Archetype Extraction Report for composition

advance_care

Archetype ID: openEHR-EHR-COMPOSITION.advance_care.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: en

Purpose: To hold information about a plan for the management of future health and social care requirements, including chronic illness and end of life care.

Use: Use as a container to hold information about a plan for the management of future health and social care requirements, including chronic illness and end of life care, and the content should reflect the individual's unique health situation and circumstances. This archetype has been specifically designed to carry one, or more, of: - the EVALUATION.advance_care_directive, representing the preferences of an individual about their future care, from the point of view of the individual or their guardian; and - the EVALUATION.advance_intervention_decisions archetypes, representing the decisions about the overall intent of care and possible treatments, activities and diagnostic or therapeutic procedures that may be life-saving, life-prolonging or cause undesirable side effects, from the point of view of a clinician; or - other archetypes that are clinically relevant and relevant to integrated care or end-of-life planning. This archetype can be used as a single COMPOSITION for querying information about any anticipatory care preferences or decisions, with different archetypes clearly differentiating the source of the information as individual or clinician.

Misuse: Not to be used to carry archetypes that are related to orders or management of an acute or emergency situation. Not to be used to carry archetypes that are related to care plans related to management current health and social requirements - use COMPOSITION.care_plan for this purpose.

Keywords: advance care, directive, intervention, decision,

Concepts:

- at0000::Advance care - A plan for the management of future health and social care requirements, including chronic illness and end of life care.
- at0001::Coded text - None
- at0002::Event Context - None

adverse_reaction_list

Archetype ID: openEHR-EHR-COMPOSITION.adverse_reaction_list.v1

Lifecycle State: published

Category: COMPOSITION

Languages: es-ar, pt-br, en, he

Purpose: To record a persistent and managed list of all previous adverse reactions experienced by the subject or, alternatively, positive statements about known exclusions or actual absence of any information about adverse reactions; all of which may contribute to or influence clinical decision-making and care provision.

Use: Use to record a persistent and managed list of all previous adverse reactions (including allergies, hypersensitivities, side effects or intolerances) experienced by the subject or, alternatively, positive statements about known exclusions or actual absence of any information about adverse reactions. This list can also be utilised as a source of up-to-date adverse reaction data for exchange or as the basis for decision support. This list can include three types of archetypes that record the clinical data: - positive statements about the occurrence of actual adverse reactions experienced by the subject during their lifetime are recorded using the EVALUATION.adverse_reaction archetype; OR - a positive statement about the exclusion of any previous known adverse reactions can be recorded using the specific EVALUATION.exclusion-adverse_reaction archetype - for example: "No known adverse reactions"; OR - a positive statement about no information being available - neither known previous adverse reactions nor known exclusions - can be recorded using the EVALUATION.absence archetype. In addition a SECTION archetype can be included as an organiser that will suit local jurisdictions and clinical practice. For example: SECTION.adverse_reaction. In order for this list to be accurate and safe to use as the basis for decision support activities and for exchange, this list should ideally be curated by a clinician responsible for the health record, rather than managed automatically by the clinical system through business rules alone. While it is reasonable for clinically verified adverse reactions to be persisted over time, the same approach does not apply to statements about exclusions or absence. They should only be regarded as valid at that they are recorded. For example recording a statement that the subject is not known to be allergic to penicillin is out-of-date as soon as the clinician gives the subject a dose of penicillin and they react. This archetype is usually managed as a persistent list, however there are situations where the list may be used within episodic care and require additional attributes such as context etc to enable accurate recording. The openEHR reference model currently only allows context to be recorded within Event-based COMPOSITION archetypes. As a result, this archetype has been modelled as an Event, rather than Persistent, COMPOSITION,

to allow for flexibility so that some clinical systems can safely manage Adverse Reaction Lists for episodes of care, while others will choose to implement this COMPOSITION to act in a persistent manner.

Keywords: adverse, reaction, allergy, intolerance, effect, hypersensitivity, side effect

Concepts:

- at0000::Adverse reaction list - A persistent and managed list of adverse reactions experienced by the subject that may influence clinical decision-making and care provision.
- at0001::Tree - @ internal @
- at0002::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

care_plan

Archetype ID: openEHR-EHR-COMPOSITION.care_plan.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: nb, en, nl

Purpose: To record a persistent and managed list of any combination of archetypes that will support the accurate recording of a Care plan.

Use: Use to record a persistent and managed list of any combination of archetypes that will support the accurate recording of a Care plan that may evolve over time. This archetype will be contain combinations of planned activities, activies that are in progress or have been carried out, goals/objectives, targets, and recommendations. This care plan may include: - the order and activity status for the care plan as a whole, using INSTRUCTION.care_plan_request and ACTION.care_plan; - the order for each of the proposed activities, for example INSTRUCTION.service_request or INSTRUCTION.health_education_request; - the corresponding ACTION archetypes for each activity, which will indicate the status of each order - for example those that are planned, in progress, completed or cancelled; and - optionally, instances of EVALUATION.goal to record the overall goal of the care plan and/or clinical targets for each of activities. The SECTION.care_plan archetype is an example of a framework for clinical content that could be used within this archetype.

Keywords: care plan, plan, care management plan, management plan

Concepts:

- at0000::Care plan - A persistent and managed list of any combination of archetypes that will support the accurate recording of a Care plan.
- at0001::Tree - @ internal @
- at0002::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

data_collection

Archetype ID: openEHR-EHR-COMPOSITION.data_collection.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: en

Purpose: To record a collection of health and related data, intentionally captured or extracted from a health record for a specific purpose, usually related to reporting, research, or a disease registry.

