgency] refers to the urgency of the care of the visit.	string(1)	• Refer to the code set of "Urgency" in eHR Office website • 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	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
40	Visit specialty	[eHR value] of the "Specialty" code table. [Visit specialty] refers to the specialty for the visit.	string(10)	Refer to the code set of “Specialty” in eHR Office website	N/A	N/A	O	O	O	O	O	O
41	Visit specialty remarks	Details on specialty of the patient for the visit	string(255)		N/A	N/A	O	O	O	O	O	O
42	Visit attendance indicator	[eHR value] of the "Attendance indicator" code table. [Visit attendance indicator] is an indicator to identify whether the visit has been attended.	string(1)	Refer to the code set of “Attendance Indicator” in eHR Office website	N/A	N/A	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
43	Attending healthcare professional identifier	eHR identifier of the healthcare professional who attended the visit	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
44	Attending healthcare professional name prefix	English name prefix of the healthcare professional who attended the visit	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
45	Attending healthcare professional English name	English full name of the healthcare professional who attended the visit	string(100)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
46	Attending healthcare professional English given name	English given name of the healthcare professional who attended the visit	string(40)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
47	Attending healthcare professional Chinese name	Chinese full name of the healthcare professional who attended the visit	string(10)	• Maximum 10 Chinese characters • Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
48	Attending healthcare professional Chinese name suffix	Chinese name suffix of the healthcare professional who attended the visit	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
49	Referral number	A unique number issued by the healthcare institution for each referral	string(20)		O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
50	Refer-from-institution identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution where the patient is referred from	string(10)	Fixed length	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	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

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
51	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)		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	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

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
52	Refer-from-institution local name	Local description of the healthcare institution where the patient is referred from	string(255)		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	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
53	Refer-from-healthcare professional English name	Full English name with prefix of the healthcare professional who referred the episode	string(100)		O	O	O	O	O	O	O	O
54	Refer-from-healthcare professional Chinese name	Full Chinese name with suffix of the healthcare professional who referred the episode	string(10)	Maximum 10 Chinese characters	O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
55	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)		O	O	O	O	O	O	O	O
56	Referral source code	[eHR value] of the "Referral source" code table, to define the referral source for the current episode / visit	string(1)	Refer to the code set of “Referral Source” in eHR Office website	O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
57	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)	Refer to the code set of "Referral Source" in eHR Office website	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	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
58	Referral source local description	Local description of referral source for the current episode / visit, defined by healthcare institution	string(255)		O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
59	Referral specialty	The specialty of the patient in which the referral was initiated	string(10)	Refer to the code set of "Specialty" in eHR Office website	O	O	O	O	O	O	O	O
60	Referral specialty remarks	Details on specialty of the patient in which the referral was initiated	string(255)		O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
61	Case healthcare professional identifier	eHR identifier of the healthcare professional who in-charged the care	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
62	Case healthcare professional name prefix	English name prefix of the healthcare professional who was in charge of the care	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
63	Case healthcare professional English name	Full English name with prefix of the healthcare professional who was in-charge of the care	string(100)		O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
64	Case healthcare professional English given name	English given name of healthcare professional who was in charge of the care	string(40)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	Case healthcare professional Chinese name	Full Chinese name with suffix of the healthcare professional who was in-charge of the care	string(10)	Maximum 10 Chinese characters	O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
66	Case healthcare professional Chinese name suffix	Chinese name suffix of the healthcare professional who was in charge of the care	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
67	Record creation datetime	Datetime when the record was created in source system of HCP	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	O	N/A	O	N/A	O	N/A	O	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
68	Record creation institution identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution who created the record	string(10)	Fixed length	O	N/A	O	N/A	O	N/A	O	N/A
69	Record creation institution name	Name of healthcare institution who created the record	string(255)		O	N/A	O	N/A	O	N/A	O	N/A
70	Record last update datetime	Datetime when the record was last updated in source system of HCP	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	O	N/A	O	N/A	O	N/A	O	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
71	Record update institution identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution who updated the record	string(10)	Fixed length	O	N/A	O	N/A	O	N/A	O	N/A
72	Record update institution name	Name of healthcare institution who updated the record	string(255)		O	N/A	O	N/A	O	N/A	O	N/A
File Trailer												
1	EOF	File trailer indicator	string(3)	Fixed value	M	M	M	M	M	M	M	M
2	Total number of records	Total number of records in this batch being processed excluding the trailer	string(10)	Numeric value: 1-9999999999	M	M	M	M	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Appointment of Inpatient		Appointment of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Appointment of Outpatient – w Episode no.		Appointment of Other Encounter Type	
					Insert or Update (SCN 1, 4)	Delete (SCN 7)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 2, 5)	Delete (SCN 8)	Insert or Update (SCN 3, 6)	Delete (SCN 9)
3	File name of data file	File name of data file	string(83)	Please refer to *Section 10.2 - File Name for naming convention of data file name*	M	M	M	M	M	M	M	M

