

Archetype Extraction Report for observation

abbey_pain_scale

Archetype ID: openEHR-EHR-OBSERVATION.abbey_pain_scale.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: sv, en

Purpose: To assess and record the severity of pain in cognitively impaired and non-verbal individuals.

Use: Use to assess and record the severity of pain in cognitively impaired and non-verbal individuals.

Keywords: dementia

Concepts:

- at0000::Abbey pain scale - Rapid tool to assess the severity of pain in cognitively impaired and non-verbal individuals.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Vocalization - None
- at0005::Facial expression - None
- at0006::Change in body language - None
- at0008::Physiological change - None
- at0009::Physical changes - None
- at0010::Absent - None
- at0011::Mild - None
- at0012::Moderate - None
- at0013::Severe - None
- at0014::Total pain score - The total sum of each component parameter for the Abbey pain scale.
- at0024::Tree - @ internal @
- at0025::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0007::Behavioural change - None

- at0015::Pain score category - Category of pain, based on the total score.
- at0016::No pain - Total pain score 0-2.
- at0017::Mild pain - Total pain score 3-7.
- at0018::Moderate pain - Total pain score 8-13.
- at0019::Severe pain - Total pain score 14+.
- at0020::Type of pain - None
- at0021::Chronic - None
- at0022::Acute - None
- at0023::Acute on chronic - None

[abcd2_score](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.abcd2_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To record the results of the ABCD2 assessment tool.

****Use:**** Use to record the results of the ABCD2 assessment tool.

****Keywords:**** ABCD, ABCD2, Stroke, TIA

****Concepts:****

- at0000::ABCD2 score - Tool to assess the risk of subsequent stroke in an individual presenting with a transient ischaemic attack (TIA).
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Age \geq 60 years - Is the person 60 years or older?
- at0005::Blood pressure elevation - Was the initial systolic pressure >140 mmHg and/or diastolic pressure ≥ 90 mmHg?
- at0007::Clinical features - What are the clinical features of the TIA?
- at0008::Diabetes history - Does the patient have a history of diabetes mellitus?
- at0009::Symptom duration - What is the duration of symptoms?
- at0010::Absent - *
- at0011::Present - *

- at0012::Absent - *
- at0013::Present - *
- at0014::Other symptoms - *
- at0015::Speech disturbance without focal weakness - *
- at0016::Unilateral weakness - *
- at0017::Absent - *
- at0018::Present - *
- at0019::<10 minutes - *
- at0020::10-59 minutes - *
- at0021::≥60 minutes - *
- at0022::Total score - Sum of the individual scores assigned for each of the contributing variables.
- at0023::Tree - @ internal @
- at0024::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[abc_score_massive_transfusion](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.abc_score_massive_transfusion.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To record the assessment and total of the Assessment of Blood Consumption (ABC) Score.

****Use:**** Use to record the assessment and total of the Assessment of Blood Consumption (ABC) Score.

****Keywords:**** trauma, transfusion

****Concepts:****

- at0000::Assessment of Blood Consumption (ABC) Score - Tool used as a rapid and initial assessment of the need for massive transfusion in acutely injured patients.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @

- at0004::Penetrating trauma - Did the patient's trauma involve a penetrating mechanism?
- at0005::No - No penetrating injury at assessment.
- at0006::Yes - Penetrating injury present at assessment.
- at0007::Systolic blood pressure (SBP) - What was the systolic blood pressure at initial assessment?
- at0008::>90 mmHg - SBP at initial assessment greater than 90 mmHg.
- at0009::≤90 mmHg - SBP at initial assessment less than or equals 90 mmHg.
- at0010::Heart rate - What was the heart rate at initial assessment?
- at0011::<120 /min - Heart rate at initial assessment less than 120 /min.
- at0012::≥120 /min - Heart rate at initial assessment greater than or equals 120 /min.
- at0013::Focused assessment with sonography for trauma (FAST) - What was the result of a FAST scan?
- at0014::Negative - Negative FAST scan.
- at0015::Positive - Positive FAST scan.
- at0016::Total score - Sum of the individual scores assigned for each of the contributing variables.
- at0017::Comment - Additional narrative about the ABC score, not captured in other fields.
- at0018::Tree - @ internal @
- at0019::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[abc_stroke_risk_score](#)

Archetype ID: openEHR-EHR-OBSERVATION.abc_stroke_risk_score.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en

Purpose: To record the component values and the total of the ABC-stroke risk score, plus the predicted risk values based on the total score.

Use: Use to record the component values and the total of the ABC-stroke risk score, plus the predicted risk values based on the total score.

Misuse: Not to be used to record the actual values of each component. Use separate archetypes for this purpose: OBSERVATION.age, OBSERVATION.laboratory_test_result and EVALUATION.problem_diagnosis for this purpose.

****Keywords:**** atrial fibrillation, stroke risk, systemic embolism risk

****Concepts:****

- at0000::ABC-stroke risk score - Biomarker-based risk assessment tool for predicting stroke in individuals with atrial fibrillation.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Prior stroke or transient ischaemic attack - Points assigned based on the presence or absence of a prior history of stroke or TIA in an individual.
- at0006::Age - Points assigned based on an individual's age.
- at0007::cTnT-hs - Points assigned based on an individual's plasma concentration of cardiac troponin-T high-sensitivity (or cardiac troponin-I high sensitivity).
- at0008::NT-proBNP - Points assigned based on an individual's plasma concentration of N-terminal fragment B-type natriuretic peptide.
- at0009::Total score - Sum of the points assigned for each of the contributing variables.
- at0012::Comment - Additional narrative about the score, not captured in other fields.
- at0013::Tree - @ internal @
- at0014::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0015::1-year risk - Predicted risk of developing a stroke or systemic embolism within 1 year based on ABC-stroke score.
- at0016::3-year risk - Predicted risk of developing a stroke or systemic embolism within 3 years based on ABC-stroke score.

[**acoustic_reflex_result**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.acoustic_reflex_result.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record measurements from an acoustic reflex test, and their interpretation by a clinician.

****Use:**** Use to record measurements from a single acoustic reflex test, for diagnostic or screening purposes. Ipsilateral testing, contralateral testing or both, can be recorded per

test ear. Use to record the interpretation of all measurements for each single ear test configuration, and an overall interpretation (or audiological diagnosis). Acoustic reflexes measure the eardrum movement generated by the stapedius and tensor tympani reflex in response to intense sound. The acoustic reflex threshold can be helpful in checking for particular types of hearing loss in situations where patient reliability is questionable. Acoustic reflex testing can also be done as part of a battery of tests to investigate central nervous system pathology, although this usage is now uncommon.

****Keywords:**** hearing, test, acoustic, reflex, decibels

****Concepts:****

- at0000::Acoustic reflex test result - Record of measurements from an acoustic reflex test, and their clinical interpretation.
- at0001::Event Series - @ internal @
- at0002::Any Point-in-time Event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Test Result Name - Identification of the acoustic reflex test performed.
- at0005::Acoustic Reflex Test - Test of the reflex elicited from the stapedius muscle in response to an acoustic stimulus.
- at0006::Non Acoustic Reflex Test - Test of the reflex elicited from the stapedius muscle in response to a non-acoustic stimulus e.g. tactile or orbital air-jet.
- at0007::Result Details - The test measurements and interpretations which can be recorded per ear, and includes ipsilateral and contralateral testing.
- at0008::Test Ear Configuration - Identification of the ear to which the stimulus is presented and the ear where the probe is situated.
- at0009::Left Ipsilateral - Stimulus presented to the left ear; probe is situated in left ear.
- at0010::Right Ipsilateral - Stimulus presented to the right ear; probe is situated in right ear.
- at0011::Left Contralateral - Stimulus presented to the left ear; probe is situated in right ear.
- at0012::Right Contralateral - Stimulus presented to the right ear; probe is situated in left ear.
- at0013::Diagnostic Test - Reflex test that measures threshold levelss, reflex latency, reflex amplitude and reflex decay.
- at0014::Screening Result - Reflex test that identifies the presence or absence of a reflex at a predetermined stimulation level.
- at0015::Result - Result of the test.
- at0016::Present - The reflex has been observed as present.
- at0017::Absent - The reflex has not been observed.
- at0018::No Screening Result - No screening test result is available for the test ear configuration.

- at0019::Reason For No Test Result - Reason why no screening test result is available for the test ear configuration.
- at0020::Threshold Level - The lowest stimulation level at which a reflex could be measured by the probe.
- at0021::Clinical Interpretation - Clinical interpretation of all diagnostic results for the specified test ear configuration.
- at0022::Test Signal - Identification of the stimulation signal used for the test.
- at0023::Broad Band Noise - Noise with components over a wide range of frequencies.
- at0024::Narrow Band Noise - Noise centred on a specified frequency.
- at0025::Pure Tone - 500 Hz - A pure tone signal set at 500Hz.
- at0026::Pure Tone - 1000 Hz - A pure tone signal set at 1000Hz.
- at0027::Pure Tone - 2000Hz - A pure tone signal set at 2000Hz.
- at0028::Pure Tone - 4000Hz - A pure tone signal set at 4000Hz.
- at0029::Reflex Latency - Length of time from onset of the stimulation tone to the onset of the middle ear muscle reflex.
- at0030::Reflex Decay - Length of time that the reflex amplitude can be sustained.
- at0031::No Diagnostic Result - No diagnostic test result is available for the test ear configuration.
- at0032::Reason For No Test Result - Reason why no diagnostic test result is available for the test ear configuration.
- at0033::Overall Interpretation - Overall clinical interpretation of all of the results.
- at0034::Intensity - Clinical interpretation of reflex threshold during diagnostic testing, based on intensity.
- at0035::Result - The result of the test.
- at0036::Comment - Additional narrative about the test results and interpretation not captured in other fields.
- at0037::Test Result Image - Digital representation of the entire result.
- at0038::Normal Range - The intensity range in dB at which a reflex is expected in a normal hearing ear.
- at0039::Absent - No reflex was elicited in response to a stimulation tone.
- at0040::Elevated - Reflex was elicited at an elevated stimulation level.
- at0041::Sensation Level - Clinical interpretation of reflex Threshold Level result based on sensation level.
- at0042::Normal - The reflex was observed at a sensation level expected in a normal hearing ear.
- at0043::Reduced - The reflex was observed at a reduced sensation level compared to a normal hearing ear.
- at0044::Elevated - The reflex was observed at a higher sensation level than expected for a normal hearing ear.
- at0045::Absent - No reflex was elecited in response to a stimulation tone.
- at0046::Clinical Interpretation - Clinical interpretation of the screening test result.
- at0047::Tree - @ internal @

- at0048::Calibration Reference dB - Scale used for acoustic calibration of the test signal.
- at0049::dB SPL - The test stimuli are calibrated using the sound pressure level scale.
- at0050::dB HL - The test stimuli are calibrated using the hearing level scale.
- at0051::Criteria for Screening Assessment Pass - The criteria by which the Screening Assessment is passed.
- at0052::Intensity - The loudness of the screening stimulus.
- at0053::Frequency - The frequency of the test signal.
- at0054::Test Signal Type - The type of stimulation used to elicit a reflex.
- at0055::Immittance Machine - Details of immittance machine used to conduct the test.
- at0056::Confounding Factors - Description of incidental factors that may be contributing to the test result.
- at0057::Comment - Additional narrative about the method of testing not captured in other fields.
- at0058::Probe Tone Frequency - The frequency of the probe tone.
- at0059::226Hz - The probe tone frequency was set at 226Hz.
- at0060::1000Hz - The probe tone frequency was set at 1000Hz.
- at0061::Normal Range Definition - Definition of the 'Normal Range' value specified within the Intensity data element used for Clinical Interpretation of the Diagnostic Test.
- at0062::Tree - @ internal @
- at0063::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

acvpu

****Archetype ID:**** openEHR-EHR-OBSERVATION.acvpu.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

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

****Purpose:**** To record an individual's level of consciousness.

****Use:**** Use to make a simple assessment of an individual's level of consciousness, especially suitable for assessment in emergency situations. This scale is a refinement of the original AVPU, updated in 2017 by adding 'C', where C represents 'a new onset or worsening confusion, delirium or any other altered mentation'. This scale is now published as a component of NEWS2.

****Keywords:**** avpu, alert, voice, pain, unresponsive, awake, speech, pain, unconscious, consciousness, verbal, semicomatose, conscious, level of consciousness, comatose, confusion, news2

****Concepts:****

- at0000::ACVPU scale - Simple scale used as part of an assessment to measure and record an individual's level of consciousness.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::ACVPU - The assessment of the patient's level of consciousness.
- at0005::Alert - Fully awake. Spontaneous opening of the eyes, responds to voice and have motor function.
- at0006::Voice - Any verbal, motor or eye response to a voice stimulus.
- at0007::Pain - Any verbal, motor or eye response to a pain stimulus.
- at0008::Unresponsive - No response to voice or pain stimuli.
- at0009::Tree - @ internal @
- at0011::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0013::Tree - @ internal @
- at0015::Confusion - A new onset or worsening confusion, delirium or any other altered mentation.

[adverse_reaction_monitoring](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.adverse_reaction_monitoring.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To record information about the outcome of monitoring for adverse reactions, during or after the administration of a substance.

****Use:**** Use to record information about the outcome of monitoring for adverse reactions, during or after the administration of a substance. This can include both immune mediated or non-immune mediated reactions. This archetype has been designed to capture whether a reaction occurred after administration of an agent to an individual. This includes but is not

limited to monitoring during or after vaccinations, chemotherapy, or blood transfusions. It includes details about any mitigation efforts in the context of administration, such as corticosteroid cover, or ICU admission. Details about a reaction that occurred can be recorded using the CLUSTER.reaction_event archetype in the 'Reaction event' SLOT.

****Misuse:**** Not to be used to record a propensity of the individual to have adverse reactions to specific substances or groups or classes of substances. Use the EVALUATION.adverse_reaction_risk archetype for this purpose. Not to be used to record the result of the administration of a substance with the intention of provoking a reaction, for example Mantoux or skin prick tests. Use other appropriate OBSERVATION archetypes for this purpose. Not to be used to record details about an adverse reaction event. Use the CLUSTER.adverse_reaction_event archetype for this purpose.

****Concepts:****

- at0000::Adverse reaction monitoring - Information about the outcome of monitoring for adverse reactions, during or after the administration of a substance.
- at0001::History - @ internal @
- at0002::Monitoring interval - The interval of time from onset of monitoring to end of monitoring.
- at0003::Tree - @ internal @
- at0004::Substance - Identification of a substance administered to the individual.
- at0005::Reaction? - Was there a reaction to the agent administered?
- at0006::Yes - The individual reacted.
- at0007::No - The individual did not react.
- at0008::Comment - Additional narrative about the monitoring, not captured in other fields.
- at0009::Item tree - @ internal @
- at0010::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0011::Mitigation factor - Description of actions undertaken prior to or during substance administration to prevent an anticipated reaction or reduce an actual reaction.
- at0012::Item tree - @ internal @
- at0013::Purpose - The reason why the reaction monitoring was carried out.
- at0014::Substance details - Structured details about the substance administered to the individual.
- at0015::Indeterminate - It cannot be determined whether the individual reacted or not.
- at0016::Reaction event - Details about the adverse reaction event.
- at0017::Method - The method of how the presence or absence of an adverse reaction was assessed.

adverse_reaction_screening

****Archetype ID:**** openEHR-EHR-OBSERVATION.adverse_reaction_screening.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about adverse reactions.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about past adverse reactions. This archetype has deliberately been loosely modelled to be inclusive of the broadest range of adverse reactions, including but not limited to allergies, sensitivities, intolerances and side effects which warrant avoiding exposure to the identified substance. Common use cases include, but are not limited to: - Systematic questioning in any consultation, for example: --- Allergy to penicillin? Yes, No, Unknown, Unsure. --- Reaction to sticking plasters? Yes, No, Unknown, Unsure. The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. Use a separate instance of this archetype to distinguish between a questionnaire recording information about an adverse reaction that has occurred at any time in the past and information about an adverse reaction which occurred within a specified time interval - for example the difference between "Do you have any allergies?" compared to "Have you had any reactions to any medications in the last four weeks?" The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies the presence of a adverse reaction, it is recommended that clinical system record and persist the specific details about the adverse reaction (such as the date of clinical recognition) using the EVALUATION.adverse_reaction_risk archetype.

****Misuse:**** Not to be used to record details about the presence or absence of an adverse reaction, outside of a screening context. Use openEHR-EHR-EVALUATION.adverse_reaction_risk.v2 or EVALUATION.exclusion_specific for these purposes.

****Keywords:**** Condition, state, illness, syndrome, questionnaire, screening, issue

****Concepts:****

- at0000::Adverse reaction screening questionnaire - Series of questions and associated answers used to screen for adverse reactions.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Substance name - Identification of a substance, or substance class, that the individual may have had prior reactions to.
- at0005::Presence? - Is there a history of adverse reactions to the 'Substance name', relevant to the screening purpose?
- at0007::Item tree - @ internal @
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0022::Specific adverse reaction - Details about a specific adverse reaction to an identified substance, or substance class or grouping, relevant for the screening purpose.

- at0025::Comment - Additional narrative about the specific adverse reaction question, not captured in other fields.
- at0028::Any adverse reactions? - Is there a history of any adverse reactions relevant for the screening purpose?
- at0034::Screening purpose - The context or reason for screening.
- at0039::Additional details - Structured details or questions about the specific adverse reaction.
- at0040::Onset - Timing of the initial recognition of the adverse reaction.
- at0042::Additional details - Structured details or questions about screening for adverse reactions.
- at0043::Description - Narrative description about the history of any adverse reactions relevant for the screening purpose.
- at0044::Yes - None
- at0045::No - None
- at0046::Unknown - None
- at0047::Unsure - None
- at0052::Yes - None
- at0053::No - None
- at0054::Unknown - None
- at0055::Unsure - None

aedes_indices

****Archetype ID:**** openEHR-EHR-OBSERVATION.aedes_indices.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the parameters used to monitor the population density and breeding rate of Aedes mosquitoes.

****Use:**** Use to record parameters used to monitor the population density and breeding rate of Aedes mosquitoes, as vectors for Dengue fever, Zika virus, Chikungunya and Yellow fever.

****Keywords:**** aedes, mosquito, dengue, ovitrap

****Concepts:****

- at0000::Aedes indices - Public health parameters used to monitor the population density and breeding rate of Aedes mosquitoes.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Location category - The category or type of location being monitored.
- at0006::Breteau index (BI) - The number of positive containers per 100 houses.
- at0007::House index (HI) - The percentage of houses or premises infested with larvae and/or pupae.
- at0008::Container index (CI) - The percentage of water-holding containers infested with larvae or pupae.
- at0009::Ovitrap index (OI) - The percentage of ovitrap devices that contain eggs or larvae.
- at0010::Extension - None
- at0005::ITEM_TREE - None

affected_body_surface_area-burn

****Archetype ID:**** openEHR-EHR-OBSERVATION.affected_body_surface_area-burn.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record details about the estimated proportion of body surface area affected by a burn injury.

****Use:**** Use to record details about the estimated proportion of body surface area affected by a burn injury, including the total body surface area affected, the body surface area affected per body site and the body surface area affected per severity. This archetype has been designed as a component of a templated full burn assessment which may comprise a range of ENTRY archetypes and nested CLUSTERS, describing the history, physical examination findings, and other measurements.

****Misuse:**** Not to be used to record the measured or calculated body surface area of an individual - use the OBSERVATION.body_surface_area for this purpose. Not to be used to record the estimated proportion of body surface area affected by other conditions of the skin - use the parent archetype OBSERVATION.affected_body_surface_area for this purpose.

****Keywords:**** TBSA, BSA, burn, surface, area, burns, assessment, Lund-Browder, skin, rule, nines, palmar, method, TBSA%

****Concepts:****

- at0000.1::Burn-affected body surface area - Estimation of the proportion of body surface area affected by a burn.
- at0004.1::Condition name - The name of the injury or disease affected the skin.
- at0.1::Burn - The condition is a burn.
- at0.2::Cause of burn - The aetiology of the burn.
- at0000::Affected body surface area - Estimation of the proportion of body surface area affected by a skin injury or disease.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Condition name - The name of the injury or disease affected the skin.
- at0005::Description - Narrative description about the affected body surface area assessment.
- at0006::Per body site - Details about body surface area affected at each body site.
- at0007::Body site name - The name of the body site assessed.
- at0008::Site surface area - The estimated percentage of total body surface area apportioned for the entire identified body site.
- at0009::Item tree - @ internal @
- at0010::Affected site surface area - The estimated extent of total body surface area affected at the identified body site.

- at0011::Per severity - Details about each severity of findings at the identified body site.
- at0012::Severity - The degree of severity of the condition at the identified site.
- at0013::Affected site surface area - The estimated extent of total body surface area affected by the degree of identified severity, at the identified body site.
- at0014::Total body surface area (TBSA) affected - The total sum of affected surface area across all body sites.
- at0015::Total body surface area per severity - Details about the total sum of surface area affected per severity, across all body sites.
- at0016::Severity - The degree of severity of the condition.
- at0017::Total body surface area affected - The total sum of body surface area affected by the degree of the identified severity, across all body sites.
- at0018::Additional detail - Additional details about the estimation of affected body surface area.
- at0019::Image representation - Digital image, video or diagram representing the affected body surface area findings.
- at0020::Comment - Additional narrative about the estimation of affected body surface area, not captured in other fields.
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

affected_body_surface_area

****Archetype ID:**** openEHR-EHR-OBSERVATION.affected_body_surface_area.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record details about the estimated proportion of body surface area affected by a skin injury or disease.

****Use:**** Use to record details about the estimated proportion of body surface area affected by a skin injury or disease, including the total body surface area affected, the body surface area affected per body site and the body surface area affected per severity.

****Misuse:**** Not to be used to record the measured or calculated body surface area of an individual - use the OBSERVATION.body_surface_area for this purpose.

****Keywords:**** TBSA, BSA, burn, rash, psoriasis

****Concepts:****

- at0000::Affected body surface area - Estimation of the proportion of body surface area affected by a skin injury or disease.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Condition name - The name of the injury or disease affected the skin.
- at0005::Description - Narrative description about the affected body surface area assessment.
- at0006::Per body site - Details about body surface area affected at each body site.
- at0007::Body site name - The name of the body site assessed.
- at0008::Site surface area - The estimated percentage of total body surface area apportioned for the entire identified body site.
- at0009::Item tree - @ internal @
- at0010::Affected site surface area - The estimated extent of total body surface area affected at the identified body site.
- at0011::Per severity - Details about each severity of findings at the identified body site.
- at0012::Severity - The degree of severity of the condition at the identified site.
- at0013::Affected site surface area - The estimated extent of total body surface area affected by the degree of identified severity, at the identified body site.
- at0014::Total body surface area (TBSA) affected - The total sum of affected surface area across all body sites.
- at0015::Total body surface area per severity - Details about the total sum of surface area affected per severity, across all body sites.
- at0016::Severity - The degree of severity of the condition.
- at0017::Total body surface area affected - The total sum of body surface area affected by the degree of the identified severity, across all body sites.
- at0018::Additional detail - Additional details about the estimation of affected body surface area.
- at0019::Image representation - Digital image, video or diagram representing the affected body surface area findings.
- at0020::Comment - Additional narrative about the estimation of affected body surface area, not captured in other fields.
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[**agatston_score**](#)

Archetype ID: openEHR-EHR-OBSERVATION.agatston_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each vessel distribution and their total sum for the Agatston score.

****Use:**** Use to record the results for each vessel distribution and their total sum for the Agatston score.

****Keywords:**** Noncontrast computed tomography, CT scan, Coronary artery calcium, CAC, Coronary calcium scoring

****Concepts:****

- at0000::Agatston score - An assessment score used to quantify and measure coronary artery calcium, usually as part of a preliminary noncontrast examination for coronary artery and other cardiac structural calcification to estimate risk of cardiovascular diseases.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Item tree - @ internal @
- at0010::Percentile - Calcium score percentile based on database representative of the cohort being assessed. This item indicates the percentage of people that have higher score compared to the age, gender, and race matched peers.
- at0012::Risk classification - Overall risk classification based on the total score.
- at0013::Technical details - Structured technical parameters of the imaging examination in which the score was measured.
- at0014::Very low - Score = 0.
- at0015::Mildly increased - Score = 1 - 99.
- at0016::Moderately increased - Score = 100 - 299.
- at0017::Moderate to severely increased - Score >= 299.
- at0018::LM - Left main coronary artery calcium score.
- at0019::LAD - Left anterior descending artery calcium score.
- at0020::LCx - Left circumflex artery calcium score.
- at0021::RCA - Right coronary artery calcium score.
- at0022::Total - The score of all individual calcified lesions in all coronary arteries extending through the z-axis of the heart is summed up to give the total coronary artery calcium score.

age_assertion

****Archetype ID:**** openEHR-EHR-OBSERVATION.age_assertion.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en, fr, ca

****Purpose:**** To record a statement about the age of an individual at a point in time, as clinical context for the other information in the same COMPOSITION.

****Use:**** Use to record a statement about the age of an individual at a point in time, as clinical context for the other information in the same COMPOSITION. This archetype is structured to support the recording of either chronological or adjusted age independently, while also providing the capability to record both simultaneously for comparison purposes. Both the Chronological age and Adjusted age are calculated based on actual or estimated dates of birth and/or due date. The EVENT structure from the reference model can be used to specify whether the age assertion relates to a current point in time or a historical point in time. Use cases include, but are not limited to: - simultaneously record the chronological age and adjusted age alongside child growth parameters; - record the age of an individual at the time of recording as context for the other content in a document, such as the age of a child at the time of referral; - record the age of the mother (designated as the subject of care at ENTRY level) at the time of recording within a newborn's record; or - the age of an individual at the time of filling out a health assessment questionnaire. - the basis for calculated reference values for physiological measurements. For example in the CHA₂DS₂-VASc score archetype.

****Misuse:**** Not to be used to display the individual's current age in the user interface of an electronic health record. Use a formal patient registry or archetypes based on the openEHR demographic information model for this purpose. Not to be used to record skeletal age, use OBSERVATION.skeletal_age for this purpose. Not to be used to record the estimate or known period or duration of the pregnancy or gestational age of the foetus or new born, use OBSERVATION.gestational_age_assertion for this purpose. Not to be used to record the Biological age, which refers to the condition of an individual's body systems, indicating how well or poorly the body is functioning relative to the expected norm for their chronological age - use appropriate archetypes for this purpose. Not to be used to record an assessment of the mental, cognitive or developmental age, or similar assessments, which refers to the age that reflects an individual's functions and abilities. Use an appropriate archetype for this purpose. Not to be used to record an estimated age in a forensic report or for an unconscious individual - use an appropriate archetype for this purpose.

****Keywords:**** chronological, corrected, adjusted, age

****Concepts:****

- at0000::Age assertion - A statement about the age of an individual at a point in time.
- at0001::Event Series - @ internal @
- at0002::Point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Chronological age - The age of an individual at the event time, calculated from date of birth.
- at0005::Adjusted age - The age of a premature infant, calculated from their expected due date rather than their actual date of birth.
- at0006::Comment - Additional narrative about the age of an individual, not captured in other fields.
- at0008::Item tree - @ internal @
- at0009::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[**air_score**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.air_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To assist the diagnosis and prediction of severity of suspected acute appendicitis.

****Use:**** Use to assist the diagnosis and prediction of severity of suspected acute appendicitis. AIR is an acronym for Appendicitis Inflammatory Response and consists of seven components, each contributing points to the total score generating an estimated probability as well as a recommendation based on the risk level; - Vomiting 0-1 - Pain in right inferior fossa 0-1 - Rebound tenderness or muscular defense 0-3 - Body temperature ≥ 38.5 0-1 - Neutrophils 0-2 - White blood cell count 0-2 - CRP 0-2 The tool has a maximum score of 12 points, and the result is associated with one of three categories estimating probability along with a recommendation on appropriate action; Sum 0-4 - low probability. Consider outpatient follow-up if unaltered general condition. Sum 5-8 - indeterminate group. Consider in-hospital active observation with rescore and/or further examination in accordance with local tradition. Sum 9-12 - high probability. Consider surgical exploration.

****Keywords:**** AIR Score, appendicitis inflammatory response score, appendicitis, surgery

****Concepts:****

- at0000::Appendicitis Inflammatory Response (AIR) Score - Tool to assist the diagnosis and prediction of severity of suspected acute appendicitis.
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0004::Vomiting - *
- at0005::Pain in right inferior fossa - *
- at0006::Rebound tenderness or muscular defense - *
- at0007::Body temperature ≥ 38.5 C - *
- at0008::No - *
- at0009::Yes - *
- at0010::No - *
- at0011::Yes - *
- at0012::None - *
- at0013::Light - *
- at0014::Medium - *
- at0015::Strong - *
- at0016::No - *
- at0017::Yes - *
- at0021::Total score - The sum of each ordinal score recorded for each of the seven component responses.
- at0025::Neutrophils, % - *
- at0026::WBC count, $\times 10^9/L$ - *
- at0027::CRP level, mg/L - *
- at0028::<70% - *
- at0029::70-84% - *
- at0030:: $\geq 85\%$ - *
- at0031::<10 - *
- at0032::10-14,9 - *
- at0033:: ≥ 15 - *
- at0034::<10 - *
- at0035::10-49 - *
- at0036:: ≥ 50 - *
- at0037::Tree - @ internal @
- at0038::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

alcohol_audit

****Archetype ID:**** openEHR-EHR-OBSERVATION.alcohol_audit.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, en

****Purpose:**** To identify individuals with hazardous and harmful patterns of alcohol consumption, indicators of alcohol dependence and some consequences from harmful drinking.

****Use:**** Use to record the results of the AUDIT screening test (or the AUDIT-C subset) as a means to identify individuals with hazardous and harmful patterns of alcohol consumption, indicators of alcohol dependence and some consequences from harmful drinking. The test can be administered during an oral interview or as a self-reported questionnaire. Each of the questions in the AUDIT test will be recorded as a separate data element. For pragmatic reasons, in this archetype, each data element is not labelled as the full question, but as a summary of the question topic. The full question to which each data element refers is identified in the 'Description' for each data element. For example: "How often did you have six or more drinks on one occasion in the past year?" is represented as the 'Bingeing' data element. The AUDIT-C test is a shortened version of the full AUDIT test, using only the first three questions related to consumption.

****Misuse:**** Not to be used to record a diary of alcohol consumption - use OBSERVATION.alcohol_use. Not to be used to record an overview of the individual's pattern of alcohol consumption - use the EVALUATION.alcohol_consumption_summary for this purpose.

****Keywords:**** AUDIT, AUDIT-C, alcohol, binge

****Concepts:****

- at0000::Alcohol Use Disorders Identification Test (AUDIT) - Ten question screening test to identify harmful alcohol consumption.
- at0001::Event Series - @ internal @
- at0002::Any point in time - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Frequency of consumption - How often did you have a drink containing alcohol in the past year?
- at0005::Never - No drinking of alcohol in the past year.
- at0006::Monthly or Less - Drinking alcohol monthly or less frequently during the past year.

- at007::2 to 4 Times a Month - Drinking alcohol two to four times a month during the past year.
- at008::2 to 3 Times a Week - Drinking alcohol two to three times a week during the past year.
- at009::4 or More Times a Week - Drinking alcohol four or more times a week during the past year.
- at010::Typical consumption - How many drinks did you have on a typical day when you were drinking in the past year?
- at011::1 or 2 - One or two drinks of alcohol on a typical day in the past year.
- at012::3 or 4 - Three or four drinks of alcohol on a typical day in the past year.
- at013::5 or 6 - Five or six drinks of alcohol on a typical day in the past year.
- at014::7 to 9 - Seven, eight or nine drinks of alcohol on a typical day in the past year.
- at015::10 or More - Ten or more drinks of alcohol on a typical day in the past year.
- at016::Binge drinking - How often did you have six or more drinks on one occasion in the past year?
- at017::Never - Never, in the past year.
- at018::Less than Monthly - Less than monthly, during the past year.
- at019::Monthly - Monthly, during the past year.
- at020::Weekly - Weekly, during the past year.
- at021::Daily or Almost Daily - Daily, or almost daily, during the past year.
- at022::AUDIT total score - Total Score calculated from the 10 AUDIT questions.
- at023::Inability to stop - How often during the last year have you found that you were not able to stop drinking once you had started?
- at024::Failed expectations - How often during the last year have you failed to do what was normally expected of you because of drinking?
- at025::Morning drinking - How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
- at026::Guilt/remorse - How often during the last year have you had a feeling of guilt or remorse after drinking?
- at027::Loss of memory - How often during the last year have you been unable to remember what happened the night before because of your drinking?
- at028::Injuries - Have you or someone else been injured because of your drinking?
- at029::External concern - Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?
- at030::No - No occurrence.
- at031::Yes, but not in the last year. - Yes, this has occurred, but not in the last year.
- at032::Yes, during the last year. - Yes this has occurred during the last year.
- at033::AUDIT-C total score - Total Score calculated from the first 3 questions only.
- at034::Comment - Additional narrative about the screening test, not captured in other fields.
- at035::Tree - @ internal @

- at0036::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

alcohol_intake

Archetype ID: openEHR-EHR-OBSERVATION.alcohol_intake.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: pt-br, en

Purpose: To record details about actual consumption of alcohol at a specified point in time or over an identified period of time.

Use: Use to record details about actual consumption of alcohol and associated behaviour at a specified point in time or over an identified period of time. An alcohol consumption diary could be built up over time by recording the consumption of alcohol on multiple, sequential days - recording actual consumptions using the 'Specified Day' event for each daily entry. A record of average alcohol use during a period can be recorded by recording the amount of alcohol consumed using the 'Average use' event - the mean use over a specified period of time. Data that might be used to assess the risk of alcohol abuse or dependence will be recorded using two archetypes: this OBSERVATION archetype (recording the repeatable observations/measurements) and in the EVALUATION.alcohol_consumption_summary archetype (recording the summary and persisting data). Binge drinking is not directly referred to in this archetype, yet this archetype will be a key resource used to support the identification of binge drinking through the accurate recording of the amount and frequency of drinking, triggers and social/cultural context of consumption. The assessment of 'binge drinking' may be recorded as part of a 'Problem List'.

Misuse: Not to be used for recording persistent, summary details about typical patterns of alcohol drinking. Use the EVALUATION.alcohol_consumption_summary archetype for this purpose. Not to be used to record an assessment about alcohol dependence. Use specific archetypes for this purpose, for example the AUDIT assessment - openEHR-EHR-OBSERVATION.alcohol_audit. Not to be used to record information about consumption of other substances other than alcohol.

Keywords: alcohol, beer, wine, spirits, fortified, consumption, use, abuse, binge

Concepts:

- at0000::Alcohol intake - Actual intake or consumption of alcohol.

- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Per type - Details about consumption of a specified type of alcoholic beverage.
- at0006::Specific type - Specific type of alcohol consumed, if required.
- at0014::Standard drinks consumed - Number of standard drinks of this type of alcohol consumed.
- at0016::Grams consumed - Grams of alcohol consumed.
- at0017::Triggers - Narrative description about triggers which may increase consumption of this form of alcohol.
- at0018::Context - Narrative description about the social or cultural context in which this form of alcohol is consumed.
- at0019::Evidence of dependence - Narrative description about any behavioural issues that may indicate alcohol abuse or dependence.
- at0021::Comment - Additional narrative about the individual's consumption of alcohol, not captured in other fields.
- at0022::Average intake - Average, or typical, consumption over a specified time interval. For example, allows recording of average number of standard drinks consumed per week for the previous 10 years.
- at0023::Specified day - Actual alcohol consumption on a specified day. Supports recording consumption in a Alcohol Diary.
- at0024::Tree - @ internal @
- at0025::Standard drink definition - Amount of alcohol defining a standard drink.
- at0027::Readiness for change - Details about readiness to change consumption of alcohol.
- at0028::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0029::Beer - Fermented beverage made from grain mash.
- at0030::Wine - Fermented beverage made from grapes and sometimes other fruits.
- at0031::Cider - Fermented beverage made from any fruit juice.
- at0032::Mead - Fermented beverage made from honey, sometimes with various fruits spices, grains or hops.
- at0033::Pulque - Fermented beverage made from 'honey water" of cacti.
- at0034::Spirits - Fermented beverage made by a distillation process. Usually has an alcohol content >20%. Includes liquors, cocktails and rectified spirits.
- at0035::Fortified wine - Wine with added spirits.
- at0036::Description - Narrative description about the consumption of the type of alcohol.
- at0037::Overall description - Narrative description about the consumption of the all types of alcohol.

- at0038::Standard drinks consumed - Number of standard drinks of all alcohol consumed.

alдрete_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.alдрete_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter and their total sum for the Aldrete score.

****Use:**** Use to record the results for each component parameter and their total sum for the Aldrete score.

****Keywords:**** Aldrete, score, recovery, anesthesia, PACU, post-anesthesia, care, unit, discharge

****Concepts:****

- at0000::Aldrete score - An assessment score used to evaluate recovery after anaesthesia and patient readiness to be discharged from a post-anaesthesia care unit (PACU).
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Activity - None
- at0005::Unable to move extremities voluntarily or on command - None
- at0006::Able to move 2 extremities voluntarily or on command - None
- at0007::Able to move 4 extremities voluntarily or on command - None
- at0008::Respiration - None
- at0009::Apnoeic - None
- at0010::Dyspnoea or limited breathing - None
- at0011::Able to breathe deeply and cough freely - None
- at0012::Circulation - None
- at0013::BP ±50% of pre-anaesthetic level - None
- at0014::BP between 20-49% of pre-anaesthetic level - None
- at0015::BP ±20% of pre-anaesthetic level - None
- at0016::Consciousness - None

- at0017::Not responding - None
- at0018::Arousable on calling - None
- at0019::Fully awake - None
- at0020::Colour - None
- at0021::Cyanotic - None
- at0022::Pale, dusky, blotchy, jaundiced, or other - None
- at0023::Normal - None
- at0024::Total score - The total sum of each component parameter for the Aldrete score.
- at0025::Item tree - @ internal @
- at0026::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[**alsfrs_r**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.alsfrs_r.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter and the ALSFRS-R score.

****Use:**** Use to record the results for each component parameter and the ALSFRS-R score.

****Keywords:**** amyotrophic, lateral, sclerosis, ALS, respiratory

****Concepts:****

- at0000::Revised Amyotrophic Lateral Sclerosis Functional Rating Scale (ALSFRS-R) - An assessment score used to stratify severity of amyotrophic lateral sclerosis (ALS), including respiratory function.
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0004::Speech - *
- at0005::Loss of useful speech - *
- at0006::Speech combined with nonvocal communications - *
- at0007::Intelligible with repeating - *
- at0008::Detectable speech disturbance - *
- at0009::Normal - *

- at0010::Salivation - *
- at0011::Marked drooling; requires constant tissue or handkerchief - *
- at0012::Marked excess of saliva with some drooling - *
- at0013::Moderately excessive saliva; may have minimal drooling - *
- at0014::Slight but definite excess of saliva in mouth; may have nighttime drooling - *
- at0015::Normal - *
- at0016::Swallowing - *
- at0017::Nothing by mouth; exclusively parenteral or enteral feeding - *
- at0018::Needs supplemental tube feedings - *
- at0019::Dietary consistency changes - *
- at0020::Early eating problems; occasional choking - *
- at0021::Normal eating habits - *
- at0022::Handwriting - *
- at0023::Unable to grip pen - *
- at0024::Able to grip pen but unable to write - *
- at0025::Not all words are legible - *
- at0026::Slow or sloppy; all words are legible - *
- at0027::Normal - *
- at0028::Patients with gastrostomy and >50% daily nutrition intake via G-tube - *
- at0029::Yes - *
- at0030::No - *
- at0031::Cutting food and handling utensils (patients with gastrostomy) - *
- at0032::Unable to perform any aspect of task - *
- at0033::Provides minimal assistance to caregiver - *
- at0034::Some help needed with closures and fasteners - *
- at0035::Clumsy but able to perform all manipulations independently - *
- at0036::Normal - *
- at0037::Dressing and hygiene - *
- at0038::Total dependence - *
- at0039::Needs attendant for self-care - *
- at0040::Intermittent assistance or substitute methods - *
- at0041::Independent and complete self-care with effort or decreased efficiency - *
- at0042::Normal function - *
- at0043::Turning in bed and adjusting bed clothes - *
- at0044::Helpless - *
- at0045::Can initiate but not turn or adjust sheets alone - *
- at0046::Can turn alone or adjust sheets but with great difficulty - *
- at0047::Somewhat slow and clumsy but no help needed - *
- at0048::Normal - *
- at0049::Walking - *
- at0050::No purposeful leg movement - *
- at0051::Nonambulatory functional movement - *

- at0052::Walks with assistance - *
- at0053::Early ambulation difficulties - *
- at0054::Normal - *
- at0055::Climbing stairs - *
- at0056::Cannot do - *
- at0057::Needs assistance - *
- at0058::Mild unsteadiness or fatigue - *
- at0059::Slow - *
- at0060::Normal - *
- at0061::Dyspnea - *
- at0062::Significant difficulty, considering using mechanical respiratory support - *
- at0063::Occurs at rest, difficulty breathing when either sitting or lying - *
- at0064::Occurs with one or more of the following eating, bathing, dressing - *
- at0065::Occurs when walking - *
- at0066::None - *
- at0067::Orthopnea - *
- at0068::Unable to sleep - *
- at0069::Can only sleep sitting up - *
- at0070::Needs extra pillows in order to sleep (>2) - *
- at0071::Some difficulty sleeping at night due to shortness of breath; does not routinely use >2 pillows - *
- at0072::None - *
- at0073::Respiratory insufficiency - *
- at0074::Invasive mechanical ventilation by intubation or tracheostomy - *
- at0075::Continuous use of BiPAP during the night and day - *
- at0076::Continuous use of BiPAP during the night - *
- at0077::Intermittent use of BiPAP - *
- at0078::None - *
- at0079::Total score - *
- at0081::Cutting food and handling utensils (patients without gastrostomy) - *
- at0082::Needs to be fed - *
- at0083::Food must be cut by someone but can still feed slowly - *
- at0084::Can cut most foods although clumsy and slow; some help needed - *
- at0085::Somewhat slow and clumsy but no help needed - *
- at0086::Normal - *

[alvarado_score](#)

Archetype ID: openEHR-EHR-OBSERVATION.alvarado_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To determine the likelihood of appendicitis based on symptoms, signs and laboratory test results.

****Use:**** Use to determine the likelihood of appendicitis based on symptoms, signs and laboratory test results. The total score, derived by adding up the individual scores for each of the 8 items ranges from 0 to 10 with score weights allocated thus: +2 points - Right lower quadrant tenderness +1 point - Elevated temperature ($>37.3^{\circ}\text{C}$ or 99.1°F) +1 point - Rebound tenderness +1 point - Migration of pain to the right lower quadrant +1 point - Anorexia +1 point - Nausea or vomiting +2 point - Leukocytosis $> 10,000$ +1 point - Leukocyte left shift - A CT scan is recommended for scores 4-6 - A surgical consultation for scores ≥ 7 . - For scores ≤ 3 : a CT scan is not needed due to the low probability of appendicitis.

****Keywords:**** acute appendicitis, appendicitis

****Concepts:****

- at0000::Alvarado score - Clinical scoring system used to determine the likelihood of appendicitis based on symptoms, signs and laboratory test results.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Right lower quadrant tenderness? - Score 2 if positive.
- at0005::Elevated temperature ($>37.3^{\circ}\text{C}$ or 99.1°F)? - Score 1 if positive.
- at0006::Rebound tenderness? - Score 1 if positive.
- at0007::Migration of pain to the right lower quadrant? - Score 1 if positive.
- at0008::Anorexia? - Score 1 if positive.
- at0009::Nausea or vomiting? - Score 1 if positive.
- at0010::Leukocytosis $> 10,000$? - Score 2 if positive.
- at0011::Leukocyte left shift - Score 1 if positive.
- at0012::Total score - The sum of each ordinal score recorded for each of the eight component responses.
- at0014::No - *
- at0015::Yes - *
- at0016::No - *
- at0017::Yes - *
- at0018::No - *
- at0019::Yes - *

- at0020::No - *
- at0021::Yes - *
- at0022::No - *
- at0023::Yes - *
- at0024::No - *
- at0025::Yes - *
- at0026::No - *
- at0027::Yes - *
- at0028::No - *
- at0029::Yes - *
- at0030::Tree - @ internal @
- at0031::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

aofas

****Archetype ID:**** openEHR-EHR-OBSERVATION.aofas.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** For the recording of subjective assessment for completion by patient of ankle or hindfoot pain and function.

****Use:**** Use to record patient-reported ankle or hindfoot pain and function assessment. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Concepts:****

- at0000::AOFAS - American Orthopaedic Foot and Ankle Society Score (AOFAS).
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @

- at0004::Tree - @ internal @
- at0005::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0006::Tree - @ internal @
- at0007::Confounding factors - Record any issues or factors that may impact on the overall assessment or score.
- at0008::Total score - The total score for the four questions.
- at0027::Comment - Narrative comment.
- at0028::Q1 Pain - Patient reported pain assessment.
- at0029::No pain - The patient reports no pain.
- at0030::Mild or occasional - The patient reports mild or occasional pain.
- at0031::Moderate or daily - The patient reports moderate or daily pain.
- at0032::Severe pain - The patient reports severe pain.
- at0033::Q2 Activity limitations and support requirements - Patient-reported activity limitations and support requirements.
- at0034::None - The patient reports no activity limitations and support requirements.
- at0035::Mild or occasional - The patient reports mild or occasional activity limitations and support requirements.
- at0036::Moderate or daily - The patient reports moderate or daily activity limitations and support requirements.
- at0037::Severe - The patient reports severe activity limitations and support requirements.
- at0038::Q3 Walking - Patient-reported maximum walking distance in blocks (1 block = 100-200 yards).
- at0039::Greater than 6 - The patient reports a maximum walking distance of greater than 6 blocks.
- at0040::4 to 6 - The patient reports a maximum walking distance of 4 to 6 blocks.
- at0041::1 to 3 - The patient reports a maximum walking distance of 1 to 3 blocks.
- at0042::Less than 1 - The patient reports a walking distance of less than 1 block.
- at0043::Q4 Walking surfaces - Patient-reported assessment of difficulty of walking on various surfaces.
- at0044::No difficulty on any walking surface - The patient reports no difficulty walking on any surface.
- at0045::Some difficulty on uneven surfaces - The patient reports some difficulty walking on uneven terrains, stairs, inclines or ladders.
- at0046::Severe difficulty on uneven surfaces - The patient reports severe difficulty walking on uneven terrains, stairs, inclines or ladders.

aos_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.aos_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** For the capture and reporting of the Ankle Osteoarthritis Score (AOS) questionnaire details.

****Use:**** Use to record details of the Ankle Osteoarthritis Score questionnaire. This is a patient reported outcome measure (PROM) questionnaire. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Concepts:****

- at0000::AOS - Ankle Osteoarthritis Score (AOS) questionnaire.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tree - @ internal @
- at0005::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0006::Tree - @ internal @
- at0007::Confounding factors - Record any issues or factors that may impact on the score or interpretation.
- at0008::Pain - Details of patient-reported extent of pain during past week.
- at0009::1 Pain at its worst - Patient-reported estimation of pain at its worst during past week, on a scale of 0 to 100, where 0 indicates no pain and 100 indicates worst pain imaginable.
- at0010::2 Pain before getting up in the morning - Patient-reported estimation of pain before getting up in the morning during past week, on a scale of 0 to 100, where 0 indicates no pain and 100 indicates worst pain imaginable.
- at0011::3 Pain when walking barefoot - Patient-reported estimation of pain when walking barefoot during past week, on a scale of 0 to 100, where 0 indicates no pain and 100 indicates worst pain imaginable.

- at0012::4 Pain when standing barefoot - Patient-reported estimation of pain when standing barefoot during past week, on a scale of 0 to 100, where 0 indicates no pain and 100 indicates worst pain imaginable.
- at0013::5 Pain when walking wearing shoes - Patient-reported estimation of pain when walking wearing shoes during past week, on a scale of 0 to 100, where 0 indicates no pain and 100 indicates worst pain imaginable.
- at0014::6 Pain when standing wearing shoes - Patient-reported estimation of pain when standing wearing shoes during past week, on a scale of 0 to 100, where 0 indicates no pain and 100 indicates worst pain imaginable.
- at0015::7 Pain when walking wearing shoe inserts or braces - Patient-reported estimation of pain when walking wearing shoe inserts or braces during past week, on a scale of 0 to 100, where 0 indicates no pain and 100 indicates worst pain imaginable.
- at0016::8 Pain when standing wearing shoe inserts or braces - Patient-reported estimation of pain when standing wearing shoe inserts or braces during past week, on a scale of 0 to 100, where 0 indicates no pain and 100 indicates worst pain imaginable.
- at0017::9 Pain at the end of the day - Patient-reported estimation of pain at the end of the day during past week, on a scale of 0 to 100, where 0 indicates no pain and 100 indicates worst pain imaginable.
- at0018::Total pain score - Total score from questions 1 to 9, calculated as sum of 1 to 9 divided by 9.
- at0019::Difficulty - Details of patient-reported extent of difficulty performing activities.
- at0020::1 Walking around house - Patient-reported estimation of difficulty walking around the house during past week, on a scale of 0 to 100, where 0 indicates no difficulty and 100 indicates so difficult unable.
- at0021::2 Walking outside on uneven ground - Patient-reported estimation of difficulty walking outside on uneven ground during past week, on a scale of 0 to 100, where 0 indicates no difficulty and 100 indicates so difficult unable.
- at0022::3 Walking four blocks or more - Patient-reported estimation of difficulty walking four blocks or more during past week, on a scale of 0 to 100, where 0 indicates no difficulty and 100 indicates so difficult unable.
- at0023::4 Climbing stairs - Patient-reported estimation of difficulty climbing stairs during past week, on a scale of 0 to 100, where 0 indicates no difficulty and 100 indicates so difficult unable.
- at0024::5 Descending stairs - Patient-reported estimation of difficulty descending stairs during past week, on a scale of 0 to 100, where 0 indicates no difficulty and 100 indicates so difficult unable.
- at0025::6 Standing on tip toes - Patient-reported estimation of difficulty standing on tip toes during past week, on a scale of 0 to 100, where 0 indicates no difficulty and 100 indicates so difficult unable.
- at0026::7 Getting out of chair - Patient-reported estimation of difficulty getting out of chair during past week, on a scale of 0 to 100, where 0 indicates no difficulty and 100 indicates so difficult unable.

- at0027::8 Climbing up or down curbs - Patient-reported estimation of difficulty climbing up or down curbs during past week, on a scale of 0 to 100, where 0 indicates no difficulty and 100 indicates so difficult unable.
- at0028::9 Walking fast or running - Patient-reported estimation of difficulty walking fast or running during past week, on a scale of 0 to 100, where 0 indicates no difficulty and 100 indicates so difficult unable.
- at0029::Total difficulty score - Total score from questions 1 to 9, calculated as sum of 1 to 9 divided by 9.
- at0030::Total AOS score - Total combined score for pain and difficulty, calculated as total (pain score + total difficulty score) / 2.
- at0031::Total COFAS score - Total score according to Canadian Orthopaedics Foot and Ankle Society.

apgar

****Archetype ID:**** openEHR-EHR-OBSERVATION.apgar.v2

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, ru, fi, sv, pt-br, en, ar-sy, es-cl, zh-cn, es, nb, fa, nl, ca

****Purpose:**** To record the results for each component parameter and their total sum for the Apgar score.

****Use:**** Use to record the results for each component parameter and their total sum for the Apgar score. This archetype has been designed to support the explicit recording of Apgar scores at 1, 2, 3, 5 and/or 10 minute points in time offset from the time of birth, plus additional events as required. Usual practice is to document the Apgar score at 1 and 5 minutes; further scores can be recorded as clinically indicated. It is possible to record the Apgar score at any time after birth using this archetype. Common clinical practice is to record all 5 parameters plus the total, however this archetype allows any partial information to be recorded, if that is all that is available for example from historical data.

****Keywords:**** newborn, index, score, birth, infant, neonate, assessment

****Concepts:****

- at0000::Apgar score - A tool to assess the clinical status of the newborn infant immediately after birth and their response to resuscitation.
- at0001::Tree - @ internal @
- at0002::History - @ internal @

- at0003::1 minute - Apgar score 1 minute after birth.
- at0005::Heart rate - Recording of the infant's heart rate.
- at0006::Absent - No heart beat is seen, felt or heard.
- at0007::<100 beats per minute - Heart rate less than 100 beats per minute.
- at0008::≥100 beats per minute - Heart rate greater than or equal to 100 beats per minute.
- at0009::Respiratory effort - Observation of the infant's respiratory effort.
- at0010::Absent - No effort to breath.
- at0011::Weak or irregular - Some effort to breath, moving chest.
- at0012::Normal - Breathing normally or crying.
- at0013::Muscle tone - Observation of the infant's muscle tone.
- at0014::Limp or flaccid - No spontaneous movement.
- at0015::Reduced tone - Some flexion of extremities.
- at0016::Normal tone - Normal, vigorous movements.
- at0017::Reflex irritability - Observation of the response of the infant to an irritant stimulation, for example, suctioning the oropharynx and nares with a soft rubber catheter.
- at0018::No response - No response to stimulation.
- at0019::Reduced response - Grimace or feeble cry when stimulated.
- at0020::Normal response - Grimace, sneeze, cough or pulls away when stimulated.
- at0021::Skin colour - Observation of the skin colour of the infant.
- at0022::Completely blue - Body and extremities are blue.
- at0023::Body pink; extremities blue - Body is pink; extremities are blue.
- at0024::Completely pink - Body and extremities are pink; no cyanosis.
- at0025::Total - The total sum of each component parameter for the Apgar score.
- at0026::2 minute - Apgar score 2 minutes after birth.
- at0027::3 minute - Apgar score 3 minutes after birth.
- at0028::5 minute - Apgar score 5 minutes after birth.
- at0029::Tree - @ internal @
- at0031::10 minute - Apgar score 10 minutes after birth.
- at0037::Any event - Apgar score at any additional time, as required.
- at0040::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[asa_status](#)

Archetype ID: openEHR-EHR-OBSERVATION.asa_status.v1

Lifecycle State: published

****Category:**** OBSERVATION

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

****Purpose:**** To record the classification system adopted by the American Society of Anesthesiologists (ASA) as part of a pre-surgical risk assessment.

****Use:**** To record the classification system adopted by the American Society of Anesthesiologists (ASA) as part of a pre-surgical risk assessment. The ASA (2020) reference defines each classification and provides some adult, paediatric and obstetric examples to guide clinicians to assign a physical status classification level. However, because these examples are numerous and can further be refined or described at the institution level, specific examples are not included in this archetype.

****Keywords:**** ASA, pre-operative, surgery, anaesthesiology, anesthesia, anaesthesia, anesthesiology

****Concepts:****

- at0000::ASA physical status classification system - Classification system adopted by the American Society of Anesthesiologists (ASA) as part of a pre-surgical risk assessment.
- at0001::Classification - Assessed classification of a patient.
- at0015::Event Series - @ internal @
- at0016::Any point in time event - Unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0017::Tree - @ internal @
- at0018::ItemTree - @ internal @
- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0020::Emergency (E) - Record as True if the surgery was carried out in an emergency situation.
- at0003::ASA 1 - A normal healthy patient.
- at0004::ASA 2 - A patient with mild systemic disease.
- at0005::ASA 3 - A patient with severe systemic disease.
- at0006::ASA 4 - A patient with severe systemic disease that is a constant threat to life.
- at0007::ASA 5 - A moribund patient who is not expected to survive without the operation.
- at0008::ASA 6 - A declared brain-dead patient whose organs are being removed for donor purposes.

atria_bleeding_risk

Archetype ID: openEHR-EHR-OBSERVATION.atria_bleeding_risk.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: sv, en

Purpose: To record the results for each component parameter and their total sum for the ATRIA bleeding risk score.

Use: Use to record the results for each component parameter and their total sum for the ATRIA bleeding risk score.

Misuse: Do not use if the patient does not have atrial fibrillation.

Keywords: anticoagulation, atrial fibrillation, warfarin, major hemorrhage, hemorrhage risk, cardiology

Concepts:

- at0000::ATRIA bleeding risk score - An assessment score used to predict the risk of warfarin-associated haemorrhage and guide physician decision-making regarding warfarin use in atrial fibrillation.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Anemia - Presence of hemoglobin concentration <13 g/dl (male) or <12 g/dl (female).
- at0005::Severe renal disease - Presence of estimated glomerular filtration rate (eGFR) <30 ml/min or dialysis-dependent.
- at0006::Age ≥75 years - Individual is 75 years or older.
- at0007::Prior hemorrhage diagnosis - Any prior hemorrhage diagnosis (internal or external hemorrhage).
- at0008::History of hypertension - History of diagnosed hypertension.
- at0009::Total score - Sum of points assigned for each of the component parameters.
- at0011::No - *
- at0012::Yes - *
- at0013::No - *
- at0014::Yes - *
- at0015::No - *
- at0016::Yes - *

- at0017::No - *
- at0018::Yes - *
- at0019::No - *
- at0020::Yes - *
- at0021::Item tree - @ internal @
- at0022::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[atria_stroke_risk](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.atria_stroke_risk.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To record the results for each component parameter and their total sum for the ATRIA stroke risk score.

****Use:**** Use to record the results for each component parameter and their total sum for the ATRIA stroke risk score.

****Misuse:**** Do not use if the patient does not have atrial fibrillation.

****Keywords:**** atrial fibrillation, stroke risk, thromboembolism risk

****Concepts:****

- at0000::ATRIA stroke risk score - An assessment tool used to determine the risk of stroke in patients with atrial fibrillation.
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0004::History of stroke - Does the individual have a history of cerebrovascular accident/stroke?
- at0005::Age - What is the age and has the individual ever had a prior stroke?
- at0006::Sex - Is the individual male or female?
- at0007::History of diabetes mellitus - Does the individual have a history of diabetes mellitus?
- at0008::History of congestive heart failure - Does the individual have a history of congestive heart failure?

- at0009::History of hypertension - Does the individual have a history of hypertension?
- at0010::Proteinuria - Does the individual have proteinuria?
- at0011::eGFR - The estimated glomerular filtration rate (based on MDRD equation) or presence of end-stage renal disease (ESRD).
- at0012::Total score - Sum of points assigned for each of the component parameters.
- at0013::Age <65 years with no history of stroke. - *
- at0014::Age 65-74 years with no history of stroke. - *
- at0015::Age 75-84 years with no history of stroke. - *
- at0016::Age ≥85 years with no history of stroke. - *
- at0017::Age 65-84 years with a history of stroke. - *
- at0018::Age <65 years with a history of stroke. - *
- at0019::Age ≥85 years with a history of stroke. - *
- at0020::Male - Individual is male.
- at0021::Female - Individual is female.
- at0022::eGFR ≥45 - Estimated GFR equal or greater than 45 ml/min/1.73m²
- at0023::eGFR <45 - Estimated GFR less than 45 ml/min/1.73m² or presence of end-stage renal disease (ESRD)
- at0024::No - Proteinuria absent.
- at0025::Yes - Proteinuria present.
- at0026::No - No history of hypertension.
- at0027::Yes - Positive history of hypertension.
- at0028::No - No history of congestive heart failure.
- at0029::Yes - Positive history of congestive heart failure.
- at0030::No - No history of diabetes mellitus.
- at0031::Yes - Positive history of diabetes mellitus.
- at0032::No - No history of stroke.
- at0033::Yes - Has a history of stroke.
- at0034::Item tree - @ internal @
- at0035::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

atrs

Archetype ID: openEHR-EHR-OBSERVATION.atrs.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en

****Purpose:**** For the capture and reporting of patient-reported limitations and difficulties relating to Achilles tendon injury (ATRS = Achilles Tendon Total Rupture Score).

****Use:**** Use to record patient-reported limitations and difficulties relating to injured Achilles tendon. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Concepts:****

- at0000::ATRS - Achilles Tendon Total Rupture Score (ATRS).
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tree - @ internal @
- at0005::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0006::Tree - @ internal @
- at0007::Confounding factors - Record any issues or factors that may impact on the overall assessment or score.
- at0008::Limitation due to decreased strength - Assessment of degree of limitation due to decreased strength in calf or Achilles tendon or foot.
- at0009::Limitation due to fatigue - Assessment of degree of limitation due to fatigue in calf or Achilles tendon or foot.
- at0010::Limitation due to stiffness - Assessment of degree of limitation due to stiffness in calf or Achilles tendon or foot.
- at0011::Limitation due to pain - Assessment of degree of limitation due to pain in calf or Achilles tendon or foot.
- at0012::Limitation during activities of daily living - Assessment of degree of limitation during activities of daily living.
- at0013::Limitation walking on uneven surfaces - Assessment of degree of limitation when walking on uneven surfaces.
- at0014::Limitation walking quickly up stairs or hill - Assessment of degree of limitation when walking quickly up the stairs or up a hill.
- at0015::Limitation running - Assessment of degree of limitation during activities that include running.
- at0016::Limitation jumping - Assessment of degree of limitation during activities that include jumping.

- at0017::Limitation performing hard physical labour - Assessment of degree of limitation performing hard physical labour.
- at0018::Total score - Total score from all individual scores.

[audiogram_result](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.audiogram_result.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record measurements of hearing acuity using a calibrated hearing test device, and their interpretation by a clinician.

****Use:**** Use to record measurements and related findings for a single identified test of hearing acuity, for each ear tested separately or both ears simultaneously, via air conduction and/or bone conduction, with masking when required. Use to record the interpretation of all measurements of hearing acuity for each ear or both ears if tested simultaneously, and an overall interpretation (or audiological diagnosis). This archetype has been designed to capture hearing threshold determination for air conduction and/or bone conduction (with or without masking) for the following tests: - Pure Tone Audiometry; - Play Audiometry; - Auditory Brainstem Response; and - Visual Reinforcement Orientation Audiometry. All of the data elements are recorded using a single method or protocol. If, during the test, any of the protocol parameters need to be modified, then the subsequent part of the test will need to be recorded within a separate instance of the test data, using the updated protocol parameters.

****Misuse:**** Not to be used for hearing screening assessment - use the OBSERVATION.hearing_screening archetype. Not to be used to record other auditory assessments such as: - Behavioural Observation Audiometry (BOA); - Most Comfortable Listening Level (MCL) and Uncomfortable Listening Level (UCL); and - Auditory Brainstem Response (ABR) for any purpose other than hearing threshold determination. These assessments need to be recorded in specific archetypes for the purpose.

****Keywords:**** hearing, test, audiogram, audiometry, acuity, threshold, decibels, ABR, VROA, VRA, play

****Concepts:****

- at0000::Audiogram test result - Measurement of hearing acuity using a calibrated hearing test device, and associated clinical interpretation.

- at0001::Event Series - @ internal @
- at0002::Any point in time event - Default, unspecified point in time which may be explicitly defined in a template or at run-time. For example, in a template, this event can be cloned and specifically identified to be the first and/or second test conducted as a part of a comprehensive assessment, such as a Hearing Conservation or Industrial Audiometric Assessment.
- at0003::Tree - @ internal @
- at0006::Result details - The test result measurements and interpretations which can be recorded per ear, or for both ears simultaneously.
- at0007::Test ear - Identification of the ear(s) to which the test stimulus is being presented.
- at0008::Left ear - The test stimuli were presented to the left ear only.
- at0009::Right ear - The test stimuli were presented to the right ear only.
- at0011::Frequency - The stimulus frequency tested.
- at0012::Threshold level - The stimulus intensity at threshold for the test frequency.
- at0013::Tree - @ internal @
- at0027::Comment - Additional narrative about the test results and interpretation not captured in other fields.
- at0028::Aided status - Indication regarding use of an assistive listening device by the test subject during the test.
- at0029::Left aided - Left ear testing has been aided by a hearing device, such as a hearing aid or cochlear implant.
- at0030::Unaided - Testing has not been aided by a hearing device, such as a hearing aid or cochlear implant.
- at0032::Tree - @ internal @
- at0034::Test stimulus - Identification of the stimulus used in the hearing test to measure the hearing threshold.
- at0035::Tone burst - The test stimulus is a tone burst.
- at0036::Click - The test stimulus is a click.
- at0037::Test result name - Identification of the Audiometry test performed.
- at0047::Test instrument - Details of device used to conduct the test.
- at0048::Measurement - The measured frequency/threshold dB level pair for air conduction results.
- at0049::Binaural - The test stimuli were presented to both ears simultaneously in a soundfield.
- at0055::Hearing threshold interpretation - Interpretation of a series of audiometric measurements for purposes of hearing threshold assessment.
- at0056::Pure tone average - The average pure tone threshold according to the specified averaging criteria.
- at0061::Criteria for pure tone average - The criteria on which the Pure Tone Average is calculated. The average is based on air conduction thresholds and masked thresholds replace unmasked thresholds when applying the formula.

- at0062::3 frequency average - The pure tone hearing threshold is calculated using 0.5, 1 and 2 kHz.
- at0063::4 frequency average - The pure tone hearing threshold is calculated using 0.5, 1, 2 and 4 kHz.
- at0065::Type of loss - Identified type of hearing loss for the test ear, based on all measurements.
- at0066::Mixed - A mixed hearing loss pattern has been identified for the Test Ear, based on the presence of an air/bone gap and bone conduction thresholds outside normal range.
- at0067::Sensorineural - A sensorineural hearing loss pattern has been identified for the Test Ear, based on no air/bone gap and thresholds outside normal range.
- at0068::Conductive - A conductive hearing loss pattern has been identified for the Test Ear, based on the presence of an air/bone gap and bone conduction thresholds within normal range.
- at0069::Indeterminate - It is not possible to determine the pattern of hearing loss.
- at0070::Clinical interpretation - Clinical interpretation of all measurements for the test ear.
- at0071::Sensorineural symmetry - An interpretation about the symmetry of sensorineural component of hearing loss, based on bone conduction measurements for both ears.
- at0072::Symmetrical - The hearing loss is symmetrical.
- at0073::Asymmetrical - The hearing loss is asymmetrical.
- at0075::Test environment - The environment in which the audiometric test is administered.
- at0076::Audiotmetric booth - Sound-treated test environment that meets audiotmetric standards for ambient noise.
- at0080::Warble Tone - The test stimulus is a frequency modulated tone.
- at0081::Pure Tone - The test stimulus is a pure tone.
- at0085::Click stimulus specification - Identification of parameters specifying a click stimulus.
- at0086::Onset ramp - Time over which the stimulus grows to full amplitude.
- at0087::Offset ramp - Time over which the stimulus depletes to zero amplitude.
- at0088::Total duration - Total duration of the click stimulus.
- at0089::Calibration reference dB - Scale used for acoustic calibration of the test signal.
- at0090::dB SPL - The test stimuli are calibrated using the sound pressure level scale.
- at0091::dB HL - The test stimuli are calibrated using the hearing level scale.
- at0092::dB nHL - The test stimuli are calibrated using the normal hearing level scale.
- at0093::Threshold determination protocol - Protocol used to measure the hearing threshold for pure tone, play and visual reinforcement orientation audiology only.
- at0094::Step size - The step size (in decibels) of the change in the stimulus intensity for threshold determination.
- at0095::1 dB - Step size of one decibel.

- at0096::5 dB - Step size of five decibels.
- at0097::10 dB - Step size of ten decibels.
- at0098::20 dB - Step size of twenty decibels.
- at0099::Direction - The direction of change in the stimulus intensity.
- at0100::Ascending - Threshold is calculated based on the ascending runs where the stimulus moves from below threshold to above threshold.
- at0101::Descending - Threshold is calculated based on the descending runs where the stimulus moves from above threshold to below threshold.
- at0109::Air presentation - Presentation of the air conduction test stimulus indirectly to the inner ear through the atmosphere, via the auditory canal and middle ear structures.
- at0110::Soundfield - The stimulus is presented via a loudspeaker located at least one metre away from the subject.
- at0111::Insert earphone - The stimulus is presented via insert earphones.
- at0112::Headphones - The stimulus is presented via external headphones - either circumaural or supraaural.
- at0113::Bone presentation - Presentation of the bone conduction test stimulus directly to the inner ear via the cranial bones.
- at0114::Mastoid - The posterior part of the temporal bone, including the mastoid process.
- at0115::Forehead - Area of the head bounded by the normal hairline, eyebrows and the temples on either side.
- at0119::Test modifications required - Narrative description of any modifications to the standard methodology required to enable successful completion of the test.
- at0120::Comment - Additional narrative about the protocol for the audiogram not captured in other fields.
- at0121::Overall interpretation - Overall clinical interpretation of the measurements and related findings using an audiometer.
- at0122::No test result - No air conduction test result is available for the test ear.
- at0123::Reason for no result - Reason why no air conduction result is available for the test ear.
- at0126::Articulation index - An algorithm to predict the amount of speech that is audible to a patient with a specific hearing loss.
- at0127::Threshold definition - Definition of the protocol used to define the threshold level used in the test.
- at0128::Minimum response level - The softest level at which a subject responds to a stimulus.
- at0129::2/3 responses - The softest level at which the subject responds to two out of three consecutive threshold runs.
- at0130::3/6 responses - The softest level at which the subject responds to three out of six consecutive threshold runs.
- at0131::Laterality of loss - An interpretation about the laterality of hearing loss, based on all hearing acuity measurements for both ears.

- at0132::Bilateral - Loss of hearing in both ears.
- at0133::Unilateral - Loss of hearing in one ear.
- at0134::Reliability - Narrative description of the reliability of the test results.
- at0135::Degree of loss - Category of the degree of hearing loss derived from the dB threshold values using specified criteria.
- at0138::Criteria for asymmetry - The criteria on which asymmetry is defined in the test result interpretation.
- at0139::Air conduction result - The thresholds obtained using air conduction testing.
- at0140::Bone conduction result - The thresholds obtained using bone conduction testing.
- at0141::Air conduction masking - A masking stimulus was applied to the non-test ear to obtain specified air conduction thresholds.
- at0142::Bone conduction masking - A masking stimulus was applied to the non-test ear to obtain specified bone conduction thresholds.
- at0143::Measurement - The measured frequency/threshold dB level pair for bone conduction results.
- at0144::Frequency - The stimulus frequency of the test signal.
- at0145::Threshold level - The intensity of the test stimulus at the subject's threshold for the test frequency.
- at0146::No test result - No bone conduction test result is available for the test ear.
- at0147::Reason for no result - Reason why no bone conduction result is available for the test ear.
- at0148::Narrow Band Noise - The test stimulus is a narrow band noise centred on the specified frequency.
- at0149::Hearing device - Details of the hearing device used.
- at0150::Right aided - Right ear testing has been aided by a hearing device, such as a hearing aid or cochlear implant.
- at0151::Bilateral aided - Testing has been aided by use of bilateral hearing devices, such as a hearing aids or cochlear implants.
- at0152::Bone conduction aided - Testing has been aided by a bone conduction device.
- at0153::No response - No response from subject at identified frequency.
- at0154::No response - No response from subject at identified frequency.
- at0155::Retrocochlear - A form of sensorineural hearing loss in which the lesion is proximal to the cochlear.
- at0156::Non-sound treated room - Test environment that does not meet audiometric standards for ambient noise.
- at0157::Background noise - The amount and nature of noise in the environment that may influence the test results.
- at0158::Not clinically significant - The background noise is not likely to compromise test results.
- at0159::Clinically significant - The background noise may compromise test results.
- at0160::Pulse tone - The test stimulus is a pulse tone.

- at0163::Average - Record of the average measured results from more than one test. For example, the average of the 3000Hz to 6000Hz measurements in a Hearing Conservation or Industrial Audiometry Assessment. The data elements required in this use case may be quite limited and relevant ones revealed via templating.
- at0164::Confounding factors - Narrative description of factors, not recorded elsewhere, that may influence the threshold measurements.
- at0165::Degree of impairment - Category of the degree of overall hearing impairment derived from the dB threshold values using specified criteria based on the better hearing ear.
- at0166::Comment - Additional narrative about the hearing threshold interpretation not captured in other fields.
- at0167::Multimedia - Digital representation of the test results.
- at0171::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0172::Test not done - Details to explicitly record that this test was not performed.

audiology_speech_test_result

****Archetype ID:**** openEHR-EHR-OBSERVATION.audiology_speech_test_result.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record results from an audiology speech test conducted for the purpose of assessing speech discrimination and speech recognition, and their clinical interpretation.

****Use:**** Use to record the results of audiology speech tests carried out to assess speech discrimination and speech recognition. Use to record the clinical interpretation of audiology speech tests carried out to assess speech discrimination and speech recognition.

****Misuse:**** Not to be used for audiology speech testing that is used for phonemic confusions analysis. Not to be used to assess speech production. Not to be used to record audiology speech tests where the presentaton level is not known - for example: unmonitored live voice.

****Keywords:**** speech, audiology

****Concepts:****

- at0000::Audiology speech test result - Record of results from an audiology speech test conducted for the purpose of assessing speech discrimination and speech recognition, and their clinical interpretation.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Test result name - Identification of the audiology speech test performed.
- at0005::Result details - The test measurements and interpretations which can be recorded per ear, or for both ears simultaneously.
- at0006::Test ear - The ear to which the speech signal is presented.
- at0007::Left ear - The test stimuli were presented to the left ear only.
- at0008::Right ear - The test stimuli were presented to the right ear only.
- at0009::Binaural - The test stimuli were presented to both ears simultaneously in a soundfield.
- at0010::Performance intensity function - Results obtained for performance intensity function at each test level.
- at0011::Loudness - The stimulus intensity.
- at0013::Reliability - Details about the responses correct of the subject being tested.
- at0014::Words correct - Percentage of words to which the test subject responds correctly.
- at0015::Elements correct - Percentage of elements to which the test subject responds correctly.
- at0016::Standard error - A measure to compare a sample mean and a population mean.
- at0017::Adaptive speech test - Details of the adaptive test protocol.
- at0018::Loudness to achieve target - The mean dB loudness level of the speech stimuli required to achieve the target correct performance.
- at0019::Signal to noise ratio - The relationship of the loudness of the speech signal in dB to the loudness level of the noise stimulus.
- at0020::Clinical interpretation - Clinical interpretation of all responses for the identified test ear.
- at0021::Overall interpretation - Overall clinical interpretation of the responses for both ears.
- at0022::Comment - Additional narrative about the test results and interpretation not captured in other fields.
- at0023::Tree - @ internal @
- at0024::Aided status - Indication regarding use of an assistive listening device by the test subject during the test.
- at0025::Aided - The test has been conducted with the patient using a form of auditory assistance, such as a hearing aid or cochlear implant.
- at0026::Unaided - The test has been conducted without the patient using any form of auditory assistance, such as a hearing aid or cochlear implant.

- at0027::Type of listening device - Identification of type of assistive listening device used.
- at0028::Hearing aid - A type of hearing device.
- at0029::Cochlear implant - A type of hearing device.
- at0030::Bone conductor aid - A type of hearing device.
- at0031::Listening device settings - Narrative description of the details of the assistive listening device settings.
- at0032::Tree - @ internal @
- at0033::Contralateral masking - Contralateral masking signal was presented to the non test ear.
- at0034::Present - Masking noise is presented to the non test ear.
- at0035::Absent - No masking noise is presented.
- at0036::Masking presentation method - The method used to present the contralateral masking test signal.
- at0037::Earphone - A device that converts electric signals to audible sound and fits over or in the ear.
- at0038::Loudspeaker - A listening condition in which the listener is 1 metre from a loud speaker and hears sounds presented via the loud speaker.
- at0039::Masking stimulus level - The level of the contralateral masking speech spectrum noise in dB.
- at0040::SNR competing noise - Type of signal used as a competing signal during Signal to Noise Ratio testing.
- at0041::White noise - Noise that has the same power at all frequencies (i.e., a flat power spectrum).
- at0042::Speech spectrum noise - Noise spectrum that approximates the average long term spectrum of adult male speech and has a slope below 100 Hz of +6 dB/octave, a flat spectrum between 100 Hz and 320 Hz, and above 320 Hz a slope of -6 dB/octave.
- at0043::Multitalker babble - A recording of the voices of many people who are talking simultaneously, resulting in an unintelligible babble.
- at0044::Alternate speaker - The masker is a single person speaking and this speaker is different to the speaker used for the test stimulus.
- at0045::Number of voices - Number of voices used to generate multispeaker babble.
- at0046::Calibration reference dB - Scale used for acoustic calibration check.
- at0047::dB SPL - The sound pressure level scale was used.
- at0048::dB HL - The hearing level scale was used.
- at0052::Target performance level - The specified percentage correct used to setup the adaptive test protocol.
- at0054::Presentation voice - The mode by which the speech test stimuli are presented.
- at0055::Live voice - Presentation of the speech test stimuli by monitored live voice presentation by the tester.
- at0056::Recorded voice - Presentation of the speech test stimuli from a recorded medium.
- at0057::Presentation method - The method used to present the speech test stimulus.

- at0058::Headphone - The stimulus is presented via external headphones - either circumaural or supraaural..
- at0059::Soundfield - The stimulus is presented via a loudspeaker located at least one metre away from the subject.
- at0060::Response type - The type of response the patient is asked to give after hearing each stimulus.
- at0061::Vocal - The person repeats the stimulus item that was heard.
- at0062::Picture pointing - The test subject points to a picture of the stimulus item that was heard.
- at0063::Written response alternatives - The test subject points to written text that corresponds to the stimulus item that was heard.
- at0064::Response set - The size of the response set.
- at0065::Open set - The size of the response set is unlimited.
- at0066::Closed set - The size of the response set is limited.
- at0067::Closed task domain - The response set is limited and the response alternatives remain constant for the whole test list.
- at0068::Closed set alternatives - The number of response alternatives offered in the Closed Set.
- at0069::Closed domain items - The number of response items offered in the Closed Task Domain.
- at0070::Stimulus type - The type of speech stimulus used for the speech test.
- at0071::Nonsense syllable - A consonant-vowel (CV) or CCV or VC or VCC item that is not a real word but is phonotactically correct.
- at0072::Nonsense CVC - Nonsense word comprising a consonant, then a vowel, then a final consonant, for example, "wub" or "yat".
- at0073::Nonsense word - A speech stimulus that is not a real word but is phonotactically correct.
- at0074::Monosyllabic word - A word comprised of a single syllable. For example, 'green'.
- at0075::Spondee word - A word comprised of 2 syllables with equal stress on each syllable. For example, 'sunshine'.
- at0076::Trochee word - A word that is comprised of two syllables with stress on the first syllable. For example 'bucket'.
- at0077::Sentence - A grammatical unit of one or more words that expresses an independent statement, question, request, command, exclamation, etc.
- at0078::Confidence interval - A term used in inferential statistics that measures the probability that a population parameter will fall between two set values.
- at0079::No test result - No test result is available for the test ear.
- at0080::Reason for no test result - Reason why no result is available for the test ear.
- at0081::Sample size - The number of reversals in an adaptive threshold test used for calculating estimates of a given test result.
- at0082::Listening device - Details about the specific assistive listening device used during the test.

- at0083::SNR competing noise presentation - The type of noise used in a speech test measuring speech perception in noise.
- at0084::Ipsilateral - The noise is presented to the same ear as the speech signal.
- at0085::Contralateral - The noise is presented to the ear opposite to the speech signal.
- at0086::Concrete object pointing - The subject response is to point to a 3 dimensional (i.e., concrete) object.
- at0087::Type of adaptive test - The type of adaptive test used. Typically either in quiet or in noise.
- at0088::Quiet - The speech signal is presented in optimal listening conditions, without any interference from other auditory signals.
- at0089::Signal to noise ratio - The ratio of the signal intensity to the noise intensity.
- at0090::Step size - The number of dB by which the stimulus intensity is changed after each response.
- at0091::Start level - The initial presentation level in dB.
- at0092::SNR speech presentation level - The initial signal to noise ratio level in dB. For example, +20 dB.
- at0093::Presentation method - The method used to present the speech test stimulus.
- at0094::Auditory test - An auditory stimulus is presented to the test subject.
- at0095::Audiovisual test - A combination of auditory and visual stimuli are presented to the test subject.
- at0096::Visual test - A visual stimulus is presented to the test subject.
- at0097::dB A - The A-weighted decibels of the sound pressure level scale were used.
- at0098::Insert earphone - The stimulus is presented via insert earphones.

[auditory_brainstem_response_result](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.auditory_brainstem_response_result.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To measure auditory brainstem function in response to auditory stimuli and the clinical interpretation of the measurements.

****Use:**** This archetype is in early draft. Details still need to be confirmed with clinicians, although the generic pattern of data elements is regarded as fit for cautious use.

****Keywords:**** hearing, test, infant

****Concepts:****

- at0000::Auditory brainstem response (ABR) result - Measurement of auditory brainstem function in response to auditory stimuli, and associated clinical interpretation.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Ear tested - Identification of the ear being tested.
- at0005::Right ear - The right ear was tested.
- at0006::Left ear - The left ear was tested.
- at0015::Result details - The test result observations and interpretations.
- at0016::No test result - No test result is available for the side stimulated.
- at0017::Reason for no test result - Reason why no result is available for the side stimulated.
- at0018::Clinical interpretation - Clinical interpretation of all measurements for the test ear.
- at0019::Overall interpretation - Overall clinical interpretation of the responses for both ears.
- at0020::Comment - Additional narrative about the test responses, not captured in other fields.
- at0021::Multimedia - Digital image, video or diagram representing the test results.
- at0022::Tree - @ internal @
- at0032::Confounding factors - Narrative description of factors, not recorded elsewhere, that may influence the response results.
- at0033::Test not done - Details to explicitly record that this test was not performed.
- at0034::Tree - @ internal @
- at0035::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0036::Response state - The response state of the child during the test.
- at0037::Light sleep - The child was lightly sleeping.
- at0038::Quiet and alert - The child was awake, quiet and alert.
- at0039::Crying - The child was crying.
- at0040::Test environment - The environment in which the test is administered.
- at0041::Audiometric booth - Sound treated room that provides a test environment that meets audiometric standards for ambient noise inside the booth.
- at0042::Other - The test environment was not a booth that meets audiometric standards for ambient noise inside the booth.
- at0043::Background noise - The amount and nature of noise in the environment that may influence the test results.
- at0044::Not clinically significant - The background noise is not clinically significant.

- at0045::Clinically significant - The background noise is clinically significant.
- at0046::Calibration reference dB - Scale used for acoustic calibration of the test signal.
- at0047::dB SPL - The test stimuli are calibrated using the sound pressure level scale.
- at0048::dB HL - The test stimuli are calibrated using the hearing level scale.
- at0049::dB A - The test stimuli are calibrated using the A-weighted pressure scale.
- at0050::Air presentation - Presentation of the air conduction test stimulus indirectly to the inner ear through the atmosphere, via the auditory canal and middle ear structures.
- at0051::Soundfield - The stimulus is presented via a loudspeaker located at least one metre away from the subject.
- at0052::Insert earphone - The stimulus is presented via insert earphones.
- at0053::Headphone - The stimulus is presented via external headphones - either circumaural or supraaural.
- at0054::Air conduction results - *
- at0055::Frequency - *
- at0056::Threshold - *
- at0058::Bone conduction results - *
- at0059::Frequency - *
- at0060::Threshold - *
- at0061::Device - *
- at0062::dB nHL - The test stimuli are calibrated using the normalised hearing level pressure scale.

au_absolute_cvd_risk

Archetype ID: openEHR-EHR-OBSERVATION.au_absolute_cvd_risk.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en

Purpose: To record the results for each component parameter and their total sum for the Australian absolute CVD risk in the next 5 years.

Use: Use to record the results for each component parameter and their total sum for the Australian absolute CVD risk in the next 5 years. The AusCVDRisk and NVDPA risk calculators in the references, below, share a common subset of data elements. The AusCVDRisk version has some additional data elements that have been included in this maximal data set.

Concepts:

- at0000::Australian absolute cardiovascular disease risk calculator - An assessment tool used to calculate the absolute cardiovascular disease risk (CVD) in the next 5 years.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Gender - The gender of an individual.
- at0005::Female - The individual is female.
- at0006::Male - The individual is male.
- at0007::Age - Age, in years.
- at0008::Systolic blood pressure - Recent systolic blood pressure measurement.
- at0009::Smoker - Currently smoking or quite within last year.
- at0010::Yes - Currently smoking or quit within last year.
- at0011::No - Not currently smoking or quit longer than a year ago.
- at0012::Total cholesterol - Recent test result for total cholesterol.
- at0013::HDL cholesterol - Recent test result for HDL cholesterol.
- at0014::Diabetes - Diabetes diagnosed?
- at0015::Yes - Condition is diagnosed.
- at0016::No - Condition not present.
- at0017::ECG LVH - LVH diagnosed on ECG?
- at0018::Yes - LVH is present on ECG.
- at0019::No - LVH is not present on ECG.
- at0020::Unknown - It is not known if LVH is present or absent on ECG.
- at0021::Diastolic blood pressure - Recent systolic blood pressure measurement.
- at0022::Familial hypercholesterolaemia - Familial hypercholesterolaemia diagnosed?
- at0023::Chronic kidney disease - Chronic kidney disease diagnosed?
- at0024::Aboriginal or Torres Strait Islander - Is the individual an aboriginal or Torres Strait islander?
- at0025::Yes - Individual is an aboriginal or Torres Strait islander.
- at0026::No - Individual is not an aboriginal or Torres Strait islander.
- at0027::Item tree - @ internal @
- at0028::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0029::Calculated risk score - The calculated risk score.

avpu

Archetype ID: openEHR-EHR-OBSERVATION.avpu.v0

Lifecycle State: in_development

****Category:**** OBSERVATION

****Languages:**** nb, pt-br, en

****Purpose:**** To record an individual's level of consciousness.

****Use:**** Use to record a quick and simple assessment of an individual's level of consciousness, especially in an emergency situation.

****Keywords:**** avpu, alert, voice, pain, unresponsive, awake, speech, pain, unconscious, voice, consciousness, verbal, verbal response, semicomatose, conscious, level of consciousness, comatose

****Concepts:****

- at0000::AVPU - Simple scale used as part of an assessment to measure and record an individual's level of consciousness. AVPU is an acronym for 'Alert', 'Voice', 'Pain', 'Unresponsive'.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Observation - The observation of the patient's level of consciousness.
- at0005::Alert - Eyes open spontaneously, oriented speech, obeys commands.
- at0006::Voice - Any verbal, motor or eye response to a voice stimulus.
- at0007::Pain - Any verbal, motor or eye response to a pain stimulus, such as pressing the nail root, but not to voice stimulus.
- at0008::Unresponsive - No response to voice or pain stimuli.
- at0009::Tree - @ internal @
- at0010::Pain stimulus - Description of the type of pain stimulus used to elicit the observation.
- at0011::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0012::Comment - Additional narrative about the observation, not captured in other fields.
- at0013::Tree - @ internal @
- at0014::Confounding factors - Narrative description of any issues or factors that may impact on the observation.

behavioural_observation_audiometry_result

****Archetype ID:**** openEHR-EHR-OBSERVATION.behavioural_observation_audiometry_result.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record unconditioned responses of an infant or young child's response to auditory stimuli. To record the interpretation of responses.

****Use:**** Use to record child's Minimum Response Levels (MRL's) and reflexive responses (eg. APR) to noisemakers and speech. Recorded in the free-field measuring a binaural response. Use to record an overall interpretation of response levels and response qualities to provide an indication of the probable hearing status. BOA is generally used as a secondary testing technique in infants under 6mo to provide supporting information to objective measures of hearing levels (ABR/SSEP). In cases where an infant cannot be conditioned to VROA, is not developmentally able to perform VROA, or if VROA equipment is unavailable, BOA may be used to obtain information about behavioural hearing. Please note: - MRL: the lowest intensity level at which a response to a stimulus is recorded. An ascending technique should be used when establishing MRL's. - dBA: Decibels measured in the sound field using the A scale sound level filter. Using this filter, the sound level meter is thus less sensitive to very high and very low frequencies Details about assisted hearing devices used as aids in this test should be recorded in the EVALUATION.assisted_hearing_summary.

****Misuse:**** Not to be used to record hearing threshold levels (HTL's) Not to be used to record any other assessments such as: - VROA; - PTA; - Play; and - Objective Assessments.

****Keywords:**** hearing, test, audiometry, MRL, decibels, observation, infant, boa

****Concepts:****

- at0000::Behavioural observation audiometry (BOA) result - Observations of an infant or young child's unconditioned response to sound, and associated clinical interpretation.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0008::Stimulus - The type of stimulus used in the test.
- at0009::Minimum response level - Lowest intensity at which a response to a stimulus is observed.
- at0010::Frequency - The frequency or range of frequency of the identified stimulus.

- at0011::Result details - The test result observations and interpretations.
- at0012::Latency - *
- at0014::Reliability - Narrative description of the reliability of the response, as determined by the tester.
- at0016::No test result - No test result is available for the side stimulated.
- at0017::Reason for no test result - Reason why no result is available for the side stimulated.
- at0019::Overall interpretation - Overall clinical interpretation of the responses for both ears.
- at0020::Comment - Additional narrative about the test responses, not captured in other fields.
- at0021::Multimedia representation - Digital image, video or diagram representing the test results.
- at0022::Tree - @ internal @
- at0032::Confounding factors - Narrative description of factors, not recorded elsewhere, that may influence the response results.
- at0033::Exam not done - Details to explicitly record that this examination was not performed.
- at0034::Tree - @ internal @
- at0035::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0036::Response state - The response state of the child during the test.
- at0037::Light sleep - The child was lightly sleeping.
- at0038::Quiet and alert - The child was awake, quiet and alert.
- at0039::Crying - The child was crying.
- at0040::Test environment - The environment in which the test is administered.
- at0041::Audiometric booth - Sound-treated test environment that meets audiometric standards for ambient noise.
- at0042::Non-sound treated room - Test environment that does not meet audiometric standards for ambient noise.
- at0043::Background noise - The amount and nature of noise in the environment that may influence the test results.
- at0044::Not clinically significant - The background noise is not likely to compromise test results.
- at0045::Clinically significant - The background noise may compromise test results.
- at0046::Calibration reference dB - Scale used for acoustic calibration of the test signal.
- at0047::dB SPL - The test stimuli are calibrated using the sound pressure level scale.
- at0048::dB HL - The test stimuli are calibrated using the hearing level scale.
- at0049::dB A - The test stimuli are calibrated using the A-weighted scale.
- at0050::Air presentation - Presentation of the air conduction test stimulus indirectly to the inner ear through the atmosphere, via the auditory canal and middle ear structures.

- at0051::Soundfield - The stimulus is presented via a loudspeaker located at least one metre away from the subject.
- at0052::Insert earphone - The stimulus is presented via insert earphones.
- at0053::Headphone - The stimulus is presented via external headphones - either circumaural or supraaural.
- at0054::Response - *
- at0055::Startle reflex - Moro reflex in response to stimulus.
- at0056::Auropalpebral reflex - An involuntary blink of the eye caused by contraction of the orbicularis oculi muscle in response to loud sounds.
- at0057::No response - *
- at0058::Arousal - Baby has heightened state of arousal in response to the stimulus.
- at0059::Stilling - Baby ceases current activity.
- at0060::Eye response - Eye widening, eye movement or eye turn.
- at0061::Head turn - Baby turns head in response to stimulus.

beighton_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.beighton_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** For recording the details of the Beighton hypermobility score for quantifying joint laxity and hypermobility.

****Use:**** To be used to record a the Beighton hypermobility score as one of the criteria in diagnosing benign joint hypermobility syndrome.

****Keywords:**** beighton, hypermobility, joint laxity, BHJS

****Concepts:****

- at0000::Beighton hypermobility score - The Beighton hypermobility score for quantifying joint laxity and hypermobility.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Left little finger - Assessment of passive dorsiflexion in the left little (fifth) finger.

- at0005::Less than or equal to 90 degrees - Passive dorsiflexion in the left little finger is less than or equal to 90 degrees.
- at0006::Beyond 90 degrees - Passive dorsiflexion in the left little finger is beyond 90 degrees.
- at0007::Right little finger - Assessment of passive dorsiflexion in the right little (fifth) finger.
- at0008::Less than or equal to 90 degrees - Passive dorsiflexion in the right little finger is less than or equal to 90 degrees.
- at0009::Beyond 90 degrees - Passive dorsiflexion in the right little finger is beyond 90 degrees.
- at0010::Tree - @ internal @
- at0011::Confounding factors - Narrative record of any issues or factors that may have contributed to the Brighton score.
- at0012::Tree - @ internal @
- at0013::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0014::Left thumb - Assessment of passive dorsiflexion of the left thumb.
- at0015::No passive dorsiflexion to flexor - Passive dorsiflexion in left thumb is not observed to be to the flexor aspect of the forearm.
- at0016::Passive dorsiflexion to flexor - Passive dorsiflexion in left thumb is observed to be to the flexor aspect of the forearm.
- at0017::Right thumb - Assessment of passive dorsiflexion of the right thumb.
- at0018::No passive dorsiflexion to flexor - Passive dorsiflexion in right thumb is not observed to be to the flexor aspect of the forearm.
- at0019::Passive dorsiflexion to flexor - Passive dorsiflexion in right thumb is observed to be to the flexor aspect of the forearm.
- at0020::Left elbow - Assessment of hyperextension in left elbow.
- at0021::Less than or equal to 10 degrees - Hyperextension in left elbow is observed to be less than or equal to 10 degrees.
- at0022::Beyond 10 degrees - Hyperextension in left elbow is observed to be beyond 10 degrees.
- at0023::Right elbow - Assessment of hyperextension in right elbow.
- at0024::Less than or equal to 10 degrees - Hyperextension in right elbow is observed to be less than or equal to 10 degrees.
- at0025::Beyond 10 degrees - Hyperextension in right elbow is observed to be beyond 10 degrees.
- at0026::Left knee - Assessment of hyperextension in left knee.
- at0027::Less than or equal to 10 degrees - Hyperextension in left knee is observed to be less than or equal to 10 degrees.
- at0028::Beyond 10 degrees - Hyperextension in left knee is observed to be beyond 10 degrees.
- at0029::Right knee - Assessment of hyperextension in right knee.

- at0030::Trunk - Assessment of forward flexion of trunk with knees fully extended.
- at0031::Not resting flat - Palms and hands are observed to not rest flat on the floor.
- at0032::Resting flat - Palms and hands are observed to rest flat on the floor.
- at0033::Less than or equal to 10 degrees - Hyperextension in right knee is observed to be less than or equal to 10 degrees.
- at0034::Beyond 10 degrees - Hyperextension in left knee is observed to be beyond 10 degrees.
- at0035::Total score - Total score of all 9 elements of Beighton test.
- at0036::Clinical interpretation - Narrative interpretation of assessment.

bishop_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.bishop_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the Bishop Score findings on vaginal examination of a pregnant woman.

****Use:**** Use to record the Bishop Score findings on vaginal examination of a pregnant woman.

****Misuse:**** Not to be used to record the findings of physical examination of the vagina and cervix. Use the CLUSTER.exam-palpation-cervix for this purpose.

****Keywords:**** Bishop score, Cervix score, ripeness, induction

****Concepts:****

- at0000::Bishop score - Assessment of readiness of the cervix in anticipation of induction of labour.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Fetal station - The position of the fetal head in relation to the ischial spines.
- at0005::- 3 - Fetal station is 3cm above the level of the ischial spines.
- at0006::- 2 - Fetal station is 2cm above the level of the ischial spines.

- at0007::-1, 0 - Fetal station is 1cm above the level of the ischial spines or leveled with the ischial spines; 0cm.
- at0008::+1, +2 - Fetal station is 1 or 2cm below the level of the ischial spines.
- at0009::Dilation - Diameter of the cervical os.
- at0010::Closed - The cervical os is closed.
- at0011::1-2 cm - The cervical os is 1-2 cm dilated.
- at0012::3-4 cm - The cervical os is 3-4 cm dilated.
- at0013::5+ cm - The cervical os is 5+ cm dilated.
- at0014::Effacement - Thinning of the cervix.
- at0015::0 - 30% - Cervical effacement is estimated to 0 - 30%.
- at0016::40 - 50% - Cervical effacement is estimated to 40 - 50%.
- at0017::60 - 70% - Cervical effacement is estimated to 60 - 70%.
- at0018::80+ % - Cervical effacement is estimated to 80+ %.
- at0019::Consistency - The amount of softening of the cervix, indicating a decline in the tissue tensile strength.
- at0020::Firm - The cervix feels firm.
- at0021::Medium - The cervix feels neither firm nor soft, but in between.
- at0022::Soft - The cervix feels soft.
- at0023::Position - Position of the cervix.
- at0024::Posterior - The cervix is located posteriorly, towards the sacrum.
- at0025::Middle - The cervix is located centrally, in the typical anatomical position.
- at0026::Anterior - The cervix is located anteriorly, towards the pubis.
- at0027::Total score - Sum of the individual scores assigned for each of the contributing variables.
- at0028::ItemTree - @ internal @
- at0030::Comment - Additional narrative about the overall Bishop score not captured in other fields.
- at0031::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

blood_pressure

****Archetype ID:**** openEHR-EHR-OBSERVATION.blood_pressure.v2

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, ru, sv, fi, ko, pt-br, el, ar-sy, en, zh-cn, es, es-ar, nb, ja, fa, nl, ca

****Purpose:**** To record the systemic arterial blood pressure of an individual.

****Use:**** Use to record all representations of systemic arterial blood pressure measurement, no matter which method or body location is used to record it. The archetype is intended to capture blood pressure measurements in all clinical scenarios - for example: - self-measurement with a home blood pressure machine; - an emergency assessment of systolic using palpation and a sphygmomanometer; - measurements taken in clinical consultations or during exercise stress testing; and - a series of measurements made by a machine in Intensive Care. There is a rich state model that supports interpretation of measurements through identifying patient position, exercise, confounding factors and angle of a tilt table in research. Named events have been limited to average over a 24 hour period, however templates can further constrain the default 'any event' to cater for specific requirements for blood pressure measurements such as recording Blood Pressure against specific points in time, or over a range of intervals (+/- mathematical functions).

****Misuse:**** Not to be used to record the measurement of arterial blood pressure which is NOT a surrogate for arterial pressure in the systemic circulation eg specific measurement of right pulmonary artery pressure. Use OBSERVATION.intravascular_pressure in this situation. Not to be used to record measurements of intravenous pressure. Use the appropriate specialisations of OBSERVATION.intravascular_pressure in this situation.

****Keywords:**** observations, measurement, bp, vital signs, mean arterial pressure, pulse pressure, systolic, diastolic, RR, NIBP

****Concepts:****

- at0000::Blood pressure - The local measurement of arterial blood pressure which is a surrogate for arterial pressure in the systemic circulation.
- at0001::History - History Structural node.
- at0003::blood pressure - @ internal @
- at0004::Systolic - Peak systemic arterial blood pressure - measured in systolic or contraction phase of the heart cycle.
- at0005::Diastolic - Minimum systemic arterial blood pressure - measured in the diastolic or relaxation phase of the heart cycle.
- at0006::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0007::state structure - @ internal @
- at0008::Position - The position of the individual at the time of measurement.
- at0011::Tree - List structure.
- at0013::Cuff size - The size of the cuff used for blood pressure measurement.
- at0014::Location of measurement - Simple body site where blood pressure was measured.
- at0015::Adult Thigh - A cuff used for an adult thigh.
- at0016::Large Adult - A cuff for adults with larger arms.
- at0017::Adult - A cuff that is standard for an adult.
- at0025::Right arm - The right arm of the person.

- at0026::Left arm - The left arm of the person.
- at0027::Right thigh - The right thigh of the person.
- at0028::Left thigh - The left thigh of the person.
- at0033::Comment - Additional narrative about the measurement, not captured in other fields.
- at1000::Standing - Standing at the time of blood pressure measurement.
- at1001::Sitting - Sitting (for example on bed or chair) at the time of blood pressure measurement.
- at1002::Reclining - Reclining at the time of blood pressure measurement.
- at1003::Lying - Lying flat at the time of blood pressure measurement.
- at1005::Tilt - The craniocaudal tilt of the surface on which the person is lying at the time of measurement.
- at1006::Mean arterial pressure - The average arterial pressure that occurs over the entire course of the heart contraction and relaxation cycle.
- at1007::Pulse pressure - The difference between the systolic and diastolic pressure.
- at1008::Small Adult - A cuff used for a small adult.
- at1009::Paediatric/Child - A cuff that is appropriate for a child or adult with a thin arm.
- at1010::Diastolic endpoint - Record which Korotkoff sound is used for determining diastolic pressure using auscultative method.
- at1011::Phase IV - The fourth Korotkoff sound is identified as an abrupt muffling of sounds.
- at1012::Phase V - The fifth Korotkoff sound is identified by absence of sounds as the cuff pressure drops below the diastolic blood pressure.
- at1014::Lying with tilt to left - Lying flat with some lateral tilt, usually angled towards the left side. Commonly required in the last trimester of pregnancy to relieve aortocaval compression.
- at1018::Infant - A cuff used for infants.
- at1019::Neonatal - A cuff used for a neonate, assuming cuff is the appropriate size for maturity and birthweight of the neonate.
- at1020::Right wrist - The right wrist of the individual.
- at1021::Left wrist - The left wrist of the individual.
- at1025::Device - Details about sphygmomanometer or other device used to measure the blood pressure.
- at1026::Right ankle - The right ankle of the individual.
- at1030::Exertion - Details about physical activity undertaken at the time of blood pressure measurement.
- at1031::Left ankle - The left ankle of the individual.
- at1032::Finger - A finger of the individual.
- at1035::Method - Method of measurement of blood pressure.
- at1036::Auscultation - Method of measuring blood pressure externally, using a stethoscope and Korotkoff sounds.

- at1037::Palpation - Method of measuring blood pressure externally, using palpation (usually of the brachial or radial arteries).
- at1038::Mean arterial pressure formula - Formula used to calculate the Mean Arterial Pressure (if recorded in data).
- at1039::Machine - Method of measuring blood pressure externally, using a blood pressure machine.
- at1040::Invasive - Method of measuring blood pressure internally ie involving penetration of the skin and measuring inside blood vessels.
- at1042::24 hour average - Estimate of the average blood pressure over a 24 hour period.
- at1043::Sleep status - Sleep status - supports interpretation of 24 hour ambulatory blood pressure records.
- at1044::Awake - The individual is fully conscious.
- at1045::Sleeping - The individual is in the natural state of bodily rest.
- at1051::Toe - A toe of the individual.
- at1052::Confounding factors - Comment on and record other incidental factors that may be contributing to the blood pressure measurement. For example, level of anxiety or 'white coat syndrome'; pain or fever; changes in atmospheric pressure etc.
- at1053::Intra-arterial - Invasive measurement via transducer access line within an artery.
- at1054::Systolic pressure formula - Formula used to calculate the systolic pressure from mean arterial pressure (if recorded in data).
- at1055::Diastolic pressure formula - Formula used to calculate the diastolic pressure from mean arterial pressure (if recorded in data).
- at1057::Structured measurement location - Structured anatomical location of where the measurement was taken.
- at1058::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at1059::Clinical interpretation - Single word, phrase or brief description that represents the clinical meaning and significance of the blood pressure measurement.
- at1056::Dorsum of foot - The individual's dorsum of the foot.

body_composition

****Archetype ID:**** openEHR-EHR-OBSERVATION.body_composition.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** pt, en

****Purpose:**** To record the measurement of the amounts and percentages of fat, bone, water and muscle in the body of an individual.

****Use:**** Use to record the measurement of the amounts and percentages of fat, bone, water and muscle in the body of an individual, either directly or through calculation from measurements of skin folds or similar.

****Misuse:**** Not to be used to record the total body weight of an individual. Use the OBSERVATION.body_weight archetype for this purpose. Not to be used for recording the actual measurement of skin folds or other measurements that may be used to calculate body composition. Use other relevant OBSERVATION archetypes for these purposes.

****Keywords:**** Body fat, Muscle mass, Fat free mass, Adiposity, Body fat percentage, body fat %

****Concepts:****

- at0000::Body composition - Measurement of the amounts and percentages of fat, bone, water and muscle in the body of an individual.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Fat mass - Body fat measurement in mass.
- at0008::Fat free mass - Measurement of fat free mass (FFM) which corresponds to protein, water and minerals.
- at0010::Tree - @ internal @
- at0012::Method - The methods used to measure body composition.
- at0018::Device - Details about devices used to measurement of body composition.
- at0022::Fat percentage formula - Formula used to calculate the fat percentage by skinfold thickness.
- at0028::Tree - @ internal @
- at0036::State of dress - Description of the state of dress of the individual at the time of measurement.
- at0042::Confounding factors - Other incidental factors that may impact on the body composition measurement.
- at0043::Lightly clothed/underwear - Clothing which will not add to weight significantly.
- at0044::Naked - Without any clothes.
- at0045::Nappy/diaper - Wearing only a nappy.
- at0060::Atomic level - Measurement of four compartments model of body composition.
- at0064::Molecular level - Measurement of four compartments model of body composition, eg: Minerals, protein, fat and water.
- at0065::Cellular level - Measurement of three compartments model of body composition. eg: fat mass, lean body mass and bone.

- at0068::Tissue-system level - Measurement of five compartments model of body composition, eg: other tissue, visceral organs, bone, skeletal muscle and adipose tissue.
- at0069::Whole body - Measurement of five compartments model of body composition, eg: lower limbs, upper limbs, trunk, neck and head.
- at0096::Oxygen - Assessment of chemical element oxygen.
- at0097::Carbon - Assessment of chemical element carbon.
- at0098::Chemical elements - Assessment of chemical elements eg: N, Ca, P, S, Na, K, Cl ; H, C and O.
- at0100::Hydrogen - Assessment of chemical element hydrogen.
- at0101::Water - Assessment of body water.
- at0102::Fat - Assessment of body fat.
- at0103::Protein - Assessment of body protein.
- at0104::Minerals - Assessment of body minerals.
- at0105::Cell mass - Measurement of cellular mass.
- at0106::Extracellular fluids - Measurement of extracellular fluids.
- at0107::Extracellular solids - Measurement of extracellular solids.
- at0109::Skeletal muscle - Measurement of skeletal muscle.
- at0110::Bone - Measurement of body bone.
- at0111::Visceral organs - Measurement of visceral organs.
- at0112::Other tissues - Measurement of other body tissues.
- at0113::Head - Measurement of head.
- at0114::Neck - Measurement of neck.
- at0116::Trunk - Measurement of trunk.
- at0118::Lower limbs - Measurement of lower limbs.
- at0119::Upper limbs - Measurement of upper limbs.
- at0120::Basic model - Two compartment model with partitions into fat mass (FM) and fat-free mass (FFM).
- at0124::Fat percentage - Body fat measurement in percentage.
- at0139::Adipose Tissue - Adipose tissue is defined as sum of adipose tissue, usually excluding bone marrow and adipose tissue

in the head, hands, and feet.

- at0141::Subcutaneous adipose tissue mass - Measurement of subcutaneous adipose tissue (SAT) mass.
- at0142::Menstrual cycle - Details of women's menstrual cycle.
- at0144::Total adipose tissue - Measurement of adipose tissue (TAT).
- at0145::Visceral adipose tissue mass - Measurement of visceral adipose tissue (VAT) mass.
- at0146::Interstitial adipose tissue area - Measurement of Interstitial adipose tissue (IAT).
- at0150::Location of measurement - Body site where the measurement was performed.

- at0160::Visceral adipose tissue area - Measurement of visceral adipose tissue (VAT) area.
- at0161::Visceral adipose tissue volume - Measurement of visceral adipose tissue (VAT) volume.
- at0162::Subcutaneous adipose tissue area - Measurement of subcutaneous adipose tissue (SAT) area.
- at0163::Subcutaneous adipose tissue volume - Measurement of subcutaneous adipose tissue (SAT) volume.

body_mass_index

****Archetype ID:**** openEHR-EHR-OBSERVATION.body_mass_index.v2

****Lifecycle State:**** published

****Category:**** OBSERVATION

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

****Purpose:**** To record the Body Mass Index (BMI) of an individual.

****Use:**** Use to record the Body Mass Index of both adults and children. Use to enter the Body Mass Index either manually (ie calculated and directly entered by the clinician), or automatically (ie calculation and entry is done automatically by a software application, based on separate height and weight measurements). Formulas: Body Mass Index is commonly calculated as weight (kg) / [height (m) squared]. This is the assumed formula unless otherwise specified in the Formula element within Protocol. Alternatively estimate Body Mass Index using pounds and inches: weight (lb) / [height (in) squared] x 703 (with ounces (oz) and fractions changed to decimal values). In some situations the Body Mass Index formula is corrected eg for use in amputees - this specific formula can be recorded as part of the protocol. Alternatively the common Body Mass Index calculation can be used with amputees and similar injuries or disabilities if using adjusted height and/or adjusted weight, as appropriate, rather than actual height and weight. See openEHR-EHR-OBSERVATION.height-adjusted and openEHR-EHR-OBSERVATION.body_weight-adjusted. See WHO reference re adjusting height/length for Body Mass Index in paediatrics. In children and teens, BMI needs to be assessed using age-related reference charts.

****Misuse:**** Not intended to record information regarding Body Mass Index percentiles - use the OBSERVATION.child_growth archetype for this purpose.

****Keywords:**** obesity, index, body mass, BMI, anorexia, Quetelet, malnutrition, failure to thrive, bulimia

****Concepts:****

- at0000::Body mass index - Calculated measurement which compares a person's weight and height.
- at0001::history - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Single - @ internal @
- at0004::Body mass index - Index describing ratio of weight to height.
- at0005::Tree - @ internal @
- at0006::Method - The method of entering the body mass index.
- at0007::Automatic entry - Body Mass Index calculated and entered automatically without user intervention.
- at0008::Direct entry - Body Mass Index calculated and entered directly by user.
- at0010::Formula - Formula used to derive the body mass index.
- at0011::Confounding factors - Narrative description of any issues or factors that may impact on the calculation.
- at0012::Comment - Additional narrative about the calculation, not captured in other fields.
- at0013::Clinical interpretation - Single word, phrase or brief description that represents the clinical meaning and significance of the body mass index.
- at0014::Tree - @ internal @
- at0015::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

body_segment_area

****Archetype ID:**** openEHR-EHR-OBSERVATION.body_segment_area.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the calculation of the cross-sectional area of an identified part of the body, usually identified in relation to points of surface anatomy.

****Use:**** Use to record the calculation of the cross-sectional area of an identified part of the body, usually identified in relation to points of surface anatomy, including an indication of the relative location of the measurement point, if required. For example: to record the estimation of a mid upper arm area at the mid point between the acromion process of the

scapula and the olecranon process of the ulna. The body segment area may be recorded and tracked over time, for example to provide insight into the shape and proportions of an individual's body for purposes of clinical, anthropometric or ergonomic assessment.

Common parameters that are measured as circumferences have been added to the DV_CODED_TEXT data type in the 'Body segment name' data element. As further parameters are identified, these can be added to this list over time.

****Misuse:**** Not to be used to record a body surface area measurement - use the OBSERVATION.body_surface_area for this purpose. Not to be used to record common body segment measurements that have been modelled as separate archetypes, including, but not limited to: - for Head circumference - use OBSERVATION.head_circumference; - for Hip circumference - use OBSERVATION.hip_circumference; - for Waist circumference - use OBSERVATION.waist_circumference; and - for Chest circumference - use OBSERVATION.chest_circumference. Not to be used to record the length, height or width measured between two identified points on the body - use OBSERVATION.body_segment_length for this purpose. Not to be used to record the circumference of a body segment - use OBSERVATION.body_segment_circumference for this purpose. Not to be used to record the area of an internal body organ or a lesion.

****Keywords:**** anthropometry, measurement, area

****Concepts:****

- at0000::Body segment area - Calculation of the cross-sectional area of an identified part of the body, usually identified in relation to points of surface anatomy.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Body segment name - Name of the measured body segment.
- at0005::Laterality - Side of the segment measured.
- at0006::Left - Left side of the body.
- at0007::Right - Right side of the body.
- at0008::Area - Calculated area of the identified body segment.
- at0009::Comment - Additional narrative about the calculation of the area of the body segment, not captured in other fields.
- at0010::ItemTree - @ internal @
- at0011::Confounding factors - Record any issues or factors that may impact on the measurement of the body segment.
- at0014::ItemTree - @ internal @
- at0015::Measuring device - Details of the device used for measuring the body part.
- at0016::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

- at0017::Upper arm muscle area - Calculation of the area of the upper arm, usually derived from the measurement of the upper arm circumference.
- at0027::Measurement method - Narrative description of the method used for measurement.
- at0029::Measurement origin/endpoint - Identification of a simple body site for the location of the origin/end point of the circumference measurement.
- at0030::Structured origin/endpoint - A structured anatomical location for the start/end point of the circumference measurement including relative location, if required.
- at0031::Body position - The position of the individual at the time of measurement.
- at0036::Standing - Standing at the time of measurement.
- at0037::Sitting - Sitting (for example on bed or chair) at the time of measurement.
- at0039::Lying - Lying flat at the time of measurement.

body_segment_circumference

****Archetype ID:**** openEHR-EHR-OBSERVATION.body_segment_circumference.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the measurement of the distance around a part of the body, usually identified in relation to points of surface anatomy.

****Use:**** Use to record the measurement of the distance around a part of the body, usually identified in relation to points of surface anatomy, including an indication of the relative location of the measurement start/endpoint, if required. For example: to record that a measurement around the calf was taken 10cm distal to the tibial tuberosity. Body segment measurements that are ubiquitous and, most commonly, used as part of growth charting in childhood have been modelled as unique and discrete archetypes. Rather than create an archetype for every single possible body segment measurement, the intent of this archetype is to use a common recording pattern to capture any, or all, other possible measurements of measurements around a part of the body, identified by the 'Body segment name' data element. This measurement may be recorded and tracked over time, for example to provide insight into the shape and proportions of an individual's body for purposes of clinical, anthropometric or ergonomic assessment, to record the measurement of abnormal clinical findings or observations in order to track the progress of a condition or disease. Common parameters that are measured as circumferences have been added to the DV_CODED_TEXT data type in the 'Body segment name' data element. As further parameters are identified, these can be added to this list over time.

****Misuse:**** Not to be used to record common body segment measurements that have been modelled as separate archetypes, including, but not limited to: - for Head circumference - use OBSERVATION.head_circumference; - for Hip circumference - use OBSERVATION.hip_circumference; - for Waist circumference - use OBSERVATION.waist_circumference; and - for Chest circumference - use OBSERVATION.chest_circumference. Not to be used to record the circumference of an internal body organ or a lesion. Not to be used to record the length, height or width measured between two identified points on the body - use OBSERVATION.body_segment_length for this purpose. Not to be used to record the area of a body segment - use OBSERVATION.body_segment_area for this purpose.

****Keywords:**** anthropometry, measurement, circumference

****Concepts:****

- at000::Body segment circumference - Measurement of the distance around an identified part of the body, usually identified in relation to points of surface anatomy.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Body segment name - Name of the measured body segment.
- at0005::Laterality - Side of the segment measured.
- at0006::Left - Left side of the body.
- at0007::Right - Right side of the body.
- at0008::Circumference - Measured girth of the identified body segment.
- at0009::Comment - Additional narrative about the circumference measurement of the body segment, not captured in other fields.
- at0010::ItemTree - @ internal @
- at0011::Confounding factors - Record any issues or factors that may impact on the measurement of the body segment.
- at0012::Average measurement - The average of several measurements of the same body segment taken during a single examination.
- at0014::ItemTree - @ internal @
- at0015::Measuring device - Details of the device used for measuring the body part.
- at0016::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0017::Arm Circumference - Girth of the upper arm.
- at0018::Thigh circumference - Girth of the upper leg.
- at0019::Calf circumference - Girth of the calf muscle of the lower leg.
- at0027::Measurement method - Narrative description of the method used for measurement.

- at0029::Measurement origin/endpoint - Identification of a simple body site for the location of the start/end point of the measurement.
- at0030::Structured origin/endpoint - A structured anatomical location for the start/end point of the measurement including relative location, if required.
- at0031::Body position - The position of the individual at the time of measurement.
- at0036::Standing - Standing at the time of measurement.
- at0037::Sitting - Sitting (for example on bed or chair) at the time of measurement.
- at0039::Lying - Lying flat at the time of measurement.
- at0041::Forearm circumference - Girth of the forearm.

body_segment_discrepancy

****Archetype ID:**** openEHR-EHR-OBSERVATION.body_segment_discrepancy.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the difference in length or circumference between paired body segments.

****Use:**** Use to record the difference in length or circumference between paired body segments. Body segment length is a measurement of the distance between two points of surface anatomy, and body segment circumference is the measurement of the distance around an identified part of the body. The design intent of this archetype is to use a common recording pattern to capture length discrepancies between paired body segments, identified by the 'Paired body segment name' data element. The discrepancy may be recorded and tracked over time, for example tracking the discrepancy as a child grows, or used to provide insight into the shape and proportions of an individual's body for purposes of clinical, anthropometric or ergonomic assessment. Common parameters that are measured between two identified points have been added to the DV_CODED_TEXT data type in the 'Body segment name' data element. As further parameters are identified, these can be added to the list within the 'Body segment name' element. The elements 'Measurement method', 'Measurement origin', 'Structured origin', 'Measurement endpoint' and 'Structured endpoint' is redundant if already recorded in the OBSERVATION.body_segment_length when recording the actual length of the body segments.

****Misuse:**** Not to be used to record the length of a body segment - use OBSERVATION.body_segment_length for this purpose.

****Keywords:**** anthropometry, measurement, length, height, width, assymetry, circumference

****Concepts:****

- at0000::Body segment discrepancy - The difference in length or circumference between paired body segments.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Body segment measurement - Name of the body segment measurement, which is used to calculate the discrepancy.
- at0008::Discrepancy - Measured or calculated discrepancy between paired body segments.
- at0009::Comment - Additional narrative about the discrepancy, not captured in other fields.
- at0014::ItemTree - @ internal @
- at0015::Measuring device - Details of the device used for measuring the body segment.
- at0016::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0027::Measurement method - Narrative description of the method used for measurement.
- at0029::Measurement origin - Identification of a simple body site for the location of the starting point of the measurement.
- at0030::Structured origin - A structured anatomical location for the starting point of the measurement.
- at0033::Measurement endpoint - Identification of a simple body site for the location of the ending point of the measurement.
- at0035::Structured endpoint - A structured anatomical location for the endpoint of the measurement.
- at0046::Longest side - The laterality of the longest paired segment.
- at0047::Left - None
- at0048::Right - None
- at0049::Upper arm length - None
- at0050::Leg length - None
- at0051::Upper leg length - None
- at0052::Foot length - None
- at0053::Knee height - None
- at0054::Forearm length - None
- at0055::Lower leg length - None
- at0056::Shoulder height - None
- at0057::Sitting shoulder height - None

- at0058::Calf circumference - None

body_segment_length

****Archetype ID:**** openEHR-EHR-OBSERVATION.body_segment_length.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** sv, nb, en

****Purpose:**** To record the measurement of the distance between two points of surface anatomy.

****Use:**** Use to record the measurement of the distance between two points of surface anatomy. Body segment measurements that are ubiquitous and, most commonly, used as part of growth charting in childhood have been modelled as unique and discrete archetypes. Rather than create an archetype for every single possible body segment measurement, the intent of this archetype is to use a common recording pattern to capture any, or all, other possible measurements between two identified body points, identified by the 'Body segment name' data element. This measurement may be recorded and tracked over time, for example tracking child growth parameters, or used to provide insight into the shape and proportions of an individual's body for purposes of clinical, anthropometric or ergonomic assessment. It may also be used to record the measurement of abnormal clinical findings or observations in order to track the progress of a condition or disease. Common parameters that are measured between two identified points have been added to the DV_CODED_TEXT data type in the 'Body segment name' data element. As further parameters are identified, these can be added to this list over time.

****Misuse:**** Not to be used to record common body segment measurements that have been modelled as separate archetypes, including, but not limited to: - for Head circumference - use OBSERVATION.head_circumference; - for Hip circumference - use OBSERVATION.hip_circumference; - for Waist circumference - use OBSERVATION.waist_circumference; and - for Chest circumference - use OBSERVATION.chest_circumference. Not to be used to record the circumference of a body segment - use OBSERVATION.body_segment_circumference for this purpose. Not to be used to record the area of a body segment - use OBSERVATION.body_segment_area for this purpose. Not to be used to record the dimensions of an internal body organ or a lesion. Not to be used to record skinfold measurements - use archetypes that are specific for this purpose. Not to be used to measure the Crown-rump length for a fetus, using imaging technology. Not to be used to record the measurement of the difference in length between

paired body segments. Use the OBSERVATION.body_segment_length_discrepancy archetype for this purpose.

****Keywords:**** anthropometry, measurement, length, height, width, span

****Concepts:****

- at000::Body segment length - Measurement of the distance between two points of surface anatomy.
- at001::Event Series - @ internal @
- at002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at003::ItemTree - @ internal @
- at004::Body segment name - Name of the measured body segment.
- at005::Laterality - Side of the segment measured.
- at006::Left - Left side of the body.
- at007::Right - Right side of the body.
- at008::Length - Measured value of the length of the body segment.
- at009::Comment - Additional narrative about the length measurement of the body segment, not captured in other fields.
- at010::ItemTree - @ internal @
- at011::Confounding factors - Record any issues or factors that may impact on the measurement of the body segment.
- at012::Average measurement - The average of several measurements of the same body segment taken during a single examination.
- at014::ItemTree - @ internal @
- at015::Measuring device - Details of the device used for measuring the body part.
- at016::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at017::Sitting height - Vertical distance between the sitting surface and the vertex of the head. A measure of trunk length, performed with the individual sitting erect.
- at018::Upper arm length - Distance between the shoulder and the elbow.
- at019::Leg length - Distance between the hip joint and the ankle joint.
- at020::Upper leg length - Distance between the hip joint and the knee joint.
- at021::Foot length - Distance between the base of the heel to the tip of the longest toe.
- at022::Crown-rump length - Distance between vertex of head to the lowest part of the trunk.
- at023::Knee height - Distance between the sole of the foot and the top of the lower leg.
- at024::Armspan - Distance from fingertip to fingertip with both arms fully extended at right angles to the body.
- at027::Measurement method - Narrative description of the method used for measurement.

- at0029::Measurement origin - Identification of a simple body site for the location of the starting point of the measurement.
- at0030::Structured origin - A structured anatomical location for the starting point of the measurement.
- at0031::Body position - The position of the individual at the time of measurement.
- at0033::Measurement endpoint - Identification of a simple body site for the location of the ending point of the measurement.
- at0035::Structured endpoint - A structured anatomical location for the endpoint of the measurement.
- at0036::Standing - Standing at the time of measurement.
- at0037::Sitting - Sitting (for example on bed or chair) at the time of measurement.
- at0039::Lying - Lying flat at the time of measurement.
- at0041::Forearm length - Distance from the elbow to the wrist.
- at0042::Lower leg length - Distance between the knee joint and the ankle joint.
- at0043::Shoulder height - Vertical distance from the standing surface to the acromion.
- at0044::Sitting shoulder height - Vertical distance from the sitting surface to the acromion.

body_surface_area

****Archetype ID:**** openEHR-EHR-OBSERVATION.body_surface_area.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, fi, nb, en

****Purpose:**** To record the measured or calculated surface area of a human body.

****Use:**** Use to record the measured or calculated surface area of a human body. BSA can be used to support clinical decision-making, including but not limited to: - determine the dosage of chemotherapy and other drugs with a narrow therapeutic index; - calculation of the cardiac index; and - calculation of intravenous fluid requirements.

****Misuse:**** Not to be used to record the percentage of body surface area involvement in burns or other skin damage etc. This information should be carried in separate specific archetypes related to burns assessment. Not to be used to record the adjusted Body surface area eg a calculation of the BSA of a person with limb amputation, based on other body part measurements and an algorithm - use OBSERVATION.body_surface_area-adjusted.

****Keywords:**** body, surface, area, BSA, surface area

****Concepts:****

- at0000::Body surface area - The measured or calculated surface area of a human body.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Body Surface Area - The measured or calculated surface area of a human body.
- at0005::Tree - @ internal @
- at0006::Formula - Formula used to calculate the BSA.
- at0007::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0008::Device - The device used to measure or estimate the body surface area.
- at0009::Method - The method by which the body surface area was entered into the clinical system.
- at0010::System entry - The Area was entered automatically by the clinical system and without manual intervention of the clinician.
- at0011::Manual entry - The Area was entered manually by the clinician.
- at0012::Dubois and Dubois - The Dubois and Dubois formula was used to calculate the body surface area.
- at0013::Mosteller - The Mosteller formula was used to calculate the body surface area.
- at0014::Haycock - The Haycock formula was used to calculate the body surface area.
- at0015::Gehan and George - The Gehan and George formula was used to calculate the body surface area.
- at0016::Boyd - The Boyd formula was used to calculate the body surface area.
- at0017::Fujimoto - The Fujimoto formula was used to calculate the body surface area.
- at0018::Takihara - The Takihara formula was used to calculate the body surface area.
- at0019::Comment - Additional narrative about the measurement, not captured in other fields.
- at0020::Tree - @ internal @
- at0021::Confounding factors - Record of any issues or factors that may impact on the measurement or calculation of body surface area.

body_temperature

****Archetype ID:**** openEHR-EHR-OBSERVATION.body_temperature.v2

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, ru, sv, fi, pt-br, ar-sy, en, it, es, nb, es-ar, ja, fa, nl

****Purpose:**** To record the measured temperature of a person - as a surrogate for the core body temperature.

****Use:**** Used for recording the measurement of an individual's body temperature, which is a surrogate for the core body temperature of the individual. Additional clusters can be included to provide additional state data - including environmental conditions and exertion details, where appropriate. Please Note: The site and method of recording may need to be displayed to the end user to facilitate accurate interpretation of the temperature recorded.

****Misuse:**** This archetype is not to be used to record the temperature of any other object. This archetype is not to be used to record the temperature of a part of the body in isolation e.g. temperature of the sole of the foot as a part of chronic diabetes management.