Concepts:

- at0000::Data collection - A collection of health and related data, intentionally captured or extracted from a health record for a specific purpose, usually related to reporting, research, or a disease registry.
- at0001::Tree - @ internal @
- at0002::Focus - Name of the topic, theme or focus of the data collection.
- at0003::Description - Narrative description about the purpose of the data collection.

disease_surveillance

Archetype ID: openEHR-EHR-COMPOSITION.disease_surveillance.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: en

Purpose: __unknown__

Concepts:

- at0000::Disease surveillance - Disease surveillance.
- at0001::Coded text - None
- at0002::Event Context - None
- at0003::Item tree - @ internal @
- at0005::Disease - The name of the disease that has been diagnosed.
- at0006::Report type - The type of submission or report submitted.
- at0007::Report date - None

empower_odl

Archetype ID: openEHR-EHR-COMPOSITION.empower_odl.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: en

Purpose: Aggregating several observations and action for recording of observations of daily living (ODLs) by a patient. Based on the data model developed within the EMPOWER project, www.empower-fp7,eu.

Use: Composition of ODLs for self-monitoring.

Concepts:

- at0000::ODL (EMPOWER) - Observation of daily living data that is reported by the patient himself while self-monitoring.
- at0001::Baum - @ internal @
- at0002::OBSERVATION - Slot for an observation.
- at0003::ACTION - Slot for an action.
- at0004::EVALUATION - Slot for an evaluation.

encounter

Archetype ID: openEHR-EHR-COMPOSITION.encounter.v1

Lifecycle State: published

Category: COMPOSITION

Languages: de, sv, fi, ko, pt-br, ar-sy, en, it, fr, es, pt-pt, es-ar, nb, nl, ca

Purpose: To record the document level details of a single interaction, contact or care event between a subject of care and healthcare provider(s) for the provision of healthcare service(s). This can be either a face-to-face or remote interaction.

Use: Use as a generic document-level container for recording details of a single interaction, contact or care event between a subject of care and healthcare provider(s). The contact may be face-to-face, via telephone or another electronic medium. Modality can be captured, if required, via the reference model COMPOSITION/mode attribute. The main Sections/Content component has been deliberately left unconstrained. This will allow it to be populated with any SECTION or ENTRY archetypes appropriate for the clinical purpose within a template. Even though unconstrained for clinical content, specification of COMPOSITION.Encounter provides significant value by allowing for explicit querying of all Encounters within a patient record. The Context component contains an optional 'Extension' SLOT that can be used in template design to: - add optional contextual information, such as episode information; or - allow for harmonisation or alignment with other model formalisms such as FHIR or CIMI, such as explicit representation of participants that are usually managed by the openEHR Reference Model in an openEHR archetype. Typical examples are a clinic visit, a nursing observation or a telemedicine consultation.

Misuse: Not to be used to record details about an entire episode of care. Not to be used to carry persistent, summarised patient information, such as a problem list or medication summary. Not to be used to represent the report of a diagnostic service, such as imaging or laboratory testing. Not to be used to represent the FHIR resource of the same name - there is a mismatch scope and intent.

Keywords: encounter, contact, visit, care event

Concepts:

- at0000::Encounter - Interaction, contact or care event between a subject of care and healthcare provider(s).
- at0001::Tree - @ internal @
- at0002::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

event_summary

Archetype ID: openEHR-EHR-COMPOSITION.event_summary.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: de, nb, pt-br, en

Purpose: To record a summary of a single, significant healthcare event, with the intent of being made available to multiple providers within a shared health record environment.

Use: Use to record a summary of a single, significant healthcare event or episode of care for viewing or exchange within a shared health record environment.

Misuse: Not to be used to record the complete and contemporaneous details of a healthcare event, encounter or episode of care within a care provider's health record. Use COMPOSITION.encounter (and specialisations) for this purpose.

Keywords: event, encounter, episode

Concepts:

- at0000::Event summary - Summary record of a single, significant healthcare event, encounter or episode.
- at0001::Tree - @ internal @
- at0002::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

family_history

Archetype ID: openEHR-EHR-COMPOSITION.family_history.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: de, en

Purpose: To record a persistent and managed list of all relevant family history for an individual or statements about positive exclusion or actual absence of information about family history, that may influence clinical decision-making and care provision.

Use: Use to record a persistent and managed list of all relevant family history for an individual or statements about positive exclusion or actual absence of information about family history, that may influence clinical decision-making and care provision. It is also possible to record family history information for individuals other than the subject of the health record - for example information about the father of an unborn fetus needs to be stored in the mother's health record until birth. In this situation the subject of care must be explicitly specified. The intent of this COMPOSITION is for use as a persistent summary, however it has been identified that for implementation the archetype also needs additional attributes related to the context of the event. As a result, the COMPOSITION has been temporarily modified as an EVENT COMPOSITION which allows addition of an Items SLOT into which additional context-related archetypes can be included. This new requirement for context-related attributes in the Persistent COMPOSITION has been requested as a future openEHR Reference Model update.

Keywords: family, history, pedigree

Concepts:

- at0000::Family history - A persistent and managed list about relevant family history of the subject that may influence clinical decision-making and care provision.
- at0003::Tree - @ internal @
- at0005::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

health_certificate

Archetype ID: openEHR-EHR-COMPOSITION.health_certificate.v1

Lifecycle State: published

Category: COMPOSITION

Languages: de, nb, en

Purpose: To record a formal assessment regarding the health status of an individual, usually asserted by the treating clinician and intended for sharing with third parties.

Use: Use to record a formal assessment regarding the health status of an individual, usually asserted by the treating clinician and intended for sharing with third parties. Use cases asserted by a healthcare professional include, but are not limited to: - reduced capacity for work duties or hours; - death certificate - using the content of the EVALUATION.cause_of_death archetype to carry the specific death-related information within a Death Certificate template; - functional capacity; - fitness for specific activities,

including driving, flying or diving; or - certificate of vaccination status. Use cases asserted by an administrator include, but are not limited to: - attendance at a health facility.

Keywords: certificate,statement,death,sick leave,fitness,vaccination,exercise,employment,flying,driving,diving

Concepts:

- at0000::Health certificate - A formal statement about the health status or situation related to an individual.
- at0001::Coded text - None
- at0002::Event Context - None
- at0003::Item tree - @ internal @
- at0004::Individual - Identification of the subject of the certificate.
- at0006::Certificate ID - Identification information about the certificate.
- at0009::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0010::Certificate type - Type of certificate.

health_summary

Archetype ID: openEHR-EHR-COMPOSITION.health_summary.v1

Lifecycle State: published

Category: COMPOSITION

Languages: sv, nb, pt-br, en, es

Purpose: To record a summary of health information about an individual, representing a subset of their health record at a specified point in time.

