

December 21, 2012 Errata Update to

CDAR2\_IG\_IHE\_CONSOL\_DSTU\_R1.1\_2012JUL

HL7 Implementation Guide for CDA® Release2:

IHE Health Story Consolidation, DSTU Release1.1

(US Realm)

Draft Standard for Trial Use

July 2012

Sponsored by:  
HL7 Structured Documents Working Group

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December 21, 2012 C-CDA Errata Update

This document is a companion to the July 2012 *HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation, DSTU Release 1.1 - US Realm,* also known as the *Consolidated CDA (C-CDA) Implementation Guide*.[[1]](#footnote-1)

On December 21, 2012, the Health Level Seven (HL7) Structured Documents Working Group (SDWG) approved a final set of 2012 errata to the *C-CDA Implementation Guide*. The list of approved errata is available on the Consolidated CDA July 2012 Errata webpage (<http://wiki.hl7.org/index.php?title=Consolidated_CDA_July_2012_Errata>).

This document provides the updated templates, which address the errata. For the constraint numbers and template identifiers related to errata updates, see the Errata Change List spreadsheet (listed below).

The 2012-12-21 Errata Package includes:

* This C-CDA Template Library document
* An Errata Change List spreadsheet of errata corrections and affected templates (C-CDA\_Change\_List\_2012\_12\_21.xls)
* readme.txt file detailing the content of the package
* The CDA schema (cda.xsd) enhanced to support the sdtc namespace (SDTC.xsd)
* The Schematron validation file, (Consolidation.sch) and its vocabulary-support file (voc.xml)
* Ten sample files
* A browser style sheet (cda.xsl) for displaying CDA documents
* The *C-CDA Implementation Guide*, with non-normative content updated (CDAR2\_IG\_IHE\_CONSOL\_DSTU\_R1dot1\_2012JUL.docx)

The Schematron validation file and the vocabulary-support file were updated to incorporate the 2012-12-21 errata and to provide better validation.

The sample files in the *C-CDA Implementation Guide* were updated to incorporate the 2012-12-21 errata and to reduce the number of warning messages related to optional (SHOULD) elements. The errata package includes an updated sample file for each document type.

In the *C-CDA Implementation Guide*, non-normative content has been updated to reflect the 2012-12-21 errata, including the Figures (example code) and Appendix D listing vocabularies.

This work was done in December 2012 and January 2013 by the Lantana HL7 Volunteer Support Team, under the direction of Bob Dolin and Liora Alschuler. The team members for this effort were Lauren Wood, Sean McIlvenna, Meenaxi Gosai, John Baker, Ashley Swain, Zabrina Gonzaga, Dale Nelson, Diana Wright, Sarah Quaynor, Rick Geimer, Gaye Dolin, and Kate Hamilton.

Deloitte team members Kanwarpreet Sethi, Russ Ott, and Rich Kernan collaborated with Lantana in the work on errata updates.

To review candidate errata currently under consideration by the SDWG, or to report new errata candidates, please see the HL7 DSTU Comment webpage for C-CDA (<http://www.hl7.org/dstucomments/showdetail.cfm?dstuid=82>).

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# Document-Level Templates

* 1. Consultation Note

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.4 (open)]

Table 1: Consultation Note Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional)  [Assessment and Plan Section](#S_Assessment_and_Plan_Section)  [Assessment Section](#S_Assessment_Section)  [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S)  [Chief Complaint Section](#S_Chief_Complaint_Section)  [Family History Section](#S_Family_History_Section)  [General Status Section](#S_General_Status_Section)  [History of Past Illness Section](#S_History_of_Past_Illness_Section)  [History of Present Illness Section](#S_History_of_Present_Illness_Section)  [Immunizations Section (entries optional)](#S_Immunizations_Section_entries_optional)  [Medications Section (entries optional)](#S_Medications_Section_entries_optional)  [Physical Exam Section](#S_Physical_Exam_Section)  [Plan of Care Section](#S_Plan_of_Care_Section)  [Problem Section (entries optional)](#S_Problem_Section_entries_optional)  [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional)  [Reason for Referral Section](#S_Reason_for_Referral_Section)  [Reason for Visit Section](#S_Reason_for_Visit_Section)  [Results Section (entries optional)](#S_Results_Section_entries_optional)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Social History Section](#S_Social_History_Section)  [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) |

For the purpose of this Implementation Guide, a consultation visit is defined by the evaluation and management guidelines for a consultation established by the Centers for Medicare and Medicaid Services (CMS). According to those guidelines, a Consultation Note must be generated as a result of a physician or non-physician practitioner's (NPP) request for an opinion or advice from another physician or NPP. Consultations must involve face-to-face time with the patient or fall under guidelines for telemedicine visits.

A Consultation Note must be provided to the referring physician or NPP and must include the reason for the referral, history of present illness, physical examination, and decision-making component (Assessment and Plan).

An NPP is defined as any licensed medical professional as recognized by the state in which the professional practices, including, but not limited to, physician assistants, nurse practitioners, clinical nurse specialists, social workers, registered dietitians, physical therapists, and speech therapists.

Reports on visits requested by a patient, family member, or other third party are not covered by this specification. Second opinions, sometimes called ""confirmatory consultations,"" also are not covered here. Any question on use of the Consultation Note defined here should be resolved by reference to CMS or American Medical Association (AMA) guidelines.

1. Conforms to [US Realm Header](#D_US_Realm_Header) template (2.16.840.1.113883.10.20.22.1.1).
2. SHALL contain exactly one [1..1] templateId (CONF:8375).
   1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.4" (CONF:10040).
3. SHALL contain exactly one [1..1] code (CONF:17176).
   1. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ConsultDocumentType 2.16.840.1.113883.11.20.9.31 DYNAMIC (CONF:17177).
4. SHALL contain at least one [1..\*] inFulfillmentOf (CONF:8382).
   1. Such inFulfillmentOfs SHALL contain exactly one [1..1] order (CONF:8385).
      1. This order SHALL contain at least one [1..\*] id (CONF:9102).
5. SHALL contain exactly one [1..1] componentOf (CONF:8386).
   1. This componentOf SHALL contain exactly one [1..1] encompassingEncounter (CONF:8387).
      1. This encompassingEncounter SHALL contain exactly one [1..1] id (CONF:8388).
      2. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:8389).
         1. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10132).
      3. This encompassingEncounter MAY contain zero or one [0..1] responsibleParty (CONF:8391).
         1. The responsibleParty element records only the party responsible for the encounter, not necessarily the entire episode of care (CONF:8393).
         2. The responsibleParty element, if present, SHALL contain an assignedEntity element which SHALL contain an assignedPerson element, a representedOrganization element, or both (CONF:8394).
      4. This encompassingEncounter MAY contain zero or more [0..\*] encounterParticipant (CONF:8392).
         1. The encounterParticipant element, if present, records only participants in the encounter, not necessarily in the entire episode of care (CONF:8395).
         2. An encounterParticipant element, if present, SHALL contain an assignedEntity element which SHALL contain an assignedPerson element, a representedOrganization element, or both (CONF:8396).
6. SHALL contain exactly one [1..1] component (CONF:8397).
   1. A Consultation Note can have either a structuredBody or a nonXMLBody (CONF:8398).
      1. A Consultation Note can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.4), coded entries are optional (CONF:8399).
   2. If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9503).
      1. MAY contain zero or one [0..1] [Assessment Section](#S_Assessment_Section) (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:9487).
      2. MAY contain zero or one [0..1] [Plan of Care Section](#S_Plan_of_Care_Section) (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9489).
      3. MAY contain zero or one [0..1] [Assessment and Plan Section](#S_Assessment_and_Plan_Section) (templateId:2.16.840.1.113883.10.20.22.2.9) (CONF:9491).
      4. SHALL contain exactly one [1..1] [History of Present Illness Section](#S_History_of_Present_Illness_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:9493).
      5. SHOULD contain zero or one [0..1] [Physical Exam Section](#S_Physical_Exam_Section) (templateId:2.16.840.1.113883.10.20.2.10) (CONF:9495).
      6. MAY contain zero or one [0..1] [Reason for Referral Section](#S_Reason_for_Referral_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.1) (CONF:9498).
      7. MAY contain zero or one [0..1] [Reason for Visit Section](#S_Reason_for_Visit_Section) (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:9500).
      8. SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan of Care Section (CONF:9501).
      9. SHALL include a Reason for Referral or Reason for Visit section (CONF:9504).
      10. MAY contain zero or one [0..1] [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.6) (CONF:9507).
      11. MAY contain zero or one [0..1] [Chief Complaint Section](#S_Chief_Complaint_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:9509).
      12. MAY contain zero or one [0..1] [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S) (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:9511).
      13. MAY contain zero or one [0..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:9513).
      14. MAY contain zero or one [0..1] [General Status Section](#S_General_Status_Section) (templateId:2.16.840.1.113883.10.20.2.5) (CONF:9515).
      15. MAY contain zero or one [0..1] [History of Past Illness Section](#S_History_of_Past_Illness_Section) (templateId:2.16.840.1.113883.10.20.22.2.20) (CONF:9517).
      16. MAY contain zero or one [0..1] [Immunizations Section (entries optional)](#S_Immunizations_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.2) (CONF:9519).
      17. MAY contain zero or one [0..1] [Medications Section (entries optional)](#S_Medications_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.1) (CONF:9521).
      18. MAY contain zero or one [0..1] [Problem Section (entries optional)](#S_Problem_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.5) (CONF:9523).
      19. MAY contain zero or one [0..1] [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.7) (CONF:9525).
      20. MAY contain zero or one [0..1] [Results Section (entries optional)](#S_Results_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.3) (CONF:9527).
      21. MAY contain zero or one [0..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:9529).
      22. MAY contain zero or one [0..1] [Social History Section](#S_Social_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.17) (CONF:9531).
      23. MAY contain zero or one [0..1] [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.4) (CONF:9533).
      24. SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:10028).
      25. SHALL NOT include a combined Chief Complaint and Reason for Visit Section with either a Chief Complaint Section or a Reason for Visit Section (CONF:10029).
   3. Continuity of Care Document (CCD)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.2 (open)]

Table 2: Continuity of Care Document (CCD) Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Advance Directives Section (entries optional)](#S_Advance_Directives_Section_entries_opt)  [Allergies Section (entries required)](#S_Allergies_Section_entries_required)  [Encounters Section (entries optional)](#S_Encounters_Section_entries_optional)  [Family History Section](#S_Family_History_Section)  [Functional Status Section](#S_Functional_Status_Section)  [Immunizations Section (entries optional)](#S_Immunizations_Section_entries_optional)  [Medical Equipment Section](#S_Medical_Equipment_Section)  [Medications Section (entries required)](#S_Medications_Section_entries_required)  [Payers Section](#S_Payers_Section)  [Plan of Care Section](#S_Plan_of_Care_Section)  [Problem Section (entries required)](#S_Problem_Section_entries_required)  [Procedures Section (entries required)](#S_Procedures_Section_entries_required)  [Results Section (entries required)](#S_Results_Section_entries_required)  [Social History Section](#S_Social_History_Section)  [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) |

This section—Continuity of Care Document (CCD) Release 1.1—describes CDA constraints in accordance with Stage 1 Meaningful Use. The CCD requirements in this guide supersede CCD Release 1; in the near future, this guide could supersede HITSP C32.

The CCD is a core data set of the most relevant administrative, demographic, and clinical information facts about a patient's healthcare, covering one or more healthcare encounters. It provides a means for one healthcare practitioner, system, or setting to aggregate all of the pertinent data about a patient and forward it to another practitioner, system, or setting to support the continuity of care. The primary use case for the CCD is to provide a snapshot in time containing the pertinent clinical, demographic, and administrative data for a specific patient . More specific use cases, such as a Discharge Summary or Progress Note, are available as alternative documents in this guide.

1. Conforms to [US Realm Header](#D_US_Realm_Header) template (2.16.840.1.113883.10.20.22.1.1).
2. SHALL contain exactly one [1..1] templateId (CONF:8450) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.2" (CONF:10038).
3. SHALL contain exactly one [1..1] code (CONF:17180).
   1. This code SHALL contain exactly one [1..1] @code="34133-9" Summarization of Episode Note (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:17181).
4. SHALL contain at least one [1..\*] author (CONF:9442).
   1. Such authors SHALL contain exactly one [1..1] assignedAuthor (CONF:9443).
      1. SHALL contain exactly one [1..1] assignedPerson or exactly one [1..1] representedOrganization (CONF:8456).
      2. If assignedAuthor has an associated representedOrganization with no assignedPerson or assignedAuthoringDevice, then the value for “ClinicalDocument/author/assignedAuthor/id/@NullFlavor” SHALL be “NA” “Not applicable” 2.16.840.1.113883.5.1008 NullFlavor STATIC (CONF:8457).
5. SHALL contain exactly one [1..1] documentationOf (CONF:8452).
   1. This documentationOf SHALL contain exactly one [1..1] serviceEvent (CONF:8480).
      1. This serviceEvent SHALL contain exactly one [1..1] @classCode="PCPR" Care Provision (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8453).
      2. This serviceEvent SHALL contain exactly one [1..1] effectiveTime (CONF:8481).
         1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:8454).
         2. This effectiveTime SHALL contain exactly one [1..1] high (CONF:8455).
      3. This serviceEvent SHOULD contain zero or more [0..\*] performer (CONF:8482).
         1. The performer, if present, SHALL contain exactly one [1..1] @typeCode="PRF" Participation physical performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8458).
         2. The performer, if present, MAY contain zero or one [0..1] assignedEntity (CONF:8459).
            1. The assignedEntity, if present, SHALL contain at least one [1..\*] id (CONF:8460).

SHOULD include zero or one [0..1] id where id/@root ="2.16.840.1.113883.4.6" National Provider Identifier (CONF:10027).

* + - * 1. The assignedEntity, if present, MAY contain zero or one [0..1] code (CONF:8461).

