Archetype Extraction Report for evaluation

absence

Archetype ID: openEHR-EHR-EVALUATION.absence.v2

Lifecycle State: published

Category: EVALUATION

Languages: de, pt-br, en, fr, es

Purpose: To enable recording or exchange of an explicit statement by a clinician that specified health information is not available for inclusion in the health record or record extract at the time of recording.

Use: Use to enable recording or exchange of an explicit statement that specified health information is not available for inclusion in the health record or record extract at the time of recording. This statement is the third component of a family of statements - statements of positive presence, statements of positive exclusion and statements of absence: - Statements of positive presence indicate that there is relevant health information in the record or extract - for example, EVALUATION.adverse_reaction stating that the patient has an allergy to penicillin or EVALUATION.problem_diagnosis stating that the patient has diabetes. - Equivalent statements about exclusion are used to indicate that it is known that there is no relevant health information in the health record or extract - for example, EVALUATION.exclusion_adverse stating that the patient does not have a known allergy to penicillin or EVALUATION.exclusion_problem_diagnosis stating that the patient is not diabetic; and; - In this context, the EVALUATION.absence could be used to record that there is no health information available about penicillin allergy or the diagnosis of diabetes - it is not known if it is present or excluded, but there is no information that can be provided. This archetype has been developed specifically for the use case where a clinician is preparing an extract from a health record, so that the receiver has explicit and unambiguous understanding of the information available - that which is present, excluded or just not available. It is primarily intended to be used within SLOTS in persistent COMPOSITIONS such as 'Therapeutic precautions', 'Medication list', 'Problem list', or 'Adverse reaction list'. It is also deliberately intended to be statement made by a clinician in the same way that they would record any allergies or diagnoses, and is intended to be quite different to technical use of null flavours in data. Absence statements can only be considered to be current and accurate at the time of recording. This archetype has been designed specifically to avoid the need to use of flags to express negation about any entry within the health record.

Misuse: Not to be used to record the presence of adverse reactions, medication use, procedures, problems or diagnoses - use specific archetypes for this purpose. Not to be used to record the exclusion of adverse reactions, medication use, procedures, problems or diagnoses - use specific specialisations of the EVALUATION.exclusion archetype for this purpose.

Keywords: absence, information, adverse, reaction, problem, diagnosis, medication, procedure, vaccination, adverse reaction

Concepts:

- at0000::Absence of information - Statement that specified health information is not available for inclusion in the health record or extract at the time of recording.
- at0001::Tree - @ internal @
- at0002::Absence statement - Positive statement that no information is available.
- at0003::Tree - @ internal @
- at0004::Last updated - The date at which the absence was last updated.
- at0005::Reason for absence - Description of the reason why there is no information available.
- at0006::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

adl

Archetype ID: openEHR-EHR-EVALUATION.adl.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: nb, en

Purpose: To record summary information about an individual's ability to perform an identified activity of daily living.

Use: Use to record summary information about an individual's ability to perform an identified activity of daily living. This archetype has been designed to be used in a variety of contexts. For example, recording an ADL assessment during a clinical consultation; as part of a persistent care plan; or to provide a summary statement within a nursing admission or discharge report. It is intended to be instantiated once for each identified ADL activity.

Misuse: Not to be used to record the results of formal instruments, scores or scales, assessing capability for activities of daily living, such as the Barthel Index - use specific archetypes for each score or scale, such as OBSERVATION.modified_barthel_index.

Concepts:

- at0000::ADL activity summary - Summary information about an individual's ability to perform an identified activity of daily living.
- at0003::Tree - @ internal @
- at0004::Activity name - The name of the activity of daily living.
- at0005::Clinical description - Narrative description about the individual's ability to perform the activity.
- at0006::Capability - Category of the ability for the individual to perform the identified activity.
- at0007::Independent - The individual is able to perform the activity independently.
- at0008::Independent with equipment - The individual is able to perform the activity with the assistance of equipment or aids.
- at0009::Requires assistance - The individual requires active support to perform the activity.
- at0010::Dependent - The individual is not able to perform the activity by themselves.
- at0011::Support description - Description about the support required to carry out the activity.
- at0012::Equipment description - Description about the equipment or aide required to carry out the activity.
- at0013::Equipment - Structured details about the equipment required.
- at0014::Additional details - Additional structured details about the ability to perform the activity.
- at0015::Comment - Additional narrative about the individual's ability to perform the activity not captured in other fields.
- at0016::Item tree - @ internal @
- at0017::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0018::Limitation - A limitation of the individual in carrying out the identified activity.
- at0019::Not applicable - Assessment of the activity is not applicable to the individual.

advance_care_directive

Archetype ID: openEHR-EHR-EVALUATION.advance_care_directive.v2

Lifecycle State: published

Category: EVALUATION

Languages: de, nb, pt-br, en, nl

Purpose: To record the preferences of an individual for future medical treatment and care.

Use: Use to record the preferences of an individual for future medical treatment and care. Advance care directive may also be known as living will, advance directive, advance decision, advance decision to refuse treatment, personal directive, advance healthcare directive, or medical directive. An advance care directive is commonly used to refuse life-sustaining treatment which may include, but is not limited to: cardiopulmonary resuscitation (CPR); clinically assisted nutrition and hydration; assisted ventilation; and antibiotics for life-threatening infections. It could also include positive preferences and instructions for future health care priorities, living arrangements and personal matters. An individual with capacity may create an advance care directive to record their preferences for medical care and treatment in advance, which is intended to guide decision-making in future situations in which the individual is unable to make or communicate decisions. This archetype has been specifically designed as a framework or structure that can be extended for the complex range of use cases and local requirements by nesting a variety of possible CLUSTER archetypes which will contain specific details as per national or other local requirements. In some countries, an advance care directive is legally persuasive without having an official legal status. In others it is a legally-binding document, and it MUST be ensured that the advance care directive archetype and any nested archetypes adhere to relevant legal requirements.

Misuse: Not to be used to record organ donation preferences. Use a specific archetype for this purpose. Not to be used to record details about a Power of Attorney or other legal representative/proxy. Use a specific archetype for this purpose. Not to be used to record anticipatory decisions about CPR decisions, other possible intervention decisions, and intent of care as asserted by a clinician in a health record. Use the EVALUATION.advance_intervention_decisions archetype for this purpose.

Keywords: living, will, advance, advanced, directive, decision, legal, preference, EoL, DNR, DNACPR, resuscitation,

Concepts:

- at0000::Advance care directive - A framework to communicate the preferences of an individual for future medical treatment and care.
- at0001::Item tree - @ internal @
- at0004::Status - The status of the advance care directive.
- at0005::Type of directive - The type of advance care directive.
- at0006::Description - Narrative description of the overall advance care directive.

- at0007::Condition - The conditions or situations in which the individual wishes the advance care directive to apply.
- at0010::Item tree - @ internal @
- at0025::Witness - Personal details of a person who witnesses the completion of the advance care directive.
- at0027::Mandate - Description of any legislation or other authoritative guidance that apply.
- at0030::Location - Physical or digital location of the Advance care directive.
- at0038::Comment - Additional narrative about the advance care directive not captured in other fields.
- at0044::Present - The individual has an advance care directive.
- at0045::Absent - The individual does not have an advance care directive.
- at0047::Unknown - It is not known whether the individual has an advance care directive.
- at0052::Directive detail - Structured details about the advance care directive decisions.
- at0053::Valid period start - The date/time that marks the beginning of the valid period of time for this advance care directive.
- at0054::Valid period end - The date/time that marks the conclusion of the valid period of time for this advance care directive.
- at0055::Last updated - The date when this advance directive record was last updated.
- at0056::Review due date - The date at which the advance care directive is due to be reviewed.
- at0058::Directive location - Information about the physical or digital location of the Advance care directive.
- at0059::Copy holder - Details of a person who has a copy of the Advance care directive.
- at0060::Digital representation - Digital document, image or video representing the Advance care directive.
- at0061::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.

advance_intervention_decisions

Archetype ID: openEHR-EHR-EVALUATION.advance_intervention_decisions.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, nb, en

Purpose: To record anticipatory decisions about the overall intent of care and possible interventions, usually asserted by a clinician.

Use: Use to record anticipatory decisions about the overall intent of care and possible interventions for an individual. The decisions will support clinicians by providing guidance regarding possible treatments, activities, and diagnostic or therapeutic procedures that may be life-saving, life-prolonging or cause undesirable side effects. This archetype is intended to be used as part of integrated care or end-of-life planning, and not as a reaction to an acute or emergency situation. Each decision should be made in response to the individual's overall health and general circumstances, and usually asserted by a clinician after consideration of the individual's advance care directives or stated preferences. It may be necessary to record temporary overrides to usual advance intervention decisions in specific circumstances, for example during pregnancy or preoperatively. In this situation it will be necessary to record a separate instance of this archetype, using a combination of relevant validity and review dates.

Misuse: Not to be used to record an 'Advance care directive' or the individual's preferences for care - use EVALUATION.advance_care_directive for this purpose. Not to be used to record the orders required as a consequence of the decisions made and recorded using this archetype. Use specific INSTRUCTION or ACTION archetypes for this purpose.

Keywords: DNR, DNAR, DNACPR, NFR, resuscitation, resuscitate, EoL, end of life, directive, preference, goal, care, intervention, ceiling, limit, limitation, treatment, scope, escalation, intent, EOLC, life-prolonging, life-saving, palliative, decision, direction

Concepts:

- at0000::Advance intervention decisions - Anticipatory decisions about the overall intent of care and possible interventions (including treatments, activities, and diagnostic or therapeutic procedures), asserted by a clinician.
- at0001::Tree - @ internal @
- at0002::Intent of care - The overall intent for future care and treatment for the individual.
- at0003::Curative - The condition is curable; all appropriate life-prolonging treatment will be offered.
- at0004::Restorative - The condition is treatable with potential for restoration to the previous state of health or a prolonged remission; all appropriate life-prolonging treatment will be offered.
- at0005::Supportive - The condition is incurable and progressive; active treatment of the underlying disease may be appropriate for specific symptom relief and/or short term life expectancy gains; focused on comfort, quality of life and dignity. Also referred to as 'Palliative'.
- at0006::Terminal - Life expectancy is short (hours or days); no active treatment of the underlying disease or treatment-related harm; focus on comfort, quality of life and dignity.

- at0007::Unknown - The intent of care decision is not known.
- at0008::Decisions description - Narrative description about all advance intervention decisions, including the CPR decision.
- at0009::CPR decision - Decision about the extent of cardiopulmonary resuscitation (CPR) intervention appropriate for this individual.
- at0010::Full CPR - All appropriate cardiopulmonary resuscitation treatments should be attempted to save or prolong life.
- at0011::Limited CPR - Cardiopulmonary resuscitation treatments should be attempted, as specified in the 'Decisions description' narrative or as structured data in the 'Per intervention' cluster.
- at0012::No CPR - No cardiopulmonary resuscitation treatments should be attempted to save or prolong life. Also known as 'Do not resuscitate (DNR)'; 'Do not attempt resuscitation (DNAR)'; 'Not for resuscitation (NFR)' or similar.
- at0013::Unknown - The CPR decision is not known.
- at0014::Per intervention - Details of the decision about possible treatments or activities that may be life-saving, life-prolonging or cause undesirable side effects.
- at0015::Intervention - Name of the possible treatment, procedure or activity.
- at0016::Chest compressions - Technique used to manually pump blood around the body during a cardiac arrest.
- at0017::Defibrillation - Use of electric shock to reset the electrical state of the heart.
- at0018::Intubation - Placement of a tube into the trachea to maintain an open airway, including a tracheostomy.
- at0019::Invasive ventilation - Artificial ventilation where invasive means are used to assist or replace spontaneous breathing.
- at0020::Non-invasive ventilation - Artificial ventilation where non-invasive means are used to assist or replace spontaneous breathing.
- at0021::Peripheral intravenous line - Insertion of a peripheral intravenous line.
- at0022::Central venous line or any arterial line - Insertion of a central venous line or any arterial line.
- at0023::Parenteral fluids - Maintenance of hydration by means other than eating or drinking.
- at0024::Parenteral or artificial nutrition - Provision of nutrients by means other than eating or drinking.
- at0025::Arrest medications - Medications used during an emergency resuscitation to prolong life. For example: adrenaline, atropine, sodium bicarbonate, calcium, other vasoactive medications.
- at0026::Circulatory regulation medications - Medication that supports heart function, including but not limited to: vasopressors, inotropes and chronotropes.
- at0027::Antibiotics, antiviral or antifungal agents - Medications to treat infections.
- at0028::Blood products - Therapeutic substance prepared from human blood including, but not limited to: whole blood; blood components; and plasma derivatives.
- at0029::Chest tube insertion - Insertion of a tube into the pleural space.

- at0030::Cardiac pacemaker - Insertion of an artificial pacemaker to control the heart beat.
- at0031::Dialysis - Process of removing excess water, solutes, and toxins from the blood.
- at0032::Transfer to hospital - Transfer to hospital for assessment or admission.
- at0033::Transfer to Intensive Care - Transfer and admission to an intensive care or high dependency unit.
- at0034::Decision - Decision about the identified intervention.
- at0035::Recommended - The intervention is recommended.
- at0036::Conditional recommendation - The intervention is recommended only in specific circumstances, captured using the 'Preconditions' data element.
- at0037::Not recommended - The intervention is not recommended.
- at0038::Unknown - The intervention decision is not known.
- at0039::Precondition - Description of the circumstance/s in which a 'Conditional recommendation' is applicable.
- at0040::Comment - Additional narrative about the intervention decision, not captured in other fields.
- at0041::Additional details - Additional structured details about advance intervention decisions.
- at0042::Patient awareness - Narrative description about awareness of the Advance intervention decisions by the individual.
- at0043::Carer awareness - Narrative description about awareness of the Advance intervention decisions by family, carers or legal proxy.
- at0044::Overall comment - Additional narrative about all advance intervention decisions, not captured in other fields.
- at0045::Tree - @ internal @
- at0046::Last updated - The date and/or time when the Advance intervention decisions were last updated.
- at0047::Valid period start - The date/time that marks the beginning of the valid period of time for the Advance intervention decisions.
- at0048::Valid period end - The date/time that marks the conclusion of the valid period of time for the Advance intervention decisions.
- at0049::Review due - The date when review of the Advance intervention decisions are due.
- at0050::Mandate - Description of any legislation or other authoritative guidance that apply.
- at0051::Digital representation - Digital document, image or video representing these Advance intervention decisions.
- at0052::Document location - Information about the physical or digital location of the advance intervention decisions record.
- at0053::Location - Physical or digital location of the Advance intervention decisions record.

- at0054::Copy holder - Details of a person who has a copy of the Advance intervention decisions record.
- at0055::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0056::Rationale - Narrative description about the logic and justification for the 'Intent of care' decision.

adverse_reaction_risk

Archetype ID: openEHR-EHR-EVALUATION.adverse_reaction_risk.v2

Lifecycle State: published

Category: EVALUATION

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

Purpose: To record the clinical assessment of the propensity for an individual to experience an adverse reaction if exposed, or re-exposed, to a specified substance or class of substances.

Use: Use to record a clinical assessment of a propensity for an adverse reaction upon future exposure to a specified substance or class of substances including, but not limited to, incipients and excipients in medicinal preparations, biological products, metal salts, and organic chemical compounds. This archetype is intended to provide a single place within the health record to document the propensity for the full range of reactions, from trivial to life-threatening: - immune-mediated: Types I-IV (including allergic reactions and hypersensitivities); or - non-immune-mediated: including pseudo-allergic reactions, side effects, intolerances, and drug toxicities. In clinical practice distinguishing between immune-mediated and non-immune-mediated reactions can be difficult. Identification of the type of reaction is not a proxy for seriousness or risk of harm to the patient. Where a propensity is identified, information or evidence about one or more reaction events can be recorded using the CLUSTER.adverse_reaction_event archetype in the 'Reaction event summary' SLOT. Identification of the severity of the manifestation of the reaction, recorded in the CLUSTER.adverse_reaction_event archetype, can inform the 'Criticality' of the adverse reaction risk. For example, experiencing anaphylaxis on first exposure to a substance would warrant setting a 'Criticality' of 'high', due to the high risk that anaphylaxis is likely to recur on second and subsequent exposures. This archetype has been designed to allow the recording of information about a specific substance (amoxycillin, oysters, or bee sting venom) or, alternatively, a class of substance (e.g. Penicillins). If a class of substance is recorded, identification of the exact substance can be recorded on a per-reaction basis using the CLUSTER.adverse_reaction_event archetype. Use to record information about the

positive presence of the risk of an adverse reaction: - to support the direct clinical care of an individual; - as part of a managed adverse reaction or allergy/intolerance list; - to support the exchange of information about the propensity and events related to adverse reactions; - to inform adverse reaction reporting; and - to assist with computerised knowledge-based activities such as clinical decision support and alerts. The risk of an adverse reaction event or manifestation must always propose a causative substance or class of substance. If there is a degree of uncertainty that a specific substance is the cause, the level of uncertainty can be recorded using the 'Verification status' data element. If more than one possible substance may have caused a reaction/manifestation, each substance should be recorded using a separate instance of this adverse reaction risk archetype with the 'Verification status' set to an initial state of 'Unconfirmed' so that adverse reaction checking can be activated in clinical systems. If the substance is later proven not to be causal then the 'Verification status' can be modified to 'Refuted' - for example, after allergy testing.

Misuse: Not to be used for recording physiological reactions to physical agents, such as heat, cold, sunlight, vibration, exercise activity, by infectious agents or food contaminants. Use a specific archetype for EVALUATION.problem/diagnosis or CLUSTER.symptom/sign for this purpose. Not to be used to record adverse events, including failures of clinical process, interventions or products. For example: abnormal use, incorrect dosage or maladministration of an agent or substance; mislabelling; harm or injury caused by an intervention or procedure; overdose/poisoning etc. Use a specific archetype for the purpose. Not to be used to record an adverse reaction where the substance is unknown. Use EVALUATION.problem_diagnosis or CLUSTER.symptom_sign to record as part of the health record until a possible substance is identified. Not to be used to record reactions to transfusions of blood products. Use a specific archetype for this purpose. Not to be used for recording 'alerts'. Use EVALUATION.precaution, EVALUATION.contraindication or related archetypes for this purpose. Not to be used for recording failed therapy. Not to be used for the explicit recording of an absence (or negative presence) of a reaction to 'any substances' or to identified substances, for example 'No known allergies or adverse reactions' or 'No known allergies to Penicillin'. Use the EVALUATION.exclusion_global or EVALUATION.exclusion_specific archetypes to express a positive statement of adverse reaction exclusion. Not to be used for the explicit recording that no information was able to be obtained about the adverse reaction status of a patient. Use the EVALUATION.absence archetype to record that a positive statement that information was not able to be obtained, for example, if a non-cooperative patient refuses to answer questions.

Keywords: reaction, allergy, allergic, adverse, event, effect, sensitivity, intolerance, hypersensitivity, side effect, toxicity, drug, food, agent, substance, immune, non-immune, chemical, anaphylaxis, allergen, medication, supplement, medicine, natural remedies, immunological, non-immunological, risk

Concepts:

- at0000::Adverse reaction risk - Clinical assessment of the propensity for an individual to experience a harmful or undesirable physiological response if exposed, or re-exposed, to a substance.
- at0001::Tree - @ internal @
- at0002::Substance - Identification of a substance, or substance class, that is considered to put the individual at risk of an adverse reaction event.
- at0006::Comment - Additional narrative about the propensity for the adverse reaction, not captured in other fields.
- at0042::Tree - @ internal @
- at0047::Supporting clinical record information - Link to further information about the presentation and findings that exist elsewhere in the health record, including allergy test reports.
- at0058::Reaction mechanism - Identification of the underlying physiological mechanism for the adverse reaction.
- at0059::Immune mediated - Immune mediated reaction, including allergic reactions and hypersensitivities.
- at0060::Non-immune mediated - A non-immune mediated reaction, which can include pseudo-allergic reactions, side effects, intolerances, drug toxicities (for example, to Gentamicin).
- at0062::Last updated - Date when the propensity or the reaction event was updated.
- at0063::Verification status - Assertion about the certainty of the propensity, or potential future risk, of the identified 'Substance' to cause a reaction.
- at0064::Unconfirmed - The propensity for a reaction to the identified 'Substance' has not been objectively verified.
- at0065::Confirmed - The propensity for a reaction to the identified 'Substance' has been objectively verified. This may include clinical evidence by testing, re-challenge or observation.
- at0066::Refuted - A propensity for a reaction to the identified 'Substance' has been disputed or disproven with a sufficient level of clinical certainty to justify invalidating the assertion. This may include clinical evidence by testing, re-challenge or observation.
- at0101::Criticality - An indication of the potential for critical system organ damage or life threatening consequence.
- at0102::Low - Exposure to substance unlikely to result in critical system organ damage or life threatening consequence. Future exposure to the identified 'Substance' should be considered a relative contra-indication in normal clinical circumstances.
- at0103::High - Exposure to substance may result in critical organ system damage or life threatening consequence. Future exposure to the identified 'Substance' should be considered an absolute contra-indication in normal clinical circumstances.
- at0117::Onset of last reaction - The date and/or time of the onset of the last known occurrence of a reaction event.
- at0120::Category - Category of the identified 'Substance'.
- at0121::Food - Any substance consumed to provide nutritional support for the body, such as peanut or egg.

- at0122::Medication - Any substance administered to achieve a physiological effect.
- at0123::Other - Any other substance encountered including venom, latex and other environmental substances.
- at0124::Indeterminate - Unable to assess with information available.
- at0126::Indeterminate - The physiological mechanism could not be determined.
- at0128::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0129::Reaction event summary - Summary details about each adverse reaction event linked to exposure to the identified 'Substance'.
- at0130::Active/inactive status - Status about whether the adverse reaction risk statement is active or inactive.
- at0131::Active - The subject is currently experiencing, or is at risk of, a reaction to the identified substance.
- at0132::Inactive - The subject is no longer at risk of a reaction to the identified substance.
- at0133::Onset of first reaction - The onset of the first known occurrence of a reaction event.

alcohol_consumption_summary

Archetype ID: openEHR-EHR-EVALUATION.alcohol_consumption_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, sv, nb, en, fr, nl

Purpose: To record summary information about the individual's typical pattern of alcohol consumption.

Use: Use to record summary information about the individual's typical pattern of alcohol consumption. This archetype is to be used to record information about both current and previous alcohol consumption. The specific scope of this archetype is about documentation about all types of alcohol consumed or ingested by an individual, because of the associated health risks. The history of waxing and waning of consumption for each type of alcohol over time can be captured using the repeatable 'Per episode' cluster. Triggers for closing one episode and commencing a new one will largely reflect local data collection preferences, including if the individual: - quits for a significant period of time (which will likely be locally defined); or - significantly changes the amount or the pattern of alcohol consumption. The 'Per type' cluster of data elements allows for recording of specific details about each type of alcohol consumed, and can be repeated for every type alcoholic beverage

consumed in the actual episode. The element 'Type' identifies the type of alcohol, either as a free text or coded text with a defined valueset. In many situations the individual will only consume one type of alcohol, such as beer. If other types of alcohol are consumed, the details will be recorded in another instance of the 'Per type' cluster. Use to incorporate the narrative descriptions of alcohol consumption within existing or legacy clinical systems into an archetyped format, using the 'Overall description' data element.

Misuse: Not to be used to record event-or period-based information about alcohol drinking, such as actual daily drinking/binging or the average drinking over a specified period of time - use the OBSERVATION.alcohol_intake archetype. Not to be used to record an assessment about alcohol dependence. Use specific archetypes for this purpose - for example OBSERVATION.audit. Not to be used to record administration of alcohol by other routes, such as inhalation.

Keywords: drinking, drunk, dipsomania, alcoholic, alcoholism

Concepts:

- at0000::Alcohol consumption summary - Summary or persistent information about the typical alcohol consumption of an individual.
- at0001::Tree - @ internal @
- at0003::Current drinker - Individual is a current consumer of alcohol.
- at0005::Former drinker - Individual has previously consumed alcohol but is not a current drinker.
- at0006::Lifetime non-drinker - Individual has never consumed alcohol.
- at0013::Episode start date - Date when this episode commenced.
- at0014::Quit date - Date when the individual last consumed alcohol.
- at0015::Regular consumption commenced - The date or partial date when the individual first started frequent or regular, but usually non-daily, consumption of alcohol.
- at0016::Overall quit date - The date when the individual last ceased consuming alcohol of any type.
- at0019::Overall comment - Additional narrative about all alcohol consumption that has not been captured in other fields.
- at0021::Tree - @ internal @
- at0022::Last updated - The date this alcohol consumption summary was last updated.
- at0023::Typical consumption (alcohol units) - Estimate of number of alcohol units consumed.
- at0025::Number of quit attempts - Total number of times the individual has attempted to stop consuming alcohol within this episode.
- at0026::Episode details - Additional structured details about the specified episode of alcohol consumption.
- at0029::Per type - Details about consumption of a specified type of alcohol.
- at0030::Pattern - The typical pattern of consumption of alcohol.

- at0043::Overall description - Narrative summary about the individual's overall alcohol consumption pattern and history.
- at0052::Status - Statement about current alcohol drinking behaviour.
- at0053::Description - Narrative summary about alcohol consumption for the specified type of alcohol.
- at0061::Current drinker - Individual consumed alcohol during this period.
- at0064::Per episode - Details about a discrete period of time with a consistent pattern of typical consumption.
- at0069::Comment - Additional narrative about consumption of the specified type of alcohol, not captured in other fields.
- at0071::Quit date definition - The applied definition for the 'Quit date' data elements used in this archetype.
- at0073::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0075::Current drinker definition - The applied definition for the 'Current drinker' value in each of the 'Status' data elements used in this archetype.
- at0076::Former drinker definition - The applied definition for the 'Former drinker' value in each of the 'Status' data elements used in this archetype.
- at0077::Type details - Additional structured details about the consumption of the specified alcohol.
- at0079::Lifetime non-drinker definition - The applied definition for the 'Lifetime non-drinker' value in each of the 'Status' data elements used in this archetype.
- at0080::Daily consumption commenced - The date or partial date when the individual first started consuming alcohol on a daily basis.
- at0081::Episode label - Identification of an episode of alcohol consumption - either as a number in a sequence and/or a named event.
- at0082::Episode end date - Date when this episode ceased.
- at0083::Daily - Consuming alcoholic beverage at least once every day.
- at0084::Non-daily - Not consuming alcoholic beverage every day.
- at0085::Quit attempt definition - The applied definition for a Quit attempt used to determine value for the 'Number of quit attempts' data element used in this archetype.
- at0086::Overall details - Additional structured details about the overall alcohol consumption.
- at0087::Episode comment - Additional narrative about alcohol consumption during the specified episode, not captured in other fields.
- at0089::Overall status - Statement about current consumption for all types of alcohol.
- at0091::Non-drinker - Individual has not consumed alcohol during this episode.
- at0097::Binge drinking frequency - The individual's typical frequency of heavy drinking over a short period of time with the intent of becoming intoxicated.
- at0104::Alcohol unit definition (mass) - Mass of alcohol defining a standard drink or alcohol unit as used in the 'Typical drinking (alcohol units)' element in this archetype.
- at0108::Type - The name of the specific type or grouping of alcohol.

- at0110::Alcohol free days - The number of days where no alcohol was consumed in the specified period.
- at0111::Typical consumption (alcohol units) - Estimate of number of standard drinks of the specified type of alcohol consumed.
- at0112::Episode description - Narrative summary about the individual's overall pattern of alcohol consumption during the specified episode.
- at0113::Binge drinking description - Narrative description about the individual's typical pattern of binge drinking.
- at0114::Date first intoxicated - The date or partial date when the individual became intoxicated for the first time.
- at0115::Beer - Fermented beverage made from grain mash.
- at0116::Wine - Fermented beverage made from grapes and sometimes other fruits.
- at0117::Cider - Fermented beverage made from any fruit juice.
- at0118::Mead - Fermented beverage made from honey, sometimes with various fruits spices, grains or hops.
- at0119::Pulque - Fermented beverage made from 'honey water" of cacti.
- at0120::Spirits - Fermented beverage made by a distillation process. Usually has an alcohol content >20%. Includes liquers, cocktails and rectified spirits.
- at0121::Fortified wine - Wine with added spirits.

art_cycle_summary

Archetype ID: openEHR-EHR-EVALUATION.art_cycle_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: nb, en

Purpose: To record summary or persistent information about a single cycle of assisted reproduction treatment.

Use: Use to record summary or persistent information about a single cycle of assisted reproduction treatment. The start of a treatment cycle is triggered by the initiation of ovulation stimulation or monitoring. The end of a treatment cycle is triggered by identifying a 'Cycle outcome': - the cancellation of treatment for any reason; - embryo transfer; - the recognition that no embryo is suitable for transfer; - embryo freezing; or - successful harvesting of oocytes that are frozen or donated.

Misuse: Not to be used to record details about a pregnancy conceived by assisted reproduction treatment beyond a week eight ultrasound scan.

Keywords: ART, IVF, ICSI, reproduction, in vitro, fertilisation, insemination, infertility, reproductive

Concepts:

- at0000::Assisted reproduction treatment cycle summary - Summary or persistent information about a single cycle of assisted reproduction treatment.
- at0001::Item tree - @ internal @
- at0002::Cycle sequence - The cycle number within a sequence of cycles.
- at0003::Cycle identifier - Identifier of the treatment cycle within the treating organisation.
- at0004::Start date - The date of commencement for the treatment cycle.
- at0005::Description - Narrative description about the treatment cycle.
- at0006::Intent - The intended purpose at the onset of the treatment cycle.
- at0012::Activities - Activity or treatment caried out during the treatment cycle.
- at0013::Intrauterine insemination - None
- at0014::Conventional in vitro insemination - None
- at0015::Intracytoplasmatic sperm injection (ICSI) - None
- at0016::Frozen-thawed embryo transfer - None
- at0017::Surgical sperm collection - None
- at0018::Pre-implantation genetic testing - None
- at0019::Oocyte aspiration - None
- at0020::Embryo transfer - None
- at0021::Donation received - Cell or tissue type donated to the individual as part of the treatment cycle.
- at0022::None - None
- at0023::Sperm - Donated sperm were used as part of the treatment cycle.
- at0024::Oocyte donation - Donated oocyte/s were used as part of the treatment cycle.
- at0025::Embryo donation - Donated embryo/s were used as part of the treatment cycle.
- at0026::Hormone protocol - Identification of the hormone protocol used during the treatment cycle.
- at0027::Natural cycle - None
- at0028::Modified natural cycle - None
- at0029::Hormone replacement cycle - None
- at0030::Mild stimulation - None
- at0031::Long-term GnRH agonist, conventional simulation - None
- at0032::Flare-up GnRH agonist, conventional stimulation - None
- at0033::GnRH antagonist, conventional stimulation - None
- at0034::Cycle outcome - Identification of the outcome of the treatment cycle.
- at0035::Embryo transfer completed - None
- at0036::Cycle cancelled before oocyte aspiration - None
- at0037::Cycle cancelled after oocyte aspiration - None
- at0038::All embryos frozen - None

- at0039::All oocytes frozen - None
- at0040::Oocytes donated - None
- at0041::No embryo is suitable for transfer - None
- at0042::Number of oocytes collected - None
- at0043::Number of mature (M2) oocytes collected - Number of collected oocytes in metaphase 2 of the meiotic cell division.
- at0044::Number of oocytes attempted fertilized - Number of oocytes subjected to conventional in vitro fertilisation (IVF) or to intracytoplasmatic sperm injection (ICSI).
- at0045::Number of embryos transferred - Number of embryo transferred.
- at0046::Transferred embryo quality - Narrative description about the quality of the embryos transferred.
- at0047::Number of embryos frozen - Number of cryopreserved embryos.
- at0048::Number of oocytes frozen - Number of cryopreserved oocytes.
- at0049::Number of embryos thawed - Number of embryos thawed.
- at0050::Number of embryos surviving thaw - Number of embryos surviving thaw.
- at0051::Number of embryos biopsied - Number of embryos biopsied for preimplantation genetic test.
- at0052::Number of embryos surviving biopsy - Number of embryos surviving biopsy for preimplantation genetic test.
- at0053::Number of viable fetuses - The number of fetuses with cardiac activity on the eight week ultrasound.
- at0054::Pregnancy test outcome - Outcome of pregnancy test with human chorionic gonadotropin (hCG).
- at0055::Positive - The end of cycle hCG test result was positive.
- at0056::Negative - The end of cycle hCG test result was negative.
- at0057::Complications - Details about one or more complications due to treatment or activities during the assisted reproduction treatment cycle.
- at0058::Condition - Name of the condition identified as a complication of treatment.
- at0059::Mild ovarian hyperstimulation syndrome - None
- at0060::Moderate ovarian hyperstimulation syndrome - None
- at0061::Severe ovarian hyperstimulation syndrome - None
- at0062::Infection - None
- at0063::Bleeding - None
- at0064::Thrombosis - None
- at0065::Description - Narrative description about the complication.
- at0066::Date of onset - Date of onset of the complication.
- at0067::Comment - Additional narrative about the treatment cycle, not captured in other fields.
- at0068::Item tree - @ internal @
- at0069::Last updated - The date this treatment cycle summary was last updated.
- at0070::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

- at0071::Number of 2PN zygotes - Number of zygotes with two visible pronuclei.
- at0072::Cumulative gonadotropin dose - Total gonadotropin dose administered for ovarian stimulation during the treatment cycle.
- at0073::Duration of gonadotropin administration - Number of days for gonadotropin administration during ovarian stimulation.
- at0074::Additional details - Additional details about the assisted reproduction treatment.

birth_summary

Archetype ID: openEHR-EHR-EVALUATION.birth_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: nb, en, es, ca

Purpose: To record an overview or summary record of the pregnancy and birth of an individual.