Use: Use as a generic containter to record a summary or overview of a patient's health and/or welfare status as a snapshot of their health at a specified point in time. The author of a health summary is usually a clinician who is familiar with the all of the relevant aspects of the individual's health that is the content of the summary. The scope of a health summary can vary in different contexts, ranging from an overview of all key aspects of the individual's health and/or welfare to a summary of information focused on a limited aspect of the individual's health. The intended readers of the health summary will vary according to the primary purpose and focus of the summary, and may include: - any future healthcare providers; - clinicians who have no personal knowledge of the individual but are required to provide healthcare, such as emergency treatment or when the individual is travelling; - clinicians managing only specific aspects of the individual's health, such as diabetes or

pregnancy; and - the individual themselves. The main Sections/Content component has been deliberately left unconstrained. This will allow it to be populated with any SECTION or ENTRY archetypes appropriate for the clinical purpose within a template. Even though clinical content is unconstrained, this archetype supports simple querying for all Health summaries that might be contained within a health record.

Misuse: Not to be used to record details about a single clinical consultation, procedure, test or assessment etc.

Keywords: summary, synopsis, overview, status

Concepts:

- at0000::Health summary - Generic document containing a summary of health information about an individual.
- at0001::Tree - @ internal @
- at0002::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

lifestyle_factors

Archetype ID: openEHR-EHR-COMPOSITION.lifestyle_factors.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: de, el, en, nl

Purpose: To record a persistent and evolving summary record of information about lifestyle choices and activities that may influence health outcomes, clinical decision-making and provision of care.

Use: Use to record a persistent and evolving summary record of information about relevant lifestyle choices and activities that may influence health outcomes, clinical decision-making and provision of care. The scope of this record can includes, but is not limited to: an overview of smoking and tobacco use; alcohol consumption; substance use; gambling; physical activity; diet and nutrition; and sexual health. This archetype is usually managed as a persistent list, however there are situations where the list may be used within episodic care and require additional attributes such as context etc to enable accurate recording. The openEHR reference model currently only allows context to be recorded within Event-based COMPOSITION archetypes. As a result, this archetype has been modelled as an Event, rather than Persistent, COMPOSITION, to allow for flexibility so that some clinical systems can safely manage Lifestyle Factors for episodes of care, while others

will choose to implement this COMPOSITION to act in a persistent manner. Initial design of this archetype was funded by the iCareNet Antenatal Shared Care Plan project, Northern Territory, Australia.

Misuse: Not to record a series of OBSERVATIONS about current activity, such as might be used to create a daily diary of alcohol consumption or activity in a specific exercise session.

Keywords: life, style, lifestyle, risk, factor, tobacco, smoking, alcohol, binge, diet, exercise

Concepts:

- at0000::Lifestyle risk factors - A persistent and evolving summary record of information about lifestyle risk factors that may influence health outcomes, clinical decision-making and provision of care.
- at0002::Tree - @ internal @
- at0003::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

medication_list

Archetype ID: openEHR-EHR-COMPOSITION.medication_list.v1

Lifecycle State: published

Category: COMPOSITION

Languages: de, sv, es-ar, nb, ar-sy, en, nl

Purpose: To record a persistent and managed list of medicines for an individual or, alternatively, positive and explicit statements about known exclusions or actual absence of any information about medications; all of which may influence clinical decision-making and care provision.

Use: Use to record a persistent and managed list of medicines for an individual, potentially including all prescribed and 'over the counter' medicines, supplements or natural remedies. Alternatively, it may contain positive and explicit statements about known exclusions or absence of information about medications. The intent of this archetype is to be a generic container for any Medication list, which may have a specific context or limitation of scope set within a template. This list can be utilised as a source of medicines data for an active current medication list within a clinical system, for transition of care, data exchange, or as the basis for decision support. Most commonly, this list will be comprised of three types of archetype: - statements about the positive use of medications are recorded using the INSTRUCTION.medication_order and/or ACTION.medication archetypes; OR - a

positive statement about the general exclusion of medication use can be recorded using the general EVALUATION.exclusion_global archetype - for example: "Not currently taking any medications"; OR - a positive statement about the exclusion of use of a specific medication can be recorded using the EVALUATION.exclusion_specific archetype - for example: "Not currently taking penicillin" - a positive statement about no information being available - neither a positive known use of medication nor a positive exclusion - can be recorded using the EVALUATION.absence archetype. In order for a Medication list to be accurate and safe to use as the basis for decision support activities and for exchange, this Medication list should ideally be curated by a clinician responsible for the health record, rather than managed automatically by the clinical system through business rules alone. There can be a subtle but important difference between types of medication lists. Some examples include: 'Current Medication' or 'Regular Medication'. A 'Current medication list' may be regarded as a list of all medicines that the individual would have in their body at a given time, including any stat or prn doses of a medicine that should be considered when prescribing to ensure that drug-drug interaction checking continues for the duration of its physiological effect. A 'Regular Medication' list may only include those medicines that are taken by the individual on a regular and ongoing basis. In addition, it is common in clinical practice to create Medication Lists that have temporal constraints, including 'Admission Medication List' and 'Discharge Medication List', which will be relevant only at a specified point in time. Other examples include 'Past Medications' or 'Inactive Medications'. This will ultimately be an implementation decision for each clinical system - an alternative approach may be to record these contextual clinical constructs as the result of a query or use of a different COMPOSITION archetype, yet to be determined. This archetype is intended to be represented and managed as a persistent list, however there are situations where the list may be used within episodic care and require additional attributes such as context etc to enable accurate recording. The openEHR reference model currently only allows context to be recorded within Event-based COMPOSITION archetypes. As a result, this archetype has been modelled as an Event, rather than Persistent, COMPOSITION, to allow for flexibility so that some clinical systems can safely manage Medication lists for episodes of care, while others will choose to implement this COMPOSITION to act in a persistent manner.