I. The code MAY be the NUCC Health Care Provider Taxonomy (CodeSystem: 2.16.840.1.113883.6.101). (See http://www.nucc.org) (CONF:8462).

* + - 1. ServiceEvent/performer represents the healthcare providers involved in the current or pertinent historical care of the patient. Preferably, the patient’s key healthcare providers would be listed, particularly their primary physician and any active consulting physicians, therapists, and counselors (CONF:10026).

1. The component/structuredBody SHALL conform to the section constraints below (CONF:9536).
   1. SHALL contain exactly one [1..1] [Allergies Section (entries required)](#S_Allergies_Section_entries_required) (templateId:2.16.840.1.113883.10.20.22.2.6.1) (CONF:9445).
   2. SHALL contain exactly one [1..1] [Medications Section (entries required)](#S_Medications_Section_entries_required) (templateId:2.16.840.1.113883.10.20.22.2.1.1) (CONF:9447).
   3. SHALL contain exactly one [1..1] [Problem Section (entries required)](#S_Problem_Section_entries_required) (templateId:2.16.840.1.113883.10.20.22.2.5.1) (CONF:9449).
   4. SHOULD contain zero or one [0..1] [Procedures Section (entries required)](#S_Procedures_Section_entries_required) (templateId:2.16.840.1.113883.10.20.22.2.7.1) (CONF:9451).
   5. SHALL contain exactly one [1..1] [Results Section (entries required)](#S_Results_Section_entries_required) (templateId:2.16.840.1.113883.10.20.22.2.3.1) (CONF:9453).
   6. MAY contain zero or one [0..1] [Payers Section](#S_Payers_Section) (templateId:2.16.840.1.113883.10.20.22.2.18) (CONF:9455).
   7. MAY contain zero or one [0..1] [Social History Section](#S_Social_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.17) (CONF:9974).
   8. MAY contain zero or one [0..1] [Medical Equipment Section](#S_Medical_Equipment_Section) (templateId:2.16.840.1.113883.10.20.22.2.23) (CONF:9975).
   9. MAY contain zero or one [0..1] [Immunizations Section (entries optional)](#S_Immunizations_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.2) (CONF:9976).
   10. MAY contain zero or one [0..1] [Functional Status Section](#S_Functional_Status_Section) (templateId:2.16.840.1.113883.10.20.22.2.14) (CONF:9977).
   11. MAY contain zero or one [0..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:9978).
   12. MAY contain zero or one [0..1] [Encounters Section (entries optional)](#S_Encounters_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.22) (CONF:9979).
   13. MAY contain zero or one [0..1] [Advance Directives Section (entries optional)](#S_Advance_Directives_Section_entries_opt) (templateId:2.16.840.1.113883.10.20.22.2.21) (CONF:9980).
   14. MAY contain zero or one [0..1] [Plan of Care Section](#S_Plan_of_Care_Section) (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9981).
   15. MAY contain zero or one [0..1] [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.4) (CONF:9983).
   16. Diagnostic Imaging Report

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.5 (open)]

Table 3: Diagnostic Imaging Report Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [DICOM Object Catalog Section - DCM 121181](#S_DICOM_Object_Catalog_Section__DCM_121)  [Fetus Subject Context](#S_Fetus_Subject_Context)  [Findings Section (DIR)](#S_Findings_Section_DIR)  [Observer Context](#S_Observer_Context)  [Physician of Record Participant](#U_Physician_of_Record_Participant)  [Physician Reading Study Performer](#U_Physician_Reading_Study_Performer)  [Procedure Context](#E_Procedure_Context) |

A Diagnostic Imaging Report (DIR) is a document that contains a consulting specialist’s interpretation of image data. It conveys the interpretation to the referring (ordering) physician and becomes part of the patient’s medical record. It is for use in Radiology, Endoscopy, Cardiology, and other imaging specialties.

1. Conforms to [US Realm Header](#D_US_Realm_Header) template (2.16.840.1.113883.10.20.22.1.1).
2. SHALL contain exactly one [1..1] templateId (CONF:8404) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.5" (CONF:10042).
3. SHALL contain exactly one [1..1] code (CONF:14833).
   1. This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet DIRDocumentTypeCodes 2.16.840.1.113883.11.20.9.32 DYNAMIC (CONF:14834).
4. SHALL NOT contain [0..0] informant (CONF:8410).
5. MAY contain zero or more [0..\*] informationRecipient (CONF:8411).
   1. The physician requesting the imaging procedure (ClincalDocument/participant[@typeCode=REF]/associatedEntity), if present, SHOULD also be recorded as an informationRecipient, unless in the local setting another physician (such as the attending physician for an inpatient) is known to be the appropriate recipient of the report (CONF:8412).
   2. When no referring physician is present, as in the case of self-referred screening examinations allowed by law, the intendedRecipient MAY be absent. The intendedRecipient MAY also be the health chart of the patient, in which case the receivedOrganization SHALL be the scoping organization of that chart (CONF:8413).
6. MAY contain zero or one [0..1] participant (CONF:8414) such that it
   1. SHALL contain exactly one [1..1] assignedPerson (CONF:8415).
      1. This assignedPerson SHALL contain exactly one [1..1] name (CONF:9406).
         1. The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10478).
7. SHALL contain exactly one [1..1] documentationOf (CONF:8416) such that it
   1. SHALL contain exactly one [1..1] serviceEvent (CONF:8431).
      1. This serviceEvent SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8430).
      2. This serviceEvent SHOULD contain zero or more [0..\*] id (CONF:8418).
      3. This serviceEvent SHALL contain exactly one [1..1] code (CONF:8419).
         1. The value of serviceEvent/code SHALL NOT conflict with the ClininicalDocument/code. When transforming from DICOM SR documents that do not contain a procedure code, an appropriate nullFlavor SHALL be used on serviceEvent/code (CONF:8420).
      4. This serviceEvent SHOULD contain zero or more [0..\*] [Physician Reading Study Performer](#U_Physician_Reading_Study_Performer) (templateId:2.16.840.1.113883.10.20.6.2.1) (CONF:8422).
8. MAY contain zero or one [0..1] relatedDocument (CONF:8432) such that it
   1. When a Diagnostic Imaging Report has been transformed from a DICOM SR document, relatedDocument/@typeCode SHALL be XFRM, and relatedDocument/parentDocument/id SHALL contain the SOP Instance UID of the original DICOM SR document (CONF:8433).
   2. SHALL contain exactly one [1..1] id (CONF:10030).
      1. This id MAY contain zero or one [0..1] componentOf (CONF:8434).
         1. The componentOf, if present, SHALL contain exactly one [1..1] encompassingEncounter (CONF:8449).
            1. This encompassingEncounter SHALL contain at least one [1..\*] id (CONF:8435).

In the case of transformed DICOM SR documents, an appropriate null flavor MAY be used if the id is unavailable (CONF:8436).

* + - * 1. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:8437).

The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10133).

* + - * 1. This encompassingEncounter MAY contain zero or one [0..1] responsibleParty (CONF:8438).

The responsibleParty, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:9407).

SHOULD contain zero or one [0..1] assignedPerson OR SHOULD contain zero or one [0..1] representedOrganization (CONF:8439).

* + - * 1. This encompassingEncounter SHOULD contain zero or one [0..1] [Physician of Record Participant](#U_Physician_of_Record_Participant) (templateId:2.16.840.1.113883.10.20.6.2.2) (CONF:8448).
    1. OIDs SHALL be represented in dotted decimal notation, where each decimal number is either 0 or starts with a nonzero digit. More formally, an OID SHALL be in the form ([0-2])(.([1-9][0-9]\*|0))+ (CONF:10031).
    2. OIDs SHALL be no more than 64 characters in length (CONF:10032).

1. SHALL contain exactly one [1..1] component (CONF:14907).
   1. A Diagnostic Imaging Report can have either a structuredBody or a nonXMLBody (CONF:14908).
   2. If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:14910).
2. The ClinicalDocument/id/@root attribute SHALL be a syntactically correct OID, and SHALL NOT be a UUID (CONF:8405).
   1. OIDs SHALL be represented in dotted decimal notation, where each decimal number is either 0 or starts with a nonzero digit. More formally, an OID SHALL be in the form ([0-2])(.([1-9][0-9]\*|0))+ (CONF:8406).
   2. OIDs SHALL be no more than 64 characters in length (CONF:8407).
3. SHALL contain exactly one [1..1] code/@code, which SHALL be selected from ValueSet DIRDocumentTypeCodes 2.16.840.1.113883.11.20.9.32 DYNAMIC (CONF:8408).
4. The DICOM Object Catalog section (templateId 2.16.840.1.113883.10.20.6.1.1), if present, SHALL be the first section in the document Body (CONF:9408).
5. With the exception of the DICOM Object Catalog (templateId 2.16.840.1.113883.10.20.6.1.1), all sections within the Diagnostic Imaging Report content SHOULD contain a title element (CONF:9409).
6. The section/code SHOULD be selected from LOINC® or DICOM for sections not listed in the DIR Section Type Codes table (CONF:9410).
   1. Descriptions for sections is under development in DICOM in cooperation with the RSNA reporting initiative (CONF:9423).
7. All sections defined in the DIR Section Type Codes table SHALL be top-level sections (CONF:9411).
8. A section element SHALL have a code element, which SHALL contain a LOINC code or DCM code for sections that have no LOINC equivalent. This only applies to sections described in the DIR Section Type Codes table (CONF:9412).
9. Apart from the DICOM Object Catalog (templateId 2.16.840.1.113883.10.20.6.1.1), all other instances of section SHALL contain at least one text element or one or more component elements (CONF:9413).
10. All text or component elements SHALL contain content. Text elements SHALL contain PCDATA or child elements, and component elements SHALL contain child elements (CONF:9414).
11. The text elements (and their children) MAY contain Web Access to DICOM Persistent Object (WADO) references to DICOM objects by including a linkHtml element where @href is a valid WADO URL and the text content of linkHtml is the visible text of the hyperlink (CONF:9415).
12. If clinical statements are present, the section/text SHALL represent faithfully all such statements and MAY contain additional text (CONF:9416).
13. MAY contain zero or more [0..\*] [Procedure Context](#E_Procedure_Context) (templateId:2.16.840.1.113883.10.20.6.2.5) (CONF:9417).
    1. If the service context of a section is different from the value specified in documentationOf/serviceEvent, then the section SHALL contain one or more entries containing Procedure Context (templateId 2.16.840.1.113883.10.20.6.2.5), which will reset the context for any clinical statements nested within those elements (CONF:9418).
14. MAY contain zero or more [0..\*] [Fetus Subject Context](#S_Fetus_Subject_Context) (templateId:2.16.840.1.113883.10.20.6.2.3) (CONF:9419).
    1. If the subject of a section is a fetus, the section SHALL contain a subject element containing a Fetus Subject Context (templateId 2.16.840.1.113883.10.20.6.2.3) (CONF:9420).
15. MAY contain zero or more [0..\*] [Observer Context](#S_Observer_Context) (templateId:2.16.840.1.113883.10.20.6.2.4) (CONF:9421).
    1. : If the author of a section is different from the author(s) listed in the Header, an author element SHALL be present containing Observer Context (templateId 2.16.840.1.113883.10.20.6.2.4) (CONF:9422).
16. SHALL contain exactly one [1..1] [Findings Section (DIR)](#S_Findings_Section_DIR) (templateId:2.16.840.1.113883.10.20.6.1.2) (CONF:9484).
17. SHOULD contain zero or one [0..1] [DICOM Object Catalog Section - DCM 121181](#S_DICOM_Object_Catalog_Section__DCM_121) (templateId:2.16.840.1.113883.10.20.6.1.1) (CONF:15141).
    1. Discharge Summary

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.8 (open)]

Table 4: Discharge Summary Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional)  [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S)  [Chief Complaint Section](#S_Chief_Complaint_Section)  [Discharge Diet Section](#S_Discharge_Diet_Section)  [Family History Section](#S_Family_History_Section)  [Functional Status Section](#S_Functional_Status_Section)  [History of Past Illness Section](#S_History_of_Past_Illness_Section)  [History of Present Illness Section](#S_History_of_Present_Illness_Section)  [Hospital Admission Diagnosis Section](#S_Hospital_Admission_Diagnosis_Section)  [Hospital Admission Medications Section (entries optional)](#S_Hospital_Admission_Medications_Section)  [Hospital Consultations Section](#S_Hospital_Consultations_Section)  [Hospital Course Section](#S_Hospital_Course_Section)  [Hospital Discharge Diagnosis Section](#S_Hospital_Discharge_Diagnosis_Section)  [Hospital Discharge Instructions Section](#S_Hospital_Discharge_Instructions_Sectio)  [Hospital Discharge Medications Section (entries optional)](#S_Hospital_Discharge_Medications_ent_opt)  [Hospital Discharge Physical Section](#S_Hospital_Discharge_Physical_Section)  [Hospital Discharge Studies Summary Section](#S_Hospital_Discharge_Studies_Summary_Sec)  [Immunizations Section (entries optional)](#S_Immunizations_Section_entries_optional)  [Plan of Care Section](#S_Plan_of_Care_Section)  [Problem Section (entries optional)](#S_Problem_Section_entries_optional)  [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional)  [Reason for Visit Section](#S_Reason_for_Visit_Section)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Social History Section](#S_Social_History_Section)  [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) |

The Discharge Summary is a document that is a synopsis of a patient's admission to a hospital; it provides pertinent information for the continuation of care following discharge. The Joint Commission requires the following information to be included in the Discharge Summary:

• The reason for hospitalization

• The procedures performed

• The care, treatment, and services provided

• The patient’s condition and disposition at discharge

• Information provided to the patient and family

• Provisions for follow-up care

1. Conforms to [US Realm Header](#D_US_Realm_Header) template (2.16.840.1.113883.10.20.22.1.1).
2. SHALL contain exactly one [1..1] templateId (CONF:8463) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.8" (CONF:10044).
3. SHALL contain exactly one [1..1] code (CONF:17178).
   1. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet DischargeSummaryDocumentTypeCode 2.16.840.1.113883.11.20.4.1 DYNAMIC (CONF:17179).
4. MAY contain zero or more [0..\*] participant (CONF:8467).
   1. If present, the participant/associatedEntity element SHALL have an associatedPerson or scopingOrganization element (CONF:8468).
   2. B. When participant/@typeCode is IND, associatedEntity/@classCode SHALL be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:8469).
5. SHALL contain exactly one [1..1] componentOf (CONF:8471).
   1. This componentOf SHALL contain exactly one [1..1] encompassingEncounter (CONF:8472).
      1. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime/low (CONF:8473).
      2. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime/high (CONF:8475).
      3. The dischargeDispositionCode SHALL be present where the value of code SHOULD be selected from ValueSet 2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status DYNAMIC (www.nubc.org) (CONF:8476).
         1. The dischargeDispositionCode, @displayName, or NUBC UB-04 Print Name, SHALL be displayed when the document is rendered (CONF:8477).
      4. The encounterParticipant elements MAY be present. If present, the encounterParticipant/assignedEntity element SHALL have at least one assignedPerson or representedOrganization element present (CONF:8478).
      5. The responsibleParty element MAY be present. If present, the responsibleParty/assignedEntity element SHALL have at least one assignedPerson or representedOrganization element present (CONF:8479).
6. SHALL contain exactly one [1..1] component (CONF:9539).
   1. A Discharge Summary can have either a structuredBody or a nonXMLBody (CONF:9537).
      1. A Discharge Summary can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.8), coded entries are optional (CONF:9538).
   2. If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9540).
      1. SHALL contain exactly one [1..1] [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.6) (CONF:9542).
      2. SHALL contain exactly one [1..1] [Hospital Course Section](#S_Hospital_Course_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.5) (CONF:9544).
      3. SHALL contain exactly one [1..1] [Hospital Discharge Diagnosis Section](#S_Hospital_Discharge_Diagnosis_Section) (templateId:2.16.840.1.113883.10.20.22.2.24) (CONF:9546).
      4. SHALL contain exactly one [1..1] [Hospital Discharge Medications Section (entries optional)](#S_Hospital_Discharge_Medications_ent_opt) (templateId:2.16.840.1.113883.10.20.22.2.11) (CONF:9548).
      5. SHALL contain exactly one [1..1] [Plan of Care Section](#S_Plan_of_Care_Section) (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9550).
      6. MAY contain zero or one [0..1] [Chief Complaint Section](#S_Chief_Complaint_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:9554).
      7. MAY contain zero or one [0..1] [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S) (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:9556).
      8. MAY contain zero or one [0..1] [Discharge Diet Section](#S_Discharge_Diet_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.33) (CONF:9558).
      9. MAY contain zero or one [0..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:9560).
      10. MAY contain zero or one [0..1] [Functional Status Section](#S_Functional_Status_Section) (templateId:2.16.840.1.113883.10.20.22.2.14) (CONF:9562).
      11. MAY contain zero or one [0..1] [History of Past Illness Section](#S_History_of_Past_Illness_Section) (templateId:2.16.840.1.113883.10.20.22.2.20) (CONF:9564).
      12. MAY contain zero or one [0..1] [History of Present Illness Section](#S_History_of_Present_Illness_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:9566).
      13. MAY contain zero or one [0..1] [Hospital Discharge Physical Section](#S_Hospital_Discharge_Physical_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.26) (CONF:9568).
      14. MAY contain zero or one [0..1] [Hospital Discharge Studies Summary Section](#S_Hospital_Discharge_Studies_Summary_Sec) (templateId:2.16.840.1.113883.10.20.22.2.16) (CONF:9570).
      15. MAY contain zero or one [0..1] [Immunizations Section (entries optional)](#S_Immunizations_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.2) (CONF:9572).
      16. MAY contain zero or one [0..1] [Problem Section (entries optional)](#S_Problem_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.5) (CONF:9574).
      17. MAY contain zero or one [0..1] [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.7) (CONF:9576).
      18. MAY contain zero or one [0..1] [Reason for Visit Section](#S_Reason_for_Visit_Section) (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:9578).
      19. MAY contain zero or one [0..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:9580).
      20. MAY contain zero or one [0..1] [Social History Section](#S_Social_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.17) (CONF:9582).
      21. MAY contain zero or one [0..1] [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.4) (CONF:9584).
      22. MAY contain zero or one [0..1] [Hospital Consultations Section](#S_Hospital_Consultations_Section) (templateId:2.16.840.1.113883.10.20.22.2.42) (CONF:9924).
      23. MAY contain zero or one [0..1] [Hospital Discharge Instructions Section](#S_Hospital_Discharge_Instructions_Sectio) (templateId:2.16.840.1.113883.10.20.22.2.41) (CONF:9926).
      24. MAY contain zero or one [0..1] [Hospital Admission Diagnosis Section](#S_Hospital_Admission_Diagnosis_Section) (templateId:2.16.840.1.113883.10.20.22.2.43) (CONF:9928).
      25. SHALL NOT include a Chief Complaint and Reason for Visit Section with either a Chief Complaint Section or a Reason for Visit Section (CONF:10055).
      26. MAY contain zero or one [0..1] [Hospital Admission Medications Section (entries optional)](#S_Hospital_Admission_Medications_Section) (templateId:2.16.840.1.113883.10.20.22.2.44) (CONF:10111).
   3. History and Physical

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.3 (open)]

Table 5: History and Physical Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional)  [Assessment and Plan Section](#S_Assessment_and_Plan_Section)  [Assessment Section](#S_Assessment_Section)  [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S)  [Chief Complaint Section](#S_Chief_Complaint_Section)  [Family History Section](#S_Family_History_Section)  [General Status Section](#S_General_Status_Section)  [History of Past Illness Section](#S_History_of_Past_Illness_Section)  [History of Present Illness Section](#S_History_of_Present_Illness_Section)  [Immunizations Section (entries optional)](#S_Immunizations_Section_entries_optional)  [Instructions Section](#S_Instructions_Section)  [Medications Section (entries optional)](#S_Medications_Section_entries_optional)  [Physical Exam Section](#S_Physical_Exam_Section)  [Plan of Care Section](#S_Plan_of_Care_Section)  [Problem Section (entries optional)](#S_Problem_Section_entries_optional)  [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional)  [Reason for Visit Section](#S_Reason_for_Visit_Section)  [Results Section (entries optional)](#S_Results_Section_entries_optional)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Social History Section](#S_Social_History_Section)  [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) |

A History and Physical (H&P) Note is a medical report that documents the current and past conditions of the patient. It contains essential information that helps determine an individual's health status.

The first portion of the report is a current collection of organized information unique to an individual, typically supplied by the patient or their caregiver, about the current medical problem or the reason for the patient encounter. This information is followed by a description of any past or ongoing medical issues, including current medications and allergies. Information is also obtained about the patient's lifestyle, habits, and diseases among family members.

The next portion of the report contains information obtained by physically examining the patient and gathering diagnostic information in the form of laboratory tests, imaging, or other diagnostic procedures.

The report ends with the clinician's assessment of the patient's situation and the intended plan to address those issues.

A History and Physical Examination is required upon hospital admission as well as before operative procedures. An initial evaluation in an ambulatory setting is often documented in the form of an H&P Note.

1. Conforms to [US Realm Header](#D_US_Realm_Header) template (2.16.840.1.113883.10.20.22.1.1).
2. SHALL contain exactly one [1..1] templateId (CONF:8283) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.3" (CONF:10046).
3. SHALL contain exactly one [1..1] code (CONF:17185).
   1. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet HPDocumentType 2.16.840.1.113883.1.11.20.22 DYNAMIC (CONF:17186).
4. MAY contain zero or more [0..\*] participant (CONF:8286).
   1. A participant element, if present, SHALL contain an associatedEntity element which SHALL contain either an associatedPerson or scopingOrganization element (CONF:8287).
   2. A special class of participant is the supporting person or organization: an individual or an organization that has a relationship to the patient, including parents, relatives, caregivers, insurance policyholders, and guarantors. In the case of a supporting person who is also an emergency contact or next-of-kin, a participant element should be present for each role recorded (CONF:8288).
   3. C. When participant/@typeCode is IND, associatedEntity/@classCode SHALL be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:8333).
5. MAY contain zero or more [0..\*] inFulfillmentOf (CONF:8336).
   1. An inFulfillmentOf element records the prior orders that are fulfilled (in whole or part) by the service events described in this document. For example, the prior order might be a referral and this H&P Note may be in partial fulfillment of that referral (CONF:8337).
6. SHALL contain exactly one [1..1] componentOf (CONF:8338).
   1. This componentOf SHALL contain exactly one [1..1] encompassingEncounter (CONF:8339).
      1. This encompassingEncounter SHALL contain exactly one [1..1] id (CONF:8340).
      2. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:8341).
         1. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10135).
      3. This encompassingEncounter MAY contain zero or one [0..1] responsibleParty (CONF:8345).
         1. The responsibleParty element records only the party responsible for the encounter, not necessarily the entire episode of care (CONF:8347).
         2. The responsibleParty element, if present, SHALL contain an assignedEntity element, which SHALL contain an assignedPerson element, a representedOrganization element, or both (CONF:8348).
      4. This encompassingEncounter MAY contain zero or more [0..\*] encounterParticipant (CONF:8342).
         1. An encounterParticipant element, if present, SHALL contain an assignedEntity element, which SHALL contain an assignedPerson element, a representedOrganization element, or both (CONF:8343).
         2. The encounterParticipant element, if present, records only participants in the encounter, not necessarily in the entire episode of care (CONF:8346).
      5. This encompassingEncounter MAY contain zero or one [0..1] location (CONF:8344).
7. SHALL contain exactly one [1..1] component (CONF:8349).
   1. A History and Physical document can have either a structuredBody or a nonXMLBody (CONF:8350).
      1. A History and Physical document can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.3), coded entries are optional (CONF:8352).
   2. If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9597).
      1. SHALL contain exactly one [1..1] [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.6) (CONF:9602).
      2. MAY contain zero or one [0..1] [Assessment Section](#S_Assessment_Section) (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:9605).
      3. MAY contain zero or one [0..1] [Plan of Care Section](#S_Plan_of_Care_Section) (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9607).
      4. MAY contain zero or one [0..1] [Chief Complaint Section](#S_Chief_Complaint_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:9611).
      5. MAY contain zero or one [0..1] [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S) (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:9613).
      6. SHALL contain exactly one [1..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:9615).
      7. SHALL contain exactly one [1..1] [General Status Section](#S_General_Status_Section) (templateId:2.16.840.1.113883.10.20.2.5) (CONF:9617).
      8. SHALL contain exactly one [1..1] [History of Past Illness Section](#S_History_of_Past_Illness_Section) (templateId:2.16.840.1.113883.10.20.22.2.20) (CONF:9619).
      9. SHOULD contain zero or one [0..1] [History of Present Illness Section](#S_History_of_Present_Illness_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:9621).
      10. SHALL contain exactly one [1..1] [Medications Section (entries optional)](#S_Medications_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.1) (CONF:9623).
      11. SHALL contain exactly one [1..1] [Physical Exam Section](#S_Physical_Exam_Section) (templateId:2.16.840.1.113883.10.20.2.10) (CONF:9625).
      12. MAY contain [] [Reason for Visit Section](#S_Reason_for_Visit_Section) (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:9627).
      13. SHALL contain exactly one [1..1] [Results Section (entries optional)](#S_Results_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.3) (CONF:9629).
      14. SHALL contain exactly one [1..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:9631).
      15. SHALL contain exactly one [1..1] [Social History Section](#S_Social_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.17) (CONF:9633).
      16. SHALL contain exactly one [1..1] [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.4) (CONF:9635).
      17. SHALL include a Chief Complaint and Reason for Visit Section, Chief Complaint Section, or a Reason for Visit Section (CONF:9642).
      18. SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan Section (CONF:9986).
      19. MAY contain zero or one [0..1] [Assessment and Plan Section](#S_Assessment_and_Plan_Section) (templateId:2.16.840.1.113883.10.20.22.2.9) (CONF:9987).
      20. MAY contain zero or one [0..1] [Immunizations Section (entries optional)](#S_Immunizations_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.2) (CONF:9988).
      21. MAY contain zero or one [0..1] [Problem Section (entries optional)](#S_Problem_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.5) (CONF:9989).
      22. MAY contain zero or one [0..1] [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.7) (CONF:9990).
      23. SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:10056).
      24. SHALL NOT contain a Chief Complaint and Reason for Visit Section when either a Chief Complaint Section or a Reason for Visit Section is present (CONF:10057).
      25. MAY contain zero or one [0..1] [Instructions Section](#S_Instructions_Section) (templateId:2.16.840.1.113883.10.20.22.2.45) (CONF:16807).
   3. Operative Note

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.7 (open)]

Table 6: Operative Note Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Anesthesia Section](#S_Anesthesia_Section)  [Complications Section](#S_Complications_Section)  [Operative Note Fluids Section](#S_Operative_Note_Fluids_Section)  [Operative Note Surgical Procedure Section](#S_Operative_Note_Surgical_Procedure_Sect)  [Plan of Care Section](#S_Plan_of_Care_Section)  [Planned Procedure Section](#S_Planned_Procedure_Section)  [Postoperative Diagnosis Section](#S_Postoperative_Diagnosis_Section)  [Preoperative Diagnosis Section](#S_Preoperative_Diagnosis_Section)  [Procedure Description Section](#S_Procedure_Description_Section)  [Procedure Disposition Section](#S_Procedure_Disposition_Section)  [Procedure Estimated Blood Loss Section](#S_Procedure_Estimated_Blood_Loss_Section)  [Procedure Findings Section](#S_Procedure_Findings_Section)  [Procedure Implants Section](#S_Procedure_Implants_Section)  [Procedure Indications Section](#S_Procedure_Indications_Section)  [Procedure Specimens Taken Section](#S_Procedure_Specimens_Taken_Section)  [Surgical Drains Section](#S_Surgical_Drains_Section) |

The Operative Note is a frequently used type of procedure note with specific requirements set forth by regulatory agencies.