****Keywords:**** temperature, body, core, fever, hypothermia, hyperthermia

****Concepts:****

- at0000::Body temperature - A measurement of the body temperature, which is a surrogate for the core body temperature of the individual.
- at0001::Tree - @ internal @
- at0002::History - @ internal @
- at0003::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0004::Temperature - The measured temperature.
- at0020::Protocol - @ internal @
- at0021::Location of measurement - Simple description about the site of measurement.
- at0022::Mouth - Temperature is measured within the mouth.
- at0023::Ear canal - Temperature is measured from within the external auditory canal.
- at0024::Axilla - Temperature is measured from the skin of the axilla with the arm positioned down by the side.
- at0025::Rectum - Temperature measured within the rectum.
- at0026::Nasopharynx - Temperature is measured within the nasopharynx.
- at0027::Urinary bladder - Temperature is measured in the urinary bladder.
- at0028::Intravascular - Temperature is measured within the vascular system.
- at0029::State - State information about the patient.
- at0030::Body exposure - The degree of exposure of the individual at the time of measurement.
- at0031::Naked - No clothing, bedding or covering.
- at0032::Reduced clothing/bedding - The person is covered by a lesser amount of clothing or bedding than deemed appropriate for the environmental circumstances.
- at0033::Appropriate clothing/bedding - The person is covered by an amount of clothing or bedding deemed appropriate for the environmental circumstances.

- at0034::Increased clothing/bedding - The person is covered by an increased amount of clothing or bedding than deemed appropriate for the environmental circumstances.
- at0041::Description of thermal stress - Narrative description of the conditions applied to the subject that might influence their measured body temperature.
- at0043::Skin - Temperature is measured from exposed skin.
- at0051::Vagina - Temperature is measured within the vagina.
- at0054::Oesophagus - Temperature is measured within the oesophagus.
- at0055::Inguinal skin crease - Temperature is measured in the inguinal skin crease between the leg and abdominal wall.
- at0056::Environmental conditions - Details about the environmental conditions at the time of temperature measurement.
- at0057::Exertion - Details about the exertion of the person at the time of temperature measurement.
- at0059::Device - Details about the device used to measure body temperature.
- at0060::Temple - Temperature is measured at the temple, over the superficial temporal artery.
- at0061::Forehead - Temperature is measured on the forehead.
- at0062::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0063::Comment - Additional comment about the body temperature measurement not captured in other fields.
- at0064::Structured measurement location - Structured details about the location of measurement.
- at0065::Day of menstrual cycle - Current day of the menstrual cycle.
- at0066::Confounding factors - Additional issues or factors that may impact on the measurement of body temperature, not captured in other fields.

body_weight

****Archetype ID:**** openEHR-EHR-OBSERVATION.body_weight.v2

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, ru, sv, fi, pt-br, ar-sy, en, fr, zh-cn, es, nb, ja, fa, nl, ca

****Purpose:**** To record the body weight of an individual - both actual and approximate.

****Use:**** To be used for recording the actual measurement of body weight, including when the individual is missing a body part due to a congenital cause or after surgical removal. A statement identifying the physical incompleteness of the body can be recorded in the

'Confounding factors' data element, if required. This is the usual archetype to be used for a typical measurement of weight, for example self-measured by the individual at home, a clinician measurement in a clinic/hospital, or a fitness instructor in a gymnasium. Can also be used for recording an approximation of body weight measurement in a clinical scenario where it is not possible to measure accurately body weight - for example, weighing an uncooperative child, or estimating the weight of an unborn fetus (where the 'subject of data' is the Fetus and recording occurs within the mother's health record). This is not modelled explicitly in the archetype as the openEHR Reference model allows approximations for any Quantity data type by setting the attribute Magnitude_status to the value '~'. At implementation, for example, an application user interface could allow clinicians to select an appropriately labelled check box adjacent to the Weight data field to indicate that the recorded weight is an approximation, rather than actual. To be used for recording weight change, that is, either weight loss or weight gain. This can currently be modelled by constraining the 'any event' to an interval with associated mathematical function of increase or decrease, as appropriate.

****Misuse:**** Not to be used to record a calculated body weight, such as an estimation of the body weight of a person with one or more limbs missing. A calculated body weight may be based on, some or all of, the measured body weight, other body measurements and an algorithm. Use other OBSERVATION archetypes for this purpose. Not to be used to record the weight of a body part or other object.

****Keywords:**** weight, gain, loss, increase, decrease, mass, estimate, actual

****Concepts:****

- at0000::Body weight - Measurement of the body weight of an individual.
- at0001::Simple - @ internal @
- at0002::history - @ internal @
- at0003::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0004::Weight - The weight of the individual.
- at0008::state structure - @ internal @
- at0009::State of dress - Description of the state of dress of the person at the time of weighing.
- at0010::Fully clothed, including shoes - Clothing which may add significantly to weight, including shoes.
- at0011::Lightly clothed/underwear - Clothing which will not add to weight significantly.
- at0013::Naked - Without any clothes.
- at0015::protocol structure - @ internal @
- at0017::Nappy/diaper - Wearing only a nappy - which may add significantly to weight.
- at0020::Device - Details about the weighing device.
- at0024::Comment - Additional narrative about the measurement of Body weight, not captured in other fields.

- at0025::Confounding factors - Record any issues or factors that may impact on the measurement of body weight eg timing in menstrual cycle, timing of recent bowel motion or noting of amputation.
- at0026::Birth - Usually the first weight, measured soon after birth. This event will only be used once per health record
- at0027::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0028::Fully clothed, without shoes - Clothing which may add significantly to weight.

[**boston_carpal_tunnel**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.boston_carpal_tunnel.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Use to capture and report Boston Carpal Tunnel Questionnaire (BOSTON) score details.

****Use:**** Use to capture and report Boston Carpal Tunnel Questionnaire Score. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Concepts:****

- at0000::Boston Carpal Tunnel Questionnaire Score (BOSTON) - Boston Carpal Tunnel Questionnaire Score.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Tree - @ internal @

- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0008::1 Severity at night - Patient-reported extent of hand or wrist pain at night.
- at0009::I do not have hand or wrist pain at night - The patient does not have hand or wrist pain at night.
- at0010::Mild pain - The patient has mild hand or wrist pain at night.
- at0011::Moderate pain - The patient has moderate hand or wrist pain at night.
- at0012::Severe pain - The patient has severe hand or wrist pain at night.
- at0104::Total score - Total score from Questions 1 to 11.
- at0105::Average score - Average score from Questions 1-11.
- at0110::2 Frequency waking due to pain - Patient-reported extent of hand or wrist pain at waking them at night.
- at0112::Never - The patient did not wake because of hand or wrist pain at night in the past two weeks.
- at0113::Once - The patient woke once because of hand or wrist pain at night in the past two weeks.
- at0114::Two or three times - The patient woke two or three times because of hand or wrist pain at night in the past two weeks.
- at0115::Four or five times - The patient woke four or five times of hand or wrist pain at night in the past two weeks.
- at0116::Very severe pain - The patient has very severe hand or wrist pain at night.
- at0118::3 Daytime pain - Patient-reported extent of hand or wrist pain at during the daytime.
- at0119::I never have pain during the day - The patient does not have hand or wrist pain during the day.
- at0120::I have mild pain during the day - The patient has mild hand or wrist pain during the day.
- at0121::I have moderate pain during the day - The patient has moderate hand or wrist pain during the day.
- at0122::I have severe pain during the day - The patient has severe hand or wrist pain during the day.
- at0123::I have very severe pain during the day - The patient has very severe hand or wrist pain during the day.
- at0124::More than five times - The patient woke more than five times of hand or wrist pain at night in the past two weeks.
- at0125::4 Frequency of daytime pain - Patient-reported extent frequency of hand or wrist pain at during the daytime.
- at0126::Never - The patient does not have hand or wrist pain during the day.
- at0127::Once or twice a day - The patient has hand or wrist pain once or twice a day.
- at0128::Three to five times a day - The patient has hand or wrist pain three to five times a day.

- at0129::More than five times a day - The patient has hand or wrist pain more than five times a day.
- at0130::The pain is constant - The patient has constant hand or wrist pain during the day.
- at0131::5 Duration of daytime pain - Patient-reported extent duration of hand or wrist pain at during the daytime.
- at0132::I never get pain during the day - The patient does not have hand or wrist pain during the day.
- at0133::Less than 10 minutes - The patient has experiences an episode of hand or wrist pain for less than 10 minutes during the day.
- at0134::10 to 60 minutes - The patient has experiences an episode of hand or wrist pain for 10 to 60 minutes during the day.
- at0135::Greater than 60 minutes - The patient has experiences an episode of hand or wrist pain for greater than 60 minutes during the day.
- at0136::The pain is constant throughout the day - The patient has experiences constant episodes of hand or wrist pain during the day.
- at0137::6 Numbness - Patient-reported extent of numbness (loss of sensation) in hand.
- at0138::No - The patient does not have numbness in hand.
- at0139::I have mild numbness - The patient has mild numbness in hand.
- at0140::I have moderate numbness - The patient has moderate numbness in hand.
- at0141::I have severe numbness - The patient has severe numbness in hand.
- at0142::I have very severe numbness - The patient has very severe numbness in hand.
- at0143::7 Weakness - Patient-reported extent of weakness in hand or wrist.
- at0144::No weakness - The patient does not have weakness in hand or wrist.
- at0145::Mild weakness - The patient has mild weakness in hand or wrist.
- at0146::Moderate weakness - The patient has moderate weakness in hand or wrist.
- at0147::Severe weakness - The patient has severe weakness in hand or wrist.
- at0148::Very severe weakness - The patient has very severe weakness in hand or wrist.
- at0149::8 Tingling - Patient-reported extent of tingling in hand or wrist.
- at0150::No tingling - The patient does not have tingling in hand or wrist.
- at0151::Mild tingling - The patient has mild tingling in hand or wrist.
- at0152::Moderate tingling - The patient has moderate tingling in hand or wrist.
- at0153::Severe tingling - The patient has severe tingling in hand or wrist.
- at0154::Very severe tingling - The patient has very severe tingling in hand or wrist.
- at0155::9 Numbness or Tingling at night - Patient-reported extent of numbness (loss of sensation) or tingling in hand or wrist at night.
- at0156::I have no numbness or tingling at night - The patient does not have numbness or tingling in hand or wrist at night.
- at0157::Mild - The patient has mild numbness or tingling in hand or wrist at night.
- at0158::Moderate - The patient has moderate numbness or tingling in hand or wrist at night.
- at0159::Severe - The patient has severe numbness or tingling in hand or wrist at night.

- at0160::Very severe - The patient has very severe numbness or tingling in hand or wrist at night.
- at0161::10 Frequency waking due to numbness - Patient-reported frequency waking due to numbness (loss of sensation) or tingling in hand or wrist at night.
- at0162::Never - The patient was not woken due to numbness or tingling in hand or wrist at night during the past two weeks.
- at0163::Once - The patient was woken once due to numbness or tingling in hand or wrist at night during the past two weeks.
- at0164::Two or three times - The patient was woken two or three times due to numbness or tingling in hand or wrist at night during the past two weeks.
- at0165::Four or five times - The patient was woken four or five times due to numbness or tingling in hand or wrist at night during the past two weeks.
- at0166::More than five times - The patient was woken more than five times due to numbness or tingling in hand or wrist at night during the past two weeks.
- at0167::11 Difficulty grasping - Patient-reported level of difficulty grasping and using small objects such as keys or pencils.
- at0168::No difficulty - The patient has no difficulty grasping and using small objects such as keys or pencils.
- at0169::Mild difficulty - The patient has mild difficulty grasping and using small objects such as keys or pencils.
- at0170::Moderate difficulty - The patient has moderate difficulty grasping and using small objects such as keys or pencils.
- at0171::Severe difficulty - The patient has severe difficulty grasping and using small objects such as keys or pencils.
- at0172::Very severe difficulty - The patient has very severe difficulty grasping and using small objects such as keys or pencils.

braden_scale

****Archetype ID:**** openEHR-EHR-OBSERVATION.braden_scale.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** fi, es-ar, nb, pt-br, en, zh-cn

****Purpose:**** To record information about factors used to assess the risk of pressure ulcer development, and the total Braden Scale score.

****Use:**** Use to assess risk of pressure ulcer development in an adult population or for children aged 5 and over, in both hospital and community settings. There are two

commonly used variants - one intended for hospital use and the other for home use. They differ only in the description of the Moisture data element where the frequency of bedding change is described as "three times per 24 hours" for home use or "once per shift" for hospital use. As these two descriptions have the same essential meaning, this archetype has used the most generally applicable wording, based on the home use variant. While openEHR archetypes are all freely available under an open license, the specific content of this Braden Scale archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. Copyright statement: Barbara Braden and Nancy Bergstrom, 1988 All rights reserved Copyright information: <http://bradenscale.com/copyright.htm>.

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****Keywords:**** pressure, sore, ulcer, Braden, adult, score, assessment

****Concepts:****

- at000::Braden scale - The Braden scale is a tool used to assess the risk of pressure ulcer development in adults and children over the age of five years.
- at001::Event Series - @ internal @
- at002::Any event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at003::Tree - @ internal @
- at004::Sensory perception - Ability to respond meaningfully to pressure-related discomfort.
- at005::Completely limited - Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body.
- at006::Very limited - Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.
- at007::Slightly limited - Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.
- at008::No impairment - Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
- at009::Moisture - Degree to which skin is exposed to moisture.
- at010::Activity - Degree of physical ability.
- at011::Bedfast - Confined to bed.

- at0012::Chairfast - Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.
- at0013::Walks occasionally - Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. OR spends majority of each day at home in bed or chair.
- at0014::Walks frequently - Walks outside room at least twice a day and inside room at least once every two hours during waking hours.
- at0015::Constantly moist - Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.
- at0016::Very moist - Skin is often, but not always moist. Linen must be changed as often as 3 times in 24 hours.
- at0017::Occasionally moist - Skin is occasionally moist, requiring an extra linen change approximately once a day.
- at0018::Rarely moist - Skin is usually dry, linen only requires changing at routine intervals.
- at0019::Mobility - Ability to change and control body position.
- at0020::Nutrition - Usual food intake pattern.
- at0021::Friction and shear - Friction occurs when skin moves against support surfaces. Shear occurs when skin and adjacent bony surface slide across one another.
- at0022::Total score - The sum of the ordinal scores recorded for each of the six component responses.
- at0023::Problem - Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.
- at0024::Potential problem - Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.
- at0025::No apparent problem - Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.
- at0026::Completely immobile - Does not make even slight changes in body or extremity position without assistance.
- at0027::Very limited - Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.
- at0028::Slightly limited - Makes frequent though slight changes in body or extremity position independently.
- at0029::No limitation - Makes major and frequent changes in position without assistance.
- at0030::Very poor - Never eats a complete meal. Rarely eats more than a 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids

poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.

- at0031::Probably inadequate - Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.
- at0032::Adequate - Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of their nutritional needs.
- at0033::Excellent - Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
- at0034::Comment - Additional narrative about the assessment of the Braden scale, not captured in other fields.
- at0035::Item tree - @ internal @
- at0036::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[**braden_scale_q**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.braden_scale_q.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** fi, es-ar, nb, pt-br, en, zh-cn

****Purpose:**** To record information about factors used to assess the risk of pressure ulcer development, and the total Braden Scale score.

****Use:**** Use to assess risk of pressure ulcer development in children aged between 21 days and 5 years. There are two commonly used variants - one intended for hospital use and the other for home use. They differ only in the description of the Moisture data element where the frequency of bedding change is described as "three times per 24 hours" for home use or "once per shift" for hospital use. As these two descriptions have the same essential meaning, this archetype has used the most generally applicable wording, based on the home use variant. While openEHR archetypes are all freely available under an open license, the specific content of this Braden Scale archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the

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****Keywords:**** pressure, sore, ulcer, Braden, adult, score, assessment

****Concepts:****

- at0000::Modified Braden Q scale - The Modified Braden Q scale is a tool used to assess the risk of pressure ulcer development in children aged between 21 days and 5 years.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Sensory perception - Ability to respond meaningfully to pressure-related discomfort.
- at0005::Completely Limited - Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation. OR, limited ability to feel pain over most of body surface.
- at0006::Very Limited - Responds to only painful stimuli. Cannot communicate discomfort except by moaning or restlessness; OR has sensory impairment that limits the ability to feel pain or discomfort over half of body.
- at0007::Slightly Limited - Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has sensory impairment that limits the ability to feel pain or discomfort in one or two extremities.
- at0008::No Impairment - Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.
- at0009::Moisture - Degree to which skin is exposed to moisture.
- at0010::Activity - Degree of physical ability.
- at0015::Constantly moist - Skin is kept moist almost constantly by perspiration, urine, drainage etc. Dampness is detected every time patient is moved or turned.
- at0016::Very moist - Skin is often, but not always, moist. Linen must be changed at least every 8 hours.
- at0017::Occasionally moist - Skin is occasionally moist, requiring linen change every 12 hours.
- at0018::Rarely moist - Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.
- at0019::Mobility - Ability to change and control body position.

- at0020::Nutrition - Usual food intake pattern.
- at0021::Friction and shear - Friction occurs when skin moves against support surfaces. Shear occurs when skin and adjacent bony surface slide across one another.
- at0022::Total score - The sum of the ordinal scores recorded for each of the seven component responses.
- at0023::Significant problem - Spasticity, contractures, itching or agitation leads to almost constant thrashing and friction.
- at0024::Problem - Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.
- at0025::Potential problem - Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraint or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.
- at0026::Completely immobile - Does not make even slight changes in body or extremity position without assistance.
- at0027::Very limited - Makes occasional slight changes in body or extremity position but unable to completely turn self independently.
- at0028::Slightly limited - Makes frequent though slight changes in body or extremity position independently.
- at0029::No limitations - Makes major and frequent changes in position without assistance.
- at0030::Very poor - NPO and/or maintained on clear fluids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.
- at0031::Inadequate - Is on a liquid diet or tube feedings/TPN, which provide inadequate calories and minerals for age OR albumin<3mg/dl OR rarely eats a complete meal and generally eats only half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.
- at0032::Adequate - Is on tube feedings or TPN, which provides adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein each day. Occasionally eats between meals. Does not require supplementation.
- at0033::Excellent - Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
- at0034::Comment - Additional narrative about the assessment of the Braden scale, not captured in other fields.
- at0035::Item tree - @ internal @
- at0036::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0037::Bedfast - Confined to bed.

- at0038::Chairfast - Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.
- at0039::Walks occasionally - Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.
- at0040::All patients too young to ambulate OR walks frequently - Walks outside the room at least twice a day.
- at0042::Tissue perfusion & oxygenation - *
- at0043::Extremely compromised - Hypotensive (MAP<50mmHg; <40 in newborn) or the patient does not physiologically tolerate position changes.
- at0044::Compromised - Normotensive oxygen saturation may be <95%; haemoglobin may be <10mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.
- at0045::Adequate - Normotensive oxygen saturation may be <95%; haemoglobin may be <10mg/dl; capillary refill may be 2 seconds; serum pH is normal.
- at0046::Excellent - Normotensive, oxygen saturation >95%; normal haemoglobin; capillary refill <2 seconds.

[briganti_risk_score](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.briganti_risk_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Intended for recording details of Briganti Risk Score for prostate cancer.

****Use:**** Use to capture details and total scores under Briganti Risk score.

****Keywords:**** Briganti, score, prostate, cancer, lymph, malignancy, recurrence

****Concepts:****

- at0000::Briganti Risk Score - The Briganti risk score is a score for predicting probabilities of survival, recurrence, lymph node involvement, organ-defined involvement, extracapsular extension and seminal invasion.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Age - Patient age when risk score is calculated.
- at0005::PSA level before biopsy - PSA level from laboratory report before the biopsy.

- at0019::Tumour Staging - Clinical tumor stage is determined by digital rectal examination and does not include stages determined by imaging studies.

What was your clinical tumor stage, using the AJCC Version 7/2010 Staging System?

Note: Although it is possible to be stage TX or stage T4, this nomogram is not applicable for these stages.

- at0020::Positive biopsy cores - Number of positive cores taken during biopsy. Information on cores taken at biopsy is optional. The nomogram can provide predictions without this information if not available. However, using this information, the nomogram can provide more refined predictions.
- at0021::Negative biopsy cores - Number of negative cores taken during biopsy. Information on cores taken at biopsy is optional. The nomogram can provide predictions without this information if not available. However, using this information, the nomogram can provide more refined predictions.
- at0022::Percentage positive - What percentage of the biopsy samples taken were positive?
- at0023::Probability 10-year survival - Probability of cancer-specific survival for 10 years after radical prostatectomy.
- at0024::Probability 15-year survival - Probability of cancer-specific survival for 15 years after radical prostatectomy.
- at0025::Progression free probability 5 years - Progression-free probability for 5 years after radical prostatectomy.
- at0026::Progression free probability 10 years - Progression-free probability for 10 years after radical prostatectomy.
- at0027::Organ-confined disease probability - This number shows, as a percentage, the probability that the cancer will be found to be confined to the prostate gland when the prostate is removed.
- at0028::Extra-capsular extension probability - This number shows, as a percentage, the probability of "extracapsular extension," meaning the probability that the cancer extends through the capsule of the prostate into the surrounding tissue.
- at0029::Lymph node involvement probability - This number shows, as a percentage, the probability that prostate cancer has spread to the pelvic lymph nodes.
- at0030::Seminal invasion probability - This number shows, as a percentage, the probability of "seminal vesicle invasion," which occurs when prostate cancer has spread into the seminal vesicles — glands attached to the prostate that help to produce semen. This number shows the probability that the cancer has spread to one or both seminal vesicles.
- at0031::Tree - @ internal @
- at0032::Confounding factors - Description of any incidental factors that may have contributed to the score.
- at0033::Tree - @ internal @

- at0034::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0035::Gleason Grade - Primary, secondary and tertiary Gleason grades and Total Gleason score.

[bristol_stool_scale](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.bristol_stool_scale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en, sl, nl

****Purpose:**** To record a classification of characteristics of faeces after defaecation, according to the Bristol Stool Scale/Score, sometimes termed the 'Meyers' score.

****Use:**** To record a classification of characteristics of faeces according to the Bristol Stool Scale/Score.

****Keywords:**** stool, faeces, Bristol, Meyers

****Concepts:****

- at0000::Bristol stool scale - Classification of faeces characteristics according to the Bristol Stool Scale/Score.
- at0001::Event Series - @ internal @
- at0002::Point-in-time - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Comment - Additional narrative about the stool scale, not captured in other fields.
- at0005::Bristol stool scale - A score to assess the characteristics of faeces after defaecation.
- at0006::Separate hard lumps, like nuts (hard to pass) - Stool consists of separate hard lumps, like nuts (hard to pass).
- at0007::Sausage-shaped, but lumpy - Stool is sausage-shaped, but lumpy.
- at0008::Like a sausage but with cracks on its surface - Stool is like a sausage but with cracks on its surface.
- at0009::Like a sausage or snake, smooth and soft - Stool is like a sausage or snake, smooth and soft.

- at0010::Soft blobs with clear cut edges (passed easily) - Stool consists of soft blobs with clear cut edges (passed easily).
- at0011::Fluffy pieces with ragged edges, a mushy stool - Stool consists of fluffy pieces with ragged edges, a mushy stool.
- at0012::Watery, no solid pieces. Entirely liquid - Stool is watery, no solid pieces. Entirely liquid.
- at0013::Tree - @ internal @
- at0014::Confounding factors - Record any issues or factors that may impact on the stool scale.
- at0015::Item tree - @ internal @
- at0016::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

bvc

****Archetype ID:**** openEHR-EHR-OBSERVATION.bvc.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the results for each component parameter and their total sum for the BVC score.

****Use:**** Use to record the results for each component parameter and their total sum for the BVC score. The BVC is intended for adults. While openEHR archetypes are all freely available under an open license, the specific content of this Brøset Violence Checklist (BVC) archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. Copyright statement: © Copyright Linaker & Bush Iversen (1995). Almvik & Woods (2000). All rights reserved, do not use without the written permission of the copyright holders. Copyright information: <http://www.riskassessment.no/#apps>.

****Keywords:**** verbal, physical, attacking, violent, behaviour, broset

****Concepts:****

- at0000::Brøset Violence Checklist (BVC) - A checklist which assists in the prediction of imminent violent behaviour.
- at0001::History - @ internal @

- at0002::Day shift - Specific point in time event that represents the observations made during a 'Day' shift.
- at0003::Tree - @ internal @
- at0004::Confused - Appears obviously confused and disorientated. May be unaware of time, place or person.
- at0005::Irritable - Easily annoyed or angered. Unable to tolerate the presence of others.
- at0006::Boisterous - Behaviour is overtly "loud" or noisy.
- at0007::Verbal threats - A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person.
- at0008::Physical threats - Where there is a definite intent to physically threaten another person.
- at0009::Attacking objects - An attack directed at an object and not an individual.
- at0016::Item tree - @ internal @
- at0017::Total score - The total sum of each component variable for the BCV score.
- at0018::Present - None
- at0024::Absent - None
- at0030::Interpretation - Interpretation of the total score.
- at0031::Small risk of violence - BVC score 0: The risk of violence is small.
- at0032::Moderate risk of violence - BVC score 1-2: The risk of violence is moderate. Preventive measures should be taken.
- at0033::High risk of violence - BVC score 3-6: The risk of violence is very high. Preventive measures should be taken In addition, a plan should be developed to manage the potential violence.
- at0088::Evening shift - Specific point in time event that represents the observations made during an 'Evening' shift.
- at0113::Night shift - Specific point in time event that represents the observations made during a 'Night' shift.
- at0138::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0163::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

cage

****Archetype ID:**** openEHR-EHR-OBSERVATION.cage.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To record the results of the CAGE questionnaire.

****Use:**** Use to record the results of the CAGE questionnaire.

****Misuse:**** Not to be used to record a summary of alcohol consumption - use the EVALUATION.alcohol_consumption_summary for this purpose. Not to be used to record actual alcohol consumption - use the OBSERVATION.alcohol_intake for this purpose.

****Keywords:**** alcohol abuse, alcohol use disorder, DSM, CAGE, psychiatry

****Concepts:****

- at0000::CAGE questionnaire - Questionnaire to screen for harmful alcohol use and potential alcohol dependency.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Cut down? - Have you ever felt you needed to cut down on your drinking?
- at0005::Annoyed? - Have you ever felt you needed to cut down on your drinking?
- at0006::Guilty? - Have you ever felt guilty about drinking?
- at0007::Eye opener? - Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover?
- at0008::Total score - Sum of the individual scores assigned for each of the contributing variables.
- at0009::No - *
- at0010::Yes - *
- at0011::No - *
- at0012::Yes - *
- at0013::No - *
- at0014::Yes - *
- at0015::No - *
- at0016::Yes - *
- at0017::ItemTree - @ internal @
- at0018::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

capillary_refill

****Archetype ID:**** openEHR-EHR-OBSERVATION.capillary_refill.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** sv, nb, en

****Purpose:**** To record findings related to the capillary refill time.

****Use:**** Use to record findings related to the capillary refill time.

****Keywords:**** return

****Concepts:****

- at0000::Capillary refill time (CRT) - Measurement of the time taken for color to return to an external capillary bed after pressure is applied to cause blanching.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Clinical interpretation - A clinical interpretation of the capillary refill time.
- at0006::Normal capillary filling time - None
- at0007::Increased capillary filling time - None
- at0008::Decreased capillary filing time - None
- at0009::Refill time - The measured time taken for color to return after blanching.
- at0019::Item tree - @ internal @
- at0020::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0021::Item tree - @ internal @
- at0023::Confounding factors - Issues or factors that may impact on measurement of the capillary refill time, not captured in other fields.
- at0024::Location of measurement - Simple body site where the capillary filling time was measured.
- at0037::Device - Details about any device used to measure capillary refill time.
- at0039::Structured measurement location - Structured anatomical location of where the measurement was taken.
- at0040::Comment - Additional narrative about the capillary refill time not captured in other fields.
- at0041::Measurement method - Narrative description of the method used for measuring the capillary refill time.

[**caprini_score**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.caprini_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record values for individual Caprini score parameters and the total score.

****Use:**** Use to record values for individual Caprini score parameters and the total score as part of a pre-operative assessment for venous thromboembolism.

****Keywords:**** VTE, Venous, Thromboembolism, Surgery, Pre-op, PE, DVT, thrombosis, embolus, pulmonary

****Concepts:****

- at0000::Caprini score - Assessment tool used to stratify risk for venous thromboembolism (VTE).
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0007::Age - None
- at0008::≤40 years - None
- at0009::41-60 years - None
- at0010::61-74 years - None
- at0011::≥75 years - None
- at0004::Gender - None
- at0005::Female - None
- at0006::Male - None
- at0012::Planned surgery - None
- at0013::Minor (<45 minutes) - None
- at0014::Major surgery (>45 minutes), laparoscopic surgery (>45 minutes) or arthroscopic surgery - None
- at0028::History of major surgery (<1 month) - None
- at0026::Congestive heart failure (<1 month) - None
- at0025::Serious lung disease, including pneumonia (<1 month) - None
- at0024::Sepsis (<1 month) - None
- at0022::Pregnant or postpartum <1 month - None
- at0036::Current central venous access - None
- at0047::Malignant tumour (current or past) - None
- at0046::Stroke (<1 month) - None
- at0048::Multiple trauma (<1 month) - None
- at0049::Acute spinal cord injury (<1 month) - None
- at0019::Varicose veins - None

- at0020::Swollen legs - None
- at0037::History of VTE - None
- at0038::Family history of VTE - None
- at0039::Factor V Leiden - None
- at0031::Bed rest or restricted mobility during past month - None
- at0029::History of inflammatory bowel disease - None
- at0016::Overweight or obese ($BMI \geq 25$) - None
- at0027::Acute myocardial infarction (<1 month) - None
- at0021::Abnormal pulmonary function (COPD) - None
- at0023::Current oral contraceptives or hormone replacement - None
- at0032::None - None
- at0033::Yes, <3 days - None
- at0034::Yes, >3 days - None
- at0017::No - None
- at0018::Yes - None
- at0050::Total score - The total sum of each component parameter for the Caprini score.
- at0015::Elective hip or knee replacement - None
- at0040::Prothrombin 20210A - None
- at0041::Lupus anticoagulant - None
- at0042::Anticardiolipin antibodies - None
- at0043::Elevated serum homocysteine - None
- at0044::Heparin-induced thrombocytopenia - None
- at0045::Other congenital or acquired thrombophilia - None
- at0030::History of unexplained stillborn infant, recurrent spontaneous abortion (≥ 3 factors present), premature birth with toxæmia or growth restricted infant. - None
- at0035::Malignant tumour (current or past) - None
- at0051::Item tree - @ internal @
- at0052::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

categorical_loudness_scaling

****Archetype ID:**** openEHR-EHR-OBSERVATION.categorical_loudness_scaling.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the loudness perception assessed by loudness scaling tests.

****Use:**** Use to record responses to a loudness scaling measurement and/or the corresponding loudness perception curve with or without using hearing aids.

****Misuse:**** Not to be used to record any other auditory assessment than categorical loudness scaling. Use the specific archetypes for these purposes.

****Keywords:**** hearing, audiology, categorial

****Concepts:****

- at0000::Categorical loudness scaling - A psychoacoustic method used to categorise and quantify an individual's perception of sound at various levels of loudness across the dynamic range of hearing.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0027::Stimulated side - Identification of the ear(s) to which the test stimulus is being presented.
 - at0028::Right ear - The test stimuli were presented to the right ear.
 - at0029::Left ear - The test stimuli were presented to the left ear.
 - at0030::Binaural - The test stimuli were presented to both ears simultaneously.
- at0035::Measurement - The reported loudness category for a given stimulus level.
- at0036::Frequency of test stimulus - Frequency of stimulus tested if applicable.
- at0060::Item tree - @ internal @
- at0061::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0069::Test environment - The environment in which the audiometric test is administered.
- at0070::Sound treated room - Test environment that has been treated acoustically.
- at0071::Non-sound treated room - Test environment that has not been treated acoustically.
- at0075::Type of test stimulus - Identification of the stimulus used in the categorical loudness scaling procedure.
 - at0076::Tone burst - The test stimulus is a tone burst.
 - at0077::Click - The test stimulus is a click.
 - at0078::Warble tone - The test stimulus is a frequency modulated tone.
 - at0079::Pure tone - The test stimulus is a pure tone.
- at0080::Narrowband noise - The test stimulus is a narrow band noise centred on the specified frequency.
- at0081::Pulsed pure tone - The test stimulus is a pulsed pure tone.
- at0082::Presentation method details - Details of device used to present test stimulus as specified in 'Presentation method'.
- at0083::Hearing device - Details of the hearing device used.

- at0095::Scaling method - Choice of scaling method.
- at0096::Adaptive Categorical Loudness Scaling (ACALOS) - Method by Brand & Hohmann 2002.
- at0097::Würzburger Hörfeldskalierung - Method by Hellbrück & Moser 1985.
- at0101::Loudness perception curve - Loudness perception curve fitted to measured data.
- at0103::Lower slope value - Slope value for lower section of fitted loudness perception curve corresponding to 'Curve equation'.
- at0110::Stimulus level - The level of the stimulus.
- at0111::Response category - The reported loudness category for a given stimulus level.
- at0119::Item tree - @ internal @
- at0126::Free-field - Room with free-field characteristics.
- at0127::Broadband noise - The test stimulus is a broad band noise.
- at0128::Presentation method - The method used to present the test stimulus.
- at0129::Loudspeaker - The stimulus is presented via a loudspeaker located at least one metre away from the subject.
- at0130::Insert earphone - The stimulus is presented via insert earphones.
- at0131::Headphone - The stimulus is presented via external headphones - either circumaural or supraaural.
- at0133::Overall comment - Additional narrative about the measurement of categorical loudness scaling not captured in other fields.
- at0134::Name of test stimulus - Further specification of test stimulus if applicable.
- at0135::Natural sound - The test stimulus is a natural/recording sound.
- at0136::Curve sample - Data point of fitted loudness perception curve represented by a combination of a given response category and corresponding stimulus level.
- at0137::Stimulus level - The stimulus level for the chosen CU value of fitted loudness perception curve.
- at0138::Response category - The chosen loudness category of the curve sample.

- at0139::Fit procedure name - Name of the procedure applied to fit the loudness function to the data.
- at0140::Curve equation - Equation for loudness perception curve with explanation of included variables.
- at0142::Hearing device during test - Information about hearing device use during loudness scaling test.
- at0143::Side of hearing device - Identification of the side where the hearing device is worn during the test.
- at0144::Comment - Additional information about the hearing device that is not captured in "Hearing device" or "Side of hearing device".
- at0145::Left - The hearing device is worn at the left side.
- at0146::Right - The hearing device is worn at the right side.

- at0147::Test environment details - Additional details of 'Test environment'.
- at0149::Upper slope value - Slope value for upper section of fitted loudness perception curve corresponding to 'Curve equation'.
- at0150::Curve comment - Additional narrative about the loudness perception curve not captured in other fields.
- at0151::Confounding factors - Additional issues or factors that may impact loudness scaling tests, not captured in other fields.
- at0152::Loudness growth in 1/2 octave bands (LGOB) - Method by Allen et al. 1990,
- at0153::Direct streaming to sound processor - The stimulus is directly streamed to the sound processor of a hearing device.
- at0154::No test result - No test result is available.
- at0155::Reason for no test result - Reason why no result is available.

[**ccs_angina_status**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.ccs_angina_status.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, en

****Purpose:**** To record a classification of patient angina on the basis of reported chest pain. Based on Canadian Cardiovascular Society (CCS) Angina Status score, adjusted to add Class 0, to record situations where patients have no symptoms.

****Use:**** Use to record a classification of patient angina on the basis of reported chest pain based on the CCS Angina Status Score.

****Misuse:**** Note that Class 0 is not defined in the formal Canadian Cardiovascular Society (CCS) Angina Status score.

****Keywords:**** discomfort, pain, cardiac, angina

****Concepts:****

- at0000::Angina symptom classification (CCS) - Angina symptom score based on Canadian Cardiovascular Society (CCS) Angina Status score.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @

- at0004::Angina classification - Angina symptom score based on Canadian Cardiovascular Society (CCS) Angina Status classification.
- at0005::Class 0 - Patient has no angina symptoms.
- at0006::Class I - Angina which does not limit ordinary physical activity.
- at0007::Class II - Slight limitation of ordinary activity.
- at0008::Class III - Marked limitation of ordinary physical activity.
- at0009::Class IV - Inability to perform any physical activity without discomfort.
- at0010::Tree - @ internal @
- at0011::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

cgas

****Archetype ID:**** openEHR-EHR-OBSERVATION.cgas.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** fi, nb, en

****Purpose:**** To score a child's most impaired level of emotional and behavioural functioning in the specified period of time.

****Use:**** Use to score a child's most impaired level of emotional and behavioural functioning in the specified time period by selecting the lowest level which describes his/her functioning on a hypothetical continuum of health-illness. The scores can range from 1, which is the very worst, to 100, which is the very best. Use intermediary levels (e.g. 35, 58, 62). The score is used for children over the age of 4. Different sources have different upper limits for the age of the individual being scored, the most common being 16 or 18 years of age.

****Misuse:**** Not to be used for children under the age of 4.

****Keywords:**** CGAS

****Concepts:****

- at0000::Children's Global Assessment Scale - Children's Global Assessment Scale (CGAS) to score a subject's most impaired level of emotional and behavioural functioning in a specified period of time.
- at0001::Event Series - @ internal @

- at0002::Unspecified event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Score - The child's most impaired level of emotional and behavioural functioning in a specified period of time.
- at0005::Comment - Additional comment about the overall CGAS score not captured in other fields.
- at0012::Tree - @ internal @
- at0013::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

chadsvas_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.chadsvas_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, nb, en

****Purpose:**** To record individual CHA₂DS₂-VASC score parameters and total score.

****Use:**** Use to record individual CHA₂DS₂-VASC score parameters and total score as part of stroke risk stratification in patients with atrial fibrillation.

****Keywords:**** atrial fibrillation, stroke, diabetes, hypertension, congestive heart failure, CHF, vascular disease, age, gender

****Concepts:****

- at0000::CHA₂DS₂-VASC score - Risk stratification for stroke based on the CHA₂DS₂-VASC score defined by the European Society of Cardiology (ESC) guidelines for management of atrial fibrillation.
- at0001::Tree - None
- at0002::history - None
- at0003::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0026::Congestive Heart Failure - None
- at0027::Absent - None
- at0028::Present - None
- at0029::Hypertension - None
- at0032::Diabetes - None

- at0035::Age - None
- at0036::Under 65 - None
- at0037::Between 65-74 - None
- at0038::Above or equals to 75 - None
- at0039::Previous stroke - None
- at0042::Gender - None
- at0043::Male - None
- at0044::Female - None
- at0046::Vascular disease - None
- at0099::Total score - The total sum of each component parameter for the CHA₂DS₂-VASc score.
- at0100::Item tree - @ internal @
- at0101::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

chaq

****Archetype ID:**** openEHR-EHR-OBSERVATION.chaq.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** For the recording of details of the Childhood Health Assessment Questionnaire used to assess how a child's arthritis affects his or her ability to function in daily life.

****Use:**** To record the details of the Childhood Health Assessment Questionnaire used in Rare Diseases management settings to assess how a child's arthritis affects his or her ability to function in daily life. The questionnaire is completed by parents or carers of the child, and it is intended that the person completing the questionnaire checks the one response which best describes the child's usual activities (averaged over an entire day) OVER THE PAST WEEK. It is also intended that only those difficulties or limitations are noted which are due to illness. If most children at the child's age are not expected to do a certain activity, the responder should mark it as "Not Applicable". For example, if the child has difficulty in doing a certain activity or is unable to do it because he/she is too young but not because he/she is RESTRICTED BY ILLNESS, the activity should be marked as "NOT Applicable".

****Concepts:****

- at0000::Childhood Health Assessment Questionnaire - The Childhood Health Assessment Questionnaire for arthritis.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Dress - Assessment of child's ability to dress, including tying shoelaces and doing buttons.
- at0005::Shampoo - Assessment of the child's ability to shampoo his or her hair.
- at0006::Remove socks - Assessment of the child's ability to remove socks.
- at0007::Cut fingernails - Assessment of the child's ability to cut his or her fingernails.
- at0008::Dressing and grooming - Assessment of child's ability to perform functions related to dressing and grooming.
- at0009::Without any difficulty - The child is able to dress without any difficulty.
- at0010::With some difficulty - The child is able to dress with some difficulty.
- at0011::With much difficulty - The child is able to dress with much difficulty.
- at0012::Unable to do - The child is unable to dress.
- at0013::Not applicable - This question is not applicable.
- at0014::Without any difficulty - The child is able to shampoo his or her hair without any difficulty.
- at0015::With some difficulty - The child is able to shampoo his or her hair with some difficulty.
- at0016::With much difficulty - The child is able to shampoo his or her hair with much difficulty.
- at0017::Unable to do - The child is unable to shampoo his or her hair.
- at0018::Not applicable - This question is not applicable.
- at0019::Without any difficulty - The child is able to remove socks without any difficulty.
- at0020::With some difficulty - The child is able to remove socks with some difficulty.
- at0021::With much difficulty - The child is able to remove socks with much difficulty.
- at0022::Unable to do - The child is unable to remove socks.
- at0023::Not applicable - This question is not applicable.
- at0024::Without any difficulty - The child is able to cut his or her fingernails without any difficulty.
- at0025::With some difficulty - The child is able to cut his or her fingernails with some difficulty.
- at0026::With much difficulty - The child is unable to cut his or her fingernails with much difficulty.
- at0027::Unable to do - The child is unable to cut his or her fingernails.
- at0028::Not applicable - This question is not applicable.
- at0029::Arising - Assessment of the child's ability to stand up from low chair or floor or get in and out of bed or stand up in a crib.
- at0030::Stand up - Assessment of child's ability to stand up from low chair or floor.

- at0031::Without any difficulty - The child is able to stand up from low chair or floor without any difficulty.
- at0032::With some difficulty - The child is able to stand up from low chair or floor with some difficulty.
- at0033::With much difficulty - The child is able to stand up from low chair or floor with much difficulty.
- at0034::Unable to do - The child is unable to stand up from low chair or floor.
- at0035::Not applicable - This question is not applicable.
- at0036::Get in and out of bed or stand up in crib - Assessment of the child's ability to get in and out of bed or stand up in a crib.
- at0037::Without any difficulty - The child is able to get in and out of bed or stand up in a crib without any difficulty.
- at0038::With some difficulty - The child is able to get in and out of bed or stand up in a crib with some difficulty.
- at0039::With much difficulty - The child is able to get in and out of bed or stand up in a crib with much difficulty.
- at0040::Unable to do - The child is unable to get in and out of bed or stand up in a crib.
- at0041::Not applicable - The question is not applicable.
- at0042::Eating - Assessment of the child's ability to perform functions related to eating.
- at0043::Cut meat - Assessment of the child's ability to cut his or her own meat.
- at0044::Without any difficulty - The child is able to cut his or her own meat without any difficulty.
- at0045::With some difficulty - The child is able to cut his or her own meat with some difficulty.
- at0046::With much difficulty - The child is able to cut his or her own meat with much difficulty.
- at0047::Unable to do - The child is unable to cut his or her own meat.
- at0048::Not applicable - This question is not applicable.
- at0049::Lift up cup or glass to mouth - Assessment of the child's ability to lift a cup or glass to mouth.
- at0050::Without any difficulty - The child is able to lift a cup or glass to mouth without any difficulty.
- at0051::With some difficulty - The child is able to lift a cup or glass to mouth with some difficulty.
- at0052::With much difficulty - The child is able to lift a cup or glass to mouth with much difficulty.
- at0053::Unable to do - The child is unable to lift a cup or glass to mouth.
- at0054::Not applicable - This question is not applicable.
- at0055::Open new cereal box - Assessment of the child's ability to open a new cereal box.
- at0056::Without any difficulty - The child is able to open a new cereal box without any difficulty.

- at0057::WIth some difficulty - The child is able to open a new cereal box with some difficulty.
- at0058::With much difficulty - The child is able to open a new cereal box with much difficulty.
- at0059::Unable to do - The child is unable to open a new cereal box.
- at0060::Not applicable - This question is not applicable.
- at0061::Walking - Assessment of the child's ability to perform functions related to walking.
- at0062::Walk outdoors on flat ground - Assessment of the child's ability to walk outdoors on flat ground.
- at0063::Without any difficulty - The child is able to walk outdoors on flat ground without any difficulty.
- at0064::With some difficulty - The child is able to walk outdoors on flat ground with some difficulty.
- at0065::With much difficulty - The child is able to walk outdoors on flat ground with much difficulty.
- at0066::Unable to do - The child is unable to walk outdoors on flat ground.
- at0067::Not applicable - The question is not applicable.
- at0068::Climb up five steps - Assessment of the child's ability to climb up five steps.
- at0069::Without any difficulty - The child is able to climb up five steps without any difficulty.
- at0070::With some difficulty - The child is able to climb up five steps with some difficulty.
- at0071::With much difficulty - The child is able to climb up five steps with much difficulty.
- at0072::Unable to do - The child is unable to climb up five steps.
- at0073::Not applicable - The question is not applicable.
- at0074::Devices used - Statement about the aids or devices usually used by the child for dressing, grooming, arising, eating and walking.
- at0075::Cane - The child usually uses a cane.
- at0076::Walker - The child usually uses a walker.
- at0077::Crutches - The child usually uses crutches.
- at0078::Wheelchair - The child usually uses a wheelchair.
- at0079::Dressing aids - The child usually using devices used dor dressing, such as button hook, zipper pull, long-handled shoe horn,etc.
- at0080::Built up pencil or special utensils - The child usually uses a built up pencil or special utensils.
- at0081::Special or built up chair - The child usually uses a special or built-up chair.
- at0082::Needs help from other person - Statement of which activity categories (dressing and grooming, arising, eating and walking) usually require help for the child from another person because of the child's illness.

- at0083::Dressing and grooming - The child usually needs help from another person for dressing and grooming because of his or her illness.
- at0084::Arising - The child usually needs help from another person for arising because of his or her illness.
- at0085::Eating - The child usually needs help from another person for eating because of his or her illness.
- at0086::Walking - The child usually needs help from another person for walking because of his or her illness.
- at0087::Hygiene - Assessment of the child's ability to perform functions related to hygiene.
- at0088::Wash and dry entire body - Assessment of the child's ability to wash and dry entire body.
- at0089::Without any difficulty - The child is able to wash and dry his or her entire body without any difficulty.
- at0090::With some difficulty - The child is able to wash and dry his or her entire body with some difficulty.
- at0091::With much difficulty - The child is able to wash and dry his or her entire body with much difficulty.
- at0092::Unable to do - The child is unable to wash and dry his or her entire body.
- at0093::Not applicable - The question is not applicable.
- at0094::Take a tub bath - Assessment of the child's ability to take a tub bath including getting in and out of the tub).
- at0095::Without any difficulty - The child is able to take a tub bath without any difficulty.
- at0096::With some difficulty - The child is able to take a tub bath with some difficulty.
- at0097::Get on and off toilet or potty chair - Assessment of the child's ability to get on and off the toilet or potty chair.
- at0098::With much difficulty - The child is able to take a tub bath with much difficulty.
- at0099::Unable to do - The child is unable to take a tub bath.
- at0100::Not applicable - This question is not applicable.
- at0101::Brush teeth - Assessment of the child's ability to brush his or her teeth.
- at0102::Without any difficulty - The child is able to get on and off toilet or potty chair without any difficulty.
- at0103::With some difficulty - The child is able to get on and off toilet or potty chair with some difficulty.
- at0104::With much difficulty - The child is able to get on and off toilet or potty chair with much difficulty.
- at0105::Unable to do - The child is unable to get on and off toilet or potty chair.
- at0106::Not applicable - This question is not applicable.
- at0107::Without any difficulty - The child is able to brush his or her teeth without any difficulty.

- at0108::With some difficulty - The child is able to brush his or her teeth with some difficulty.
- at0109::With much difficulty - The child is able to brush his or her teeth with much difficulty.
- at0110::Unable to do - The child is unable to brush his or her teeth.
- at0111::Not applicable - The question is not applicable.
- at0112::Comb or brush hair - Assessment of the child's ability to comb or brush his or her hair.
- at0113::Without any difficulty - The child is able to comb or brush his or her hair without any difficulty.
- at0114::With some difficulty - The child is able to comb or brush his or her hair with some difficulty.
- at0115::With much difficulty - The child is able to comb or brush his or her hair with much difficulty.
- at0116::Unable to do - The child is unable to comb or brush his or her hair.
- at0117::Not applicable - The question is not applicable.
- at0118::Reach - Assessment of the child's ability to perform functions related to reaching.
- at0119::Reach and get down heavy object - Assessment of the child's ability to reach and get down a heavy object such as a large game or books from just above his/her head.
- at0120::Without any difficulty - The child is able to reach and get down a heavy object such as a large game or books from just above his/her head without any difficulty.
- at0121::With some difficulty - The child is able to reach and get down a heavy object such as a large game or books from just above his/her head with some difficulty.
- at0122::With much difficulty - The child is able to reach and get down a heavy object such as a large game or books from just above his/her head with much difficulty.
- at0123::Unable to do - The child is unable to reach and get down a heavy object such as a large game or books from just above his/her head.
- at0124::Not applicable - The question is not applicable.
- at0125::Bend down to pick up - Assessment of the child's ability to bend down to pick up clothing or a piece of paper from the floor.
- at0126::Without any difficulty - The child is able to bend down to pick up clothing or a piece of paper from the floor without any difficulty.
- at0127::With some difficulty - The child is able to bend down to pick up clothing or a piece of paper from the floor with some difficulty.
- at0128::With much difficulty - The child is able to bend down to pick up clothing or a piece of paper from the floor with much difficulty.
- at0129::Unable to do - The child is unable to bend down to pick up clothing or a piece of paper from the floor.
- at0130::Not applicable - The question is not applicable.

- at0131::Pull on sweater - Assessment of the child's ability to pull on a sweater over his or her head.
- at0132::Without any difficulty - The child is able to pull on a sweater over his or her head without any difficulty.
- at0133::With some difficulty - The child is able to pull on a sweater over his or her head with some difficulty.
- at0134::With much difficulty - The child is able to pull on a sweater over his or her head with much difficulty.
- at0135::Unable to do - The child is unable to pull on a sweater over his or her head.
- at0136::Not applicable - The question is not applicable.
- at0137::Turn neck - Assessment of the child's ability to turn his or her neck to look back over his or her shoulder.
- at0138::Without any difficulty - The child is able to turn his or her neck to look back over his or her shoulder without any difficulty.
- at0139::With some difficulty - The child is able to turn his or her neck to look back over his or her shoulder with some difficulty.
- at0140::With much difficulty - The child is able to turn his or her neck to look back over his or her shoulder with much difficulty.
- at0141::Unable to do - The child is unable to turn his or her neck to look back over his or her shoulder.
- at0142::Not applicable - The question is not applicable.
- at0143::Grip - Assessment of the child's ability to perform functions related to gripping.
- at0144::Write or scribble - Assessment of the child's ability to write or scribble with a pen or pencil.
- at0145::Without any difficulty - The child is able to write or scribble with a pen or pencil without any difficulty.
- at0146::With some difficulty - The child is able to write or scribble with a pen or pencil with some difficulty.
- at0147::With much difficulty - The child is able to write or scribble with a pen or pencil with much difficulty.
- at0148::Unable to do - The child is unable to write or scribble with a pen or pencil.
- at0149::No applicable - The question is not applicable.
- at0150::Open car doors - Assessment of the child's ability to open car doors.
- at0151::Without any difficulty - The child is able to open car doors without any difficulty.
- at0152::With some difficulty - The child is able to open car doors with some difficulty.
- at0153::With much difficulty - The child is able to open car doors with much difficulty.
- at0154::Unable to do - The child is unable to open car doors.
- at0155::Not applicable - The question is not applicable.
- at0156::Open jars - Assessment of child's ability to open jars that have been previously opened.

- at0157::Without any difficulty - The child is able to open jars that have been previously opened without any difficulty.
- at0158::With some difficulty - The child is able to open jars that have been previously opened with some difficulty.
- at0159::With much difficulty - The child is able to open jars that have been previously opened with much difficulty.
- at0160::Unable to do - The child is unable to open jars that have been previously opened.
- at0161::Not applicable - The question is not applicable.
- at0162::Turn faucets on and off - Assessment of child's ability to turn faucets on and off.
- at0163::Without any difficulty - The child is able to turn faucets on and off without any difficulty.
- at0164::With some difficulty - The child is able to turn faucets on and off with some difficulty.
- at0165::With much difficulty - The child is able to turn faucets on and off with much difficulty.
- at0166::Unable to do - The child is unable to turn faucets on and off.
- at0167::No applicable - The question is not applicable.
- at0168::Push open door - Assessment of the child's ability to push open a door when he or she has to turn a door knob.
- at0169::Without any difficulty - The child is able to push open a door when he or she has to turn a door knob without any difficulty.
- at0170::With some difficulty - The child is able to push open a door when he or she has to turn a door knob with some difficulty.
- at0171::With much difficulty - The child is able to push open a door when he or she has to turn a door knob with much difficulty.
- at0172::Unable to do - The child is unable to push open a door when he or she has to turn a door knob.
- at0173::Not applicable - The question is not applicable.
- at0174::Activities - Assessment of the child's ability to perform general activities.
- at0175::Run errands and shop - Assessment of the child's ability to run errands and shop.
- at0176::Without any difficulty - The child is able to run errands and shop without any difficulty.
- at0177::Get in and out of car - Assessment of the child's ability to get in and out of a car, toy car or school bus.
- at0178::With some difficulty - The child is able to run errands and shop with some difficulty.
- at0179::With much difficulty - The child is able to run errands and shop with much difficulty.
- at0180::Unable to do - The child is unable to run errands and shop.
- at0181::Not applicable - The question is not applicable.

- at0182::Without any difficulty - The child is able to get in and out of car, toy car or school bus without any difficulty.
- at0183::With some difficulty - The child is able to get in and out of car, toy car or school bus with some difficulty.
- at0184::With much difficulty - The child is able to get in and out of car, toy car or school bus with much difficulty.
- at0185::Unable to do - The child is unable to get in and out of car, toy car or school bus.
- at0186::Not applicable - The question is not applicable.
- at0187::Ride bike or tricycle - Assessment of the child's ability to ride a bike or tricycle.
- at0188::Without any difficulty - The child is able to ride a bike or tricycle without any difficulty.
- at0189::With some difficulty - The child is able to ride a bike or tricycle with some difficulty.
- at0190::With much difficulty - The child is able to ride a bike or tricycle with much difficulty.
- at0191::Unable to do - The child is unable to ride a bike or tricycle.
- at0192::Not applicable - The question is no applicable.
- at0193::Do household chores - Assessment of the child's ability to do household chores (e.g. wash dishes, take out trash, vacuuming, yardwork, make bed, clean room).
- at0194::Without any difficulty - The child is able to do household chores without any difficulty.
- at0195::With some difficulty - The child is able to do household chores with some difficulty.
- at0196::With much difficulty - The child is able to do household chores with much difficulty.
- at0197::Unable to do - The child is unable to do household chores.
- at0198::Not applicable - The question is not applicable.
- at0199::Run and play - Assessment of the child's ability to run and play.
- at0200::Without any difficulty - The child is able to run and play without any difficulty.
- at0201::With some difficulty - The child is able to run and play with some difficulty.
- at0202::With much difficulty - The child is able to run and play with much difficulty.
- at0203::Unable to do - The child is unable to run and play.
- at0204::Not applicable - The question is not applicable.
- at0205::Devices used - Statement about the aids or devices usually used by the child for hygiene, reach, grip and activities.
- at0206::Raised toilet seat - The child usually uses a raised toilet seat.
- at0207::Bathtub seat - The child usually uses a bathtub seat.
- at0208::Jar opener - The child usually uses a jar opener for jars that have been previously opened.
- at0209::Bathtub bar - The child usually uses a bathtub bar.
- at0210::Long-handled appliances for reach - The child usually uses long-handled appliances for reach.

- at0211::Long-handled appliances in bathroom - The child usually uses long-handled appliances in the bathroom.
- at0212::Needs help from other person - Statement of which activity categories (hygiene, reach, gripping and opening and errands and chores) usually require help for the child from another person because of the child's illness.
- at0213::Hygiene - The child usually needs help from another person for hygiene because of his or her illness.
- at0214::Reach - The child usually needs help from another person for reaching because of his or her illness.
- at0215::Gripping and opening things - The child usually needs help from another person for gripping and opening things because of his or her illness.
- at0216::Errands and chores - The child usually needs help from another person for errands and chores because of his or her illness.
- at0217::Pain score - Rating of how much pain the child has had because of his/her illness in the past week on a scale of 0 (no pain) to 100 (very severe pain).
- at0218::Global evaluation - Rating of how child is doing, considering all the ways arthritis is affecting him or her, on a scale of 0 (very well) to 100 (very poor).
- at0219::Tree - @ internal @
- at0220::Confounding factors - Record any issues or factors that may impact on the questionnaire answers.
- at0221::Tree - @ internal @
- at0222::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0223::Total score - Total score from the eight assessment categories, with the highest score in each category counting towards the total score. Use of devices always scores 2, but can be superceded by a 3 score in that category.
- at0224::Disability Index - Calculated from the total score divided by the number of categories answered.
- at0225::Clinical interpretation - Narrative description of clinical interpretation.

[charlson_comorbidity_index](#)

Archetype ID: openEHR-EHR-OBSERVATION.charlson_comorbidity_index.v2

Lifecycle State: published

Category: OBSERVATION

Languages: nb, en, es

****Purpose:**** To record the result for each component parameter of the Charlson Comorbidity Index (CCI) and its total sum, and to calculate the 10 year estimated survival.

****Use:**** To record the result for each component parameter of the Charlson Comorbidity Index (CCI) and its total sum, and to calculate the 10 year estimated survival. This data and value set is from the original Charlson et al study in 1987. In the original paper, 19 'conditions' were represented, including a number that had separate representations of the same condition, but with different severity. In this archetype, these conditions have been grouped together - for example, 'Mild liver disease' and 'Moderate to severe liver disease' are values under the condition 'Liver disease'. As a result, there are only 16 conditions represented in this archetype.

****Keywords:**** CCI, comorbidity, concurrent conditions, estimated survival, mortality, prognosis, assessment, risk

****Concepts:****

- at0000::Charlson Comorbidity Index (CCI) - An assessment tool used to predict the risk of death from comorbid disease.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0006::Peripheral vascular disease - None
- at0007::No - None
- at0008::Yes - Intermittent claudication or past bypass for chronic arterial insufficiency, history of gangrene or acute arterial insufficiency, or untreated thoracic or abdominal aneurysm (≥ 6 cm).
- at0009::Congestive heart failure - None
- at0010::No - None
- at0011::Yes - Exertional or paroxysmal nocturnal dyspnea and has responded to symptomatically (or on physical examination) to digitalis, diuretics, or afterload reducing agents.
- at0012::Myocardial infarction - None
- at0013::No - None
- at0014::Yes - History of definite or probable Myocardial infarction (EKG changes and/or enzyme changes).
- at0015::Cerebrovascular disease - None
- at0016::No - None
- at0017::Yes - History of a cerebrovascular accident (CVA) with minor or no residua and transient ischemic attacks (TIA).
- at0018::Dementia - None
- at0019::No - None
- at0020::Yes - Dementia or chronic cognitive deficit.

- at0021::Chronic pulmonary disease - None
- at0022::No - None
- at0023::Yes - Mild or moderate or severe chronic pulmonary disease.
- at0024::Ulcer disease - None
- at0025::No - None
- at0026::Yes - Any history of treatment for ulcer disease or history of ulcer bleeding, or history of gastrointestinal bleeding requiring transfusions from causes other than ulcer disease.
- at0027::Liver disease - None
- at0028::None - None
- at0029::Mild - Cirrhosis without portal hypertension or chronic hepatitis.
- at0030::Connective tissue disease - None
- at0031::No - None
- at0032::Yes - None
- at0033::Diabetes mellitus - None
- at0034::None or diet-controlled - None
- at0035::Uncomplicated - Diabetes treated with insulin or oral hypoglycemics, but not diet alone.
- at0036::Hemiplegia - None
- at0037::No - None
- at0038::Yes - None
- at0039::Moderate or severe renal disease - None
- at0040::No - None
- at0041::Yes - Moderate: creatinine >3 mg/dL (0.27 mmol/L). Severe: on dialysis, status post kidney transplant, uremia.
- at0045::Solid tumor - None
- at0046::None - None
- at0047::Leukemia - None
- at0048::Localized - Solid tumor without documented metastases.
- at0049::No - None
- at0050::Lymphoma - None
- at0051::Yes - None
- at0052::No - None
- at0053::Yes - None
- at0060::AIDS - None
- at0061::Age group - The age category of the patient.
- at0062::<50 years - None
- at0063::50-59 years - None
- at0064::60-69 years - None
- at0065::70-79 years - None
- at0066::≥80 years - None

- at0067::Moderate to severe - Moderate: cirrhosis with portal hypertension, but without bleeding. Severe: cirrhosis with portal hypertension and a history of variceal bleeding.
- at0068::End-organ damage - Diabetes with end organ damage.
- at0069::Metastatic - Metastatic solid tumor.
- at0070::No - None
- at0071::Yes - Patients with define or probable AIDS, i.e. AIDS related complex.
- at0072::CCI total score - The total sum of each component variable for the Charlson Comorbidity Index.
- at0073::Estimated 10-year survival - The predicted 10-year survival rate.
- at0074::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0004::ITEM_TREE - None

[**cheop_scale**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.cheop_scale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To record each assessment parament and the total score for CHEOPS.

****Use:**** Use to record the results for each of the 6 parameters of the CHEOPS assessment.

****Keywords:**** pain, assessment, pediatric

****Concepts:****

- at0000::Children's Hospital of Eastern Ontario Pain Scale (CHEOPS) - Assessment tool used to asses post-operative pain in children between the age of 1 to 5 years.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0008::Cry - None
- at0009::Facial expression - None
- at0010::Child verbal - None
- at0011::Torso - None
- at0012::Wound evaluation - None
- at0013::Legs - None

- at0014::Total score - The total sum of each component parameter for CHEOPS.
- at0016::No crying - None
- at0017::Moaning - None
- at0018::Screaming - None
- at0019::Smiling - Score only if definite positive facial expression.
- at0020::Composed, neutral - Neutral facial expression.
- at0021::Grimace - Score only if definite negative facial expression.
- at0022::Positive statements - None
- at0023::Not talking - None
- at0024::Complains about pain - None
- at0025::Neutral - None
- at0026::Shifting - None
- at0027::Child not touching their wound - None
- at0028::Reaching for their wound - None
- at0029::Neutral position - None
- at0030::Squirm/kicking - None
- at0031::Crying - None
- at0032::Complains but not about pain - None
- at0033::Complains about pain and other subjects - None
- at0034::Tense - None
- at0035::Shivering - None
- at0036::Upright - None
- at0037::Restrained - None
- at0038::Touching their wound - None
- at0039::Grabbing vigorously at wound - None
- at0040::Arms are restrained - None
- at0041::Drawn up/tensed legs - None
- at0042::Standing/kneeling - None
- at0043::Legs are restrained - None
- at0044::Item tree - @ internal @
- at0045::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[**chest_circumference**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.chest_circumference.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the measurement of the circumference of the chest.

****Use:**** Use to record the measurement of the circumference of the chest. There is no clear agreement on exactly where the chest circumference should be measured. In cases where this is important to the interpretation of the results, this should be documented in the 'Method' element. Use to record change from repeated measurements. This can currently be modeled by constraining the 'any event' to an interval in a template with an associated mathematical function, as appropriate. This archetype can also be used for recording an approximation of the chest circumference measurement in a clinical scenario where it is not possible to measure an accurate chest circumference - for example, measuring an uncooperative child. This is not modelled explicitly in the archetype as the openEHR Reference model allows the attribute of Approximation for any Quantity data type. At implementation, for example, an application user interface could allow clinicians to select an appropriately labelled check box adjacent to the 'chest circumference' data field to indicate that the recorded chest circumference is an approximation, rather than actual.

****Misuse:**** Not to be used to record the speed of which the chest circumference is increasing. Use a growth velocity archetype for this purpose. Not to be used to record the circumference of another body part. Use OBSERVATION.body_segment in these circumstances except where more specific archetypes exist such as OBSERVATION.hip_circumference.

****Keywords:**** anthropometry, measurement, estimation, circumference, chest, girth, thorax

****Concepts:****

- at0000::Chest circumference - The measurement of the distance around the chest.
- at0001::Event Series - @ internal @
- at0003::Tree - @ internal @
- at0004::Chest circumference - The measurement of the circumference of the chest.
- at0005::Tree - @ internal @
- at0006::Device - Details about the device used for the measurement.
- at0007::Comment - Additional narrative about the measurement of chest circumference not captured in other fields.
- at0008::Tree - @ internal @
- at0009::Confounding factors - Narrative description of any issues or factors that may impact on the measurement.
- at0010::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0012::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0013::Method - The method by which the chest circumference was measured.

- at0014::Chest expansion - Event which captures the increase in chest circumference from full expiration to full inspiration.
- at0015::Full inspiration - Point in time event which captures the chest circumference at full inspiration.
- at0016::Full expiration - Point in time event which captures the chest circumference at full expiration.

child_growth_indicator

****Archetype ID:**** openEHR-EHR-OBSERVATION.child_growth_indicator.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record details about parameters plotted as percentiles on a growth chart.

****Use:**** Use to record details about parameters plotted as percentiles on a growth chart. Use the URI to explicitly link the original measurement as recorded. Use in a template alongside OBSERVATION.age to record the adjusted age of an infant as part of monitoring child growth patterns.

****Misuse:**** Not to be used to record actual measurements. Use appropriate OBSERVATION archetypes for this purpose - for example OBSERVATION.height, OBSERVATION.weight, OBSERVATION.head_circumference, OBSERVATION.body_segment or OBSERVATION.blood_pressure.

****Keywords:**** growth, calculation, centile, percentile, z-score, SD, height, weight, head circumference

****Concepts:****

- at0000::Child growth indicator - Details about parameters plotted on a growth chart to allow monitoring of a child's growth over time, relative to a reference population.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0010::Percentile - Percentile calculated using standard normal distribution for the age (or adjusted age).

- at0011::Z-score - The deviation of an individual's value from the median value for a reference population, divided by the standard deviation of the reference population.
- at0014::Growth indicator - The name of the growth parameter.
- at0019::Comment - A comment about the growth indicator, not captured in other fields.
- at0020::Length/height-for-age - Length or height plotted against age, or adjusted age.
- at0021::Sitting height-for-age - Sitting height plotted against age, or adjusted age.
- at0022::Leg length-for-age - Subischial leg length plotted against age, or adjusted age.
- at0023::Weight-for-age - Weight plotted against age, or adjusted age.
- at0024::Head circumference-for-age - Head circumference plotted against age, or adjusted age.
- at0025::Weight-for-length/height - Weight plotted against height/length.
- at0026::Systolic blood pressure-for-age-and-height - Systolic blood pressure plotted against age (or adjusted age) and height/length.
- at0027::Diastolic blood pressure-for-age-and-height - Diastolic blood pressure plotted against age (or adjusted age) and height/length.
- at0029::Body mass index-for-age (BMI-for-age) - Body mass index plotted against age, or adjusted age.
- at0031::Tree - @ internal @
- at0032::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0034::Arm circumference-for-age - Arm circumference plotted against age, or adjusted age.
- at0035::URI to original measurement - Link to the original measurement.
- at0036::Subscapular skinfold-for-age - Subscapular skinfold plotted against age, or adjusted age.
- at0037::Triceps skinfold-for-age - Triceps skinfold plotted against age, or adjusted age.
- at0038::Weight velocity - Weight velocity plotted against age, or adjusted age.
- at0039::Length velocity - Length velocity plotted against age, or adjusted age.
- at0040::Head circumference velocity - Head circumference velocity plotted against age, or adjusted age.
- at0041::Clinical interpretation - Clinical interpretation of the growth indicator chart.
- at0042::Growth reference chart - Specifies the standard or syndrome-specific reference charts used to calculate the growth indicator data.
- at0043::Z-score category - The category or grouping of the Z score.

[child_pugh_score](#)

Archetype ID: openEHR-EHR-OBSERVATION.child_pugh_score.v0

Lifecycle State: in_development

****Category:**** OBSERVATION

****Languages:**** de, en

****Purpose:**** To record an assessment of prognosis for chronic liver disease.

****Use:**** Use to record an assessment of prognosis for chronic liver disease.

****Misuse:**** Not to be used to record the results of various liver function tests or the INR test- use the Laboratory test result family of archetypes for this purpose. Not to be used to record the diagnosis of hepatic encephalopathy - use EVALUATION.problem_diagnosis for this purpose. Not to be used to record the finding of ascites - use the Physical examination family of archetypes for this purpose.

****Keywords:**** Child-Pugh, liver, cirrhosis, score, Hepatitis C,

****Concepts:****

- at0000::Child-Pugh score - Tool used to assess the prognosis of chronic liver disease, mainly cirrhosis.
- at0001::History - @ internal @
- at0002::Any Event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Total bilirubin - Score for total bilirubin in micromole per litre.
- at0005::Less than 34 - Total bilirubin is less than 34.
- at0006::34 to 50 - Total bilirubin is between 34 and 50.
- at0007::Greater than 50 - Total bilirubin is more than 50.
- at0008::Serum albumin - Score for serum albumin in grams per litre.
- at0009::Greater than 35 - Serum albumin is greater than 35.
- at0010::28 to 35 - Serum albumin is between 28 and 35.
- at0011::Less than 28 - Serum albumin is less than 28.
- at0012::INR - Score for INR.
- at0013::Less than 1.7 - INR is less than 1.7.
- at0014::1.7 to 2.3 - INR is between 1.7 and 2.3.
- at0015::Greater than 2.3 - INR is greater than 2.3.
- at0016::Ascites - Score for presence of ascites.
- at0017::None - No ascites is present.
- at0018::Mild - Mild ascites is present.
- at0019::Moderate to severe - Moderate to severe ascites is present.
- at0020::Hepatic encephalopathy - Score for presence of hepatic encephalopathy.
- at0021::None - No hepatic encephalopathy is present.
- at0022::Grade I to II or suppressed with medication - Grade I or Grade II hepatic encephalopathy is present or hepatic encephalopathy is suppressed with medication.

- at0023::Grade III to IV or refractory - Grade III or Grade IV hepatic encephalopathy is present or hepatic encephalopathy is refractory.
- at0024::Adjusted bilirubin - Score for total bilirubin if the patient has primary biliary cirrhosis or sclerosing cholangitis.
- at0025::Less than 68 - Total bilirubin is less than 68.
- at0026::68 to 170 - Total bilirubin is between 68 and 170.
- at0027::Greater than 170 - Total bilirubin is greater than 170.
- at0028::Total score - Sum of the individual scores assigned for each of the contributing variables.
- at0029::Grade - Grading, based on total score.
- at0030::Class A 5 to 6 points - The Child-Pugh grade is Class A with a total score of 5 to 6 points.
- at0031::Class B 7 to 9 points - The Child-Pugh grade is Class B with a total score of 7 to 9 points.
- at0032::Class C 10 to 15 points - The Child-Pugh grade is Class C with a total score of 10 to 15 points.
- at0035::ItemTree - @ internal @
- at0037::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[child_snapshot](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.child_snapshot.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record summary information about an identified child, who is not the subject of care, at a specified point in time.

****Use:**** Use to record summary information about an identified child, who is not the subject of care, at a specified point in time. This archetype has been designed to be used as a component of a maternal mortality surveillance report and specifically to record details about the neonate(s)/child(ren) of a deceased mother.

****Concepts:****

- at0000::Child snapshot - Key summary information about an identified child, who is not the subject of care, at a specified point in time.

- at0001::History - @ internal @
- at0002::Any event - None
- at0003::Tree - @ internal @
- at0004::Name - Identification of a child by name.
- at0005::Label - A label to distinguish this child from other children.
- at0006::Alive or deceased? - The vital status of the child.
- at0007::Alive - The child is alive.
- at0008::Deceased - The child has died.
- at0009::General health description - Narrative description about the general health of the child.
- at0010::Sex assigned at birth - The formal sex assigned to the child at or around birth.
- at0011::Male - None
- at0012::Female - None
- at0013::Intersex - None
- at0014::Unknown - None
- at0015::Current age - The current age of the child.
- at0016::Primary caregiver - Identification of the primary caregiver category for the child.
- at0017::Usual primary care clinician - Identification of the usual general practitioner or primary care clinician for the child.
- at0018::Usual primary care clinic - Identification of the usual general practice or primary care clinic for the child.
- at0019::Last check-up - Date of the last health check-up.
- at0020::Last immunisation - Date of the last immunisation.
- at0021::Item tree - @ internal @
- at0022::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[clinical_frailty_scale](#)

Archetype ID: openEHR-EHR-OBSERVATION.clinical_frailty_scale.v1

Lifecycle State: published

Category: OBSERVATION

Languages: de, nb, pt-br, en

Purpose: To record the Clinical Frailty Scale assessment.

****Use:**** Use to record the Clinical Frailty Scale assessment. While openEHR archetypes are all freely available under an open license, the specific content of this Clinical Frailty Scale archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. Copyright statement: ©2009. Version 1.2_EN. All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada. Copyright information: <https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html>.

****Keywords:**** frailty, geriatric, old age, activity, end of life, rockwood, elderly, aging

****Concepts:****

- at0000::Clinical Frailty Scale (CFS) - An assessment scale used to screen for frailty and to broadly stratify degrees of fitness and frailty in an older adult.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Assessment - Assessed level of frailty.
- at0005::Very Fit - People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.
- at0006::Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.
- at0007::Managing Well - People whose medical problems are well controlled, but are not regularly active beyond routine walking.
- at0008::Vulnerable - While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.
- at0009::Mildly Frail - These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.
- at0010::Moderately Frail - People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
- at0011::Severely Frail - Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within - 6 months).
- at0012::Very Severely Frail - Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.
- at0013::Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.
- at0014::ItemTree - @ internal @

- at0015::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.

[**clinical_frailty_scale2**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.clinical_frailty_scale2.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the Clinical Frailty Scale (CFS) 2.0 assessment.

****Use:**** Use to record the Clinical Frailty Scale (CFS) 2.0 assessment. In 2020 the CFS was revised (version 2.0) with minor clarifying edits to the level descriptions and their corresponding labels. Most notably, CFS level 2 changed from "Well" to "Fit", level 4 from "Vulnerable" to "Living with Very Mild Frailty", and levels 5-8 were each restated as "Living with..." and added their respective grades of frailty. While openEHR archetypes are all freely available under an open license, the specific content of this Clinical Frailty Scale archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. Copyright statement: Clinical Frailty Scale ©2005-2020 Rockwood, Version 2.0(EN). All rights reserved. For permission: <https://www.geriatricmedicineresearch.ca>.

****Keywords:**** frailty, geriatric, old age, activity, end of life, rockwood, elderly, aging

****Concepts:****

- at0000::Clinical Frailty Scale (CFS 2.0) - An assessment scale used to screen for frailty and to broadly stratify degrees of fitness and frailty in an individual over the age of 65.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Assessment - Assessed level of frailty.
- at0014::ItemTree - @ internal @
- at0015::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0034::Very fit - People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.

- at0035::Fit - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.
- at0036::Managing well - People whose medical problems are well controlled, even if occasionally symptomatic, but often are not regularly active beyond routine walking.
- at0037::Living with very mild frailty - Previously 'Vulnerable', this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities. A common complaint is being 'slowed up' and/or being tired during the day.
- at0038::Living with mild frailty - People who often have more evident slowing, and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
- at0039::Living with moderate frailty - People who need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
- at0040::Living with severe frailty - Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
- at0041::Living with very severe frailty - Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
- at0042::Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise living with severe frailty. (Many terminally ill people can still exercise until very close to death).

[cmas_score](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.cmas_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the findings of the Childhood Myositis Assessment Scale for the assessment of muscle function in children with idiopathic inflammatory myopathies.

****Use:**** To be used for the recording of findings obtained in the Childhood Myositis Assessment Scale.

****Concepts:****

- at000::Childhood Myositis Assessment Scale - The Childhood Myositis Assessment Scale (CMAS).
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::1.Head lift - Duration of head lift.
- at0005::Unable - The subject is unable to lift his or her head.
- at0006::1-9 sec - The subject is able to lift his or her head for 1 to 9 seconds.
- at0007::10-29 sec - The subject is able to lift his or her head for 10 to 29 seconds.
- at0008::30-59 sec - The subject is able to lift his or her head for 30 to 59 seconds.
- at0009::60-119 sec - The subject is able to lift his or her head for 60 to 119 seconds.
- at0010::More than 2 min - The subject is able to lift his or her head for more than 2 minutes.
- at0011::Number of seconds head lift - The total number of seconds the subject is able to lift his or her head.
- at0012::2.Leg raise/touch object - Assessment of leg raise and object touch capabilities.
- at0013::Unable - The subject is unable to lift leg off the table.
- at0014::Able but no touch - The subject is able to clear the table but cannot touch object (examiner's hand).
- at0015::Able and touch - The subject is able to lift leg high enough to touch object (examiner's hand).
- at0016::3.Straight leg lift - Duration of straight leg lift.
- at0017::Unable - The subject is unable to lift his or her leg.
- at0018::1-9 sec - The subject is able to lift his or her leg for 1 to 9 seconds.
- at0019::10-29 sec - The subject is able to lift his or her leg for 10 to 29 seconds.
- at0020::30-59 sec - The subject is able to lift his or her leg for 30 to 59 seconds.
- at0021::60-119 sec - The subject is able to lift his or her leg for 60 to 119 seconds.
- at0022::More than 2 min - The subject is able to lift his or her leg for more than 2 minutes.
- at0023::Number of seconds leg lift - The total number of seconds the subject is able to lift his or her leg.
- at0024::4.Supine to prone - Assesment of subject's ability to turn from supine to prone.
- at0025::Unable - The subject has difficulty even turning on one side, able to pull right arm under torso only slightly or not at all.
- at0026::Fairly easily, but unable to free arm - The subject turns onto side faily easily, but cannot fully free right arm and is unable to fully assume a prone position.
- at0027::Easily with difficulty freeing arm - The subject turns onto side easily, has some difficulty freeing arm, but fully frees arm and fully assumes a prone position.
- at0028::Easily - The subject turns over easily, fully frees right arm with no difficulty.
- at0029::5.Sit-ups - Assessment of the subject's ability to do sit-ups.

- at0033::Hands on thighs with counterbalance - The subject is able to sit up with hands on thighs with counterbalance.
- at0034::Hands across chest with counterbalance - The subject is able to sit up with hands across chest and counterbalance.
- at0035::Hands behind head with counterbalance - The subject is able to sit up with hands behind the head and counterbalance.
- at0036::Hands across thighs without counterbalance - The subject is able to sit up with hands across the thighs and without counterbalance.
- at0037::Hands across chest without counterbalance - The subject is able to sit up with hands across the chest and without counterbalance.
- at0038::Hands behind head without counterbalance - The subject is able to sit up with hands behind the head and without counterbalance.
- at0039::Total sit-up score - The total sit-up score calculated from the sum of each sit-up capability achieved, i.e. each achieved capability scores 1 point.
- at0040::6.Supine to sit - Assessment of the subject's ability to sit up from the supine position.
- at0041::Unable by self - The subject is not able to sit up from supine position by himself or herself.
- at0042::Almost unable - The subject is able to sit up from supine position with much difficulty, very slow, struggles greatly, barely makes it.
- at0043::Able - The subject is able to sit up from supine position with some difficulty, somewhat slow, struggles some.
- at0044::No difficulty - The subject is able to sit up from supine position without any difficulty.
- at0045::7.Arm raise/straighten - Assessment of the subject's ability to raise and straighten wrists and arms.
- at0046::Unable - The subject cannot raise wrist up to the level of the A-C joint.
- at0047::Up to A-C joint - The subject is able to raise wrists at least up to the level of the A-C joint, but not above top of head.
- at0048::Above top of head - The subject is able to raise wrists above top of head, but cannot raise arm straight above head so that elbows are in full extension.
- at0049::Elbows in full extension - The subject is able to raise arms straight above head so that elbows are in full extension.
- at0050::8.Arm raise duration - Duration of ability to maintain wrists above top of head.
- at0051::Unable - The subject is unable to maintain wrists above top of head.
- at0052::1-9 sec - The subject is able to maintain wrists above top of head for 1 to 9 seconds.
- at0053::10-29 sec - The subject is able to maintain wrists above top of head for 10 to 29 seconds.
- at0054::30-59 sec - The subject is able to maintain wrists above top of head for 30 to 59 seconds.

- at0055::More than 60 sec - The subject is able to maintain wrists above top of head for more than 60 seconds.
- at0056::Number of seconds arm raised - The total number of seconds the subject is able to maintain wrists above top of head.
- at0057::9.Floor sit - Assessment of the subject's ability to go from a standing position to a sitting position on the floor.
- at0058::Unable - The subject is unable to go from a standing position to a sitting position on the floor. Afraid to even try, even if allowed a chair for support. Child fears that he or she will collapse, fall into a sit or harm self.
- at0059::Much difficulty - The subject is able to go from a standing position to a sitting position on the floor, but needs to hold onto a chair for support during descent. Unable or unwilling to try if not allowed a chair for support.
- at0060::Some difficulty - The subject is able to go from a standing position to a sitting position on the floor without using a chair for support, but has at least some difficulty during descent. May need Gower's, descends somewhat slowly and apprehensively, may not have full control or balance as maneuvers into a sit.
- at0061::No difficulty - The subject is able to go from a standing position to a sitting position on the floor without requiring any compensatory maneuvering.
- at0062::10.All fours maneuver - Assessment of the subject's ability to perform all fours maneuvers.
- at0063::Unable - The subject is unable to go from a prone to an all-fours position.
- at0064::Barely able - The subject is barely able to assume and maintain an all-fours position and is unable to raise head to look straight ahead.
- at0065::Maintain without ability to creep or crawl - The subject is able to maintain all-fours position with back straight and head raised (so as to look straight ahead), but cannot creep or crawl forward.
- at0066::Maintain with creep or crawl - The subject is able to maintain all-fours position, look straight ahead and creep or crawl forward.
- at0067::Maintains balance with lift and extend - The subject is able to maintain balance while lifting and extending one leg.
- at0068::11.Floor rise - Assessment of the subject's ability to go from a kneeling position on the floor to a standing position.
- at0069::Unable - The subject is unable to go from a kneeling position on the floor to a standing position even if allowed to use a chair for support.
- at0070::Much difficulty - The subject is able to go from a kneeling position on the floor to a standing position but needs to use a chair for support and is unable if not allowed to use a chair.
- at0071::Moderate difficulty - The subject is able to get up without using a chair for supports, but needs to place one or both hands on thighs or knees or floor (unable without using hands).
- at0072::Mild difficulty - The subject is able to get up and does not need to place hands on knees, thighs or floor, but has at least some difficulty during ascent.

- at0073::No difficulty - The subject is able to go from a kneeling position on the floor to a standing position without any difficulty.
- at0074::12.Cham rise - Assessment of the subject's ability to rise up from a chair.
- at0075::Unable - The subject is unable to rise up from chair, even if allowed to place hands on chair seat.
- at0076::Much difficulty - The subject is able to rise up from chair, but needs to place hands on sides of chair and is unable to rise up from chair if not allowed to place hands on sides of seat.
- at0077::Moderate difficulty - The subject is able to rise up from chair, but needs to place hands on knees or thighs, does not need to place hands on sides of seat.
- at0078::Mild difficulty - The subject is able to rise up from chair and does not need to place hands on knees, thighs or seat, but has at least some difficulty during ascent.
- at0079::No difficulty - The subject is able to rise up from chair without any difficulty at all.
- at0080::13.Stool step - Assessment of the subject's ability to step on a stool.
- at0081::Unable - The subject is unable to step on a stool.
- at0082::Much difficulty - The subject is able to step on a stool, but needs to place one hand on exam table or examiner's hand.
- at0083::Some difficulty - The subject is able to step on a stool and does not need to use exam table for support, but needs to hand on knee or thigh.
- at0084::Able - The subject is able to step on a stool and does not need to use exam table or hand on knee or thigh.
- at0085::14.Pick-up - Assessment of the subject's ability to pick up a pencil off the floor.
- at0086::Unable - The subject is unable to bend over and pick up pencil off floor.
- at0087::Much difficulty - The subject is able to pick up pencil off floor, but relies heavily on support gained by placing hands on knees or thighs.
- at0088::Some difficulty - The subject is able to pick up pencil off floor, but needs to at least minimally and briefly place hand(s) on knees or thighs for support, is somewhat slow.
- at0089::No difficulty - The subject is able to pick up pencil off floor without any difficulty or compensatory maneuvers.
- at0090::Total CMAS score - The total score for the 14 maneuvers.
- at0091::Tree - @ internal @
- at0092::Confounding factors - Record any issues or factors that may impact on the assessment and the score.
- at0093::Tree - @ internal @
- at0094::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0095::Clinical interpretation - Narrative description of clinical interpretation of assessment.

comfortBehaviourScale

****Archetype ID:**** openEHR-EHR-OBSERVATION.comfortBehaviourScale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** es-ar, en

****Purpose:**** The Comfort Behavioural scale is a modification of the original Comfort scale (1992), used for pain assessment in children in ICU and, complementarily, for sedation assessment in nonsurgical pediatric ICU patients.

****Use:**** Used for pain and/or sedation assessment in pediatric ICU patients.

****Misuse:**** Not to be used for pain and/or sedation assessment in adult populations.

****Keywords:**** Comfort Behavioural scale, Comfort B scale, pain, sedation, scale, pediatric

****Concepts:****

- at0000::Comfort behaviour scale - A numerical scale for pain and/or sedation assessment in pediatric ICU patients.
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0004::Alertness - Degree of alertness.
- at0005::Deeply asleep - Eyes closed, no response to changes in the environment.
- at0006::Lightly asleep - Eyes mostly closed, occasional responses.
- at0007::Drowsy - Child closes his/her eyes frequently, less responsive to the environment.
- at0008::Awake and alert - Child responsive to the environment.
- at0009::Awake and hyper-alert - Exaggerated responses to environmental stimuli.
- at0010::Calmness/Agitation - Degree of calmness or agitation.
- at0011::Calm - Child appears serene and tranquil.
- at0012::Slightly anxious - Child shows slight anxiety.
- at0013::Anxious - Child appears agitated but remains in control.
- at0014::Very anxious - Child appears very agitated, just able to control.
- at0015::Panicky - Severe distress with loss of control
- at0016::Respiratory response - Degree of respiratory response.
- at0017::No spontaneous respiration - No spontaneous respiration.
- at0018::Spontaneous and ventilator respiration - Both spontaneous and ventilator respiration.

- at0019::Restlessness or resistance to ventilator - Either restlessness or resistance to ventilator.
 - at0020::Actively breathes against ventilator or coughs regularly - Either actively breathes against ventilator or coughs regularly.
 - at0021::Fights ventilator - Fights ventilator.
 - at0022::Crying - Whether the patient is crying.
 - at0023::Quiet breathing, no crying sounds - Quiet breathing, with no crying sounds.
 - at0024::Occasional sobbing or moaning - Occasional sobbing or moaning.
 - at0025::Whining (monotonous sound) - Whining (as monotonous sound).
 - at0026::Crying
- Actively crying
- at0027::Screaming or shrieking - Screaming and/or shrieking.
 - at0028::Physical movement - Degree of physical movement.
 - at0029::No movement - No movements.
 - at0030::Occasional slight movements - Occasional, (three or fewer) slight movements.
 - at0031::Frequent slight movements - Frequent, (more than three) slight movements.
 - at0032::Vigorous movements limited to extremities - Vigorous movements limited to extremities.
 - at0033::Vigorous movements including torso and head - Vigorous movements including torso and head.
 - at0034::Muscle tone - Degree of muscle tone.
 - at0035::Muscles totally relaxed; no muscle tone - Muscles totally relaxed or no muscle tone.
 - at0036::Reduced muscle tone - Reduced muscle tone; less resistance than normal
 - at0037::Normal muscle tone - Normal muscle tone.
 - at0038::Increased muscle tone and flexion of fingers and toes - Increased muscle tone and flexion of fingers and toes.
 - at0039::Extreme muscle rigidity and flexion of fingers and toes - Extreme muscle rigidity and flexion of fingers and toes.
 - at0040::Facial tension - Degree of facial tension.
 - at0041::Facial muscles totally relaxed
- Facial muscles are totally relaxed.
- at0042::Normal facial tone - Normal facial tone.
 - at0043::Tension evident in some facial muscles (not sustained) - Tension evident in some facial muscles (not sustained).

- at0044::Tension evident throughout facial muscles (sustained) - Tension evident throughout facial muscles (sustained).
- at0045::Facial muscles contorted and grimacing - Facial muscles contorted and there is grimacing.
- at0046::Total score - Total score

conference

****Archetype ID:**** openEHR-EHR-OBSERVATION.conference.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the text conversation, or video- or audio-conference recording, between two or more clinicians, captured as part of the record of health care.

****Use:**** Use to document evidence of interactions between healthcare providers that support the record of health care. For example, use to record phone or online chat conversations between remote healthcare providers; or audio- and video-conference recordings that record aspects of telemedicine consultations or case conferences.

****Keywords:**** chat, videoconference, audioconference, conversation, discussion

****Concepts:****

- at0000::Conference - Text conversation, or video- or audio-conference recording, between two or more clinicians, captured as part of the record of health care.
- at0001::Event Series - @ internal @
- at0002::Time - Default, unspecified point in time recording which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Text record - The text conversation between two or more healthcare providers.
- at0005::Audio or video record - The audio or video conversation between two or more healthcare providers.
- at0006::Recording interval - Default, unspecified interval recording event which may be explicitly defined in a template or at run-time.
- at0007::Author - The author of the chat or instigator of the recording.
- at0008::Item tree - @ internal @
- at0009::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

container

****Archetype ID:**** openEHR-EHR-OBSERVATION.container.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, sv, nb, 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 OBSERVATION 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::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Detail - Clinical details held within CLUSTER archetypes.

cormack_lehane

****Archetype ID:**** openEHR-EHR-OBSERVATION.cormack_lehane.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** fi, nb, en

****Purpose:**** To describe the structures visible during direct laryngoscopy and indirectly to indicate the likely difficulty of laryngeal intubation.

****Use:**** Use to describe the structures visible during direct laryngoscopy and indirectly to indicate the likely difficulty of laryngeal intubation. The position of the head and other relevant information will be carried in other relevant ENTRY archetypes.

****Misuse:**** Not to be used for recording Modified Cormack-Lehane grading (Yentis & Lee, 1998). Use a specific archetype for this purpose.

****Keywords:**** intubation, laryngoscopy, grading, airway, glottis, epiglottis, difficult airway

****Concepts:****

- at0000::Cormack-Lehane classification - The Cormack-Lehane system classifies views obtained by direct laryngoscopy based on the structures seen.
- at0001::Grading - A grading of the laryngeal anatomical visibility.
- at0002::Grade 1: Full view of the glottis - Full view of the glottis.
- at0003::Grade 2: Partial view of the glottis or arytenoids - Partial view of the glottis or arytenoids.
- at0004::Grade 3: Only epiglottis visible - Only epiglottis visible.
- at0005::Grade 4: Neither glottis nor epiglottis visible - Neither glottis nor epiglottis visible.
- at0006::Comment - Narrative comment about the Cormack-Lehane grading.
- at0007::Event Series - @ internal @
- at0008::Any point in time event - Unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0009::Tree - @ internal @
- at0010::Tree - @ internal @
- at0011::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

cow_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.cow_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To record individual COWS parameters and total score.

****Use:**** Use to record individual COWS parameters and total score as part of an objective and subjective opiate withdrawal assessment.

****Concepts:****

- at0000::Clinical Opiate Withdrawal Scale (COWS) - Assessment tool used to measures the severity of opiate withdrawal.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Resting pulse rate (BPM) - Measure pulse rate after patient is sitting or lying down for 1 minute.
- at0005::Sweating - Sweating not accounted for by room temperature or patient activity over the last 0.5 hours.
- at0006::Restlessness observation during assessment - None
- at0007::Pupil size - None
- at0008::Bone or joint aches - If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored.
- at0009::Runny nose or tearing - Not accounted for by cold symptoms or allergies.
- at0010::GI upset - Over last 0.5 hours.
- at0011::Tremor observation of outstretched hands - None
- at0012::Yawning observation during assessment - None
- at0013::Anxiety or irritability - None
- at0014::Gooseflesh skin - None
- at0015::Total score - The total sum of each component parameter for COWS.
- at0017::≤ 80 - None
- at0018::81-100 - None
- at0019::101-120 - None
- at0020::> 120 - None
- at0021::No report of chills or flushing - None
- at0022::Subjective report of chills or flushing - None

- at0023::Flushed or observable moistness on face - None
- at0024::Beads of sweat on brow or face - None
- at0025::Sweat streaming off face - None
- at0026::Able to sit still - None
- at0027::Reports difficulty sitting still, but is able to do so - None
- at0028::Frequent shifting or extraneous movements of legs/arms - None
- at0029::Unable to sit still for more than a few seconds - None
- at0030::Pupils pinned or normal size for room light - None
- at0031::Pupils possibly larger than normal for room light - None
- at0032::Pupils moderately dilated - None
- at0033::Pupils so dilated that only the rim of the iris is visible - None
- at0034::Not present - None
- at0035::Mild diffuse discomfort - None
- at0036::Patient reports severe diffuse aching of joints/ muscles - None
- at0037::Patient is rubbing joints or muscles and is unable to sit still because of discomfort - None
- at0038::Not present - None
- at0039::Nasal stuffiness or unusually moist eyes - None
- at0040::Nose running or tearing - None
- at0041::Nose constantly running or tears streaming down cheeks - None
- at0042::No GI symptoms - None
- at0043::Stomach Cramps - None
- at0044::Nausea or loose stool - None
- at0045::Vomiting or diarrhea - None
- at0046::Multiple episodes of vomiting or diarrhea - None
- at0047::No tremor - None
- at0048::Tremor can be felt, but not observed - None
- at0049::Slight tremor observable - None
- at0050::Gross tremor or muscle twitching - None
- at0051::No yawning - None
- at0052::Yawning once or twice during assessment - None
- at0053::Yawning three or more times during assessment - None
- at0054::Yawning several times/minute - None
- at0055::None - None
- at0056::Patient reports increasing irritability or anxiousness - None
- at0057::Patient obviously irritable/anxious - None
- at0058::Patient so irritable or anxious that participation in the assessment is difficult - None
- at0059::Skin is smooth - None
- at0060::Piloerection of skin can be felt or hairs standing up on arms - None
- at0061::Prominent piloerection - None
- at0062::Item tree - @ internal @

- at0063::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

cpax

****Archetype ID:**** openEHR-EHR-OBSERVATION.cpax.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the results for each component parameter for the Chelsea Critical Care Physical Assessment Tool (CPAx).

****Use:**** Use to record the results for each component parameter for the Chelsea Critical Care Physical Assessment Tool (CPAx).

****Concepts:****

- at0000::Chelsea Critical Care Physical Assessment (CPAx) tool - A scoring system to measure physical morbidity in critical care.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Respiratory function - None
- at0005::Complete ventilator dependence. Mandatory breaths only. May be fully sedated/ paralysed - None
- at0006::Ventilator dependence. Mandatory breaths with some spontaneous effort - None
- at0007::Spontaneously breathing with continuous invasive or non-invasive ventilatory support - None
- at0008::Spontaneously breathing with intermittent invasive or non-invasive ventilatory support or continuous high flow oxygen (>15 L) - None
- at0009::Receiving standard oxygen therapy (<15L) - None
- at0010::Self-ventilating with no oxygen therapy - None
- at0012::Cough - None
- at0013::Grip strength (predicted mean for age and gender on the strongest hand) - None
- at0014::Moving within the bed (e.g. rolling) - None

- at0015::Supine to sitting on the edge of the bed - None
- at0016::Dynamic sitting (i.e. when sitting on the edge of the bed/unsupported sitting) - None
- at0017::Standing balance - None
- at0018::Sit to stand (starting position: ≤90° hip flexion) - None
- at0019::Transferring from bed to chair - None
- at0020::Stepping - None
- at0021::Absent cough, may be fully sedated or paralysed - None
- at0022::Cough stimulated on deep suctioning only - None
- at0023::Weak ineffective voluntary cough, unable to clear independently (e.g. requires deep suction) - None
- at0024::Weak, partially effective voluntary cough, sometimes able to clear secretions (e.g. requires Yankauer suctioning) - None
- at0025::Effective cough, clearing secretions with airways clearance techniques - None
- at0026::Consistent effective voluntary cough, clearing secretions independently - None
- at0027::Unable, maybe fully sedated/ paralysed - None
- at0028::Initiates movement. Requires assistance of two or more people (maximal) - None
- at0029::Initiates movement. Requires assistance of at least one person (moderate) - None
- at0030::Initiates movement. Requires assistance of one person (minimal) - None
- at0031::Independent in ≥3 seconds - None
- at0032::Independent in <3 seconds - None
- at0033::Unable/unstable - None
- at0034::Initiates movement. Requires assistance of two or more people (maximal) - None
- at0035::Initiates movement. Requires assistance of at least one person (moderate) - None
- at0036::Initiates movement. Requires assistance of one person (minimal) - None
- at0037::Independent in ≥3 seconds - None
- at0038::Independent in <3 seconds - None
- at0039::Unable/unstable - None
- at0040::Requires assistance of two or more people (maximal) - None
- at0041::Requires assistance of at least one person (moderate) - None
- at0042::Requires assistance of one person (minimal) - None
- at0043::Independent with some dynamic sitting balance (i.e. able to alter trunk position within base of support) - None
- at0044::Independent with full dynamic sitting balance (i.e. able to reach out of base of support) - None
- at0045::Unable/unstable/bedbound - None
- at0046::Tilt table or similar - None
- at0047::Standing hoist or similar - None

- at0048::Dependent on frame, crutches or similar - None
- at0049::Independent without aids - None
- at0050::Independent without aids and full dynamic standing balance (i.e. able to reach out of base of support) - None
- at0051::Unable/unstable - None
- at0052::Sit to stand with maximal assistance (standing hoist or similar) - None
- at0053::Sit to stand with moderate assistance (e.g. one or two people) - None
- at0054::Sit to stand with minimal assistance (e.g. one person) - None
- at0055::Sit to stand independently pushing through arms of the chair - None
- at0056::Sit to stand independently without upper limb involvement - None
- at0057::Unable/unstable - None
- at0058::Full hoist - None
- at0059::Standing hoist or similar - None
- at0060::Pivot transfer (no stepping) with mobility aid or physical assistance - None
- at0061::Stand and step transfer with mobility aid or physical assistance - None
- at0062::Independent transfer without equipment - None
- at0063::Unable/unstable - None
- at0064::Using a standing hoist or similar - None
- at0065::Using mobility aids and assistance of at least one person (moderate) - None
- at0066::Using mobility aid and assistance of one person (minimal) - None
- at0067::Using mobility aid or assistance of one person (minimal) - None
- at0068::Independent without aid - None
- at0069::Unable to assess - None
- at0070::<20% - None
- at0071::<40% - None
- at0072::<60% - None
- at0073::<80% - None
- at0074::≥80% - None
- at0076::Total score - The total sum of each component variable for the Chelsea Critical Care Physical Tool.
- at0077::Item tree - @ internal @
- at0078::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[**crb_65**](#)

Archetype ID: openEHR-EHR-OBSERVATION.crb_65.v1

Lifecycle State: published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the results for each component parameter and their total sum for the CRB-65 score.

****Use:**** Use to record the results for each component parameter and their total sum for the CRB-65 score.

****Misuse:**** Not to be used to record the CURB-65 score, which is intended for use in a hospital setting. Use the OBSERVATION.curb_65 archetype for this purpose.

****Keywords:**** pneumonia, CAP, community, acquired, LRTI, community-acquired

****Concepts:****

- at0000::CRB-65 score - An assessment score used within a community or primary care setting to estimate the severity of community-acquired pneumonia.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Confusion - Does the patient have recent onset confusion?
- at0005::No - None
- at0006::Yes - None
- at0007::Respiratory rate - Does the patient have a respiratory rate equal to or greater than 30 /min?
- at0008::No - None
- at0009::Yes - None
- at0010::Blood pressure - Does the patient have a systolic blood pressure <90 OR a diastolic blood pressure ≤60 mmHg?
- at0011::No - None
- at0012::Yes - None
- at0013::Item tree - @ internal @
- at0014::Age - Is the patient 65 years or older?
- at0015::No - None
- at0016::Yes - None
- at0017::Total score - The total sum of each component variable for the CRB-65 score.
- at0018::Grade - Assessment of severity based on the CRB-65 score.
- at0019::Low severity - CRB-65 score 0: Low risk of death.
- at0020::Moderate severity - CRB-65 score 1-2: Moderate risk of death.
- at0021::High severity - CRB-65 score 3-4: High risk of death.
- at0022::Extension SLOT - Additional information required to extend the model with local content or to align with other reference models or formalisms.

critical_pain_observation_tool

****Archetype ID:**** openEHR-EHR-OBSERVATION.critical_pain_observation_tool.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** es-ar, en

****Purpose:**** A pain assessment scale for uncommunicative and sedated intensive care unit (ICU) patients based on clinical observation.

****Use:**** The scale consists of four behavioral parameters: facial expression, body movements, muscle tension and compliance with the ventilation for intubated patients or vocalization for extubated patients. Patient's behavior for each of the parameters is scored between 0 and 2. Possible total score ranges from 0 (no pain) to 8 (maximum pain).

****Misuse:**** Not to be used outside the scope of uncommunicative or sedated intensive care patients.

****Keywords:**** pain, score, facial expression, body movements, muscle tension, ventilation, intubation, vocalization

****Concepts:****

- at0000::Critical care pain observation tool (CPOT) - A pain scale for uncommunicative and sedated intensive care unit (ICU) patients based on clinical observation.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Ventilator compliance - Used in mechanically ventilated patients.
- at0005::Tolerating ventilator or movement - Alarms not activated, easy ventilation.
- at0006::Coughing but tolerating - Alarms stop spontaneously.
- at0007::Fighting ventilator - Asynchrony: blocking ventilation, alarms frequently activated.
- at0008::Vocalization - Used in non-ventilated patients.
- at0009::Talking in normal tone or no sound - Talking in normal tone or no sound.
- at0010::Sighing, moaning - Sighing, moaning.
- at0011::Crying out, sobbing - Crying out, sobbing.
- at0012::Facial expression - The state and changes in the patient's facial gestures.
- at0013::Relaxed, neutral - No muscular tension observed.

- at0014::Tense - Presence of frowning, brow lowering, orbit tightening, and levator contraction.
- at0015::Grimacing - All of the above facial movements plus eyelid tightly closed.
- at0016::Body movements - The patient's pattern of movements.
- at0017::Absence of movements - Does not move at all (does not necessarily mean absence of pain).
- at0018::Protection - Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements.
- at0019::Restlessness - Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed.
- at0020::Muscle tension - Generally evaluated by performing a passive flexion and extension of the patient's arm.
- at0021::Relaxed - No resistance to passive movements.
- at0022::Tense, rigid - Resistance to passive movements.
- at0023::Very tense or rigid - Strong resistance to passive movements, inability to complete them.
- at0024::Intubated? - True if the patient is intubated.
- at0025::Total score - The value which results from adding up the four variables measured.
- at0026::Comment - Additional information regarding pain which were not captured by the structured variables but which might be of interest in the individual patient's assessment.
- at0027::Tree - @ internal @
- at0032::Tree - @ internal @
- at0033::Confounding factors - Any incidental factors related to the state of the subject which may affect clinical interpretation of the measurement.
- at0034::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

[**crusade_bleeding**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.crusade_bleeding.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter, the total sum and grade for the CRUSADE bleeding score.

****Use:**** Use to record the results for each component parameter, the total sum and grade for the CRUSADE bleeding score.

****Keywords:**** ACS, Acute coronary syndrome, Bleeding, CBRS, CRUSADE bleeding risk score, NSTEMI, Non-ST segment elevation myocardial infarction, PCI, percutaneous coronary intervention, prognosis, ST segment elevation myocardial infarction, STEMI, ischaemic heart disease, myocardial infarction, primary percutaneous coronary intervention, risk score

****Concepts:****

- at0000::CRUSADE bleeding score - An assessment tool used to stratify risk for major bleeding in patients presenting with NSTEMI or STEMI prior to initiation of treatment.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Baseline haematocrit - Haematocrit measured in %.
- at0005::<31 - Less than 31%.
- at0006::31-33.9 - Between 31 and 33.9%.
- at0007::34-36.9 - Between 34 and 36.9%.
- at0008::37-39.9 - Between 37 and 39.9%.
- at0009::>=40 - Greater than or equal to 40%.
- at0010::Creatinine clearance - Creatinine clearance estimated using the Cockcroft-Gault equation.
- at0011::<=15 - Less than or equal to 15 mL/min.
- at0012::>15-30 - Greater than 15 to 30 mL/min.
- at0013::>30-60 - Greater than 30 to 60 mL/min.
- at0014::>60-90 - Greater than 60 to 90 mL/min.
- at0015::>90-120 - Greater than 90 to 120 mL/min.
- at0016::>120 - Greater than 120 mL/min.
- at0017::Heart rate - Heart rate measured in beats/min.
- at0018::<=70 - Less than or equal to 70 bpm.
- at0019::71-80 - Between 71 and 80 bpm.
- at0020::81-90 - Between 81 and 90 bpm.
- at0021::91-100 - Between 91 and 100 bpm.
- at0022::101-110 - Between 101 and 110 bpm.
- at0023::111-120 - Between 111 and 120 bpm.
- at0024::>=121 - Greater than or equal to 121.
- at0025::Sex - Patient sex.
- at0026::Female - Patient sex is female.
- at0027::Male - Patient sex is male.
- at0028::Signs of heart failure - Signs of congestive heart failure at presentation?

- at0029::No - No signs of congestive heart failure at presentation.
- at0030::Yes - Signs of Congestive Heart Failure at presentation.
- at0031::Prior vascular disease - History of vascular disease?
- at0032::No - No history of vascular disease.
- at0033::Yes - Patient has history of vascular disease.
- at0034::Diabetes mellitus - History of diabetes mellitus?
- at0035::No - No history of diabetes mellitus.
- at0036::Yes - Patient has history of diabetes mellitus.
- at0044::ItemTree - @ internal @
- at0046::Score version - The version of the score used, normally recorded as the year.
- at0063::Risk grade - Overall CRUSADE risk score.
- at0064::Total score - Sum of the individual scores assigned for each of the contributing variables.
- at0065::<=20 - Very low risk.
- at0066::21-30 - Low risk.
- at0067::31-40 - Moderate risk.
- at0068::41-50 - High risk.
- at0069::>=51 - Very high risk.
- at0071::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0073::Systolic blood pressure - Systolic blood pressure measured in mm Hg.
- at0074::<=90 - Systolic blood pressure is less than or equal to 90 mm Hg.
- at0075::91-100 - Between 91 and 100 mm Hg.
- at0076::101-120 or >=201 - Between 101 and 120 mm Hg or greater than or equal to 201.
- at0077::121-180 - Between 121 and 180 mm Hg.
- at0078::181-200 - Between 181 and 200 mm Hg.

[crusade_bleeding_risk_score](#)

Archetype ID: openEHR-EHR-OBSERVATION.crusade_bleeding_risk_score.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en

Purpose: The CRUSADE bleeding score is used to quantify risk for in-hospital major bleeding across all postadmission treatments, which enhances baseline risk assessment for NSTEMI care.

****Use:**** The CRUSADE bleeding score is a tool to help providers consider the baseline risk of bleeding for their patients. With this, selection of bleeding reduction strategies, and increased care in dosing of adjustable anticoagulants should be considered. Lower hematocrit and renal function are the most predictive items in the score.

****Misuse:**** Risk of bleeding is strongly correlated with risk of mortality. It is not the case that those with highest bleeding risk are the same patients without a benefit from anticoagulants. Rather, the opposite is often the case. Higher bleeding risk, greater benefit to be gained from treatment. Key is in the awareness of that risk, and exercising care in dosing and treatment selection.

****Keywords:**** ACS, Acute coronary syndrome, Bleeding, CBRS, CRUSADE bleeding risk score, NSTEMI, Non-ST segment elevation myocardial infarction, PCI, percutaneous coronary intervention, prognosis, ST segment elevation myocardial infarction, STEMI, ischaemic heart disease, myocardial infarction, primary percutaneous coronary intervention, risk score

****Concepts:****

- at0000::Crusade Bleeding Risk Score - Crusade Bleeding Risk Score is used to stratify risk for major bleeding in patients presenting with NSTEMI or STEMI prior to initiation of treatment.
- at0001::History - *
- at0002::Any event - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Baseline HCT / Hematocrit - Score based on hematocrit % measurements.
- at0005::<31 - Hematocrit is less than 31%.
- at0006::31-33.9 - Hematocrit is between 31 and 33.9%.
- at0007::34-36.9 - Hematocrit is between 34 and 36.9%.
- at0008::37-39.9 - Hematocrit is between 37 and 39.9%.
- at0009::>=40 - Hematocrit is greater than or equal to 40%.
- at0010::Creatinine Clearance - Score for Creatinine Clearance estimated using the Cockcroft-Gault equation.
- at0011::<=15 - Less than or equal to 15 mL/min.
- at0012::>15-30 - Greater than 15 to 30 mL/min.
- at0013::>30-60 - Greater than 30 to 60 mL/min.
- at0014::>60-90 - Greater than 60 to 90 mL/min.
- at0015::>90-120 - Greater than 90 to 120 mL/min.
- at0016::>120 - Greater than 120 mL/min.
- at0017::Heart Rate - Heart rate score based on measurements in beats/min.
- at0018::<=70 - Less than or equal to 70 bpm.
- at0019::71-80 - Between 71 and 80 bpm.
- at0020::81-90 - Between 81 and 90 bpm.

- at0021::91-100 - Between 91 and 100 bpm.
- at0022::101-110 - Between 101 and 110 bpm.
- at0023::111-120 - Between 111 and 120 bpm.
- at0024::>=121 - Greater than or equal to 121.
- at0025::Sex - Patient sex.
- at0026::Female - Patient sex is female.
- at0027::Male - Patient sex is male.
- at0028::Signs of CHF at presentation - Did the patient show signs of Congestive Heart Failure at presentation?
- at0029::No - No signs of congestive heart failure at presentation.
- at0030::Yes - Signs of Congestive Heart Failure at presentation.
- at0031::Prior vascular disease - Does the patient have history of vascular disease?
- at0032::No - No history of vascular disease.
- at0033::Yes - Patient has history of vascular disease.
- at0034::Diabetes mellitus - Does the patient have a history of diabetes mellitus?
- at0035::No - No history of diabetes mellitus.
- at0036::Yes - Patient has history of diabetes mellitus.
- at0044::ItemTree - @ internal @
- at0046::Score version - The version of the score used, normally recorded as the year.
- at0047::ItemTree - @ internal @
- at0049::Confounding factors - Issues that may affect interpretation of the score.
- at0063::CRUSADE Risk Grade - Overall CRUSADE risk score.
- at0064::CRUSADE Risk Score - The total summed score of all recorded individual risks.
- at0065::<=20 - Very low risk.
- at0066::21-30 - Low risk.
- at0067::31-40 - Moderate risk.
- at0068::41-50 - High risk.
- at0069::>=51 - Very high risk.
- at0071::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0073::Systolic blood pressure - Score based on systolic blood pressure ranges measured in mm Hg.
- at0074::<=90 - Systolic blood pressure is less than or equal to 90 mm Hg.
- at0075::91-100 - Between 91 and 100 mm Hg.
- at0076::101-120 or >=201 - Between 101 and 120 mm Hg or greater than or equal to 201.
- at0077::121-180 - Between 121 and 180 mm Hg.
- at0078::181-200 - Between 181 and 200 mm Hg.

curb_65

****Archetype ID:**** openEHR-EHR-OBSERVATION.curb_65.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the results for each component parameter and their total sum for the CURB-65 score.

****Use:**** Use to record the results for each component parameter and their total sum for the CURB-65 score.

****Misuse:**** Not to be used to record the CRB-65 score, which is intended for use in a community or primary care setting. Use the OBSERVATION.crb_65 archetype for this purpose.

****Keywords:**** pneumonia, community, acquired, hospital, LRTI, CAP, community-acquired

****Concepts:****

- at000::CURB-65 score - An assessment score used within an acute hospital setting to estimate the severity of community-acquired pneumonia.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Confusion - Does the patient have recent onset confusion?
- at0005::No - None
- at0006::Yes - None
- at0007::Respiratory rate - Does the patient have a respiratory rate equal to or greater than 30 /min?
- at0008::No - None
- at0009::Yes - None
- at0010::Blood pressure - Does he patient have a systolic blood pressure <90 OR a diastolic blood pressure ≤60 mmHg?
- at0011::No - None
- at0012::Yes - None
- at0013::Item tree - @ internal @
- at0014::Age - Is the patient 65 years or older?
- at0015::No - None
- at0016::Yes - None

- at0017::Total score - The total sum of each component variable for the CURB-65 score.
- at0018::Grade - Severity assessment based on the CURB-65 score.
- at0019::Low severity - CURB-65 score 0-1: Low risk of death.
- at0020::Moderate severity - CURB-65 score 2: Moderate risk of death.
- at0021::High severity - CURB-65 score 3-5: High risk of death.
- at0022::Urea - Does the patient have a blood urea of >7 mmol/L (or 19 mg/dL)?
- at0023::No - None
- at0024::Yes - None
- at0025::Extension SLOT - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[current_pregnancy_screening](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.current_pregnancy_screening.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the responses to a screening questionnaire about a current pregnancy and associated antenatal care intended to provide an instant snapshot of a current pregnancy situation at a point in time.

****Use:**** Use to record the responses to a screening questionnaire about a current pregnancy and associated antenatal care. Common use cases include, but are not limited to:
 - Systematic questioning in any consultation or general health screening situation; or -
 Specific questioning related to infectious disease surveillance. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry about the pregnancy at a specific point in time. If the individual is pregnant and it is intended that the details are to be recorded and persisted as part of an ongoing health record, any further specific details about the exposure should be recorded using the EVALUATION.pregnancy_summary and related archetypes.

****Misuse:**** Not to be used to record persistent details about a known pregnancy. Use the EVALUATION.pregnancy_summary archetype for this purpose.

****Keywords:**** pregnancy, antenatal

****Concepts:****

- at000::Current pregnancy screening questionnaire - An individual- or self-reported questionnaire about the current pregnancy and associated antenatal care.
- at0001::History - @ internal @
- at0002::Any event - None
- at0003::Tree - @ internal @
- at0014::First antenatal appointment - The date and time of the first scheduled antenatal appointment.
- at0010::Antenatal referral status - Has the individual been referred for antenatal care?
- at0011::Referred - The individual has been referred for antenatal care.
- at0012::Not referred - The individual has not been referred for antenatal care.
- at0013::Refused referral - The individual has refused referral for antenatal care.
- at0017::Item tree - @ internal @
- at0018::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0016::Antenatal care - Details about the provider or organisation providing antenatal care.
- at0015::Next antenatal appointment - The date and time of the next scheduled antenatal appointment.
- at0004::Pregnant? - Is the individual currently pregnant?
- at0005::Yes - None
- at0006::Unknown - None
- at0007::No - None
- at0019::Comment - Additional narrative about the screening for current pregnancy and associated antenatal care, not captured in other fields.
- at0020::Planned delivery location - The anticipated place of delivery.
- at0024::Multiple pregnancy? - None
- at0025::Yes - None
- at0026::Unknown - None
- at0027::No - None

das28-CRP

****Archetype ID:**** openEHR-EHR-OBSERVATION.das28-CRP.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the individual DAS28-CRP parameters and total score.

****Use:**** Use to record the individual DAS28-CRP parameters and total score as an assessment of disease activity in rheumatoid arthritis.

****Misuse:**** Not to be used to record the DAS28 score using the ESR result. Use OBSERVATION.das28 for this purpose.

****Keywords:**** DAS28, rheumatoid arthritis, disease activity

****Concepts:****

- at0000.1::Disease Activity Score-28 with CRP (DAS28-CRP) - Assessment tool used as a measure of disease activity in rheumatoid arthritis (RA), using CRP result.
- at0006.1::ESR result - Erythrocyte sedimentation rate test result.
- at0.1::CRP result - C-reactive protein test result.
- at0008.1::DAS28-CRP score - Total DAS 28-CRP score.
- at0015.1::DAS28-CRP(3) score - DAS 28-CRP score using only 3 variables, when the Global health parameter is not available.
- at0000::Disease Activity Score-28 (DAS28) - Assessment tool used as a measure of disease activity in rheumatoid arthritis (RA), using ESR result.
- at0001::Event Series - @ internal @
- at0002::Point in time - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tender joint count - The total number of tender joints observed.
- at0005::Swollen joint count - The total number of swollen joints observed.
- at0006::ESR result - Erythrocyte sedimentation rate test result.
- at0007::Global health - Visual analogue scale assessment of overall health and disease activity.
- at0008::DAS28 score - Total DAS 28 score.
- at0009::Tree - @ internal @
- at0010::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0015::DAS28(3) score - DAS 28 score using only 3 variables, when the Global health parameter is not available.

das28

****Archetype ID:**** openEHR-EHR-OBSERVATION.das28.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en, sl

****Purpose:**** To record the individual DAS28 parameters and total score.

****Use:**** Use to record the individual DAS28 parameters and total score as an assessment of disease activity in rheumatoid arthritis.

****Misuse:**** Not to be used to record the DAS28 score using the CRP result. Use OBSERVATION.das28-CRP for this purpose.

****Keywords:**** DAS28, rheumatoid arthritis, disease activity

****Concepts:****

- at0000::Disease Activity Score-28 (DAS28) - Assessment tool used as a measure of disease activity in rheumatoid arthritis (RA), using ESR result.
- at0001::Event Series - @ internal @
- at0002::Point in time - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tender joint count - The total number of tender joints observed.
- at0005::Swollen joint count - The total number of swollen joints observed.
- at0006::ESR result - Erythrocyte sedimentation rate test result.
- at0007::Global health - Visual analogue scale assessment of overall health and disease activity.
- at0008::DAS28 score - Total DAS 28 score.
- at0009::Tree - @ internal @
- at0010::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0015::DAS28(3) score - DAS 28 score using only 3 variables, when the Global health parameter is not available.

[**dash_score**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.dash_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To record individual DASH prediction score parameters and total score.

****Use:**** Use to record individual DASH prediction score parameters and total score as part of an evaluation for the need for ongoing anticoagulant therapy.

****Concepts:****

- at0000::DASH prediction score - Assessment tool used to predict the risk of recurring venous thromboembolism (VTE).
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::D-Dimer abnormal - Measured ~1 month after stopping anticoagulation.
- at0005::No - None
- at0006::Yes - None
- at0007::Age ≤ 50 years - None
- at0008::No - None
- at0009::Yes - None
- at0010::Male patient - None
- at0013::Hormone use at VTE onset - None
- at0014::No - None
- at0015::Yes - None
- at0016::Total score - The total sum of each component parameter for the DASH score.
- at0017::Item tree - @ internal @
- at0018::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

demo

****Archetype ID:**** openEHR-EHR-OBSERVATION.demo.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, pt-br, en

****Purpose:**** To provide an overview of the display of each of the datatypes available in an openEHR archetype, and of the Data, State, Event and Protocol models within the context of a HTML display and associated ADL.

****Use:**** To provide a visual overview of archetype data types and archetype components to potential and current clinical content reviewers in the openEHR Clinical Knowledge Manager.

****Misuse:**** Not to carry any real clinical data.

****Keywords:**** demonstration, test, prototype, datatypes, state, protocol, event, data

****Concepts:****

- at0000::Demonstration - Demonstration archetype with descriptions and explanations.
- at0001::Event Series - @ internal @
- at0002::Any Event - All archetypes of the OBSERVATION class contain a HISTORY or EVENT model which contains information about the timing of the observation and the 'width' of the information - either a point in time or an interval. The default is 'Any event' and it is not specified if this is a Point in time or an Interval.
- at0003::Tree - @ internal @
- at0004::Heading1 - This is a symbol for a cluster which can have other elements 'nested' within it.
- at0005::Free Text or Coded - Text data type in which free text can be entered or coding can be incorporated either in the template or at run time.
- at0006::Text That Uses Internal Codes - Text data type which can use an internal vocabulary. Each of these 'internal codes' can be bound to a terminology code.
- at0007::Lying - Patient is lying supine.
- at0008::Reclining - Patient is reclining, propped up on one medium pillow.
- at0009::Sitting - Patient is sitting on a chair.
- at0010::Standing - Patient is standing.
- at0011::Text That is Sourced From an External Terminology - Text data type utilising codes derived from an external terminology source eg a SNOMED-CT, LOINC or ICD subset.
- at0012::Quantity - A quantity data type used to record a measurement associated with its' appropriate units. These are derived from ISO standards and the Reference model enables conversion between these units. The example shown here is length.
- at0013::Count - Count data types are composed of an integer with no units eg for recording the number of children - in this example the minimum is set at 0 and the maximum not specified.
- at0014::Date/Time - Date/Time datatype allows recording of a date and/or time, including partial dates such as year only or month and year only. Allow all is the default - so all forms of date/time are permitted.
- at0015::Ordinal - Ordinal datatypes pair a number and text - in this way scores can be calculated in software, or progression can be assessed eg if used in a pain score.
- at0016::Boolean - Boolean datatype that allows for true or false answers.
- at0017::Any - The datatype for this 'any' element can be specified or constrained in a template or at run-time, but is not explicitly modelled in the archetype.

- at0018::Heading 2 - This is a symbol for a cluster which can have other elements 'nested' within it.
- at0019::Slot To Contain Other Cluster Archetypes - List of CLUSTER archetypes allowed to be included or excluded within this OBSERVATION archetype.
- at0020::Slot To Contain Other Element Archetypes - List of ELEMENT archetypes allowed to be included or excluded within this OBSERVATION archetype.
- at0021::Duration - Duration datatype allows recording of the duration of clinical concepts. 'Allow all time units' is the default, although specific time units can be explicitly modelled. Maximum and minimum values can be set for each time unit.
- at0022::Interval of Integer - Interval of integer datatype allows for recording of a range of counts eg 1-2 tablets prescribed. Maximum and minimum values can be set for the lower count and the upper count.
- at0023::Interval of Quantity - Interval of quantity datatypes allow for the recording of a range of measurements in association with appropriate units eg 1-2cm (prescribed amount of cream for a rash).
- at0024::Interval of Date - Interval of integer datatype allows for recording of a range of dates eg between September 1, 2008 and September 8, 2008.
- at0025::Choice - Choice datatype allows for a number of types of element to be specified simultaneously and which can constrained or selected within a template or at run-time. In this example, a text datatype set to Free text or Coded and another that is constrained to Terminology record data about the same data element.
- at0026::Multimedia - Multimedia datatypes allow for the recording of many types of multimedia files to be captured. All available types have been explicitly selected in this example.
- at0027::URI - resource identifier - URI datatypes allow for recording of relationships from this data to data recorded elsewhere. These links can be within the same EHR, or external eg to a URL.
- at0028::Proportion - Proportion datatypes allow for ratios, percent, fractions and proportions to be modelled.
- at0030::Tree - @ internal @
- at0031::State - Definition - All archetypes of the OBSERVATION class can contain a STATE model which contains information about the subject of data at the time the information was collected, and this information is required for safe clinical interpretation of the core information. An example is the position of the patient at the time of measuring a blood pressure. Datatypes are identical to those explained in the Data model, above.
- at0032::Data - Definition - All archetypes of the OBSERVATION class contain a DATA model which contains the core information e.g. the systolic and diastolic pressures when measuring a blood pressure.
- at0033::Named Point In Time - An event that is both named (eg Birth) and constrained as a Point in time event records the data elements in relation to a specified point in time eg Weight at Birth.

- at0034::Named Interval - An event that is both named and constrained as an Interval event records the data elements in relation to a period of time eg Weight Loss over time. The interval can be fixed or left unspecified. In addition there are mathematical functions that can be specified to capture concepts such as change, decrease, increase, maximum, minimum, mean etc.
- at0035::Offset Point In Time - Offset Point in time records data at a point in time with a fixed offset of 5 minutes from another specified event eg recording a 2 minute Apgar reading at 2 minutes offset from Birth.
- at0036::Tree - @ internal @
- at0037::Protocol - Definition - All archetypes of the OBSERVATION class can contain a PROTOCOL model which records information on how the information was gathered or measured, and any other information that is not required for safe clinical interpretation of the core Data. Datatypes are identical to those explained in the Data model, above.
- at0038::No pain - No pain at all.
- at0039::Slight pain - Pain level rated as 1 out of a possible maximum score of 10.
- at0040::Mild pain - Pain level rated as 2 out of a possible maximum score of 10.
- at0041::Moderate pain - Pain level rated as 5 out of a possible maximum score of 10.
- at0042::Severe pain - Pain level rated as 9 out of a possible maximum score of 10.
- at0043::Most severe pain imaginable - Pain level rated as 10 out of a possible maximum score of 10.
- at0044::Identifier - Identifier datatypes enable recording of formal data identifiers.
- at0045::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

[**dermatology_therapy_summary**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.dermatology_therapy_summary.v1

****Lifecycle State:**** AuthorDraft

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record summaries of dermatology therapy for registry use.

****Concepts:****

- at0000::Dermatology therapy summary - Summarised dermatology therapy for registry use.
- at0001::Event Series - @ internal @
- at0002::Any event - *

- at0003::Tree - @ internal @
- at0004::Therapy category - The general category of therapy.
- at0005::Phototherapy - Phototherapy.
- at0006::Systemic therapy - Systemic therapy.
- at0007::Hospitalisation - Hospitalisation.
- at0009::Specific therapy - Details of specific therapies within a category.
- at0011::Start date - The start date of the therapy.
- at0012::Duration of therapy - The duration of the therapy.
- at0013::Frequency of therapy - The frequency of the therapy.
- at0016::Effectiveness - An estimate of the effectiveness of the therapy.
- at0017::Good - *
- at0018::Moderate - *
- at0019::None (primary) - *
- at0020::None (secondary) - *
- at0021::Reason for stopping - The reason for stopping the therapy.
- at0022::Daycare treatment - Daycare treatment.
- at0023::Topical therapy - Topical therapy.
- at0024::Emollients - Emollients.
- at0025::Antihistamines - Antihistamines.
- at0026::Antibiotics - Antibiotics.
- at0034::Sanata - Sanata.
- at0035::Adverse event - Adverse event.
- at0036::Ineffective - Ineffective.
- at0037::Number of treatments - The total number of treatments.
- at0038::Therapy category used? - Has the therapy category been used?
- at0039::Current therapy? - Is this a currently used treatment?
- at0046::Therapy details - To record details of specific therapies.