Misuse: Not to be used to record lists of Medications that are not intended for persistence and ongoing revision and curation. Not to be used to record individual Prescriptions - use COMPOSITION.prescription for this purpose. Not to be used to record actual changes to therapy, including dose changes, new medicines and ceased medications. Each order will be recorded using individual instances of the INSTRUCTION.medication_order archetype, and only the latest one should be represented within the latest version of this COMPOSITION. Not to be used to record vaccinations administered - use COMPOSITION.immunisation_list for this purpose.

Keywords: medication, medicine, list, drug, current, prescription

Concepts:

- at0000::Medication list - A persistent and versioned list of medicines for an individual.

- at0005::Tree - @ internal @
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

notification

Archetype ID: openEHR-EHR-COMPOSITION.notification.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: pt-br, en

Purpose: Generic container archetype to carry information about a notification.

Use: Use as a generic container archetype to carry information about a notification. For example: if a specified laboratory report is received by a clincal system, automated business rules could trigger a notification to be sent to a monitoring clinician for initiation of a task. Both the notifier and the receiver could be either healthcare provider or a clinical system.

Keywords: notification, event, event notification

Concepts:

- at0000::Notification - This is a generic composition used for all sorts of notifications, such as an infection event and surgical site surveillance event.

  Document to communicate notifications to healthcare providers or be used as triggers for automated business rules.
- at0001::Tree - @ internal @
- at0002::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0003::Notification ID - Identification information about the notification.

obstetric_history

Archetype ID: openEHR-EHR-COMPOSITION.obstetric_history.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: pt, pt-br, en

Purpose: To record and update a summary of all pregnancies and outcomes as well as detailed summaries of all individual pregnancies.

Use: To record all persistent data about pregnancies and a summary statement of all past and current pregnancies.

Misuse: Not to be used to record event data relating to a pregnancy.

Keywords: obstetric, summary, history

Concepts:

- at0000::Obstetric history - Information about current and previous pregnancies which may include a summary count of outcomes.
- at0001::Coded text - None
- at0002::Event Context - None
- at0003::Item tree - @ internal @

pregnancy_summary

Archetype ID: openEHR-EHR-COMPOSITION.pregnancy_summary.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: en

Purpose: To record a collection of summary or persistent details about a single pregnancy.

Use: Use to record a collection of summary or persistent details about a single pregnancy. For example, this COMPOSITION may contain: - a single EVALUATION.pregnancy_summary that can evolve in detail and be updated throughout the pregnancy; and - a single instance of the EVALUATION.estimated_date_delivery that can also be updated throughout the pregnancy as more accurate information is available. This COMPOSITION has been designed for use as a persistent episode, however event-based information for Antenatal visits, labour and delivery should be recorded using clinically appropriate EVENT-based COMPOSITIONs.

Misuse: Not to be used to record a summary of all significant pregnancy outcomes or clinical metrics - use the EVALUATION.obstetric_summary for this purpose.

Concepts:

- at0000::Pregnancy summary - Summary or persistent details about a single pregnancy.
- at0003::Pregnancy - Cumulative overview of a single pregnancy.
- at0004::Tree - @ internal @
- at0006::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0007::Other details - None

prescription

Archetype ID: openEHR-EHR-COMPOSITION.prescription.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: ar-sy, en

Purpose: A composition for transferring medication orders to the pharmacy.

Use: This composition is only required for transfer of medications to the pharmacy.

Misuse: Medication orders, as instructions, have a prescribe action that records prescription and communication to the pharmacy. This composition is only required if the medication orders are required to be transmitted within openEHR to the pharmacy.

Keywords: medication, prescribe, order

Concepts:

- at0000::Prescription - Set of medication orders communicated to pharmacy.
- at0001::Tree - @ internal @
- at0007::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0008::Prescription identifier - An identifier for the prescription as a whole.

problem_list

Archetype ID: openEHR-EHR-COMPOSITION.problem_list.v2

Lifecycle State: published

Category: COMPOSITION

Languages: de, ko, pt-br, el, ar-sy, en, zh-cn, nl, es

Purpose: To record a persistent and managed list of diagnoses identified, problems experienced by the subject or previous procedures performed, that may influence clinical decision-making and care provision.

Use: Use to record a persistent and managed list of diagnoses identified, problems experienced by the subject or previous procedures performed, or, alternatively, positive statements about known exclusions or actual absence of any information about the the medical history. This list can also be utilised as a source of up-to-date medical history data for exchange or as the basis for decision support. This list can be comprised of three types of statements, each represented by specific archetypes: - statements about the positive presence of problems, diagnoses or previous procedures are recorded using the EVALUATION.problem_diagnosis and/or ACTION.procedure archetypes; OR - statements about the positive exclusion of problems, diagnoses or previous procedures can be recorded using the specific EVALUATION.exclusion-problem_diagnosis or EVALUATION.exclusion-procedure archetypes - for example: "No significant problems or diagnoses" or "No history of significant operations or procedures"; OR - statements about no information being available - neither a positive presence of a problem, diagnosis or procedure performed nor a positive exclusion - can be recorded using the EVALUATION.absence archetype. In order for this list to be accurate and safe to use as the basis for decision support activities and for exchange, this Problem List should ideally be curated by a clinician responsible for the health record, rather than managed automatically by the clinical system through business rules alone. In a closed clinical system, it is expected that provenance of this Problem list can be managed through versioning of this COMPOSITION and its contents, with the additional option of a system-based audit trail. While it may be ideal to have only one Problem list for each subject of care, it is more realistic to expect that in a distributed environment there may be multiple Problem lists for a single subject of care, each managed and prioritised for a specific clinician, episode of care or other context. For example, a Problem list for a primary care clinician may be a very different configuration to that which is useful for a specialist surgeon or for reference during a hospital inpatient episode. In primary care it is common to organise the Problem list based on active or inactive problems or diagnoses; specialists may prefer to see their list organised around primary diagnoses which are related to their specific speciality and secondary ones which are not; and an inpatient admission may include additional issues related to immediate nursing priorities that would not be relevant once discharged home - for these purposes there is a Status SLOT in the Problem/Diagnosis archetype, which allow use of an archetype that could

support clinical systems to organise Problem lists according to the preference of the clinical users of the system, without perpetuating these contextual status labels to other clinical scenarios or for persistence. This archetype is usually managed as a persistent list, however there are situations where the list may be used within episodic care and require additional attributes such as context etc to enable accurate recording. The openEHR reference model currently only allows context to be recorded within Event-based COMPOSITION archetypes. As a result, this archetype has been modelled as an Event, rather than Persistent, COMPOSITION, to allow for flexibility so that some clinical systems can safely manage Problem lists for episodes of care, while others will choose to implement this COMPOSITION to act in a persistent manner.