Use: Use to record an overview or summary record of the pregnancy and birth of an individual.

Misuse: Not to be used to record information about a pregnancy and birth for use in a maternal health record - use EVALUATION.pregnancy_summary and related archetypes for this purpose.

Keywords: birth, DOB, birthplace, plurality

Concepts:

- at0000::Birth summary - Overview or summary record of the pregnancy and birth of an individual.
- at0001::Item tree - @ internal @
- at0002::Country of birth - The country of birth of the individual.
- at0003::DOB alternatives - Additional details about possible alternative dates of birth.
- at0004::Date/time of birth (DOB) - The date/time of birth of the individual.
- at0005::Structured place of birth - Structured details about the place of birth.
- at0006::Pregnancy/birth summary - Narrative description about the entire pregnancy, labour and delivery of the individual, including both maternal and infant complications.
- at0007::Birth plurality - Term representing the total number of live births and stillbirths resulting from the pregnancy.

- at0008::Birth details - A subset of persistent or summary information about the pregnancy and birth of an infant, selected for utility of use within both the maternal and infant health records.
- at0009::Item tree - @ internal @
- at0010::Last updated - The date when the birth summary was last updated.
- at0011::Extension - None
- at0012::Place of birth - Simple representation about the place of birth.
- at0013::Additional details - Additional structured details related to the birth.
- at0014::Comment - Additional narrative about the birth not captured in other fields.

blood_group

Archetype ID: openEHR-EHR-EVALUATION.blood_group.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record the blood group and rhesus status of an individual.

Use: Use to record the blood group and rhesus status of an individual. As the blood group and rhesus status of an individual is usually stable over the life of an individual, this archetype has been modelled as an EVALUATION.

Misuse: Not to be used to record the result of blood group and antigen test results which may need to be performed at various times over an individual's life - for example, to confirm their blood group and antigen status prior to transfusion, organ transplantation, in pregnancy and investigating certain neonatal conditions. Use the CLUSTER.laboratory_test_analyte nested within the OBSERVATION.laboratory_test_result archetype to record the result of each individual test.

Keywords: blood, grouping, rhesus

Concepts:

- at0000::Blood group - Identification of the persistent blood group and rhesus status of an individual.
- at0001::Item tree - @ internal @
- at0002::Item tree - @ internal @
- at0003::ABO blood group - None
- at0004::Rh(D) antigen status - The presence or absence the Rh(D) antigen.

- at0005::Last updated - None
- at0006::Extension - None
- at0007::O - None
- at0008::A - None
- at0009::B - None
- at0010::AB - None
- at0011::Positive - Rh(D) antigen is detected.
- at0012::Negative - Rh(D) antigen is not detected.

breast_feeding_summary

Archetype ID: openEHR-EHR-EVALUATION.breast_feeding_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record summary information about the breastfeeding experience of an individual.

Use: Use to record summary information about the breastfeeding experience of an individual.

Misuse: Not to be used to record details about the feeding of an infant. Use EVALUATION.infant_feeding_summary for an overview of infant feeding and OBSERVATION.infant_feeding to record a feeding diary.

Keywords: breast

Concepts:

- at0000::Breast feeding summary - Summary or persistent information about the all breastfeeding experience of an individual.
- at0001::Item tree - @ internal @
- at0002::Status - None
- at0013::Item tree - @ internal @
- at0006::Description - Narrative description about the overall breastfeeding history for an individual.
- at0007::Per episode - Detail about a discrete episode of breastfeeding activity.
- at0010::Start date - The date when the episode of breastfeeding commenced.
- at0011::Stop date - The date when the episode of breastfeeding ceased.

- at0009::Episode description - Narrative description about breastfeeding during the identified episode.
- at0014::Last updated - The date when the breast feeding summary was last updated.
- at0015::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0003::Currently breastfeeding - The individual is currently breastfeeding.
- at0004::Previous breastfeeding - The individual has breastfed in the past.
- at0005::Never breastfed - The individual has never breastfed.
- at0012::Comment - Additional narrative about all breastfeeding not captured in other fields.
- at0008::Episode label - Identification of an episode of breastfeeding - either as a number in a sequence and/or a named event.

cause_of_death

Archetype ID: openEHR-EHR-EVALUATION.cause_of_death.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, pt-pt, nb, el, en

Purpose: To record details about specific diseases, conditions or injuries that caused or contributed to the death of an individual.

Use: Use to record details about specific diseases, conditions or injuries that caused or contributed to the death of an individual. Examples of use cases include, but are not limited to: - a death certificate or notification, nested within the COMPOSITION.certificate archetype; - a post mortem report, nested within the COMPOSITION.report-post_mortem archetype, as one of a number of components of a post mortem report; or - disease registries and epidemiological surveillance, nested within the COMPOSITION.report-case_investigation archetype, as one of a number of components of a case investigation, such as a maternal mortality investigation. Example 1: - Cerebral haemorrhage (as 'Direct cause', A) -- 'due to' Metastasis of the brain (as 'Antecedent cause B'); -- 'due to' Breast cancer (as the earliest 'Antecedent cause C'). As Breast cancer is the earliest recorded antecedent cause, this condition may also be known as the 'Underlying cause'. Example 2: - Pulmonary embolus (as 'Direct cause', A) -- 'due to' Fractured femur (as 'Antecedent cause B') -- 'due to' Accidental fall (as 'Antecedent/Underlying cause C').

Misuse: Not to be used to record details about diseases, conditions or injuries that have not contributed to the death of an individual. Use the EVALUATION.problem_diagnosis or ACTION.procedure archetypes for this purpose.

Keywords: certificate, cause, reason, death, condition, antecedent, post mortem, surveillance, notification, injury, disease, summary, autopsy

Concepts:

- at0000::Cause of death - Details about specific diseases, conditions or injuries that caused or contributed to the death of an individual.
- at0001::Item tree - @ internal @
- at0014::Item tree - @ internal @
- at0002::Direct cause - The disease, condition or injury that directly led to, or occurred closest to, the time of death.
- at0003::Antecedent cause(s) - Details about one or more diseases, conditions or injuries in the sequence of events preceding death, recorded in order from most recent onset to the earliest onset.
- at0004::Cause - Identification of an antecedent disease, condition or injury that directly contributed to the 'Direct cause'.
- at0005::Order - Order of onset of the identified 'Antecedent cause' in the sequence of events leading to death.
- at0006::B - The disease, condition or injury most closely preceding the 'Direct cause (A)'.
- at0007::C - The disease, condition or injury most closely preceding the 'Cause' order 'B'.
- at0008::D - The disease, condition or injury considered the earliest in the sequence of events leading to death.
- at0009::Duration - The approximate interval from onset of the identified 'Cause' to death.
- at0015::Last updated - The date when the cause of death was last updated.
- at0013::Comment - Additional narrative about the cause of death, not captured in other fields.
- at0012::Additional details - Additional details about the cause of death.
- at0016::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0017::Direct cause duration - The approximate interval from onset of the identified 'Direct cause' to death.
- at0018::Condition - Name of a significant condition that may have contributed to the death, but without a causal association.
- at0019::Description - Narrative description about the contributing diseases, injuries, conditions and events leading to death.
- at0020::Contributing conditions - Details about other significant conditions that may have contributed to the death, but without a causal association.

- at0021::Duration - The approximate interval from onset of the identified 'Condition' to death.

clinical_synopsis

Archetype ID: openEHR-EHR-EVALUATION.clinical_synopsis.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, sv, es-ar, nb, pt-br, ar-sy, en, fa, zh-cn

Purpose: To manually synthesise and record a narrative summary about a patient, from the perspective of a healthcare provider.

Use: Use to record a narrative, summary view of the patient's health. This unstructured summary may include identified health issues; health care provided; associated interpretation; patient understanding; and enable communication about some of the softer, more subjective aspects of the patient’s experience and journey. Most commonly this summary is likely to be related to a specific health event such as a specific consultation or hospital admission, but may also be used to summarise the patient's health experience over varying time periods. In practice, Clinical Synopsis is a meta observation that will complement the existing structured clinical record, allowing for expression of subtle, subjective or interpretive information about the patient that might not otherwise be obvious through structured data alone, providing balance and context to the EHR record. For example, a Clinical Synopsis can communicate a succinct summary of the patient's hospital admission as one component of a comprehensive and structured Discharge Summary document.

Misuse: Not to be used to record specific and structured health information. For example, detailed information about Problems, Diagnoses, and Test Results should be recorded using the specific relevant archetypes EVALUATION.problem, EVALUATION.problem-diagnosis, and laboratory or radiology results in OBSERVATIONs. The Clinical Synopsis may convey some critical and selected numerical results from these structured details when judged important for completeness of the Synopsis but is NOT the primary recording site for them. The term “Clinical Synopsis” can sometimes refer to complex and comprehensive documents, such as a Discharge Summary or a Report. In openEHR these documents should be represented as aggregations of constrained archetypes, that is, a Discharge Summary template or a Report template, comprising a number of separate archetypes, of which this Clinical Synopsis archetype may be one.

Keywords: summary, conclusion, outline, precis, abstract, assessment, synopsis, epicrisis, comment, note

Concepts:

- at0000::Clinical synopsis - Narrative summary or overview about a patient, specifically from the perspective of a healthcare provider, and with or without associated interpretations.
- at0001::List - @ internal @
- at0002::Synopsis - The summary, assessment, conclusions or evaluation of the clinical findings.
- at0003::Tree - @ internal @
- at0004::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

communication_capability

Archetype ID: openEHR-EHR-EVALUATION.communication_capability.v1

Lifecycle State: published

Category: EVALUATION

Languages: fi, sv, nb, en, es

Purpose: To record details about the practical ability of an individual to communicate, including impairments and need for communication aids.

Use: Use to record details about the practical ability of an individual to communicate, including impairments and need for communication aids. This archetype is intended to capture how an individual communicates with others and how healthcare providers can best communicate with an individual.

Misuse: Not to be used to record details about a language - use CLUSTER.language for this purpose. Not to be used to record details about a request for interpreter services - use CLUSTER.Interpreter_request with a suitable INSTRUCTION archetype, for example INSTRUCTION.service_request. Not to be used to record details about an interpretation that was performed - use the proposed ACTION.interpretation.

Keywords: language, interpreter, translation, translater, translator

Concepts:

- at0000::Communication capability - The ability of an individual to communicate.

- at0001::ItemTree - @ internal @
- at0002::Description - Narrative description about the overall capability of an individual to communicate, including impairments and need for communication aids.
- at0003::Language - Language and method of communication for an individual.
- at0005::Additional details - Additional structured details about the individual's overall communication capability.
- at0009::Overall comment - Additional overall narrative about the communication capability of an individual not captured in other fields.
- at0011::ItemTree - @ internal @
- at0012::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0013::Last updated - Date when the Communication capability was last updated.
- at0015::Per language - Details about the capabilities of an individual for a specific language.
- at0018::Capability details - Additional structured details about the communication capability for the specific language.
- at0019::Preferred language - Preferred language and/or method of communication for an individual.
- at0020::Alternative language - Other language, and/or method of communication that could be used for an individual.
- at0021::Comment - Additional narrative about the specific language capability not captured in other fields.
- at0022::Communication aid - Identification of an aid to assist communication.

comorbidity_summary_covid

Archetype ID: openEHR-EHR-EVALUATION.comorbidity_summary_covid.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: fi, en, it

Purpose: __unknown__

Concepts:

- at0000::Condition summary - Comorbidity summary_covid
- at0001::Item tree - @ internal @
- at0002::Extension - *
- at0003::Item tree - @ internal @

- at0004::Status - *
- at0005::Yes - The patient has one or more underlying conditions.
- at0006::No - The patient has no underlying conditions.
- at0012::Condition - *
- at0020::Condition name - *
- at0021::Any underlying conditions? - *
- at0022::Yes - The patient has underlying conditions.
- at0023::No - The patient does not have underlying conditions.
- at0024::Unknown - It is not known if the patient has underlying conditions.
- at0025::Pregnancy - Pregnancy
- at0026::Post-partum (<6 weeks) - Post-partum (<6 weeks)
- at0027::Immunodeficiency including HIV - Immunodeficiency including HIV
- at0028::Cardiovascular disease including hypertension - Cardiovascular disease including hypertension
- at0029::Diabetes - Diabetes
- at0030::Liver disease - Liver disease
- at0031::Renal disease - Renal disease
- at0032::Chronic neurological or neuromuscular disease - Chronic neurological or neuromuscular disease
- at0033::Malignancy - Malignancy
- at0034::Chronic lung disease - Chronic lung disease
- at0035::Trimester if pregnant - *
- at0036::First - First trimester
- at0037::Second - Second trimester
- at0038::Third - Third trimester

consumer_note

Archetype ID: openEHR-EHR-EVALUATION.consumer_note.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record health-related information about an individual, as entered into a health record by that individual or their carer. This note may include details about an individual's health status, events, and issues. The intent of this note could be for the sole use of that individual or for sharing with healthcare providers.

Use: Use to record health-related information about an individual, as entered into a health record by that individual or their carer. If the note requires association with a physical location, then the reference model can be used for this purpose. If the note requires association with a healthcare provider, then participations can be used for this purpose.

Misuse: Not to be used for recording health information about an individual by a healthcare provider.

Concepts:

- at0000::Consumer note - Health related information about an individual, entered into a health record by that individual or their carer.
- at0001::Tree - @ internal @
- at0002::Topic name - Identification of the topic of the note, by name.
- at0003::Note - Narrative description of information that the consumer wishes to record.
- at0004::Date - Option to make the note relevant for a specific date and/or time.

container

Archetype ID: openEHR-EHR-EVALUATION.container.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: pt-br, en

Purpose: To enable the clinical content held within existing CLUSTER archetypes to be represented as standalone data in the health record.

Use: Use to enable the clinical content held within existing CLUSTER archetypes, and usually represented within the context of other archetypes, to be represented as standalone data in the health record when clinically appropriate. This archetype is intended only to act as a container archetype that supports flexible expression of existing CLUSTER archetypes. It is not intended to hold any content other than the unconstrained SLOT. For example, the CLUSTER.nyha_heart_failure archetype is most commonly used to provide a standardised assessment of heart failure with EVALUATION.problem_diagnosis archetypes, but by inserting it within this EVALUATION allows it to be recorded as data outside the context of a Diagnosis, if clinically appropriate. Similarly CLUSTER.tos is usually recorded by ENT specialists in the context of an examination using CLUSTER.exam_tympanic_membrane, but by inserting it into this archetype, it allows it to be recorded outside the context of examination findings, if clinically appropriate.

Misuse: Not to be used to represent specific clinical content defined within this archetype.

Keywords: generic, container, slot

Concepts:

- at0000::Container - Generic archetype to contain existing CLUSTER archetypes which need to be represented as standalone data.
- at0001::Tree - @ internal @
- at0004::Detail - Clinical details held within CLUSTER archetypes.

contraceptive_summary

Archetype ID: openEHR-EHR-EVALUATION.contraceptive_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: nb, en

Purpose: To record the current status and episodic details about specific types of contraception used by an individual.

Use: Use to record the current status and episodic details about specific types of contraception used by an individual. This archetype is to be used to record information about both current and previous use of contraception. The specific scope of this archetype is on overall documentation about the use of all types of contraception, including episodes where more than one type of contraception may have been used simultaneously. The 'Per type' cluster of data elements allows for recording of specific details and episodes about each type of contraception used and can be repeated only once per type. In many situations the individual will use only one type of contraception at a time. However, if other types of contraception are used at the same time, the details will be recorded in another instance of the 'Per type' cluster. For each type of contraception the history of use over time can be captured using the repeatable 'Per episode' cluster. This cluster of data elements allows for a very detailed pattern of contraception use to be recorded, if necessary. Use to incorporate the narrative descriptions of contraceptive history within existing or legacy clinical systems into an archetyped format, using the 'Overall description' data element.

Misuse: Not to be used to record detailed information about the medication prescription. Links from this archetype to the relevant INSTRUCTION.medication_order or ACTION.medication should be used to record the detail. Not to be used to record detailed information about the procedures performed, such as an IUD insertion or a vasectomy.

Links from this archetype to the relevant ACTION.procedure should be used to record the detail.

Keywords: contraceptive, hormone, contraception, control, family planning, birth control measures

Concepts:

- at0000::Contraceptive use summary - Summary and persistent information about the use of methods to prevent pregnancy.
- at0001::Tree - @ internal @
- at0003::Current user - Individual currently uses contraception.
- at0005::Not current user - Individual has previously used contraception but is not a current user.
- at0006::Never used - Individual has never used any type of contraception.
- at0013::Episode start date - Date when this episode commenced.
- at0019::Overall comment - Additional narrative about the use of contraception that has not been captured in other fields.
- at0021::Tree - @ internal @
- at0022::Last updated - The date this contraceptive use summary was last updated.
- at0023::Specific name - Identification of the specific contraception used in this episode, by name.
- at0025::Goal - Intended outcome as a result of use of the specified contraception.
- at0026::Episode details - Additional structured details about the specified episode of contraception use.
- at0029::Per type - Details about use of a specified type of contraception.
- at0030::Description - Narrative description about the overall use of contraception during this episode.
- at0043::Overall description - Narrative summary about the individual's overall use of contraception.
- at0053::Description - Narrative summary about the use of the specified type of contraception.
- at0064::Per episode - Details about contraceptive use during an identified period of time.
- at0069::Comment - Additional narrative about use of the specified type of contraception, not captured in other fields.
- at0073::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0074::Reason for cessation - Narrative description for the reason for stopping use of the specified type of contraception during this episode.
- at0077::Type details - Additional structured details about the specified type of contraception used.

- at0081::Episode label - Identification of an episode of contraception use - either as a number in a sequence and/or a named event.
- at0082::Episode end date - Date when this episode ceased.
- at0087::Episode comment - Additional narrative about the use of the specified contraception during the specified episode, not captured in other fields.
- at0089::Overall status - Statement about regular use of any type of contraception.
- at0144::Status - Statement about current use of the specified type of contraception.
- at0145::Current user - Individual is a current user of the specified type of contraception.
- at0146::Not current user - Individual has previously used the specified type of contraception but is not a current user.
- at0147::Never used - Individual has never used the specified type of contraception.
- at0148::Start date - Date when the individual first used the specified type of contraception.
- at0149::End date - Date when the individual last used the specified type of contraception.
- at0150::Overall details - Additional structured details about the overall use of contraception.
- at0151::Type - The type of contraception used by the individual.
- at0152::Male condom - A barrier covering the penis to physically block ejaculated sperm from entering the vagina.
- at0153::Female condom - A barrier worn inside the vagina to physically block ejaculated sperm from entering the cervix.
- at0154::Diaphragm - A shallow, dome shaped barrier placed in the vagina to cover the cervix.
- at0155::Combination pill - A combination oral contraceptive pill containing both an oestrogen and progestin.
- at0156::Combination skin patch - A combination skin patch containing both an oestrogen and progestin.
- at0157::Progestogen-only pill - Progestogen-only form of oral hormonal contraception.
- at0158::Depot progestogen injection - Progestogen-only injectable of hormonal contraception.
- at0159::Hormone implant - Hormonal contraception inserted under the skin.
- at0160::Vaginal ring - Hormone impregnated ring inserted into the vagina.
- at0161::Female sterilisation - Procedure intended to permanently prevent pregnancy, usually by tubal ligitation.
- at0162::Male sterilisation - Procedure intended to permanently prevent pregnancy, usually by vasectomy.
- at0163::IUD without hormone - Device inserted into the uterus to prevent implantation.
- at0164::Withdrawal - Withdrawing the penis from the vagina and away from a woman's external genitals before ejaculation.
- at0165::Fertility awareness method - Cyclical use of abstinence or barrier methods during likely fertile periods.

- at0166::Abstinence - Avoidance of vaginal intercourse or intimate activities which may result in pregnancy.
- at0167::Vaginal douching - Intravaginal cleansing with a liquid solution.
- at0168::Clinical indication - Clinical reason for using the specified type of contraception during this episode.
- at0169::IUD with hormone - Device inserted into the uterus to prevent implantation.

contraindication-intravitreal_antiVEGF

Archetype ID: openEHR-EHR-EVALUATION.contraindication-intravitreal_antiVEGF.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record the identification of a treatment, medication or procedure which should not be administered or performed on this subject.

Use: Use to record the identification of a treatment, medication or procedure which should not be administered or performed on this subject. This contraindication may be identified in a number of ways, for example: - previous experience of a procedure being performed and subsequent clinical assessment that this should not be repeated; - genomic testing results that indicate an adverse event may take place if a treatment or medication is administered; or - experience of a family member to a similar treatment, medication or procedure. Clinical decision support for prescribing should include checking of both known adverse reactions to the proposed medicine (EVALUATION.adverse_reaction) plus known contraindications using this archetype.

Misuse: Not to be used to record the occurrence of an adverse reaction to a substance or agent - use EVALUATION.adverse_reaction for this purpose.

Keywords: contraindication, prevent, avoid, adverse event

Concepts:

- at0.10::Reaction to anti-VEGF - Establishment or suspicion of any reaction due to hypersensitivity to anti-VEGF agents used in intravitreal injections.
- at0.11::No response to treatment - Visual acuity decreased for three consecutive reviews below 0.1 in decimal scale.
- at0.12::Morphologic deterioration - Progressive deterioration of the morphology of the lesion.

- at0.13::Intravitreal anti-VEGF - Treatment of intravitreal anti-VEGF injections contraindicated.
- at0.7::Very low VA - Visual acuity on first clinical encounter below 0.1 in decimal scale.
- at0.8::Healed lesions - Identified signs of previous treatments such as photodynamic therapy, laser photocoagulation scars, or any vitreoretinal operative procedure.
- at0.9::Multimorbidity - Coexistence of additional alterations on the retina causative of visual impairment.
- at0000::Contraindication - Identification of a treatment, medicine, vaccine or procedure which should not be administered or performed on this subject.
- at0000.1::Contraindication of intravitreal anti-VEGF injections - Identification of the criteria considered for exclude patients from treatment using intravitreal anti-VEGF injections.
- at0001::Tree - @ internal @
- at0002::Contraindication - Identified contraindication to a treatment, medicine, vaccine or procedure.
- at0002.1::Contraindication - Identified contraindication to a treatment, medicine, vaccine or procedure.
- at0003::Evidence/Rationale - Evidence or rationale for the contraindication.
- at0003.1::Evidence/Rationale - Evidence or rationale for the contraindication.
- at0004::Date Last Updated - The date at which the contraindication was most recently deemed to apply, normally as a result of clinical assertion or affirmation.
- at0006::Tree - @ internal @

contraindication

Archetype ID: openEHR-EHR-EVALUATION.contraindication.v1

Lifecycle State: published

Category: EVALUATION

Languages: nb, en

Purpose: To record a contraindication for a clinical intervention (including, but not limited to, a treatment, test or procedure) that should not be carried out due to the likelihood, or possibility, of harm being caused to an individual.

Use: To record a contraindication for a clinical intervention in the health record of an individual due to the likelihood, or possibility, of causing harm to the individual if the identified intervention is carried out. This archetype may also be used to record a contraindication for a clinical intervention in the health record of the individual, even though the resulting clinical effect may cause harm to others and not directly on the

individual. For example: administration of live vaccines should be contraindicated in an individual who has a family member in an immunosuppressed state or actively taking immunosuppressive therapy, as that family member may be at significant risk of contracting the infectious disease. This archetype should be regarded as a critical archetype by any clinical decision support system testing for any relevant therapeutic precautions as a clinician commences a new clinical Intervention for an individual. This contraindication may be identified in a number of ways including, but not limited to: - previous experience of a procedure being performed and subsequent clinical assessment that this should not be repeated; - implantation of a metal device which precludes some imaging examinations - genomic test results that indicate an adverse event may take place if a treatment or medication is administered; or - adverse experience by a family member to a similar treatment, medication or procedure. In the case of medications or vaccines, this archetype complements the EVALUATION.adverse_reaction_risk archetype by identifying other reasons why a medication or vaccine should not be administered, other than an adverse reaction. In view of this, clinical decision support for prescribing should include reference to this archetype plus the EVALUATION.adverse_reaction_risk as part of a safe prescribing process.

Misuse: Not to be used to record the occurrence of an adverse reaction to a substance or agent. Adverse reaction risk is a very specific type of contradiction and because of its ubiquity has been modelled separately as EVALUATION.adverse_reaction_risk for this purpose. Not to be used to record a condition or state of the individual that is clinically significant and unique or idiosyncratic for this individual, and is considered vital information when making treatment decisions. Use EVALUATION.precaution for this purpose. Not to be used to record personal preferences of the individual. Use specific archetypes for this purpose.

Keywords: contraindication, prevent, avoid, adverse event, caution, alert, warning

Concepts:

- at0000::Contraindication - A clinical intervention (including, but not limited to, use of a treatment or performance of a test or procedure) that should not be carried out due to the likelihood, or possibility, of harm being caused to an individual.
- at0001::Tree - @ internal @
- at0002::Contraindicated intervention - Identification, by name, of a clinical intervention or class of intervention including, but not limited to, a treatment, test or procedure that should not be performed.
- at0003::Rationale - Narrative description explaining the relationship between the 'Indication' and the 'Contraindicated intervention'.
- at0004::Last updated - Date when the contraindication information was last updated.
- at0006::Tree - @ internal @
- at0007::Criticality - An indication of the potential for critical system organ damage or life threatening consequence.

- at0008::Comment - Additional narrative about the contraindication, not captured in other fields.
- at0009::Review date - Date when next due for review by a clinician.
- at0010::Low - Carrying out of the 'Contraindicated intervention' is unlikely to result in critical system organ damage or life threatening consequences for the individual or family member. Future exposure to the identified intervention should be considered a relative contraindication in normal clinical circumstances.
- at0011::High - Carrying out of the 'Contraindicated intervention' may result in critical organ system damage or life threatening consequences for the individual or family member. Future exposure to the identified intervention should be considered an absolute contraindication in normal clinical circumstances.
- at0012::Indeterminate - Unable to assess with information available.
- at0013::Category - Category of the identified 'Contraindicated intervention'.
- at0014::Status - Assertion about the certainty or potential future risk, of the identified 'Contraindicated intervention'.
- at0015::Suspected - A low level of clinical certainty that carrying out the 'Contraindicated intervention' will cause harm to the individual or family member.
- at0016::Likely - A reasonable level of clinical certainty that carrying out the 'Contraindicated intervention' will cause harm to the individual or family member.
- at0017::Confirmed - A high level of clinical certainty that carrying out the 'Contraindicated intervention' will cause harm to the individual or family member.
- at0018::Resolved - The previous assertion that the subject should not be exposed to the 'Contraindicated intervention' has been clinically reassessed and considered no longer to be an active risk.
- at0019::Refuted - The previous assertion that the subject should not be exposed to the 'Contraindicated intervention' has been clinically reassessed or has been disproved with a high level of clinical certainty by testing.
- at0020::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0021::Clinical indication - Identification of the clinical reason why the identified 'Contraindicated intervention' should not be used or performed.
- at0022::Valid period start - Date/time when the contraindication becomes active.
- at0023::Valid period end - Date/time when the contraindication becomes inactive.

death_summary

Archetype ID: openEHR-EHR-EVALUATION.death_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, nb, en

Purpose: To record summary information about the circumstances and context of the death of an individual, excluding the cause(s) of death.

Use: Use to record summary information about the circumstances and context of the death of an individual, excluding the cause(s) of death. This archetype has been designed to carry the details about the death of an individual that only need to be recorded once within a health record, including, but not limited to: - the date and time of death; - the place of death, as a category, named place or an address; - context about the death of a mother giving birth; - context about the death of a newborn; and - manner and circumstances related to the death. It is anticipated that one or more data elements in this archetype may be used in the following use cases: - Death certificate - date/time of death and location of death; - Post mortem report - describing known circumstances related to the death, including information related to maternal, fetal or neonatal death. - Disease registries.

Misuse: Not to be used to record information about the formal cause(s) of death - use EVALUATION.cause_of_death for this purpose. Not to be used to record information about post-mortem examination findings such as lividity or rigor mortis - use appropriate examination-related findings within the COMPOSITION.report-post_mortem container archetype. Not to be used to record information about vital status - use OBSERVATION.vital_status for this purpose.

Keywords: certificate, death, MCCD, dead, summary, note, killed, attestation, fatal accident

Concepts:

- at0000::Death summary - Summary information about the circumstances and context of the death of an individual, excluding the cause(s) of death.
- at0001::Item tree - @ internal @
- at0009::Item tree - @ internal @
- at0010::Manner of death - Context or setting of the death.
- at0021::Place category - The category of the place where the individual died.
- at0042::Additional details - Additional structured details related to the death.
- at0044::Gestation at death - Number of completed weeks of gestation of the foetus at the time of foetal death.
- at0054::Age at death - The age of the individual at the time of death.
- at0092::Date/time of death - The known, or assumed, date and time of death.
- at0093::Manner description - Narrative description about the context or setting of the death.
- at0100::Structured place of death - Structured detail about the place where the individual died.
- at0101::Last updated - The date when the death summary was last updated.

- at0102::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0103::Information source(s) - Narrative description about source(s) of information.
- at0104::Date of death alternatives - Additional details about possible alternative dates of death.
- at0105::Comment - Additional narrative about the death, not captured in other fields.
- at0106::Days post partum - The number of days after birth to the death of a mother.
- at0109::Place of death - The simple name, address or landmark of the place where the individual died.
- at0110::Pregnancy context - Timing of a woman's death categorised as a phase of the active pregnancy.
- at0112::Antenatal - The woman died while pregnant and before labour commenced.
- at0113::During labour/delivery - The woman died during labour or delivery.
- at0114::Postnatal - The woman died ≤42 days after delivery.
- at0115::Late postnatal - The woman died >42 days and ≤1 year after delivery.
- at0116::Stillbirth context - Timing of a stillborn foetus' death categorised as a phase of pregnancy.
- at0117::Antenatal - The foetus died before labour commenced.
- at0118::During labour/delivery - The foetus died during labour or delivery.
- at0119::Place of injury - The category of the place where the injury contributing to death occurred.
- at0120::Date of injury - The known, or assumed, date and time of injury.
- at0121::Activity at the time of injury - Type of activity at the time of injury.

developmental_milestones

Archetype ID: openEHR-EHR-EVALUATION.developmental_milestones.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record a description about progress for all age-relevant milestones, and details about each specific milestone.

Use: Use to record a description about progress for all age-relevant milestones, and details about each specific milestone.

Keywords: childhood, infant, baby, achievement, toddler, child

Concepts:

- at0000::Developmental milestones - A theoretical framework about when behaviours or physical skills are typically expected to be observed in infants and children as they grow and develop.
- at0001::Tree - @ internal @
- at0004::Milestone name - Name of the developmental milestone.
- at0005::Achieved - Detail about the achievement of the milestone.
- at0006::Comment - Comment about the milestone.
- at0007::Item tree - @ internal @
- at0003::Per milestone - Details about achievement of a milestone.
- at0008::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0002::Description - Narrative description about progress related to achievement of developmental milestones.
- at0009::Last updated - The date when the developmental milestones record was last updated.

device_summary

Archetype ID: openEHR-EHR-EVALUATION.device_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: de, nb, en

Purpose: To record an ongoing and persistent overview about medical devices that have been fitted or implanted.

Use: Use to record a summary of medical devices that have been fitted or implanted including, but not limited to: - assisted hearing devices, such as hearing aids or auditory implants; - orthotics or artificial limbs; - dentures or dental implants; and - eyeglasses or contact lenses. This archetype has been specifically designed to assist in providing an overview of management of medical devices over time. It may be used to share as a summary within messages or between clinical systems, where the detail is not required. If specific devices have been used in the past, as much detail as is available can be added in this archetype to create a context which may influence decisions about current or future devices of the same type. In practice, some clinical systems will need to record specific and detailed INSTRUCTION and ACTION archetypes to reflect the request for an medical device and subseqent activities that need to be recorded as that request is carried out. It is

inevitable that there will be some overlap in this summary and these detailed archetypes. All are neccessary in various situations. If clinicians are recording the process of request and provision of medical devices, then this summary should be derived from those recordings, to ensure that there is no duplication of clinical input.

Misuse: Not to be used to request a medical device - use the INSTRUCTION.request family for this purpose. Not to be used to record the activities that occur in the planning and fitting of a device - use the ACTION.device_fitting archetype for this purpose. Not to be used to record the activities that occur in the planning and fitting of an implant - use the ACTION.procedure archetype for this purpose.