10.2.2 Admission or attendance data component

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
File Content												
1	eHR number	A unique eHR healthcare recipient identifier assigned to each patient for each participation in the Hong Kong eHR	string(12)	Fixed length	M	M	M	M	M	M	M	M
2	Record key	A unique identifier for each encounter record within HCP	string(50)		M	M	M	M	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
3	Transaction datetime	The datetime indicates the transaction sequence	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	M	M	M	M	M	M	M	M
4	Transaction type	Insert/Update/Delete	string(1)	Possible value: **I**: Insert operation - Applied when the record identified by HCP's [Record Key] has not been submitted to eHR	M	M	M	M	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
				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								

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
				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'***								

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
				and 'D' are not accepted in materialisation Mode.								
5	Last update datetime	The last update datetime for HCP system	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	M	M	M	M	M	M	M	M
6	Transaction profile type	The event type indicates the objective of the message	string(10)	Refer to the code table 'Transaction profile type' in *Section 12.1 - Transaction profile type*	M Fixed value: "ADM-IP"	M Fixed value: "ADM-IP"	M Fixed value: "ADM-AE"	M Fixed value: "ADM-AE"	M Fixed value: "ADM-OP"	M Fixed value: "ADM-OP"	M Fixed value: "ADM-OP-EP" (for SCN12, 16)	M Fixed value: "ADM-OP-EP" (for SCN 20) "ADM-OTH"

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
											"ADM-OTH" (for SCN13, 17)	(for SCN21)
7	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)		M	M	M	M	N/A	N/A	M (for SCN12, 16) O (for SCN13, 17)	M (for SCN 20) O (for SCN21)
8	Attendance institution identifier	A unique identifier assigned by eHR Healthcare	string(10)	Fixed length	O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
		Provider Index to each healthcare institution for participant attendance										
9	Encounter healthcare provider identifier	[Healthcare provider identifier] in the Healthcare Provider Index for the healthcare provider who created the encounter	string(10)	Fixed length	M	M	M	M	M	M	M	M
10	Encounter healthcare institution identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution who created the	string(10)	Fixed length	M	M	M	M	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
		encounter										
11	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)	Refer to the code set of "Encounter Type" in eHR Office website	M Fixed value "I" is expected	M Fixed value "I" is expected	M Fixed value "A" 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 "O" / "T" is expected for Outpatient or Consultation without patient's physical presence cases. Fixed value "H" is expected for other encounter type.	M Fixed value "O" / "T" is expected for Outpatient or Consultation without patient's physical presence cases. Fixed value "H" is expected for other encounter type.

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
12	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)	• Refer to the code set of "Service Type" in eHR Office website • Required only for Encounter type = 'O' / 'T' / 'H' • If Encounter type = 'H', Service type must NOT be = 'OPD', 'GOPD', or 'SOPD'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
13	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/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
14	Appointment number	A unique reference number assigned by the healthcare institution to an appointment (a scheduled encounter)	string(20)		O	O	N/A	N/A	O	O	O	O
15	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	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-	M	M	M	M	N/A	N/A	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
		scheduled episode.		31 16:30:05.005								
16	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)	• Refer to the code set of "Urgency" in eHR Office website • 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'	O	O	N/A	N/A	N/A	N/A	N/A (for SCN12, 16) O (for SCN13, 17)	N/A (for SCN20) O (for SCN21)

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
				• If Urgency type is 'W', Encounter type must be 'O' or 'H'								
17	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)	Refer to the code set of “Specialty” in eHR Office website	O	O	O	O	N/A	N/A	O	O
18	Episode start specialty remarks	Details on specialty of the patient upon commencement of an episode	string(255)		O	O	O	O	N/A	N/A	O	O
19	Episode attendance	[eHR value] of the "Attendance	string(1)	Refer to the code set of	O	O	O	O	N/A	N/A	N/A (for SCN12,	N/A (for SCN20)