[device_screening](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.device_screening.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about the presence of implanted medical devices or use of assistive devices.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about the presence of implanted devices or use of assistive aids. Common use cases include, but are not limited to: - Screening for implanted devices before an MRI test. - Checklist questions about whether the individual uses any assistive devices on admission to hospital. The initial question about any medical device use is focused on implanted devices due to the clinical safety implications, especially when undergoing imaging examinations. Examples of implanted medical devices include, but are not limited to: - cochlear implant; - pacemaker; - aneurysm clips; - joint replacement; - heart valve; - coronary stent; - bone fixation device eg screws or plates; - deep brain stimulator; or - intraocular lens. Examples of assistive aids include, but are not limited to: - wheelchair; - walking stick; - hearing aid; - reading glasses; - prosthetic limb; - braille reader; - speech generating device; or - medication organiser or dispenser. The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to a point in time or over a period of time. Use a separate instance of the EVENT structure to distinguish between a questions related to different timeframes, such as 'ever', 'now' and in a specified interval of time - for example, the difference between "Have you ever used a hearing aid?", "Do you currently use a hearing aid?" and "Have you used a hearing aid in the past year?" The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies the presence or usage of a medical device, it is recommended that the clinical system record and persist the specific details about the device using EVALUATION.device_summary.

****Misuse:**** Not to be used to record answers to pre-defined screening questions about surgical/operative procedures when a medical device was implanted. Use the OBSERVATION.procedure_screening for this purpose. Not to be used to record answers to pre-defined screening questions about medications that have been implanted. Use the OBSERVATION.medication_screening for this purpose.

****Keywords:**** device, implant

****Concepts:****

- at0000::Medical device screening questionnaire - Series of questions and associated answers used to screen for the presence of implanted medical devices or use of assistive aids.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.

- at0003::Tree - @ internal @
- at0004::Device name - Name of the implanted medical device or device type being screened.
- at0005::Presence? - Presence of the implanted device.
- at0007::Item tree - @ internal @
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0022::Implanted device screening - Screening details about the presence of a specific implanted medical device.
- at0023::Yes - The specific device is present or being used.
- at0024::No - The specific device is not present or being used.
- at0025::Comment - Additional narrative about the implanted device, not captured in other fields.
- at0027::Unknown - It is not known whether the device is present or absent.
- at0028::Any implanted medical device? - Presence of any implanted devices.
- at0031::Yes - None
- at0032::No - None
- at0033::Unknown - None
- at0034::Screening purpose - The reason for overall screening.
- at0039::Screening details - Additional details or questions about the implanted device.
- at0040::Description - Narrative description about the implanted device.
- at0041::Assistive aid screening - Screening details about the use of a specific assistive medical device.
- at0042::Aid name - Name of the medical device or device type being screened.
- at0043::Presence? - Usage of the assistive aid.
- at0044::Yes - The specific device is present or being used.
- at0045::No - The specific device is not present or being used.
- at0046::Unknown - It is not known whether the device is present or absent.
- at0047::Description - Narrative description about the assistive aid.
- at0048::Screening details - Additional details or questions about the assistive aid.
- at0049::Comment - Additional narrative about the assistive aid, not captured in other fields.
- at0050::Timing - Indication of timing related to the implanted device.
- at0051::Unsure - None
- at0052::Unsure - None
- at0053::Unsure - None

[diabetic_wound_wagner](#)

Archetype ID: openEHR-EHR-OBSERVATION.diabetic_wound_wagner.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** es-ar, en

****Purpose:**** To record an assessment of a diabetic foot ulcer, according to the Wagner Classification.

****Use:**** Use to record an assessment of a diabetic foot ulcer, according to the Wagner Classification.

****Misuse:**** Not to be used to record assessments of other wounds.

****Keywords:**** diabetic foot, wound, ulcer, classification

****Concepts:****

- at0000::Diabetic wound classification (Wagner) - Wound classification for a diabetic foot ulcer using the Wagner system.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Examined foot - The foot examined for diabetic ulcers.
- at0005::Left foot - The left foot was examined for diabetic ulcers.
- at0006::Right foot - The rightfoot was examined for diabetic ulcers.
- at0008::Classification - Wagner diabetic foot ulcers classification.
- at0009::0 - Intact skin in patients who are at risk.
- at0010::I - Superficial ulcers with exposed subcutaneous tissue.
- at0011::II - Exposed tendon and deep structures.
- at0012::III - Ulcers extend to the deep tissue and have either associated soft tissue abscess or osteomyelitis.
- at0013::IV - Ulcers include feet with partial gangrene.
- at0014::V - Feet ulcers with more extensive gangrenous tissue.
- at0015::Comment - Additional narrative about the assessment.
- at0016::Item tree - @ internal @
- at0017::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

digit_span

****Archetype ID:**** openEHR-EHR-OBSERVATION.digit_span.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record a result of the digit span forward and backwards test.

****Use:**** Use to record the result of digit span forward and backwards test.

****Keywords:**** Digit span, digit span forward test, digit span backwards test, DSF, DSB, short-term verbal memory, neuropsychological assessment.

****Concepts:****

- at0000::Digit span (DS) - Digit span is a cognitive assessment tool used to measure working memory, attention, and short-term auditory memory.
- at0001::History - @ internal @
- at0002::Forward digit span (FS) - Digit span forward is a neuropsychological test to assess a subjects simple attention.
- at0003::Tree - @ internal @
- at0005::Result of first digit span - The result of the first digit span answer.
- at0006::Error - None
- at0007::Pass - None
- at0011::Total score - The number of correctly answered digit spans.
- at0012::First digit span - The first of two digit spans the subject has to repeat.
- at0013::Second digit span - The second of two digit spans the subject has to repeat.
- at0014::Result of second digit span - The result of the second digit span answer.
- at0015::Error - None
- at0016::Pass - None
- at0017::Max round (span) - Maximum number of rounds the subject passed.
- at0018::Item tree - @ internal @
- at0019::Trial not completed - Could the trial not be completed or was the trial terminated prematurely?
- at0020::Reasons for non-completion - Record the reasons if the trial was not completed or the test was terminated prematurely.
- at0021::Confounding factors - Record any circumstances that you believe may have affected the patient's performance.
- at0022::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0023::Item tree - @ internal @
- at0024::Round - An instance of one round of the digit span test.
- at0025::Backward digit span (BS) - Digit span backwards test is a neuropsychological test to assess a subjects short-term verbal memory.

- at0026::Reliable digit span (RDS) - The longest sequence of numbers that the individual can accurately recall without errors across both the forward and backward tasks.

downton_fall_risk_index

****Archetype ID:**** openEHR-EHR-OBSERVATION.downton_fall_risk_index.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, nb, en

****Purpose:**** To record the results of the DFRI risk assessment.

****Use:**** Use to record the results of the DFRI risk assessment.

****Keywords:**** Downton Fall Risk Index, DFRI, elderly, fall, risk, Senior Alert

****Concepts:****

- at0000::Downton Fall Risk Index (DFRI) - A validated assessment tool used to identify risk factors for falls.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Known previous falls - None
- at0005::No - None
- at0006::Yes - None
- at0007::Medications - None
- at0008::None - None
- at0009::Tranquillisers/sedatives - None
- at0010::Diuretics - None
- at0011::Antihypertensives (other than diuretics) - None
- at0012::Antiparkinsonian drugs - None
- at0013::Antidepressants - None
- at0014::Other medications - None
- at0015::Sensory deficits - None
- at0016::None - None
- at0017::Visual impairment - None
- at0018::Hearing impairment - None

- at0019::Limbs (amputation, stroke, neuropathy, etc.) - None
- at0020::Mental state - None
- at0021::Orientated - None
- at0022::Confused (MTS <7/10) - None
- at0023::Gait - None
- at0024::Normal - None
- at0025::Safe with walking aids - None
- at0026::Unsafe with/without aids - None
- at0027::Unable - None
- at0028::Total score - The total sum of each component parameter for the DFRI.
- at0029::Item tree - @ internal @
- at0030::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

easi_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.easi_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record details of the Atopic dermatitis EASI score.

****Concepts:****

- at0000::EASI score - Atopic dermatitis EASI score.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Body area - The part of the body being assessed.
- at0005::Head and neck - Head and neck skin area.
- at0006::Upper limbs - Upper limb skin area.
- at0007::Trunk - The trunk skin area.
- at0008::Lower limbs - Lower limbs skin area.
- at0009::Severity index - The level of severity of the symptom for a representative part of the body area.
- at0010::Redness - The extent of redness.
- at0011::Thickness - The thickness of the lesion.

- at0012::Crusting - The extent of crusting.
- at0013::Lichenification - The extent of lichenification.
- at0014::Absent - The symptom is absent.
- at0015::Mild - The symptom is mild.
- at0016::Moderate - The symptom is moderate.
- at0017::Severe - The symptom is severe.
- at0018::Affected area - The extent of the area affected.
- at0019::1% to 9% - 1% to 9% of the body area is affected.
- at0020::10% to 29% - 10% to 29% of the body area is affected.
- at0021::30% to 49% - 30% to 49% of the body area is affected.
- at0022::50% to 69% - 50% to 69% of the body area is affected.
- at0023::70% to 89% - 70% to 89% of the body area is affected.
- at0024::90% to 100% - 90% to 100% of the body area is affected.
- at0025::Total EASI score - The total EASI score.
- at0026::Item tree - @ internal @
- at0027::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[ecg_result](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.ecg_result.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, ar-sy, en

****Purpose:**** To record the measurements of electrical activity generated by the heart over a short period of time and its associated clinical interpretation.

****Use:**** Use to record the results of a 3-, 5-, 12-, 15- or 18-lead electrocardiograph (ECG) and its associated clinical interpretation. Each ECG variation can be constrained in a separate template to allow for easy re-use. The default 'Any event' can be constrained in templates or at run time to specifically record ECGs conducted during exercise or under stress-testing conditions.

****Misuse:**** Not to be used to record the results from ongoing cardiac monitoring or telemetry. Not to be used to record results from trans-oesophageal electrophysiological studies.

****Keywords:**** electrocardiograph, ECG, EKG, electrocardiogram, electrocardiography, 3 lead, 5 lead, 15 lead, 12 lead, stress ECG, resting ECG, rhythm strip, standard ECG, 18 lead

****Concepts:****

- at0000::ECG result - Measurement of the electrical activity generated by the heart.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Tree - @ internal @
- at0007::QT interval global - Interval measurement from the onset of the QRS complex to the end of the T wave across the ECG as a whole (multiple leads).
- at0008::QTc interval global - Correction applied to the 'QT interval global'.
- at0009::Device interpretation - Interpretative comment on this ECG result, originating from a device.
- at0012::PR interval global - PR interval measurement across the ECG as a whole (multiple leads).
- at0013::Ventricular heart rate - The frequency of ventricular electrical contractions across the ECG as a whole (multiple leads).
- at0014::QRS duration global - Duration of QRS complex across the ECG as a whole (multiple leads).
- at0020::P axis - Average direction of electrical activity during atrial depolarization.
- at0021::QRS axis - Average direction of electrical activity during ventricular depolarization.
- at0022::T axis - Average direction of electrical activity during ventricular repolarization.
- at0025::QTc algorithm - Algorithm used to correct QT interval.
- at0027::Per-lead - Details about measured parameters for each named lead (specified in the run-time name constraint).
- at0028::P duration - Duration of P wave.
- at0029::Lead I - Lead I is the voltage difference between the left arm electrode and right arm electrode, directed towards the left arm at zero degrees.
- at0030::Lead II - Lead II is the voltage difference between the left leg electrode and the right arm electrode, directed towards the left leg at +60 degrees.
- at0031::Lead III - Lead III is the voltage difference between the left leg electrode and the left arm electrode, directed towards the left leg at +120 degrees.
- at0032::Lead aVR - Lead augmented vector right (aVR) has the positive electrode on the right arm and the negative pole is a combination of the left arm electrode and the left leg electrode. It is directed towards the right arm at -150 degrees.
- at0033::Lead aVL - Lead augmented vector left (aVL) has the positive electrode on the left arm and the negative pole is a combination of the right arm electrode and the left leg electrode. It is directed towards the left arm electrode at -30 degrees.

- at0034::Lead aVF - Lead augmented vector foot (aVF) has the positive electrode on the left leg and the negative pole is a combination of the right arm electrode and the left arm electrode. It is directed towards the left leg electrode at +90 degrees.
- at0035::Lead V1 - A precordial lead, placed to the right of the sternum in the fourth intercostal space. Also known as lead V2R.
- at0036::Lead V2 - A precordial lead, placed to the left of the sternum in the fourth intercostal space. Also known as lead V1R.
- at0037::Lead V3 - A precordial lead, placed directly between leads V2 and V4.
- at0038::Lead V4 - A precordial lead, placed in the left fifth intercostal space at the midclavicular line.
- at0039::Lead V5 - A precordial lead, placed level with lead V4 at the left anterior axillary line.
- at0040::Lead V6 - A precordial lead, placed level with lead V5 at the left midaxillary line.
- at0041::P amplitude - Amplitude of the P wave.
- at0042::P area - Area of a monophasic P wave or the area of the initial portion of a biphasic P wave.
- at0043::P' amplitude - Amplitude of P' wave.
- at0044::P' duration - Duration of P' wave.
- at0046::P' area - Area of the terminal portion of a biphasic P wave.
- at0048::Q amplitude - Amplitude of the Q wave.
- at0049::Q duration - Duration of the Q wave.
- at0050::R amplitude - Amplitude of the R wave.
- at0051::R duration - Duration of the R wave.
- at0053::S amplitude - Amplitude of the S wave.
- at0054::S duration - Duration of the S wave.
- at0055::R' amplitude - Amplitude of the R' wave.
- at0056::R' duration - Duration of the R' wave.
- at0057::S' amplitude - Amplitude of the S' wave.
- at0058::S' duration - Duration of the S' wave.
- at0059::Ventricular Activation Time (VAT) - Interval from the onset of the QRS complex to the latest positive peak in the complex, or the latest substantial notch on the latest peak (whichever is later).
- at0060::QRS p-p - Amplitude of the peak-to-peak QRS complex.
- at0061::QRS duration - Duration of the QRS complex.
- at0062::QRS area - Area of the QRS complex.
- at0063::ST onset - Elevation or depression at the onset (J point) of the ST segment.
- at0064::ST midpoint - Elevation or depression at the midpoint of the ST segment.
- at0065::ST 80ms - Elevation or depression of the ST segment 80 ms after the end of the QRS complex (J point).
- at0066::ST end - Elevation or depression at the end of the ST segment.
- at0067::ST duration - Duration of the ST segment.
- at0068::ST slope - Slope of the ST segment.

- at0069::ST segment morphology - Shape of the ST segment.
- at0070::ST depression - horizontal - The ST segment is depressed but not sloping. This is a more specific form of 'ST depression'.
- at0071::ST depression - upsloping - The ST segment is depressed and sloping upward. This is a more specific form of 'ST depression'.
- at0072::ST depression - downsloping - The ST segment is depressed and downsloping. This is a more specific form of 'ST depression'.
- at0073::T amplitude - Amplitude of the T wave.
- at0074::T duration - Duration of the T wave.
- at0075::T area - Area of the T wave.
- at0076::Recording device - Details about the electrocardiograph device used to record the ECG.
- at0077::Tree - @ internal @
- at0078::Tilt - The craniocaudal tilt of the surface on which the person is lying during the ECG. Lying horizontally is considered the 0 degrees position.
- at0079::Confounding factors - Comment on and record other incidental factors that may be contributing to ECG result.
- at0080::Level of exertion - Details about physical activity undertaken at the time of ECG recording.
- at0081::ECG diagnosis - Single word, phrase or brief description that represents the overall clinical meaning and significance of the ECG result.
- at0082::Viewing device - Details of device used to view the ECG output.
- at0083::Multimedia representation - Digital representation of the ECG result.
- at0084::Lead V7 - Lead V7 is a posterior lead, placed in the posterior axillary line.
- at0085::Lead V8 - Lead V8 is a posterior lead, placed in the midscapular region.
- at0086::Lead V9 - Lead V9 is a posterior lead, placed in the paraspinal region.
- at0087::Lead V4R - A precordial lead, placed in the right fifth intercostal space at the midclavicular line.
- at0088::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0089::Conclusion - Narrative synthesis about all of the key findings in the ECG result.
- at0090::Comment - Additional narrative about the ECG result, not captured in other fields.
- at0091::Lead V5R - A precordial lead, placed level with lead V4R at the right anterior axillary line.
- at0092::Lead V6R - A precordial lead, placed level with lead V5R at the right midaxillary line.
- at0093::Lead V3R - A precordial lead, placed directly on the right side of the chest between leads V1 and V4R.
- at0094::Atrial heart rate - The frequency of atrial electrical contractions across the ECG as a whole (multiple leads).

- at0095::Device interpretation comment - Comment about the interpretation by the device.
- at0096::Clinical information provided - Narrative description of clinical information available at the time of interpretation of results.
- at0097::ECG lead placement - Lead placement for the ECG recording.
- at0098::Description - Narrative description about the findings for the specified lead.
- at0100::ECG type - Type of ECG performed.
- at0101::Finding - Single word, phrase or brief description that represents a significant finding in the ECG result.
- at0102::Technical quality - Single word, phrase or brief description that represents a significant technical quality issue that impacts the ECG result.
- at0103::ST elevation - The ST segment is elevated.
- at0104::ST depression - The ST segment is depressed.
- at0105::RR interval global - The interval between successive R waves across the ECG as a whole (multiple leads).
- at0106::ST 60ms - Elevation or depression of the ST segment 60 ms after the end of the QRS complex (J point).
- at0107::Position - The position of the subject at the time of measurement.
- at0108::Standing - Standing at the time of ECG testing.
- at0109::Sitting - Sitting (for example on bed or chair) at the time of ECG testing.
- at0110::Reclining - Reclining at the time of ECG testing.
- at0111::Lying - Lying flat at the time of ECG testing.
- at0112::Lying with tilt to left - Lying flat with some lateral tilt, usually angled towards the left side at the time of ECG testing.
- at0113::Additional details - Additional structured details about the ECG result.
- at0114::Lead details - Additional structured details about the specified lead.
- at0115::Lead comment - Additional narrative about the lead results, not captured in other fields.
- at0116::Pacemaker stimulation - Narrative description about pacemaker activity.

ecog

Archetype ID: openEHR-EHR-OBSERVATION.ecog.v1

Lifecycle State: published

Category: OBSERVATION

Languages: de, nb, en, fr

****Purpose:**** To record the measurement of the functional performance status of a patient with a diagnosis of cancer.

****Use:**** Used to record the measurement of the functional performance status of a patient with a diagnosis of cancer, to: - assess how a patient's disease is progressing; - assess how the disease affects the daily living abilities of the patient; and - determine appropriate treatment and prognosis. The ECOG performance status is in the public domain therefore available for public use. For more information, contact the Eastern Cooperative Oncology Group, Robert Comis M.D., Group Chair - http://www.ecog.org/general/perf_stat.html.

****Keywords:**** performance, status, oncology, who, zubrod, World Health Organization

****Concepts:****

- at0000::ECOG performance status - A scale used by clinicians to assess the functional performance status of a patient with a diagnosis of cancer. Also known as the WHO performance status or Zubrod performance status.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::ECOG performance status - The functional performance status of a patient with a diagnosis of cancer.
- at0005::Asymptomatic - Fully active, able to carry on all pre-disease performance without restriction.
- at0006::Symptomatic, fully ambulatory - Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
- at0007::Symptomatic, in bed <50% of the day - Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours.
- at0008::Symptomatic, in bed >50% of the day (but not bedridden) - Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours.
- at0009::Bedridden - Completely disabled; cannot carry on any selfcare; totally confined to bed or chair.
- at0010::Dead - Patient has died.
- at0011::Tree - @ internal @
- at0012::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0013::Comment - Additional narrative about the overall ECOG performance status not captured in other fields.

edinburgh_pnd_scale

****Archetype ID:**** openEHR-EHR-OBSERVATION.edinburgh_pnd_scale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To detect depression in women who are pregnant or have recently had a baby. Developed by Cox JL, Holden JM and Sagovsky R 1987 (See references). Internationally, the Edinburgh Postnatal Depression Scale (EPDS) is the most widely accepted screening instrument used in the perinatal period. The EPDS was designed to allow screening of postnatal depression in the primary care setting¹. It excludes some symptoms that are common in the perinatal period (tiredness, sleep disturbance, irritability) that other depression instruments include, as such symptoms do not differentiate between depressed and non-depressed postnatal women. The value of the EPDS lies in the fact that it is easy to complete, has been validated in relation to other standardized psychiatric measures and has been found to be acceptable to women who are asked to complete it. Its use provides women with the opportunity to discuss their feelings and enables health professionals to discreetly raise the issue of postnatal depression.

****Use:**** As a screening instrument, the EPDS should only be used to assess a woman's mood over the past seven (7) days. High scores do not themselves confirm a depressive illness and, similarly, some women who score below a set threshold might have depression. Thus, the EPDS does not provide a clinical diagnosis of depression and it should not be used as a substitute for full psychiatric assessment or clinical judgement. Importantly the EPDS cannot be used to predict whether or not a respondent will experience depression in the future - it can only be used to determine current mood. There is consensus in the literature that women with scores consistently ≥ 13 have a 60-100% probability of meeting diagnostic criteria for depression.

****Misuse:**** Should not be used to assess depression in general population.

****Keywords:**** childbirth, score

****Concepts:****

- at0000::Edinburgh postnatal depression scale - The 10-question Edinburgh Postnatal Depression Scale (EPDS) is used to screen for pregnancy or postnatal depression by assessing how a women has been feeling over the past 7 days.
- at0001::Event Series - @ internal @
- at0002::Any Event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @

- at0004::I have been able to laugh and see the funny side of things - Item 1.
- at0005::As much as I always could - Able to laugh as much as in the past.
- at0006::Not quite so much now - Able to laugh but a little less than in the past.
- at0007::Definitely not so much now - Laughing considerably less than in the past.
- at0008::Not at all - Not able to laugh at all.
- at0009::I have looked forward with enjoyment to things - Item 2.
- at0010::As much as I ever did - Looking forward to things as much as in the past.
- at0011::Rather less than I used to - Still looking forward to things but a little less than in the past.
- at0012::Definitely less than I used to - Definitely looking forward to things less than in the past.
- at0013::Hardly at all - Almost always not looking forward to things.
- at0014::I have blamed myself unnecessarily when things went wrong - Item 3.
- at0015::Never - I do not blame myself unnecessarily.
- at0016::Not very often - I hardly ever blame myself unnecessarily.
- at0017::Yes, some of the time - I do sometimes blame myself unnecessarily.
- at0018::Yes, most of the time - I almost always blame myself unnecessarily.
- at0019::I have been worried and anxious for no good reason - Item 4.
- at0020::No, not at all - I have not been worried or anxious unless there is good reason.
- at0021::Hardly ever - I do get worried very occasionally when there is no good reason.
- at0022::Yes, sometimes - I am definitely worried or anxious when there is no good reason but not often.
- at0023::Yes, very often - I am worried or anxious for no good reason frequently.
- at0024::I have felt scared or panicky for no very good reason - Item 5.
- at0025::No, not at all - I do not get scared or panicky at all.
- at0026::No, not much - I hardly ever get scared or panicky.
- at0027::Yes, sometimes - Sometimes I do get scared or panicky.
- at0028::Yes, quite a lot - I am scared or panicky quite often.
- at0029::Things have been getting on top of me - Item 6.
- at0030::No, I have been coping as well as ever - Things do not get on top of me.
- at0031::No, most of the time I have coped - I am coping most of the time.
- at0032::Yes, sometimes I haven't been coping as well as usual - Sometimes things get on top of me and I am not coping.
- at0033::Yes, most of the time I haven't been able to cope at all - Often things are getting on top of me and I am not coping at all.
- at0034::I have been so unhappy that I have had difficulties sleeping - Item 7.
- at0035::No, not at all - Difficulty sleeping due to unhappiness has not been a problem.
- at0036::Not very often - I have occasionally had difficulties sleeping because I have felt unhappy.
- at0037::Yes, quite often - I have difficulties sleeping due to feeling unhappy quite frequently.

- at0038::Yes, most of the time - Most of the time I am having difficulties sleeping due to unhappiness.
- at0039::I have felt sad or miserable - Item 8.
- at0040::No, not at all - I am not sad or miserable at all.
- at0041::Not very often - I am only occasionally sad or sad or miserable.
- at0042::Yes, quite often - I am frequently sad or miserable.
- at0043::Yes, most of the time - I am almost constantly sad or miserable.
- at0044::I have been so unhappy that I have been crying - Item 9.
- at0045::No, never - I am not crying at all.
- at0046::Only occasionally - Sometimes I cry because I have been very unhappy.
- at0047::Yes, quite often - I am crying because I am so unhappy frequently.
- at0048::Yes, most of the time - I am almost always crying because I am so unhappy.
- at0049::The thought of harming myself has occurred to me - Item 10.
- at0050::Never - I do not have thoughts of harming myself.
- at0051::Hardly ever - I have had thoughts of harming myself but only very occasionally.
- at0052::Sometimes - I have had thoughts of harming myself from time to time.
- at0053::Yes, quite often - I do have thoughts of harming myself quite frequently.
- at0054::Total score - Total score for the Edinburgh Postnatal Depression Scale.
- at0055::Item tree - @ internal @
- at0056::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[edmonton_frail_scale](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.edmonton_frail_scale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** For the recording of the Edmonton Frail Scale individual domain items and overall score.

****Use:**** Use to record the Edmonton Frail Scale items and score.

****Concepts:****

- at0000::Edmonton frail scale - Edmonton Frail Scale.
- at0001::Event Series - @ internal @

- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Cognition: clock drawing - Ability to place numbers and hands in the correct position on a pre-drawn circle to indicate a clock.
- at0005::No errors - The subject made no errors.
- at0006::Minor spacing error - The subject made one or more minor spacing errors.
- at0007::Other errors - The subject made other errors.
- at0008::Hospital admissions - Number of times admitted to hospital in last year.
- at0009::None - The subject has not been admitted to hospital in the last year.
- at0010::Once or twice - The subject has been admitted to hospital once or twice in the last year.
- at0011::More than twice - The subject has been admitted to hospital more than twice in the last year.
- at0012::General health description - General description of health.
- at0013::Excellent, very good, good - The subject describes their general health as excellent, very good or good.
- at0014::Fair - The subject describes their general health as fair.
- at0015::Poor - The subject describes their general health as poor.
- at0016::Functional independence - Number of activities requiring help.
- at0017::None or one - The subject requires help with none or one activities.
- at0018::Two to four - The subject requires help with two to four activities.
- at0019::Five to eight - The subject requires help with five to eight activities.
- at0020::Social support - Able to count on someone willing and able to meet needs when help required.
- at0021::Always - The subject always has social support.
- at0022::Sometimes - The subject sometimes has social support.
- at0023::Never - The subject never has social support.
- at0024::Medication use - Using five or more different prescription medications on a regular basis.
- at0025::No - The subject does not use five or more different prescription medications on a regular basis.
- at0026::Yes - The subject uses five or more different prescription medications on a regular basis.
- at0027::Forget to take medications - Does the subject forget to take their prescription medications at times?
- at0028::No - The subject does not forget to take their prescription medications.
- at0029::Yes - The subject at times forgets to take their prescription medications.
- at0030::Nutrition - Has the subject recently lost weight so that clothing has become looser?
- at0031::No - The subject has not lost weight recently.
- at0032::Yes - The subject has lost weight recently.

- at0033::Mood - Does the subject often feel sad or depressed?
- at0034::No - The subject does not feel sad or depressed.
- at0035::Yes - The subject often feels sad or depressed.
- at0036::Continence - Does the subject have a problem with losing control of urine involuntarily?
- at0037::No - The subject does not have a problem with losing control of urine involuntarily.
- at0038::Yes - The subject has a problems with losing control of urine involuntary.
- at0039::Functional performance - Length of time taken to get up from chair, walk to mark about 3 metres away at a safe and comforable pace and return to chair.
- at0040::0 to 10 seconds - The subject takes 0 to 10 seconds to perform the task.
- at0041::11 to 20 seconds - The subject takes 11 to 20 seconds to perform the task.
- at0042::More than 20 seconds or unwilling or requiring assistance - The subject takes more than 20 seconds to perform the task or is unwilling or requires help.
- at0043::Total score - Sum of individual scores.
- at0044::Tree - @ internal @
- at0045::Confounding factors - Record any issues or factors that may impact on the observation or the score.
- at0046::Tree - @ internal @
- at0047::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

[ejection_fraction-left_ventricle](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.ejection_fraction-left_ventricle.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the calculated ejection fraction from the left ventricle of the heart.

****Use:**** Use to record the calculated ejection fraction from the left ventricle of the heart. The volume measurements will be recorded in other archetypes, specific for the purpose. Measurements of ejection fraction for the same chamber, but by different modalities, are not interchangeable.

****Misuse:**** Not to be used to record the ejection fraction for any anatomical site other than the left ventricle - use the parent archetype OBSERVATION.ejection_fraction for this purpose.

****Keywords:**** ejection, fraction, ef

****Concepts:****

- at0000.1::Left ventricular ejection fraction - The volumetric fraction of fluid ejected from the left ventricle with each heartbeat.
- at0004.1::Chamber - The organ or part of organ where the volumes were measured.
- at0.1::Left ventricle - None
- at0000::Ejection fraction - The calculation of the volumetric fraction of fluid volume ejected from a chamber when it contracts.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0006::Ejection fraction - The calculated volumetric fraction based on volume measurements taken from the identified chamber or specific site.
- at0004::Chamber - The organ or part of organ where the volumes were measured.
- at0009::Item tree - @ internal @
- at0011::Equation - The equation used to calculate the ejection fraction.
- at0012::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0007::Item tree - @ internal @
- at0008::Confounding factors - Issues or factors that may impact on the calculation of ejection fraction, not captured in other fields.
- at0010::Modality - The modality used to measure the ejection fraction volumes.
- at0005::Specific site - Specific anatomical location of volume measurements when identification of the 'Chamber' is not sufficient.

ejection_fraction

****Archetype ID:**** openEHR-EHR-OBSERVATION.ejection_fraction.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, en

****Purpose:**** To record the calculated ejection fraction from a chamber in the body.

****Use:**** Use to record the calculated ejection fraction from a chamber in the body. It can be used to estimate the efficiency of contraction of the atria and ventricles of the heart, gall

bladder, or leg veins. The volume measurements will be recorded Measurements of ejection fraction for the same chamber, but by different modalities, are not interchangeable.

****Misuse:**** Not to be used to record the ejection fraction for the left ventricle - use the specialised archetype OBSERVATION.ejection_fraction-left_ventricle for this purpose.

****Keywords:**** ejection, fraction, ef

****Concepts:****

- at0000::Ejection fraction - The calculation of the volumetric fraction of fluid volume ejected from a chamber when it contracts.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Chamber - The organ or part of organ where the volumes were measured.
- at0005::Specific site - Specific anatomical location of volume measurements when identification of the 'Chamber' is not sufficient.
- at0006::Ejection fraction - The calculated volumetric fraction based on volume measurements taken from the identified chamber or specific site.
- at0007::Item tree - @ internal @
- at0008::Confounding factors - Issues or factors that may impact on the calculation of ejection fraction, not captured in other fields.
- at0009::Item tree - @ internal @
- at0010::Modality - The modality used to measure the ejection fraction volumes.
- at0011::Equation - The equation used to calculate the ejection fraction.
- at0012::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[embryo_assessment](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.embryo_assessment.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record details about the assessment of morphology and development of a single oocyte or embryo.

****Use:**** Use to record details about assessment of morphology and development of a single oocyte, zygote, cleavage-stage embryo or blastocyst, usually as part of assisted reproduction treatment. This OBSERVATION archetype also supports recording morphokinetic data and timed annotations obtained during time-lapse microscopy of embryo development.

****Misuse:**** Not to be used for recording details of procedures involving oocytes and embryos, like insemination, microinjection or biopsy - use specific ACTION archetype for this purpose. Not to be used for recording non-morphological assessment of single oocyte or embryo, like genetic or metabolic tests - use relevant OBSERVATION archetype for this purpose.

****Keywords:**** in vitro, fertilization, IVF, reproductive medicine, zygote, fertilised, fertilized, oocyte, egg, fertilisation, embryo, reproduction, ART, blastocyst, morphology, time-lapse

****Concepts:****

- at0000::Oocyte and embryo assessment - Assessment of morphological features and development of a single oocyte or embryo.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Item tree - @ internal @
- at0005::Device - Details of the device used to assess morphology and development of the oocyte or embryo.
- at0006::Culture dish ID - The unique identifier for the culture dish containing the oocyte or embryo.
- at0007::Method - Method for assessment of morphology and development of the oocyte or embryo.
- at0008::Manual - Morphology and development were assessed by manual microscopy.
- at0009::Time-lapse - Morphology and development were assessed by automated device.
- at0010::Label - Label or name identifying an oocyte or embryo.
- at0011::ID - The unique identifier for the oocyte or embryo.
- at0013::Morphological findings - Structured morphological findings appropriate for the developmental stage of the oocyte or embryo.
- at0022::Image representation - Digital image, video or diagram representing morphology and development of the oocyte or embryo.
- at0023::Time post-insemination - The duration since insemination.
- at0024::Interpretation - Clinical interpretation of the morphological and developmental assessment of the oocyte or embryo.
- at0027::Fertilisation assessment - Observation of the inseminated oocyte to assess fertilization.
- at0028::Syngamy assessment - Observation of the inseminated oocyte to assess syngamy.

- at0029::Early cleavage assessment - Observation of the embryo to assess early first cell cleavage.
- at0030::Day-2 embryo assessment - Embryo observation on Day 2 post insemination.
- at0031::Day-3 embryo assessment - Embryo observation on Day 3 post insemination.
- at0032::Day-4 embryo assessment - Embryo observation on Day 4 post insemination.
- at0033::Day-5 embryo assessment - Embryo observation on Day 5 post insemination.
- at0034::Description - General description of the oocyte or embryo.
- at0035::Comment - Additional narrative about the oocyte or embryo assessment, not captured in other fields.
- at0036::Developmental stage - Developmental stage of the oocyte or embryo.
- at0037::Pronuclear stage - Pronuclear zygote stage.
- at0038::2-cell stage - 2-cell stage.
- at0039::4-cell stage - 4-cell stage.
- at0040::8-cell stage - 8-cell stage.
- at0041::Morula - Morula stage.
- at0042::Blastocyst - Blastocyst stage.
- at0043::Oocyte - Oocyte stage.
- at0044::Developmental event - Recording of a developmental event observed during time-lapse microscopy.
- at0045::tPB2 extrusion - The second polar body is completely detached from the oolemma.
- at0046::tPNa - Appearance of individual pronuclei.
- at0047::tPNf - Fading of pronuclei.
- at0048::t2 - The embryo reaches 2 blastomeres.
- at0049::t3 - The embryo reaches 3 blastomeres.
- at0050::t4 - The embryo reaches 4 blastomeres.
- at0051::t5 - The embryo reaches 5 blastomeres.
- at0052::t6 - The embryo reaches 6 blastomeres.
- at0053::t7 - The embryo reaches 7 blastomeres.
- at0054::t8 - The embryo reaches 8 blastomeres.
- at0055::tSC - Evidence of compaction.
- at0056::tM - Completion of compaction process.
- at0057::tSB - Initiation of blastulation.
- at0058::tB - Full blastocyst.
- at0059::tE - Initiation of expansion.
- at0060::tHN - Herniation.
- at0061::tHB - Fully hatched blastocyst.
- at0062::Freezing assessment - Oocyte or embryo observation at cryopreservation.
- at0063::Thawing assessment - Oocyte or embryo observation at thawing.
- at0064::Embryo transfer assessment - Embryo observation at embryo transfer.
- at0065::Day-6 embryo assessment - Embryo observation on Day 6 post insemination.
- at0066::Oocyte collection assessment - Observation of the oocyte at oocyte collection.

- at0067::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

empower_meal

****Archetype ID:**** openEHR-EHR-OBSERVATION.empower_meal.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Recording of observations of daily living related to meals. Based on the data model developed within the EMPOWER project, www.empower-fp7.eu.

****Use:**** Record the self-observations of the subject regarding the intake of food.

****Concepts:****

- at0000::Meal (EMPOWER) - Recording a single meal taken.
- at0001::Event Series - @ internal @
- at0002::Any Event - Any Event.
- at0003::Tree - @ internal @
- at0004::Time of meal - time of meal.
- at0005::breakfast - Breakfast.
- at0006::lunch - Lunch.
- at0007::dinner - Dinner.
- at0008::snack - Snack.
- at0009::Food items - Single components of a meal.
- at0010::Bread units - Amount of bread units contained in the whole meal.
- at0012::Amount - Amount of food component.
- at0013::Unit - Defines the unit for the specifies amount.
- at0014::g - Gram(s).
- at0015::L - Liter(s).
- at0016::cup(s) - Cup(s).
- at0017::slice(s) - Slice(s).
- at0018::piece(s) - Piece(s).
- at0019::glass(es) - Glass(es).
- at0020::Description - The food item taken e.g. fried egg, white bread.

empower_mood

****Archetype ID:**** openEHR-EHR-OBSERVATION.empower_mood.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Facilitate recording of the self-assessment of the subject's mood. Based on the data model developed within the EMPOWER project, www.empower-fp7.eu.

****Use:**** Self-assessment of mood.

****Concepts:****

- at0000::Mood (EMPOWER) - Self-assessment of the level of mood as an observation of daily living.
- at0001::Event Series - @ internal @
- at0002::Any event - Timepoint.
- at0003::Tree - @ internal @
- at0013::Comment - Indicates related information.
- at0019::Level of Mood - Level of mood.

empower_physical_exercises

****Archetype ID:**** openEHR-EHR-OBSERVATION.empower_physical_exercises.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, en, fr

****Purpose:**** Recording observations of daily living related to activity, in the form of either physical exercises or general activity. Based on the data model developed within the EMPOWER project, www.empower-fp7.eu.

****Use:**** Record the self-observations of the subject regarding the execution of physical activities, e.g. exercises (walking, bicycling, etc.) or non-exercise physical activity (e.g. ironing, cooking, etc.).

****Concepts:****

- at0000::Physical Activity (EMPOWER) - Recording physical activity (either physical exercises or general activity).
- at0001::Event Series - @ internal @
- at0002::Any event - Timepoint.
- at0003::Tree - @ internal @
- at0030::Exercise Intensity - Intensity level of the activity.
- at0031::Light - Recreational and household activities. (e.g. bowling, ironing).
- at0032::Moderate - Feeling of walking at a normal pace.
- at0033::Hard - Harder than walking but not as strenuous as running.
- at0043::Duration - Duration of the activity.
- at0044::Very Hard - Feeling of running.
- at0046::Physical Activity - Type of physical activity.
- at0047::Aerobics - Aerobics.
- at0048::Basketball - Basketball.
- at0049::Cycling - Cycling.
- at0050::Dancing - Dancing.
- at0051::Soccer - Soccer.
- at0052::Gardening - Gardening.
- at0053::Hiking - Hiking.
- at0054::Horse Riding - Horse Riding.
- at0055::Ironing - Ironing.
- at0056::Jogging - Jogging.
- at0057::Running - Running.
- at0058::Mopping - Mopping.
- at0059::Mountain Biking - Mountain Biking.
- at0060::Painting - Painting.
- at0061::Sailing - Sailing.
- at0062::Skiing - Skiing.
- at0063::Snowboarding - Snowboarding.
- at0064::Football - Football.
- at0065::Strength Training - Football.
- at0066::Surfing - Surfing.
- at0067::Swimming - Swimming.
- at0068::Tennis - Tennis.
- at0069::Vacuuming - Vacuuming.
- at0070::Volleyball - Volleyball.
- at0071::Walking - Walking.
- at0072::Weightlifting - Weightlifting.
- at0073::Windsurfing - Windsurfing.
- at0074::Yoga - Yoga.

- at0081::Steps - Number of steps performed.
- at0083::Comment - Indicates related information.
- at0084::Other - Other Activity.
- at0085::Location - Location.
- at0087::home - at home.
- at0088::park - at the park.
- at0089::gym - at gym.
- at0090::stadium - at stadium.
- at0091::beach - on the beach.
- at0092::mountain - on the mountain.
- at0093::pool - in the pool.
- at0094::other - other.

empower_sleep

****Archetype ID:**** openEHR-EHR-OBSERVATION.empower_sleep.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Recording observations of daily living related to sleep. Based on the data model developed within the EMPOWER project, www.empower-fp7.eu.

****Use:**** Record observations of the duration of a sleep slot and related sleep information, as observed by the monitoring subject, i.e. the patient himself. The archetype is intended to capture sleep time in the context of applications that collect Observations of Daily Living.

****Concepts:****

- at0000::Sleep (EMPOWER) - Recording observations regarding sleep.
- at0001::Event Series - @ internal @
- at0002::Any event - Any sleep event during a single day.
- at0003::Tree - @ internal @
- at0004::Comment - Any comment related to the cause of sleep disturbance.
- at0005::Sleep slot duration - The duration of a sleep event, in hours.
- at0017::Perceived Sleep Quality - Perception of sleep quality by the subject him/herself.
- at0018::Very Bad - Very Bad.
- at0019::Fairly Bad - Fairly Bad.
- at0020::Neutral - Neutral.

- at0021::Fairly Good - Fairly Good.
- at0022::Very Good - Very Good.
- at0025::Related Symptom - Symptoms related to recorded sleep session.

empower_stress

****Archetype ID:**** openEHR-EHR-OBSERVATION.empower_stress.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Facilitate recording of the level of stress perceived by a subject. Based on the data model developed within the EMPOWER project, www.empower-fp7.eu.

****Use:**** Self-assesment of stress level.

****Concepts:****

- at0000::Stress (EMPOWER) - Self-assesment of the level of perceived stress as an observation of daily living.
- at0001::Event Series - @ internal @
- at0002::Any event - Timepoint.
- at0003::Tree - @ internal @
- at0017::Comment - Indicates related information.
- at0024::Level of Stress - Level of Stress.

epic_cp

****Archetype ID:**** openEHR-EHR-OBSERVATION.epic_cp.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record urinary, bowel, sexual and vitality/hormonal health. EPIC-CP is an assessment tool constructed to record urinary incontinence, urinary irritation, bowel, sexual and hormonal health related quality of life domains.

****Use:**** Use to record an individuals subjective urinary, bowel, sexual and vitality/hormonal health in the last four weeks within a prostate cancer context. Questions are filled/answered by the individual. Symptom scores are then calculated from 5 different domains with up to 60 point total score. 0 points would represent the least negative impact on an individuals experienced quality of life, while 60 would represent the most negative impact on an individuals experienced quality of life. The 5 symptom scores are Urinary incontinence symptom score, Urinary irritation/obstruction symptom score, Bowel symptom score, Sexual symptom score, and Vitality/hormonal symptom score, which are then all added to represent an Overall Prostate Cancer QOL Score.

****Keywords:**** prostate cancer, quality of life

****Concepts:****

- at0000::EPIC CP - EPIC CP is short for Expanded Prostate Cancer Index Composite for Clinical Practice, and is a clinical tool to measure urinary, bowel, sexual and vitality/hormonal health with an overall prostate cancer quality of life score.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::1 Urinary function - Overall, how much of a problem has your urinary function been for you?
- at0005::2 Urinary control - Which of the following best describes your urinary control?
- at0006::3 Pads or adult diapers - How many pads or adult diapers per day have you been using for urinary leakage?
- at0007::4 Urinary dripping or leakage - How big a problem, if any, has urinary dripping or leakage been for you?
- at0008::Urinary Incontinence Symptom Score - ADD the answers from questions 2-4 to calculate

the Urinary Incontinence Symptom Score (out of 12).

- at0009::5a Pain or burning with urination - How big a problem, if any, has the following been for you?
- at0010::5b Weak urine stream/incomplete bladder emptying - How big a problem, if any, has the following been for you?
- at0011::5c Need to urinate frequently - How big a problem, if any, has the following been for you?
- at0012::Urinary Irritation/Obstruction Symptom Score - ADD the answers from questions 5a-5c to calculate the

Urinary Irritation/Obstruction Symptom Score (out of 12).

- at0013::6a Rectal pain or urgency of bowel movements - How big a problem, if any, has the following been for you?
- at0014::6b Increased frequency of your bowel movements - How big a problem, if any, has the following been for you?
- at0015::6c Overall problems with your bowel habits - How big a problem, if any, has the following been for you?
- at0016::Bowel Symptom Score - ADD the answers from questions 6a-6c

to calculate the Bowel Symptom Score (out of 12).

- at0017::7 Orgasm (Climax) - How would you rate your ability to reach orgasm (climax)?
- at0018::8 Erection quality - How would you describe the usual quality of your erections?
- at0019::9 Sexual function - Overall, how much of a problem has your sexual function or lack of sexual function been for you?
- at0020::Sexual Symptom Score - ADD the answers from questions 7-9 to

calculate the Sexual Symptom Score (out of 12).

- at0021::10a Hot flashes or breast tenderness/enlargement - How big a problem, if any, has the following been for you?
- at0022::10b Feeling depressed - How big a problem, if any, has the following been for you?
- at0023::10c Lack of energy - How big a problem, if any, has the following been for you?
- at0024::Vitality/Hormonal Symptom Score - ADD the answers from questions 10a-10c to calculate

the Vitality/Hormonal Symptom Score (out of 12).

- at0025::Overall Prostate Cancer QOL Score - Add the five domain summary scores to calculate the Overall Prostate Cancer QOL Score (out of 60).
- at0026::No problem - None
- at0027::Very small problem - None
- at0028::Small problem - None
- at0029::Moderate problem - None
- at0030::Big problem - None
- at0031::Total control - None
- at0032::Occasional dribbling - None
- at0033::Frequent dribbling - None
- at0034::No urinary control - None
- at0035::None - None
- at0036::One pad per day - None
- at0037::Two pads per day - None

- at0038::Three or more pads per day - None
- at0039::No problem - None
- at0040::Very small problem - None
- at0041::Small problem - None
- at0042::Moderate problem - None
- at0043::Big problem - None
- at0044::No problem - None
- at0045::Very small problem - None
- at0046::Small problem - None
- at0047::Moderate problem - None
- at0048::Big problem - None
- at0049::No problem - None
- at0050::Very small problem - None
- at0051::Small problem - None
- at0052::Moderate problem - None
- at0053::Big problem - None
- at0054::No problem - None
- at0055::Very small problem - None
- at0056::Small problem - None
- at0057::Moderate problem - None
- at0058::Big problem - None
- at0059::No problem - None
- at0060::Very small problem - None
- at0061::Small problem - None
- at0062::Moderate problem - None
- at0063::Big problem - None
- at0064::No problem - None
- at0065::Very small problem - None
- at0066::Small problem - None
- at0067::Moderate problem - None
- at0068::Big problem - None
- at0069::No problem - None
- at0070::Very small problem - None
- at0071::Small problem - None
- at0072::Moderate problem - None
- at0073::Big problem - None
- at0074::Very good - None
- at0075::Good - None
- at0076::Fair - None
- at0077::Poor - None
- at0078::Very poor to none - None
- at0079::Firm enough for intercourse - None

- at0080::Firm enough for masturbation and foreplay only - None
- at0081::Not firm enough for any sexual activity - None
- at0082::None at all - None
- at0083::No problem - None
- at0084::Very small problem - None
- at0085::Small problem - None
- at0086::Moderate problem - None
- at0087::Big problem - None
- at0088::No problem - None
- at0089::Very small problem - None
- at0090::Small problem - None
- at0091::Moderate problem - None
- at0092::Big problem - None
- at0093::No problem - None
- at0094::Very small problem - None
- at0095::Small problem - None
- at0096::Moderate problem - None
- at0097::Big problem - None
- at0098::No problem - None
- at0099::Very small problem - None
- at0100::Small problem - None
- at0101::Moderate problem - None
- at0102::Big problem - None
- at0103::Item tree - @ internal @
- at0104::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

[eq_5d_5l](#)

Archetype ID: openEHR-EHR-OBSERVATION.eq_5d_5l.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: de, en

Purpose: EQ-5D-5L is a standardised measure of health status developed by the EuroQol Group in order to provide a simple, generic measure of health for clinical and economic appraisal.

****Use:**** Applicable to a wide range of health conditions and treatments, provides a simple descriptive profile and a single index value for health status that can be used in the clinical and economic evaluation of health care as well as in population health surveys. Further information is available in the User Guide

http://www.euroqol.org/fileadmin/user_upload/Documenten/PDF/Folders_Flyers/EQ-5D-5L_UserGuide_2015.pdf

****Misuse:**** Users of the EQ-5D-5L archetype must ensure that they comply with the terms of use of the EuroQol Research Foundation who own the copyright of the original assessment <http://www.euroqol.org/eq-5d-products/how-to-obtain-eq-5d.html>

****Keywords:**** status, eq

****Concepts:****

- at0000::EQ-5D-5L Health status - A standardised measure of health status to provide a simple, generic measure of health for clinical and economic appraisal.
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0004::Mobility - Issues with mobility.
- at0005::No problems - *
- at0006::Self-care - Issues with self-care.
- at0007::Usual activities - Issues with usual activities.
- at0008::Pain/discomfort - Issues of pain or discomfort.
- at0009::Anxiety/depression - Issue with anxiety or depression.
- at0010::Overall health - A self-assessment of overall health on a scale from 0 to 100
- at0011::State - A 5-digit code formed from the scores of each component, with 9 indicating a missing value
- at0012::Slight problems - *
- at0013::Moderate problems - *
- at0014::Severe problems - *
- at0015::Unable to walk about. - *
- at0016::No problems - *
- at0017::Slight problems - *
- at0018::Moderate problems - *
- at0019::Severe problems - *
- at0020::Unable to wash or dress - *
- at0021::No problems - *
- at0022::Slight problems - *
- at0023::Moderate problems - *
- at0024::Severe problems - *
- at0025::Unable to do my usual activities - *
- at0026::No pain or discomfort - *

- at0027::Slight pain or discomfort - *
- at0028::Moderate pain or discomfort - *
- at0029::Severe pain or discomfort - *
- at0030::Extreme pain or discomfort - *
- at0031::No anxiety or depression - *
- at0032::Slight anxiety or depression - *
- at0033::Moderate anxiety or depression - *
- at0034::Severe anxiety or depression - *
- at0035::Extreme anxiety or depression - *

[esas_r](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.esas_r.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record a self-reported assessment of symptoms, usually within a palliative care setting.

****Use:**** Use to record a self-reported assessment of symptoms, usually within a palliative care setting. The ESAS-r is intended to capture the patient's perspective on symptoms, however in some cases where the patient is unable to self-report, the source of information may be from a carer. In this situation, record the care as the source of information using the Information provider attribute in the Reference Model. Each symptom is rated on a 0 to 10 scale, with 0 representing an absence of the symptom and 10 representing the maximal experience of the symptom. If it is not possible to rate a symptom, use the null flavour 'Not applicable' to indicate 'Unable to assess' on the relevant symptom.

****Misuse:**** Not to be used to record details about a symptom or sign - use the CLUSTER.symptom_sign archetype for this purpose.

****Concepts:****

- at0000::Edmonton Symptom Assessment System Revised (ESAS-r) - Self-reporting tool used to assess the intensity of symptoms in palliative care patients.
- at0001::History - @ internal @
- at0002::Any point in time event - Unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @

- at0004::Pain - Self-rated perception of current pain.
- at0005::Tiredness - Self-rated perception of current tiredness or lack of energy.
- at0006::Drowsiness - Self-rated perception of current drowsiness or sleepiness.
- at0007::Nausea - Self-rated perception of current nausea.
- at0008::Lack of appetite - Self-rated perception of current appetite.
- at0009::Shortness of breath - Self-rated perception of current shortness of breath.
- at0010::Depression - Self-rated perception of current depression.
- at0011::Anxiety - Self-rated perception of current anxiety or feeling nervous.
- at0012::Well-being - Self-rated perception of current well-being.
- at0014::Other problem - Other symptom or problem.
- at0016::Problem name - Name of problem.
- at0017::Rating - Self-rated perception of identified problem.
- at0018::ItemTree - @ internal @
- at0019::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

estimated_glomerular_filtration_rate

****Archetype ID:**** openEHR-EHR-OBSERVATION.estimated_glomerular_filtration_rate.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, si, el, en, da

****Purpose:**** To record the estimated glomerular filtration rate (eGFR) of an individual.

****Use:**** Use to record the estimated glomerular filtration rate (eGFR) of an individual. There are multiple formulas used to calculate the eGFR. The formula used to calculate the eGFR can be recorded in the Protocol. It is also possible to record the method of recording - either calculated and directly entered by the clinician or calculated and entered by the clinical software system.

****Misuse:**** Not to be used to record values of formula components, such as creatinine. These should be recorded using archetypes designed for this purpose, such as OBSERVATION.laboratory_test_result. Not to be used to record the directly measured Glomerular filtration rate - Use the OBSERVATION.laboratory_test_result for this purpose.

****Keywords:**** kidney function, glomerular filtration rate, GFR, creatinine, kidney, chronic kidney disease, CKD-EPI formula, MDRD formula, Schwartz equation

****Concepts:****

- at0000::Estimated glomerular filtration rate (eGFR) - Calculated estimate of glomerular filtration rate as an indicator of renal function.
- at0001::History - @ internal @
- at0002::Any event - Any timed recording of Body Mass Index.
- at0003::Single - @ internal @
- at0004::Relative eGFR - Estimation of glomerular filtration rate normalised to a body surface area of $1.73m^2$ ($mL/min/1.73m^2$).
- at0006::Method - The method of entering the Estimated Glomerular Filtration Rate.
- at0007::Automatic entry - Calculated and entered automatically by the clinical system.
- at0008::Direct entry - Calculated and entered directly by user.
- at0010::Formula - Formula used to calculate the Estimated Glomerular Filtration Rate.
- at0013::MDRD formula - non-IDMS-normalized serum Cr - Modification of Diet in Renal Disease study formula using standard creatinine measurement.
- at0014::MDRD formula - IDMS-normalized serum Cr - Modification of Diet in Renal Disease study formula using creatinine measured by an IDMS-calibrated assay.
- at0015::CKD-EPI Creatinine - Chronic Kidney Disease Epidemiology Collaboration formula using creatinine.
- at0016::Cockcroft-Gault formula - Estimated creatinine clearance rate (eCCr) using Cockcroft-Gault formula.
- at0017::Bedside Schwartz equation - Bedside IDMS-traceable Schwartz GFR Calculator for Children.
- at0018::Comment - Additional narrative about the eGFR, not captured in other fields.
- at0020::Absolute eGFR - Estimation of glomerular filtration rate calculated using the relative eGFR, weight and height.
- at0021::LM Revised - Revised Lund-Malmö Study equation.
- at0022::Item tree - @ internal @
- at0024::Extension - None
- at0025::CKD-EPI Cystatin C - Chronic Kidney Disease Epidemiology Collaboration formula using cystatin C.
- at0026::CKD-EPI Creatinine-Cystatin C - Chronic Kidney Disease Epidemiology Collaboration formula using creatinine and cystatin C.

exam

Archetype ID: openEHR-EHR-OBSERVATION.exam.v1

Lifecycle State: published

Category: OBSERVATION

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

****Purpose:**** For recording details about findings on physical examination of the subject of care.

****Use:**** Use to record details about findings on physical examination of the subject of care. This may include a narrative description of the findings, a framework in which to nest detailed CLUSTER examination archetypes, and a clinical interpretation of the findings. Examples of detailed CLUSTER examination archetypes include those that describe inspection, palpation, auscultation, percussion and movement of body systems or anatomical structures, such as CLUSTER.exam_pupils. Narrative descriptions of clinical findings from existing clinical systems may be captured using the 'Description' data element. Clinicians may sometimes want to record a summative phrase such as 'chronic otitis media' as an Interpretation of the physical examination. In the context of the physical examination archetype this should only be understood as 'physical signs are consistent with chronic otitis media'. While the summative phrase may appear to represent a diagnosis, safe and consistent querying requires a diagnosis to be recorded using the EVALUATION.problem_diagnosis archetype, even if the phrases are identical.

****Misuse:**** Not to be used for recording history-taking observations - use specific OBSERVATION and CLUSTER archetypes. For example OBSERVATION.story and CLUSTER.symptom. Not to be used to record stand-alone clinical observations - use specific OBSERVATION archetypes. For example OBSERVATION.blood_pressure, OBSERVATION.body_weight, or OBSERVATION.height.

****Keywords:**** examination, physical, exam, findings, clinical

****Concepts:****

- at0000::Physical examination findings - Findings observed during the physical examination of a subject of care.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Description - Narrative description of the overall findings observed during a physical examination of a patient.
- at0005::Examination detail - Structured details of the physical examination.
- at0006::Interpretation - Single word, phrase or brief description which represents the clinical meaning and significance of the physical examination findings.
- at0007::Tree - @ internal @
- at0008::Confounding factors - Description of any incidental factors that may have contributed to the physical examination findings.
- at0009::Tree - @ internal @
- at0010::Device Details - Details about any device used during the physical examination.

- at0011::Comment - Additional narrative about the overall physical examination findings not captured in other fields.
- at0012::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0013::Position - The body position of the subject during the examination.

exclusion-adverse_reactions

****Archetype ID:**** openEHR-EHR-OBSERVATION.exclusion-adverse_reactions.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record a positive and explicit statement about exclusion of known adverse reactions.

****Use:**** Use to enable a clinician, at a specified point of time, to record a clear and unambiguous statement about exclusion of known adverse reactions. This approach is used in preference to relying on flags or terminology to express negation. The 'Statement' data element allows for recording of a single statement. Each exclusion should be recorded in a separate instance - for example a separate instance for a statement about medications and another for adverse reactions. Please note that exclusion statements should only be considered to be current and accurate at the time of recording, and should not be assumed to be correct at a later date. For example, it is possible (and appropriate from a medico-legal point of view) for a clinician to record, based on history-taking, that an individual has NO KNOWN history of any adverse reactions (using an exclusion statement) but a few minutes later needing to record evidence of an adverse reaction that occurred in response to administration of penicillin.

****Misuse:**** Not to be used to record the exclusion of a specific adverse reaction - use the EVALUATION.exclusion_specific archetype for this purpose. Not to be used to record the absence of information - use the EVALUATION.absence archetype for this purpose.

****Concepts:****

- at0000.1::Exclusion of adverse reactions - A positive and explicit statement about exclusion of known adverse reactions.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.

- at0003::Tree - @ internal @
- at0004::Item tree - @ internal @
- at0005::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

- at0006::Exclusion statement - An overall statement of exclusion.
- at0007::Comment - Additional narrative about the exclusion.

[exclusion-pregnancy](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.exclusion-pregnancy.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record a positive and explicit statement about exclusion of known at the time of recording.

****Use:**** Use to enable a clinician, at a specified point of time, to record a clear and unambiguous statement about exclusion of known pregnancy at the time of recording. This approach is used in preference to relying on flags or terminology to express negation. Please note that exclusion statements should only be considered to be current and accurate at the time of recording, and should not be assumed to be correct at a later date. For example, it is possible (and appropriate from a medico-legal point of view) for a clinician to record, based on best efforts of history-taking and laboratory testing, that an individual is not currently pregnant at a point in time and make clinical decisions based on that assertion, but this assertion should be revisited for each subsequent decision as time passes.

****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 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.absence archetype for this purpose. Not to be used to record that it is not possible for the patient to become pregnant. For example, after hysterectomy or due to infertility issues. Use appropriate Procedure or Diagnosis archetypes to record these situations.

****Concepts:****

- at0000.1::Exclusion of pregnancy - A positive and explicit statement about the exclusion of pregnancy at the time of recording.
 - at0001::History - @ internal @
 - at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
 - at0003::Tree - @ internal @
 - at0004::Item tree - @ internal @
 - at0005::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
-
- at0006::Exclusion statement - An overall statement of exclusion.
 - at0007::Comment - Additional narrative about the exclusion.

exclusion

****Archetype ID:**** openEHR-EHR-OBSERVATION.exclusion.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record a positive and explicit statement about exclusion of known current and/or past conditions, treatments or significant aspects of clinical history.

****Use:**** Use to enable a clinician, at a specified point of time, to record a clear and unambiguous statement about exclusion of known current and/or past conditions, treatments or significant aspects of clinical history. This approach is used in preference to relying on flags or terminology to express negation. The scope of exclusions should be limited to clinically significant concepts, in particular where it is relevant to patient safety, informing clinical decision-making or medico-legal documentation. It is not intended to encourage recording exclusions of any or all health information. The 'Statement' data element allows for recording of a single statement. Each exclusion should be recorded in a separate instance - for example a separate instance for a statement about medications and another for adverse reactions. Please note that exclusion statements should only be considered to be current and accurate at the time of recording, and should not be assumed to be correct at a later date. For example, it is possible (and appropriate from a medico-legal point of view) for a clinician to record, based on history-taking, that an individual has NO

KNOWN history of any adverse reactions (using an exclusion statement) but a few minutes later needing to record evidence of an adverse reaction that occurred in response to administration of penicillin. 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 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.absence archetype for this purpose.

****Concepts:****

- at0000::Exclusion - A positive and explicit statement about exclusion of known current and/or past conditions, treatments or significant aspects of clinical history.
 - at0001::History - @ internal @
 - at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
 - at0003::Tree - @ internal @
 - at0004::Item tree - @ internal @
 - at0005::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
-
- at0006::Exclusion statement - An overall statement of exclusion.
 - at0007::Comment - Additional narrative about the exclusion.

[**expanded_prostate_cancer_index_composite**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.expanded_prostate_cancer_index_composite.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the results from the health-related quality of life (HRQoL) questionnaire in patients with prostate cancer.

****Use:**** Use to record the results from the questionnaire used to measure the health-related quality of life (HRQoL) in patients with prostate cancer. This archetype consists of all 51 elements in the EPIC 2.2002 version questionnaire, which by the copyright holders is identified as "Most Recent Version". The questionnaire is unchanged since 2002 and considered stable, and the archetype contains no information on version in the archetype's technical or concept name. If there are future changes, a new version of the archetype will have to be made. This archetype can also be used to represent the 6.2002 version of EPIC Short Form (EPIC-26) in a template. See the example template in the CKM's 'Resource Centre'. The EPIC questionnaire itself does not contain any summary scores, neither subscores or total score. The authors of EPIC have provided scoring instructions for the urinary, bowel, hormonal and sexual domains, see the 'Reference' section. With respect to the archetypes are for data capture and storage, not only representing the questionnaire, elements for all the scores described in the scoring instructions has been added. Note that the response for each item needs to be standardized to a 0 to 100 scale according to the scoring instructions, and assembled to the various scores. The required computing and logic has to be made in an application. Even though the question numbers differ between the full EPIC-51 form and the short EPIC-26 form, they share the same unique 'Item number', which can be found in each element's 'Annotations', in the Key attribute 'epic_item_id'. This, along with the additional 'Annotations' keys 'domain', 'subscale' and 'subscale2', allows data consumers to use the archetype as a look-up structure to compute scores as described in "Scoring Instructions for the Expanded Prostate cancer Index Composite" and "Scoring Instructions for the Expanded Prostate cancer Index Composite Short Form". In addition each element has identified the number each question appears as in EPIC 2.2002 and EPIC-SF 6.2002 versions as Keys in Annotation. The Annotations Keys are as follows: -
"epic_item_id" identifies the unique 'Item number' shared between EPIC 50 and EPIC Short form. - "domain" identifies which domain each question belongs to: 'Urinary', 'Bowel', 'Sexual' or 'Hormonal'. - "subscale" indicates the specific subscale ('Function' or 'Bother') associated with each question and is named in the format [domain name + subscale]. - "subscale2" indicates the specific subscale ('Incontinence' or 'Irritative/Obstructive') associated with each question in the 'Urinary' domain. - "epic_2_2002_number" identifies the number the question has in the most recent version (EPIC 2.2002) Expanded Prostate Cancer Index Composite. - "sf_6_2002_number" identifies the number the question has in the Expanded Prostate Cancer Index Composite Short Form (EPIC-26, EPIC-SF 6.2002) version. In clinical practice it is normal to make a baseline measure ahead of the treatment. However, in situations where the individual is under active surveillance in expectancy of a future treatment, more than one pre-treatment measure might exist. A 'Baseline' event could be explicitly modelled as a specified point in time event in a template or at run-time, if required. While this archetype normally will reside in COMPOSITION.self_reported_data, it might be justified to use an other COMPOSITION depending on the situation. While openEHR archetypes are all freely available under an open license, the specific content of this Expanded Prostate cancer Index Composite (EPIC) archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. Commercial use license inquiries can be directed to

the University of Michigan as outlined below. Copyright statement: © 2000 The Regents of the University of Michigan, Regents of the University of California, Emory University and Cedars-Sinai. All rights reserved. Copyright information: MImeasures@umich.edu.

****Misuse:**** Not to be used for the EPIC-CP questionnaire. Use the OBSERVATION.epic_cp for this purpose.

****Keywords:**** prostate cancer, quality of life, QOL, PROM, EPIC-26, HRQoL

****Concepts:****

- at0000::Expanded Prostate Cancer Index Composite (EPIC) - A questionnaire used to measure the health-related quality of life (HRQoL) in patients with prostate cancer.
- at0001::History - @ internal @
- at0003::Tree - @ internal @
- at0004::Over the past 4 weeks, how often have you leaked urine? - None
- at0005::More than once per day - None
- at0006::About once a day - None
- at0007::More than once a week - None
- at0008::About once a week - None
- at0009::Rarely or never - None
- at0010::Which of the following best describes your urinary control during the last 4 weeks? - None
- at0011::No urinary control whatsoever. - None
- at0012::Frequent dribbling - None
- at0013::Occasional dribbling - None
- at0014::Total control - None
- at0015::How many bowel movements have you had on a typical day during the last 4 weeks? - None
- at0017::Two or less - None
- at0018::Three to four - None
- at0019::Five or more - None
- at0022::Dripping or leaking urine - None
- at0023::No problem - None
- at0024::Very small problem - None
- at0025::Small problem - None
- at0026::Moderate problem - None
- at0027::Big problem - None
- at0028::Pain or burning on urination - None
- at0029::No problem - None
- at0030::Very small problem - None
- at0031::Small problem - None
- at0032::Moderate problem - None

- at0033::Big problem - None
- at0034::Bleeding with urination - None
- at0035::No problem - None
- at0036::Very small problem - None
- at0037::Small problem - None
- at0038::Moderate problem - None
- at0039::Big problem - None
- at0040::Weak urine stream or incomplete emptying - None
- at0041::No problem - None
- at0042::Very small problem - None
- at0043::Small problem - None
- at0044::Moderate problem - None
- at0045::Big problem - None
- at0046::Need to urinate frequently during the day - None
- at0047::No problem - None
- at0048::Very small problem - None
- at0049::Small problem - None
- at0050::Moderate problem - None
- at0051::Big problem - None
- at0052::Overall, how big a problem has your urinary function been for you during the last 4 weeks? - None
- at0053::No problem - None
- at0054::Very small problem - None
- at0055::Small problem - None
- at0056::Moderate problem - None
- at0057::Big problem - None
- at0059::Increased frequency of bowel movements - None
- at0060::No problem - None
- at0061::Very small problem - None
- at0062::Small problem - None
- at0063::Moderate problem - None
- at0064::Big problem - None
- at0065::Watery bowel movements - None
- at0066::No problem - None
- at0067::Very small problem - None
- at0068::Small problem - None
- at0069::Moderate problem - None
- at0070::Big problem - None
- at0071::Losing control of your stools - None
- at0072::No problem - None
- at0073::Very small problem - None
- at0074::Small problem - None

- at0075::Moderate problem - None
- at0076::Big problem - None
- at0077::Bloody stools - None
- at0078::No problem - None
- at0079::Very small problem - None
- at0080::Small problem - None
- at0081::Moderate problem - None
- at0082::Big problem - None
- at0083::Abdominal/Pelvic/Rectal pain - None
- at0084::No problem - None
- at0085::Very small problem - None
- at0086::Small problem - None
- at0087::Moderate problem - None
- at0088::Big problem - None
- at0089::Overall, how big a problem have your bowel habits been for you during the last 4 weeks? - None
- at0090::No problem - None
- at0091::Very small problem - None
- at0092::Small problem - None
- at0093::Moderate problem - None
- at0094::Big problem - None
- at0095::Your ability to have an erection - None
- at0097::Your ability to reach orgasm (climax) - None
- at0098::Very poor to none - None
- at0099::Poor - None
- at0100::Fair - None
- at0101::Good - None
- at0102::Very good - None
- at0103::Very poor to none - None
- at0104::Poor - None
- at0105::Fair - None
- at0106::Good - None
- at0107::Very good - None
- at0108::How would you describe the usual QUALITY of your erections during the last 4 weeks? - None
- at0109::None at all - None
- at0110::Not firm enough for any sexual activity - None
- at0111::Firm enough for masturbation and foreplay only - None
- at0112::Firm enough for intercourse - None
- at0113::How would you describe the FREQUENCY of your erections during the last 4 weeks? - None
- at0114::I NEVER had an erection when I wanted one - None

- at0115::I had an erection LESS THAN HALF the time I wanted one - None
- at0116::I had an erection ABOUT HALF the time I wanted one - None
- at0117::I had an erection MORE THAN HALF the time I wanted one - None
- at0118::I had an erection WHENEVER I wanted one - None
- at0119::Overall, how would you rate your ability to function sexually during the last 4 weeks? - None
- at0120::Very poor - None
- at0121::Poor - None
- at0122::Fair - None
- at0123::Good - None
- at0124::Very good - None
- at0125::Overall, how big a problem has your sexual function or lack of sexual function been for you during the last 4 weeks? - None
- at0126::No problem - None
- at0127::Very small problem - None
- at0128::Small problem - None
- at0129::Moderate problem - None
- at0130::Big problem - None
- at0132::Hot flashes - None
- at0133::No problem - None
- at0134::Very small problem - None
- at0135::Small problem - None
- at0136::Moderate problem - None
- at0137::Big problem - None
- at0138::Breast tenderness/enlargement - None
- at0139::No problem - None
- at0140::Very small problem - None
- at0141::Small problem - None
- at0142::Moderate problem - None
- at0143::Big problem - None
- at0144::Feeling depressed - None
- at0145::No problem - None
- at0146::Very small problem - None
- at0147::Small problem - None
- at0148::Moderate problem - None
- at0149::Big problem - None
- at0150::Lack of energy - None
- at0151::No problem - None
- at0152::Very small problem - None
- at0153::Small problem - None
- at0154::Moderate problem - None
- at0155::Big problem - None

- at0156::Change in body weight - None
- at0157::No problem - None
- at0158::Very small problem - None
- at0159::Small problem - None
- at0160::Moderate problem - None
- at0161::Big problem - None
- at0162::Over the past 4 weeks, how often have you urinated blood? - None
- at0163::More than once a day - None
- at0164::About once a day - None
- at0165::More than once a week - None
- at0166::About once a week - None
- at0167::Rarely or never - None
- at0168::Over the past 4 weeks, how often have you had pain or burning with urination?
- None
- at0169::More than once a day - None
- at0170::About once a day - None
- at0171::More than once a week - None
- at0172::About once a week - None
- at0173::Rarely or never - None
- at0174::Waking up to urinate - None
- at0175::No problem - None
- at0176::Very small problem - None
- at0177::Small problem - None
- at0178::Moderate problem - None
- at0179::Big problem - None
- at0180::How often have you had rectal urgency (felt like I had to pass stool, but did not)
during the last 4 weeks? - None
- at0181::More than once a day - None
- at0182::About once a day - None
- at0183::More than once a week - None
- at0184::About once a week - None
- at0185::Rarely or never - None
- at0186::How often have you had bloody stools during the last 4 weeks? - None
- at0187::Never - None
- at0188::Rarely - None
- at0189::About half the time - None
- at0190::Usually - None
- at0191::Always - None
- at0192::How often have you had stools (bowel movements) that were loose or liquid
(no form, watery, mushy) during the last 4 weeks? - None
- at0193::Never - None
- at0194::Rarely - None

- at0195::About half the time - None
- at0196::Usually - None
- at0197::Always - None
- at0198::How often have you had crampy pain in your abdomen, pelvis or rectum during the last 4 weeks? - None
- at0199::More than once a day - None
- at0200::About once a day - None
- at0201::More than once a week - None
- at0202::About once a week - None
- at0203::Rarely or never - None
- at0204::How often have your bowel movements been painful during the last 4 weeks? - None
- at0205::Never - None
- at0206::Rarely - None
- at0207::About half the time - None
- at0208::Usually - None
- at0209::Always - None
- at0210::Urgency to have a bowel movement - None
- at0211::No problem - None
- at0212::Very small problem - None
- at0213::Small problem - None
- at0214::Moderate problem - None
- at0215::Big problem - None
- at0216::Your level of sexual desire - None
- at0217::Very poor to none - None
- at0218::Poor - None
- at0219::Fair - None
- at0220::Good - None
- at0221::Very good - None
- at0222::How many pads or adult diapers per day did you usually use to control leakage during the last 4 weeks? - None
- at0223::How often have you had uncontrolled leakage of stool or feces? - None
- at0224::More than once a day - None
- at0225::About once a day - None
- at0226::More than once a week - None
- at0227::About once a week - None
- at0228::Rarely or never - None
- at0235::How often have you awakened in the morning or night with an erection during the last 4 weeks? - None
- at0236::Never - None
- at0237::Less than once a week - None
- at0238::About once a week - None

- at0239::Several times a week - None
- at0240::Daily - None
- at0241::During the last 4 weeks, how often did you have any sexual activity? - None
- at0242::Not at all - None
- at0243::Less than once a week - None
- at0244::About once a week - None
- at0245::Several times a week - None
- at0246::Daily - None
- at0247::During the last 4 weeks, how often did you have sexual intercourse? - None
- at0248::Not at all - None
- at0249::Less than once a week - None
- at0250::About once a week - None
- at0251::Several times a week - None
- at0252::Daily - None
- at0253::Your ability to have an erection - None
- at0254::No problem - None
- at0255::Very small problem - None
- at0256::Small problem - None
- at0257::Moderate problem - None
- at0258::Big problem - None
- at0259::Your level of sexual desire - None
- at0260::No problem - None
- at0261::Very small problem - None
- at0262::Small problem - None
- at0263::Moderate problem - None
- at0264::Big problem - None
- at0265::Your ability to reach an orgasm - None
- at0266::No problem - None
- at0267::Very small problem - None
- at0268::Small problem - None
- at0269::Moderate problem - None
- at0270::Big problem - None
- at0271::Over the last 4 weeks, how often have you experienced hot flashes? - None
- at0272::More than once a day - None
- at0273::About once a day - None
- at0274::More than once a week - None
- at0275::About once a week - None
- at0276::Rarely or never - None
- at0277::How often have you had breast tenderness during the last 4 weeks? - None
- at0278::More than once a day - None
- at0279::About once a day - None
- at0280::More than once a week - None

- at0281::About once a week - None
- at0282::Rarely or never - None
- at0283::During the last 4 weeks, how often have you felt depressed? - None
- at0284::More than once a day - None
- at0285::About once a day - None
- at0286::More than once a week - None
- at0287::About once a week - None
- at0288::Rarely or never - None
- at0289::During the last 4 weeks, how often have you felt a lack of energy? - None
- at0290::More than once a day - None
- at0291::About once a day - None
- at0292::More than once a week - None
- at0293::About once a week - None
- at0294::Rarely or never - None
- at0295::How much change in your weight have you experienced during the last 4 weeks, if any? - None
- at0296::Gained 10 pounds or more - None
- at0297::Gained less than 10 pounds - None
- at0298::No change in weight - None
- at0299::Lost less than 10 pounds - None
- at0300::Lost 10 pounds or more - None
- at0301::Loss of body hair - None
- at0302::No problem - None
- at0303::Very small problem - None
- at0304::Small problem - None
- at0305::Moderate problem - None
- at0306::Big problem - None
- at0307::Overall, how satisfied are you with the treatment you received for your prostate cancer? - None
- at0308::Extremely dissatisfied - None
- at0309::Dissatisfied - None
- at0310::Uncertain - None
- at0311::Satisfied - None
- at0312::Extremely satisfied - None
- at0313::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0314::Item tree - @ internal @
- at0315::None - None
- at0316::1 pad per day - None
- at0317::2 pads per day - None
- at0318::3 or more pads per day - None

- at0319::How big a problem, if any, had each of the following been for you during the last 4 weeks? - A header question, with answers to be recorded in the elements within the Cluster only.
- at0320::How big a problem, if any, has each of the following been for you? - A header question, with answers to be recorded in the elements within the Cluster only.
- at0321::How would you rate each of the following during the last 4 weeks? - A header question, with answers to be recorded in the elements within the Cluster only.
- at0322::How big a problem during the last 4 weeks, if any, has each of the following been for you? - A header question, with answers to be recorded in the elements within the Cluster only.
- at0323::How big a problem during the last 4 weeks, if any, has each of the following been for you? - A header question, with answers to be recorded in the elements within the Cluster only.
- at0324::Urinary summary score - The HRQoL domain urinary summary score.
- at0325::Bowel summary score - The HRQoL domain bowel summary score.
- at0326::Sexual summary score - The HRQoL domain sexual summary score.
- at0327::Hormonal summary score - The HRQoL domain hormonal summary score.
- at0328::Urinary function subscale - The subscale for urinary function.
- at0329::Urinary bother subscale - The subscale for urinary bother.
- at0330::Urinary incontinence subscale - The subscale for urinary incontinence.
- at0331::Urinary irritative/obstructive subscale - The subscale for urinary irritation/obstruction.
- at0332::Bowel function subscale - The subscale for bowel function.
- at0333::Bowel bother subscale - The subscale for bowel bother.
- at0334::Sexual function subscale - The subscale for sexual function.
- at0335::Sexual bother subscale - The subscale for sexual bother.
- at0336::Hormonal function subscale - The subscale for hormonal function.
- at0337::Hormonal bother subscale - The subscale for hormonal bother.

[exposure_screening](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.exposure_screening.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about situations or events where the individual has been, or may have been, exposed to a harmful agent.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about situations or events where the individual has been, or may have been, exposed to a harmful agent. Examples of agents and groupings of agents are 'hepatitis C' and 'blood borne infectious agents'; or 'asbestos' and 'carcinogenic substances'. Common use cases include, but are not limited to: - Systematic questioning in any consultation related to exposure, for example: --- Have you been to a malaria endemic area in the last 6 weeks? --- Have you had a bee sting in the last 8 weeks? --- Have you worked in a slaughterhouse in the last 3 months? --- Have you ever lived or worked in a building with asbestos? --- Have you ever shared used injection needles? --- Have you eaten chicken from ACME Chicken Company in the last 24 hours? --- Did your parents smoke inside the house when you were a child? The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about exposure that has happened at any time in the past and information about exposure within a specified time interval - for example the difference between "Have you ever used any drug by injection?" compared to "Have you injected any drug during the last 6 months?". The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies the presence of exposure it is recommended that clinical system record and persist the specific details about the exposure using a relevant exposure archetype, for example the EVALUATION.exposure to record details about the actual exposure.

****Misuse:**** Not to be used to record persistent details about a known or identified exposure. Use the EVALUATION.exposure archetype for this purpose. Not to be used to create a framework for recording answers to pre-defined screening questions about exposure to potentially harmful psychosocial factors like poverty, or traumatic experiences like bullying or war. Use an appropriate screening questionnaire archetype for this purpose. Not to be used to record information about substance use such as cigarette smoking or alcohol use. Use the OBSERVATION.substance_use_screening or an appropriate EVALUATION archetype for this purpose.

****Concepts:****

- at0000::Exposure screening questionnaire - Series of questions and associated answers used to screen for potential exposure to a chemical, physical or biological agent which has caused or may cause harm to an individual.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Item tree - @ internal @
- at0004::Screening purpose - The context or reason for screening.
- at0005::Any exposure? - Presence of any relevant exposure.
- at0006::Yes - None
- at0007::No - None
- at0008::Unknown - None
- at0009::Specific exposure - Details about each possible specific exposure circumstance.
- at0010::Situation - The exposure event, or situation or activity where exposure may have occurred.
- at0011::Presence? - Has the specified 'Situation' occurred?
- at0012::Yes - None
- at0013::No - None
- at0014::Unknown - None
- at0015::Timing - Indication of timing related to the exposure situation.
- at0016::Additional details - Additional details about the specific exposure event, location or associated contacts.
- at0017::Comment - Additional narrative about the specific exposure situation, not captured in other fields.
- at0018::Item tree - @ internal @
- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0020::Agent name - The name of the chemical, physical or biological agent or grouping of agents to which an individual may have been exposed.
- at0021::Unsure - None
- at0022::Description - Narrative description about the history of exposure to the identified chemical, physical or biological agent or grouping of agents.
- at0023::Additional details - Structured details or questions about screening for exposure.
- at0024::Unsure - None

fact_g-Hep

Archetype ID: openEHR-EHR-OBSERVATION.fact_g-Hep.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter and their total sum for the FACT-Hep measure.

****Use:**** Use to record the results for each component parameter and their total sum for the FACT-Hep measure. Several of the score item response scores are reversed on scoring, to convert a low response on a negatively phrased question to a high quality of life score, or opposite. Reversal is performed by subtracting the item response from 4. The subscale scores are calculated by summing the item scores after reversing the relevant item responses, multiplying by the number of items in the subscale, and dividing by the number of items answered. While openEHR archetypes are all freely available under an open license, the specific content of this archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. Copyright statement: © Copyright 1987, 1997 David Cella, Ph.D Terms and conditions for use: <https://www.facit.org/FACITOrg/AboutUs/Copyright>

****Misuse:**** Not to be used for recording any FACT measure other than FACT-Hep. Use the parent or a sibling of this archetype for this purpose.

****Keywords:**** FACT, cancer, QOL, quality of life, assessment,liver, bile duct, pancreas

****Concepts:****

- at0000.1::FACT-Hep - Functional Assessment of Cancer Therapy-General, a 45-Item measure of physical, role, emotional, and social/family functioning, as well additional concern and global quality of life in patients with hepatobiliary cancer.
- at0.1::Swelling or cramps in stomach area - I have swelling or cramps in my stomach area
- at0.3::Losing weight - I am losing weight
- at0.4::Control of bowels - I have control of my bowels
- at0.5::Could digest food well - I can digest my food well
- at0.6::Diarrhea - I have diarrhea (diarrhoea)
- at0.7::Good appetite - I have a good appetite
- at0.8::Unhappy about appearance change - I am unhappy about a change in my appearance
- at0.9::Back pain - I have pain in my back
- at0.10::Bothered by constipation - I am bothered by constipation
- at0.11::Felt fatigued - I feel fatigued
- at0.12::Able to do usual activities - I am able to do my usual activities
- at0.13::Bothered by jaundice - I am bothered by jaundice or yellow color to my skin

- at0.14::Fever - I have had fevers (episodes of high body temperature)
- at0.15::Itching - I have had itching
- at0.16::Changes on food taste - I have had a change in the way food tastes
- at0.17::Chills - I have had chills
- at0.18::Dry mouth - My mouth is dry
- at0.19::Discomfort or pain in stomach area - I have discomfort or pain in my stomach area
- at0.2::Hepatobiliary cancer subscale score - The score for the hepatobiliary cancer subscale.
- at0000::FACT-G - Functional Assessment of Cancer Therapy-General, a 27-Item measure of physical, role, emotional, and social/family functioning, as well as global quality of life in patients with cancer.
- at0001::History - @ internal @
- at0002::The past 7 days - The standard "past 7 days" recording of FACT scores.
- at0003::Tree - @ internal @
- at0004::Lack of energy - I have a lack of energy
- at0005::Nausea - I have nausea
- at0006::Trouble on meeting family needs due to physical condition - Because of my physical condition, I have trouble meeting the needs of my family
- at0007::Pain - I have pain
- at0008::Bothered by side effects of treatment - I am bothered by side effects of treatment
- at0009::Felt ill - I feel ill
- at0010::Forced to spend time in bed - I am forced to spend time in bed
- at0011::Felt close to friends - I feel close to my friends
- at0012::Got emotional support from family - I get emotional support from my family
- at0013::Got support from friends - I get support from my friends
- at0014::Family has accepted illness - My family has accepted my illness
- at0015::Satisfied with family communication about illness - I am satisfied with family communication about my illness
- at0016::Felt close to partner - I feel close to my partner (or the person who is my main support)
- at0017::Satisfied with sex life - I am satisfied with my sex life
- at0018::Felt sad - I feel sad
- at0019::Satisfied with coping with illness - I am satisfied with how I am coping with my illness
- at0020::Losing hope to fight against illness - I am losing hope in the fight against my illness
- at0021::Felt nervous - I feel nervous
- at0022::Worried about dying - I worry about dying
- at0023::Worried that condition will get worse - I worry that my condition will get worse

- at0024::Able to work (including work at home) - I am able to work (include work at home)
- at0025::Felt that work was fulfilling - My work (include work at home) is fulfilling
- at0026::Able to enjoy life - I am able to enjoy life
- at0027::Accepted illness - I have accepted my illness
- at0028::Slept well - I am sleeping well
- at0029::Enjoyed things usually done for fun - I am enjoying the things I usually do for fun
- at0030::Content with quality of life right now - I am content with the quality of my life right now
- at0049::Item tree - @ internal @
- at0051::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0055::FACT-G total score - Total score from from the PWB, SWB, EWB and FWB subscales. The higher the score, the better the QOL.
- at0056::Not at all - None
- at0057::A little bit - None
- at0058::Somewhat - None
- at0059::Quite a bit - None
- at0060::Very much - None
- at0061::Physical well-being subscale score - The score for the physical well-being subscale.
- at0062::Social/family well-being subscale score - The score for the social/family well-being subscale.
- at0063::Emotional well-being subscale score - The score for the emotional well-being subscale.
- at0064::Functional well-being subscale score - The score for the functional well-being subscale.
- at0065::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0.20::FACT-Hep Trial Outcome Index (TOI) - Total score from from the PWB, FWB and HCS subscales.
- at0.21::FACT-Hep total score - Total score from from all the subscales.

fact_g

Archetype ID: openEHR-EHR-OBSERVATION.fact_g.v0

Lifecycle State: in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter and their total sum for the FACT-G measure.

****Use:**** Use to record the results for each component parameter and their total sum for the FACT-G measure. Several of the score item response scores are reversed on scoring, to convert a low response on a negatively phrased question to a high quality of life score, or opposite. Reversal is performed by subtracting the item response from 4. The subscale scores are calculated by summing the item scores after reversing the relevant item responses, multiplying by the number of items in the subscale, and dividing by the number of items answered. While openEHR archetypes are all freely available under an open license, the specific content of this archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. Copyright statement: © Copyright 1987, 1997 David Cella, Ph.D Terms and conditions for use: <https://www.facit.org/FACITOrg/AboutUs/Copyright>

****Misuse:**** Not to be used for recording any FACT measure for a specific tumour type such as FACT-C or FACT-Hep. Use an appropriate specialisation of this archetype for this purpose.

****Keywords:**** FACT, cancer, QOL, quality of life, assessment

****Concepts:****

- at0000::FACT-G - Functional Assessment of Cancer Therapy-General, a 27-Item measure of physical, role, emotional, and social/family functioning, as well as global quality of life in patients with cancer.
- at0001::History - @ internal @
- at0002::The past 7 days - The standard "past 7 days" recording of FACT scores.
- at0003::Tree - @ internal @
- at0004::Lack of energy - I have a lack of energy
- at0005::Nausea - I have nausea
- at0006::Trouble on meeting family needs due to physical condition - Because of my physical condition, I have trouble meeting the needs of my family
- at0007::Pain - I have pain
- at0008::Bothered by side effects of treatment - I am bothered by side effects of treatment
- at0009::Felt ill - I feel ill
- at0010::Forced to spend time in bed - I am forced to spend time in bed
- at0011::Felt close to friends - I feel close to my friends
- at0012::Got emotional support from family - I get emotional support from my family
- at0013::Got support from friends - I get support from my friends

- at0014::Family has accepted illness - My family has accepted my illness
- at0015::Satisfied with family communication about illness - I am satisfied with family communication about my illness
- at0016::Felt close to partner - I feel close to my partner (or the person who is my main support)
- at0017::Satisfied with sex life - I am satisfied with my sex life
- at0018::Felt sad - I feel sad
- at0019::Satisfied with coping with illness - I am satisfied with how I am coping with my illness
- at0020::Losing hope to fight against illness - I am losing hope in the fight against my illness
- at0021::Felt nervous - I feel nervous
- at0022::Worried about dying - I worry about dying
- at0023::Worried that condition will get worse - I worry that my condition will get worse
- at0024::Able to work (including work at home) - I am able to work (include work at home)
- at0025::Felt that work was fulfilling - My work (include work at home) is fulfilling
- at0026::Able to enjoy life - I am able to enjoy life
- at0027::Accepted illness - I have accepted my illness
- at0028::Slept well - I am sleeping well
- at0029::Enjoyed things usually done for fun - I am enjoying the things I usually do for fun
- at0030::Content with quality of life right now - I am content with the quality of my life right now
- at0049::Item tree - @ internal @
- at0051::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0055::FACT-G total score - Total score from from the PWB, SWB, EWB and FWB subscales. The higher the score, the better the QOL.
- at0056::Not at all - None
- at0057::A little bit - None
- at0058::Somewhat - None
- at0059::Quite a bit - None
- at0060::Very much - None
- at0061::Physical well-being subscale score - The score for the physical well-being subscale.
- at0062::Social/family well-being subscale score - The score for the social/family well-being subscale.
- at0063::Emotional well-being subscale score - The score for the emotional well-being subscale.
- at0064::Functional well-being subscale score - The score for the functional well-being subscale.

- at0065::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.

faecal_output

****Archetype ID:**** openEHR-EHR-OBSERVATION.faecal_output.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en, nl

****Purpose:**** To record details about faecal output.

****Use:**** Use to record details about faecal output. This archetype can be used to record details about: - each single bowel motion, including episodes of diarrhoea; or - the total faecal output over a specified period of time, for example the amount of diarrhoea as part of a fluid balance chart over an 8 hour nursing shift. Each measurement should be recorded using a separate instance of this archetype. If an individual has diarrhoea, a fluid balance chart may require inclusion of this archetype alongside multiple instances of OBSERVATION.fluid_output and OBSERVATION.fluid_input archetype to capture all of the various inputs and outputs, plus a single instance of the OBSERVATION.fluid_balance to record the overall fluid status.

****Misuse:**** Not to be used to record fluid input. Use OBSERVATION.fluid_input for this purpose. Not to be used to record fluid output, other than diarrhoea. Use OBSERVATION.fluid_output for this purpose. Not to be used to record fluid balance calculations or to record the calculation of insensible fluid loss. Use OBSERVATION.fluid_balance for this purpose.

****Keywords:**** fluid, balance, output, urine, vomit, drain, drainage, aspirate, exudate, loss

****Concepts:****

- at0000::Faecal output - The measurement of faeces excreted from the body.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::List - @ internal @
- at0004::Amount - The amount of faeces excreted.
- at0005::Faecal details - Additional details about the faeces, including macroscopic appearance or other tests not currently captured in the structured data.

- at0006::Comment - Additional narrative about the faecal output not captured in other fields.
- at0008::List - @ internal @
- at0009::Method - The approach used to quantify the amount of faeces.
- at0010::Estimated - The faecal output has been estimated.
- at0011::Measured - The faecal output has been directly measured.
- at0012::Output device - Details of the device that was used to collect the faeces.
- at0013::Measurement device - Details of the device used to measure the faecal output.
- at0014::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

fagerstrom

****Archetype ID:**** openEHR-EHR-OBSERVATION.fagerstrom.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, en

****Purpose:**** To assess physical dependence on nicotine.

****Use:**** Use to estimate a individual's level of nicotine dependence once they have been identified as a cigarette smoker. This test may be used by the physician to document indications for prescribing medication for nicotine withdrawal. While openEHR archetypes are all freely available under an open license, the specific content of this Fagerström test for nicotine dependence archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners: - The Fagerström Tolerance Questionnaire was developed by Karl-Olov Fagerström. This instrument was modified to the Fagerström Test for Nicotine Dependence by Todd Heatherton, et al. in 1991. The FTND is copyrighted by Taylor and Francis Ltd., but may be reproduced without permission, as available from the source reference (Heatherton, et al., 1991).

****Keywords:**** nicotine, tobacco, smoking, dependence, fagerstrom

****Concepts:****

- at0000::Fagerström test for nicotine dependence - Standard instrument for assessing physical dependence on nicotine.
- at0001::Event Series - @ internal @

- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Morning cigarette - How soon after you wake up do you smoke your first cigarette?
- at0005::After 60 Minutes - First cigarette is smoked more than 60 minutes after waking.
- at0006::Within 6-30 Minutes - First cigarette is smoked between 6 and 30 minutes after waking.
- at0007::Within 31-60 Minutes - First cigarette is smoked between 31 and 60 minutes after waking.
- at0008::Within 5 Minutes - First cigarette is smoked in the first 5 minutes after waking.
- at0009::Difficult to refrain - Do you find it difficult to refrain from smoking in places where it is forbidden (e.g., in church, at the library, in cinema, etc)?
- at0010::No - It is not difficult to refrain from smoking.
- at0011::Yes - It is difficult to refrain from smoking.
- at0012::Hate to give up - Which cigarette would you hate most to give up?
- at0013::Any other - Any cigarette other than the first cigarette in the morning would be most difficult to give up.
- at0014::The first in the morning - First cigarette in the morning would be most difficult to give up.
- at0015::Daily consumption - How many cigarettes per day do you smoke?
- at0016::10 or Less - Smoking <=10 cigarettes per day.
- at0017::11-20 - Smoking 11-20 cigarettes per day.
- at0018::21-30 - Smoking 21-30 cigarettes per day.
- at0019::31 or more - Smoking >30 cigarettes per day.
- at0020::Early morning pattern - Do you smoke more during the first hours after waking than during the rest of the day?
- at0021::No - Not smoking more during the first hours after waking.
- at0022::Yes - Smoke more during the first hours after waking.
- at0023::During illness - Do you smoke even when you are ill enough to be in bed most of the day?
- at0024::No - Not smoking if ill enough to be in bed most of the day.
- at0025::Yes - Smoke continues, even if ill enough to be in bed most of the day.
- at0026::Total - Aggregate total from all components.
- at0027::Tree - @ internal @
- at0028::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

family_history_screening_questionnaire

****Archetype ID:**** openEHR-EHR-OBSERVATION.family_history_screening_questionnaire.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about health-related problems found in both genetic and non-genetic family members.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about health-related problems found in both genetic and non-genetic family members. 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. Templates for specific use cases may be constrained to relationships with genetic family members if required. Common use cases include, but are not limited to: - Systematic questioning in any consultation, for example: --- Is there a history of heart disease in the family? --- Is there a history of mental health problems in the family? --- Is there a history of addiction in the family? --- Did your mother have diabetes? - Specific questioning related to chronic disease management or preventive health. The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about a significant health-related problem the family at any time in the past and information about a significant health-related problem the family in a specified time interval - for example the difference between "Have any family members COVID now?" compared to "Have any family members had COVID the past 4 weeks?" The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies the presence of a health concern in a family member, it is recommended that the clinical system record the specific details using the EVALUATION.family_history archetype or the CLUSTER.family_prevalence archetype.

****Misuse:**** Not to be used to record details about the presence or absence of a significant health-related problem, outside of a screening context. Use EVALUATION.family_history or EVALUATION.exclusion_specific for these purposes. Not to be used to record details about a specific health-related problem. Use EVALUATION.problem_diagnosis for this purpose. Not to be used to record a Family Pedigree chart of health problems/diagnoses. Use the EVALUATION.family_history archetype for this purpose.

****Keywords:**** family, history, health, condition, problem, diagnosis, family history, relative, biological, relationship, background, genetic

****Concepts:****

- at0000::Family history screening questionnaire - Series of questions and associated answers used to screen for health-related problems found in genetic and non-genetic family members.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Screening purpose - The context or reason for screening.
- at0009::Specific relationship - Details about a specific problem or diagnosis in identified family member(s).
- at0010::Presence? - Is there a history of a problem or diagnosis in family members?
- at0011::Yes - None
- at0012::No - None
- at0013::Unknown - None
- at0018::Relationship - The relationship of the family member to the individual.
- at0021::Item tree - @ internal @
- at0028::Comment - Additional narrative about the specific problem, diagnosis or family member, not captured in other fields.
- at0029::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0035::Problem/diagnosis name - Identification of a problem or diagnosis, or grouping of problems or diagnoses in the family.
- at0036::Additional details - Structured details or questions about the specific problem or diagnosis.
- at0038::Description - Narrative description about the history of any problem or diagnosis in the family.
- at0039::Additional details - Structured details or questions about screening for significant problems or diagnoses in family members.
- at0041::Unsure - None
- at0042::Problem or diagnosis in the family - Details about a specific problem or diagnosis or grouping of problems or diagnoses in the family.

- at0043::Problem/diagnosis name - Identification of a problem or diagnosis, or grouping of problems or diagnoses in the family.
- at0044::Presence? - Is there a history of a problem or diagnosis, or grouping of problems or diagnoses in the family?
- at0045::Yes - None
- at0046::No - None
- at0047::Unknown - None
- at0048::Unsure - None
- at0049::Timing - Indication of timing related to the problem or diagnosis.

fetal_biometry

****Archetype ID:**** openEHR-EHR-OBSERVATION.fetal_biometry.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record ultrasound and doppler measurements of an embryo or foetus in utero.

****Use:**** Use to record ultrasound and doppler measurements of an embryo or foetus in utero. This archetype has been designed as one component of an imaging examination and will need to be added in a template alongside the OBSERVATION.imaging_exam_result and the imaging family of CLUSTERs..

****Misuse:**** Not to be used to record direct measurements of an infant. Use OBSERVATION.height, OBSERVATION.head_circumference, OBSERVATION.body_segment_length and OBSERVATION.body_weight for equivalent measurements. Not to be used to record information about the gestational sac, use openEHR-EHR-CLUSTER.imaging_exam-gestational_sac.

****Keywords:**** fetus, embryo, femur, humerus, crown-rump, head, abdomen, ultrasound, antenatal, obstetric, foetus

****Concepts:****

- at0000::Foetal biometry - Ultrasound and Doppler measurements of the dimensions of an embryo or foetus.
- at0001::History - @ internal @
- at0002::Any event - None

- at0003::Tree - @ internal @
- at0004::Crown-rump length (CRL) - The length of the embryo or foetus from the top of its head to bottom of its rump.
- at0006::Biparietal diameter (BDP) - The maximum diameter of a transverse section of the foetal skull.
- at0007::Occipito-frontal diameter (OFG) - The maximal diameter from the occiput to the frontal bone in the midline of the foetal skull.
- at0008::Head circumference (HC) - The distance around the foetal head.
- at0009::Trans-cerebellar diameter (TCD) - The maximum transverse diameter of the foetal cerebellum.
- at0010::Interocular distance (IOD) - The distance between medial osseous structures of the two orbitae.
- at0011::Binocular distance (BOD) - The distance between lateral osseous structures of the two orbitae.
- at0012::Abdominal circumference (AC) - The distance around the foetal abdomen.
- at0013::Femur length (FL) - The length of the diaphysis of the femur.
- at0014::Humeral length (HL) - The length of the diaphysis of the humerus.
- at0015::Comment - Additional narrative about the foetal biometry, not captured in other fields.
- at0016::Item tree - @ internal @
- at0017::BDP method - The method of measuring the biparietal diameter.
- at0019::Outer-to-outer - From the leading edge of the near-field parietal bone to the far edge of the far-sided parietal bone.
- at0020::Outer-to-inner - From the leading edge of the near-field parietal bone to the leading edge of the far-sided parietal bone.
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.

fetal_heart-monitoring

****Archetype ID:**** openEHR-EHR-OBSERVATION.fetal_heart-monitoring.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record observations about the fetal heart rate, usually using a cardiotocograph or similar device over a time in late pregnancy or labour, as an assessment about fetal wellbeing in utero.

****Use:**** Use to record observations about the fetal heart rate, usually using a cardiotocograph or similar device over a period of time in late pregnancy or labour, as an assessment about fetal wellbeing. Use to capture findings from electronic monitoring, including cardiotocography. Use is restricted to recording details about the heart beat of a fetus.

****Misuse:**** Not to be used to record simple, intermittent measurements of fetal heart rate - use the parent archetype **OBSERVATION.fetal_heart** instead. Not to be used for recording the heart rate of infants, children or adults.

****Keywords:**** fetal, heart, beat, rate, rhythm

****Concepts:****

- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Presence - The fetal heart beat is detected.
- at0005::Rate - The observed fetal heart rate.
- at0009::Comment - Additional narrative about the fetal heart rate, not captured in other fields.
- at0010::Clinical interpretation - Single word, phrase or brief description that represents the clinical meaning and significance of the fetal heart rate.
- at0011::Tree - @ internal @
- at0012::Position of mother - The position of the mother when the fetal heart rate was measured.
 - at0013::Standing - Mother standing at the time of fetal heart rate measurement.
 - at0014::Sitting - Mother sitting at the time of fetal heart rate measurement.
 - at0015::Reclining - Mother reclining at the time of fetal heart rate measurement.
 - at0016::Lying - Lying flat at the time of fetal heart rate measurement.
 - at0017::Lying with tilt to left - Mother lying flat with some lateral tilt towards the left.
 - at0018::Tree - @ internal @
- at0022::Confounding factors - Description of incidental factors, not recorded elsewhere, that may be influencing the fetal heart rate measurement.
- at0020::Device - Details about the device used to detect the fetal heart rate.
- at0026::Present - The fetal heart beat is detected.
- at0027::Absent - The fetal heart beat is not detected.
- at0021::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0023::In labour - Is the mother in active labor during the observation?
- at0024::In labour - The mother is in labour as the observation is made.
- at0025::Not in labour - The mother is not in labour as the observation is made.

- at0000.1::Fetal heart monitoring - Observations about the fetal heart rate, usually using a cardiotocograph or similar device over a period of time.
- at0.1::Variability - Variability in the fetal heart rate observed during the monitoring interval.
- at0.2::Variability category - Variability in the fetal heart rate observed during the monitoring interval.
- at0.3::Variability description - Narrative description of the pattern of variability observed during the monitoring interval.
- at0.4::Accelerations - Presence of accelerations observed during the monitoring interval.
- at0.5::Early decelerations - Frequency of early accelerations observed during the monitoring interval.
- at0.6::Uncomplicated variable decelerations - Frequency of uncomplicated variable decelerations observed during the monitoring interval.
- at0.7::Complicated variable decelerations - Frequency of complicated variable decelerations observed during the monitoring interval.
- at0.8::Late decelerations - Frequency of late decelerations observed during the monitoring interval.
- at0.9::Prolonged decelerations - Duration of a single, prolonged deceleration observed during the monitoring interval.
- at0.10::Multimedia representation - Digital representation of the monitoring findings.
- at0.11::Absent - Heart rate variability is undetectable.
- at0.12::Minimal - Heart rate variability is greater than undetectable, but less than or equal to 5 beats per minute.
- at0.13::Moderate - Heart rate variability is between 6-25 beats per minute.
- at0.14::Marked - Heart rate variability is greater than 25 beats per minute.
- at0.15::Absent - Heart rate accelerations are undetectable.
- at0.16::Spontaneously present - Heart rate accelerations are present and occurring spontaneously.
- at0.17::Present with fetal scalp stimulation - Fetal heart accelerations are detected as a result of fetal scalp stimulation.
- at0.18::Absent with fetal scalp stimulation - Fetal heart rate accelerations are not detected with fetal scalp stimulation.
- at0.19::None - No decelerations detected.
- at0.20::Occasional - Occasional decelerations detected but occur in association with less than 50% of uterine contractions.
- at0.21::Repetitive - Decelerations detected in association with over 50% of uterine contractions.
- at0.22::None - No decelerations detected.
- at0.23::Occasional - Occasional decelerations detected but occur in association with less than 50% of uterine contractions.

- at0.24::Repetitive - Decelerations detected in association with over 50% of uterine contractions.
- at0.25::None - No decelerations detected.
- at0.26::Occasional - Occasional decelerations detected but occur in association with less than 50% of uterine contractions.
- at0.27::Repetitive - Decelerations detected in association with over 50% of uterine contractions.
- at0.28::None - No decelerations detected.
- at0.29::Occasional - Occasional decelerations detected but occur in association with less than 50% of uterine contractions.
- at0.30::Repetitive - Decelerations detected in association with over 50% of uterine contractions.

[**fetal_heart**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.fetal_heart.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record details about the fetal heart rate via intermittent observations.

****Use:**** Use to record the intermittent observations of the heart rate and heart beat characteristics of a fetus during pregnancy. Only to be used where the subject of care is the fetus.

****Misuse:**** Not to be used to record more the complex details required for intervals of electronic fetal heart monitoring - use the specialisation OBSERVATION.fetal_heart-monitoring instead. Not to be used for recording the heart rate of infants, children or adults.

****Keywords:**** fetal, heart, beat, rate, rhythm

****Concepts:****

- at0000::Fetal heart rate - Observations about the fetal heart rate.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Presence - The fetal heart beat is detected.

- at0005::Rate - The observed fetal heart rate.
- at0009::Comment - Additional narrative about the fetal heart rate, not captured in other fields.
- at0010::Clinical interpretation - Single word, phrase or brief description that represents the clinical meaning and significance of the fetal heart rate.
- at0011::Tree - @ internal @
- at0012::Position of mother - The position of the mother when the fetal heart rate was measured.
- at0013::Standing - Mother standing at the time of fetal heart rate measurement.
- at0014::Sitting - Mother sitting at the time of fetal heart rate measurement.
- at0015::Reclining - Mother reclining at the time of fetal heart rate measurement.
- at0016::Lying - Lying flat at the time of fetal heart rate measurement.
- at0017::Lying with tilt to left - Mother lying flat with some lateral tilt towards the left.
- at0018::Tree - @ internal @
- at0022::Confounding factors - Description of incidental factors, not recorded elsewhere, that may be influencing the fetal heart rate measurement.
- at0020::Device - Details about the device used to detect the fetal heart rate.
- at0026::Present - The fetal heart beat is detected.
- at0027::Absent - The fetal heart beat is not detected.
- at0021::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0023::In labour - Is the mother in active labor during the observation?
- at0024::In labour - The mother is in labour as the observation is made.
- at0025::Not in labour - The mother is not in labour as the observation is made.

[**fitzpatrick_skin_type**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.fitzpatrick_skin_type.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** The concept of skin typing was developed in 1975 in order to select correct ultraviolet A dosage for treatment of psoriasis with oral methoxsalen, known as photochemotherapy (PUVA). It was further developed in subsequent years to include 6 types, ranging from white to black skin, characterised based on skin tolerance of ultraviolet radiation exposure.

****Use:**** Classification of skin colour type based on skin tolerance of ultraviolet radiation exposure.

****Keywords:**** Dermatology, Skin colour

****Concepts:****

- at0000::Fitzpatrick skin type - Numerical schema for classifying skin colour type based on reaction to ultraviolet radiation exposure.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Skin type - The Fitzpatrick Skin type.
- at0005::I - Always burn, never tan.
- at0006::II - Usually burn, tan less than average (with difficulty).
- at0007::III - Sometimes mild burn, tan about average.
- at0008::IV - Rarely burn, tan more than average (with ease).
- at0009::V - Brown skin, rarely burns, tans profusely.
- at0010::VI - Black skin, never burns.
- at0011::Item tree - @ internal @
- at0012::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

fluid_balance

****Archetype ID:**** openEHR-EHR-OBSERVATION.fluid_balance.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, sv, fi, nb, es-ar, en

****Purpose:**** To record the cumulative or total amounts of fluid input and output, plus an estimation of the fluid balance status of an individual over specified intervals of time. To record the estimation of the difference between fluid input and output during a specified interval of time.

****Use:**** Use to record cumulative or total amounts of fluid input and output, plus an estimation of the fluid balance status of a subject over specified periods of time. A fluid balance chart will typically require a combination of multiple instances of both the OBSERVATION.fluid_output archetype and the OBSERVATION.fluid_input archetype to

capture all of the various inputs and outputs, plus a single instance of the OBSERVATION.fluid_balance to record the overall fluid status.

****Misuse:**** Not to be used to record individual measurements of fluid input or output. Use the OBSERVATION.fluid_input or OBSERVATION.fluid_output archetypes for these purposes.

****Keywords:**** fluid, balance, input, output, loss, sweat, insensible, evaporation, perspiration

****Concepts:****

- at0000::Fluid balance - The difference between fluid input and output during a specified interval of time.
- at0001::Event Series - @ internal @
- at0002::Any interval event - Unspecified interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Insensible loss - The amount of fluid loss by evaporation from the skin and respiratory tract.
- at0005::Total input - The total amount of fluid administered or ingested during a specified interval of time.
- at0006::Total output - The total amount of fluid lost or excreted during a specified interval of time.
- at0007::Fluid balance - The difference between fluid input and output during a specified interval of time.
- at0008::24 hour total - Total fluid volume recorded during an interval of 24 hour duration.
- at0009::Tree - @ internal @
- at0010::Insensible loss formula - The formula used to calculate the amount of insensible loss.
- at0011::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[fluid_input](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.fluid_input.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, sv, fi, nb, es-ar, sl, en

****Purpose:**** To record details of measured fluid input, often used as part of fluid balance calculation.

****Use:**** Use to record details about fluids ingested and/or administered. This archetype is intended to be used to mirror current clinical practice with fluid input recorded in orders and in fluid balance charts. In a clinical system business rules can support automation of orders involving fluid input using this archetype to prevent the need for clinicians to duplicate data entry. This archetype will also be the basis for all monitored fluid intake, including ordered fluids and ad hoc consumption. This archetype will be used to record details about: - each single fluid ingested or administered, for example each individual cup of tea or glass of water; or - the total fluid input of a fluid over a specified period of time, for example the total amount of 0.9% NaCl administered over an 8 hour nursing shift. Each fluid measurement should be recorded using a separate instance of this archetype. The details recorded using this fluid input archetype may inform fluid balance calculations. A fluid balance chart will typically require a combination of multiple instances of this archetype and multiple instances of OBSERVATION.fluid_output archetype to capture all of the various inputs and outputs, plus a single instance of the OBSERVATION.fluid_balance to record the overall fluid status.

****Misuse:**** Not to be used to record fluid output. Use OBSERVATION.fluid_output for this purpose. Not to be used to order fluid administration - use INSTRUCTION.medication or an INSTRUCTION specific for fluid intake. Not to be used to order changes in fluid input, such as fluid restriction. Use an appropriate INSTRUCTION archetype for this purpose. Not to be used to record fluid balance calculations. Use OBSERVATION.fluid_balance for this purpose.

****Keywords:**** fluid, input, balance, drinking, intake, parenteral, eating

****Concepts:****

- at0000::Fluid input - The amount of fluid ingested or administered to the individual.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::List - @ internal @
- at0008::List - @ internal @
- at0018::Estimated - The fluid volume has been estimated.
- at0019::Measured - The fluid volume has been directly measured.
- at0028::Measurement device - The device used to measure the volume of fluid.
- at0031::Method - The approach used to quantify the volume of fluid.
- at0032::Comment - Additional narrative about the fluid input not captured in other fields.
- at0033::Input device - The device used to administer or deliver the fluid.
- at0034::Route - The delivery route of the fluid.
- at0035::Volume - The volume of fluid ingested or administered.

- at0036::Fluid name - Identification of the fluid ingested or administered.
- at0039::Fluid details - Additional details about the fluid.
- at0040::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

fluid_output-blood

****Archetype ID:**** openEHR-EHR-OBSERVATION.fluid_output-blood.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, es-ar, nb, sl, en

****Purpose:**** To record details about measured blood loss via any mechanism.

****Use:**** Use to record details about measured fluids lost or excreted via any mechanism. This archetype will be used to record details about: - each single measurement, for example the volume of each bleeding event from a single source; or - the total amount of bleeding over a specified period of time, for example the blood loss over an 8 hour nursing shift. Each fluid measurement should be recorded using a separate instance of this archetype. Each separate source of blood loss may be recorded using a separate instance of this archetype. The details recorded using this blood loss archetype may inform fluid balance calculations.

****Misuse:**** Not to be used to record fluid input. Use OBSERVATION.fluid_input for this purpose. Not to be used to record fluid balance calculations or to record the calculation of insensible fluid loss. Use OBSERVATION.fluid_balance for this purpose.

****Keywords:**** fluid, balance, output, drain, drainage, bleeding, exsanguination, hypovolaemia

****Concepts:****

- at0000.1::Blood loss - The measurement of blood loss from the body via any mechanism.
- at0036.1::Fluid name - Identification of the fluid lost or excreted.
- at0.1::Blood - Fluid loss from the body as a result of bleeding.
- at0.2::Blood clots? - Description the presence or absence of blood clots.
- at0.3::Present - Blood clots were present.
- at0.4::Absent - Blood clots were not present.
- at0000::Fluid output - The measurement of fluid lost or excreted from the body via any mechanism.

- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::List - @ internal @
- at0008::List - @ internal @
- at0018::Estimated - The fluid volume has been estimated.
- at0019::Measured - The fluid volume has been directly measured.
- at0028::Measurement device - Details of the device used to measure the fluid output.
- at0031::Method - The approach used to quantify the volume of fluid.
- at0032::Comment - Additional narrative about the fluid output not captured in other fields.
- at0033::Output device - Details of the device that was used to collect the fluid.
- at0035::Volume - The volume of fluid.
- at0036::Fluid name - Identification of the fluid lost or excreted.
- at0038::Fluid details - Additional details about the fluid, including macroscopic appearance or other tests not currently captured in the structured data.
- at0040::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0041::Source - The source from which the fluid is lost or excreted.

[fluid_output](#)

Archetype ID: openEHR-EHR-OBSERVATION.fluid_output.v1

Lifecycle State: published

Category: OBSERVATION

Languages: de, sv, fi, nb, es-ar, en, sl

Purpose: To record details about measured fluids lost or excreted via any mechanism.

Use: Use to record details about measured fluids lost or excreted via any mechanism. This archetype will be used to record details about: - each single fluid output measurement, for example the volume of each vomit; or - the total fluid output from a single source over a specified period of time, for example the total urine output over an 8 hour nursing shift. Each fluid measurement should be recorded using a separate instance of this archetype. The details recorded using this fluid output archetype may inform fluid balance calculations. A fluid balance chart will typically require a combination of multiple instances of this archetype and multiple instances of OBSERVATION.fluid_input archetype to capture all of the various inputs and outputs, plus a single instance of the OBSERVATION.fluid_balance to record the overall fluid status.

****Misuse:**** Not to be used to record fluid input. Use OBSERVATION.fluid_input for this purpose. Not to be used to record fluid balance calculations or to record the calculation of insensible fluid loss. Use OBSERVATION.fluid_balance for this purpose.

****Keywords:**** fluid, balance, output, urine, vomit, drain, drainage, aspirate, exudate, loss

****Concepts:****

- at0000::Fluid output - The measurement of fluid lost or excreted from the body via any mechanism.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::List - @ internal @
- at0008::List - @ internal @
- at0018::Estimated - The fluid volume has been estimated.
- at0019::Measured - The fluid volume has been directly measured.
- at0028::Measurement device - Details of the device used to measure the fluid output.
- at0031::Method - The approach used to quantify the volume of fluid.
- at0032::Comment - Additional narrative about the fluid output not captured in other fields.
- at0033::Output device - Details of the device that was used to collect the fluid.
- at0035::Volume - The volume of fluid.
- at0036::Fluid name - Identification of the fluid lost or excreted.
- at0038::Fluid details - Additional details about the fluid, including macroscopic appearance or other tests not currently captured in the structured data.
- at0040::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0041::Source - The source from which the fluid is lost or excreted.

foetal_growth

****Archetype ID:**** openEHR-EHR-OBSERVATION.foetal_growth.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record details about parameters plotted as percentiles on a growth chart for a foetus.

****Use:**** Use to record details about parameters plotted as percentiles on a growth chart for a foetus. Use the URI to explicitly link the original measurement as recorded.

****Misuse:**** Not to be used to record actual measurements. Use appropriate OBSERVATION archetypes for this purpose - for example OBSERVATION.height, OBSERVATION.weight, OBSERVATION.head_circumference, OBSERVATION.body_segment or OBSERVATION.blood_pressure. Not to be used to record growth indicators for an infant or child. Use OBSERVATION.child_growth for this purpose.

****Keywords:**** growth, calculation, centile, percentile, z-score, SD, height, weight, head circumference

****Concepts:****

- at0000::Foetal growth indicators - Details about parameters plotted on a growth chart to allow monitoring of foetal growth over time, relative to a reference population.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0010::Percentile - Percentile calculated using standard normal distribution for the gestational age.
- at0011::Z-score - The deviation of a fetal value from the median value for a reference population, divided by the standard deviation of the reference population.
- at0014::Growth indicator - The name of the growth parameter.
- at0019::Comment - A comment about the growth indicator, not captured in other fields.
- at0020::Crown-rump length-for-gestational-age - Crown-rump length plotted against gestational age.
- at0021::Biparietal diameter-for-gestational-age - Biparietal diameter plotted against gestational age.
- at0022::Femur length-for-gestational-age - Femur length plotted against gestational age.
- at0023::Estimated weight-for-gestational-age - Estimated weight plotted against gestational age
- at0024::Head circumference-for-gestational-age - Head circumference plotted against gestational age.
- at0025::Abdominal circumference-for-gestational age - Abdominal circumference plotted against gestational age.
- at0026::Humerus length-for-gestational-age - Humerus length plotted against gestational age.
- at0027::Fundal height-for-gestational-age - Uterine fundal height plotted against gestational age.
- at0029::Liquor volume-for-gestational-age - Liquor volume plotted against gestational age.

- at0031::Tree - @ internal @
- at0032::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0035::URI to original measurement - Link to the original measurement.
- at0041::Clinical interpretation - Clinical interpretation of the growth indicator chart.

foetal_movement

****Archetype ID:**** openEHR-EHR-OBSERVATION.foetal_movement.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** fi, en, es-cl

****Purpose:**** To record the presence and pattern of any and all spontaneous foetal movements in utero, as perceived by the mother.

****Use:**** Use to record evidence of foetal activity as an indirect indicator of foetal well-being. Use to record the presence of foetal movements and pattern as part of routine antenatal visits from second trimester of pregnancy onwards. Use to record details of the number of foetal movements felt over a specified time interval, and represented in a 'Kick Chart', most often in the third trimester.

****Misuse:**** Not to be used to record the response of a foetus to deliberate stimulation eg vibroacoustic stimulation. Not to be used to represent formal foetal heart rate monitoring eg using cardiotocographs.

****Keywords:**** fetal, kicks, movements, flutters, hits, baby, foetus

****Concepts:****

- at0000::Foetal movement - Spontaneous movements of the foetus in utero, as perceived by the mother. Movements include kicks, jabs, rolls, twists, and turns.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Presence - Presence of spontaneous foetal movements.
- at0006::Movements - Number of spontaneous foetal movements counted during the period of observation.
- at0007::Present - Spontaneous foetal movements have been perceived by the mother.

- at0011::Absent - Spontaneous foetal movements have not been perceived by the mother.
- at0019::Pattern - Pattern of spontaneous foetal movements.
- at0021::Increased - Spontaneous foetal movements are increased or stronger compared to normal.
- at0022::Normal - The foetus is moving and kicking normally.
- at0024::Reduced - Spontaneous foetal movements are reduced or weaker compared to normal.
- at0025::Time since last movement - Length of time since last spontaneous foetal movement was noticed by mother.
- at0027::Period of observation - Period of time during which the number of spontaneous foetal movements) are counted or observed.
- at0028::Description - Narrative description of the foetal movements as noted by the mother.

food_item

****Archetype ID:**** openEHR-EHR-OBSERVATION.food_item.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record information about a single food item consumed by an individual.

****Use:**** Use to record information about a single food item consumed by an individual. Multiple instances of this archetype could be used to record each food consumed by an individual within a specified timeframe as part of a food diary. This archetype may be extended using specific CLUSTER archetypes that represent further detail about the food item, such as CLUSTER.macronutrient or CLUSTER.micronutrient and other related archetypes.

****Misuse:**** Not to be used to record planned consumption of a food item.

****Keywords:**** nutrition, diet, diary

****Concepts:****

- at0000::Food item - Information about a single food item consumed by an individual.
- at0001::Event Series - @ internal @

- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Food item name - The name of the item of food being recorded.
- at0005::Amount - The amount of food consumed.
- at0006::Mass - The mass of food consumed.
- at0007::Volume - The volume of food consumed.
- at0008::Serving - The number of servings of food consumed.
- at0009::Glycaemic load - A number that estimates how much the food will raise an individual's blood glucose level after eating it.
- at0010::Nutrients - Details about the component nutrients for this food.
- at0011::Comment - Additional narrative about the food item not captured in other fields.
- at0012::Tree - @ internal @
- at0013::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0014::Serving size (mass) - Definition of the size of a single serving of the food item, by mass.
- at0015::Serving size (volume) - Definition of the size of a single serving of the food item, by volume.
- at0016::Method - The method used to measure the amount of food.
- at0017::Device - Details about the device used to measure or record the amount of the food item.
- at0018::Estimated - An approximation of the amount of the food item.
- at0019::Measured - Actual measurement of the amount of the food item.
- at0020::Memory - The amount of food was recorded from memory.
- at0021::Observation - The amount of food was recorded at the time of consumption.
- at0022::Accuracy - The qualitative precision of the amount of the food item.
- at0023::One day - One day interval event, which may be further defined in a template or at run-time, for example: specifically named as 'Friday' or 'Saturday'.
- at0024::One week - One week interval event, which may be further defined in a template or at run-time, for example: specifically named as 'Last week'.

[**four_a_test**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.four_a_test.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the results for each component parameter and their sum for the 4AT test.

****Use:**** Use to record the results for each component parameter and their sum for the 4AT test. This archetype is intended to represent version 1.2 of 4AT test.

****Keywords:**** delirium, assessment, alertness, cognitive, screening, screening tool, cognitive impairment, confused

****Concepts:****

- at0000::4AT - A screening tool used for rapid initial assessment of delirium and cognitive impairment.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Alertness - None
- at0005::Normal (fully alert, but not agitated, throughout assessment) - None
- at0006::Mild sleepiness for <10 seconds after waking, then normal - None
- at0007::Clearly abnormal - None
- at0008::Abbreviated Mental Test 4 (AMT-4) score - None
- at0009::No mistakes - None
- at0010::1 mistake - None
- at0011::2 or more mistakes/untestable - None
- at0012::Attention - None
- at0013::Achieves 7 months or more correctly - None
- at0014::Starts but scores <7 months / refuses to start - None
- at0015::Untestable (cannot start because unwell, drowsy, inattentive) - None
- at0016::Acute change or fluctuating course - None
- at0017::No - None
- at0018::Yes - None
- at0019::Total score - The sum of each component parameter in 4AT.
- at0020::ItemTree - @ internal @
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

four_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.four_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter and their total sum for the FOUR score.

****Use:**** Use to record the results for each component parameter and their total sum for the FOUR score.

****Keywords:**** four, Glasgow, Coma

****Concepts:****

- at0000::Full Outline of UnResponsiveness (FOUR) score - Screening tool to assess individuals with impaired levels of consciousness.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Eye response - None
- at0008::Item tree - @ internal @
- at0009::Motor response - None
- at0010::Brain stem reflexes - None
- at0011::Respiration - None
- at0012::Eyelids open or opened, tracking, or blinking to command - None
- at0013::Eyelids open but not tracking - None
- at0014::Eyelids closed but open to loud voice - None
- at0015::Eyelids closed but open to pain - None
- at0016::Eyelids remain closed with pain - None
- at0017::Thumbs-up, fist, or peace sign - None
- at0018::Localizing to pain - None
- at0019::Flexion response to pain - None
- at0020::Extension response to pain - None
- at0021::No response to pain or generalized myoclonus status - None
- at0022::Pupil and corneal reflexes present - None
- at0023::One pupil wide and fixed - None
- at0024::Pupil or corneal reflexes present - None
- at0025::Pupil and corneal reflexes absent - None

- at0026::Absent pupil, corneal and cough reflex - None
- at0027::Not intubated, regular breathing pattern - None
- at0028::Not intubated, Cheyne-Stokes breathing pattern - None
- at0029::Not intubated, irregular breathing - None
- at0030::Breathes above ventilator rate - None
- at0031::Breathes at ventilator rate or apnoea - None
- at0032::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0033::Total score - The total sum of each component parameter for the FOUR score.

fundoscopic_examination

****Archetype ID:**** openEHR-EHR-OBSERVATION.fundoscopic_examination.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** pt-br, en, es

****Purpose:**** To record details about clinical findings on fundoscopy of eyes.

****Concepts:****

- at0000::Fundoscopic examination of eyes - Record of clinical findings on fundoscopy of eyes.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Eye examined - Identification of the eye which is being examined.
- at0008::Clinical description - Narrative description of the overall findings observed during the physical examination of the eye examined.
- at0013::Tree - @ internal @
- at0014::Mydriatic used - True if mydriatic is used.
- at0028::Tree - @ internal @
- at0029::Method - Method chosen to perform the funduscopic examination.
- at0030::Direct - Study performed by direct ophthalmoscopy.
- at0031::Indirect - Study of eye fundus by indirect ophthalmoscopy method.
- at0053::Red reflex - True if Red Reflex is present.
- at0054::Small pupil - True if during the acquisition, pupil diameter is smaller than normal (3,3mm).

- at0055::Cataract artifact - True if cataract obstructs the visualization of eye fundus.
- at0056::Shadow artifact - True if shadow artifact is present on the border of the image.
- at0058::Visualisation description - Narrative description about visualisation.
- at0059::Quality of visualisation - Levels quantifying the quality of each acquisition, based in the ease to visualize the structures on the eye fundus.
- at0060::Quality inadequate for any diagnostic purpose - *
- at0061::Unable to exclude all emergent findings - *
- at0062::Only able to exclude emergent findings - *
- at0063::Quality not ideal, but is possible to exclude subtle findings - *
- at0064::Ideal quality - *
- at0067::Field angle - Describes the optical acceptance angle of the lens used during the test.
- at0068::30° - 30° angle used for small pupil (SP) capture (for patients with pupil diameter <3.3mm).
- at0069::45° - 45° angle used to acquire eye fundus of normal pupils.
- at0070::100° - Wide angle acquisition.
- at0071::200° - Ultra-wide angle acquisition.
- at0072::Attempts - Number of attempts before obtaining the acquisition (doesn't compute if test is repeated by a specific recognized technical failure).
- at0073::Subdivision of the retina - Subdivision of the retina identifying eye fundus image locations.
- at0074::ETRDS fields - Subdivision of the retina based on Diabetic Retinopathy Study fields.
- at0075::Study field 1 - *
- at0076::Study field 2 - *
- at0077::Study field 3 - *
- at0078::Study field 4 - *
- at0079::Study field 5 - *
- at0080::Study field 6 - *
- at0081::Study field 7 - *
- at0082::Mosaic and peripherals - Division of the retina in quadrants + mosaic obtained from the combination of them.
- at0083::Mosaic - Mosaic obtained from combining every peripheral acquisitions and the center one.
- at0084::Central - Image centered on the macula.
- at0085::Nasal - Image centered on the optic nerve or papila.
- at0086::Temporal - Image centered on the temporal quadrant of the retina.
- at0087::Superior - Image centered on the superior half of the retina.
- at0088::Inferior - Image centered on the inferior half of the retina.
- at0089::Device details - Details of the device used to acquire eye fundus images.
- at0090::Macula description - Narrative description about the macula.
- at0091::Optic disc description - Narrative description about the optic disc.