Concepts:

- at0000::Medical device summary - An ongoing and persistent overview about medical devices that have been fitted or implanted.
- at0001::Tree - @ internal @
- at0002::Status - Assertion about the fitting or implanting of devices, as at the date 'Last updated'.
- at0003::Never - The device type has never been fitted or implanted.
- at0004::Current - The device type is currently fitted or implanted.
- at0005::Previous - The device type has been fitted or implanted in the past.
- at0007::Device name - Identification of the specific device, by name.
- at0008::Start date - Date of fitting or implant of the device.
- at0009::End date - Date when the device stopped being used or was removed.
- at0010::Structured detail - Additional structured detail about the device.
- at0012::Body site - Identification of the body site where the device is fitted/implanted.
- at0013::Structured body site - A structured anatomical location of the body site where the device is fitted/implanted.
- at0014::Description - Narrative description about the device.
- at0015::Description - Narrative description about the use of the fitted device type.
- at0016::Tree - @ internal @
- at0017::Last updated - The date this summary was last updated.
- at0018::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0019::Next review due - Date on which this device should be reviewed.
- at0020::Device type - Name of the type of medical device.
- at0021::Multimedia - Digital image, video or diagram about the device.
- at0022::Device details - Details about each device.
- at0023::URI to original data - Link to the original data about the fitting or insertion.

differential_diagnoses

Archetype ID: openEHR-EHR-EVALUATION.differential_diagnoses.v1

Lifecycle State: published

Category: EVALUATION

Languages: nb, en

Purpose: To record details about one or more differential diagnoses that may be responsible for a single clinical presentation, examination findings and/or test results.

Use: To record details about one or more differential diagnoses that may be responsible for a single clinical presentation, examination findings and/or test results. This archetype has been designed to ensure that all differential diagnoses are recorded using a single model. In a clinical system, it would be expected that each differential diagnosis would be recorded using a separate instance of the 'Per differential' cluster. Each differential diagnosis should be regarded as a temporary diagnostic hypothesis and should only be used in the earliest phases of the diagnostic process. In practice, clinicians may identify a list of one or more differential diagnoses, any one of which may explain the clinical presentation. As more information is gathered from the examination, diagnostic test results, or referrals, the list of differential diagnoses is gradually refined and outliers eliminated until one or more working, provisional, or preliminary diagnosis is determined. If a differential diagnosis is accepted as a likely diagnosis, it is anticipated that it will be formally entered into the health record as a Problem/Diagnosis using the EVALUATION.problem_diagnosis archetype. The CLUSTER.problem_qualifier archetype may be nested within the Problem/Diagnosis archetype to support annotation of the diagnosis as 'working' or 'preliminary'.

Misuse: Not to be used to record detailed information about a persistent problem or formal diagnosis - use the EVALUATION.problem_diagnosis for this purpose.

Keywords: differential, diagnosis, hypothesis, alternative, diagnostic

Concepts:

- at0000::Differential diagnoses - One or more possible conditions, problems or diagnoses that may be responsible for a clinical presentation, examination findings and/or test results.
- at0001::Tree - @ internal @
- at0005::Status - Likelihood of the differential diagnosis being responsible for the clinical situation.
- at0009::Rationale - Narrative description about the rationale for the diagnosis being accepted or excluded.
- at0004::Diagnosis name - Identification of the differential diagnosis, by name.

- at0007::Accepted - Accepted as a formal diagnosis.
- at0006::Possible - Under investigation; neither accepted as a formal diagnosis, nor excluded.
- at0013::Item tree - @ internal @
- at0014::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0010::Clinical evidence - Structured details about clinical evidence supporting or excluding the differential diagnosis.
- at0012::Comment - Additional narrative about the differential diagnosis, not captured in other fields.
- at0008::Excluded - Ruled out as a formal diagnosis.
- at0015::Last updated - The date/time the differential diagnoses were last updated.
- at0002::Overall description - Narrative overview about all of the differential diagnoses identified.
- at0003::Per differential - Details about a single differential diagnosis.
- at0011::Order - Tag assigned to supporting ordering within a list of differential diagnoses.

dr_screening_convenient

Archetype ID: openEHR-EHR-EVALUATION.dr_screening_convenient.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en, es

Purpose: Register the statement/s about the convenience of a patient within a screening service for a specific disease.

Use: Use to record statement/s about the admission or exclusion of a patient for a screening service, at a specific point in time of its clinical history. The statement is considered only at the time it is registered. That is to say, a patient excluded from the screening service may be admitted in the future if given the right conditions.

Misuse: Archetype specifically designed to validate DR screening. It should not be used for other conditions. Choose the appropriate archetype for such cases.

Keywords: admission, diabetic retinopathy

Concepts:

- at0000::DR screening convenient - Statement/s about patient's compliance of the requirements established to access to a service of screening for diabetic retinopathy.
- at0001::Arbol - @ internal @
- at0002::Exclusion statement - Description of the reason of excluding the patient from the screening service.
- at0005::Arbol - @ internal @
- at0006::Date last decision - The date at which the decision of admittance or exclusion in screening was confirmed.
- at0007::Admittance in screening - Identifies if the patient has been accepted or not to take part in the screening service.
- at0008::Screening compliant - The patient meets the criteria be included in the screening.
- at0009::Screening not necessary - The clinician does not consider necessary including the patient into the screening.
- at0010::Excluded from Screening - Patient non-compliant with admission criteria, thus it is definitely excluded from the screening.
- at0011::Blind - Excluded from screening as blind.
- at0012::Deceased - Excluded from screening as deceased.
- at0013::Learning disability - Excluded from screening as learning disability.
- at0014::Moved away - Excluded from screening as moved away.
- at0015::No current contact details - Excluded from screening as no current contact details.
- at0016::No longer diabetic - Excluded from screening as no longer diabetic.
- at0017::Physical disorder - Excluded from screening as physical disorder.
- at0018::Terminal illness - Excluded from screening as terminal illness.
- at0019::Under care of ophthalmologist - Excluded from screening as under care of ophthalmologist.
- at0020::Other - Other exclusion criteria.
- at0021::Comment - Additional narrative information about the inclusion or exclusion of the patient in the screening service.

education_summary

Archetype ID: openEHR-EHR-EVALUATION.education_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, nb, en, fr

Purpose: To record summary information about an individual's current and past education or training, which provides an overview of their educational background.

Use: Use to record summary information about an individual's current and past formal education or training, which provides an overview of their educational background. In the context of this archetype, formal education includes all education that is based on a structured curriculum and delivered by trained professionals. This archetype has been designed to be used as a standalone archetype within the context of a Social History (or similar) template. It is intended to provide a summary of all education or training, considered in the broadest sense. For each education or training, use a separate instance of the CLUSTER.education_record within the SLOT for 'Education record'.

Misuse: Not to be used for recording structured details about a specific education or training. Use the CLUSTER.education_record archetype within 'Education record' SLOT for this purpose. Not to be used to record details about the teaching provided to individuals to improve their health literacy and life skills. Use ACTION.health_education for this purpose.

Keywords: education, school, university, secondary, tertiary, college, apprenticeship, training, needs, primary

Concepts:

- at0000::Education summary - Summary or persistent information about an individual's current and past education or training.
- at0001::Tree - @ internal @
- at0002::Highest level completed - Description of highest category of education or training completed.
- at0003::Age started - Age when an individual first commenced formal education.
- at0007::Comment - Additional narrative about an individual's education, not captured in other fields.
- at0018::Description - Narrative description about the overall education or training history of an individual.
- at0026::Tree - @ internal @
- at0027::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0028::Last updated - The date that this education summary was last updated.
- at0029::Education record - Structured details about each education or training, both current and past.
- at0030::Additional details - Additional details about the education or training, or previous education history of an individual.
- at0031::Age ended - Age when an individual last attended formal education.

environmental_survey

Archetype ID: openEHR-EHR-EVALUATION.environmental_survey.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record details about environmental factors related to the local community and built environment that may impact health, especially those relevant to disease surveillance and public health.

Use: Use to record details about environmental factors related to the local community and built environment that impact health.

Misuse: Not to be used to record details about environmental factors related to a specific dwelling - use CLUSTER.dwelling for this purpose.

Concepts:

- at0000::Environmental survey - Details about environmental factors related to the local community and built environment that impact health.
- at0002::Urban setting - The type of setting in which an individual lives or works.
- at0003::Urban - Within an area of high population density relative to other areas, often characterised by a relatively high presence of administrative structures, government services and other infrastructure.
- at0004::Peri-urban - Location with mixed urban and rural characteristics, often on the outskirts of cities or large urban areas.
- at0005::Rural - Within an area of low population density relative to other areas, often characterised by low presence of administrative structures, government services and other infrastructure. Livelihood is predominantly centred on agricultural production.
- at0006::Water supply - The type of water supply to the local area.
- at0007::Piped - None
- at0008::Stored - None
- at0009::Waste collection frequency - Indication of solid waste collection frequency.
- at0010::Frequent - At least once weekly.
- at0011::Infrequent - Less than once weekly.
- at0012::Mosquito population - Type of mosquitoes found in the local area.
- at0013::Community planning - The level of planning in the local area or community.
- at0014::Planned - None
- at0015::Unplanned - None
- at0016::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

- at0017::Last updated - The date when the environmental survey was last updated.
- at0018::Description - Narrative description about the local environment.
- at0019::Comment - Narrative description about the environmental survey, not captured in other fields.
- at0001::ITEM_TREE - None
- at0020::ITEM_TREE - None

estimated_date_delivery

Archetype ID: openEHR-EHR-EVALUATION.estimated_date_delivery.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record estimated due dated for a pregnancy, calculated or estimated by a variety of methods.

Use: Use to record the estimated date of delivery (EDD), calculated or estimated by various methods at different times during a single pregnancy, including the 'Agreed EDD' which is used as the basis for clinical decision-making. As a pregnancy evolves, and the 'Agreed EDD' is updated or amended, the health record will present the latest version of 'Agreed EDD' to the clinical user, and all previous versions should be available in the health record version history.

Keywords: EDD, EDB, EDC

Concepts:

- at0000::Estimated date of delivery (EDD) - Estimated date of delivery for a pregnancy.
- at0001::Item tree - @ internal @
- at0002::Item tree - @ internal @
- at0003::EDD by date of conception - The EDD calculated from a known date of conception.
- at0004::EDD by cycle - The EDD estimated from the onset of the last normal menstrual period by Naegle's method.
- at0005::Date of ultrasound - The date on which the ultrasound was carried out.
- at0006::By ultrasound - Details about an EDD estimated from the findings on a pregnancy ultrasound.
- at0007::Gestation by scan - The gestation estimated from the scan.

- at0008::EDD by ultrasound - Details about an EDD estimated from the findings on a pregnancy ultrasound.
- at0009::Agreed EDD - Details about the EDD which is used as the basis for clinical decision-making during the pregnancy.
- at0010::EDD - The EDD which is to be used as the basis for clinical decision-making.
- at0011::Rationale - The rationale for the 'EDD'.
- at0012::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0013::Last updated - The date any EDD was last updated.

ethnicity

Archetype ID: openEHR-EHR-EVALUATION.ethnicity.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, nb, en

Purpose: To record the affiliation, kinship or connection of an individual with one or more groupings of people, usually self-identified.

Use: Use to record the affiliation, kinship or connection of an individual with one or more groupings of people, usually self-identified. Ethnicity is a concept that is frequently used inconsistently, such that existing or legacy data may be quite varied in content, including but not limited to: - A long-shared history (written or oral); - A cultural tradition, including family, social and religious customs; - A common geographic origin; - A common language; or - A minority or distinct group within the local community context. In designing this archetype, the structure has deliberately been kept simple, to support any and all requirements for representing ethnicity. As the understanding around ethnicity and appropriate value sets are identified and agreed upon, this archetype may grow to support evolving clarity of requirements. The data element 'Ethnicity' allows multiple occurrences so that more than one ethnic and cultural identity to be recorded for the individual from a single value set, and also so that more than one representation of 'Ethnicity' can be recorded, for example explicitly recording First People status. The 'Ancestry' data element has also been included to support health risk assessment related to family history and inherited disease, such as a genetic variations that increase the risk of Crohn's disease in Ashkenazi Jews. The amount of overlap between 'Ethnicity' and 'Ancestry may vary enormously between individuals, but separating each into distinct data elements will allow appropriate usage within the clinical context for decision support and provision of healthcare. This archetype has been designed to be recorded as a single instance within a

health record, persisted, updated and revised over time as a new version. Ethnicity is often considered as a component of a demographic record for an individual however it has been represented within this clinical archetype for situations when it needs to be represented in a clinical data collection or is required to support culturally sensitive and appropriate healthcare delivery, for example in First Nations communities. The concept of categorisation by race or skin colour is controversial. In some places, the term 'race' may be considered acceptable and interchangeable with 'ethnicity', yet is illegal in others. Contributing to the confusion, many value sets for ethnicity also contain values that describe physical characteristics such as skin colour or geographical origin. The concept of 'Race' may sometimes be used as a clumsy proxy for identifying risk factors related to social determinants of health (SDOH), however it is strongly recommended that archetypes that represent SDOH concepts be used for more accurate data capture.

Misuse: Not to be used to represent the 'Country of birth' of an individual. Use the 'Country of birth' data element within the EVALUATION.birth_details archetype for this purpose. Not to be used to record a religious affiliation. Use the CLUSTER.religion archetype for this purpose. Not to be used to record self-identified gender. Use the 'Gender identity' data element within the EVALUATION.gender archetype for this purpose. Not to be used to record language requirements for translation purposes. Use the CLUSTER.language for this purpose. Not to be used to represent or replace formal records of ethnic background or for the purposes of maintaining an official demographic register or index. Use a formal Master Patient Index for this purpose, or archetypes based on the openEHR Demographic Information Model.

Keywords: ethnicity, culture, language, race, tribe, affiliation, belief, kinship, identity, clan, group, nationality, citizenship, nation, political

Concepts:

- at0000::Ethnic identity - Affiliation, kinship or connection with one or more groupings of people, according to common origins or background.
- at0001::Item tree - @ internal @
- at0002::Description - Narrative description about the self-identified affiliations, kinship or connections with one or more groupings of people, by an individual.
- at0003::Ethnicity - Name of the ethnic or cultural grouping with whom the individual identifies an affiliation, kinship or connection.
- at0004::Ancestry - The hereditary or genetic line origins of the individual.
- at0005::Comment - Additional narrative about the identified cultural and ethnic identity, not captured in other fields.
- at0006::Item tree - @ internal @
- at0007::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0008::Last updated - The date the cultural and ethnic identity details were last updated.

- at0009::Additional details - Additional details about the cultural and ethnic identity.
- at0010::National identity - Self identification with an ethno-national group.

event_investigation_classification

Archetype ID: openEHR-EHR-EVALUATION.event_investigation_classification.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record the disease classification for an identified health event as part of a disease surveillance investigation.

Use: Use to record the disease for an identified health event as part of a disease surveillance investigation, most commonly the final determination at the completion of a case investigation but may also record initial classification in a suspected event. Use a separate instance of this archetype to record the conclusion for each suspected 'Index event'.

Concepts:

- at0000::Health event investigation classification - Classification for an identified health event as part of a public health surveillance investigation.
- at0001::Item tree - @ internal @
- at0002::Initial classification - Classification of the likelihood of the 'Index event' as causal at the initiation of a case investigation.
- at0003::Probable - A case is 'Probable' when common, relevant symptoms and/or signs are exhibited and there is an epidemiological link.
- at0004::Not suspected - A case is 'Not suspected' if the clinical or laboratory findings do not meet the criteria to suspect disease.
- at0007::Index event - The name of the infectious event under investigation.
- at0008::Reason for classification - The broad category of the reason for the classification.
- at0009::Reason description - Narrative description about the reason for the classification.
- at0013::Item tree - @ internal @
- at0014::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

- at0015::Last updated - The date when this health event investigation classification was last updated.
- at0016::Additional details - Additional structured details about the classification.
- at0017::Comment - Additional narrative about the classification, not captured in other fields.
- at0035::Suspected - A case is 'Suspected' when common, relevant symptoms and/or signs are exhibited.
- at0060::Final classification - Classification of the likelihood of the 'Index event' as causal after completion of a case investigation.
- at0061::Pending - A case is 'Pending' at the completion of an adequate investigation when it is not possible to confirm or discard due to inadequate information, and further information is anticipated. It is usually a temporary classification.
- at0062::Probable - A case is 'Probable' at the completion of an adequate investigation when clinical evidence criteria are met and/or an epidemiological link has been identified, with laboratory test results suggesting causality rather than being conclusive.
- at0063::Laboratory confirmed - A case is 'Laboratory confirmed' at the completion of an adequate investigation when positive laboratory test results confirm the clinical evidence and/or epidemiological link.
- at0064::Discarded - A case is 'Discarded' or 'Excluded' at the completion of an adequate investigation due to negative laboratory test results that exclude causality.
- at0065::Inconclusive - A case is 'Inconclusive' at the completion of an adequate investigation when it is not possible to confirm or discard due to inadequate information, and no further information is anticipated. It is not a temporary classification.
- at0066::Clinically confirmed - A case is 'Clinically confirmed' at the completion of an adequate investigation on the basis of clinical evidence alone.
- at0068::Contribution to death - Assessment of the relationship between the index event and the death of the individual.
- at0069::Related - The index disease was directly or indirectly related to the death of the infected individual.
- at0070::Unrelated - The index disease was not related to the death of the infected individual.
- at0071::Unknown - It is unknown if the index disease is related to the death of the individual or not.

exclusion_global

Archetype ID: openEHR-EHR-EVALUATION.exclusion_global.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, sv, nb, pt-br, en, fr

Purpose: To record an overall statement of exclusion about all Problem/diagnosis, Family history, Medications, Procedures, Adverse reactions or other clinical item that are either not currently present, or have not been present in the past.

Use: Use to record an overall statement of exclusion about all Problem/diagnosis, Family history, Medications, Procedures, Adverse reactions or other clinical item that are either not currently present, or have not been present in the past. This archetype has been specifically designed to make a clear and unambiguous statement of an overall exclusion of a type of clinical item from the health record. This approach is used in preference to relying on flags or terminology to express negation. Each global statement should be recorded in a separate instance - for example a separate instance for a statement about medications and another for adverse reactions. The 'Global statement' data element allows for recording of a single Global statement. The different Global statements listed in the "Global statement' run-time name constraint identifies the the different global exclusions. This name constraint can be applied during template modelling or at run-time within a software application. Please note that exclusion statements can only be considered to be current and accurate at the point-in-time of recording. It is possible for a record to be able to state that an individual has NO KNOWN history of any problems or diagnoses (using an exclusion statement) at the same consultation as recording the evidence of their first experience of a problem or diagnosis (using the EVALUATION.problem_diagnosis archetype). In future record statements, the individual may have a KNOWN history of the problem or diagnosis recorded in their problem list.

Misuse: Not to be used to record the exclusion of a specific problem/diagnosis, medication, procedure, family history, adverse reaction or other clinical item - use the EVALUATION.exclusion_specific archetype for this purpose. Not to be used to record the exclusion of any component of a physical examination - use the CLUSTER.exclusion_exam archetype within an appropriate OBSERVATION or CLUSTER archetype. Not to be used to record the exclusion of symptoms use the CLUSTER.exclusion_symptom archetype within an appropriate OBSERVATION or CLUSTER archetype. Not to be used to record the absence of information - use the EVALUATION.absense archetype for this purpose.

Keywords: exclusion, negation, rule out, rule-out, r/o, absence

Concepts:

- at0000::Exclusion - global - An overall statement of exclusion about all Problems/diagnoses, Family history, Medications, Procedures, Adverse reactions or other clinical items that are either not currently present, or have not been present in the past.
- at0001::Tree - @ internal @

- at0002::Global exclusion statement - An overall statement of exclusion about all Problems/diagnoses, Family history, Medications, Procedures, Adverse reactions or other clinical items.
- at0003::Global exclusion of problems/diagnoses - Overall statement of exclusion of all problems or diagnoses at the time of recording.
- at0004::Global exclusion of family history - Overall statement of exclusion of all significant health-related problems in relatives or family members of the individual at the time of recording.
- at0005::Global exclusion of medication use - Overall statement of exclusion about the use of all medications at the time of recording.
- at0006::Global exclusion of procedures - Overall statement of exclusion about all procedures at the time of recording.
- at0007::Global exclusion of adverse reactions - Overall statement of exclusion about all adverse reactions at the time of recording.
- at0008::Tree - @ internal @
- at0010::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0011::Comment - Additional comment not covered in other fields.

exclusion_specific

Archetype ID: openEHR-EHR-EVALUATION.exclusion_specific.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, sv, nb, en

Purpose: To record a statement of exclusion about a specific Problem/diagnosis, Family history, Medication, Procedure, Adverse reaction or other clinical item that is either not currently present, or have not been present in the past.

Use: Use to record a statement of exclusion of a specific Problem/diagnosis, Family history, Medication, Procedure, Adverse reaction or other clinical item that is either not currently present, or have not been present in the past. This archetype has been specifically designed to make a clear and unambiguous statement of a specific exclusion of a type of clinical item from the health record. This approach is used in preference to relying on flags or terminology to express negation. The data element 'Excluded concept' allows for recording of a single specific statement. The different specific concepts listed in the "Excluded concept' run-time name constraint identifies the different specific exclusions. This name constraint can be applied during template modelling or at run-time within a

software application. Each specific exclusion should be recorded in a separate instance of this archetype. For example: record 'no past history of adverse reaction to penicillin V', 'no past history of adverse reaction to cephalosporins' and 'no known family history of heart disease' in 3 separately constrained instances of this archetype. Please note that exclusion statements can only be considered to be current and accurate at the point-in-time of recording. It is possible for a record to be able to state that an individual has NO KNOWN history of a specific problem or diagnosis (using an exclusion statement) at the same consultation as recording the evidence of their first experience of the same problem or diagnosis (using the EVALUATION.problem_diagnosis archetype). In future record statements, the individual may have a KNOWN history of the problem or diagnosis recorded in their problem list.

Misuse: Not to be used to record the exclusion of all problems or diagnoses, medications, procedures, family history, adverse reactions or other clinical items - use the EVALUATION.exclusion_global archetype for this purpose. Not to be used to record the exclusion of any component of a physical examination - use the CLUSTER.exclusion_exam archetype within an appropriate OBSERVATION or CLUSTER archetype. Not to be used to record the exclusion of symptoms use the CLUSTER.exclusion_symptom archetype within an appropriate OBSERVATION or CLUSTER archetype. Not to be used to record the absence of information - use the EVALUATION.absense archetype for this purpose.

Keywords: exclusion, negation, rule out, rule-out, r/o, absence

Concepts:

- at0000::Exclusion - specific - A statement of exclusion of a specific Problem/diagnosis, Family history, Medication, Procedure, Adverse reaction or other clinical item that is either not currently present, or have not been present in the past.
- at0001::Tree - @ internal @
- at0002::Exclusion statement - A qualifying statement about the exclusion of a Problem/diagnosis, Family history, Medication, Procedure, Adverse reaction or other clinical item.
- at0003::Excluded concept - Identification of the specific concept which has been excluded.
- at0004::Problem/diagnosis - The problem or diagnosis to which the 'Exclusion statement' applies. For example: 'Diabetes', 'COPD' or 'Asthma'.
- at0005::Family problem/diagnosis - The Family history item to which the 'Exclusion statement' applies. For example: 'Heart desease', 'Diabetes' or 'Alzheimer'.
- at0006::Medication - The Medication to which the 'Exclusion statement' applies. For example: 'Paracetamol', 'Codeine' or 'Antidepressants'.
- at0007::Procedure - The Procedure to which the 'Exclusion statement' applies. For example: 'Heart surgery' or 'Appendectomy' or 'Hip replacement'.
- at0008::Adverse reaction substance - The Adverse reaction substance/agent to which the 'Exclusion statement' applies. For example: 'Penicillin', 'Peanuts' or 'Latex'.

- at0009::Tree - @ internal @
- at0011::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0012::Comment - Additional narrative about the Specific Exclusion not captured in other fields.

exposure

Archetype ID: openEHR-EHR-EVALUATION.exposure.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record summary details of exposure of the subject to a chemical, physical or biological agent within their environment that has caused, or may possibly cause in the future, a negative impact on health.

Use: Use to record summary details of exposure of the subject to a chemical, physical or biological agent within their environment that has caused, or may possibly cause in the future, a negative impact on health. This archetype has been designed primarily to capture a simple amount of details about exposure, fitting current requirements for NT Hearing Health exposure to passive smoking, campfire smoke and noise. However additional research should be conducted to enhance this archetype to cater for the detailed occupation exposure summaries etc.

Keywords: substance, chemical, smoke, passive, noise, pollution, chemical

Concepts:

- at0000::Exposure - Exposure of the subject to a chemical, physical or biological agent within their environment that has caused, or may possibly cause in the future, a negative impact on health.
- at0001::Tree - @ internal @
- at0002::Agent - Identification of the chemical, physical or biological agent to which the subject was exposed.
- at0003::Overall Description - Overall description of the exposure to the identified substance.
- at0004::Ongoing Exposure - Does the subject remain exposed to the substance to a degree that could be regarded as a potential risk to health?
- at0005::Category - Type of exposure.

- at0006::Environmental - Exposure occurred in the environment.
- at0007::Occupational - Exposure occurred in the occupational environment or workplace.
- at0008::Tree - @ internal @
- at0009::Date Updated - The date this exposure summary was last updated.
- at0010::Exposure Details - Detailed information about an episode of exposure to the agent.
- at0011::Date of Onset - Date of onset of exposure to the agent.
- at0012::Date Ceased - Date of cessation of exposure to the agent.
- at0013::Description - Detailed description of an episode of exposure to the identified substance.

family_history

Archetype ID: openEHR-EHR-EVALUATION.family_history.v2

Lifecycle State: in_development

Category: EVALUATION

Languages: de, sv, nb, pt-br, el, en, fr, zh-cn

Purpose: To record information about the occurrence of significant health-related problems in genetic and non-genetic family members - both alive and deceased. The intended scope of this archetype is deliberately kept loose to include the broadest range of problems or issues that might be found within families. It specifically includes known problems and diagnoses, identified biological markers, plus any relevant psychosocial factors and environmental factors.

Use: Use to record a summary of information about problems or diagnoses found in family members. This information may be used to contribute to the identification of a current health problem, assessment of future risk from familial problems or conditions, or to initiate preventive health activities. Traditionally the scope of family history has been focused on genetic factors or biomarkers as indicators of risk or potential risk. The scope of this archetype includes both recording of problems or diagnoses that have an inheritable origin as well as those that are not directly inheritable but influenced by the domestic setting, including psychosocial or environmental factors. Examples include exposure to toxins in the family environment, domestic violence, sexual abuse, alcoholism and other addictions. Non-genetic family members can include adopted or long term fostered children, those related by marriage, or other unrelated individuals who participate in the regular life and influence of the family. This archetype has been designed to include: - a narrative overview as free text. This will allow family history details from existing systems

to be incorporated as non-structured text; and - a detailed area focusing on relevant health details about specific family members, including their medical history and biomarkers. This archetype can be used within many contexts. For example, recording a family history entry within a clinical consultation; populating a Family History List; or to provide a summary statement within a Discharge Summary document. Additional detail about a family member's specific problem, diagnosis or past procedures can be captured using the EVALUATION.problem_diagnosis or the ACTION.procedure archetype and specifying the 'Subject of Care' as the family member, rather than the subject of the health record. This archetype can be used as the basis for a Family Pedigree chart of health problems/diagnoses or to support estimations of risk of a condition based on prevalence in the family history or known biomarkers. It may be necessary to identify each family member specifically and not just by the relationship to the patient. For example, while there will be only one maternal grandmother, there may be many female maternal cousins. This may be required to ensure that a pedigree chart is accurate. It will also enable accurate amendments to the record for each identified family member. If the record is private and will not be shared, for reasons of clarity it may be preferable to record the relative's actual name. If the record, or part of the record, is to be shared, it may be more appropriate for the family member to be identified by a unique label or alias.

Misuse: Not to be used to record information about the relative or absolute risk of developing a condition due to family history - use the EVALUATION.health_risk archetype, including the CLUSTER.family_prevalence for details about the affected ratio of family members. Not to be used for contact tracing for infectious diseases requiring immediate action. Use specific archetypes for this purpose. Not to be used to record an exclusion of Family History - use the EVALUATION.exclusion-family_history archetype for this purpose.

Keywords: family, history, health, condition, problem, diagnosis, genetic, pedigree, genealogy, family history, relative, hereditary, inherited, familial, heredity

Concepts:

- at0000::Family history - Summary information about the significant health-related problems found in family members.
- at0001::Tree - @ internal @
- at0002::Summary - Narrative overview about problems, diagnoses, psychosocial, environmental and genetic markers that have been identified in family members.
- at0003::Per family member - Details about a specific family member.
- at0004::Family member name - Name of family member.
- at0005::Date of birth - Full or partial date of birth of the family member.
- at0008::Clinical history - Detail about problems or diagnoses for the family member.
- at0009::Problem/diagnosis name - Identification of the significant problem or diagnosis in the identified family member.
- at0010::Age at onset - Estimated or actual age of the family member when the problem/diagnosis was clinically recognised.

- at0011::Age at death - Exact or estimated age of the family member at death.
- at0012::Clinical description - Narrative description or comments about clinical aspects of the family member's problem/diagnosis.
- at0014::Cause of death? - Relationship of the problem/diagnosis to the death of this family member.
- at0016::Relationship - The relationship of the family member to the subject of care.
- at0020::Alias - An alternative name or label to uniquely identify a family member, without using a personal name which might publicly identify the individual.
- at0022::Biomarker description - Description of risk-related biological markers identified in this family member.
- at0023::Deceased? - Is the family member deceased?
- at0024::Biomarkers - Detailed information about measurable indicators of a biological state or condition of the family member.
- at0025::Tree - @ internal @
- at0026::Last Updated - The date this family history summary was last updated.
- at0027::Biomarker details - Structured details about biological markers.
- at0028::Per problem - Details about the presence of a specific problem or diagnosis in family members.
- at0029::Problem/diagnosis name - Identification of the significant problem or diagnosis in the family overall.
- at0030::Description - Narrative description about occurrence of the problem or diagnosis in family members.
- at0045::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0046::Comment - Additional narrative about the family member not captured in other fields.
- at0048::Family member details - Structured detail about the identified family member.
- at0053::Multimedia - Multimedia representation of the family history.
- at0058::Date of death - Full or partial date of death of the family member.
- at0059::Problem details - Structured details about the identified problem or diagnosis.
- at0060::Biological sex - The family member's biological sex.
- at0061::Direct cause or closely related - The problem or diagnosis was a direct cause or closely related to the direct cause of death.
- at0062::Unrelated - The problem or diagnosis was unrelated to the cause of death.
- at0063::Indeterminate - It is impossible to determine whether the problem or diagnosis was closely related to the direct cause of death.
- at0064::Relationship degree - The degree of relationship between the subject of care and the family member.
- at0065::First degree relative - 50% genetic share with the subject - for example, parent, sibling or child.
- at0066::Second degree relative - 25% genetic share with the subject - for example, grandparent, aunt, uncle, niece, nephew, grandchildren and half siblings.

- at0067::Third degree relative - 12.5% genetic share with the subject - for example, great grandparent, great aunt, great uncle, first cousin, children of nieces and nephews, and great grandchildren.
- at0068::Family line - Identification of the maternal or paternal family line in the relationship.
- at0069::Maternal line - Related through the subject's mother.
- at0070::Paternal line - Related through the subject's father.

financial_summary

Archetype ID: openEHR-EHR-EVALUATION.financial_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, nb, en, fr

Purpose: To record summary information about the financial situation of an individual, particularly the impact on social determinants of health.

Use: Use to record summary information about the financial situation of an individual, particularly the impact on social determinants of health. Multiple instances of the CLUSTER.financial_record used within the Financial record SLOT will allow aggregation of a history of both past and present finances. The 'Last updated' data element will record the last time that the Financial summary as a whole, including individual financial records, was updated. Use to incorporate the narrative descriptions of financial history within existing or legacy clinical systems into an archetyped format, using the 'Description' data element.

Misuse: Not to be used to record information about the occupation(s) of the individual. Use the EVALUATION.occupation_summary or CLUSTER.occupation_record archetypes for this purpose.

Concepts:

- at0000::Financial summary - Summary information about the financial situation of an individual.
- at0001::Tree - @ internal @
- at0007::Main source of income - The main source of income for the individual.
- at0002::Description - Narrative description about the financial situation of the individual.
- at0009::Comment - Additional narrative about the Financial summary not captured in other fields.

- at0008::Financial record - None
- at0010::Item tree - @ internal @
- at0011::Last updated - The date this Financial summary was last updated.
- at0012::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0003::Financial security status - Category describing the individual's perception about their income being adequate to cover their expenses.
- at0004::Secure - The individual has a sense of certainty and peace of mind about their financial situation - their income is stable and/or adequate to cover their expenses.
- at0005::At risk - The individual has a sense of uncertainty about their financial situation - their income may vary and/or sometimes may not be adequate to cover their expenses.
- at0006::Insecure - The individual has a sense of worry and concern about financial hardship - their income is not stable and/or not adequate to cover their expenses.
- at0013::Financial security description - Narrative description about the financial security status of the individual.

food_nutrition_summary

Archetype ID: openEHR-EHR-EVALUATION.food_nutrition_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: de, en, nl

Purpose: To record an overview of the food and nutritional situation for an individual, including the impact on social determinants of health.