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
	indicator	indicator" code table. [Episode attendance indicator] is an indicator to identify whether the episode has been attended in relation to inpatient or emergency service.		"Attendance Indicator" in eHR Office website							16) O (for SCN13, 17)	 O (for SCN21)
20	Episode end datetime	The date and time when the episode of care was ended	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	N/A	N/A	N/A	N/A	N/A	N/A	O	O
21	Episode end	[eHR value] of the	string(10)	Refer to the	N/A	N/A	N/A	N/A	N/A	N/A	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
	specialty	"Specialty" code table. [Episode end specialty] refers to the specialty of the patient upon completion of an episode.		code set of "Specialty" in eHR Office website								
22	Episode end specialty remarks	Details on specialty of the patient upon completion of an episode.	string(255)		N/A	N/A	N/A	N/A	N/A	N/A	O	O
23	Death before arrival indicator	[eHR value] of the "Yes No Unspecified" code table. [Death before arrival indicator] is an indicator to identify whether	string(1)	Refer to the code set of "Yes No Unspecified" in eHR Office website	N/A	N/A	N/A	N/A	N/A	N/A	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
		the patient was dead before arrival to the healthcare institution.										
24	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)	Refer to the code set of “Discharge Type” in eHR Office website	N/A	N/A	N/A	N/A	N/A	N/A	O	O
25	Discharge-to-institution identifier	[Healthcare institution identifier] in the Healthcare	string(10)	Fixed length	N/A	N/A	N/A	N/A	N/A	N/A	O M if [Discharge-	O M if [Discharge-

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
		Provider Index for the healthcare institution where the patient was discharged to									to-institution long name] is not blank	to-institution long name] is not blank
26	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	string(255)		N/A	N/A	N/A	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

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
		[Discharge-to-institution identifier].										
27	Discharge-to-institution local name	Local description of the healthcare institution where the patient was discharged to	string(255)		N/A	N/A	N/A	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
28	Discharge healthcare professional identifier	eHR identifier of the healthcare professional who discharged the patient	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
				encounter record v1.0.0’								
29	Discharge healthcare professional name prefix	English name prefix of the healthcare professional who discharged the episode	string(10)	• Not use • Retained for backward compatibility to ‘BLS technical interface specification for eHR encounter record v1.0.0’	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
30	Discharge healthcare professional English	English full name of the healthcare professional who discharged the	string(100)	• Not use • Retained for	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
	name	episode		backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'								
31	Discharge healthcare professional English given name	English given name of the healthcare professional who discharged the episode	string(40)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
				v1.0.0’								
32	Discharge healthcare professional Chinese name	Chinese full name of the healthcare professional who discharged the episode	string(10)	• Maximum 10 Chinese characters • Not use • Retained for backward compatibility to ‘BLS technical interface specification for eHR encounter record v1.0.0’	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
33	Discharge	Chinese name	string(10)	• Not use	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
	healthcare professional Chinese name suffix	suffix of the healthcare professional who discharged the episode		• Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'								

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
34	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/A	N/A	N/A	N/A	M	M	M	M
35	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)	Fixed Length	N/A	N/A	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	O M if [Visit clinic long name] is not blank

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
36	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/A	N/A	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	O M if [Visit clinic identifier] is not blank

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
37	Visit clinic local name	Local description of the healthcare institution where the patient received / will receive healthcare services	string(255)		N/A	N/A	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	O M if [Visit clinic identifier] is not blank
38	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)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	N/A	N/A	N/A	N/A	M	M	M	M
39	Visit urgency	[eHR value] of the "Urgency" code table. [Visit urgency] refers to the urgency of the care of the visit.	string(1)	• Refer to the code set of “Urgency” in eHR Office website	N/A	N/A	N/A	N/A	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
				• 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'							