- at0092::Retinal arteries description - Narrative description about the retinal arteries.
- at0093::Retinal veins description - Narrative description about the retinal veins.
- at0094::Retinal background description - Narrative description about the retinal background.
- at0098::Vitreous description - Narrative description about the vitreous humour.
- at0122::60° - 60° angle used to acquire eye fundus in some DR screening studies.
- at0123::High refraction - True if the refraction of the eye exceeds the range from -12D to +15D.
- at0124::Uncooperative patient - True if patient doesn't collaborate during the image acquisition.
- at0126::Comment - Additional narrative about the physical examination findings, not captured in other fields.
- at0129::Mydriatic retinography - Observation of retina through funduscopic images acquired by previous dilatation of patient's pupils.
- at0130::Non-mydriatic retinography - Observation of retina through funduscopic images acquired without previous dilatation of patient's pupils.
- at0131::Contact lens biomicroscopy - Eye fundus viewing through biomicroscopy lens in contact to patient's eye surface.
- at0132::Non-contact lens biomicroscopy - Eye fundus viewing through biomicroscopy lens without contact to patient's eye surface.
- at0135::Angiography - Observation of the eye fundus using a fluorescent dye injected to emphasize the blood vessels in the eye retina.
- at0136::Test Result - Details of the funduscopic examination test result for each eye.
- at0137::Left eye - The left eye was examined.
- at0138::Right eye - The right eye was examined.
- at0139::Additional findings - Additional structured details about the physical examination findings.
- at0140::Confounding factors - Narrative description of factors, not recorded elsewhere, that may influence the clinical findings.
- at0141::Examination not done - Details to explicitly record that this examination was not performed.
- at0142::Multimedia representation - Digital image, video or diagram representing the physical examination findings.
- at0143::Clinical interpretation - Single word, phrase or brief description that represents the clinical meaning and significance of the physical examination findings for the eye examined.
- at0144::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

gad_7_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.gad_7_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results and total score of the GAD-7 scale.

****Use:**** Use to record the results and total score of the GAD-7 scale.

****Concepts:****

- at0000::GAD-7 score - Generalized Anxiety Disorder 7-item (GAD-7) scale recording the experience of anxiety related symptoms in the previous two weeks.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tree - @ internal @
- at0005::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0006::Tree - @ internal @
- at0007::Confounding factors - Record any issues or factors that may impact on the score or it's interpretation.
- at0008::Feeling nervous, anxious or on edge - Over the last 2 weeks, on how many days have you felt nervous, anxious or on edge?
- at0009::Not at all - The patient reports that they have not felt nervous, anxious or on edge at all over the last 2 weeks.
- at0010::Several days - The patient reports that they have felt nervous, anxious or on edge several days over the last 2 weeks.
- at0011::More than half the days - The patient reports that they have felt nervous, anxious or on edge more than half the days over the last 2 weeks.
- at0012::Nearly every day - The patient reports that they have felt nervous, anxious or on edge over the last 2 weeks.
- at0013::Not being able to stop or control worrying - Over the last 2 weeks, on how many days have you not been able to stop or control worrying?
- at0014::Not at all - The patient reports that they have not at all been affected by not being able to stop or control worrying over the last 2 weeks.
- at0015::Several days - The patient reports that they have not been able to stop or control worrying several days over the last 2 weeks.

- at0016::More than half the days - The patient reports that they have not been able to stop or control worrying more than half the days over the last 2 weeks.
- at0017::Nearly every day - The patient reports that they have not been able to stop or control worrying nearly every day over the last 2 weeks.
- at0018::Worrying too much about different things - Over the last 2 weeks, on how many days have you been worrying too much about different things?
- at0019::Not at all - The patient reports that they have not at all been affected by worrying too much about different things over the last 2 weeks.
- at0020::Several days - The patient reports that they have been worrying too much about different things several days over the last 2 weeks.
- at0021::More than half the days - The patient reports that they have been worrying too much about different things more than half the days over the last 2 weeks.
- at0022::Nearly every day - The patient reports that they have been worrying too much about different things nearly every day over the last 2 weeks.
- at0023::Trouble relaxing - Over the last 2 weeks, on how many days have you had trouble relaxing?
- at0024::Not at all - The patient reports that they have not at all had trouble relaxing over the last 2 weeks.
- at0025::Several days - The patient reports that they have had trouble relaxing several days over the last 2 weeks.
- at0026::More than half the days - The patient reports that they have had trouble relaxing more than half the days over the last 2 weeks.
- at0027::Nearly every day - The patient reports that they have had trouble relaxing nearly every day over the last 2 weeks.
- at0028::Being so restless it is hard to sit still - Over the last 2 weeks, on how many days have you been so restless it is hard to sit still?
- at0029::Not at all - The patient reports that they have not at all been affected by being so restless it is hard to sit still over the last 2 weeks.
- at0030::Several days - The patient reports that they had been so restless it is hard to sit still several days over the last 2 weeks.
- at0031::More than half the days - The patient reports that they had been so restless it is hard to sit still more than half the days over the last 2 weeks.
- at0032::Nearly every day - The patient reports that they had been so restless it is hard to sit still nearly every day over the last 2 weeks.
- at0033::Becoming easily annoyed or irritable - Over the last 2 weeks, on how many days have you become easily annoyed or irritable?
- at0034::Not at all - The patient reports that they have not at all been affected by becoming easily annoyed or irritable over the last 2 weeks.
- at0035::Several days - The patient reports that they have become easily annoyed or irritable several days over the last 2 weeks.
- at0036::More than half the days - The patient reports that they have become easily annoyed or irritable more than half the days over the last 2 weeks.

- at0037::Nearly every day - The patient reports that they have become easily annoyed or irritable nearly every day over the last 2 weeks.
- at0038::Feeling afraid as if something awful might happen - Over the last 2 weeks, on how many days have you felt afraid as if something awful might happen?
- at0039::Not at all - The patient reports that they have not at all been affected by feeling afraid as if something awful might happen over the last 2 weeks.
- at0040::Several days - The patient reports that they have felt afraid as if something awful might happen several days over the last 2 weeks.
- at0041::More than half the days - The patient reports that they have felt afraid as if something awful might happen more than half the days over the last 2 weeks.
- at0042::Nearly every day - The patient reports that they have felt afraid as if something awful might happen nearly every day over the last 2 weeks.
- at0043::Total score - Total GAD-7 score calculated from sum of all seven individual responses.

[gestation_assertion](#)

Archetype ID: openEHR-EHR-OBSERVATION.gestation_assertion.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: nb, en

Purpose: To record the estimated or known duration of an active pregnancy at a point in time.

Use: To record the estimated or known duration of an active pregnancy at a point in time, especially to provide clinical context for associated pregnancy-related findings or assessments. For example: in the context of an antenatal consultation, an assertion by the clinician that the history, findings, assessments and plans were recorded on the basis of an assertion that the gestation of the pregnancy was 32 weeks.

Misuse: Not to record the historical gestational age of the fetus at or after birth. This is recorded in the CLUSTER.birth_detail.

Keywords: gestation, gestational age, conceptional age

Concepts:

- at000::Gestation assertion - A statement or declaration by a clinician about the estimated or known duration of an active pregnancy at a specific point-in-time, usually based on EDD estimations and used as the basis for clinical decision-making.
- at0001::Event Series - @ internal @
- at0002::Date of measurement - The date and time of the measurement of gestation.
- at0003::Tree - @ internal @
- at0004::Gestational age - Estimated duration of an active pregnancy.
- at0005::Fetal age - Calculated duration of an active pregnancy based on a known date/time of conception.
- at0006::Gestational age basis - The rationale underpinning the calculation of gestational age.
- at0007::Ultrasound - first trimester - An ultrasound done before 14 weeks gestation.
- at0008::Ultrasound - second trimester - An ultrasound done between 14 and 28 weeks gestation.
- at0009::Ultrasound - third trimester - An ultrasound done greater than 28 weeks gestation.
- at0010::Onset of Last Menstrual Period (LMP) - The date of the first day of the last menstruation.
- at0011::Date of conception - The date of conception is known.
- at0012::Uterine examination - first trimester - The size of the uterus before 14 weeks gestation.
- at0013::Uterine examination - second trimester - The fundal height measured between 14 and 28 weeks gestation.
- at0014::Uterine examination - third trimester - The fundal height after 28 weeks gestation.
- at0015::Date of first positive pregnancy test - Date of first positive pregnancy test, ideally involving serial pregnancy tests with a known sensitivity.
- at0016::Expected Date of Delivery (EDD) - Calculated back from the agreed or active EDD.
- at0017::Tree - @ internal @
- at0019::Comment - Narrative description about the assertion of gestation, not captured in other fields.
- at0020::Trimester - Duration of pregnancy grouped into 12-14 week intervals.
- at0021::First trimester - First day of last normal menstrual period until the end of week 12 of a pregnancy.
- at0022::Second trimester - Beginning of week 13 to the end of week 28 of a pregnancy.
- at0023::Third trimester - Beginning of week 29 until birth.

[glasgow_coma_scale](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.glasgow_coma_scale.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

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

****Purpose:**** To record clinical responses of an adult to defined stimuli as an objective assessment of the level of consciousness.

****Use:**** Use to record clinical responses of an adult to defined stimuli as an objective assessment of the level of consciousness. It is commonly used to establish a baseline conscious state and neurological function assessment and/or to detect patients who may require immediate medical intervention. The Glasgow coma scale has three subscales E (eye), V (verbal) and M (motor). In clinical practice all three subscales are reported individually plus the 'Total score', if applicable. A recorded response for each of E, V and M is mandatory. If a response cannot be tested, then the 'Not Applicable' null flavour should be recorded; do not use the 'None' ordinal value to record a missing component. Details about the reason for not being able to test a response can be recorded in the 'Confounding factors' data element. The 'Total score' can be derived as the sum of the recorded eye, motor and verbal response scores. It is not appropriate to report a 'Total score' when one or more components are not testable because the score will be artificially low - in this situation record the EVM profile instead. The three response values are considered separately as well as their sum. The 'EVM profile' can be derived as a concatenation of each of the recorded eye, motor and verbal response scores. For example, E3 V4 M2 represents the conscious state of a subject who opens eyes to speech, utters incomprehensible sounds and has an extensor response to stimulation. The minimum possible 'Total score' value is 3 (equivalent to E1 V1 M1) and the maximum possible is 15 (equivalent to E4 V5 M6). In practical use, Glasgow coma scale is recorded as one component of clinical monitoring, using sequential and repeated point-in-time measurements. Date and time should be recorded for each measurement, as well as any factors that may influence interpretation of changes. Changes in 'Total score' or any E, V or M values may have as much clinical significance as the value recorded initially.

****Misuse:**** Not to be used for assessing infants and young children - use OBSERVATION.glasgow_coma_scale_paediatric for this purpose to ensure that the eye, motor and verbal response choices are appropriate for the age and ability of the child.

****Keywords:**** response, motor, verbal, eye, stimulus, glasgow, coma, scale, neurological, responsiveness, EMV, conscious, GCS, trauma, central nervous system, consciousness

****Concepts:****

- at0000::Glasgow Coma Scale (GCS) - Fifteen point scale used to assess impairment of consciousness in response to defined stimuli.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0007::Best verbal response (V) - Best verbal response to test stimulus.
- at0008::Best motor response (M) - Best motor response to test stimulus.
- at0009::Best eye response (E) - Best response of eyes to test stimulus.
- at0010::None - No eye opening at any time, no interfering factor. For example: eyes closed by local swelling.
- at0011::To pressure - Eyes opening after finger tip stimulus.
- at0012::To sound - Eyes opening after spoken or shouted request. Not to be confused with wakening of a sleeping person.
- at0013::Spontaneous - Eyes open before stimulus.
- at0014::None - No audible response, no interfering factor. For example: intubation; profound deafness.
- at0015::Sounds - Only moans/groans.
- at0016::Words - Intelligible single words.
- at0017::Confused - Not orientated but communicates coherently.
- at0018::Orientated - Correctly gives name, place and date.
- at0019::None - No movement in arms/legs, no interfering factor. For example: paralysed.
- at0020::Extension - Decerebrate extension of arms and/or legs in response to stimuli. For example: extends arm at elbow.
- at0021::Abnormal flexion - Slow, decorticate flexion of arms and/or legs. For example: bends arm at elbow, but features predominantly abnormal.
- at0022::Normal flexion - Rapid flexion in response to stimuli but features predominantly normal. For example: flexion of wrist when supra-orbital pressure applied; pulls part of body away when nailbed pinched.
- at0023::Localising - Purposeful flexion towards painful stimuli. For example: brings hand above the clavicle when supra-orbital pressure is applied.
- at0024::Obey commands - Follows verbal request for movement.
- at0026::Total score - The sum of the ordinal scores recorded for each of the three component responses.
- at0030::EVM profile - Alternative assessment to 'Total Score' where the Eye Verbal Motor profile is expressed as three discrete components.
- at0037::Comment - Additional narrative about the measurement of the scale not captured in other fields.
- at0038::Tree - @ internal @
- at0039::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

- at0040::Tree - @ internal @
- at0041::Confounding factors - Narrative record of factors that may have contributed to the GCS scores.

[glasgow_coma_scale_paediatric](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.glasgow_coma_scale_paediatric.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record clinical responses of the child or infant to defined stimuli as an objective assessment of the level of consciousness that is also appropriate for age and ability.

****Use:**** Use to record clinical responses of the child or infant to defined stimuli as an objective assessment of the level of consciousness that is also appropriate for age and ability. It is commonly used to establish a baseline conscious state and neurological function assessment and/or to detect patients who may require immediate medical intervention. The Glasgow coma scale has three subscales E (eye), V (verbal) and M (motor). In clinical practice all three subscales are reported individually plus the 'Total score', if applicable. A recorded response for each of E, V and M is mandatory. If a response cannot be tested, then the 'Not Applicable' null flavour should be recorded; do not use the 'None' ordinal value to record a missing component. Details about the reason for not being able to test a response can be recorded in the 'Confounding factors' data element. The 'Total score' can be derived as the sum of the recorded eye, motor and verbal response scores. It is not appropriate to report a 'Total score' when one or more components are not testable because the score will be artificially low - in this situation record the EVM profile instead. The three response values are considered separately as well as their sum. The 'EVM profile' can be derived as a concatenation of each of the recorded eye, motor and verbal response scores. For example, E3 V4 M2 represents the conscious state of a subject who opens eyes to speech, utters incomprehensible sounds and has an extensor response to stimulation. The minimum possible 'Total score' value is 3 (equivalent to E1 V1 M1) and the maximum possible is 15 (equivalent to E4 V5 M6). In practical use, Glasgow coma scale is recorded as one component of clinical monitoring, using sequential and repeated point-in-time measurements. Date and time should be recorded for each measurement, as well as any factors that may influence interpretation of changes. Changes in 'Total score' or any E, V or M values may have as much clinical significance as the value recorded initially.

****Misuse:**** Not to be used for assessing adults - use OBSERVATION.glasgow_coma_scale for this purpose.

****Keywords:**** response, motor, verbal, eye, stimulus, glasgow, coma, scale, neurological, responsiveness, EMV, conscious, GCS, trauma, central nervous system, consciousness

****Concepts:****

- at0000::Paediatric Glasgow Coma Scale (pGCS) - Fifteen point scale used to assess impairment of consciousness in response to defined stimuli in a child or infant.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0007::Best verbal response (V) - Best verbal response to test stimulus.
- at0008::Best motor response (M) - Best motor response to test stimulus.
- at0009::Best eye response (E) - Best response of eyes to test stimulus.
- at0010::None - No response to any stimulus and no interfering factors. For example: eyes physically closed due to local swelling.
- at0011::To pain - Eyes opening in response to pain only.
- at0012::To sound - Eyes opening after verbal stimuli. Not to be confused with wakening of a sleeping person.
- at0013::Spontaneous - Eyes open before stimulus.
- at0014::None - No verbal response and no interfering factor. For example: intubation or profound deafness.
- at0015::Child: Sounds OR Infant: Moans in response to pain - Child makes incomprehensible words or non-specific sounds; Infant moans in response to pain.
- at0016::Child: Words OR Infant: Cries in response to pain - Child makes intelligible single words; Infant cries in response to pain.
- at0017::Child: Confused OR Infant: Irritable cries - Child is not orientated but communicates; Infant cries irritably.
- at0018::Child: Orientated OR Infant: Coos and babbles - Child oriented and appropriate; Infant coos or babbles as normal.
- at0019::None - No movement in arms/legs and no interfering factor. For example: paralysis.
- at0020::Abnormal extension - Decerebrate extension of arms and/or legs in response to stimuli. For example: extending arm at elbow.
- at0021::Abnormal flexion - Slow, decorticate flexion of arms and/or legs. For example: bends arm at elbow, but features predominantly abnormal.
- at0022::Normal flexion - Withdraws in response to pain. For example: flexion of wrist when supra-orbital pressure applied; pulls part of body away when nailbed pinched.
- at0023::Localising - Withdraws to touch. For example: brings hand above the clavicle when supra-orbital pressure is applied.

- at0024::Child: obeys commands OR Infant: Moves spontaneously and purposefully - Child follows verbal request for movement; Infant moves as expected.
- at0026::Total score - The sum of the ordinal scores recorded for each of the three component responses.
- at0030::EVM profile - Alternative assessment to 'Total Score' where the Eye Verbal Motor profile is expressed as three discrete components.
- at0037::Comment - Additional narrative about the measurement of the scale not captured in other fields.
- at0038::Tree - @ internal @
- at0039::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0040::Tree - @ internal @
- at0041::Confounding factors - Narrative record of factors that may have contributed to the GCS scores.

[glasgow_outcome_scale_extended](#)

Archetype ID: openEHR-EHR-OBSERVATION.glasgow_outcome_scale_extended.v1

Lifecycle State: published

Category: OBSERVATION

Languages: nb, en

Purpose: To record the result for each component parameter and the total score for Glasgow Outcome Scale - Extended.

Use: Use to record the result for each component parameter and the total score for Glasgow Outcome Scale - Extended. A valid outcome of a GOSE assessment is that the 'Category' will have no result. The ordinal '99' in some elements is intended to represent an unscored value, and any Category calculation should take this into account. The 'Category' data element should remain empty if the lowest recorded ordinal value is '99'.

Keywords: Head injury, trauma, outcome, function, activity

Concepts:

- at0000::Glasgow Outcome Scale - Extended (GOSE) - A scale for assessing outcome after head injury and non-traumatic acute brain insults.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.

- at0003::Tree - @ internal @
- at0004::Date of injury - None
- at0005::Age at injury - None
- at0006::Interval post-injury - None
- at0008::Consciousness - None
- at0010::Independence in the home - None
- at0011::1. Is the head injured person able to obey simple commands, or say any words? - None
- at0012::2a Is the assistance of another person at home essential every day for some activities of daily living? - None
- at0013::2b Do they need frequent help or someone to be around at home most of the time? - None
- at0014::2c Was the assistance at home essential before the injury? - None
- at0015::Independence outside the home - None
- at0016::3a Are they able to shop without assistance? - None
- at0017::3b Were they able to shop without assistance before the injury? - None
- at0018::4a Are they able to travel locally without assistance? - None
- at0019::4b Were they able to travel without assistance before the injury? - None
- at0020::Work - None
- at0022::5a Are they currently able to work to their previous capacity? - None
- at0023::5b How restricted are they? - None
- at0024::5c Were they either working or seeking employment before the injury (answer 'yes') or were they doing neither (answer 'no')? - None
- at0025::Social & leisure activities - None
- at0026::6a Are they able to resume regular social and leisure activities outside home? - None
- at0027::6b What is the extent of restriction on their social and leisure activities? - None
- at0028::6c Did they engage in regular social and leisure activities outside home before the injury? - None
- at0029::Family & friendships - None
- at0030::7a Have there been psychological problems which have resulted in ongoing family disruption or disruption to friendships? - None
- at0031::7b What has been the extent of disruption or strain? - None
- at0032::7c Were there problems with family or friends before the injury? - None
- at0033::Return to normal life - None
- at0034::8a Are there any other current problems relating to the injury which affect daily life? - None
- at0036::Category - The overall rating based on the lowest outcome value indicated on the scale.
- at0037::Respondent - None
- at0038::Patient alone - None
- at0039::Relative/friend/carer alone - None

- at0040::Patient + relative/friend/carer - None
- at0041::No - None
- at0042::Yes - None
- at0043::No - None
- at0044::Yes - None
- at0045::No - None
- at0046::Yes - None
- at0047::No - None
- at0048::Yes - None
- at0049::No - None
- at0050::Yes - None
- at0051::No - None
- at0052::Yes - None
- at0053::No - None
- at0054::Yes - None
- at0055::No - None
- at0056::Yes - None
- at0057::No - None
- at0058::Yes - None
- at0059::Reduced work capacity. - None
- at0060::Able to work only in a sheltered workshop or non-competitive job, or currently unable to work. - None
- at0061::No - None
- at0062::Yes - None
- at0063::No - None
- at0064::Yes - None
- at0065::Participate a bit less: at least half as often as before injury. - None
- at0066::Participate much less: less than half as often. - None
- at0067::Unable to participate: rarely, if ever, take part. - None
- at0068::No - None
- at0069::Yes - None
- at0070::No - None
- at0071::Yes - None
- at0072::Occasional - less than weekly - None
- at0073::Frequent - once a week or more, but tolerable. - None
- at0074::Constant - daily and intolerable. - None
- at0075::No - None
- at0076::Yes - None
- at0077::No - None
- at0078::Yes - None
- at0081::Dead - None
- at0082::Vegetative state - None

- at0083::Lower severe disability - None
- at0084::Upper severe disability - None
- at0085::Lower moderate disability - None
- at0086::Upper moderate disability - None
- at0087::Lower good recovery - None
- at0088::Upper good recovery - None
- at0089::8b Were similar problems present before the injury? - None
- at0090::No - None
- at0091::Yes - None
- at0092::Since the injury has the head injured person had any epileptic fits? - None
- at0093::Have they been told that they are currently at risk of developing epilepsy? - None
- at0094::What is the most important factor in outcome? - None
- at0095::Item tree - @ internal @
- at0096::No - None
- at0097::Yes - None
- at0098::No - None
- at0099::Yes - None
- at0100::Effects of head injury - None
- at0101::Effects of illness or injury to another part of the body - None
- at0102::A mixture of these - None

gpaq

****Archetype ID:**** openEHR-EHR-OBSERVATION.gpaq.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the responses to the WHO Global Physical Activity Questionnaire.

****Use:**** Use to record the responses to the WHO Global Physical Activity Questionnaire.

****Concepts:****

- at0000::Global Physical Activity Questionnaire (GPAQ) - WHO surveillance tool to assess levels of physical activity.
- at0001::History - @ internal @

- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::1. Work - Vigorous activity? - Does your work involve vigorous-intensity activity that causes large increases in breathing or heart rate for at least 10 minutes continuously?
- at0005::2. Work - Vigorous activity/week - In a typical week, on how many days do you do vigorous-intensity activities as part of your work?
- at0006::3. Work - Vigorous activity/day - How much time do you spend doing vigorous-intensity activities at work on a typical day?
- at0007::4. Work - Moderate activity? - Does your work involve moderate-intensity activity that causes small increases in breathing or heart rate for at least 10 minutes continuously?
- at0008::5. Work - Moderate activity/week - In a typical week, on how many days do you do moderate-intensity activities as part of your work?
- at0009::6. Work - Moderate activity/day - How much time do you spend doing moderate-intensity activities at work on a typical day?
- at0010::7. Travel activity? - Do you walk or use a bicycle for at least 10 minutes continuously to get to and from places?
- at0011::8. Travel/week - In a typical week, on how many days do you walk or bicycle for at least 10 minutes continuously to get to and from places?
- at0023::9. Travel/day - How much time do you spend walking or bicycling for travel on a typical day?
- at0024::10. Leisure - Vigorous activity? - Do you do any vigorous-intensity sports, fitness or recreational activities that cause large increases in breathing or heart rate for at least 10 minutes continuously?
- at0025::11. Leisure - Vigorous activity/week - In a typical week, on how many days do you do vigorous-intensity sports, fitness or recreational activities?
- at0026::12. Leisure - Vigorous activity/day - How much time do you spend doing vigorous-intensity sports, fitness or recreational activities on a typical day?
- at0027::13. Leisure - Moderate activity? - Do you do any moderate-intensity sports, fitness or recreational activities that causes a small increase in breathing or heart rate for at least 10 minutes continuously?
- at0028::14. Leisure - Moderate activity/week - In a typical week, on how many days do you do moderate-intensity sports, fitness or recreational activities?
- at0029::15. Leisure - Moderate activity/day - How much time do you spend doing moderate-intensity sports, fitness or recreational activities on a typical day?
- at0030::16. Sedentary/day - How much time do you usually spend sitting or reclining on a typical day?
- at0031::Yes - *
- at0032::No - *

gpcog_screening_test

****Archetype ID:**** openEHR-EHR-OBSERVATION.gpcog_screening_test.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Recording of the General Practitioner Assessment of Cognition (GPCOG) screening test. This test was designed as a GP screening tool for dementia. There are two components: a cognitive assessment conducted with the patient, and an informant questionnaire (only considered necessary if the results of the cognitive section are equivocal, i.e. score 5-8 inclusive). Results > 8 or < 5 on the GPCOG patient section were assumed to be cognitively intact or impaired, respectively. For patients requiring a informant questionnaire, scores of 3 or less out of 6 in this section indicates cognitive impairment.

****Use:**** To record the results of the General Practitioner Assessment of Cognition (GPCOG) screening test.

****Keywords:**** GPCOG, screening, dementia, cognitive, impairment

****Concepts:****

- at0000::GPCOG screening test - The General Practitioner Assessment of Cognition (GPCOG) screening test.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tree - @ internal @
- at0005::Confounding factors - Narrative record of factors that may have contributed to the score.
- at0006::Tree - @ internal @
- at0007::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0008::Time orientation - Statement whether the patient gives a correct or incorrect answer when asked to give the exact date today.
- at0009::Incorrect - The patient gives an incorrect answer.
- at0010::Correct - The patient gives the correct answer.

- at0011::Clock drawing - all numbers - Statement whether or not the patient marks all the correct numbers to indicate the hours of the clock with the correct spacing.
- at0012::Incorrect - The patient does not mark all the correct numbers to indicate the hours of the clock with the correct spacing.
- at0013::Correct - The patient marks all the correct number to indicate the hours of the clock with the correct spacing.
- at0014::Clock drawing - specific time - Statement whether the patient correctly marks in hands a specified time (i.e. 10 minutes past 11 o'clock) on a clock face.
- at0015::Incorrect - The patient does not correctly mark in hands a specified time (11.10) on a clock face.
- at0016::Correct - The patient correctly marks in hands a specified time (11.10) on a clock face.
- at0017::Information - Statement whether the patient gives a correct and specific answer when asked to say something that happened in the news recently. Recently = in the last week. If a general answer is given, e.g. "lot of rain", "war", further details should be asked for.
- at0018::Incorrect - Patient does not give specific and correct answer when asked to say something that happened in the news recently.
- at0019::Correct - Patient gives specific and correct answer when asked to say something that happened in the news recently.
- at0020::Recall first name - Statement whether patient correctly recalls first name of name and address phrase given at the start of the test.
- at0021::Incorrect - Patient does not correctly recall first name of name and address phrase given at the start of the test.
- at0022::Correct - Patient correctly recalls first name of name and address phrase given at the start of the test.
- at0023::Recall surname - Statement whether patient correctly recalls surname of name and address phrase given at the start of the test.
- at0024::Incorrect - Patient does not correctly recall surname of name and address phrase given at the start of the test.
- at0025::Correct - Patient correctly recalls surname of name and address phrase given at the start of the test.
- at0027::Recall house number - Statement whether patient correctly recalls house number of name and address phrase given at the start of the test.
- at0028::Incorrect - Patient does not correctly recall house number of name and address phrase given at the start of the test.
- at0029::Correct - Patient correctly recalls house number of name and address phrase given at the start of the test.
- at0030::Recall street name - Statement whether patient correctly recalls street name of name and address phrase given at the start of the test.
- at0031::Incorrect - Patient does not correctly recall street name of name and address phrase given at the start of the test.

- at0032::Correct - Patient correctly recalls street name of name and address phrase given at the start of the test.
- at0033::Recall locality or town - Statement whether patient correctly recalls locality or town of name and address phrase given at the start of the test.
- at0034::Incorrect - Patient does not correctly recall locality or town of name and address phrase given at the start of the test.
- at0035::Correct - Patient correctly recalls locality or town of name and address phrase given at the start of the test.
- at0036::Total score - The total score from all nine individual scores. If patient scores 9, no significant cognitive impairment and further testing not necessary. If patient scores 5-8, more information required. Proceed with Step 2, informant section. If patient scores 5-8, more information required. Proceed with Step 2, informant section.
- at0037::Trouble remembering - Statement whether, compared to a few years ago, the patient has more trouble remembering things that have happened recently than he/she used to.
- at0038::Step 1: patient examination - Step 1 of the GPCOG screening test, relating to the patient examination.
- at0039::Step 2: informant interview - Step 2 of the GPCOG screening test, relating to the informant interview. This section is required if the total score from Step 1 is between 5 and 8.
- at0040::Yes - The patient has more trouble remembering things that have happened recently than he/she used to.
- at0041::No - The patient does not have more trouble remembering things that have recently happened than he/she used to.
- at0042::Don't know - The informant doesn't know whether the patient has more trouble remembering things that have happened recently than he/she used to.
- at0043::Trouble recalling conversations - Statement whether, compared to a few years ago, the patient has more trouble recalling conversations a few days later.
- at0044::Yes - The patient has trouble recalling conversations a few days later.
- at0045::No - The patient does not have trouble recalling conversations a few days later.
- at0046::Don't know - The informant doesn't know whether the patient has trouble recalling conversations a few days later.
- at0047::Difficulty finding right words or using wrong words - Statement whether, compared to a few years ago, the patient, when speaking, has more difficulty in finding the right words or tends to use the wrong words more often.
- at0048::Yes - When speaking, the patient has difficulty in finding the right words or tends to use the wrong words more often.
- at0049::No - When speaking, the patient does not have difficulty in finding the right words and does not tend to use the wrong words more often.
- at0050::Don't know - The informant doesn't know whether the patient, when speaking, has more difficulty in finding the right words or tends to use the wrong words more often.

- at0051::Less able to manage money - Statement whether, compared to a few years ago, the patient is less able to manage money and financial affairs (e.g. paying bills, budgeting).
- at0052::Yes - The patient is less able to manage money and financial affairs.
- at0053::No - The patient is not less able to manage money and financial affairs.
- at0054::Don't know - The informant doesn't know whether the patient is less able to manage money and financial affairs.
- at0055::Not applicable - The question of whether the patient is less able to manage money or financial affairs is not applicable to this patient.
- at0056::Less able to manage medication - Statement whether, compared to a few years ago, the patient is less able to manage his/her medication independently.
- at0057::Yes - The patient is less able to manage his/her medication independently.
- at0058::No - The patient is not less able to manage his/her medication independently.
- at0059::Don't know - The informant doesn't know whether the patient is less able to manage his/her medication independently.
- at0060::Not applicable - The question whether the patient is less able to manage his/her medication independently is not relevant to this patient.
- at0061::Needs more assistance with transport - Statement whether, compared to a few years ago, the patient needs more assistance with transport (either private or public). If patient has difficulties only due to physical problems, e.g. bad leg, 'No' should be selected.
- at0062::Yes - The patient needs more assistance with transport.
- at0063::No - The patient does not need more assistance with transport.
- at0064::Don't know - The informant doesn't know whether the patient needs more assistance with transport.
- at0065::Not applicable - The question whether the patient needs more assistance with transport is not applicable to this patient.
- at0066::Total score - To get the total score, add the number of items answered 'No', 'Don't know' or 'Not applicable'. A total score of 0-3 indicates cognitive impairment, and standard investigations should be conducted.

grace_admission

****Archetype ID:**** openEHR-EHR-OBSERVATION.grace_admission.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To record the results for each component parameter, the total sum and grade for the GRACE score recorded at presentation or on admission.

****Use:**** Use to record the results for each component parameter, the total sum and grade for the GRACE score recorded at presentation or on admission.

****Misuse:**** Not to be used to record details about the followup GRACE score recorded at discharge - use the OBSERVATION.grace_discharge for this purpose. Not to be used to record details about the GRACE 2.0 score.

****Keywords:**** GRACE, ACS, Risk, score, STEMI, NSTEMI, ACS, Acute Coronary Syndrome, cardiology

****Concepts:****

- at0000::GRACE score (admission) - The original 8 variable version of an assessment tool used to risk stratify patients diagnosed with Acute Coronary Syndrome - specifically to estimate their risk of death in-hospital and up to 6 months after the ACS event.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Age - Age at admission.
- at0005::Heart rate - Category of heart rate on admission.
- at0006::Systolic blood pressure - Category of systolic blood pressure on admission.
- at0007::Creatinine level - Category of creatinine measurement on admission.
- at0008::Cardiac arrest at admission - Resuscitated after cardiac arrest at admission.
- at0009::ST segment deviation on ECG - ST segment deviation on admission.
- at0010::Elevated/abnormal cardiac enzymes - Cardiac enzymes out of normal range on admission.
- at0011::Killip class - Killip Classification at admission.
- at0012::Total score - Sum of points assigned for each of the component parameters.
- at0014::≤ 30 years - Patient is aged ≤ 30 years.
- at0015::30-39 years - Patient is aged 30-39 years.
- at0016::40-49 years - Patient is aged 40-49 years.
- at0017::50-59 years - Patient is aged 50-59 years.
- at0018::60-69 years - Patient is aged 60-69 years.
- at0019::70-79 years - Patient is aged 70-79 years.
- at0020::80-89 years - Patient is aged 80-89 years.
- at0021::≥ 90 years - Patient is aged ≥ 90 years.
- at0022::≤ 50 bpm - Less than 50 beats per minute.
- at0023::50-69 bpm - Between 50 and 69 beats per minute.
- at0024::70-89 bpm - Between 70 and 89 beats per minute.
- at0025::90-109 bpm - Between 90 and 109 beats per minute.

- at0026::110-149 bpm - Between 110 and 149 beats per minute.
- at0027::150-199 bpm - Between 150 and 199 beats per minute.
- at0028::≥ 200 bpm - Greater than 200 beats per minute.
- at0029::≥ 200 mmHg - Greater than 200 mmHg.
- at0030::160-199 mmHg - Between 160 and 199 mmHg.
- at0031::140-159 mmHg - Between 140 and 159 mmHg.
- at0032::120-139 mmHg - Between 120 and 139 mmHg.
- at0033::100-119 mmHg - Between 100 and 119 mmHg.
- at0034::80-99 mmHg - Between 80 and 99 mmHg.
- at0035::≤ 80 mmHg - Less than 80 mmHg.
- at0036::NA - Not available.
- at0037::0-0.39 mg/dL - Between 0 and 0.39 mg/dL.
- at0038::0.4-0.79 mg/dL - Between 0.4 and 0.79 mg/dL.
- at0039::0.8-1.19 mg/dL - Between 0.8 and 1.19 mg/dL.
- at0040::1.20-1.59 mg/dL - Between 1.20 and 1.59 mg/dL.
- at0041::1.60-1.99 mg/dL - Between 1.60 and 1.99 mg/dL.
- at0042::2.00-3.99 mg/dL - Between 2.00 and 3.99 mg/dL.
- at0043::> 4.0 mg/dL - Greater than 4.0 mg/dL.
- at0044::No - No cardiac arrest on admission.
- at0045::Yes - Cardiac arrest on admission.
- at0046::No - No ST segment deviation observed on ECG.
- at0047::Yes - ST segment deviation observed on ECG.
- at0048::No - Cardiac enzymes in normal range.
- at0049::Yes - Cardiac enzymes not in normal range.
- at0050::Class 1 - No clinical signs of heart failure.
- at0051::Class 2 - Rales or crackles in the lungs, an S3, and elevated jugular venous pressure.
- at0052::Class 3 - Acute pulmonary oedema.
- at0053::Class 4 - Cardiogenic shock or hypotension (measured as systolic blood pressure lower than 90 mmHg), and evidence of peripheral vasoconstriction (oliguria, cyanosis or sweating).
- at0054::Item tree - @ internal @
- at0055::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.

grace_discharge

Archetype ID: openEHR-EHR-OBSERVATION.grace_discharge.v0

Lifecycle State: in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To record the results for each component parameter, the total sum and grade for the GRACE score recorded at or after discharge.

****Use:**** Use to record the results for each component parameter, the total sum and grade for the GRACE score recorded at or after discharge.

****Misuse:**** Not to be used to record details about the initial GRACE score recorded during admission - use the OBSERVATION.grace_admission for this purpose. Not to be used to record details about the GRACE 2.0 score.

****Keywords:**** GRACE, ACS, Risk, score, STEMI, NSTEMI, ACS, Acute Coronary Syndrome, cardiology

****Concepts:****

- at0000::GRACE score (discharge) - The original 9 variable version of an assessment tool used to risk stratify patients diagnosed with Acute Coronary Syndrome - specifically to estimate their risk of death on discharge and up to 6 months after the ACS event.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Age - Age at assessment.
- at0005::Heart rate at presentation - Category of heart rate at initial hospital presentation.
- at0006::Systolic blood pressure at presentation - Category of systolic blood pressure at initial hospital presentation.
- at0007::Creatinine level at presentation - Category of serum creatinine measurement at initial hospital presentation.
- at0009::Depressed ST segment at presentation - ST segment depression at initial hospital presentation.
- at0010::Elevated cardiac enzymes or markers - Raised cardiac enzymes or markers during hospitalisation.
- at0011::Percutaneous revascularisation - In-hospital percutaneous coronary intervention.
- at0012::Total score - Sum of points assigned for each of the component parameters.
- at0014::≤ 30 years - Patient is aged ≤ 30 years.
- at0015::30-39 years - Patient is aged 30-39 years.
- at0016::40-49 years - Patient is aged 40-49 years.
- at0017::50-59 years - Patient is aged 50-59 years.
- at0018::60-69 years - Patient is aged 60-69 years.

- at0019::70-79 years - Patient is aged 70-79 years.
- at0020::80-89 years - Patient is aged 80-89 years.
- at0021::≥ 90 years - Patient is aged ≥ 90 years.
- at0022::≤ 50 bpm - Less than 50 beats per minute.
- at0023::50-69 bpm - Between 50 and 69 beats per minute.
- at0024::70-89 bpm - Between 70 and 89 beats per minute.
- at0025::90-109 bpm - Between 90 and 109 beats per minute.
- at0026::110-149 bpm - Between 110 and 149 beats per minute.
- at0027::150-199 bpm - Between 150 and 199 beats per minute.
- at0028::≥ 200 bpm - Greater than 200 beats per minute.
- at0029::≥ 200 mmHg - Greater than 200 mmHg.
- at0030::160-199 mmHg - Between 160 and 199 mmHg.
- at0031::140-159 mmHg - Between 140 and 159 mmHg.
- at0032::120-139 mmHg - Between 120 and 139 mmHg.
- at0033::100-119 mmHg - Between 100 and 119 mmHg.
- at0034::80-99 mmHg - Between 80 and 99 mmHg.
- at0035::≤ 80 mmHg - Less than 80 mmHg.
- at0037::0-0.39 mg/dL - Between 0 and 0.39 mg/dL.
- at0038::0.4-0.79 mg/dL - Between 0.4 and 0.79 mg/dL.
- at0039::0.8-1.19 mg/dL - Between 0.8 and 1.19 mg/dL.
- at0040::1.20-1.59 mg/dL - Between 1.20 and 1.59 mg/dL.
- at0041::1.60-1.99 mg/dL - Between 1.60 and 1.99 mg/dL.
- at0042::2.00-3.99 mg/dL - Between 2.00 and 3.99 mg/dL.
- at0043::> 4.0 mg/dL - Greater than 4.0 mg/dL.
- at0046::No - No ST segment depression observed on ECG.
- at0047::Yes - ST segment depression observed on ECG.
- at0048::No - Cardiac enzymes or markers are in the normal range.
- at0049::Yes - Cardiac enzymes or markers are raised.
- at0050::No - No intervention performed.
- at0051::Yes - Intervention performed.
- at0054::Item tree - @ internal @
- at0055::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0056::History of heart failure - Known history of congestive heart failure?
- at0057::No - No history of heart failure.
- at0058::Yes - Known history of heart failure.
- at0059::History of AMI - Known history of acute myocardial infarction?
- at0060::No - No history of AMI.
- at0061::Yes - Known history of AMI.

growth_velocity

****Archetype ID:**** openEHR-EHR-OBSERVATION.growth_velocity.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the rate of growth for common measurements, over a known period of time.

****Use:**** To record the rate of growth for common measurements, such as body length/height, head circumference and body weight, over a known period of time. The growth velocity will usually be positive, especially in childhood, although there may be circumstances where it is necessary to record a negative velocity, for example in situations of loss of height with age.

****Misuse:**** Not to be used to record the actual point-in-time measurements for body length/height, head circumference and body weight. Use the appropriate OBSERVATION archetypes for this purpose - OBSERVATION.height, OBSERVATION.head_circumference or OBSERVATION.body_weight. Not to be used to record the actual change in measurements over actual, identified time periods for body length/height, head circumference and body weight. Use the interval event model and the 'Change' mathematical function in appropriate OBSERVATION archetypes for this purpose - OBSERVATION.height, OBSERVATION.head_circumference or OBSERVATION.body_weight.

****Concepts:****

- at0000::Growth velocity - The rate of growth, or change in growth measurements, over a period of time.
- at0001::Event Series - @ internal @
- at0002::Point in time event - Unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Body weight - The rate of change of body weight for an individual.
- at0005::Body length/height - The rate of change in the length or height of an individual.
- at0008::Comment - Additional narrative about the velocity measurements, not captured in other fields.
- at0009::Head circumference - The rate of change in the head circumference of an individual.
- at0010::Tree - @ internal @
- at0012::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

guss

****Archetype ID:**** openEHR-EHR-OBSERVATION.guss.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the result for each component parameter and the total sum for The Gugging Swallowing Screen (GUSS).

****Use:**** Use to record the result for each component parameter and the total sum for The Gugging Swallowing Screen (GUSS).

****Keywords:**** dysphagia, aspiration, swallowing

****Concepts:****

- at0000::The Gugging Swallowing Screen (GUSS) - The Gugging Swallowing Screen (GUSS) is a tool used to screen for dysphagia and aspiration risk.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Preliminary Investigation/Indirect Swallowing Test - None
- at0005::Vigilance - None
- at0006::Yes - None
- at0007::No - None
- at0008::Cough and/or throat clearing - None
- at0009::Yes - None
- at0010::No - None
- at0011::Swallowing successful - None
- at0012::Yes - None
- at0013::No - None
- at0014::Drooling - None
- at0015::Yes - None
- at0016::No - None
- at0017::Voice change - None
- at0018::Yes - None
- at0019::No - None

- at0020::Semisolid - Step 1 of the Direct Swallowing Test.
- at0021::Deglutition - None
- at0022::Swallowing not possible - None
- at0023::Swallowing delayed - > 2 sec (Solid textures > 10 sec).
- at0024::Swallowing successful - None
- at0025::Cough (involuntary) - None
- at0026::Yes - None
- at0027::No - None
- at0028::Drooling - None
- at0029::Yes - None
- at0030::No - None
- at0031::Voice change - None
- at0032::Yes - None
- at0033::No - None
- at0034::Sum Indirect Swallowing Test - None
- at0035::Semisolid sum - None
- at0036::Liquid - Step 2 of the Direct Swallowing Test.
- at0037::Deglutition - None
- at0038::Swallowing not possible - None
- at0039::Swallowing delayed - > 2 sec (Solid textures > 10 sec).
- at0040::Swallowing successful - None
- at0041::Cough (involuntary) - None
- at0042::Yes - None
- at0043::No - None
- at0044::Drooling - None
- at0045::Yes - None
- at0046::No - None
- at0047::Voice change - None
- at0048::Yes - None
- at0049::No - None
- at0050::Liquid sum - None
- at0051::Solid - Step 3 of the Direct Swallowing Test.
- at0052::Deglutition - None
- at0053::Swallowing not possible - None
- at0054::Swallowing delayed - > 2 sec (Solid textures > 10 sec).
- at0055::Swallowing successful - None
- at0056::Cough (involuntary) - None
- at0057::Yes - None
- at0058::No - None
- at0059::Drooling - None
- at0060::Yes - None
- at0061::No - None

- at0062::Voice change - None
- at0063::Yes - None
- at0064::No - None
- at0065::Solid sum - None
- at0066::Total sum - The sum of the Indirect Swallowing Test and the Direct Swallowing Test.
- at0067::Item tree - @ internal @
- at0068::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0069::Severity code - None
- at0070::Slight / No dysphagia with no or minimal risk of aspiration - None
- at0071::Slight dysphagia with aspiration risk - None
- at0072::Moderate dysphagia with aspiration risk - None
- at0073::Severe dysphagia with high risk of aspiration - None

guss_icu

****Archetype ID:**** openEHR-EHR-OBSERVATION.guss_icu.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the results of the Gugging Swallow Screen for Intensive Care Units.

****Use:**** Use to record the results of the Gugging Swallow Screen for Intensive Care Units.

****Keywords:**** dysphagia, aspiration, swallowing

****Concepts:****

- at0000::Gugging Swallow Screen for Intensive Care Units (GUSS - ICU) - A bedside swallowing screen for the identification of post-extubation dysphagia on the intensive care unit.
- at0001::History - @ internal @
- at0002::Any event - @ internal @
- at0003::Tree - @ internal @
- at0004::Preliminary Investigation / Indirect Swallowing Test - None
- at0005::RASS from 0 to +2 - RASS (Richmond Agitaion Sedation scale).
- at0006::Yes - None
- at0007::No - None

- at0008::Coughing and/or throat clearing efficiently - None
- at0009::Swallowing saliva possible - None
- at0010::Drooling (saliva) - None
- at0011::Change of voice after swallowing saliva - None
- at0012::Yes - None
- at0013::No - None
- at0014::Yes - None
- at0015::No - None
- at0016::Yes - None
- at0017::No - None
- at0018::Yes - None
- at0019::No - None
- at0020::Sum Indirect Swallowing Test - The sum of the Preliminary Investigation / Indirect Swallowing Test.
- at0021::Direct Swallowing Test (4 subtests) - None
- at0022::Semisolid - Give 3-5 tsp. of thickened water (IDDSI 3).
- at0023::Liquids - Give 3, 5, 10, 20, 50 ml of water (IDDSI 0).
- at0024::Solids - Give a piece of bread (1.5 x 1.5cm).
- at0025::Liquids & Solids - Give a piece of bread (1.5 x 1.5cm) and a sip of water after half of the chewing time.
- at0026::Sum Direct Swallowing Test - The sum of the Direct Swallowing Test.
- at0027::Total sum - The sum of Indirect Swallowing Test and the Direct Swallowing Test.
- at0028::Item tree - @ internal @
- at0029::Extension - None
- at0030::Severity code - None
- at0031::Severe Dysphagia with high risk of aspiration - Preliminary investigation or semisolids failed.
- at0032::Moderate dysphagia with aspiration risk - Semisolids passed, fluids failed.
- at0033::Mild dysphagia with low risk of aspiration - Semisolids passed, fluids passed, solids failed.
- at0034::Mild dysphagia with low risk of aspiration - Semisolids passed, fluids passed, solids passed, mixed textures failed.
- at0035::Stridor present - None
- at0036::Yes - None
- at0037::No - None
- at0038::Minimal/no Dysphagia; Minimal/no risk of aspiration - All textures passed.
- at0039::Pass - None
- at0040::Fail - None
- at0047::Pass - None
- at0048::Fail - None
- at0049::Pass - None

- at0050::Fail - None
- at0051::Pass - None
- at0052::Fail - None

[hannallah_pain_scale](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.hannallah_pain_scale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** es-ar, en

****Purpose:**** A numerical scale for monitoring pain in children after surgery. Also used for monitoring pain in children outside postoperative setting.

****Use:**** To be user only in patients age 8 months to 13 years.

****Misuse:**** Not to be used for patients outside the intended age range.

****Keywords:**** pain, score, blood pressure, crying, movements, agitation, Hannallah

****Concepts:****

- at0000::Hannallah Objective Pain Scale (OPS) - Numerical scale for monitoring pain in children after surgery.
- at0001::Event Series - @ internal @
- at0002::Any event - Specified point in time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Systolic blood pressure - Changes in systolic blood pressure.
- at0005::Increase < 20% of preoperative blood pressure - Increase of preoperative blood pressure below 20%.
- at0006::Increase 20-30% of preoperative blood pressure - Increase of preoperative blood pressure between 20 and 30%.
- at0007::Increase > 30% of preoperative blood pressure - Increase of preoperative blood pressure above 30%.
- at0008::Crying - Presence and degree of crying.
- at0009::Not crying - Patient not crying.
- at0010::Responds to age appropriate nurturing (tender loving care) - Patient responds to age appropriate nurturing (tender loving care).
- at0011::Does not respond to nurturing - Patient does not respond to nurturing.

- at0012::Movements - Patient's movements.
- at0013::No movements, relaxed - Patient shows no movements and/or is relaxed.
- at0014::Restless, moving about in bed constantly - Patient is restless, moving about in bed constantly.
- at0015::Thrashing (moving wildly) or rigid (stiff) - Patient thrashing (moving wildly) or rigid (stiff).
- at0016::Agitation - Presence and degree of agitation.
- at0017::Asleep or calm - Patient asleep or calm.
- at0018::Can be comforted to lessen the agitation (mild) - Patient can be comforted to lessen the agitation (mild).
- at0019::Cannot be comforted (hysterical) - Patient cannot be comforted (hysterical).
- at0020::Complaints of pain - Presence and degree of pain.
- at0021::Asleep or states no pain - Patient asleep or states no pain.
- at0022::Cannot localize - Patient cannot localize pain.
- at0023::Localizes pain - Patient localizes pain.
- at0024::Total score - Total score.
- at0025::Tree - @ internal @
- at0026::Confounding factors - Factors that may interfere with interpretation of the measurement.
- at0027::Comment - Any information not captured in the structured variables but important for adequate interpretation of the score.
- at0028::Tree - @ internal @
- at0029::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

haq

****Archetype ID:**** openEHR-EHR-OBSERVATION.haq.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** For the recording of details of the Health Assessment Questionnaire used to assess how a subject's arthritis affects his or her ability to function in daily life.

****Use:**** To record the details of the Health Assessment Questionnaire used in Rare Diseases management settings to assess how a subject's arthritis affects his or her ability to function in daily life.

****Keywords:**** HAQ, Health Assessment, Questionnaire, Arthritis

****Concepts:****

- at0000::Health Assessment Questionnaire - The Health Assessment Questionnaire for arthritis.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Dress - Assessment of subject's ability to dress, including tying shoelaces and doing buttons.
- at0005::Shampoo - Assessment of the subject's ability to shampoo his or her hair.
- at0008::Dressing and grooming - Assessment of subject's ability to perform functions related to dressing and grooming.
- at0009::Without any difficulty - The subject is able to dress without any difficulty.
- at0010::With some difficulty - The subject is able to dress with some difficulty.
- at0011::With much difficulty - The subject is able to dress with much difficulty.
- at0012::Unable to do - The subject is unable to dress.
- at0014::Without any difficulty - The subject is able to shampoo his or her hair without any difficulty.
- at0015::With some difficulty - The subject is able to shampoo his or her hair with some difficulty.
- at0016::With much difficulty - The subject is able to shampoo his or her hair with much difficulty.
- at0017::Unable to do - The subject is unable to shampoo his or her hair.
- at0029::Arising - Assessment of the subject's ability to stand up from low chair or floor or get in and out of bed.
- at0030::Stand up - Assessment of subject's ability to stand up from low chair or floor.
- at0031::Without any difficulty - The subject is able to stand up from low chair or floor without any difficulty.
- at0032::With some difficulty - The subject is able to stand up from low chair or floor with some difficulty.
- at0033::With much difficulty - The subject is able to stand up from low chair or floor with much difficulty.
- at0034::Unable to do - The subject is unable to stand up from low chair or floor.
- at0036::Get in and out of bed - Assessment of the subject's ability to get in and out of bed.
- at0037::Without any difficulty - The subject is able to get in and out of bed without any difficulty.
- at0038::With some difficulty - The subject is able to get in and out of bed with some difficulty.

- at0039::With much difficulty - The subject is able to get in and out of bed with much difficulty.
- at0040::Unable to do - The subject is unable to get in and out of bed .
- at0042::Eating - Assessment of the subject's ability to perform functions related to eating.
- at0043::Cut meat - Assessment of the subject's ability to cut his or her own meat.
- at0044::Without any difficulty - The subject is able to cut his or her own meat without any difficulty.
- at0045::With some difficulty - The subject is able to cut his or her own meat with some difficulty.
- at0046::With much difficulty - The subject is able to cut his or her own meat with much difficulty.
- at0047::Unable to do - The subject is unable to cut his or her own meat.
- at0049::Lift up cup or glass to mouth - Assessment of the subject's ability to lift a full cup or glass to mouth.
- at0050::Without any difficulty - The subject is able to lift a cup or glass to mouth without any difficulty.
- at0051::With some difficulty - The subject is able to lift a cup or glass to mouth with some difficulty.
- at0052::With much difficulty - The subject is able to lift a cup or glass to mouth with much difficulty.
- at0053::Unable to do - The subject is unable to lift a cup or glass to mouth.
- at0055::Open new carton of milk - Assessment of the subject's ability to open a new carton of milk.
- at0056::Without any difficulty - The subject is able to open a new carton of milk without any difficulty.
- at0057::WIth some difficulty - The subject is able to open a new carton of milk with some difficulty.
- at0058::With much difficulty - The subject is able to open a new carton of milk with much difficulty.
- at0059::Unable to do - The subject is unable to open a new carton of milk.
- at0061::Walking - Assessment of the subject's ability to perform functions related to walking.
- at0062::Walk outdoors on flat ground - Assessment of the subject's ability to walk outdoors on flat ground.
- at0063::Without any difficulty - The subject is able to walk outdoors on flat ground without any difficulty.
- at0064::With some difficulty - The subject is able to walk outdoors on flat ground with some difficulty.
- at0065::With much difficulty - The subject is able to walk outdoors on flat ground with much difficulty.
- at0066::Unable to do - The subject is unable to walk outdoors on flat ground.

- at0068::Climb up five steps - Assessment of the subject's ability to climb up five steps.
- at0069::Without any difficulty - The subject is able to climb up five steps without any difficulty.
- at0070::With some difficulty - The subject is able to climb up five steps with some difficulty.
- at0071::With much difficulty - The subject is able to climb up five steps with much difficulty.
- at0072::Unable to do - The subject is unable to climb up five steps.
- at0087::Hygiene - Assessment of the subject's ability to perform functions related to hygiene.
- at0088::Wash and dry entire body - Assessment of the subject's ability to wash and dry entire body.
- at0089::Without any difficulty - The subject is able to wash and dry his or her entire body without any difficulty.
- at0090::With some difficulty - The subject is able to wash and dry his or her entire body with some difficulty.
- at0091::With much difficulty - The subject is able to wash and dry his or her entire body with much difficulty.
- at0092::Unable to do - The subject is unable to wash and dry his or her entire body.
- at0094::Take a bath - Assessment of the subject's ability to take a tub bath including getting in and out of the tub).
- at0095::Without any difficulty - The subject is able to take a tub bath without any difficulty.
- at0096::With some difficulty - The subject is able to take a tub bath with some difficulty.
- at0097::Get on and off toilet - Assessment of the subject's ability to get on and off the toilet or potty chair.
- at0098::With much difficulty - The subject is able to take a tub bath with much difficulty.
- at0099::Unable to do - The subject is unable to take a tub bath.
- at0102::Without any difficulty - The subject is able to get on and off toilet or potty chair without any difficulty.
- at0103::With some difficulty - The subject is able to get on and off toilet or potty chair with some difficulty.
- at0104::With much difficulty - The subject is able to get on and off toilet or potty chair with much difficulty.
- at0105::Unable to do - The subject is unable to get on and off toilet or potty chair.
- at0118::Reach - Assessment of the subject's ability to perform functions related to reaching.
- at0119::Reach and get down 5lb object - Assessment of the subject's ability to reach and get down a 5lb object from just above his/her head.
- at0120::Without any difficulty - The subject is able to reach and get down a 5lb object from just above his/her head without any difficulty.

- at0121::With some difficulty - The subject is able to reach and get down a 5lb object from just above his/her head with some difficulty.
- at0122::With much difficulty - The subject is able to reach and get down a 5lb object from just above his/her head with much difficulty.
- at0123::Unable to do - The subject is unable to reach and get down a 5lb object from just above his/her head.
- at0125::Bend down to pick up - Assessment of the subject's ability to bend down to pick up clothing or a piece of paper from the floor.
- at0126::Without any difficulty - The subject is able to bend down to pick up clothing or a piece of paper from the floor without any difficulty.
- at0127::With some difficulty - The subject is able to bend down to pick up clothing or a piece of paper from the floor with some difficulty.
- at0128::With much difficulty - The subject is able to bend down to pick up clothing or a piece of paper from the floor with much difficulty.
- at0129::Unable to do - The subject is unable to bend down to pick up clothing or a piece of paper from the floor.
- at0143::Grip - Assessment of the subject's ability to perform functions relating to gripping or handling.
- at0150::Open car doors - Assessment of the subject's ability to open car doors.
- at0151::Without any difficulty - The subject is able to open car doors without any difficulty.
- at0152::With some difficulty - The subject is able to open car doors with some difficulty.
- at0153::With much difficulty - The subject is able to open car doors with much difficulty.
- at0154::Unable to do - The subject is unable to open car doors.
- at0156::Open jars - Assessment of subject's ability to open jars that have been previously opened.
- at0157::Without any difficulty - The subject is able to open jars that have been previously opened without any difficulty.
- at0158::With some difficulty - The subject is able to open jars that have been previously opened with some difficulty.
- at0159::With much difficulty - The subject is able to open jars that have been previously opened with much difficulty.
- at0160::Unable to do - The subject is unable to open jars that have been previously opened.
- at0162::Turn taps on and off - Assessment of subject's ability to turn taps on and off.
- at0163::Without any difficulty - The subject is able to turn taps on and off without any difficulty.
- at0164::With some difficulty - The subject is able to turn taps on and off with some difficulty.
- at0165::With much difficulty - The subject is able to turn taps on and off with much difficulty.
- at0166::Unable to do - The subject is unable to turn taps on and off.

- at0174::Activities - Assessment of the subject's ability to perform general activities.
- at0175::Run errands and shop - Assessment of the subject's ability to run errands and shop.
- at0176::Without any difficulty - The subject is able to run errands and shop without any difficulty.
- at0177::Get in and out of car - Assessment of the subject's ability to get in and out of a car.
- at0178::With some difficulty - The subject is able to run errands and shop with some difficulty.
- at0179::With much difficulty - The subject is able to run errands and shop with much difficulty.
- at0180::Unable to do - The subject is unable to run errands and shop.
- at0182::Without any difficulty - The subject is able to get in and out of car without any difficulty.
- at0183::With some difficulty - The subject is able to get in and out of car with some difficulty.
- at0184::With much difficulty - The subject is able to get in and out of car with much difficulty.
- at0185::Unable to do - The subject is unable to get in and out of car.
- at0193::Do household chores - Assessment of the subject's ability to do household chores (e.g. wash dishes, take out trash, vacuuming, yardwork, make bed, clean room).
- at0194::Without any difficulty - The subject is able to do household chores without any difficulty.
- at0195::With some difficulty - The subject is able to do household chores with some difficulty.
- at0196::With much difficulty - The subject is able to do household chores with much difficulty.
- at0197::Unable to do - The subject is unable to do household chores.
- at0205::Devices used - Statement about the aids or devices usually used by the subject for hygiene, reach, grip and activities.
- at0206::Raised toilet seat - The subject usually uses a raised toilet seat.
- at0207::Bath seat - The subject usually uses a bath seat.
- at0208::Jar opener - The subject usually uses a jar opener for jars that have been previously opened.
- at0209::Bath rail - The subject usually uses a bath rail.
- at0210::Long-handled appliances for reach - The subject usually uses long-handled appliances for reach.
- at0212::Needs help from other person - Statement of which activity categories (hygiene, reach, gripping and opening and errands and chores) usually require help for the subject from another person because of the subject's illness.
- at0213::Hygiene - The subject usually needs help from another person for hygiene because of his or her illness.

- at0214::Reach - The subject usually needs help from another person for reaching because of his or her illness.
- at0215::Gripping and opening things - The subject usually needs help from another person for gripping and opening things because of his or her illness.
- at0216::Errands and chores - The subject usually needs help from another person for errands and chores because of his or her illness.
- at0217::Pain score - Rating of how much pain the subject has had because of his/her illness in the past week on a scale of 0 (no pain) to 100 (very severe pain).
- at0219::Canes - The subject usually uses canes.
- at0220::Walker - The subject usually uses a walker.
- at0221::Crutches - The subject usually uses crutches.
- at0222::Wheelchair or scooter - The subject usually uses a wheelchair or scooter.
- at0223::Special or built-up utensils - The subject usually uses special or built-up utensils.
- at0224::Special or built-up chair - The subject usually uses a special or built-up chair.
- at0225::Dressing and grooming - The subject usually needs help from another person for dressing and grooming because of his or her illness.
- at0226::Eating - The subject usually needs help from another person for eating because of his or her illness.
- at0227::Walking - The subject usually needs help from another person for walking because of his or her illness.
- at0228::Rising - The subject usually needs help from another person for rising because of his or her illness.
- at0229::Tree - @ internal @
- at0230::Confounding factors - Record any issues or factors that may impact on the assessment.
- at0231::Tree - @ internal @
- at0232::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0233::Comment - Narrative description of overall assessment by the subject.

[harris_ hip_ score](#)

Archetype ID: openEHR-EHR-OBSERVATION.harris_ hip_score.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en, sl

****Purpose:**** To record the result of a Harris hip score assessment.

****Misuse:**** Should not be used without permission of Journal of Bone & Joint Surgery.

****Keywords:**** hip, joint

****Concepts:****

- at0000::Harris hip score - The Harris hip score.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Harris hip score result - The result of the Harris hip score.
- at0005::Grading - Grading derived from Harris hip score.
- at0006::Poor - Less than 70.
- at0007::Fair - 70 to 79.
- at0008::Good - 80 to 89.
- at0009::Excellent - 90 to 100.
- at0010::Item tree - @ internal @
- at0011::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

has_bled

****Archetype ID:**** openEHR-EHR-OBSERVATION.has_bled.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To record the results for each component parameter and their total sum for the HAS-BLED bleeding risk score.

****Use:**** Use to record the results for each component parameter and their total sum for the HAS-BLED bleeding risk score.

****Keywords:**** HAS-BLED, stroke, atrial fibrillation, anticoagulants, hemorrhage, bleeding

****Concepts:****

- at0000::HAS-BLED score - A risk assessment score to assess the bleeding risk in individuals with atrial fibrillation.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Hypertension - The systolic blood pressure is >160 mmHg.
- at0005::Abnormal renal function - The presence of chronic dialysis or renal transplantation or serum creatinine ≥200µmol/L.
- at0006::Abnormal liver function - Chronic hepatic disease (eg. cirrhosis) or biochemical evidence of significant hepatic derangement (eg. bilirubin >2x upper limit of normal, in association with AST/ALT/ALP >3x upper limit normal, etc).
- at0007::Stroke - A previous history of stroke, particularly lacunar.
- at0008::Bleeding history or predisposition - A previous bleeding history and/or predisposition to bleeding .
- at0009::Labile INR - Unstable/high INRs or poor time in therapeutic range.
- at0010::Elderly - Age >65 yrs.
- at0011::Drugs concomitantly - The concomitant use of drugs, such as antiplatelet agents, non-steroidal anti-inflammatory drugs, etc.
- at0012::Alcohol concomitantly - Alcohol consumption ≥ 8 units per week.
- at0013::Total score - Sum of points assigned for each of the component parameters.
- at0014::No - The risk factor is not present.
- at0015::Yes - The risk factor is present.
- at0017::Item tree - @ internal @
- at0018::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.

[head_circumference](#)

Archetype ID: openEHR-EHR-OBSERVATION.head_circumference.v1

Lifecycle State: published

Category: OBSERVATION

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

Purpose: To record the measurement of the longest distance around the head.

Use: Use to record the measurement of the longest distance around the head. This archetype can also be used for recording an approximation of the head circumference measurement in a clinical scenario where it is not possible to measure an accurate head

circumference - for example, measuring an uncooperative child. This is not modelled explicitly in the archetype as the openEHR Reference model allows the attribute of Approximation for any Quantity data type. At implementation, for example, an application user interface could allow clinicians to select an appropriately labelled check box adjacent to the Head circumference data field to indicate that the recorded head circumference is an approximation, rather than actual. A statement identifying the physical incompleteness of the head can be recorded in the 'Confounding factors' protocol element, if required.

****Misuse:**** Not to be used to record the circumference of another body part. Use OBSERVATION.body_segment in these circumstances except where more specific archetypes exist such as OBSERVATION.waist_circumference.

****Keywords:**** anthropometry, measurement, estimation, circumference, cephalic, perimeter, HC

****Concepts:****

- at0000::Head circumference - The measurement of the longest distance around the head.
- at0001::Event Series - @ internal @
- at0003::Tree - @ internal @
- at0004::Head circumference - The measurement of the longest distance around the head.
- at0005::Tree - @ internal @
- at0006::Device - Details about the device used for the measurement.
- at0007::Comment - Additional narrative about the head circumference not captured in other fields.
- at0008::Tree - @ internal @
- at0009::Confounding factors - Narrative descripiton of any issues or factors that may impact on the measurement.
- at0010::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0011::Birth - The first measurement of head circumference that is recorded soon after birth. This event should only be used once per record.
- at0012::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

[**hearing_screening_result**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.hearing_screening_result.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record of results of a hearing screening assessment and the screening outcome.

****Use:**** Use to record subject responses to hearing screening for one ear at a time or both ears simultaneously. Use to record the outcome of all responses to hearing screening (or Screening Outcome). This archetype has been designed to capture screening assessment for hearing, using pass/fail criteria, for the following tests: - Pure Tone Audiometry; - Play Audiometry; - Automated Auditory Brainstem Response; and - Visual Reinforcement Orientation Audiometry. All of the data elements are recorded using a single method or protocol. If, during the test, any of the protocol parameters need to be modified, then the subsequent part of the test will need to be recorded within a separate instance of the test data, using the updated protocol parameters.

****Misuse:**** Not to be used for hearing threshold assessment - use the OBSERVATION.audiogram archetype. Not to be used to record other auditory assessments such as: - Behavioural Observation Audiometry (BOA); - Most Comfortable Listening Level (MCL) and Uncomfortable Listening Level (UCL); - Auditory Brainstem Response (ABR) for diagnostic purposes - Transient Evoked Otoacoustic Emission (TEOAE); and - Distortion Product Otoacoustic Emission (DPOAE). These assessments need to be recorded in specific archetypes for the purpose.

****Keywords:**** hearing, test, audiometry, acuity, decibels, screen, screening, VROA, VRA, play, AABR, neonatal, audiogram

****Concepts:****

- at0000::Hearing screening test result - Record of results of a hearing screening assessment and the screening outcome.
- at0001::Event Series - @ internal @
- at0002::Any point in time - Default, unspecified point in time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0006::Test - The screening test result which can be recorded per ear or for both ears simultaneously.
- at0007::Test ear - Identification of the ear to which the test stimulus is being presented.
- at0008::Left ear - The test stimuli were presented to the left ear only.
- at0009::Right ear - The test stimuli were presented to the right ear only.
- at0011::Frequency - The stimulus frequency tested.
- at0012::Intensity - The stimulus intensity tested.
- at0013::Tree - @ internal @

- at0027::Comment - Additional narrative about the test results and interpretation not captured in other fields.
- at0028::Sleep status - The status of the subject during testing.
- at0029::Awake - The test subject was awake during the testing.
- at0030::Asleep - The test subject was asleep during testing.
- at0032::Tree - @ internal @
- at0034::Test stimulus - Identification of the frequency-specific stimulus used in screening.
- at0035::Tone burst - The test stimulus is a tone burst centred on the specified frequency.
- at0036::Click - The test stimulus is a click.
- at0037::Test result name - Identification of the type of screening test performed.
- at0047::Test device - Details of device used to conduct the test.
- at0048::Stimulus response - The grouping of the subject's response to each stimulus presented.
- at0049::Binaural - The test stimuli were presented to both ears simultaneously in a soundfield.
- at0051::Screening outcome - Overall result of screening.
- at0052::Pass - The test was passed, based on screening criteria.
- at0053::Fail - The test was failed, based on screening criteria.
- at0075::Test environment - The physical environment in which the audiometric test is administered.
- at0076::Audиometric booth - Sound-treated test environment that meets audiometric standards for ambient noise.
- at0077::Clinically significant - The background noise may compromise test results.
- at0078::Not clinically significant - The background noise is not likely to compromise test results.
- at0079::Non-sound treated room - Test environment that does not meet audiometric standards for ambient noise.
- at0080::Warble tone - The test stimulus is a frequency modulated tone centred on the specified frequency.
- at0081::Pure tone - The test stimulus is a pure tone centred on the specified frequency.
- at0089::Calibration reference dB - Scale used for acoustic calibration check.
- at0090::db SPL - The sound pressure level scale was used.
- at0091::dB HL - The hearing level scale was used.
- at0092::dB nHL - The normal hearing level scale was used.
- at0102::Screening assessment pass criteria - Criteria used to determine a screening assessment pass.
- at0106::Screening level - Identification of the level of stimulus used to determine a screening assessment pass.
- at0107::Screening frequency - Identification of the stimulus frequency used to determine a screening assessment pass.

- at0116::Earphones - Details of earphones, either insert or external, used to conduct the test.
- at0120::Comment - Additional narrative about the protocol for the screening test not captured in other fields.
- at0122::No test result - No test result is available for the test ear.
- at0123::Reason for no test result - Reason why no result is available for the test ear.
- at0134::Reliability - Narrative description of the reliability of the test results, as determined by the tester.
- at0137::Response - The response of the test subject as a consequence of presentation of the frequency/intensity pair.
- at0138::Positive response - The subject responded, in a prescribed manner, to the stimulus.
- at0139::No response - The subject did not respond to the stimulus.
- at0140::Confounding factors - Narrative description of factors, not recorded elsewhere, that may contribute to the screening result.
- at0141::Narrow band noise - The test stimulus is a narrow band noise centred on the specified frequency.
- at0142::Neonatal screening - Test performed soon after birth to screen for hearing defects that warrant urgent investigation.
- at0143::Multimedia - Digital representation of the test results.
- at0144::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0145::Background noise - The amount of noise present in the test environment.
- at0146::Test not done - Details to explicitly record that this test was not performed.

heartbeat-pulse

****Archetype ID:**** openEHR-EHR-OBSERVATION.heartbeat-pulse.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, fi, sv, ru, nb, pt-br, ar-sy, en, es, es-co

****Purpose:**** To record findings about a series of pulses, observed at a single, specified arterial site.

****Use:**** Use to record findings about a series of pulses, including rate and regularity, observed at a single, specified arterial site. In clinical practice and daily use, the terms 'heart beat' and 'pulse' may be used interchangeably, depending on the context and method of measurement. 'Heart beat' is the broader term that covers any method of measuring the

heart action, whereas 'pulse' specifically describes measuring the heart action through the palpation of a pulse. When designing templates for scenarios where it can't be anticipated whether specifically 'heart beat' or specifically 'pulse' will be measured, and it's not important to the clinical scenario to tell them apart, the 'Heart beat' archetype should be used. Measurements such as the maximum pulse rate during an interval can be recorded using 'Maximum' event.

****Misuse:**** Not to be used to record findings about a series of heartbeats, observed at the heart. Use the parent `OBSERVATION.heartbeat` archetype for this purpose. Not to be used to record findings about 'pulse'/'heart beat' in scenarios where it can't be anticipated whether specifically 'heart beat' or specifically 'pulse' will be measured. Use the parent `OBSERVATION.heartbeat` archetype for this purpose. Not to be used to record the heart rate measured as R-R rate in the context of an electrocardiograph (ECG) report. Use the `OBSERVATION.ecg` archetype for this purpose. Not to be used to record other details of a cardiovascular examination or assessment. Use the `CLUSTER.exam-heart` archetype or other archetypes from the `CLUSTER.exam` family to record physical examination findings. Not to be used to record fetal heart rate. Use the `OBSERVATION.fetal_heart` archetype for this purpose. Not to be used to record a pulse deficit. Use the `OBSERVATION.pulse_deficit` archetype for this purpose. Not to be used to record concepts such as "Target pulse". Use specific archetypes such as `EVALUATION.goal` for these purposes.

****Keywords:**** rate, rhythm, beat, heart, vital, sign

****Concepts:****

- `at0000.1::Pulse` - A series of pressure waves observed in an artery, generated as the heart pumps blood through the circulatory system.
- `at1005.1::Presence` - Observation about the detection of an arterial pulse.
- `at0004.1::Pulse rate` - The measured rate of the pulse.
- `at0005.1::Regularity` - The regularity of the pulse.
- `at1022.1::Clinical description` - Narrative description about the pulse.
- `at1023.1::Clinical interpretation` - Single word, phrase or brief description that represents the clinical meaning and significance of the pulse findings, including the rhythm.
- `at1059.1::Comment` - Additional narrative about the pulse findings not captured in other fields.
- `at1036.1::Maximum pulse rate` - Maximum pulse rate observed during a specified time interval.
- `at1019.1::Method` - Method used to observe the pulse.
- `at0.1::Pulse oximetry` - The findings are observed using a pulse oximetry device.
- `at0.2::Doppler` - The findings are observed using a doppler ultrasound device.
- `at0.3::Oscillometry` - The findings are observed using an oscillometric device, such as an automatic blood pressure device.

- at0.4::Intra-arterial probe - The findings are observed using an intra-arterial probe, directly measuring the pressure wave in the artery.
- at1013.1::Device - Details about the device used to measure the pulse.
- at0.5::Character - The character of the pulse.
- at0.6::Artery site - Identification of the arterial site where the pulse was observed.
- at0.7::Radial artery - Left - The left radial artery.
- at0.8::Radial artery - Right - The right radial artery.
- at0.9::Carotid artery - Left - The left carotid artery.
- at0.10::Carotid artery - Right - The right carotid artery.
- at0.11::Femoral artery - Left - The left femoral artery.
- at0.12::Femoral artery - Right - The right femoral artery.
- at0.13::Brachial artery - Right - The right brachial artery.
- at0.14::Brachial artery - Left - The left brachial artery.
- at0.15::Finger - An unspecified finger.
- at0.16::Toe - An unspecified toe.
- at0.17::Ear lobe - The lobe of an unspecified ear.
- at0.18::Present - A pulse can be detected.
- at0.19::Not detected - A pulse cannot be detected.
- at1005::Presence - Observation about detection of a heartbeat.
- at0000::Heartbeat - A series of cardiac cycles of contraction and relaxation.
- at1019::Method - The method used to observe the heartbeat.
- at0001::structure - @ internal @
- at0002::history - @ internal @
- at0003::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0004::Heart rate - The measured rate of the heartbeat.
- at0005::Regularity - The regularity of the heartbeat.
- at0006::Regular - The pattern is regular.
- at0010::List - @ internal @
- at0012::List - @ internal @
- at0013::Position - The body position of the individual during the observation.
- at1000::Lying - The subject was lying flat.
- at1001::Sitting - The subject was sitting (for example on bed or chair).
- at1002::Reclining - The subject was reclining at an approximate angle of 45 degrees, with the legs elevated to the level of the pelvis.
- at1003::Standing/upright - The subject was standing, walking or running.
- at1013::Device - Details about the device used to observe the heartbeat.
- at1017::Exertion - Details about the level of physical activity performed during the observation.
- at1018::Confounding factors - Narrative description about any incidental factors that may affect interpretation of the physical findings.
- at1022::Clinical description - Narrative description about the heartbeat.

- at1023::Clinical interpretation - Single word, phrase or brief description that represents the clinical meaning and significance of the findings, including the rhythm.
- at1024::Present - A heartbeat can be detected.
- at1025::Not detected - A heartbeat cannot be detected.
- at1028::Irregular - The pattern is irregular.
- at1032::Palpation - The findings are observed by physical touch of the observer on the subject.
- at1033::Auscultation - The findings are observed using a manual amplifying device, such as a stethoscope.
- at1036::Maximum heart rate - Maximum heart rate observed during a specified time interval.
- at1056::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at1059::Comment - Additional narrative about the findings not captured in other fields.
- at1060::Electric - The findings are observed using a device which measures the electrical activity of the heart, such as a chest strap monitor.

heartbeat

****Archetype ID:**** openEHR-EHR-OBSERVATION.heartbeat.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, ru, sv, fi, nb, pt-br, en, ar-sy, es, es-co

****Purpose:**** To record findings about a series of heartbeats.

****Use:**** Use to record findings about a series of heartbeats, including rate and regularity. In clinical practice and daily use, the terms 'heart beat' and 'pulse' may be used interchangeably, depending on the context and method of measurement. 'Heart beat' is the broader term that covers any method of measuring the heart action, whereas 'pulse' specifically describes measuring the heart action through the palpation of a pulse. When designing templates for scenarios where it can't be anticipated whether specifically 'heart beat' or specifically 'pulse' will be measured, and it's not important to the clinical scenario to tell them apart, this archetype should be used. When 'heartbeat' and 'pulse' are both being recorded, use this archetype to record only the heartbeat measured at or near the heart. A companion archetype has been created as a specialisation of this archetype - OBSERVATION.heartbeat-pulse - to specifically record the 'Pulse' as pressure waves in the arteries. The measured heart rate can be recorded using a device, although the R-R rate

recorded as part of an ECG should be recorded separately. Measurements such as the maximum heart rate during an interval can be recorded using 'Maximum' event.

****Misuse:**** Not to be used to record findings specifically about a series of arterial pulses, observed directly from a single arterial site. Use the specialised OBSERVATION.heartbeat-pulse archetype for this purpose. Not to be used to record the heart rate measured as R-R rate in the context of an Electrocardiograph report. Use the OBSERVATION.ecg archetype for this purpose. Not to be used to record other details of a cardiovascular examination or assessment. Use the CLUSTER.exam-heart archetype or other archetypes from the CLUSTER.exam family for the purpose of recording physical examination findings, such as the position of the apex beat, murmurs and bruits. Not to be used to record fetal heart rate. Use the OBSERVATION.fetal_heart archetype for this purpose. Not to be used to record a pulse deficit. Use the OBSERVATION.pulse_deficit archetype for this purpose. Not to be used to record concepts such as "Target heart rate". Use specific archetypes such as EVALUATION.goal for these purposes.

****Keywords:**** rate, rhythm, beat, heart, vital, sign

****Concepts:****

- at0000::Heartbeat - A series of cardiac cycles of contraction and relaxation.
- at0001::structure - @ internal @
- at0002::history - @ internal @
- at0003::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0004::Heart rate - The measured rate of the heartbeat.
- at0005::Regularity - The regularity of the heartbeat.
- at0006::Regular - The pattern is regular.
- at0010::List - @ internal @
- at0012::List - @ internal @
- at0013::Position - The body position of the individual during the observation.
- at1000::Lying - The subject was lying flat.
- at1001::Sitting - The subject was sitting (for example on bed or chair).
- at1002::Reclining - The subject was reclining at an approximate angle of 45 degrees, with the legs elevated to the level of the pelvis.
- at1003::Standing/upright - The subject was standing, walking or running.
- at1005::Presence - Observation about detection of a heartbeat.
- at1013::Device - Details about the device used to observe the heartbeat.
- at1017::Exertion - Details about the level of physical activity performed during the observation.
- at1018::Confounding factors - Narrative description about any incidental factors that may affect interpretation of the physical findings.
- at1019::Method - The method used to observe the heartbeat.
- at1022::Clinical description - Narrative description about the heartbeat.

- at1023::Clinical interpretation - Single word, phrase or brief description that represents the clinical meaning and significance of the findings, including the rhythm.
- at1024::Present - A heartbeat can be detected.
- at1025::Not detected - A heartbeat cannot be detected.
- at1028::Irregular - The pattern is irregular.
- at1032::Palpation - The findings are observed by physical touch of the observer on the subject.
- at1033::Auscultation - The findings are observed using a manual amplifying device, such as a stethoscope.
- at1036::Maximum heart rate - Maximum heart rate observed during a specified time interval.
- at1056::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at1059::Comment - Additional narrative about the findings not captured in other fields.
- at1060::Electric - The findings are observed using a device which measures the electrical activity of the heart, such as a chest strap monitor.

heart_failure_symptom_questionnaire

****Archetype ID:**** openEHR-EHR-OBSERVATION.heart_failure_symptom_questionnaire.v1

****Lifecycle State:**** 0

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** _unknown_

****Concepts:****

- at0000::Heart failure symptom questionnaire - unknown
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0026::Lying flat - For each type of breathlessness, score each of these between 0 and 9, With 0 meaning no or none, 5 meaning troublesome and 9 being severe.
- at0027::Swelling of ankles - *
- at0028::Other symptoms - *
- at0030::Quality of life - *
- at0031::Personal rating of health - *
- at0032::Pillows used for sleeping - *

- at0033::Severe breathlessness at night - *
- at0034::Breathlessness experienced? - *
- at0035::Episodes of severe breathlessness at night experienced. - *
- at0036::Episodes of severe breathlessness at night not experienced. - *
- at0037::Episodes in past 2 months - *
- at0038::Falls - *
- at0039::Blackouts - *
- at0041::Blackouts experienced? - *
- at0042::Episodes in past 2 month - *
- at0043::Falls experienced? - *
- at0044::Episodes in past 2 month - *
- at0045::Breathlessness - *
- at0046::Slight exertion - *
- at0047::Mild exertion - *
- at0048::Moderate exertion - *
- at0049::Symptoms - *
- at0050::Swelling of legs above ankles - *
- at0051::Chest pain at rest - *
- at0052::Chest pain on exercise - *
- at0053::Indigestion or heartburn - *
- at0054::Cough and/or wheeze - *
- at0055::Dizziness - *
- at0056::Palpitations - *
- at0057::Muscle Aches and pains - *

heart_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.heart_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter and their total sum for the HEART score.

****Use:**** Use to record the results for each component parameter and their total sum for the HEART score.

****Concepts:****

- at0000::HEART score - An assessment tool used to identify patients at low, intermediate, and high risk for short-term adverse outcome resulting from Acute Coronary Syndrome (ACS).
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Troponin - The single serum troponin obtained during the emergency department assessment.
- at0005::Electrocardiogram - The interpretation of an electrocardiograph.
- at0006::Age - The age of the patient, defined in years.
- at0007::Risk factors - Presence of risk factors for the development of coronary artery disease (CAD).
- at0008::History - The level of suspicion from patient history or anamnesis.
- at0009::Nonspecific history for ACS. - A history that is not consistent with chest pain concerning for ACS.
- at0010::Mixed historic elements. - A history that contains traditional & non-traditional elements of typical ACS presentation.
- at0011::Specific history for ACS - A history with traditional features of ACS.
- at0012::Normal ECG. - A normal ECG tracing.
- at0013::Abnormal ECG. - Abnormal ECG, with repolarization abnormalities* yet lacking significant ST depression. *BBB, LVH, digoxin effect, implanted right-ventricular pacemaker, past MI, +/- unchanged repolarization abnormalities.
- at0014::Abnormal ECG, with significant ST deviation (depression ± elevation). - Either new or not known to be old significant ST deviation (i.e., no prior ECG available for comparison).
- at0015::<45 years. - The patient is less than 45 years of age.
- at0016::Between 45 and 64 years. - The patient is aged between 45 and 64 years.
- at0017::≤65 years or older. - The patient is 65 years of age or older.
- at0018::No risk factors. - The patient has no identifiable risk factors.
- at0019::1 to 2 risk factors - Risk factors: DM, tobacco smoker, HTN, hypercholesterolemia, obesity, +/- family history of CAD.
- at0020::3 or more risk factors - Automatic score of 2 with established diagnosis of the any of the following conditions: peripheral arterial disease, myocardial infarction, past coronary revascularization procedure, or stroke.
- at0021::Troponin < discriminative level. - Hospital lab discriminative level and/or AccuTroponin <0.04 ng/ml.
- at0022::Troponin elevated 1-3 times discriminative level. - Hospital lab discriminative level and/or AccuTroponin 0.04–0.12 ng/ml.
- at0023::Troponin elevated > 3 times discriminative Level. - Hospital lab discriminative level and/or AccuTroponin >0.12 ng/ml.
- at0026::Total score - Sum of points assigned for each of the component parameters.

- at0028::Risk category - Risk category & recommended management strategy.
- at0029::0-3 - Low risk, potential candidate for early discharge.
- at0030::4-6 - Moderate risk, potential candidate for observation & further evaluation.
- at0031::7-10 - High risk, candidate for urgent or emergent intervention.
- at0032::Item tree - @ internal @
- at0033::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.

height

****Archetype ID:**** openEHR-EHR-OBSERVATION.height.v2

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, ru, sv, fi, pt-br, ar-sy, en, fr, zh-cn, es-ar, nb, fa, nl

****Purpose:**** To record the length of the body from crown of head to sole of foot of an individual - either measured or approximated, and either in a standing or recumbent position.

****Use:**** To be used for recording the measured height or body length of an individual at any point in time. A statement identifying the physical incompleteness of the body can be recorded in the 'Confounding factors' protocol element, if required. This is the usual archetype to be used for a typical measurement of height or body length, independent of the clinical setting. Can also be used for recording an approximation of height or body length measurement in a clinical scenario where it is not possible to measure an accurate height or length - for example, measuring an uncooperative child. This is not modelled explicitly in the archetype as the openEHR Reference model allows approximations for any Quantity data type by setting the attribute Magnitude_status to the value '~'. At implementation, for example, an application user interface could allow clinicians to select an appropriately labelled check box adjacent to the Height data field to indicate that the recorded height is an approximation, rather than actual. In general, length measurements are recommended for children under 2 years of age and individuals who cannot stand; height measurements for all others. When recording the first length of an infant shortly after birth, "birth length", use the event "Birth". Use to record growth or loss of height. This can currently be modelled by constraining the 'any event' to an interval event within a template, with the associated mathematical function of increase or decrease, as appropriate.

****Misuse:**** Not to be used to record an adjusted height, a calculation of the full height of a person who for example are missing parts or all of the lower limbs, or has contractures. A

calculated body weight may be based on measurements of other body parts and an algorithm. Use specific archetypes for this purpose. Not to be used to record growth velocity. Not to be used to record the length of an object or specific body part.

****Keywords:**** shrinkage, increase, decrease, height loss, height, length, growth

****Concepts:****

- at0000::Height/Length - Height, or body length, is measured from crown of head to sole of foot.
- at0001::history - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Simple - @ internal @
- at0004::Height/Length - The length of the body from crown of head to sole of foot.
- at0007::List - @ internal @
- at0011::Device - Description of the device used to measure height or body length.
- at0013::Tree - @ internal @
- at0014::Position - Position of individual when measured.
- at0016::Standing - Height is measured standing on both feet with weight distributed evenly, heels together and both buttocks and heels in contact with a vertical back board.
- at0018::Comment - Additional narrative about the measurement, not captured in other fields.
- at0019::Confounding factors - Narrative description of any issues or factors that may impact on the measurement.
- at0020::Lying - Length is measured in a fully extended, recumbent position with the pelvis flat, legs extended and feet flexed.
- at0021::Birth - Usually the first length measurement, recorded soon after birth. This event will only be used once per health record
- at0022::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[**hip_circumference**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.hip_circumference.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, pt-br, en

****Purpose:**** To record the measurement of the distance around the hips.

****Use:**** Use to record the measurement of the distance around the hips, usually taken at the largest circumference including the buttocks. Use to record change from repeated measurements. This can currently be modeled by constraining the 'Any event' to an interval in a template with an associated mathematical function, as appropriate. This archetype can also be used for recording an approximation of the hip circumference measurement in a clinical scenario where it is not possible to measure an accurate hip circumference - for example, measuring an uncooperative child. This is not modelled explicitly in the archetype as the openEHR Reference model allows the attribute of Approximation for any Quantity data type. At implementation, for example, an application user interface could allow clinicians to select an appropriately labelled check box adjacent to the 'Hip circumference' data field to indicate that the recorded hip circumference is an approximation, rather than actual.

****Misuse:**** Not to be used to record the speed of which the hip circumference is increasing or decreasing. Use the OBSERVATION.growth_velocity archetype for this purpose. Not to be used to record the circumference of another body part. Use OBSERVATION.body_segment in these circumstances except where more specific archetypes exist such as OBSERVATION.waist_circumference.

****Keywords:**** anthropometry, measurement, circumference

****Concepts:****

- at0000::Hip circumference - The measurement of the distance around the hips.
- at0001::Event Series - @ internal @
- at0003::Tree - @ internal @
- at0004::Hip circumference - The measurement of the distance around the widest point of the hip and buttocks.
- at0005::Tree - @ internal @
- at0006::Device - Details about the device used for the measurement.
- at0007::Comment - Additional narrative about the hip circumference not captured in other fields.
- at0008::Tree - @ internal @
- at0009::Confounding factors - Narrative description of any issues or factors that may impact on the measurement.
- at0010::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0012::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

hirsutism_scales

****Archetype ID:**** openEHR-EHR-OBSERVATION.hirsutism_scales.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record hair scores for up to thirteen body areas and a total sum of scores, in order to quantify excessive male-pattern hair growth in women.

****Use:**** Use to record pattern of growth of androgen-sensitive terminal hair in women. This archetype has been designed to be inclusive of all hirsutism scales that are associated with the original scale originally proposed by Ferriman and Gallwey which includes eleven body sites. The extended version is inclusive of all the original sites plus the sideburn area and the perineum. The modified Ferriman-Gallwey score, includes nine body sites, excluding the lower arm, lower leg, sideburn area and perineum. Use a template to constrain the data elements to represent the dataset for the required scale.

****Misuse:**** Not to be used to record information about generalised or excessive hair growth that does not represent hirsutism.

****Keywords:**** Ferriman Gallwey score, hirsutes, hirsutism, hyperandrogenism, body hair growth, terminal hair, virilization, male-pattern hair growth, androgen-sensitive hair growth, androgenic hair

****Concepts:****

- at0000::Hirsutism scales - A grouping of related assessment scales used to quantify distribution and growth of body hair in women.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Upper lip hair - Hair score on the upper lip.
- at0007::None - No excess hair.
- at0008::Grade 1 - A few hairs at outer margin.
- at0009::Grade 2 - A small moustache at outer margin.
- at0010::Grade 3 - A moustache extending halfway from outer margin.
- at0011::Grade 4 - A moustache extending to mid-line.
- at0012::Item tree - @ internal @

- at0019::Chin hair - Hair score on the chin.
- at0020::None - No excess hair.
- at0021::Grade 1 - A few scattered hairs.
- at0022::Grade 2 - Scattered hairs with small concentrations.
- at0023::Grade 3 - Complete light cover.
- at0024::Grade 4 - Complete heavy cover.
- at0025::Chest hair - Hair score on the chest.
- at0026::None - No excess hair.
- at0027::Grade 1 - Circumareolar hairs.
- at0028::Grade 2 - Circumareolar hairs with midline hair in addition.
- at0029::Grade 3 - Fusion of circumareolar and midline areas, with three-quarter cover.
- at0030::Grade 4 - Complete cover.
- at0031::Upper back hair - Hair score on the upper back.
- at0032::None - No excess hair.
- at0033::Grade 1 - A few scattered hairs.
- at0034::Grade 2 - Rather more hairs, still scattered.
- at0035::Grade 3 - Complete light cover.
- at0036::Grade 4 - Complete heavy cover.
- at0037::Lower back hair - Hair score on the lower back.
- at0038::None - No excess hair.
- at0039::Grade 1 - A sacral tuft of hair.
- at0040::Grade 2 - A sacral tuft of hair with some lateral extension.
- at0041::Grade 3 - Three-quarter cover.
- at0042::Grade 4 - Complete cover.
- at0043::Upper abdomen hair - Hair score on the upper abdomen.
- at0044::None - No excess hair.
- at0045::Grade 1 - A few mid-line hairs.
- at0046::Grade 2 - Rather more hairs, still mid-line.
- at0047::Grade 3 - Half cover.
- at0048::Grade 4 - Full cover.
- at0049::Lower abdomen hair - Hair score on the lower abdomen.
- at0050::None - No excess hair.
- at0051::Grade 1 - A few mid-line hairs.
- at0052::Grade 2 - A mid-line streak of hair.
- at0053::Grade 3 - A mid-line band of hair.
- at0054::Grade 4 - An inverted V-shaped growth.
- at0055::Upper arm hair - Hair score on the upper arms.
- at0056::None - No excess hair.
- at0057::Grade 1 - Sparse growth not affecting more than a quarter of the limb surface.
- at0058::Grade 2 - More than sparse growth, cover still incomplete.
- at0059::Grade 3 - Complete light cover.
- at0060::Grade 4 - Complete heavy cover.

- at0061::Lower arm hair - Hair score on the lower arms.
- at0062::None - No excess hair.
- at0063::Grade 1 - Light cover of dorsal surface.
- at0064::Grade 2 - Complete light cover of dorsal surface.
- at0065::Grade 3 - Heavy cover of dorsal surface.
- at0066::Grade 4 - Complete heavy cover of dorsal surface.
- at0067::Thigh hair - Hair score on the thighs.
- at0068::None - No excess hair.
- at0069::Grade 1 - Sparse growth affecting not more than a quarter of the limb surface.
- at0070::Grade 2 - More than sparse growth, cover still incomplete.
- at0071::Grade 3 - Complete light cover.
- at0072::Grade 4 - Complete heavy cover.
- at0073::Lower leg hair - Hair score on the lower legs.
- at0074::None - No excess hair.
- at0075::Grade 1 - Sparse growth affecting not more than a quarter of the limb surface.
- at0076::Grade 2 - More than sparse growth, cover still incomplete.
- at0077::Grade 3 - Complete light growth.
- at0078::Grade 4 - Complete heavy growth.
- at0079::Total score - The total sum of the hair scores recorded for each of the body area.
- at0082::Sideburn hair - Hair score on the sideburns.
- at0083::None - No excess hair.
- at0084::Grade 1 - A few scattered hairs.
- at0085::Grade 2 - Scattered hairs with small concentrations.
- at0086::Grade 3 - Complete light cover.
- at0087::Grade 4 - Complete heavy cover.
- at0088::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0089::Ferriman-Gallwey score - The total sum of the hair scores recorded for each of eleven body areas.
- at0090::Modified Ferriman-Gallwey score - The total sum of the hair scores recorded for each of nine body areas.
- at0091::Perineum hair - Hair score on the perineum.
- at0092::None - No excess hair.
- at0093::Grade 1 - Perianal terminal hair.
- at0094::Grade 2 - Lateral extension of terminal hair to edge of gluteal cleft.
- at0095::Grade 3 - Three-quarter coverage of buttocks.
- at0096::Grade 4 - Complete coverage of buttocks.

honos

****Archetype ID:**** openEHR-EHR-OBSERVATION.honos.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Records the Health of the Nation Outcome Scale score as a simple, repeatable method to document the service user's health or social status at a specific point in time, say at the start or end of an episode of care, after a course of treatment or some other intervention.

****Use:**** The use of HoNOS is recommended by the English National Service Framework for Mental Health and by the working group to the Department of Health on outcome indicators for severe mental illnesses. HoNOS is the most widely used routine clinical outcome measure used by English mental health services. The 12 scales that are scored are: 1. Overactive, aggressive, disruptive or agitated behaviour 2. Non-accidental self-injury 3. Problem drinking or drug-taking 4. Cognitive problems 5. Physical illness or disability problems 6. Problems associated with hallucinations and delusions 7. Problems with depressed mood 8. Other mental and behavioural problems 9. Problems with relationships 10. Problems with activities of daily living 11. Problems with living conditions 12. Problems with occupation and activities All scales follow the format: 0 = No problem 1 = Minor problem requiring no action 2 = Mild problem but definitely present 3 = Moderately severe problem 4 = Severe to very severe problem Each scale is rated in order from 1 to 12. Do not include information rated in an earlier item except for item 10 which is an overall rating. The rating is made on the basis of all information available to the rater (whatever the source) and is based on the most severe problem that occurred during the period rated (usually the two weeks leading up to the point of rating). The HoNOS system is not a standardised clinical assessment and cannot be a substitute for one. The minimum required is that a rating is made at the start of each episode of care and at the end. Most services using HoNOS also require ratings at any regular review (like the English Care Programme Approach review), when there is a major change in the patient's status (for instance, an admission to or discharge from hospital) HoNOS Score is a copyrighted assessment score: Health of the Nation Outcome Scales (HoNOS) © Royal College of Psychiatrists 1996. Please note, from RACP copyright guidance: - "The RCPsych allows without express permission the free use, copy and reproduction of HoNOS scoresheets for use in NHS-funded care. Use, copy or reproduction of HoNOS scoresheets for any other purpose should be with the explicit permission of the RCPsych." - "The RCPsych allows without express permission NHS organisations and other providers of NHS funded care to include HoNOS scoresheets in electronic healthcare records and other computerised clinical systems." (<http://www.rcpsych.ac.uk/traininpsychiatry/conferencestraining/resources/honos/copyright.aspx>)and, for long episodes of care, at every 6 months or so.

****Misuse:**** Users of the HoNOS Score archetype must ensure that they comply with the terms of use of the Royal College of Psychiatrists who own the copyright as per <http://www.rcpsych.ac.uk/traininpsychiatry/conferencestraining/resources/honos/copyright.aspx>. It should not be used outside the terms of the copyright.

****Keywords:**** HoNOS, assessment, score, mental health, health of the nation, index

****Concepts:****

- at0000::Health of the Nation Outcome Scale - Clinical score based on 12 simple scales on which service users with severe mental illness are rated by clinical staff.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Overactive, aggressive, disruptive or agitated behaviour - Observation of the service user's behaviour.
- at0005::No problem - No problem.
- at0006::Minor problem requiring no action - Minor problem requiring no action.
- at0007::Mild problem but definitely present - Mild problem but definitely present.
- at0008::Moderately severe problem. - moderately severe problem.
- at0009::Severe to very severe problem - Severe to very severe problem.
- at0010::Non-accidental self-injury - Observation of any non-accidental self-injuries.
- at0011::No problem - No problem.
- at0012::Minor problem requiring no action - Minor problem requiring no action.
- at0013::Mild problem but definitely present - Mild problem but definitely present.
- at0014::Problem drinking or drug-taking - Problem drinking or drug-taking.
- at0015::Cognitive problems - Cognitive problems.
- at0016::Physical illness or disability problems - Physical illness or disability problems.
- at0017::Problems associated with hallucinations and delusions - Problems associated with hallucinations and delusions.
- at0018::Problems with depressed mood - Problems with depressed mood.
- at0019::Other mental and behavioural problems - Other mental and behavioural problems.
- at0020::Problems with relationships - Problems with relationships.
- at0021::Problems with activities of daily living - Problems with activities of daily living.
- at0022::Problems with living conditions - Problems with living conditions.
- at0023::Problems with occupation and activities - Problems with occupation and activities.
- at0024::No problem - No problem.
- at0025::No problem - No problem.
- at0026::No problem - No problem.
- at0027::No problem - No problem.

- at0070::Severe to very severe problem - Severe to very severe problem.
- at0071::Severe to very severe problem - Severe to very severe problem.
- at0072::Severe to very severe problem - Severe to very severe problem.
- at0073::Severe to very severe problem - Severe to very severe problem.
- at0074::Severe to very severe problem - Severe to very severe problem.
- at0075::Severe to very severe problem - Severe to very severe problem.
- at0076::Start of episode of care - HoNOS score at start of episode of care.
- at0077::End of episode of care - HoNOS score at end of episode of care.

hoos

****Archetype ID:**** openEHR-EHR-OBSERVATION.hoos.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter, subscale scores, total score for the HOOS survey.

****Use:**** Use to record the results for each component parameter, subscale scores, total score for the HOOS survey. While openEHR archetypes are all freely available under an open license, the specific content of this Hip Disability and Osteoarthritis Outcome Score archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners.

****Keywords:**** hip, function, disability,

****Concepts:****

- at0000::Hip Disability and Osteoarthritis Outcome Score (HOOS) - An assessment tool to evaluate symptoms and functional limitations related to the hip.
- at0001::History - @ internal @
- at0002::Any event - @ internal @
- at0003::Tree - @ internal @
- at0004::Item tree - @ internal @
- at0005::P3. Bending your hip fully - None
- at0006::None - None
- at0007::Mild - None
- at0008::Moderate - None
- at0009::Severe - None

- at0010::Extreme - None
- at0011::S1. Do you feel grinding, hear clicking or any other type of noise from your hip?
- None
- at0012::Never - None
- at0013::Rarely - None
- at0014::Sometimes - None
- at0015::Often - None
- at0016::Always - None
- at0029::S3. Difficulties to stride out when walking - None
- at0030::None - None
- at0031::Mild - None
- at0032::Moderate - None
- at0033::Severe - None
- at0034::Extreme - None
- at0035::S4. How severe is your hip joint stiffness after first wakening in the morning? - None
- at0036::None - None
- at0037::Mild - None
- at0038::Moderate - None
- at0039::Severe - None
- at0040::Extreme - None
- at0041::S5. How severe is your hip stiffness after sitting, lying or resting later in the day? - None
- at0042::None - None
- at0043::Mild - None
- at0044::Moderate - None
- at0045::Severe - None
- at0046::Extreme - None
- at0047::Symptoms + Stiffness subtotal - The total for the Symptoms + Stiffness subscore.
- at0049::P1. How often is your hip painful? - None
- at0050::Never - None
- at0051::Monthly - None
- at0052::Weekly - None
- at0053::Daily - None
- at0054::Always - None
- at0055::P2. Straightening your hip fully - None
- at0056::None - None
- at0057::Mild - None
- at0058::Moderate - None
- at0059::Severe - None
- at0060::Extreme - None

- at0061::P4. Walking on flat surface - None
- at0062::None - None
- at0063::Mild - None
- at0064::Moderate - None
- at0065::Severe - None
- at0066::Extreme - None
- at0067::P5. Going up or down stairs - None
- at0068::None - None
- at0069::Mild - None
- at0070::Moderate - None
- at0071::Severe - None
- at0072::Extreme - None
- at0073::P6. At night while in bed - None
- at0074::None - None
- at0075::Mild - None
- at0076::Moderate - None
- at0077::Severe - None
- at0078::Extreme - None
- at0079::P7. Sitting or lying - None
- at0080::None - None
- at0081::Mild - None
- at0082::Moderate - None
- at0083::Severe - None
- at0084::Extreme - None
- at0085::P8. Standing upright - None
- at0086::None - None
- at0087::Mild - None
- at0088::Moderate - None
- at0089::Severe - None
- at0090::Extreme - None
- at0091::P9. Walking on a hard surface (asphalt, concrete, etc.) - None
- at0092::None - None
- at0093::Mild - None
- at0094::Moderate - None
- at0095::Severe - None
- at0096::Extreme - None
- at0097::P10. Walking on an uneven surface - None
- at0098::None - None
- at0099::Mild - None
- at0100::Moderate - None
- at0101::Severe - None
- at0102::Extreme - None

- at0103::A1. Descending stairs - None
- at0104::None - None
- at0105::Mild - None
- at0106::Moderate - None
- at0107::Severe - None
- at0108::Extreme - None
- at0109::Pain Subtotal - The total for the Pain subscale.
- at0110::A2. Ascending stairs - None
- at0111::None - None
- at0112::Mild - None
- at0113::Moderate - None
- at0114::Severe - None
- at0115::Extreme - None
- at0116::A3. Rising from sitting - None
- at0117::None - None
- at0118::Mild - None
- at0119::Moderate - None
- at0120::Severe - None
- at0121::Extreme - None
- at0122::A4. Standing - None
- at0123::None - None
- at0124::Mild - None
- at0125::Moderate - None
- at0126::Severe - None
- at0127::Extreme - None
- at0128::A5. Bending to floor/pick up an object - None
- at0129::None - None
- at0130::Mild - None
- at0131::Moderate - None
- at0132::Severe - None
- at0133::Extreme - None
- at0134::A6. Walking on flat surface - None
- at0135::None - None
- at0136::Mild - None
- at0137::Moderate - None
- at0138::Severe - None
- at0139::Extreme - None
- at0140::A7. Getting in/out of car - None
- at0141::None - None
- at0142::Mild - None
- at0143::Moderate - None
- at0144::Severe - None

- at0145::Extreme - None
- at0146::A8. Going shopping - None
- at0147::None - None
- at0148::Mild - None
- at0149::Moderate - None
- at0150::Severe - None
- at0151::Extreme - None
- at0152::A9. Putting on socks/stockings - None
- at0153::None - None
- at0154::Mild - None
- at0155::Moderate - None
- at0156::Severe - None
- at0157::Extreme - None
- at0158::A10. Rising from bed - None
- at0159::None - None
- at0160::Mild - None
- at0161::Moderate - None
- at0162::Severe - None
- at0163::Extreme - None
- at0164::A11. Taking off socks/stockings - None
- at0165::None - None
- at0166::Mild - None
- at0167::Moderate - None
- at0168::Severe - None
- at0169::Extreme - None
- at0170::A12. Lying in bed (turning over, maintaining hip position) - None
- at0171::None - None
- at0172::Mild - None
- at0173::Moderate - None
- at0174::Severe - None
- at0175::Extreme - None
- at0176::A13. Getting in/out of bath - None
- at0177::None - None
- at0178::Mild - None
- at0179::Moderate - None
- at0180::Severe - None
- at0181::Extreme - None
- at0182::A14. Sitting - None
- at0183::None - None
- at0184::Mild - None
- at0185::Moderate - None
- at0186::Severe - None

- at0187::Extreme - None
- at0188::A15. Getting on/off toilet - None
- at0189::None - None
- at0190::Mild - None
- at0191::Moderate - None
- at0192::Severe - None
- at0193::Extreme - None
- at0194::A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc) - None
- at0195::None - None
- at0196::Mild - None
- at0197::Moderate - None
- at0198::Severe - None
- at0199::Extreme - None
- at0200::A17. Light domestic duties (cooking, dusting, etc) - None
- at0201::None - None
- at0202::Mild - None
- at0203::Moderate - None
- at0204::Severe - None
- at0205::Extreme - None
- at0206::Function, daily living subtotal - The total for Function, daily living subscale.
- at0207::SP1. Squatting - None
- at0208::None - None
- at0209::Mild - None
- at0210::Moderate - None
- at0211::Severe - None
- at0212::Extreme - None
- at0213::SP2. Running - None
- at0214::None - None
- at0215::Mild - None
- at0216::Moderate - None
- at0217::Severe - None
- at0218::Extreme - None
- at0219::SP3. Twisting/pivoting on your injured hip - None
- at0220::None - None
- at0221::Mild - None
- at0222::Moderate - None
- at0223::Severe - None
- at0224::Extreme - None
- at0225::SP4. Walking on uneven surface - None
- at0226::None - None
- at0227::Mild - None
- at0228::Moderate - None

- at0229::Severe - None
- at0230::Extreme - None
- at0231::Q1. How often are you aware of your hip problem? - None
- at0232::Never - None
- at0233::Monthly - None
- at0234::Weekly - None
- at0235::Daily - None
- at0236::Constantly - None
- at0237::Q2. Have you modified your life style to avoid potentially damaging activities to your hip? - None
- at0238::Not at all - None
- at0239::Mildly - None
- at0240::Moderately - None
- at0241::Severely - None
- at0242::Extremely - None
- at0243::Q3. How much are you troubled with lack of confidence in your hip? - None
- at0244::Not at all - None
- at0245::Mildly - None
- at0246::Moderately - None
- at0247::Severely - None
- at0248::Extremely - None
- at0249::Q4. In general, how much difficulty do you have with your hip? - None
- at0250::None - None
- at0251::Mild - None
- at0252::Moderate - None
- at0253::Severe - None
- at0254::Extreme - None
- at0255::Function, sports and recreational activities subtotal - The total for the Function, sports and recreational activities subscale.
- at0256::Quality of life subtotal - The total for the Quality of life subscale.
- at0257::Total score - The total sum of each subscale total for the HOOS survey.
- at0258::S2. Difficulties spreading legs wide apart - None
- at0259::None - None
- at0260::Mild - None
- at0261::Moderate - None
- at0262::Severe - None
- at0263::Extreme - None
- at0264::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

howru

****Archetype ID:**** openEHR-EHR-OBSERVATION.howru.v1

****Lifecycle State:**** AuthorDraft

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record information captured by the howRU™ patient-reported outcomes instrument.

****Use:**** 'howRU' (TM) is a generic patient-reported outcomes instrument, designed to meet these requirements, and answer the central question: "How are you today?" It has four dimensions, which reflect the presence or absence of what matters most to patients, in addition to survival: - Symptoms such as pain - includes discomfort such as breathlessness or nausea - Feeling low or worried - includes anxiety, depression and fatigue. - Limits to what you can do - includes physical incapacity, loss of memory, sight or hearing. - Dependence on others - reliance on other people or equipment. For each dimension, the patient picks one of four levels, indicated using a traffic-light metaphor with labels, colour, position and images. The four dimensions and four levels give 256 (44) different permutations, each of which represents a different health state. For data storage and analysis, each level is recorded on a 0-3 ordinal scale, with none = 3, slight = 2 quite a lot = 1, and extreme = 0. Higher score means better health. A simple aggregate howRU score is calculated by adding the scores for each dimension, giving a range from 12 (4 x none, ceiling) to 0 (4 x extreme, floor). Copyright 2008 Routine Health Outcomes Ltd. All rights reserved. Used with Permission. Users should notify Tim Benson by email: timbenson@routinehealthoutcomes.com

****Misuse:**** Should not be used other than to record information derived from the patient-reported outcomes instrument. Copyright 2008 Routine Health Outcomes Ltd. All rights reserved - Do not use without permission.

****Keywords:**** proms, pain, symptom, patient, dependent, outcome

****Concepts:****

- at0000::howRU score - Information captured by the howRU™ patient-reported outcomes instrument.
- at0001::Event Series - @ internal @
- at0002::Recording event - The event at which the recording was made.
- at0003::List - @ internal @
- at0004::Summary score - An overall score combining the 4 individual ratings.
- at0006::Dependent on others - Dependent on others – the need to rely on other people or equipment.

- at0008::Feeling low or worried - Feeling low or worried – includes all psychological states, including anxiety, feeling low and depression.
- at0022::List - @ internal @
- at0038::Device - The device used to obtain this set of readings.
- at0039::Limited in what I can do - Limited in what I can do – includes incapacity due to physical or psychological reasons, such as not being able to perform activities of daily living, or not being able to carry out leisure activities.
- at0040::none - The subject is not affected at all.
- at0041::slight - The subject is only slightly affected.
- at0042::quite a lot - The subject is considerably affected.
- at0043::extreme - The subject is extremely affected.
- at0044::Pain or discomfort - Symptoms such as pain – includes all physical forms of discomfort such as breathlessness, itching, dizziness or nausea.

hscore

****Archetype ID:**** openEHR-EHR-OBSERVATION.hscore.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record an estimation of an individual's risk of having reactive hemophagocytic syndrome.

****Use:**** Use to record an estimation of an individual's risk of having reactive hemophagocytic syndrome.

****Keywords:**** HLH, Hemophagocytic lymphohistiocytosis, COVID-19, infection,

****Concepts:****

- at0000::HScore - Estimate an individual's risk of having reactive hemophagocytic syndrome.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Temperature - Range category for the body temperature measurement.

- at0005::<38.4°C - The body temperature of the individual is less than 38.4°C.
- at0006::38.4-39.4°C - The body temperature of the individual is between 38.4 and 39.4°C.
- at0007::>39.4°C - The body temperature of the individual is greater than 39.4°C.
- at0008::Organomegaly - Findings of any enlargement of the liver or/and spleen in the individual.
- at0009::None - No enlargement of the liver or the spleen.
- at0010::Hepatomegaly or splenomegaly - Enlargement of the liver or the spleen.
- at0011::Hepatomegaly and splenomegaly - Enlargement of both the liver and the spleen.
- at0012::Number of cytopenias - Number of cytopenias present - in red cells, white cells and/or platelets.
- at0013::One lineage - Cytopenia in only one cell lineage.
- at0014::Two lineages - Cytopenia in two cell lineages.
- at0015::Three lineages - Cytopenia in three cell lineages.
- at0016::Triglycerides - The triglycerides category, measured in mmol/L or mg/dL.
- at0017::Fibrinogen - The fibrinogen category, measured in g/L or mg/dL.
- at0018::Ferritin - The ferritin category, measured in ng/mL or µg/L.
- at0019::Aspartate aminotransferase - An individual's serum aspartate aminotransferase level measured in U/L.
- at0020::Haemophagocytosis on bone marrow aspirate - Presence of hemophagocytosis features in bone marrow aspirate.
- at0021::Known immunosuppression - Presence of known underlying immunosuppression.
- at0022::No - No known underlying immunosuppression.
- at0023::Yes - Known underlying immunosuppression.
- at0024::<1.5 mmol/L - The Triglyceride level is less than 1.5 mmol/L or 132.7 mg/dL.
- at0025::1.5-4.0 mmol/L - The Triglyceride level is 1.5-4.0 mmol/L or 132.7-354 mg/dL.
- at0026::>4.0 mmol/L - The Triglyceride level is greater than 4.0 mmol/L or 354 mg/dL.
- at0027::>2.5 g/L - The fibrinogen level is greater than 2.5 g/L or 250 mg/dL.
- at0028::≤2.5 g/L - The fibrinogen level is less than or equal to 2.5 g/L 250 mg/dL.
- at0029::<2000 ng/ml - The ferritin level is less than 2000 ng/ml or 2000 µg/L.
- at0030::2000-6000 ng/ml - The ferritin level is 2000-6000 ng/ml or 2000-6000 µg/L.
- at0031::>6000 ng/ml - The ferritin level is greater than 6000 ng/ml or 6000 µg/L.
- at0032::<30 U/L - The aspartate aminotransferase level is less than 30 U/L.
- at0033::≥30 U/L - The aspartate aminotransferase level is greater than or equal to 30 U/L.
- at0034::No - No hemophagocytosis features are present in bone marrow aspirate.
- at0035::Yes - Hemophagocytosis features are present in bone marrow aspirate.
- at0036::Total HScore - The total sum for each component variable for the HScore.
- at0037::Probability of HS - Probability of an individual having reactive hemophagocytic syndrome.
- at0038::Item tree - @ internal @

- at0039::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

humpty_dumpty_falls_risk_assessment_tool

****Archetype ID:**** openEHR-EHR-OBSERVATION.humpty_dumpty_falls_risk_assessment_tool.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

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

****Purpose:**** A tool for the assesment of risk of falls in children, based on the measurement of 7 parameters.

****Use:**** Seven parameters are evaluated and a numerical score is assigned to each: Age, Gender, Diagnosis, Cognitive impairments, Environmental factors, Response to surgery/sedation/anesthesia and Medication usage.

****Misuse:**** Not to be used in patients above 18 years of age.

****Keywords:**** falls, scale, age, gender, diagnosis, cognitive impairment, environmental factor, surgery, sedation, anesthesia, medication

****Concepts:****

- at0000::Humpty dumpty falls scale - A scale for the assesment of risk of falls in children, based on the measurement of 7 parameters.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Age - Age of patient.
- at0005::Less than 3 years old - Patient is less than 3 years old.
- at0006::3 to less than 7 years old - Patient is 3 to less than 7 years old.
- at0007::7 to less than 13 years old - Patient is 7 to less than 13 years old.
- at0008::13 years and above - Patient is 13 years and above.
- at0009::Gender - Gender.
- at0010::Female - Patient is female.

- at0011::Male - Patient is male.
- at0012::Diagnosis - Diagnosis.
- at0013::Other diagnosis - Patient has.
- at0014::Psychological/behavioural diagnosis - Patient has other diagnosis.
- at0015::Alterations in oxygenation (respiratory diagnosis, dehydration, anemia, anorexia, syncope/dizziness, etc.) - Patient has alterations in oxygenation (respiratory diagnosis, dehydration, anemia, anorexia, syncope/dizziness, etc.).
- at0016::Neurological diagnosis - Patient has neurological diagnosis.
- at0017::Cognitive impairments - Cognitive impairments.
- at0018::Oriented to own ability - Patient is oriented to own ability.
- at0019::Forgets limitations - Patient forgets limitations.
- at0020::Not aware of limitations - Patient is not aware of limitations.
- at0021::Environmental factors - Environmental factors.
- at0022::Outpatient area - Patient is in outpatient area.
- at0023::Patient placed in bed - Patient is placed in bed.
- at0024::Patient uses assistive device or infant-toddler in crib or furniture/lighting (tripled room) - Patient uses assistive device or infant-toddler in crib or furniture/lighting (tripled room).
- at0025::History of falls or infant-toddler placed in bed - Patient has history of falls or is an infant-toddler placed in bed.
- at0026::Response to surgery/sedation/anesthesia - Patient's response to surgery/sedation/anesthesia.
- at0027::More than 48 hours/None - Patient is more than 48 hours from surgery/sedation/anesthesia or has had none.
- at0028::Within 48 hours - Patient within 48 hours from surgery/sedation/anesthesia.
- at0029::Within 24 hours - Patient within 24 hours from surgery/sedation/anesthesia.
- at0030::Medication usage - Medication usage.
- at0031::Other medications/none - Patient receives other medications or none.
- at0032::One of the meds listed above - Patient receives one of the medications listed above.
- at0033::Multiple usage of: sedatives (excluding ICU patients sedated and paralyzed), hypnotics, barbiturates, phenothiazines, antidepressants, laxatives/diuretics, narcotic - Multiple usage of: sedatives (excluding ICU patients sedated and paralyzed), hypnotics, barbiturates, phenothiazines, antidepressants, laxatives/diuretics, narcotic.
- at0034::Total score - Total score.
- at0035::Comment - Comments.
- at0037::Confounding factors - Any incidental factors related to the state of the subject which may affect clinical interpretation of the measurement.
- at0038::Tree - @ internal @
- at0040::Tree - @ internal @
- at0041::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

iciq_ui_short

****Archetype ID:**** openEHR-EHR-OBSERVATION.iciq_ui_short.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Intended to capture the result of the short form of the ICIQ (International Consultation on Incontinence Questionnaire), also referred to as ICIQ-UI Short Form. The form is used to obtain a brief yet comprehensive summary of the level, impact and perceived cause of symptoms of incontinence.

****Use:**** Use to record ICIQ-UI Short form answers to questions and total score.

****Keywords:**** incontinence, ICIQ, score, urine, leakage, leak, questionnaire

****Concepts:****

- at0000::ICIQ-UI Short Form - International Consultation on Incontinence (ICIQ) Urinary Incontinence (UI) Short Form.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Frequency - Frequency of urine leakage over past 4 weeks.
- at0005::Never - Over the past 4 weeks I have never leaked urine.
- at0006::About once a week or less often - Over the past 4 weeks I have leaked urine about once a week or less often on average.
- at0007::Two or three times a week - Over the past 4 weeks I have leaked urine two or three times a week on average.
- at0008::About once a day - Over the past 4 weeks I have leaked urine about once a day on average.
- at0009::Several times a day - Over the past 4 weeks I have leaked urine several times a day on average.
- at0010::All the time - Over the past 4 weeks I have leaked urine all the time.
- at0011::Quantity - Perceived quantity of urine leakage.
- at0012::None - Over the past 4 weeks I have not leaked any urine.
- at0013::A small amount - Over the past 4 weeks I have leaked a small amount of urine on average.

- at0014::A moderate amount - Over the past 4 weeks I have leaked a moderate amount of urine on average.
- at0015::A large amount - Over the past 4 weeks I have leaked a large amount of urine on average.
- at0016::Interference with daily life - Perceived interference of urine leakage with daily life on a scale of 0 - 10.
- at0017::ICIQ Score - Sum of scores for frequency, quantity and interference.
- at0018::When does urine leak? - Occasions when urine leakage occurs.
- at0019::Never - Urine never leaks.
- at0020::Before getting to toilet - Urine leaks before you can get to the toilet.
- at0021::Cough or sneeze - Urine leaks when you cough or sneeze.
- at0022::Asleep - Urine leaks when you are asleep.
- at0023::Physically active/exercising - Urine leaks when you are physically active or exercising.
- at0024::Finished urinating and are dressed - Urine leaks when you have finished urinating and are dressed.
- at0025::No obvious reason - Urine leaks for no obvious reason.
- at0026::All the time - Urine leaks all the time.
- at0027::Tree - @ internal @
- at0028::Confounding factors - Description of any incidental factors that may have contributed to the score.
- at0029::Tree - @ internal @
- at0030::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[iga_eczema_treat](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.iga_eczema_treat.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record a clinical assessment of the severity of atopic dermatitis. This version is being used by the TREAT eczema group.

****Use:**** A representative area should be chosen as a means to determine a patient's IGA.

****Keywords:**** Atopic Dermatitis, Dermatology, Effectiveness outcome parameter, Severity scale

****Concepts:****

- at0000::IGA eczema (TREAT) - Investigator global assessment (PGA) to describe the severity of their eczema for the treatment of severe atopic eczema trial (TREAT).
- at0001::Event Series - @ internal @
- at0002::Any event - Any event.
- at0003::List - @ internal @
- at0004::Assessment score - The total IGA score.
- at0005::Clear - No inflammatory signs of atopic dermatitis.
- at0006::Almost clear - Just perceptible erythema and just perceptible papulation/infiltration.
- at0007::Mild disease - Mild erythema and mild papulation/infiltration.
- at0008::Moderate disease - Moderate erythema and moderate papulation/infiltration.
- at0009::Severe disease - Severe erythema and severe papulation/infiltration.
- at0010::Very severe disease - Severe erythema and severe papulation/infiltration with oozing/crusting.
- at0011::Item tree - @ internal @
- at0012::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

iief_5

****Archetype ID:**** openEHR-EHR-OBSERVATION.iief_5.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Intended to capture the 5-item version of the International Index of Erectile Function (IIEF-5) as a diagnostic tool for erectile dysfunction.

****Use:**** Use to record 5-item scoring test for erectile dysfunction.

****Keywords:**** erectile, dysfunction, IIEF, score, index, prostate

****Concepts:****

- at0000::IIEF-5-Score - International index of erectile dysfunction (IIEF-5).
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.

- at0003::Tree - @ internal @
- at0004::Confidence - Confidence to get and keep erection.
- at0005::Very low - Over past 6 months confidence of ability to get and keep erection is very low.
- at0006::Low - Over past 6 months confidence of ability to get and keep erection is low.
- at0007::Moderate - Over the past 6 months confidence of ability to get and keep erection is moderate.
- at0008::High - Over the past 6 months confidence of ability to get and keep erection is high.
- at0009::Very high - Over the past 6 months confidence of ability to get and keep erection is very high.
- at0010::Hard enough for penetration - Frequency of erection being hard enough for penetration.
- at0011::No sexual activity - There was no sexual activity over the past 6 months.
- at0012::Almost never or never - Over the past 6 months erections were almost never or never hard enough for penetration.
- at0013::A few times - Over the past 6 months erections were hard enough for penetration a few times.
- at0014::Sometimes - Over the past 6 months erections were sometimes hard enough for penetration.
- at0015::Most times - Over the past 6 months erections were hard enough for penetration most times.
- at0016::Almost always or always - Over the past 6 months erections were almost always or always hard enough for penetration.
- at0017::Maintain after penetration - Frequency of erection being maintained after penetration.
- at0018::Did not attempt intercourse - Over the past 6 months intercourse was not attempted.
- at0019::Almost never or never - Over the past 6 months erection was almost never or never maintained after penetration.
- at0020::A few times - Over the past 6 months erection was maintained after penetration a few times.
- at0021::Sometimes - Over the past 6 months erection was sometimes maintained after penetration.
- at0022::Most times - Over the past 6 months erection was maintained after penetration most times.
- at0023::Almost always or always - Over the past 6 months erection was almost always or always maintained after penetration.
- at0024::Maintain to completion - Frequency of erection being maintained to completion of intercourse.
- at0025::Did not attempt intercourse - Over the past 6 months intercourse was not attempted.

- at0026::Extremely difficult - Over the past 6 months it was extremely difficult to maintain erections to completion of intercourse.
- at0027::Very difficult - Over the past 6 months it was very difficult to maintain erections to completion of intercourse.
- at0028::Difficult - Over the past 6 months it was difficult to maintain erections to completion of intercourse.
- at0029::Slightly difficult - Over the past 6 months it was slightly difficult to maintain erections to completion of intercourse.
- at0030::Not difficult - Over the past 6 months it was not difficult to maintain erections to completion of intercourse.
- at0031::Satisfactory - Frequency of satisfactory outcome of intercourse.
- at0032::Did not attempt intercourse - Over the past 6 months intercourse was not attempted.
- at0033::Almost never or never - Over the past 6 months intercourse was almost never or never satisfactory.
- at0034::A few times - Over the past 6 months intercourse was satisfactory a few times.
- at0035::Sometimes - Over the past 6 months intercourse was sometimes satisfactory.
- at0036::Most times - Over the past 6 months intercourse was satisfactory most times.
- at0037::Almost always or always - Over the past 6 months intercourse was almost always or always satisfactory.
- at0038::IIEF-5 Score - The IIEF-5 is administered as a screening instrument for the presence & severity of ED in conjunction with the clinical assessment. The score is the sum of the responses to the five items, so that overall score may range from 1 to 25. A score of 20 or higher indicates a normal degree of erectile functioning. Low scores (10 or less) indicate moderate to severe ED.
- at0039::Tree - @ internal @
- at0040::Confounding factors - Description of any incidental factors that may have contributed to the score.
- at0041::Tree - @ internal @
- at0042::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

Comment: e.g. Local information requirements or additional metadata to align with FHIR or CIMI equivalents.

ikdc

Archetype ID: openEHR-EHR-OBSERVATION.ikdc.v0

Lifecycle State: in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** For the recording and reporting of the patient reported results of the Subjective knee evaluation score developed by the International Knee Documentation Committee.