Use: Use to record an overview of the food and nutritional situation for an individual, including the impact on social determinants of health.

Misuse: Not to be used to record measurements such as body weight, height or Body Mass Index. Use specific archetypes to record these measurements - OBSERVATION.weight, OBSERVATION.height and OBSERVATION.body_mass_index.

Keywords: nutrition, obese, overweight, underweight, malnourished

Concepts:

- at0000::Food and nutrition summary - Summary of the food and nutritional situation for an individual.

- at0001::Tree - @ internal @
- at0002::Nutrition status - Description of the individual's nutritional status as assessed by a clinician, for example, malnourished or well nourished. Coding with a terminology is desirable, where possible.
- at0003::Weight status - Assessment of the individual's weight status.
- at0004::Underweight - Is underweight for age and sex according to BMI or other measure.
- at0005::Overweight - Is overweight for age and sex according to BMI or other measure.
- at0006::Obese - Is obese for age and sex according to BMI or other measure.
- at0007::Normal - Is normal weight for age and sex according to BMI or other measure.
- at0008::Dietary preference - A description of an individual's dietary preference.
- at0009::Dietary constraints - Description of a special dietary requirements or constraints.
- at0010::Comment - Comment about the individual's nutrition.
- at0011::Description - Narrative description about the individual's diet and eating patterns.
- at0012::Item tree - @ internal @
- at0013::Food security status - Category describing the individual's perception about about secure and reliable access to food that is adequate in quantity and nutritional quality; culturally acceptable; safe; and acquired in socially acceptable ways.
- at0014::Secure - The individual has a sense of certainty and peace of mind about their access to appropriate food.
- at0015::Changeable - The individual has a sense of uncertainty about reliable and consistent access to appropriate food.
- at0016::Insecure - The individual has a sense of worry and concern about their access to appropriate food.
- at0018::Last updated - The date this summary was last updated.
- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0020::Food security description - Narrative description about the individual's ability to access appropriate food.
- at0021::Milk supply - The type of milk available for consumption.
- at0022::Pasteurised - Available milk is pasteurised.
- at0023::Non-pasteurised - Available milk is non-pasteurised.

gambling_summary

Archetype ID: openEHR-EHR-EVALUATION.gambling_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record an overview of the gambling activity by an individual or the impact of gambling on them by others.

Use: Use to record an overview of the gambling activity by an individual or the impact of gambling on them by others.

Concepts:

- at0000::Gambling summary - Summary about the gambling activity by an individual or the impact of gambling on them by others.
- at0001::Item tree - @ internal @
- at0002::Description - Narrative description about the individual's gambling activity or the impact of gambling on them by others.
- at0003::Item tree - @ internal @
- at0004::Last updated - The date this summary was last updated.
- at0005::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.

gender

Archetype ID: openEHR-EHR-EVALUATION.gender.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, pt-pt, sv, nb, en, fr, ca, es

Purpose: To record details about the gender of an individual.

Use: Use to record details about the individual's gender, including administrative and legal gender and assigned sex at birth, in addition to gender identity, expression and preferred pronoun. The intent of this archetype is to record a broad range of details connected to the gender of an individual, due to modern thinking of gender as well as new knowledge of psychological, biological and social manifestations of gender. This archetype also allows the recording of, and differentiation between, legal and administrative gender. In most common use cases 'Administrative gender' will be used, as equivalent of the traditional definition of "Sex" in current or legacy systems.

Misuse: Not to be used for recording information relating to the sexual orientation or sexual activity of an individual. Not to be used for recording genetic or chromosomal sex. Currently this is usually recorded as a laboratory test result. Formal representation of 'Genetic sex' is not yet well defined and may involve the combination of information axes, including chromosomal and receptor data, mosaic variants and diagnoses.

Keywords: sex, male, female, androgynous, boy, girl, man, woman, transsexual, bigender, agender, transgender, transman, transwoman

Concepts:

- at0000::Gender - Details about the gender of an individual.
- at0001::Gender identity - The individual's perception of their own gender.
- at0002::Tree - @ internal @
- at0003::Tree - @ internal @
- at0004::Last updated - The date this gender data was last updated.
- at0005::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0014::Comment - Additional narrative about the individual's gender not captured in other data elements.
- at0019::Sex assigned at birth - The sex of an individual determined by anatomical characteristics observed and registered at birth.
- at0020::Preferred pronoun - The pronoun an individual chooses to identify with, and would prefer others to use when talking to or about that individual.
- at0022::Administrative gender - The gender of an individual used for administrative purposes.
- at0023::Additional details - Additional structured details about the individuals gender.
- at0025::Gender expression - The expression of the gender by the individual as demonstrated by behaviour, speech, clothes or other external characteristics.
- at0026::Legal gender - The gender of an individual used for official or legal purposes.
- at0027::Gender category - Category describing the alignment of an individual's gender identity with their sex assigned at birth.

goal

Archetype ID: openEHR-EHR-EVALUATION.goal.v1

Lifecycle State: published

Category: EVALUATION

Languages: fi, es-ar, pt-br, ar-sy, en, nl

Purpose: To record details about a health-related goal and any associated targets and deadlines.

Use: Use to record a health-related goal, as well as one or more specific, measurable targets that will support assessment of success or allow for recording difficulties in achieving the target. This archetype is intended for use as a component of a care plan, COMPOSITION.care_plan, and will be versioned over time as any changes are made. For example, if a new goal is added to a care plan, or or any other change made, the data will be added/updated and the Care plan saved as a new version. It can be used in any other COMPOSITION or SECTION archetypes, where clinically relevant.

Keywords: target, goal, plan, outcome

Concepts:

- at0000::Goal - A desired health, or well-being, outcome for the subject of care.
- at0001::Tree - @ internal @
- at0002::Goal name - The name of the desired health outcome.
- at0003::Goal proposed date - The desired or proposed date for achieving the goal.
- at0004::Goal end date - The actual date that the goal was achieved or abandoned.
- at0005::Target - Detail about the intended target.
- at0006::Target path - The archetype and path to the node for target data.
- at0007::Target - The intended target.
- at0008::Target proposed date - The desired or proposed date for achieving the target.
- at0009::Target end date - The actual date that the target was achieved or abandoned.
- at0010::Clinical indication - Name of the problem or diagnosis which is intended to be impacted by achievement of this goal.
- at0011::Target name - Identification of the intended target, by name.
- at0012::Goal description - A narrative description of the goal, including target/s to be achieved if relevant.
- at0013::Goal outcome - Single word, phrase or brief description which represents the outcome actually achieved for the goal.
- at0015::Achieved - The proposed goal was realised.
- at0016::Partially achieved - The proposed goal was partially realised.
- at0017::Not achieved - The proposed goal was not realised and abandoned.
- at0018::Target outcome - Single word, phrase or brief description which represents the outcome actually achieved for the target.
- at0019::Achieved - The target was realised.
- at0020::Partially achieved - The target was partially realised.
- at0021::Not achieved - The target was not realised and abandoned.
- at0022::Goal comment - Additional narrative about the goal not captured in other fields.
- at0023::Target comment - Additional narrative about the target not captured in other fields.
- at0024::Target description - Narrative description about the intended target.

- at0025::Goal start date - The anticipated or proposed date for commencing work towards the goal.
- at0026::Tree - @ internal @
- at0027::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0028::Readiness for change - Details about the readiness to change behaviour to achieve the desired goal.
- at0029::Last updated - The date on which the goal was last updated.

health_risk-covid

Archetype ID: openEHR-EHR-EVALUATION.health_risk-covid.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: de, sv, fi, es-ar, nb, en, ar-sy, it

Purpose: To record known risk factors for, and assess the potential risk of Covid-19 infection. The intent of this archetype is to document potential risk at a point in time, and to support decision-making that may reduce the identified risk, whether by clinicians or the individual themselves.

Use: To record known risk factors for, and assess the potential risk of Covid-19 infection. As risk factors may be gradually identified over time and the overall risk reassessed as a result, the 'Date identified' will record the date on which each risk factor has been identified and the 'Last updated' data element will record the last time that the whole assessment was updated.

Keywords: assessment, risk, evaluation, adverse, factor, health, issue, estimated, management, risk factor, risk stratification

Concepts:

- at0000.1::Covid-19 infection risk assessment - Assessment of the potential and likelihood of Covid-19 infection as determined by identified risk factors.
- at0002.1::Health risk - Identification of the potential future disease, condition or health issue for which the risk is being assessed, by name.
- at0.1::COVID-19 Risk assessment - Assessment of risk of COVID-19 infection.
- at0013.1::Risk factor - Identification of the risk factor, by name.
- at0.9::Contact with confirmed Covid-19 case - Contact with confirmed Covid-19 case within 14 days before symptom onset.

- at0.10::Contact with suspected case/ pneumonia case - Contact with suspected case/ pneumonia case within 14 days before symptom onset.
- at0.11::Contact with birds in China - Contact with birds in China in 10 days before symptom onset.
- at0.12::Contact with confirmed human case of Avian flu in China - Contact with confirmed human case of Avian flu in China in 10 days before symptom onset.
- at0.13::Contact with severe, unexplained respiratory disease - Contact with severe, unexplained respiratory disease in 10 days before symptom onset.
- at0.14::Potential contact exposure based on location - Potential contact exposure based on location.
- at0027.1::Detail - Structured detail about other aspects of the risk factor assessment.
- at0017.1::Presence - Presence of the risk factor.
- at0.15::Unknown - No information is available for this risk factor.
- at0003.1::Risk assessment - Evaluation of the health risk.
- at0.16::Low risk - The risk of the a patient having a Covid-19 infection is assessed to be low.
- at0.17::High risk - The risk of the a patient having a Covid-19 infection is assessed to be high.
- at0.18::Needs admission for respiratory disease - Does the patient require hospital admission with either clinical or radiological evidence of pneumonia, adult respiratory distress syndrome, or influenza like illness?
- at0000::Health risk assessment - Assessment of the potential and likelihood of future adverse health effects as determined by identified risk factors.
- at0001::structure - @ internal @
- at0002::Health risk - Identification of the potential future disease, condition or health issue for which the risk is being assessed, by name.
- at0003::Risk assessment - Evaluation of the health risk.
- at0004::Rationale - Justification for this risk assessment.
- at0010::Tree - @ internal @
- at0011::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0012::Link to evidence - Identification of the path to the archetype or data node for the evidence of risk.
- at0013::Risk factor - Identification of the risk factor, by name.
- at0014::Description - Narrative description about the risk factor.
- at0015::Comment - Additional narrative about the risk assessment not captured in other fields.
- at0016::Risk factors - Details about each possible risk factor.
- at0017::Presence - Presence of the risk factor.
- at0018::Present - The risk factor has been identified for this individual.
- at0019::Absent - The risk factor has not been identified for this individual.

- at0020::Assessment type - Record of whether the risk assessment is a relative or absolute.
- at0021::Relative risk - Ratio of probability of a health event or condition occurring compared to a population with similar characteristics eg same age and sex.
- at0022::Absolute risk - Ratio of probability of a health event or condition occurring compared to the population as a whole.
- at0023::Time period - The time period during which the predicted health risk is relevant.
- at0024::Last updated - The date this health risk assessment was last updated.
- at0025::Assessment method - Identification of the algorithm or guideline used to make the assessment of risk.
- at0026::Indeterminate - It is not possible to determine if the risk factor is present or absent.
- at0027::Detail - Structured detail about other aspects of the risk factor assessment.
- at0028::Mitigated - The risk factor has been identified as present, but then subsequently been mitigated by treatment or investigation.
- at0029::Date identified - The date/time that the risk factor was identified.
- at0030::Comment - Additional narrative about the risk factor not captured in other fields.
- at0.19::Other household members are ill - The patient is in a house with other household members who are ill
- at0.20::Household members with travel exposure - Members of the patient's household have travel exposure.

health_risk

Archetype ID: openEHR-EHR-EVALUATION.health_risk.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, sv, fi, es-ar, nb, el, ar-sy, en, it

Purpose: To record known risk factors for an identified disease, condition, or other potentially adverse health issue, and/or an evaluation of the likelihood of the individual experiencing it in the future. This archetype has been deliberately left open and broad in scope. The 'Health Risk' could be determined from risk factors from any or all of: medical; biomarker; lifestyle; social; occupational hazard; or environmental domains. The intent of this archetype is to document potential risk at a point in time, and to support decision-making that may reduce the identified risk, whether by clinicians or the individual themselves.

Use: Use to record known risk factors for an identified disease, condition, or other potentially adverse health issue, and/or an evaluation of the likelihood of the individual experiencing it in the future. As risk factors may be gradually identified over time and the overall risk reassessed as a result, the 'Date identified' will record the date on which each risk factor has been identified and the 'Last updated' data element will record the last time that the whole assessment was updated.

Keywords: assessment, risk, evaluation, adverse, factor, health, issue, estimated, management, risk factor, risk stratification

Concepts:

- at0000::Health risk assessment - Assessment of the potential and likelihood of future adverse health effects as determined by identified risk factors.
- at0001::structure - @ internal @
- at0002::Health risk - Identification of the potential future disease, condition or health issue for which the risk is being assessed, by name.
- at0003::Risk assessment - Evaluation of the health risk.
- at0004::Rationale - Justification for this risk assessment.
- at0010::Tree - @ internal @
- at0011::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0012::Link to evidence - Identification of the path to the archetype or data node for the evidence of risk.
- at0013::Risk factor - Identification of the risk factor, by name.
- at0014::Description - Narrative description about the risk factor.
- at0015::Comment - Additional narrative about the risk assessment not captured in other fields.
- at0016::Risk factors - Details about each possible risk factor.
- at0017::Presence - Presence of the risk factor.
- at0018::Present - The risk factor has been identified for this individual.
- at0019::Absent - The risk factor has not been identified for this individual.
- at0020::Assessment type - Record of whether the risk assessment is a relative or absolute.
- at0021::Relative risk - Ratio of probability of a health event or condition occurring compared to a population with similar characteristics eg same age and sex.
- at0022::Absolute risk - Ratio of probability of a health event or condition occurring compared to the population as a whole.
- at0023::Time period - The time period during which the predicted health risk is relevant.
- at0024::Last updated - The date this health risk assessment was last updated.
- at0025::Assessment method - Identification of the algorithm or guideline used to make the assessment of risk.

- at0026::Indeterminate - It is not possible to determine if the risk factor is present or absent.
- at0027::Detail - Structured detail about other aspects of the risk factor assessment.
- at0028::Mitigated - The risk factor has been identified as present, but then subsequently been mitigated by treatment or investigation.
- at0029::Date identified - The date/time that the risk factor was identified.
- at0030::Comment - Additional narrative about the risk factor not captured in other fields.

housing_summary

Archetype ID: openEHR-EHR-EVALUATION.housing_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, nb, en, fr

Purpose: To record summary or persistent information about an individual's current and past housing or accommodation situation.

Use: Use to record summary or persistent information about an individual's current and past housing or accommodation situation. Multiple instances of the CLUSTER.housing_record used within the Housing record SLOT will allow aggregation of a history of both past and present housing, including the flexibility to record situations where individuals live in more than one place during the same period of time, for main residences and holiday houses, etc. The 'Last updated' data element will record the last time that the Housing summary as a whole, including individual housing records, was updated. Use to incorporate the narrative descriptions of housing history within existing or legacy clinical systems into an archetyped format, using the 'Description' data element.

Misuse: Not to be used to record specific details about the setting in which an individual usually resides - use CLUSTER.housing_record nested within the Housing record SLOT in this archetype. Not to be used to record specific details about the people with which an individual lives - use CLUSTER.living_arrangement nested within the Additional details SLOT in the CLUSTER.housing_record, or similar archetypes which are clinically appropriate. Not to be used to record specific details about the housing structure in which an individual lives - use CLUSTER.dwelling nested within the Additional details SLOT in the CLUSTER.housing_record, or similar archetypes which are clinically appropriate. Not to be used to record the physical address where an individual lives - use demographic archetypes

for this purpose, or CLUSTER.address within the CLUSTER.housing_record, or similar, if the individual's address needs to be recorded within the health record.

Keywords: housing,accommodation,living,dwelling,house,living,arrangement,share house,retirement home,nursing home

Concepts:

- at0000::Housing summary - Summary or persistent information about an individual's current and past housing or accommodation situation.
- at0001::Tree - @ internal @
- at0002::Description - Narrative description about the overall housing situation for the individual.
- at0003::Additional details - Structured details about the overall housing situation for an individual.
- at0005::Comment - Additional narrative about the overall housing situation, not captured in other fields.
- at0009::Housing record - Structured details about the each housing record, both current and past.
- at0012::Tree - @ internal @
- at0013::Last updated - Date when the housing summary or associated housing records was updated.
- at0014::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

implanted_device_summary

Archetype ID: openEHR-EHR-EVALUATION.implanted_device_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record a summary or overview detailing the history and context of use for a specified type of implantable medical device.

Use: Use to record a summary or overview of a single implanted medical device, or category of device. The intended scope of this archetype includes, but is not limited to: - a cochlear implant; - an intracardiac pacemaker; - one or more aneurysm clips; - a femoral head prosthesis; - a coronary stent; - bone fixation devices such as screws or plates; - deep brain electrical stimulation system lead; or - deep brain electrical stimulation system pulse

generator. This archetype has been specifically designed to: - support the management of implanted medical devices over time; - assist in the identification of implanted medical devices in situ that may carry health risks for imaging and other health-related activities; and - carry critical information such as device identification that will support product recalls. The repeating 'Specific implant details' CLUSTER supports documentation about each insertion of each specific medical device, including more precise identification and summary details about the device insertion and removal. This archetype can be further developed to document medical device details such as the manufacturer, batch numbers and device identifiers by nesting the CLUSTER.device_details in the 'Structured device detail' SLOT. In practice, some clinical systems will need to record specific and detailed INSTRUCTION and ACTION archetypes to reflect the request for a medical device and subsequent activities that need to be recorded as that request is carried out. There will inevitably be some overlap between this summary and these detailed archetypes. All may be necessary in different contexts however, where possible, ideally this summary should be derived from the point of care INSTRUCTION and ACTION documentation by clinicians, to prevent the need for clinicians to duplicate data input.

Misuse: Not to be used to request a medical device. Use a relevant INSTRUCTION archetype for this purpose. Not to be used to record the activities that occur in the insertion or removal of an implant. Use the ACTION.procedure archetype for this purpose.

Concepts:

- at0000::Implanted medical device summary - A summary or overview detailing the history and context of use for a specified type of implantable medical device, including details about specific implantation episodes.
- at0001::Tree - @ internal @
- at0003::Overall status - Assertion about the whether the device type is currently in situ.
- at0004::In situ - The device type is currently inserted or implanted in the body.
- at0005::Removed - The device type has been removed from the body.
- at0008::Device name - Name of the implanted medical device.
- at0014::Insertion date - The Date/time when the device was implanted.
- at0019::Removal date - The Date/time when the device was removed.
- at0017::Structured device detail - Additional structured detail about the specific implanted device.
- at0015::Implant body site - Identification of the area of the body where the device has been inserted.
- at0016::Structured implant body site - Structured identification of the body site where the device has been inserted.
- at0013::Description - Narrative description about the device.
- at0006::Overall description - A narrative description about the history or context of use for this device type over time.
- at0026::Tree - @ internal @

- at0024::Last updated - The date this Implanted medical device summary was last updated.
- at0025::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0021::Next review due - Date on which this device should be reviewed.
- at0002::Device type name - Name of the medical device category.
- at0018::Multimedia representation - Digital image, video or diagram related to the specific implanted device.
- at0007::Specific implanted device details - Details about a specific implanted medical device.
- at0010::Status - Assertion about the whether the identified device is currently in situ.
- at0009::Label - An alternative name or label to identify a specific device, when the 'Device name' is not unique.
- at0020::Reason for removal - Description about why the implanted device was removed.
- at0022::Comment - Additional narrative about the impanted medical device not captured in other fields.
- at0023::Overall comment - Additional narrative about the implanted medical device type, not captured in other fields.
- at0011::In situ - The specific device is currently inserted or implanted in the body.
- at0012::Removed - The specific device has been removed from the body.

infant_feeding

Archetype ID: openEHR-EHR-EVALUATION.infant_feeding.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record a summary of early infant feeding activity, particularly focused on breast and formula feeding.

Use: Use to record a summary of early infant feeding activity, particularly focused on breast and formula feeding.

Keywords: breast, feeding, infant, formula, bottle, fed, wean

Concepts:

- at0000::Infant feeding summary - Summary of early infant feeding activity, particularly focused on breast and formula feeding.
- at0001::Tree - @ internal @
- at0002::Description - Narrative description about the overall feeding history for the infant.
- at0003::Feeding episode - Details about a pattern of feeding.
- at0004::Age Commenced - The age of the infant when the selected type of feeding was commenced.
- at0005::Age Ceased - The age of the infant when the selected type of feeding was ceased.
- at0006::Type - The predominant type of feeding for a period of time.
- at0007::Total Duration of Breast Feeding - The total amount of time that the infant was predominantly breastfed.
- at0008::Age Commenced Solid Foods - The age of the infant when commenced on solid foods.
- at0009::Comment - Additional narrative about the feeding activity not captured in other fields.
- at0010::Age Weaned - The age of the infant when weaned.
- at0011::Predominantly Breastfed - Infant was solely breast fed, or the proportion of the volume of milk supplied by breast feeding was significantly greater than the volume from bottled formula.
- at0012::Predominantly Formula - Infant was solely fed on bottled formula, or the proportion of the volume of milk supplied by feeding with bottled formula was significantly greater than by breast feeding.
- at0013::Mixed - The volume of milk supplied by breast feeding was similar to that supplied as bottled formula.
- at0014::Overall feeding type - None
- at0015::Predominantly breastfed - None
- at0016::Predominantly formula fed - None
- at0017::Mixed breast and formula feeding - None
- at0019::Comment - None
- at0020::Extension - None
- at0021::Item tree - @ internal @

infectious_disease_investigation_classification

Archetype ID: openEHR-EHR-EVALUATION.infectious_disease_investigation_classification.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record the disease classification for an identified infectious disease as part of a disease surveillance investigation.

Use: Use to record the disease for an identified infectious disease as part of a disease surveillance investigation, most commonly the final determination at the completion of a case investigation but may also record initial classification as a suspected infection. Use a separate instance of this archetype to record the conclusion for each suspected 'Index disease'. For example in a fever & rash investigation, considering Measles and Rubella as the potential causes, use one instance of this archetype to record the conclusion, rationale, evidence etc related to Measles, and another to carry the information related to Rubella.

Concepts:

- at0000::Infectious disease investigation classification - Classification for an identified infectious disease as part of a disease surveillance investigation.
- at0001::Item tree - @ internal @
- at0002::Initial classification - Classification of the likelihood of the 'Index disease' as causal at the initiation of a case investigation.
- at0003::Probable - A case is 'Probable' when common, relevant symptoms and/or signs are exhibited and there is an epidemiological link.
- at0004::Not suspected - A case is 'Not suspected' if the clinical or laboratory findings do not meet the criteria to suspect disease.
- at0007::Index disease - The name of the infectious disease under investigation.
- at0008::Reason for classification - The broad category of the reason for the classification.
- at0009::Reason description - Narrative description about the reason for the classification.
- at0011::Aetiology category - The category for the cause of infection.
- at0013::Item tree - @ internal @
- at0014::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0015::Last updated - The date when this infectious disease investigation classification was last updated.
- at0016::Additional details - Additional structured details about the classification.
- at0017::Comment - Additional narrative about the classification, not captured in other fields.
- at0021::Source country - Country identified as the (likely or probable) source for an imported or import-related case.
- at0035::Suspected - A case is 'Suspected' when common, relevant symptoms and/or signs are exhibited.
- at0036::Aetiology description - Narrative description about the cause of infection.
- at0045::Imported case - Exposure occurred outside of the country.

- at0046::Import-related case - Exposure occurred locally, but is directly associated to an imported case.
- at0047::Endemic case - Exposure occurred locally, as part of a chain of endemic transmission.
- at0048::Vaccine-associated case - Exposure occurred as an adverse event following exposure to a vaccine.
- at0049::Congenital case - Exposure occurred during pregnancy.
- at0050::Unknown - The exposure event has not been identified.
- at0051::Endemic source category - The category for the source of an endemic case.
- at0052::Endemic source description - Narrative description about the source of an endemic case.
- at0054::Epidemiological link - None
- at0055::Animal to human transmission - None
- at0056::Exposure to a common source - None
- at0057::Exposure to contaminated food/drinking water - None
- at0058::Environmental exposure - None
- at0059::Laboratory exposure - None
- at0060::Final classification - Classification of the likelihood of the 'Index disease' as causal after completion of a case investigation.
- at0061::Pending - A case is 'Pending' at the completion of an adequate investigation when it is not possible to confirm or discard due to inadequate information, and further information is anticipated. It is usually a temporary classification.
- at0062::Probable - A case is 'Probable' at the completion of an adequate investigation when clinical evidence criteria are met and/or an epidemiological link has been identified, with laboratory test results suggesting causality rather than being conclusive.
- at0063::Laboratory confirmed - A case is 'Laboratory confirmed' at the completion of an adequate investigation when positive laboratory test results confirm the clinical evidence and/or epidemiological link.
- at0064::Discarded - A case is 'Discarded' or 'Excluded' at the completion of an adequate investigation due to negative laboratory test results that exclude causality.
- at0065::Inconclusive - A case is 'Inconclusive' at the completion of an adequate investigation when it is not possible to confirm or discard due to inadequate information, and no further information is anticipated. It is not a temporary classification.
- at0066::Clinically confirmed - A case is 'Clinically confirmed' at the completion of an adequate investigation on the basis of clinical evidence alone.
- at0067::Human to human transmission - None
- at0068::Contribution to patient death - None
- at0069::Related - The index disease was directly or indirectly related to the death of the infected individual.
- at0070::Unrelated - The index disease was not related to the death of the infected individual.

- at0071::Unknown - It is unknown if the index disease is related to the death of the individual or not.

infectious_disease_summary

Archetype ID: openEHR-EHR-EVALUATION.infectious_disease_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record summary details about an infectious disease and factors related to assessment of immunity.

Use: Use to record summary details about an infectious disease and factors related to assessment of immunity.

Concepts:

- at0000::Infectious disease summary - Summary details about an infectious disease and factors related to assessment of immunity.
- at0001::Tree - @ internal @
- at0002::Infectious disease - Name of the infectious disease.
- at0003::Immune status - Assertion about the immune status of the subject.
- at0014::Comment - Narrative information about the infectious disease not captured in other fields.
- at0020::Tree - @ internal @
- at0021::Last Updated - The date at which the infectious disease summary was last clinically asserted, affirmed or confirmed.
- at0042::Description of immune status - Narrative description about the assessment of immune status for the infectious disease.
- at0046::Evidence - Details about evidence that supports the assertion of an immune status.
- at0047::Previous infection? - Has the subject been exposed through a previous infection to the same infectious disease?
- at0048::Confirmed - Previous infection has been confirmed by history or findings.
- at0049::Suspected - Previous infection is suspected from history or findings, but has not been confirmed.
- at0050::No Evidence - There is no history or findings to suggest that the subject has had a previous infection.

- at0051::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

infectious_investigation_classification

Archetype ID: openEHR-EHR-EVALUATION.infectious_investigation_classification.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record the disease classification for an identified infectious disease as part of a disease surveillance investigation.

Use: Use to record the disease for an identified infectious disease as part of a disease surveillance investigation, most commonly the final determination at the completion of a case investigation but may also record initial classification as a suspected infection. Use a separate instance of this archetype to record the conclusion for each suspected 'Index disease'. For example in a fever & rash investigation, considering Measles and Rubella as the potential causes, use one instance of this archetype to record the conclusion, rationale, evidence etc related to Measles, and another to carry the information related to Rubella.

Concepts:

- at0000::Infectious disease investigation classification - Classification for an identified infectious disease as part of a disease surveillance investigation.
- at0001::Item tree - @ internal @
- at0002::Initial classification - Classification of the likelihood of the 'Index disease' as causal at the initiation of a case investigation.
- at0003::Probable - A case is 'Probable' when common, relevant symptoms and/or signs are exhibited and there is an epidemiological link.
- at0004::Not suspected - A case is 'Not suspected' if the clinical or laboratory findings do not meet the criteria to suspect disease.
- at0007::Index disease - The name of the infectious disease under investigation.
- at0008::Reason for classification - The broad category of the reason for the classification.
- at0009::Reason description - Narrative description about the reason for the classification.
- at0011::Aetiology category - The category for the cause of infection.
- at0013::Item tree - @ internal @

- at0014::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0015::Last updated - The date when this infectious disease investigation classification was last updated.
- at0016::Additional details - Additional structured details about the classification.
- at0017::Comment - Additional narrative about the classification, not captured in other fields.
- at0021::Source country - Country identified as the (likely or probable) source for an imported or import-related case.
- at0035::Suspected - A case is 'Suspected' when common, relevant symptoms and/or signs are exhibited.
- at0036::Aetiology description - Narrative description about the cause of infection.
- at0045::Imported case - Exposure occurred outside of the country.
- at0046::Import-related case - Exposure occurred locally, but is directly associated to an imported case.
- at0047::Endemic case - Exposure occurred locally, as part of a chain of endemic transmission.
- at0048::Vaccine-associated case - Exposure occurred as an adverse event following exposure to a vaccine.
- at0049::Congenital case - Exposure occurred during pregnancy.
- at0050::Unknown - The exposure event has not been identified.
- at0051::Endemic source category - The category for the source of an endemic case.
- at0052::Endemic source description - Narrative description about the source of an endemic case.
- at0054::Epidemiological link - Identification of the cause or source of transmission.
- at0055::Animal to human transmission - None
- at0056::Exposure to a common source - None
- at0057::Exposure to contaminated food/drinking water - None
- at0058::Environmental exposure - None
- at0059::Laboratory exposure - None
- at0060::Final classification - Classification of the likelihood of the 'Index disease' as causal after completion of a case investigation.
- at0061::Pending - A case is 'Pending' at the completion of an adequate investigation when it is not possible to confirm or discard due to inadequate information, and further information is anticipated. It is usually a temporary classification.
- at0062::Probable - A case is 'Probable' at the completion of an adequate investigation when clinical evidence criteria are met and/or an epidemiological link has been identified, with laboratory test results suggesting causality rather than being conclusive.
- at0063::Laboratory confirmed - A case is 'Laboratory confirmed' at the completion of an adequate investigation when positive laboratory test results confirm the clinical evidence and/or epidemiological link.

- at0064::Discarded - A case is 'Discarded' or 'Excluded' at the completion of an adequate investigation due to negative laboratory test results that exclude causality.
- at0065::Inconclusive - A case is 'Inconclusive' at the completion of an adequate investigation when it is not possible to confirm or discard due to inadequate information, and no further information is anticipated. It is not a temporary classification.
- at0066::Clinically confirmed - A case is 'Clinically confirmed' at the completion of an adequate investigation on the basis of clinical evidence alone.
- at0067::Human to human transmission - None
- at0068::Contribution to death - Assessment of the relationship between the index disease and the death of the individual.
- at0069::Related - The index disease was directly or indirectly related to the death of the infected individual.
- at0070::Unrelated - The index disease was not related to the death of the infected individual.
- at0071::Unknown - It is unknown if the index disease is related to the death of the individual or not.

intervention_summary

Archetype ID: openEHR-EHR-EVALUATION.intervention_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: nb, en

Purpose: To record a summary about a single therapeutic intervention, or series of interventions, that has been carried out.

Use: Use to record a summary about a single therapeutic intervention, or series of interventions, that has been carried out. Examples of use include, but are not limited to: - A course of radiotherapy carried out as part of a cancer protocol. - A course of medical treatment that has been administered. - A surgical procedure that has been performed. - Cognitive behavioural therapy sessions used in the treatment of depression.

Misuse: Not to be used to record all details of each intervention event or activity. Use an appropriate ACTION archetype for this purpose, for example ACTION.procedure.

Keywords: treatment line, treatment cycle, treatment course, treatment plan, treatment protocol, therapy, outcome, final result, treatment effect

Concepts:

- at0000::Intervention summary - A summary about a single therapeutic activity, or series of activities, intended to prevent, diagnose, treat, or manage health conditions, support mental or physical well-being, or address social and environmental factors that influence health outcomes.
- at0001::Item tree - @ internal @
- at0002::Item tree - @ internal @
- at0003::Intervention name - The name of the intervention.
- at0004::End date - The date when the identified intervention was carried out to completion or stopped prior to completion.
- at0005::Completion status - Whether or not the intervention was carried out as intended.
- at0007::Reason for non-completion - Description of the reason why the course of intervention was not completed (incomplete).
- at0008::Outcome category - Category of outcome for the intervention.
- at0010::Date of last contact - Most recent date on which communication or interaction occurred with the individual.
- at0016::Comment - Narrative description about the intervention, not captured in other fields.
- at0017::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0018::Last updated - The date this intervention summary was last updated.
- at0019::Additional details - Additional structured details about the intervention.
- at0021::Complete - Completed as intended.
- at0022::Incomplete - Not completed as intended.
- at0027::Reason for outcome category - Description of the reason behind the outcome category.
- at0028::Description - Narrative description about the intervention.
- at0032::Start date - The date when the identified intervention commenced.
- at0033::Clinical indication - The symptom, sign, problem or diagnosis that necessitates the intervention.
- at0034::Intent - Description of the intent for the intervention.
- at0051::Sequence - The sequence of the identified intervention within a series or a course of interventions.
- at0054::Protocol name - The name of the clinical protocol or guideline that underpins the identified intervention.
- at0055::Category - Catogory of the identified intervention.
- at0056::Number of interventions - Number of interventions in a series.

issue

Archetype ID: openEHR-EHR-EVALUATION.issue.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record details about a health-related issue or concern identified and described by the individual (or their proxy) about the individual's health.