The Operative Note or Report is created immediately following a surgical or other high-risk procedure and records the pre- and post-surgical diagnosis, pertinent events of the procedure, as well as the condition of the patient following the procedure. The report should be sufficiently detailed to support the diagnoses, justify the treatment, document the course of the procedure, and provide continuity of care.

1. Conforms to [US Realm Header](#D_US_Realm_Header) template (2.16.840.1.113883.10.20.22.1.1).
2. SHALL contain exactly one [1..1] templateId (CONF:8483) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.7" (CONF:10048).
3. SHALL contain exactly one [1..1] code (CONF:17187).
   1. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet SurgicalOperationNoteDocumentTypeCode 2.16.840.1.113883.11.20.1.1 DYNAMIC (CONF:17188).
4. SHALL contain at least one [1..\*] documentationOf (CONF:8486).
   1. Such documentationOfs SHALL contain exactly one [1..1] serviceEvent (CONF:8493).
      1. This serviceEvent SHALL contain exactly one [1..1] effectiveTime (CONF:8494).
         1. The serviceEvent/effectiveTime SHALL be present with effectiveTime/low (CONF:8488).
         2. If a width is not present, the serviceEvent/effectiveTime SHALL include effectiveTime/high (CONF:10058).
         3. When only the date and the length of the procedure are known a width element SHALL be present and the serviceEvent/effectiveTime/high SHALL not be present (CONF:10060).
         4. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10136).
      2. This serviceEvent SHALL contain exactly one [1..1] performer (CONF:8489) such that it
         1. SHALL contain exactly one [1..1] @typeCode="PPRF" Primary performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8495).
         2. SHALL contain exactly one [1..1] assignedEntity (CONF:10917).
            1. This assignedEntity SHALL contain exactly one [1..1] code (CONF:8490).

This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Provider Role Value Set 2.16.840.1.113883.3.88.12.3221.4 DYNAMIC (CONF:8491).

* + 1. I. The value of Clinical Document /documentationOf/serviceEvent/code SHALL be from ICD9 CM Procedures (CodeSystem 2.16.840.1.113883.6.104), CPT-4 (CodeSystem 2.16.840.1.113883.6.12), or values descending from 71388002 (Procedure) from the SNOMED CT (CodeSystem 2.16.840.1.113883.6.96) ValueSet Procedure 2.16.840.1.113883.3.88.12.80.28 DYNAMIC (CONF:8487).
  1. Any assistants SHALL be identified and SHALL be identified as secondary performers (SPRF) (CONF:8512).

1. SHALL contain exactly one [1..1] component (CONF:9585).
   1. An Operative Note can have either a structuredBody or a nonXMLBody (CONF:9586).
      1. An Operative Note can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.7), coded entries are optional (CONF:9587).
   2. If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9596).
      1. SHALL contain exactly one [1..1] [Anesthesia Section](#S_Anesthesia_Section) (templateId:2.16.840.1.113883.10.20.22.2.25) (CONF:9883).
      2. SHALL contain exactly one [1..1] [Complications Section](#S_Complications_Section) (templateId:2.16.840.1.113883.10.20.22.2.37) (CONF:9885).
      3. SHALL contain exactly one [1..1] [Preoperative Diagnosis Section](#S_Preoperative_Diagnosis_Section) (templateId:2.16.840.1.113883.10.20.22.2.34) (CONF:9888).
      4. SHALL contain exactly one [1..1] [Procedure Estimated Blood Loss Section](#S_Procedure_Estimated_Blood_Loss_Section) (templateId:2.16.840.1.113883.10.20.18.2.9) (CONF:9890).
      5. SHALL contain exactly one [1..1] [Procedure Findings Section](#S_Procedure_Findings_Section) (templateId:2.16.840.1.113883.10.20.22.2.28) (CONF:9892).
      6. SHALL contain exactly one [1..1] [Procedure Specimens Taken Section](#S_Procedure_Specimens_Taken_Section) (templateId:2.16.840.1.113883.10.20.22.2.31) (CONF:9894).
      7. SHALL contain exactly one [1..1] [Procedure Description Section](#S_Procedure_Description_Section) (templateId:2.16.840.1.113883.10.20.22.2.27) (CONF:9896).
      8. MAY contain zero or one [0..1] [Procedure Implants Section](#S_Procedure_Implants_Section) (templateId:2.16.840.1.113883.10.20.22.2.40) (CONF:9898).
      9. MAY contain zero or one [0..1] [Operative Note Fluids Section](#S_Operative_Note_Fluids_Section) (templateId:2.16.840.1.113883.10.20.7.12) (CONF:9900).
      10. MAY contain zero or one [0..1] [Operative Note Surgical Procedure Section](#S_Operative_Note_Surgical_Procedure_Sect) (templateId:2.16.840.1.113883.10.20.7.14) (CONF:9902).
      11. MAY contain zero or one [0..1] [Plan of Care Section](#S_Plan_of_Care_Section) (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9904).
      12. MAY contain zero or one [0..1] [Planned Procedure Section](#S_Planned_Procedure_Section) (templateId:2.16.840.1.113883.10.20.22.2.30) (CONF:9906).
      13. MAY contain zero or one [0..1] [Procedure Disposition Section](#S_Procedure_Disposition_Section) (templateId:2.16.840.1.113883.10.20.18.2.12) (CONF:9908).
      14. MAY contain zero or one [0..1] [Procedure Indications Section](#S_Procedure_Indications_Section) (templateId:2.16.840.1.113883.10.20.22.2.29) (CONF:9910).
      15. MAY contain zero or one [0..1] [Surgical Drains Section](#S_Surgical_Drains_Section) (templateId:2.16.840.1.113883.10.20.7.13) (CONF:9912).
      16. SHALL contain exactly one [1..1] [Postoperative Diagnosis Section](#S_Postoperative_Diagnosis_Section) (templateId:2.16.840.1.113883.10.20.22.2.35) (CONF:9913).
2. A consent, if present, SHALL be represented as ClinicalDocument/authorization/consent (CONF:8485).
   1. Procedure Note

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.6 (open)]

Table 7: Procedure Note Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional)  [Anesthesia Section](#S_Anesthesia_Section)  [Assessment and Plan Section](#S_Assessment_and_Plan_Section)  [Assessment Section](#S_Assessment_Section)  [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S)  [Chief Complaint Section](#S_Chief_Complaint_Section)  [Complications Section](#S_Complications_Section)  [Family History Section](#S_Family_History_Section)  [History of Past Illness Section](#S_History_of_Past_Illness_Section)  [History of Present Illness Section](#S_History_of_Present_Illness_Section)  [Medical (General) History Section](#S_Medical_General_History_Section)  [Medications Administered Section](#S_Medications_Administered_Section)  [Medications Section (entries optional)](#S_Medications_Section_entries_optional)  [Physical Exam Section](#S_Physical_Exam_Section)  [Plan of Care Section](#S_Plan_of_Care_Section)  [Planned Procedure Section](#S_Planned_Procedure_Section)  [Postprocedure Diagnosis Section](#S_Postprocedure_Diagnosis_Section)  [Procedure Description Section](#S_Procedure_Description_Section)  [Procedure Disposition Section](#S_Procedure_Disposition_Section)  [Procedure Estimated Blood Loss Section](#S_Procedure_Estimated_Blood_Loss_Section)  [Procedure Findings Section](#S_Procedure_Findings_Section)  [Procedure Implants Section](#S_Procedure_Implants_Section)  [Procedure Indications Section](#S_Procedure_Indications_Section)  [Procedure Specimens Taken Section](#S_Procedure_Specimens_Taken_Section)  [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional)  [Reason for Visit Section](#S_Reason_for_Visit_Section)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Social History Section](#S_Social_History_Section) |

Procedure Note is a broad term that encompasses many specific types of non-operative procedures including interventional cardiology, interventional radiology, gastrointestinal endoscopy, osteopathic manipulation, and many other specialty fields. Procedure Notes are documents that are differentiated from Operative Notes in that the procedures documented do not involve incision or excision as the primary act.

The Procedure Note is created immediately following a non-operative procedure and records the indications for the procedure and, when applicable, post-procedure diagnosis, pertinent events of the procedure, and the patient’s tolerance of the procedure. The document should be sufficiently detailed to justify the procedure, describe the course of the procedure, and provide continuity of care.

1. Conforms to [US Realm Header](#D_US_Realm_Header) template (2.16.840.1.113883.10.20.22.1.1).
2. SHALL contain exactly one [1..1] templateId (CONF:8496) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.6" (CONF:10050).
3. SHALL contain exactly one [1..1] code (CONF:17182).
   1. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ProcedureNoteDocumentTypeCodes 2.16.840.1.113883.11.20.6.1 DYNAMIC (CONF:17183).
4. MAY contain zero or more [0..\*] participant (CONF:8504) such that it
   1. SHALL contain exactly one [1..1] @typeCode="IND" Individual (CodeSystem: participationFunction 2.16.840.1.113883.5.88 STATIC) (CONF:8505).
   2. SHALL contain exactly one [1..1] functionCode="PCP" Primary Care Physician (CodeSystem: participationFunction 2.16.840.1.113883.5.88 STATIC) (CONF:8506).
   3. SHALL contain exactly one [1..1] associatedEntity/@classCode="PROV" Provider (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8507).
      1. This associatedEntity/@classCode SHALL contain exactly one [1..1] associatedPerson (CONF:8508).
5. SHALL contain at least one [1..\*] documentationOf (CONF:8510) such that it
   1. SHALL contain exactly one [1..1] serviceEvent (CONF:10061).
      1. This serviceEvent SHALL contain exactly one [1..1] effectiveTime (CONF:10062).
         1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:26449).
         2. The serviceEvent/effectiveTime SHALL be present with effectiveTime/low (CONF:8513).
         3. If a width is not present, the serviceEvent/effectiveTime SHALL include effectiveTime/high (CONF:8514).
         4. When only the date and the length of the procedure are known a width element SHALL be present and the serviceEvent/effectiveTime/high SHALL not be present (CONF:8515).
         5. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10063).
      2. This serviceEvent SHALL contain exactly one [1..1] performer (CONF:8520) such that it
         1. SHALL contain exactly one [1..1] @typeCode="PPRF" Primary Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8521).
         2. SHALL contain exactly one [1..1] assignedEntity (CONF:14911).
            1. This assignedEntity SHOULD contain zero or one [0..1] code (CONF:14912).

The code, if present, SHOULD contain zero or one [0..1] @code, which SHALL be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:14913).

* + 1. The value of Clinical Document /documentationOf/serviceEvent/code SHALL be from ICD9 CM Procedures (codeSystem 2.16.840.1.113883.6.104), CPT-4 (codeSystem 2.16.840.1.113883.6.12), or values descending from 71388002 (Procedure) from the SNOMED CT (codeSystem 2.16.840.1.113883.6.96) ValueSet 2.16.840.1.113883.3.88.12.80.28 Procedure DYNAMIC (CONF:8511).
  1. Any assistants SHALL be identified and SHALL be identified as secondary performers (SPRF) (CONF:8524).