Keywords: problem, list, diagnosis, diagnoses, procedure, problem list

Concepts:

- at0000::Problem list - A persistent and managed list of any combination of diagnoses, problems and/or procedures that may influence clinical decision-making and care provision for the subject of care.
- at0006::Tree - @ internal @
- at0008::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

progress_note

Archetype ID: openEHR-EHR-COMPOSITION.progress_note.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: de, nb, en

Purpose: To record details of health-related events that have occurred as part of the subject's care, and/or the subject's health status, findings, opinions and plans that are current at the time of recording.

Use: Use to record details of health-related events that have occurred as part of the subject's care, and/or the subject's health status, findings, opinions and plans that are current at the time of recording. Progress notes are more typically used to record ongoing care notes by various providers participating in aspects of care during some kind of healthcare episode, as distinct from a one-off face-to-face meeting in a clinic which is typically recorded as a COMPOSITION.encounter. A progress note may not include a face-to-face meeting between a clinician and the subject, but may be used to record health

information remotely from the patient or report on a follow-up telephone conversation or liaison between healthcare providers without the subject present. A typical nursing progress note during a hospital episode might include EVALUATION.reason_for_encounter, EVALUATION.progress_note to record the narrative summary of the nursing shift, a combination of OBSERVATIONS for recording vital signs measurements and/or ACTIONS to record the tasks or procedures carried out.

Keywords: progress note

Concepts:

- at0000::Progress Note - Document used to record details of health-related events that have occurred as part of the subject's care, and/or the subject's health status, findings, opinions and plans that are current at the time of recording.

report-case_classification

Archetype ID: openEHR-EHR-COMPOSITION.report-case_classification.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: de, sv, fi, ko, pt-br, en, ar-sy, it, zh, nb, es-ar, sl, nl

Purpose: To carry information about a clinical investigation, such as the result of an interview or complete investigation into a death or occurrence of an infectious disease.

Use: Use to carry information about a clinical investigation, such as the record of an interview or investigation into a death or infectious disease notification. The main Sections/Content component has been deliberately left unconstrained. This will allow it to be populated with any SECTION or ENTRY archetypes appropriate for the clinical purpose within a template.

Misuse: Not to be used to carry information about the initial notification of a death or infectious disease for surveillance purposes. Use COMPOSITION.report-clinical_notification for this purpose.

Keywords: report

Concepts:

- at0000.1::Case classification report - Container archetype to carry information about a clinical investigation.
- at0.1::Index item - The name or type of the health item under investigation.

- at0.2::Report type - The type of report.
- at0.4::Date investigation initiated - The date when the investigation was assigned to an investigator.
- at0.5::Classifier - Details about the individual(s) assigned to investigate the disease notification.
- at0.7::Date of classification - The date when the investigation report was completed.
- at0.10::Index infectious disease - Name of the infectious disease under investigation.
- at0.11::Index health event - Type of health event under investigation.
- at0.8::Review type - Identification of the category or level of review.
- at0.9::Date report submitted - Date when the final report was submitted to the final health authority.
- at0.12::Reviewed by - Details about the review process and reviewers of the report.
- at0.13::Reviewer role - The formal role or position of the reviewer.
- at0.14::Reviewer - Structured details about the individual or organisation who reviewed the report.
- at0.15::Report comment - Narrative response to the content of the report by the reviewer.
- at0.16::Date review completed - Date when the review of the report was completed.
- at0.18::Health region - Identification of the local health region where the index case was identified or the index event happened.
- at0.20::Date review submitted - Date when the review was submitted to the next level of review.
- at0.23::Date of notification - Date when the disease or event notification was submitted.
- at0.25::Notifier - Identification of the facility or individual notifying about the disease or event.
- at0.27::Date received for review - None
- at0000::Report - Document to communicate information to others, commonly in response to a request from another party.
- at0001::Tree - @ internal @
- at0002::Report ID - Identification information about the report.
- at0005::Status - The status of the entire report. Note: This is not the status of any of the report components.
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

report-clinical_investigation

Archetype ID: openEHR-EHR-COMPOSITION.report-clinical_investigation.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: de, sv, fi, ko, pt-br, en, ar-sy, it, zh, nb, es-ar, sl, nl

Purpose: To carry information about a clinical investigation, such as the result of an interview or complete investigation into a death or occurrence of an infectious disease.

Use: Use to carry information about a clinical investigation, such as the record of an interview or investigation into a death or infectious disease notification. The main Sections/Content component has been deliberately left unconstrained. This will allow it to be populated with any SECTION or ENTRY archetypes appropriate for the clinical purpose within a template.

Misuse: Not to be used to carry information about the initial notification of a death or infectious disease for surveillance purposes. Use COMPOSITION.report-clinical_notification for this purpose.