Use: Use to record details about a health-related issue or concern identified and described by the individual (or their proxy) about the individual's health.

Misuse: Not to be used to record details about a symptom or sign - use CLUSTER.symptom_sign for this purpose. Not to be used to record details about a health-related event - use CLUSTER.health_event for this purpose.

Concepts:

- at0000::Issue - A health-related concern or worry identified and described by the individual (or their proxy) about the individual's health, usually related to personal perceptions about their state of health or the identification of external factors that influence or impact upon their health.
- at0001::Item tree - @ internal @
- at0002::Issue name - The name of the issue or concern as presented by the individual.
- at0003::Description - Narrative description about the issue.
- at0004::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0005::Item tree - @ internal @
- at0006::Last updated - The date when this issue record was last updated.

last_menstrual_period

Archetype ID: openEHR-EHR-EVALUATION.last_menstrual_period.v1

Lifecycle State: published

Category: EVALUATION

Languages: nb, en

Purpose: To record the details about the first day of the most recent menstrual cycle for the individual.

Use: Use to record the details about the first day of the most recent menstrual cycle for the individual. Use the data element 'Certainty' to record the level of certainty the date was correct. The assumption when recording the onset of the last menstrual cycle is that the menstruation was 'normal'.

Misuse: Not to be used to record information about menses or related symptoms, use the OBSERVATION.menstruation archetype for this purpose. Not to be used to record information about a specific day in a menstrual cycle, use the OBSERVATION.menstrual_diary archetype for this purpose. Not to be used to record information about an individual's menstruation history events or patterns of menstruation over time, use the EVALUATION.menstruation_summary archetype for this purpose.

Keywords: menstruation, menses, LNMP, LMP, LNP, DLMP

Concepts:

- at0000::Last menstrual period - Identification of the first day of the most recent menstrual cycle for the individual.
- at0001::Item tree - @ internal @
- at0002::Date of onset (LMP) - Date of onset of menstrual bleeding.
- at0003::Item tree - @ internal @
- at0004::Last updated - Date when the Last menstrual period was updated.
- at0006::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0007::Description - Narrative description about the last menstrual period.
- at0008::Comment - Additional narrative about the last menstrual period, not captured in other fields.
- at0009::Certainty - The level of certainty the date was accurate.

living_arrangement

Archetype ID: openEHR-EHR-EVALUATION.living_arrangement.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: de, nb, en, it

Purpose: To record the circumstances about how an individual lives alone or with others.

Use: Use to record the circumstances about how an individual lives alone or with others. This archetype has been designed as one of a family of archetypes that describe the social connectedness of an individual in their home environment. Within this archetype, the intent of the concept of 'household' is to capture information about one or more people who reside together, including sharing meals, economic resources and/or living space. In this context, a single household might comprise varieties of blended families, a student share house, a group home, or a single person living alone. A single dwelling may be considered to contain multiple households if they don't share meals or resources, or have separate living spaces.

Misuse: Not to be used to record overall information about an individual's current and past housing or housing situation. Use EVALUATION.housing_summary for this purpose. Not to be used to record details of the dwelling where the individual resides - use CLUSTER.dwelling for this purpose. Not to be used to describe the social connections of the individual, including identification of household members - use EVALUATION.social_network for this purpose. Not to be used to record details of the individual's housing or housing for a specified period of time. Use CLUSTER.housing_record for this purpose.

Keywords: alone, solo, family, friends, others, household

Concepts:

- at0000::Living arrangement - The circumstances about an individual living alone or with others.
- at0001::Item tree - @ internal @
- at0002::Item tree - @ internal @
- at0003::Description - Narrative description about the living arrangements.
- at0004::Living arrangement - Single word or phrase that describes if an individual usually resides alone or with others.
- at0005::Household type - Single word or phrase that describes the composition or structure of the household.
- at0006::Household description - Narrative description about the individuals who reside together, including sharing meals, economic resources and/or living space.
- at0007::Number of household members - The number of individuals who belong to the household.
- at0008::Additional details - Further details about the living arrangement.
- at0010::Comment - Additional narrative about the living arrangement not captured in other fields.
- at0011::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0012::Last updated - The date this summary was last updated.

- at0013::Houshold members - Name of the members of the houshold.

living_arrangement_hl

Archetype ID: openEHR-EHR-EVALUATION.living_arrangement_hl.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: de, nb, en, it

Purpose: To record the circumstances about how an individual lives alone or with others.

Use: Use to record the circumstances about how an individual lives alone or with others. This archetype has been designed as one of a family of archetypes that describe the social connectedness of an individual in their home environment. Within this archetype, the intent of the concept of 'household' is to capture information about one or more people who reside together, including sharing meals, economic resources and/or living space. In this context, a single household might comprise varieties of blended families, a student share house, a group home, or a single person living alone. A single dwelling may be considered to contain multiple households if they don't share meals or resources, or have separate living spaces.

Misuse: Not to be used to record overall information about an individual's current and past housing or housing situation. Use EVALUATION.housing_summary for this purpose. Not to be used to record details of the dwelling where the individual resides - use CLUSTER.dwelling for this purpose. Not to be used to describe the social connections of the individual, including identification of household members - use EVALUATION.social_network for this purpose. Not to be used to record details of the individual's housing or housing for a specified period of time. Use CLUSTER.housing_record for this purpose.

Keywords: alone, solo, family, friends, others, household

Concepts:

- at0000::Living arrangement - The circumstances about an individual living alone or with others.
- at0001::Item tree - @ internal @
- at0002::Item tree - @ internal @
- at0003::Description - Narrative description about the living arrangements.

- at0004::Living arrangement - Single word or phrase that describes if an individual usually resides alone or with others.
- at0005::Household type - Single word or phrase that describes the composition or structure of the household.
- at0006::Household description - Narrative description about the individuals who reside together, including sharing meals, economic resources and/or living space.
- at0007::Number of household members - The number of individuals who belong to the household.
- at0008::Additional details - Further details about the living arrangement.
- at0010::Comment - Additional narrative about the living arrangement not captured in other fields.
- at0011::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0012::Last updated - The date this summary was last updated.
- at0013::Household members - Name of the members of the houshold.
- at0014::Number of children under 5 - The number of children who belong to the household under the age of 5 years old.

long_term_process_enrollment-antiVEGF_AMD

Archetype ID: openEHR-EHR-EVALUATION.long_term_process_enrollment-antiVEGF_AMD.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: Record a contribution to the decision of admittance of a patient in the process of wet AMD treatment by intravitreal anti-VEGF periodical injections.

Use: It can be used for enrollment of new patients into the cycles of anti-VEGF injections to treat wet AMD, but also it is possible to evaluate already registered patients to reconsider the continuity of their treatment at a given time.

Misuse: Most of archetypes are focused on register acute episodes identified on clinical environment. Conversely, this one is aimed at periodically review a decision made about a protracted healthcare process (for instance, a therapeutic decision for a chronic condition that requires regular treatment). Thus, this archetype is not intended for registering decisions about occasional actions.

Keywords: chronic, admittance, wet amd, anti-vegf

Concepts:

- at0.13::Very low VA - Visual acuity on first clinical encounter below 0.1 in decimal scale.
- at0.14::Healed lesions - Identified signs of previous treatments such as photodynamic therapy, laser photocoagulation scars, or any vitreoretinal operative procedure.
- at0.15::Multimorbidity - Coexistence of additional alterations on the retina causative of visual impairment.
- at0.16::Reaction to anti-VEGF - Establishment or suspicion of any reaction due to hypersensitivity to anti-VEGF agents used in intravitreal injections.
- at0.17::VA decrease - Visual acuity decreased for three consecutive reviews below 0.1 in decimal scale.
- at0.18::Morphologic deterioration - Progressive deterioration of the morphology of the lesion.
- at0000::Enrollment in a long-term healthcare process - Manages the enrollment of patients in a specific long-term healthcare process.
- at0000.1::Enrollment in intravitreal anti-VEGF therapy for wet AMD - Manages the enrollment of patients in intravitreal anti-VEGF therapy to treat wet AMD.
- at0001::Tree - @ internal @
- at0002::Tree - @ internal @
- at0003::Date decision - Date at which decision was made about the enrollment or exclusion of the patient with regard to the healthcare process.
- at0004::Healthcare process - Identification of the healthcare process about which the enrollment of a specific patient is discussed.
- at0005::Description - Narrative description about the healthcare service to which the patient has been proposed for admittance.
- at0010::Criteria - Narrative description of criteria considered to make a decision with regard to patient's admittance into the healthcare process.
- at0010.1::Criteria - Different criteria considered to make a decision with regard to patient's admittance into the healthcare process.
- at0011::Decision review - Next revision date scheduled for the current decision of enrollment.
- at0012::Admittance - If true, the patient meets the criteria required to be inscribed in the healthcare process.

long_term_process_enrollment

Archetype ID: openEHR-EHR-EVALUATION.long_term_process_enrollment.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: Record a contribution to the decision of admittance of a patient in a specific long-term healthcare process.

Use: It can be used for enrollment of new patients into a specific healthcare process, but also it is possible to evaluate already registered patients to reconsider their continuity in the service at a given time.

Misuse: Most of archetypes are focused on register acute episodes identified on clinical environment. Conversely, this one is aimed at periodically review a decision made about a protracted healthcare process (for instance, a therapeutic decision for a chronic condition that requires regular treatment). Thus, this archetype is not intended for registering decisions about occasional actions.

Keywords: chronic, long-term healthcare, admittance

Concepts:

- at0000::Enrollment in a long-term healthcare process - Manages the enrollment of patients in a specific long-term healthcare process.
- at0001::Tree - @ internal @
- at0002::Tree - @ internal @
- at0003::Date decision - Date at which decision was made about the enrollment or exclusion of the patient with regard to the healthcare process.
- at0004::Healthcare process - Identification of the healthcare process about which the enrollment of a specific patient is discussed.
- at0005::Description - Narrative description about the healthcare service to which the patient has been proposed for admittance.
- at0010::Criteria - Narrative description of criteria considered to make a decision with regard to patient's admittance into the healthcare process.
- at0011::Decision review - Next revision date scheduled for the current decision of enrollment.
- at0012::Admittance - If true, the patient meets the criteria required to be inscribed in the healthcare process.

management_summary

Archetype ID: openEHR-EHR-EVALUATION.management_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record summary or persistent details about the outcome of a treatment course or protocol for an identified condition, such as an infectious disease or cancer, or injury.

Use: Use to record summary or persistent details about the outcome of a treatment course or protocol for an identified condition, such as an infectious disease or cancer, or injury.

Concepts:

- at0000::Management summary - Summary or persistent details about the outcome of a treatment course or protocol for an identified condition.
- at0001::Item tree - @ internal @
- at0002::Item tree - @ internal @
- at0003::Management name - The name of the treatment or course of treatment.
- at0004::Date management completed - The date when the treatment or course of treatment was completed.
- at0005::Management status - Description about the status of the treatment course.
- at0006::Index problem - The name of the index disease, condition, injury or event.
- at0007::Reason for non-completion - Description of the reason why the course of treatment was not completed.
- at0008::Management outcome - Category of the treatment outcome for the individual.
- at0010::Date last seen - The date when the individual last attended for treatment.
- at0012::Issue name - Name of the issue.
- at0013::Issue - Details about an issue that impacted the treatment outcome.
- at0014::Date identified - Date when the issue was identified.
- at0015::Comment - Narrative description about the issue, not captured in other data elements.
- at0016::Comment - Narrative description about the overall treatment, not captured in other data elements.
- at0017::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0018::Last updated - The date and/or time when the Treatment outcome summary was last updated.
- at0019::Additional details - Additional structured details about the treatment outcome.
- at0021::Completed - The treatment course was completed.
- at0022::Not completed - The treatment course was not completed.
- at0023::Treatment successful - Individual is considered cured; there is no ongoing evidence of the index problem.
- at0024::Treatment failed - Treatment was not successful; there is ongoing evidence of the index problem.
- at0025::Indeterminate - It is not known if the treatment was successful or unsuccessful.

- at0027::Reason for outcome - Reason for a failed treatment outcome.
- at0028::Description - Narrative description about the treatment outcome.
- at0029::Indeterminate - It is not known if the treatment was completed or not.
- at0030::Issue details - Structured details about the issue.
- at0031::Reason for management - The reason for treatment.

maternal_mortality_classification

Archetype ID: openEHR-EHR-EVALUATION.maternal_mortality_classification.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record the final death-related classification at the conclusion of a maternal mortality case investigation.

Use: Use to record the final death-related classification at the conclusion of a maternal mortality case investigation.

Concepts:

- at0000::Maternal mortality classification - Death classification at the conclusion of a maternal mortality case investigation.
- at0001::Item tree - @ internal @
- at0007::Timing classification - Determination of the timing of the maternal death in relation to the pregnancy and postnatal period.
- at0008::Maternal death - Death of a woman from direct or indirect causes, during pregnancy, childbirth or within 42 days of the end of the pregnancy, irrespective of the duration and site of the pregnancy.
- at0009::Late maternal death - Death of a woman from direct or indirect causes, more than 42 days but less than one year after the end of a pregnancy.
- at0002::Cause classification - Determination of the role of antenatal, labour and postnatal factors in causing death.
- at0003::Direct - Death of a pregnant woman resulting from obstetric complications of pregnancy or its management.
- at0004::Indirect - Death of a pregnant woman resulting from diseases or conditions that were not due to a direct obstetric cause, but were aggravated by the physiologic effects of pregnancy.

- at0005::Coincidental - Death of a pregnant woman considered to be causally unrelated to pregnancy.
- at0006::Indeterminate - Not able to determine a classification for the death of the pregnant woman.
- at0010::Item tree - @ internal @
- at0011::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0012::Last updated - The date when this maternal mortality classification was last updated.

medication_safety_event

Archetype ID: openEHR-EHR-EVALUATION.medication_safety_event.v1

Lifecycle State: AuthorDraft

Category: EVALUATION

Languages: en, sl

Purpose: To record a summary of a patient safety event associated with medication for reporting purposes.

Concepts:

- at0000::Medication safety event - Summary of a patient safety event associated with medication for reporting purposes.
- at0001::Tree - @ internal @
- at0002::Safety event type - The type of event reported.
- at0003::MEDRA classification - The category of event reported using MedDRA classification.
- at0004::DateTime of event onset - The date and/or time that the adverse event took place.
- at0012::Intervention - The clinical intervention undertaken to resolve or ameliorate the adverse effect, uses PCNE terminology.
- at0014::Intervention result - The result(s) of any interventions undertaken, recorded using MEDRA classification subset.
- at0018::Adverse effect - Details of one or more side effects.
- at0020::Related trigger - Triggers thought to be related to this safety event recorded using IHCI classification.
- at0021::Reaction - Description of the side-effect reported or observed using MEDRA or ATC codes.

- at0022::Liklihood of causation - An estimate of how likely the side-effects noted are due to the safety event.
- at0041::Description of event - A narrative description of the medication safety event.
- at0042::Actual patient outcome - The overall impact actually experienced by the patient.
- at0043::Patient outcome category - The caetgory of impact on the patient's life.
- at0053::[A] Circumstances or events that have the capacity to cause error - *
- at0054::[B] An error that did not reach the patient - *
- at0055::[C] An error that reached the patient but did not cause harm - *
- at0056::[D] An error that reache the patient and reqired monitoring or intervention to confirm that it resulted in no harm to the patient - *
- at0057::[E] Temporary harm to the patient and required intervention - *
- at0058::[F] Temporary harm to the patient and required initial or prolonged hospitalization - *
- at0059::[G] Permanent patient harm - *
- at0060::[H] Intervention required to sustain life - *
- at0061::[I] Patient death - *
- at0062::Estimated cause of event - The reason suspected for this event occurring.
- at0063::Clinical - *
- at0064::Personal - *
- at0065::Economic - *
- at0067::Verbal miscommunication - Verbal understanding
- at0068::Written miscomunication-Illegible handwritting - Written understanding
- at0069::Written miscomunication-Abbreviations - Illegible writing
- at0071::Written miscomunication-Non metric units of measurement - *
- at0072::Written miscomunication-Decimal point - *
- at0073::Misread or didnt read - *
- at0074::Misinterpretation of the order - *
- at0075::Sound-alike drug name - *
- at0076::Look-alike drug name - *
- at0077::Packaging-Inappropriate Packaging or Design - *
- at0078::Packing-Dosage form - *
- at0079::Packaging-Error due to similarity to another drug (colour, form, size) - *
- at0080::Packaging-Error due different strength - *
- at0081::Human factors-Lack of information/knowledge - *
- at0082::Work not accomplished - *
- at0083::Incomplete documentation - *
- at0084::Work overload, burn out syndrome - *
- at0085::Fatigue/Lack of sleep - *
- at0086::Confrontational or intimidating behaviour - *
- at0087::Inappropriate lighting - *
- at0088::Inappropriate temperature/humidity - *
- at0089::Frequent interuptions and distractions - *

- at0090::Lack of staff - *
- at0091::Other - *
- at0108::DateTime of reaction onset - The datetime at which the side effects began.
- at0222::Severity - The severity of the reaction.
- at0223::Low - *
- at0224::Medium - *
- at0225::High - *
- at0231::Potential patient outcome - An assessment of potential impact on the patient if interventions had been unsuccesful. Uses the MERP index. other remediation had not occured.
- at0232::Additional comment - Any additional comment or narrative.
- at0233::Cause of event - Details of the estimated cause of the event.
- at0234::Comment - An additional comment on the estimated cause of the event.
- at0235::Main event for case? - Is this the principal or main event recorded during the case?
- at0236::Intervention details - Details of interventions.
- at0237::Summary details - Details included only in Case Summary.
- at0238::Admission diagnosis classification - Admission diagnosis using ICD classification.
- at0239::Discharge diagnosis classification - Discharge diagnosis using ICD classification.
- at0240::TNM classification - Malignant disease classification using TNM.
- at0241::Oncological case details - Details required for oncological cases.
- at0242::Order of treatment - ???????
- at0243::Reason for case closure - Reason for the case being closed.
- at0244::Effectiveness of therapy - *
- at0245::Completely effective - The therapy has been fully effective.
- at0246::Partially effective - The therpay has been partially effective.
- at0247::Disease status unchanged - *
- at0248::Ineffective - disease progressing unchecked. - The therapy has been ineffective and the disease is progressing unchecked.
- at0249::Link to main event - A link to the main case event.
- at0266::Treatment complete - *
- at0267::Treatment aborted - *
- at0268::Reason treatment aborted - The reason why the treatment was aborted.
- at0270::Transfusion of Blood or Use of Blood Products - **(en)
- at0271::Acute Dialysis - **(en)
- at0272::Positive Blood Culture - **(en)
- at0273::X-Ray or Doppler Studies for Emboli or Deep Vein Thrombosis - **(en)
- at0274::Decrease in Hemoglobin or Hematocrit of 25% or Greater - **(en)
- at0275::Patient Fall - **(en)
- at0276::Pressure Ulcers - **(en)
- at0277::Readmission within 30 Days - **(en)

- at0278::Restraint Use - **(en)
- at0279::Healthcare-Associated Infections - **(en)
- at0280::In-Hospital Stroke - **(en)
- at0281::Clostridium difficile Positive Stool - **(en)
- at0282::Partial Thromboplastin Time (PTT) Greater than 100 Seconds - **(en)
- at0283::International Normalized Ratio (INR) Greater than 6 - **(en)
- at0284::Glucose Less than 50 mg/dl - **(en)
- at0285::Rising BUN or Serum Creatinine Two Times (2x) over Baseline - **(en)
- at0286::Vitamin K Administration - **(en)
- at0287::Diphenhydramine (Benadryl) Administration - **(en)
- at0288::Romazicon (Flumazenil) Administration - **(en)
- at0289::Naloxone (Narcan) Administration - **(en)
- at0290::Anti-Emetic Administration - **(en)
- at0291::Over-Sedation/Hypotension - **(en)
- at0292::Abrupt Medication Stop - **(en)
- at0293::Intra- or Post-Operative Death - **(en)
- at0294::Mechanical Ventilation Greater than 24 Hours Post-Operatively - **(en)
- at0295::Intra-Operative Administration of Epinephrine, Norepinephrine, Naloxone, or Romazicon - **(en)
- at0296::Pneumonia Onset - **(en)
- at0297::Readmission to the Intensive Care Unit - **(en)
- at0298::Terbutaline Use - **(en)
- at0299::Platelet Count Less than 50,000 - **(en)
- at0300::Administration of Oxytocic Agents (such as oxytocin, methylergonovine, and 15-methyl-prostaglandin in the post-partum period) - **(en)
- at0301::Administration of General Anesthesia - **(en)
- at0302::Readmission to the ED within 48 Hours - **(en)
- at0303::Time in ED Greater than 6 Hours - **(en)
- at0304::Prescriber informed - **(en)
- at0305::Nurse informed/instructed - **(en)
- at0306::Dispensing rejected - **(en)
- at0307::Drug recalled from the ward - **(en)
- at0308::Dietary regime changed - **(en)
- at0309::Food supplement discontinued - **(en)
- at0310::Food supplement initiated - **(en)
- at0311::Reconstitution solvent changed - **(en)
- at0312::Diluent changed - **(en)
- at0314::Drug changed - **(en)
- at0315::Dose increased - **(en)
- at0316::Dose decreased - **(en)
- at0317::Dosage form changed - **(en)
- at0318::Administration interval changed - **(en)

- at0319::Drug discontinued - **(en)
- at0320::Drug initiated - **(en)
- at0321::Drug administration rate changed - **(en)
- at0322::Route of administration changed - **(en)
- at0323::Resuscitation required - **(en)
- at0324::Heamodialysis required - **(en)
- at0325::Transplantation required - **(en)
- at0326::Transfusion required - **(en)
- at0327::Operating procedure required - **(en)
- at0328::Additional laboratory test(s) required - **(en)
- at0329::Physiotherapy required - **(en)
- at0330::Psychotherapy required - **(en)
- at0331::Other - **(en)
- at0332::Unknown - **(en)
- at0335::*Intervencija preprečila, da bi zaplet dosegel pacienta(en) - *(en)
- at0336::*Intervencija popolnoma odpravila posledice, ki jih je zaplet povzročil pacientu(en) - *(en)
- at0337::*Intervencija delno odpravila posledice, ki jih je zaplet povzročil pacientu(en) - *(en)
- at0338::*Intervencija ni odpravila posledic, ki jih je zaplet povzročil pacientu(en) - *(en)
- at0339::*Intervencija ni bila možna(en) - *(en)
- at0340::*Rezultat intervencije ni poznan(en) - *(en)
- at0341::*Zmanjšanje stroškov zdravljenja(en) - *(en)
- at0342::*Skrajšan čas hospitalizacije(en) - *(en)
- at0343::*Pacient je bil odpuščen(en) - *(en)
- at0344::*Izboljšana kvaliteta življenja(en) - *(en)
- at0345::Reaction details - Details of reaction
- at0346::Comment - An additional comment on the Reaction details.
- at0347::Intervention additional details - *
- at0348::Comment - *
- at0349::Actual patient outcome details - *
- at0350::Comment - An additional comment on the Actual patient outcome comment.
- at0351::Medications involved - The medicine, vaccine or other therapetic good being ordered, administered to or used by the subject
- at0352::Medications administered - Medications administered is used to enter wrongly administered drug for Safety event type

  at0254 Pacient dobil drugo zdravilo od predpisanega Wrong drug administered to a patient
- at0353::Side effect recurrence - This information is aplicable when at least one Intervention is Dose decreased or Drug discontinued
- at0354::Yes - *

- at0355::No - *
- at0356::NA - *
- at0357::No trigger - *
- at0358::Characteristics of the medicine - *
- at0359::Error corrected - *
- at0360::Monitoring required - *
- at0361::Abnormal laboratory parameter - *
- at0362::Falsely abnormal laboratory parameter - *
- at0363::Patient informed - *
- at0365::Control not carried out - *
- at0366::Medical device (or change) suggested - *

medication_summary

Archetype ID: openEHR-EHR-EVALUATION.medication_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, nb, pt-br, en

Purpose: To record summary or persistent information about the use of a single medication or group or class of medications, especially where the pattern of use or cumulative dosage needs to be monitored.

Use: Use to record summary information about the use of a single medication or group or class of medications, especially where the pattern of use or cumulative dosage needs to be monitored. This archetype has been designed to represent an overview of the use of medication only in specific situations where it adds value to the health record, such as where the cumulative dose of the medication has significant toxic effects or long term use has adverse health impacts. A single instance of the archetype will be used to capture one or more episodes of use, so that a pattern of use can be identified and/or a cumulative dose can be calculated. Examples of use include: - monitoring of the cumulative dose of doxorubicin or methotrexate taken over a lifetime. - monitoring the duration of high dose bisphosphanates. - monitoring the use of an experimental medication in a trial. Use a new instance of this archetype to record details about each medication or group or class of medications. Triggers for closing one episode and commencing a new one will largely reflect local data collection preferences and clinical priorities, including if the individual: - stops using the medication for a significant period of time (which will likely be locally defined). - significantly changes their amount or pattern of use. - changes in the route by which the medication was administered.

Misuse: Not to be used to represent a 'Medication list' - use COMPOSITION.medication_list for this purpose. In addition, not to be used to represent a medication within a 'Medication list' - use either an INSTRUCTION.medication_order or ACTION.medication for this purpose. Not to be used for recording an order for a medication to be administered or consumed - use INSTRUCTION.medication_order for this purpose. Not to be used for documenting the actual administration or consumption of a medication - use ACTION.medication for this purpose. Not to be used for recording the status of use or screening question/answer pairs regarding the medication - use OBSERVATION.medication_screening for this purpose. Not to be used to record an observation about the use of a medication - use OBSERVATION.medication_statement for this purpose.

Keywords: drug, lifelong, medication, self-medicate, medicine, history, lifetime, cumulative, dose, use, administration, consumption

Concepts:

- at0000::Medication summary - Summary or persistent information about the use of a single medication or group of medications, especially where the pattern of use or cumulative dosage needs to be monitored.
- at0001::Tree - @ internal @
- at0002::Medication name - Name of medication or group of medications.
- at0005::Tree - @ internal @
- at0006::Last updated - The date this medication summary was last updated.
- at0007::Clinical description - Narrative description about the overall use of the medication.
- at0008::Episode - Details about use of the medication during a specified period of time.
- at0009::Onset of use - The date when the medication was first administered.
- at0010::Cessation of use - The date when the medication was last administered.
- at0011::Episode onset - The date of the first administration of the medication for this episode.
- at0012::Episode cessation - The date of the last administration of the medication for this episode.
- at0013::Episode reason for cessation - The reason why use of the medication was stopped.
- at0014::Description - Narrative description about the use of the medication during this episode.
- at0015::Cumulative dose - Total amount of the medication used over the lifetime of the individual.
- at0016::Episode amount - Cumulative dose of the medication used in this episode.
- at0018::Episode indication - The clinical indication for the use of the medication during this episode, particularly if this is more specific or differs from the 'Clinical indication', or there is no clinical indication that applies for all episodes.

- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0020::Therapeutic intent - The therapeutic intent for use of the medication during this episode.
- at0022::Therapeutic response - The observed response to the treatment with this medication during this episode.
- at0027::Cumulative duration - The sum of the duration of all episodes.
- at0028::Clinical indication - The overall clinical indication for the use of the medication.
- at0029::Additional details - Additional details about medication use during this episode.
- at0030::Reason for cessation - The reason why all use of the medication was stopped.
- at0031::Episode duration - The duration of the use of the medication in this episode.
- at0032::Route - The route by which the ordered item was, administed during this episode.

menstruation_summary

Archetype ID: openEHR-EHR-EVALUATION.menstruation_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, fi, sv, nb, en

Purpose: To record summary or persistent information about an individual's menstruation history events or patterns of menstruation over time.

Use: Use to record summary or persistent information about an individual's menstruation history events or patterns of menstruation over time. Multiple instances of the 'Per episode' CLUSTER will allow aggregation of an evolving history of both past and present episodes, or patterns, of menstruation. The 'Last updated' data element will record the last time that the Menstruation summary as a whole, including each episode, was updated. Use to incorporate the narrative descriptions of Menstruation or menstrual history within existing or legacy clinical systems into an archetyped format, using the 'Overall description' data element.

Misuse: Not to be used to record information about a specific menstrual cycle. Use OBSERVATION.menstruation for this purpose.

Keywords: menstruation, menarche, menopause, menopausal, perimenopausal, postmenopausal

Concepts:

- at0000::Menstruation summary - Summary or persistent information about an individual's menstruation history.
- at0001::Tree - @ internal @
- at0002::Menarche - Onset of first menstrual cycle.
- at0003::Menstrual status - Statement about the current menstrual activity.
- at0004::Menopause - Cessation of all menstrual cycles.
- at0005::Premenopausal - After menarche, preceding menopause and without symptoms related to the hormonal changes preceding menopause.
- at0006::Perimenopausal - Preceding menopause with symptoms related to the hormonal changes leading up to menopause.
- at0007::Postmenopausal - After menopause.
- at0008::Item tree - @ internal @
- at0009::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0010::Per episode - Details about a typical pattern of menstruation during a specified interval of time.
- at0011::Episode label - A name or label associated with this episode of menstruation.
- at0012::Episode start date - Date when this episode commenced.
- at0013::Description - Narrative description about this episode.
- at0014::Typical pattern - The usual predictability of menstruation during this episode.
- at0015::Regular - The start of menses is roughly predictable from month to month.
- at0016::Irregular - The start of menses is not predictable month to month.
- at0017::Typical cycle length - The usual length of cycle during this episode.
- at0018::Typical menses duration - The usual duration of menses during this episode.
- at0020::Additional details - Additional structured details about this episode of menstruation.
- at0021::Episode end date - Date when this episode ceased.
- at0022::Episode comment - Additional narrative about this episode of menstruation not captured in other fields.
- at0023::Comment - Additional narrative about the overall patterns and episodes of menstruation not captured in other fields.
- at0024::Date last updated - Date when the Menstruation summary, including episodes, was updated.
- at0025::Overall description - Narrative description about the overall pattern of menstruation.
- at0026::Premenarchal - Before the first onset of menstruation.

mental_capacity

Archetype ID: openEHR-EHR-EVALUATION.mental_capacity.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record details about the ability of an individual to use and understand information to make a decision or plan.

Use: Use to record details about the ability of an individual to use and understand information to make a decision or plan. This archetype is intended to capture information about the mental capacity status of an individual, which is typically assessed in relation to a specific decision or plan that needs to be made about their medical care or treatment at a particular time. If specific details about the mental capacity assessments are required, additional archetypes can be nested within the 'Assessment details' SLOT.

Keywords: mental, capacity, competency, competent, decision

Concepts:

- at0000::Mental capacity - The ability of an individual to use and understand information to make a decision or plan.
- at0001::Item tree - @ internal @
- at0002::Status - The individual's mental capacity status.
- at0003::Has capacity - The individual has sufficient mental capacity to make the decision or plan.
- at0004::Does not have capacity - The individual does not have sufficient mental capacity to make the decision or plan.
- at0005::Indeterminate - It has not been able to determinate whether the individual has sufficient mental capacity to make decision or plan.
- at0006::Description - Narrative description of the individual's mental capacity or incapacity.
- at0008::Assessment - Details of a mental capacity assessment undertaken in relation to the specific decision or plan.
- at0009::Decision/plan - Description of the specific decision or plan to which the mental capacity status and assessment details relate.
- at0012::Assessor - Details of the person carrying out the mental capacity assessment.
- at0013::Person consulted - Details of a person who has been consulted in relation to the mental capacity assessment.
- at0014::Assessment details - Additional structured details about the mental capacity assessment.
- at0022::Comment - Additional narrative about the individual's mental capacity or incapacity not captured in other fields.
- at0023::Item tree - @ internal @

- at0024::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0027::Valid period end - The date/time that marks the conclusion of the valid period of time for this mental capacity assessment.
- at0028::Valid period start - The date/time that marks the beginning of the valid period of time for this mental capacity assessment.

obstetric_summary-JM

Archetype ID: openEHR-EHR-EVALUATION.obstetric_summary-JM.v0

Lifecycle State: in_development

Category: EVALUATION

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

Purpose: To record summary or persistent information about the numbers of key obstetric events that may impact risk assessment or decision support.