1. SHALL contain exactly one [1..1] component (CONF:9588).
   1. A Procedure Note can have either a structuredBody or a nonXMLBody (CONF:9589).
      1. A Procedure Note can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.6), coded entries are optional (CONF:9590).
   2. If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9595).
      1. SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan Section (CONF:9643).
      2. MAY contain zero or one [0..1] [Assessment Section](#S_Assessment_Section) (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:9645).
      3. MAY contain zero or one [0..1] [Plan of Care Section](#S_Plan_of_Care_Section) (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:9647).
      4. MAY contain zero or one [0..1] [Assessment and Plan Section](#S_Assessment_and_Plan_Section) (templateId:2.16.840.1.113883.10.20.22.2.9) (CONF:9649).
      5. SHALL contain exactly one [1..1] [Complications Section](#S_Complications_Section) (templateId:2.16.840.1.113883.10.20.22.2.37) (CONF:9802).
      6. SHALL contain exactly one [1..1] [Procedure Description Section](#S_Procedure_Description_Section) (templateId:2.16.840.1.113883.10.20.22.2.27) (CONF:9805).
      7. SHALL contain exactly one [1..1] [Procedure Indications Section](#S_Procedure_Indications_Section) (templateId:2.16.840.1.113883.10.20.22.2.29) (CONF:9807).
      8. MAY contain zero or one [0..1] [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.6) (CONF:9809).
      9. MAY contain zero or one [0..1] [Anesthesia Section](#S_Anesthesia_Section) (templateId:2.16.840.1.113883.10.20.22.2.25) (CONF:9811).
      10. MAY contain zero or one [0..1] [Chief Complaint Section](#S_Chief_Complaint_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:9813).
      11. MAY contain zero or one [0..1] [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S) (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:9815).
      12. MAY contain zero or one [0..1] [Family History Section](#S_Family_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.15) (CONF:9817).
      13. MAY contain zero or one [0..1] [History of Past Illness Section](#S_History_of_Past_Illness_Section) (templateId:2.16.840.1.113883.10.20.22.2.20) (CONF:9819).
      14. MAY contain zero or one [0..1] [History of Present Illness Section](#S_History_of_Present_Illness_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:9821).
      15. MAY contain zero or one [0..1] [Medical (General) History Section](#S_Medical_General_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.39) (CONF:9823).
      16. MAY contain zero or one [0..1] [Medications Section (entries optional)](#S_Medications_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.1) (CONF:9825).
      17. MAY contain zero or one [0..1] [Medications Administered Section](#S_Medications_Administered_Section) (templateId:2.16.840.1.113883.10.20.22.2.38) (CONF:9827).
      18. MAY contain zero or one [0..1] [Physical Exam Section](#S_Physical_Exam_Section) (templateId:2.16.840.1.113883.10.20.2.10) (CONF:9829).
      19. MAY contain zero or one [0..1] [Planned Procedure Section](#S_Planned_Procedure_Section) (templateId:2.16.840.1.113883.10.20.22.2.30) (CONF:9831).
      20. MAY contain zero or one [0..1] [Procedure Disposition Section](#S_Procedure_Disposition_Section) (templateId:2.16.840.1.113883.10.20.18.2.12) (CONF:9833).
      21. MAY contain zero or one [0..1] [Procedure Estimated Blood Loss Section](#S_Procedure_Estimated_Blood_Loss_Section) (templateId:2.16.840.1.113883.10.20.18.2.9) (CONF:9835).
      22. MAY contain zero or one [0..1] [Procedure Findings Section](#S_Procedure_Findings_Section) (templateId:2.16.840.1.113883.10.20.22.2.28) (CONF:9837).
      23. MAY contain zero or one [0..1] [Procedure Implants Section](#S_Procedure_Implants_Section) (templateId:2.16.840.1.113883.10.20.22.2.40) (CONF:9839).
      24. MAY contain zero or one [0..1] [Procedure Specimens Taken Section](#S_Procedure_Specimens_Taken_Section) (templateId:2.16.840.1.113883.10.20.22.2.31) (CONF:9841).
      25. MAY contain zero or one [0..1] [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.7) (CONF:9843).
      26. MAY contain zero or one [0..1] [Reason for Visit Section](#S_Reason_for_Visit_Section) (templateId:2.16.840.1.113883.10.20.22.2.12) (CONF:9845).
      27. MAY contain zero or one [0..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:9847).
      28. MAY contain zero or one [0..1] [Social History Section](#S_Social_History_Section) (templateId:2.16.840.1.113883.10.20.22.2.17) (CONF:9849).
      29. SHALL contain exactly one [1..1] [Postprocedure Diagnosis Section](#S_Postprocedure_Diagnosis_Section) (templateId:2.16.840.1.113883.10.20.22.2.36) (CONF:9850).
      30. Each section SHALL have a title and the title SHALL NOT be empty (CONF:9937).
      31. SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:10064).
      32. SHALL NOT include a Chief Complaint and Reason for Visit Section with either a Chief Complaint Section or a Reason for Visit Section (CONF:10065).
2. SHOULD contain zero or one [0..1] componentOf/encompassingEncounter (CONF:8499).
   1. The componentOf/encompassingEncounter, if present, SHALL contain at least one [1..\*] location/healthCareFacility/id (CONF:8500).
   2. The componentOf/encompassingEncounter, if present, SHALL contain exactly one [1..1] code (CONF:8501).
   3. The componentOf/encompassingEncounter, if present, MAY contain zero or one [0..1] encounterParticipant (CONF:8502) such that it
      1. SHALL contain exactly one [1..1] @typeCode="REF" Referrer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8503).
3. A consent, if present, SHALL be represented as ClinicalDocument/authorization/consent (CONF:8509).
   1. Progress Note

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.9 (open)]

Table 8: Progress Note Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional)  [Assessment and Plan Section](#S_Assessment_and_Plan_Section)  [Assessment Section](#S_Assessment_Section)  [Chief Complaint Section](#S_Chief_Complaint_Section)  [Instructions Section](#S_Instructions_Section)  [Interventions Section](#S_Interventions_Section)  [Medications Section (entries optional)](#S_Medications_Section_entries_optional)  [Objective Section](#S_Objective_Section)  [Physical Exam Section](#S_Physical_Exam_Section)  [Plan of Care Section](#S_Plan_of_Care_Section)  [Problem Section (entries optional)](#S_Problem_Section_entries_optional)  [Results Section (entries optional)](#S_Results_Section_entries_optional)  [Review of Systems Section](#S_Review_of_Systems_Section)  [Subjective Section](#S_Subjective_Section)  [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) |

A Progress Note documents a patient’s clinical status during a hospitalization or outpatient visit; thus, it is associated with an encounter.

Taber’s medical dictionary defines a Progress Note as “An ongoing record of a patient's illness and treatment. Physicians, nurses, consultants, and therapists record their notes concerning the progress or lack of progress made by the patient between the time of the previous note and the most recent note.”

Mosby’s medical dictionary defines a Progress Note as “Notes made by a nurse, physician, social worker, physical therapist, and other health care professionals that describe the patient's condition and the treatment given or planned.”

A Progress Note is not a re-evaluation note. A Progress Note is not intended to be a Progress Report for Medicare. Medicare B Section 1833(e) defines the requirements of a Medicare Progress Report.

1. Conforms to [US Realm Header](#D_US_Realm_Header) template (2.16.840.1.113883.10.20.22.1.1).
2. SHALL contain exactly one [1..1] templateId (CONF:7588) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.9" (CONF:10052).
3. SHALL contain exactly one [1..1] code (CONF:17189).
   1. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ProgressNoteDocumentTypeCode 2.16.840.1.113883.11.20.8.1 DYNAMIC (CONF:17190).
4. SHOULD contain zero or one [0..1] documentationOf (CONF:7603).
   1. The documentationOf, if present, SHALL contain exactly one [1..1] serviceEvent (CONF:7604).
      1. This serviceEvent SHALL contain exactly one [1..1] @classCode="PCPR" Care Provision (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:26420).
      2. This serviceEvent SHALL contain exactly one [1..1] templateId (CONF:9480) such that it
         1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.21.3.1" (CONF:10068).
      3. This serviceEvent SHOULD contain zero or one [0..1] effectiveTime (CONF:9481).
         1. The serviceEvent/effectiveTime element SHOULD be present with effectiveTime/low element (CONF:9482).
         2. If a width element is not present, the serviceEvent SHALL include effectiveTime/high (CONF:10066).
         3. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10137).
5. SHALL contain exactly one [1..1] componentOf (CONF:7595).
   1. This componentOf SHALL contain exactly one [1..1] encompassingEncounter (CONF:7596).
      1. This encompassingEncounter SHALL contain at least one [1..\*] id (CONF:7597).
      2. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:7598).
         1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:7599).
         2. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DT.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:10138).
      3. This encompassingEncounter SHALL contain exactly one [1..1] location/healthCareFacility/id (CONF:7611).
6. SHALL contain exactly one [1..1] component (CONF:9591).
   1. A Progress Note can have either a structuredBody or a nonXMLBody (CONF:9592).
      1. A Progress Note can conform to CDA Level 1 (nonXMLBody), CDA Level 2 (structuredBody with sections that contain a narrative block), or CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.9), coded entries are optional (CONF:9593).
   2. If structuredBody, the component/structuredBody SHALL conform to the section constraints below (CONF:9594).
      1. SHALL include an Assessment and Plan Section, or an Assessment Section and a Plan Section (CONF:8704).
      2. MAY contain zero or one [0..1] [Objective Section](#S_Objective_Section) (templateId:2.16.840.1.113883.10.20.21.2.1) (CONF:8770).
      3. MAY contain zero or one [0..1] [Medications Section (entries optional)](#S_Medications_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.1) (CONF:8771).
      4. MAY contain zero or one [0..1] [Chief Complaint Section](#S_Chief_Complaint_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:8772).
      5. MAY contain zero or one [0..1] [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.6) (CONF:8773).
      6. MAY contain zero or one [0..1] [Assessment and Plan Section](#S_Assessment_and_Plan_Section) (templateId:2.16.840.1.113883.10.20.22.2.9) (CONF:8774).
      7. MAY contain zero or one [0..1] [Plan of Care Section](#S_Plan_of_Care_Section) (templateId:2.16.840.1.113883.10.20.22.2.10) (CONF:8775).
      8. MAY contain zero or one [0..1] [Assessment Section](#S_Assessment_Section) (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:8776).
      9. MAY contain zero or one [0..1] [Interventions Section](#S_Interventions_Section) (templateId:2.16.840.1.113883.10.20.21.2.3) (CONF:8778).
      10. MAY contain zero or one [0..1] [Physical Exam Section](#S_Physical_Exam_Section) (templateId:2.16.840.1.113883.10.20.2.10) (CONF:8780).
      11. MAY contain zero or one [0..1] [Results Section (entries optional)](#S_Results_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.3) (CONF:8782).
      12. MAY contain zero or one [0..1] [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.4) (CONF:8784).
      13. MAY contain zero or one [0..1] [Problem Section (entries optional)](#S_Problem_Section_entries_optional) (templateId:2.16.840.1.113883.10.20.22.2.5) (CONF:8786).
      14. MAY contain zero or one [0..1] [Review of Systems Section](#S_Review_of_Systems_Section) (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:8788).
      15. MAY contain zero or one [0..1] [Subjective Section](#S_Subjective_Section) (templateId:2.16.840.1.113883.10.20.21.2.2) (CONF:8790).
      16. SHALL NOT include an Assessment/Plan Section when an Assessment Section and a Plan of Care Section are present (CONF:10069).
      17. MAY contain zero or one [0..1] [Instructions Section](#S_Instructions_Section) (templateId:2.16.840.1.113883.10.20.22.2.45) (CONF:16806).
7. SHALL contain exactly one [1..1] code/@code, which SHALL be selected from ValueSet ProgressNoteDocumentTypeCode 2.16.840.1.113883.11.20.8.1 DYNAMIC (CONF:7589).
   1. Unstructured Document

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.10 (open)]

Table 9: Unstructured Document Contexts

An unstructured document is a document which is used when the patient record is captured in an unstructured format that is encapsulated within an image file or as unstructured text in an electronic file such as a word processing or Portable Document Format (PDF) document.

There is a need to raise the level of interoperability for these documents to provide full access to the longitudinal patient record across a continuum of care. Until this gap is addressed, image and multi-media files will continue to be a portion of the patient record that remains difficult to access and share with all participants in a patient’s care. The Unstructured Document type addresses this gap by providing consistent guidance on the use of CDA for such documents.

An Unstructured Document (UD) document type can (1) include unstructured content, such as a graphic, directly in a text element with a mediaType attribute, or (2) reference a single document file, such as a word-processing document, using a text/reference element.

1. Conforms to [US Realm Header](#D_US_Realm_Header) template (2.16.840.1.113883.10.20.22.1.1).
2. SHALL contain exactly one [1..1] templateId (CONF:7710) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.10" (CONF:10054).
3. SHALL contain exactly one [1..1] component/nonXMLBody (CONF:7620).
   1. This component/nonXMLBody SHALL contain exactly one [1..1] text (CONF:7622).
      1. The text element SHALL either contain a reference element with a value attribute, or have a representation attribute with the value of B64, a mediaType attribute, and contain the media content (CONF:7623).
         1. The value of @mediaType, if present, SHALL be drawn from the value set 2.16.840.1.113883.11.20.7.1 SupportedFileFormats STATIC 20100512 (CONF:7624).
4. SHALL contain exactly one [1..1] author/assignedAuthor (CONF:7640).
   1. This author/assignedAuthor SHALL contain exactly one [1..1] addr (CONF:7641).
   2. This author/assignedAuthor SHALL contain exactly one [1..1] telecom (CONF:7642).
5. SHALL contain exactly one [1..1] recordTarget/patientRole/id (CONF:7643).
6. SHALL contain exactly one [1..1] custodian/assignedCustodian/representedCustodianOrganization (CONF:7645).
   1. This custodian/assignedCustodian/representedCustodianOrganization SHALL contain exactly one [1..1] id (CONF:7648).
   2. This custodian/assignedCustodian/representedCustodianOrganization SHALL contain exactly one [1..1] name (CONF:7649).
   3. This custodian/assignedCustodian/representedCustodianOrganization SHALL contain exactly one [1..1] telecom (CONF:7650).
   4. This custodian/assignedCustodian/representedCustodianOrganization SHALL contain exactly one [1..1] addr (CONF:7651).
   5. US Realm Header

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.1 (open)]

Table 10: US Realm Header Contexts

This section describes constraints that apply to the header for all documents within the scope of this implementation guide. Header constraints specific to each document type are described in the appropriate document-specific section below.