****Use:**** Use to record the patient reported results of the Subjective knee evaluation score developed by the International Knee Documentation Committee. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Keywords:**** knee, evaluation, subjective, score, PROM

****Concepts:****

- at0000::IKDC subjective knee evaluation - International Knee Documentation Committee (IKDC) Subjective knee evaluation score.
- at0001::History - *
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0006::ItemTree - @ internal @
- at0007::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0008::Highest level of activity without pain - Patient reported highest level of activity they can perform without significant knee pain.
- at0009::Unable to perform any activities - Patient reports that they are unable to perform any activities due to knee pain.
- at0010::Light activities - Patient reports that they are able to perform light activities like walking, housework or gardening.
- at0011::Moderate activities - Patient reports that they are able to perform moderate activities like moderate physical work, running or jogging.
- at0012::Strenuous activities - Patient reports that they are able to perform strenuous activities like heavy physical work, skiing or tennis.
- at0013::Very strenuous activities - Patient reports that they are able to perform very strenuous activities like jumping or pivoting as in gymnastics or football.
- at0014::Symptoms - Patient reported extent of symptoms due to knee pain.

- at0015::Frequency of pain - Patient reported frequency of pain during past 4 weeks or since injury where 0 represents never and 10 represents constant.
- at0016::Severity of pain - Patient reported severity of pain where 0 represents no pain and 10 represents worst pain imaginable.
- at0017::Stiff or swollen knee - Patient reported degree of stiffness or swelling of knee during past 4 weeks or since injury.
- at0018::Extremely - Patient reports that knee has been extremely stiff or swollen during past 4 weeks or since injury.
- at0019::Very - Patient reports that knee has been very stiff or swollen during past 4 weeks or since injury.
- at0020::Moderately - Patient reports that knee has been moderately stiff or swollen during past 4 week or since injury.
- at0021::Mildly - Patient reports that knee has been mildly stiff or swollen during past 4 weeks or since injury.
- at0022::Not at all - Patient reports that knee has not at all been stiff or swollen during past 4 weeks or since injury.
- at0023::Highest level of activity without swelling - Patient reported highest level of activity they can perform without significant swelling in knee.
- at0024::Unable to perform any activities - Patient reports that they are unable to perform any activities due to knee swelling.
- at0025::Light activities - Patient reports that they are able to perform light activities like walking, housework or gardening.
- at0026::Moderate activities - Patient reports that they are able to perform moderate activities like moderate physical work, running or jogging.
- at0027::Strenuous activities - Patient reports that they are able to perform strenuous activities like heavy physical work, skiing or tennis.
- at0028::Very strenuous activities - Patient reports that they are able to perform very strenuous activities like jumping or pivoting as in gymnastics or football.
- at0029::Locked or caught - Patient indicates if knee has locked or caught in the past 4 weeks.
- at0030::Highest level of activity without giving way - Patient reported highest level of activity they can perform without significant giving way in their knee.
- at0031::Unable to perform any activities - Patient reports that they are unable to perform any activities due to knee pain.
- at0032::Light activities - Patient reports that they are able to perform light activities like walking, housework or gardening.
- at0033::Moderate activities - Patient reports that they are able to perform moderate activities like moderate physical work, running or jogging.
- at0034::Strenuous activities - Patient reports that they are able to perform strenuous activities like heavy physical work, skiing or tennis.
- at0035::Very strenuous activities - Patient reports that they are able to perform very strenuous activities like jumping or pivoting as in gymnastics or football.

- at0037::Sport Activities - Patient reported impact on sporting activities undertaken due to knee pain.
- at0038::Highest level of activity you can participate in - Patient reported highest level of activity they can participate in on a regular basis.
- at0039::Unable to perform any activities - Patient reports that they are unable to perform any activities on a regular basis.
- at0040::Light activities - Patient reports that they are able to perform light activities like walking, housework or gardening on a regular basis.
- at0041::Moderate activities - Patient reports that they are able to perform moderate activities like moderate physical work, running or jogging on a regular basis.
- at0042::Strenuous activities - Patient reports that they are able to perform strenuous activities like heavy physical work, skiing or tennis on a regular basis.
- at0043::Very strenuous activities - Patient reports that they are able to perform very strenuous activities like jumping or pivoting as in gymnastics or football on a regular basis.
- at0044::How does knee affect your ability to - Collection of questions relating to the patients ability to participate in various activities.
- at0045::Go up stairs - Patient reported ability to go up stairs.
- at0046::Unable to do - The patient is unable to perform the activity.
- at0047::Extremely difficult - The patient finds it extremely difficult to perform the activity.
- at0048::Moderately difficult - The patient finds it moderately difficult to perform the activity.
- at0049::Minimally difficult - The patient finds it minimally difficult to perform the activity.
- at0050::Not difficult at all - The patient finds it not difficult at all to perform the activity.
- at0051::Go down stairs - Patient reported ability to go down stairs.
- at0052::Unable to do - The patient is unable to perform the activity.
- at0053::Extremely difficult - The patient finds it extremely difficult to perform the activity.
- at0054::Moderately difficult - The patient finds it moderately difficult to perform the activity.
- at0055::Minimally difficult - The patient finds it minimally difficult to perform the activity.
- at0056::Not difficult at all - The patient finds it not difficult at all to perform the activity.
- at0057::Kneel on front of knee - Patient reported ability to kneel on front of knee.
- at0058::Unable to do - The patient is unable to perform the activity.
- at0059::Extremely difficult - The patient finds it extremely difficult to perform the activity.
- at0060::Moderately difficult - The patient finds it moderately difficult to perform the activity.

- at0061::Minimally difficult - The patient finds it minimally difficult to perform the activity.
- at0062::Not difficult at all - The patient finds it not difficult at all to perform the activity.
- at0063::Squat - Patient reported ability to squat.
- at0064::Unable to do - The patient is unable to perform the activity.
- at0065::Extremely difficult - The patient finds it extremely difficult to perform the activity.
- at0066::Moderately difficult - The patient finds it moderately difficult to perform the activity.
- at0067::Minimally difficult - The patient finds it minimally difficult to perform the activity.
- at0068::Not difficult at all - The patient finds it not difficult at all to perform the activity.
- at0069::Sit with your knee bent - Patient reported ability to sit with your knee bent.
- at0070::Unable to do - The patient is unable to perform the activity.
- at0071::Extremely difficult - The patient finds it extremely difficult to perform the activity.
- at0072::Moderately difficult - The patient finds it moderately difficult to perform the activity.
- at0073::Minimally difficult - The patient finds it minimally difficult to perform the activity.
- at0074::Not difficult at all - The patient finds it not difficult at all to perform the activity.
- at0075::Rise from a chair - Patient reported ability to rise from a chair.
- at0076::Unable to do - The patient is unable to perform the activity.
- at0077::Extremely difficult - The patient finds it extremely difficult to perform the activity.
- at0078::Moderately difficult - The patient finds it moderately difficult to perform the activity.
- at0079::Minimally difficult - The patient finds it minimally difficult to perform the activity.
- at0080::Not difficult at all - The patient finds it not difficult at all to perform the activity.
- at0081::Run straight ahead - Patient reported ability to run straight ahead.
- at0082::Unable to do - The patient is unable to perform the activity.
- at0083::Extremely difficult - The patient finds it extremely difficult to perform the activity.
- at0084::Moderately difficult - The patient finds it moderately difficult to perform the activity.
- at0085::Minimally difficult - The patient finds it minimally difficult to perform the activity.
- at0086::Not difficult at all - The patient finds it not difficult at all to perform the activity.
- at0087::Jump and land on your involved leg - Patient reported ability to jump and land on your involved leg.
- at0088::Unable to do - The patient is unable to perform the activity.

- at0089::Extremely difficult - The patient finds it extremely difficult to perform the activity.
- at0090::Moderately difficult - The patient finds it moderately difficult to perform the activity.
- at0091::Minimally difficult - The patient finds it minimally difficult to perform the activity.
- at0092::Not difficult at all - The patient finds it not difficult at all to perform the activity.
- at0093::Stop and start quickly - Patient reported ability to stop and start quickly.
- at0094::Unable to do - The patient is unable to perform the activity.
- at0095::Extremely difficult - The patient finds it extremely difficult to perform the activity.
- at0096::Moderately difficult - The patient finds it moderately difficult to perform the activity.
- at0097::Minimally difficult - The patient finds it minimally difficult to perform the activity.
- at0098::Not difficult at all - The patient finds it not difficult at all to perform the activity.
- at0099::Function - Patient reported knee function before injury and current state.
- at0100::Function prior - Patient reported function prior to knee injury where 0 represents couldn't perform daily activities and 10 represents no limitation in daily activities.
- at0103::Function current - Patient reported current knee function where 0 represents couldn't perform daily activities and 10 represents no limitation in daily activities.
- at0104::Total score - Total score from Questions 1 to 10
- at0105::Total score as percentage - Total score from all questions as a percentage.

[imaging_exam_result](#)

Archetype ID: openEHR-EHR-OBSERVATION.imaging_exam_result.v1

Lifecycle State: published

Category: OBSERVATION

Languages: de, sv, nb, en

Purpose: To record the findings on imaging examination of a specified body structure or region and their interpretation, using radiological techniques.

Use: Use to record the findings on imaging examination of a specified body structure or region and their interpretation, using radiological techniques. This archetype has been designed to focus on the reporting of findings and interpretation associated with a single imaging examination (equivalent to a single DICOM study). References to DICOM-related

attributes are included but the focus is on the representation of a clinical report from an imaging examination and not on representing DICOM-related attributes that might be expected within a radiology information system. Specific details about the DICOM series can be recorded using the CLUSTER.imaging_series nested within the 'Series details' SLOT. Detailed findings observed during an imaging examination and targeting a specified structure or region can be recorded by nesting the CLUSTER.imaging_exam and/or its family of specialised archetypes within the 'Structured imaging findings' SLOT in this archetype. It is intended that over time the specific detail in each specialisation will grow to include findings using all imaging modalities. If an imaging examination is carried out as part of a more complex activity, such as a surgical operation carried out under imaging guidance, the imaging findings should be recorded using this archetype. Structured details about the surgical procedure and medications or contrast administered should be recorded using the ACTION.procedure and/or ACTION.medication archetypes, respectively. In this situation, it is recommended that all related archetypes should be reported within the same template. This result will normally be reported back to the requesting clinician as one component within the context of an overall COMPOSITION-based report.

****Misuse:**** Not to be used to record findings on physical examination. Use the CLUSTER.exam and/or its family of specialised archetypes for this purpose. Not to be used to replicate the functionality or specifications of a radiology information or source system. Not to be used to record structured details about any procedure undertaken. Use the specific procedure-related archetypes, such as ACTION.procedure archetype for this purpose. Not to be used to record structured details about medications administered during the imaging test. Use specific medication-related archetypes, such as the ACTION.medication archetype for this purpose. Not to be used to record photographs or videos within the health record. Use the CLUSTER.media_file archetype for this purpose.

****Keywords:**** image, radiology, modality, xray, CT, ultrasound, MRI, diagnostic, scan, x-ray, imaging, biomagnetic, densitometry, tomography, radiography, magnetic, resonance, mammography, nuclear, medicine, positron, PET, angiography, fluoroscopy

****Concepts:****

- at0000::Imaging examination result - The result of an imaging examination performed on an individual, using radiological techniques.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Study name - The name of the imaging examination performed.
- at0006::Structured target body site - Structured detail about the body site or region targetted for imaging.
- at0008::Imaging findings - Narrative description or overview of all clinical findings.

- at0014::Clinical summary - Narrative description of relevant clinical history that provides context for the examination and interpretation of results.
- at0020::Imaging diagnosis - Single word, phrase or brief description representing the likely condition or diagnosis.
- at0021::Overall impression - Narrative concise, clinically relevant interpretation of all imaging findings, and include a comparison with previous studies where appropriate.
- at0023::Comment - Additional narrative about the examination not captured in other fields.
- at0025::Tree - @ internal @
- at0026::Imaging service - Details about the service, organisation or individual carrying out the imaging examination.
- at0027::Examination request details - Details about a single imaging examination requested.
- at0028::Requester order identifier - Unique identifier for the imaging examination order assigned by the requester.
- at0029::Examination requested name - Identification of imaging examination requested.
- at0030::Requester - Details about the clinician and/or organisation requesting the imaging examination.
- at0031::Receiver order identifier - Unique identifier for the imaging examination order assigned by the radiology service.
- at0041::Structured technique/procedure - Additional structured details of technical and clinical aspects of capturing the image/s.
- at0044::Structured imaging findings - Structured details about the imaging examination findings targeting a specific structure or region.
- at0045::Report representation - Digital representation of the examination result.
- at0046::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0047::Tree - @ internal @
- at0048::Confounding factors - Narrative description of factors, not recorded elsewhere, that may influence the examination findings and/or result.
- at0049::Technique summary - Narrative description about the radiological procedure used to capture the study.
- at0055::Target body site - Description of the simple body site or region targetted for imaging.
- at0056::Comparison findings - Narrative description about the comparison of this examination with previous similar studies.
- at0057::Imaging quality description - Narrative description about the quality of the examination.
- at0058::Imaging differential diagnosis - Single word, phrase or brief description representing a possible condition or diagnosis.
- at0059::Recommendation - Suggestion for further imaging, investigations and/or referral, and associated rationale.

- at0061::Clinical indication - Narrative description about the reason the examination was originally requested.
- at0062::Procedure summary - Narrative description about the clinical procedure or other clinical considerations used to capture the study.
- at0063::Imaging quality - Assessment about the quality of the examination.
- at0065::Series details - Details about a series included in this report.
- at0067::Comparison series details - Details about an imaging series being compared to the reported study.
- at0069::Device - Details about imaging device/s used to capture the study.
- at0070::Study date - Date/time when the imaging started.
- at0071::Status timestamp - The date and/or time that 'Overall result status' was assigned.
- at0072::Overall result status - The status of the imaging examination result as a whole.
- at0073::Registered - The existence of the study is registered, but no result is yet available.
- at0074::Partial - This is a partial (e.g. initial, interim or preliminary) result but data may be incomplete or unverified.
- at0075::Preliminary - Verified early results are available, but not all results are final. This is a sub-category of 'Partial'.
- at0076::Final - The result is complete and verified by an authorised person.
- at0077::Amended - Subsequent to being final, the result has been modified.
- at0078::Corrected - Subsequent to being final, the result has been modified to correct an error. This is a sub-category of 'Amended'.
- at0079::Appended - Subsequent to being final, the result has been modified by adding new content. The existing content is unchanged. This is a sub-category of 'Amended'.
- at0080::Cancelled - The result is unavailable because the test was not started or not completed (also sometimes called 'aborted').
- at0083::Distribution list - Details of additional clinicians or organisations who require a copy of the examination result.
- at0087::Technique - Name of the radiological procedure used to capture the study.
- at0088::Procedure - Identification of the clinical procedure or management used to capture the study.
- at0090::Unknown - The status of the result is not known.
- at0091::Modality - The type of imaging device, process or method that originally acquired or produced the data used to create the images in the study.
- at0092::Study instance identifier - Unique identifier for the imaging study assigned by the imaging device.
- at0093::Comparison study details - Details about images from a prior study used for comparison to the reported study.
- at0094::Study name - The name of the comparison imaging examination performed.
- at0095::Study identifier - Unique identifier for the comparison imaging study.
- at0096::Study date - Date and time the comparison examination started.

- at0097::Study end point - Digital location of the comparison imaging content and metadata.
- at0098::Study end point - Digital location of the imaging content and metadata.
- at0099::Study status - The current state of the imaging study.
- at0100::Registered - The existence of the imaging study is registered, but there is nothing yet available.
- at0101::Available - At least one instance has been associated with this imaging study.
- at0102::Cancelled - The imaging study is unavailable because the study was not started or not completed.
- at0103::Unknown - The status is not known by the radiology source system.
- at0104::Report identifier - Unique identifier for the imaging report assigned by the radiology service.
- at0105::Study description - Radiology service-generated description or classification of the study.
- at0106::Image details - Link to full details of any imaging carried out during the study.
- at0107::Stabilising appliance - Identification of a stabilising appliance in use.
- at0108::Position - Position of the individual during the imaging examination.

[infant_feeding](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.infant_feeding.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** pt-br, en, ar-sy

****Purpose:**** Record details about feeding a person.

****Concepts:****

- at0000::Feeding - Information about the feeding of the person.
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0004::Function - *
- at0005::Sucking - The ability to suck.
- at0006::unable to suck - No ability to suck.
- at0007::some ability - Can make sucking action but not effective.
- at0008::reduced sucking - Can suck effectively but not sufficient for needs.
- at0009::normal - Able to suck normally.

- at0010::Description - Description of feeding.
- at0011::Swallowing - Ability to swallow.
- at0012::Unable to swallow - Not able to pass food to the back of mouth and swallow.
- at0013::Some ability to swallow - Some ability to swallow but very limited and/or does not protect airway.
- at0014::Reduced swallow - Able to swallow but not sufficient for needs or major risk of aspiration.
- at0015::Normal - Can swallow normally.
- at0016::Other method - The method of feeding.
- at0017::Type - Type of feeding.
- at0019::Bottle - Feeding from the bottle.
- at0020::Nasogastric tube - Feeding by naso-gastric tube.
- at0021::Gastrostomy tube - Feeding by gastrostomy tube.
- at0022::Proportion - The proportion by this method.
- at0023::Volume by this method - Volume delivered by this method.
- at0024::Time taken - Time feeding by this method.
- at0026::Content - The milk or other food delivered.
- at0027::Spoon - Feeding by spoon or similar.
- at0028::Breast feeding - Record about breast feeding.
- at0029::Description - *
- at0030::Infant feeding category - The content of the feeding.
- at0031::Breast - Only breast milk.
- at0032::Formula - Only baby formula.
- at0033::Mixed - Breast and formular mixed.

[**intermacs_profile**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.intermacs_profile.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the INTERMACS profile of a patient at the time of implant of a mechanical support.

****Use:**** Use to record the INTERMACS profile of a patient at the time of implant of a mechanical support.

****Keywords:**** INTERMACS, heart failure, profiles

****Concepts:****

- at0000::INTERMACS profile - Categorisation of the severity and level of limitation of advanced heart failure on a patient at the time of implant of a mechanical support, as defined by the Interagency Registry for Mechanically Assisted Circulatory Support (INTERMACS) data registry.
- at0001::History - History.
- at0002::Any Event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0006::Profile - Categorisation of the level of limitation at the time of implant.
- at0007::Critical cardiogenic shock - Patients with life-threatening hypotension despite rapidly escalating inotropic support, critical organ hypoperfusion, often confirmed by worsening acidosis and/or lactate levels. "Crash and burn".
- at0008::Progressive decline on inotropic support - Patient with declining function despite intravenous inotropic support, may be manifest by worsening renal function, nutritional depletion, inability to restore volume balance "Sliding on inotropes." Also describes declining status in patients unable to tolerate inotropic therapy.
- at0009::Stable but inotrope dependent - Patient with stable blood pressure, organ function, nutrition, and symptoms on continuous intravenous inotropic support (or a temporary circulatory support device or both), but demonstrating repeated failure to wean from support due to recurrent symptomatic hypotension or renal dysfunction "Dependent stability".
- at0010::Resting symptoms - Patient can be stabilized close to normal volume status but experiences daily symptoms of congestion at rest or during ADL. Doses of diuretics generally fluctuate at very high levels. More intensive management and surveillance strategies should be considered, which may in some cases reveal poor compliance that would compromise outcomes with any therapy. Some patients may shuttle between 4 and 5.
- at0011::Exertion intolerant - Comfortable at rest and with ADL but unable to engage in any other activity, living predominantly within the house. Patients are comfortable at rest without congestive symptoms, but may have underlying refractory elevated volume status, often with renal dysfunction. If underlying nutritional status and organ function are marginal, patient may be more at risk than INTERMACS 4, and require definitive intervention.
- at0012::Exertion limited - Patient without evidence of fluid overload is comfortable at rest, and with activities of daily living and minor activities outside the home but fatigues after the first few minutes of any meaningful activity. Attribution to cardiac limitation requires careful measurement of peak oxygen consumption, in some cases with hemodynamic monitoring to confirm severity of cardiac impairment. "Walking wounded".
- at0013::Advanced NYHA Class III symptoms - A placeholder for more precise specification in future, this level includes patients who are without current or recent

episodes of unstable fluid balance, living comfortably with meaningful activity limited to mild physical exertion.

- at0016::ItemTree - @ internal @
- at0018::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0019::'A' modifier - Modifier indicating the occurrence of frequent arrhythmias (A).
- at0020::'TCS' modifier - Modifier indicating the use of temporary circulatory support (TCS).
- at0021::Present - The qualifier is present.
- at0022::Absent - The qualifier is absent.
- at0023::'FF' modifier - Modifier indicating the need for frequent rehospitalisation (FF).

[intraocular_pressure](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.intraocular_pressure.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the measurement of intraocular pressure in a single eye.

****Use:**** Use to record the measurement of intraocular pressure in a single eye. Record the details of each eye using a separate data instance from this archetype. The CLUSTER.exclusion_exam archetype can be nested within the 'Measurement not done' SLOT to optionally record explicit details about the measurement not being performed.

****Keywords:**** IOP, tonometry, glaucoma, eye

****Concepts:****

- at0000::Intraocular pressure test result - The local measurement of intraocular pressure, most commonly using a tonometry device.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0007::Tree - @ internal @
- at0042::Pressure - Measured intraocular pressure.
- at0046::Tonometry method - Type of tonometry used to measure intraocular pressure.
- at0047::Goldmann - Goldmann tonometry.

- at0048::Perkins - Perkins tonometry.
- at0049::Tono-Pen - Tono-Pen tonometry.
- at0050::Icare (Rebound) - Icare (Rebound) tonometry.
- at0051::Dynamic Contour - Dynamic Contour tonometry.
- at0052::Ocular Response Analyzer - Ocular Response Analyzer.
- at0053::TGDC-01 - A TGDC-01 device was used to perform the test.
- at0055::Device details - Details about the tonometry device used to measure intraocular pressure.
- at0057::Eye examined - Identification of the eye under examination.
- at0058::Left eye - The left eye was examined.
- at0059::Right eye - The right eye was examined.
- at0061::Clinical interpretation - Single word, phrase or brief description that represents the clinical meaning and significance of the physical examination findings.
- at0063::Comment - Additional narrative about the measurement, not captured in other fields.
- at0065::Applanation time - The time taken for a non-contact tonometer to flatten the cornea, used to calculate intraocular pressure.
- at0066::Non-contact tonometry - Non-contact tonometry was used to perfrom the test.
- at0068::Tree - @ internal @
- at0074::Confounding factors - Description of any incidental factors related to the state of the subject which may affect clinical interpretation of the measurement.
- at0078::Test not done - Details to explicitly record that this test was not performed.
- at0079::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0080::Multimedia - Digital image, video or diagram representing the measurement of intraocular pressure.
- at0081::Corrected pressure - Corrected value for intraocular pressure.
- at0082::Correction description - Narrative description about the method used to correct the original intraocular pressure measurement.

intravascular_pressure

****Archetype ID:**** openEHR-EHR-OBSERVATION.intravascular_pressure.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en, ar-sy

****Purpose:**** To record intravascular venous, arterial, pulmonary or cardiac pressure measurement.

****Use:**** Use to record the measured pressure in a specific location, blood vessel or heart cavity, at a specific phase of the heart or an average over the heart cycle.

****Misuse:**** Not to be used for Systolic and Diastolic blood pressure. Use the OBSERVATION.blood_pressure for this purpose.

****Keywords:**** pressure, intravascular, central, venous

****Concepts:****

- at0000::Intravascular pressure - The measured pressure in a specific location, blood vessel or heart cavity, at a specific phase of the heart or an average over the heart cycle.
- at0001::history - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Average over heart cycle - The average over one heart cycle.
- at0005::Pressure - The measured intravascular pressure.
- at0007::Phase of heart cycle - The phase of the heart cycle at the time of the measurement.
- at0008::Systolic - During contraction of the heart.
- at0009::Diastolic - During relaxation of the heart.
- at0021::Tree - @ internal @
- at0023::Pre-systolic - Phase of the heart immediately prior to contraction of the heart.
- at0024::Pre-diastolic - The phase of the heart immediately prior to filling of the ventricle.
- at0027::Whole cycle - The pressure measured is over the whole heart cycle.
- at0030::Device - Details about the device used to record the measurement.
- at0033::Multimedia representation - Digital image, video, wave form or diagram representing the findings.
- at0035::Comment - Additional narrative about the intravascular pressure measurement not captured in other fields.
- at0036::Structured measurement location - Structured anatomical location of where the measurement was taken.
- at0038::Tree - @ internal @
- at0039::Position - Position of patient during measurement.
- at0040::Confounding factors - Comment on and record other incidental factors that may be contributing to the intravascular pressure measurement.
- at0041::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

- at0042::Clinical interpretation - Single word, phrase or brief description that represents the clinical meaning and significance of the intravascular pressure.
- at0043::Location of measurement - Simple body site where blood pressure was measured.
- at0044::Method - Description about how the intravascular pressure was measured.

investigation_screening-JM

****Archetype ID:**** openEHR-EHR-OBSERVATION.investigation_screening-JM.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about diagnostic investigations or group of investigations, including but not limited to imaging examinations and laboratory tests.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about diagnostic investigations or groups of investigations. The scope of diagnostic investigations includes all modalities of imaging examinations and the broadest range of laboratory and anatomical pathology tests. In addition, this archetype can also be used to record when other diagnostic tests have been carried out, such as cardiac stress testing, hearing and vision testing, electrocardiography (ECG) and electroencephalography (EEG). Common use cases include, but are not limited to: - Patient self-reporting - Creating a patient profile in a disease registry - Systematic questioning in any consultation related to patterns of investigation administration The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. Each data element would usually be renamed in a template to represent the specific question asked. Where value sets have been proposed for common use cases, these can be adapted to align with local requirements by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. Utilising this framework within a template can enable documentation of a broad range of question/answer pairs such as: - Have you ever had your cholesterol level tested? Yes, No, Unknown. - Have you been tested for rubella antibodies? Yes, No, Unknown. - Have you ever been screened for sickle cell disease? Yes, No, Unknown. - When was your last Chest X-ray? - What was the result of your most recent INR test? - What were the findings of the electrocardiogram? - Did the infant pass/fail a Neonatal hearing screen? The EVENT structure from the reference model can be used to specify whether the questions relate to a point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire

recording information about an investigation or test that has been done at any time in the past and information about an investigation or test done within a specified time interval - for example, the difference between "Have you ever had an INR test?" compared to "Have you had an INR test during the last four weeks?". The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies an investigation has been carried out, additional details required for persistence as part of a clinical record can be captured using specific test result archetypes.

****Misuse:**** Not to be used for recording an order for an investigation - use INSTRUCTION.service_request for this purpose. Not to be used for recording the progress of activities performed as part of an investigation - use appropriate ACTION archetypes for this purpose. Not to be used to record formal diagnostic test results - use appropriate OBSERVATIONS for this purpose. For example, the OBSERVATION.laboratory_test_result or OBSERVATION.imaging_examination_result.

****Keywords:**** investigation, screening, questionnaire, prevention, imaging, laboratory, pathology, blood, sample, sputum, EMG, ECG, hearing, test, examination, spinal fluid, biopsy, EEG, MRI, CT, X-ray, PET, ultrasound, spirometry

****Concepts:****

- at0001::Tree - @ internal @
- at0002::Conclusion - Brief description, summary or interpretation of the investigation outcome.
- at0003::Timing - Indication of timing related to the investigation.
- at0005::Tree - @ internal @
- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0021::Investigation name - Name of the diagnostic investigation or grouping of investigations.
- at0022::Event Series - @ internal @
- at0023::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0024::Done? - Is there a history of the investigation being carried out?
- at0025::Comment - Additional narrative about the diagnostic investigation test not captured in other fields.
- at0026::Specific investigation - Details about a specified investigation or grouping of investigations relevant for the screening purpose.
- at0027::Any investigations? - Is there a history of any diagnostic tests or investigations related to the screening purpose?
- at0028::Yes - None

- at0029::No - None
- at0030::Unknown - None
- at0036::Yes - None
- at0037::No - None
- at0039::Unknown - None
- at0040::Screening purpose - The context or reason for screening.
- at0041::Additional details - Structured details or questions about the specific investigation or group of investigations.
- at0043::Description - Narrative description about the history of any investigations relevant for the screening purpose.
- at0044::Additional details - Structured details or questions about screening for diagnostic investigations.
- at0000.1::Diagnostic investigation screening questionnaire - Series of questions and associated answers used to screen whether diagnostic investigations have been carried out.
- at0.1::Result details - None

investigation_screening

****Archetype ID:**** openEHR-EHR-OBSERVATION.investigation_screening.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en, es, ca

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about diagnostic investigations or group of investigations, including but not limited to imaging examinations and laboratory tests.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about diagnostic investigations or groups of investigations. The scope of diagnostic investigations includes all modalities of imaging examinations and the broadest range of laboratory and anatomical pathology tests. In addition, this archetype can also be used to record when other diagnostic tests have been carried out, such as cardiac stress testing, hearing and vision testing, electrocardiography (ECG) and electroencephalography (EEG). Common use cases include, but are not limited to: - Patient self-reporting - Creating a patient profile in a disease registry - Systematic questioning in any consultation related to patterns of investigation administration The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. Each data element would usually be renamed in a template to

represent the specific question asked. Where value sets have been proposed for common use cases, these can be adapted to align with local requirements by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. Utilising this framework within a template can enable documentation of a broad range of question/answer pairs such as: - Have you ever had your cholesterol level tested? Yes, No, Unknown. - Have you been tested for rubella antibodies? Yes, No, Unknown. - Have you ever been screened for sickle cell disease? Yes, No, Unknown. - When was your last Chest X-ray? - What was the result of your most recent INR test? - What were the findings of the electrocardiogram? - Did the infant pass/fail a Neonatal hearing screen? The EVENT structure from the reference model can be used to specify whether the questions relate to a point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about an investigation or test that has been done at any time in the past and information about an investigation or test done within a specified time interval - for example, the difference between "Have you ever had an INR test?" compared to "Have you had an INR test during the last four weeks?". The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies an investigation has been carried out, additional details required for persistence as part of a clinical record can be captured using specific test result archetypes.

****Misuse:**** Not to be used for recording an order for an investigation - use INSTRUCTION.service_request for this purpose. Not to be used for recording the progress of activities performed as part of an investigation - use appropriate ACTION archetypes for this purpose. Not to be used to record formal diagnostic test results - use appropriate OBSERVATIONS for this purpose. For example, the OBSERVATION.laboratory_test_result or OBSERVATION.imaging_examination_result.

****Keywords:**** investigation, screening, questionnaire, prevention, imaging, laboratory, pathology, blood, sample, sputum, EMG, ECG, hearing, test, examination, spinal fluid, biopsy, EEG, MRI, CT, X-ray, PET, ultrasound, spirometry

****Concepts:****

- at0000::Diagnostic investigation screening questionnaire - Series of questions and associated answers used to screen whether diagnostic investigations have been carried out.
- at0001::Tree - @ internal @
- at0002::Conclusion - Brief description, summary or interpretation of the investigation outcome.
- at0003::Timing - Indication of timing related to the investigation.
- at0005::Tree - @ internal @

- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0021::Investigation name - Name of the diagnostic investigation or grouping of investigations.
- at0022::Event Series - @ internal @
- at0023::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0024::Done? - Is there a history of the investigation being carried out?
- at0025::Comment - Additional narrative about the diagnostic investigation test not captured in other fields.
- at0026::Specific investigation - Details about a specified investigation or grouping of investigations relevant for the screening purpose.
- at0027::Any investigations? - Is there a history of any diagnostic tests or investigations related to the screening purpose?
- at0028::Yes - None
- at0029::No - None
- at0030::Unknown - None
- at0036::Yes - None
- at0037::No - None
- at0039::Unknown - None
- at0040::Screening purpose - The context or reason for screening.
- at0041::Additional details - Structured details or questions about the specific investigation or group of investigations.
- at0043::Description - Narrative description about the history of any investigations relevant for the screening purpose.
- at0044::Additional details - Structured details or questions about screening for diagnostic investigations.
- at0045::Unsure - None
- at0046::Unsure - None
- at0047::Type - The method, technique, modality or other more specific identification of the diagnostic investigation.

ipss

Archetype ID: openEHR-EHR-OBSERVATION.ipss.v1

Lifecycle State: published

Category: OBSERVATION

Languages: nb, en

****Purpose:**** To record the results for each component parameter and their total sum for the IPSS.

****Use:**** Use to record the results for each component parameter and their total sum for the IPSS.

****Misuse:**** Do not use to record prostate-related symptoms - use the CLUSTER.symptom_sign for this purpose.

****Keywords:**** I-PSS, IPSS, prostate, BPH

****Concepts:****

- at0000::International prostate symptom score (IPSS) - An assessment score used to screen for, diagnose, and track symptoms of benign prostatic hyperplasia (BPH).
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Incomplete emptying - Over the past month how often have you had the sensation of not emptying your bladder completely after urinating?
- at0005::Not at all - None
- at0006::Less than 1 time in 5 - None
- at0007::Less than half the time - None
- at0008::About half the time - None
- at0009::More than half the time - None
- at0010::Almost always - None
- at0011::Frequency - Over the past month, how often have you had to urinate again less than two hours after you finished urinating?
- at0012::Intermittency - Over the past month, how often have you found you stopped and started again several times when you urinated?
- at0013::Urgency - Over the past month, how often have you found it difficult to postpone urination?
- at0014::Weak Stream - Over the last month, how often have you had a weak urinary stream?
- at0015::Straining - Over the past month, how often have you had to push or strain to begin urination?
- at0016::Nocturia - Over the past month how many times did you most typically get up each night to urinate, from the time you went to bed until the time you got up in the morning?
- at0017::None - None
- at0018::1 time - None
- at0019::2 times - None
- at0020::3 times - None

- at0021::4 times - None
- at0022::5 or more - None
- at0023::Total score (S) - The total sum of each component parameter for the IPSS.
- at0024::Quality of life - If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?
- at0025::Delighted - None
- at0026::Pleased - None
- at0027::Mostly satisfied - None
- at0028::Equally satisfied/dissatisfied - None
- at0029::Mostly dissatisfied - None
- at0030::Unhappy - None
- at0031::Terrible - None
- at0033::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0032::Tree - @ internal @

iss-revised

****Archetype ID:**** openEHR-EHR-OBSERVATION.iss-revised.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter and the resulting R-ISS stage.

****Use:**** Use to record the results for each component parameter and the resulting R-ISS stage.

****Keywords:**** albumin, multiple, myeloma, staging, system

****Concepts:****

- at0.1::CA by iFISH - Chromosomal abnormalities (CA) detected by
 - interphase fluorescent in situ hybridization (iFISH).
- at0.10::R-ISS III - ISS stage III and either high-risk CA by iFISH or high LDH.
- at0.2::Standard risk - No high risk CA.
- at0.3::High risk - Presence of del(17p) and/or translocation t(4;14) and/or translocation t(14;16).

- at0.4::Serum LDH - None
- at0.5::Normal - Serum LDH < the upper limit of normal.
- at0.6::High - Serum LDH > the upper limit of normal.
- at0.7::Revised ISS stage - None
- at0.8::R-ISS I - ISS stage I and standard-risk CA by iFISH and normal LDH.
- at0.9::R-ISS II - Not R-ISS stage I or III.
- at0000.1::Revised International Staging System for Multiple Myeloma (R-ISS) - A staging system for classifying and stratifying patients with multiple myeloma.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Serum β 2 microglobulin - None
- at0005::<3.5 mg/L - None
- at0006::3.5-5.4 mg/L - None
- at0007::>5.4 mg/L - None
- at0008::Serum albumin - None
- at0009::<3.5 g/dL - None
- at0010:: \geq 3.5 g/dL - None
- at0011::ISS stage - None
- at0012::ISS I - Serum β 2-microglobulin <3.5 mg/L and serum albumin \geq 3.5 g/dL.
- at0013::ISS II - Not stage I or III.
- at0014::ISS III - Serum β 2-microglobulin \geq 5.5 mg/L.
- 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.

iss

****Archetype ID:**** openEHR-EHR-OBSERVATION.iss.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter and the resulting ISS stage.

****Use:**** Use to record the results for each component parameter and the resulting ISS stage.

****Misuse:**** Not to be used to record the results for the Revised Multiple Myeloma International Staging System (R-ISS) - use the specialisation of this archetype for this purpose.

****Keywords:**** albumin, multiple, myeloma, staging, system

****Concepts:****

- at0000::International Staging System for Multiple Myeloma (ISS) - A staging system for classifying and stratifying patients with multiple myeloma.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Serum β 2 microglobulin - None
- at0008::Serum albumin - None
- at0011::ISS stage - None
- at0012::ISS I - Serum β 2-microglobulin <3.5 mg/L and serum albumin \geq 3.5 g/dL.
- at0013::ISS II - Not stage I or III.
- at0014::ISS III - Serum β 2-microglobulin \geq 5.5 mg/L.
- at0005::<3.5 mg/L - None
- at0006::3.5-5.4 mg/L - None
- at0007::>5.4 mg/L - None
- at0009::<3.5 g/dL - None
- at0010:: \geq 3.5 g/dL - None
- 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.

[jugular_venous_pressure](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.jugular_venous_pressure.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the indirectly observed pressure over the venous system via visualization of the internal jugular vein.

****Use:**** Use to record the indirectly observed pressure over the venous system via visualization of the internal jugular vein.

****Keywords:**** jvp, jugular, venous, pressure

****Concepts:****

- at0000::Jugular venous pressure - The indirectly observed pressure over the venous system via visualization of the internal jugular vein.
- at0001::History - @ internal @
- at0002::Any Event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Column height - The observed height of the jugular vein filling level.
- at0005::JVP presence - The JVP is observed as present or absent.
- at0006::Character - Description of the character of the jugular wave.
- at0007::Abdominojugular test - Observation of the change in the JVP in response to changes of abdominal pressure.
- at0008::Positive - The JVP rises with increased abdominal pressure.
- at0009::Negative - The JVP does not rise with increased abdominal pressure.
- at0010::Kussmaul sign - Observation of the paradoxical rise in jugular venous pressure (JVP) on inspiration, or a failure in the appropriate fall of the JVP with inspiration.
- at0011::Present - The Kussmaul sign is observed.
- at0012::Absent - The Kussmaul sign is not observed.
- at0013::ItemTree - @ internal @
- at0014::Body position - Position of individual during measurement.
- at0015::Supine - The individual is lying flat on a surface.
- at0016::Reclining at 45 degrees - The individual is reclining at approximately 45 degrees.
- at0017::Sitting - The individual is sitting upright.
- at0018::Confounding factors - Comment on and record other incidental factors that may be contributing to the jugular venous pressure measurement.
- at0019::ItemTree - @ internal @
- at0020::Device - Details about the device used to record the measurement.
- at0022::Location of measurement - was measured.
- at0023::Left - The left JVP was measured.
- at0024::Right - The right JVP was measured.
- at0025::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0026::Comment - Additional narrative about the jugular venous pressure findings not captured in other fields.

- at0027::Clinical description - Narrative description about finding on observation of the jugular venous pressure.
- at0028::Clinical interpretation - Single word, phrase or brief description that represents the clinical meaning and significance of the jugular venous pressure.
- at0029::Multimedia representation - Digital image, video, wave form or diagram representing the findings.
- at0030::Present - The JVP is observed.
- at0031::Absent - The JVP is not observed.
- at0032::Indeterminate - It is not possible to determine if the JVP is present or absent.

kads

****Archetype ID:**** openEHR-EHR-OBSERVATION.kads.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results of the Kutcher Adolescent Depression questionnaire.

****Use:**** Use to record the results of the Kutcher Adolescent Depression Questionnaire. The original version of the KADS had 16 component questions. The most broadly used versions have either 6 or 11 questions. This archetype currently contains only the questions for the 11-item questionnaire. The 6-item version is a subset of the 11-item questionnaire.

****Keywords:**** screening, mood, assessment, depression, mental health, adolescent

****Concepts:****

- at0000::Kutcher Adolescent Depression Scale (KADS) - Psychological self-rating scale to assess the level of depression in adolescents.
- at0001::History - @ internal @
- at0003::Tree - @ internal @
- at0002::Point in time - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0006::Much of the time - None
- at0021::Item tree - @ internal @
- at0004::Low mood... - "Low mood, sadness, feeling blah or down, depressed, just can't be bothered."
- at0012::Feelings of worthlessness... - "Feelings of worthlessness, hopelessness, letting people down, not being a good person."

- at0013::Feeling tired... - "Feeling tired, feeling fatigued, low in energy, hard to get motivated, have to push to get things done, want to rest or lie down a lot."
- at0015::Life is not much fun... - "Feeling that life is not very much fun, not feeling good when usually (before getting sick) would feel good, not getting as much pleasure from fun things as usual (before getting sick)."
- at0016::Feeling worried... - "Feeling worried, nervous, panicky, tense, keyed up, anxious."
- at0018::Thoughts, plans, or actions about suicide or self-harm - "Thoughts, plans, or actions about suicide or self-harm."
- at0005::Hardly Ever - None
- at0007::Most of the time - None
- at0008::All of the time - None
- at0022::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0020::KADS-11 score - The total sum of each component parameter for the 11-item KADS score.
- at0017::Physical feelings of worry... - "Physical feelings of worry like: headaches, butterflies, nausea, tingling, restlessness, diarrhea, shakes or tremors."
- at0010::Trouble falling asleep... - "Trouble falling asleep, lying awake in bed."
- at0009::Irritable... - "Irritable, losing your temper easily, feeling pissed off, losing it."
- at0011::Feeling decreased interest... - "Feeling decreased interest in hanging out with friends; being with your best friend; being with your spouse/boyfriend/girlfriend; going out of the house; doing schoolwork or work; doing hobbies, sports, or recreation."
- at0014::Trouble concentrating... - "Trouble concentrating, can't keep your mind on schoolwork or work, daydreaming when you should be working, hard to focus when reading, getting "bored" with work or school."
- at0019::KADS-6 score - The total sum of each component parameter for the 6-item KADS score.
- at0023::No thoughts or plans or actions - None
- at0024::Occasional thoughts, no plans or actions - None
- at0025::Frequent thoughts, no plans or actions - None
- at0026::Plans and/or actions that have hurt - None

[karnofsky_performance_status_scale](#)

Archetype ID: openEHR-EHR-OBSERVATION.karnofsky_performance_status_scale.v1

Lifecycle State: published

Category: OBSERVATION

****Languages:**** de, pt, nb, en, nl

****Purpose:**** To record the result of a Karnofsky Performance Status (KPS) scale assessment.

****Use:**** Use to record the result of a Karnofsky Performance Status (KPS) scale assessment. While the original 1949 paper by Karnofsky et al is referenced in this archetype, it has not been possible to obtain a copy to verify the original content. However, this archetype has been designed to reflect the practical use of Karnofsky Performance Status scale rather than an academic construct and the current wording reflects descriptions found in common use within the other references.

****Misuse:**** Not to be used to record variations of the KPS scale, such as the Thorne-modified Karnofsky (TKPS) or the Australia-modified Karnofsky (AKPS). Use purpose-specific archetypes for this purpose.

****Keywords:**** KPS, assessment, functional, performance, oncology, cancer, Karnofsky, status, quality, score, index

****Concepts:****

- at0000::Karnofsky Performance Status (KPS) scale - An assessment scale used to quantify functional capacity in an individual.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Karnofsky performance status - None
- at0005::Dead - None
- at0006::Moribund; fatal processes progressing rapidly. - None
- at0007::Very sick; hospital admission necessary; active supportive treatment necessary - None
- at0008::Severely disabled; hospital admission is indicated although death not imminent - None
- at0009::Disabled; requires special care and assistance - None
- at0010::Requires considerable assistance and frequent medical care - None
- at0011::Requires occasional assistance, but is able to care for most of his personal needs - None
- at0012::Cares for self; unable to carry on normal activity or to do active work - None
- at0013::Normal activity with effort; some signs or symptoms of disease - None
- at0014::Able to carry on normal activity; minor signs or symptoms of disease - None
- at0015::Normal; no complaints; no evidence of disease - None
- 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.

kessler_k10_scale

****Archetype ID:**** openEHR-EHR-OBSERVATION.kessler_k10_scale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** For measuring anxiety and depression through a 10-item questionnaire. It's intended to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4 week period.

****Use:**** Use for measuring anxiety and depression through a 10-item questionnaire. The numbers attached to the subject's 10 responses are added up and the total score is the score on the Kessler Psychological Distress Scale (K10). Scores will range from 10 to 50.

****Misuse:**** Not to be used to record any other measures of anxiety and depression than the Kessler Psychological Distress Scale (K10).

****Concepts:****

- at0000::Kessler Psychological Distress Scale (K10) - The Kessler Psychological Distress Scale (K10) is a tool for measuring anxiety and depression through a 10-item questionnaire. Each question pertains to an emotional state and each has a five-level response scale.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::During the last 30 days, about how often did you feel tired out for no good reason? - During the last 30 days, about how often did you feel tired out for no good reason?
- at0005::None of the time - None
- at0006::A little of the time - None
- at0007::Some of the time - None
- at0008::Most of the time - None
- at0009::All of the time - None
- at0014::Total score - The total score on the Kessler Psychological Distress Scale (K10).
- at0015::During the last 30 days, about how often did you feel nervous? - During the last 30 days, about how often did you feel nervous?

- at0016::None of the time - None
- at0017::A little of the time - None
- at0018::Some of the time - None
- at0019::Most of the time - None
- at0020::All of the time - None
- at0021::During the last 30 days, about how often did you feel so nervous that nothing could calm you down? - During the last 30 days, about how often did you feel so nervous that nothing could calm you down?
- at0022::None of the time - None
- at0023::A little of the time - None
- at0024::Some of the time - None
- at0025::Most of the time - None
- at0026::All of the time - None
- at0027::During the last 30 days, about how often did you feel hopeless? - During the last 30 days, about how often did you feel hopeless?
- at0028::None of the time - None
- at0029::A little of the time - None
- at0030::Some of the time - None
- at0031::Most of the time - None
- at0032::All of the time - None
- at0033::During the last 30 days, about how often did you feel restless or fidgety? - During the last 30 days, about how often did you feel restless or fidgety?
- at0034::None of the time - None
- at0035::A little of the time - None
- at0036::Some of the time - None
- at0037::Most of the time - None
- at0038::All of the time - None
- at0039::During the last 30 days, about how often did you feel so restless you could not sit still? - During the last 30 days, about how often did you feel so restless you could not sit still?
- at0040::None of the time - None
- at0041::A little of the time - None
- at0042::Some of the time - None
- at0043::Most of the time - None
- at0044::All of the time - None
- at0045::During the last 30 days, about how often did you feel depressed? - During the last 30 days, about how often did you feel depressed?
- at0046::None of the time - None
- at0047::A little of the time - None
- at0048::Some of the time - None
- at0049::Most of the time - None
- at0050::All of the time - None

- at0051::During the last 30 days, about how often did you feel that everything was an effort? - During the last 30 days, about how often did you feel that everything was an effort?
- at0052::None of the time - None
- at0053::A little of the time - None
- at0054::Some of the time - None
- at0055::Most of the time - None
- at0056::All of the time - None
- at0057::During the last 30 days, about how often did you feel so sad that nothing could cheer you up? - During the last 30 days, about how often did you feel so sad that nothing could cheer you up?
- at0058::None of the time - None
- at0059::A little of the time - None
- at0060::Some of the time - None
- at0061::Most of the time - None
- at0062::All of the time - None
- at0063::During the last 30 days, about how often did you feel worthless? - During the last 30 days, about how often did you feel worthless?
- at0064::None of the time - None
- at0065::A little of the time - None
- at0066::Some of the time - None
- at0067::Most of the time - None
- at0068::All of the time - None
- at0069::Comment - Additional narrative about the overall Kessler Psychological Distress Scale not captured in other fields.
- at0070::Tree - @ internal @
- at0071::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

laboratory_test_result

****Archetype ID:**** openEHR-EHR-OBSERVATION.laboratory_test_result.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

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

****Purpose:**** To record the result, including findings and the laboratory's interpretation, of an investigation performed on specimens collected from an individual or related to that individual.

****Use:**** Use to record the result, including findings and the laboratory's interpretation, of an investigation performed on specimens collected from an individual or related to that individual. This is typically done in a laboratory, but may be done in other environments such as at the point of care. This archetype is intended to cover the result of a single ordered investigation where the specimen(s) are collected as a single procedure, and may include multiple analyte results or other components. Examples of this could include 'Full blood count', which would yield a separate analyte result for the count of each type of blood cell, or 'kidney biopsy non-neoplastic', which would yield findings from microscopy, immunohistochemistry and electron microscopy. This archetype has been designed to be a framework that will usually be extended with CLUSTER archetypes to enable appropriate recording of specific laboratory test result patterns. This includes, but is not limited to, tests for biochemistry, haematology, immunology and transfusion services etc and specific patterns for the unique requirements for microbiology and anatomical pathology. If the ordered tests or investigations do not commonly belong together in a named group or panel, each test result would normally be represented using separate instances of this archetype. There is, however, considerable variation in actual reporting/messaging practice and this archetype/related archetypes are designed to handle such variation. This archetype supports multiple approaches to recording of specimen, reflecting current practice which varies enormously. A Laboratory test result has a high degree of alignment to an HL7 FHIR Diagnostic Report resource. It is anticipated that one or more instances of this archetype, or archetype family, will be sent back to a requesting clinician within a laboratory report document comprising COMPOSITION.report_result archetype, or similar, and other relevant ENTRY archetypes. The recording of confounding factors may be inconsistent, often depending on the analysing laboratory and on clinical information sent by the requester. In the State section of the archetype there is a simple 'Confounding factors' data element that is optional and can be repeated as one way to record a variety of simple factors that need to be made explicit as they may influence interpretation of the results. If the confounding factors are more complex, it may be appropriate to create a local/shared CLUSTER archetype that can be nested in the 'Confounding factors details' SLOT. Note 1: Known or required pre-conditions, such as 'fasting' or 'Day 1 of menstrual cycle', should be reported in the 'Sampling conditions' data element in the CLUSTER.specimen archetype, nested within this OBSERVATION archetype. Note 2: Known issues with specimen collection or handling, such as 'sample haemolysed' or 'prolonged use of tourniquet' should be reported within 'Specimen quality' in the CLUSTER.specimen archetype, nested within this OBSERVATION archetype. Where 'reflex tests' are performed by the laboratory, these may be handled as per US/FHIR guidance (see <https://www.hl7.org/fhir/2015may/uslabreport-guide.html>) or other local policy. For example, one of the following ... 1. Record the reflex test results additional 'Test findings' within the same 'openEHR-EHR-OBSERVATION.laboratory_test_result' 2. Record the reflex test results as 'Test findings' within a new 'openEHR-EHR-

OBSERVATION.laboratory_test_result' but refer to the original lab test request via 'Test request details'. 3. Record the reflex test results as 'Test findings' within a new 'openEHR-EHR-OBSERVATION.laboratory_test_result' but reference a new lab test request as well as the original lab test request via 'Test request details'.

****Misuse:**** Not to be used to record an Autopsy or a Forensic report, although tests on some specimens that are taken in such situations may be represented using this archetype. For these, additional or specialised archetypes will be required to represent the data. This archetype is suitable for representation of general laboratory test results, but not intended to cover full synoptic reports. For these, additional specialising archetypes are required to represent the data.

****Keywords:**** lab, pathology, biochemistry, haematology, microbiology, immunology, laboratory, anatomical, chemical, clinical, immunopathology, cytology, histopathology, test, biopsy, specimen, forensic, genetic, laboratory medicine, results, analysis

****Concepts:****

- at0000::Laboratory test result - The result, including findings and the laboratory's interpretation, of an investigation performed on specimens collected from an individual or related to that individual.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tree - @ internal @
- at0005::Test name - Name of the laboratory investigation performed on the specimen(s).
- at0017::Receiving laboratory - Details of the laboratory which received the request and has overall responsibility to manage reporting of the test, even if other labs perform specific aspects.
- at0035::Distribution list - Details of additional clinicians or organisations who require a copy of the test result.
- at0037::Partial - This is a partial (e.g. initial, interim or preliminary) Test Result: data in the Test Result may be incomplete or unverified.
- at0038::Final - The Test result is complete and verified by an authorised person.
- at0040::Amended - The result has been modified subsequent to being Final, and is complete and verified by the responsible pathologist, and result data has been changed.
- at0057::Conclusion - Narrative description of the key findings.
- at0062::Requester order identifier - The local identifier assigned by the requesting clinical system.
- at0063::Receiver order identifier - The local identifier assigned to the test order by the order filler, usually by the Laboratory Information System (LIS).
- at0065::Specimen detail - Details about the physical substance that has been analysed.

- at0068::Laboratory internal identifier - A local identifier assigned by the receiving Laboratory Information System (LIS) to track the test process.
- at0073::Overall test status - The status of the laboratory test result as a whole.
- at0074::Cancelled - The result is unavailable because the test was not started or not completed (also sometimes called 'aborted').
- at0075::Overall test status timestamp - The date and/or time that 'Overall test status' was issued.
- at0077::Diagnostic service category - The diagnostic service or discipline that is responsible for the laboratory test result.
- at0090::Requester - Details of the clinician or organisation requesting the laboratory test result.
- at0094::Test request details - Details about the test request.
- at0097::Test result - Results of the test performed on the specimen(s).
- at0098::Test diagnosis - Single word, phrase or brief description that represents the clinical meaning and significance of the laboratory test result.
- at0100::Clinical information provided - Description of clinical information available at the time of interpretation of results.
- at0101::Comment - Additional narrative about the test result not captured in other fields.
- at0106::Original test requested name - Name of the original laboratory test requested.
- at0107::Registered - The existence of the test is registered in the Laboratory Information System, but there is nothing yet available.
- at0110::Testing details - Structured details about the method of analysis, device or interpretation used.
- at0111::Point-of-care test - This indicates whether the test was performed directly at Point-of-Care (POCT) as opposed to a formal result from a laboratory or other service delivery organisation.
- at0112::Tree - @ internal @
- at0113::Confounding factors - Issues or circumstances that impact on the accurate interpretation of the measurement or test result.
- at0114::Structured confounding factors - Details of issues or circumstances that impact on the accurate interpretation of the measurement or test result.
- at0115::Corrected - The result has been modified subsequent to being Final, and is complete and verified by the responsible pathologist. This is a sub-category of 'Amended'.
- at0116::Entered in error - The Test Result has been withdrawn following previous Final release.
- at0117::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0118::Multimedia representation - Digital image, video or diagram representing the test result.

- at0119::Appended - Subsequent to being final, the report has been modified by adding new content. The existing content is unchanged. This is a sub-category of 'Amended'.
- at0120::Preliminary - Verified early results are available, but not all results are final. This is a sub-category of 'Partial'.
- at0121::Test method - Description about the method used to perform the test.
- at0122::Structured test diagnosis - A structured or complex diagnosis for the laboratory test.

lenke_classification

Archetype ID: openEHR-EHR-OBSERVATION.lenke_classification.v1

Lifecycle State: published

Category: OBSERVATION

Languages: nb, en

Purpose: To record the results for each component parameter and the classification for the Lenke classification system.

Use: Use to record the results for each component parameter and the classification for the Lenke classification system.

Keywords: scoliosis, orthopedics

Concepts:

- at0000::Lenke classification system - A system for classification of adolescent idiopathic scoliosis.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Curve type - Based on evaluation of each of the three major spinal column regions; Proximal Thoracic, Main Thoracic, and Thoracolumbar/Lumbar.
- at0011::Lumbar spine modifier - Based on the position of the center sacral vertical line (CSVL) to the apex of the lumbar curve.
- at0012::A - Between pedicles.
- at0013::B - Touches apical body(ies).
- at0014::C - Completely medial.
- at0015::Thoracic sagittal modifier - Based on the T5–T12 sagittal Cobb measurement on the standing lateral radiograph.

- at0016:: - (Hypo), < 10°.
- at0017::N - (Normal), 10° - 40°.
- at0018::+ - (Hyper), < 40°.
- at0019::Classification - Concatenation of the three discrete components.
- at0020::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0021::Item tree - @ internal @
- at0022::1 - Main Thoracic.
- at0023::2 - Double Thoracic.
- at0024::3 - Double Major.
- at0025::4 - Triple Major.
- at0026::5 - Thoracolumbar/Lumbar.
- at0027::6 - Thoracolumbar/Lumbar-Main Thoracic.

malinas_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.malinas_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** pt, en

****Purpose:**** The Malinas score supports the evaluation of pregnant women allowing to determine whether a is about to give birth.

****Use:**** It is mainly used in case of unexpected prehospital cases: the score indicates if it is possible to transport the pregnant woman or if it is best to let her give birth onsite.

****Misuse:**** Partially complete score and add the 5 to give the total values.

****Concepts:****

- at0000::Malinas score - The Malinas score is an evaluation that allows to determine whether a pregnant woman is about to give birth.
- at0001::*Event Series(pt) - *@ internal @(pt)
- at0002::Point in time - Specified point in time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Number of pregnancies to date - Number of times a woman has been pregnant, including the current pregnancy, if appropriate.
- at0005::One - *

- at0006::Two - *
- at0007::Three or more - *
- at0008::Duration of labour - Recording the duration of the labour so far.
- at0009::< 3 hours - *
- at0010::Between 3 and 5 hours - *
- at0011::> 6 hours - *
- at0012::Duration of contractions - Observation of the duration of each contraction.
- at0013::< 1 minute - *
- at0014::1 minute - *
- at0015::> 1 minute - *
- at0016::Interval between two contractions - Observation of the interval between two contractions
- at0017::> 5 minutes - *
- at0018::Between 3 and 5 minutes - *
- at0019::< 3 minutes (at least 2 in 5 minutes) - *
- at0020::Breaking of waters - Observation of whether or not her waters have broken.
- at0021::No - *
- at0022::Recently (< 1 hour) - *
- at0023::> 1 hour - *
- at0025::Tree - @ internal @
- at0026::Notes on measurement - Notes on measurement of the Malinas score.
- at0028::Total score - The sum of the 5 ordinal scores for each component parameter.

[**mallampati_classification**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.mallampati_classification.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To be used as a part of the assesment level of intubation difficulty before a planned anesthesia.

****Use:**** To be used as a part of the assesment level of intubation difficulty before a planned anesthesia. The examination is done while the patient is sitting, upright with the head in a neutral position, with an open mouth, tongue protuded and without phonation.

****Keywords:**** mallampati, anaesthetic, intubation, airway

****Concepts:****

- at0000::Modified Mallampati classification - A classification that relates to the degree of visibility in the oral cavity and pharynx to assess the difficulty of oral intubation by direct laryngoscopy.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Mallampati classification - Mallampati classification.
- at0005::Comment - Narrative comment about the Mallampati Classification.
- at0006::Class 1 - The entire tonsillar pillars, uvula, hard and soft palates are visualised.
- at0007::Class 2 - Partial uvula and soft palate are visualised.
- at0008::Class 3 - Only the soft palate is visualised.
- at0009::Class 4 - No visualisation of any structures beyond the tongue, only the hard palate is visible.
- at0010::Tree - @ internal @
- at0011::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

malnutrition_screening_tool

****Archetype ID:**** openEHR-EHR-OBSERVATION.malnutrition_screening_tool.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the results for each component parameter and their total sum for the MST score.

****Use:**** Use to record the results for each component parameter and their total sum for the MST score. While openEHR archetypes are all freely available under an open license, the specific content of this Malnutrition screening tool archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. For permission: Rightslink® by Copyright Clearance Center,

<https://s100.copyright.com/AppDispatchServlet?publisherName=ELS&contentID=S0899900799000842&orderBeanReset=true>.

****Misuse:**** Not to be used for assessment of eating disorders, use an appropriate archetype for this purpose.

****Keywords:**** Nutrition assessment, Malnutrition, Screening, MST, weight, loss, nutrition, nutritional, eating, risk

****Concepts:****

- at0000::Malnutrition Screening Tool (MST) - An assessment tool used to identify if an individual is at risk of malnutrition.
- at0001::Event Series - @ internal.
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Have you lost weight recently without trying? - None
- at0016::Have you been eating poorly because of a decreased appetite? - None
- at0019::MST score - The sum of each component variable for the MST score.
- at0020::No - None
- at0021::Unsure - None
- at0027::No - None
- at0028::Yes - None
- at0029::Item tree - @ internal @
- at0030::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0031::Yes, 1-5 kg - None
- at0032::Yes, 6-10 kg - None
- at0033::Yes, 11-15 kg - None
- at0034::Yes, >15 kg - None
- at0035::Yes, unsure - None

management_screening

****Archetype ID:**** openEHR-EHR-OBSERVATION.management_screening.v2

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en, it

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about the broad range of clinical management that has been carried out in the past, with the exception of medications or surgical/operative procedures.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about the broad range of clinical management that has been carried out in the past, with the exception of medications or surgical/operative procedures. Common use cases include, but are not limited to:

- Systematic questioning in any consultation, for example: --- Have you ever been admitted to hospital? --- Have you ever worn compression stockings? --- Have you ever been placed on a ventilator? --- Have you ever been on dialysis?
- Specific questioning related to disease surveillance. --- Was the patient isolated on admission? Yes, No, Unknown. --- Did the patient receive home oxygen therapy? Yes, No, Unknown. --- Was the patient admitted to ICU? Yes, No, Unknown. The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about management that has been performed at any time in the past and information about management performed within a specified time interval - for example the difference between "Have you been admitted to hospital?" compared to "Have you been admitted to hospital in the past 4 weeks. The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies the presence of management or treatment, it is recommended that clinical system record and persist the specific details about the management or treatment using archetypes specific for the clinical purpose.

****Misuse:**** Not to be used to record answers to pre-defined screening questions about surgical/operative procedures that have been carried out in the past. Use the OBSERVATION.procedure_screening for this purpose. Not to be used to record answers to pre-defined screening questions about medications that have been used in the past. Use the OBSERVATION.medication_screening for this purpose. Not to be used to record details about a simple selection list where a question may be recorded as either "present" or "indeterminate". Use OBSERVATION.selection_list for this purpose.

****Keywords:**** treatment, screening, intervention, questionnaire, care, support, therapy

****Concepts:****

- at000::Management screening questionnaire - Series of questions and associated answers used to screen for clinical management including, but not limited to treatments, therapies and hospitalisation.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Management name - Name of a specific management or treatment activity or grouping of management or treatment activities.
- at0005::Specific management? - Is there a history of the specific management or treatment activity?
- at0007::Item tree - @ internal @
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0022::Management activity - Details about a specific management or treatment activity or grouping of management or treatment activities relevant for the screening purpose.
- at0023::Yes - None
- at0024::No - None
- at0027::Unknown - None
- at0034::Screening purpose - The context or reason for screening.
- at0035::Comment - Additional narrative about a specific management or treatment question, not captured in other fields.
- at0036::Additional details - Structured details or questions about the specific management or treatment activity.
- at0037::Timing - Indication of timing related to the management activity.
- at0039::Any management? - Is there a history of management or treatment activities relevant for the screening purpose?
- at0040::Yes - None
- at0041::No - None
- at0042::Unknown - None
- at0043::Additional details - Structured details or questions about screening for management or treatment.
- at0044::Description - Narrative description about the history of any management or treatment activities relevant for the screening purpose.
- at0045::Unsure - None
- at0046::Unsure - None

mantoux_test_result

****Archetype ID:**** openEHR-EHR-OBSERVATION.mantoux_test_result.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the test result, including findings and interpretation, following administration of the Mantoux Tuberculin Skin Test (TST).

****Use:**** Use to record the test result, including findings and interpretation, following administration of the Mantoux Tuberculin Skin Test (TST).

****Keywords:**** TB, Mantoux, reaction, tuberculin, TST

****Concepts:****

- at0000::Mantoux test result - The test result, including findings and interpretation, following administration of the Mantoux Tuberculin Skin Test (TST).
- at0001::Event Series - @ internal @
- at0002::Any point-in-time event - Default, unspecified point-in-time event which may be more explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Interpretation - Clinical interpretation of the induration response.
- at0007::Rationale for interpretation - Rationale used to interpret the reaction.
- at0008::Comment - Additional narrative about the Mantoux test result, not captured in other fields.
- at0009::Positive - The reaction is positive, based on the specified patient criterion.
- at0010::Negative - The reaction is negative, based on the specified patient criterion.
- at0011::Diameter - The measured diameter of the induration reaction.
- at0012::Clinical description - Narrative description about the Mantoux reaction findings.
- at0014::Tree - @ internal @
- at0015::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0016::Multimedia representation - Digital image, video or diagram representing the test result.

map_hand

****Archetype ID:**** openEHR-EHR-OBSERVATION.map_hand.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the results of the MAP-Hand tool.

****Use:**** Use to record the results of the MAP-Hand tool. A patient-reported assessment tool for evaluating hand activity performance for patients with rheumatoid arthritis or osteoarthritis affecting the hands, particularly those who have, or are at risk of developing functional difficulties related to arthritis in the hands. While openEHR archetypes are all freely available under an open license, the specific content of this Measure of activity performance of the hand (MAP-Hand) archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. Copyright information: Ingvild Kjeken, Diakonhjemmet sykehus (author).

****Keywords:**** activity, PROM, rheumatoid arthritis, osteoarthritis, hand, activity, function

****Concepts:****

- at000::Measure of activity performance of the hand (MAP-Hand) - A patient-reported assessment tool for evaluating hand activity performance (MAP-Hand).
- at0001::History - @ internal @
- at0002::Point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::2. Putting on socks or tights - None
- at0009::1. Buttoning buttons - None
- at0014::3. Tying shoelaces - None
- at0019::4. Squeezing out of tubes (e.g. toothpaste) - None
- at0024::5. Brushing teeth - None
- at0029::6. Wiping yourself after using the toilet - None
- at0030::7. Opening bottle screw tops - None
- at0031::8. Opening hermetic cans - None
- at0032::9. Opening jam jars - None
- at0033::10. Slicing bread using a knife - None
- at0034::11. Peeling raw vegetables - None
- at0035::12. Stirring food in a pan - None
- at0036::13. Wringing out cloths - None
- at0037::14. Carrying shopping bags - None

- at0038::15. Writing by hand - None
- at0039::16. Typing on a computer - None
- at0040::17. Pushing with hands when getting up from a chair - None
- at0041::18. Carrying heavy objects like suitcases and bags (over 5 kg/10lbs) - None
- at0094::Activity - None
- at0095::Item tree - @ internal @
- at0096::Grading - None
- at0097::Self-defined activities - Other important activities that you either have difficulties with or that you cannot do at all because of your hand problem.
- at0102::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0103::No difficulty - None
- at0104::Some difficulty - None
- at0105::Great difficulty - None
- at0106::Not able to do - None
- at0107::No difficulty - None
- at0108::Some difficulty - None
- at0109::Great difficulty - None
- at0110::Not able to do - None
- at0111::No difficulty - None
- at0112::Some difficulty - None
- at0113::Great difficulty - None
- at0114::Not able to do - None
- at0115::No difficulty - None
- at0116::Some difficulty - None
- at0117::Great difficulty - None
- at0118::Not able to do - None
- at0119::No difficulty - None
- at0120::Some difficulty - None
- at0121::Great difficulty - None
- at0122::Not able to do - None
- at0123::No difficulty - None
- at0124::Some difficulty - None
- at0125::Great difficulty - None
- at0126::Not able to do - None
- at0127::No difficulty - None
- at0128::Some difficulty - None
- at0129::Great difficulty - None
- at0130::Not able to do - None
- at0131::No difficulty - None
- at0132::Some difficulty - None
- at0133::Great difficulty - None

- at0134::Not able to do - None
- at0135::No difficulty - None
- at0136::Some difficulty - None
- at0137::Great difficulty - None
- at0138::Not able to do - None
- at0139::No difficulty - None
- at0140::Some difficulty - None
- at0141::Great difficulty - None
- at0142::Not able to do - None
- at0143::No difficulty - None
- at0144::Some difficulty - None
- at0145::Great difficulty - None
- at0146::Not able to do - None
- at0147::No difficulty - None
- at0148::Some difficulty - None
- at0149::Great difficulty - None
- at0150::Not able to do - None
- at0151::No difficulty - None
- at0152::Some difficulty - None
- at0153::Great difficulty - None
- at0154::Not able to do - None
- at0155::No difficulty - None
- at0156::Some difficulty - None
- at0157::Great difficulty - None
- at0158::Not able to do - None
- at0159::No difficulty - None
- at0160::Some difficulty - None
- at0161::Great difficulty - None
- at0162::Not able to do - None
- at0163::No difficulty - None
- at0164::Some difficulty - None
- at0165::Great difficulty - None
- at0166::Not able to do - None
- at0167::No difficulty - None
- at0168::Some difficulty - None
- at0169::Great difficulty - None
- at0170::Not able to do - None
- at0171::No difficulty - None
- at0172::Some difficulty - None
- at0173::Great difficulty - None
- at0174::Not able to do - None
- at0175::No difficulty - None

- at0176::Some difficulty - None
- at0177::Great difficulty - None
- at0178::Not able to do - None
- at0179::Mean score of predefined activities - The mean score of predefined activites is calculated based on the number of items with answers, a minimum of 15 completed items is required.
- at0180::Mean score of self-defined activites - The mean score of the self defined activities is calculated based on the number of items with answers.

[mayo_score](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.mayo_score.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To record an assessment of the severity of ulcerative colitis.

****Use:**** Use to record an assessment of the severity of ulcerative colitis. This archetype allows the recording of one or more of: the full Mayo score (12 points); the partial Mayo score (9 points); the Simplified Mayo score (6 points); and the Endoscopic subscore (3 points, from 'Endoscopic findings' data element).

****Keywords:**** IBD, Inflammatory bowel disease, Ulcerative colitis, Colitis ulcerosa, Disease Activity Index, DAI

****Concepts:****

- at0000::Mayo score - An assessment score used to estimate the severity of ulcerative colitis.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0009::Stool frequency - The number stools per day, in excess of normal for the individual.
- at0010::Normal number of stools - None
- at0011::1-2 stools more than normal - None
- at0012::3-4 stools more than normal - None
- at0013::5 or more stools more than normal - None

- at0014::Rectal bleeding - The most severe rectal bleeding of the day.
- at0015::No blood seen - None
- at0016::Streaks of blood with stool less than half the time - None
- at0017::Obvious blood with stool most of the time - None
- at0018::Blood alone passed - None
- at0019::Endoscopy findings - Assessment of the mucosal appearance during endoscopy.
- at0020::Normal or inactive disease - None
- at0021::Mild disease - Characterised by erythema, decreased vascular pattern, mild friability.
- at0022::Moderate disease - Characterised by marked erythema, absent vascular pattern, friability, erosions.
- at0023::Severe disease - Characterised by spontaneous bleeding, ulceration.
- at0024::Global assessment - Overall assessment of ulcerative colitis severity, as made by a physician.
- at0025::Normal or inactive disease - None
- at0026::Mild disease - None
- at0027::Moderate disease - None
- at0028::Severe disease - None
- at0029::Total Mayo score - The total sum of all 4 component parameters.
- at0030::Item tree - @ internal @
- at0032::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0033::Partial Mayo score - The total sum of the 3 non-invasive component parameters only.
- at0034::Simplified Mayo score - The total sum of the 2 symptom-related component parameters.

medication_screening

****Archetype ID:**** openEHR-EHR-OBSERVATION.medication_screening.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en, nl, ca, es

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about the use of any specified medication or grouping of medications.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about the use of any specified medication or grouping (including classes) of

medications. Examples of medications, groupings and classes of medications are 'alendronic acid', 'anti osteoporosis medications' and 'bisphosphonates', respectively. Common use cases include, but are not limited to:

- Systematic questioning in any consultation related to patterns of medication usage, for example: --- Do you use paracetamol? Yes, No, Unknown.
- - Have you been using any anticoagulants the last four weeks? Yes, No, Unknown.

The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about a medication that has been used at any time in the past and information about a medication used within a specified time interval - for example the difference between "Do you use paracetamol?" compared to "Have you been using any anticoagulants during the last four weeks?". The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies the presence of a medication it is recommended that clinical system record and persist the specific details about the medication using a relevant medication archetype, for example the OBSERVATION.medication_statement to record a detailed snapshot view about the actual use of a single specified medication.

****Misuse:**** 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 recording the administration, dispensing or consumption of a medication - use ACTION.medication for this purpose. Not to be used for recording a summary of use of a medication over the lifetime of the individual - use EVALUATION.medication_summary for this purpose. Not to be used to record a detailed snapshot view about the actual use of a single specified medication, outside of a screening context. - use OBSERVATION.medication_statement for this purpose. Not to be used to record details about the positive absence of a specific medication or grouping of medication, outside of a screening context. Use EVALUATION.exclusion_specific for this purpose. Not to be used to create a framework for recording answers to pre-defined screening questions about adverse reactions, use an appropriate archetype for this purpose. Not to be used to record details about a simple selection list where a question may be recorded as either "present" or "indeterminate". Use OBSERVATION.selection_list for this purpose.

****Keywords:**** medication, screening, questionnaire, drug, treatment

****Concepts:****

- at0000::Medication screening questionnaire - Series of questions and associated answers used to screen for the use of medications.
- at0001::Tree - @ internal @
- at0002::Timing - Indication of timing related to the use of the medication or grouping of medications.
- at0003::Latest dose - The date and/or time of administration of the most recent dose of the medication or group of medications.
- at0005::Tree - @ internal @
- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0021::Medication name - Name of medication or grouping of medication.
- at0022::Event Series - @ internal @
- at0023::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0024::Used - Is there a history of use of a specific medication or group of medications?
- at0025::Comment - Additional narrative about the specific medication question, not captured in other fields.
- at0026::Specific medication - Details about a specified medication or grouping of medications relevant for the screening purpose.
- at0027::Any medications used? - Is there a history of use of any medication related to the screening purpose?
- at0028::Yes - None
- at0029::No - None
- at0030::Unknown - None
- at0036::Yes - None
- at0037::No - None
- at0039::Unknown - None
- at0040::Screening purpose - The context or reason for screening.
- at0041::Additional details - Structured details or questions about the specific medication or grouping of medications.
- at0042::Additional details - Structured details or questions about the screening for medications.
- at0043::Description - Narrative description about the history of use of any medication relevant for the screening purpose.

[medication_statement-JM](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.medication_statement-JM.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, nb, en, nl

****Purpose:**** To record an assertion about the current use of a single medication by an individual at a specified point in time.

****Use:**** Use to record an assertion about the current use of a single medication by an individual at a specified point in time. In this medication statement context, 'medication' describes a wide range of items that may be prescribed or obtained 'over the counter'. This includes: - a single pharmaceutical item or agent; - an extemporaneous preparation; - a combination therapy product; - a nutritional product; or - another therapeutic item used to treat or prevent disease, such as a bandage or dressing containing an antimicrobial agent. It is anticipated that this archetype will commonly be used within an exchange context, for example as part of a health summary or transition of care summary, where one or more instances of this data group may be used to represent a 'Current medication list'. For example: - on admission to hospital; - as part of a specialist referral; or - as the basis for a medication review. The source of information may be an individual, their carer or a clinician. This archetype has been designed to align with INSTRUCTION.medication or ACTION.medication_management, where possible. However, it has been constrained to represent only essential information necessary for exchange or summary purposes, plus the addition of event-based data elements such as the 'Last administered' data element to support a seamless transition of care. Record one instance of this archetype per medication or combination pack. If the same medication is being used in different dose amounts or varying dose frequencies, each unique dosage and frequency variation should be recorded as a separate instance. This archetype should only be considered up-to-date at the time of authoring. This archetype has been designed to align with the FHIR MedicationStatement resource but is intentionally constrained to 'current use', rather than past or future use.

****Misuse:**** Not to be used to record summary or persistent information about past use of a medication - use EVALUATION.medication_summary for this purpose. Not to be used to record details about a medication order - use INSTRUCTION.medication_order for this purpose. Not to be used to record details about specific medication related activities, such as administration or dispensing - use ACTION.medication for this purpose. Not to be used to create a framework for recording answers to pre-defined screening questions about the use of any specified medication or grouping of medications - use OBSERVATION.medication_screening for this purpose. Not to be used to represent a vaccination that has been administered - use an appropriate archetype for this purpose. Not to be used to record information about medical devices that are used or implanted.

****Keywords:**** statement, snapshot

****Concepts:****

- at0049::Date first prescribed - None
- at0050::Date last prescribed - None

- at0051::Date stopped - None
- at0000.1::Medication use statement - JM - An assertion about the current use of a single medication by an individual.
- at0.1::First administered - The date and time when the medication was first taken by, or administered to, the individual.
- at0.2::Number of doses administered - The total number of doses administered.
- at0000::Medication use statement - An assertion about the current use of a single medication by an individual.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Item tree - @ internal @
- at0005::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0006::Medication name - Name of the medication.
- at0023::Clinical indication - The clinical symptom, sign or diagnosis that necessitates the use of the medication.
- at0026::Last administered - The date and time when the medication was last taken by, or administered to, the individual.
- at0029::Comment - Additional narrative about the medication statement not captured in other fields.
- at0030::Route of administration - The route by which the medication is administrated into the body.
- at0032::Description - Narrative description of the use of the medication.
- at0037::Endpoint - The intended absolute end date for the use of the medication or a textual indication that the medication will be used indefinitely.
- at0038::Indefinite - There is no proposed end date for this medication.
- at0045::Structured dose and timing - Details of structured dose and timing directions.
- at0046::Medication details - Structured details about the overall medication including strength, form and constituent substances.
- at0047::Overall directions description - Complete narrative description about how the ordered item is to be used.
- at0048::Addtional details - Structured details about the medication use.

medication_statement

Archetype ID: openEHR-EHR-OBSERVATION.medication_statement.v0

Lifecycle State: in_development

****Category:**** OBSERVATION

****Languages:**** de, nb, en, nl

****Purpose:**** To record an assertion about the current use of a single medication by an individual at a specified point in time.

****Use:**** Use to record an assertion about the current use of a single medication by an individual at a specified point in time. In this medication statement context, 'medication' describes a wide range of items that may be prescribed or obtained 'over the counter'. This includes: - a single pharmaceutical item or agent; - an extemporaneous preparation; - a combination therapy product; - a nutritional product; or - another therapeutic item used to treat or prevent disease, such as a bandage or dressing containing an antimicrobial agent. It is anticipated that this archetype will commonly be used within an exchange context, for example as part of a health summary or transition of care summary, where one or more instances of this data group may be used to represent a 'Current medication list'. For example: - on admission to hospital; - as part of a specialist referral; or - as the basis for a medication review. The source of information may be an individual, their carer or a clinician. This archetype has been designed to align with INSTRUCTION.medication or ACTION.medication_management, where possible. However, it has been constrained to represent only essential information necessary for exchange or summary purposes, plus the addition of event-based data elements such as the 'Last administered' data element to support a seamless transition of care. Record one instance of this archetype per medication or combination pack. If the same medication is being used in different dose amounts or varying dose frequencies, each unique dosage and frequency variation should be recorded as a separate instance. This archetype should only be considered up-to-date at the time of authoring. This archetype has been designed to align with the FHIR MedicationStatement resource but is intentionally constrained to 'current use', rather than past or future use.

****Misuse:**** Not to be used to record summary or persistent information about past use of a medication - use EVALUATION.medication_summary for this purpose. Not to be used to record details about a medication order - use INSTRUCTION.medication_order for this purpose. Not to be used to record details about specific medication related activities, such as administration or dispensing - use ACTION.medication for this purpose. Not to be used to create a framework for recording answers to pre-defined screening questions about the use of any specified medication or grouping of medications - use OBSERVATION.medication_screening for this purpose. Not to be used to represent a vaccination that has been administered - use an appropriate archetype for this purpose. Not to be used to record information about medical devices that are used or implanted.

****Keywords:**** statement, snapshot

****Concepts:****

- at0000::Medication use statement - An assertion about the current use of a single medication by an individual.

- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Item tree - @ internal @
- at0005::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0006::Medication name - Name of the medication.
- at0023::Clinical indication - The clinical symptom, sign or diagnosis that necessitates the use of the medication.
- at0026::Last administered - The date and time when the medication was last taken by, or administered to, the individual.
- at0029::Comment - Additional narrative about the medication statement not captured in other fields.
- at0030::Route of administration - The route by which the medication is administrated into the body.
- at0032::Description - Narrative description of the use of the medication.
- at0037::Endpoint - The intended absolute end date for the use of the medication or a textual indication that the medication will be used indefinitely.
- at0038::Indefinite - There is no proposed end date for this medication.
- at0045::Structured dose and timing - Details of structured dose and timing directions.
- at0046::Medication details - Structured details about the overall medication including strength, form and constituent substances.
- at0047::Overall directions description - Complete narrative description about how the ordered item is to be used.
- at0048::Addtional details - Structured details about the medication use.

[menstrual_diary](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.menstrual_diary.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en, nl

****Purpose:**** To record details about menstrual bleeding and associated symptoms within a specified day.

****Use:**** Use to record details about menstrual bleeding and associated symptoms within a specified day. For example in a period tracker or diary.

****Misuse:**** Not to be used to record the Last menstrual period (LNMP) use the EVALUATION.last_menstrual_period archetype for this purpose. Not to be used to record overall information about menses or related symptoms in a cycle, use the OBSERVATION.menstruation archetype for this purpose. Not to be used to record details about menarche or menopause, use the EVALUATION.menstruation_summary 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, cycle, menstrual, dysmenorrhoea, pain, bloating

****Concepts:****

- at0000::Menstrual diary - Details about menstrual bleeding and associated symptoms within a specified day.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Flow - Semi-quantitative estimation of menstrual flow per day.
- at0005::Flooding - For example a presence of heavy menstrual flow that exceeded capacity of menstrual products to absorb the flow.
- at0006::Heavy flow - For example needing to change a high-absorbency tampon or pad every one to four hours.
- at0007::Medium flow - For example needing to change a regular-absorbency tampon or pad every three to four hours.
- at0008::Light flow - For example needing to change a low- or regular-absorbency tampon or pad one to three times per day.
- at0009::Spotting - For example a drop or two of blood, not even requiring menstrual products.
- at0010::Volume - Estimated volume of menstrual blood loss in any 24hr time period.
- at0011::Item tree - @ internal @
- at0012::Per day - To record a specific single day in a cycle.
- at0013::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0014::Blood clots - Presence of blood clots.
- at0015::Present - Blood clots occurred during the menstrual flow.
- at0016::Absent - Blood clots did not occur during the menstrual flow.
- at0017::Color - Color of blood.
- at0018::Description - Narrative description of the menstrual cycle on the day in question. For example day 2.
- at0020::Additional details - Additional details about the specific day of the menstrual cycle.

- at0021::Comment - Additional narrative about the specific day of the menstrual cycle, not captured in other fields.
- at0022::No bleeding - No menstrual bleeding.

menstruation

****Archetype ID:**** openEHR-EHR-OBSERVATION.menstruation.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** fi, nb, pt-br, en, nl

****Purpose:**** To record details about one single menstrual cycle.

****Use:**** Use to record details about one single menstrual cycle.

****Misuse:**** Not to be used to record the Last menstrual period (LMP) use the EVALUATION.last_menstrual_period archetype for this purpose. Not to be used to record information about a specific day in a menstrual cycle, use OBSERVATION.menstrual_diary for this purpose. Not to be used to record details about menarche or menopause - use the EVALUATION.menstruation_summary 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 EVALUATION.menstruation_summary for this purpose.

****Keywords:**** menstruation, menses, cycle, menstrual, dysmenorrhoea, pain, bloating

****Concepts:****

- at0000::Menstrual cycle - Details about one single menstrual cycle.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Start of menses - Date of onset of menstrual bleeding in a single cycle.
- at0005::Duration of menses - Duration of menstrual bleeding in this cycle.
- at0006::Description of the cycle - Narrative description of the menstrual cycle.
- at0007::Relative flow - Subjective assessment about the menstrual bleeding for the cycle, relative to typical cycles.
- at0009::Heavier than normal - Heavier menstrual bleeding than normal.
- at0010::Normal, or typical, flow - Normal menstrual bleeding.
- at0011::Lighter than normal - Lighter menstrual bleeding than normal.

- at0013::Blood clots - Presence of blood clots.
- at0014::Present - Blood clots occurred during the menstrual flow.
- at0015::Absent - Blood clots did not occur during the menstrual flow.
- at0019::Additional details - Additional details about the menstrual cycle.
- at0020::Tree - @ internal @
- at0021::Confounding factors - Confounding factors that may affect the menstruation.
- at0022::Tree - @ internal @
- at0023::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0032::Comment - Additional narrative about the menstrual cycle, not captured in other fields.

[mini_nutritional_assessmemt_short_form](#)

Archetype ID: openEHR-EHR-OBSERVATION.mini_nutritional_assessmemt_short_form.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: pt, en

Purpose: *(pt) The purpose is to identify persons at nutritional risk providing information needed for intervention planning.

Use: *(pt) To be used in geriatric assessment (patients from the age of 65 years); To be used for detecting nutritional problems.

Misuse: *(pt) Not to be used in young adults and children.

Keywords: Nutrition assessment, Malnutrition, Screening, MNA-SF

Concepts:

- at0000::*Mini nutritional assessment short form (MNA-SF)(pt) - Screening for nutrition assessment

- at0001::*Event Series(pt) - *@ internal @(pt)
- at0002::*Point in time(pt) - *(pt) A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::*Tree(pt) - *@ internal @(pt)

- at0004::Appetite - * Has food intake declined over the past three months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
- at0005::0: Several loss of appetite. - The patient presents a several loss of appetite.
- at0006::1: Moderate loss of appetite - The patient presents a moderate loss of appetite
- at0007::2: No loss of appetite. - The patient presents no loss of appetite.
- at0008::Weight loss - * Weight loss during last three months?
- at0009::0: Weight loss greater - The patient presents a weight loss greater.
- at0010::1: Does not know - The patient does not know inform about weight loss.
- at0011::2: Weight loss between 1 and 3 kg. - The patient presents a weight loss between 1 and 3 kg.
- at0012::Mobility - *Mobility
- at0013::0: Bed or chair - No patients mobility.
- at0014::1: Able to get out of bed/chair but does not go out. - The patient can get out of bed/chair, but does not go out.
- at0015::2: Goes out - The patient is able to go out.
- at0017::Psychological stress - * Has suffered psychological stress or acute disease in the past three months?
- at0018::0: Yes - The patient suffered psychological stress or acute disease in the past three months.
- at0019::2: No - The patient did not suffer psychological stress or acute disease in the past three months.
- at0020::Neuropsychological problems - *Neuropsychological problems.
- at0021::0: Severe dementia or depression - Patient presents a severe dementia or depression.
- at0022::1: Mild dementia - Patient presents a mild dementia.
- at0023::2: No psychological problems - Patient does not present neuropsychological problems.
- at0025::Body mass index (BMI) - *Body mass index (BMI) (weight in kg)/(height in m²).
- at0026::0: BMI less than 19 - BMI value
- at0027::1: BMI 19 to less than 21 - BMI value
- at0028::2: BMI 21 to less than 23 - BMI value
- at0029::3: BMI 23 or greater - BMI value
- at0030::Screening score - *12 points or greater: normal - no need for further assessment; 11 points or below: possible malnutrition - continue assessment.

modified_alдрete_score

Archetype ID: openEHR-EHR-OBSERVATION.modified_alдрete_score.v0

Lifecycle State: in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter and their total sum for the modified Aldrete score.

****Use:**** Use to record the results for each component parameter and their total sum for the modified Aldrete score.

****Misuse:**** Not to be used to record the results and score for the original Aldrete score - use OBSERVATION.alдрete_score for this purpose.

****Keywords:**** Aldrete, score, recovery, anesthesia, PACU, post-anesthesia, care, unit, discharge

****Concepts:****

- at0000::Modified Aldrete score - An assessment score used to evaluate recovery after anaesthesia and patient readiness to be discharged from a post-anaesthesia care unit (PACU).
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Activity - None
- at0005::Unable to move extremities voluntarily or on command - None
- at0006::Able to move 2 extremities voluntarily or on command - None
- at0007::Able to move 4 extremities voluntarily or on command - None
- at0008::Respiration - None
- at0009::Apnoeic - None
- at0010::Dyspnoea or limited breathing - None
- at0011::Able to breathe deeply and cough freely - None
- at0012::Circulation - None
- at0013::BP $\pm 50\%$ of pre-anaesthetic level - None
- at0014::BP between 20-49% of pre-anaesthetic level - None
- at0015::BP $\pm 20\%$ of pre-anaesthetic level - None
- at0016::Consciousness - None
- at0017::Not responding - None
- at0018::Arousable on calling - None
- at0019::Fully awake - None
- at0020::O₂ saturation - None
- at0021::SpO₂ <90% despite supplementary O₂ - None
- at0022::Needs supplementary O₂ to maintain SpO₂ >90% - None
- at0023::Able to maintain SpO₂ >92% on room air - None

- at0024::Total score - The total sum of each component parameter for the modified Aldrete score.
- at0025::Item tree - @ internal @
- at0026::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

modified_barthel_index

Archetype ID: openEHR-EHR-OBSERVATION.modified_barthel_index.v0

Lifecycle State: in_development

Category: OBSERVATION

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

Purpose: To record a functional assessment for activities of daily living using the modified version of the Barthel index.

Use: Use to record a functional assessment for activities of daily living using the modified version of the Barthel index.

Keywords: score, index, activities, daily living, dependency

Concepts:

- at0000::Modified Barthel index - Modification of the Barthel index, used as a functional assessment for activities of daily living (ADL).
- at0001::Tree - @ internal @
- at0002::History - @ internal @
- at0003::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0004::Bladder - Assessment of urinary control over the previous week, occasional accident <= 1 time per week.
- at0005::Incontinent (or unable to manage catheter) - Incontinent of urine or catheterised.
- at0006::Occasional accident - Less than or equal to once per week.
- at0007::Continent (manages catheter alone) - Continent includes self management of catheter.
- at0008::Bowels - Over the previous week, occasional accident is once per week.
- at0009::Bathing - Independent = without supervision or help when getting in and out of the bath and when washing.
- at0010::Dependent - Needs assistance with baths or showers.

- at0011::Independent - No help required when getting in and out of the bath or when washing.
- at0012::Dressing - Ability to choose clothes, put them on and fasten them.
- at0013::Dependent - Requires assistance choosing and putting on clothes.
- at0014::Needs help but can do about half unaided - Needs help only with buttons, zippers but can put on clothes unaided.
- at0016::Total score - Sum of the individual scores assigned for each of the contributing variables.
- at0017::Mobility - Ability to get about the house or institution.
- at0018::Immobile - Person can get less than 50 metres in wheelchair.
- at0019::Wheel chair independent - Wheelchair independent (including corners).
- at0020::Walks with help - Person walks with assistance of one person, with physical or verbal assistance.
- at0021::Transfer - Transfer from bed to chair and back.
- at0022::Unable, no sitting balance - No sitting balance, a lifting device is used.
- at0023::Major help, can sit - A strong trained person or 2 people required, patient can sit straight.
- at0024::Minor help - A person is required for supervision or some help.
- at0025::Independent - Person can move from bed to chair independently.
- at0026::Feeding - Ability to eat food.
- at0027::Unable to eat unassisted - Requires manual feeding.
- at0028::Needs help - Requires help cutting, spreading butter or requires modified diet - able to eat alone.
- at0029::Independent - Able to eat alone.
- at0030::Toilet use - Ability to use toilet over the previous 48 hours.
- at0031::Dependent - Person is completely dependent of others to use the toilet.
- at0032::Needs some help but can do some tasks alone - Person is self-supporting in some toileting tasks.
- at0033::Independent (on & off, dressing, wiping) - Person is fully self-supporting in all toileting tasks.
- at0034::Grooming - Ability over the previous 24-48 hours to attend to personal hygiene such as brushing teeth, shaving and washing.
- at0035::Needs help - Needs help with personal care.
- at0036::Independent - Able to brush teeth, hair, wash face, shave.
- at0037::Incontinent (or requires enemas) - Incontinent of faeces or requires enemas.
- at0038::Continent - Continent of faeces.
- at0039::Independent - Person can use any aid (not wheelchair) around the house or ward.
- at0040::Stairs - Ability to negotiate stairs.
- at0041::Unable - Unable to use stairs.
- at0042::Needs help - Verbal, physical or other assistance.
- at0043::Independent - Can carry aid alone if required.

- at0044::Occasional accident - Less than or equal to once per week.
- at0045::Tree - @ internal @
- at0046::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0047::Comment - Additional narrative about the modified Barthel index, not captured in other fields.
- at0048::Tree - @ internal @
- at0049::Confounding factors - Narrative descriptiton of any issues or factors that may impact on the scoring.

modified_rankin_scale

****Archetype ID:**** openEHR-EHR-OBSERVATION.modified_rankin_scale.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To record the degree of disability and level of assistance required after a stroke or another neurological event.

****Use:**** Use to record the degree of disability and level of assistance required after a stroke or another neurological event.

****Keywords:**** Stroke, function, neurological, disability, nursing, ADL, mrs

****Concepts:****

- at0000::Modified Rankin Scale (mRS) - An assessment tool used to measure the degree of disability and level of assistance required after a stroke or another neurological event.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Item tree - @ internal @
- at0005::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0007::Modified Rankin Scale - Degree of disability and level of assistance required after a stroke or another neurological event.
- at0008::No symptoms - No symptoms at all.

- at0009::No significant disability - Despite symptoms, able to carry out all usual duties and activities.
- at0010::Slight disability - Unable to perform all previous activities but able to look after own affairs without assistance.
- at0011::Moderate disability - Requiring some help but able to walk without assistance.
- at0012::Moderately severe disability - Unable to walk without assistance and unable to attend to own bodily needs without assistance.
- at0013::Severe disability - Bedridden, incontinent and requiring constant nursing care and attention.
- at0014::Death - Death.

moxfq

****Archetype ID:**** openEHR-EHR-OBSERVATION.moxfq.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Use to capture and report Manchester Oxford Foot Questionnaire (MOXFQ) score details.

****Use:**** Use to record the details of the Manchester Oxford Foot Questionnaire score. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Concepts:****

- at0000::MOXFQ - Manchester Oxford Foot Questionnaire (MOXFQ).
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tree - @ internal @
- at0005::Tree - @ internal @

- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0007::Confounding factors - Record any issues or factors that may impact on the score or interpretation.
- at0008::1 Pain in foot or ankle - Patient-reported extent of pain in foot or ankle during past 4 weeks.
- at0009::None of the time - The patient has not experienced any pain in foot or ankle during past 4 weeks.
- at0010::Rarely - The patient has rarely experienced pain in foot or ankle during past 4 weeks.
- at0011::Some of the time - The patient has experienced pain in foot or ankle some of the time during past 4 weeks.
- at0012::Most of the time - The patient has experienced pain in foot or ankle most of the time during past 4 weeks.
- at0013::All of the time - The patient has experienced pain in foot or ankle all of the time during past 4 weeks.
- at0014::2 Avoid walking long distances - Patient-reported extent of avoiding walking long distances because of pain in foot or ankle.
- at0015::All of the time - The patient has avoided all of the time walking long distances during past 4 weeks because of pain in foot or ankle.
- at0016::Most of the time - The patient has avoided most of the time walking long distances during past 4 weeks because of pain in foot or ankle.
- at0017::Some of the time - The patient has avoided some of the time walking long distances during past 4 weeks because of pain in foot or ankle.
- at0018::Rarely - The patient has avoided rarely walking long distances during past 4 weeks because of pain in foot or ankle.
- at0019::None of the time - The patient has not avoided walking long distances during past 4 weeks because of pain in foot or ankle.
- at0020::3 Change way of walking - Patient-reported extent to which they have changed the way they walk due to pain in foot or ankle.
- at0021::All of the time - The patient has changed the way they walk all of the time during past 4 weeks due to pain in foot or ankle.
- at0022::Most of the time - The patient has changed the way they walk most of the time during past 4 weeks due to pain in foot or ankle.
- at0023::Some of the time - The patient has changed the way they walk some of the time during past 4 weeks due to pain in foot or ankle.
- at0024::Rarely - The patient has changed the way they walk rarely during past 4 weeks due to pain in foot or ankle.
- at0025::None of the time - The patient has not changed the way they walk during past 4 weeks due to pain in foot or ankle.
- at0026::4 Walk slowly - Patient-reported extent to which they have walked slowly because of pain in foot or ankle during past 4 weeks.

- at0027::All of the time - The patient has walked slowly all of the time during past 4 weeks because of pain in foot or ankle.
- at0028::Most of the time - The patient has walked slowly most of the time during past 4 weeks because of pain in foot or ankle.
- at0029::Some of the time - The patient has walked slowly some of the time during past 4 weeks because of pain in foot or ankle.
- at0030::Rarely - The patient has walked slowly rarely during past 4 weeks because of pain in foot or ankle.
- at0031::None of the time - The patient has not walked slowly during past 4 weeks because of pain in foot or ankle.
- at0032::5 Stop and rest - Patient-reported extent to which they have had to stop and rest foot or ankle because of pain in past 4 weeks.
- at0033::All of the time - The patient has had to stop and rest foot or ankle because of pain all of the time during past 4 weeks.
- at0034::Most of the time - The patient has had to stop and rest foot or ankle because of pain most of the time during past 4 weeks.
- at0035::Some of the time - The patient has had to stop and rest foot or ankle because of pain some of the time during past 4 weeks.
- at0036::Rarely - The patient has had to stop and rest foot or ankle because of pain rarely during past 4 weeks.
- at0037::None of the time - The patient has not had to stop and rest foot or ankle because of pain during past 4 weeks.
- at0038::6 Avoid hard or rough surfaces - Patient-reported extent to which they have avoided hard or rough surfaces because of pain in foot or ankle in past 4 weeks.
- at0039::All of the time - The patient has avoided hard or rough surfaces all of the time in past 4 weeks because of pain in foot or ankle.
- at0040::Most of the time - The patient has avoided hard or rough surfaces most of the time in past 4 weeks because of pain in foot or ankle.
- at0041::Some of the time - The patient has avoided hard or rough surfaces some of the time in past 4 weeks because of pain in foot or ankle.
- at0042::Rarely - The patient has avoided hard or rough surfaces rarely in past 4 weeks because of pain in foot or ankle.
- at0043::None of the time - The patient has not avoided hard or rough surfaces in past 4 weeks because of pain in foot or ankle.
- at0044::7 Avoid standing for long time - Patient-reported extent to which they have avoided standing for a long time because of pain in foot or ankle during past 4 weeks.
- at0045::All of the time - The patient has avoided standing for a long time all of the time in past 4 weeks because of pain in foot or ankle.
- at0046::Most of the time - The patient has avoided standing for a long time most of the time in past 4 weeks because of pain in foot or ankle.
- at0047::Some of the time - The patient has avoided standing for a long time some of the time in past 4 weeks because of pain in foot or ankle.

- at0048::Rarely - The patient has avoided standing for a long time rarely in past 4 weeks because of pain in foot or ankle.
- at0049::None of the time - The patient has not avoided standing for a long time in past 4 weeks because of pain in foot or ankle.
- at0050::8 Use bus or car instead of walking - Patient-reported extent to which they have caught a bus or used the car instead of walking because of pain in foot or ankle during past 4 weeks.
- at0051::All of the time - The patient has caught a bus or used the car instead of walking all of the time in past 4 weeks because of pain in foot or ankle.
- at0052::Most of the time - The patient has caught a bus or used the car instead of walking most of the time in past 4 weeks because of pain in foot or ankle.
- at0053::Some of the time - The patient has caught a bus or used the car instead of walking some of the time in past 4 weeks because of pain in foot or ankle.
- at0054::Rarely - The patient has caught a bus or used the car instead of walking rarely in past 4 weeks because of pain in foot or ankle.
- at0055::None of the time - The patient has not caught a bus or used the car instead of walking in past 4 weeks because of pain in foot or ankle.
- at0056::9 Feel self-conscious - Patient-reported extent to which they have felt self-conscious about foot or ankle during past 4 weeks.
- at0057::All of the time - The patient has felt self-conscious about foot or ankle all of the time in past 4 weeks.
- at0058::Most of the time - The patient has felt self-conscious about foot or ankle most of the time in past 4 weeks.
- at0059::Some of the time - The patient has felt self-conscious about foot or ankle some of the time in past 4 weeks.
- at0060::Rarely - The patient has felt self-conscious about foot or ankle rarely in past 4 weeks.
- at0061::None of the time - The patient has not felt self-conscious about foot or ankle in past 4 weeks.
- at0062::10 Feel self-conscious about shoes - Patient-report extent to which they have felt self-conscious about shoes they have to wear during past 4 weeks.
- at0063::All of the time - The patient has felt self-conscious about the shoes they have to wear all of the time in past 4 weeks.
- at0064::Most of the time - The patient has felt self-conscious about the shoes they have to wear most of the time in past 4 weeks.
- at0065::Some of the time - The patient has felt self-conscious about the shoes they have to wear some of the time in past 4 weeks.
- at0066::Rarely - The patient has felt self-conscious about the shoes they have to wear rarely in past 4 weeks.
- at0067::None of the time - The patient has not felt self-conscious about the shoes they have to wear in past 4 weeks.

- at0068::11 Pain is more painful in the evening - Patient-reported extent to which pain in foot or ankle has been more painful in the evening during past 4 weeks.
- at0069::All of the time - The patient reports that the pain in foot or ankle has been more painful in the evening all of the time in last 4 weeks.
- at0070::Most of the time - The patient reports that the pain in foot or ankle has been more painful in the evening most of the time in last 4 weeks.
- at0071::Some of the time - The patient reports that the pain in foot or ankle has been more painful in the evening some of the time in last 4 weeks.
- at0072::Rarely - The patient reports that the pain in foot or ankle has been more painful in the evening rarely in last 4 weeks.
- at0073::None of the time - The patient reports that the pain in foot or ankle has not been more painful in the evening in last 4 weeks.
- at0074::12 Shooting pains - Patient-reported extent of shooting pains in foot or ankle during past 4 weeks.
- at0075::All of the time - The patient has experienced shooting pains in foot or ankle all of the time in past 4 weeks.
- at0076::Most of the time - The patient has experienced shooting pains in foot or ankle most of the time in past 4 weeks.
- at0077::Some of the time - The patient has experienced shooting pains in foot or ankle some of the time in past 4 weeks.
- at0078::Rarely - The patient has experienced shooting pains in foot or ankle rarely in past 4 weeks.
- at0079::None of the time - The patient has not experienced shooting pains in foot or ankle in past 4 weeks.
- at0080::13 Pain prevents activities - Patient-reported extent to which pain in foot or ankle has prevented them from carrying out work or everyday activities during past 4 weeks.
- at0081::All of the time - The patient reports that the pain in foot or ankle has prevented them from carrying out work or everyday activities all of the time in past 4 weeks.
- at0082::Most of the time - The patient reports that the pain in foot or ankle has prevented them from carrying out work or everyday activities most of the time in past 4 weeks.
- at0083::Some of the time - The patient reports that the pain in foot or ankle has prevented them from carrying out work or everyday activities some of the time in past 4 weeks.
- at0084::Rarely - The patient reports that the pain in foot or ankle has prevented them from carrying out work or everyday activities rarely in past 4 weeks.
- at0085::None of the time - The patient reports that the pain in foot or ankle has not prevented them from carrying out work or everyday activities in past 4 weeks.
- at0086::14 Unable to do all social or recreational activities - Patient-reported extent to which they have been unable to do all their social or recreational activities due to pain in foot or ankle during past 4 weeks.

- at0087::All of the time - The patient has been unable to do all their social or recreational activities due to pain in foot or ankle all of the time in past 4 weeks.
- at0088::Most of the time - The patient has been unable to do all their social or recreational activities due to pain in foot or ankle most of the time in past 4 weeks.
- at0089::Some of the time - The patient has been unable to do all their social or recreational activities due to pain in foot or ankle some of the time in past 4 weeks.
- at0090::Rarely - The patient has been unable to do all their social or recreational activities due to pain in foot or ankle rarely in past 4 weeks.
- at0091::None of the time - The patient has been able to do all their social or recreational activities due to pain in foot or ankle in past 4 weeks.
- at0092::15 Pain severity - Patient-reported estimation of usual pain severity in foot or ankle during past 4 weeks.
- at0093::Severe - Patient reports usual pain during past 4 weeks to have been severe.
- at0094::Moderate - Patient reports usual pain during past 4 weeks to have been moderate.
- at0095::Mild - Patient reports usual pain during past 4 weeks to have been mild.
- at0096::Very mild - Patient reports usual pain during past 4 weeks to have been very mild.
- at0097::None - Patient reports no pain during past 4 weeks.
- at0098::16 Pain at night - Patient-reported extent of being troubled by pain from foot or ankle at night during past 4 weeks.
- at0099::Every night - Patient has been troubled by pain from foot or ankle every night in past 4 weeks.
- at0100::Most nights - Patient has been troubled by pain from foot or ankle most nights in past 4 weeks.
- at0101::Some nights - Patient has been troubled by pain from foot or ankle some nights in past 4 weeks.
- at0102::Only 1 or 2 nights - Patient has been troubled by pain from foot or ankle only 1 or 2 nights in past 4 weeks.
- at0103::No nights - Patient has not been troubled by pain from foot or ankle at night in past 4 weeks.
- at0104::Total score - Total score from Questions 1 to 16, weighted according to these rules: sum of Questions 1,11,12,15 and 16 multiplied by 5 PLUS sum of Questions 2-8 multiplied by 3.57 PLUS sum of Questions 9, 10, 13 and 14 multiplied by 6.25 rounded to nearest integer.
- at0105::Average score - Average score from Questions 1-16, weighted according to these rules: sum of Questions 1,11,12,15 and 16 multiplied by 5 PLUS sum of Questions 2-8 multiplied by 3.57 PLUS sum of Questions 9, 10, 13 and 14 multiplied by 6.25, rounded to nearest integer.
- at0106::Pain score - Total pain score calculated from Questions 1, 11,12,15 and 16 multiplied by 5 rounded to nearest integer.

- at0107::Walking and standing score - Total score from questions 2-8 multiplied by 3.57 and rounded to nearest integer.
- at0108::Social interaction score - Total score from questions 9, 10, 13 and 14 multiplied by 6.25 and rounded to nearest integer.

msfc_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.msfc_score.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, en

****Purpose:**** To record the MSFC Score for an individual with respect to a reference population. The MSFC was developed by the National Multiple Sclerosis Society's Clinical Outcomes Assessment Task Force. The MSFC Score forms a total value that correlates with the severity of the disease with respect to a reference population. In three separate tests (Timed 25-Foot Walk, Nine Hole Peg Test and Paced Auditory Serial Addition Test) various aspects of higher brain functions are measured. The results of these three tests are standardized into Z-scores and merged into the MSFC Score.

****Use:**** Use to record the MSFC Score and the reference data set, as well as links to the measured results of the three individual tests (Timed 25-Foot Walk, Nine Hole Peg Test and Paced Auditory Serial Addition Test). The MSFC Score is a computed value based on the average of each test result, adjusted to the reference population. I.e. $MSFC\ Score = 1/3 * (Z_{arm,avg.} + Z_{leg,avg.} + Z_{cognitive})$, where Z_x = Z-score of each test result. This score has to be computed externally, only the resulting value is to be recorded here. Use the MSFC Manual for further scoring instructions, formulas and background information.

****Misuse:**** Not to be used to record the result of the three individual tests of the MSFC. Each test should use the correct specific archetype: openEHR-EHR-OBSERVATION.timed_25_foot_walk.v1.adl, openEHR-EHR-OBSERVATION.nine_hole_peg_test.v1.adl, and openEHR-EHR-OBSERVATION.paced_auditory_serial_addition_test.v1.adl.

****Keywords:**** Multiple Sclerosis Functional Composite, MSFC, Multiple Sclerosis, MS, Neurology

****Concepts:****

- at0000::MSFC score - The Multiple Sclerosis Functional Composite (MSFC) is a three-part, quantitative, and standardised assessment instrument for use in clinical studies and trials of Multiple Sclerosis.
- at0001::Event Series - @ internal @
- at0003::Tree - @ internal @
- at0004::MSFC score - Record of the MSFC Score.
- at0005::Tree - @ internal @
- at0006::Reference Population - Specification of the underlying reference population.
- at0007::Timed 25-Foot Walk Record - Link to the detailed original record of the Timed 25-Foot Walk.
- at0008::Nine Hole Peg Test Record - Link to the detailed original record of the Nine Hole Peg Test.
- at0009::Paced Auditory Serial Addition Test Record - Link to the detailed original record of the Paced Auditory Serial Addition Test.
- at0010::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.

mskcc_bowel_function_instrument

Archetype ID: openEHR-EHR-OBSERVATION.mskcc_bowel_function_instrument.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en, fr

Purpose: To record the results for each component parameter and their total sum for the MSKCC Bowel Function Instrument.

Use: Use to record the results for each component parameter and their total sum for the MSKCC Bowel Function Instrument.

Keywords: Memorial Sloan Kettering Cancer Centre Bowel Function Instrument, MSKCC BFI, MSKCC, cancer, rectal, colorectal

Concepts:

- at0000::MSKCC Bowel Function Instrument - Questionnaire for assessing bowel function after sphincter-preserving surgery for rectal cancer.
- at0001::History - @ internal @
- at0002::Over the last 4 weeks - The standard "over the last 4 weeks" recording of the MSKCC Bowel Function Instrument.

- at0003::Tree - @ internal @
- at0004::How many bowel movements in 24h? - How many bowel movements do you generally have in 24 hours?
- at0005::Certain solid foods increase the number of bowel movements in a day - Do certain solid foods increase the number of bowel movements in a day?
- at0006::Certain liquids increase the number of bowel movements in a day - Do certain liquids that you drink increase the number of bowel movements in a day?
- at0007::Feel like had totally emptied your bowels after a bowel movement - Do you feel like you have totally emptied your bowels after a bowel movement?
- at0008::Go to the toilet on time - Do you get to the toilet on time?
- at0009::Had another bowel movement within 15 min of your last bowel movement - Do you have another bowel movement within 15 minutes of your last bowel movement?
- at0010::Know the difference between gas and bowel movement - Do you know the difference between having to pass gas (air) and needing to have a bowel movement?
- at0011::Had used medicines to decrease the number of bowel movements - Have you used medicines to decrease the number of bowel movements (drugs like Imodium®, Lomotil®)?
- at0012::Had diarrhea - Have you had diarrhea (no form, watery stool)?
- at0013::Had loose stool - Have you had loose stool (slight form, but mushy)?
- at0014::Had been able to wait 15 min to get to the toilet - Have you been able to wait 15 minutes to get to the toilet when you feel like you are going to have a bowel movement?
- at0015::Were able to control the passage of gas - Have you been able to control the passage of gas (air)?
- at0016::Had limited the types of solid foods to control bowel movements - Have you limited the types of solid foods you eat to control your bowel movements?
- at0017::Had limited the types of liquids to control bowel movements - Have you limited the types of liquids you drink to control your bowel movements?
- at0018::Had soilage of your undergarments during the day - Have you had soilage (leakage of stool) of your undergarments during the day?
- at0019::Had used tissue, napkin, pad during day - Have you used a tissue, napkin, and/or pad in your undergarments during the day in case of stool leakage?
- at0020::Had had soil undergarments in bed - Have you had soilage (leakage of stool) of your undergarments when you go to bed?
- at0021::Had altered activities because of bowel function - Have you had to alter your activities because of your bowel function?
- at0023::Always - None
- at0024::Most of the time - None
- at0025::Sometimes - None
- at0026::Rarely - None
- at0027::Never - None
- at0108::Item tree - @ internal @
- at0110::Total score - The total score of the MSKCC Bowel Function Instrument.

- at0111::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

mskcc_motzer

****Archetype ID:**** openEHR-EHR-OBSERVATION.mskcc_motzer.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results for each component parameter and their total sum for the MSKCC/Motzer score.

****Use:**** Use to record the results for each component parameter and their total sum for the MSKCC/Motzer score.

****Keywords:**** renal, cell, carcinoma, RCC, cancer, metastatic

****Concepts:****

- at0000::Memorial Sloan-Kettering Cancer Center (MSKCC/Motzer) score - An assessment score used for metastatic renal cell carcinoma (RCC) to predict survival based on clinical and laboratory data in metastatic RCC patients.
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0004::Time from diagnosis to systemic treatment <1 year - Measured ~1 month after stopping anticoagulation
- at0005::No - *
- at0006::Yes - *
- at0007::Hemoglobin < Lower Limit of Normal - Men (Normal): 13.5-17.5 g/dL- Women (Normal): 12.0-15.5 g/dL
- at0008::No - *
- at0009::Yes - *
- at0010::Calcium >10mg/dL (>2.5 mmol/L) - *
- at0011::No - *
- at0012::Yes - *
- at0013::LDH > 1.5x Upper Limit of Normal - Normal: 140 U/L
- at0014::No - *
- at0015::Yes - *

- at0016::Performance status <80% (Karnofsky) - *
- at0017::No - *
- at0018::Yes - *
- at0019::Total score - *

murray_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.murray_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, en

****Purpose:**** To record the score for each component parameter and the calculated final score for the Murray score.

****Use:**** Use to record the score for each component parameter and the calculated final score for the Murray score.

****Misuse:**** The Murray score is a guide only and should not replace clinical evaluation by clinicians on the appropriateness of ECMO initiation.

****Keywords:**** lung, injury, ARDS

****Concepts:****

- at0000::Murray score - Clinical tool used to estimate the severity of acute lung injury.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Consolidation on CXR - Radiographic findings on Xray of the lung.
- at0006::None - No alveolar consolidation.
- at0008::1 quadrant - Alveolar consolidation confined to 1 quadrant.
- at0009::2 quadrants - Alveolar consolidation confined to 2 quadrants.
- at0010::3 quadrants - Alveolar consolidation confined to 3 quadrants.
- at0011::4 quadrants - Alveolar consolidation in all 4 quadrants.
- at0012::PaO₂/FiO₂ ratio - Index of oxygenation (PaO₂/FIO₂).
- at0014::≥300 - Ratio is greater than or equal to 300.
- at0015::225-299 - Ratio is between 225 and 299.
- at0016::175-224 - Ratio is between 175 and 225.

- at0017::100-174 - Ratio is between 100 and 174.
- at0018::<100 - Ratio is less than 100.
- at0019::PEEP - The Positive End Expiratory Pressure (PEEP), measured in cm H₂O.
- at0021::≤5 - PEEP is less than or equal to 5 cmH₂O.
- at0022::6-8 - PEEP is between 6 and 8 cmH₂O.
- at0023::9-11 - PEEP is between 9 and 11 cmH₂O.
- at0024::12-14 - PEEP is between 12 and 14 cmH₂O.
- at0025::≥15 - PEEP is greater than or equal to 15 cmH₂O.
- at0026::Compliance - Lung compliance, calculated in ml/cm H₂O.
- at0028::≥80 - Compliance is greater than or equal to 80 ml/cmH₂O.
- at0029::60-79 - Compliance is between 60 and 79 ml/cmH₂O.
- at0030::40-59 - Compliance is between 40 and 59 ml/cmH₂O.
- at0031::20-39 - Compliance is between 20 and 39 ml/cmH₂O.
- at0032::≤19 - Compliance is less than or equal to 19 ml/cmH₂O.
- at0039::Score - Sum of points assigned for each of the component parameters divided by the number of parameters.
- at0044::Item tree - @ internal @
- at0045::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0046::Severity assessment - The assessment about severity of the lung injury, based on the Murray score.
- at0040::0 - No lung injury.
- at0041::1-2.5 - Mild to moderate lung injury.
- at0042::>2.5 - Severe lung injury (ARDS).

must

Archetype ID: openEHR-EHR-OBSERVATION.must.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: es-ar, en

Purpose: The Malnutrition Universal Screening Tool (MUST) is a scoring system designed to help identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. It intends to identify risk of poor protein-energy status, rather than status of individual nutrients. It has not been designed to detect deficiencies in or excessive intakes of vitamins and minerals. It was developed and is maintained by the British Association for Parenteral and Enteral Nutrition (BAPEN).

****Use:**** MUST is a five-step screening tool: Step 1.- Measure height and weight to get a BMI score. If unable to obtain height and weight, the alternative procedures shown in the MUST Explanatory Booklet should be used. Step 2.- Note percentage unplanned weight loss and score using tool specific tables. Step 3.- Establish acute disease effect and score. Step 4.- Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition. Step 5.- Use management guidelines and/or local policy to develop care plan. This archetype registers data for calculation of the overall risk of malnutrition score.

****Misuse:**** Not to be used for children.

****Keywords:**** MUST, malnutrition, undernutrition, obesity, nutrition, nourishment

****Concepts:****

- at0000::Malnutrition Universal Screening Tool (MUST) - Screening tool for malnourishment, undernutrition or obesity.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Body mass index score - Derived from the subject's body mass index.
- at0005::>20 (>30 Obese) - *
- at0006::18.5 -20 - *
- at0007::<18.5 - *
- at0008::Weight loss score - To establish the subject's weight loss score, ask if there has been any weight loss in the last 3 – 6 months, and if so how much (or look in their medical records).
- at0009::<5 % - *
- at0010::5-10 % - *
- at0011::>10 % - *
- at0012::Acute disease effect score - If the subject is currently affected by an acute pathophysiological or psychological condition, and there has been no nutritional intake or likelihood of no intake for more than 5 days, they are likely to be at nutritional risk.
- at0013::Not acutely ill and sufficient nutritional intake for >5 days - If patient is not acutely ill and there has not been or is not likely to be no nutritional intake for >5 days.
- at0014::Acutely ill and there has been or is likely to be no nutritional intake for >5 days - If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days.
- at0015::Total score - The sum of scores for body mass index, weight loss and acute disease effect.
- at0016::Risk category - The overall risk of malnutrition as derived from the total score.
- at0017::Low risk - Total score equal to 0.
- at0018::Medium risk - Total score equal to 1.
- at0019::High risk - Total score equal or greater than 2.

- at0020::Tree - @ internal @
- at0021::Height determination method for body mass index - Method used for determining height as a part of body mass index calculation.
- at0022::Weight determination method for body mass index - Method used for determining weight as a part of body mass index calculation.
- at0023::Direct height measurement - *
- at0024::Recently documented or self-reported height - Recently documented or self-reported height (if reliable and realistic).
- at0025::Derived from ulna length - *
- at0026::Derived from knee height - *
- at0027::Derived from demispan - *
- at0028::Direct weight measurement - *
- at0029::Recently documented or self-reported weight - Recently documented or self-reported weight (if reliable and realistic).
- at0030::Body mass index estimation method - Method used for determining body mass index.
- at0031::Calculation from height and weight measurements - *
- at0032::Derived from mid upper arm circumference measurement - *
- at0033::Weight loss determination method - Method used for determining weight change.
- at0034::Direct weight change measurement - *
- at0035::Recently documented or self-reported weight change - *
- at0036::Clinical impression - *
- at0037::Derived from changes in mid upper arm circumference measurement - *
- at0038::Confounding factors - Some variables used in the calculation of the MUST score may be influenced by confounding factors, specially in the case of weight and BMI determination.
- at0039::Comment - Additional narrative about the screening, not captured in other fields.
- at0040::Tree - @ internal @
- at0042::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

[neonatal_skin_risk_assessment](#)

Archetype ID: openEHR-EHR-OBSERVATION.neonatal_skin_risk_assessment.v0

Lifecycle State: in_development

Category: OBSERVATION

****Languages:**** en

****Purpose:**** To record details of a clinical assessment of neonates at risk of skin breakdown or pressure sore development.

****Use:**** Use record details of a clinical assessment of neonates at risk of skin breakdown or pressure sore development. It should be noted that although the purpose of the scale is similar to that of the adult Braden Scale and Braden-Q scale for older children, the scoring methodology is completely different, particularly that a high score is associated with high risk, the opposite from these other Braden scales where a low score equates to high risk. The Neonatal Skin Risk Assessment Scale (NSRAS) should only be used to assess neonates under 21 days of age.

****Misuse:**** Not to be used for pressure sore risk assessment in children aged over 21 days. Use OBSERVATION.braden_scale-q for children between 21 days and 5 years of age. Use OBSERVATION.braden_scale for children over 5 years of age and adults.

****Keywords:**** braden, neonate, score, skin, pressure, ulcer, sore

****Concepts:****

- at0000::Neonatal Skin Risk Assessment Scale (NSRAS) - A clinical assessment for neonates at risk for skin breakdown, based on the Braden Scale used in adults.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Graded risk - A graded risk derived from the 'Total score'.
- at0005::Moisture - The degree to which the infant's skin is exposed to moisture.
- at0006::Nutrition - The usual food intake of the neonate.
- at0007::Activity - The amount of physical activity of the neonate.
- at0008::Mobility - The neonate's ability to change and control body position.
- at0009::Mental status - An evaluation of the mental status or sensory perception of the neonate.
- at0010::Total score - The sum of all sub-scores.
- at0011::General physical condition - An assessment of general condition, based on gestational age.
- at0012::Best - Gestational Age > 38 Weeks To Postterm.
- at0013::Good - Gestational Age > 33 Weeks But < 38 weeks.
- at0014::Poor - Gestational Age > 28 Weeks But < 33 weeks.
- at0015::Very poor - Gestational Age > 28 Weeks But < 33 weeks.
- at0016::Comment - Additional narrative about the Neonatal Skin Risk Assessment Scale, not captured in other fields.
- at0017::Rarely moist - Skin is usually dry, linen requires changing only every 24 hours.

- at0018::Occasionally moist - Skin is occasionally moist/damp. Requiring an extra linen change approximately once a day.
- at0019::Moist - Skin is often but not always moist/damp; linen must be changed at least once a shift.
- at0020::Constantly moist - Skin is moist/damp every time infant is moved or turned.
- at0021::Excellent - Bottlebreastfeeds every meal which meets nutritional needs for growth.
- at0022::Adequate - Is on tube feedings which meet nutritional needs for growth.
- at0023::Inadequate - Receives less than optimum amount of liquid diet for growth (formula/breast milk) and supplemented with intravenous fluids.
- at0024::Very poor - NPO on intravenous fluids.
- at0025::Unlimited - In an open crib.
- at0026::Slightly limited - In a double walled isolette.
- at0027::Limited bed-bound - In a radiant warmer without a clear plastic "saran" tent.
- at0028::Completely bed-bound - In a radiant warmer with a clear plastic "saran" tent.
- at0029::No limitation - Makes major and frequent changes in position without assistance (e.g., turn head).
- at0030::Slightly limited - Makes frequent though slight changes in body or extremity position independently.
- at0031::Very limited - Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.
- at0032::Completely immobile - Does not make even slight changes in body or extremity position without assistance (e.g., Pavulon).
- at0033::No impairment - Alert and active.
- at0034::Slightly limited - Lethargic.
- at0035::Very limited - Responds only to painful stimuli (flinches, grasps, moans, increased blood pressure or heart rate).
- at0036::Completely limited - Unresponsive (does not flinch, grasp, moan, increase blood pressure, or heart rate) to painful stimuli due to diminished level of consciousness or sedation.
- at0037::At risk - Total score 13 or over - The neonate is not at risk of developing a pressure ulcer.
- at0038::Not at risk - Total score less than 13 - The neonate is at risk of developing a pressure ulcer.

[neurologic_assessment_in_neuro_oncology_scale](#)

Archetype ID: openEHR-EHR-OBSERVATION.neurologic_assessment_in_neuro_oncology_scale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the result for each component parameter for the NANO-scale and Overall NANO score.

****Use:**** Use to record the result for each component parameter for the NANO-scale and the Overall NANO score. The ordinal value '98' is included to represent the non-numerical value 'Not assessed' and value '99' to represent 'Not evaluable'. Neither current modelling tools nor any current implementations allow using a combination of numerical and non-numerical values within a single value set.