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
40	Visit specialty	[eHR value] of the "Specialty" code table. [Visit specialty] refers to the specialty for the visit.	string(10)	Refer to the code set of “Specialty” in eHR Office website	N/A	N/A	N/A	N/A	O	O	O	O
41	Visit specialty remarks	Details on specialty of the patient for the visit	string(255)		N/A	N/A	N/A	N/A	O	O	O	O
42	Visit attendance indicator	[eHR value] of the "Attendance indicator" code table. [Visit attendance indicator] is an indicator to identify whether the visit has been attended.	string(1)	Refer to the code set of “Attendance Indicator” in eHR Office website	N/A	N/A	N/A	N/A	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
43	Attending healthcare professional identifier	eHR identifier of the healthcare professional who attended the visit	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
44	Attending healthcare professional name prefix	English name prefix of the healthcare professional who attended the visit	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
45	Attending healthcare professional English name	English full name of the healthcare professional who attended the visit	string(100)	• Not use • Retained for backward compatibility to 'BLS technical	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
				interface specification for eHR encounter record v1.0.0’								
46	Attending healthcare professional English given name	English given name of the healthcare professional who attended the visit	string(40)	• Not use • Retained for backward compatibility to ‘BLS technical interface specification for eHR encounter record v1.0.0’	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
47	Attending healthcare professional Chinese name	Chinese full name of the healthcare professional who attended the visit	string(10)	• Maximum 10 Chinese characters • Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
48	Attending healthcare professional Chinese name suffix	Chinese name suffix of the healthcare professional who attended the visit	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
49	Referral number	A unique number issued by the healthcare institution for each referral	string(20)		O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
50	Refer-from-institution identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution where the patient is referred from	string(10)	Fixed length	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	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
51	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.	string(255)		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	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

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
		It should be the corresponding description of the selected [Refer-from-institution identifier].										
52	Refer-from-institution local name	Local description of the healthcare institution where the patient is referred from	string(255)		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	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
53	Refer-from-healthcare professional English name	Full English name with prefix of the healthcare professional who referred the episode	string(100)		O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
54	Refer-from-healthcare professional Chinese name	Full Chinese name with suffix of the healthcare professional who referred the episode	string(10)	Maximum 10 Chinese characters	O	O	O	O	O	O	O	O
55	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)		O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
56	Referral source code	[eHR value] of the "Referral source" code table, to define the referral source for the current episode / visit	string(1)	Refer to the code set of “Referral Source” in eHR Office website	O	O	O	O	O	O	O	O
57	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)	Refer to the code set of “Referral Source” in eHR Office website	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	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

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
58	Referral source local description	Local description of referral source for the current episode / visit, defined by healthcare institution	string(255)		O	O	O	O	O	O	O	O
59	Referral specialty	The specialty of the patient in which the referral was initiated	string(10)	Refer to the code set of "Specialty" in eHR Office website	O	O	O	O	O	O	O	O
60	Referral specialty remarks	Details on specialty of the patient in which the referral was initiated	string(255)		O	O	O	O	O	O	O	O
61	Case healthcare professional identifier	eHR identifier of the healthcare professional who in-charged the	string(10)	• Not use • Retained for	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
		care		backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'								

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
62	Case healthcare professional name prefix	English name prefix of the healthcare professional who was in charge of the care	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
63	Case healthcare professional English name	Full English name with prefix of the healthcare professional who was in-charge of the care	string(100)		O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
64	Case healthcare professional English given name	English given name of healthcare professional who was in charge of the care	string(40)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	Case healthcare professional Chinese name	Full Chinese name with suffix of the healthcare professional who was in-charge of the care	string(10)	Maximum 10 Chinese characters	O	O	O	O	O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
66	Case healthcare professional Chinese name suffix	Chinese name suffix of the healthcare professional who was in charge of the care	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
67	Record creation datetime	Datetime when the record was created in source system of HCP	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	O	N/A	O	N/A	O	N/A	O	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
68	Record creation institution identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution who created the record	string(10)	Fixed length	O	N/A	O	N/A	O	N/A	O	N/A
69	Record creation institution name	Name of the institution who created the record	string(255)		O	N/A	O	N/A	O	N/A	O	N/A
70	Record last update datetime	Datetime when the record was last updated in source system of HCP	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	O	N/A	O	N/A	O	N/A	O	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
71	Record update institution identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution who updated the record	string(10)	Fixed length	O	N/A	O	N/A	O	N/A	O	N/A
72	Record update institution name	Name of healthcare institution who updated the record	string(255)		O	N/A	O	N/A	O	N/A	O	N/A
File Trailer												
1	EOF	File trailer indicator	string(3)	Fixed value	M	M	M	M	M	M	M	M
2	Total number of records	Total number of records in this batch being processed	string(10)	Numeric value: 1-9999999999	M	M	M	M	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)							
					Level 3							
					Admission of Inpatient		Admission of A&E patient		Attendance of Outpatient – w/o Episode no. (also include Consultation without patient's physical presence)		Attendance of Outpatient – w Episode no. (also include Consultation without patient's physical presence) and Other Encounter Type	
					Insert or Update (SCN 10, 14)	Delete (SCN 18)	Insert or Update (SCN 11, 15)	Delete (SCN 19)	Insert or Update (SCN 12, 16)	Delete (SCN 20)	Insert or Update (SCN 12, 13, 16, 17)	Delete (SCN 20, 21)
		excluding the trailer										
3	File name of data file	File name of data file	string(83)	Please refer to *Section 10.2 - File Name for naming convention of data file name*	M	M	M	M	M	M	M	M