1. SHALL contain exactly one [1..1] realmCode="US" (CONF:16791).
2. SHALL contain exactly one [1..1] typeId (CONF:5361).
   1. This typeId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.1.3" (CONF:5250).
   2. This typeId SHALL contain exactly one [1..1] @extension="POCD\_HD000040" (CONF:5251).
3. SHALL contain exactly one [1..1] templateId (CONF:5252) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.1" (CONF:10036).
4. SHALL contain exactly one [1..1] id (CONF:5363).
   1. This id SHALL be a globally unique identifier for the document (CONF:9991).
5. SHALL contain exactly one [1..1] code (CONF:5253).
   1. This code SHALL specify the particular kind of document (e.g. History and Physical, Discharge Summary, Progress Note) (CONF:9992).
6. SHALL contain exactly one [1..1] title (CONF:5254).
   1. Can either be a locally defined name or the display name corresponding to clinicalDocument/code (CONF:5255).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:5256).
   1. The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:16865).
8. SHALL contain exactly one [1..1] confidentialityCode, which SHOULD be selected from ValueSet HL7 BasicConfidentialityKind 2.16.840.1.113883.1.11.16926 STATIC 2010-04-21 (CONF:5259).
9. SHALL contain exactly one [1..1] languageCode, which SHALL be selected from ValueSet Language 2.16.840.1.113883.1.11.11526 DYNAMIC (CONF:5372).
10. MAY contain zero or one [0..1] setId (CONF:5261).
    1. If setId is present versionNumber SHALL be present (CONF:6380).
11. MAY contain zero or one [0..1] versionNumber (CONF:5264).
    1. If versionNumber is present setId SHALL be present (CONF:6387).
12. SHALL contain at least one [1..\*] recordTarget (CONF:5266).
    1. Such recordTargets SHALL contain exactly one [1..1] patientRole (CONF:5267).
       1. This patientRole SHALL contain at least one [1..\*] id (CONF:5268).
       2. This patientRole SHALL contain at least one [1..\*] addr (CONF:5271).
          1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10412).
       3. This patientRole SHALL contain at least one [1..\*] telecom (CONF:5280).
          1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:5375).
       4. This patientRole SHALL contain exactly one [1..1] patient (CONF:5283).
          1. This patient SHALL contain exactly one [1..1] name (CONF:5284).
             1. The content of name SHALL be a conformant US Realm Patient Name (PTN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1) (CONF:10411).
          2. This patient SHALL contain exactly one [1..1] administrativeGenderCode, which SHALL be selected from ValueSet Administrative Gender (HL7 V3) 2.16.840.1.113883.1.11.1 DYNAMIC (CONF:6394).
          3. This patient SHALL contain exactly one [1..1] birthTime (CONF:5298).
             1. SHALL be precise to year (CONF:5299).
             2. SHOULD be precise to day (CONF:5300).
          4. This patient SHOULD contain zero or one [0..1] maritalStatusCode, which SHALL be selected from ValueSet Marital Status Value Set 2.16.840.1.113883.1.11.12212 DYNAMIC (CONF:5303).
          5. This patient MAY contain zero or one [0..1] religiousAffiliationCode, which SHALL be selected from ValueSet Religious Affiliation Value Set 2.16.840.1.113883.1.11.19185 DYNAMIC (CONF:5317).
          6. This patient MAY contain zero or one [0..1] raceCode, which SHALL be selected from ValueSet Race Value Set 2.16.840.1.113883.1.11.14914 DYNAMIC (CONF:5322).
          7. This patient MAY contain zero or one [0..1] ethnicGroupCode, which SHALL be selected from ValueSet EthnicityGroup 2.16.840.1.114222.4.11.837 DYNAMIC (CONF:5323).
          8. This patient MAY contain zero or more [0..\*] guardian (CONF:5325).
             1. The guardian, if present, SHOULD contain zero or one [0..1] code, which SHALL be selected from ValueSet PersonalRelationshipRoleType 2.16.840.1.113883.1.11.19563 DYNAMIC (CONF:5326).
             2. The guardian, if present, SHOULD contain zero or more [0..\*] addr (CONF:5359).

The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10413).

* + - * 1. The guardian, if present, MAY contain zero or more [0..\*] telecom (CONF:5382).

The telecom, if present, SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7993).

* + - * 1. The guardian, if present, SHALL contain exactly one [1..1] guardianPerson (CONF:5385).

This guardianPerson SHALL contain at least one [1..\*] name (CONF:5386).

The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10414).

* + - 1. This patient MAY contain zero or one [0..1] birthplace (CONF:5395).
         1. The birthplace, if present, SHALL contain exactly one [1..1] place (CONF:5396).

This place SHALL contain exactly one [1..1] addr (CONF:5397).

This addr SHOULD contain zero or one [0..1] country, which SHALL be selected from ValueSet CountryValueSet 2.16.840.1.113883.3.88.12.80.63 DYNAMIC (CONF:5404).

This addr MAY contain zero or one [0..1] postalCode, which SHALL be selected from ValueSet PostalCodeValueSet 2.16.840.1.113883.3.88.12.80.2 DYNAMIC (CONF:5403).

If country is US, this addr SHALL contain exactly one [1..1] state, which SHALL be selected from ValueSet 2.16.840.1.113883.3.88.12.80.1 StateValueSet DYNAMIC (CONF:5402).

* + - 1. This patient SHOULD contain zero or more [0..\*] languageCommunication (CONF:5406).
         1. The languageCommunication, if present, SHALL contain exactly one [1..1] languageCode, which SHALL be selected from ValueSet Language 2.16.840.1.113883.1.11.11526 DYNAMIC (CONF:5407).
         2. The languageCommunication, if present, MAY contain zero or one [0..1] modeCode, which SHALL be selected from ValueSet LanguageAbilityMode Value Set 2.16.840.1.113883.1.11.12249 DYNAMIC (CONF:5409).
         3. The languageCommunication, if present, SHOULD contain zero or one [0..1] proficiencyLevelCode, which SHALL be selected from ValueSet LanguageAbilityProficiency 2.16.840.1.113883.1.11.12199 DYNAMIC (CONF:9965).
         4. The languageCommunication, if present, MAY contain zero or one [0..1] preferenceInd (CONF:5414).
      2. This patient MAY contain zero or more [0..\*] sdtc:raceCode, where the @code SHALL be selected from ValueSet Race Value Set 2.16.840.1.113883.1.11.14914 DYNAMIC (CONF:7263).
    1. This patientRole MAY contain zero or one [0..1] providerOrganization (CONF:5416).
       1. The providerOrganization, if present, SHALL contain at least one [1..\*] id (CONF:5417).
          1. Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:16820).
       2. The providerOrganization, if present, SHALL contain at least one [1..\*] name (CONF:5419).
       3. The providerOrganization, if present, SHALL contain at least one [1..\*] telecom (CONF:5420).
          1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7994).
       4. The providerOrganization, if present, SHALL contain at least one [1..\*] addr (CONF:5422).
          1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10415).

1. SHALL contain at least one [1..\*] author (CONF:5444).
   1. Such authors SHALL contain exactly one [1..1] time (CONF:5445).
      1. The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:16866).
   2. Such authors SHALL contain exactly one [1..1] assignedAuthor (CONF:5448).
      1. This assignedAuthor SHALL contain exactly one [1..1] id (CONF:5449) such that it
         1. SHALL contain exactly one [1..1] @root (CONF:16786).
            1. If this assignedAuthor is an assignedPerson the assignedAuthor id SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:19521).
      2. This assignedAuthor SHOULD contain zero or one [0..1] code (CONF:16787).
         1. The code, if present, SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:16788).
      3. This assignedAuthor SHALL contain at least one [1..\*] addr (CONF:5452).
         1. The content SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:16871).
      4. This assignedAuthor SHALL contain at least one [1..\*] telecom (CONF:5428).
         1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7995).
      5. This assignedAuthor SHOULD contain zero or one [0..1] assignedPerson (CONF:5430).
         1. The assignedPerson, if present, SHALL contain at least one [1..\*] name (CONF:16789).
            1. The content SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:16872).
      6. This assignedAuthor SHOULD contain zero or one [0..1] assignedAuthoringDevice (CONF:16783).
         1. The assignedAuthoringDevice, if present, SHALL contain exactly one [1..1] manufacturerModelName (CONF:16784).
         2. The assignedAuthoringDevice, if present, SHALL contain exactly one [1..1] softwareName (CONF:16785).
      7. There SHALL be exactly one assignedAuthor/assignedPerson or exactly one assignedAuthor/assignedAuthoringDevice (CONF:16790).
2. MAY contain zero or one [0..1] dataEnterer (CONF:5441).
   1. The dataEnterer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:5442).
      1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:5443).
         1. Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:16821).
      2. This assignedEntity SHALL contain at least one [1..\*] addr (CONF:5460).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10417).
      3. This assignedEntity SHALL contain at least one [1..\*] telecom (CONF:5466).
         1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7996).
      4. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:5469).
         1. This assignedPerson SHALL contain at least one [1..\*] name (CONF:5470).
            1. The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10418).
      5. This assignedEntity MAY contain zero or one [0..1] code which SHOULD be selected from coding system NUCC Health Care Provider Taxonomy 2.16.840.1.113883.6.101 (CONF:9944).
3. MAY contain zero or more [0..\*] informant (CONF:8001).
   1. The informant, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:8002).
      1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:9945).
         1. If assignedEntity/id is a provider then this id, SHOULD include zero or one [0..1] id where id/@root ="2.16.840.1.113883.4.6" National Provider Identifier (CONF:9946).
      2. This assignedEntity SHALL contain at least one [1..\*] addr (CONF:8220).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10419).
      3. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:8221).
         1. This assignedPerson SHALL contain at least one [1..\*] name (CONF:8222).
            1. The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10420).
      4. Ii. This assignedEntity MAY contain zero or one [0..1] code which SHOULD be selected from coding system NUCC Health Care Provider Taxonomy 2.16.840.1.113883.6.101 (CONF:9947).
4. SHALL contain exactly one [1..1] custodian (CONF:5519).
   1. This custodian SHALL contain exactly one [1..1] assignedCustodian (CONF:5520).
      1. This assignedCustodian SHALL contain exactly one [1..1] representedCustodianOrganization (CONF:5521).
         1. This representedCustodianOrganization SHALL contain at least one [1..\*] id (CONF:5522).
            1. Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:16822).
         2. This representedCustodianOrganization SHALL contain exactly one [1..1] name (CONF:5524).
         3. This representedCustodianOrganization SHALL contain exactly one [1..1] telecom (CONF:5525).
            1. This telecom SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7998).
         4. This representedCustodianOrganization SHALL contain exactly one [1..1] addr (CONF:5559).
            1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10421).
5. MAY contain zero or more [0..\*] informationRecipient (CONF:5565).
   1. The informationRecipient, if present, SHALL contain exactly one [1..1] intendedRecipient (CONF:5566).
      1. This intendedRecipient MAY contain zero or one [0..1] informationRecipient (CONF:5567).
         1. The informationRecipient, if present, SHALL contain at least one [1..\*] name (CONF:5568).
            1. The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10427).
      2. This intendedRecipient MAY contain zero or one [0..1] receivedOrganization (CONF:5577).
         1. The receivedOrganization, if present, SHALL contain exactly one [1..1] name (CONF:5578).
6. SHOULD contain zero or one [0..1] legalAuthenticator (CONF:5579).
   1. The legalAuthenticator, if present, SHALL contain exactly one [1..1] time (CONF:5580).
      1. The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:16873).
   2. The legalAuthenticator, if present, SHALL contain exactly one [1..1] signatureCode (CONF:5583).
      1. This signatureCode SHALL contain exactly one [1..1] @code="S" (CodeSystem: Participationsignature 2.16.840.1.113883.5.89 STATIC) (CONF:5584).
   3. The legalAuthenticator, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:5585).
      1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:5586).
         1. Such ids MAY contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:16823).
      2. This assignedEntity MAY contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066 STATIC (CONF:17000).
      3. This assignedEntity SHALL contain at least one [1..\*] addr (CONF:5589).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10429).
      4. This assignedEntity SHALL contain at least one [1..\*] telecom (CONF:5595).
         1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:7999).
      5. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:5597).
         1. This assignedPerson SHALL contain at least one [1..\*] name (CONF:5598).
            1. The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10430).
7. MAY contain zero or more [0..\*] authenticator (CONF:5607).
   1. The authenticator, if present, SHALL contain exactly one [1..1] time (CONF:5608).
      1. The content SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:16874).
   2. The authenticator, if present, SHALL contain exactly one [1..1] signatureCode (CONF:5610).
      1. This signatureCode SHALL contain exactly one [1..1] @code="S" (CodeSystem: Participationsignature 2.16.840.1.113883.5.89 STATIC) (CONF:5611).
   3. The authenticator, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:5612).
      1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:5613).
         1. Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier  (CONF:16824).
      2. This assignedEntity MAY contain zero or one [0..1] code (CONF:16825).
         1. The code, if present, MAY contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) 2.16.840.1.114222.4.11.1066 STATIC (CONF:16826).
      3. This assignedEntity SHALL contain at least one [1..\*] addr (CONF:5616).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10425).
      4. This assignedEntity SHALL contain at least one [1..\*] telecom (CONF:5622).
         1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) 2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:8000).
      5. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:5624).
         1. This assignedPerson SHALL contain at least one [1..\*] name (CONF:5625).
            1. The content of name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:10424).
8. MAY contain zero or more [0..\*] participant (CONF:10003).
   1. The participant, if present, MAY contain zero or one [0..1] time (CONF:10004).
   2. Such participants, if present, SHALL have an associatedPerson or scopingOrganization element under participant/associatedEntity (CONF:10006).
   3. Unless otherwise specified by the document specific header constraints, when participant/@typeCode is IND, associatedEntity/@classCode SHALL be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:10007).
9. MAY contain zero or more [0..\*] inFulfillmentOf (CONF:9952).
   1. The inFulfillmentOf, if present, SHALL contain exactly one [1..1] order (CONF:9953).
      1. This order SHALL contain at least one [1..\*] id (CONF:9954).
10. MAY contain zero or more [0..\*] documentationOf (CONF:14835).
    1. The documentationOf, if present, SHALL contain exactly one [1..1] serviceEvent (CONF:14836).
       1. This serviceEvent SHALL contain exactly one [1..1] effectiveTime (CONF:14837).
          1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:14838).
       2. This serviceEvent SHOULD contain zero or more [0..\*] performer (CONF:14839).
          1. The performer, if present, SHALL contain exactly one [1..1] @typeCode (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:14840).
             1. The performer participant represents clinicians who actually and principally carry out the serviceEvent. In a transfer of care this represents the healthcare providers involved in the current or pertinent historical care of the patient. Preferably, the patient’s key healthcare care team members would be listed, particularly their primary physician and any active consulting physicians, therapists, and counselors (CONF:16753).
          2. The performer, if present, MAY contain zero or one [0..1] functionCode (CONF:16818).
             1. The functionCode, if present, SHOULD contain zero or one [0..1] @codeSystem, which SHOULD be selected from CodeSystem participationFunction (2.16.840.1.113883.5.88) STATIC (CONF:16819).
          3. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:14841).
             1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:14846).

Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:14847).

* + - * 1. This assignedEntity SHOULD contain zero or one [0..1] code (CONF:14842).

The code, if present, SHALL contain exactly one [1..1] @code, which SHOULD be selected from CodeSystem NUCCProviderTaxonomy (2.16.840.1.113883.6.101) STATIC (CONF:14843).