****Keywords:**** neurologic function, NANO, brain tumor, assessment, CNS, neuro-oncology, outcome

****Concepts:****

- at0000::Neurologic Assessment in Neuro-Oncology (NANO) scale - The NANO scale is a tool for assessing neurologic function in patients with brain tumor.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Gait - None
- at0005::Normal - None
- at0006::Abnormal but walks without assistance - None
- at0007::Abnormal and requires assistance (companion, cane, walker, etc.) - None
- at0008::Unable to walk - None
- at0009::Strength - None
- at0010::Normal - None
- at0011::Movement present but decreased against resistance - None
- at0012::Movement present but none against resistance - None
- at0013::No movement - None
- at0014::Ataxia (upper extremity) - None
- at0015::Able to finger to nose touch without difficulty - None
- at0016::Able to finger to nose touch but difficult - None
- at0017::Unable to finger to nose touch - None
- at0018::Sensation - None
- at0019::Normal - None
- at0020::Decreased but aware of sensory modality - None
- at0021::Unaware of sensory modality - None
- at0022::Visual fields - None

- at0023::Normal - None
- at0024::Inconsistent or equivocal partial hemianopsia (\geq quadrantanopsia) - None
- at0025::Consistent or unequivocal partial hemianopsia (\geq quadrantanopsia) - None
- at0026::Complete hemianopsia - None
- at0027::Facial strength - None
- at0028::Normal - None
- at0029::Mild/moderate weakness - None
- at0030::Severe facial weakness - None
- at0031::Language - None
- at0032::Normal - None
- at0033::Abnormal but easily conveys meaning to examiner - Includes word finding difficulty; few paraphasic errors/neologisms/word substitutions; but able to form sentences (full/broken).
- at0034::Abnormal and difficulty conveying meaning to examiner - Includes inability to form sentences (<4 words per phrase/sentence); limited word output; fluent but "empty" speech.
- at0035::Abnormal. If verbal, unable to convey meaning to the examiner OR non-verbal (mute/global aphasia) - None
- at0036::Level of consciousness - None
- at0037::Normal - None
- at0038::Drowsy (easily arousable) - None
- at0039::Somnolent (difficult to arouse) - None
- at0040::Unarousable/coma - None
- at0041::Behavior - None
- at0042::Normal - None
- at0043::Mild/moderate alteration - None
- at0044::Severe alteration - None
- at0046::ITEM_TREE - None
- at0047::Not assessed - None
- at0048::Not evaluable - None
- at0049::Not assessed - None
- at0050::Not evaluable - None
- at0051::Not assessed - None
- at0052::Not evaluable - None
- at0053::Not assessed - None
- at0054::Not evaluable - None
- at0055::Not assessed - None
- at0056::Not evaluable - None
- at0057::Not assessed - None
- at0058::Not evaluable - None
- at0059::Not assessed - None
- at0060::Not evaluable - None

- at0061::Not assessed - None
- at0062::Not evaluable - None
- at0063::Not assessed - None
- at0064::Not evaluable - None
- at0065::Additional details - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0066::Overall NANO score - None
- at0067::Neurological response - ≥ 2 level improvement in at least one domain without worsening in other domains from baseline or best level of function that is not attributable to change in concurrent medications or recovery from a comorbid event.
- at0068::Neurological progression - ≥ 2 level worsening from baseline or best level of function within ≥ 1 domain or worsening to the highest score within ≥ 1 domain that is felt to be related to underlying tumor progression and not attributable to a comorbid event or change in concurrent medication.
- at0069::Neurological stability - Neurologic function that does not meet criteria for neurologic response, neurologic progression, non-evaluable, or not assessed.
- at0070::Not assessed - If the clinician omits evaluation of that particular domain during his/her examination.
- at0071::Non-evaluable - If it is more likely than not that a factor other than underlying tumor activity contributed to an observed change in neurologic function.

news2

****Archetype ID:**** openEHR-EHR-OBSERVATION.news2.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, sv, nb, en

****Purpose:**** To record the value for each component variable for the NEWS2 score, and their total sum.

****Use:**** Use to record the value for each component variable for the NEWS2 score, and their total sum. In clinical practice, NEWS2 may be used to identify clinical deterioration in an at risk patient, or to provide an objective indication of the degree of deterioration in an acutely unwell patient. If the patient has hypercapnic respiratory failure, calculation of the NEWS score should use 'SpO₂ Scale 2'. In all other situations calculation of the NEWS2 score should use 'SpO₂ Scale 1'.

****Misuse:**** Not to be used to record actual measurements for each variable. Use specific OBSERVATION archetypes for this purpose: - OBSERVATION.blood_pressure; - OBSERVATION.pulse; - OBSERVATION.respiration; - OBSERVATION.body_temperature; - OBSERVATION.acvpu; and - OBSERVATION.pulse_oximetry. Not to be used for children or teenagers under the age of 16 years. Use an archetype representing the Paediatric Early Warning Score (PEWS) for this purpose. Not to be used during pregnancy and the postpartum period. Use a pregnancy specific archetype such as Maternal Early Warning Score or Modified Early Obstetric Warning Score for this purpose.

****Keywords:**** warning, triage, NEWS, Sats, EWS, deterioration, NEWS2

****Concepts:****

- at0000::National Early Warning Score 2 (NEWS2) - A simple assessment score used to identify clinical deterioration in a patient.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Systolic blood pressure - Category for the systolic blood pressure measurement.
- at0005::Pulse - Category for the pulse measurement.
- at0006::Respiration rate - Category for the respiratory rate measurement.
- at0007::Temperature - Range category for the body temperature measurement.
- at0008::Consciousness - Category for the observed conscious state, using the ACVPU scale.
- at0010::≤40 - The pulse measurement is less than/equal to 40 beats/min.
- at0011::111-130 - The pulse measurement is between 111 and 130 beats/min.
- at0012::41-50 - The pulse measurement is between 41 and 50 beats/min.
- at0013::51-90 - The pulse measurement is between 51 and 90 beats/min.
- at0014::111-219 - The systolic blood pressure measurement is between 111 and 219 mmHg.
- at0015::101-110 - The systolic blood pressure measurement is between 101 and 110 mmHg.
- at0016::91-100 - The systolic blood pressure measurement is between 91 and 100 mmHg.
- at0017::≤90 - The systolic blood pressure measurement is less than/equal to 90 mmHg.
- at0018::12-20 - The respiratory rate measurement is between 12 and 20 breaths/min.
- at0019::9-11 - The respiratory rate measurement is between 9 and 11 breaths/min.
- at0020::21-24 - The respiratory rate measurement is between 21 and 24 breaths/min.
- at0021::≤8 - The respiratory rate measurement is less than/equal to 8 breaths/min.
- at0022::36.1-38.0 - The body temperature measurement is between 36.1 and 38.0 degrees Celsius.

- at0023::35.1-36.0 - The body temperature measurement is between 35.1 and 36.0 degrees Celsius.
- at0024::Alert - The patient is alert or awake; scored as 0 points.
- at0025::C, V, P or U - The patient is newly confused, responds only to voice or pain, or is unresponsive; scored as 3 points.
- at0028::Total score - The sum of points assigned for each of the component variables.
- at0029::SpO₂ Scale 1 - Category for the oxygen saturation measurement.
- at0030::≥96 - The oxygen saturation level is greater than/equal to 96%.
- at0031::94-95 - The oxygen saturation level is between 94% and 95%.
- at0032::92-93 - The oxygen saturation level is between 92% and 93%.
- at0033::≤91 - The oxygen saturation level is less than/equal to 91%.
- at0034::Air or oxygen? - Is the patient receiving supplemental oxygen?
- at0036::Air - The patient is breathing room air; not receiving supplemental oxygen.
- at0037::Oxygen - The patient is receiving supplemental oxygen.
- at0038::≥39.1 - The body temperature is greater than/equal to 39.1 degrees Celcius.
- at0039::≤35.0 - The body temperature is less than/equal to 35 degrees Celcius.
- at0045::Tree - @ internal @
- at0046::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0047::SpO₂ Scale 2 - Category for the oxygen saturation measurement in patients with a target oxygen saturation range of 88–92%.
- at0048::88-92 or ≥93 on air - The oxygen saturation level is between 88% and 92% or greater than/equal to 93% on air.
- at0049::86-87 - The oxygen saturation level is between 86% and 87%.
- at0050::84-85 - The oxygen saturation level is between 84% and 85%.
- at0051::≥97 on oxygen - The oxygen saturation level is greater than/equal to 97% on supplemental oxygen.
- at0056::Clinical risk category - Overall category representing the urgency and scale of the clinical response required in response to the physiological variables.
- at0057::Low - Ward-based response.
- at0058::Low-medium - Urgent ward-based response.
- at0059::Medium - Key threshold for urgent response.
- at0060::High - Urgent or emergency response.
- at0061::≤83 - The oxygen saturation level is less/equal to 83%.
- at0062::93-94 on oxygen - The oxygen saturation level is between 93% and 94% on supplemental oxygen.
- at0063::95-96 on oxygen - The oxygen saturation level is between 95% and 96% on supplemental oxygen.
- at0064::≥25 - The respiratory rate measurement is greater than/equal to 25 breaths/min.
- at0065::≥131 - The pulse measurement is greater than/equal to 131 beats/min.

- at0066::38.1-39.0 - The body temperature measurement is between 38.1 and 39.0 degrees Celsius.
- at0067::≥220 - The systolic blood pressure measurement is greater than/equal to 220 mmHg.
- at0068::91-110 - The pulse measurement is between 91 and 110 beats/min.

[news_uk_rcp](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.news_uk_rcp.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

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

****Purpose:**** To record a composite score based on categorising physiological readings and observations, as a simple method to support objective assessment of the degree of clinical deterioration in an unwell patient over the age of 16 years.

****Use:**** Use to record a composite score to support assessment of the degree of clinical deterioration in an unwell patient, over the age of 16 years.

****Misuse:**** Not to be used to record each physical measurement or clinical observation. Use specific OBSERVATION archetypes for this purpose - OBSERVATION.blood_pressure, OBSERVATION.pulse, OBSERVATION.respirations, OBSERVATION.body_temperature, OBSERVATION.avpu, CLUSTER.ambient_oxygen or OBSERVATION.indirect_oximetry. Not to be used for children/teens under the age of 16 years or in pregnancy.

****Keywords:**** warning, AVPU, RR, HR, BP, Temp, SBP, triage, NEWS, Sats, MEWS, EWS, oxygen, saturation, illness, degree, score

****Concepts:****

- at0000::National Early Warning Score (NEWS) - NEWS (National Early Warning Score) is a simple score used to provide an objective indication of a patient's degree of clinical deterioration. This version follows guidance issued by the UK Royal College of Physicians.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @

- at0004::Systolic blood pressure - Range category for the systolic blood pressure (SBP) measurement of a patient.
- at0005::Heart rate - Range category for the heart rate (HR) measurement of a patient.
- at0006::Respiration rate - Range category for the respiratory rate (RR) measurement of a patient.
- at0007::Body temperature - Range category for the body temperature (Temp) measurement of a patient.
- at0008::Level of consciousness - Observed category for the AVPU scale rating of a patient's conscious state.
- at0010::<=40 or >=131 - The heart rate measurement is less than/equal to 40 beats/min or greater than/equal to 131 beats/min; scored as 3 points.
- at0011::111-130 - The heart rate measurement is between 111 and 130 beats/min; scored as 2 points.
- at0012::41-50 or 91-110 - The heart rate measurement is between 41 and 50 beats/min or between 91 and 110 beats/min; scored as 1 point.
- at0013::51-90 - The heart rate measurement is between 51 and 90 beats/min; scored as 0 points.
- at0014::111-219 - The systolic blood pressure measurement is between 111 and 219 mmHg; scored as 0 points.
- at0015::101-110 - The systolic blood pressure measurement is between 101 and 110 mmHg; scored as 1 point.
- at0016::91-100 - The systolic blood pressure measurement is between 91 and 100 mmHg; scored as 2 points.
- at0017::<=90 or >= 220 - The systolic blood pressure measurement is less than/equal to 90 mmHg or greater than/equal to 220 mmHg; scored as 3 points.
- at0018::12-20 - The respiratory rate measurement is between 12 and 20 breaths/min; scored as 0 points.
- at0019::9-11 - The respiratory rate measurement is between 9 and 11 breaths/min; scored as 1 point.
- at0020::21-24 - The respiratory rate measurement is between 21 and 24 breaths/min; scored as 2 points.
- at0021::<=8 or >=25 - The respiratory rate measurement is less than/equal to 8 breaths/min or greater than/equal to 25 breaths/min; scored as 3 points.
- at0022::36.1-38.0 - The body temperature measurement is between 36.1 and 38.0 degrees Celsius; scored as 0 points.
- at0023::35.1-36.0 or 38.1-39.0 - The body temperature measurement is between 35.1 and 36.0 degrees Celsius or between 38.1 and 39.0 degrees Celsius; scored as 1 point.
- at0024::A - The patient is alert or awake; scored as 0 points.
- at0025::V, P or U - The patient responds only to voice or pain, or is unresponsive; scored as 3 points.
- at0028::Total score - The total sum of all the NEWS parameter ordinals.

- at0029::Oxygen saturation - Range category for the oxygen saturation measurement of a patient.
- at0030::>= 96 - The oxygen saturation level is greater than/equal to 96%;scored as 0 points.
- at0031::94-95 - The oxygen saturation level is between 94% and 95%; scored as 1 point.
- at0032::92-93 - The oxygen saturation level is between 92% and 93%; scored as 2 points.
- at0033::<=91 - The oxygen saturation level is less than/equal to 91%; scored as 3 points.
- at0034::Supplemental oxygen - Range category depending on whether the patient is receiving supplemental oxygen.
- at0036::No - The patient is not receiving supplemental oxygen; scored as 0 points.
- at0037::Yes - The patient is receiving supplemental oxygen; scored as 2 points.
- at0038::>=39.1 - The body temperature is greater than/equal to 39.1 degrees Celcius; scored as 2 points.
- at0039::<=35.0 - The body temperature is less than/equal to 35 degrees Celcius ; scored as 3 points.
- at0041::Tree - @ internal @
- at0043::Confounding factors - Description of any incidental factors that may have contributed to the score.
- at0044::Comment - Additional narrative about the overall NEWS score not captured in other fields.
- at0045::Tree - @ internal @
- at0046::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0047::Clinical risk category - Overall category representing the urgency and scale of the clinical response required in response to the physiological parameters.
- at0048::Low - Ward-based response.
- at0049::Low-medium - Urgent ward-based response.
- at0050::Medium - Key threshold for urgent response.
- at0051::High - Urgent or emergency response.

nihss

Archetype ID: openEHR-EHR-OBSERVATION.nihss.v0

Lifecycle State: in_development

Category: OBSERVATION

****Languages:**** nb, pt-br, en

****Purpose:**** To record the results of NIHSS as a quantitative measurement of stroke-related neurologic deficit.

****Use:**** Used to record the results of NIHSS scoring as a quantitative measurement of stroke-related neurological deficits. The total score is the arithmetic sum of all 15 responses, with all 'untestable' values excluded. The ordinal value '99' is included to represent the non-numeric value 'untestable'. Currently, neither modeling tools nor existing openEHR journal systems allow for a combination of numeric and non-numeric values within a single value set.

****Keywords:**** scale, neurological, stroke, assessment, examination, NIHSS

****Concepts:****

- at0000::NIHSS - 15-item neurologic examination stroke scale that provides a quantitative measure of stroke-related neurological deficit.
- at0001::History - @ internal @
- at0002::Baseline - Baseline assessment.
- at0003::Tree - @ internal @
- at0004::LOC responsiveness - Observed level of consciousness of the patient.
- at0005::Alert - Keenly responsive.
- at0006::Not alert, but arousable - Not alert; but arousable by minor stimulation to obey, answer or respond.
- at0007::Not alert, requires repeated stimulation - Not Alert; requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped).
- at0008::Reflex responses only or totally unresponsive - Responds only with reflex motor or autonomic effects, or totally unresponsive, flaccid, and areflexic.
- at0009::LOC questions - The patient is asked the month and his/her age.
- at0010::Both correct - Answers both questions correctly.
- at0011::One correct - Answers one question correctly.
- at0012::Neither correct - Answers neither question correctly.
- at0013::LOC commands - The patient is asked to open and close the eyes and then to grip and release the nonparetic hand.
- at0014::Both correct - Patient performs both tasks correctly.
- at0015::One correct - Patient performs one task correctly.
- at0016::Neither correct - Patient performs neither task correctly.
- at0017::Best Gaze - Horizontal eye movement observation.
- at0018::Normal - Normal eye movement.
- at0019::Partial gaze palsy - Gaze is abnormal in one or both eyes, but forced deviation or total gaze paresis is not present.

- at0020::Forced deviation or total gaze paresis - Forced deviation or total gaze paresis is not overcome by the oculocephalic maneuver.
- at0021::Visual - Visual field test observation.
- at0022::No visual loss - No visual loss detected.
- at0023::Partial hemianopia - Partial hemianopia or complete quadrantanopia detected.
- at0024::Complete hemianopia - Complete hemianopia detected.
- at0025::Bilateral hemianopia - Blindness from any cause, including cortical blindness.
- at0026::Facial palsy - Facial palsy observation.
- at0027::Normal - Normal symmetrical movements.
- at0028::Minor paralysis - Flattened nasolabial fold, asymmetry on smiling.
- at0029::Partial paralysis - Total or near-total paralysis of lower face.
- at0030::Complete paralysis of one or both sides - Absence of facial movement in the upper and lower face.
- at0067::Sensory - Observation of sensory loss.
- at0068::Normal - No sensory loss.
- at0069::Mild-to-moderate sensory loss - Patient feels pinprick is less sharp or is dull on the affected side; or there is a loss of superficial pain with pinprick, but patient is aware of being touched.
- at0070::Severe or total sensory loss - Patient is not aware of being touched in the face, arm, and leg.
- at0071::Best Language - Observation of language capability.
- at0072::No aphasia - Normal
- at0073::Mild-to-moderate aphasia - Some obvious loss of fluency or facility of comprehension, without significant limitation on ideas expressed or form of expression. Reduction of speech and/or comprehension, however, makes conversation about provided materials difficult or impossible. For example, in conversation about provided materials, examiner can identify picture or naming card content from patient's response.
- at0074::Severe aphasia - All communication is through fragmentary expression; great need for inference, questioning, and guessing by the listener. Range of information that can be exchanged is limited; listener carries burden of communication. Examiner cannot identify materials provided from patient response.
- at0075::Mute, global aphasia - No usable speech or auditory comprehension.
- at0082::Extinction and inattention - Observation of any evidence of extinction or inattention.
- at0083::No abnormality - No abnormality observed.
- at0084::Inattention, or bilateral extinction in one sensory modality - Visual, tactile, auditory, spatial, or personal inattention, or extinction to bilateral simultaneous stimulation in one of the sensory modalities.
- at0085::Profound hemi-inattention or extinction to more than one modality - Does not recognize own hand or orients to only one side of space.

- at0086::Total score - The total score is the arithmetic sum of all 15 responses, excluding any untestable responses.
- at0092::Item tree - @ internal @
- at0031::Motor - left arm - Observation of left arm motor function.
- at0032::No drift - Limb holds 90 (or 45) degrees for full 10 seconds.
- at0033::Drift - Limb holds 90 (or 45) degrees, but drifts down before full 10 seconds; does not hit bed or other support.
- at0034::Some effort against gravity - Limb cannot get to or maintain (if cued) 90 (or 45) degrees, drifts down to bed, but has some effort against gravity.
- at0124::No effort against gravity - Limb falls.
- at0035::No movement - There is no observed limb movement.
- at0036::Untestable - Amputation or joint fusion at the shoulder.
- at0038::Motor - right arm - Observation of right arm motor function.
- at0039::No drift - Limb holds 90 (or 45) degrees for full 10 seconds.
- at0040::Drift - Limb holds 90 (or 45) degrees, but drifts down before full 10 seconds; does not hit bed or other support.
- at0041::Some effort against gravity - Limb cannot get to or maintain (if cued) 90 (or 45) degrees, drifts down to bed, but has some effort against gravity.
- at0042::No effort against gravity - Limb falls.
- at0043::No movement - There is no observed limb movement.
- at0044::Untestable - Amputation or joint fusion at the shoulder.
- at0046::Motor - left leg - Observation of left leg motor function.
- at0047::No drift - Leg holds 30-degree position for full 5 seconds.
- at0048::Drift - Leg falls by the end of the 5-second period but does not hit the bed.
- at0049::Some effort against gravity - Leg falls to bed by 5 seconds but has some effort against gravity.
- at0050::No effort against gravity - Leg falls to bed immediately.
- at0051::No movement - There is no observed leg movement.
- at0052::Untestable - Amputation or joint fusion at the hip.
- at0141::Motor - right leg - Observation of right leg motor function.
- at0054::No drift - Leg holds 30-degree position for full 5 seconds.
- at0055::Drift - Leg falls by the end of the 5-second period but does not hit the bed.
- at0056::Some effort against gravity - Leg falls to bed by 5 seconds but has some effort against gravity.
- at0057::No effort against gravity - Leg falls to bed immediately.
- at0058::No movement - There is no observed leg movement.
- at0059::Untestable - Amputation or joint fusion at the hip.
- at0061::Limb ataxia - Observation of limb ataxia as evidence of a unilateral cerebellar lesion.
- at0062::Absent - No limb ataxia observed.
- at0063::Present in one limb - Limb ataxia observed in one limb.
- at0064::Present in two limbs - Limb ataxia observed in two limbs.

- at0065::Untestable - Amputation or joint fusion.
- at0076::Dysarthria - Observation about speech capability.
- at0077::Normal - Normal speech.
- at0078::Mild-to-moderate dysarthria - Patient slurs at least some words and, at worst, can be understood with some difficulty.
- at0079::Severe dysarthria - Patient's speech is so slurred as to be unintelligible in the absence of or out of proportion to any dysphasia, or is mute/anarthric.
- at0087::2 hours post treatment - Assessment carried out 2 hours post treatment.
- at0088::24 hours post symptom onset - Assessment carried out 24 hours post onset of symptoms (with tolerance of +/-20 minutes).
- at0089::7-10 days - Assessment carried out 7-10 days after stroke.
- at0090::3 months - Assessment carried out 3 months after stroke.
- at0091::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0037::Reason left arm untestable - Narrative description about why the left arm motor function was untestable.
- at0045::Reason right arm untestable - Narrative description about why the right arm motor function was untestable.
- at0053::Reason left leg untestable - Narrative description about why the left leg motor function was untestable.
- at0060::Reason right leg untestable - Narrative description about why the right leg motor function was untestable.
- at0066::Reason limb ataxia untestable - Narrative description about why limb ataxia was untestable.
- at0081::Reason speech untestable - Narrative description about why speech was untestable.
- at0080::Untestable - Intubated or other physical barrier.
- at0093::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[nine_hole_peg_test](#)

Archetype ID: openEHR-EHR-OBSERVATION.nine_hole_peg_test.v1

Lifecycle State: Published

Category: OBSERVATION

Languages: de, en, zh-cn

****Purpose:**** To record the measurements recorded during a Nine Hole Peg Test, normally as part of the Multiple Sclerosis Functional Composite suite of tests.

****Use:**** Use to record the measurements recorded during a Nine Hole Peg Test. This test is commonly carried out as one component of the Multiple Sclerosis Functional Composite (MSFC) assessment, but may be performed independently. Both the dominant and non-dominant hand of the patient are tested twice (two consecutive trials of the dominant hand, followed by two consecutive trials of the non-dominant hand). For each trial nine pegs are picked one by one from a container, placed in the holes on a pegboard and then separately returned to the container. The subject may only use one hand at each trial, but may hold the pegboard with the free hand. This archetype covers variations of the test. According to Mathiowetz et al. (1985) an untimed practice trial should be administered prior to the timed trial for each hand. The MSFC Manual stipulates two timed trials for each hand, but no practice trial. Use the MSFC Manual or see Mathiowetz et al. (1985) for detailed administration instructions. The test should only be administered by a suitably trained person.

****Misuse:**** Not to be used for the assessment of patients with serious physical impairments.

****Keywords:**** NHPT, 9-Hole Peg Test, 9-HPT, Multiple Sclerosis Functional Composite, MSFC, Multiple Sclerosis, MS, Neurology

****Concepts:****

- at0000::Nine Hole Peg Test - The Nine Hole Peg Test is a quantitative measure of upper extremity function, and used for rapid assessment of finger dexterity of a subject. It is the second component of the Multiple Sclerosis Functional Composite (MSFC), a series of three tests to document the course of Multiple Sclerosis. It is also known as NHTP, as 9-Hole Peg Test, or 9-HPT.
- at0001::Event Series - @ internal @
- at0003::Tree - @ internal @
- at0004::Tree - @ internal @
- at0008::Tree - @ internal @
- at0013::Practice Trial For Dominant Hand? - Was an untimed practice trial conducted with the dominant hand prior to the timed dominant hand trial?
- at0017::Total Time - The time taken to successfully complete the trial for one hand.
- at0035::Interim Time - Interim time measured after the placement of the last peg on the pegboard, before returning them to the container.
- at0050::Number Of Pegs Placed - The number of pegs successfully placed on the pegboard.
- at0051::Number Of Pegs Returned - The number of pegs successfully returned to the container.
- at0064::Confounding Factors - Record any circumstances that are believed to have affected the patient's performance.

- at0074::Dominant Hand - Trial 1 - First trial of the dominant hand.
- at0075::Dominant Hand - Trial 2 - Second trial of the dominant hand.
- at0076::Non-dominant Hand - Trial 1 - First trial of the non-dominant hand.
- at0077::Non-dominant Hand - Trial 2 - Second trial of the non-dominant hand.
- at0080::Trial Not Completed? - Was the trial incomplete?
- at0081::Reason For Non-completion - If the trial was terminated prematurely, record any reasons.
- at0082::Practice Trial For Non-dominant Hand? - Was an untimed practice trial conducted with the non-dominant hand prior to the timed non-dominant hand trial?
- at0083::Dominant Hand - Indication of the dominant hand (if the subject uses both hands equally, the hand that is preferred for writing).
- at0084::Pegs Placed But Not Returned - Mark as true if the trial only consists in placing the pegs on the board, i.e. without returning them to the container.
- at0085::Right hand dominant - The subject's right hand is dominant.
- at0086::Left hand dominant - The subject's left hand is dominant.
- at0087::More Than Two Attempts? - Did it take more than two attempts to get two successful trials per hand?
- at0088::Reason For More Than Two Attempts - If multiple attempts were needed to complete the trials, please specify reasons.

[nutritional_risk_screening](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.nutritional_risk_screening.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** NRS is a tool used for screening the patients nutritional status. There are several NRS models, in this case a translation from 2014 made by Lene Thoresen and Hilde Wøie and corrected by Jens Kondrup is used. The version recommended by the Norwegian Directorate of Health has other time interval values in the scores. Nutritional risk is defined by combining current nutritional status and the risk of impaired nutritional status due to increased need for nutrition, caused by stress metabolism in the clinical situation.

****Use:**** To be used for adults only. The first 4 questions are used as a initial screening. The main screening is only done if any of the questions in the initial screening are answered YES If all the questions in the initial screening is answered "NO" the patient needs a weekly re screening. If a patient, e.g will undergo a planned major surgery, a preventive nutritional plan needs to be considered to avoid expected nutritional risks. Is the total score ≥ 3 the

patient has a nutritional risk, and a nutritional plan needs to be effectuated. If the total score is <3 the patient needs weekly re screening. If the patient e.g will undergo major surgery a preventive nutrition plan have to be considered to avoid the expected nutritional risk.

Misuse: Not to be used in children under the age of 18 years old.

Keywords: nutrition, Nutritional risk screening, NRS, NRS 2002, malnutrition, undernourishment, weight loss, weight, BMI, nutritional risk

Concepts:

- at0000::Nutritional Risk Screening (NRS 2002) - Screening for malnutrition using the tool NRS 2002.
- at0001::Event Series - @ internal @
- at0002::Unspecified event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @(nb).
- at0004::Is the body mass index <20.5 kg/m²? - Is the patients body mass index below 20.5 kg/m²?
- at0005::Has the patient lost weight in the previous 3 months? - Weightloss during the last 3 months?
- at0006::Was nutritional intake reduced in the previous week? - Reduced nutritional intake in the previous week?
- at0007::Is the patient very ill? (e.g. in intensive care)? - Do the patient have an increased stress metabolism related to relevant disease (trauma, intensive care patient).
- at0016::Nutritional status - Nutritional status (≈ degree of weakening).
- at0017::Illness severity - Severity of disease (≈ increased needs).
- at0018::None - Normal nutritional status.
- at0019::Mild - Weight loss > 5% over the last 3 months or nutritional intake <50–75% of required nutritional intake in the previous week.
- at0020::Moderate - Weight loss >5% within 2 months or BMI 18.5–20.5 kg/m² and reduced general condition (GC) or nutritional intake 25–50% of required nutritional intake in the previous week.
- at0021::Severe - Weight loss >5 % within a month (>15% over the last 3 months) or BMI <18.5

kg/m² and reduced general condition or nutritional intake 0–25% of required nutritional intake in the previous week.

- at0022::None - Normal nutritional requirements.
- at0023::Mild - For example: Femoral neck fracture, chronic disease especially if complications are present: liver cirrhosis*, chronic obstructive lung disease*, chronic hemodialysis#, diabetes#, cancer#. Patients that have a disease that causes a mildly reduced general condition status.

- at0024::Moderate - For example: Major abdominal surgery*, stroke*, severe pneumonia, hematologic cancers.
- at0025::Severe - For example: Head injury*, bone marrow transplantation*, patients in intensive care (APACHE-II >10).
- at0027::Is the patients age \geq 70? - Is the patients age 70 or more.
- at0028::No - The patient is younger than 70 years.
- at0029::Yes - The patient is 70 years or old.
- at0030::Total score (age adjusted) - The total score is a combination of nutritional status, disease severity and age.
- at0031::Initial screening - The main screening is done if any of the questions in the initial screening is answered "YES".
- at0032::Main screening - The main screening is performed only if any of the questions in the initial screening is answered "YES".
- at0033::Yes - The patients body mass index is below 20.5 kg/m².
- at0034::No - The patients body mass index is equal or above 20.5 kg/m².
- at0035::Yes - The patient has lost weight during the last 3 months.
- at0036::No - The patient did not lose weight during the last 3 months.
- at0037::Yes - The patient had reduced nutritional intake in the previous week.
- at0038::No - Reduced nutritional intake in the previous week?
- at0039::Yes - The patient is very ill (e.g. in intensive care).
- at0040::No - The patient is not very ill.
- at0041::Comment - Additional narrative about the assessment of the Nutritional Risk Screening, not captured in the structured elements.

[nutrition_intake](#)

Archetype ID: openEHR-EHR-OBSERVATION.nutrition_intake.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en

Purpose: For recording the total intake of nutrients at a point in time or interval of time, such as a meal or a day.

Use: Use for recording the total intake of nutrients at a point in time or interval of time, such as a meal or a day.

****Misuse:**** Not to be used for recording the details of food items consumed. Use the OBSERVATION.food_item archetype for this purpose.

****Keywords:**** nutrition, nutrients

****Concepts:****

- at0000::Nutrition intake - The total intake of nutrients at a point in time or interval of time, such as a meal or a day.
- at0001::History - *
- at0002::Any Event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Cumulative total - Cumulative nutritional intake within a specified interval of time, which should be explicitly defined in a template or at run-time.
- at0010::Nutrients - Details about the component nutrients for the event.
- at0011::Comment - Additional narrative about the nutrition intake not captured in other fields.
- at0012::ItemTree - @ internal @
- at0013::Nutritional day definition - The applied definition for the starting time of the 'Cumulative total' event used in this archetype.
- at0014::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0015::Meal - A unspecified meal, either as a point in time or interval event, which should be explicitly defined and renamed in a template or at run-time.

[nyha_heart_failure](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.nyha_heart_failure.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, fi, nb, en

****Purpose:**** To record one or both of: - a functional assessment of heart failure based on symptoms; and - an objective assessment based on both evidence of cardiovascular disease and symptoms.

****Use:**** Use to record one or both of: - a functional assessment of heart failure based on symptoms; and - an objective assessment based on both evidence of cardiovascular disease and symptoms.

****Keywords:**** heart, failure, cardiac, breathlessness, fatigue, dysfunction, ventricular

****Concepts:****

- at0000::New York Heart Association functional classification - A simple method of classifying the extent of heart failure, as defined by the New York Heart Association.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Functional capacity - Assessment of heart failure based on how a patient with cardiac disease feels during physical activity.
- at0005::Class I - No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).
- at0006::Class II - Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).
- at0007::Class III - Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
- at0008::Class IIIa - As per Class III; no dyspnoea at rest.
- at0009::Class IIIb - As per Class III; recent dyspnoea at rest.
- at0010::Class IV - Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.
- at0011::Objective assessment - Assessment of heart failure based on evidence of cardiovascular disease and symptoms.
- at0012::Class A - No objective evidence of cardiovascular disease. No symptoms and no limitation in ordinary physical activity.
- at0013::Class B - Objective evidence of minimal cardiovascular disease. Mild symptoms and slight limitation during ordinary activity. Comfortable at rest.
- at0014::Class C - Objective evidence of moderately severe cardiovascular disease. Marked limitation in activity due to symptoms, even during less-than-ordinary activity. Comfortable only at rest.
- at0015::Class D - Objective evidence of severe cardiovascular disease. Severe limitations. Experiences symptoms even while at rest.
- at0016::Tree - @ internal @
- at0017::Confounding factors - Narrative description of any issues or factors that may impact on the assessment.
- at0018::Tree - @ internal @
- at0019::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

onews_se

****Archetype ID:**** openEHR-EHR-OBSERVATION.onews_se.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To record the results for each component parameter and their total sum for the Swedish Obstetric National Early Warning Score (ONEWS).

****Use:**** To record the results for each component parameter and their total sum for the Swedish Obstetric National Early Warning Score (ONEWS).

****Keywords:**** ONEWS, NEWS2, Svensk, Sverige, Swedish, Sweden

****Concepts:****

- at0000::Obstetric National Early Warning Score (ONEWS) - Sweden - A Swedish assessment score used to identify clinical deterioration in an individual who is pregnant or up to 6 weeks postpartum.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Respiratory rate - Category for the respiratory rate measurement.
- at0005::10-20 - None
- at0006::21-29 - None
- at0007::<10 - None
- at0008::≥30 - None
- at0009::Oxygen saturation - Category for the oxygen saturation measurement.
- at0010::≥96 - None
- at0011::≤95 - None
- at0012::Oxygen delivered - Is the patient receiving supplemental oxygen?
- at0013::No - None
- at0014::Yes - None
- at0015::Systolic blood pressure - Category for the systolic blood pressure measurement.
- at0016::90-139 - None
- at0017::140-149 - None
- at0018::80-89 - None
- at0019::150-159 - None
- at0020::<80 - None
- at0021::≥160 - None

- at0022::Diastolic blood pressure - Category for the diastolic blood pressure measurement.
- at0023::<90 - None
- at0024::90-99 - None
- at0025::100-109 - None
- at0026::≥110 - None
- at0027::Pulse rate - Category for the pulse measurement.
- at0028::60-110 - None
- at0029::111-129 - None
- at0030::<60 - None
- at0031::≥130 - None
- at0032::Level of consciousness - Category for the observed conscious state, using the ACVPU scale.
- at0033::Alert - The patient is alert or awake.
- at0034::C, V, P or U - The patient is newly confused, responds only to voice or pain, or is unresponsive.
- at0035::Temperature - Range category for the body temperature measurement.
- at0036::36.1-37.9 - None
- at0037::35.1-36.0 - None
- at0038::38.0-38.9 - None
- at0039::≤35.0 - None
- at0040::≥39.0 - None
- at0041::Total score - The sum of points assigned for each of the component variables.
- at0042::Clinical response steps - Overall category representing the urgency and scale of the clinical response required in response to the physiological variables.
- at0043::0 - At the latest within 12 hours.
- at0044::Total 1-3 - At the latest within 4 hours.
- at0045::Total of 4-5 or 3 points in one parameter - At the latest within 1 hour.
- at0046::Total ≥6 - At the latest within 15 minutes.
- at0047::Item tree - @ internal @
- at0048::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.

[**ophthalmic_tomography_examination**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.ophthalmic_tomography_examination.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en, es

****Purpose:**** Register details about ophthalmic studies with regard to the ophthalmic tomography test.

****Use:**** This archetype can be used for the following: - Register the protocol/strategy used to conduct ophthalmic tomography test. - Review with diagnostic purposes, the studies acquired using ophthalmic tomography, looking for clinically relevant findings on eye fundus.

****Keywords:**** ophthalmic, coherence, tomography, OCT

****Concepts:****

- at0000::Ophthalmic tomography examination - Record of clinical findings using optical coherence tomography with ophthalmic purposes.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Arbol - @ internal @
- at0004::Arbol - @ internal @
- at0008::Arbol - @ internal @
- at0011::Device details - Details of the device used to acquire OCT images.
- at0038::Clinical description - A term, commonly coded, expressing an overall interpretation of the OCT test.
- at0039::Test result - Details of the ophthalmic tomography examination test result for each eye.
- at0040::Side - Determines the eye on which the test was performed. Matches to DICOM Laterality (0020,0060) attribute.
- at0045::Structure analyzed - The anatomic structure analyzed in this study.
- at0046::Image type - Identifies the fundus imaging modalities obtained from the acquisition of the reference image.
- at0047::Multiframe properties - Information about the slices of the retina obtained by OCT the test.
- at0048::Number of frames - Number of slices in the study (from 1 to n).
- at0049::Frame pointer - Number identifying a frame among the rest in the study, to highlight its relevance on diagnosis.
- at0054::OCT slice - Current slice of the retina regarding the image of reference.
- at0055::Reports - Information about image reports related to the current OCT study.
- at0056::Report type - Defines the purpose of the report built from data acquired on the OCT device.
- at0088::Report - Report related to the current OCT study.
- at0090::Reference image - Information about the image on which the position of OCT acquisitions/slices will be referenced.

- at0091::Acquisition method - Ophthalmic photography acquisition method chosen to obtain the reference image.
- at0093::Comment - Narrative description of clinically relevant information identifiable on the reference image.
- at0094::Ophthalmic thickness details - Details about a study of thickness of ophthalmic structures.
- at0115::Confounding factors - Patient circumstances which may affect interpretation of the result.
- at0123::Intraocular pressure - Value of intraocular pressure in mmHg.
- at0124::Axial length of the eye - Axial length of the eye in mm.
- at0125::Horizontal field of view - The horizontal field of view in degrees.
- at0130::Contrast/Bolus - Information about the contrast agents administered prior to or during the acquisition.
- at0131::Contrast/bolus agent - Identification of the contrast agent.
- at0132::Contrast/bolus volume - Volume injected in milliliters of diluted contrast agent.
- at0133::Contrast/bolus volume ingredient concentration - Milligrams of active ingredient per milliliter of (diluted) agent.
- at0134::Refraction details - Details of refractive correction applied to each eye.
- at0135::Left eye - The left eye was examined.
- at0136::Right eye - The right eye was examined.
- at0186::Retinal thickness - Information related to retinal thickness measurement.
- at0187::FA - Fluorescein Angiography.
- at0188::ICGA - Indocyanine green angiography.
- at0190::AF - BluePeak blue laser autofluorescence imaging.
- at0191::IR - Infrared reflectance imaging.
- at0192::RF - Red-free imaging.
- at0204::Reference image - Image on which the position of OCT acquisitions/slices will be referenced.
- at0205::OCT overview - Details about slice/s of the retina regarding its/their position in the reference image.
- at0206::Retina exam - Study of a slice of the retina and measurement of its thickness profile.
- at0207::Retina change - Measurement of the thickness profile for each slice of retina in study and comparison of thickness progression in time during a follow-up.
- at0208::3D view - Study of a 3D reconstruction of the retina.
- at0209::Thickness map exam - Thickness study over the image of reference for multi-frame acquisition.
- at0210::Thickness map change - Thickness progression study between several images of reference using different multi-frame acquisitions taken along time.
- at0211::RNFL thickness exam - Measurement of thickness for retinal nerve fiber layer and comparison regarding the values from an age-adjusted normative database.

- at0212::RNFL thickness change - Measurement of thickness for retinal nerve fiber layer and comparison regarding other measures obtained during a follow-up process.
- at0213::RNFL thickness trend - Trend study for the evolution of retinal nerve fiber layer thickness.
- at0214::Asymmetry analysis - Study of difference in thickness comparing: values in different eyes (OD-OS), and superior-inferior hemispheres of the same eye.
- at0215::RNFL & asymmetry analysis - Study centered in retinal nerve fiber layer thickness and asymmetry of the retina.
- at0216::Posterior pole assessment - Study centered in thickness around the optic nerve and macula.
- at0217::Other - Other type of report.
- at0230::Fluorescein - Corresponds to DICOM Code value C-B02CC.
- at0231::Indocyanine green - Corresponds to DICOM Code value C-B0156.
- at0232::Rose Bengal - Corresponds to DICOM Code value C-B0295.
- at0233::Trypan blue - Corresponds to DICOM Code value C-22853.
- at0234::Methylene blue - Corresponds to DICOM Code value C-B02C5.
- at0251::Mydriasis Details - Details of any mydriatic procedure carried out whenever necessary.
- at0252::Acquisition details - Details about the strategy to conduct acquisitions using ophthalmic tomography.
- at0253::Report content - Which kind of graphs are included in the report.
- at0254::Reference image - The image of the retina used to indicate the position of OCT slices.
- at0255::Single OCT scan - Report including a specific OCT scan.
- at0256::OCT volume scan - A 3D reconstruction of eye structure using several OCT frames.
- at0257::Retinal thickness profile - Graph showing the thickness of retina for a specific OCT scan.
- at0258::Retinal thickness map - Coloured map showing the thickness of retina over the reference image.
- at0259::RNFL thickness profile - Graph representing the thickness of the retinal nerve fiber layer around the optic nerve.
- at0260::RNFL thickness map - Retinal nerve fiber layer thickness profile measured, compared to normal thickness values for different sections around the optic nerve.
- at0262::Thickness profile change - Graph showing the thickness of retina from a specific OCT slice and compares them to values obtained in different acquisitions during a follow-up.
- at0263::Thickness map change - Retinal thickness map obtained from the comparison of thickness values obtained in different acquisitions during a follow-up.
- at0264::Peripapillary RNFL thickness classification - Classification of total thickness measured for different sections around the papilla according to an age-adjusted normative database.

- at0265::Retinal average thickness - Average thickness values in sections of retina located close to the macula.
- at0266::Asymmetry OD-OS - Asymmetry map comparing thickness values from different eyes in the same locations.
- at0267::Hemisphere asymmetry - Asymmetry map comparing thickness at superior and inferior hemispheres in retina.
- at0268::RNFL thickness trend - Graph that represents the evolution along time of the thickness in retinal nerve fiber layer.
- at0269::Comment - Narrative description of clinically relevant information identifiable on the current report.
- at0270::Comment - Narrative description of clinically relevant information identifiable on the specific frames selected from the acquisition.
- at0271::Clinical findings - Every finding considered clinically relevant, found on posterior chamber of the eye.
- at0272::Comment - Narrative description of clinically relevant information identifiable on the analysis of ophthalmic thickness measurements.
- at0277::OCT slice analysis - Analysis of OCT slices considered relevant in the study.

[oucher_pain_scale](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.oucher_pain_scale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** es-ar, en

****Purpose:**** A self-report pain assessment tool for children aged 3 to 12.

****Use:**** There are two manners of administration of the Oucher scale: numerical or photographic. If the numerical (0 - 10) scale is used , after being asked to grade his or her pain in a 0 (no pain) to 10 (maximum pain) range, the number named by the child represents his or her score. If the photographic scale is used, the child must select the one picture which best represents the pain he or her is experiencing out of a collection of six pictures representing faces exhibiting increasing degrees of pain. The picture sets, as well as the conversion rule to the 0-10 numeric scale, may be downloaded from http://www.oucher.org/the_scales.html. The criteria to use either scale may be reviewed in the Oucher User's Manual, available in http://www.oucher.org/downloads/2009_Users_Manual.pdf. In general, the numeric scale should be used if the child can count to 100 by ones or tens, or if he or she can identify which of any two numbers is larger.

****Misuse:**** Not to be used outside the age range 3 to 12 years.

****Keywords:**** pain, scale, Oucher, children

****Concepts:****

- at0000::Oucher pain scale - A self-report pain assessment tool for children aged 3 to 12.
- at0001::Event Series - @ internal @
- at0002::Any event - Specified point in time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Total score - Pain intensity from 0 to 10.
- at0005::Tree - @ internal @
- at0006::Comment - Additional information not adequately captured by the numerical scale but which might assist in evaluating the pain experienced by the child.
- at0007::Tree - @ internal @
- at0008::Administration method - The method used to arrive at the final score value.
- at0009::Numeric - Using a 0 (no pain) to 10 (maximum pain) scale.
- at0010::Photographic - Using a set of six photograph out of which the child must select the one which most appropriately reflects his/her pain.
- at0011::Confounding factors - Any incidental factors related to the state of the subject which may affect clinical interpretation of the measurement.
- at0012::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[oxford_elbow](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.oxford_elbow.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Use to capture and report Oxford Elbow Questionnaire (OSE) score details.

****Use:**** Use to capture and report Oxford Elbow Questionnaire score. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Concepts:****

- at0000::Oxford Elbow Questionnaire Score (OSE) - Oxford Elbow Questionnaire Score.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Tree - @ internal @
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0008::1 Lifting - Patient-reported extent of difficulty lifting due to their elbow problem in the last 4 weeks.
- at0009::Extreme difficulty - The patients had extreme difficulty lifting things in the home due to their elbow problem during the last 4 weeks.
- at0010::Moderate difficulty - The patients had moderate difficulty lifting things in the home due to their elbow problem during the last 4 weeks.
- at0011::A little bit difficult - The patients found it a little difficult lifting things in the home due to their elbow problem during the last 4 weeks.
- at0012::No difficulty - The patients had no difficulty lifting things in the home due to their elbow problem during the last 4 weeks.
- at0104::Total score - Total score from Questions 1 to 12.
- at0105::Average score - Average score from Questions 1-12.
- at0109::Impossible to do - The patients found it impossible to lift things in the home due to their elbow problem during the last 4 weeks.
- at0157::2 Carrying bags - Patient-reported extent of difficulty carrying bags due to their elbow problem in the last 4 weeks.
- at0158::Impossible to do - The patients found it impossible to carry bags of shopping due to their elbow problem during the last 4 weeks.
- at0159::Extreme difficulty - The patients had extreme difficulty carrying bags of shopping due to their elbow problem during the last 4 weeks.
- at0160::Moderate difficulty - The patients had moderate difficulty carrying bags of shopping due to their elbow problem during the last 4 weeks.
- at0161::A little bit difficult - The patients found it a little difficult to carry bags of shopping due to their elbow problem during the last 4 weeks.
- at0162::No difficulty - The patients had no difficulty carrying bags of shopping due to their elbow problem during the last 4 weeks.
- at0163::3 Washing - Patient-reported extent of difficulty washing due to their elbow problem in the last 4 weeks.
- at0164::Impossible to do - The patients found it impossible to wash all over due to their elbow problem during the last 4 weeks.

- at0165::Extreme difficulty - The patients had extreme difficulty washing all over due to their elbow problem during the last 4 weeks.
- at0166::Moderate difficulty - The patients had moderate difficulty washing all over due to their elbow problem during the last 4 weeks.
- at0167::A little bit difficult - The patients found it a little difficult washing all over due to their elbow problem during the last 4 weeks.
- at0168::No difficulty - The patients had no difficulty washing all over due to their elbow problem during the last 4 weeks.
- at0169::4 Dressing - Patient-reported extent of difficulty dressing due to their elbow problem in the last 4 weeks.
- at0170::No, impossible - The patients found it impossible to dress due to their elbow problem during the last 4 weeks.
- at0171::Extreme difficulty - The patients had extreme difficulty dressing due to their elbow problem during the last 4 weeks.
- at0172::Moderate difficulty - The patients had moderate difficulty dressing due to their elbow problem during the last 4 weeks.
- at0173::A little bit difficult - The patients found it a little difficult dressing due to their elbow problem during the last 4 weeks.
- at0174::No difficulty - The patients had no difficulty dressing due to their elbow problem during the last 4 weeks.
- at0175::5 Controlling your life - Patient-reported extent to which they feel their elbow problem is controlling their life.
- at0176::Every day - The patients found their elbow problem was controlling their life every day during the last 4 weeks.
- at0177::Most days - The patients found their elbow problem was controlling their life most days during the last 4 weeks.
- at0178::Some days - The patients found their elbow problem was controlling their life some days during the last 4 weeks.
- at0179::Occasionally - The patients found their elbow problem was controlling their life occasionally during the last 4 weeks.
- at0180::No, not at all - The patients found their elbow problem was not controlling their life during the last 4 weeks.
- at0181::6 On your mind - Patient-reported extent to which they feel their elbow problem is on their mind over the last 4 weeks.
- at0182::All of the time - The patients found their elbow problem was on their mind all of the time during the last 4 weeks.
- at0183::Most of the time - The patients found their elbow problem was on their mind most the time during the last 4 weeks.
- at0184::Some of the time - The patients found their elbow problem was on their mind some of the time during the last 4 weeks.
- at0185::A little of the time - The patients found their elbow problem was on their mind a little of the time during the last 4 weeks.

- at0186::No, not at all - The patients found their elbow problem was not on their mind time during the last 4 weeks.
- at0187::7 Pain at night - Patient-reported extent to which they feel their elbow problem has troubled them at night over the last 4 weeks.
- at0188::Every night - The patients found they were troubled by elbow problem every night during the last 4 weeks.
- at0189::Most nights - The patients found they were troubled by elbow problem most nights during the last 4 weeks.
- at0190::Some nights - The patients found they were troubled by elbow problem some nights during the last 4 weeks.
- at0191::1 or 2 nights - The patients found they were troubled by elbow problem 1 or 2 nights during the last 4 weeks.
- at0192::No, not at all - The patients found they were not troubled by elbow problem at night during the last 4 weeks.
- at0193::8 Interfered with sleep - Patient-reported extent to which they feel their elbow problem has interfered with sleep over the last 4 weeks.
- at0194::Every day - The patients found their elbow problem had interfered with sleep every day during the last 4 weeks.
- at0195::Most days - The patients found their elbow problem had interfered with sleep most days during the last 4 weeks.
- at0196::Some days - The patients found their elbow problem had interfered with sleep some days during the last 4 weeks.
- at0197::Occasionally - The patients found their elbow problem had interfered with sleep occasionally during the last 4 weeks.
- at0198::No, not at all - The patients found their elbow problem was not interfering with sleep during the last 4 weeks.
- at0199::9 Interfered with work - Patient-reported extent to which they feel their elbow problem has interfered with work over the last 4 weeks.
- at0200::Totally - The patients found their elbow problem had totally interfered with work during the last 4 weeks.
- at0201::Greatly - The patients found their elbow problem had greatly interfered with work during the last 4 weeks.
- at0202::Moderately - The patients found their elbow problem had moderately interfered with work during the last 4 weeks.
- at0203::A little bit - The patients found their elbow problem had interfered with work a little bit during the last 4 weeks.
- at0204::No, not at all - The patients found their elbow problem had not interfered with work during the last 4 weeks.
- at0205::10 Leisure - Patient-reported extent to which they feel their elbow problem has limited their ability to take part in leisure activities over the last 4 weeks.
- at0206::Every day - The patients found their elbow problem had limited their ability to take part in leisure activities every day during the last 4 weeks.

- at0207::Most days - The patients found their elbow problem had limited their ability to take part in leisure activities most days during the last 4 weeks.
- at0208::Some days - The patients found their elbow problem had limited their ability to take part in leisure activities some days during the last 4 weeks.
- at0209::Occasionally - The patients found their elbow problem had limited their ability to take part in leisure activities occasionally during the last 4 weeks.
- at0210::No, not at all - The patients found their elbow problem had not limited their ability to take part in leisure activities during the last 4 weeks.
- at0211::11 Worst pain - Patient-reported extent to which they feel the worst pain from elbow problem over the last 4 weeks.
- at0212::Unbearable - The patient found the worst pain from their elbow problem unbearable during the last 4 weeks.
- at0213::Severe pain - The patient found the worst pain from their elbow problem severe during the last 4 weeks.
- at0214::Moderate pain - The patient found the worst pain from their elbow problem moderate during the last 4 weeks.
- at0215::Mild pain - The patient found the worst pain from their elbow problem mild during the last 4 weeks.
- at0216::No pain - The patient found the no pain from their elbow problem during the last 4 weeks.
- at0217::12 Usual pain - Patient-reported extent to which they usually feel pain from elbow problem over the last 4 weeks.
- at0218::Unbearable - The patient found the usual pain from their elbow problem unbearable during the last 4 weeks.
- at0219::Severe pain - The patient found the usual pain from their elbow problem severe during the last 4 weeks.
- at0220::Moderate pain - The patient found the usual pain from their elbow problem moderate during the last 4 weeks.
- at0221::Mild pain - The patient found the usual pain from their elbow problem mild during the last 4 weeks.
- at0222::No pain - The patient found the no pain from their elbow problem during the last 4 weeks.
- at0223::Grading - Grading system for total score.
- at0224::Severe - May indicate severe elbow arthritis.
- at0225::Moderate to severe - May indicate moderate to severe elbow arthritis.
- at0226::Moderate - May indicate mild to moderate elbow arthritis.
- at0227::Satisfactory - May indicate satisfactory joint function.

[oxford_ hip](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.oxford_ hip.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Use to capture and report Oxford Hip Questionnaire (OHS) score details.

****Use:**** Use to capture and report Oxford Hip Questionnaire score. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Keywords:**** orthopaedics, hip

****Concepts:****

- at0000::Oxford Hip Questionnaire Score (OHS) - Oxford Hip Questionnaire Score (OHS).
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Tree - @ internal @
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0008::1 Usual pain - Patient-reported extent of usual pain in hip during past 4 weeks.
- at0009::Moderate - The patient has experienced moderate pain in hip during past 4 weeks.
- at0010::Mild - The patient has experienced mild pain in hip during past 4 weeks.
- at0011::Very mild - The patient has experienced very mild pain in hip during past 4 weeks.
- at0012::None - The patient has experienced no pain in hip during past 4 weeks.
- at0014::2 Washing and drying - Patient-reported trouble washing and drying because of hip pain.
- at0015::All of the time - The patient has trouble all the time washing and drying in the last 4 weeks because of pain in the hip.

- at0016::No trouble at all - The patient has no trouble washing and drying in the last 4 weeks because of pain in the hip.
- at0017::Little trouble - The patient has little trouble washing and drying in the last 4 weeks because of pain in the hip.
- at0018::Moderate trouble - The patient has moderate trouble washing and drying in the last 4 weeks because of pain in the hip.
- at0019::Extreme difficulty - The patient has extreme difficulty trouble washing and drying in the last 4 weeks because of pain in the hip.
- at0020::3 Vehicle use - Patient-reported extent to which they are able to access vehicles due to pain in their hip.
- at0021::Impossible to do - The patient found it impossible to get into a vehicle during the past 4 weeks due to pain in hip.
- at0022::Extreme difficulty - The patient has extreme difficulty at all getting into a vehicle during the past 4 weeks due to pain in hip.
- at0023::Moderate trouble - The patient has moderate trouble at all getting into a vehicle during the past 4 weeks due to pain in hip..
- at0024::Very little trouble - The patient has very little trouble at all getting into a vehicle during the past 4 weeks due to pain in hip.
- at0025::No trouble at all - The patient has no trouble at all getting into a vehicle during the past 4 weeks due to pain in hip.
- at0026::4 Socks - Patient-reported extent to which they experience pain in hip during past 4 weeks when putting on socks, stockings or tights.
- at0027::No, impossible - The patient found it impossible to put on socks, stockings or tights during past 4 weeks because of pain in the shoulder.
- at0028::With extreme difficulty - The patient had extreme difficulty putting on socks, stockings or tights during past 4 weeks because of pain in the shoulder.
- at0029::With moderate difficulty - The patient had moderate difficulty putting on socks, stockings or tights during past 4 weeks because of pain in the shoulder.
- at0030::With little difficulty - The patient had little difficulty putting on socks, stockings or tights during the past 4 weeks because of pain in the shoulder.
- at0031::Yes, easily - The patient found it easy to put on socks, stockings or tights during the past 4 weeks because of pain in the shoulder..
- at0032::5 Household shopping - Patient-reported extent to which they complete household shopping because of pain in hip in past 4 weeks.
- at0033::No, impossible - The patient found it impossible to complete household shopping because of hip pain all of the time during past 4 weeks.
- at0034::With extreme difficulty - The patient can complete household shopping with extreme difficulty because of hip pain all of the time during past 4 weeks.
- at0035::With moderate difficulty - The patient can complete household shopping with moderate difficulty because of hip pain all of the time during past 4 weeks.
- at0036::With little difficulty - The patient can complete household shopping with little difficulty because of hip pain all of the time during past 4 weeks.

- at0037::Yes, easily - The patient can complete household shopping easily because of hip pain all of the time during past 4 weeks.
- at0038::6 Walk duration - Patient-reported extent to which they duration they were able to walk due to hip pain in past 4 weeks.
- at0039::Not at all - pain severe on walking - The patient found that they can't walk without pain becoming severe during the past 4 weeks.
- at0040::Around the house only - The patient found that they could walk around the house only before pain becomes severe during the past 4 weeks.
- at0041::5 to 15 minutes - The patient found that they could walk 5 to 15 minutes before pain becomes severe during the past 4 weeks.
- at0042::16 to 30 minutes - The patient found that they could walk 16 to 30 minutes before pain becomes severe during the past 4 weeks.
- at0043::No pain / More than 30 minutes - The patient found that they could walk with no pain or more than 30 minutes before pain becomes severe during the past 4 weeks.
- at0044::7 Stairs - Patient-reported extent to which they could climb stairs during the past 4 weeks.
- at0050::8 Standing after meal - Patient-reported extent to which they could stand from a chair after a meal during past 4 weeks.
- at0051::Unbearable - The patient found it unbearable to stand after a meal due to hip pain over the last 4 weeks.
- at0052::Very painful - The patient found it very painful to stand after a meal due to hip pain over the last 4 weeks.
- at0053::Moderately painful - The patient found it moderately painful to stand after a meal due to hip pain over the last 4 weeks.
- at0054::Slightly painful - The patient found it slightly painful to stand after a meal due to hip pain over the last 4 weeks.
- at0055::Not at all painful - The patient found it not at all painful to stand after a meal due to hip pain over the last 4 weeks.
- at0056::9 Limping - Patient-reported extent to which they were limping when walking because of hip pain during past 4 weeks.
- at0057::All of the time - The patient has been limping when walking all of the time, because of hip pain during past 4 weeks.
- at0058::Most of the time - The patient has been limping when walking most of the time, because of hip pain during past 4 weeks.
- at0059::Often, not just at first - The patient has been limping when walking often, not just at first, because of hip pain during past 4 weeks.
- at0060::Sometimes, or just at first - The patient has been limping when walking sometimes, or just at first, because of hip pain during past 4 weeks.
- at0061::Rarely / never - The patient has been rarely / never been limping when walking, because of hip pain during past 4 weeks.
- at0062::10 Sudden pain - Patient-reported extent to which experienced sudden severe hip pain during past 4 weeks.

- at0063::Every day - The patient had severe hip pain every day during past 4 weeks.
- at0064::Most days - The patient had severe hip pain most days during past 4 weeks.
- at0065::Some days - The patient had severe hip pain some days during past 4 weeks.
- at0066::Only 1 or 2 days - The patient had severe hip pain only 1 or 2 days during past 4 weeks.
- at0067::No days - The patient had severe hip pain no days during past 4 weeks.
- at0068::11 Interfered with work - Patient-reported extent to which hip pain has interfered with work during past 4 weeks.
- at0069::Totally - The patient reports that hip pain has interfered totally with their work in last 4 weeks.
- at0070::Greatly - The patient reports that hip pain has interfered greatly with their work in last 4 weeks.
- at0071::Moderately - The patient reports that hip pain has interfered moderately with their work in last 4 weeks.
- at0072::A little bit - The patient reports that hip pain has interfered a little bit with their work in last 4 weeks.
- at0073::Not at all - The patient reports that hip pain has not interfered with their work in last 4 weeks.
- at0074::12 Night pain - Patient-reported extent of pain in hip at night during past 4 weeks.
- at0075::Every night - The patient has experienced hip pain every night in past 4 weeks.
- at0076::Most nights - The patient has experienced hip pain most nights in past 4 weeks.
- at0077::Some nights - The patient has experienced hip pain some nights in past 4 weeks.
- at0078::Only 1 or 2 nights - The patient has experienced hip pain only 1 or 2 nights in past 4 weeks.
- at0079::No nights - The patient has experienced hip pain no nights in past 4 weeks.
- at0104::Total score - Total score from Questions 1 to 12.
- at0105::Average score - Average score from Questions 1-12.
- at0109::Severe - The patient has experienced severe pain in hip during past 4 weeks.
- at0110::No, impossible - The patient found it impossible to climb stairs due to hip pain during past 4 weeks.
- at0111::With extreme difficulty - The patient found it extremely difficult to climb stairs due to hip pain during past 4 weeks.
- at0112::With moderate difficulty - The patient found it moderately difficult to climb stairs due to hip pain during past 4 weeks.
- at0113::With little difficulty - The patient found it a little difficult to climb stairs due to hip pain during past 4 weeks.
- at0114::Yes, easily - The patient found it they could easily climb stairs due to hip pain during past 4 weeks.
- at0115::Grading - *
- at0116::Severe - May indicate severe hip arthritis.

- at0117::Moderate to severe - May indicate moderate to severe hip arthritis.
- at0118::Moderate - May indicate mild to moderate hip arthritis.
- at0119::Satisfactory - May indicate satisfactory joint function.

[**oxford_knee**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.oxford_knee.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Use to capture and report Oxford Knee Questionnaire Score (OKS) score details.

****Use:**** Use to capture and report Oxford Knee Questionnaire Score (OKS). While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Keywords:**** orthopaedics, knee

****Concepts:****

- at0000::Oxford Knee Questionnaire Score (OKS) - Oxford Knee Questionnaire Score (OKS).
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Tree - @ internal @
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0008::1 Usual pain - Patient-reported extent of usual pain in knee during past 4 weeks.
- at0009::Moderate - The patient has experienced moderate pain in knee during past 4 weeks.

- at0010::Mild - The patient has experienced mild pain in knee during past 4 weeks.
- at0011::Very mild - The patient has experienced very mild pain in knee during past 4 weeks.
- at0012::None - The patient has experienced no pain in knee during past 4 weeks.
- at0014::2 Washing and drying - Patient-reported trouble washing and drying because of knee pain.
- at0015::All of the time - The patient has trouble all the time washing and drying in the last 4 weeks because of pain in the knee.
- at0016::No trouble at all - The patient has no trouble washing and drying in the last 4 weeks because of pain in the knee.
- at0017::Little trouble - The patient has little trouble washing and drying in the last 4 weeks because of pain in the knee.
- at0018::Moderate trouble - The patient has moderate trouble washing and drying in the last 4 weeks because of pain in the knee.
- at0019::Extreme difficulty - The patient has extreme difficulty trouble washing and drying in the last 4 weeks because of pain in the knee.
- at0020::3 Vehicle use - Patient-reported extent to which they are able to access vehicles due to pain in their knee.
- at0021::Impossible to do - The patient found it impossible to get into a vehicle during the past 4 weeks due to pain in knee.
- at0022::Extreme difficulty - The patient has extreme difficulty at all getting into a vehicle during the past 4 weeks due to pain in knee.
- at0023::Moderate trouble - The patient has moderate trouble at all getting into a vehicle during the past 4 weeks due to pain in knee.
- at0024::Very little trouble - The patient has very little trouble at all getting into a vehicle during the past 4 weeks due to pain in knee.
- at0025::No trouble at all - The patient has no trouble at all getting into a vehicle during the past 4 weeks due to pain in knee.
- at0026::4 Walking duration - Patient-reported extent of how long have they been able to walk before pain from their knee becomes severe? (with or without a stick)
- at0027::Not at all - pain severe when walking - The patient cannot walk before pain from the knee becomes severe.
- at0028::Around the house only - The patient can walk around the house before pain from the knee becomes severe.
- at0029::5 to 15 minutes - The patient can walk 5 to 15 minutes before pain from the knee becomes severe.
- at0030::16 to 30 minutes - The patient can walk 16 to 30 minutes before pain from the knee becomes severe.
- at0031::No pain/More than 30 minutes - The patient can walk without pain or for more than 30 minutes before pain from the knee becomes severe.
- at0032::5 Stand from table - Patient-reported how painful it has been to stand up from a chair after a meal in the past 4 weeks.

- at0033::Unbearable - The patient found it unbearable to stand up from a table after a meal in the past 4 weeks.
- at0034::Very painful - The patient found it very painful to stand up from a table after a meal in the past 4 weeks.
- at0035::Moderately painful - The patient found it moderately painful to stand up from a table after a meal in the past 4 weeks.
- at0036::Slightly painful - The patient found it slightly painful to stand up from a table after a meal in the past 4 weeks.
- at0037::Not at all painful - The patient did not find it painful to stand up from a table after a meal in the past 4 weeks.
- at0044::11 Shopping - Patient-reported extent to which they could do the household shopping the past 4 weeks.
- at0056::6 Limping - Patient-reported extent to which they were limping when walking because of knee pain during past 4 weeks.
- at0057::All of the time - The patient has been limping when walking all of the time, because of knee pain during past 4 weeks.
- at0058::Most of the time - The patient has been limping when walking most of the time, because of knee pain during past 4 weeks.
- at0059::Often, not just at first - The patient has been limping when walking often, not just at first, because of knee pain during past 4 weeks.
- at0060::Sometimes, or just at first - The patient has been limping when walking sometimes, or just at first, because of knee pain during past 4 weeks.
- at0061::Rarely / never - The patient has been rarely / never been limping when walking, because of knee pain during past 4 weeks.
- at0062::10 Sudden pain - Patient-reported extent to they felt their knee would give way or let them down pain during past 4 weeks.
- at0063::All of the time - The patient felt their knee might suddenly give way all of the time during past 4 weeks.
- at0064::Most of the time - The patient felt their knee might suddenly give way most of the time during past 4 weeks.
- at0065::Often, not just at first - The patient felt their knee might suddenly give way often, not just at first during past 4 weeks.
- at0066::Sometimes, or just at first - The patient felt their knee might suddenly give way sometimes, or just at first during past 4 weeks.
- at0067::Rarely/never - The patient felt their knee might suddenly give way rarely/never during past 4 weeks.
- at0068::9 Interfered with work - Patient-reported extent to which knee pain has interfered with work during past 4 weeks.
- at0069::Totally - The patient reports that knee pain has interfered totally with their work in last 4 weeks.
- at0070::Greatly - The patient reports that knee pain has interfered greatly with their work in last 4 weeks.

- at0071::Moderately - The patient reports that knee pain has interfered moderately with their work in last 4 weeks.
- at0072::A little bit - The patient reports that knee pain has interfered a little bit with their work in last 4 weeks.
- at0073::Not at all - The patient reports that knee pain has not interfered with their work in last 4 weeks.
- at0074::8 Night pain - Patient-reported extent of pain in knee at night during past 4 weeks.
- at0075::Every night - The patient has experienced knee pain every night in past 4 weeks.
- at0076::Most nights - The patient has experienced knee pain most nights in past 4 weeks.
- at0077::Some nights - The patient has experienced knee pain some nights in past 4 weeks.
- at0078::Only 1 or 2 nights - The patient has experienced knee pain only 1 or 2 nights in past 4 weeks.
- at0079::No nights - The patient has experienced knee pain no nights in past 4 weeks.
- at0104::Total score - Total score from Questions 1 to 12.
- at0105::Average score - Average score from Questions 1-12.
- at0109::Severe - The patient has experienced severe pain in knee during past 4 weeks.
- at0110::No, impossible - The patient found it impossible to climb stairs due to knee pain during past 4 weeks.
- at0111::With extreme difficulty - The patient found it extremely difficult to climb stairs due to knee pain during past 4 weeks.
- at0112::With moderate difficulty - The patient found it moderately difficult to climb stairs due to knee pain during past 4 weeks.
- at0113::With little difficulty - The patient found it a little difficult to climb stairs due to knee pain during past 4 weeks.
- at0114::Yes, easily - The patient found it they could easily climb stairs due to knee pain during past 4 weeks.
- at0115::Grading - *
- at0116::Severe - May indicate severe hip arthritis.
- at0117::Moderate to severe - May indicate moderate to severe hip arthritis.
- at0118::Moderate - May indicate mild to moderate hip arthritis.
- at0119::Satisfactory - May indicate satisfactory joint function.
- at0120::7 Kneeling - Patient-reported extent to which they were able to kneel and get up again during past 4 weeks.
- at0121::No impossible - The patient finds it impossible to kneel and get up again, because of knee pain during past 4 weeks.
- at0122::With extreme difficulty - The patient was able to kneel and get up again with extreme difficulty, because of knee pain during past 4 weeks.

- at0123::With moderate difficulty - The patient was able to kneel and get up again with moderate difficulty, because of knee pain during past 4 weeks.
- at0124::With little difficulty - The patient was able to kneel and get up again with little difficulty, because of knee pain during past 4 weeks.
- at0125::Yes, easily - The patient was able to kneel and get up again easily, because of knee pain during past 4 weeks.
- at0126::12 Stairs - Patient-reported extent to which they could walk down one flight of stairs during the past 4 weeks.
- at0127::No, impossible - The patient found it impossible to walk down stairs due to knee pain during past 4 weeks.
- at0128::With extreme difficulty - The patient found it extremely difficult to walk down stairs due to knee pain during past 4 weeks.
- at0129::With moderate difficulty - The patient found it moderately difficult to walk down stairs due to knee pain during past 4 weeks.
- at0130::With little difficulty - The patient found it a little difficult to walk down stairs due to knee pain during past 4 weeks.
- at0131::Yes, easily - The patient found it they could easily walk down stairs due to knee pain during past 4 weeks.

[oxford_shoulder](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.oxford_shoulder.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** Use to capture and report Oxford Shoulder Questionnaire (OSS) score details.

****Use:**** Use to capture and report Oxford Shoulder Questionnaire score. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Concepts:****

- at0000::Oxford Shoulder Questionnaire Score (OSS) - Oxford Shoulder Questionnaire Score.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Tree - @ internal @
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0008::1 Worst pain in shoulder - Patient-reported extent of worst pain in shoulder during past 4 weeks.
- at0009::Severe - The patient has experienced severe pain in shoulder during past 4 weeks.
- at0010::Moderate - The patient has experienced moderate pain in shoulder during past 4 weeks.
- at0011::Mild - The patient has experienced mild pain in shoulder during past 4 weeks.
- at0012::None - The patient has experienced no pain in shoulder during past 4 weeks.
- at0014::2 Trouble dressing - Patient-reported trouble dressing because of pain shoulder.
- at0015::All of the time - The patient has trouble dressing all of the time in the last 4 weeks because of pain in the shoulder.
- at0016::No trouble at all - The patient has no trouble dressing in the last 4 weeks because of pain in the shoulder.
- at0017::Little trouble - The patient has no little trouble dressing in the last 4 weeks because of pain in the shoulder.
- at0018::Moderate trouble - The patient has no moderate trouble dressing in the last 4 weeks because of pain in the shoulder.
- at0019::Extreme difficulty - The patient has no extreme difficulty dressing in the last 4 weeks because of pain in the shoulder.
- at0020::3 Vehicle use - Patient-reported extent to which they are able to access vehicles due to pain in their shoulder.
- at0021::Impossible to do - The patient found it impossible to get into a vehicle during the past 4 weeks due to pain in shoulder.
- at0022::Extreme difficulty - The patient has extreme difficulty at all getting into a vehicle during the past 4 weeks due to pain in shoulder.
- at0023::Moderate trouble - The patient has moderate trouble at all getting into a vehicle during the past 4 weeks due to pain in shoulder.
- at0024::Very little trouble - The patient has very little trouble at all getting into a vehicle during the past 4 weeks due to pain in shoulder.
- at0025::No trouble at all - The patient has no trouble at all getting into a vehicle during the past 4 weeks due to pain in shoulder.

- at0026::4 Cutlery use - Patient-reported extent to which they pain in shoulder during past 4 weeks when using a knife and fork.
- at0027::No, impossible - The patient found it impossible to use a knife and fork during past 4 weeks because of pain in the shoulder.
- at0028::With extreme difficulty - The patient has extreme difficulty using a knife and fork during past 4 weeks because of pain in the shoulder.
- at0029::With moderate difficulty - The patient has moderate difficulty using a knife and fork during past 4 weeks because of pain in the shoulder.
- at0030::With little difficulty - The patient has little difficulty using a knife and fork during the past 4 weeks because of pain in the shoulder.
- at0031::Yes, easily - The patient found it easy to use a knife and fork during the past 4 weeks because of pain in the shoulder..
- at0032::5 Household shopping - Patient-reported extent to which they complete household shopping because of pain in shoulder in past 4 weeks.
- at0033::No, impossible - The patient found it impossible to complete household shopping because of shoulder pain all of the time during past 4 weeks.
- at0034::With extreme difficulty - The patient can complete household shopping with extreme difficulty because of shoulder pain all of the time during past 4 weeks.
- at0035::With moderate difficulty - The patient can complete household shopping with moderate difficulty because of shoulder pain all of the time during past 4 weeks.
- at0036::With little difficulty - The patient can complete household shopping with little difficulty because of shoulder pain all of the time during past 4 weeks.
- at0037::Yes, easily - The patient can complete household shopping easily because of shoulder pain all of the time during past 4 weeks.
- at0038::6 Carry a tray - Patient-reported extent to which they were able to carry a tray because of pain in the shoulder in past 4 weeks.
- at0039::No, impossible - The patient found it impossible to complete carry a tray, because of shoulder pain all of the time during past 4 weeks.
- at0040::With extreme difficulty - The patient could carry a tray with extreme difficulty, because of shoulder pain all of the time during past 4 weeks.
- at0041::With moderate difficulty - The patient could carry a tray with moderate difficulty, because of shoulder pain all of the time during past 4 weeks.
- at0042::With little difficulty - The patient could carry a tray with little difficulty, because of shoulder pain all of the time during past 4 weeks.
- at0043::Yes, easily - The patient could carry a tray with easily, because of shoulder pain all of the time during past 4 weeks.
- at0044::7 Brush hair - Patient-reported extent to which they could brush/comb their hair due to pain in shoulder during past 4 weeks.
- at0050::8 Usual pain in shoulder - Patient-reported extent to which they usually experience pain in shoulder during past 4 weeks.
- at0051::Severe - The patient usually experienced severe pain in their shoulder over the last 4 weeks.

- at0052::Moderate - The patient usually experienced moderate pain in their shoulder over the last 4 weeks.
- at0053::Mild - The patient usually experienced mild pain in their shoulder over the last 4 weeks.
- at0054::Very Mild - The patient usually experienced very mild pain in their shoulder over the last 4 weeks.
- at0055::None - The patient usually experienced no pain in their shoulder over the last 4 weeks.
- at0056::9 Hanging clothes - Patient-reported extent to which they could hang clothes in a wardrobe using the effected arm during past 4 weeks.
- at0057::No, impossible - The patient found it impossible to hang clothes, because of shoulder pain all of the time during past 4 weeks.
- at0058::With great difficulty - The patient could hang clothes with great difficulty, because of shoulder pain all of the time during past 4 weeks.
- at0059::With moderate difficulty - The patient could hang clothes with moderate difficulty, because of shoulder pain all of the time during past 4 weeks.
- at0060::With little difficulty - The patient could hang clothes with little difficulty, because of shoulder pain all of the time during past 4 weeks.
- at0061::Yes, easily - The patient could hang clothes easily, because of shoulder pain all of the time during past 4 weeks.
- at0062::10 Drying - Patient-reported extent to which they could dry under both arms during past 4 weeks.
- at0063::No, impossible - The patient found it impossible to dry under both arms, because of shoulder pain all of the time during past 4 weeks.
- at0064::With extreme difficulty - The patient found it extremely difficult to dry under both arms, because of shoulder pain all of the time during past 4 weeks.
- at0065::With moderate difficulty - The patient found it moderately difficult to dry under both arms, because of shoulder pain all of the time during past 4 weeks.
- at0066::With little difficulty - The patient found it a little difficult to dry under both arms, because of shoulder pain all of the time during past 4 weeks.
- at0067::Yes, easily - The patient found it easy to dry under both arms, because of shoulder pain all of the time during past 4 weeks.
- at0068::11 Interfered with work - Patient-reported extent to which pain in shoulder has interfered with work during past 4 weeks.
- at0069::Totally - The patient reports that the pain in shoulder has interfered totally with their work in last 4 weeks.
- at0070::Greatly - The patient reports that the pain in shoulder has interfered greatly with their work in last 4 weeks.
- at0071::Moderately - The patient reports that the pain in shoulder has interfered moderately with their work in last 4 weeks.
- at0072::A little bit - The patient reports that the pain in shoulder has interfered a little bit with their work in last 4 weeks.

- at0073::Not at all - The patient reports that the pain in shoulder has not interfered with their work in last 4 weeks.
- at0074::12 Night pain - Patient-reported extent of pain in shoulder at night during past 4 weeks.
- at0075::Every night - The patient has experienced shoulder pain every night in past 4 weeks.
- at0076::Most nights - The patient has experienced shoulder pain most nights in past 4 weeks.
- at0077::Some nights - The patient has experienced shoulder pain some nights in past 4 weeks.
- at0078::Only 1 or 2 nights - The patient has experienced shoulder pain only 1 or 2 nights in past 4 weeks.
- at0079::No nights - The patient has experienced shoulder pain no nights in past 4 weeks.
- at0104::Total score - Total score from Questions 1 to 12.
- at0105::Average score - Average score from Questions 1-12.
- at0109::Unbearable - The patient has experienced unbearable pain in shoulder during past 4 weeks.
- at0110::No, impossible - The patient found it impossible to complete carry a tray, because of shoulder pain all of the time during past 4 weeks.
- at0111::With extreme difficulty - The patient could brush/comb their hair with extreme difficulty, because of shoulder pain all of the time during past 4 weeks.
- at0112::With moderate difficulty - The patient could brush/comb their hair with moderate difficulty, because of shoulder pain all of the time during past 4 weeks.
- at0113::With little difficulty - The patient could brush/comb their hair with little difficulty, because of shoulder pain all of the time during past 4 weeks.
- at0114::Yes, easily - The patient could brush/comb their hair easily, because of shoulder pain all of the time during past 4 weeks.
- at0115::Grading - Grading system for total score.
- at0116::Severe - May indicate severe shoulder arthritis.
- at0117::Moderate to severe - May indicate moderate to severe shoulder arthritis.
- at0118::Mild to moderate - May indicate mild to moderate shoulder arthritis.
- at0119::Satisfactory - May indicate satisfactory joint function.

[oxford_shoulder_instability](#)

Archetype ID: openEHR-EHR-OBSERVATION.oxford_shoulder_instability.v0

Lifecycle State: in_development

Category: OBSERVATION

****Languages:**** en

****Purpose:**** Use to capture and report Oxford Shoulder Instability Questionnaire (OSI) score details.

****Use:**** Use to capture and report Oxford Shoulder Instability Questionnaire score. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Concepts:****

- at0000::Oxford Shoulder Instability Questionnaire Score (OSI) - Oxford Shoulder Instability Questionnaire Score.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Tree - @ internal @
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0008::1 Slipped out of joint - Patient-reported extent of shoulder slipping out of joint during last 6 months.
- at0009::1 or 2 times per week - The patients shoulder has slipped out of joint 1 or 2 times a week during past six months.
- at0010::1 or 2 times per month - The patients shoulder has slipped out of joint 1 or 2 times a month during past six months.
- at0011::1 or 2 times in 6 months - The patients shoulder has slipped out of joint 1 or 2 in the last six months.
- at0012::Not at all in 6 months - The patients shoulder has slipped out of joint not at all in the last six months.
- at0014::2 Trouble dressing - Patient-reported trouble dressing because pain shoulder during the last 3 months.
- at0015::No trouble at all - The patient has no trouble (or worry) dressing in the last six months because of pain in the shoulder.
- at0016::Slight trouble or worry - The patient has slight trouble (or worry) dressing in the last six months because of pain in the shoulder.
- at0017::Moderate trouble or worry - The patient has moderate trouble (or worry) dressing in the last six months because of pain in the shoulder.

- at0018::Extremely difficulty - The patient has extreme difficulty (or worry) dressing in the last six months because of pain in the shoulder.
- at0019::Impossible to do - The patient found it impossible dressing in the last six months because of pain in the shoulder.
- at0020::3 Worst Pain - Patient-reported extent of worst pain in their shoulder in the last three months.
- at0021::Unbearable - The patient described pain in shoulder as unbearable during the last three months.
- at0022::Severe - The patient described pain in shoulder as severe during the last three months.
- at0023::Moderate - The patient described pain in shoulder as moderate during the last three months.
- at0024::Mild ache - The patient described pain in shoulder as a mild ache during the last three months.
- at0025::None - The patient described pain in shoulder as having none during the last three months.
- at0026::4 Work - Patient-reported extent to which pain in shoulder during the last 3 months has interfered with usual work (including school, college or housework).
- at0027::Totally - The patient found that shoulder pain totally interfered with their work during the last three months.
- at0028::Greatly - The patient found that shoulder pain greatly interfered with their work during the last three months.
- at0029::Moderately - The patient found that shoulder pain moderately interfered with their work during the last three months.
- at0030::A little bit - The patient found that shoulder pain interfered with their work a little bit during the last three months.
- at0031::Not at all - The patient found that shoulder pain did not interfere with their work during the last three months.
- at0032::5 Activities - Patient-reported extent to which they have avoided activities in the last three months due to fear that their shoulder may slip out of joint.
- at0033::Every day or many activities - The patient found that they avoided activities due to worry about their shoulder slipping out of joint every day or during many activities in the past three months.
- at0034::Most days or more than one activity - The patient found that they avoided activities due to worry about their shoulder slipping out of joint most days or during more than one activity in the past three months.
- at0035::Some days - The patient found that they avoided activities due to worry about their shoulder slipping out of joint some days in the past three months.
- at0036::Very occasionally - The patient found that they avoided activities due to worry about their shoulder slipping out of joint very occasionally in the past three months.
- at0037::Not at all - The patient found that they did not avoid activities due to worry about their shoulder slipping out of joint in the past three months.

- at0104::Total score - Total score from Questions 1 to 12.
- at0105::Average score - Average score from Questions 1-12.
- at0109::More often than 1 or 2 times/week - The patients shoulder has slipped out of joint more often than 1 or 2 times a week during past six months.
- at0115::6 Important things - Patient-reported extent to which they have been prevented from doing things that are important to them in the last three months due to the problem with their shoulder.
- at0116::Every day or many activities - The patient found that they were prevented doing things important to them due to their shoulder problem every day or during many activities in the past three months.
- at0117::Most days or more than one activity - The patient found that they were prevented doing things important to them due to their shoulder problem most days or during more than one activity in the past three months.
- at0118::Some days - The patient found that they were prevented doing things important to them due to their shoulder problem some days in the past three months.
- at0119::Very occasionally - The patient found that they were prevented doing things important to them due to their shoulder problem very occasionally in the past three months.
- at0120::Not at all - The patient found that they were not prevented doing things important to them due to their shoulder problem in the past three months.
- at0121::7 Social Life - Patient-reported extent to which shoulder pain has interfered with their social life in the last three months.
- at0122::Every day - The patient found that shoulder pain interfered with their social life every day in the past three months.
- at0123::Most days - The patient found that shoulder pain interfered with their social life most days in the past three months.
- at0124::Some days - The patient found that shoulder pain interfered with their social life some days in the past three months.
- at0125::Occasionally - The patient found that shoulder pain interfered with their social life occasionally in the past three months.
- at0126::Not at all - The patient found that shoulder pain did not interfere with their social life in the past three months.
- at0127::8 Sport or hobbies - Patient-reported extent to which shoulder pain has interfered with their sporting activities or hobbies in the last three months.
- at0128::All of the time - The patient found that shoulder pain interfered with their sporting activities or hobbies all of the time in the last 4 weeks.
- at0129::Most of the time - The patient found that shoulder pain interfered with their sporting activities or hobbies most of the time in the last 4 weeks.
- at0130::Some of the time - The patient found that shoulder pain interfered with their sporting activities or hobbies some of the time in the last 4 weeks.
- at0131::A little/occasionally - The patient found that shoulder pain interfered with their sporting activities or hobbies a little/occasionallyin the last 4 weeks.

- at0132::Not at all - The patient found that shoulder pain did not interfere with their sporting activities or hobbies in the last 4 weeks.
- at0133::9 Thought about shoulder - Patient-reported extent to which they have thought about shoulder pain in the last 4 weeks.
- at0134::Every day - The patient found that they thought about shoulder pain every day in the last 4 weeks.
- at0135::Most days - The patient found that they thought about shoulder pain most days in the last 4 weeks.
- at0136::Some days - The patient found that they thought about shoulder pain every some days in the last 4 weeks.
- at0137::Occasionally - The patient found that they thought about shoulder pain occasionally in the last 4 weeks.
- at0138::Never, only if someone asks - The patient found that they never thought about shoulder pain unless asked in the last 4 weeks.
- at0139::10 Heavy objects - Patient-reported extent to which the shoulder problem has interfered with lifting in the last 4 weeks.
- at0140::Every day - The patient found that the shoulder problem interfered with lifting every day in the last 4 weeks.
- at0141::Most days - The patient found that the shoulder problem interfered with lifting most days in the last 4 weeks.
- at0142::Some days - The patient found that the shoulder problem interfered with lifting some days in the last 4 weeks.
- at0143::Occasionally - The patient found that the shoulder problem interfered with lifting occasionally in the last 4 weeks.
- at0144::Not at all - The patient found that the shoulder problem did not interfere with lifting in the last 4 weeks.
- at0145::11 Pain - Patient-reported extent to which they would describe shoulder pain in the last 4 weeks.
- at0146::Severe - The patient reported that their shoulder pain was severe in the last 4 weeks.
- at0147::Moderate - The patient reported that their shoulder pain was moderate in the last 4 weeks.
- at0148::Mild - The patient reported that their shoulder pain was mild in the last 4 weeks.
- at0149::Very mild - The patient reported that their shoulder pain was very mild in the last 4 weeks.
- at0150::None - The patient reported that they had no shoulder pain in the last 4 weeks.
- at0151::12 Sleep position - Patient-reported extent to which they avoided lying in certain positions because of their shoulder problem in the last 4 weeks.
- at0152::Every night - The patient found that they avoided lying in certain positions at night due to their shoulder problem every night in the last 4 weeks.

- at0153::Most nights - The patient found that they avoided lying in certain positions at night due to their shoulder problem most nights in the last 4 weeks.
- at0154::Some nights - The patient found that they avoided lying in certain positions at night due to their shoulder problem some nights in the last 4 weeks.
- at0155::Only 1 or 2 nights - The patient found that they avoided lying in certain positions at night due to their shoulder problem only 1 or 2 nights in the last 4 weeks.
- at0156::No nights - The patient found that they did not avoid lying in certain positions at night due to their shoulder problem in the last 4 weeks.
- at0157::Grading - *
- at0158::Poor - May indicate poor shoulder instability.
- at0159::Fair - May indicate fair shoulder instability.
- at0160::Good - May indicate good shoulder instability.
- at0161::Excellent - May indicate excellent shoulder instability.

paced_auditory_serial_addition_test

Archetype ID: openEHR-EHR-OBSERVATION.paced_auditory_serial_addition_test.v1

Lifecycle State: Published

Category: OBSERVATION

Languages: de, en

Purpose: To record the measurements recorded during a Paced Auditory Serial Addition Test, normally as part of the Multiple Sclerosis Functional Composite suite of tests.

Use: Use to record the measurements recorded during a Paced Auditory Serial Addition Test. This test is commonly carried out as one component of the Multiple Sclerosis Functional Composite, but may be performed independently. 61 single-digit numbers are presented to the subject one by one. During PASAT-3" a new number is presented every three seconds, in the optional PASAT-2" every two seconds. In each case the subject is asked to respond with the sum of the last two digits (not the running total). That is, there is a maximum of 60 possible correct sums. Use the MSFC Manual for detailed administration instructions. Prior to the recording of the actual tests at least one practice trial has to be performed (this training sequence is part of the PASAT). If less than three correct answers were given, the practice trial should be repeated (up to three times). If more than two correct answers were given, the PASAT-3" can be administered (the patient should have understood the task sufficiently). To obtain additional information about the cognitive functions, the PASAT-2" can be performed optionally after the 3" test. The tests should only be administered by a suitably trained person.

****Keywords:**** PASAT, Multiple Sclerosis Functional Composite, MSFC, Multiple Sclerosis, MS, Neurology

****Concepts:****

- at0000::Paced Auditory Serial Addition Test - The Paced Auditory Serial Addition Test (PASAT) measures the cognitive function that specifically assesses auditory information processing speed and flexibility, as well as calculation ability of a patient. It is the third component of the Multiple Sclerosis Functional Composite (MSFC), a series of three tests to document the course of Multiple Sclerosis.
- at0001::Tree - @ internal @
- at0002::Event Series - @ internal @
- at0007::Tree - @ internal @
- at0012::Number Sequence Used - Record which sequence of numbers was used.
- at0013::Form A - The Form A number sequence was used.
- at0014::Form B - The Form B number sequence was used.
- at0015::Total Correct Answers - The number of correctly summed answers.
- at0029::First Half Total Correct Answers - The number of correctly summed answers in the first half of the test.
- at0030::Second Half Total Correct Answers - The number of correctly summed answers in the second half of the test.
- at0031::Total Errors of Commission - The total number of occasions where the subject was able to give a response but the answer was incorrect.
- at0032::Total Errors of Omission - The total number of occasions where the subject was unable to perform the calculation.
- at0049::Reason for Non-completion - If the trial was terminated prematurely, record any reasons for this.
- at0050::Tree - @ internal @
- at0054::Confounding Factors - Record any circumstances that may have affected the patient's performance.
- at0055::Test Not Completed? - Was the test incomplete?
- at0063::Percentage of Correct Answers - Percentage of correctly summed answers.
- at0064::PASAT-3" - PASAT where stimuli are given to the subject every three seconds.
- at0065::PASAT-2" - PASAT where stimuli are given to the subject every two seconds (not to be used if the subject is unable to give single correct answer on PASAT-3").
- at0068::Practice Trial Conducted? - Has a practice trial been conducted?
- at0069::Additional Attempts? - Did it take more than one attempt to achieve one successful trial?
- at0070::Reason for Additional Attempts - If more than one attempted trial was needed to complete the test, please specify reasons.

padss

Archetype ID: openEHR-EHR-OBSERVATION.padss.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en

Purpose: To record the results for each component parameter and their total sum for the PADSS.

Use: Use to record the results for each component parameter and their total sum for the PADSS.

Keywords: recovery, anaesthesia, post-anaesthesia, discharge, ambulatory

Concepts:

- at0000::Post Anaesthesia Discharge Scoring System (PADSS) - An assessment score used to evaluate recovery after anaesthesia for determining home-readiness.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Activity level - None
- at0005::Unable to ambulate - None
- at0006::Requires assistance - None
- at0007::Steady gait, no dizziness, or meets preoperative level - None
- at0008::Nausea and vomiting - None
- at0009::Severe: continues after repeated treatment - None
- at0010::Moderate: successfully treated with IM medication - None
- at0011::Minimal: successfully treated with PO medication - None
- at0012::Vital signs - None
- at0013::BP and pulse $\pm>40\%$ of pre-operative baseline - None
- at0014::BP and pulse $\pm20\text{--}40\%$ of pre-operative baseline - None
- at0015::BP and pulse $\pm<20\%$ of pre-operative baseline - None
- at0016::Pain acceptable - None
- at0018::No - None
- at0019::Yes - None
- at0020::Surgical bleeding - None
- at0021::Severe: more than three dressing changes required - None
- at0022::Moderate: up to two dressing changes required - None
- at0023::Minimal: does not require dressing change - None

- at0024::Total score - The total sum of each component parameter for the PADSS.
- at0025::Item tree - @ internal @
- at0026::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

pasi_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.pasi_score.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the result for each component parameter and the total score for the Psoriasis Area Severity Index (PASI).

****Use:**** Use to record the result for each component parameter and the total score for the Psoriasis Area Severity Index (PASI).

****Keywords:**** skin

****Concepts:****

- at0000::Psoriasis Area Severity Index (PASI) - A quantitative rating scale for measuring the severity of psoriatic lesions based on area coverage and plaque appearance.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Head region (h) - None
- at0005::Erythema (E) - Assessment of the redness/erythema of the psoriatic plaques.
- at0006::None - None
- at0007::Mild - None
- at0008::Moderate - None
- at0009::Severe - None
- at0010::Very severe - None
- at0011::Infiltration (I) - Assessment of thickening of the psoriatic plaques.
- at0012::None - None
- at0013::Mild - None
- at0014::Moderate - None
- at0015::Severe - None

- at0016::Very severe - None
- at0017::Desquamation (D) - Assessment of scaling of the psoriatic plaques.
- at0018::None - None
- at0019::Mild - None
- at0020::Moderate - None
- at0021::Severe - None
- at0022::Very severe - None
- at0023::Body surface area involvement (A) - None
- at0024::No involvement - None
- at0025::<10% - None
- at0026::10%-29% - None
- at0027::30%-49% - None
- at0028::50%-69% - None
- at0029::70%-89% - None
- at0030::90%-100% - None
- at0032::Trunk region (t) - None
- at0033::Upper extremities region (u) - None
- at0034::Lower extremities region (l) - None
- at0035::Total PASI-score - The total PASI score.
- at0036::Item tree - @ internal @
- at0037::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0038::Score head region - The total score for the head region.
- at0039::Score trunk region - The total score for the trunk region.
- at0040::Score upper extremities region - The total score for the upper extremities region.
- at0041::Score lower extremities region - The total score for the lower extremities region.

[**penetration_aspiration_scale**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.penetration_aspiration_scale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** A tool used to quantify the depth to which material passes into the airway, and to qualify if material entering the airway is able to be expelled or is retained.

****Use:**** For use, usually by speech pathologists, in the assessment of a patient's dysphagia by video-fluoroscopic swallowing studies.

****Keywords:**** dysphagia, swallow, speech, aspiration

****Concepts:****

- at0000::Penetration-aspiration scale - Scale to describe the disordered physiology of a person's swallow.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Penetration-aspiration scale - Scale to describe penetration and aspiration events.
- at0005::Neither penetration nor aspiration - Material does not enter airway.
- at0006::Penetration; above vocal folds; ejected - Material enters airway, but remains above vocal folds; ejected from airway; no stasis.
- at0007::Penetration; above vocal folds; not ejected - Material remains above vocal folds; visible stasis remains.
- at0008::Penetration; contacts vocal folds; ejected - Material contacts vocal folds, but is ejected; no stasis.
- at0009::Penetration; contacts vocal folds; not ejected - Material contacts vocal folds, and is not ejected; visible stasis remains.
- at0010::Aspiration; ejected - Material passes glottis, but is ejected from airway; no visible subglottic stasis.
- at0011::Aspiration; not ejected despite effort - Material passes glottis, but is not ejected from airway; visible subglottic stasis despite patient's response.
- at0012::Aspiration; no effort to eject - Material passes glottis, and is not ejected; visible subglottic stasis; absent patient response.
- at0013::Item tree - @ internal @
- at0014::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

pews

****Archetype ID:**** openEHR-EHR-OBSERVATION.pews.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the value for each component variable for the PEWS and the total sum.

****Use:**** Use to record the value for each component variable for the PEWS and the total sum. As there is no standard model for the component variables that make up PEWS, this archetype has been designed to provide a framework in which one specific PEWS representation can be selected and added to the 'PEWS components' SLOT added as CLUSTERs in a template.

****Misuse:**** Not to be used to record actual measurements for each variable. Use specific OBSERVATION archetypes for this purpose: - OBSERVATION.blood_pressure; - OBSERVATION.pulse; - OBSERVATION.respiration; - OBSERVATION.body_temperature; - OBSERVATION.acvpu; and - OBSERVATION.pulse_oximetry. Not to be used for adults. Use an archetype representing the National Early Warning Score (NEWS) for this purpose. Not to be used during pregnancy and the postpartum period. Use a pregnancy-specific archetype such as Maternal Early Warning Score or Modified Early Obstetric Warning Score for this purpose.

****Keywords:**** warning, triage, NEWS, Sats, EWS, deterioration

****Concepts:****

- at0000::Paediatric Early Warning Score (PEWS) - A simple assessment score used to identify clinical deterioration in a paediatric patient.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::PEWS components - Structured details for a specific PEWS model representation.
- at0005::Total score - The total sum of each component parameter for the PEWS.
- at0006::Item tree - @ internal @
- at0007::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0008::Model - The name of the PEWS model used in the 'PEWS components SLOT and/or the 'Total score'.
- at0009::Clinical risk category - Overall category representing the urgency and scale of the clinical response required in response to the component variables.

pf_ratio

****Archetype ID:**** openEHR-EHR-OBSERVATION(pf_ratio.v1)

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** Use to record the ratio between the partial pressure of oxygen in blood (PaO_2) and the fraction of oxygen in the inspired air (FiO_2).

****Use:**** Use to record the ratio between the partial pressure of oxygen in blood (PaO_2), and the fraction of oxygen in the inspired air (FiO_2). The value of PaO_2 will usually be recorded elsewhere in the health record as part of an arterial blood gas test result (OBSERVATION.laboratory_test_result). The value of FiO_2 will usually be recorded elsewhere in the health record using the ' FiO_2 ' data element (at0052) in the CLUSTER.inspired_oxygen. This ratio may be used within other scores, such as SOFA Score (OBSERVATION.sofa_score), SMART-COP risk score, ARDS severity score and Simplified Acute Physiology Score (SAPS) II.

****Keywords:**** Carrico, Horowitz, index, ratio, PF, P/F, PaO_2 , FiO_2

****Concepts:****

- at0000:: $\text{PaO}_2/\text{FiO}_2$ ratio - Ratio between the partial pressure of oxygen in blood (PaO_2) and the fraction of oxygen in the inhaled air (FiO_2).
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Ratio - Calculated ratio.
- at0005::Item tree - @ internal @
- at0006::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0007::Clinical interpretation - A clinical interpretation of the $\text{PaO}_2/\text{FiO}_2$ ratio.
- at0008::Comment - Additional narrative about the $\text{PaO}_2/\text{FiO}_2$ ratio not captured in other fields.
- at0009::Item tree - @ internal @
- at0010::Confounding factors - Issues or factors that may impact on measurement of the $\text{PaO}_2/\text{FiO}_2$ ratio, not captured in other fields.

[**pga_eczema_treat**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.pga_eczema_treat.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To be used by a patient to estimate the severity of their atopic dermatitis. This PGA is being utilised by the TREAT eczema group.

****Keywords:**** Atopic Dermatitis, Dermatology, Disease severity score, Effectiveness outcome parameter, Severity scale

****Concepts:****

- at0000::PGA eczema (TREAT) - Patient global assessment (PGA) to describe the severity of their eczema for the treatment of severe atopic eczema trial (TREAT).
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Assessment - The patient's assessment of their eczema.
- at0005::Clear - Clear.
- at0006::Almost clear - Almost clear.
- at0007::Mild disease - Mild disease.
- at0008::Moderate disease - Moderate disease.
- at0009::Severe disease - Severe disease.
- at0010::Very severe disease - Very severe disease.
- at0011::Item tree - @ internal @
- at0012::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[**phfrat1**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.phfrat1.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, fi, en

****Purpose:**** To record the outcomes of a screening assessment of an individual at risk for falling.

****Use:**** Use to record the outcomes of a screening assessment of an individual at risk for falling. Peninsula Health Falls Risk Assessment Tool (PHFRAT) has three sections: Part 1 - falls risk status; Part 2 – risk factor checklist; and Part 3 –action plan. The complete tool (including instructions for use) is a complete falls risk assessment tool. Part 1 is validated as a falls risk screen. This archetype contains only Part 1.

****Keywords:**** fall, risk, assessment, FRAT, peninsula, screening, falls

****Concepts:****

- at0000::Falls risk assessment screening tool (PHFRAT - part 1) - Validated Part 1 of the Peninsula Health Falls Risk Assessment Tool (PHFRAT) to screen an individual at risk for falling.
- at0001::History - *
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Recent falls - Frequency/timing of most recent fall.
- at0005::None in last 12 months - *
- at0006::One or more between 3 and 12 months ago - *
- at0007::One or more in last 3 months - *
- at0008::One or more in last 3 months whilst inpatient/resident - *
- at0009::Medications - Assessment of medications.
- at0010::Not taking any of these - *
- at0011::Taking one - *
- at0012::Taking two - *
- at0013::Taking more than two - *
- at0014::Psychological - Assessment of psychological conditions.
- at0015::Does not appear to have any of these - *
- at0016::Appears mildly affected by one or more - *
- at0017::Appears moderately affected by one or more - *
- at0018::Appears severely affected by one or more - *
- at0019::Cognitive status - Subjective assessment of cognitive status or Abbreviated Mental Test Score (AMTS).
- at0020::Intact or AMTS score 9-10 - *
- at0021::Mildly impaired or AMTS score 7-8 - *
- at0022::Moderately impaired or AMTS score 5-6 - *
- at0023::Severely impaired or AMTS score 4 or less - *

- at0025::Total score - The sum of the ordinal scores recorded for each of the four component responses.
- at0026::Interpretation - Assessment of falls status risk, based on the Total score and additional boolean questions.
- at0027::Low risk - Low risk.
- at0028::Medium risk - Medium risk.
- at0029::High risk - High risk.
- at0030::Recent (or anticipated) changes affecting safe mobility - Recent change in functional status and / or medications affecting safe mobility (or anticipated).
- at0031::Dizziness/postural hypotension - Presence of dizziness/postural hypotension.
- at0032::Item tree - @ internal @
- at0033::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

phq_9

****Archetype ID:**** openEHR-EHR-OBSERVATION.phq_9.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results of the Patient Health Questionnaire-9 (PHQ-9) and its subset assessment PHQ-2.

****Use:**** Use to record the results of the Patient Health Questionnaire-9 (PHQ-9) and its subset assessment PHQ-2. The archetype has been designed such that the actual PHQ questions are recorded as the description for each questionnaire data element. The data element name is a pragmatic description that is indicative of the question intent. The original PHQ-9 tool was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. From the PHQ Screeners website (<http://www.phqscreeners.com/overview.aspx>): "All PHQ, GAD-7 screeners and translations are downloadable from this website and no permission is required to reproduce, translate, display or distribute them." And from the PHQ webpage (http://www.phqscreeners.com/pdfs/01_PHQ/English.pdf): "No permission required to reproduce, translate, display or distribute". The Australian indigenous adaptation for the PHQ-9 subset assessing mood was developed by Dr. Alex Brown, Baker IDI Heart and Diabetes Institute, Alice Springs, 2009. The adapted questions are expressed within the Comments area for each questionnaire data element. Used with permission.

****Keywords:**** screening, depression, mood, assessment, mental health

****Concepts:****

- at0000::Patient health questionnaire-9 (PHQ-9) - Screening questionnaire for mental health that can be used by health professionals or self-reported by individuals.
- at0001::Event Series - @ internal @
- at0002::Point in Time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Interest/pleasure - Over the last two weeks, how often have you been bothered by little interest or pleasure in doing things?
- at0005::Not at all - The topic of the question has not affected the subject at all during the last two weeks.
- at0006::Several days - The topic of the question has affected the subject on several days during the last two weeks.
- at0007::More than half the days - The topic of the question has affected the subject more than half the days during the last two weeks.
- at0008::Nearly every day - The topic of the question has affected the subject nearly every day during the last two weeks.
- at0009::Feeling down - Over the last two weeks, how often have you been bothered by feeling down, depressed, or hopeless?
- at0010::PHQ-2 score - Total score for the first two questions on 'Interest/Pleasure' and 'Feeling Down'.
- at0011::PHQ-9 score - Total Score for all nine questions.
- at0012::Sleep issues - Over the last two weeks, how often have you been bothered by trouble falling or staying asleep, or sleeping too much?
- at0013::Tired/little energy - Over the last two weeks, how often have you been bothered by feeling tired or having little energy?
- at0014::Appetite - Over the last two weeks, how often have you been bothered by poor appetite or overeating?
- at0015::Feeling bad about yourself - Over the last two weeks, how often have you been bothered by feeling bad about yourself — or that you are a failure or have let yourself or your family down?
- at0016::Trouble concentrating - Over the last two weeks, how often have you been bothered by trouble concentrating on things, such as reading the newspaper or watching television?
- at0017::Slow/fidgety - Over the last two weeks, how often have you been bothered by moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual?
- at0018::Death/self-harm - Over the last two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?

- at0019::Difficulty in life activities - If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
- at0020::No difficulty at all - The individual found no difficulty working, taking care of things at home or getting along with other people.
- at0021::Somewhat difficult - The individual found it somewhat difficult to work, take care of things at home or get along with other people.
- at0022::Very difficult - The individual found it very difficult to work, take care of things at home or get along with other people.
- at0023::Extremely difficult - The individual found it extremely difficult to work, take care of things at home or get along with other people.
- at0024::Tree - @ internal @
- at0025::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

physical_activity

****Archetype ID:**** openEHR-EHR-OBSERVATION.physical_activity.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record actual physical activity level of an individual at a specified point in time or over a specified period of time.

****Use:**** Use to record actual physical activity level of children and adults at a specified point in time or over a specified period of time. Please note: There is some apparent overlap between the 'Physical activity category' data element in this archetype and the 'Physical activity level (PAL) status' data element in EVALUATION.physical_activity_summary archetype - they both use the same value set. Use this archetype when recording the category at a specified point in time or during a specified period of time, however if the intent is to record the typical activity as a summative statement then use the equivalent data point in the EVALUATION.physical_activity_summary. It is anticipated that this archetype will be further enhanced to record activity-specific data.

****Misuse:**** Not to be used to record typical activity or summative data about physical activity. Use the EVALUATION.physical_activity_summary for this purpose.

****Keywords:**** exercise, activity, physical, fitness

****Concepts:****

- at0000::Physical activity - Measurement of the actual physical activity of an individual.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Physical activity level (PAL) - Calculated physical activity level (PAL) of an individual.
- at0006::Tree - @ internal @
- at0008::Techniques - Details of the techniques used to assess the body part.
- at0009::Direct Observation - Is carried out by observers who watch or videotape activities performed by the subjects and quantify them.
- at0010::Questionnaires - Quantifying physical activity in daily life through questionnaire and diaries has the advantage of being inexpensive and easy to apply. E.g.: International physical activity questionnaire; Physical activity questionnaire by Crocker et al. 1997; Behavioral risk factor surveillance system, etc.
- at0011::Motion sensors - Electronic or mechanical methods (Motion sensors are instruments used to detect body movement which can be used to objectively quantify physical activity in daily life over a period.
- at0015::Physical activity category - The category of the physical activity level (PAL) of an individual.
- at0016::Extremely inactive - The individual is extremely inactive, for example a bedridden patient.
- at0017::Sedentary - The individual spends most of their time sitting, for example an office worker getting little or no exercise.
- at0018::Moderately active - The individual is moderately active, for example a construction worker or a person running one hour daily.
- at0019::Vigorously active - The individual is very active, for example a manual labourer or a person swimming two hours daily.
- at0020::Extremely active - The individual is extremely active, for example a competitive cyclist.
- at0021::Exclusion - Additional information required to capture local content or to align with other reference models/formalisms.

[**physical_activity_screening_questionnaire**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.physical_activity_screening_questionnaire.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the responses to a screening questionnaire for physical activity.

****Concepts:****

- at0000::Physical activity screening questionnaire - A screening questionnaire for physical activity.
- at0001::History - @ internal @
- at0002::Any event - None
- at0003::Tree - @ internal @
- at0006::Specific physical activity - Grouping of data elements related to screening for a specific type of physical activity.
- at0007::Physical activity name - Name of the physical activity being screened.
- at0008::Participating? - None
- at0009::Specific episode - None
- at0010::Episode pattern? - None
- at0011::Yes - The object is participating the specific physical activity.
- at0012::No - The object is not participating the specific physical activity.
- at0013::Unknown - It is not known whether the object is participating the specific physical activity.
- at0014::Item tree - @ internal @
- at0015::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0016::Additional detailed questions - Additional questionnaire questions directly related to the specific physical.
- at0017::Additional detailed questions - Additional questionnaire questions directly related to the specific episode.
- at0018::Typical exercise - Typical hour of exercise.

[**physical_environment_screening**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.physical_environment_screening.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about factors or characteristics in the physical environment which have caused or could potentially cause harm to an individual.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about factors or characteristics in the physical environment which have caused or could potentially cause harm to an individual. Common use cases include, but are not limited to: - Systematic questioning in any consultation related to exposure, for example: --- Have you ever lived or worked in a building with asbestos? --- Are chemicals stored in appropriate conditions in your workplace? --- Is your workplace well ventilated? The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about exposure that has happened at any time in the past and information about exposure within a specified time interval - for example the difference between "Have you ever used any drug by injection?" compared to "Have you injected any drug during the last 6 months?". The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry or public health surveillance.

****Misuse:**** Not to be used to record persistent details about a known or identified exposure. Use the EVALUATION.exposure archetype for this purpose. Not to be used to create a framework for recording answers to pre-defined screening questions about exposure to potentially harmful psychosocial factors like poverty, or traumatic experiences like bullying or war. Use an appropriate screening questionnaire archetype for this purpose. Not to be used to record information about substance use such as cigarette smoking or alcohol use. Use the OBSERVATION.substance_use_screening or an appropriate EVALUATION archetype for this purpose.

****Concepts:****

- at0000::Physical environment screening - Series of questions and associated answers used to screen for factors or characteristics in the physical environment which have caused or could potentially cause harm to an individual.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.

- at0003::Item tree - @ internal @
- at0004::Screening purpose - The context or reason for screening.
- at0009::Specific condition - Details about each possible specific environmental condition or factor.
- at0010::Environmental condition - The condition or factor in the physical environment being screened for.
- at0011::Presence? - Has the specified 'Condition' been identified?
- at0012::Yes - The exposure situation has occurred.
- at0013::No - The exposure situation has not occurred.
- at0014::Unknown - It is not known whether or not the exposure situation has occurred.
- at0016::Additional details - Additional details about the specific condition or factor identified in the physical environment.
- at0017::Comment - Additional narrative about the specific exposure situation, not captured in other fields.
- at0018::Item tree - @ internal @
- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[poem_score](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.poem_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** The Patient-Oriented Eczema Measure (POEM), is a simple measure, developed "for research purposes, and to assist health care professionals such as general practitioners, dermatologists, pediatricians, and specialist nurses caring for patients in routine clinical practice"(1). It is a tool that enables measurement of "atopic eczema severity from the patients' perspective"(1,2).

****Misuse:**** Should not be utilised in children.

****Keywords:**** Atopic dermatitis, Eczema, PROM (patient-reported outcome measure)

****Concepts:****

- at0000::POEM score - POEM (Patient-Oriented Eczema Measure).
- at0001::Event Series - @ internal @
- at0002::Any event - Any event.

- at0003::Tree - @ internal @
- at0004::Symptom score - The symptom score.
- at0005::Frequency - Frequency of the symptom.
- at0006::0 days - The symptom was not experienced in the past week.
- at0007::1-2 days - The symptom was experienced on 1 or 2 days of the last week.
- at0008::3-4 days - The symptom was experienced on 3 or 4 days of the last week.
- at0009::5-6 days - The symptom was experienced on 5 or 6 days of the last week.
- at0010::Every day - The symptom was experienced every day of the past week.
- at0013::Symptom name - Symptom experienced by the patient in the past week.
- at0014::Itch - The patient experienced itch.
- at0015::Sleep loss - The patient experienced sleep loss.
- at0016::Weeping - The patient experienced weeping skin.
- at0017::Cracking - The patient experienced cracking of skin.
- at0018::Flaking - The patient experienced flaking skin.
- at0019::Dry or rough skin - The patient experienced dry or rough skin.
- at0020::Total Poem score - The total Poem score.

pregnancy_finding

****Archetype ID:**** openEHR-EHR-OBSERVATION.pregnancy_finding.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To record a statement or declaration about the pregnancy status of the individual, which is to be considered accurate only at the date and time of assertion.

****Use:**** Use to record a statement or declaration about the pregnancy status of the individual at a specific point in time. This data group is very deliberately defined as the recording of an assertion, a careful clinical statement made by a clinician about whether they believe, based on their best knowledge, that an individual is pregnant or not pregnant. 'May be pregnant' is not usually offered as a value, much less recorded in the health record, as this is every clinician's default assumption for any woman of child-bearing age, until proven otherwise. Asserting that an individual is pregnant is relatively straightforward and safe to do on the basis of evidence such as a positive urine or blood test or physical examination findings. Typically, the consequences of an error in this scenario lead to overly cautious treatment choices, which are unlikely to cause clinical harm. However, the opposite situation where a clinician needs to assert that an individual who has been assigned as female at birth is not pregnant is often not a straightforward or safe

determination. Incorrectly asserting that the individual is not pregnant can have significant clinical consequences if it results in clinical management choices that can cause harm to a pregnant woman or to the fetus in an unrecognised pregnancy. Absolute exclusion of pregnancy is possible only in limited cases, such as after the confirmed absence or removal of both ovaries and the uterus. In most other situations, clinicians can only make a determination of 'not pregnant' based on a combination of history taking, physical examination, diagnostic testing and clinical judgment. Any statement of pregnancy exclusion should include the clinician's rationale or justification, which may reference contemporaneous test results, an organ inventory or a past history of diagnoses and procedures. An assertion should be considered accurate only at the time of assertion. For example, an assertion that an individual is pregnant is needed to diagnose an ectopic pregnancy, however they should no longer be pregnant following surgery. Similarly, an assertion that an individual is not pregnant, based on history taking and a urine pregnancy test result, may need to be revised shortly after if a blood test for pregnancy returns positive.

****Misuse:**** Not to be used to record summary information about a single pregnancy. Use the EVALUATION.pregnancy_summary archetype for this purpose. Not to be used to record the phase of an active pregnancy, such as preconception, pregnant, or postpartum. Use the EVALUATION.pregnancy_phase archetype 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 or other relevant archetypes for this purpose. Not to be used in the context of questionnaire-style representations, such as self-reported data with questions like 'Are you pregnant?'. Use the openEHR-EHR-OBSERVATION.problem_screening.v1 or other relevant archetypes for this purpose.

****Keywords:**** pregnancy, pregnant, exclusion,

****Concepts:****

- at0000::Pregnancy assertion - A statement or declaration by a clinician about the known pregnancy state of the individual at a specific point-in-time, to be used as the basis for clinical decision-making.
- at0001::History - @ internal @
- at0003::Tree - @ internal @
- at0015::Comment - Additional narrative about the pregnancy assertion, not captured in other fields.
- at0004::Pregnancy assertion - A statement or declaration about the pregnancy status of the individual at a specified point in time.
- at0005::Pregnant - Pregnancy has been confirmed.
- at0007::Not pregnant - Pregnancy has been excluded, as best as can be determined.
- at0009::Justification - Narrative description of the justification or rationale for the assertion.
- at0017::Item tree - @ internal @

- at0018::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0016::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0019::Clinical evidence - Structured clinical evidence supporting the assertion.

[pregnancy_test](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.pregnancy_test.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** es-ar, en, ar-sy

****Purpose:**** To record the result of a simple test to detect early pregnancy, usually a commercial product tested on urine.

****Use:**** A simple pregnancy test, usually testing urine, that provides a positive or negative result for early pregnancy. The test is not performed in a laboratory but by the woman or healthcare provider.

****Misuse:**** Providing the interpretation of a B-HCG or other assessment of pregnancy. Use the Pregnancy Summary archetype to record pregnancy.

****Keywords:**** pregnancy, test, confirmation

****Concepts:****

- at0000::Pregnancy test result - Result of a simple test to detect early pregnancy, usually a commercial product tested on urine.
- at0001::Event Series - @ internal @
- at0002::Point in time - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::List - @ internal @
- at0004::Result - The result of the test.
- at0005::Negative - The result does not show any sign of pregnancy.
- at0006::Inconclusive - The result is inconclusive.
- at0007::Weakly positive - The result is consistent with the products criteria for pregnancy, but only weakly.
- at0008::Strongly positive - The result is strongly consistent with the product's criteria for pregnancy.

- at0009::List - @ internal @
- at0011::Indeterminate - It is not possible to tell if the test is positive or negative.
- at0012::Device - Identification of the product used for the test.
- at0013::Image representation - An image of the test result.
- at0014::Method - Description of the method used to perform the test.

problem_screening

****Archetype ID:**** openEHR-EHR-OBSERVATION.problem_screening.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en, fr, ca, nl

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about issues, problems or diagnoses.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about issues, problems or diagnoses. This archetype has deliberately been loosely modelled to be inclusive of the broadest range of issues and problems, as well as diagnoses. Common use cases include, but are not limited to: - Systematic questioning in any consultation, for example: --- Diagnosed with cancer? Yes, No, Unknown. --- Diagnosed with COVID 19 or Influenza in the past twelve months? Yes, No, Unknown. --- Do you have any worries or concerns? Yes, No, Unknown. - Specific questioning related to disease surveillance. The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about a procedure that has been performed at any time in the past and information about a procedure performed within a specified time interval - for example the difference between "Do you have influenza?" compared to "Have you had influenza in the past 4 weeks?" The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies the presence of a problem or diagnosis, it is recommended that

clinical system record and persist the specific details about the problem or diagnosis (such as the date of clinical recognition) using the EVALUATION.problem_diagnosis archetype.

****Misuse:**** Not to be used to record details about the presence or absence of a problem or diagnosis, outside of a screening context. Use EVALUATION.problem_diagnosis or EVALUATION.exclusion_specific for these purposes. Not to be used to create a framework for recording answers to pre-defined screening questions about procedures that has been carried out in the past. Use the OBSERVATION.procedure_screening for this purpose. Not to be used to create a framework for recording answers to pre-defined screening questions about adverse reactions, use an appropriate archetype for this purpose. Not to be used to record details about a simple selection list where a question may be recorded as either "present" or "indeterminate". Use OBSERVATION.selection_list for this purpose.

****Keywords:**** Condition, state, illness, syndrome, questionnaire, screening, issue

****Concepts:****

- at0000::Problem/Diagnosis screening questionnaire - Series of questions and associated answers used to screen for issues, problems or diagnoses.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Problem/diagnosis name - Identification of an issue, problem or diagnosis, or grouping of issues, problems or diagnoses, by name.
- at0005::Presence? - Is there a history of the specific issue, problem or diagnosis?
- at0007::Item tree - @ internal @
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0022::Specific problem or diagnosis - Details about a specific issue, problem or diagnosis or grouping of problems or diagnoses relevant for the screening purpose.
- at0023::Yes - None
- at0024::No - None
- at0025::Comment - Additional narrative about the specific issue, problem or diagnosis question, not captured in other fields.
- at0027::Unknown - None
- at0028::Any problems or diagnoses? - Is there a history of any issues, problems or diagnoses relevant for the screening purpose?
- at0031::Yes - None
- at0032::No - None
- at0033::Unknown - None
- at0034::Screening purpose - The context or reason for screening.
- at0039::Additional details - Structured details or questions about the specific issue, problem or diagnosis.

- at0040::Timing - Indication of timing related to the issue, problem or diagnosis.
- at0042::Additional details - Structured details or questions about screening for issues, problems or diagnoses.
- at0043::Description - Narrative description about the history of any issues, problems or diagnoses relevant for the screening purpose.
- at0044::Unsure - None
- at0045::Unsure - None

[procedure_screening](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.procedure_screening.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en, it, fr

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about clinical management related to surgical/operative procedures that have been carried out in the past.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about clinical management related to surgical/operative procedures that have been carried out in the past. Common use cases include, but are not limited to: - Specific questioning about previous procedures before admission to a hospital. - Systematic questioning in any consultation, for example: --- Have you ever had an appendectomy? Yes, No, Unknown. --- Have you had a hip or knee replacement in the past twelve months? Yes, No, Unknown. The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about a procedure that has been performed at any time in the past and information about a procedure performed within a specified time interval - for example the difference between "Have you ever had any hip or knee surgery?" compared to "Have you had any hip or knee surgery in the last 12 months? The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a

screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening process identifies a completed procedure, it is recommended that clinical system record and persist the specific details about the procedure (such as the duration of the procedure) using the ACTION.procedure archetype.

****Misuse:**** Not to be used to record details about the presence or absence of a procedure, outside of a screening context. Use ACTION.procedure or EVALUATION.exclusion_specific for these purposes. Not to be used to record non-surgical or non-invasive clinical management. Use OBSERVATION.management_screening for this purposes. Not to be used to record details about a simple selection list where a question may be recorded as either "present" or "indeterminate". Use OBSERVATION.selection_list for this purpose.

****Keywords:**** Procedure, surgery, operation, assessment, investigation, questionnaire, screening

****Concepts:****

- at0000::Procedure screening questionnaire - Series of questions and associated answers used to screen for procedures that has been carried out in the past.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Procedure name - Name of a procedure or grouping of procedures.
- at0005::Carried out? - Is there a history of the identified procedure being done or carried out?
- at0007::Item tree - @ internal @
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0022::Specific procedure - Details about a specific procedure or grouping of procedures relevant for the screening purpose.
- at0023::Yes - None
- at0024::No - None
- at0025::Comment - Additional narrative about the specific procedure question, not captured in other fields.
- at0028::Any previous procedures? - Is there a history of any past procedures relevant for the screening purpose?
- at0031::Yes - None
- at0032::No - None
- at0034::Screening purpose - The context or reason for screening.
- at0036::Additional details - Structured details or questions about the specific procedure.
- at0037::Timing - Timing of the procedure.
- at0038::Unknown - None

- at0039::Unknown - None
- at0040::Additional details - Structured details or questions about screening for procedures.
- at0041::Description - Narrative description about the history of any past procedures relevant for the screening purpose.
- at0042::Unsure - None
- at0043::Unsure - None

[**progress_note**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.progress_note.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, es-ar, en, nl

****Purpose:**** To manually synthesise and record a narrative description about health related events that are current at the time of recording, from the perspective of a healthcare provider.

****Use:**** Use to manually synthesise and record a narrative description about contemporary health-related events and activities from the perspective of a healthcare provider. This unstructured description may include the subject's health status and findings, that are current at the time of recording. Most commonly this description is likely to be related to nursing notes at the end of a shift, or the daily notes from healthcare providers such as a physician or a physiotherapist. In practice, Progress note 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. In many situations, this archetype will be combined alongside other more structured archetypes within a single COMPOSITION. This archetype may also be used if there are no structured archetypes available, or to record progress notes imported from legacy systems.

****Misuse:**** Not to be used to record specific structured or semi-structured health information. For example, detailed information about problems/diagnoses, test results and vital signs, examination findings and patient story/history should be recorded using the specific relevant archetypes EVALUATION or OBSERVATION archetypes. Not to be used to record a narrative, summary view of the patient's health, for example to communicate a succinct summary of the patient's hospital admission as one component of a comprehensive

and structured Discharge Summary document. Use the EVALUATION.clinicalSynopsis archetype for this purpose.

Keywords: comment, note, progress

Concepts:

- at000::Progress note - Narrative description of health-related events at a specific point-in-time about an individual, specifically from the perspective of a healthcare provider.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Progress Note - Narrative description of health-related events, health status, findings, opinions at a specific point-in-time.
- at0005::Tree - @ internal @
- at0006::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

promis

Archetype ID: openEHR-EHR-OBSERVATION.promis.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: de, en

Purpose: To record any PROMIS measure.

Use: Use to record any PROMIS measure. This archetype has been designed to be used as a framework for constructing templates for specific PROMIS measures, such as PROMIS-29 or PROMIS-57. CLUSTER archetypes should be modeled for each PROMIS question bank, constrained within this archetype. While openEHR archetypes are all freely available under an open license, the specific content of this archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. Copyright statement: PROMIS tests, test protocols, test items, norms, norms tables, scoring programs, scoring keys (including scoring algorithms, scale definitions, scale membership, and scoring directions), score reports, software, and other PROMIS-related materials are ©2006-2017 PROMIS Health Organization or other individuals/entities that have contributed information and materials, and are being used

with the permission of the copyright holders. Terms and conditions for use:
https://www.healthmeasures.net/images/PROMIS/Terms_of_Use_HM_approved_1-12-17_-Updated_Copyright_Notes.pdf

****Misuse:**** Not to be used to record any measures other than PROMIS.

****Concepts:****

- at0000::PROMIS - Patient Reported Outcomes Measurement Information System®, a set of over 300 measures of physical, mental, and social health for use with the general population and with individuals living with chronic conditions.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::PROMIS questions - Specific PROMIS questions.
- at0005::Item tree - @ internal @
- at0006::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0007::Assessment or test name - The name of the PROMIS assessment or test performed.
- at0008::Total score - The total score of the PROMIS assessment.

pulse

****Archetype ID:**** openEHR-EHR-OBSERVATION.pulse.v2

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, ru, sv, fi, nb, pt-br, el, en, ar-sy, es, nl, es-co

****Purpose:**** To record details about the rate and associated attributes for a pulse or heart beat.

****Use:**** Use to record the presence or absence of a pulse or heart beat. In practice, the terms 'heart rate' and 'pulse rate' are often used interchangeably, although they may be measured at different body sites. This archetype is intended to be used for either term and the measurement site element is used to differentiate them. Use to record the measurement of the pulse rate, or heart rate, observations about the associated pattern and character, and clinical interpretation of the findings. Measurements such as the maximum pulse or heart rate over an interval of time can be recorded using 'Maximum' event. Others point-in-time

or interval events may be specified within a template or at run-time. In development of this archetype, there has been some tension around representation of the regularity of the pulse or heart beat. This archetype represents the relevant data points separately: firstly establishing 'Regular' vs 'Irregular' and then, if 'Irregular', further options of 'Regularly irregular' and 'Irregularly irregular'. In practice, clinical systems could offer users a combination of the values from the 'Regularity' and 'Irregular type' - for example, 'Regular', 'Regularly irregular' and 'Irregularly irregular' drawn from these two data elements. Data could be recorded against both data elements with the assumption that if one of the irregular types are selected, then the 'Irregular' value in the 'Regularity' data element is also automatically selected. In certain situations it is important to be very specific so that a rate observed at a peripheral body site, such as the radial artery, can be differentiated from the rate of the heart. To record a pulse deficit, record the measurements of the mechanical heart rate and a peripheral pulse rate in two instances of this archetype - the difference between these measurements is the pulse deficit. The actual pulse deficit will be recorded in a separate OBSERVATION archetype.

****Misuse:**** Not to be used to record the R-R rate in the context of an Electrocardiograph report - use the OBSERVATION.ecg archetype for this purpose. Not to be used to record other details of the full cardiovascular examination or assessment. Other specific CLUSTER archetypes will be used to record characteristics such as apex beat, murmurs and bruits, or auscultatory findings. In particular, this archetype is not intended to record the assessment of peripheral vascular disease, which requires documentation of the presence and strength of each peripheral pulse. A specific CLUSTER archetype will be used to record the general findings on examination of peripheral pulses. Not to be used to record fetal heart rate - use the OBSERVATION.fetal_heart archetype for this purpose. Not to be used to record the pulse deficit - use a specific OBSERVATION archetype for this purpose. Concepts such as Target Heart Rate should be recorded in separate EVALUATION archetypes related to goals and exercise assessment.

****Keywords:**** rate, rhythm, beat, pulse, heart, vital, sign

****Concepts:****

- at0000::Pulse/Heart beat - The rate and associated attributes for a pulse or heart beat.
- at0001::structure - @ internal @
- at0002::history - @ internal @
- at0003::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0004::Rate - The rate of the pulse or heart beat, measured in beats per minute.
- at0005::Regularity - Regularity of the pulse or heart beat.
- at0006::Regular - The pattern is regular.
- at0007::Regularly Irregular - The pattern is irregular in a regular pattern,. For example, a dropped beat once every 'n' beats.