10.2.3 Discharge data component

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
File Content								
1	eHR number	A unique eHR healthcare recipient identifier assigned to each patient for each participation in the Hong Kong eHR	string(12)	Fixed length	M	M	M	M
2	Record key	A unique identifier for each encounter record within HCP	string(50)		M	M	M	M
3	Transaction datetime	The datetime indicates the transaction sequence	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	M	M	M	M
4	Transaction type	Insert/Update/Delete	string(1)	Possible value: **I**: Insert operation - Applied when the record identified by HCP's [Record Key] has not been submitted to eHR before	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
				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.***				

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
5	Last update datetime	The last update datetime for HCP system	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	M	M	M	M
6	Transaction profile type	The event type indicates the objective of the message	string(10)	Refer to the code table 'Transaction profile type' in *Section 12.1 - Transaction profile type*	M Fixed value: "DIS-IP"	M Fixed value: "DIS-IP"	M Fixed value: "DIS-AE"	M Fixed value: "DIS-AE"
7	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)		M	M	M	M
8	Attendance institution identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution for participant attendance	string(10)	Fixed length	O	O	O	O
9	Encounter healthcare provider	[Healthcare provider identifier] in the Healthcare Provider Index for the healthcare	string(10)	Fixed length	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
	identifier	provider who created the encounter						
10	Encounter healthcare institution identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution who created the encounter	string(10)	Fixed length	M	M	M	M
11	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)	Refer to the code set of “Encounter Type” in eHR Office website	M Fixed value “I” is expected	M Fixed value “I” is expected	M Fixed value “A” is expected	M Fixed value “A” is expected
12	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)	• Refer to the code set of “Service Type” in eHR Office website • Required only for Encounter type = 'O' / 'T' / 'H' • If Encounter type = 'H', Service type must NOT be = 'OPD', 'GOPD', or 'SOPD'	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
13	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/A	N/A	N/A	N/A
14	Appointment number	A unique reference number assigned by the healthcare institution to an appointment (a scheduled encounter)	string(20)		O	O	N/A	N/A
15	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)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	M	M	M	M
16	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)	• Refer to the code set of “Urgency” in eHR Office website • If Urgency type is 'E', Encounter type must be 'I' or 'T' or 'H'	O	O	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
				• 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'				
17	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)	Refer to the code set of “Specialty” in eHR Office website	O	O	O	O
18	Episode start specialty remarks	Details on specialty of the patient upon commencement of an episode	string(255)		O	O	O	O
19	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)	Refer to the code set of “Attendance Indicator” in eHR Office website	O	O	O	O
20	Episode end datetime	The date and time when the episode of care was ended	string(23)	In format: YYYY-MM-DD	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
				hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005				
21	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)	Refer to the code set of “Specialty” in eHR Office website	O	O	O	O
22	Episode end specialty remarks	Details on specialty of the patient upon completion of an episode.	string(255)		O	O	O	O
23	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)	Refer to the code set of “Yes No Unspecified” in eHR Office website	O	O	O	O
24	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)	Refer to the code set of “Discharge Type” in eHR Office website	M	M	M	M

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
25	Discharge-to-institution identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution where the patient was discharged to	string(10)	Fixed length	O M if [Discharge-to-institution long name] is not blank	O M if [Discharge-to-institution long name] is not blank	O M if [Discharge-to-institution long name] is not blank	O M if [Discharge-to-institution long name] is not blank
26	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)		O M if [Discharge-to-institution identifier] is not blank	O M if [Discharge-to-institution identifier] is not blank	O M if [Discharge-to-institution identifier] is not blank	O M if [Discharge-to-institution identifier] is not blank
27	Discharge-to-institution local name	Local description of the healthcare institution where the patient was discharged to	string(255)		O M if [Discharge-to-institution identifier] is not blank	O M if [Discharge-to-institution identifier] is not blank	O M if [Discharge-to-institution identifier] is not blank	O M if [Discharge-to-institution identifier] is not blank