Keywords: report

Concepts:

- at0000.1::Clinical investigation report - Container archetype to carry information about a clinical investigation.
- at0.1::Index item - The name or type of the health item under investigation.
- at0.2::Report type - The type of report.
- at0.4::Date investigation initiated - The date when the investigation was assigned to an investigator.
- at0.5::Investigator - Details about the individual(s) assigned to investigate the disease notification.
- at0.7::Date investigation completed - The date when the investigation report was completed.
- at0.6::Investigation location - The place where the investigation was carried out.
- at0.10::Index infectious disease - Name of the infectious disease under investigation.
- at0.11::Index health event - Type of health event under investigation.
- at0.8::Review type - Identification of the category or level of review.
- at0.9::Date report submitted - Date when the final report was submitted to the final health authority.
- at0.12::Reviewed by - Details about the review process and reviewers of the report.
- at0.13::Reviewer role - The formal role or position of the reviewer.
- at0.14::Reviewer - Structured details about the individual or organisation who reviewed the report.
- at0.15::Report comment - Narrative response to the content of the report by the reviewer.
- at0.16::Date review completed - Date when the review of the report was completed.

- at0.18::Health region - Identification of the local health region where the index case was identified or the index event happened.
- at0.20::Date review submitted - Date when the review was submitted to the next level of review.
- at0.21::Information source - Description about one or more source types for the information contained in the report.
- at0.22::Epidemiological week - The number of completed weeks in the year.
- at0.23::Date of notification - Date when the disease or event notification was submitted.
- at0.25::Notifier - Identification of the facility or individual notifying about the disease or event.
- at0.26::Detection method - Method of detection of the index disease or event.
- at0.27::Date received for review - None
- at0000::Report - Document to communicate information to others, commonly in response to a request from another party.
- at0001::Tree - @ internal @
- at0002::Report ID - Identification information about the report.
- at0005::Status - The status of the entire report. Note: This is not the status of any of the report components.
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0.28::Treating Physician - None

report-post_mortem

Archetype ID: openEHR-EHR-COMPOSITION.report-post_mortem.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: de, fi, sv, ko, pt-br, ar-sy, en, it, zh, es-ar, nb, sl, nl

Purpose: To carry information about a post mortem or autopsy.

Use: Use as a container archetype to carry information about a post mortem or autopsy. The main Sections/Content component has been deliberately left unconstrained. This will allow it to be populated with any SECTION or ENTRY archetypes appropriate for the clinical purpose within a template.

Keywords: report

Concepts:

- at0.1::Date of autopsy - The date when the autopsy was completed.
- at0.2::Pathologist - Identification of the individual(s) who carried out the autopsy.
- at0.3::Pathologist category - The category/credentials of the individual who carried out the autopsy.
- at0.4::Investigator - Details about the individual(s) assigned to investigate the disease notification.
- at0.5::Date report completed - The date when the post mortem report was completed.
- at0.6::Date report submitted - The date when the post mortem report was submitted to the public health authority.
- at0000.1::Post mortem report - Container archetype to carry information about a post mortem or autopsy.
- at0000::Report - Document to communicate information to others, commonly in response to a request from another party.
- at0001::Tree - @ internal @
- at0002::Report ID - Identification information about the report.
- at0005::Status - The status of the entire report. Note: This is not the status of any of the report components.
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

report-procedure

Archetype ID: openEHR-EHR-COMPOSITION.report-procedure.v1

Lifecycle State: published

Category: COMPOSITION

Languages: de, nb, pt-br, en

Purpose: Generic container archetype to carry information about any stand-alone procedure or operation performed.

Use: Use as a generic procedure-related archetype to carry information about any stand-alone procedure or operation performed. It is anticipated that each COMPOSITION.report-procedure archetype will contain at least one ACTION.procedure (or related archetype) but depending on the complexity of the procedure it may contain a variety of other archetypes depending on the nature and complexity of the procedure performed. For example, archetypes to describe the associated anaesthetic or imaging activities carried out during the procedure. Common use cases are: - any procedure that is not recorded as part of a consultation but needs to be carried out recorded as a stand-alone activity; - Endoscopy Report; through to a - complete Operation Report for an laparotomy or

joint replacement. Record of the anaesthetic used to cover the procedure will be recorded using purpose-specific archetypes. They can be committed to the health record at the same time as the Procedure report, most likely in one of two ways: - in a separate Anaesthetic report. This is most likely if the anaesthetic is administered by a separate clinician to the one performing the procedure; or - in the same Procedure report as the procedure is recorded. This is most likely if the anaesthetic was administered by the same clinician who performed the procedure. The Sections component has been deliberately left unconstrained to maximise re-use of this archetype.

Misuse: Not to be used for reports that are not related to a procedure. Use the generic COMPOSITION.report or purpose specific COMPOSITIONs as appropriate. Not to be used for procedures that are recorded as part of a consultation note, for example removal of a skin lesion in a primary care consultation - use a ACTION.procedure archetype inside the COMPOSITION.encouter for this purpose. Not to be used for procedures that are recorded as part of a nursing progress note, for example insertion of a catheter - use an ACTION.procedure archetype inside the COMPOSITION.progress_note.

Keywords: report, procedure, operation

Concepts:

- at0000::*Report(en) - *Document to communicate information to others, commonly in response to a request from another party.(en)
- at0000.1::Procedure report - Document to communicate information to others about any stand-alone procedure or operation performed.
- at0001::Tree - @ internal @
- at0002::Report ID - Identification information about the report.
- at0005::Status - The status of the entire report. Note: This is not the status of any of the report components.
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

report-result

Archetype ID: openEHR-EHR-COMPOSITION.report-result.v1

Lifecycle State: published

Category: COMPOSITION

Languages: de, es-ar, nb, ko, pt-br, ar-sy, sl, en

Purpose: Generic container archetype to carry information about the result of a test or assessment.

Use: Use as a generic archetype to carry information about the result of a stand-alone test or assessment, or a group of related results. It is anticipated that each COMPOSITION.report-result archetype will contain at least one OBSERVATION archetype that will hold the test results, but depending on the complexity of the test or assessment other archetypes may also be included to provide the complete clinical context. Common use cases are: - one or more specimen-related pathology/laboratory test results; - one or more time-related imaging examination test results; - an ECG result; or - an audiogram hearing assessment. The Sections component has been deliberately left unconstrained to maximise re-use of this archetype.