- at0008::Irregularly Irregular - The pattern is irregular in a chaotic and unpredictable manner. For example, atrial fibrillation.
- at0010::List - @ internal @
- at0012::List - @ internal @
- at0013::Position - The body position of the subject during the observation.
- at1000::Lying - The subject was lying flat.
- at1001::Sitting - The subject was sitting (for example on bed or chair).
- at1002::Reclining - The subject was reclining at an approximate angle of 45 degrees, with the legs elevated to the level of the pelvis.
- at1003::Standing/upright - The subject was standing, walking or running.
- at1005::Presence - Presence of a pulse or heart beat.
- at1013::Device - Details about the device used to measure the pulse rate or heart rate.
- at1017::Exertion - Details about physical exertion being undertaken during the examination.
- at1018::Confounding factors - Narrative description about any incidental factors that may affect interpretation of the physical findings.
- at1019::Method - Method used to observe the pulse or heart beat.
- at1022::Clinical description - Narrative description about the pulse or heart beat.
- at1023::Clinical interpretation - Single word, phrase or brief description that represents the clinical meaning and significance of the pulse or heart beat findings, including the rhythm.
- at1024::Present - A pulse or heart beat can be detected.
- at1025::Not detected - A pulse or heart beat cannot be detected.
- at1028::Irregular - The pattern is irregular.
- at1030::Character - Description of the character of the pulse or heart beat.
- at1032::Palpation - The findings are observed by physical touch of the observer on the subject.
- at1033::Auscultation - The findings are observed with the assistance of a device, such as a stethoscope.
- at1034::Automatic, non-invasive - The findings are observed non-invasively using a device such as a pulse oximeter or a stethoscope.
- at1036::Maximum - Maximum pulse rate or heart rate observed during a period of exertion.
- at1037::Body site - Body site where the pulse or heart beat were observed.
- at1038::Radial Artery - Left - The left radial artery.
- at1039::Radial Artery - Right - The right radial artery.
- at1040::Heart - The region of the heart.
- at1041::Carotid Artery - Left - The left carotid artery.
- at1042::Carotid Artery - Right - The right carotid artery.
- at1043::Femoral Artery - Left - The left femoral artery.
- at1044::Femoral Artery - Right - The right femoral artery.
- at1047::Finger - An unspecified finger.

- at1048::Brachial artery - Left - The left brachial artery.
- at1049::Brachial artery - Right - The right brachial artery.
- at1050::Automatic, invasive - The findings are observed invasively using a device such as an arterial catheter.
- at1051::Ear lobe - The lobe of an unspecified ear.
- at1054::Toe - An unspecified toe.
- at1055::Irregular type - More specific pattern of an irregular pulse or heart beat.
- at1056::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at1057::Clinical interpretation - Generic label to allow for any or all statements about the pulse or heart beat.
- at1058::Rhythm - Specific conclusion about the rhythm of the pulse or heartbeat, drawn from a combination of the heart rate, pattern and other characteristics observed on examination.
- at1059::Comment - Additional narrative about the pulse or heart beat findings not captured in other fields.

pulse_deficit

****Archetype ID:**** openEHR-EHR-OBSERVATION.pulse_deficit.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the difference between the apical heart rate and peripheral pulse rate when measured simultaneously.

****Use:**** Use to record the difference between the apical heart rate and peripheral pulse rate when measured simultaneously. The heart rate and pulse rate should be each be recorded separately, using the OBSERVATION.pulse archetype.

****Misuse:**** Not to be used to record the actual pulse rate or heart rate - use the OBSERVATION.pulse archetype for this purpose.

****Concepts:****

- at0000::Pulse deficit - The difference between the apical heart rate and peripheral pulse rate.
- at0001::Event Series - @ internal @

- at0002::Any point in time event - Default, unspecified point in time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Deficit - The difference between the apical heart rate and peripheral pulse rate when measured simultaneously.

pulse_oximetry

****Archetype ID:**** openEHR-EHR-OBSERVATION.pulse_oximetry.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, ru, sv, fi, es-ar, nb, pt-br, ar-sy, en, fa, nl

****Purpose:**** To record blood oxygen and related measurements, measured by pulse oximetry or pulse CO-oximetry.

****Use:**** Use to record blood oxygen and related measurements, measured by pulse oximetry or pulse CO-oximetry. Waveforms should be recorded here when used to document quality of the blood gas measurement.

****Misuse:**** Not used for other non-invasive blood gas measurements such as transcutaneous CO₂, lateral end-tidal CO₂ or non-invasive cerebral oximetry. Not to be used for recording plethysmography. Use another appropriate archetype for this purpose. Not to be used for recording another type of measurement, such as pulse rate, where the recording device also provides this. This should be recorded in a separate archetype, appropriate for that particular measurement to allow consistent querying. In this example, record the pulse rate in the OBSERVATION.pulse archetype. Not to be used to record any peripheral blood gas measurement that involves direct contact with blood. For example, PaO₂, PaCO₂ should be recorded using the OBSERVATION.laboratory_test_result archetype. Not to be used to record invasive blood gas measurement. For example, arterial (SaO₂), venous (SvO₂) oxygen saturation or Oxygen content (CaOC) which are usually determined by invasive methods such as laboratory blood gases or vascular catheter devices. These should also be recorded within the OBSERVATION.laboratory_test_result archetype.

****Keywords:**** oxygen, oxygenation, saturation, SpO₂, spMet, spCO, spOC, carboxyhaemoglobin, methaemoglobin, pulse, oximeter, oximetry, concentration, partial, pressure, non-invasive, vital, O₂, SaO₂, SaO2, sat, sats, hypoxaemia

****Concepts:****

- at0000::Pulse oximetry - Blood oxygen and related measurements, measured by pulse oximetry or pulse CO-oximetry.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0006::SpO₂ - The saturation of oxygen in the peripheral blood, measured via pulse oximetry.
- at0007::List - @ internal @
- at0009::Sensor site - The site of the measurement sensor.
- at0014::Tree - @ internal @
- at0015::Inspired oxygen - Details of the amount of oxygen available to the subject at the time of observation.
- at0016::Confounding factors - Comment on and record other incidental factors that may be affect interpretation of the observation.
- at0018::Oximetry device - Details of the non-invasive oximetry device used.
- at0034::Exertion - Details about physical activity undertaken at the time of measurement.
- at0036::Comment - A text comment about the pulse oximetry result.
- at0044::SpOC - The oxygen content of the peripheral blood, calculated based on pulse oximetry and pulse CO-oximetry.
- at0045::SpCO - The saturation of carboxyhaemoglobin in the peripheral blood, measured via pulse CO-oximetry.
- at0046::SpMet - The saturation of methaemoglobin in the peripheral blood, measured via pulse CO-oximetry.
- at0054::Waveform - A waveform reading associated with the oximetry measurement.
- at0058::Interpretation - Single word, phrase or brief description which represents the clinical meaning and significance of the measurements.
- at0059::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0060::Multimedia image - Details of a series of oximetry readings, other than waveforms, expressed as a multimedia image or series of images. Waveforms should be recorded using the Waveform slot and associated cluster archetype.
- at0061::Pre/post-ductal - Sensor site relative to the ductus arteriosus in neonates, to determine whether the blood supply to limb of the sensor site is pre- or post-ductal in cases of patent ductus arteriosus.
- at0062::Pre-ductal - The sensor site is pre-ductal.
- at0063::Post-ductal - The sensor site is post-ductal.
- at0064::Indeterminate - Unable to assess whether the sensor site is pre- or post-ductal.

qsofa_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.qsofa_score.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To record qSOFA answers and score.

****Use:**** Use to record qSOFA answers and score.

****Misuse:**** Not to be used to record ordinary SOFA scores. Use the archetype SOFA score for this purpose. Not to be used to record the actual values of respiration frequency, blood pressure, or Glasgow Coma Scale. Use the archetypes Respiration, Blood pressure or Glasgow Coma Scale for these purposes. Not to be used for individuals under 18 years of age.

****Keywords:**** sepsis, organ failure, organ dysfunction, septic shock, infection, assessment, multi organ failure

****Concepts:****

- at0000::qSOFA score - Quick Sepsis-related Organ Failure Assessment (qSOFA) is a simplified version of the SOFA score, which is used outside intensive care units to quickly assess sepsis risk in adults.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0004::Comment - Additional comment about the qSOFA score not captured in other fields.
- at0005::qSOFA score - The qSOFA score is the sum of the scores for the three parameters.
- at0006::Respiratory rate - If the respiration rate is $\geq 22/\text{min}$, one point is recorded.
- at0007::Blood pressure - If the systolic blood pressure is $\leq 100 \text{ mmHg}$, one point is recorded.
- at0008::Mental status - If the individual has an altered mental status, one point is recorded.
- at0009::Respiration rate < 22 - The individual's respiration rate is $< 22/\text{min}$.
- at0010::Respiration rate ≥ 22 - The individual's respiration rate is $\geq 22/\text{min}$.
- at0011::No altered mental status - The individual doesn't have an altered mental status.
- at0012::Altered mental status - The individual has an altered mental status.

- at0014::Systolic blood pressure >100 - The individual's systolic blood pressure is >100 mmHg.
- at0015::Systolic blood pressure ≤100 - The individual's systolic blood pressure is ≤100 mmHg.
- at0016::Tree - @ internal @
- at0017::ItemTree - @ internal @
- at0018::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

rass

****Archetype ID:**** openEHR-EHR-OBSERVATION.rass.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the result for the Richmond Agitation-Sedation Scale (RASS).

****Use:**** Used to record the result for the Richmond Agitation-Sedation Scale (RASS).

****Keywords:**** agitation, sedation, alertness, cognition,

****Concepts:****

- at0000::Richmond Agitation-Sedation Scale (RASS) - The Richmond Agitation-Sedation Scale (RASS) is a tool used to measure the agitation or sedation level of a patient.
- at0001::History - @ internal @
- at0002::Any event - @ internal @
- at0003::Tree - @ internal @
- at0004::The Richmond Agitation-Sedation Scale - None
- at0005::Combative - Overtly combative or violent; immediate danger to staff
- at0006::Very agitated - Pulls on or removes tube(s) or catheter(s) or has aggressive behavior toward staff
- at0007::Agitated - Frequent nonpurposeful movement or patient-ventilator dyssynchrony
- at0008::Restless - Anxious or apprehensive but movements not aggressive or vigorous
- at0009::Alert and calm - Spontaneously pays attention to caregiver
- at0010::Drowsy - Not fully alert, but has sustained (more than 10 seconds) awakening, with eye contact, to voice

- at0011::Light sedation - Briefly (less than 10 seconds) awakens with eye contact to voice
- at0012::Moderate sedation - Any movement (but no eye contact) to voice
- at0013::Deep sedation - No response to voice, but any movement to physical stimulation
- at0014::Unarousable - No response to voice or physical stimulation
- 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.

reach_b

Archetype ID: openEHR-EHR-OBSERVATION.reach_b.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en

Purpose: To record the results for each component parameter and their total sum for the REACH-B score.

Use: Use to record the results for each component parameter and their total sum for the REACH-B score.

Keywords: HCC, hepatitis, HBeAg, ALT, carcinoma, hepatocellular

Concepts:

- at0000::REACH-B score - An assessment score used to estimate risk of hepatocellular carcinoma (HCC) in patients with chronic hepatitis B.
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0004::Sex - *
- at0005::Female - *
- at0006::Male - *
- at0007::Age (years) - *
- at0008::30-34 - *
- at0009::35-39 - *
- at0010::40-44 - *
- at0011::45-49 - *

- at0012::50-54 - *
- at0013::55-59 - *
- at0014::60-65 - *
- at0015::ALT (U/L) - Alanine aminotransferase (ALT)
- at0016::<15 - *
- at0017::15-44 - *
- at0018::≥45 - *
- at0019::HBeAg - hepatitis B e-antigen
- at0020::Negative - *
- at0021::Positive - *
- at0022::Hepatitis B virus DNA level (copies/mL) - *
- at0023::<300 (undetectable) - *
- at0024::300-9,999 - *
- at0025::10,000-99,999 - *
- at0026::100,000-999,999 - *
- at0027::≥10⁶ - *
- at0028::Total score - *

reaction_screening

****Archetype ID:**** openEHR-EHR-OBSERVATION.reaction_screening.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To record the responses to a screening questionnaire for reactions.

****Use:**** Use to record the responses to a screening questionnaire for reactions.

****Concepts:****

- at0000::Reaction screening - An screeing questionnaire for adverse reaction.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Agent administered - Name of the agent related to the adverse reaction being screened.
- at0005::Reaction? - Presence of the reaction.

- at0007::Item tree - @ internal @
- at0021::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0022::Specific agent - Grouping of data elements related to screening for a single agent.
- at0023::Present - The specific condition is present.
- at0024::Absent - The specific condition is not present.
- at0025::Comment - Additional narrative about the reactions, not captured in other fields.
- at0027::Unknown - It is not known whether the condition is present or absent.
- at0028::Presence of any reactions? - Presence of any relevant reactions.
- at0031::Present - Conditions are present.
- at0032::Absent - Conditions are not present.
- at0033::Unknown - It is not known whether any conditions are present or absent.
- at0034::Screening purpose - The reason for overall screening.
- at0039::Additional detailed questions - Additional questionnaire questions directly related to the specific agent.

refraction

****Archetype ID:**** openEHR-EHR-OBSERVATION.refraction.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** For recording the results of a refraction assessment, either performed on the patient's usual correction or by refraction of the patient.

****Use:**** Use to record the results of measurement of refraction. The 'Description' data element can be used to record simple narrative summary or as a means to integrate legacy data.

****Keywords:**** eye, sight, vision, ophthalmic, visual, refraction, refraction, correction

****Concepts:****

- at0000::Refraction assessment - Assessment of the refraction required to achieve optimal visual acuity.
- at0001::Event Series - @ internal @
- at0003::Tree - @ internal @

- at0020::Tree - @ internal @
- at0025::Device Details - Details of the device used to measure refraction.
- at0039::Description - An overall narrative description of the visual acuity test result.
- at0040::Comment - Any additional narrative comment about the visual acuity test.
- at0041::Tree - @ internal @
- at0042::Refractive Correction - The specific type(s) of refractive correction applied.
- at0053::Result details - Details of the refraction result for each eye.
- at0054::Overall interpretation - A term, commonly coded, expressing an overall interpretation of the visual acuity test.
- at0055::No test result - No refraction test result is available for the test eye.
- at0066::Interpretation - The test result expressed as a qualitative term, normally coded.
- at0071::Spectacles - The subject's vision was corrected by spectacles.
- at0072::Contact lenses - The subject's vision was corrected by contact lenses.
- at0073::Pinhole - The subject's vision was corrected by use of a pinhole.
- at0074::Autorefraction - The subject's vision was corrected by autorefraction.
- at0075::Retinoscopy - The subject's vision was corrected by retinoscopy.
- at0112::Confounding Factors - Patient circumstances which affect interpretation of the result. Often termed 'reliability' in ophthalmological documentation.
- at0134::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0139::Refraction details - Details of refraction for a single eye.
- at0140::Examination not done - Details to explicitly record that this test was not performed.
- at0141::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0144::Test eye - Identification of the eye which is being tested.
- at0145::Right eye - Assessment of the right eye was performed.
- at0146::Left eye - Assessment of the left eye was performed.
- at0147::Reason for no test result - Reason why no refraction result is available for the test eye.

[registro_periodontal_simplificado](#)

Archetype ID: openEHR-EHR-OBSERVATION.registro_periodontal_simplificado.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: pt, pt-br, en

****Purpose:**** To register the value of probing depth of simply and quickly by sextant.

****Use:**** Used to record the value of probing depth of simply and quickly by sextant in any patient.

****Misuse:**** Can not be used to probe areas other than dental-alveolus.

****Keywords:**** Gingival probing, PSR, Periodontal Screening and Recording, Periodontium

****Concepts:****

- at0000::Periodontal screening and recording - The periodontal screening and recording (PSR) system was designed to initiate the promotion, prevention, and early treatment of periodontal diseases.
- at0001::*Event Series(pt) - *@ internal @(pt)
- at0002::*Any event(pt) - **(pt)
- at0003::**Tree(pt)(pt) - **@ internal @(pt)(pt)
- at0010::Code * - The * symbol is added to the code of a sextant exhibiting any abnormalities, like tooth mobility,

furcation involvement, gingival recession, mucogingival problems.

- at0011::Probing depth - Distance from the gingival margin to the most coronal portion of the junctional epithelium (base of gingival sulcus / pocket).
- at0012::Code X - Sextant under two teeth able to take or edentulous.
- at0013::Code 0 - Color-coded reference mark is completely visible. No presence of bleeding on probing, calculus or defective margins on restorations of the sextant.
- at0014::Code 1 - Color-coded reference mark is completely visible. Presence bleeding on probing, without calculus or defective margins on restorations of the sextant.
- at0015::Code 2 - Color-coded reference mark is completely visible. Presence bleeding on probing, calculus and/or defective margins on restorations of the sextant.
- at0016::Code 3 - Color-coded reference mark is partially visible. Presence of bleeding on probing, presence of calculus, defective margins on restorations, depth pockets of 3,5mm to 5,5mm of the sextant.
- at0017::Code 4 - Color-coded reference mark is not visible. Presence of bleeding on probing, presence of calculus and / or defective margins on restorations, probing depth of

greater than 5.5 mm in the sextant.

- at0018::Comments - Field designed for comments about code *
- at0023::Details of Code * - The * symbol is added to the code of a sextant exhibiting any abnormalities like tooth mobility,

furcation involvement, gingival recession, mucogingival problems.

- at0024::Furcation involvement - Bone resorption and insertion loss in the interradicular space.
- at0025::Tooth mobility - Resorption of the alveolar bone around the tooth and also the destruction of the periodontal

ligament.

- at0026::Mucogingival problems - Alterations of the dimension and morphology of the relationship between the gingiva and alveolar

mucosa.

- at0027::Gingival recession - Gingiva displacement which causes the exposure in the tooth roots.

respiration

Archetype ID: openEHR-EHR-OBSERVATION.respiration.v2

Lifecycle State: published

Category: OBSERVATION

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

Purpose: To record the characteristics of spontaneous breathing by an individual.

Use: Use to record the observed and measured characteristics of spontaneous breathing by an individual, including respiratory rate, depth and rhythm. Respirations are commonly recorded as one component of vital signs.

Misuse: Not to be used to record the physical examination of the respiratory system - use the physical examination family of archetypes for this purpose, such as CLUSTER.exam-chest or CLUSTER.exam-lung. Not to be used to record other measurements related to breathing - use specific archetypes for the purpose, for example OBSERVATION.pulse_oximetry. Not to be used to record functional assessments of breathing - use specific archetypes for the purpose, for example

OBSERVATION.pulmonary_function. Not to be used for recording details about individuals who are undergoing assisted ventilation.

Keywords: respirations, breathing, breath, resp, respiration

Concepts:

- at0000::Respiration - The characteristics of spontaneous breathing by an individual.
- at0001::history - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::List - @ internal @
- at0004::Rate - The frequency of spontaneous breathing.
- at0005::Regularity - The regularity of spontaneous breathing.
- at0006::Regular - The breathing pattern is regular.
- at0007::Irregular - The breathing pattern is not regular.
- at0009::Clinical interpretation - Single word, phrase or brief description which represents the clinical meaning and significance of the respiration findings.
- at0016::Depth - The depth of spontaneous breathing.
- at0017::Normal - Normal depth of breathing.
- at0018::Shallow - Shallow depth of breathing.
- at0019::Deep - Deep breathing.
- at0022::List - @ internal @
- at0024::Clinical description - A narrative description about the spontaneous breathing of the individual.
- at0025::Variable - Variable depth of breathing.
- at0037::Exertion - Details about physical exertion being undertaken during the examination.
- at0055::Inspired oxygen - Details of the amount of oxygen being delivered to the individual at the time of observation.
- at0056::Confounding factors - Identification of any issues or incidental factors that may impact on interpretation of the observation.
- at0057::Tree - @ internal @
- at0058::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0062::Presence - Observation of spontaneous respiration.
- at0063::Present - Respiratory movements are observed.
- at0064::Not detected - Respiratory movements are not detected on observation.
- at0065::Body position - The body position of the individual during the observation.
- at0066::Standing/upright - The individual was standing, walking or running.
- at0067::Sitting - The individual was sitting (for example, on a bed or chair).
- at0068::Reclining - The individual was reclining at an approximate angle of 45 degrees, with the legs elevated to the level of the pelvis.

- at0069::Lying - The individual was lying on their back.
- at0070::Comment - Additional narrative about the respirations, not captured in other fields.
- at0071::Prone - The individual was lying on their front.

revised_cardiac_risk_index

****Archetype ID:**** openEHR-EHR-OBSERVATION.revised_cardiac_risk_index.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, en

****Purpose:**** To record the result for each component parameter, and their total sum and estimated risk for the Revised Cardiac Risk Index (RCRI).

****Use:**** Use to record the Revised cardiac risk index (RCRI).

****Keywords:**** Revised cardiac risk index, RCRI, Lee score, Lee index, perioperative risk, myocardial infarction, MI, cardiac arrest, risk, anesthesia, preoperative assessment.

****Concepts:****

- at0000::Revised cardiac risk index - The Revised Cardiac Risk Index (RCRI) is a preoperative prediction tool to estimate the perioperative risk of major cardiac complications during non-cardiac surgery.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Elevated serum creatinine - Preoperative serum Creatinine ≥ 2 mg/dl or ≥ 177 $\mu\text{mol}/\text{L}$.
- at0005::Preoperative serum creatinine < 2 mg/dl or < 177 $\mu\text{mol}/\text{L}$. - None
- at0006::Preoperative serum creatinine ≥ 2 mg/dl or ≥ 177 $\mu\text{mol}/\text{L}$. - None
- at0007::Ischemic heart disease - History of probable or definite myocardial infarction (MI; ECG changes and/or enzyme changes); history of positive exercise test; current chest pain considered due to myocardial ischemia; use of nitrate therapy; ECG with pathological Q waves.
- at0008::Absent - None
- at0009::Present - None

- at0010::Congestive heart failure - History of congestive heart failure; pulmonary edema; paroxysmal nocturnal dyspnea; physical examination showing bilateral rales or S3 gallop; chest radiograph showing pulmonary vascular redistribution; has responded symptomatically (or on physical examination) to digitalis, diuretics, or afterload reducing agents.
- at0011::Absent - None
- at0012::Present - None
- at0013::Cerebrovascular disease - History of stroke, cerebrovascular accident (CVA) with minor or no residual or transient ischemic attacks (TIA).
- at0014::Absent - None
- at0015::Present - None
- at0016::Diabetes mellitus on insulin - Diabetes mellitus treated with insulin.
- at0017::Absent - None
- at0018::Present - None
- at0022::High risk surgery - Surgical procedures that carry a significant risk of complications or adverse events e.g. intraperitoneal, intrathoracic, or suprainguinal vascular procedures.
- at0023::Absent - None
- at0024::Present - None
- at0025::Item tree - @ internal @
- at0026::Total score - The total sum of each component variable for the Revised cardiac risk index.
- at0027::Estimated risk - Estimated risk of major cardiac complications (myocardial infarction, pulmonary edema, ventricular fibrillation or primary cardiac arrest, and complete heart block) after non-cardiac surgery:

0 points = Very low risk;

1 point = Low risk;

2 points = Moderate risk;

≥ 3 points = High risk.

- at0028::Very low risk - According to Lee et al. equivalent to 0.4%.
- at0029::Low risk - According to Lee et al. equivalent to 0.9%.
- at0030::Moderate risk - According to Lee et al. equivalent to 6.6%.
- at0031::High risk - According to Lee et al. $\geq 11\%$.
- at0032::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

richmond_agitation_sedation_scale

****Archetype ID:**** openEHR-EHR-OBSERVATION.richmond_agitation_sedation_scale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** es-ar, en

****Purpose:**** To measure the agitation or sedation level of a hospitalized patients.

****Use:**** RASS is mostly used in the setting of mechanically ventilated patients in the intensive care unit to avoid over- and under-sedation. Also as the first step in administering the Confusion Assessment Method in the ICU (CAM-ICU), a tool to detect delirium in intensive care unit patients.

****Keywords:**** Richmond Agitation Sedation Scale, RASS, scale, agitation, sedation, mechanical ventilation, intensive care unit

****Concepts:****

- at0000::Richmond agitation sedation scale (RASS) - A scale used to measure the agitation or sedation level of a patient.
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0004::Scale - The Richmond agitation/sedation scale.
- at0005::Combative - Overtly combative or violent; immediate danger to staff.
- at0006::Very agitated - Pulls on or removes tube(s) or catheter(s) or has aggressive behavior toward staff.
- at0007::Agitated - Frequent nonpurposeful movement or patient-ventilator dyssynchrony.
- at0008::Restless - Anxious or apprehensive but movements not aggressive or vigorous.
- at0009::Alert and calm - Spontaneously pays attention to caregiver
- at0010::Drowsy - Patient has eye opening and eye contact, which is sustained for more than 10 seconds.
- at0011::Light sedation - Patient has eye opening and eye contact, but this is not sustained for 10 seconds.
- at0012::Moderate sedation - Patient has any movement in response to voice, excluding eye contact.
- at0013::Deep sedation - Patient has any movement to physical stimulation.
- at0014::Unarousable - Patient has no response to voice or physical stimulation.

rinne_weber_result

****Archetype ID:**** openEHR-EHR-OBSERVATION.rinne_weber_result.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results of the Rinne and Weber tests as part of screening for hearing loss.

****Use:**** Use to record the results of the Rinne and Weber tests as part of screening for hearing loss.

****Misuse:**** Not to be used to record the results of other hearing tests. Use other OBSERVATION archetypes specific for the purpose, for example, OBSERVATION.audiometry_result and OBSERVATION.tympanogram_226hz.

****Keywords:**** rinne, weber, test, result, air, bone, conduction, lateralisation, lateralization

****Concepts:****

- at0000::Rinne and Weber test results - Two hearing screening tests, commonly recorded together to determine the presence and character of any detected hearing loss.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Weber Test Result - A test to compare bone conduction in both ears.
- at0005::No Lateralisation - The sound from vibration is heard equally in both ears.
- at0006::Lateralising Left - The sound from the vibration is heard predominantly on the left.
- at0007::Lateralising Right - The sound from the vibration is heard predominantly on the right.
- at0008::Rinne Test - A test to compare the subject's perception of sounds transmitted by air conduction to those transmitted by bone conduction through the mastoid.
- at0009::Rinne Test Result - The result of the Rinne Test.
- at0010::Ear Tested - Identification of the ear being tested.
- at0011::Left - The left ear was tested.
- at0012::Right - The right ear was tested.
- at0013::Negative - Air Conduction is less than bone conduction.

- at0014::Positive - Air Conduction is greater than bone conduction.
- at0017::Clinical Interpretation - Single word, phrase or brief description represents the clinical meaning and significance of the physical examination findings.
- at0018::Comment - Additional narrative about the Rinne and Weber tests not captured in other fields.

safas

****Archetype ID:**** openEHR-EHR-OBSERVATION.safas.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** For the capture and reporting of details of the Sports Athlete Foot and Ankle Score (SAFAS). This is a patient reported outcomes measure (PROM).

****Use:**** Use to record details of the Sports Athlete Foot and Ankle Score (SAFAS). While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Keywords:**** foot, ankle, SAFAS, injury, score

****Concepts:****

- at0000::SAFAS - Sports Athlete Foot and Ankle Score (SAFAS).
- at0001::History - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tree - @ internal @
- at0005::Swollen foot or ankle - Patient-reported extent to which foot or ankle has been swollen during last week.
- at0006::Never - Foot or ankle has not been swollen in last week.
- at0007::Rarely - Foot or ankle has rarely been swollen in last week.
- at0008::Sometimes - Foot or ankle has sometimes been swollen in last week.

- at0009::Often - Foot or ankle has often been swollen in last week.
- at0010::Grinding or noise when moving foot or ankle - Patient-reported extent of feeling grinding, hearing clicking or any other type of noise when foot or ankle moved during last week.
- at0011::Tree - @ internal @
- at0012::Swollen foot or ankle after low impact activity - Patient-report extent to which foot or ankle has been swollen after low impact activity during last week.
- at0013::Never - Foot or ankle has never been swollen after low impact activity in last week.
- at0014::Rarely - Foot or ankle has rarely been swollen after low impact activity in last week.
- at0015::Sometimes - Foot or ankle has sometimes been swollen after low impact activity in last week.
- at0016::Often - Foot or ankle has often been swollen after low impact activity in last week.
- at0017::Never - The patient never felt grinding or heard clicking or any other noise when foot or ankle moved in last week.
- at0018::Swollen foot or ankle after heavy activity - Patient-reported extent to which foot or ankle has been swollen after heavy activity.
- at0019::Never - Foot or ankle has never been swollen after heavy activity in last week.
- at0020::Rarely - Foot or ankle has rarely been swollen after heavy activity in last week.
- at0021::Sometimes - Foot or ankle has sometimes been swollen after heavy activity in last week.
- at0022::Often - Foot or ankle has often been swollen after heavy activity in last week.
- at0023::Rarely - The patient rarely felt grinding or heard clicking or any other noise when foot or ankle moved in last week.
- at0024::Sometimes - The patient sometimes felt grinding or heard clicking or any other noise when foot or ankle moved in last week.
- at0025::Often - The patient often felt grinding or heard clicking or any other noise when foot or ankle moved in last week.
- at0026::Difficulty pointing toes - Patient-reported extent of difficulty pointing toes towards the ground fully during last week.
- at0027::None - The patient experienced no difficulty pointing toes towards the ground fully during last week.
- at0028::Mild - The patient experienced mild difficulty pointing toes towards the ground fully during last week.
- at0029::Moderate - The patient experienced moderate difficulty pointing toes towards the ground fully during last week.
- at0030::Severe - The patient experienced severe difficulty pointing toes towards the ground fully during last week.
- at0031::Difficulty moving ankle - Patient-reported extent of difficulty moving ankle from side to side fully during last week.

- at0032::None - The patient experienced no difficulty moving ankle from side to side fully in last week.
- at0033::Mild - The patient experienced mild difficulty moving ankle from side to side fully in last week.
- at0034::Moderate - The patient experienced moderate difficulty moving ankle from side to side fully in last week.
- at0035::Severe - The patient experienced severe difficulty moving ankle from side to side fully in last week.
- at0036::Confounding factors - Record any issues or factors that may impact on the score or interpretation.
- at0037::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0038::Ankle stiffness after wakening - Patient-reported extent of ankle stiffness after first wakening in the morning.
- at0039::None - The patient experienced no ankle stiffness after first wakening in last week.
- at0040::Mild - The patient experienced mild ankle stiffness after first wakening in last week.
- at0041::Moderate - The patient experienced moderate ankle stiffness after first wakening in last week.
- at0042::Severe - The patient experienced severe ankle stiffness after first wakening in last week.
- at0043::Always - Foot or ankle has always been swollen in last week.
- at0044::Always - Foot or ankle has always been swollen after low impact activity in last week.
- at0045::Always - Foot or ankle has always been swollen after heavy activity in last week.
- at0046::Always - The patient always felt grinding or heard clicking or any other noise when foot or ankle moved in last week.
- at0047::Extreme - The patient experienced extreme difficulty pointing toes towards the ground fully during last week.
- at0048::Extreme - The patient experienced extreme difficulty moving ankle from side to side fully in last week.
- at0049::Extreme - The patient experienced extreme ankle stiffness after first wakening in last week.
- at0050::Ankle stiffness after sitting, lying or resting - Patient-reported extent of ankle stiffness after sitting, lying or resting later in the day during the last week.
- at0051::Extreme - The patient experienced extreme ankle stiffness after sitting, lying or resting later in the day in last week.
- at0052::Severe - The patient experienced severe ankle stiffness after sitting, lying or resting later in the day in last week.

- at0053::Moderate - The patient experienced moderate ankle stiffness after sitting, lying or resting later in the day in last week.
- at0054::Mild - The patient experienced mild ankle stiffness after sitting, lying or resting later in the day in last week.
- at0055::None - The patient experienced no ankle stiffness after sitting, lying or resting later in the day in last week.
- at0056::Ankle stiffness after activity - Patient-reported extent of ankle stiffness after activity during last week.
- at0057::Extreme - The patient experienced extreme ankle stiffness after activity in last week.
- at0058::Severe - The patient experienced severe ankle stiffness after activity in last week.
- at0059::Moderate - The patient experienced moderate ankle stiffness after activity in last week.
- at0060::Mild - The patient experienced mild ankle stiffness after activity in last week.
- at0061::None - The patient experienced no ankle stiffness after activity in last week.
- at0062::Pain in joint - Patient-reported extent of pain in joint during last week.
- at0063::Always - The patient always experienced pain in the joint in last week.
- at0064::Often - The patient often experienced pain in the joint in last week.
- at0065::Sometimes - The patient sometimes experienced pain in the joint in last week.
- at0066::Rarely - The patient rarely experienced pain in the joint in last week.
- at0067::Never - The patient never experienced pain in the joint in last week.
- at0068::Pain at rest (sitting) - Patient-reported estimation of amount of pain experienced in foot / ankle when at rest (sitting) during last week.
- at0069::Extreme - The patient experienced extreme pain in foot/ankle when at rest in last week.
- at0070::Severe - The patient experienced severe pain in foot/ankle when at rest in last week.
- at0071::Moderate - The patient experienced moderate pain in foot/ankle when at rest in last week.
- at0072::Mild - The patient experienced mild pain in foot/ankle when at rest in last week.
- at0073::None - The patient experienced no pain in foot/ankle when at rest in last week.
- at0074::Pain during full weight bearing - Patient-reported estimation of amount of pain experienced in foot / ankle during full weight bearing during last week.
- at0075::Extreme - The patient experienced extreme pain in foot/ankle during full weight bearing in last week.
- at0076::Severe - The patient experienced severe pain in foot/ankle during full weight bearing in last week.
- at0077::Moderate - The patient experienced moderate pain in foot/ankle during full weight bearing in last week.

- at0078::Mild - The patient experienced mild pain in foot/ankle during full weight bearing in last week.
- at0079::None - The patient experienced no pain in foot/ankle during full weight bearing in last week.
- at0080::Pain during low impact activity - Patient-reported estimation of amount of pain experienced in foot / ankle during low impact activity during last week.
- at0081::Extreme - The patient experienced extreme pain in foot/ankle during low impact activity in last week.
- at0082::Severe - The patient experienced severe pain in foot/ankle during low impact activity in last week.
- at0083::Moderate - The patient experienced moderate pain in foot/ankle during low impact activity in last week.
- at0084::Mild - The patient experienced mild pain in foot/ankle during low impact activity in last week.
- at0085::None - The patient experienced no pain in foot/ankle during low impact activity in last week.
- at0086::Pain after low impact activity - Patient-reported estimation of amount of pain experienced in foot / ankle after low impact activity during last week.
- at0087::Extreme - The patient experienced extreme pain in foot/ankle after low impact activity in last week.
- at0088::Severe - The patient experienced severe pain in foot/ankle after low impact activity in last week.
- at0089::Moderate - The patient experienced moderate pain in foot/ankle after low impact activity in last week.
- at0090::Mild - The patient experienced mild pain in foot/ankle after low impact activity in last week.
- at0091::None - The patient experienced no pain in foot/ankle after low impact activity in last week.
- at0092::Pain during heavy activity - Patient-reported estimation of amount of pain experienced in foot / ankle during heavy activity during last week.
- at0093::Extreme - The patient experienced extreme pain in foot/ankle during heavy activity in last week.
- at0094::Severe - The patient experienced severe pain in foot/ankle during heavy activity in last week.
- at0095::Moderate - The patient experienced moderate pain in foot/ankle during heavy activity in last week.
- at0096::Mild - The patient experienced mild pain in foot/ankle during heavy activity in last week.
- at0097::None - The patient experienced no pain in foot/ankle during heavy activity in last week.
- at0098::Pain after heavy activity - Patient-reported estimation of amount of pain experienced in foot / ankle after heavy activity during last week.

- at0099::Extreme - The patient experienced extreme pain in foot/ankle after heavy activity in last week.
- at0100::Severe - The patient experienced severe pain in foot/ankle after heavy activity in last week.
- at0101::Moderate - The patient experienced moderate pain in foot/ankle after heavy activity in last week.
- at0102::Mild - The patient experienced mild pain in foot/ankle after heavy activity in last week.
- at0103::None - The patient experienced no pain in foot/ankle after heavy activity in last week.
- at0104::Pain when twisting or pivoting on ankle - Patient-reported estimation of amount of pain experienced in foot / ankle when twisting or pivoting on ankle during last week.
- at0105::Extreme - The patient experienced extreme pain in foot/ankle when twisting or pivoting on ankle in last week.
- at0106::Severe - The patient experienced severe pain in foot/ankle when twisting or pivoting on ankle in last week.
- at0107::Moderate - The patient experienced moderate pain in foot/ankle when twisting or pivoting on ankle in last week.
- at0108::Mild - The patient experienced mild pain in foot/ankle when twisting or pivoting on ankle in last week.
- at0109::None - The patient experienced no pain in foot/ankle when twisting or pivoting on ankle in last week.
- at0110::Pain when pointing toes to ground - Patient-reported estimation of amount of pain experienced in foot / ankle when pointing toes to ground fully during last week.
- at0111::Extreme - The patient experienced extreme pain in foot/ankle when pointing toes to ground fully in last week.
- at0112::Severe - The patient experienced severe pain in foot/ankle when pointing toes to ground fully in last week.
- at0113::Moderate - The patient experienced moderate pain in foot/ankle when pointing toes to ground fully in last week.
- at0114::Mild - The patient experienced mild pain in foot/ankle when pointing toes to ground fully in last week.
- at0115::None - The patient experienced no pain in foot/ankle when pointing toes to ground fully in last week.
- at0116::Pain when bending ankle - Patient-reported estimation of amount of pain experienced in foot / ankle when bending ankle fully during last week.
- at0117::Extreme - The patient experienced extreme pain in foot/ankle when bending ankle fully in last week.
- at0118::Severe - The patient experienced severe pain in foot/ankle when bending ankle fully in last week.

- at0119::Moderate - The patient experienced moderate pain in foot/ankle when bending ankle fully in last week.
- at0120::Mild - The patient experienced mild pain in foot/ankle when bending ankle fully in last week.
- at0121::None - The patient experienced no pain in foot/ankle when bending ankle fully in last week.
- at0122::Symptoms - Patient-reported symptoms.
- at0123::Pain - Patient-reported pain.
- at0124::Pain at night while in bed - Patient-reported estimation of amount of pain experienced in foot / ankle at night while in bed during last week.
- at0125::Extreme - The patient experienced extreme pain in foot/ankle at night while in bed in last week.
- at0126::Severe - The patient experienced severe pain in foot/ankle at night while in bed in last week.
- at0127::Moderate - The patient experienced moderate pain in foot/ankle at night while in bed in last week.
- at0128::Mild - The patient experienced mild pain in foot/ankle at night while in bed in last week.
- at0129::None - The patient experienced no pain in foot/ankle at night while in bed in last week.
- at0130::Pain going upstairs - Patient-reported estimation of amount of pain experienced in foot / ankle going upstairs during last week.
- at0131::Extreme - The patient experienced extreme pain in foot/ankle going upstairs in last week.
- at0132::Severe - The patient experienced severe pain in foot/ankle going upstairs in last week.
- at0133::Moderate - The patient experienced moderate pain in foot/ankle going upstairs in last week.
- at0134::Mild - The patient experienced mild pain in foot/ankle going upstairs in last week.
- at0135::None - The patient experienced no pain in foot/ankle going upstairs in last week.
- at0136::Pain going downstairs - Patient-reported estimation of amount of pain experienced in foot / ankle going downstairs during last week.
- at0137::Extreme - The patient experienced extreme pain in foot/ankle going downstairs in last week.
- at0138::Severe - The patient experienced severe pain in foot/ankle going downstairs in last week.
- at0139::Moderate - The patient experienced moderate pain in foot/ankle going downstairs in last week.
- at0140::Mild - The patient experienced mild pain in foot/ankle going downstairs in last week.

- at0141::None - The patient experienced no pain in foot/ankle going downstairs in last week.
- at0142::Daily living - Patient-reported difficulties in daily living activities.
- at0143::Rising from sitting - Patient-reported extent of difficulty rising from sitting due to foot / ankle during last week.
- at0144::Extreme - The patient experienced extreme difficulty rising from sitting due to ankle in last week.
- at0145::Severe - The patient experienced severe difficulty rising from sitting due to ankle in last week.
- at0146::Moderate - The patient experienced moderate difficulty rising from sitting due to ankle in last week.
- at0147::Mild - The patient experienced mild difficulty rising from sitting due to ankle in last week.
- at0148::None - The patient experienced no difficulty rising from sitting due to ankle in last week.
- at0149::Ascending stairs - Patient-reported extent of difficulty ascending stairs due to foot / ankle during last week.
- at0150::Extreme - The patient experienced extreme difficulty ascending stairs due to ankle in last week.
- at0151::Severe - The patient experienced severe difficulty ascending stairs due to ankle in last week.
- at0152::Moderate - The patient experienced moderate difficulty ascending stairs due to ankle in last week.
- at0153::Mild - The patient experienced mild difficulty ascending stairs due to ankle in last week.
- at0154::None - The patient experienced no difficulty ascending stairs due to ankle in last week.
- at0155::Descending stairs - Patient-reported extent of difficulty descending stairs due to foot / ankle during last week.
- at0156::Extreme - The patient experienced extreme difficulty descending stairs due to ankle in last week.
- at0157::Severe - The patient experienced severe difficulty descending stairs due to ankle in last week.
- at0158::Moderate - The patient experienced moderate difficulty descending stairs due to ankle in last week.
- at0159::Mild - The patient experienced mild difficulty descending stairs due to ankle in last week.
- at0160::None - The patient experienced no difficulty descending stairs due to ankle in last week.
- at0161::Putting on socks or stockings - Patient-reported extent of difficulty putting on socks or stockings due to foot / ankle during last week.

- at0162::Extreme - The patient experienced extreme difficulty putting on socks or stockings due to ankle in last week.
- at0163::Severe - The patient experienced severe difficulty putting on socks or stockings due to ankle in last week.
- at0164::Moderate - The patient experienced moderate difficulty putting on socks or stockings due to ankle in last week.
- at0165::Mild - The patient experienced mild difficulty putting on socks or stockings due to ankle in last week.
- at0166::None - The patient experienced no difficulty putting on socks or stockings due to ankle in last week.
- at0167::Getting in and out of bath - Patient-reported extent of difficulty getting in and out of bath due to foot / ankle during last week.
- at0168::Extreme - The patient experienced extreme difficulty getting in and out of bath due to ankle in last week.
- at0169::Severe - The patient experienced severe difficulty getting in and out of bath due to ankle in last week.
- at0170::Moderate - The patient experienced moderate difficulty getting in and out of bath due to ankle in last week.
- at0171::Mild - The patient experienced mild difficulty getting in and out of bath due to ankle in last week.
- at0172::None - The patient experienced no difficulty getting in and out of bath due to ankle in last week.
- at0173::Getting on and off toilet - Patient-reported extent of difficulty getting on and off toilet due to foot / ankle during last week.
- at0174::Extreme - The patient experienced extreme difficulty getting on and off toilet due to ankle in last week.
- at0175::Severe - The patient experienced severe difficulty getting on and off toilet due to ankle in last week.
- at0176::Moderate - The patient experienced moderate difficulty getting on and off toilet due to ankle in last week.
- at0177::Mild - The patient experienced mild difficulty getting on and off toilet due to ankle in last week.
- at0178::None - The patient experienced no difficulty getting on and off toilet due to ankle in last week.
- at0179::Bending to floor or pick up object - Patient-reported extent of difficulty bending to floor or picking up object due to foot / ankle during last week.
- at0180::Extreme - The patient experienced extreme difficulty bending to floor or picking up object due to ankle in last week.
- at0181::Severe - The patient experienced severe difficulty bending to floor or picking up object due to ankle in last week.
- at0182::Moderate - The patient experienced moderate difficulty bending to floor or picking up object due to ankle in last week.

- at0183::Mild - The patient experienced mild difficulty bending to floor or picking up object due to ankle in last week.
- at0184::None - The patient experienced no difficulty bending to floor or picking up object due to ankle in last week.
- at0185::Driving car - Patient-reported extent of difficulty driving car due to foot / ankle during last week.
- at0186::Extreme - The patient experienced extreme difficulty driving car due to ankle in last week.
- at0187::Severe - The patient experienced severe difficulty driving car due to ankle in last week.
- at0188::Moderate - The patient experienced moderate difficulty driving car due to ankle in last week.
- at0189::Mild - The patient experienced mild difficulty driving car due to ankle in last week.
- at0190::None - The patient experienced no difficulty driving car due to ankle in last week.
- at0191::Sports participation - Patient-reported difficulties in sports participation.
- at0192::Squatting without extra weight - Patient-reported extent of difficulty experienced when squatting without extra weight during last week.
- at0193::Unable - The patient was unable to squat without extra weight during last week.
- at0194::Extreme - The patient experienced extreme difficulty when squatting without extra weight during last week.
- at0195::Moderate - The patient experienced moderate difficulty when squatting without extra weight during last week.
- at0196::Mild - The patient experienced mild difficulty when squatting without extra weight during last week.
- at0197::None - The patient experienced no difficulty when squatting without extra weight during last week.
- at0198::Squatting with extra weight - Patient-reported extent of difficulty experienced when squatting with extra weight during last week.
- at0199::Unable - The patient was unable to squat with extra weight during last week.
- at0200::Extreme - The patient experienced extreme difficulty when squatting with extra weight during last week.
- at0201::Moderate - The patient experienced moderate difficulty when squatting with extra weight during last week.
- at0202::Mild - The patient experienced mild difficulty when squatting with extra weight during last week.
- at0203::None - The patient experienced no difficulty when squatting with extra weight during last week.
- at0204::Squatting on one leg (injured ankle) - Patient-reported extent of difficulty experienced when squatting on one leg (injured ankle) during last week.

- at0205::Unable - The patient was unable to squat on one leg (injured ankle) during last week.
- at0206::Extreme - The patient experienced extreme difficulty when squatting on one leg (injured ankle) during last week.
- at0207::Moderate - The patient experienced moderate difficulty when squatting on one leg (injured ankle) during last week.
- at0208::Mild - The patient experienced mild difficulty when squatting on one leg (injured ankle) during last week.
- at0209::None - The patient experienced no difficulty when squatting on one leg (injured ankle) during last week.
- at0210::Jogging - Patient-reported extent of difficulty experienced when jogging during last week.
- at0211::Unable - The patient was unable to jog during last week.
- at0212::Extreme - The patient experienced extreme difficulty when jogging during last week.
- at0213::Moderate - The patient experienced moderate difficulty when jogging during last week.
- at0214::Mild - The patient experienced mild difficulty when jogging during last week.
- at0215::None - The patient experienced no difficulty when jogging during last week.
- at0216::Running - Patient-reported extent of difficulty experienced when running during last week.
- at0217::Unable - The patient was unable to run during last week.
- at0218::Extreme - The patient experienced extreme difficulty when running during last week.
- at0219::Moderate - The patient experienced moderate difficulty when running during last week.
- at0220::Mild - The patient experienced mild difficulty when running during last week.
- at0221::None - The patient experienced no difficulty when running during last week.
- at0222::Sudden cutting or lateral movements - Patient-reported extent of difficulty experienced when making sudden cutting or lateral movements during last week.
- at0223::Unable - The patient was unable to make sudden cutting or lateral movements during last week.
- at0224::Extreme - The patient experienced extreme difficulty when making sudden cutting or lateral movements during last week.
- at0225::Moderate - The patient experienced moderate difficulty when making sudden cutting or lateral movements during last week.
- at0226::Mild - The patient experienced mild difficulty when making sudden cutting or lateral movements during last week.
- at0227::None - The patient experienced no difficulty when making sudden cutting or lateral movements during last week.
- at0228::Starting quickly - Patient-reported extent of difficulty experienced when starting quickly during last week.

- at0229::Unable - The patient was unable to start quickly during last week.
- at0230::Extreme - The patient experienced extreme difficulty when starting quickly during last week.
- at0231::Moderate - The patient experienced moderate difficulty when starting quickly during last week.
- at0232::Mild - The patient experienced mild difficulty when starting quickly during last week.
- at0233::None - The patient experienced no difficulty when starting quickly during last week.
- at0234::Stopping quickly - Patient-reported extent of difficulty experienced when stopping quickly during last week.
- at0235::Unable - The patient was unable to stop quickly during last week.
- at0236::Extreme - The patient experienced extreme difficulty when stopping quickly during last week.
- at0237::Moderate - The patient experienced moderate difficulty when stopping quickly during last week.
- at0238::Mild - The patient experienced mild difficulty when stopping quickly during last week.
- at0239::None - The patient experienced no difficulty when stopping quickly during last week.
- at0240::Jumping - Patient-reported extent of difficulty experienced when jumping during last week.
- at0241::Unable - The patient was unable to jump during last week.
- at0242::Extreme - The patient experienced extreme difficulty when jumping during last week.
- at0243::Moderate - The patient experienced moderate difficulty when jumping during last week.
- at0244::Mild - The patient experienced mild difficulty when jumping during last week.
- at0245::None - The patient experienced no difficulty when jumping during last week.
- at0246::Landing - Patient-reported extent of difficulty experienced when landing during last week.
- at0247::Unable - The patient was unable to land during last week.
- at0248::Extreme - The patient experienced extreme difficulty when landing during last week.
- at0249::Moderate - The patient experienced moderate difficulty when landing during last week.
- at0250::Mild - The patient experienced mild difficulty when landing during last week.
- at0251::None - The patient experienced no difficulty when landing during last week.
- at0252::Performing activities with normal technique - Patient-reported extent of difficulty experienced when performing activities with normal technique during last week.

- at0253::Unable - The patient was unable to perform activity with normal technique during last week.
- at0254::Extreme - The patient experienced extreme difficulty when performing activity with normal technique during last week.
- at0255::Moderate - The patient experienced moderate difficulty when performing activity with normal technique during last week.
- at0256::Mild - The patient experienced mild difficulty when performing activity with normal technique during last week.
- at0257::None - The patient experienced no difficulty when performing activity with normal technique during last week.
- at0258::Participating activity as long as would like - Patient-reported extent of difficulty experienced when participating in activity as long as they would like during last week.
- at0259::Unable - The patient was unable to participate in activity as long as they would like during last week.
- at0260::Extreme - The patient experienced extreme difficulty participating in activity as long as they would like during last week.
- at0261::Moderate - The patient experienced moderate difficulty participating in activity as long as they would like during last week.
- at0262::Mild - The patient experienced mild difficulty participating in activity as long as they would like during last week.
- at0263::None - The patient experienced no difficulty participating in activity as long as they would like during last week.
- at0264::Total score - Total score from all individual items.

[sara_scale](#)

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Purpose: SARA is a clinical scale that is based on a semiquantitative assessment of cerebellar ataxia on an impairment level. SARA has 8 items that are related to gait, stance, sitting, speech, finger-chase test, nose-finger test, fast alternating movements and heel-shin test. Although the cerebellum is directly involved in the coordination of eye movements, oculomotor functions are not considered, as the validation trials indicated that they are determined by other factors than appendicular and midline ataxia. SARA underwent a rigorous validation procedure involving three large multi-center trials in SCA and non-SCA ataxia patients, as well as controls.

****Use:**** Assessment of cerebellar ataxia on an impairment level for patients with Ataxia. Depending on the disease stage, its administration takes 5–40 min (mean 14.2 min) and does not require special training or technical equipment (Schmitz-Hubsch et al. 2006). The eight measuring items were selected from a standard neurological examination for their specificity for ataxia and their qualities of standardizing testing and rating procedures. A maximum score of 40 reflects most severe ataxia. The items are the following: gait (score 0 to 8), stance (score 0 to 6), sitting (score 0 to 4), speech disturbance (score 0 to 6), finger chase (score 0 to 4), nose-finger test (score 0 to 4), fast alternating hand movements (score 0 to 4), and heelshin slide (score 0 to 4). Testing of limb function is rated independently for both sides. The arithmetic mean of both sides is considered for sum scores.

****Keywords:**** SARA, ataxia, assessment, scale

****Concepts:****

- at0000::SARA ataxia scale - Scale for the assessment and rating of ataxia.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::1. Gait - Assessment of gait.
- at0005::Normal - No difficulties in walking, turning and walking tandem (up to one misstep allowed).
- at0006::Slight difficulties - Slight difficulties which are only visible when walking 10 consecutive steps in tandem.
- at0007::Clearly abnormal - Clearly abnormal, tandem walking more than 10 steps not possible.
- at0008::Considerable staggering - Considerable staggering, difficulties in half-turn, but without support.
- at0009::Marked staggering - Marked staggering, intermittent support of wall required.
- at0010::Severe staggering - Severe staggering, permanent support of one stick or light support by one arm required.
- at0011::Walking more than 10m with strong support - Walking more than 10m with strong support only (two special sticks or stroller or accompanying person).
- at0012::Walking less than 10m with strong support - Walking less than 10m with strong support only (two special sticks or stroller or accompanying person).
- at0013::Unable to walk - Unable to walk, even supported.
- at0014::2. Stance - Assessment of stance.
- at0015::Normal - Normal, able to stand in tandem for more than 10 seconds.
- at0016::Feet together without sway - Able to stand with feet together without sway, but not in tandem for > 10s.
- at0017::Feet together for more than 10 seconds - Able to stand with feet together for more than 10 seconds, but only

with sway.

- at0018::Natural position more than 10 seconds without support - Able to stand for more than 10 seconds without support in natural position, but not with feet together.
- at0019::Natural position more than 10 seconds with intermittent support - Able to stand for more than 10 seconds in natural position only with intermittent support.
- at0020::Natural position more than 10 seconds with constant support - Able to stand more than 10 seconds in natural position only with constant support of one arm.
- at0021::Unable to stand more than 10 seconds - Unable to stand for more than 10 seconds even with constant support of one arm.
- at0022::3. Sitting - Assessment of sitting.
- at0023::Normal - Normal, no difficulty sitting more than 10 seconds.
- at0024::Slight difficulties - Slight difficulties, intermittent sway.
- at0025::Constant sway - Constant sway, but able to sit more than 10 seconds without support.
- at0026::Sit more than 10 seconds with intermittent support - Able to sit for more than 10 seconds only with intermittent support.
- at0027::Unable to sit more than 10 seconds - Unable to sit for more than 10 seconds without continuous support.
- at0028::4. Speech disturbance - Assessment of speech.
- at0029::Normal - Assessment indicates that speech is normal.
- at0030::Suggestion of speech disturbance - Assessment indicates that there may be a speech disturbance.
- at0031::Impaired speech, but easy to understand - Assessment indicates that speech is impaired, but easy to understand.
- at0032::Occasional words difficult to understand - Assessment indicates that occasional words are difficult to understand.
- at0033::Many words difficult to understand - Assessment indicates that many words are difficult to understand.
- at0034::Only single words understandable - Assessment indicates that only single words are understandable.
- at0035::Speech unintelligible / anarthria - Assessment indicates that speech is unintelligible or the proband suffers from anarthria.
- at0036::5L. Finger chase left - Assessment of ability to follow movements with left index finger.

- at0037::No dysmetria - Finger chase assessment indicates that no dysmetria is present.
- at0038::Dysmetria, under/overshooting target <5cm - Finger chase assessment indicates that dysmetria with under/overshooting target by <5cm is present.
- at0039::Dysmetria, under/overshooting target <15cm - Finger chase assessment indicates that dysmetria with under/overshooting target by <15cm is present.
- at0040::Dysmetria, under/overshooting target >15cm - Finger chase assessment indicates that dysmetria with under/overshooting target by >15cm is present.
- at0041::Unable to perform 5 pointing movements - Finger chase assessment indicates that proband is unable to perform 5 pointing movements.
- at0047::5R. Finger chase right - Assessment of ability to follow movements with right index finger.
- at0048::No dysmetria - Finger chase assessment indicates that no dysmetria is present.
- at0049::Dysmetria, under/overshooting target <5cm - Finger chase assessment indicates that dysmetria with under/overshooting target by <5cm is present.
- at0050::Dysmetria, under/overshooting target <15cm - Finger chase assessment indicates that dysmetria with under/overshooting target by <15cm is present.
- at0051::Dysmetria, under/overshooting target >15cm - Finger chase assessment indicates that dysmetria with under/overshooting target by >15cm is present.
- at0052::Unable to perform 5 pointing movements - Finger chase assessment indicates that proband is unable to perform 5 pointing movements.
- at0054::5. Finger chase mean score - Mean score for both sides of finger chase assessment.
- at0055::6L. Nose-finger test left - Assessment of ability to point with left index finger from proband's nose to examiner's finger.
- at0056::No tremor - Nose-finger test indicates that no tremor is present.
- at0057::Tremor less than 2cm - Nose-finger test indicates tremor with an amplitude less than 2 cm.
- at0058::Tremor less than 5cm - Nose-finger test indicates tremor with an amplitude less than 5 cm.
- at0059::Tremor more than 5cm - Nose-finger test indicates tremor with an amplitude more than 5 cm.
- at0060::Unable to perform 5 pointing movements - Nose-finger test indicates that proband is unable to perform 5 pointing movements.
- at0062::6R. Nose-finger test right - Assessment of ability to point with right index finger from proband's nose to examiner's finger.
- at0063::No tremor - Nose-finger test indicates that no tremor is present.
- at0064::Tremor less than 2cm - Nose-finger test indicates tremor with an amplitude less than 2 cm.
- at0065::Tremor less than 5cm - Nose-finger test indicates tremor with an amplitude less than 5 cm.
- at0066::Tremor more than 5cm - Nose-finger test indicates tremor with an amplitude more than 5 cm.

- at0067::Unable to perform 5 pointing movements - Nose-finger test indicates that proband is unable to perform 5 pointing movements.
- at0069::6. Nose-finger test mean score - Mean score for both sides of nose-finger test.
- at0070::7L. Fast alternating hand movements left - Assessment of ability to perform fast alternating left hand movements.
- at0071::Normal - Fast alternating hand movement assessment indicates a normal performance with no irregularities, and the patient is able to perform in less than 10 seconds.
- at0072::Slightly irregular - Fast alternating hand movement assessment indicates slight irregularities, and the patient is able to perform in less than 10 seconds.
- at0073::Clearly irregular - Fast alternating hand movement assessment indicates a clear irregularity, and single movements are difficult to distinguish or relevant interruptions are observed, but the patient is able to perform in less than 10 seconds.
- at0074::Very irregular - Fast alternating hand movement assessment indicates a definite irregularity, and single movements are difficult to distinguish or relevant interruptions are observed, and the patient is only able to perform in more than 10 seconds.
- at0075::Unable to complete - Fast alternating hand movement assessment indicates that the patient is unable to complete 10 cycles of fast alternating hand movements.
- at0076::7R. Fast alternating hand movements right - Assessment of ability to perform fast alternating left hand movements.
- at0077::Normal - Fast alternating hand movement assessment indicates a normal performance with no irregularities, and the patient is able to perform in less than 10 seconds.
- at0078::Slightly irregular - Fast alternating hand movement assessment indicates slight irregularities, and the patient is able to perform in less than 10 seconds.
- at0079::Clearly irregular - Fast alternating hand movement assessment indicates a clear irregularity, and single movements are difficult to distinguish or relevant interruptions are observed, but the patient is able to perform in less than 10 seconds.
- at0080::Very irregular - Fast alternating hand movement assessment indicates a definite irregularity, and single movements are difficult to distinguish or relevant interruptions are observed, and the patient is only able to perform in more than 10 seconds.
- at0081::Unable to complete - Fast alternating hand movement assessment indicates that the patient is unable to complete 10 cycles of fast alternating hand movements.
- at0082::7. Fast alternating hand movements mean score - Mean score for both sides of the fast alternating hand movements test.
- at0083::8L. Heel-shin slide left - Assessment of ability to perform heel-shin slide with the left leg.
- at0084::Normal - Heel-shin slide assessment indicates normal performance.
- at0085::Slightly abnormal - Heel-shin slide assessment indicates slightly abnormal performance, but contact to shin is maintained.

- at0086::Clearly abnormal - Heel-shin slide assessment indicates clearly abnormal performance with the patient going off shin up to 3 times in 3 cycles.
- at0087::Severely abnormal - Heel-shin slide assessment indicates severely abnormal performance, with the patient going off shin 4 or more times during 3 cycles.
- at0088::Unable to perform task - Heel-shin slide assessment indicates that the patient is unable to perform the task.
- at0089::8R. Heel-shin slide right - Assessment of ability to perform heel-shin slide with the right leg.
- at0090::Normal - Heel-shin slide assessment indicates normal performance.
- at0091::Slightly abnormal - Heel-shin slide assessment indicates slightly abnormal performance, but contact to shin is maintained.
- at0092::Clearly abnormal - Heel-shin slide assessment indicates clearly abnormal performance with the patient going off shin up to 3 times in 3 cycles.
- at0093::Severely abnormal - Heel-shin slide assessment indicates severely abnormal performance, with the patient going off shin 4 or more times during 3 cycles.
- at0094::Unable to perform task - Heel-shin slide assessment indicates that the patient is unable to perform the task.
- at0095::8. Heel-shin slide mean score - Mean score for heel-shin slide assessment on both sides.
- at0096::Total score - Total score obtained from the sum of the individual scores for 1. to 4. and the sum of the mean scores for 5. to 8.
- at0097::Tree - @ internal @
- at0098::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0099::Tree - @ internal @
- at0100::Confounding factors - Record any issues or factors that may impact on the use of the scale and the overall score.

scoff_questionnaire

****Archetype ID:**** openEHR-EHR-OBSERVATION.scoff_questionnaire.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, fi, en

****Purpose:**** A simple five question test devised for use by non-professionals to assess the possible presence of an eating disorder. The letters in the full acronym are taken from key words in the questions: - Sick - Control - One stone (14 lbs./6.5 kg.) - Fat - Food

****Use:**** One point is assigned for every "yes"; a score greater than two (≥ 2) indicates a possible case of anorexia nervosa or bulimia nervosa.

****Keywords:**** eating, disorder, screening

****Concepts:****

- at0000::Eating disorder screening (SCOFF) - Screening tool for eating disorders.
- at0001::History - *
- at0002::Any event - *
- at0003::ItemTree - @ internal @
- at0004::Do you make yourself sick because you feel uncomfortably full? - Do you make yourself sick because you feel uncomfortably full?
- at0005::No - *
- at0006::Yes - *
- at0007::Do you worry that you have lost control over how much you eat? - Do you worry that you have lost control over how much you eat?
- at0008::No - *
- at0009::Yes - *
- at0010::Have you recently lost more than one stone (14 lb, 6,5 kg) in a 3-month period?
- Have you recently lost more than one stone (14 lb, 6,5 kg) in a 3-month period?
- at0011::No - *
- at0012::Yes - *
- at0013::Do you believe yourself to be fat when others say you are too thin? - Do you believe yourself to be fat when others say you are too thin?
- at0014::No - *
- at0015::Yes - *
- at0016::Would you say that food dominates your life? - Would you say that food dominates your life?
- at0017::No - *
- at0018::Yes - *
- at0019::Total score - One point is assigned for every "yes"; a score greater than two (≥ 2) indicates a possible case of anorexia nervosa or bulimia nervosa.
- at0020::Comment - Additional narrative about the assessment of the SCOFF questionnaire, not captured in the structured elements.

[scorad_index](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.scorad_index.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record an estimate of severity of atopic dermatitis.

****Concepts:****

- at0000::SCORAD index - Clinical assessment tool used to assess the extent and severity of eczema (SCORing Atopic Dermatitis).
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Affected area total (A) - The estimated total of affected area on the body.
- at0005::Intensity - erythema - The level of intensity of a erythema or redness.
- at0006::None - Erythema is absent.
- at0007::Mild - Erythema is mild.
- at0008::Moderate - Erythema is moderate.
- at0009::Severe - Erythema is severe.
- at0039::SCORAD index - The calculated index score.
- at0040::Total intensity grade - The total score expressed as a set of grades.
- at0041::Mild - The overall score is less than 25.
- at0042::Moderate - The score is between 25 and 50.
- at0043::Severe - The toal score is over 50.
- at0010::Intensity - oedema/papulation - The level of intensity of a oedema or papulation.
- at0011::None - Oedema or papulation is absent.
- at0012::Mild - Oedema or papulation is mild.
- at0013::Moderate - Oedema or papulation is moderate.
- at0014::Severe - Oedema or papulation is severe.
- at0015::Intensity - lichenification - The level of intensity of a lichenification or thickening of the skin.
- at0016::None - Lichenification is absent.
- at0017::Mild - Lichenification is mild.
- at0018::Moderate - Lichenification is moderate.
- at0019::Severe - Lichenification is severe.
- at0030::Intensity - dryness - The level of intensity of dryness of unaffected skin.
- at0031::None - Dryness is absent.
- at0032::Mild - Dryness is mild.
- at0033::Moderate - Dryness is moderate.
- at0034::Severe - Dryness is severe.
- at0020::Intensity - excoriation - The level of intensity of a excoriation or scratching.

- at0021::None - Excoriation is absent.
- at0022::Mild - Excoriation is mild.
- at0023::Moderate - Excoriation is moderate.
- at0024::Severe - Excoriation is severe.
- at0025::Intensity - oozing/crusts - The level of intensity of a oozing or crusting.
- at0026::None - Oozing or crusting is absent.
- at0027::Mild - Oozing or crusting is mild.
- at0028::Moderate - Oozing or crusting is moderate.
- at0029::Severe - Oozing or crusting is severe.
- at0035::Intensity total (B) - The total score for the 6 intensity-related values.
- at0036::Subjective - daily pruritis - Subjective assessment of the amount of itchiness experienced.
- at0038::Subjective total (C) - Total of the subjective scores.
- at0037::Subjective - sleeplessness - Subjective assessment of the amount of sleeplessness experienced.
- at0044::Objective SCORAD index - The calculated index score based on the affected area total and intensity only.
- at0045::Item tree - @ internal @
- at0046::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[self_test_result-pregnancy](#)

Archetype ID: openEHR-EHR-OBSERVATION.self_test_result-pregnancy.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en

Purpose: To record the result of a diagnostic test performed on a specimen in a non-laboratory environment, including a self-test by the individual.

Use: To record the result of a simple diagnostic test performed on a specimen within a non-laboratory or non-clinical (POCT) environment, usually by an individual or their carer. Use cases include, but are not limited to: - a urine pregnancy test; - home blood glucose monitoring; or - weekly INR self-testing.

Misuse: Not to be used to record the result of a test carried out in a laboratory or point of care test (POCT) setting - use the OBSERVATION.laboratory_test_result archetype for this purpose.

****Keywords:**** home, results

****Concepts:****

- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tree - @ internal @
- at0005::Test name - Name of the test carried out on investigation performed on the specimen(s).
- at0101::Comment - Additional narrative about the test result not captured in other fields.
- at0117::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0118::Multimedia representation - Digital image, video or diagram representing the test result.
- at0121::Method - Description about the method used to carry out the test.
- at0123::Result - None
- at0124::Negative - The test result is negative.
- at0127::Positive - The test result is positive.
- at0128::Indeterminate - It is not possible to tell if the test is positive or negative.
- at0130::Fasting - None
- at0132::Item tree - @ internal @
- at0133::Specimen - Simple description about the specimen tested.
- at0134::Device - Description of the device used for carrying out the test.
- at0000.1::Pregnancy test result - The result of a diagnostic test performed on a specimen in a non-laboratory environment.
- at0005.1::Test name - Name of the test carried out on investigation performed on the specimen(s).
- at0.1::Urine pregnancy test - Home pregnancy test carried out on urine.

self_test_result

****Archetype ID:**** openEHR-EHR-OBSERVATION.self_test_result.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the result of a diagnostic test performed on a specimen in a non-laboratory environment, including a self-test by the individual.

****Use:**** To record the result of a simple diagnostic test performed on a specimen within a non-laboratory or non-clinical (POCT) environment, usually by an individual or their carer. Use cases include, but are not limited to: - a urine pregnancy test; - home blood glucose monitoring; or - weekly INR self-testing.

****Misuse:**** Not to be used to record the result of a test carried out in a laboratory or point of care test (POCT) setting - use the OBSERVATION.laboratory_test_result archetype for this purpose.

****Keywords:**** home, results

****Concepts:****

- at0000::Self-test result - The result of a diagnostic test performed on a specimen in a non-laboratory environment.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tree - @ internal @
- at0005::Test name - Name of the test carried out on investigation performed on the specimen(s).
- at0101::Comment - Additional narrative about the test result not captured in other fields.
- at0117::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0118::Multimedia representation - Digital image, video or diagram representing the test result.
- at0121::Method - Description about the method used to carry out the test.
- at0123::Result - None
- at0124::Negative - The test result is negative.
- at0127::Positive - The test result is positive.
- at0128::Indeterminate - It is not possible to tell if the test is positive or negative.
- at0130::Fasting - None
- at0132::Item tree - @ internal @
- at0133::Specimen - Simple description about the specimen tested.
- at0134::Device - Description of the device used for carrying out the test.

sexual_health_screening

****Archetype ID:**** openEHR-EHR-OBSERVATION.sexual_health_screening.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the responses to a questionnaire about sexual health behaviour, especially screening for potentially at-risk behaviours.

****Use:**** Use to record the responses to a questionnaire about sexual health behaviour, especially screening for potentially at-risk behaviours. Common use cases include, but are not limited to: - Systematic questioning in any consultation; or - Specific questioning related to infectious disease surveillance. In order to record the response at a specific point in time or within an interval of time, use the EVENT RM attribute. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening process identifies a health risk or condition and it is intended that the details are to be recorded and persisted as part of an ongoing health record, any further specific details about the exposure should be recorded using appropriate EVALUATION archetypes.

****Misuse:**** Not to be used to record details about a specific problem condition identified as part of the questionnaire screening. Use EVALUATION.problem_diagnosis for this purpose. Not to be used to record persistent details about a risk assessment for a specific health condition, such as HIV. Use EVALUATION.health_risk for this purpose.

****Keywords:**** sex, sexual, risk, STD, STI

****Concepts:****

- at0000::Sexual health screening questionnaire - An individual- or self-reported questionnaire screening about sexual health behaviour, especially screening for potentially at-risk behaviours.
- at0001::History - @ internal @
- at0002::Any event - None
- at0003::Tree - @ internal @
- at0004::Sexually active? - Is the individual sexually active?
- at0005::Yes - None
- at0006::No - None
- at0007::Sexual contacts - The gender of sexual partners or contacts.
- at0008::Male only - None
- at0009::Female only - None
- at0011::Item tree - @ internal @

- at0012::Extension - None
- at0010::Both men and women - None
- at0013::Lifetime sex partners - The total number of sexual partners.

simplified_tanner_whitehouse_3

****Archetype ID:**** openEHR-EHR-OBSERVATION.simplified_tanner_whitehouse_3.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the simplified Tanner-Whitehouse III skeletal maturity assessment.

****Use:**** Use to record the simplified Tanner-Whitehouse III skeletal maturity assessment.

****Keywords:**** sanders, maturity, scoliosis, skeletal, age, bone

****Concepts:****

- at0000::Simplified Tanner-Whitehouse III assessment - A classification for the skeletal maturity stage in children, based on radiological assessment of the hand and wrist.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Stage - Assessed skeletal maturity.
- at0005::Juvenile slow - Digital epiphyses are not covered.
- at0006::Preadolescent slow - All digital epiphyses are covered.
- at0007::Adolescent rapid-early - The preponderance of digits are capped. The second through fifth metacarpal epiphyses are wider than their metaphyses.
- at0008::Adolescent rapid-late - Any of distal phalangeal physes are clearly beginning to close.
- at0009::Adolescent steady-early - All distal phalangeal physes are closed. Others are open.
- at0010::Adolescent steady-late - Middle or proximal phalangeal physes are closing.
- at0011::Early mature - Only distal radial physis is open. Metacarpal physeal scars may be present.
- at0012::Mature - Distal radial physis is completely closed.
- at0013::Item tree - @ internal @

- at0014::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

six_cit

Archetype ID: openEHR-EHR-OBSERVATION.six_cit.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: pt-br, en

Purpose: To record the results for each component parameter and their total sum for the 6CIT.

Use: Use to record the results for each component parameter and their total sum for the 6CIT. While openEHR archetypes are all freely available under an open license, the specific content of this 6CIT archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. The Kingshill Research Centre, Swindon, UK owns the copyright to The Kingshill Version 2000 of the 6CIT but allows free usage to healthcare professionals. Copyright information: <https://6cit.co.uk/>.

Keywords: 6CIT, cognitive, impairment, dementia

Concepts:

- at0000::6 Item Cognitive Impairment Test (6CIT) - An assessment score used to screen for dementia.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::What year is it? - None
- at0005::Correct - None
- at0006::Incorrect - None
- at0007::What month is it? - None
- at0008::Correct - None
- at0009::Incorrect - None
- at0010::About what time is it? - None
- at0011::Correct - None
- at0012::Incorrect - None

- at0013::Count backwards from 20 - None
- at0014::Correct - None
- at0015::1 error - None
- at0016::More than 1 error - None
- at0017::Say the months of the year in reverse - None
- at0018::Correct - None
- at0019::1 error - None
- at0020::More than 1 error - None
- at0021::Repeat address phrase - None
- at0022::Correct - None
- at0023::1 error - None
- at0024::2 errors - None
- at0025::3 errors - None
- at0026::4 errors - None
- at0027::All wrong - None
- at0028::Total score - The total sum of each component parameter for the 6CIT.
- at0031::Tree - @ internal @
- at0032::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[**skeletal_age**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.skeletal_age.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record an estimate of biological age by assessing the degree of maturation of an individual's bones.

****Use:**** Use to record an estimate of biological age by assessing the degree of maturation of an individual's bones. The skeletal age can be determined by several different methods including but not limited to: Hand-wrist radiograph, Cervical vertebrae radiograph, Frontal sinus radiograph, Midpalatine suture.

****Keywords:**** bone, skeleton

****Concepts:****

- at0000::Skeletal age - An estimate of biological age by assessing the degree of maturation of an individual's bones.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Skeletal age - An estimate of biological age by assessing the degree of maturation of an individual's bones.
- at0006::Comment - Additional narrative not covered in other fields.
- at0007::Tree - @ internal @
- at0009::Modality - The modality used to estimate the skeletal age.
- at0010::Radiograph - *
- at0011::MRI - *
- at0012::CT - *
- at0014::Body site - Simple bodysite where the assessment was performed.
- at0015::Structured body site - The structured bodysite where the assessment was performed.
- at0017::Hand and wrist - *
- at0018::Cervical vertebrae - *
- at0019::Frontal sinus - *
- at0020::Midpalatal suture - *
- at0021::Assesment method - The assessment method used to estimate the skeletal age.
- at0022::Ultrasound - *
- at0023::Teeth - *
- at0024::Clavicle - *
- at0025::Iliac bone - *
- at0026::Femoral head - *
- at0027::Tree - @ internal @
- at0028::Confounding factors - Narrative descripiton of any issues or factors that may impact on the assessment.
- at0029::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

[soas_r](#)

Archetype ID: openEHR-EHR-OBSERVATION.soas_r.v0

Lifecycle State: in_development

Category: OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the frequency, nature, and severity of aggressive incidents.

****Use:**** Use to record the frequency, nature, and severity of aggressive incidents. While openEHR archetypes are all freely available under an open license, the specific content of this Staff Observation Aggression Scale – Revised archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. Copyright statement: ©Henk Nijman, Tom Palmstierna1999 –Not to be copied without express written permission by one of the author or Frenzs B.V.

Copyright information: <https://www.frenzs.org/soas-r/>.

****Keywords:**** verbal, physical, attacking, violent, behaviour

****Concepts:****

- at0000::Staff Observation Aggression Scale - Revised (SOAS-R) - An instrument for monitoring the frequency, nature, and severity of aggressive incidents.
- at0001::History - @ internal @
- at0002::Any event - None
- at0003::Tree - @ internal @
- at0005::Incident number - A number that can be used as a reference. For example a reference number recorded in a incident reporting system.
- at0009::Provocation - None
- at0010::Target of aggression - None
- at0011::Means used by the patient - None
- at0012::Consequence(s) for victim(s) - None
- at0013::Measures to stop aggression - None
- at0014::No understandle provocation - None
- at0015::Provoked by - None
- at0016::Other patient(s) - None
- at0017::Help with ADL - None
- at0018::Patient being denied something - None
- at0019::Staff requiering patient to take medication - None
- at0020::Other provocations, namely - None
- at0021::Other named provocations - Related to the 'Other, provocations, namely:' option from the 'Provocation' element.
- at0022::Verbal aggression - None
- at0023::Ordinary objects - None
- at0024::Chari(s) - None
- at0025::Glass(ware) - None
- at0026::Other, namely - None
- at0027::Other named objects - Related to the 'Other, objects:' option from the 'Ordinary objects' element.

- at0028::Parts of the body - None
- at0029::Hand - Hitting, puncing etc.
- at0030::Foot - Kicking.
- at0031::Teeth - Biting.
- at0032::Other, namely - None
- at0033::Other - Related to the 'Other, namely:' option from the 'Parts of the body' element.
- at0034::Dangerous objects or methods - None
- at0035::Knife - None
- at0036::Strangulation - None
- at0037::Other, namely - None
- at0038::Other objects or methods - Related to the 'Other, namely:' option from the 'Dangerous objects or methods' element.
- at0039::Nothing/nobody - None
- at0040::Target - None
- at0041::Objetc(s) - None
- at0042::Other patient(s) - None
- at0043::Patient self - None
- at0044::Staff member(s) - None
- at0045::Other persons, namely - None
- at0046::Other persons - Related to the 'Other, persons:' option from the 'Target' element.
- at0047::No - None
- at0048::Objects - None
- at0049::Damaged, replacement not necessary - None
- at0050::Damaged, replacement necessary - None
- at0051::Persons - None
- at0052::Felt threatened - None
- at0053::Pain < 10 min - None
- at0054::Pain > 10 min - None
- at0055::Visible injury - None
- at0056::Need for treatment - None
- at0057::Need for treatment by a physician - None
- at0058::Other, namely - None
- at0059::Other, namely - Related to the 'Other, namely:' option from the 'Persons' element.
- at0060::None - None
- at0061::Measures - None
- at0062::Talk to patient - None
- at0063::Calmly brought away - None
- at0064::Peroral medication - None
- at0065::Parenteral medication - None

- at0066::Held with force - None
- at0067::Seclusion/isolation - Locked door.
- at0068::Mechanical restraints - None
- at0069::Other measures, namely - None
- at0070::Other measures - Related to the 'Other, measures:' option from the 'Measures' element.
- at0073::Item tree - @ internal @
- at0074::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

soas_re

****Archetype ID:**** openEHR-EHR-OBSERVATION.soas_re.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the frequency, nature, and severity of aggressive incidents.

****Use:**** Use to record the frequency, nature, and severity of aggressive incidents. While openEHR archetypes are all freely available under an open license, the specific content of this Staff Observation Aggression Scale – Revised – Emergency primary care archetype is copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners. Copyright statement: ©Henk Nijman, Tom Palmstierna1999 –Not to be copied without express written permission by one of the author or Frenzs B.V. Copyright information: <https://www.frenzs.org/soas-r/>.

****Keywords:**** verbal, physical, attacking, violent, behaviour

****Concepts:****

- at0000::The Staff Observation Aggression Scale – Revised Emergency (SOAS-RE) - An instrument for monitoring the frequency, nature, and severity of aggressive incidents.
- at0001::History - @ internal @
- at0002::Any event - None
- at0003::Tree - @ internal @
- at0004::Item tree - @ internal @
- at0007::Provocation of aggressive behaviour - None
- at0008::Means used by the aggressor - None

- at0010::Target of aggression - None
- at0011::Consequence(s) for victim(s) - None
- at0012::Measure(s) to stop aggression - None
- at0013::Persons involved in measure(s) to stop aggression - None
- at0014::Provoked by - None
- at0015::Person had to wait - None
- at0016::The person was denied something - None
- at0017::The person disagreed about assessment/advice - None
- at0018::Involuntary assessment of health condition - None
- at0019::Description - Description related to the 'Other, describe:' option from the 'Provoked by' element.
- at0020::No understandable provocation - None
- at0022::Ordinary objects - None
- at0023::Parts of the body - None
- at0026::Room contents/ objects. - None
- at0027::Hand - None
- at0028::Foot - None
- at0029::Other, describe - None
- at0030::Other, describe - None
- at0031::Dangerous objects or methods - None
- at0032::Attempt of strangulation. - None
- at0033::Used/had weapon. - None
- at0034::Used/had pointed weapon. - None
- at0035::Other dangerous objects incl. syringe. - None
- at0036::Target - None
- at0038::Furniture/objects - None
- at0039::Physician - None
- at0040::Nurse - None
- at0041::Ambulance personnel - None
- at0042::Security guard - None
- at0043::Police - None
- at0044::Other patients - None
- at0045::Other persons, describe - None
- at0046::None - None
- at0047::Objects - None
- at0048::Person - None
- at0049::Damaged - None
- at0050::Psychological/ emotional stress - None
- at0051::Felt threatened - None
- at0052::Pain - None
- at0053::Visible injury - None
- at0054::Need for treatment by a physician - None

- at0055::Needed to be taken off duty - None
- at0056::Other, describe: - None
- at0058::Descriptipon - Description related to the 'Other, describe:' option from the 'Parts of the body' element.
- at0059::Verbal aggression - None
- at0060::Threat - None
- at0061::None - None
- at0062::Description - Description related to the 'Other persons, describe:' option from the 'Target' element.
- at0063::Description - Description related to the 'Other, describe:' option from the 'Person' element.
- at0064::None - None
- at0065::Measure(s) - None
- at0066::Talked to person - None
- at0067::Took the person aside - None
- at0068::Withdrew from situation /ended cal - None
- at0069::Complied with the person's wish - None
- at0070::Asked the person to leave the site - None
- at0071::Forced the person to leave - None
- at0072::Held the person by force - None
- at0073::Medication - None
- at0074::Other, describe: - None
- at0075::Description - Description related to the 'Other, describe:' option from the 'Measure(s)' element.
- at0076::Persons involved - None
- at0077::Physician - None
- at0078::Nurse - None
- at0079::Ambulance personnel - None
- at0080::Security guard - None
- at0081::Police - None
- at0082::Other patients - None
- at0083::Next-of-kin - None
- at0084::Others, describe - None
- at0085::Description - Description related to the 'Other, describe:' option from the 'Persons involved' element.
- at0086::Visual Analogue Scale (VAS) - An evaluation scale.
- at0087::Not severe at all - None
- at0089::1 - None
- at0090::2 - None
- at0091::3 - None
- at0092::4 - None
- at0093::5 - None

- at0094::6 - None
- at0095::7 - None
- at0096::8 - None
- at0097::9 - None
- at0098::Extremely severe - None
- at0099::Where was the incident? - None
- at0100::At the clinic - None
- at0101::Over the phone - None
- at0102::At home visit - None
- at0103::Other - None
- at0104::Other place of incident - Related to the 'Other' option from the 'Where was the incident' element.
- at0106::Staff member exposed to incident - None
- at0107::Occupation - None
- at0108::Sex - None
- at0109::Female - None
- at0110::Male - None
- at0111::Were you alone in the situation? - None
- at0112::Yes - None
- at0113::No - None
- at0114::Aggressor - None
- at0115::Who - None
- at0116::Patient - None
- at0117::Next-of-kin - None
- at0118::Other - None
- at0119::Sex - None
- at0120::Female - None
- at0121::Male - None
- at0122::Does the aggressor have a known mental illness? - None
- at0123::Was the aggressor under influence of drugs or alcohol? - None
- at0124::Yes - None
- at0125::No - None
- at0126::Unknown - None
- at0127::Yes - None
- at0128::No - None
- at0129::Unknown - None
- at0130::Age - None
- at0132::When was the incident? - Date (dd/mm 20yy), Time
- at0133::Other aggressor - Related to the 'Other' option from the 'Who' element.
- at0134::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

social_context_screening

****Archetype ID:**** openEHR-EHR-OBSERVATION.social_context_screening.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** fi, nb, en, it

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about the social context.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about the social context. Common use cases include, but are not limited to: - Systematic enquiry in any consultation, for example: --- Are you homeless? Yes, No, Unknown --- Do you feel socially isolated? --- Do you feel safe at home/school/work? --- Do you think you are a problem gambler? --- Are any individuals dependent on you? --- Do you need an interpreter when you visit the clinic? The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to a point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about a social context issue that has been present at any time in the past and information about a social context issue within a specified time interval - for example, the difference between "Are you safe at home now?" compared to "Have you experienced any domestic violence in the past 4 weeks?" The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening process identifies a social context circumstance, issue or concern and it is intended that the details are to be recorded and persisted as part of an ongoing health record, any further specific details about the social context should be recorded using archetypes specific for the clinical purpose.

****Misuse:**** Not to be used to record persistent details about social context-related concepts. Use existing archetypes for this purpose - for example EVALUATION.housing, EVALUATION.education, EVALUATION.occupation, EVALUATION.social_network and other

archetypes within the Social context project -
<https://ckm.openehr.org/ckm/projects/1013.30.39>.

Keywords: homelessness, housing, gambling, employment, safety, domestic, violence, dependent, guardian, situation, circumstances, abuse, education, insecurity, inclusion, exclusion, transportation, equity, hardship, unemployment, stress, connection, literacy, wellness, social, sociological, socioeconomic, poverty, hunger, refugee, immigrant, minority

Concepts:

- at0000::Social context screening questionnaire - Series of questions and associated answers used to screen about the social environment and social situation which may impact the health and well-being of the individual, especially to identify potential issues or risks.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Context - Identification of a specific social circumstance, issue or concern relevant for the questionnaire or grouping of such, by name.
- at0005::Presence? - Has there been experience of the specified 'Context'?
- at0007::Item tree - @ internal @
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0022::Specific social context - Details about a specified social context or issue, or a grouping of these, relevant for the screening purpose.
- at0023::Yes - None
- at0024::No - None
- at0025::Comment - Additional narrative about the specific social context, not captured in other fields.
- at0026::Additional details - Additional details or questions about the specific social context.
- at0027::Unknown - None
- at0034::Screening purpose - The context or reason for screening.
- at0044::Additional details - Additional structured details or questions about screening for social context items.
- at0048::Homeless - The individual does not have a stable place to live.
- at0049::Interpreter needed - The individual needs assistance with language translation.
- at0050::Unsure - None

[social_context_screening_hl](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.social_context_screening_hl.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** fi, nb, en, it

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about the social context.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about the social context. Common use cases include, but are not limited to: - Systematic enquiry in any consultation, for example: --- Are you homeless? Yes, No, Unknown --- Do you feel socially isolated? --- Do you feel safe at home/school/work? --- Do you think you are a problem gambler? --- Are any individuals dependent on you? --- Do you need an interpreter when you visit the clinic? The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to a point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about a social context issue that has been present at any time in the past and information about a social context issue within a specified time interval - for example, the difference between "Are you safe at home now?" compared to "Have you experienced any domestic violence in the past 4 weeks?" The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening process identifies a social context circumstance, issue or concern and it is intended that the details are to be recorded and persisted as part of an ongoing health record, any further specific details about the social context should be recorded using archetypes specific for the clinical purpose.

****Misuse:**** Not to be used to record persistent details about social context-related concepts. Use existing archetypes for this purpose - for example EVALUATION.housing, EVALUATION.education, EVALUATION.occupation, EVALUATION.social_network and other archetypes within the Social context project -

<https://ckm.openehr.org/ckm/projects/1013.30.39>.

****Keywords:**** homelessness, housing, gambling, employment, safety, domestic, violence, dependent, guardian, situation, circumstances, abuse, education, insecurity, inclusion, exclusion, transportation, equity, hardship, unemployment, stress, connection, literacy, wellness, social, sociological, socioeconomic, poverty, hunger, refugee, immigrant, minority

****Concepts:****

- at0000::Social context screening questionnaire JM - Series of questions and associated answers used to screen about the social environment and social situation which may impact the health and well-being of the individual, especially to identify potential issues or risks.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Context - Identification of a specific social circumstance, issue or concern relevant for the questionnaire or grouping of such, by name.
- at0005::Presence? - Has there been experience of the specified 'Context'?
- at0007::Item tree - @ internal @
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0022::Specific social context - Details about a specified social context or issue, or a grouping of these, relevant for the screening purpose.
- at0023::Yes - None
- at0024::No - None
- at0025::Comment - Additional narrative about the specific social context, not captured in other fields.
- at0026::Additional details - Additional details or questions about the specific social context.
- at0027::Unknown - None
- at0034::Screening purpose - The context or reason for screening.
- at0044::Additional details - Additional structured details or questions about screening for social context items.
- at0048::Homeless - The individual does not have a stable place to live.
- at0049::Interpreter needed - The individual needs assistance with language translation.
- at0050::Living biological children - The number of living biological children of a woman.
- at0051::Children under 5 - The number of children under five years of age in the individual's household.

sofa_score

****Archetype ID:**** openEHR-EHR-OBSERVATION.sofa_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To record the results for each component parameter and their total sum for the SOFA score.

****Use:**** Use to record the results for each component parameter and their total sum for the SOFA score. SOFA score is usually used in intensive care units and in acute settings, but can be used in all patients where organ dysfunction is suspected or identified, for example in sepsis patients. SOFA score is used in adults over the age of 16.

****Misuse:**** Not to be used to record actual measurements for each component. Use specific OBSERVATION archetypes for this purpose: - OBSERVATION.pf_ratio; - OBSERVATION.blood_pressure; - OBSERVATION.glasgow_coma_scale; and - OBSERVATION.laboratory_test. Not to be used to record SOFA score in children younger than 16 years of age. Not to be used to record qSOFA (quick SOFA). Use the archetype OBSERVATION.qsofa_score for this purpose.

****Keywords:**** sepsis, organ failure, organ dysfunction, septic shock, infection

****Concepts:****

- at0000::SOFA score - A scoring system to grade and follow the development of organ dysfunction in six vital organ systems. Previously known as "Sepsis related Organ Failure Assessment".
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Respiration - The ratio between the partial pressure of oxygen (PaO_2) and the fraction of inspired oxygen (FiO_2) is an indicator for a possible dysfunction of the respiratory system.
- at0005:: $\text{PaO}_2/\text{FiO}_2 \geq 400 \text{ mmHg}$ - The partial pressure of oxygen in arterial or capillary blood measured in mmHg, divided by the fraction of inspired oxygen is greater than or equal to 400 mmHg. Equivalent to $\text{PaO}_2/\text{FiO}_2 \geq 53.3 \text{ kPa}$.
- at0006:: $\text{PaO}_2/\text{FiO}_2 300-399 \text{ mmHg}$ - The partial pressure of oxygen in arterial or capillary blood measured in mmHg, divided by the fraction of inspired oxygen is between 300 and 399 mmHg. Equivalent to $\text{PaO}_2/\text{FiO}_2 40.0 - 53.2 \text{ kPa}$.

- at0007::PaO₂/FiO₂ < 300 mmHg - The partial pressure of oxygen in arterial or capillary blood measured in mmHg, divided by the fraction of inspired oxygen is lower than 300 mmHg. Equivalent to PaO₂/FiO₂ 40 kPa.
- at0008::Mechanically ventilated and PaO₂/FiO₂ 100-199 mmHg - On mechanical ventilation, the partial pressure of oxygen in arterial or capillary blood measured in mmHg, divided by the fraction of inspired oxygen is between 100 and 199 mmHg. Equivalent to PaO₂/FiO₂ 13.3 - 26.5 kPa.
- at0009::Mechanically ventilated and PaO₂/FiO₂ < 100 mmHg - On mechanical ventilation, the partial pressure of oxygen in arterial or capillary blood measured in mmHg, divided by the fraction of inspired oxygen is less than 100 mmHg. Equivalent to PaO₂/FiO₂ < 13.3 kPa.
- at0010::Cardiovascular system - The mean arterial pressure (MAP), or the need for vasopressors (VP), (dopamine (DA), adrenaline (A), noradrenaline (NA) or dobutamine) are indicators for a possible dysfunction of the cardiovascular system.
- at0011::MAP ≥ 70 mmHg - The mean arterial pressure (MAP) is greater than or equal to 70 mmHg.
- at0012::MAP < 70 mmHg - The mean arterial pressure (MAP) is less than 70 mmHg.
- at0013::DA ≤ 5; Dobutamine - The dopamine (DA) dosage is less than 5 µg/kg/minute, or any dosage of dobutamine.
- at0014::DA > 5; NA/A ≤ 0.1 - The dosage of dopamine (DA) is greater than 5 µg/kg/minute, or the dosage of noradrenaline (NA) is less than or equal to 0.1 µg/kg/minute, or the dosage of adrenaline (A) is less than or equal to 0.1 µg/kg/minutt.
- at0015::NA/A > 0.1 - The dosage of noradrenaline (N) or adrenaline (A) is greater than 0.1 µg/kg/minute.
- at0016::Central nervous system - The Glasgow Coma Scale (GCS) is an indicator for a possible dysfunction of the central nervous system.
- at0017::GCS 15 - Glasgow Coma Scale is 15.
- at0018::GCS 13 - 14 - Glasgow Coma Scale is 13 or 14.
- at0019::GCS 10 - 12 - Glasgow Coma Scale is 10, 11 or 12.
- at0020::GCS 6 - 9 - Glasgow Coma Scale is 6, 7, 8 or 9.
- at0021::GCS < 6 - Glasgow Coma Scale is less than 6.
- at0022::Renal function - Creatinine concentration and 24 h urine output (UOP) are indicators for a possible dysfunction of the central nervous system.
- at0023::Creatinine < 1.2 mg/dL - The creatinine concentration is less than 1.2 mg/dL. Equivalent to creatinine < 110 µmol/L.
- at0024::Creatinine 1.2-1.9 mg/dL - The creatinine concentration is between 1.2 and 1.9 mg/dL. Equivalent to creatinine 110 - 170 µmol/L.
- at0025::Creatinine 2.0-3.4 mg/dL - The creatinine concentration is between 2.0 and 3.4 mg/dL. Equivalent to creatinine 171 - 299 µmol/L.
- at0026::Creatinine 3.5-4.9 mg/dL or UOP < 500 mL/24h - The creatinine concentration is between 3.5 and 4.9 mg/dL, or the urine output is between 500 and 200 mL/24h. Equivalent to creatinine 300 - 440 µmol/L or UOP < 500 mL/24h.

- at0027::Creatinine \geq 5.0 mg/dL or UOP < 200 mL/24h - The creatinine concentration is greater than or equal to 5.0 mg/dL, or the urine output is less than 200 mL/24h.
Equivalent to creatinine > 440 $\mu\text{mol}/\text{L}$ or UOP < 200 mL/24h.
- at0028::Liver function - Bilirubin concentration is an indicator for a possible dysfunction of the central nervous system.
- at0029::Bilirubin < 1.2 mg/dL - The bilirubin concentration is less than 1.2 mg/dL.
Equivalent to bilirubin < 20 $\mu\text{mol}/\text{L}$.
- at0030::Bilirubin 1.2-1.9 mg/dL - The bilirubin concentration is between 1.2 and 1.9 mg/dL. Equivalent to bilirubin 20-32 $\mu\text{mol}/\text{L}$.
- at0031::Bilirubin 2.0-5.9 mg/dL - The bilirubin concentration is between 2.0 and 5.9 mg/dL. Equivalent to bilirubin 33-101 $\mu\text{mol}/\text{L}$.
- at0032::Bilirubin 6.0-11.9 mg/dL - The bilirubin concentration is between 6.0 and 11.9 mg/dL. Equivalent to bilirubin 102-204 $\mu\text{mol}/\text{L}$.
- at0033::Bilirubin \geq 12.0 mg/dL - The bilirubin concentration is greater than or equal to 12.0 mg/dL. Equivalent to bilirubin > 204 $\mu\text{mol}/\text{L}$.
- at0034::Blood clotting - Platelets concentration is an indicator for a possible dysfunction of the blood clotting system.
- at0035::Platelets \geq 150 ($\times 10^3/\mu\text{L}$) - The platelet concentration is greater than or equal to 150,000 $/\mu\text{L}$.
- at0036::Platelets < 150 ($\times 10^3/\mu\text{L}$) - The platelet concentration is between 150,000 and 100,000 $/\mu\text{L}$.
- at0037::Platelets < 100 ($\times 10^3/\mu\text{L}$) - The platelet concentration is between 100,000 and 50,000 $/\mu\text{L}$.
- at0038::Platelets < 50 ($\times 10^3/\mu\text{L}$) - The platelet concentration is between 50,000 and 20,000 $/\mu\text{L}$.
- at0039::Platelets < 20 ($\times 10^3/\mu\text{L}$) - The platelet concentration is less than 20,000 $/\mu\text{L}$.
- at0041::Total score - The total sum of each component parameter for the SOFA score.
- at0043::Item tree - @ internal @
- at0044::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

speech

Archetype ID: openEHR-EHR-OBSERVATION.speech.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en, ar-sy

****Purpose:**** To record observations of a patient's speech

****Keywords:**** speech

****Concepts:****

- at0000::Speech - To record observations of a patient's speech pattern or quality
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0004::Clarity of speech - *
- at0005::Incomprehensible - *
- at0006::Unclear to parents - *
- at0007::Unclear to strangers - *
- at0008::Clear - *

spirometry_result

****Archetype ID:**** openEHR-EHR-OBSERVATION.spirometry_result.v2

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, fi, nb, sl, en

****Purpose:**** To record the results of a pulmonary function test performed using a spirometer or peak flow meter.

****Use:**** Use to record the results of a pulmonary function test performed using a spirometer or peak flow meter. This archetype is intended to be used to record the results from: - electronic or mechanical measurement devices. Use the 'Type of measurement' element in Protocol to record how the result was measured; - oral, nasal or tracheostomy tests. Use the 'Method' element in Protocol to record the type of breathing equipment used to perform the test. For example: mouth piece or face mask. Measurements with different 'Method' will have to be recorded using separate instances of the archetype. - inspiratory and expiratory tests. The name of each test will indicate whether the test records an inspiratory or expiratory result. If the spirometry test is performed in association with the administration of bronchodilators or challenge substances, this can be recorded using the 'Challenge/reversibility' element. Details of what was administered should be recorded using an instance of the ACTION.medication archetype committed within the same COMPOSITION. If additional information about body temperature, ambient pressure or humidity is required, this can be recorded using additional archetypes. Body temperature

can be recorded using an instance of the OBSERVATION.body_temperature archetype committed within the same COMPOSITION. Ambient pressure or humidity can be recorded using the CLUSTER.environmental_conditions in the 'Enviromental conditions' slot. The 'Any event' can be cloned and constrained to support the representation of: - Multiple measurements and their average - clone the 'Any event' as many times as needed, plus an additional event set to 'Interval' and selecting the 'Mean' attribute; - Pre- and post bronchial challenge or bronchodilator results - clone the 'Any event' and rename as 'Baseline' and 'Post challenge/bronchodilator', associated with a time offset if required.

****Misuse:**** Not to be used to record the results of other types of lung function tests, for example body plethysmography or lung diffusion tests. Use specific archetypes for these purposes. Not to be used to record details about incentive spirometry. Use specific archetypes for these purposes. Not to be used to record the results of blood gas tests. Use the OBSERVATION.laboratory_test_result for this purpose. Not to be used to record measurements about pulse oximetry. Use the OBSERVATION.pulse_oximetry for this purpose.

****Keywords:**** respiratory, pulmonary, spirometry, peak flow, lung, bronchial, airway, pef, pefr

****Concepts:****

- at0000::Spirometry result - Pulmonary function test results using a spirometer or peak flow meter.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0008::Predicted result - Predicted flow rate.
- at0013::Forced expiratory time (FET) - The time taken to complete a forced expiration.
- at0018::Predicted result - Predicted ratio.
- at0029::Tree - @ internal @
- at0030::Device - Details of the device used to measure spirometry.
- at0031::Tree - @ internal @
- at0044::Measured/predicted ratio - The ratio of the measured to predicted test results.
- at0052::Volume - Test result represented as a measured volume or calculated capacity.
- at0053::Result - Measured volume.
- at0054::Predicted result - Predicted volume.
- at0055::Ratio - A calculated test result expressed as a ratio.
- at0056::Result - Calculated ratio.
- at0057::Flow rate - Test result represented as a measured flow rate.
- at0058::Result - Measured flow rate.

- at0064::SVC - Slow vital capacity (SVC) is the maximal volume of air that can be slowly exhaled from a position of full inspiration. Also known as Expiratory vital capacity (EVC). Equal to IRV + TV + ERV.
- at0065::FVC - Forced vital capacity (FVC) is the maximal volume of air that can be forcibly exhaled from a position of full inspiration.
- at0067::FEV1 - Forced expiratory volume at 1 second (FEV1) is the volume of air that has been exhaled during the first second of forced exhalation, during the performance of FVC.
- at0068::FEV3 - Forced expiratory volume at 3 seconds (FEV3) is the volume of air that has been exhaled during the first three seconds of forced exhalation, during the performance of FVC.
- at0069::FEV6 - Forced expiratory volume at 6 seconds (FEV6) is the volume of air that has been exhaled during the first six seconds of forced exhalation, during the performance of FVC.
- at0070::FEV0.75 - Forced expiratory volume at 0.75 seconds (FEV0.75) is the volume of air that has been exhaled during the first three quarters of a second of forced exhalation, during the performance of FVC.
- at0072::FEF25-75% - Forced expiratory flow 25-75 % (FEF25-75%) is the mean forced expiratory flow of air measured during the expiration of 25-75 % of the volume of the forced vital capacity (FVC).
- at0073::FEF25-50% - Forced expiratory flow 25-50 % (FEF25-50%) is the mean forced expiratory flow of air measured during the expiration of 25-50 % of the volume of the forced vital capacity (FVC).
- at0074::FIF25-75% - Forced inspiratory flow 25-75 % (FIF25-75%) is the mean forced inspiratory flow of air measured during the inspiration of 25-75 % of the volume of the forced inspiratory vital capacity (FIVC).
- at0075::FIF25-50% - Forced inspiratory flow 25-50 % (FIF25-50%) is the mean forced inspiratory flow of air measured during the inspiration of 25-50 % of the volume of the forced inspiratory vital capacity (FIVC).
- at0076::IC - Inspiratory capacity (IC) is the maximal volume of air that can be inhaled after exhalation of normal tidal volume. Equal to TV + IRV.
- at0077::ERV - Expiratory reserve volume (ERV) is the maximal volume of air that can be forcibly exhaled after exhalation of normal tidal volume.
- at0078::IRV - Inspiratory reserve volume (IRV) is the maximal volume of air that can be forcibly inhaled after a inhalation of normal tidal volume.
- at0080::FEV1/SVC ratio - The ratio of 'Forced expiratory volume in 1 second (FEV1)' to 'Slow vital capacity (SVC)'.
- at0081::FEV1/FVC ratio - The ratio of 'Forced expiratory volume in 1 second (FEV1)' to 'Forced vital capacity (FVC)'. Also known as FEV1%FVC or FEV1%F.
- at0082::TV - Tidal volume (TV) is the normal volume of air that can be inhaled or exhaled during one respiratory cycle when no extra effort is applied. Also known as VT.
- at0098::Confounding factors - Record any issues or factors that may impact on the spirometry test.

- at0101::Comment - Additional narrative about the test results and interpretation not captured in other fields.
- at0115::Position - The body position of the individual at the time of measurement.
- at0116::Standing - Standing at the time of measurement.
- at0117::Sitting - Sitting (for example on a bed or chair) at the time of measurement.
- at0118::Reclining - Reclining at the time of measurement.
- at0119::Lying - Lying flat at the time of measurement.
- at0122::Measured/predicted ratio - The ratio of measured to predicted test results.
- at0130::Clinical interpretation - Overall clinical interpretation about all of the measurements and calculated ratios.
- at0131::Multimedia representation - Digital representation of the test results.
- at0132::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0145::FEV0.5 - Forced expiratory volume at 0.5 seconds (FEV0.5) is the volume of air that has been exhaled during the first half second of forced exhalation, during the performance of FVC.
- at0146::FEV2 - Forced expiratory volume at 2 seconds (FEV2) is the volume of air that has been exhaled during the first two seconds of forced exhalation, during the performance of FVC.
- at0152::PEFR - Peak expiratory flow rate (PEFR) is the peak flow rate during a forced vital capacity (FVC) maneuver. Also known as forced expiratory flow at maximum effort (FEFmax).
- at0156::Pressure - Test result represented as a measured pressure.
- at0165::Result - Measured pressure.
- at0166::Predicted result - Predicted pressure.
- at0167::Measured/predicted ratio - The ratio of measured to predicted test results.
- at0170::MEP - Maximal expiratory pressure (MEP) is the maximal expiratory pressure during a forced vital capacity (FVC) maneuver.
- at0171::FIV1 - Forced inspiratory volume at 1 second (FIV1) is the volume of air that has been inhaled during the first second of forced inhalation, during the performance of FIVC.
- at0172::FIVC - Forced inspiratory vital capacity (FIVC) is the maximal volume of air that can be forcibly inhaled from a position of full expiration.
- at0174::IVC - Inspiratory vital capacity (IVC) is the maximal volume of air that can be slowly inhaled from a position of full expiration. Equal to ERV + TV + IRV.
- at0176::MVV - Maximum voluntary ventilation (MVV) is the maximum volume of air the individual can breathe during a period of time specified by an interval event.
- at0177::FEF25% - Forced expiratory flow 25 % (FEF25%) is the maximal instantaneous expiratory flow when 25 % of the volume of the forced vital capacity (FVC) has been expired. Also known as maximal voluntary flow 75% (MEF75%).

- at0178::FEF50% - Forced expiratory flow 50 % (FEF50%) is the maximal instantaneous expiratory flow when 50 % of the volume of the forced vital capacity (FVC) has been expired. Also known as maximal voluntary flow 50 % (MEF50%).
- at0179::FEF75% - Forced expiratory flow 75 % (FEF75%) is the maximal instantaneous expiratory flow when 75 % of the volume of the forced vital capacity (FVC) has been expired. Also known as maximal voluntary flow 25 % (MEF25%).
- at0181::MIP - Maximal inspiratory pressure (MIP) is the maximal inspiratory pressure during a forced inspiratory vital capacity (FIVC) maneuver.
- at0182::SNIP - Sniff nasal inspiratory pressure (SNIP) is the maximal inspiratory pressure in one occluded nostril during a maximal sniff performed from relaxed end-expiration through the other patent nostril.
- at0185::Predicted results source - The knowledge base used for the predicted results.
- at0186::FIF25% - Forced inspiratory flow 25 % (FIF25%) is the maximal instantaneous inspiratory flow when 25 % of the volume of the forced inspiratory vital capacity (FIVC) has been inspired. Also known as maximum inspiratory flow 75% (MIF75%).
- at0187::FIF50% - Forced inspiratory flow 50 % (FIF50%) is the maximal instantaneous inspiratory flow when 50 % of the volume of the forced inspiratory vital capacity (FIVC) has been inspired. Also known as maximum inspiratory flow 50% (MIF50%).
- at0188::FIF75% - Forced inspiratory flow 75 % (FIF75%) is the maximal instantaneous inspiratory flow when 75 % of the volume of the forced inspiratory vital capacity (FIVC) has been inspired. Also known as maximum inspiratory flow 25% (MIF25%).
- at0189::FEV1/FEV6 ratio - The ratio of 'Forced expiratory volume in 1 second (FEV1)' to 'Forced expiratory volume in 6 seconds (FEV6)'.
- at0190::FEV1/IVC ratio - The ratio of 'Forced expiratory volume in 1 second (FEV1)' to 'Inspired vital capacity (IVC)'.
- at0191::Level of exertion - Details about physical activity undertaken at the time of spirometry recording.
- at0192::Challenge/reversibility - Statement about whether the spirometry test was performed as a reversibility test or a bronchial challenge test.
- at0193::None - The spirometry test was performed neither as a reversibility test nor a bronchial challenge test.
- at0194::Bronchial challenge test - The spirometry test was performed as a bronchial challenge test.
- at0195::Reversibility test - The spirometry test was performed as a reversibility test.
- at0196::Type of measurement - Type of measurement of spirometry.
- at0197::Mechanical - Measurement using a purely mechanical device.
- at0198::Electronic - Measurement using an electronic device.
- at0199::Method - Method used to perform the test.
- at0205::PIFR - Peak inspiratory flow rate (PIFR) is the peak flow rate during a forced inspiratory vital capacity (FIVC) maneuver.
- at0209::Environmental conditions - Details about environmental conditions undertaken at the time of spirometry recording.

sprs

Archetype ID: openEHR-EHR-OBSERVATION.sprs.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en

Purpose: For the recording of details of the Spastic Paraplegia Rating Scale to measure disease severity in spastic paraplegia.

Use: To be used to record the individual items and the total score of the Spastic Paraplegia Rating Scale to rate functional impairment occurring in pure forms of spastic paraplegia. The clinical Spastic Paraplegia Rating Scale (SPRS) measures disease severity and progression.

Keywords: SPRS, spastic, paraplegia, rating scale

Concepts:

- at0000::Spastic Paraplegia Rating Scale (SPRS) - 13-item Spastic Paraplegia Rating Scale (SPRS) to measure disease severity in spastic paraplegia.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::1. Walking distance without pause - Assessment of the subject's walking distance without pause.
- at0005::Normal, unlimited - The subject's walking distance is normal and unlimited.
- at0006::Abnormal exhaustion - The subject experiences abnormal exhaustion due to spasticity after more than 500 metres.
- at0007::Less than 500 metres - The subject's walking distance is less than 500 metres.
- at0008::Less than 10 metres - The subject's walking distance is less than 10 metres.
- at0009::Unable to walk - The subject is unable to walk.
- at0010::2. Gait quality - Assessment of the subject's gait quality.
- at0011::Normal - The subject's gait quality is normal.
- at0012::Mild stiffness - The subject experiences mild stiffness with running still possible.
- at0013::Clearly spastic gait - The subject exhibits clearly spastic gait which is interfering with running.

- at0014::Spastic gait requiring use of canes or walker - The subject requires the use of canes or a walker due to spastic gait.
- at0015::Unable to walk - The subject is unable to walk for a 10 meter distance even with maximal support.
- at0016::3. Maximum gait speed - Assessment of the subject's maximum gait speed.
- at0017::Normal - The subject's maximum gait speed is normal.
- at0018::Slightly reduced - The subject's maximum gait speed is slightly reduced (more than or equal 5 seconds for 10 metres).
- at0019::Moderately reduced - The subject's maximum gait speed is moderately reduced (more than or equal 10 seconds for 10 metres).
- at0020::Severely reduced - The subject's maximum gait speed is severely reduced (more than or equal 20 seconds for 10 metres).
- at0021::Unable - The subject is unable to walk 10 metres or the time taken is more than or equal 40 seconds.
- at0022::4. Climbing stairs - Assessment of the subject's ability to climb stairs.
- at0023::Normal - The subject is able to climb stairs in a normal manner and needs no support of the banister.
- at0024::Mild impairment - The subject's ability to climb stairs is mildly impaired, and the subject needs intermittent support of the banister.
- at0025::Moderate impairment - The subject's ability to climb stairs is moderately impaired, and the subject needs permanent support of the banister.
- at0026::Severe impairment - The subject's ability to climb stairs is severely impaired, and the subject needs support of another person or additional walking aid to perform task.
- at0027::Unable - The subject is unable to climb stairs.
- at0028::5. Speed of stair climbing - Assessment of the subject's speed of stair climbing.
- at0029::Normal - The subject is able to climb stairs at a normal speed.
- at0030::Slightly reduced - The subject is able to climb stairs at a slightly reduced speed (more than or equal 5 seconds to climb 5 steps upstairs, turn and 5 steps downstairs).
- at0031::Moderately reduced - The subject is able to climb stairs at a moderately reduced speed (more than or equal 10 seconds to climb 5 steps upstairs, turn and 5 steps downstairs).
- at0032::Severely reduced - The subject is able to climb stairs at a severely reduced speed (more than or equal 20 seconds to climb 5 steps upstairs, turn and 5 steps downstairs).
- at0033::Unable - The subject is unable to climb stairs.
- at0034::6. Arising from chair - Assessment of subject's ability to arise from straight-back wood or metal chair with arms folded across chest.
- at0035::Normal - The subject is able to arise from a chair in a normal manner.
- at0036::Slow or more than one attempt - The subject is able to arise from a chair slowly or may need more than one attempt.

- at0037::Pushes up from arms of chair - The subject has to push self up from arms of chair.
- at0038::Tends to fall back but able to get up - The subject tends to fall back and may have to try more than one time but is able to get up without help.
- at0039::Unable to arise - The subject is unable to arise from a chair without help.
- at0040::7. Spasticity - hip adductor muscles - Assessment of the hip adductor muscle spasticity (Modified Ashford scale).
- at0041::No increase in muscle tone - The subject does not exhibit any increase in muscle tone.
- at0042::Slight increase in muscle tone - The subject exhibits a slight increase in muscle tone, manifested by a catch and release.
- at0043::More marked increase in muscle tone - The subject exhibits a more marked increase in muscle tone through most of the range of motion.
- at0044::Considerable increase in muscle tone - The subject exhibits considerable increase in muscle tone, making passive movement difficult.
- at0045::Limb stiff in adduction - The subject exhibits limb stiffness in adduction.
- at0046::8. Spasticity - knee flexion - Assessment of the knee flexion spasticity (Modified Ashford scale).
- at0047::No increase in muscle tone - The subject does not exhibit any increase in muscle tone.
- at0048::Slight increase in muscle tone - The subject exhibits a slight increase in muscle tone, manifested by a catch and release.
- at0049::More marked increase in muscle tone - The subject exhibits a more marked increase in muscle tone through most of the range of motion.
- at0050::Considerable increase in muscle tone - The subject exhibits considerable increase in muscle tone, making passive movement difficult.
- at0051::Limb stiff in flexion or extension - The subject exhibits limb stiffness in flexion or extension.
- at0052::9. Weakness - hip abduction - Assessment of weakness in hip abduction (Medical Research Council 1976).
- at0053::No weakness - The subject exhibits no weakness in hip abduction.
- at0054::Mild weakness (4/5) - The subject exhibits mild weakness (4/5) in hip abduction.
- at0055::Moderate weakness (3/5) - The subject exhibits moderate weakness (3/5) in hip abduction.
- at0056::Severe weakness (2/5) - The subject exhibits severe weakness (1-2/5) in hip abduction.
- at0057::Plegia (0/5) - The subject exhibits plegia (0/5) in hip abduction.
- at0058::10. Weakness - foot dorsiflexion - Assessment of weakness in foot dorsiflexion (Medical Research Council 1976).
- at0059::No weakness - The subject exhibits no weakness in foot dorsiflexion.

- at0060::Mild weakness (4/5) - The subject exhibits mild weakness (4/5) in foot dorsiflexion.
- at0061::Moderate weakness (3/5) - The subject exhibits moderate weakness (3/5) in foot dorsiflexion.
- at0062::Severe weakness (2/5) - The subject exhibits severe weakness (1-2/5) in foot dorsiflexion.
- at0063::Plegia (0/5) - The subject exhibits plegia (0/5) in foot dorsiflexion.
- at0064::11. Contractures of lower limbs - Assessment of the contractures of lower limbs, scored in supine position.
- at0065::No contractures - The subject does not exhibit any lower limb contractures.
- at0066::Mild - The subject exhibits mild contractures, with no fixed abnormal position of one joint (unilaterally or bilaterally).
- at0067::Fixed one joint - The subject exhibits fixed contracture of one joint (unilaterally or bilaterally).
- at0068::Fixed two joints - The subject exhibits fixed contracture of two joints (unilaterally or bilaterally).
- at0069::Fixed more than two joints - The subject exhibits fixed contracture of more than two joints (unilaterally or bilaterally).
- at0070::12. Pain due to SP related symptoms - Assessment of pain due to spastic paraplegia related symptoms.
- at0071::None - The subject does not experience any pain due to spastic paraplegia related symptoms.
- at0072::Less than or equal 50 percent of day and low intensity - The subject experiences pain due to spastic paraplegia related symptoms for less than or equal 50 percent of the waking day and with an intensity of 0 to 3 on visual analogue scale.
- at0073::Less than or equal 50 percent of day and high intensity - The subject experiences pain due to spastic paraplegia related symptoms for less than or equal 50 percent of the waking day and with an intensity of 4 to 10 on visual analogue scale.
- at0074::More than 50 percent of day and low intensity - The subject experiences pain due to spastic paraplegia related symptoms for more than 50 percent of the waking day and with an intensity of 0 to 3 on visual analogue scale.
- at0075::More than 50 percent of day and high intensity - The subject experiences pain due to spastic paraplegia related symptoms for more than 50 percent of the waking day and with an intensity of 4 to 10 on visual analogue scale.
- at0076::13. Bladder and bowel function - Assessment of bladder and bowel function.
- at0077::Normal - The subject experiences normal bladder and bowel function.
- at0078::Urgency - The subject experiences urinary or fecal urgency with difficulties to reach toilet in time.
- at0079::Rare and mild urge incontinence - The subject experiences rare and mild urge incontinence with no nappy required.
- at0080::Moderate urge incontinence - The subject experiences moderate urge incontinence and requires a nappy or catheter when out of the house.

- at0081::Permanent catheter or nappy - The subject requires permanent catheterisation or a permanent nappy.
- at0082::Total score - The total score from Items 1 to 13.
- at0083::Inventory of complicating signs and symptoms - The inventory of complicating signs and symptoms.
- at0084::Mental retardation - The subject suffers from mental retardation.
- at0085::Dementia - The subject suffers from dementia.
- at0086::Psychosis - The subject suffers from psychosis.
- at0087::Epilepsy - The subject suffers from epilepsy.
- at0088::Visual loss (c.c. less than 0.8) - The subject suffers from visual loss (c.c. less than 0.8).
- at0089::Cataract - The subject suffers from cataract.
- at0090::Gaze evoked nystagmus - The subject suffers from gaze evoked nystagmus.
- at0091::Dysarthria - The subject suffers from dysarthria.
- at0092::Dysphagia - The subject suffers from dysphagia.
- at0093::Limb ataxia - The subject suffers from limb ataxia.
- at0094::Gait ataxia - The subject suffers from gait ataxia.
- at0095::Extrapyramidal motor signs - The subject suffers from extrapyramidal motor signs.
- at0096::Muscle wasting (upper limbs) - The subject suffers from muscle wasting in upper limbs.
- at0097::Muscle wasting (lower limbs) - The subject suffers from muscle wasting in lower limbs.
- at0098::Loss of muscle stretch reflexes (upper limbs) - The subject suffers from loss of muscle stretch reflexes in upper limbs.
- at0099::Loss of muscle stretch reflexes (lower limbs) - The subject suffers from loss of muscle stretch reflexes in lower limbs.
- at0100::Impaired touch sense - The subject suffers from impaired touch sense.
- at0101::Impaired pinprick sensation - The subject suffers from impaired pinprick sensation.
- at0102::Impaired vibration sense - The subject suffers from impaired vibration sense.
- at0103::Impaired joint position sense - The subject suffers from impaired joint position sense.
- at0104::Impaired temperature discrimination - The subject suffers from impaired temperature discrimination.
- at0105::Facial dysmorphism - The subject suffers from facial dysmorphism.
- at0106::Skin abnormalities - The subject suffers from skin abnormalities.
- at0107::Skeletal abnormalities - The subject suffers from skeletal abnormalities.
- at0108::Tree - @ internal @
- at0109::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

- at0111::Assessment method - The method used to for the spastic paraplegia rating scale.
- at0112::Clinical interpretation - Narrative interpretation of assessment.

story

****Archetype ID:**** openEHR-EHR-OBSERVATION.story.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

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

****Purpose:**** To record a narrative description of the clinical history of the subject of care and to provide a framework in which to nest detailed CLUSTER archetypes, each of which will support the narrative with additional structured detail for symptoms, health events and related topics. Use to record detail about the clinical history as reported by an individual, parent, care-giver or other party. It may be recorded by a clinician as part of a clinical history record as reported to them, or self-recorded as part of a clinical questionnaire or personal health record.

****Use:**** Use to record a description about subjective health-related observations or impressions from the point of view of the subject of care. When recorded by a clinician within the context of healthcare provision the story can be used for capturing the clinical history, as reported by the subject themselves, a parent, care-giver or other related party. If recorded by the subject, it can be used as an account of their 'story' of symptoms and health experiences, which might be used to share with healthcare providers or to document within their own personal health record. Use: - to record a simple narrative; and/or - as a container archetype to enable recording of a detailed structured history by inclusion of relevant CLUSTER archetypes within the 'Detail' SLOT. For example: CLUSTER.symptom, CLUSTER.issue or CLUSTER.health_event archetypes can be appropriately used in this SLOT. Use to incorporate the narrative descriptions of clinical history captured from existing or legacy clinical systems into an archetyped format, using the 'Story' text data element.

****Misuse:**** Not to be used to record formal assessments by clinicians which would usually be recorded using the EVALUATION class of archetypes.

****Keywords:**** history, presenting, complaint, story, symptom, health, record, presenting complaint, anamnesis

****Concepts:****

- at0000::Story/History - The subjective clinical history of the subject of care as recorded directly by the subject, or reported to a clinician by the subject or a carer.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Story - Narrative description of the story or clinical history for the subject of care.
- at0006::Structured detail - Structured detail about the individual's story or patient's history.
- at0007::Tree - @ internal @
- at0008::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

stratify_no

****Archetype ID:**** openEHR-EHR-OBSERVATION.stratify_no.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** For screening for falls risk in patients over 65 years of age, and other adults with neurological or cognitive conditions or significant visual impairment.

****Use:**** To be used for risk assessment of all patients over the age of 65 and other adults with neurological or cognitive conditions or significant visual impairment, within 24h of being admitted to a healthcare institution. The dataelements 'Transfer' and 'Mobility' under the cluster 'Transfer + Mobility' was in the original STRATIFY collected from the Barthel ADL Index. As STRATIFY and Barthel has diverged, is this archetype made independent of the Barthel archetype. The final score can either be calculated manually (entered by the clinician) or automatically (automatic calculation based on the values recorded).

****Keywords:**** risk, fall, balance

****Concepts:****

- at0000::STRATIFY Falls Risk Assessment Tool - Assessment tool for identifying falls risk in elderly patients admitted to hospital or other 24h healthcare institutions. This version of the tool is based on a modified Norwegian translation, which has been deployed by the The Norwegian Patient Safety Programme.

- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Falls during the last three months - Has the patient fallen during the last 3 months?
- at0005::Agitation - Does the patient show agitated, desoriented or confused behaviour?
- at0006::Visual impairments - Is the patient visually impaired to the extent that everyday function is affected?
- at0007::Frequent toileting - Do you think the patient is in need of especially frequent toileting?
- at0009::Total score - Sum of the scores from all the elements.
- at0011::No - The patient hasn't had any falls during the last 3 months.
- at0012::Yes - The patient has had falls during the last 3 months.
- at0013::No - The patient doesn't show agitated behaviour.
- at0014::Yes - The patient shows agitated behaviour.
- at0015::No - The patient doesn't have significant visual impairments.
- at0017::Yes - The patient has significant visual impairments.
- at0018::No - The patient isn't in need of frequent toileting.
- at0019::Yes - The patient is in need of frequent toileting.
- at0022::Transfer + Mobility - The sum of the scores from the elements 'Transfer' and 'Mobility' are used in 'Points', which is then used in the 'Total score'.
- at0023::Transfer - Describe the patient's level of independence in transfer from bed to a chair.
- at0024::Mobility - Describe the patient's level of independent mobility.
- at0025::Points - The points from "Transfer" and "Mobility" are added together. If the sum is 0-2 or 5-6, 0 points are given. If the sum is 3-4, 1 point is given.
- at0026::Unable to move - **(nb)(nb)
- at0027::Needs major help - **(nb)(nb)
- at0028::Needs minor help - **(nb)(nb)
- at0029::Independent with or without aids - **(nb)(nb)
- at0030::Immobile - **(nb)(nb)
- at0031::Independent in a wheelchair - **(nb)(nb)
- at0032::Uses a walking aid or walks with help of one person - **(nb)(nb)
- at0034::Independent - **(nb)(nb)

substance_use

Archetype ID: openEHR-EHR-OBSERVATION.substance_use.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** pt-br, en, ar-sy

****Purpose:**** To record the consumption of a specific substance or class of substances that may harm an individual's health or social well-being at a specific point or interval of time.

****Use:**** Use to record the consumption of a specific substance or class of substances that may harm an individual's health or social well-being. This includes use at specific point or interval of time, and use of mathematical functions such as average or maximum consumption over a interval of time. This archetype has been designed as a framework for objectively documenting the use or administration of a single substance. While it supports recognition of abuse and dependence, it is not intended exclusively for this purpose. A typical use of this archetype will be related to a diary record of use or consumption of substances. Substances that fall within the scope of this archetype include harmful or potentially addictive substances, legal and illegal 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: - tobacco; - alcohol; - 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.

****Misuse:**** Not to be used to record summary details about the use of the substance. Use EVALUATION.substance_use_summary 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 to record use of consumption of tobacco or alcohol. Use a separate archetype for this purpose, or a specialisation of this archetype. 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 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 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 - The consumption of a specific substance or class of substances that may harm an individual's health or social well-being at a specific point or interval of time.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Substance name - The name of the substance or class of substance.
- at0005::Pattern - The pattern of frequency of use of the specific substance.
- at0006::Daily use - Used every day.
- at0007::Weekly use - Used at least weekly.
- at0008::Irregular use - Used irregularly.
- at0009::No use - Not used at all.
- at0010::Consumption details - Details about the consumption of the substance.
- at0011::Form - Form of the substance used.
- at0012::Amount - Amount of substance consumed. Data type can be further specified in specialised archetypes or in templates.
- at0013::Triggers - Identified triggers which stimulate or cause use.
- at0014::Readiness for change - Details about the readiness to change use or consumption of substance.
- at0016::Evidence of dependence - Description of any evidence of dependence on the substance.
- at0018::Route - The name of the route of administration of the specified substance.

substance_use_screening

****Archetype ID:**** openEHR-EHR-OBSERVATION.substance_use_screening.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, nb, en, nl

****Purpose:**** To record a framework for documenting answers to pre-defined screening questions about the use of any substances or a specific grouping, class or individual substance/s that may harm an individual's health or social well-being.