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
28	Discharge healthcare professional identifier	eHR identifier of the healthcare professional who discharged the patient	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A
29	Discharge healthcare professional name prefix	English name prefix of the healthcare professional who discharged the episode	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
30	Discharge healthcare professional English name	English full name of the healthcare professional who discharged the episode	string(100)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A
31	Discharge healthcare professional English given name	English given name of the healthcare professional who discharged the episode	string(40)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A
32	Discharge healthcare professional Chinese name	Chinese full name of the healthcare professional who discharged the episode	string(10)	• Maximum 10 Chinese characters • Not use • Retained for backward compatibility to 'BLS technical interface	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
				specification for eHR encounter record v1.0.0’				
33	Discharge healthcare professional Chinese name suffix	Chinese name suffix of the healthcare professional who discharged the episode	string(10)	• Not use • Retained for backward compatibility to ‘BLS technical interface specification for eHR encounter record v1.0.0’	N/A	N/A	N/A	N/A
34	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/A	N/A	N/A	N/A
35	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)	Fixed Length	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
36	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/A	N/A	N/A	N/A
37	Visit clinic local name	Local description of the healthcare institution where the patient received / will receive healthcare services	string(255)		N/A	N/A	N/A	N/A
38	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)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	N/A	N/A	N/A	N/A
39	Visit urgency	[eHR value] of the "Urgency" code table. [Visit urgency] refers to the urgency of the care	string(1)	• Refer to the code set of “Urgency” in eHR Office website	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
		of the visit.		• 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'				
40	Visit specialty	[eHR value] of the "Specialty" code table. [Visit specialty] refers to the specialty for the visit.	string(10)	Refer to the code set of "Specialty" in eHR Office website	N/A	N/A	N/A	N/A
41	Visit specialty remarks	Details on specialty of the patient for the visit	string(255)		N/A	N/A	N/A	N/A
42	Visit attendance indicator	[eHR value] of the "Attendance indicator" code table. [Visit attendance indicator] is an indicator to identify whether the visit has been attended.	string(1)	Refer to the code set of "Attendance Indicator" in eHR Office website	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
43	Attending healthcare professional identifier	eHR identifier of the healthcare professional who attended the visit	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A
44	Attending healthcare professional name prefix	English name prefix of the healthcare professional who attended the visit	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A
45	Attending healthcare professional English name	English full name of the healthcare professional who attended the visit	string(100)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
				encounter record v1.0.0’				
46	Attending healthcare professional English given name	English given name of the healthcare professional who attended the visit	string(40)	• Not use • Retained for backward compatibility to ‘BLS technical interface specification for eHR encounter record v1.0.0’	N/A	N/A	N/A	N/A
47	Attending healthcare professional Chinese name	Chinese full name of the healthcare professional who attended the visit	string(10)	• Maximum 10 Chinese characters • Not use • Retained for backward compatibility to ‘BLS technical interface specification for eHR encounter record v1.0.0’	N/A	N/A	N/A	N/A
48	Attending healthcare professional	Chinese name suffix of the healthcare professional who attended the visit	string(10)	• Not use • Retained for	N/A	N/A	N/A	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
	Chinese name suffix			backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'				
49	Referral number	A unique number issued by the healthcare institution for each referral	string(20)		O	O	O	O
50	Refer-from-institution identifier	[Healthcare institution identifier] in the Healthcare Provider Index for the healthcare institution where the patient is referred from	string(10)	Fixed length	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
51	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	string(255)		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

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
		[Refer-from-institution identifier].						
52	Refer-from-institution local name	Local description of the healthcare institution where the patient is referred from	string(255)		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
53	Refer-from-healthcare professional English name	Full English name with prefix of the healthcare professional who referred the episode	string(100)		O	O	O	O
54	Refer-from-healthcare professional Chinese name	Full Chinese name with suffix of the healthcare professional who referred the episode	string(10)	Maximum 10 Chinese characters	O	O	O	O
55	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)		O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
56	Referral source code	[eHR value] of the "Referral source" code table, to define the referral source for the current episode / visit	string(1)	Refer to the code set of “Referral Source” in eHR Office website	O	O	O	O
57	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)	Refer to the code set of “Referral Source” in eHR Office website	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
58	Referral source local description	Local description of referral source for the current episode / visit, defined by healthcare institution	string(255)		O	O	O	O
59	Referral specialty	The specialty of the patient in which the referral was initiated	string(10)	Refer to the code set of “Specialty” in eHR Office website	O	O	O	O
60	Referral specialty remarks	Details on specialty of the patient in which the referral was initiated	string(255)		O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
61	Case healthcare professional identifier	eHR identifier of the healthcare professional who in-charged the care	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A
62	Case healthcare professional name prefix	English name prefix of the healthcare professional who was in charge of the care	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A
63	Case healthcare professional English name	Full English name with prefix of the healthcare professional who was in-charge of the care	string(100)		O	O	O	O