Misuse: Not to be used for reports that are not related to a result for a test or assessment. Use the generic COMPOSITION.report or purpose specific COMPOSITIONs as appropriate. Not to be used for test or assessment results that are recorded as part of a consultation note, for example Glasgow coma scale in the context of an emergency consultation - use the OBSERVATION.glasgow_coma_scale archetype as one component within the COMPOSITION.encouter for this purpose.

Keywords: report, test, result, diagnostic

Concepts:

- at0000::Report - Document to communicate information to others, commonly in response to a request from another party.
- at0000.1::Result report - Document to communicate information to others about the result of a test or assessment.
- at0001::Tree - @ internal @
- at0002::Report ID - Identification information about the report.
- at0005::Status - The status of the entire report. Note: This is not the status of any of the report components.
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

report

Archetype ID: openEHR-EHR-COMPOSITION.report.v1

Lifecycle State: published

Category: COMPOSITION

Languages: de, fi, sv, ko, pt-br, ar-sy, en, it, zh-cn, zh, es-ar, nb, sl, nl, ca

Purpose: Generic container archetype to carry information that needs to be shared with others.

Use: Use as a generic archetype to carry information that needs to be shared with others, where no specialised archetype for a specific report type exists. Common use cases are: documenting a response to a request for information; the outcome of testing; activities that have been performed; or events that have occurred. The main Sections/Content component has been deliberately left unconstrained. This will allow it to be populated with any SECTION or ENTRY archetypes appropriate for the clinical purpose within a template.

Keywords: report

Concepts:

- at0000::Report - Document to communicate information to others, commonly in response to a request from another party.
- at0001::Tree - @ internal @
- at0002::Report ID - Identification information about the report.
- at0005::Status - The status of the entire report. Note: This is not the status of any of the report components.
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

request

Archetype ID: openEHR-EHR-COMPOSITION.request.v1

Lifecycle State: published

Category: COMPOSITION

Languages: de, sv, nb, ar-sy, en, nl

Purpose: To request advice, a specified service or transfer of care from a healthcare provider or organisation about the subject of care.

Use: Use as basis for a request for advice, a service or transfer of care from a healthcare provider or organisation about the subject of care. This document will typically include details about the scope and duration of validity of the request, as well as relevant clinical information about the subject. Requests can vary from a simple request for a consultation, seeking recommendation about further action, requesting a specific procedure or diagnostic test, through to full handover of care and clinical responsibility to the receiving healthcare

provider. Use cases include, but are not limited to a request for: - a consultation, second opinion or management advice from a specialist; - a diagnostic test; - home care from visiting nurses; - transfer of care to a rehabilitation facility; - for aged care assessment; - for a medication review by a pharmacist; and - for provision of physiotherapy or occupational therapy. Requests may be targeted (identifying a specific healthcare provider or organisation to carry out the request) or untargeted (identifying only the type of care desired).

Misuse: Not to be used to represent the document recorded as part of a single clinical encounter or visit. Use COMPOSITION.encounter for this purpose. Not to be used to provide a transfer of care summary to another organisation or provider - use COMPOSITION.transfer_summary for this purpose.

Keywords: referral, request, service

Concepts:

- at0000::Request for service - Document sent from one treating healthcare provider or organisation to another, for the purpose of requesting advice, a service or transfer of care.
- at0001::Tree - @ internal @
- at0042::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

review

Archetype ID: openEHR-EHR-COMPOSITION.review.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: pt-pt, sv, nb, en

Purpose: To record the details of a formal review of a subject's clinical situation or any specific aspect of their clinical care.

Use: Use to record the details of a formal review of a subject's clinical situation or any specific aspect of their clinical care. For example: use to record Medicines reviews; or Case Coordinator reviews.

Keywords: review, assessment, medicine, clinical, case, file

Concepts:

- at0000::Review - Composition for the recording of the details of a formal review of a subject's clinical situation or any specific aspect of their clinical care.
- at0001::Event Context - None
- at0002::Item tree - @ internal @
- at0003::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

self_reported_data

Archetype ID: openEHR-EHR-COMPOSITION.self_reported_data.v1

Lifecycle State: published

Category: COMPOSITION

Languages: nn, de, sv, fi, pt, nb, en, fr, zh-cn

Purpose: A container for information provided by an individual, to support clear separation of patient generated from clinician-generated health data.

Use: Use as a generic container to record information provided by an individual, to support clear separation of patient-generated from clinician-generated health data. The scope of content for this archetype can be very broad and be inclusive of many contexts. The anticipated scope of content includes, but not limited to: - self-generated responses to questionnaires, including PREMs or PROMs - pain or mood diary - tobacco smoking diary - self-generated health summary for sharing with others - self-monitoring of measurements and observations The anticipated use of this archetype includes, but is not limited to: - submission of a self-reported questionnaire to a clinician in advance of a planned contact - submission of a contact request form - daily measurements within a Personal Health Record - patient-entered data in a shared clinical portal - patient generated records of information from personal or medical devices The main Sections/Content component has been deliberately left unconstrained. This will allow it to be populated with any SECTION or ENTRY archetypes appropriate for the clinical purpose within a template.

Misuse: Not to be used to represent clinician-generated records.

Keywords: questionnaire, self-report, form, survey, PROM, PREM, PRO, diary, journal

Concepts:

- at0000::Self-reported data - Generic container for information provided by an individual.
- at0003::Item tree - @ internal @

- at0004::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0005::Device - To capture the device used to report data.
- at0006::Information Source - About one or more source types for the information contained in the report.

social_summary

Archetype ID: openEHR-EHR-COMPOSITION.social_summary.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: en

Purpose: To record a persistent and evolving summary record of information about social circumstances and experiences that may impact an individual's health.