****Use:**** Use to record a framework for documenting answers to pre-defined screening questions about the use of any substances or a specific grouping, class or individual substance/s that may harm an individual's health or social well-being. Substances that fall within the scope of this archetype include harmful or potentially addictive substances, legal

and illegal 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: - tobacco; - alcohol; - 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. Common use cases include, but are not limited to: - Systematic questioning in any consultation, for example: --- Have you smoked a cigarette during the last week? Yes, No, Unknown. --- When did you last smoke a cigarette? --- Have you ever injected drugs? Yes, No, Unknown. --- Do you use anabolic steroids? Yes, No, Unknown. --- Have you consumed any alcohol during the last 4 hours? Yes, No, Unknown. The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN data types choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to a point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about a substance that has been used at any time in the past and information about a substance used within a specified time interval - for example the difference between "Do you drink alcohol?" compared to "Have you been drinking any alcohol during the last four weeks?". The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies the presence of a substance, it is recommended that clinical system record and persist the specific details about the substance using a relevant archetype, for example the EVALUATION.alcohol_consumption_summary, EVALUATION.tobacco_smoking_summary, EVALUATION.substance_use_summary, or EVALUATION.health_risk archetypes.

Misuse: Not to be used to record the typical frequency or amount of use of any substance. Use the EVALUATION.substance_use_summary or an appropriate substance-specific summary archetype. Not to be used for recording a summary of use of a substance over the lifetime of the individual. Use EVALUATION.substance_use_summary for this purpose. Not to be used for recording a summary of use of tobacco over the lifetime of the individual. Use EVALUATION.smokeless_tobacco_summary or EVALUATION.tobacco_smoking_summary for this purpose. Not to be used for recording a summary of use of alcohol over the lifetime of the individual. Use EVALUATION.alcohol_consumption_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 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:**** substance, screening, questionnaire, drug, addiction, abuse, misuse, dependence, doping, stimulants, sedatives

****Concepts:****

- at0000::Substance use screening questionnaire - Series of questions and associated answers to screen for use of any substances or a specific grouping, class or individual substance/s that may harm an individual's health or social well-being.
- at0001::Tree - @ internal @
- at0002::Timing - Indication of timing related to the use of the substance or class/grouping of substances.
- at0003::Last used - The date and/or time of the most recent use of the substance or class/grouping of substances.
- at0005::Tree - @ internal @
- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0021::Substance name - Name of a substance or class/grouping of substances.
- at0022::Event Series - @ internal @
- at0023::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0024::Used? - Is there a history of use of a specific substance or class/grouping of substances.
- at0025::Comment - Additional narrative about use of the specific substance or class/grouping of substances, not captured in other fields.
- at0026::Specific substance - Details about a specified substance or class/grouping of substances relevant for the screening purpose.
- at0036::Yes - None
- at0037::No - None
- at0039::Unknown - None
- at0040::Screening purpose - The context or reason for screening.
- at0041::Additional details - Structured details or questions about the specific substance recent use of the substance or class/grouping of substances.
- at0042::Description - Narrative description about the history of use of any substance, or class/grouping of substances, relevant for the screening purpose.
- at0043::Additional details - Structured details or questions about the screening for any substance or class/grouping of substances.

- at0052::Any substance use? - Is there a history of use of any substance or class/grouping of substances, related to the screening purpose?
- at0053::Yes - None
- at0054::No - None
- at0055::Unknown - None
- at0056::Overall comment - Additional narrative about the screening for any substance or class/grouping of substances, not captured in other fields.
- at0057::Unsure - None
- at0058::Unsure - None

symptom_sign

****Archetype ID:**** openEHR-EHR-OBSERVATION.symptom_sign.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, fi, sv, nb, pt-br, ar-sy, en

****Purpose:**** To record details about a single episode of a reported symptom or sign including context, but not details, of previous episodes if appropriate.

****Use:**** Use to record details about a single episode of a symptom or reported sign in an individual, as reported by the individual, parent, care-giver or other party. It may be recorded by a clinician as part of a clinical history record as reported to them, observed by the clinician or self-recorded as part of a clinical questionnaire or personal health record. A complete clinical history or patient story may include varying level of details about multiple episodes of an identified symptom or reported sign, as well as multiple symptoms/signs. In the purest sense, symptoms are subjective observations of a physical or mental disturbance and signs are objective observations of the same, as experienced by an individual and reported to the history taker by the same individual or another party. From this logic it follows that we will need two archetypes to record clinical history - one for reported symptoms and another for reported signs. In reality this is impractical as it will require clinical data entry into either one of these models which adds significant overheads to modellers and those entering data. In addition, there is often overlap in clinical concepts - for example, is previous vomiting or bleeding to be categorised as a symptom or reported sign? In response, this archetype has been specifically designed to provide a single information model that allows for recording of the entire continuum between clearly identifiable symptoms and reported signs when recording a clinical history. This archetype has been intended to be used as a generic pattern for all symptoms and reported signs. The 'Specific details' SLOT can be used to extend the archetype to include additional, specific

data elements for more complex symptoms or signs. This archetype has been specifically designed to be used in the 'Structured detail' SLOT within the OBSERVATION.story archetype, but can also be used within other OBSERVATION or CLUSTER archetypes and in the 'Associated symptom/sign' or 'Previous episode' SLOT within other instances of this CLUSTER.symptom_sign archetype. Clinicians frequently record the phrase 'nil significant' against specific symptoms or reported signs as an efficient method to indicate that they asked the individual and it was not reported as causing any discomfort or disturbance - effectively used more like a 'normal statement' rather than an explicit exclusion. The 'Nil significant' data element has been deliberately included in this archetype to allow clinicians to record this same information in a simple and effective way in a clinical system. It can be used to drive a user interface, for example if 'Nil significant' is recorded as true then the remaining data elements can be hidden on a data entry screen. This pragmatic approach supports the majority of simple clinical recording requirements around reported symptoms and signs. However if there is a clinical imperative to explicitly record that a Symptom or Sign was reported as not present, for example if it will be used to drive clinical decision support, then it would be preferable to use the CLUSTER.exclusion_symptom_sign archetype. The use of CLUSTER.exclusion_symptom_sign will increase the complexity of template modelling, implementation and querying. It is recommended that the CLUSTER.exclusion_symptom_sign archetype only be considered for use if clear benefit can be identified in specific situations, but should not be used for routine symptom/sign recording.

****Misuse:**** Not to be used to record that a symptom or sign was explicitly reported as not present - use CLUSTER.exclusion_symptom_sign carefully for specific purposes where the overheads of recording in this way warrant the additional complexity, and only if the 'Nil significant' in this archetype is not specific enough for recording purposes. Not to be used for recording objective findings as part of a physical examination - use OBSERVATION.exam and related examination CLUSTER archetypes for this purpose. Not to be used for diagnoses and problems that form part of a persisting Problem List - use EVALUATION.problem_diagnosis.

****Keywords:**** complaint, symptom, disturbance, problem, discomfort, presenting complaint, presenting symptom, sign

****Concepts:****

- at000::Symptom/Sign - Reported observation of a physical or mental disturbance in an individual.
- at001::Symptom/Sign name - The name of the reported symptom or sign.
- at002::Description - Narrative description about the reported symptom or sign.
- at003::Pattern - Narrative description about the pattern of the symptom or sign during this episode.
- at017::Effect - Perceived effect of the modifying factor on the symptom or sign.

- at0018::Modifying factor - Detail about how a specific factor effects the identified symptom or sign during this episode.
- at0019::Factor - Name of the modifying factor.
- at0021::Severity category - Category representing the overall severity of the symptom or sign.
- at0023::Mild - The intensity of the symptom or sign does not cause interference with normal activity.
- at0024::Moderate - The intensity of the symptom or sign causes interference with normal activity.
- at0025::Severe - The intensity of the symptom or sign causes prevents normal activity.
- at0026::Severity rating - Numerical rating scale representing the overall severity of the symptom or sign.
- at0028::Duration - The duration of this episode of the symptom or sign since onset.
- at0031::Number of previous episodes - The number of times this symptom or sign has previously occurred.
- at0035::Nil significant - The identified symptom or sign was reported as not being present to any significant degree.
- at0037::Episode description - Narrative description about the course of the symptom or sign during this episode.
- at0056::Description - Narrative description of the effect of the modifying factor on the symptom or sign.
- at0057::Description of previous episodes - Narrative description of any or all previous episodes.
- at0063::Associated symptom/sign - Structured details about any associated symptoms or signs that are concurrent.
- at0146::Previous episodes - Structured details of the symptom or sign during a previous episode.
- at0147::Structured body site - Structured body site where the symptom or sign was reported.
- at0151::Body site - Simple body site where the symptom or sign was reported.
- at0152::Episode onset - The onset for this episode of the symptom or sign.
- at0153::Specific details - Specific data elements that are additionally required to record as unique attributes of the identified symptom or sign.
- at0154::Factor detail - Structured detail about the factor associated with the identified symptom or sign.
- at0155::Impact - Description of the impact of this symptom or sign.
- at0156::No effect - The factor has no impact on the symptom or sign.
- at0158::Worsens - The factor increases the severity or impact of the symptom or sign.
- at0159::Relieves - The factor decreases the severity or impact of the symptom or sign, but does not fully resolve it.
- at0161::Resolution date/time - The timing of the cessation of this episode of the symptom or sign.

- at0163::Comment - Additional narrative about the symptom or sign not captured in other fields.
- at0164::Onset type - Description of the onset of the symptom or sign.
- at0165::Precipitating/resolving factor - Details about specified factors that are associated with the precipitation or resolution of the symptom or sign.
- at0167::Precipitating factor - Identification of factors or events that trigger the onset or commencement of the symptom or sign.
- at0168::Resolving factor - Identification of factors or events that trigger resolution or cessation of the symptom or sign.
- at0170::Factor - Name of the health event, symptom, reported sign or other factor.
- at0171::Time interval - The interval of time between the occurrence or onset of the factor and onset/resolution of the symptom or sign.
- at0175::Episodicity - Category of this episode for the identified symptom or sign.
- at0176::New - A new episode of the symptom or sign - either the first ever occurrence or a reoccurrence where the previous episode had completely resolved.
- at0177::Indeterminate - It is not possible to determine if this occurrence of the symptom or sign is new or ongoing.
- at0178::Ongoing - This symptom or sign is ongoing, effectively a single, continuous episode.
- at0180::Progression - Description progression of the symptom or sign at the time of reporting.
- at0181::Improving - The severity of the symptom or sign has improved overall during this episode.
- at0182::Unchanged - The severity of the symptom or sign has not changed overall during this episode.
- at0183::Worsening - The severity of the symptom or sign has worsened overall during this episode.
- at0184::Resolved - The severity of the symptom or sign has resolved.
- at0185::Description - Narrative description about the effect of the factor on the identified symptom or sign.
- at0186::Occurrence - Type of occurrence for this symptom or sign?
- at0187::First occurrence - This is the first ever occurrence of this symptom or sign.
- at0188::Recurrence - New occurrence of the same symptom or sign after a previous episode was resolved.
- at0189::Character - Word or short phrase describing the nature of the symptom or sign.
- at0190::Event Series - @ internal @
- at0191::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0192::Tree - @ internal @
- at0193::Item tree - @ internal @
- at0194::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[symptom_sign_screening](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.symptom_sign_screening.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** de, sv, fi, nb, en, it, fr, zh-cn

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about symptoms or signs.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about symptoms or signs. Common use cases include, but are not limited to: - Systematic inquiry in any consultation, for example: --- Do you have headaches? Yes, No, Unknown. --- Have you had dizziness in the past four weeks? Yes, No, Unknown. - Specific questioning related to disease surveillance. The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about a symptom that has been present at any time in the past and information about a symptom within a specified time interval - for example the difference between ""Are you dizzy now?" compared to "Have you had any dizziness in the past 4 weeks? The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies the presence of a symptom or sign, it is recommended that clinical system record and persist the specific details about the symptom or sign using the CLUSTER.symptom_sign archetype nested within the Additional details SLOT in this archetype.

****Misuse:**** Not to be used to record details about the presence or absence of a symptom, outside of a screening context. Use CLUSTER.symptom_sign or CLUSTER.exclusion_symptom_sign for these purposes. Not to be used to record details about a simple selection list where a question may be recorded as either "present" or "indeterminate". Use OBSERVATION.selection_list for this purpose.

****Keywords:**** screening, questionnaire, complaint, symptom, disturbance, problem, discomfort, sign

****Concepts:****

- at0000::Symptom/sign screening questionnaire - Series of questions and associated answers used to screen for symptoms or signs.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Symptom/sign name - Identification of a specific symptom or sign or grouping of symptoms or signs, by name.
- at0005::Presence? - Is there a history of the specific symptom or sign being present?
- at0007::Item tree - @ internal @
- at0021::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0022::Specific symptom/sign - Details about a specific symptom or sign or grouping of symptoms or signs relevant for the screening purpose.
- at0023::Yes - None
- at0024::No - None
- at0026::Additional details - Structured details or questions about the specific symptom or sign.
- at0027::Unknown - None
- at0028::Any symptoms or signs? - Is there a history of any symptoms or signs relevant for the screening purpose?
- at0029::Onset - Timing of the initial recognition of any symptom or sign relevant for the screening purpose.
- at0031::Yes - None
- at0032::No - None
- at0033::Unknown - None
- at0034::Screening purpose - The context or reason for screening.
- at0035::Comment - Additional narrative about the specific symptom/sign question, not captured in other fields.
- at0036::Description - Narrative description about the history of any symptoms or signs relevant for the screening purpose.
- at0037::Timing - Indication of timing related to the specific symptom or sign.
- at0039::Additional details - Structured details or questions about screening for symptoms or signs.
- at0040::Unsure - None
- at0041::Unsure - None

tanner

****Archetype ID:**** openEHR-EHR-OBSERVATION.tanner.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To describe progression of pubertal changes in genitals, breasts and pubic hair.

****Use:**** Normally used to describe progression of pubertal changes in children, but can also be used to adults, for example evaluate gynaecomasty in adult men. Boys and girls are rated on a scale from 1 to 5. Boys are rated for genital development and pubic hair growth, and girls are rated for breast development and pubic hair growth.

****Keywords:**** pubertal, puberty, genitals, breasts, breast, pubical, pubic hair, sexual, maturity

****Concepts:****

- at0000::Tanner stages - A scale to describe the onset and progression of pubertal changes.
- at0001::*Event Series(nb) - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::*Tree(nb) - @ internal @
- at0004::Genitals - The stages for development in male genitals.
- at0005::Breasts - The stages for breast development in young women.
- at0006::Pubic hair - The stages for pubic hair development in females and males.
- at0007::Stage 1 - Prepubertal.
- at0008::Stage 2 - Enlargement of scrotum and testes; scrotal skin reddens and changes in texture.
- at0009::Stage 3 - Enlargement of penis (length at first); further growth of testes.
- at0010::Stage 4 - Increased size of penis with growth in breadth and development of glans; testes and scrotum larger, scrotal skin darker.
- at0011::Stage 5 - Adult genitalia.
- at0012::Stage 1 - Prepubertal.
- at0013::Stage 2 - Breast bud stage with elevation of breast and papilla; enlargement of areola.

- at0014::Stage 3 - Further enlargement of breast and areola; no separation of their contour.
- at0015::Stage 4 - Areola and papilla form a secondary mound above level of breast.
- at0016::Stage 5 - Mature stage: projection of papilla only, related to recession of areola.
- at0017::Stage 1 - Prepubertal (the pubic area may have vellus hair, similar to that of forearms).
- at0018::Stage 2 - Sparse growth of long, slightly pigmented hair, straight or curled, at base of penis or along labia.
- at0019::Stage 3 - Darker, coarser and more curled hair, spreading sparsely over junction of pubes.
- at0020::Stage 4 - Hair adult in type, but covering smaller area than in adult; no spread to medial surface of thighs.
- at0021::Stage 5 - Adult in type and quantity, with horizontal upper border.
- at0022::Tree - @ internal @
- at0025::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0027::Comment - Additional narrative about the pubertal examination findings not captured in other fields.

[**tegner_activity_level_scale**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.tegner_activity_level_scale.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** For the recording and reporting of patient-reported outcome information following knee operations.

****Use:**** Used to record patient-reported outcome information following knee operations. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Keywords:**** Outcome, knee, questionnaire

****Concepts:****

- at0000::Tegner Activity Level Scale - Tegner Activity Level Scale.
- at0001::History - *
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::ItemTree - @ internal @
- at0005::ItemTree - @ internal @
- at0006::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0019::Any other operations on operated knee? - Patient reported statement whether they had any other operations on operated knee since last operation.
- at0026::Details - Patient provided details of other problems, other operations and other useful operation information to supplement yes answers to previous questions.
- at0028::Before Level - Patient described level of the highest level of activity before injury.
- at0029::Level 1 - Work- sedentary (secretarial, etc.).
- at0030::Level 0 - Sick leave or disability pension because of knee problems.
- at0031::Level 2 - Work- light labour. Walking on uneven ground possible, but impossible to back pack or hike.
- at0032::Level 3 - Work- light labour (nursing, etc.).
- at0033::Level 4 - Work- moderately heavy labour (e.g. truck driving, etc.).
- at0034::Level 5 - Work- heavy labour (construction, etc.) Competitive sports- cycling, cross-country skiing. Recreational sports- jogging on uneven ground at least twice weekly.
- at0035::Level 6 - Recreational sports- tennis and badminton, handball, racquetball, down-hill skiing, jogging at least 5 times per week.
- at0036::Level 7 - Competitive sports- tennis, running, motorcars speedway, handball. Recreational sports- soccer, football, rugby, bandy, ice hockey, basketball, squash, racquetball, running.
- at0037::Level 8 - Competitive sports- racquetball or bandy, squash or badminton, track and field athletics (jumping, etc.), down-hill skiing.
- at0038::Level 9 - Competitive sports- soccer, football, rugby (lower divisions), ice hockey, wrestling, gymnastics, basketball.
- at0039::Level 10 - Competitive sports- soccer, football, rugby (national elite).
- at0040::Current Level - Patient described level of the highest level of activity currently.
- at0041::Level 0 - Sick leave or disability pension because of knee problems.
- at0042::Level 1 - Work- sedentary (secretarial, etc.).
- at0043::Level 2 - Work- light labour. Walking on uneven ground possible, but impossible to back pack or hike.
- at0044::Level 3 - Work- light labour (nursing, etc.).
- at0045::Level 4 - Work- moderately heavy labour (e.g. truck driving, etc.).

- at0046::Level 5 - Work- heavy labour (construction, etc.) Competitive sports- cycling, cross-country skiing. Recreational sports- jogging on uneven ground at least twice weekly.
- at0047::Level 6 - Recreational sports- tennis and badminton, handball, racquetball, down-hill skiing, jogging at least 5 times per week.
- at0048::Level 7 - Competitive sports- tennis, running, motorcars speedway, handball. Recreational sports- soccer, football, rugby, bandy, ice hockey, basketball, squash, racquetball, running.
- at0049::Level 8 - Competitive sports- racquetball or bandy, squash or badminton, track and field athletics (jumping, etc.), down-hill skiing.
- at0050::Level 9 - Competitive sports- soccer, football, rugby (lower divisions), ice hockey, wrestling, gymnastics, basketball.
- at0051::Level 10 - Competitive sports- soccer, football, rugby (national elite).
- at0052::Date of surgery - Details of surgery date.
- at0053::Who performed surgery? - Details of who performed the surgery.

telecommunication

****Archetype ID:**** openEHR-EHR-OBSERVATION.telecommunication.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record evidence of interactions between healthcare providers that support the record of health care.

****Use:**** Use to record the (bi-directional) text conversation, or video- or audio-conference recording, between two or more parties and which is captured as part of the record of health care. For example, capture a phone or online chat conversation between remote healthcare providers about patient management decisions; or audio- and video-conference recordings that record aspects of telemedicine consultations or case conferences. The record of interaction may take place over a specified interval of time.

****Keywords:**** chat, videoconference, audioconference, conversation, discussion, teleconference, telehealth, telecommunication

****Concepts:****

- at0000::Telecommunication Record - Record of a telecommunication, usually a text conversation, or video- or teleconference recording between two or more parties, captured as part of the record of health care.
- at0001::Event Series - @ internal @
- at0002::Start Time - The time that represents the start of the telecommunication.
- at0003::Tree - @ internal @
- at0004::Comment - Additional narrative about the telecommunication.
- at0005::Record - The actual record of any telecommunication between two or more healthcare providers.
- at0006::Recording Interval - The period of time over which the telecommunication was recorded.
- at0008::Tree - @ internal @
- at0009::Device - Details of device used to capture the telecommunication.
- at0010::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

temperature

****Archetype ID:**** openEHR-EHR-OBSERVATION.temperature.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** eu, de, es-ar, en, ar-sy

****Purpose:**** To record the measured temperature of an identified object.

****Use:**** Used for recording the specific temperature of an identified object.

****Misuse:**** Not to be used to record the body temperature, which is a surrogate for the whole body temperature of the subject - use OBSERVATION.body_temperature for this purpose.

****Keywords:**** temperature

****Concepts:****

- at0000::Temperature - A measurement of temperature of a specified object.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Single - @ internal @

- at0004::Temperature - The measured temperature of the object.
- at0006::Object - Identify the object for which the temperature is being measured.
- at0007::List - @ internal @
- at0009::Device - Details of the device used to measure the temperature.
- at0010::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

[testicular_volume](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.testicular_volume.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the volume of an individual's testicle.

****Use:**** Use to record the volume of an individual's testicle. While the measurement of testicular volume may be one component of a full genital examination, this archetype for recording testicular volume has been developed as a standalone OBSERVATION to support the common monitoring of testicular volume by use of growth charts in childhood and puberty. Use to record change from repeated measurements. This can currently be modeled by constraining the 'any event' to an interval in a template with an associated mathematical function, as appropriate.

****Misuse:**** Not to be used to record the volume of an object or other bodypart than testicles. Use an appropriate archetype for this purpose.

****Keywords:**** testis, testicle, orchiometer, orchidometer, volume

****Concepts:****

- at0000::Testicular volume - The estimated or calculated volume of a testicle.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Comment - Additional narrative not covered in other fields.
- at0006::Tree - @ internal @
- at0007::Device - Structured details about the device used to measure the testicles.
- at0008::Formula - The formula used to calculate the testicular volume.

- at0010::Testicular volume - Estimated or calculated volume of a testicle.
- at0011::Tree - @ internal @
- at0012::Confounding factors - Issues or factors that may impact on the measurement.
- at0013::Method - The method used to measure the testicles.
- at0019::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0020::Testicle examined - Identification of the testicle that was measured.
- at0021::Left testicle - Measurement of the left testicle.
- at0022::Right testicle - Measurement of the right testicle.

third_party_observation

****Archetype ID:**** openEHR-EHR-OBSERVATION.third_party_observation.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** ar-sy, en

****Purpose:**** To record a third party observer/carer's observations or concerns about an individual.

****Use:**** Use to record a third party observer/carer's observations or concerns about an individual.

****Concepts:****

- at0000::Carer observation - Third party observer/carer's observations or concerns about an individual.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Stimulus - Stimulus triggering the response being observed.
- at0005::Description - Narrative description about the observation or concern.
- at0006::Comment - Additional narrative about the observation or concern, not captured in other fields.
- at0007::Level of concern - Degree of concern displayed by third party.
- at0014::Third party details - Information about the observer.
- at0015::Tree - @ internal @

- at0016::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

timed_25_foot_walk

****Archetype ID:**** openEHR-EHR-OBSERVATION.timed_25_foot_walk.v1

****Lifecycle State:**** Published

****Category:**** OBSERVATION

****Languages:**** de, en

****Purpose:**** To record the measurements recorded during a Timed 25-Foot Walk test, normally as part of the Multiple Sclerosis Functional Composite (MSFC) suite of tests.

****Use:**** Use to record the measurements recorded during a Timed 25-Foot Walk test. This test is commonly carried out as one component of the Multiple Sclerosis Functional Composite (MSFC) assessment, but may be performed independently. The patient is directed to one end of a clearly marked 25-foot (7,62 m) course. Then he is instructed to walk this course as quickly as possible, but safely. The task is immediately administered again by having the patient walk back the same distance. Assistive devices (in general, customary walking devices) may be used when doing this task. Use the MSFC Manual for detailed administration instructions. The test should only be administered by a suitably trained person.

****Keywords:**** Timed 25-Foot Walk, T25-FW, T25FW, TW, Multiple Sclerosis Functional Composite, MSFC

****Concepts:****

- at0000::Timed 25-Foot Walk - The Timed 25-Foot Walk is a quantitative test of lower extremity mobility and motor function. It is the first component of the Multiple Sclerosis Functional Composite (MSFC), a series of three tests to document the course of Multiple Sclerosis.
- at0001::Event Series - @ internal @
- at0002::Trial 1 - First of two trials of the Timed 25-Foot Walk.
- at0003::Tree - @ internal @
- at0004::Time - Time required to successfully complete the 25-foot walking distance.
- at0005::Trial Not Completed? - Could the distance not be completed or was the trial terminated prematurely?
- at0006::Reasons For Non-completion - Record the reasons, if the distance could not be completed or the test was terminated prematurely.

- at0007::Trial 2 - Second of two trials of the Timed 25-Foot Walk.
- at0009::Tree - @ internal @
- at0010::Confounding Factors - Record any circumstances that you believe may have affected the patient's performance.
- at0011::Tree - @ internal @
- at0012::Unilateral Assistive Device - Record which unilateral assistive devices were used.
- at0013::Ankle-foot orthosis - Ankle-Foot Orthosis (AFO).
- at0014::Cane - Walking stick or cane.
- at0015::Crutch - Underarm crutch.
- at0016::Walker/rollator - Walker or rollator device.
- at0017::More Than Two Attempts? - Were there more than two attempts to get two successful trials?
- at0018::Reasons For More Than Two Attempts - Reasons for more than two attempts to get two successful trials.
- at0020::Bilateral Assistive Device - Record which bilateral assistive devices were used.

tobacco_use

****Archetype ID:**** openEHR-EHR-OBSERVATION.tobacco_use.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record details about the actual use or consumption of tobacco and tobacco-containing products.

****Use:**** Use to record details of the use of all common forms of tobacco and tobacco-containing products. This includes actual use at specific point in time and average use over intervals of time. A smoking or tobacco use diary could be built up over time by recording the use of tobacco on multiple, sequential days - recording actual consumptions using the 'Specified Day' event for each daily entry. A record of typical tobacco use during a period can be recorded by recording the amount of tobacco used using the 'Average use' event - the mean use over a specified period of time.

****Misuse:**** Not to be used for recording persistent, summary details about tobacco use and consumption - this should be captured using the EVALUATION.tobacco_use_summary archetype.

****Keywords:**** tobacco, cigarette, cigar, pipe, snuff, kretek, beebi, bibi, shisha, snuff, snus, hookah, gutka, smoking, chewing

****Concepts:****

- at0000::Tobacco Use - Details about use of all forms of tobacco and tobacco-containing products at a specified point in time or over a specified period of time.
- at0001::Event Series - @ internal @
- at0002::Any event - An unspecified event.
- at0003::Tree - @ internal @
- at0004::Tobacco Use? - Is any tobacco being used or consumed?
- at0005::Usage Details - Details about the use or consumption of specific forms of tobacco.
- at0006::Form - Form of tobacco used or consumed.
- at0007::Cigarette - Manufactured cigarettes, containing processed tobacco and rolled into a cylinder.
- at0008::Roll-Your-Own - Hand-filled cigarettes using loose tobacco rolled in a cigarette paper.
- at0009::Cigar - Air-cured and fermented tobaccos with a tobacco-leaf wrapper.
- at0010::Pipe - Tobacco placed in a bowl and smoke inhaled through a stem.
- at0012::Waterpipe - Tobacco, often flavoured, is burned then cooled through a basin of water and consumed through a hose and mouthpiece.
- at0013::Smokeless tobacco - Tobacco consumed by inhalation or ingestion - including snuff, snus, gutka, dipping tobacco and dissolvable tobacco.
- at0014::Number Smoked - Number of units containing tobacco consumed.
- at0015::Amount - Amount of tobacco used or consumed.
- at0016::Weight Consumed - Weight of tobacco consumed.
- at0017::Triggers - Identified triggers which stimulate or cause use of this form of tobacco.
- at0018::Context - Context of use of this form of tobacco.
- at0019::Evidence of Dependence - Description of any evidence of dependence on tobacco.
- at0021::Comment - Additional narrative about the tobacco use or consumption not captured in other fields.
- at0022::Average Use Interval - Average, or typical, typical use over a specified time interval. For example, allows recording of average number of cigarettes smoked per week for the previous 10 years.
- at0023::Specified Day - Actual tobacco consumption on a specified day. Supports recording consumption in a Smoking Diary.

transmission_screening

****Archetype ID:**** openEHR-EHR-OBSERVATION.transmission_screening.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** de, nb, en

****Purpose:**** To record the responses to a screening questionnaire about situations or events where the index individual may have transmitted an infectious disease to others.

****Use:**** Use to record the responses to a screening questionnaire about situations or events where the index individual may have transmitted an infectious disease to others. Common use cases include, but are not limited to: - Systematic questioning in any consultation; or - Specific questioning related to infectious disease surveillance, such as contact with a pregnant woman. In order to record the response at a specific point in time or within an interval of time, use the EVENT RM attribute. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry.

****Misuse:**** Not to be used to record persistent details about a known or identified exposure that may cause harm to the index individual. Use the EVALUATION.exposure archetype for this purpose. Not to be used to record screening information about potentially harmful exposure to the index patient. Use the OBSERVATION.exposure_screening archetype for this purpose.

****Concepts:****

- at0000::Infection transmission screening questionnaire - An individual- or self-reported questionnaire screening for potential onward transmission of a diagnosed infectious disease from the index individual to others.
- at0001::History - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0018::Item tree - @ internal @
- at0003::Item tree - @ internal @
- at0004::Screening purpose - The name of the chemical, physical or biological agent to which an individual may have been exposed.
- at0009::Specific exposure - Details about a possible specific exposure situation.
- at0010::Exposure event - The situation oractivity where exposure may have occurred.
- at0011::Potential transmission? - Presence of the exposure situation.
- at0012::Yes - The individual has been or may have been, exposed.
- at0014::Unknown - It is not known whether the the individual has been exposed or not.

- at0013::No - The individual has not been exposed.
- at0017::Comment - Additional narrative about the specific exposure event, not captured in other fields.
- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0005::Any transmission opportunities? - Presence of any relevant exposure.
- at0006::Yes - The individual has been exposed to the harmful agent.
- at0007::No - The individual has not been exposed to the harmful agent.
- at0008::Unknown - It is not known whether the individual has been exposed to the harmful agent.
- at0016::Additional details - Additional details about the specific exposure event or identification of contacts.
- at0015::Timing - The date/s when the individual was exposed to the agent.

travel_history

****Archetype ID:**** openEHR-EHR-OBSERVATION.travel_history.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** fi, nb, en, it

****Purpose:**** To record details of a travel trip with respect to exposure to potential risk.

****Use:**** To record details of a travel trip with respect to exposure to potential risk.

****Keywords:**** travel, trip, tropical

****Concepts:****

- at0000::Travel trip history - Details of a travel trip with respect to exposure to potential risk.
- at0001::History - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0049::Recreational activities - *
- at0050::Safari - *
- at0051::Hiking - *
- at0052::Swimming - *
- at0053::Ocean (scuba diving, marine life exposure) - *
- at0054::Freshwater exposure (lake, river, stream) - *

- at0055::Swimming pools and hot tubs - *
- at0056::Rafting/boating - *
- at0057::Sightseeing - *
- at0058::Other adventuresome activities - *
- at0059::Reason for travel - *
- at0060::Leisure - *
- at0061::Visiting friends and relatives - *
- at0062::Business - *
- at0063::Research/education - *
- at0064::Missionary/volunteer work - *
- at0065::Providing medical care - *
- at0066::Receiving medical care - *
- at0070::Duration of travel - *
- at0071::Date of return - *
- at0072::Type of accommodations and sleeping arrangements - *
- at0085::Foods eaten - *
- at0086::Raw produce - *
- at0087::Undercooked meat - *
- at0088::Unpasteurized dairy products - *
- at0089::Seafood - *
- at0091::Other exposures - *
- at0092::Sexual activity during travel (use of condoms, new partner) - *
- at0093::Tattoos or piercings received while traveling - *
- at0094::Animal or arthropod bites, stings, or scratches - *
- at0095::Known outbreaks in the countries visited - *
- at0096::Use of travel precautions - *
- at0097::Effective insect repellent (DEET 25%–40% or other EPA-registered product) - *
- at0098::Bed nets - *
- at0099::Adherence to malaria prophylaxis - *
- at0100::Item tree - @ internal @
- at0101::Extension - *
- at0102::Common exposures - *
- at0103::Insect bites - *
- at0104::Source of drinking water - *
- at0109::Exposure details - *
- at0111::Recent travel - Has the patient travelled recently? The definition of 'recently' may vary depending on circumstances of the wider patient story and known current infection risk.
- at0112::Yes - The patient has recently traveled.
- at0113::No - The patient has not recently traveled.
- at0114::Unknown - Unknown.
- at0115::Incubation period - *

- at0116::Visited healthcare facilities - *
- at0117::Yes - The patient has visited a healthcare facility.
- at0118::No - The patient has not visited a healthcare facility.
- at0119::Unknown - It is not known if the patient has visited a healthcare facility.
- at0120::Known contacts - *
- at0121::Confirmed contact - *
- at0122::Yes - The patient has had contact with a confirmed case within the known incubation period.
- at0123::No - The patient has had not contact with a confirmed case within the known incubation period.
- at0124::Unknown - It is unknown if the patient has had contact with a confirmed case within the known incubation period.
- at0125::Contact details - *
- at0126::Case identifier - *
- at0129::Date of first exposure - *
- at0130::Date of last exposure - *
- at0131::Contact setting - *
- at0132::Likely location for exposure - *
- at0134::Location history - *
- at0135::Location visited - *

[travel_screening](#)

Archetype ID: openEHR-EHR-OBSERVATION.travel_screening.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: de, nb, en

Purpose: To create a framework for recording answers to pre-defined screening questions about travel activity.

Use: Use to create a framework for recording answers to pre-defined screening questions about travel activity. Common use cases include, but are not limited to: - Infectious disease surveillance - Creating a patient profile in a disease registry - Systematic questioning in any consultation related to patterns of disease. The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. Each data element would usually be renamed in a template to represent the specific question asked. Where value sets have been proposed for common use cases, these can be adapted to align with local requirements

by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. Utilising this framework within a template can enable documentation of a broad range of question/answer pairs such as: - Have you been overseas in the past 6 weeks? Yes, No, Unknown. - Have you travelled to Africa in the past 1 year? Yes, No, Unknown. - Have you travelled to an area where malaria is endemic in the past 2 weeks? Yes, No, Unknown. - Have you ever travelled to an active war zone? The EVENT structure from the reference model can be used to specify whether the questions relate to a point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about an investigation or test that has been done at any time in the past and information about an investigation or test done within a specified time interval - for example, the difference between "Have you ever travelled to an area with high radiation activity?" compared to "Have you travelled to an area with high radiation activity during the last four weeks?". The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies an investigation has been carried out, additional details required for persistence as part of a clinical record can be captured using specific test result archetypes.

****Misuse:**** Not to be used for recording a travel history - use ADMIN_ENTRY.travel_event for this purpose.

****Keywords:**** travel, overseas, domestic, local, national, abroad, international, abroad

****Concepts:****

- at0000::Travel screening questionnaire - Series of questions and associated answers used to screen for travel activity.
- at0001::Tree - @ internal @
- at0003::Timing - Indication of timing related to the travel.
- at0005::Tree - @ internal @
- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0021::Travel activity - Name of the type of travel.
- at0022::Event Series - @ internal @
- at0023::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0024::Occurred? - Is there a history of the the travel activity occurring?
- at0025::Comment - Additional narrative about the travel activity not captured in other fields.
- at0026::Specific travel - Details about a specified travel activity relevant for the screening purpose.

- at0027::Any travel? - Is there a history of any travel activity related to the screening purpose?
- at0028::Yes - None
- at0029::No - None
- at0030::Unknown - None
- at0036::Yes - None
- at0037::No - None
- at0039::Unknown - None
- at0040::Screening purpose - The context or reason for screening.
- at0041::Additional details - Structured details or questions about the specific travel activity.
- at0043::Description - Narrative description about the history of any travel activity relevant for the screening purpose.
- at0044::Additional details - Structured details or questions about screening for all travel activities.
- at0045::National travel - Travel occurred to places or regions within the usual country of residence.
- at0046::International travel - Travel occurred to places or regions within countries other than the usual country of residence.

trunk_impairment_scale

Archetype ID: openEHR-EHR-OBSERVATION.trunk_impairment_scale.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en

Purpose: To record the results for each component parameter and their total sum for the TIS scale.

Use: To record the results for each component parameter and their total sum for the TIS scale.

Keywords: TIS, trunk, impairment, scale, stroke, parkinson's, disease

Concepts:

- at0000::Trunk Impairment Scale (TIS) - An assessment score to evaluate trunk mobility and stability in patients with neurological deficits.
- at0001::Event Series - @ internal @

- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Maintains starting position - Patient maintains starting position without support for 10 seconds.
- at0005::No - None
- at0006::Yes - None
- at0007::Therapist crosses unaffected leg - Therapist crosses unaffected leg over hemiplegic leg.
- at0008::Falls or can't maintain sitting position for 10 seconds without arm support - None
- at0009::Maintains sitting position for 10 seconds - None
- at0010::Patient crosses unaffected leg - Patient crosses unaffected leg over hemiplegic leg.
- at0011::Falls - None
- at0012::Cannot cross legs without arm support - None
- at0013::Crosses legs but displaces trunk >10 cm backwards or assists crossing with hand - None
- at0014::Crosses legs without displacement or assistance - None
- at0015::Static balance score - The sum of the three parameters for the Static balance score component.
- at0016::Shortens hemiplegic side - Patient touches the bed or table with hemiplegic elbow (shortens hemiplegic side and lengthens unaffected side) and returns to starting position.
- at0017::Falls, needs support from upper extremity, or elbow does not touch the bed or table - None
- at0018::Moves actively without help, elbow touches bed or table - None
- at0019::Shortens hemiplegic side - repetition 1 - None
- at0020::No (or opposite) shortening/lengthening - None
- at0021::Appropriate shortening/lengthening - None
- at0022::Shortens hemiplegic side - repetition 2 - None
- at0023::Compensation (with upper extremity, hips, knees, or feet) - None
- at0024::Moves without compensation - None
- at0025::Shortens unaffected side - Patient touches the bed or table with unaffected elbow (shortens unaffected side and lengthens hemiplegic side) and returns to starting position.
- at0026::Shorten unaffected side - repetition 1 - None
- at0027::Shorten unaffected side - repetition 2 - None
- at0028::Lifts pelvis hemiplegic side - Lifts pelvis from bed or table at hemiplegic side (shortens hemiplegic side and lengthens unaffected side) and returns to starting position.
- at0029::Lifts pelvis hemiplegic side - repetition 1 - None

- at0030::Compensation (with upper extremity or foot) - None
- at0031::Moves without compensation - None
- at0032::Lifts pelvis unaffected side - Lifts pelvis from bed or table at unaffected side (shortens unaffected side and lengthens hemiplegic side) and returns to starting position.
- at0033::Lifts pelvis unaffected side - repetition 1 - None
- at0034::Dynamic Balance score - The sum of the ten parameters for the Dynamic balance score component.
- at0035::Rotates upper trunk - Rotates upper trunk 6x (each shoulder moved forward 3x), hemiplegic side must move first, head fixated in starting position.
- at0036::Hemiplegic side not moved 3x - None
- at0037::Assymetrical rotation - None
- at0038::Symmetrical rotation - None
- at0039::Rotates upper trunk - repetition 1 - Repeats upper trunk rotations within 6 seconds.
- at0040::Assymetrical rotation - None
- at0041::Symmetrical rotation - None
- at0042::Rotates lower trunk - Rotate lower trunk 6x (each knee moved forward 3x), hemiplegic side must move first, upper trunk fixated in starting position.
- at0043::Coordination score - The sum of the four parameters for the Coordination score component.
- at0044::Total score - The total sum of the Static balance, Dynamic balance, and Coordination scores.
- at0049::Rotates lower trunk - repetition 1 - Repeats lower trunk rotation within 6 seconds.
- at0052::Item tree - @ internal @
- at0053::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

[**tympanogram_226hz**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.tympanogram_226hz.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** ar-sy, en

****Purpose:**** To record measurements based on a 226 Hz probe tone, of the admittance or impedance of the middle ear system as a function of changing the external ear canal

pressure. To infer middle ear function from objective measurements based on a fixed 226Hz probe tone, taken at the tympanic membrane of the mobility of the tympanic membrane, in response to varying air pressure in the ear canal.

****Use:**** Use to record measurements taken during tympanometry with a 226 Hz probe tone. Use to record outcome of tympanometry screening based on 226 Hz probe tone tympanometry. Use to record the interpretation all tympanogram measurements taken with a 226 Hz probe tone, to infer middle ear function for each ear, plus an overall interpretation (or tympanometric diagnosis). All of the data elements are recorded using a single method or protocol. If, during the test, any of the protocol parameters need to be modified, then the subsequent part of the test will need to be recorded within a separate instance of the test data, using the updated protocol parameters. Each 'Pressure vs Compliance Measurement' pair will comprise one pressure measurement with one corresponding compliance measurement. Compliance measurement has been represented in the archetype twice, each with different units. Compliance measurements will only be recorded in data using the unit that is recorded by the tympanometer in use - either volume units OR conductance units, but not both. Similarly, Static Compliance has been represented in the archetype twice, each with different units. Static Compliance measurements will only be recorded in data using the unit that is recorded by the tympanometer in use - either volume units OR conductance units, but not both. If the tympanogram subtypes are to be used in an implementation, these should be substituted for the global Type B category in the 'Tympanogram Type' data element. Both 'Type B' and 'Type B - low/high compliance' should not be used in the same implementation. 'Type B - low compliance' is equivalent to the unqualified 'Type B' in the 'Tympanogram Type' data element. Similarly, if Type C subtypes describing the Tympanogram curve are to be used in an implementation, these should be substituted for the global Type C category in the 'Tympanogram Type' data element. Both Type C and Types C1-3 should not be used in the same implementation.

****Misuse:**** Not to be used to record other hearing tests. Use other archetypes as appropriate, for example OBSERVATION.audiogram. Not to be used to record high frequency tympanometry. Use the OBSERVATION.tympanogram_hf archetype instead. Not to be used to record multifrequency tympanometry. Use the OBSERVATION.tympanogram_hf archetype instead.

****Keywords:**** tympanogram, tympanometry, tympanometer, admittance, pressure, compliance, immittance, static

****Concepts:****

- at000::Tympanogram test result - 226Hz - Record of measurements of movement at the tympanic membrane in response to a 226Hz probe tone and changes in air pressure in the ear canal, and their clinical interpretation as an indication of middle ear function.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.

- at0003::Tree - @ internal @
- at0004::Tympanogram type - Description of the shape of the tympanogram curve, based on the Jerger categories.
- at0005::Type A - Curve with a distinctive sharp peak, around atmospheric pressure; normal static compliance; normal ear canal volume.
- at0006::Type B - Flat or rounded curve with no measurable peak pressure, reduced static compliance; ear canal volume within normal range.
- at0007::Type C - Curve similar to Type A , but with the sharp peak at a negative pressure.
- at0008::Type As - A Type A curve but with reduced static compliance.
- at0009::Test ear - Identification of the ear being tested.
- at0010::Left ear - The probe tone was presented to the left ear.
- at0011::Right ear - The probe tone was presented to the right ear.
- at0012::Result details - The tympanogram test result measurements and interpretations, recorded per ear.
- at0013::Peak pressure - Peak pressure (also called tympanometric peak pressure or middle ear pressure or MEP) is the ear canal pressure at which the peak of the tympanogram occurs.
- at0014::Static compliance (conductance) - Static compliance (SC) is the greatest amount of acoustic energy absorbed by the middle ear system (the vertical peak of the tympanogram curve).
- at0018::Ear canal volume - An estimate of the volume of air between the probe tip and the tympanic membrane if the tympanic membrane is intact, or the volume of the ear canal and the middle ear space if the tympanic membrane is perforated. (Fowler & Shanks, 2002, p. 180).
- at0020::Test result image - Digital representation of the entire result.
- at0021::Comment - Additional narrative about the test results and interpretation not captured in other fields.
- at0027::Measurement details - Measurements of the tympanogram to infer middle ear function.
- at0028::Pressure vs compliance measurement - The Pressure/Compliance measurement pair, captured from a tympanometer and used to define a continuous tympanogram curve.
- at0029::Tympanometric width - The pressure interval corresponding to a 50% reduction in the peak static admittance.
- at0030::Tympanometric gradient - The steepness of the slope of the tympanogram near the peak.
- at0031::No test result - No test result is available for the test ear.
- at0032::Reason for no test result - Reason why no result is available for the test ear.
- at0033::Clinical interpretation - Clinical interpretation of all measurements for the test ear.
- at0034::Type Ad - A Type A curve but with increased static compliance.

- at0035::Indeterminate - It is not possible to determine the type of tympanogram Type.
- at0036::Overall interpretation - Overall clinical interpretation of the measurements and related findings using an tympanometer.
- at0037::Baseline - Measurement collection recorded as the basis for comparison with following measurement collections that may include other variables of time or patient state.
- at0038::Post-Valsalva - Measurements are recorded after the patient has performed a valsalva manoeuvre.
- at0039::Post-Toynbee - Measurements are recorded after the patient has performed a toynbee manoeuvre.
- at0040::Tree - @ internal @
- at0041::Pre-test calibration cavity size - A cavity with a known volume used to check the calibration of the tympanometer.
- at0043::Direction of pressure change - The direction of change of pressure administered via the ear canal.
- at0044::Descending - The pressure changes from positive to negative.
- at0045::Ascending - The pressure changes from negative to positive.
- at0046::Rate of pressure change - The rate of change of pressure used in tympanometry.
- at0047::Admittance measurement - Method of acoustic admittance measurement used in the test.
- at0048::Peak compensated static - The peak pressure value of the tympanogram used to compensate for ear canal volume in measurement of static acoustic admittance.
- at0049::Ambient compensated static - Admittance was measured using the Ambient compensated static acoustic admittance.
- at0050::Pressure range - The range of air pressure used to determine the tympanogram.
- at0051::Start pressure - The pressure value in daPa at which the pressure sweep for tympanometry begins. It is a positive pressure if the direction of pressure change is descending and a negative pressure if the direction of pressure change is ascending.
- at0052::Stop pressure - The pressure value in daPa at which the pressure sweep for tympanometry ends. It is a negative pressure if the direction of pressure change is descending and a positive pressure if the direction of pressure change is ascending.
- at0053::Tympanometer - Details of tympanometer used to conduct the test.
- at0054::Comment - Additional narrative about the protocol for the tympanogram not captured in other fields.
- at0055::Pressure - The pressure measured in the ear canal.
- at0056::Compliance (conductance) - The amount of acoustic energy absorbed by the middle ear system at a specified pressure, measured in mmHo.
- at0057::Type B with high ECV - Rounded curve with measurable peak pressure; reduced static compliance; ear canal volume above the normal range.
- at0058::Tympanogram type C subtype - Subclassification of the tympanograms with negative peak pressure.

- at0059::Type C1 - A slight negative peak pressure, for example in range -100 to -199 daPa.
- at0060::Type C2 - A significant negative peak pressure, for example -200 daPa or greater.
- at0061::Type C3 - A negative peak pressure and low-normal static compliance.
- at0069::Compliance (volume) - The amount of acoustic energy absorbed by the middle ear system at a specified pressure, measured in cc3 or ml.
- at0070::Type D - A curve with a double peak; normal or reduced static compliance; normal ear canal volume.
- at0071::Tympanogram type B subtype - Subclassification of the tympanograms with a flat curve.
- at0072::Type B - high volume - Rounded curve with no measurable peak pressure; static compliance on lower limits of normal range; ear canal volume within normal range.
- at0073::Type B - low volume - Rounded curve with no measurable peak pressure, reduced static compliance; ear canal volume within normal range. Equivalent to the unqualified Type B classification.
- at0074::Static compliance (volume) - Static compliance (SC) is the greatest amount of acoustic energy absorbed by the middle ear system (the vertical peak of the tympanogram curve).

tympanogram_hf

Archetype ID: openEHR-EHR-OBSERVATION.tympanogram_hf.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: ar-sy, en

Purpose: To record measurements based on a multi-frequency (or sweep frequency) probe tone, or a probe tone higher than 226Hz, of the admittance or impedance of the middle ear system as a function of the pressure in the external ear canal pressure. To infer middle ear function from objective measurements based on a high frequency probe tone, taken at the tympanic membrane of the mobility of the tympanic membrane, in response to varying air pressure in the ear canal. To infer middle ear function from objective measurements based on a multi-frequency probe tone, taken at the tympanic membrane of the mobility of the tympanic membrane, in response to a specified air pressure in the ear canal.

Use: Use to record measurements taken during tympanometry with a high frequency probe tone (probetone higher than 226 Hz) or a multi-frequency probe tone. Use to record

outcome of tympanometry screening based on a high frequency probe tone (probe tone higher than 226 Hz) or a multi-frequency probe tone. Use to record the interpretation all tympanogram measurements taken with a high frequency probe tone (probetone higher than 226 Hz) or a multi-frequency probe tone, to infer middle ear function for each ear, plus an overall interpretation (or tympanometric diagnosis). All of the data elements are recorded using a single method or protocol. If, during the test, any of the protocol parameters need to be modified, then the subsequent part of the test will need to be recorded within a separate instance of the test data, using the updated protocol parameters. High frequency tympanometry is the test of choice in newborn to the age of two months. Both 226hz and high frequency tympanometry can be used together to test infants from from two to six months.

****Misuse:**** Not to be used to record other hearing tests. Use other archetypes as appropriate, for example OBSERVATION.audiogram_result. Not to be used to record 226Hz tympanometry. Use the OBSERVATION.tympanogram_226Hz archetype instead.

****Keywords:**** tympanogram, tympanometry, tympanometer, admittance, pressure, compliance, immittance, static, high, frequency

****Concepts:****

- at0000::Tympanogram test result - high frequency - Record of measurements of movement at the tympanic membrane in response to a multifrequency probe tone, or a probe tone higher than 226Hz, and changes in air pressure in the ear canal, and their clinical interpretation as an indication of middle ear function.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Tympanogram type - Classification of the the shape of the tympanogram curve.
- at0005::Type 1 - Curve with a single peak and TPP around 0 daPa.
- at0006::Type 2 - Flat sloping curve with no distinct peak, Ypeak < 0.2 mmho and/or TW >= 200 daPa.
- at0007::Type 4 - Double-peaked curve with TPP around 0 daPa.
- at0009::Test ear - Identification of the ear being tested.
- at0010::Left ear - The probe was in the left ear.
- at0011::Right ear - The probe was in the right ear.
- at0012::Result details - The tympanogram test result details, recorded per ear.
- at0013::Peak pressure - Peak pressure (also called tympanometric peak pressure or middle ear pressure or MEP) is the ear canal pressure at which the peak(s) of the tympanogram occurs.
- at0014::Y peak - Peak compensated static admittance.
- at0018::Ear canal volume - An estimate of the volume of air between the probe tip and the tympanic membrane if the tympanic membrane is intact, or the volume of the ear

canal and the middle ear space if the tympanic membrane is perforated. (Fowler & Shanks, 2002, p. 180).

- at0020::Test result image - Digital representation of the entire result.
- at0021::Comment - Additional narrative about the test results and interpretation not captured in other fields.
- at0027::Measurement details - Measurements derived from the tympanogram.
- at0029::Tympanometric width - The pressure interval corresponding to a 50% reduction in the peak static admittance.
- at0030::Tympanometric gradient - The steepness of the slope of the tympanogram near the peak.
- at0031::No test result - No test result is available for the test ear.
- at0032::Reason for no test result - Reason why no result is available for the test ear.
- at0033::Clinical interpretation - Clinical interpretation of all measurements for the test ear.
- at0035::Indeterminate - It is not possible to classify the type of tympanogram.
- at0036::Overall interpretation - Overall clinical interpretation of the measurements and related findings using an tympanometer.
- at0037::Baseline - Measurement collection recorded as the basis for comparison with following measurement collections that may included other variables of time or patient state.
- at0038::Post-Valsalva - Measurements are recorded after the patient has performed a valsalva manoeuvre.
- at0039::Post-Toynbee - Measurements are recorded after the patient has performed a toynbee manoeuvre.
- at0040::Tree - @ internal @
- at0046::Rate of pressure change - The rate of change of pressure used in tympanometry.
- at0050::Multi-frequency - Parameters used for multi-frequency tympanometry.
- at0051::Start pressure - The pressure value at which the pressure sweep for tympanometry begins.
- at0052::Stop pressure - The pressure value at which the pressure sweep for tympanometry ends. It is a negative pressure if the direction of pressure change is descending and a positive pressure if the direction of pressure change is ascending.
- at0053::Tympanometer - Details of tympanometer used to conduct the test.
- at0054::Comment - Additional narrative about the protocol for the tympanogram not captured in other fields.
- at0057::Type 3 - Curve with a single peak and TPP <-150 daPa.
- at0066::Vanhuyse classification type - Classification of tympanogram type based on Vanhuyse classification system.
- at0067::1B1G - The pattern of results showing 1 susceptance (B) peak and 1 conductance (G) peak.
- at0068::3B1G - The pattern of results showing 3 susceptance peaks and 1 conductance peak.

- at0070::Type 4u - Double-peaked curve with TPP <-150 daPa.
- at0074::Y+200 - Admittance at +200 daPa.
- at0075::Ear baseline value - Derived ear canal volume.
- at0076::Resonant frequency - Frequency at which the total susceptance is zero.
- at0077::F45 degree - The frequency corresponding to a 45° phase angle.
- at0078::3B3G - The pattern of results showing 3 susceptance (B) peaks and 3 conductance (G) peaks.
- at0079::5B3G - The pattern of results showing 5 susceptance (B) peaks and 3 conductance (G) peaks.
- at0080::Probe tone frequency - The frequency of the probe tone played into the ear canal for tympanometry measurement.
- at0081::Pressure - The fixed pressure in the ear canal.
- at0082::Sweep pressure - Parameters used for Sweep Pressure high frequency probe tone tympanometry.
- at0083::Start frequency - The frequency value at which the frequency sweep for tympanometry begins.
- at0084::Stop frequency - The frequency value at which the frequency sweep for tympanometry ends.
- at0085::Rate of frequency change - The rate of change of the probe tone frequency used in tympanometry.
- at0086::Y-400 - Admittance at -400 daPa.

urinalysis

****Archetype ID:**** openEHR-EHR-OBSERVATION.urinalysis.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** es-ar, sk, en, ar-sy, zh-cn

****Purpose:**** To record the results of a qualitative and semi-quantitative test array using reagent test strips to indicate possible abnormalities in a sample of urine. This test may be performed by clinicians at the point of care, technicians in a laboratory setting or individuals at home.

****Use:**** Use to record the results of a qualitative and semi-quantitative test array performed on a sample of urine, using reagent test strips. On exposure to urine, chemical pads on the reagent test strip change colour and the test result is read by visual comparison to a color chart at specified times after exposure or by an automated device. Different commercial products carry a variety of test /reagent pads. This archetype is heavily

influenced by the commonly available Multistix test strips in Australia, recording ten commonly used analytes, but is intended to be generically applicable. If requirements for other parameters become apparent to meet the requirements for other test strips then product-specific urinalysis archetypes may need to be developed.

****Misuse:**** Not to be used for recording urine microscopy or quantitative test results. Use the OBSERVATION.laboratory_test family of archetypes for this purpose. Not to be used for recording urine pregnancy tests. Use the OBSERVATION.pregnancy_test for this purpose.

****Keywords:**** urine, test, dip-stick, strip, multistix, urinalysis, analysis, dipstick, urinalyses

****Concepts:****

- at0000::Urinalysis - Qualitative and semi-quantitative test array using reagent test strips to indicate possible abnormalities in a sample of urine, often performed as part of Point of Care Testing (POCT).
- at0001::Event Series - @ internal @
- at0002::Point in Time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0030::Comment - Narrative about the urinalysis not captured in other fields.
- at0032::Blood - Detection of blood in urine sample.
- at0037::Ketones - Detection of ketones in urine sample.
- at0043::Nitrite - Detection of nitrites in urine sample.
- at0050::Glucose - Detection of glucose in urine sample.
- at0056::Urobilinogen - Detection of urobilinogen in urine sample.
- at0062::Bilirubin - Detection of bilirubin in urine sample.
- at0068::Leukocytes - Detection of white blood cells in urine sample.
- at0079::Tree - @ internal @
- at0095::Protein - Detection of protein in urine sample.
- at0096::Negative - No protein detected.
- at0097::Trace - Trace of protein detected.
- at0098::1+ - Amount equivalent to 30mg/dL (or 0.3 g/L) detected.
- at0099::2+ - Amount equivalent to 100mg/dL (or 1.0 g/L) detected.
- at0100::3+ - Amount equivalent to 300mg/dL (or 3.0 g/L) detected.
- at0101::4+ - Amount equivalent to >2000mg/dL (or >20 g/L) detected.
- at0102::Negative - No blood detected.
- at0103::Non-haemolysed Trace - Trace of non-haemolysed blood detected.
- at0104::Non-haemolysed Moderate - Moderate amount of non-haemolysed blood detected.
- at0105::Haemolysed Trace - Trace of haemolysed blood detected.
- at0106::1+ - Small amount of blood detected.
- at0107::2+ - Moderate amount of blood detected.
- at0108::3+ - Large amount of blood detected.

- at0109::Negative - No ketones detected.
- at0110::Trace - Amount equivalent to 5mg/dL (or 0.5 mmol/L) detected.
- at0111::Small - Amount equivalent to 15mg/dL (or 1.5 mmol/L) detected.
- at0112::Moderate - Amount equivalent to 40mg/dL (or 4.0 mmol/L) detected.
- at0113::Large - Amount equivalent to 80mg/dL (or 8.0 mmol/L) detected.
- at0114::Large+ - Amount equivalent to 160mg/dL (or 16 mmol/L) detected.
- at0115::Negative - No glucose detected.
- at0116::Trace - Amount equivalent to 1/10 g/dl (100mg/dL or 5 mmol/L) detected.
- at0117::1+ - Amount equivalent to 1/4 g/dL (250 mg/dL or 15 mmol/L) detected.
- at0118::2+ - Amount equivalent to 1/2 g/dl (500mg/dL or 30 mmol/L) detected.
- at0119::3+ - Amount equivalent to 1 g/dl (1000mg/dL or 60 mmol/L) detected.
- at0120::4+ - Amount equivalent >2 g/dl (>2000mg/dL or >120 mmol/L) detected.
- at0121::Negative - No bilirubin detected.
- at0122::1+ - Small amount detected.
- at0123::2+ - Moderate amount detected.
- at0124::3+ - Large amount detected.
- at0126::pH - Measurement of pH in urine sample.
- at0127::5.0 - pH of urine is equivalent to 5.0.
- at0128::5.5 - pH of urine is equivalent to 5.5.
- at0129::6.0 - pH of urine is equivalent to 6.0.
- at0130::6.5 - pH of urine is equivalent to 6.5.
- at0131::7.0 - pH of urine is equivalent to 7.0.
- at0132::7.5 - pH of urine is equivalent to 7.5.
- at0133::8.0 - pH of urine is equivalent to 8.0.
- at0134::8.5 - pH of urine is equivalent to 8.5.
- at0135::Negative - No leukocytes detected.
- at0136::Trace - Trace detected.
- at0137::1+ - Small amount detected.
- at0138::2+ - Moderate amount detected.
- at0139::3+ - Large amount detected.
- at0151::Specific gravity - Measurement of the concentration of substances dissolved (solutes) in the urine sample relative to distilled water.
- at0152::1.000 - Specific gravity is equivalent to 1.000.
- at0153::1.005 - Specific gravity is equivalent to 1.005.
- at0154::1.010 - Specific gravity is equivalent to 1.010.
- at0155::1.015 - Specific gravity is equivalent to 1.015.
- at0156::1.020 - Specific gravity is equivalent to 1.020.
- at0157::1.025 - Specific gravity is equivalent to 1.025.
- at0158::1.030 - Specific gravity is equivalent to 1.030.
- at0159::Negative - No nitrites detected.
- at0160::Positive - Nitrites were detected.
- at0161::Normal (lower) - Amount equivalent to 0.2 mg/dL detected.

- at0162::Normal (upper) - Amount equivalent to 1 mg/dL detected.
- at0163::2 mg/dL - Amount equivalent to 2mg/dL detected.
- at0164::4 mg/dL - Amount equivalent to 4mg/dL detected.
- at0165::8 mg/dL - Amount equivalent to 8mg/dL detected.
- at0176::9.0 - pH of urine is equivalent to 9.0.
- at0177::9.5 - pH of urine is equivalent to 9.5.
- at0179::10.0 - pH of urine is equivalent to 10.0.
- at0180::Reagent Strips - Details about the reagent strips used.
- at0181::Clinical interpretation - Single word, phrase or brief description represents the clinical meaning and significance of the urinalysis findings.
- at0182::Additional details - Additional details about the point of care urinalysis, including macroscopic appearance or other tests not currently captured in the structured data.
- at0183::Device - Details about the device used to automatically read the reagent strips.
- at0184::Extension - Additional information required to capture local content or to align with other reference models/formalisms.
- at0185::Exam not done - Details to explicitly record that urinalysis was not performed.
- at0186::Method - Method by which the reagent strips were read.
- at0187::Manual - The urinalysis results were determined by a person.
- at0188::Automatic - The urinalysis results were determined by a medical device.

[uterine_contractions](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.uterine_contractions.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** ar-sy, en

****Purpose:**** Documenting details about uterine contractions.

****Concepts:****

- at0000::Uterine contractions - The strength, duration and frequency of uterine contractions.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Strength - The strength of uterine contractions.

- at0005::Not noticeable to mother - The contractions are not noticeable.
- at0006::Very mild - Noticeable but not effective.
- at0007::Mild - Causing some sensation in the back or lower pelvis.
- at0008::Moderate - Causing discomfort or strong pressure in the back or lower pelvis.
- at0009::Strong - Fully active uterus during labour.
- at0010::Very strong - Possibly excessively strong contractions.
- at0011::Duration - The duration of the contractions.
- at0012::Frequency - A group of frequency statements.
- at0013::Begin every... - The time from the beginning of one contraction to the beginning of the next.
- at0014::Frequency per 10 minutes - *
- at0015::Intra-uterine pressure - The peak intra-uterine pressure during the contraction.
- at0016::Pattern - The rhythm of the contractions.
- at0017::Regular - The contractions are regular or equally spaced.
- at0018::Irregular - The contractions are irregular or at different intervals.
- at0019::Continuous - The uterus is not relaxing between contractions.
- at0023::Not effective - Contractions are not effective.
- at0024::Effectiveness - The effectiveness of the contractions.
- at0025::Effective - Contractions are effective.
- at0026::Expulsive - Uterine contractions are expelling the baby.
- at0027::Tree - @ internal @
- at0028::Method - The method used to determine the uterine contraction features.
- at0029::Manual - By palpation.
- at0030::Maternal report - By the subjects report.
- at0031::Tocogram - Measurement with a tocogram.
- at0035::Frequency per hour - *
- at0036::Diminishing - *
- at0037::Duration comment - A textual comment on the duration of contractions - e.g. '10 to 20 seconds'.
- at0038::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

vaccination_screening

Archetype ID: openEHR-EHR-OBSERVATION.vaccination_screening.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: en

****Purpose:**** To create a framework for recording answers to pre-defined screening questions about the use of any specified vaccination or grouping of vaccinations.

****Use:**** Use to create a framework for recording answers to pre-defined screening questions about the use of any specified vaccination or grouping of vaccinations. Examples of specific vaccinations and groupings of vaccinations effective against a specific infectious disease are Tetanus toxoid, and COVID-effective vaccinations, respectively. Common use cases include, but are not limited to: - Systematic questioning in any consultation related to patterns of vaccine administration, for example: --- Do you ever been vaccinated for tetanus? Yes, No, Unknown. --- Have you received a COVID booster in the past 6 months? Yes, No, Unknown. -- How many COVID boosters have you received? When was the last one? The semantics of this archetype are intentionally loose, and querying this archetype would normally only be useful or safe within the context of each specific template. In a template, each data element would usually be renamed to the specific question asked. Where value sets have been proposed for common use cases, these can be adapted for local use by using the DV_TEXT or the DV_BOOLEAN datatypes choice to match each specific use case. The EVENT structure from the reference model can be used to specify whether the questions relate to point in time or over a period of time. Use a separate instance of this archetype to distinguish between a questionnaire recording information about a medication that has been used at any time in the past and information about a medication used within a specified time interval - for example the difference between "Do you use paracetamol?" compared to "Have you been using any anticoagulants during the last four weeks?". The source of the information in a questionnaire response may vary in different contexts but can be specifically identified using the 'Information provider' element in the Reference Model. This archetype has been designed to be used as a screening tool or to record simple questionnaire-format data for use in situations such as a disease registry. If the screening questionnaire identifies the administration of a vaccination it is recommended that the clinical system record and persist the specific details about the vaccination using a relevant archetype, for example the EVALUATION.immunisation_summary to record a detailed snapshot view about the immune status of an individual for a specific infectious disease or a relevant ACTION archetype to record details about a specific administration.

****Misuse:**** Not to be used for recording an order for a vaccine to be administered - use INSTRUCTION.medication_order for this purpose. Not to be used for recording the administration, dispensing or consumption of a vaccine - use ACTION.vaccine for this purpose. Not to be used for recording a summary of use of a vaccine over the lifetime of the individual - use EVALUATION.immunisation_summary for this purpose. Not to be used to record details about the positive absence of a specific vaccine or grouping of vaccines, outside of a screening context. Use EVALUATION.exclusion_specific for this purpose. Not to be used to create a framework for recording answers to pre-defined screening questions about adverse reactions, use an appropriate archetype for this purpose.

****Keywords:**** vaccination, screening, questionnaire, prevention

****Concepts:****

- at0000::Vaccination screening questionnaire - Series of questions and associated answers used to screen for the administration of vaccination.
- at0001::Tree - @ internal @
- at0005::Tree - @ internal @
- at0019::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0021::Vaccination name - Name of vaccination or targeted infectious disease.
- at0022::Event Series - @ internal @
- at0023::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0024::Vaccinated? - Is there a history of use of a specific vaccine or group of vaccines.
- at0025::Comment - Narrative description about the Vaccination screening, not otherwise captured in data fields.
- at0026::Specific vaccination - Details about a specified vaccine or grouping of vaccines relevant for the screening purpose.
- at0027::Any vaccinations? - Is there a history of administration of any vaccinations related to the screening purpose?
- at0028::Yes - None
- at0029::No - None
- at0030::Unknown - None
- at0036::Yes - None
- at0037::No - None
- at0039::Unknown - None
- at0040::Screening purpose - The context or reason for screening.
- at0041::Additional details - Structured details or questions about the specific vaccine or grouping of vaccines.
- at0042::Additional details - Structured details or questions about vaccination screening.
- at0043::Description - Narrative description about the history of administration of any vaccinations relevant for the screening purpose.
- at0044::Vaccine name - Name of the vaccination.
- at0045::Disease name - Name of the targeted infectious disease.
- at0046::Scar present? - Presence or absence of an observed vaccine-related scar.
- at0047::Yes - None
- at0048::No - None
- at0049::Unknown - None
- at0050::Information source - Source of vaccination information provided.

vaccination_status

Archetype ID: openEHR-EHR-OBSERVATION.vaccination_status.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the vaccination status of an individual for an identified infectious disease or agent, at a specified point in time.

****Use:**** Use to record the vaccination status of an individual for an identified infectious disease or agent, at a specified point in time. This archetype has been designed to be used within the context of a Vaccine certificate or other document that requires information about whether the individual is fully vaccinated or not. It is intended to complement the EVALUATION.vaccination_summary archetype which records a summary of previously administered vaccines.

****Concepts:****

- at0000::Vaccination status - Vaccination status of an individual for an identified infectious disease or agent.
- at0001::History - @ internal @
- at0002::Any event - None
- at0003::Tree - @ internal @
- at0004::Vaccination status - An assertion about whether the individual has received all recommended vaccines for the targeted disease or agent.
- at0005::Targeted disease or agent - Name of the infectious disease or agent targeted by a vaccine.
- at0006::Item tree - @ internal @
- at0007::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.

[**ventilator_record**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.ventilator_record.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** _unknown_

****Concepts:****

- at0000::Ventilator record - Ventilator record
- at0001::History - @ internal @
- at0002::Any event - None
- at0003::Tree - @ internal @
- at0004::Respiration rate - None
- at0005::Rapid shallow breathing index (RSBI) - None
- at0006::Lung compliance - None
- at0007::End tidal CO₂ - None
- at0008::Inspired CO₂ - None
- at0009::End-Tidal N₂O - None
- at0010::Item tree - @ internal @
- at0011::Inspired N₂O - None
- at0012::End-tidal O₂ - None
- at0013::Inspired O₂ - None
- at0017::Positive end expiratory pressure (PEEP) - None
- at0018::Positive inspiratory pressure (PIP) - None
- at0019::Negative inspiratory pressure (NIP) - None
- at0020::Inspiration/expiration (I/E) ratio - None
- at0021::Tidal volume - None
- at0022::Peak inspiratory flow (PIF) - None
- at0023::Peak expiratory flow (PEF) - None
- at0024::Flow minute volume (MV) - None
- at0025::CO₂ respiration rate - Rate measured by end tidal CO₂ wave form
- at0026::Transthoracic respiration rate - Rate measuring transthoracic impedance or muscle activity
- at0027::Respiration type - None
- at0028::Spontaneous - None
- at0029::Assisted - None
- at0030::Spontaneous respiration rate - Generated by the patient
- at0032::Tidal volume (TV) - None
- at0033::Inspiration time - None
- at0034::Expiration time - None
- at0035::Total respiration rate - Sum of spontaneous rate + ventilator rate
- at0036::Ventilator respiration rate - Generated by the device
- at0037::Plateau inspiratory pressure - None
- at0038::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.

visaa

****Archetype ID:**** openEHR-EHR-OBSERVATION.visaa.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** For the capture and reporting of details of the VISA-A questionnaire, an index of the severity of Achilles tendinopathy.

****Use:**** Use to record details of the VISA-A questionnaire, an index of the severity of Achilles tendinopathy. This questionnaire is a patient-reported outcome measure (PROM) for foot and ankle surgery. While openEHR archetypes are all freely available under an open license, the specific content of this archetype may be copyright protected. Any use of this archetype within implementations must be in compliance with the terms established by the copyright owners where a copyright exists.

****Misuse:**** Not to be used unless the terms of copyright have been observed (if a copyright exists).

****Concepts:****

- at0000::VISA-A - VISA-A questionnaire: an index of the severity of Achilles tendinopathy.
- at0001::Event Series - @ internal @
- at0002::Point in time - A specific date and/or time which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::1 Minutes stiffness - Patient-reported estimation of how many minutes of stiffness in Achilles region is experienced when first getting up.
- at0005::Zero minutes - The patient experiences zero minutes of stiffness in Achilles region when first getting up.
- at0006::10 minutes - The patient experiences about 10 minutes of stiffness in Achilles region when first getting up.
- at0007::20 minutes - The patient experiences about 20 minutes of stiffness in Achilles region when first getting up.
- at0008::30 minutes - The patient experiences about 30 minutes of stiffness in Achilles region when first getting up.
- at0009::100 minutes - The patient experiences about 100 minutes or more of stiffness in Achilles region when first getting up.
- at0010::90 minutes - The patient experiences about 90 minutes of stiffness in Achilles region when first getting up.

- at0011::80 minutes - The patient experiences about 80 minutes of stiffness in Achilles region when first getting up.
- at0012::70 minutes - The patient experiences about 70 minutes of stiffness in Achilles region when first getting up.
- at0013::60 minutes - The patient experiences 60 minutes of stiffness in Achilles region when first getting up.
- at0014::50 minutes - The patient experiences about 50 minutes of stiffness in Achilles region when first getting up.
- at0015::40 minutes - The patient experiences about 40 minutes of stiffness in Achilles region when first getting up.
- at0016::2 Pain when stretching Achilles tendon - Patient-reported estimation of pain experienced, once warmed up for the day, when stretching Achilles tendon fully over the edge of a step (keeping knee straight), on a scale of 0 to 10, where 0 indicates strong severe pain and 10 indicates no pain.
- at0017::3 Pain when walking on flat ground - Patient-reported estimation of severity of pain experienced within 2 hours after walking on flat ground for 30 minutes, on a scale of 0 to 10, where 0 indicates strong severe pain or unable to walk for 30 minutes because of pain, and 10 indicates no pain.
- at0018::4 Pain walking downstairs - Patient-reported estimation of severity of pain experienced when walking downstairs with a normal gait cycle, on a scale of 0 to 10 where 0 indicates strong severe pain and 10 indicates no pain.
- at0019::5 Pain after heel raises - Patient-reported estimation of pain experienced during or immediately after doing 10 single leg heel raises from a flat surface, on a scale of 0 to 10 where 0 indicates strong severe pain and 10 indicates no pain.
- at0020::6 Single leg hops without pain - Patient-reported count of ability to do single leg hops without pain.
- at0021::7 Sport or other physical activity - Patient-reported extent to which sport or other physical activity is currently being undertaken.
- at0022::Not at all - The patient does not currently undertake sport or other physical activity.
- at0023::Modified training and or modified competition - The patient is currently undertaking sport or other physical activity at a modified training and/or modified competition level.
- at0024::Full training and or competition but not same level as before - The patient is currently undertaking sport or other physical activity at full training and/or competition level, but not the same level as when symptoms began.
- at0025::Competing at same or higher level - The patient is currently competing in sport or other physical acuity at the same or higher level as when symptoms began.
- at0026::8a No pain, length of training - For patients experiencing no pain while undertaking Achilles tendon loading sports, length of time patient can train or practise.
- at0027::Nil - Patient cannot train or practise.
- at0028::1 to 10 minutes - Patient can train or practise for 1 to 10 minutes.
- at0029::11 to 20 minutes - Patient can train or practise for 11 to 20 minutes.

- at0030::21 to 30 minutes - Patient can train or practise for 21 to 30 minutes.
- at0031::More than 30 minutes - Patient can train or practise for more than 30 minutes.
- at0032::8b Some pain, length of training - For patients experiencing some pain while undertaking Achilles tendon loading sports, but pain does not stop them from completing training or practice, length of time patient can train or practise.
- at0033::Nil - Patient cannot train or practise.
- at0034::1 to 10 minutes - Patient can train or practise for 1 to 10 minutes.
- at0035::11 to 20 minutes - Patient can train or practise for 11 to 20 minutes.
- at0036::21 to 30 minutes - Patient can train or practise for 21 to 30 minutes.
- at0037::More than 30 minutes - Patient can train or practise for more than 30 minutes.
- at0038::8c Pain stopping completion, length of training - For patients experiencing pain while undertaking Achilles tendon loading sports which stops them from completing training or practice, length of time patient can train or practise.
- at0039::Nil - Patient cannot train or practise.
- at0040::1 to 10 minutes - Patient can train or practise for 1 to 10 minutes.
- at0041::11 to 20 minutes - Patient can train or practise for 11 to 20 minutes.
- at0042::21 to 30 minutes - Patient can train or practise for 21 to 30 minutes.
- at0043::More than 30 minutes - Patient can train or practise for more than 30 minutes.
- at0044::Total score - Total score from questions 1 to 8.
- at0045::Total score as percentage - Total score from questions 1 to 8 as a percentage.
- at0046::Tree - @ internal @
- at0047::Confounding factors - Record any issues or factors that may impact on the score or interpretation.
- at0048::ItemTree - @ internal @
- at0049::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

visual_acuity

****Archetype ID:**** openEHR-EHR-OBSERVATION.visual_acuity.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en, es-cl

****Purpose:**** For recording the results of both near and distance visual acuity testing, normally measured by testing the subject's ability to read a standard test pattern at a defined distance.

****Use:**** Use to record the results of measurement of visual acuity, for both near and distance testing. The 'Clinical Description' data element can be used to record simple narrative summary or as a means to integrate legacy data. Detailed, structured visual acuity results are preferred and are generally recorded for each eye in turn. Visual acuity may be recorded using a number of different notation formats e.g. Snellen, logMar, EDTRS etc. In some settings the visual acuity result, originally captured using one of the standard notations, is converted to a 'Derived Score' capable of algorithmic conversion to the other notations., with details of the original notation and algorithm employed recorded as part of protocol. Where visual acuity is recorded using coded terms such as 'Visual Acuity 6/6' or 'Jaeger score N1', the 'Clinical Interpretation' element should be used, allowing the result to be captured for each eye. 'Overall Interpretation' should be used where the interpretation applies to both eyes or the test result as a whole. The 'Absent Test Result' element may be used to record circumstances where a test could not be performed or completed. Further details may be recorded under 'Confounding Factors' or 'Additional Comment'. When performing visual acuity testing it is customary to record a series of tests sharing a common charting methodology but with different phases of corrective refraction e.g. Unaided, Usual correction, Best corrected visual acuity etc. Each of these phases should be recorded using a separate Entry record, with the name of the test phase carried in 'Test Name'. Further specific details of the exact correction applied (which may involve applying multiple refractions) may be captured in 'Refractive Correction' and 'Refraction Details' the latter making use of separate Cluster archetypes, one for each eye.

****Misuse:**** Where details of methodology carried under protocol change between phases of the visual acuity test, a new Entry must be created at run-time.

****Keywords:**** eye, sight, vision, ophthalmic, visual, refraction

****Concepts:****

- at0000::Visual acuity test result - Visual acuity is a measure of the spatial resolution of the visual processing system.
- at0001::Event Series - @ internal @
- at0003::Tree - @ internal @
- at0007::Eye examined - The eye which is being examined.
- at0009::US Snellen - The distance test result, recorded as Snellen visual acuity expressed in feet, where 20/20 is regarded as normal.
- at0010::Derived Score - Visual acuity expressed as an integer score which is calculated from one or more of the other result notation formats. The original notation should be captured using 'Derived Score Original Notation' format'.
- at0011::ETDRS Letters - Visual acuity expressed using ETDRS Letters format, with a value of 100 regarded as normal.
- at0012::Left eye - The test result refers to the visual acuity of the left eye only.
- at0013::Right eye - The test result refers to the visual acuity of the right eye only.
- at0014::Both eyes simultaneously - Both eyes were examined simultaneously.

- at0015::Low Vision Score - Graded scale used when patient has low levels of visual acuity.
- at0016::NPL - No perception of light - The subject has no perception of light.
- at0017::PL - Perception of light - The subject can perceive light.
- at0018::HM - Hand movement - The subject can perceive hand movement.
- at0019::CF - Count fingers - The subject can count fingers.
- at0020::Tree - @ internal @
- at0021::Chart Optotype - The style of chart optotype used to assess visual acuity.
- at0022::Chart Scoring Algorithm - The algorithm used to determine the score.
- at0023::Chart Method - The charting method used to measure visual acuity.
- at0025::Measurement Device Details - Details of the device used to measure visual acuity.
- at0028::Notation - Details of a visual acuity result recorded using one of the result notation formats.
- at0039::Description - An overall narrative description of the visual acuity test result.
- at0040::Comment - Any additional narrative comment about the visual acuity test.
- at0041::Tree - @ internal @
- at0042::Refractive Correction - The specific type(s) of refractive correction applied when measuring visual acuity.
- at0046::logMar - The test result, recorded as logMar visual acuity, where a value of 0 is regarded as normal.
- at0053::Result details - Details of the visual field test result for each eye.
- at0054::Overall Interpretation - A term, commonly coded, expressing an overall interpretation of the visual acuity test.
- at0055::No test result - No visual acuity test result is available for the test eye.
- at0056::Metric Snellen - The distance test result, recorded in Snellen format expressed in metres, where 6/6 is regarded as normal.
- at0057::Decimal Snellen - The distance test result, recorded as Sn ellen visual acuity expressed as a decimal ratio, where 1.0 is regarded as normal.
- at0059::Letter Termination Adjustment - A line termination adjustment score applied to the visual acuity result.
- at0066::Interpretation - Clinical interpretation of all results for the test eye.
- at0071::Spectacles - The subject's vision was corrected by spectacles.
- at0072::Contact lenses - The subject's vision was corrected by contact lenses.
- at0073::Pinhole - The subject's vision was corrected by use of a pinhole.
- at0074::Autorefraction - The subject's vision was corrected by autorefraction.
- at0075::Retinoscopy - The subject's vision was corrected by retinoscopy.
- at0080::Refraction Details - Details of the refraction applied to each eye.
- at0081::Testing Distance - The distance at which the subject's visual acuity was measured.
- at0082::logMar chart - A logMar chart was used to measure distance visual acuity.
- at0083::Snellen chart - A Snellen chart was used to measure distance visual acuity.

- at0084::ETDRS chart - An ETDRS chart was used to measure distance visual acuity.
- at0092::Derived Score Original Notation - The original visual acuity result notation from which the Derived Score was calculated.
- at0096::Reduced logMar - A Reduced logMar chart was used to measure near visual acuity.
- at0097::Reduced Snellen - A Reduced Snellen chart was used to measure near visual acuity.
- at0098::Faculty of Ophthalmologists 'N' Score - Faculty of Ophthalmologists 'N' Score chart was used to measure near visual acuity.
- at0099::Jaeger 'J' Score - A Jaeger 'J' Score chart was used to measure near visual acuity.
- at0100::Single letter - A single letter algorithm was used to derive the visual acuity score.
- at0101::Whole line - A whole line algorithm was used to derive the visual acuity score.
- at0102::Last line single letter - A last line single letter algorithm was used to derive the visual acuity score.
- at0106::Letter - A letter optotype was used to measure distance visual acuity.
- at0107::Orientation - An orientation optotype was used to measure distance visual acuity.
- at0108::Picture - A picture optotype was used to measure distance visual acuity.
- at0109::Picture chart - A picture chart was used to measure distance visual acuity.
- at0112::Confounding Factors - Patient circumstances which affect interpretation of the result. Often termed 'reliability' in ophthalmological documentation.
- at0117::Derived Score Algorithm - Details of the algorithm used to calculate a derived score.
- at0124::Pupillary State - Details of the state of the pupil on examination.
- at0134::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0135::Pinhole visual acuity - The test is performed with pinhole refraction applied.
- at0136::Usual corrected visual acuity - The test is performed with the patient's usual refractive correction i.e spectacles or contact lenses.
- at0137::Best corrected visual acuity - The test is performed with the patient's optimal refractive correction.
- at0138::Test name - The name of the exact visual acuity test performed. This generally represents a broad category of applied refraction. Specific refraction details can be described using 'Refractive Correction'.
- at0139::Unaided visual acuity - The test was performed without visual aid.
- at0140::Reason for no test result - Reason why no visual acuity test result is available for the test eye.
- at0141::Test not done - Details to explicitly record that this test was not performed.
- at0143::Extension - Additional information required to capture local content or to align with other reference models/formalisms.

visual_field_measurement

****Archetype ID:**** openEHR-EHR-OBSERVATION.visual_field_measurement.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the results of visual field testing or perimetry.

****Use:**** Use to record the results of visual field testing or perimetry. Use to incorporate the narrative descriptions of clinical findings within existing or legacy clinical systems into an archetyped format, using the 'Clinical Description' data element. Detailed, structured visual acuity results are preferred and are generally recorded for each eye in turn. If the method of measurement or device is changed for the testing of the second eye, record the second eye's data in another instance of data which captures the new method or device.

****Keywords:**** perimetry, ophthalmic, optometry, eye, vision, visual

****Concepts:****

- at0000::Visual field measurement - Results of visual field testing / perimetry.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0005::Clinical description - Narrative description of the overall findings observed during the test.
- at0007::Test result - Details of the visual field test result for each eye.
- at0008::Eye examined - The eye which is being examined.
- at0009::Clinical interpretation - Clinical interpretation of all measurements for the test eye.
- at0010::Tree - @ internal @
- at0019::Left eye - The left eye was examined.
- at0020::Right eye - The right eye was examined.
- at0022::Tree - @ internal @
- at0023::Confounding factors - Patient circumstances which may affect interpretation of the result.
- at0024::Comment - Additional narrative about the overall test results and interpretation not captured in other fields.

- at0025::Overall interpretation - Overall clinical interpretation of the measurements and related findings of visual field testing.
- at0026::Device details - Details of the device used to measure visual fields.
- at0027::Perimetry test interpretation - A coded interpretation of the Visual field test result.
- at0028::Outside normal limits - Differences between a matched pair of corresponding zones exceeds the difference found in 99% of the normal population, or when both members of a pair of zones are more abnormal than 99.5% of the individuals with the normative population. Corresponds to DICOM Code value 111847.
- at0029::Borderline - Matched pairs of zones are abnormal at the 97th percentile within the normative database. Corresponds to DICOM Code value 111848.
- at0030::General reduction of sensitivity - Conditions for "outside normal limits" are not met, and the best region of the visual field is at or below the 99.5th percentile of the normative population. Corresponds to DICOM Code value 111850.
- at0031::Abnormally high sensitivity - Overall sensitivity in the affected region of the VF is better than 99.5% of individuals within the normative population. Corresponds to DICOM Code value 111849.
- at0032::Within normal limits - None of the abnormal conditions are met. Corresponds to DICOM Code value M-00101.
- at0034::Mean Deviation (MD) - Weighted average deviation from the age corrected normal field, in dB.
- at0035::Pattern Standard Deviation (PSD) - Average of non-uniform visual field loss or weighted square root of loss variance, in dB.
- at0036::Refractive correction - Details of refractive correction applied to each eye.
- at0037::Visual Field Index (VFI) - Visual Field Index result.
- at0038::Mean Deviation P (MD) - The P value of the Mean Deviation result.
- at0039::Pattern Standard Deviation P (PSD) - The P value of the Pattern Standard deviation result.
- at0042::Examination findings - pupils - Details of pupils from the patient during the test.
- at0048::Fixation checked quantity - The number of times that the patient's gaze fixation is checked.
- at0049::Patient not properly fixated quantity - The number of times the patient's gaze is not properly fixated.
- at0052::Test result name - Identification of the visual field test being performed, by name.
- at0053::Borderline and general reduction in sensitivity - Analysis Results identify Borderline and general reduction in sensitivity. Corresponds to DICOM Code value 111851.
- at0054::Foveal sensitivity measured - Whether foveal sensitivity was measured.
- at0055::Foveal sensitivity - Foveal Sensitivity is the reciprocal of foveal threshold (1/foveal threshold), in dB.

- at0056::False positives estimate - Estimated percentage of all patient responses that occurred at a time when no visual stimulus was present (false positive responses), as percent.
- at0057::False negatives estimate - Estimated percentage of all stimuli that were not seen by the patient but were previously seen at a lower luminance earlier in the visual field test (false negative responses), as percent. Matches to DICOM (0024,0046) attribute.
- at0058::Short-Term Fluctuation (SF) - Average deviation of sensitivity for the repeated test locations, in dB. This is used to determine the consistency of the patient's responses.
- at0059::Corrected Pattern Standard Deviation (CPSD) - Weighted square root of loss variance corrected for short term fluctuation, in dB.
- at0060::Visual field index - Index of a patient's remaining visual field normalized for both age and generalized defect. Corresponds to DICOM Code value 111852.
- at0061::Visual field loss due to diffuse defect - Estimate of the portion of a patient's visual field loss that is diffuse (i.e. spread evenly across all portions of the visual field). Corresponds to DICOM Code value 111853.
- at0062::Visual field loss due to local defect - Estimate of the portion of a patient's visual field loss that is local (i.e. not spread evenly across all portions of the visual field). Corresponds to DICOM Code value 111854.
- at0063::Glaucoma Hemifield Test Analysis (GHT) - An analysis of asymmetry between zones of the superior and inferior visual field. It is designed to be specific for defects due to glaucoma. Corresponds to DICOM Code value 111855.
- at0064::Optical fixation measurements - The data output of an optical fixation monitoring process, consisting of a list of positive and negative numbers indicating the quality of patient fixation over the course of a visual field test. The value 0 represents the initial fixation. Negative numbers indicate a measuring error (i.e. the patient blinked). Positive numbers quantify the degree of eccentricity from initial fixation. Corresponds to DICOM Code value 111856.
- at0164::Glaucoma Hemifield Test (GHT) - A coded interpretation of the Glaucoma Hemifield Test (GHT).
- at0165::Outside normal limits - Differences between a matched pair of corresponding zones exceeds the difference found in 99% of the normal population, or when both members of a pair of zones are more abnormal than 99.5% of the individuals with the normative population.
- at0166::Borderline - Matched pairs of zones are abnormal at the 97th percentile within the normative database.
- at0167::General reduction of sensitivity - Conditions for "outside normal limits" are not met, and the best region of the visual field is at or below the 99.5th percentile of the normative population.
- at0168::Abnormally high sensitivity - Overall sensitivity in the affected region of the VF is better than 99.5% of individuals within the normative population.
- at0169::Within normal limits - None of the abnormal conditions are met.

- at0170::Acquisition details - Details about the strategy to conduct the visual field test.
- at0171::Multimedia - Digital representation of the test results.
- at0172::Test not done - Details to explicitly record that this test was not performed.
- at0173::Comment - Additional narrative about the visual field testing for the eye examined, not captured in other fields.
- at0174::No test result - No visual field test result is available for the eye examined.
- at0175::Reason for no test result - Reason why no visual field test result is available for the eye examined.

vital_status

****Archetype ID:**** openEHR-EHR-OBSERVATION.vital_status.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record whether an individual is alive or dead at a specified point in time.

****Use:**** Use to record whether an individual is alive or dead at a specified point in time.

****Misuse:**** Not to be used to record details about the death of an individual - use EVALUATION.death_summary or EVALUATION.cause_of_death for this purpose.

****Keywords:**** alive, dead, deceased, living, vital, status

****Concepts:****

- at0000::Vital status - Status of an individual as alive or dead.
- at0001::History - @ internal @
- at0002::Any point in time event - Default, unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Vital status - Whether an individual is alive or dead.
- at0005::Alive - The individual is not dead.
- at0006::Dead - The individual is no longer alive.
- at0007::Item tree - @ internal @
- at0008::Extension - Additional information required to extend the model with local content or to align with other reference models/formalisms.
- at0009::Unknown - It is unknown if the individual is alive or dead.

vte_risk_uk_nice

Archetype ID: openEHR-EHR-OBSERVATION.vte_risk_uk_nice.v0

Lifecycle State: in_development

Category: OBSERVATION

Languages: nb, en

Purpose: _unknown_

Concepts:

- at0000::VTE risk (UK NICE) - *Vurdering av risiko for venøs tromboembolisme. (nb)
- at0001::Event Series - @ internal @
- at0002::Any event - *
- at0003::Tree - @ internal @
- at0004::Type of patient - *Beskriver pasienttype mtp på type problemstilling og mobilitet f.eks. kirurgisk pasient, nedsatt mobilitet osv. (nb)
- at0007::Initial screening - If the answer to any of the two first questions is "yes", the main screening is performed.
- at0010::*Tromboserisiko (nb) - *Screening for tromboserisiko. (nb)
- at0012::*Aktiv kreft eller pågående kreftbehandling (nb) - *Har pasienten aktiv kreft eller pågående kreftbehandling? (nb)
- at0013::*Alder > 60 (nb) - *Er pasienten eldre enn 60 år? (nb)
- at0014::*Dehydrert (nb) - *Er pasienten dehydrert? (nb)
- at0016::*Kjent trombofili (nb) - *Har pasienten kjent trombofili? (nb)
- at0017::*Sykelig overvekt (nb) - *Har pasienten sykelig overvekt med en BMI >30 kg/m2? (nb)
- at0018::*En eller flere medisinske relevante komorbiditeter (nb) - *Har pasienten en eller flere medisinske relevante komorbiditeter f.eks. hjertesykdom, metabolisk, hormonelle eller respiratrisk sykdom? (nb)
- at0019::*Førstegradsslektning med tidligere venøs trombose (nb) - *Har pasienten førstegradsslektning med tidligere venøs trombose? (nb)
- at0020::*Bruker hormontilskudd (HRT) (nb) - *Bruker pasienten hormontilskudd (HRT)? (nb)
- at0021::*Bruker antikonsepsjonsmiddel som inneholder østrogen (nb) - *Bruker pasienten antikonsepsjonsmiddel som inneholder østrogen? (nb)
- at0022::*Varicer med thrombophlebit (nb) - *Har pasienten varicer med thrombophlebit? (nb)

- at0023::*Gravid eller < 6 uker post partum (nb) - *Er pasienten gravid eller < 6 uker post partum? (nb)
- at0026::*Betydelig redusert mobilitet > 3 dager (nb) - *Har pasienten betydelig redusert mobilitet > 3 dager? (nb)
- at0027::*Hofte eller kneoperasjon (nb) - *Er pasienten innlagt for hofte eller kneoperasjon? (nb)
- at0028::*Hoftebrudd (nb) - *Har pasienten hoftebrudd? (nb)
- at0029::*Total operasjonstid (anestesi + kirurgi) > 90 min (nb) - *Er den totale operasjonstiden (anestesi + kirurgi) lengre enn 90 min? (nb)
- at0030::*Kirurgi på nedre ekstremitet med operasjonstid (anestesi + kirurgi) >60 min (nb) - *Har pasienten hatt kirurgi på nedre ekstremitet med operasjonstid (anestesi + kirurgi) > 60 min? (nb)
- at0031::*Akutt kirurgisk innleggelse med betennelsestilstand eller intra-abdominell tilstand (nb) - *Ble pasienten akutt innlagt på kirurgisk avdeling med en betennelsestilstand eller en intra-abdominal tilstand? (nb)
- at0032::*Innleggelse på intensivavdelingen (nb) - *Er pasienten innlagt på intensivavdelingen? (nb)
- at0033::*Kirurgi som medfører betydelig reduksjon i mobilitet (nb) - *Har/skal pasienten ha kirurgi som medfører betydelig reduksjon i mobilitet? (nb)
- at0091::*Pasientrelatert (nb) - *Pasientrelatert informasjon vedrørende tromboserisiko. (nb)
- at0092::*Innleggelsesrelatert (nb) - *Informasjon relatert til innleggelse vedrørende tromboserisiko. (nb)
- at0094::*Kirurgisk pasient (nb) - *Pasient som er innlagt for kirurgisk prosedyre (nb)
- at0095::*Pasient med forventet nedsatt mobilitet (nb) - *Ikke kirurgisk pasient med forventet nedsatt mobilitet (nb)
- at0096::*Pasient uten forventet nedsatt mobilitet (nb) - *Ikke kirurgisk pasient uten forventet nedsatt mobilitet (nb)
- at0097::*Blødningsrisiko (nb) - *Screening for blødningsrisiko (nb)
- at0098::*Aktiv blødning (nb) - *Har pasienten aktiv blødning? (nb)
- at0099::*Ervervet blødningsforstyrrelse (nb) - *Har pasienten ervervet blødningsforstyrrelse som f.eks. akutt leversvikt? (nb)
- at0100::*Bruk av antikoagulantia med kjent økt risiko for blødning (nb) - *Har pasienten bruk av antikoagulantia med kjent økt risiko for blødning f.eks. Warfaring med INR >2 (nb)
- at0102::*Akutt slaganfall (nb) - *
- at0103::*Trombocytopeni (nb) - *Har pasienten trombocytopeni (trombocyttet <75 x 10 -9/l) (nb)
- at0104::*Ukontrollert systolisk hypertensjon (nb) - *Har pasienten ukontrollert systolisk hypertensjon (230/120 mmHg eller høyere. (nb)
- at0105::*Ubehandlete arvelige blødningssykdommer (nb) - *Har pasienten ubehandlete arvelige blødningssykdommer? (nb)

- at0106::*Pasientrelatert (nb) - *Pasientrelatert informasjon vedrørende blødningsrisiko. (nb)
- at0107::*Innleggelsesrelatert (nb) - *Informasjon relatert til innleggelse vedrørende blødningsrisiko. (nb)
- at0108::*Nevrokirurgi, spinalkirurgi eller øyekirurgi (nb) - *Skal pasienten/har pasienten hatt nevrokirurgi, spinalkirurgi eller øyekirurgi? (nb)
- at0109::*Annen prosedyre med høy blødningsrisiko (nb) - *Skal pasienten/har pasienten hatt annen prosedyre med høy blødningsrisiko? (nb)
- at0110::*Forventet lumbal/spinal/epiduralanestesi innen de neste 12 timene (nb) - *Skal pasienten ha forventet lumbal/spinal/epiduralanestesi innen de neste 12 timene? (nb)
- at0111::*Lumbal/Spinal/epiduralanestesi de siste 4 timene (nb) - *Har pasienten hatt lumbal/Spinal/epiduralanestesi de siste 4 timene? (nb)
- at0112::*Tromboserisiko (nb) - *Samlet tromboserisiko. "Ja" indikerer at pasienten har tromboserisiko. "Nei" indikerer at pasienten ikke har tromboserisiko. (nb)
- at0115::*Blødningsrisiko (nb) - *Samlet blødningsrisiko. "Ja" indikerer at pasienten har blødningsrisiko. "Nei" indikerer at pasienten ikke har blødningsrisiko. (nb)
- at0116::*ItemTree (nb) - @ internal @
- at0117::Extension - *

waist_circumference

Archetype ID: openEHR-EHR-OBSERVATION.waist_circumference.v1

Lifecycle State: published

Category: OBSERVATION

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

Purpose: To record the measurement of the circumference of the waist.

Use: Use to record the measurement of the circumference of the waist. There is no clear agreement on exactly where the waist circumference should be measured. In cases where this is important to the interpretation of the results, this should be documented in the 'Method' element. Use to record change from repeated measurements. This can currently be modeled by constraining the 'any event' to an interval in a template with an associated mathematical function, as appropriate. This archetype can also be used for recording an approximation of the waist circumference measurement in a clinical scenario where it is not possible to measure an accurate waist circumference - for example, measuring an uncooperative child. This is not modelled explicitly in the archetype as the openEHR Reference model allows the attribute of Approximation for any Quantity data type. At

implementation, for example, an application user interface could allow clinicians to select an appropriately labelled check box adjacent to the 'Waist circumference' data field to indicate that the recorded waist circumference is an approximation, rather than actual.

****Misuse:**** Not to be used to record the speed of which the waist circumference is growing or decreasing. Use a growth velocity archetype for this purpose. Not to be used to record the circumference of another body part. Use OBSERVATION.body_segment in these circumstances except where more specific archetypes exist such as OBSERVATION.hip_circumference.

****Keywords:**** anthropometry, measurement, estimation, circumference, waist, girth, abdominal

****Concepts:****

- at0000::Waist circumference - The measurement of the distance around the waist.
- at0001::Event Series - @ internal @
- at0003::Tree - @ internal @
- at0004::Waist circumference - The measurement of the circumference of the waist.
- at0005::Tree - @ internal @
- at0006::Device - Details about the device used for the measurement.
- at0007::Comment - Additional narrative about the measurement of waist circumference not captured in other fields.
- at0008::Tree - @ internal @
- at0009::Confounding factors - Narrative description of any issues or factors that may impact on the measurement.
- at0010::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0012::Extension - Additional information required to capture local context or to align with other reference models/formalisms.
- at0013::Method - The method how the waist circumference was measured.

[waist_height_ratio](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.waist_height_ratio.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the ratio of the circumference of the waist to height.

****Use:**** Use to record the ratio of the circumference of the waist to the height as an indicator of central obesity and risk of developing serious health conditions, such as cardiovascular disease. Use to enter the Waist-height ratio either manually (ie calculated and directly entered by the clinician), or automatically (ie calculation and entry is done automatically by a software application, based on separate waist circumference and height measurements). The archetype is appropriate for use in adults and children > 6 years.

****Misuse:**** Not to be used to record the actual waist circumference or height measurements. Use the specific OBSERVATION.waist_circumference and/or OBSERVATION.height archetypes for this purpose.

****Keywords:**** waist, height, obesity, stature, WHtR

****Concepts:****

- at0000::Waist-height ratio - The ratio of the circumference of the waist to the height.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Default, unspecified point in the time may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0007::Waist-height ratio - Ratio of waist circumference to height.
- at0008::Comment - Additional narrative about the ratio not captured in other fields.
- at0009::Tree - @ internal @
- at0010::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

[**waist_hip_ratio**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.waist_hip_ratio.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the ratio of the circumference of the waist to the circumference of the hips. The waist-hip ratio is a calculated ratio used as an indicator of general health and risk of developing serious health conditions.

****Use:**** Use to record the ratio of the circumference of the waist to the circumference of the hips as an indicator of general health and risk of developing serious health conditions. Use to enter the Waist-hip ratio either manually (ie calculated and directly entered by the

clinician), or automatically (ie calculation and entry is done automatically by a software application, based on separate waist and hip circumference measurements). Formulas: Waist-hip ratio is usually calculated as waist measurement divided by hip measurement ($W \div H$).

****Misuse:**** Not to be used to record the actual waist or hip circumference measurements. Use the appropriate run-time name constraints for the Circumference data element within OBSERVATION.body_segment for each measurement.

****Keywords:**** waist, hip, WHR, circumference

****Concepts:****

- at0000::Waist-hip ratio - The ratio of the circumference of the waist to the circumference of the hips.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Default, unspecified point in time which may be explicitly defined in a template or at run-time.
- at0006::Waist-hip ratio - Ratio with unitary denominator.
- at0003::ItemTree - @ internal @
- at0011::Comment - Additional narrative about the ratio not captured in other fields.
- at0012::ItemTree - @ internal @
- at0013::Extension - Additional information required to capture local context or to align with other reference models/formalisms.

[**waterlow_score**](#)

****Archetype ID:**** openEHR-EHR-OBSERVATION.waterlow_score.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** en

****Purpose:**** To record the individual elements and overall score of the Waterlow Score (or Scale), for the purpose of estimating the risk of a patient developing a pressure sore or ulcer.

****Use:**** Use to record details of a Waterlow score, normally in conjunction with a more general clinical assessment of pressure sore risk. Users and implementers should familiarise themselves with the Guidance Notes. For some categories of recording e.g Build - weight for height, only a single score can be selected. For others e.g. Skin type Visual Risk areas, more

than one risk can be entered to contribute to the overall score. Some categories have overall limits e.g. although multiple Neurological deficits can be recorded , the total score for all such risks cannot exceed 6. Some centres expect only a total to be recorded for a whole category in which case, individual risk elements should not be captured.

Misuse: The Waterlow score is Copyright Protected © 2005-2007 judy-waterlow.co.uk and should not be used outside the terms of the copyright.

Keywords: pressure, ulcer, risk, sore, scale, skin

Concepts:

- at0000::Waterlow score - The Waterlow Score, Pressure Ulcer Risk Assessment Tool.
- at0001::Event Series - @ internal @
- at0002::Any point in time event - Unspecified point in time event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Build/weight for height - Risk conferred by the subject's build, based on a BMI calculation.
- at0005::Continence - Risk conferred by the subject's degree of continence.
- at0007::Mobility - Risk conferred by the mobility level of the subject.
- at0008::Sex - Risk conferred by the sex of the subject.
- at0009::Age group - Risk conferred by the age range of the subject.
- at0014::Waterlow score - The total summed score of all recorded individual risks.
- at0015::Overall risk grade - Overall Waterlow Score.
- at0016::10+ At risk - The subject is at risk of developing a pressure ulcer.
- at0017::15+ High risk - The subject is at high risk of developing a pressure ulcer.
- at0018::20+ Very high risk - The subject is at very high risk of developing a pressure ulcer.
- at0019::Comment - Additional narrative comment about the Score.
- at0020::Average - The subject's build is average : BMI 20-24.9 .
- at0021::Above average - The subject's build is above average : BMI 25-29.9 .
- at0022::Obese - The subject is obese : BMI over 30 .
- at0023::Below average - The subject's build is below average : BMI below 20 .
- at0024::Complete / catheterised - The subject is completely continent or catheterised.
- at0025::Urinary incontinence - The subject is incontinent of urine.
- at0026::Faecal incontinence - The subject is incontinent of faeces.
- at0027::Urinary and faecal incontinence - The subject is incontinent of urine and faeces.
- at0028::Male - The subject is male.
- at0029::Female - The subject is female.
- at0030::14-49 - The subject is aged between 14-49.
- at0031::50-64 - The subject is aged between 50-64.
- at0032::65-74 - The subject is aged between 65-74.

- at0033::75-80 - The subject is aged between 75-80.
- at0034::80+ - The subject is aged over 80.
- at0035::Fully mobile - The subject is fully mobile.
- at0036::Restless/ fidgety - The subject is restless and fidgety.
- at0037::Apathetic - The subject is apathetic.
- at0038::Restricted - The subject's mobility is restricted.
- at0039::Bedbound - The subject is confined to bed e.g by traction.
- at0040::Chairbound - The subject is confined to a chair or wheelchair.
- at0044::Appetite - Risk conferred by the subject's appetite and eating habit.
- at0045::Average - The subject is eating normally and has a normal appetite.
- at0046::Poor - The subject is eating poorly or has a poor appetite.
- at0054::Weight loss - Risk conferred by recent weight loss.
- at0055::0.5-5kg - The subject has recently lost 0.5-5kg in weight.
- at0056::5-10kg (or Amount unsure) - The subject has recently lost 5-10kg in weight.
- at0057::10-15kg - The subject has recently lost 10-15kg in weight or the amount of weight loss is unknown.
- at0058::Over 15kg - The subject has recently lost over 15kg in weight.
- at0066::Skin type visual risk areas - Category of risks assessed by skin inspection.
- at0067::Medication - Risk associated with medication. Each medication can be scored between 0-4 but a total of 4 only can be given by all risks in the Medication category.
- at0068::Major surgery or trauma - Risk associated with major surgery or trauma.
- at0070::Tissue malnutrition - Category of risks conferred by tissue malnutrition.
- at0071::Tree - @ internal @
- at0072::Confounding factors - Issues that may affect interpretation of the score.
- at0073::Neurological deficit - Risk conferred by neurological deficit. Each identified risk can be scored between 4-6 but a maximum of 6 only can be given for the whole neurological deficit category.
- at0106::Cytotoxics - The subject is receiving cytotoxic medication.
- at0107::Steroids - The subject is receiving high-dose or long-term steroid medication.
- at0108::Anti-inflammatories - The subject is receiving anti-inflammatory medication.
- at0114::Orthopaedic /spinal - Risks related to orthopaedic or spinal surgery.
- at0116::Healthy - The skin appears healthy.
- at0117::Tissue-paper - The skin has a tissue-paper quality.
- at0118::Dry - The skin is dry.
- at0119::Oedematous - The skin is oedematous.
- at0120::Clammy, pyrexia - The patient appears clammy or pyrexic.
- at0121::Discoloured - Stage 1 - The skin is discoloured - Pressure sore - Grade 1.
- at0122::Pressure ulcer - Stage 2-4 - The skin has a frank pressure sore - Stage 2-4.
- at0123::Terminal cachexia - The subject is terminally-ill and shows significant weight-loss.
- at0124::Single organ failure - The patient has single organ/system failure e.g. respiratory, cardiac, liver, renal.

- at0125::Multiple organ failure - The subject has multiple organ/system failure.
- at0126::Peripheral vascular disease - The subject has peripheral vascular disease.
- at0127::Anaemia (Hb < 8 g/dl) - The subject is significantly anaemic. Hb less than 8 mg/dl.
- at0128::Smoking - The subject is a smoker.
- at0129::Nutritional risk - An estimate of nutritional risk based on the MST nutritional score but can make use of another compatible nutritional score.
- at0130::Nutritional score - The nutritional score total, derived from Appetite and Weight loss scores or recorded directly from another compatible nutritional scoring system.
- at0131::No recent weight loss - The subject has not recently lost weight.
- at0132::Tree - @ internal @
- at0133::Score version - The version of the score used, normally recorded as the year.
- at0134::Less than 14 years - The subject is under 14 years old.
- at0135::Combined neurological deficit - An overall estimate of neurological deficit. Should not be used if individual neurological deficit risks are recorded.
- at0136::No neurological deficit - The subject has no overall neurological deficit.
- at0137::Mild neurological deficit - The subject has a mild overall neurological deficit.
- at0138::Moderate neurological deficit - The subject has a moderate overall neurological deficit.
- at0139::Severe neurological deficit - The subject has a severe overall neurological deficit.
- at0140::Combined medication risk - Overall pressure ulcer risk related to medication. Should not be recorded if individual medication risks are used.
- at0141::No medication risk - The subject has no risk related to medication.
- at0142::Significant medication risk - The subject has significant risk related to medication.
- at0143::Orthopaedic /spinal surgery - The subject has undergone orthopaedic or spinal surgery.
- at0144::Duration of surgery - Risks imparted by length of surgery.
- at0145::On table > 2 hrs (Past 48 hrs) - The subject has had surgery within the past 48 hours lasting over 2 hours.
- at0146::On table > 6 hrs (Past 48 hrs) - The subject has had surgery within the past 48 hours lasting over 6 hours.
- at0150::Diabetes, MS, CVA - The subject has diabetes, multiple sclerosis or has had a stroke.
- at0151::Motor / sensory deficit - The subject has a motor or sensory deficit.
- at0152::Paraplegia - The subject has a paraplegia.
- at0153::No orthopaedic / spinal surgery - The subject has no risk related to spinal / orthopaedic surgery.
- at0154::On table < 2 hrs or not in past 48 hrs - The subject has had surgery more than 48 hrs ago or lasting for less than 2 hours.

ygtss_revised

****Archetype ID:**** openEHR-EHR-OBSERVATION.ygtss_revised.v1

****Lifecycle State:**** published

****Category:**** OBSERVATION

****Languages:**** nb, en

****Purpose:**** To record the results for each component parameter, the Total tic score and the Global severity score.

****Use:**** Use to record the results for each component parameter, the Total tic score and the Global severity score.

****Keywords:**** tics, score

****Concepts:****

- at0000::Yale Global Tic Severity Scale - Revised (YGTSS-R) - Assessment tool used to quantify the severity of tic symptoms.
- at0001::History - @ internal @
- at0002::Over the past week - None
- at0003::Tree - @ internal @
- at0004::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0006::Simple Motor Tics Checklist - Simple motor tics that were present over the past week.
- at0007::Eye blinking - None
- at0009::Eye movements - None
- at0011::Nose movements - None
- at0013::Facial grimace - None
- at0015::Head jerks/movements - None
- at0017::Shoulder shrugs - None
- at0019::Arm movements - None
- at0021::Hand movements - None
- at0023::Abdominal tensing - None
- at0025::Leg, foot, or toe movements - None
- at0027::Name - The name of other complex motor tic.
- at0028::Description - Description of other complex motor tic.

- at0029::Complex Motor Tics Checklist - Complex motor tics that were present over the past week.
- at0030::Eye movements - None
- at0032::Mouth movements - None
- at0034::Facial movements or expressions - None
- at0036::Head gestures or movements - None
- at0038::Shoulder movements - None
- at0040::Arm movements - None
- at0042::Hand movements - None
- at0044::Writing tics - None
- at0046::Dystonic postures - None
- at0048::Bending or gyrating - None
- at0050::Rotating - None
- at0052::Leg or foot or toe movements - None
- at0054::Blocking - None
- at0056::Tic related compulsive behaviors - Touching, tapping, grooming, evening-up.
- at0058::Copropraxia - None
- at0060::Self-abusive behavior - None
- at0062::Paroxysms of tics (displays) - None
- at0064::Paroxysms of tics duration - None
- at0067::Complex Phonic Symptoms Checklist - Complex phonic tics that were present over the past week.
- at0068::Simple Phonic symptoms checklist - Simple phonic tics that were present over the past week.
- at0069::Other complex motor tics - List and describe.
- at0070::Coughing - None
- at0071::Throat clearing - None
- at0072::Sniffing - None
- at0073::Snorting - None
- at0074::Grunting - None
- at0075::Gulping - None
- at0076::Whistling - None
- at0077::Humming - None
- at0078::Mouth noises - For example: clicking, gargling, popping, kissing noises.
- at0079::Burping - None
- at0080::Hiccups - None
- at0081::Atypical breathing tics - For example: forceful exhalation, wheezing, gasping, panting.
- at0082::Chirping or other bird noises - For example: screeching.
- at0084::Barking or other dog noises - For example: growling.
- at0086::Other animal noises - For example: squealing.
- at0087::Other simple phonic tics - List and describe.

- at0088::Name - The name of other simple phonic tic.
- at0089::Description - Description of other simple phonic tic.
- at0090::Syllables - For example: "ahhh", "woo", "hmmm".
- at0091::Words - For example: "what", "dang", "Okay".
- at0092::Phrases - For example: "oh no", "here we go", "I know".
- at0093::Coprolalia - For example: obscene words.
- at0094::Echolalia - For example: repeating others words or phrases.
- at0095::Palalalia - For example: repeating self.
- at0096::Blocking - For example: halted speech blocked speech, stuttering.
- at0097::Speech atypicalities - For example: slow/fast speech rate, nasal speech, quivering voice, high or low pitch/tone/volume.
- at0098::Disinhibited speech - For example: blurting out words, talking excessively.
- at0099::Other complex phonic tics - List and describe.
- at0100::Name - The name of other complex phonic tic.
- at0101::Description - Description of other complex phonic tic.
- at0102::Disinhibited behavior - None
- at0103::Disinhibited behavior description - Narrative description of the disinhibited behavior.
- at0104::Other simple motor tics - List and describe.
- at0105::Name - The name of other simple motor tic.
- at0106::Description - Description of other simple motor tic.
- at0107::Score - None
- at0108::Number - None
- at0109::None - No tics present.
- at0110::Minimal - Single tic present.
- at0111::Mild - Multiple discrete tics (2-5).
- at0112::Moderate - Multiple discrete tics (>5).
- at0113::Marked - Multiple discrete tics plus as least one orchestrated pattern of multiple simultaneous or sequential tics, where it is difficult to distinguish discrete tics.
- at0114::Severe - Multiple discrete tics plus several (>2) orchestrated paroxysms of multiple simultaneous or sequential tics, where it is difficult to distinguish discrete tics.
- at0115::Frequency - None
- at0116::None - No tics present.
- at0117::Minimal - Specific tics are usually present on a daily basis, but there are long tic-free intervals during the day. Bouts of tics may occur on occasion, but are not sustained for more than a few minutes at a time.
- at0118::Mild - Specific tics are present on a daily basis. Tic free intervals as long as 3 hours are not uncommon. Bouts of tics occur regularly, but generally limited to a single setting.
- at0119::Moderate - Specific tics are present virtually every waking hour of every day. Bouts of tics are common and may not be limited to a single setting.

- at0120::Marked - Specific tics are present every waking hour. Bouts of tics are common and may occur in multiple settings.
- at0121::Severe - Specific tics are present virtually all the time. Tic free intervals are difficult to identify and do not last more than 5 to 10 minutes. Bouts of tics are very common and occur in multiple settings.
- at0122::Intensity - None
- at0123::None - No tics present.
- at0124::Minimal - Tics not visible or audible (based solely on patient's private experience), or tics are less forceful than comparable voluntary actions and are typically not noticed because of their intensity.
- at0125::Mild - Tics are not more forceful than comparable voluntary actions or utterances, and are typically not noticed because of their intensity.
- at0126::Moderate - Tics are more forceful than comparable voluntary actions, but are not outside the range of normal expression for comparable voluntary actions or utterances.
- at0127::Marked - Tics are more forceful than comparable voluntary actions or utterances and typically have an "exaggerated" character.
- at0128::Severe - Tics are extremely forceful and exaggerated in expression. These tics call attention to the individual and may result in risk of physical injury (accidental, provoked, or self-inflicted) because of their forceful expression.
- at0129::Complexity - None
- at0130::None - No tics present.
- at0131::Minimal - If present, all tics are clearly "simple" (sudden, brief, purposeless) in character.
- at0132::Mild - Some tics are not clearly "simple" in character.
- at0133::Moderate - Some tics are clearly "complex" (purposive in appearance) and mimic brief "automatic" behaviors, such as grooming, syllables, or brief meaningful utterances such as "ah huh" or "hi" that could be camouflaged.
- at0134::Marked - Some tics are more "complex" (more purposive and sustained in appearance) and may occur in orchestrated bouts that would be difficult to camouflage, but could be rationalized or "explained" as normal behavior or speech (tapping, saying "you bet", "honey", "FF", "sh", or brief echolalia).
- at0135::Severe - Some tics are very "complex" in character and tend to occur in sustained orchestrated bouts that would be difficult to camouflage and could not be easily rationalized as normal behavior or speech because of their duration and/ or their unusual, inappropriate, bizarre or obscene character (a lengthy facial contortion, touching genitals, echolalia, speech atypicalities, bouts of copropraxia, self-abusive behavior, coprolalia).
- at0136::Interference - None
- at0137::None - No tics present.
- at0138::Minimal - When ties are present, they do not interrupt the flow of behavior or speech.

- at0139::Mild - When tics are present, they occasionally interrupt the flow of behavior or speech.
- at0140::Moderate - When tics are present, they frequently interrupt the flow of behavior or speech, but do not disrupt intended behavior or speech.
- at0141::Marked - When tics are present, they frequently interrupt the flow of behavior or speech, and they occasionally disrupt intended action or communication.
- at0142::Severe - When tics are present, they frequently disrupt intended action or communication.
- at0143::Impairment scale - None
- at0144::None - None
- at0145::Minimal - Tics associated with subtle difficulties in self-esteem, family life, social acceptance, or school or Job functioning (infrequent upset or concern about tics vis a vis the future, periodic, slight increase in family tensions because of tics, friends or acquaintances may occasionally notice or comment about tics in an upsetting way).
- at0146::Mild - Tics associated with minor difficulties in self-esteem, family life, social acceptance, or school or Job functioning.
- at0147::Moderate - Tics associated with some clear problems in self-esteem family life, social acceptance, or school or Job functioning (episodes of dysphoria, periodic distress and upheaval in the family, frequent teasing by peers or episodic social avoidance, periodic interference in school or Job performance because of tics).
- at0148::Marked - Tics associated with major difficulties in self-esteem, family life, social acceptance, or school or Job functioning.
- at0149::Severe - Tics associated with extreme difficulties in self-esteem, family life, social acceptance, or school or Job functioning (severe depression with suicidal ideation, disruption of the family (separation/divorce, residential placement), disruption of social ties - severely restricted life because of social stigma and social avoidance, removal from school or loss of job).
- at0150::Total tic score - Sum of motor and phonic tic severity scales.
- at0151::Global severity score - Sum of total tic score and impairment score.
- at0152::Item tree - @ internal @
- at0153::Extension - Additional information required to extend the model with local content or to align with other reference models or formalisms.
- at0154::Motor score - None
- at0155::Phonic score - None
- at0158::Mouth movements - None
- at0159::Chirping or other bird noises description - Narrative description of the chirping or other bird noises.
- at0160::Barking or other dog noises description - Narrative description of the barking or other dog noises.
- at0161::Syllables description - Narrative description of the syllables.
- at0162::Words description - Narrative description of the words.
- at0163::Phrases description - Narrative description of the phrases.

- at0164::Coprolalia description - Narrative description of the coprolalia.
- at0165::Speech atypicalities description - Narrative description of the speech atypicalities.
- at0166::Disinhibited speech description - Narrative description of the disinhibited speech.
- at0167::Eye blinking description - Narrative description of the eye blinking.
- at0168::Eye movements description - Narrative description of the eye movements.
- at0169::Nose movements description - Narrative description of the nose movements.
- at0170::Mouth movements description - Narrative description of the mouth movements.
- at0171::Facial grimace description - Narrative description of the facial grimace.
- at0172::Head jerks/movements description - Narrative description of the head jerks/movements.
- at0173::Shoulder shrugs description - Narrative description of the shoulder shrugs.
- at0174::Arm movements description - Narrative description of the arm movements.
- at0175::Hand movements description - Narrative description of the hand movements.
- at0176::Abdominal tensing description - Narrative description of the abdominal tensing.
- at0177::Leg, foot, or toe movements description - Narrative description of the leg, foot, or toe movements.
- at0178::Eye movements description - Narrative description of the eye movements.
- at0179::Mouth movements description - Narrative description of the mouth movements.
- at0180::Facial movements or expressions description - Narrative description of the facial movements or expressions.
- at0181::Shoulder movements description - Narrative description of the shoulder movements.
- at0182::Head gestures or movements description - Narrative description of the head gestures or movements.
- at0183::Arm movements description - Narrative description of the arm movements.
- at0184::Hand movements description - Narrative description of the hand movements.
- at0185::Writing tics description - Narrative description of the writing tics.
- at0186::Dystonic postures description - Narrative description of the dystonic postures.
- at0187::Bending or gyrating description - Narrative description of the bending or gyrating.
- at0188::Rotating description - Narrative description of the rotating.
- at0189::Leg or foot or toe movements description - Narrative description of the leg or foot or toe movements.
- at0190::Blocking description - Narrative description of the blocking.
- at0191::Tic related compulsive behaviors description - Narrative description of the tic related compulsive behaviors.
- at0192::Copropraxia description - Narrative description of the copropraxia.

- at0193::Self-abusive behavior description - Narrative description of the self-abusive behavior.
- at0194::Paroxysms of tics (displays) description - Narrative description of the paroxysms of tics (displays).
- at0195::Coughing description - Narrative description of the coughing.
- at0196::Throat clearing description - Narrative description of the throat clearing.
- at0197::Sniffing description - Narrative description of the sniffing.
- at0198::Snorting description - Narrative description of the snorting.
- at0199::Grunting description - Narrative description of the grunting.
- at0200::Gulping description - Narrative description of the gulping.
- at0201::Whistling - Narrative description of the whistling.
- at0202::Humming description - Narrative description of the humming.
- at0203::Mouth noises description - Narrative description of the mouth noises.
- at0204::Burping description - Narrative description of the burping.
- at0205::Hiccups description - Narrative description of the hiccups.
- at0206::Atypical breathing tics description - Narrative description of the atypical breathing tics.
- at0207::Other animal noises description - Narrative description of the other animal noises.
- at0208::Echolalia description - Narrative description of the echolalia.
- at0209::Palalalia description - Narrative description of the palalalia.
- at0210::Blocking description - Narrative description of the blocking.

ymrs

****Archetype ID:**** openEHR-EHR-OBSERVATION.ymrs.v0

****Lifecycle State:**** in_development

****Category:**** OBSERVATION

****Languages:**** sv, en

****Purpose:**** To assess and record the severity of a manic episode.

****Use:**** Use as a tool to assess and record the severity of a manic episode. The questionnaire consists of eleven items which the clinician rates based on the assessment of the patients current condition during the course of the interview. Each contributes points to the total score which ranges from 0-60. - Elevated mood - Increased motor activity-energy - Sexual interest - Sleep - Irritability - Speech (rate and amount) - Language-thought disorder - Content - Disruptive-aggressive behaviour - Appearance - Insight Score interpretation: 14-

19 points indicate hypomania
20-30 points indicate moderate mania
>30 points indicate severe mania.

Keywords: YMRS, Young Mania Rating Scale, mania, hypomania, DSM, psychiatry

Concepts:

- at0000::Young Mania Rating Scale (YMRS) - Clinical interview scale to assess the severity of manic episodes.
- at0001::Event Series - @ internal @
- at0002::Any event - Default, unspecified point in time or interval event which may be explicitly defined in a template or at run-time.
- at0003::Tree - @ internal @
- at0004::Elevated mood - *
- at0005::Increased motor activity-energy - *
- at0006::Sexual interest - *
- at0007::Sleep - *
- at0008::Irritability - *
- at0009::Speech (rate and amount) - *
- at0010::Language - thought disorder - *
- at0011::Content - *
- at0012::Disruptive-aggressive behaviour - *
- at0013::Appearance - *
- at0014::Insight - *
- at0015::Total score - The sum of each ordinal scores recorded for each of the eleven component responses.
- at0016::Absent - *
- at0017::Mildly or possibly increased on questioning - *
- at0018::Definite subjective elevation; optimistic, self-confident; cheerful; appropriate to content - *
- at0019::Elevated, inappropriate to content; humorous - *
- at0020::Euphoric; inappropriate laughter; singing - *
- at0021::Absent - *
- at0022::Subjectively increased - *
- at0023::Animated; gestures increased - *
- at0024::Excessive energy; hyperactive at times; restless (can be calmed) - *
- at0025::Motor excitement; continuous hyperactivity (cannot be calmed) - *
- at0026::Normal; not increased - *
- at0027::Mildly or possibly increased - *
- at0028::Definite subjective increase on questioning - *
- at0029::Spontaneous sexual content; elaborates on sexual matters; hypersexual by self-report - *
- at0030::Overt sexual acts (toward patients, staff or interviewer) - *

- at0031::Reports no decrease in sleep - *
- at0032::Sleeping less than normal amount by up to one hour - *
- at0033::Sleeping less than normal by more than one hour - *
- at0034::Reports decreased need for sleep - *
- at0035::Denies need for sleep - *
- at0036::Absent - *
- at0037::Subjectively increased - *
- at0038::Irritable at times during interview; recent episodes of anger or annoyance on ward - *
- at0039::Frequently irritable during interview; short, curt throughout - *
- at0040::Hostile, unco-operative; interview impossible - *
- at0041::No increase - *
- at0042::Feels talkative - *
- at0043::Increased rate or amount at times, verbose at times - *
- at0044::Push; consistently increased rate and amount; difficult to interrupt - *
- at0045::Pressured; uninterruptible, continuous speech - *
- at0046::Absent - *
- at0047::Circumstantial; mild distractibility; quick thoughts - *
- at0048::Distractible; loses goal of thought; changes topics frequently; racing thoughts - *
- at0049::Flight of ideas; tangentiality; difficult to follow; rhyming, echolalia - *
- at0050::Incoherent; communication impossible - *
- at0051::Normal - *
- at0052::Questionable plans, new interests - *
- at0053::Special project(s); hyperreligious - *
- at0054::Grandiose or paranoid ideas; ideas of reference - *
- at0055::Delusions; hallucinations - *
- at0056::Absent - *
- at0057::Sarcastic; loud at times, guarded - *
- at0058::Demanding; threats on ward - *
- at0059::Threatens interviewer; shouting; interview difficult - *
- at0060::Assaultive; destructive; interview impossible - *
- at0061::Appropriate dress and grooming - *
- at0062::Minimally unkempt - *
- at0063::Poorly groomed; moderately dishevelled; overdressed - *
- at0064::Dishevelled; partly clothed; garish make-up - *
- at0065::Completely unkempt; decorated; bizarre garb - *
- at0066::Present; admits illness; agrees with need for treatment - *
- at0067::Possibly ill - *
- at0068::Admits behaviour change, but denies illness - *
- at0069::Admits possible change in behaviour, but denies illness - *
- at0070::Denies any behaviour change - *
- at0071::Tree - @ internal @

- at0072::Extension - Additional information required to capture local content or to align with other reference models/formalisms.