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
64	Case healthcare professional English given name	English given name of healthcare professional who was in charge of the care	string(40)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A
65	Case healthcare professional Chinese name	Full Chinese name with suffix of the healthcare professional who was in-charge of the care	string(10)	Maximum 10 Chinese characters	O	O	O	O
66	Case healthcare professional Chinese name suffix	Chinese name suffix of the healthcare professional who was in charge of the care	string(10)	• Not use • Retained for backward compatibility to 'BLS technical interface specification for eHR encounter record v1.0.0'	N/A	N/A	N/A	N/A
67	Record creation datetime	Datetime when the record was created in source system of HCP	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss	O	N/A	O	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
				e.g. 2010-01-31 16:30:05.005				
68	Record creation institution identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution who created the record	string(10)	Fixed length	O	N/A	O	N/A
69	Record creation institution name	Name of healthcare institution who created the record	string(255)		O	N/A	O	N/A
70	Record last update datetime	Datetime when the record was last updated in source system of HCP	string(23)	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005	O	N/A	O	N/A
71	Record update institution identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution who updated the record	string(10)	Fixed length	O	N/A	O	N/A

Sequence	Data Field	Definition	Maximum Length	Notes	Mandatory (M)/ Optional (O)/ Not Applicable (N/A – Data field should not be submitted. eHR will ignore the value even submitted.)			
					Level 3			
					Discharge of Inpatient		Discharge of A&E patient	
					Insert or Update (SCN 22)	Delete (SCN 24)	Insert or Update (SCN 23)	Delete (SCN 25)
72	Record update institution name	Name of healthcare institution who updated the record	string(255)		O	N/A	O	N/A
File Trailer								
1	EOF	File trailer indicator	string(3)	Fixed value	M	M	M	M
2	Total number of records	Total number of records in this batch being processed excluding the trailer	string(10)	Numeric value: 1-9999999999	M	M	M	M
3	File name of data file	File name of data file	string(83)	Please refer to *Section 10.2 - File Name for naming convention of data file name*	M	M	M	M

Example

The following example is according the data requirements of the scenarios in 'Data Compliance Level 3'.

Scenario Description	Transaction Profile Type	Reference Page	Record Detail
Create appointment for inpatient (SCN1)	APP-IP	'Appointment transaction data component' in *Section 10- Structured Data File*	Create an appointment record with following details: eHR number: 201000000001 Appointment number: A-123456789 Episode start datetime: 2011-06-31 16:30:05.005
Create admission for inpatient (SCN10)	ADM-IP	'Admission or attendance data component' in *Section 10- Structured Data File*	Create an admission record with following details: eHR number: 201000000002 Episode start datetime: 2011-07-01 08:00:00.000
Create discharge for inpatient (SCN22)	DIS-IP	'Discharge data component' in *Section 10- Structured Data File*	Create a discharge record with following details: eHR number: 201000000003 Episode end datetime: 2011-07-02 08:00:00.000 Discharge type: HOME

Sample data file of SCN1, SCN10 and SCN22 (New):

```
201000000001|ENCTRRECKEY0001|2011-07-01 08:00:00.000|I|2011-07-01
08:00:00.000|APP-IP|||8088450656|1735455950|I|||A-123456789|2011-
06-31
16:30:05.005|||||||||||||||||||||||||||||||||||||||||||||||||||||||
||\CR\
201000000002|ENCTRRECKEY0002|2011-07-01 08:00:00.000|I||ADM-IP|
HN1234567||8088450656|1735455950|I||||2011-07-01
08:00:00.000|||||||||||||||||||||||||||||||||||||||||||||||||||||||
||\CR\
201000000003|ENCTRRECKEY0003|2011-07-02 08:00:00.000|I||DIS-IP|
HN2234567||8088450656|1735455950|I||||2011-07-01
08:00:00.000|||||2011-07-02
08:00:00.000||||HOME|||||||||||||||||||||||||||||||||||||||||||||||
|\CR\
EOF.3.8088450656.BRANCHA.ENCTR.DF.1.20110702084530
```