1. MAY contain zero or more [0..\*] authorization (CONF:16792) such that it
   1. SHALL contain exactly one [1..1] consent (CONF:16793).
      1. This consent MAY contain zero or more [0..\*] id (CONF:16794).
      2. This consent MAY contain zero or one [0..1] code (CONF:16795).
         1. The type of consent (e.g., a consent to perform the related serviceEvent) is conveyed in consent/code (CONF:16796).
      3. This consent SHALL contain exactly one [1..1] statusCode (CONF:16797).
         1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:16798).
2. MAY contain zero or one [0..1] componentOf (CONF:9955).
   1. The componentOf, if present, SHALL contain exactly one [1..1] encompassingEncounter (CONF:9956).
      1. This encompassingEncounter SHALL contain at least one [1..\*] id (CONF:9959).
      2. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:9958).

# Section-Level Templates

* 1. Advance Directives Section (entries optional)

[section: templateId 2.16.840.1.113883.10.20.22.2.21 (open)]

Table 11: Advance Directives Section (entries optional) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (optional) | [Advance Directive Observation](#E_Advance_Directive_Observation) |

This section contains data defining the patient’s advance directives and any reference to supporting documentation. The most recent and up-to-date directives are required, if known, and should be listed in as much detail as possible. This section contains data such as the existence of living wills, healthcare proxies, and CPR and resuscitation status. If referenced documents are available, they can be included in the CCD exchange package.

NOTE: The descriptions in this section differentiate between “advance directives” and “advance directive documents”. The former are the directions whereas the latter are legal documents containing those directions. Thus, an advance directive might be “no cardiopulmonary resuscitation”, and this directive might be stated in a legal advance directive document.

1. SHALL contain exactly one [1..1] templateId (CONF:7928) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.21" (CONF:10376).
2. SHALL contain exactly one [1..1] code (CONF:15340).
   1. This code SHALL contain exactly one [1..1] @code="42348-3" Advance Directives (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15342).
3. SHALL contain exactly one [1..1] title (CONF:7930).
4. SHALL contain exactly one [1..1] text (CONF:7931).
5. MAY contain zero or more [0..\*] entry (CONF:7957) such that it
   1. SHALL contain exactly one [1..1] [Advance Directive Observation](#E_Advance_Directive_Observation) (templateId:2.16.840.1.113883.10.20.22.4.48) (CONF:15443).
   2. Advance Directives Section (entries required)

[section: templateId 2.16.840.1.113883.10.20.22.2.21.1 (open)]

Table 12: Advance Directives Section (entries required) Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Advance Directive Observation](#E_Advance_Directive_Observation) |

This section contains data defining the patient’s advance directives and any reference to supporting documentation. The most recent and up-to-date directives are required, if known, and should be listed in as much detail as possible. This section contains data such as the existence of living wills, healthcare proxies, and CPR and resuscitation status. If referenced documents are available, they can be included in the CCD exchange package.

NOTE: The descriptions in this section differentiate between “advance directives” and “advance directive documents”. The former are the directions whereas the latter are legal documents containing those directions. Thus, an advance directive might be “no cardiopulmonary resuscitation”, and this directive might be stated in a legal advance directive document.

1. Conforms to [Advance Directives Section (entries optional)](#S_Advance_Directives_Section_entries_opt) template (2.16.840.1.113883.10.20.22.2.21).
2. SHALL contain exactly one [1..1] templateId (CONF:8643) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.21.1" (CONF:10377).
3. SHALL contain exactly one [1..1] code (CONF:15343).
   1. This code SHALL contain exactly one [1..1] @code="42348-3" Advance Directives (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15344).
4. SHALL contain exactly one [1..1] title (CONF:8645).
5. SHALL contain exactly one [1..1] text (CONF:8646).
6. SHALL contain at least one [1..\*] entry (CONF:8647) such that it
   1. SHALL contain exactly one [1..1] [Advance Directive Observation](#E_Advance_Directive_Observation) (templateId:2.16.840.1.113883.10.20.22.4.48) (CONF:15445).
   2. Allergies Section (entries optional)

[section: templateId 2.16.840.1.113883.10.20.22.2.6 (open)]

Table 13: Allergies Section (entries optional) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (required)  [Consultation Note](#D_Consultation_Note) (optional)  [Discharge Summary](#D_Discharge_Summary) (required)  [Procedure Note](#D_Procedure_Note) (optional) | [Allergy Problem Act](#E_Allergy_Problem_Act) |

This section lists and describes any medication allergies, adverse reactions, idiosyncratic reactions, anaphylaxis/anaphylactoid reactions to food items, and metabolic variations or adverse reactions/allergies to other substances (such as latex, iodine, tape adhesives) used to assure the safety of health care delivery. At a minimum, it should list currently active and any relevant historical allergies and adverse reactions.

1. SHALL contain exactly one [1..1] templateId (CONF:7800) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.6" (CONF:10378).
2. SHALL contain exactly one [1..1] code (CONF:15345).
   1. This code SHALL contain exactly one [1..1] @code="48765-2" Allergies, adverse reactions, alerts (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15346).
3. SHALL contain exactly one [1..1] title (CONF:7802).
4. SHALL contain exactly one [1..1] text (CONF:7803).
5. SHOULD contain zero or more [0..\*] entry (CONF:7804) such that it
   1. SHALL contain exactly one [1..1] [Allergy Problem Act](#E_Allergy_Problem_Act) (templateId:2.16.840.1.113883.10.20.22.4.30) (CONF:15444).
   2. Allergies Section (entries required)

[section: templateId 2.16.840.1.113883.10.20.22.2.6.1 (open)]

Table 14: Allergies Section (entries required) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (required) | [Allergy Problem Act](#E_Allergy_Problem_Act) |

This section lists and describes any medication allergies, adverse reactions, idiosyncratic reactions, anaphylaxis/anaphylactoid reactions to food items, and metabolic variations or adverse reactions/allergies to other substances (such as latex, iodine, tape adhesives) used to assure the safety of health care delivery. At a minimum, it should list currently active and any relevant historical allergies and adverse reactions.

1. Conforms to [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional) template (2.16.840.1.113883.10.20.22.2.6).
2. SHALL contain exactly one [1..1] templateId (CONF:7527) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.6.1" (CONF:10379).
3. SHALL contain exactly one [1..1] code (CONF:15349).
   1. This code SHALL contain exactly one [1..1] @code="48765-2" Allergies, adverse reactions, alerts (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15350).
4. SHALL contain exactly one [1..1] title (CONF:7534).
5. SHALL contain exactly one [1..1] text (CONF:7530).
6. SHALL contain at least one [1..\*] entry (CONF:7531) such that it
   1. SHALL contain exactly one [1..1] [Allergy Problem Act](#E_Allergy_Problem_Act) (templateId:2.16.840.1.113883.10.20.22.4.30) (CONF:15446).
   2. Anesthesia Section

[section: templateId 2.16.840.1.113883.10.20.22.2.25 (open)]

Table 15: Anesthesia Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (required)  [Procedure Note](#D_Procedure_Note) (optional) | [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) |

The Anesthesia section briefly records the type of anesthesia (e.g., general or local) and may state the actual agent used. This may or may not be a subsection of the Procedure Description section. The full details of anesthesia are usually found in a separate Anesthesia Note.

1. SHALL contain exactly one [1..1] templateId (CONF:8066) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.25" (CONF:10380).
2. SHALL contain exactly one [1..1] code (CONF:15351).
   1. This code SHALL contain exactly one [1..1] @code="59774-0" Anesthesia (CONF:15352).
3. SHALL contain exactly one [1..1] title (CONF:8068).
4. SHALL contain exactly one [1..1] text (CONF:8069).
5. MAY contain zero or more [0..\*] entry (CONF:8092) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) (templateId:2.16.840.1.113883.10.20.22.4.14) (CONF:15447).
6. MAY contain zero or more [0..\*] entry (CONF:8094).
   1. Assessment and Plan Section

[section: templateId 2.16.840.1.113883.10.20.22.2.9 (open)]

Table 16: Assessment and Plan Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (optional)  [Consultation Note](#D_Consultation_Note) (optional)  [Procedure Note](#D_Procedure_Note) (optional) | [Plan of Care Activity Act](#E_Plan_of_Care_Activity_Act) |

The Assessment and Plan sections may be combined or separated to meet local policy requirements.

The Assessment and Plan section represents both the clinician’s conclusions and working assumptions that will guide treatment of the patient (see Assessment Section above) and pending orders, interventions, encounters, services, and procedures for the patient (see Plan of Care Section below).

1. SHALL contain exactly one [1..1] templateId (CONF:7705) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.9" (CONF:10381).
2. SHALL contain exactly one [1..1] code (CONF:15353).
   1. This code SHALL contain exactly one [1..1] @code="51847-2" Assessment and Plan (CONF:15354).
3. SHALL contain exactly one [1..1] text (CONF:7707).
4. MAY contain zero or more [0..\*] entry (CONF:7708) such that it
   1. SHALL contain exactly one [1..1] [Plan of Care Activity Act](#E_Plan_of_Care_Activity_Act) (templateId:2.16.840.1.113883.10.20.22.4.39) (CONF:15448).
   2. Assessment Section

[section: templateId 2.16.840.1.113883.10.20.22.2.8 (open)]

Table 17: Assessment Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (optional)  [Consultation Note](#D_Consultation_Note) (optional)  [Procedure Note](#D_Procedure_Note) (optional) |  |

The Assessment section (also referred to as “impression” or “diagnoses” outside of the context of CDA) represents the clinician's conclusions and working assumptions that will guide treatment of the patient. The assessment may be a list of specific disease entities or a narrative block.

1. SHALL contain exactly one [1..1] templateId (CONF:7711) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.8" (CONF:10382).
2. SHALL contain exactly one [1..1] code (CONF:14757).
   1. This code SHALL contain exactly one [1..1] @code="51848-0" Assessments (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:14758).
3. SHALL contain exactly one [1..1] title (CONF:16774).
4. SHALL contain exactly one [1..1] text (CONF:7713).
   1. Chief Complaint and Reason for Visit Section

[section: templateId 2.16.840.1.113883.10.20.22.2.13 (open)]

Table 18: Chief Complaint and Reason for Visit Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [History and Physical](#D_History_and_Physical) (optional)  [Consultation Note](#D_Consultation_Note) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional)  [Procedure Note](#D_Procedure_Note) (optional) |  |

This section records the patient's chief complaint (the patient’s own description) and/or the reason for the patient's visit (the provider’s description of the reason for visit). Local policy determines whether the information is divided into two sections or recorded in one section serving both purposes.

1. SHALL contain exactly one [1..1] templateId (CONF:7840) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.13" (CONF:10383).
2. SHALL contain exactly one [1..1] code (CONF:15449).
   1. This code SHALL contain exactly one [1..1] @code="46239-0" Chief Complaint and Reason for Visit (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15450).
3. SHALL contain exactly one [1..1] title (CONF:7842).
4. SHALL contain exactly one [1..1] text (CONF:7843).
   1. Chief Complaint Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1 (open)]

Table 19: Chief Complaint Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (optional)  [Consultation Note](#D_Consultation_Note) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional)  [Procedure Note](#D_Procedure_Note) (optional) |  |

This section records the patient's chief complaint (the patient’s own description).

1. SHALL contain exactly one [1..1] templateId (CONF:7832) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1" (CONF:10453).
2. SHALL contain exactly one [1..1] code (CONF:15451).
   1. This code SHALL contain exactly one [1..1] @code="10154-3" Chief Complaint (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15452).
3. SHALL contain exactly one [1..1] title (CONF:7834).
4. SHALL contain exactly one [1..1] text (CONF:7835).
   1. Complications (OpNote)

[section: templateId 2.16.840.1.113883.10.20.22.2.32 (open)]

Table 20: Complications (OpNote) Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Problem Observation](#E_Problem_Observation) |

The Complications section records problems that occurred during the procedure or other activity. The complications may have been known risks or unanticipated problems.

Notes: This is replaced by 2.16.840.1.113883.10.20.22.2.37

1. SHALL contain exactly one [1..1] templateId (CONF:8026) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.32" (CONF:10385).
2. SHALL contain exactly one [1..1] code/@code="10830-8" Complications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:8027).
3. SHALL contain exactly one [1..1] title (CONF:8028).
4. SHALL contain exactly one [1..1] text (CONF:8029).
5. There SHALL be a statement providing details of the complication(s) or it SHALL explicitly state there were no complications (CONF:8048).
6. MAY contain at least one [1..\*] entry (CONF:8049).
   1. Such entries SHALL contain exactly one [1..1] [Problem Observation](#E_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:8050).
   2. Complications Section

[section: templateId 2.16.840.1.113883.10.20.22.2.37 (open)]

Table 21: Complications Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (required)  [Procedure Note](#D_Procedure_Note) (required) | [Problem Observation](#E_Problem_Observation) |

The Complications section records problems that occurred during the procedure or other activity. The complications may have been known risks or unanticipated problems.

1. SHALL contain exactly one [1..1] templateId (CONF:8174) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.37" (CONF:10384).
2. SHALL contain exactly one [1..1] code (CONF:15453).
   1. This code SHALL contain exactly one [1..1] @code="55109-3" Complications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15454).
3. SHALL contain exactly one [1..1] title (CONF:8176).
4. SHALL contain exactly one [1..1] text (CONF:8177).
5. MAY contain zero or more [0..\*] entry (CONF:8795) such that it
   1. SHALL contain exactly one [1..1] [Problem Observation](#E_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15455).
6. There SHALL be a statement providing details of the complication(s) or it SHALL explicitly state there were no complications (CONF:8797).
   1. DICOM Object Catalog Section - DCM 121181

[section: templateId 2.16.840.1.113883.10.20.6.1.1 (open)]

Table 22: DICOM Object Catalog Section - DCM 121181 Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Diagnostic Imaging Report](#D_Diagnostic_Imaging_Report) (optional) | [Study Act](#E_Study_Act) |

DICOM Object Catalog lists all referenced objects and their parent Series and Studies, plus other DICOM attributes required for retrieving the objects.