Use: Use to record summary or persistent information about the numbers of key obstetric events that may impact risk assessment or decision support. Data recorded using this archetype is intended to be revised and updated after each pregnancy, either manually by a clinician or automatically calculated within a clinical system. It is anticipated that this archetype represents only one component of an obstetric history. A complete obstetric history should be represented using multiple archetypes within a template. In order to record a TPAL overview, Term Births (T), Preterm Births (P) and Abortions (A) can be recorded using this archetype. Living Children (L) can be recorded using the EVALUATION.social_network archetype, so that it can be used more broadly. Some variants may also use Gravidity (G) and the number of Multiple Births (M). In many jurisdictions, the definition of some of these data elements may vary. For this reason, definitions may be included in the Protocol to ensure clarity of intent especially if the data is being exchanged between jurisdictions.

Misuse: Not for recording summary information about a single pregnancy. Use specific archetypes for this purpose. Not to be used to record details about procedures performed during a pregnancy, for example terminations or deliveries. Use the ACTION.procedure archetype for this purpose. Not to be used to record the details about findings in each antenatal visits or during labour. Detailed data should be recorded using appropriate archetypes for this purpose such as OBSERVATION.story together with CLUSTER.symptom_sign; OBSERVATION.blood pressure; OBSERVATION.urinalysis; or EVALUATION.problem_diagnosis.

Keywords: obstetric, pregnancy, parity, para, gravidity, gravida, termination, miscarriage, abortions, birth, stillbirth, caesarean, cesarean, ectopic, tubal, TPAL, GTPAL

Concepts:

- at0000.1::Obstetric summary - Summary or persistent information about the numbers of key obstetric events.
- at0.1::Living children - Number of living children.
- at0000::Obstetric summary - Summary or persistent information about the numbers of key obstetric events.
- at0001::Tree - @ internal @
- at0002::Gravidity - Number of times a woman has been pregnant, current and past, regardless of the pregnancy outcome.
- at0003::Parity - Number of times a woman has given birth to a viable baby, regardless of the pregnancy outcome.
- at0004::Miscarriages - Number of times a woman has had a miscarriage.
- at0005::Terminations - Number of times a woman has had an induced pregnancy termination, regardless of gestation.
- at0006::Live births - Number of infants born alive.
- at0008::Tree - @ internal @
- at0009::Last updated - The date this summary was last updated.
- at0011::Ectopic pregnancies - Number of ectopic pregnancies.
- at0012::Stillbirths - Number of stillbirths.
- at0015::Term births - Number of births at or after term.
- at0016::Preterm births - Number of births before term.
- at0017::Abortions - Number of pregnancies that do not reach viability from all causes, including spontaneous miscarriages, induced terminations and ectopic pregnancies.
- at0018::Multiple births - Number of birth events in which more than one fetus has been born.
- at0021::Definition of viability - The number of weeks of gestation that differentiates between a miscarriage and a viable birth, that is used in the data collection.
- at0024::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0025::Description - Narrative description about the overall obstetric history.
- at0026::Comment - Additional narrative about the obstetric summary, not captured in other fields.
- at0027::Caesarean sections - Number of caesarean sections.
- at0028::Neonatal deaths - The number of neonatal deaths.

obstetric_summary

Archetype ID: openEHR-EHR-EVALUATION.obstetric_summary.v1

Lifecycle State: published

Category: EVALUATION

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

Purpose: To record summary or persistent information about the numbers of key obstetric events that may impact risk assessment or decision support.

Use: Use to record summary or persistent information about the numbers of key obstetric events that may impact risk assessment or decision support. Data recorded using this archetype is intended to be revised and updated after each pregnancy, either manually by a clinician or automatically calculated within a clinical system. It is anticipated that this archetype represents only one component of an obstetric history. A complete obstetric history should be represented using multiple archetypes within a template. In order to record a TPAL overview, Term Births (T), Preterm Births (P) and Abortions (A) can be recorded using this archetype. Living Children (L) can be recorded using the EVALUATION.social_network archetype, so that it can be used more broadly. Some variants may also use Gravidity (G) and the number of Multiple Births (M). In many jurisdictions, the definition of some of these data elements may vary. For this reason, definitions may be included in the Protocol to ensure clarity of intent especially if the data is being exchanged between jurisdictions.

Misuse: Not for recording summary information about a single pregnancy. Use specific archetypes for this purpose. Not to be used to record details about procedures performed during a pregnancy, for example terminations or deliveries. Use the ACTION.procedure archetype for this purpose. Not to be used to record the details about findings in each antenatal visits or during labour. Detailed data should be recorded using appropriate archetypes for this purpose such as OBSERVATION.story together with CLUSTER.symptom_sign; OBSERVATION.blood pressure; OBSERVATION.urinalysis; or EVALUATION.problem_diagnosis.

Keywords: obstetric, pregnancy, parity, para, gravidity, gravida, termination, miscarriage, abortions, birth, stillbirth, caesarean, cesarean, ectopic, tubal, TPAL, GTPAL

Concepts:

- at0000::Obstetric summary - Summary or persistent information about the numbers of key obstetric events.
- at0001::Tree - @ internal @
- at0002::Gravidity - Number of times a woman has been pregnant, current and past, regardless of the pregnancy outcome.

- at0003::Parity - Number of times a woman has given birth to a viable baby, regardless of the pregnancy outcome.
- at0004::Miscarriages - Number of times a woman has had a miscarriage.
- at0005::Terminations - Number of times a woman has had an induced pregnancy termination, regardless of gestation.
- at0006::Live births - Number of infants born alive.
- at0008::Tree - @ internal @
- at0009::Last updated - The date this summary was last updated.
- at0011::Ectopic pregnancies - Number of ectopic pregnancies.
- at0012::Stillbirths - Number of stillbirths.
- at0015::Term births - Number of births at or after term.
- at0016::Preterm births - Number of births before term.
- at0017::Abortions - Number of pregnancies that do not reach viability from all causes, including spontaneous miscarriages, induced terminations and ectopic pregnancies.
- at0018::Multiple births - Number of birth events in which more than one fetus has been born.
- at0021::Definition of viability - The number of weeks of gestation that differentiates between a miscarriage and a viable birth, that is used in the data collection.
- at0024::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0025::Description - Narrative description about the overall obstetric history.
- at0026::Comment - Additional narrative about the obstetric summary, not captured in other fields.
- at0027::Caesarean sections - Number of caesarean sections.
- at0028::Neonatal deaths - The number of neonatal deaths.

occupation_summary

Archetype ID: openEHR-EHR-EVALUATION.occupation_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, nb, en, it

Purpose: To record a summary or persistent information about an individual's current and past jobs and/or roles.

Use: Use to record a summary or persistent information about an individual's current and past jobs and/or roles. This archetype has been designed to be used as a standalone archetype within the context of a Social History (or similar) template. It is intended to

provide a summary of all occupations, considered in the broadest sense. For each job or role, use a separate instance of the CLUSTER.occupation_record within the SLOT for 'Occupation episode'.

Misuse: Not to be used for recording structured details about a specific job or role. Use the CLUSTER.occupation_record archetype within 'Occupation record' SLOT for this purpose. Not to be used for detailed descriptions of health risks or exposure to hazardous substances in the workplace. Use the EVALUATION.health_risk or EVALUATION.exposure archetype for these purposes. Not to be used to record information about sources of income or income details for the individual. Use the CLUSTER.income_summary archetype for this purpose.

Keywords: employment, study, job, work, carer, role, pensioner, student, employee, employer, profession, unemployment, occupation, child, retiree, disabled

Concepts:

- at0000::Occupation summary - Summary or persistent information about an individual's current and past jobs and/or roles.
- at0001::Tree - @ internal @
- at0002::Description - Narrative description about the entire occupation history of the individual.
- at0003::Occupation episode - Structured details about each job or role, both current and past.
- at0004::Employment status - Statement about the individual's current employment.
- at0005::Additional details - Additional details about the current jobs or roles, or previous occupation history of an individual.
- at0006::Comment - Additional narrative about an individual's current occupation or history of occupations not captured in other fields.
- at0007::Tree - @ internal @
- at0008::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0009::Last updated - Date when the occupation summary or associated occupation records were was updated.

personal_safety_summary

Archetype ID: openEHR-EHR-EVALUATION.personal_safety_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record issue and concerns about personal safety in the broadest sense including experience of, or risk of, violence in their home, work or community.

Use: Use to record issue and concerns about personal safety in the broadest sense, including experience of, or risk of, violence in their home, work or community. Record as a single instance in a health record; updated and revised over time as a new version.

Concepts:

- at0000::Personal safety summary - Summary or persistent information about an individual's perception about their personal safety.
- at0001::Item tree - @ internal @
- at0002::Overall description - Narrative description about the personal safety situation for the individual.
- at0003::Item tree - @ internal @
- at0004::Last updated - The date this personal safety summary was last updated.
- at0005::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.

pharmacogenetic_gene_profile

Archetype ID: openEHR-EHR-EVALUATION.pharmacogenetic_gene_profile.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record details of pharmacogenetic phenotype findings relating to a single genotype, in particular to record metaboliser status / functional activity against an enzyme known to impact the effectiveness/ toxicity of one or more medications. As individual pharmacogenetic tests may provide only incomplete allele testing, this archetype is intended to act as an overall cumulative representation of tall individual tests, from which therapeutic recommendations should be derived.

Use: There is crossover in purpose with the Precaution archetype https://ckm.openehr.org/ckm/archetypes/1013.1.2593, but this is designed to record many different therapeutic precautions, and to report only adverse effects e.g poor efficacy or toxicity, whereas this archetype is intended to capture both positive and negative effects and normal metaboliser status. In that respect this is perhaps closer to a a diagnosis then a

risk factor or precaution. There is an argument that Precaution might be used to flag the presence of significant phenotypes, perhaps as a general statement such as 'Significant known metaboliser issues' which reference the specific Phenotypic records. The main content is intended to be carried in a slotted CLUSTER Pharmacogenetics analyte result archetype=, but in this context to record the cumulative results and not that of a single test.

Misuse: Not to be used to record genomic phenotypes which are unrelated to pharmacogenetics, such as molecular genomics reports to support cancer care.

Keywords: pharmacogenetics, pharmacogenomics, decision support, contraindication, precaution, pgx.

Concepts:

- at0000::Pharmacogenetic gene profile - Details of cumulative pharmacogenetic phenotype findings relating to a single gene, in particular to record metaboliser status / functional activity against an enzyme known to impact the effectiveness/ toxicity of one or more medications.

  As individual pharmacogenetic tests may provide only incomplete allele testing, this archetype is intended to act as an overall cumulative representation of tall individual tests, from which therapeutic recommendations should be derived.
- at0001::Item tree - @ internal @
- at0003::Pharmacogenetic profile - Slot to include details of the genotype which relates to this phenotype.
- at0015::Item tree - @ internal @
- at0016::Date assessed - The date at which the phenotype was assessed.
- at0017::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0030::Original result - Details of those people who helped me to complete this record.

physical_activity_summary

Archetype ID: openEHR-EHR-EVALUATION.physical_activity_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: de, sv, en, nl

Purpose: To record a summary of typical physical activity of an individual.

Use: Use to record a summary of typical, or usual, physical activity of children or adults. Please note: There is some apparent overlap between the 'Physical activity level (PAL) status' data element in this archetype and the 'Physical activity category' data element in OBSERVATION.physical_activity archetype - they both use the same value set. Use this archetype when recording the the typical activity as a summative statement, however if the intent is to record the category at a specified point in time or during a specified period of time then use the equivalent data point in the OBSERVATION.physical_activity.

Misuse: Not to be used to record actual physical activity at a specific point in time or during a specified period of time - use OBSERVATION.physical_activity for this purpose.

Keywords: activity, exercise, physical, fitness

Concepts:

- at0000::Physical activity summary - A summary of the typical level of physical activity undertaken by the individual.
- at0001::Tree - @ internal @
- at0002::Physical activity level (PAL) status - The category of the typical, or usual, physical activity level of an individual.
- at0003::Description - A narrative description about the individual's typical level of physical activity.
- at0005::Barrier - Identified factor that prevents the individual to become more physically active.
- at0006::Enabler - Identified factor that may support the individual to become more physically active.
- at0007::Typical vigorous exercise - Typical number of minutes of vigorous exercise.
- at0008::Typical moderate exercise - Typical number of minutes of moderate exercise.
- at0009::Extremely inactive - The individual is extremely inactive, for example a bedridden patient.
- at0010::Sedentary - The individual spends most of their time sitting, for example an office worker getting little or no exercise.
- at0011::Moderately active - The individual is moerately active, for example a construction worker or a person running one hour daily.
- at0012::Vigorously active - The individual is very active, for example a manual labourer or a person swimming two hours daily.
- at0013::Extremely active - The individual is extremely active, for example a competitive cyclist.
- at0014::Tree - @ internal @
- at0015::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0016::Last updated - The date when the physical activity summary was last updated.

physical_appearance

Archetype ID: openEHR-EHR-EVALUATION.physical_appearance.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: nb, en

Purpose: To record details about the long-term or enduring physical appearance of an individual, common to all people.

Use: To record details about the long-term or enduring physical appearance of an individual, common to all people and that would not usually be recorded as part of a physical examination. This archetype has been designed to be used alongside the Physical examination family and other archetypes to support a detailed description of the phenotype of an individual. Examples of use cases include: - gamete donor matching; or - assisting in post-mortem identification. The initial scope of this archetype has been kept simple and it is likely that it will be extended further in the future as use cases are identified. Potential future additions for consideration have been captured in Change request CR-867.

Misuse: Not to be used to record aspects of physical appearance which are not enduring, such as the temporary dyeing of hair. Not to be used to record measured physical characteristics, such as height, weight and body mass index. Use the specific OBSERVATION archetypes for these purposes. Not to be used to record physical characteristics that would commonly be documented as part of a physical examination, such as walking with a limp, facial palsy, alopecia, and skin depigmentation. Use specific archetypes for physical examination for these purposes, including inspection of gait and the face. Not to be used to record a photograph or image of the individual - use the CLUSTER.media_file nested within the 'Photo' SLOT in the CLUSTER.person archetype.

Keywords: phenotype, skin, iris, stature, hair, characteristics, appearance

Concepts:

- at0000::Physical appearance of an individual - Enduring physical appearance of an individual, common to all people.
- at0001::Item tree - @ internal @
- at0002::Description - Narrative descripition about the physical appearance and characteristics of an individual.
- at0003::Hair colour - Description of the natural hair colour.
- at0004::Iris colour - Description of the colour of the iris in the eye.

- at0005::Skin colour - Description of the normal colour of the skin of the whole body.
- at0006::Body build - Description of the body size and/or shape.
- at0009::Item tree - @ internal @
- at0010::Last updated - The date the physical appearance was last updated.
- at0011::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0012::Comment - Additional narrative about physical appearance, not captured in other fields.
- at0013::Additional details - Additional details about the physical characteristics.

poisoning_summary

Archetype ID: openEHR-EHR-EVALUATION.poisoning_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record summary details about a single poisoning event.

Use: Use to record summary details about a single poisoning event. Use cases include, but are not limited to: - public health surveillance about poisoning events.

Misuse: Not to be used to record summary information about a broader pattern of exposure to a substance. Use the EVALUATION.exposure_summary for this purpose.

Concepts:

- at0000::Poisoning event summary - Summary details about a single poisoning event, including accidental exposure to a substance at home, in the workplace, or within the broader community or environment, as well as deliberate self-poisoning.
- at0001::Item tree - @ internal @
- at0004::Substance name - Name of the substance or agent causally linked with the poisoning.
- at0009::Substance state - The physical form or presentation of the substance at the time of exposure.
- at0015::Packaging context - Category of packaging for the substance.
- at0016::Route of exposure - The route of exposure for the affected individual.
- at0017::Ingested - None
- at0018::Injected - None
- at0019::Inhaled - None

- at0020::Direct contact - Contact via skin or mucosa.
- at0022::Amount - The amount, or estimate of the amount, of substance ingested, inhaled or absorbed by the individual.
- at0023::Unknown - An unknown amount was ingested.
- at0024::Location context - Narrative or category of the physical location where the poisoning event took place.
- at0025::Residential - Home of the poisoned individual or another person.
- at0027::School - Educational institution, such as a school, kindergarten, or university.
- at0028::Workplace - Place of employment where the individual was working or present in a professional capacity.
- at0029::Specific location - Specific details about the organisation or physical address where the poisoning event took place.
- at0034::Physical context - Narrative or category describing of the physical or environmental context where the poisoning event occurred.
- at0035::Well ventilated - None
- at0036::Poorly ventilated - None
- at0037::Item tree - @ internal @
- at0039::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0040::Description - Narrative description about the poisoning event.
- at0042::Date/time of exposure - The date and optional time of exposure to the substance or, for exposures extending over a period, the start of the exposure.
- at0043::Date/time of healthcare encounter - Date and time when the individual first attended a medical service after exposure.
- at0044::Event occurrence - The type of occurrence of the poisoning event.
- at0045::First occurrence - The event is the first ever exposure for the individual.
- at0046::Subsequent occurrence - The event is a second or subsequent exposure for the individual.
- at0047::Occurrence number - The sequence number of this event within a series of related poisoning events.
- at0048::Last updated - Date/time this poisoning event summary was last updated.
- at0053::Original packaging/container - Substance was stored in the manufacturer's original packaging and container.
- at0054::Other packaging/container - Substance was not stored in the manufacturer's original packaging or container.
- at0055::Packaging description - Narrative description about the packaging of the substance.
- at0057::Substance colour - The colour of the substance at the time of exposure.
- at0058::Occupational context - Narrative or category describing the occupational context of the poisoning event.
- at0060::Risk factor - Identification of a risk factor that contributed to the occurrence of the poisoning event.

- at0062::Other - Another site other than residential, educational or workplace.
- at0064::Liquid - Substance flows to take the shape of its container; exposure by ingestion, dermal absorption, or accidental splashes.
- at0065::Gas - Substance exists in a gaseous state, often invisible; exposure primarily by inhalation.
- at0066::Aerosol - Substance is a suspension of fine particles or liquid droplets dispersed in a gas.
- at0067::Solid - Substance is a fixed shape and volume; exposure by ingestion, inhalation as a dust or skin absorption.
- at0073::Solid state type - Specific type of solid form or presentation of the substance at the time of exposure.
- at0074::Tablet - A solid dosage form of a substance, often compacted into a small, flat, or slightly rounded shape for oral administration.
- at0075::Capsule - A solid dosage form consisting of a substance enclosed within a soluble gelatin or similar shell for oral consumption.
- at0076::Pellet - A small, solid, rounded or cylindrical mass of a substance, typically used for controlled release or specific applications (e.g., pesticide pellets).
- at0077::Block - A large, solid mass of a substance, typically uniform in shape, used in bulk applications (e.g., rat poison blocks).
- at0078::Powder - A finely ground, loose, dry substance consisting of small particles (e.g., talcum powder, powdered drugs).
- at0079::Granule - Small, irregularly shaped particles larger than powder but smaller than pellets (e.g., granular fertilizers or detergents).
- at0080::Crystal - Solid substances with a defined geometric shape and internal structure due to their molecular arrangement (e.g., salt crystals, methamphetamine).
- at0081::Shard - Sharp, irregular fragments of a brittle solid.
- at0082::Flake - Thin, flat pieces of a substance, often irregularly shaped (e.g., paint flakes, graphite flakes).
- at0083::Fibre - Thin, thread-like structures that may be woven or used individually (e.g., fiberglass, asbestos fibers).
- at0084::Liquid state type - Specific type of liquid form or presentation of the substance at the time of exposure.
- at0085::Solution - Homogeneous mixtures where the poison is fully dissolved in a solvent, such as water or alcohol. For example: antifreeze (ethylene glycol) and certain cleaning agents.
- at0086::Suspension - Heterogeneous mixtures containing solid particles dispersed in a liquid medium. For example, liquid pesticides with suspended active ingredients.
- at0087::Emulsion/Cream - Mixtures of two immiscible liquids where one is dispersed in the other, often stabilized by emulsifiers. For example: medicinal creams and lotions.
- at0088::Gel - Semi-solid systems where a liquid is entrapped within a three-dimensional polymeric network, giving a jelly-like consistency. For example, hand sanitizers and certain topical medications.

- at0089::Chunk - Irregular, larger solid pieces, not uniform in shape or size (e.g., broken pieces of solid chemicals).
- at0090::Bead - Small, spherical particles, often uniform in size, used in industrial or pharmaceutical applications (e.g., silica gel beads, bead-based medications).
- at0091::Dust - Fine, dry particulate matter suspended in air or settled on surface.
- at0092::Foam - Colloidal systems where gas bubbles are dispersed in a liquid matrix. For example, some cleaning agents and cosmetic products.
- at0093::Occupational - The exposure occurred in an occupational context.
- at0094::Non-occupational context - The exposure did not occur in an occupational context.
- at0095::Comment - Additional narrative about the poisoning event not captured in other fields.
- at0096::Safety context - Narrative or category describing the safety context of the poisoning event.

pp_cohort

Archetype ID: openEHR-EHR-EVALUATION.pp_cohort.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: __unknown__

Concepts:

- at0000::Phenopacket cohort - Phenopacket cohort
- at0001::Item tree - @ internal @
- at0002::id - *
- at0003::description - *
- at0004::members - *
- at0005::hts_files - *
- at0006::meta_data - *

pp_interpretation

Archetype ID: openEHR-EHR-EVALUATION.pp_interpretation.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: __unknown__

Concepts:

- at0000::Phenopacket interpretation - Phenopacket interpretation
- at0001::Item tree - @ internal @
- at0002::id - *
- at0003::resolution_status - *
- at0004::UNKNOWN - No information is available about the diagnosis.
- at0005::SOLVED - The interpretation is considered to be a definitive diagnosis.
- at0006::UNSOLVED - No definitive diagnosis was found.
- at0007::IN_PROGRESS - No diagnosis has been found to date but additional differential diagnostic work is in progress.
- at0008::diagnosis - *
- at0009::meta_data - *
- at0010::phenopacket_or_family - *

precaution

Archetype ID: openEHR-EHR-EVALUATION.precaution.v1

Lifecycle State: published

Category: EVALUATION

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

Purpose: To record a condition or state of the individual that is clinically significant and unique or idiosyncratic for this individual, and is considered vital information when making treatment decisions.

Use: Use to record a condition or state of the individual that is clinically significant and unique or idiosyncratic for this individual, and which are considered vital information when making treatment decisions. This archetype should be regarded as a critical archetype by any clinical decision support system testing for any relevant therapeutic precautions as a clinician commences a new clinical intervention for an individual. Examples of conditions that warrant creation of a precaution include, but are not limited to: - Immunosuppressed/on immunosuppressive therapy – linked to medication order for

chemo or steroids; or diagnosis of leukaemia; - Renal failure – linked to renal function tests and/or a formal diagnosis of renal failure; - Waiting for organ transplant; - Undergoing a regular treatment such as radiation therapy or dialysis; - Transplanted organ or metal implant in situ; - Ongoing investigation or follow up of suspected or verified malignant disease; - Participation in a pharmacological trial; or - Using anticoagulant treatment.

Misuse: Not to be used to record a clinical intervention (including, but not limited to, use of a treatment or performance of a test or procedure) that should not be carried out due to the likelihood, or possibility, of harm being caused to an individual. Use the EVALUATION.contraindication for this purpose. Not to be used to record decisions about limitations on the individuals care or future interventions or the individuals preferences of future medical treatment and care. Use EVALUATION.advance_intervention_decisions and EVALUATION.advance_care_directive respectively for this purpose.

Keywords: precaution, prevent, avoid, adverse event, prevention, caution, alert, warning

Concepts:

- at0000::Precaution - A condition or state of the individual that is clinically significant and unique or idiosyncratic for this individual, and is considered vital information when making treatment decisions.
- at0001::Tree - @ internal @
- at0002::Condition - Identification, by name, of a condition or state.
- at0003::Evidence - Description of the evidence identified to support the precaution.
- at0004::Last updated - Date when the precaution information was last updated.
- at0006::Tree - @ internal @
- at0008::Comment - Additional narrative about the precaution, not captured in other fields.
- at0009::Review date - Date when next due for review by a clinician.
- at0013::Category - Type of the 'Condition' identified.
- at0014::Status - Assertion about the current state of the identified 'Precaution'.
- at0015::Active - The precaution is currently active.
- at0018::Resolved - The previously asserted precaution has been clinically reassessed and considered no longer to be an active risk.
- at0019::Refuted - The precaution has been clinically reassessed or has been disproved with a high level of clinical certainty by testing.
- at0020::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0022::Valid period start - Date/time after which the 'Condition' is regarded as active.
- at0024::Valid period end - Date/time after which the 'Condition' is regarded as inactive.
- at0025::Additional details - Additional structured details about the precaution.

pregnancy_care_summary

Archetype ID: openEHR-EHR-EVALUATION.pregnancy_care_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record summary details about the antenatal and postnatal care received during a single pregnancy.

Use: Use to record summary details about the antenatal and postnatal care received during a single pregnancy, usually as part of an assessment about quality of care or as part of a maternal mortality review.

Concepts:

- at0000::Pregnancy care summary - Summary details about the antenatal and postnatal care received during a single pregnancy.
- at0001::Item tree - @ internal @
- at0003::First antenatal visit - The date of the first antenatal visit for the pregnancy overall.
- at0004::Antenatal care - Details about an episode of antenatal care from a single healthcare provider or using a single funding type.
- at0005::Provider type - Type of health professional or clinic providing community or outpatient antenatal care.
- at0007::Provider details - Details about the healthcare provider.
- at0009::Date of first visit - The date of the first antenatal visit for the identified for healthcare provider or funding model.
- at0010::Gestation at first visit - Gestation at the first antenatal visit for the identified for healthcare provider or funding model.
- at0011::Date of last visit - The date of the last antenatal visit for the identified for healthcare provider or funding model.
- at0012::Gestation at last visit - Gestation at the last antenatal visit for the identified for healthcare provider or funding model.
- at0013::Number of visits - The number of visits to the identified healthcare provider.
- at0016::Additional details - None
- at0018::Antenatal admission - None
- at0019::Gestation at admission - None
- at0021::Inpatient admission details - None
- at0020::Description - None
- at0008::Description - None

- at0014::Conditions managed - Significant issues, problems or diagnoses managed by the identified healthcare provider.
- at0015::Treatment summary - None
- at0022::Conditions managed - Significant issues, problems or diagnoses managed by the specified type of care.
- at0024::Treatment summary - None
- at0026::Additional details - None
- at0029::Last antenatal visit - The date of the last antenatal visit of any type or location, prior to delivery.
- at0030::Comment - None
- at0031::Description - None
- at0033::Gestation at admission - None
- at0034::Specific postnatal visit - None
- at0035::Type of visit - Type of health professional or clinic providing community or outpatient postnatal care.
- at0036::Description - None
- at0037::Assessment - None
- at0039::Additional details - None
- at0042::Postnatal admission - None
- at0051::Item tree - @ internal @
- at0043::Description - None
- at0044::Inpatient admission details - None
- at0045::Conditions managed - Significant issues, problems or diagnoses managed by the specified type of care.
- at0046::Treatment summary - None
- at0047::Additional details - None
- at0017::Total number of antenatal visits - Total number of antenatal clinic visits of all types and locations for the pregnancy overall.
- at0023::Scheduled follow up - The scheduled date for antenatal admission followup.
- at0040::Scheduled follow up - The scheduled date for postnatal care followup.
- at0032::Scheduled follow up - The scheduled date for routine postnatal followup.
- at0028::Total number of antenatal admissions - Total number of antenatal hospital admissions.
- at0048::Scheduled follow up - The scheduled date for postnatal admission followup.
- at0038::Conditions managed - Significant issues, problems or diagnoses managed by the specified type of care.
- at0050::Comment - Additional narrative about the care received during a single pregnancy and the related postnatal period, not captured in other data fields.
- at0002::Description - Narrative description about the care received during a single pregnancy and the related postnatal period.
- at0052::Extension - None
- at0049::Total number of postnatal admissions - None

- at0041::Total number of postnatal visits - None
- at0027::Gestation at discharge - None
- at0053::Last updated - The date when this care summary was last updated.
- at0056::Scheduled follow up - The scheduled date for antenatal admission followup.
- at0057::Date of visit - None
- at0058::Delivery admission - None
- at0059::Inpatient admission details - None
- at0060::Comment - None
- at0061::Comment - None
- at0062::Comment - None
- at0063::Comment - None
- at0076::No antenatal care - None
- at0095::Overall funding type - Source of funding for all pregnancy care.
- at0096::Public - Antenatal care funded from public sources.
- at0097::Private - Antenatal care funded from a private source.
- at0098::Both - Antenatal care funded from a mix of public and private sources.
- at0099::Funding type - Source of funding for this episode of antenatal care.
- at0101::Public - Antenatal care funded from public sources.
- at0102::Private - Antenatal care funded from a private source.
- at0103::Postnatal care - Details about an episode of postnatal care from a single healthcare provider or using a single funding type.
- at0104::Provider type - Type of health professional or clinic providing community or outpatient postnatal care.
- at0105::Funding type - Source of funding for this episode of postnatal care.
- at0106::Public - Postnatal care funded from public sources.
- at0107::Private - Postnatal care funded from a private source.
- at0108::Provider name - None
- at0109::Provider details - None
- at0110::Description - None
- at0111::Date of first visit - None
- at0112::Days post partum at first visit - None
- at0113::Date of last visit - The date of the last postnatal visit for this healthcare provider or funding model.
- at0114::Days post partum at last visit - None
- at0115::Number of visits - The number of visits by the identified healthcare provider.
- at0116::Conditions managed - Significant issues, problems or diagnoses managed by the specified type of care.
- at0117::Treatment summary - None
- at0118::Additional details - None
- at0119::Scheduled follow up - The scheduled date for postnatal follow-up.
- at0120::Comment - None

- at0121::Gestation at first visit - Gestation at the first antenatal visit for the pregnancy overall.

pregnancy_status

Archetype ID: openEHR-EHR-EVALUATION.pregnancy_status.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record the current status of a single pregnancy, whether known or planned for the near future.

Use: Use to record the phase or status of a single pregnancy. The scope of this archetype includes the phases of making preparations for the future pregnancy or actively attempting to conceive, being actively pregnant, or in the period of recovery after delivery. This archetype has been designed to underpin clinical decision support or exchange use cases: - To prevent medications being prescribed which may cause harm to an existing pregnancy - To trigger extra caution in the decision to use imaging in women actively trying to conceive, but not currently known to be pregnant - To alert pathologists reporting test results that they may need to interpret test results in the context of an ongoing pregnancy or postpartum state.

Keywords: pregnancy, preconception, pregnant, postnatal, postpartum

Concepts:

- at0000::Current pregnancy status - Details about the current phase of a single pregnancy.
- at0001::Item tree - @ internal @
- at0002::Item tree - @ internal @
- at0003::Current pregnancy status - The present phase of a pregnancy.
- at0004::Preconception - The individual is either making preparations for a future pregnancy or is actively attempting to conceive.
- at0005::Pregnant - The individual is currently pregnant.
- at0006::Postpartum - The individual is in the period of physical and emotional recovery following recent childbirth.
- at0007::Last updated - The date when the pregnancy status was last updated.
- at0008::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

- at0009::Comment - Additional narrative about the current pregnancy status not captured in other fields.

pregnancy_summary

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

Lifecycle State: in_development

Category: EVALUATION

Languages: nb, pt-br, en, ca, es, es-co

Purpose: To support the recording of an overview or summary record of an identified pregnancy and outcome, including the antenatal period, labor, birth and the immediate postnatal period.

Use: Use to record an overview or summary record of an identified pregnancy and outcome, including the antenatal period, labor, birth and the immediate postnatal period. During an active pregnancy, this archetype supports the evolution of a persistent pregnancy-related health summary record, with information gradually accumulated or updated, throughout the duration of the pregnancy, labour, birth and the immediate postnatal period. As the data is committed to the persistent health record, the date of the update is also recorded in the 'Last Updated' data element in Protocol, to ensure that if this pregnancy summary is taken out of context of the health record for other purposes, such as data exchange, the date of the latest update is kept with the clinical data. After birth, this summary record can be used to share essential information with other healthcare providers about the pregnancy, labour, birth and immediate postnatal period. Each completed pregnancy summary saved to the health record can be re-used to populate the Past Pregnancy History details in subsequent pregnancy records. In situations where completed pregnancy summaries are not available for each previous pregnancy, this archetype can also be used to record a relevant subset of information that can be used to populate the Past Pregnancy History details with new or active pregnancy records.

Misuse: Not to be used to record event-based information during the pregnancy, labor, birth and immediate postnatal period. These will be recorded using OBSERVATION archetypes - for example, the information related to history & examination during antenatal visits or during labour. Not to be used to record summary information about a woman's Obstetric history - use EVALUATION.obstetric_summary. Not to be used to record detailed information about a woman's Menstrual Cycle - use OBSERVATION.menstrual_cycle. Not to be used to record detailed information about infant feeding - a separate archetype will be used. Not to be used to record a general menstrual history summary or diary - separate archetypes will be used.