Scenario Description	Transaction Profile Type	Reference Page	Record Detail
Update appointment for inpatient (SCN4)	APP-IP	'Appointment transaction data component' in *Section 10- Structured Data File*	Update an existing appointment record with following details: eHR number: 201000000001 Episode start datetime: 2011-07-01 16:30:05.005
Update admission for inpatient (SCN14)	ADM-IP	'Admission or attendance data component' in *Section 10- Structured Data File*	Update an existing admission record with following details: eHR number: 201000000002 Episode start datetime: 2011-07-01 16:30:00.000
Update discharge for inpatient (SCN22)	DIS-IP	'Discharge data component' in *Section 10- Structured Data File*	Update an existing discharge record with following details: eHR number: 201000000003 Episode end datetime: 2011-07-02 07:00:00.000 Discharge type: WA

Sample data file of SCN4, SCN14 and SCN22 (Update):

```
201000000001|ENCTRRECKEY0001|2011-07-01 08:00:00.000|U|2011-07-01
08:00:00.000|APP-IP|||8088450656|1735455950|I|||A-123456789|2011-
07-01
16:30:05.005|||||||||||||||||||||||||||||||||||||||||||||||||||||
||\CR\
201000000002|ENCTRRECKEY0002|2011-07-01 08:00:00.000|U||ADM-IP|
HN1234567||8088450656|1735455950|I||||2011-07-01
16:30:00.000|||||||||||||||||||||||||||||||||||||||||||||||||||||
||\CR\
201000000003|ENCTRRECKEY0003|2011-07-02 08:00:00.000|U||DIS-IP|
HN2234567||8088450656|1735455950|I||||2011-07-01
08:00:00.000|||||2011-07-02
07:00:00.000||||WA|||||||||||||||||||||||||||||||||||||||||||||\
CR\
EOF.3.8088450656.BRANCHA.ENCTR.DF.1.20110702084530
```


Scenario Description	Transaction Profile Type	Reference Page	Record Detail
Cancel appointment for inpatient (SCN7)	APP-IP	'Appointment transaction data component' in *Section 10- Structured Data File*	Due to transmission error, the existing appointment record has to be cancelled with following details: eHR number: 201000000001 Record Key: ENCTRRECKEY0001
Cancel admission for inpatient (SCN18)	ADM-IP	'Admission or attendance data component' in *Section 10- Structured Data File*	Due to transmission error, the existing admission record has to be cancelled with following details: eHR number: 201000000002 Record Key: ENCTRRECKEY0002
Cancel discharge for inpatient (SCN24)	DIS-IP	'Discharge data component' in *Section 10- Structured Data File*	Due to transmission error, the existing discharge record has to be cancelled with following details: eHR number: 201000000003 Record Key: ENCTRRECKEY0003

Sample data file of SCN7, SCN18 and SCN 24 (Delete):

```
201000000001|ENCTRRECKEY0001|2011-07-01 08:00:00.000|D|2011-07-01
08:00:00.000|APP-IP|||8088450656|1735455950|I|||A-123456789|2011-
07-01
16:30:05.005|||||||||||||||||||||||||||||||||||||||||||||||||||||
||\CR\
201000000002|ENCTRRECKEY0002|2011-07-01 08:00:00.000|D||ADM-IP|
HN1234567||8088450656|1735455950|I||||2011-07-01
16:30:00.000|||||||||||||||||||||||||||||||||||||||||||||||||||||
||\CR\
201000000003|ENCTRRECKEY0003|2011-07-02 08:00:00.000|D||DIS-IP|
HN2234567||8088450656|1735455950|I||||2011-07-01
08:00:00.000|||||2011-07-02
07:00:00.000||||WA|||||||||||||||||||||||||||||||||||||||||||||\
CR\
EOF.3.8088450656.BRANCHA.ENCTR.DF.1.20110702084530
```


11 FILE NAME SAMPLES

The following provides some file name samples for different file upload modes:

Sample Values

Component	Sample Value	Full Form
HCP ID	8088450656	Hospital Authority
Sending Location Code	BRANCHA	Branch A of HCP
	BRANCHB	Branch B of HCP
	GATEWAY1	Gateway 1 system of HCP
	GATEWAY2	Gateway 2 system of HCP

The following table lists examples of HCR list file name and data file name, for each file upload mode:

	HCR List File	Data File
Incremental Mode	8088450656.BRANCHA.ENCTR.PL.1.20110702084530	8088450656.BRANCHA.ENCTR.DF.1.20110702084530
Materialisation Mode	8088450656.BRANCHA.ENCTR.PL.2.20110702084530	8088450656.BRANCHA.ENCTR.DF.2.20110702084530

12 APPENDIX

12.1 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