Use: Use to record a persistent and evolving summary record of information about social circumstances or experiences that may have a potential impact on an individual's health. This archetype has been designed primarily to hold the EVALUATION.social_summary archetype as the framework to contain nested, detailed CLUSTER archetypes, each of which will describe the various aspects of the specific social circumstances or experiences in detail. The scope of Social summary record/document can include, but is not limited to: - an overview; - household details; - housing details; - education and training details; - occupation details; and - domestic/family violence information. The intent of this COMPOSITION is for use as a persistent summary, however it has been identified that for implementation the archetype also needs additional attributes related to the context of the event. As a result, the COMPOSITION has been temporarily modified as an EVENT COMPOSITION which allows addition of an Items SLOT into which additional context-related archetypes can be included. This new requirement for context-related attributes in the Persistent COMPOSITION has been requested as a future openEHR Reference Model update. Initial design of this archetype was funded by the Hearing Health project, Northern Territory, Australia.

Keywords: social, family, education, occupation, environment, housing, finances

Concepts:

- at0000::Social summary - A persistent and evolving summary record of information about social circumstances and experiences that may impact an individual's health.

- at0001::Social summary - Summary information about social circumstances or experiences that may have a potential impact on an individual's health.
- at0002::Tree - @ internal @
- at0003::Items - Additional COMPOSITION related data.

therapeutic_precautions

Archetype ID: openEHR-EHR-COMPOSITION.therapeutic_precautions.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: en

Purpose: A persistent composition or managed list to record key information that will influence or preclude use of particular medications, therapies or interventions.

Use: For managing the list of adverse reactions, allergies, intolerances etc that will influence or preclude use of therapies.

Misuse: Only use for agreed archetypes to express these precautions.

Keywords: allergy list, contraindications, intolerance

Concepts:

- at0000::Therapeutic precautions - Persistent data relating to issues that may influence or preclude the administration of one or more therapies or interventions.
- at0001::Event Context - None
- at0002::Item tree - @ internal @
- at0003::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

transfer_summary

Archetype ID: openEHR-EHR-COMPOSITION.transfer_summary.v1

Lifecycle State: published

Category: COMPOSITION

Languages: pt-br, en

Purpose: To share critical clinical information recorded by the sending healthcare organisation/provider to the healthcare organisation/provider who is taking over responsbility for provision of health care for the subject.

Use: Use to provide a summary clinical report about about an episode, or period, of care provided by a healthcare organisation or provider, to support continuity of care as the subject moves under the care or another healthcare organisation or provider, including a return to their original community. This document will typically convey information about events that occurred during the period of care, diagnoses, investigation results, management at discharge and plans for follow-up. Typical senders of this report will be healthcare providers located within a clinical facility including, but not limited to: - clinicians providing care during a hospital inpatient admission; and - clinicians providing acute treatment or assessment as part of an emergency department visit. Typical recipients of this report will be healthcare providers including, but not limited to: - the subject's usual primary healthcare provider or health service; - specialists, residential aged care or rehabilitation facility, welfare or community service provider; and - all health professionals who need to participate in post-transfer care of the subject. A discharge summary can be considered as a specific type of transfer of care summary. Multiple transfer of care summaries may be required to accompany the subject in any single transfer, to ensure that the full breadth of medical, nursing and other care information is shared with the appropriate receiving healthcare providers.

Misuse: Not to be used to represent the notes recorded as part of a single clinical encounters or visits. Use COMPOSITION.encounter for this purpose.

Keywords: discharge summary, community, transfer, continuity, discharge, summary, care

Concepts:

- at0000::Transfer of care summary - Summary document to support transfer of critical clinical information from the sending healthcare organisation/provider to the receiving healthcare organisation/provider.
- at0001::Tree - @ internal @
- at0002::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

vaccination_list

Archetype ID: openEHR-EHR-COMPOSITION.vaccination_list.v0

Lifecycle State: in_development

Category: COMPOSITION

Languages: en, nl

Purpose: To record a persistent and managed list of vaccinations that have been administered to an individual over time and to enable sharing of an Vaccination list between healthcare providers.

Use: Use to record a persistent and managed list of vaccinations given to an individual. Alternatively, it may contain positive and explicit statements about known exclusions or absence of information about vaccinations. It is intended that the SECTION.vaccination_list archetype is nested within this archetype as design guidance for representing an Vaccination list. The intent of this archetype is to be a generic container for any Vaccination list, which may have a specific context or limitation of scope set within a template. This list can be utilised as a source of vaccination data for an active current Vaccination list within a clinical system, for the transition of care, data exchange, or as the basis for decision support. This list can be comprised of three types of archetype: - statements about the positive administration of vaccinations are recorded using the ACTION.medication archetypes; OR - a positive statement about the general exclusion of vaccination administration can be recorded using the general EVALUATION.exclusion_global archetype - for example: "Never received any vaccinations"; OR - a positive statement about the exclusion of use of a specific medication can be recorded using the EVALUATION.exclusion_specific archetype - for example: "Never received Hepatitis B vaccination": OR - a positive statement about no information being available - neither positive known administrations of vaccinations nor a positive exclusion - can be recorded using the EVALUATION.absence archetype. In order for a Vaccination list to be accurate and safe to use as the basis for decision support activities and for exchange, this Vaccination list should ideally be curated by a clinician responsible for the health record, rather than managed automatically by the clinical system through business rules alone. In local systems it is possible to generate a list of vaccinations by querying the database for all ACTION.medication archetypes that have been used to record each vaccination. However this list is useful to support exchange of a local Vaccination list with other healthcare. This archetype is intended to be represented and managed as a persistent list, however there are situations where the list may be used within episodic care and require additional attributes such as context etc to enable accurate recording. The openEHR reference model currently only allows context to be recorded within Event-based COMPOSITION archetypes. As a result, this archetype has been modelled as an Event, rather than Persistent, COMPOSITION, to allow for flexibility so that some clinical systems can safely manage Vaccination lists for episodes of care, while others will choose to implement this COMPOSITION to act in a persistent manner.

Misuse: Not to be used to record lists of Medications that are not intended for persistence and ongoing revision and curation - use COMPOSITION.medication_list for this purpose.

Keywords: vaccination, immunisation, list

Concepts:

- at0000::Vaccination list - A persistent and managed list of vaccinations that have been administered to an individual over time.
- at0004::Tree - @ internal @
- at0005::Extension - Additional information required to capture local context or to align with other reference models/formalisms.