Keywords: pregnancy, fetus, foetus, infant, neonate, delivery, conception, due, date, expected, labor, labour, birth, baby, babies, EDD, EDB

Concepts:

- at0000::Pregnancy summary - Overview or summary record of a pregnancy and outcome, including the antenatal period, labour, birth and the immediate postnatal period.
- at0001::Tree - @ internal @
- at0007::Number of foetuses - Number of foetuses identified in utero.
- at0008::Onset of labour - Manner in which labour started.
- at0009::Spontaneous - Onset without intervention.
- at0010::Induced - Onset through intervention.
- at0016::Total duration of labor - Total duration of all three stages of labour.
- at0022::Augmentation method - Method of labour augmentation.
- at0028::Per infant - Information about a single foetus or newborn infant.
- at0029::Date/time of delivery - Date and time of delivery for the infant.
- at0036::Label/name - Identification of the infant.
- at0037::Assigned sex - Sex of the infant by direct observation of external genitalia.
- at0038::Birthweight - Weight of the infant at delivery.
- at0045::Presenting part - Presenting part of the infant at delivery.
- at0046::Vertex - The vertex was the presenting part.
- at0047::Breech - The breech was the presenting part.
- at0048::Face - The face was the presenting part.
- at0049::Brow - The brow was the presenting part.
- at0061::Newborn complication - Details about any complications affecting the newborn.
- at0062::Complication - Identification of the complication after birth.
- at0063::Date/time of onset - Date and/or time of onset of the complication.
- at0064::Description - Narrative description of complication.
- at0065::Maternal complication - Details about pregnancy complications or birth complications affecting the mother.
- at0066::Complication - Identification of the complication.
- at0067::Date/Time of onset - Date of onset of complication, as assessed by a clinician.
- at0068::Description - Narrative description of the maternal complication.
- at0081::Tree - @ internal @
- at0082::Last updated - The date/time the pregnancy summary was last updated.
- at0083::Pregnancy synopsis - Narrative description about the entire pregnancy, labour and delivery, including complications.
- at0094::Early pregnancy outcome - Outcome of the pregnancy as a whole.
- at0096::Induction method - Method of labour induction.
- at0097::Reason for induction - Reason for induction of labour.
- at0104::Assisted reproduction? - Was the pregnancy a result of assisted reproductive technology?

- at0105::Assisted reproduction type - Type of assisted reproductive technology used to achieve pregnancy.
- at0106::Foot - A foot was the presenting part.
- at0107::Arm - An arm was the presenting part.
- at0109::Feeding - Narrative description about feeding of the infant.
- at0112::No labour - No onset of labour.
- at0113::Male - Baby appears physically male.
- at0114::Female - Baby appears physically female.
- at0115::Indeterminate - Sex of the baby has not yet been able to be determined from observation of physical characteristics.
- at0118::Perineum - Coded or narrative description about the condition of the perineum after birth, including injuries and repairs.
- at0119::Estimated blood loss - Estimation of total maternal blood loss during birth and immediately postpartum.
- at0133::Shoulder - A shoulder was the presenting part.
- at0146::Pregnancy label - None
- at0149::Position - Position of the infant at delivery.
- at0150::Left occiput anterior/transverse - The baby's back was toward the left side of the uterus at onset of labour.
- at0151::Right occiput anterior/transverse - The baby's back was toward the right side of the uterus at onset of labour.
- at0152::Unknown - It is not known which side the baby's back was positioned by onset of labour.
- at0153::First degree vaginal tear - Involve just the skin of the vaginal opening and perineum.
- at0154::Second degree vaginal tear - Involve the skin and muscle of the perineum and might extend deep into the vagina.
- at0155::Third degree vaginal tear - Tear in the vaginal tissue, perineal skin, and perineal muscles that extends into the anal sphincter.
- at0156::Fourth degree vaginal tear - Extend through the anal sphincter and into the mucous membrane that lines the rectum.
- at0157::Episiotomy - Was an episiotomy performed?
- at0158::Pregnancy confirmed - Confirmation of the pregnancy.
- at0159::Pregnancy duration - The gestation when the pregnancy has ended.
- at0160::Birth detail - A subset of persistent or summary information about the pregnancy and birth of an infant, selected for utility of use within both the maternal and infant health records.
- at0161::Additional details - Structured details about additional information related to the pregnancy summary.
- at0163::Infant outcome - Outcome of the pregnancy for the identified infant or foetus.
- at0164::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

- at0165::Neonatal outcome - Description of the outcome at the end of the neonatal period per newborn infant.
- at0166::Age at neonatal death - The age of the infant if they died during the neonatal period.
- at0167::Date/time of neonatal death - None
- at0168::Live - The infant survived the neonatal period.
- at0169::Deceased - The infant did not survive the neonatal period.
- at0170::Neonatal summary - Narrative description about issues, concerns about the infant or events occurring during the neonatal period.
- at0172::Structured place of outcome - Structured details about the location where the pregnancy was delivered or an alternative outcome of the pregnancy was treated or managed.
- at0173::Place category - Category of the place where the individual died.
- at0174::Pregnancy end date - The date and/or time marking the end of the pregnancy.
- at0175::Place of outcome - Simple details about the location where the pregnancy was delivered or an alternative outcome of the pregnancy was treated or managed.
- at0176::Intersex - None
- at0177::Unknown - None
- at0178::Multiple pregnancy? - Assertion about whether the pregnancy is cateogrised as 'multiple pregnancy'.
- at0179::Present - The pregnancy has more than one foetus.
- at0180::Absent - The pregnancy has only one foetus.

problem_diagnosis

Archetype ID: openEHR-EHR-EVALUATION.problem_diagnosis.v1

Lifecycle State: published

Category: EVALUATION

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

Purpose: For recording details about a single, identified health problem or diagnosis. The intended scope of a health problem is deliberately kept loose in the context of clinical documentation, so as to capture any real or perceived concerns that may adversely affect an individual's wellbeing to any degree. A health problem may be identified by the individual, a carer or a healthcare professional. However, a diagnosis is additionally defined based on objective clinical criteria, and usually determined only by a healthcare professional.

Use: Use for recording details about a single, identified health problem or diagnosis. Clear definitions that enable differentiation between a 'problem' and a 'diagnosis' are

almost impossible in practice - we cannot reliably tell when a problem should be regarded as a diagnosis. When diagnostic or classification criteria are successfully met, then we can confidently call the condition a formal diagnosis, but prior to these conditions being met and while there is supportive evidence available, it can also be valid to use the term 'diagnosis'. The amount of supportive evidence required for the label of diagnosis is not easy to define and in reality probably varies from condition to condition. Many standards committees have grappled with this definitional conundrum for years without clear resolution. For the purposes of clinical documentation with this archetype, problem and diagnosis are regarded as a continuum, with increasing levels of detail and supportive evidence usually providing weight towards the label of 'diagnosis'. In this archetype it is not neccessary to classify the condition as a 'problem' or 'diagnosis'. The data requirements to support documentation of either are identical, with additional data structure required to support inclusion of the evidence if and when it becomes available. Examples of problems include: the individual's expressed desire to lose weight, but without a formal diagnosis of Obesity; or a relationship problem with a family member. Examples of formal diagnoses would include a cancer that is supported by historical information, examination findings, histopathological findings, radiological findings and meets all requirements for known diagnostic criteria. In practice, most problems or diagnoses do not sit at either end of the problem-diagnosis spectrum, but somewhere in between. This archetype can be used within many contexts. For example, recording a problem or a clinical diagnosis during a clinical consultation; populating a persistent Problem List; or to provide a summary statement within a Discharge Summary document. In practice, clinicians use many context-specific qualifiers such as past/present, primary/secondary, active/inactive, admission/discharge etc. The contexts can be location-, specialisation-, episode- or workflow-specific, and these can cause confusion or even potential safety issues if perpetuated in Problem Lists or shared in documents that are outside of the original context. These qualifiers can be archetyped separately and included in the ‘Status’ slot, because their use varies in different settings. It is expected that these will be used mostly within the appropriate context and not shared out of that context without clear understanding of potential consequences. For example, a primary diagnosis to one clinician may be a secondary one to another specialist; an active problem can become inactive (or vice versa) and this can impact the safe use of clinical decision support. In general these qualifiers should be applied locally within the context of the clinical system, and in practice these statuses should be manually curated by clinicians to ensure that lists of Current/Past, Active/Inactive or Primary/Secondary Problems are clinically accurate. This archetype will be used as a component within the Problem Oriented Medical Record as described by Larry Weed. Additional archetypes, representing clinical concepts such as condition as an overarching organiser for diagnoses etc, will need to be developed to support this approach. In some situations, it may be assumed that identification of a diagnosis fits only within the expertise of physicians, but this is not the intent for this archetype. Diagnoses can be recorded using this archetype by any healthcare professional.

Misuse: Not to be used to record symptoms as described by the individual - use the CLUSTER.symptom archetype, usually within the OBSERVATION.story archetype. Not to be

used to record examination findings - use the family of examination-related CLUSTER archetypes, usually nested within the OBSERVATION.exam archetype. Not to be used to record laboratory test results or related diagnoses, for example pathological diagnoses - use an appropriate archetype from the laboratory family of OBSERVATION archetypes. Not to be used to record imaging examination results or imaging diagnoses - use an appropriate archetype from the imaging family of OBSERVATION archetypes. Not to be used to record 'Differential Diagnoses' - use the EVALUATION.differential_diagnosis archetype. Not to be used to record 'Reason for Encounter' or 'Presenting Complaint' - use the EVALUATION.reason_for_encounter archetype. Not to be used to record procedures - use the ACTION.procedure archetype. Not to be used to record details about pregnancy - use the EVALUATION.pregnancy_bf_status and EVALUATION.pregnancy and related archetypes. Not to be used to record statements about health risk or potential problems - use the EVALUATION.health_risk archetype. Not to be used to record statements about adverse reactions, allergies or intolerances - use the EVALUATION.adverse_reaction archetype. Not to be used for the explicit recording of an absence (or negative presence) of a problem or diagnosis, for example ‘No known problem or diagnoses’ or ‘No known diabetes’. Use the EVALUATION.exclusion-problem_diagnosis archetype to express a positive statement about exclusion of a problem or diagnosis.

Keywords: issue, condition, problem, diagnosis, concern, injury, clinical impression

Concepts:

- at0000::Problem/Diagnosis - Details about a single identified health condition, injury, disability or any other issue which impacts on the physical, mental and/or social well-being of an individual.
- at0001::structure - @ internal @
- at0002::Problem/Diagnosis name - Identification of the problem or diagnosis, by name.
- at0003::Date/time clinically recognised - Estimated or actual date/time the diagnosis or problem was recognised by a healthcare professional.
- at0005::Severity - An assessment of the overall severity of the problem or diagnosis.
- at0009::Clinical description - Narrative description about the problem or diagnosis.
- at0012::Body site - Identification of a simple body site for the location of the problem or diagnosis.
- at0030::Date/time of resolution - Estimated or actual date/time of resolution or remission for this problem or diagnosis, as determined by a healthcare professional.
- at0032::Tree - @ internal @
- at0039::Structured body site - A structured anatomical location for the problem or diagnosis.
- at0043::Specific details - Details that are additionally required to record as unique attributes of this problem or diagnosis.
- at0046::Status - Structured details for location-, domain-, episode- or workflow-specific aspects of the diagnostic process.

- at0047::Mild - The problem or diagnosis does not interfere with normal activity or may cause damage to health if left untreated.
- at0048::Moderate - The problem or diagnosis causes interference with normal activity or will damage health if left untreated.
- at0049::Severe - The problem or diagnosis prevents normal activity or will seriously damage health if left untreated.
- at0069::Comment - Additional narrative about the problem or diagnosis not captured in other fields.
- at0070::Last updated - The date this problem or diagnosis was last updated.
- at0071::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0072::Course description - Narrative description about the course of the problem or diagnosis since onset.
- at0073::Diagnostic certainty - The level of confidence in the identification of the diagnosis.
- at0074::Suspected - The diagnosis has been identified with a low level of certainty.
- at0075::Probable - The diagnosis has been identified with a high level of certainty.
- at0076::Confirmed - The diagnosis has been confirmed against recognised criteria.
- at0077::Date/time of onset - Estimated or actual date/time that signs or symptoms of the problem/diagnosis were first observed.
- at0078::Cause - A cause, set of causes, or manner of causation of the problem or diagnosis.
- at0079::Variant - Specific variant or subtype of the Diagnosis, if relevant.

procedure_summary_covid

Archetype ID: openEHR-EHR-EVALUATION.procedure_summary_covid.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: de, fi, en, it

Purpose: To record a summary of historical procedures and therapies for epidemiological purposes.

Use: To record a summary of historical procedures and therapies for epidemiological purposes.

Concepts:

- at0000::COVID - procedure summary - A summary of historical procedures and therapies
- at0001::Item tree - @ internal @
- at0002::Extension - *
- at0003::Item tree - @ internal @
- at0004::Status - *
- at0005::Yes - The patient has had the procedure or therapy.
- at0006::No - The patient has not had the procedure or therapy.
- at0012::Procedure - *
- at0020::Procedure name - *
- at0039::ICU care - ICU care
- at0040::Ventilation - Ventilation
- at0041::ECMO - ECMO
- at0042::Isolation - Isolation
- at0043::Procedure date - *
- at0044::Unknown - It is not known if the patient has had the procedure or therapy.
- at0047::Report phase - *
- at0048::Confirmed diagnosis - Confirmed diagnosis report phase.
- at0049::Outcome - Outcome report phase.

reason_for_encounter

Archetype ID: openEHR-EHR-EVALUATION.reason_for_encounter.v1

Lifecycle State: published

Category: EVALUATION

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

Purpose: To record the reason, or reasons, for initiation of any type of healthcare encounter or contact by the individual who is the subject of care.

Use: Use to record the reason, or reasons, for initiation of any type of healthcare encounter or contact between a healthcare provider and the individual who is the subject of care. The reason may be for clinical, social or administrative purposes. Reason for Encounter is a common phrase used in clinical medicine, however the term is often used in two common ways - one that refers to an administrative category for provision of healthcare and the other that reflects clinical or social problems that motivate individuals to seek healthcare. In an effort to clarify the phrases and intent, this archetype contains two data elements: - The first, 'Contact type', to document the administrative type of healthcare sought or required - for example the type of consultation, emergency care, pre-operative

assessment, routine antenatal visit or elective admission. This data element reflects the administrative category of care provision. Use of the phrase 'Contact type', rather than 'Reason for encounter' or 'Reason for visit' reflects the increasing trend towards alternative methods of healthcare provision that may not result in face-to-face contact between the healthcare provider and patient within a consulting room. - The second, 'Presenting problem', to document the clinical reasons for healthcare contact. Chief complaint is regarded as a synonym for 'Presenting problem'. These are intended mainly to capture the patient's perceived issues or symptoms which have triggered them to seek healthcare advice, such as desire to quit smoking, stress, shortness of breath, genetic counselling or abdominal pain. Signs such as impaired conscious state may also be captured here, for example by paramedical staff with an unconscious patient.

Misuse: Not to be used to record specific details of the patient's story or history of symptoms. Use OBSERVATION.story to capture the narrative and the related nested CLUSTER archetypes for structured content eg CLUSTER.symptom, CLUSTER.event and CLUSTER.issue. Not to be used to record specific diagnosis details that may be required in addition to a Reason for Encounter. For example, to record a Pre-operative Diagnosis as part of admission for a hospital procedure. Use the EVALUATION.problem_diagnosis archetype for this purpose.

Keywords: presentation, presenting complaint, reason for encounter, reason, chief complaint, visit, reason for visit

Concepts:

- at0000::Reason for encounter - The reason for initiation of any healthcare encounter or contact by the individual who is the subject of care.
- at0001::Tree - @ internal @
- at0002::Contact type - Identification of the type, or administrative category, of healthcare sought or required by the subject of care.
- at0004::Presenting problem - Identification of the clinical or social problem motivating the subject of care to seeking healthcare.

recommendation-amd_treatment

Archetype ID: openEHR-EHR-EVALUATION.recommendation-amd_treatment.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en, es

Purpose: To record a suggestion, advice or proposal about the most suitable treatment at a specific time, for each patient with age-related macular degeneration.

Use: Use to record a suggestion, advice or proposal about the treatment of age-related macular degeneration, valid at a specific time of healthcare. The statement is considered for the specific point-in-time it is registered, as the therapeutic guidelines may vary according to the context of the disease and the information evaluated in each clinical encounter. For example, the treatment can be modified over time depending on the progression of the disease.

Keywords: advice, proposal, suggestion, treatment, age-related macular degeneration, amd

Concepts:

- at0.11::Photodynamic Therapy (PDT) - A light-sensitive medicine is injected into the bloodstream, and blocks selectively abnormal blood vessels under the macula in response to laser light. PDT is applicable to stop further formation of wet AMD, but it cannot reverse damage.
- at0.12::High dose Antioxidant Vitamin and Mineral Supplements - Daily intake of certain antioxidants and minerals can help slow the progression of age-related macular degeneration (AMD).
- at0.14::Thermal Laser Photocoagulation Surgery - By treating the abnormal blood vessels that have formed on the retina, laser surgery can delay advancement of the disease.
- at0.15::Visual acuity decrease with macular fluid - Loss of at least one line of visual acuity, in comparison to the previous revision, associated with the presence of macular fluid indicative of activity on AMD.
- at0.16::Macular fluid - Persistence of intraretinal or subretinal macular fluid indicative of AMD activity.
- at0.17::New macular haemorrhage - Emerging new macular haemorrhage detected.
- at0.4::Do not treat - Observation of the condition is recommended when no treatment is indicated or the afection is not tratable.
- at0.5::Intravitreal anti-VEGF injection - Inhibition of neovascularization may delay or even halt progression of exudative form of AMD.
- at0000::Recommendation - A suggestion, advice or proposal for current healthcare management or for future action.
- at0000.1::Recommendation on the treatment of AMD - A suggestion, advice or proposal toward application of the appropriate therapy for patients diagnosed with age-related macular degeneration.
- at0001::Tree - @ internal @
- at0002::Recommendation - Narrative description of the recommendation.
- at0002.1::Therapeutic recommendation - Narrative description of the most effective treatment based on a previous assessment of AMD.

- at0003::Rationale - Justification for the recommendation.
- at0003.1::Rationale - Justification for the recommendation.

recommendation-DR_treatment

Archetype ID: openEHR-EHR-EVALUATION.recommendation-DR_treatment.v1

Lifecycle State: AuthorDraft

Category: EVALUATION

Languages: en, es

Purpose: To record a suggestion, advice or proposal about the most suitable treatment for each patient with diabetic retinopathy.

Use: Use to record a suggestion, advice or proposal about the treatment of DR, at a specific point in time of its clinical history. The statement is considered only at the time it is registered. That is to say, the treatment can change over time depending on the progression of the disease.

Keywords: advice, proposal, suggestion, diabetic retinopathy, treatment

Concepts:

- at0.10::Laser treatment: macular drusen photocoagulation - *
- at0.4::Do not treat - No treatment is indicated or the afection is not tratable.
- at0.5::Intravitreal injection: antiangiogenics - *
- at0.6::Intravitreal injection: corticoids - *
- at0.7::Surgery: vitrectomy - *
- at0.8::Surgery: cryotherapy to retina - *
- at0.9::Laser treatment: panretinal photocoagulation for diabetes - *
- at0000::Recommendation - A suggestion, advice or proposal for current healthcare management or for future action.
- at0000.1::Recommendation of treatment for diabetic retinopathy - A suggestion, advice or proposal to manage the treatment regarding diabetic retinopathy.
- at0001::Tree - @ internal @
- at0002::Recommendation - Narrative description of the recommendation.
- at0002.1::Therapeutic recommendation - Narrative description of the most effective treatment based on a previous assessment of DR.
- at0003::Rationale - Justification for the recommendation.
- at0003.1::Rationale - Justification for the recommendation.

recommendation-glaucoma_treatment

Archetype ID: openEHR-EHR-EVALUATION.recommendation-glaucoma_treatment.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record a suggestion, advice or proposal about the most suitable treatment at a specific time, for each patient affected with glaucoma.

Use: Use to record a suggestion, advice or proposal about the treatment of glaucoma, valid at a specific time of healthcare. The statement is considered for the specific point-in-time it is registered, as the therapeutic guidelines may vary according to the context of the disease and the information evaluated in each clinical encounter. For example, the treatment can be modified over time depending on the progression of the disease.

Keywords: advice, proposal, suggestion, glaucoma

Concepts:

- at0.10::Laser therapy - Laser trabeculoplasty lowers IOP by improving aqueous outflow. Presents an alternative for patients who cannot use medications reliably.
- at0.11::Incisional glaucoma surgery - Generally indicated when medicine or laser therapy is insufficient to control disease.
- at0.12::Glaucoma stable - No signs of progression identified in glaucoma.
- at0.13::IOP unstable - Target IOP not reached.
- at0.14::No treatment - No treatment is needed for the moment.
- at0.15::Maintain treatment - The patient is already receiving a treatment, to which is responding correctly.
- at0.16::Cyclodestructive surgery - Procedures that reduce the rate of aqueous production. There are several ways to reduce ciliary body function, such as cyclocryotherapy, transscleral and noncontact Nd:YAG laser, and transscleral and noncontact endodiode laser cyclophotocoagulation.
- at0.17::Other glaucoma surgeries - Alternative strategies of nonpenetrating glaucoma surgery. The two main types are viscocanalostomy and nonpenetrating deep sclerectomy.
- at0.6::Progressive excavation of the papilla - Progression of glaucomatous damage at the retinal nerve fiber layer (RNFL) identified on a increase in cupping of the neuroretinal rim.
- at0.7::Visual field loss - Progressive loss of visual field regarding previous examinations.

- at0.9::Medical treatment - Unless contraindicated, medical therapy is presently the most common initial intervention to lower IOP.
- at0000::Recommendation - A suggestion, advice or proposal for clinical management.
- at0000.1::Recommended treatment for glaucoma - A suggestion, advice or proposal toward application of the appropriate therapy for patients diagnosed with glaucoma.
- at0001::Tree - @ internal @
- at0002::Recommendation - Narrative description of the recommendation.
- at0002.1::Therapeutic recommendation - Narrative description of the most effective treatment based on the assessment of glaucoma.
- at0003::Rationale - Justification for the recommendation.
- at0003.1::Rationale - Justification for the recommendation.
- at0004::Tree - @ internal @
- at0005::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

recommendation

Archetype ID: openEHR-EHR-EVALUATION.recommendation.v2

Lifecycle State: published

Category: EVALUATION

Languages: de, sv, es-ar, nb, pt-br, en, nl

Purpose: To record a suggestion, advice or proposal for clinical management at a specific time.

Use: Use to record a suggestion, advice or proposal for clinical management at a specific time. The intended use case is to support a clinician recording a recommendation, or recommendations, at a specific point-in-time. For example, as a component of the conclusions drawn as part of a clinical consultation.

Misuse: Not to be used to carry structured data elements detailing additional instructions, such as timing, frequency, duration or dosage - use appropriate INSTRUCTION archetypes for this purpose.

Keywords: advice, proposal, suggestion

Concepts:

- at0000::Recommendation - A suggestion, advice or proposal for clinical management.
- at0001::Tree - @ internal @

- at0002::Recommendation - Narrative description of the recommendation.
- at0003::Rationale - Justifications for the recommendation.
- at0004::Tree - @ internal @
- at0005::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0006::Topic - The topic or subject of the recommendation.
- at0007::Last updated - The date this recommendation was last updated.

sdoh_assessment

Archetype ID: openEHR-EHR-EVALUATION.sdoh_assessment.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record a self-identified assessment of an individual's sense of security about identified aspects of social determinants of health (SDOH).

Use: Use to record a self-identified assessment of an individual's sense of security about identified aspects of social determinants of health (SDOH). This archetype has been designed to capture a simple assessment of how secure an individual feels about aspects of SDOH, such that it could be displayed on the dashboard of a health record, perhaps using a traffic light system, as a visual flag for clinicians of areas that may need inquiry, investigation or follow-up.

Concepts:

- at0000::Social determinants of health (SDOH) self-assessment - Self-identified assessment of an individual's sense of safey or security about social determinants of health (SDOH).
- at0001::Item tree - @ internal @
- at0006::Food security - Does the individual feel that their access to adequate amounts of appropriate food is secure?
- at0007::Housing security - Does the individual feel that their housing situation is adequate and secure?
- at0008::Employment security - Does the individual feel that their working situation is secure or that they have access to appropriate employment if they need it?
- at0009::Financial security - Does the individual feel that their financial situation is safe and secure?

- at0011::Personal safety - Does the individual feel that their situation regarding a sense of personal safety is safe and secure?
- at0012::Neighborhood safety - Does the individual feel that their situation regarding living, working or moving around in their community and local environment is safe and secure?
- at0002::Healthcare access - Does the individual feel that their access to high quality healthcare is adequate and secure?
- at0003::Yes - No problem!
- at0004::Sometimes - Maybe a little wobbly.
- at0005::No - Worrying.
- at0015::Item tree - @ internal @
- at0016::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0017::Last updated - Date when the SDOH security was last updated.
- at0013::Social connection - Does the individual feel that they have adequate opportunities for social connection?
- at0014::Communication - Does the individual feel that are able to communicate adequately as they need to?
- at0010::Education access - Does the individual feel that their access to high quality education is adequate and secure?

sexual_health_summary

Archetype ID: openEHR-EHR-EVALUATION.sexual_health_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record summary or persistent information about an individual's sexual health and history.

Use: Use to record summary or persistent information about an individual's sexual health and history.

Concepts:

- at0000::Sexual health summary - Summary or persistent information about an individual's sexual health and history.
- at0001::Tree - @ internal @

- at0002::Status - Is the individual sexually active?
- at0003::First ever sex - The age when the individual first had sex.
- at0004::Last updated - The date this summary was last updated.
- at0009::Sexually active, regular partner - The individual is sexually active with a regular partner.
- at0010::Sexually active, no regular partner - The individual is sexually active but not with a regular partner, has no current partner or has been sexually active in the past..
- at0011::Never sexually active - The individual has never been sexually active.
- at0012::Description - Narrative description about the sexual health history of an individual.
- at0013::Item tree - @ internal @
- at0014::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0015::Comment - Additional narrative about the sexual health history not captured in other fields.

smokeless_tobacco_summary

Archetype ID: openEHR-EHR-EVALUATION.smokeless_tobacco_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: sv, nb, en

Purpose: To record summary or persistent information about smokeless tobacco use by an individual.

Use: Use to record summary or persistent information about smokeless tobacco use by an individual. This archetype is to be used to record information about both current and previous use of smokeless tobacco. The specific scope of this archetype includes the use of all types of smokeless tobacco because of the associated health risks. Amount of nicotine, as well as use of bags and additives has been left outside of scope for the core archetype, but could be added into the 'Type details' SLOT if required. The 'Per type' cluster of data elements allows for recording of specific details and episodes about each type of tobacco used and can be repeated once per type. In many situations the individual will only use one type of smokeless tobacco, such as snus or snuff. If other types of tobacco are used the details will be recorded in another instance of the 'Per type' cluster. The history of varying use for each type of tobacco over time can be captured using the repeatable 'Per episode' cluster. This cluster of data elements allows for a very detailed pattern of tobacco usage behaviour to be recorded for each type of tobacco used such as daily usage of snus,

alongside occasional use of chewing tobacco while on holiday. Triggers for closing one episode and commencing a new one will largely reflect local data collection preferences, including if the individual: - quits for a significant period of time (which will likely be locally defined); or - significantly changes their amount of use or pattern of their usage. To incorporate narrative descriptions of smokeless tobacco usage habits within existing or legacy clinical systems into an archetyped format, use the 'Overall description' data element.

Misuse: Not to be used to record event-or period-based information about usage of smokeless tobacco, such as actual daily use or the average use over a specified period of time - use the OBSERVATION.smokeless_tobacco archetype (not yet developed). Not to be used for recording specific consumption of nicotine - including patches, chewing gum, spray and powder - or e-cigarettes. Use separate archetypes for this purpose. Not to be used to record information about tobacco smoking. Use the EVALUATION.tobacco_smoking_summary archetype for this purpose.

Keywords: tobacco, snus, snuff, dip, gutka, iqmik, naswar, toombak, shammah, mawa, gadakhu, habit, babul, zarda, dokta, paan, pan, khilli, pan masala, dohra, tombol, sada pata, chadha, kapoori, manipuri, twist, niswar, nass, nasway, nasvay, sute, ammari, saood, sauté, gudakhu, kiwam, mishri, gul, tuibur, hidakpha, hsaypaung yay, chaw, chewing, oral, spitting

Concepts:

- at0000::Smokeless tobacco summary - Summary or persistent information about smokeless tobacco use by an individual.
- at0001::Tree - @ internal @
- at0003::Current user - The individual is a current user of any type of smokeless tobacco.
- at0005::Former user - The individual has previously used smokeless tobacco, but is not a current user.
- at0006::Never used - Individual has never used any type of smokeless tobacco.
- at0013::Episode start date - Date when this episode commenced.
- at0014::Quit date - Date when the individual last used the specified type of tobacco.
- at0015::Regular use commenced - The date or partial date when the individual first started frequent or regular, but non-daily, use of smokeless tobacco of any type.
- at0016::Overall quit date - The date when the individual last ceased using smokeless tobacco of any type.
- at0017::Pack years - Estimate of the cumulative amount of smokeless tobacco used over a lifetime, for the specified type of smokeless tobacco.
- at0019::Overall comment - Additional narrative about all smokeless tobacco use, not captured in other fields.
- at0021::Tree - @ internal @
- at0022::Last updated - The date this smokeless tobacco summary was last updated.
- at0023::Typical frequency - Estimate of number of times that an individual uses smokeless tobacco per time period.

- at0025::Number of quit attempts - Total number of times the individual has attempted to stop using the specified type of smokeless tobacco within this episode.
- at0026::Episode details - Additional structured details about the specified episode of smokeless tobacco use.
- at0029::Per type - Details about use of a specified type of smokeless tobacco.
- at0030::Pattern - Details about a discrete period of use of the specified type of smokeless tobacco.
- at0043::Overall description - Narrative summary about the individual's overall smokeless tobacco use pattern and history.
- at0052::Status - Statement about current use of the specified type of smokeless tobacco.
- at0053::Description - Narrative summary about use of the specified type of smokeless tobacco.
- at0059::Former user - The individual has previously used the specified smokeless tobacco, but is not a current user.
- at0061::Current user - The individual is a current user of the specified type of smokeless tobacco.
- at0064::Per episode - Details about a discrete period of use of the specified type of smokeless tobacco.
- at0065::Typical use - Estimate of the amount of loose tobacco used.
- at0069::Comment - Additional narrative about the use of the specified type of smokeless tobacco, not captured in other fields.
- at0071::Quit date definition - The applied definition for the 'Quit date' data elements used in this archetype.
- at0072::Pack definition - The definition of the size of pack used as part of the algorithm for calculating 'Pack years' data elements used in this archetype.
- at0073::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0074::Overall pack years - Estimate of the cumulative amount of smokeless tobacco used over a lifetime, for all types of smokeless tobacco.
- at0075::Current user definition - The applied definition for the 'Current user' value in each of the 'Status' data elements used in this archetype.
- at0076::Former user definition - The applied definition for the 'Former user' value in each of the 'Status' data elements used in this archetype.
- at0077::Type details - Additional structured details relating to the specified type of smokeless tobacco use.
- at0079::Never used definition - The applied definition for the 'Never used' value in each of the 'Status' data elements used in this archetype.
- at0080::Daily use commenced - The date or partial date when the individual first started daily use of smokeless tobacco of any type.
- at0081::Episode label - Identification of an episode of smokeless tobacco use.
- at0082::Episode end date - Date when this episode ceased.
- at0083::Daily - Use of the specified type of smokeless tobacco at least once every day.

- at0084::Non-daily - Not using the specified type of smokeless tobacco every day.
- at0085::Quit attempt definition - The applied definition for a Quit attempt used to determine value for the 'Number of quit attempts' data element used in this archetype.
- at0086::Overall details - Additional structured details about the overall smokeless tobacco use.
- at0087::Episode comment - Details about a discrete period of use of the specified type of smokeless tobacco.
- at0089::Overall status - Statement about current use of all types of smokeless tobacco.
- at0091::Never used - The individual has never used the specified type of smokeless tobacco.
- at0098::Type - The name of the specific type or grouping of smokeless tobacco.

social_network-JM

Archetype ID: openEHR-EHR-EVALUATION.social_network-JM.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: de, nb, en, fr

Purpose: To record information about the key people who are connected to the individual through social interactions and personal relationships.

Use: Use to record information about the key people who are connected to the individual through social interactions and personal relationships, by the provision of personal support or care. This archetype has been designed to be recorded as part of a single, persistent template within the health record, such that any network changes are recorded as a new or updated version of the template. The scope of this archetype includes all types of interactions, such as face-to-face or using social media, with a broad range of people including family members, friends, community members or organisations. The social network can be self-identified or documented by a carer or healthcare provider. Details about each person or organisation within the individual's social network is recorded using the CLUSTER.person or CLUSTER.organisation archetypes nested within the 'Network' SLOT, including their role or relationship. In most jurisdictions, there will be limitations on what is legal to record about other people within the health record. All implementations will need to consider the legal constraints relevant to using this archetype.

Misuse: Not to be used to record details about healthcare providers or care teams. Not to be used to record details about legal constraints or directives such as custody arrangements or guardianship - use EVALUATION.legal_directive for this purpose. Not to be

used to represent or replace formal identification management or for the purposes of maintaining an official demographic register or index. Use a formal Demographic index for this purpose, or archetypes based on the openEHR Demographic Information Model. Not to be used to represent the subject of care, participants or author of the record and similar data elements that should be represented formally in the health record using the Reference Model attributes.

Keywords: partner, partnership, relationship, family, support, marital, married, defacto, marriage, single, widowed, widow, widower, divorced, unmarried, friend, neighbour

Concepts:

- at0001::Tree - @ internal @
- at0002::Partnership status - Single word or phrase that describes an individual's current relationship with a life partner.
- at0010::Tree - @ internal @
- at0011::Last updated - Date when the social network was updated.
- at0012::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0015::Description - Narrative description about the social network and connections for the individual.
- at0016::Network - Structured details about people or community organisations who are connected to the individual.
- at0017::Additional details - Additional structured details about the social network.
- at0018::Comment - Additional narrative about the social network, not captured in other fields.
- at0000.1::Social network - Group of individuals connected by social interactions and personal relationships.
- at0.1::Living children - Number of children alive.

social_network

Archetype ID: openEHR-EHR-EVALUATION.social_network.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, nb, en, fr

Purpose: To record information about the key people who are connected to the individual through social interactions and personal relationships.

Use: Use to record information about the key people who are connected to the individual through social interactions and personal relationships, by the provision of personal support or care. This archetype has been designed to be recorded as part of a single, persistent template within the health record, such that any network changes are recorded as a new or updated version of the template. The scope of this archetype includes all types of interactions, such as face-to-face or using social media, with a broad range of people including family members, friends, community members or organisations. The social network can be self-identified or documented by a carer or healthcare provider. Details about each person or organisation within the individual's social network is recorded using the CLUSTER.person or CLUSTER.organisation archetypes nested within the 'Network' SLOT, including their role or relationship. In most jurisdictions, there will be limitations on what is legal to record about other people within the health record. All implementations will need to consider the legal constraints relevant to using this archetype.

Misuse: Not to be used to record details about healthcare providers or care teams. Not to be used to record details about legal constraints or directives such as custody arrangements or guardianship - use EVALUATION.legal_directive for this purpose. Not to be used to represent or replace formal identification management or for the purposes of maintaining an official demographic register or index. Use a formal Demographic index for this purpose, or archetypes based on the openEHR Demographic Information Model. Not to be used to represent the subject of care, participants or author of the record and similar data elements that should be represented formally in the health record using the Reference Model attributes.

Keywords: partner, partnership, relationship, family, support, marital, married, defacto, marriage, single, widowed, widow, widower, divorced, unmarried, friend, neighbour

Concepts:

- at0000::Social network - Group of individuals connected by social interactions and personal relationships.
- at0001::Tree - @ internal @
- at0002::Partnership status - Single word or phrase that describes an individual's current relationship with a life partner.
- at0010::Tree - @ internal @
- at0011::Last updated - Date when the social network was updated.
- at0012::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0015::Description - Narrative description about the social network and connections for the individual.
- at0016::Network - Structured details about people or community organisations who are connected to the individual.
- at0017::Additional details - Additional structured details about the social network.

- at0018::Comment - Additional narrative about the social network, not captured in other fields.

social_summary

Archetype ID: openEHR-EHR-EVALUATION.social_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: nb, en, it

Purpose: To record a narrative summary about social circumstances or experiences that may have a potential impact on an individual's health, and to provide a framework in which to nest detailed CLUSTER archetypes, each of which will describe the various aspects of social circumstances or experiences in detail.

Use: Use to record a narrative summary about social circumstances or experiences that may have a potential impact on an individual's health. Use to incorporate the narrative descriptions of social circumstances or experiences already captured within existing clinical systems into an archetyped format. Use as a container archetype - to provide a common, queryable ENTRY archetype in which specific, detailed CLUSTER archetypes can be nested. Examples of appropriate CLUSTER archetypes may include, and are not limited to, relationships with others, social supports, living arrangements, employment, education and religion. The use of the term 'social summary' varies enormously in practice. This archetype has been designed to allow the concepts that express social history in varying clincial contexts to be represented with the appropriate mix of re-useable archetypes.

Misuse: Not to be used to record Lifestyle-related information - for example, use specific archetypes for alcohol, tobacco and other substance use; diet and nutrition; and physical activity.

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

Concepts:

- at0000::Social summary - Summary information about social circumstances or experiences that may have a potential impact on an individual's health.
- at0001::Tree - @ internal @
- at0002::Summary - Narrative description about social circumstances or experiences that may have a potential impact on an individual's health.

- at0003::Details - Structured detail about the social circumstances and experiences.
- at0004::Tree - @ internal @
- at0005::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0006::Last updated - The date this social summary was last updated.

source

Archetype ID: openEHR-EHR-EVALUATION.source.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: de, pt-br, en, fr

Purpose: To record details about information sourced from a third party that is utilised as part of a remote assessment or report.

Use: Use to record details about information sourced from a third party that is utilised as part of a remote assessment or report. This archetype has been designed to support the identification and quality of health information sourced from a third party clinical source. Each piece of clinical evidence that has been received from a third party source needs to be assessed as 'fit for use' prior to being utilisied to support clinical decision-making. For example: a digital image captured during a clinical consultation, or a digital radiograph, sent to a remote specialist for assessment and treatment advice needs to be deemed to be of the complete anatomical region and of appropriate quality.

Keywords: source, image, original

Concepts:

- at0000::Source information - Information sourced from a third party that is utilised as part of a remote assessment or report.
- at0001::Tree - @ internal @
- at0002::Source information - Identification of the original, or source of, information being assessed.
- at0003::Path - Identification of the path to the archetype or data node for the original information.
- at0004::Quality - Assessment regarding 'fitness for use' of the original information.
- at0005::Adequate for Use - The original information is deemed to be 'fit for use'.
- at0006::Not Adequate for Use - The original information is not deemed to be 'fit for use'.

- at0007::Comment - Narrative about the source information not captured in other data fields.
- at0008::Item tree - @ internal @
- at0009::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

specimen_summary

Archetype ID: openEHR-EHR-EVALUATION.specimen_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: de, nb, en

Purpose: To record summary or persistent record about the use and storage of a single specimen until final disposition.

Use: Use to record summary or persistent record about the use and storage of a single specimen until final disposition. Use cases include, but are not limited to: - oocytes, zygotes, embryos, or semen in assisted reproduction; - autologous skin graft; - Formalin Fixed Paraffin Embedded (FFPE) tissue specimens; and - Histopathology slides. Details about the specimen, including specimen type, description, type of fixative, can be recorded using the CLUSTER.specimen in the 'Specimen details' SLOT.

Keywords: biobank, biospecimen, biofluids, samples, biopsy, assisted reproduction, sperm, testicular, ovarian, tissue, oocyte, zygote, embryo, blastocyst, graft, blood, tissue, DTC, TMA, FFPE, PBMC, BMMC, Leukopak, DTC, cytology, bacterial cultures, genebank, biological materials, PCR

Concepts:

- at0000::Specimen summary - Summary or persistent information about a single specimen.
- at0001::Item tree - @ internal @
- at0002::Stored specimen ID - Unique identifier for the specimen.
- at0008::Specimen details - Details about the biospecimen.
- at0009::Biobank location - Details about the biobank/storage of the specimen.
- at0010::Disposal reason - The reason for disposal of the specimen.
- at0011::Date of disposal - The date/time for the final disposal of the specimen.
- at0012::Use by date - The date beyond the specimen is not to be used.
- at0013::Item tree - @ internal @

- at0014::Last updated - The date this specimen summary was last updated.
- at0015::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0016::Comment - Additional narrative about the specimen, not captured in other fields.
- at0017::Additional details - Additional structured details related to the stored specimen.
- at0018::Storage started - The date/time when the specimen was stored.
- at0020::Specimen storage - The storage location of the specimen within the biobank/organisation.
- at0022::Use - Details about use of the specimen.
- at0023::Reason for use - The reason for the use of the specimen.
- at0024::Date of use - The date and time when the specimen was used.
- at0026::Amount used - The amount of the specimen that was used.
- at0027::Use comment - Comment about the use of the specimen.
- at0028::Amount remaining - The residual amount of the specimen available for use.
- at0029::Number used - The number of units of the specimen used.
- at0030::Number remaining - The remaining units of the specimen available for use.
- at0031::Description - Narrative description about the history or/and the context of the specimen.
- at0032::Specimen label - Name, type or label of the specimen.
- at0033::Legally expiry date - The date beyond the specimen is not to be used based on a expiration date determend by operation of law.

substance_use_summary

Archetype ID: openEHR-EHR-EVALUATION.substance_use_summary.v1

Lifecycle State: published

Category: EVALUATION

Languages: nb, en

Purpose: To record summary or persistent information about the typical use of a specific substance or class of substances that may harm an individual's health or social well-being.

Use: Use to record summary or persistent information about the typical use of a specific substance or class of substances that may harm an individual's health or social well-being. This archetype has been designed as a framework for objectively documenting the use or administration of a single substance. While it supports the recognition of abuse and dependence, it is not intended exclusively for this purpose. Substances that fall within the

scope of this archetype include harmful or potentially addictive substances as well as medications that are misused. Misuse may involve administration without clinical supervision, use for non-recommended purposes, or consumption in quantities or frequencies that exceed safe dosages. Examples of substances that may be recorded using this archetype include but are not limited to: - caffeine; - nicotine and other clinically significant components of vaping liquid; - psychostimulants; - barbiturates; - cannabis; - hallucinogens; - opioids; - GHB; - MDMA; - sniffing of hydrocarbons or other solvents; - "bath salts"; and - medication administration, such as a laxative for purposes other than relief of constipation, beta blockers to reduce the heart rate in elite athletes and anabolic steroids in weight lifters. On the other hand, substances that are commonly recorded in health records, have a well-documented harm profile and are recorded using existing purpose-specific archetypes, are excluded from the scope of this archetype, including: - tobacco smoking; - smokeless tobacco use; - vaping; - alcohol consumption; and - medication administration according to established medical guidelines and standards, including the correct dosage and appropriate indication, timing and route of administration. This archetype is intended to be used to record information about both current and previous substance use behaviour patterns and can be updated over time. The 'Episode' Cluster allows the recording of details within a specified period of time. Triggers for closing one episode and commencing a new one will largely reflect local data collection preferences, however, a new instance of the ‘Episode’ CLUSTER should be used if: - the typical amount used or administered, the pattern of use or the route of administration changes significantly; or - the individual quits for a significant period of time. Vaping is a complex concept that requires attention to both the behaviour and the substances inhaled. In that context, use this archetype to record amounts of clinically significant ingredients of vaping liquid, such as 'Nicotine', and use EVALUATION.vaping_summary to record the patterns of vaping behaviour. In some cases, both archetypes may be required. Use a separate instance of this archetype to record each substance.

Misuse: Not to be used to record summary or persistent information about tobacco smoking. Use EVALUATION.tobacco_smoking_summary for this purpose. Not to be used to record summary or persistent information about smokeless tobacco use. Use EVALUATION.smokeless_tobacco_summary for this purpose. Not to be used to record the summary or persistent information about vaping behaviour. Use an EVALUATION.vaping_summary or similar, yet to be developed. Not to be used to record summary or persistent information about alcohol consumption. Use EVALUATION.alcohol_use_summary for this purpose. Not to be used to record the summary or persistent information about, or monitor the cumulative dose of, a medication. Use EVALUATION.medication_summary for this purpose. Not to be used to record information about actual substance use at or during a specified point or interval of time, such as daily or average use over a specified period of time, or a diary of use. Use the OBSERVATION.substance_use archetype for this purpose.. Not to be used to record accidental administration of, or exposure to, a substance or medication, overdoses or poisonings, etc. Use an Adverse event archetype for this purpose. Not to be used to record answers to pre-defined screening questions about substance use. Use

OBSERVATION.substance_use_screening archetype for this purpose. Not to be used for recording information about appropriate medication use under clinical supervision, for recommended therapeutic intent and at appropriate dosages. Use an appropriate medication archetype for this purpose.

Keywords: drugs, addiction, abuse, doping, narcotics, performance enhancing, steroids

Concepts:

- at0000::Substance use summary - Summary or persistent information about typical use of a specific substance or class of substances that may harm an individual's health or social well-being.
- at0001::Item tree - @ internal @
- at0002::Substance name - The name of the substance or class of substance.
- at0003::Overall status - Statement about current use of the substance, by all routes.
- at0004::Never used - The individual has never used the identified substance.
- at0005::Current user - The individual is currently using the identified substance.
- at0006::Former user - The individual has previously used the identified substance.
- at0007::Overall description - Narrative summary about the use of the substance over the lifetime of the individual.
- at0008::First ever use - Date when the individual first used the substance.
- at0009::Regular use commenced - The date when the individual first started frequent or regular, but usually non-daily, use of the substance.
- at0010::Daily use commenced - The date when the individual first started daily use of the substance.
- at0012::Per episode - Details about a period of use of the substance identified in 'Substance name' or, if a class of substance is used in 'Substance name, to provide details about the use of a specific substance.
- at0013::Episode label - Identification of an episode of substance use - either as a number in a sequence or a named event.
- at0014::Episode start date - Date when this episode commenced.
- at0015::Episode end date - Date when this episode ceased.
- at0016::Specific substance name - The name of the specific substance used during the episode.
- at0017::Status - Reported usage of the specific substance during the episode.
- at0018::Episode description - Narrative summary about use of the specific substance during the episode.
- at0019::Pattern - The typical pattern of frequency of use of the specific substance during the episode.
- at0020::Daily - Using the substance at least once every day.
- at0021::Not daily - Not using the substance every day.
- at0023::Typical amount - Typical amount of use of the specified substance during the episode.

- at0024::Number of quit attempts - Total number of times the individual has attempted to stop using the specified substance within this episode.
- at0025::Episode details - Additional details about the episode.
- at0026::Episode comment - Additional narrative about use of the specific substance during this episode, not captured in other fields.
- at0027::Overall details - Additional structured details about the overall use of the substance.
- at0028::Overall quit date - The date when the individual last used the substance.
- at0029::Item tree - @ internal @
- at0030::Overall comment - Additional narrative about the overall use of the substance that has not been captured in other fields.
- at0031::Last updated - The date this Substance use summary was last updated.
- at0032::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0036::Route - The name of the route of administration of the specified substance during the episode.
- at0042::Used - The individual used the identified substance during this episode.
- at0043::Not used - The individual has not used the identified substance during this episode.

tobacco_smoking_summary

Archetype ID: openEHR-EHR-EVALUATION.tobacco_smoking_summary.v1

Lifecycle State: in_development

Category: EVALUATION

Languages: de, sv, nb, en, fr, nl

Purpose: To record summary information about the individual's pattern of smoking of tobacco and tobacco-containing products.

Use: Use to record summary information about the individual's pattern of smoking of tobacco and tobacco-containing products. This archetype is to be used to record information about both current and previous smoking behaviour. The specific scope of this archetype is on documentation about the use of all types of inhaled tobacco smoke because of the associated health risks from direct inhalation of tobacco and associated chemicals. Amount of nicotine and tar, use of filters and additives has been left outside of scope for the core archetype, but could be added into the Episode SLOT if required. Please note that the scope of this archetype does not include unintentional exposure to tobacco smoke (see Misuse). The 'Per type' cluster of data elements allows for recording of specific details and

episodes about each type of tobacco smoked and can be repeated once per type. In many situations the individual will only smoke one type of tobacco, such as manufactured cigarettes. If other types of tobacco are smoked, the details will be recorded in another instance of the 'Per type' cluster. The history of waxing and waning of use for each type of tobacco over time can be captured using the repeatable 'Per episode' cluster. This cluster of data elements allows for a very detailed pattern of smoking behaviour to be recorded for each type of tobacco smoked such as daily 'roll-your-own' cigarette smoking, alongside weekly cigar smoking every Friday night and occasional Bidi smoking while on holiday in Bali. Triggers for closing one episode and commencing a new one will largely reflect local data collection preferences, including if the individual: - quits for a significant period of time (which will likely be locally defined); or - significantly changes their amount of use or pattern of their smoking. If only one type of tobacco is smoked, the value for 'Pack years' will be identical to the 'Overall pack years' data element. If more than one type of tobacco is smoked, the calculation for the value for 'Overall pack years' will require a more complex algorithm such as http://smokingpackyears.com/. Use to incorporate the narrative descriptions of tobacco smoking habits within existing or legacy clinical systems into an archetyped format, using the 'Overall description' data element. Note: Definitions of 'Current smoker' may vary. For example: the CDC uses 1 month/31 days and New Zealand uses 28 days.

Misuse: Not to be used to record event-or period-based information about tobacco smoking, such as actual daily use or the average use over a specified period of time - use the OBSERVATION.tobacco_smoking archetype. Not to be used to record information about smokeless tobacco use - for example: snus; snuff; chewing tobacco; dip; and gutka. Use the archetype EVALUATION.smokeless_tobacco_summary archetype for this purpose. Not to be used to record evidence of nicotine dependency. Use the OBSERVATION.fagerstrom for this purpose. Not to be used to record details about unintended exposure to tobacco smoke or passive smoking. Use the archetype EVALUATION.exposure for this purpose. Not to be used for recording any other administration of nicotine, such as e-cigarettes, nicotine patches or nicotine chewing gum. Use separate archetypes for this purpose.

Keywords: tobacco, cigarette, cigar, pipe, smoking, kretek, beedi, bidi, cigarillo, smoker, waterpipe, shisha, hookah, narguileh, hubble-bubble, roll-up, RYO, rollie, roll-your-own

Concepts:

- at0000::Tobacco smoking summary - Summary or persistent information about the tobacco smoking habits of an individual.
- at0001::Tree - @ internal @
- at0003::Current smoker - Individual is a current smoker of tobacco.
- at0005::Former smoker - Individual has previously smoked tobacco but is not a current smoker.
- at0006::Never smoked - Individual has never smoked any type of tobacco.
- at0013::Episode start date - Date when this episode commenced.

- at0014::Quit date - Date when the individual last smoked the specified type of tobacco.
- at0015::Regular smoking commenced - The date or partial date when the individual first started frequent or regular, but usually non-daily, smoking of tobacco of any type.
- at0016::Overall quit date - The date when the individual last ceased using tobacco of any type.
- at0017::Pack years - Estimate of the cumulative amount of tobacco smoked using the specified type of tobacco.
- at0019::Overall comment - Additional narrative about all tobacco smoking that has not been captured in other fields.
- at0021::Tree - @ internal @
- at0022::Last updated - The date this tobacco smoking summary was last updated.
- at0023::Typical use (units) - Estimate of number of units of the specified type of tobacco consumed.
- at0025::Number of quit attempts - Total number of times the individual has attempted to stop smoking the specified type of tobacco within this episode.
- at0026::Episode details - Additional structured details about the specified episode of tobacco smoking.
- at0029::Per type - Details about smoking activity for a specified type of smoked tobacco.
- at0030::Pattern - The typical pattern of smoking for the specified type of tobacco.
- at0043::Overall description - Narrative summary about the individual's overall tobacco smoking pattern and history.
- at0052::Status - Statement about current smoking behaviour for the specified type of tobacco.
- at0053::Description - Narrative summary about smoking behaviour for the specified type of tobacco.
- at0054::Cigarettes - Also known as manufactured cigarettes, 'factory made' cigarettes or 'tailor made' cigarettes. Processed tobacco, manufactured into cylinder made of paper or a substance that does not contain tobacco.
- at0055::Hand-rolled cigarettes - Also known as "rollies" or "roll-ups". Loose tobacco, hand rolled into a cylinder using cigarette papers.
- at0056::Cigars - Also known as "large cigar". Roll of tobacco wrapped within a leaf tobacco or in a substance that contains tobacco.
- at0057::Pipe - Loose tobacco placed inside a pipe bowl.
- at0059::Former smoker - Individual has previously smoked the specified type of tobacco but is not a current smoker.
- at0061::Current smoker - Individual is a current smoker of the specified type of tobacco.
- at0062::Waterpipe - Also known as "hookah", "shisha", "narguileh" and "hubble-bubble". Tobacco, often flavoured, is burned then cooled through a basin of water and consumed through a hose and mouthpiece.
- at0064::Per episode - Details about a discrete period of smoking activity for the specified type of tobacco.
- at0065::Typical use (mass) - Estimate of the weight of loose leaf tobacco smoked.

- at0066::Cigarillos - Also known as mini cigars. Short and narrow cigar.
- at0069::Comment - Additional narrative about smoking of the specified type of tobacco, not captured in other fields.
- at0071::Quit date definition - The applied definition for the 'Quit date' data elements used in this archetype.
- at0072::Pack definition - The definition of the size of pack used as part of the algorithm for calculating 'Pack years' data elements used in this archetype.
- at0073::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0074::Overall pack years - Estimate of the cumulative amount for all types of tobacco smoked.
- at0075::Current smoker definition - The applied definition for the 'Current smoker' value in each of the 'Status' data elements used in this archetype.
- at0076::Former smoker definition - The applied definition for the 'Former smoker' value in each of the 'Status' data elements used in this archetype.
- at0077::Type details - Additional structured details about the specified type of tobacco smoking.
- at0078::Bidis - Also known as Beedis. Thin hand-rolled cigarettes filled with tobacco and wrapped in a leaf, often tied with colorful string at one or both ends. They can be flavoured or unflavoured.
- at0079::Never smoked definition - The applied definition for the 'Never smoked' value in each of the 'Status' data elements used in this archetype.
- at0080::Daily smoking commenced - The date or partial date when the individual first started daily smoking of tobacco of any type.
- at0081::Episode label - Identification of an episode of smoking activity - either as a number in a sequence and/or a named event.
- at0082::Episode end date - Date when this episode ceased.
- at0083::Daily - Smoking the specified type of tobacco at least once every day.
- at0084::Non-daily - Not smoking the specified type of tobacco every day.
- at0085::Quit attempt definition - The applied definition for a Quit attempt used to determine value for the 'Number of quit attempts' data element used in this archetype.
- at0086::Overall details - Additional structured details about the overall tobacco smoking behaviour.
- at0087::Episode comment - Additional narrative about tobacco smoking during the specified episode, not captured in other fields.
- at0088::Kreteks - Also known as clove cigarettes. Cigarettes that contain a mixture of tobacco, cloves and other additives.
- at0089::Overall status - Statement about current smoking behaviour for all types of tobacco.
- at0091::Never smoked - Individual has never smoked the specified type of tobacco.
- at0093::Overall years of smoking - The cumulative number of years that the individual has smoked tobacco.

- at0094::Smoking index - An indication of the cumulative amount of tobacco smoking exposure.
- at0095::Type - The type of tobacco smoked by the individual.

transfusion_summary

Archetype ID: openEHR-EHR-EVALUATION.transfusion_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: __unknown__

Concepts:

- at0000::Transfusion summary - Transfusion summary.
- at0001::Item tree - @ internal @
- at0002::Status - None
- at0003::Never - None
- at0004::Past - None
- at0005::Transfusion event - None
- at0006::Blood product - None
- at0007::Transfusion date - None
- at0008::Organisation - None
- at0009::Comment - None
- at0010::Item tree - @ internal @
- at0011::Extension - None
- at0012::Last updated - None

transport_access_summary

Archetype ID: openEHR-EHR-EVALUATION.transport_access_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: en

Purpose: To record summary or persistent information about an individual's access, including barriers or difficulties in access, to transportation.

Use: Use to record issue and concerns about access to transportation in the broadest sense, including public or private transport, and especially in relation to their ability to access healthcare. Record as a single instance in a health record; updated and revised over time as a new version.

Keywords: public, transport, car, bus

Concepts:

- at0000::Transport access summary - Summary or persistent information about an individual's access, including barriers or difficulties in access, to transportation.
- at0001::Item tree - @ internal @
- at0002::Overall description - Narrative description about the overall transportation access and availability for the individual.
- at0003::Item tree - @ internal @
- at0004::Last updated - The date this transportation access summary was last updated.
- at0005::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.

vaccination_summary

Archetype ID: openEHR-EHR-EVALUATION.vaccination_summary.v0

Lifecycle State: in_development

Category: EVALUATION

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

Purpose: To record a summary of vaccine administration events targeting a single infectious disease or agent, or a group of infectious diseases or agents that are vaccinated simultaneously using a combination vaccine.

Use: Use to record a summary of vaccine administration events targeting a single infectious disease or agent, or a group of infectious diseases or agents that are vaccinated simultaneously using a combination vaccine. The intent of this archetype is to support a clinical determination about whether the individual is up-to-date with vaccinations for the targeted disease/s or agent/s. It is not intended to make a determination about the immunisation status, which is about whether the individual has developed an adequate

immune response following vaccination or whether protective immunity has waned. This archetype does not presume any particular schedule or protocol for immunisation.

Misuse: Not to be used to record the vaccination status of an individual at a point in time - use OBSERVATION.vaccination_status for this purpose. Not to be used for documenting the detailed administration of a vaccine, including body site, route, manufacturer and batch number etc - use ACTION.vaccination or ACTION.medication for this purpose. Not to be used for recording screening question/answer pairs regarding vaccination activity - use OBSERVATION.vaccination_screening for this purpose.

Keywords: immunisation, immunisation, immunization, summary, primary, course, booster

Concepts:

- at0000::Vaccination summary - Summary of vaccination administration for a single infectious disease or agent, or a group of infectious diseases or agents that are vaccinated simultaneously using a combination vaccine.
- at0001::Tree - @ internal @
- at0002::Targeted disease or agent - Name of the infectious disease or agent targeted by the vaccine.
- at0003::Primary course status - Status of the primary (or catch up) course of vaccinations.
- at0004::Course not commenced - A course of vaccinations is planned but not commenced.
- at0005::Course incomplete - A course of vaccinations has been commenced but not completed.
- at0006::Course complete - A course of vaccinations has been completed.
- at0007::Unknown - It is not possible to determine if the primary course has been completed.
- at0008::Date course completed - The date on which the (primary or catch-up) course of vaccines was completed.
- at0009::Date of last vaccination - The date when the most recent vaccine was administered.
- at0013::Tree - @ internal @
- at0015::Last updated - The date on which the immunisation summary was last updated.
- at0016::Administration comment - Additional narrative about the vaccine administration for the identified vaccinet, not captured in other fields.
- at0022::Per vaccine administration - Details about a specific vaccine administration.
- at0023::Specific vaccine name - Name of the specific vaccine administered.
- at0024::Date of administration - Date of administration of the specified vaccine.
- at0027::Administration location - None
- at0031::Sequence in series - The sequence of the vaccine administered within a primary course or series.

- at0033::Next vaccination due - The date when the next vaccine is due to be administered.
- at0034::Vaccine details - Details about the vaccine, including generic components and batch number if required.
- at0035::Description - Narrative description about vaccination activity and experiences related to the targeted disease or agent.
- at0038::Administration category - Category of the vaccine administered.
- at0039::Primary course - None
- at0040::Booster - None
- at0042::Description - Narrative description about the vaccine administration.
- at0044::Additional details - Additional details about the specific vaccine administration.
- at0045::Administration outcome - The observed response to the administration of vaccine.
- at0046::Information source - Identification of the source of the vaccine administration information.
- at0047::Total number of administrations - Total number of vaccine doses administered over the lifetime of the individual.
- at0048::Unknown - None
- at0049::Comment - Additional narrative about vaccination administrationfor the identified disease or agent, not captured in other fields.
- at0050::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0051::Additional details - Additional details about vaccinations related to the targeted disease or agent.
- at0052::Vaccine name - Name of the vaccine administered.
- at0053::Information source - Identification of the source of all vaccination information.

vaping_summary

Archetype ID: openEHR-EHR-EVALUATION.vaping_summary.v0

Lifecycle State: in_development

Category: EVALUATION

Languages: de, sv, nb, en

Purpose: To record summary information about the individual's pattern of vaping of substances and e-liquids.

Use: Use to record summary information about the individual's pattern of vaping of substances and e-liquids. This archetype is to be used to record information about both

current and previous vaping behaviour. Amount of nicotine has been excluded from the scope for the core archetype, but could be added into the Episode SLOT if required. The history of waxing and waning of use for each type of substance or e-liquid over time can be captured using the repeatable 'Per episode' cluster. Triggers for closing one episode and commencing a new one will largely reflect local data collection preferences, including if the individual: - quits for a significant period of time (which will likely be locally defined); or - significantly changes their amount of use or pattern of their vaping. Use to incorporate the narrative descriptions of vaping within existing or legacy clinical systems into an archetyped format, using the 'Overall description' data element.

Misuse: Not to be used to record summary-based information about tobacco smoking, such as the pattern of smoking habits - use the EVALUATION.tobacco_smoking_summary archetype. Not to be used to record event-or period-based information about tobacco smoking, such as actual daily use or the average use over a specified period of time - use the OBSERVATION.tobacco_smoking archetype. Not to be used to record summary-based information about smokeless tobacco use - for example: snus; snuff; chewing tobacco; dip; and gutka. Use the archetype EVALUATION.smokeless_tobacco_summary archetype for this purpose. Not to be used to record summary-based information about substance use - use the EVALUATION.substance_use_summary for this purpose. Not to be used to record evidence of nicotine dependency. Use the OBSERVATION.fagerstrom for this purpose. Not to be used to record details about unintended exposure to tobacco smoke or passive smoking. Use the archetype EVALUATION.exposure for this purpose. Not to be used for recording any other administration of nicotine, such as e-cigarettes, nicotine patches or nicotine chewing gum. Use separate archetypes for this purpose.

Keywords: electronic, cigarettes, e-cigs, cigs, nicotine, ENDS, ENNDS, ANDS, vaporisers, e-hookahs, hookahs, vape, pens, vapes, delivery

Concepts:

- at0000::Vaping summary - Summary or persistent information about the vaping habits of an individual.
- at0001::Tree - @ internal @
- at0003::Current vaper - Individual is a current vaper.
- at0005::Former vaper - Individual has previously vaped but is not a current vaper.
- at0006::Never vaped - Individual has never vaped any type of substance.
- at0013::Episode start date - Date when this episode commenced.
- at0014::Quit date - Date when the individual last vaped the specified substance or e-liquid.
- at0015::Regular vaping commenced - The date or partial date when the individual first started frequent or regular, but usually non-daily, vaping of any substance.
- at0016::Overall quit date - The date when the individual last ceased vaping of any substance or e-liquid.

- at0019::Overall comment - Additional narrative about all vaping that has not been captured in other fields.
- at0021::Tree - @ internal @
- at0022::Last updated - The date this vaping summary was last updated.
- at0023::???Typical use (units) - Estimate of number of units of the specified type of substance or e-liquid consumed.
- at0025::Number of quit attempts - Total number of times the individual has attempted to stop vaping the specified substance or e-liquid within this episode.
- at0026::Episode details - Additional structured details about the specified episode of vaping.
- at0029::Per substance - Details about vaping activity for a specified type of substance or e-liquid.
- at0030::Pattern - The typical pattern of vaping for the specified substance or e-liquid.
- at0043::Overall description - Narrative summary about the individual's overall vaping pattern and history.
- at0052::Status - Statement about current vaping behaviour for the specified substance or e-liquid.
- at0053::Description - Narrative summary about vaping behaviour for the specified substance or e-liquid.
- at0059::Former vaper - Individual has previously vaped the specified substance or e-liquid but is not a current vaper.
- at0061::Current vaper - Individual is a current vaper of the specified substance or e-liquid.
- at0064::Per episode - Details about a discrete period of vaping activity for the specified substance or e-liquid.
- at0069::Comment - Additional narrative about vaping of the specified substance or e-liquid, not captured in other fields.
- at0071::Quit date definition - The applied definition for the 'Quit date' data elements used in this archetype.
- at0073::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0075::Current vpaer definition - The applied definition for the 'Current vaper' value in each of the 'Status' data elements used in this archetype.
- at0076::Former vaper definition - The applied definition for the 'Former vaper' value in each of the 'Status' data elements used in this archetype.
- at0077::Substance details - Additional structured details about the specified type of substance or e-liquid vaped.
- at0079::Never vaped definition - The applied definition for the 'Never vaped' value in each of the 'Status' data elements used in this archetype.
- at0080::Daily vaping commenced - The date or partial date when the individual first started daily vaping of any substance.

- at0081::Episode label - Identification of an episode of vaping activity - either as a number in a sequence and/or a named event.
- at0082::Episode end date - Date when this episode ceased.
- at0083::Daily - Vaping the specified substance or e-liquid at least once every day.
- at0084::Non-daily - Not vaping the specified substance or e-liquid every day.
- at0085::Quit attempt definition - The applied definition for a Quit attempt used to determine value for the 'Number of quit attempts' data element used in this archetype.
- at0086::Overall details - Additional structured details about the overall vaping behaviour.
- at0087::Episode comment - Additional narrative about vaping during the specified episode, not captured in other fields.
- at0089::Overall status - Statement about current vaping behaviour for all types of substances.
- at0091::Never vaped - Individual has never vaped the specified substance or e-liquid.
- at0095::Substance name - The name of the substance or e-liquid vaped by the individual.