DICOM Object Catalog sections are not intended for viewing and contain empty section text.

1. SHALL contain exactly one [1..1] templateId (CONF:8525) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.1.1" (CONF:10454).
2. SHALL contain exactly one [1..1] code (CONF:15456).
   1. This code SHALL contain exactly one [1..1] @code="121181" Dicom Object Catalog (CodeSystem: DCM 1.2.840.10008.2.16.4 STATIC) (CONF:15457).
3. SHALL contain at least one [1..\*] entry (CONF:8530).
   1. Such entries SHALL contain exactly one [1..1] [Study Act](#E_Study_Act) (templateId:2.16.840.1.113883.10.20.6.2.6) (CONF:15458).
4. A DICOM Object Catalog SHALL be present if the document contains references to DICOM Images. If present, it SHALL be the first section in the document (CONF:8527).
   1. Discharge Diet Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.33 (open)]

Table 23: Discharge Diet Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Discharge Summary](#D_Discharge_Summary) (optional) |  |

This section records a narrative description of the expectations for diet and nutrition, including nutrition prescription, proposals, goals, and order requests for monitoring, tracking, or improving the nutritional status of the patient, used in a discharge from a facility such as an emergency department, hospital, or nursing home.

1. SHALL contain exactly one [1..1] templateId (CONF:7975) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.33" (CONF:10455).
2. SHALL contain exactly one [1..1] code (CONF:15459).
   1. This code SHALL contain exactly one [1..1] @code="42344-2" Discharge Diet (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15460).
3. SHALL contain exactly one [1..1] title (CONF:7977).
4. SHALL contain exactly one [1..1] text (CONF:7978).
   1. Encounters Section (entries optional)

[section: templateId 2.16.840.1.113883.10.20.22.2.22 (open)]

Table 24: Encounters Section (entries optional) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (optional) | [Encounter Activities](#E_Encounter_Activities) |

This section lists and describes any healthcare encounters pertinent to the patient’s current health status or historical health history. An Encounter is an interaction, regardless of the setting, between a patient and a practitioner who is vested with primary responsibility for diagnosing, evaluating, or treating the patient’s condition. It may include visits, appointments, as well as non-face-to-face interactions. It is also a contact between a patient and a practitioner who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment. This section may contain all encounters for the time period being summarized, but should include notable encounters.

1. SHALL contain exactly one [1..1] templateId (CONF:7940) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.22" (CONF:10386).
2. SHALL contain exactly one [1..1] code (CONF:15461).
   1. This code SHALL contain exactly one [1..1] @code="46240-8" Encounters (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15462).
3. SHALL contain exactly one [1..1] title (CONF:7942).
4. SHALL contain exactly one [1..1] text (CONF:7943).
5. SHOULD contain zero or more [0..\*] entry (CONF:7951) such that it
   1. SHALL contain exactly one [1..1] [Encounter Activities](#E_Encounter_Activities) (templateId:2.16.840.1.113883.10.20.22.4.49) (CONF:15465).
   2. Encounters Section (entries required)

[section: templateId 2.16.840.1.113883.10.20.22.2.22.1 (open)]

Table 25: Encounters Section (entries required) Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Encounter Activities](#E_Encounter_Activities) |

This section lists and describes any healthcare encounters pertinent to the patient’s current health status or historical health history. An Encounter is an interaction, regardless of the setting, between a patient and a practitioner who is vested with primary responsibility for diagnosing, evaluating, or treating the patient’s condition. It may include visits, appointments, as well as non-face-to-face interactions. It is also a contact between a patient and a practitioner who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment. This section may contain all encounters for the time period being summarized, but should include notable encounters.

1. Conforms to [Encounters Section (entries optional)](#S_Encounters_Section_entries_optional) template (2.16.840.1.113883.10.20.22.2.22).
2. SHALL contain exactly one [1..1] templateId (CONF:8705) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.22.1" (CONF:10387).
3. SHALL contain exactly one [1..1] code (CONF:15466).
   1. This code SHALL contain exactly one [1..1] @code="46240-8" Encounters (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15467).
4. SHALL contain exactly one [1..1] title (CONF:8707).
5. SHALL contain exactly one [1..1] text (CONF:8708).
6. SHALL contain at least one [1..\*] entry (CONF:8709) such that it
   1. SHALL contain exactly one [1..1] [Encounter Activities](#E_Encounter_Activities) (templateId:2.16.840.1.113883.10.20.22.4.49) (CONF:15468).
   2. Family History Section

[section: templateId 2.16.840.1.113883.10.20.22.2.15 (open)]

Table 26: Family History Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [History and Physical](#D_History_and_Physical) (required)  [Consultation Note](#D_Consultation_Note) (optional)  [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional)  [Procedure Note](#D_Procedure_Note) (optional) | [Family History Organizer](#E_Family_History_Organizer) |

This section contains data defining the patient’s genetic relatives in terms of possible or relevant health risk factors that have a potential impact on the patient’s healthcare risk profile.

1. SHALL contain exactly one [1..1] templateId (CONF:7932) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.15" (CONF:10388).
2. SHALL contain exactly one [1..1] code (CONF:15469).
   1. This code SHALL contain exactly one [1..1] @code="10157-6" Family History (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15470).
3. SHALL contain exactly one [1..1] title (CONF:7934).
4. SHALL contain exactly one [1..1] text (CONF:7935).
5. MAY contain zero or more [0..\*] entry (CONF:7955) such that it
   1. SHALL contain exactly one [1..1] [Family History Organizer](#E_Family_History_Organizer) (templateId:2.16.840.1.113883.10.20.22.4.45) (CONF:15471).
   2. Fetus Subject Context

[relatedSubject: templateId 2.16.840.1.113883.10.20.6.2.3 (open)]

Table 27: Fetus Subject Context Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Diagnostic Imaging Report](#D_Diagnostic_Imaging_Report) (optional) |  |

For reports on mothers and their fetus(es), information on a mother is mapped to recordTarget, PatientRole, and Patient. Information on the fetus is mapped to subject, relatedSubject, and SubjectPerson at the CDA section level. Both context information on the mother and fetus must be included in the document if observations on fetus(es) are contained in the document.

1. SHALL contain exactly one [1..1] templateId (CONF:9189) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.3" (CONF:10535).
2. SHALL contain exactly one [1..1] code with @xsi:type="CD" (CONF:9190).
   1. This code SHALL contain exactly one [1..1] @code="121026" (CodeSystem: DCM 1.2.840.10008.2.16.4 STATIC) (CONF:19129).
3. SHALL contain exactly one [1..1] subject (CONF:9191).

The name element is used to store the DICOM fetus ID, typically a pseudonym such as fetus\_1.

* 1. This subject SHALL contain exactly one [1..1] name (CONF:15347).
  2. Findings Section (DIR)

[section: templateId 2.16.840.1.113883.10.20.6.1.2 (open)]

Table 28: Findings Section (DIR) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Diagnostic Imaging Report](#D_Diagnostic_Imaging_Report) (required) |  |

The Findings section contains the main narrative body of the report. While not an absolute requirement for transformed DICOM SR reports, it is suggested that Diagnostic Imaging Reports authored in CDA follow Term Info guidelines for the codes in the various observations and procedures recorded in this section.

1. SHALL contain exactly one [1..1] templateId (CONF:8531) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.1.2" (CONF:10456).
2. This section SHOULD contain only the direct observations in the report, with topics such as Reason for Study, History, and Impression placed in separate sections. However, in cases where the source of report content provides a single block of text not separated into these sections, that text SHALL be placed in the Findings section (CONF:8532).
   1. Functional Status Section

[section: templateId 2.16.840.1.113883.10.20.22.2.14 (open)]

Table 29: Functional Status Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional) | [Assessment Scale Observation](#E_Assessment_Scale_Observation)  [Caregiver Characteristics](#E_Caregiver_Characteristics)  [Cognitive Status Problem Observation](#E_Cognitive_Status_Problem_Observation)  [Cognitive Status Result Observation](#E_Cognitive_Status_Result_Observation)  [Cognitive Status Result Organizer](#E_Cognitive_Status_Result_Organizer)  [Functional Status Problem Observation](#E_Functional_Status_Problem_Observation)  [Functional Status Result Observation](#E_Functional_Status_Result_Observation)  [Functional Status Result Organizer](#E_Functional_Status_Result_Organizer)  [Highest Pressure Ulcer Stage](#E_Highest_Pressure_Ulcer_Stage)  [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity)  [Number of Pressure Ulcers Observation](#E_Number_of_Pressure_Ulcers_Observation)  [Pressure Ulcer Observation](#E_Pressure_Ulcer_Observation_) |

The Functional Status section describes the patient’s physical state, status of functioning, and environmental status at the time the document was created.

A patient’s physical state may include information regarding the patient’s physical findings as they relate to problems, including but not limited to:

• Pressure Ulcers

• Amputations

• Heart murmur

• Ostomies

A patient’s functional status may include information regarding the patient relative to their general functional and cognitive ability, including:

• Ambulatory ability

• Mental status or competency

• Activities of Daily Living (ADLs), including bathing, dressing, feeding, grooming

• Home or living situation having an effect on the health status of the patient

• Ability to care for self

• Social activity, including issues with social cognition, participation with friends and acquaintances other than family members

• Occupation activity, including activities partly or directly related to working, housework or volunteering, family and home responsibilities or activities related to home and family

• Communication ability, including issues with speech, writing or cognition required for communication

• Perception, including sight, hearing, taste, skin sensation, kinesthetic sense, proprioception, or balance

A patient’s environmental status may include information regarding the patient’s current exposures from their daily environment, including but not limited to:

• Airborne hazards such as second-hand smoke, volatile organic compounds, dust, or other allergens

• Radiation

• Safety hazards in home, such as throw rugs, poor lighting, lack of railings/grab bars, etc.

• Safety hazards at work, such as communicable diseases, excessive heat, excessive noise, etc.

The patient's functional status may be expressed as a problem or as a result observation. A functional or cognitive status problem observation describes a patient’s problem, symptoms or condition. A functional or cognitive status result observation may include observations resulting from an assessment scale, evaluation or question and answer assessment.

Any deviation from normal function displayed by the patient and recorded in the record should be included. Of particular interest are those limitations that would interfere with self-care or the medical therapeutic process in any way. In addition, a note of normal function, an improvement, or a change in functioning status may be included.

1. SHALL contain exactly one [1..1] templateId (CONF:7920) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.14" (CONF:10389).
2. SHALL contain exactly one [1..1] code (CONF:14578).
   1. This code SHALL contain exactly one [1..1] @code="47420-5" Functional Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:14579).
3. SHALL contain exactly one [1..1] title (CONF:7922).
4. SHALL contain exactly one [1..1] text (CONF:7923).
5. MAY contain zero or more [0..\*] entry (CONF:14414) such that it
   1. SHALL contain exactly one [1..1] [Functional Status Result Organizer](#E_Functional_Status_Result_Organizer) (templateId:2.16.840.1.113883.10.20.22.4.66) (CONF:14415).
6. MAY contain zero or more [0..\*] entry (CONF:14416) such that it
   1. SHALL contain exactly one [1..1] [Cognitive Status Result Organizer](#E_Cognitive_Status_Result_Organizer) (templateId:2.16.840.1.113883.10.20.22.4.75) (CONF:14417).
7. MAY contain zero or more [0..\*] entry (CONF:14418) such that it
   1. SHALL contain exactly one [1..1] [Functional Status Result Observation](#E_Functional_Status_Result_Observation) (templateId:2.16.840.1.113883.10.20.22.4.67) (CONF:14419).
8. MAY contain zero or more [0..\*] entry (CONF:14420) such that it
   1. SHALL contain exactly one [1..1] [Cognitive Status Result Observation](#E_Cognitive_Status_Result_Observation) (templateId:2.16.840.1.113883.10.20.22.4.74) (CONF:14421).
9. MAY contain zero or more [0..\*] entry (CONF:14422) such that it
   1. SHALL contain exactly one [1..1] [Functional Status Problem Observation](#E_Functional_Status_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.68) (CONF:14423).
10. MAY contain zero or more [0..\*] entry (CONF:14424) such that it
    1. SHALL contain exactly one [1..1] [Cognitive Status Problem Observation](#E_Cognitive_Status_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.73) (CONF:14425).
11. MAY contain zero or more [0..\*] entry (CONF:14426) such that it
    1. SHALL contain exactly one [1..1] [Caregiver Characteristics](#E_Caregiver_Characteristics) (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:14427).
12. MAY contain zero or more [0..\*] entry (CONF:14580) such that it
    1. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:14581).
13. MAY contain zero or more [0..\*] entry (CONF:14582) such that it
    1. SHALL contain exactly one [1..1] [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:14583).
14. MAY contain zero or more [0..\*] entry (CONF:16777) such that it
    1. SHALL contain exactly one [1..1] [Pressure Ulcer Observation](#E_Pressure_Ulcer_Observation_) (templateId:2.16.840.1.113883.10.20.22.4.70) (CONF:16778).
15. MAY contain zero or more [0..\*] entry (CONF:16779) such that it
    1. SHALL contain exactly one [1..1] [Number of Pressure Ulcers Observation](#E_Number_of_Pressure_Ulcers_Observation) (templateId:2.16.840.1.113883.10.20.22.4.76) (CONF:16780).
16. MAY contain zero or more [0..\*] entry (CONF:16781) such that it
    1. SHALL contain exactly one [1..1] [Highest Pressure Ulcer Stage](#E_Highest_Pressure_Ulcer_Stage) (templateId:2.16.840.1.113883.10.20.22.4.77) (CONF:16782).
    2. General Status Section

[section: templateId 2.16.840.1.113883.10.20.2.5 (open)]

Table 30: General Status Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [History and Physical](#D_History_and_Physical) (required)  [Consultation Note](#D_Consultation_Note) (optional) |  |

The General Status section describes general observations and readily observable attributes of the patient, including affect and demeanor, apparent age compared to actual age, gender, ethnicity, nutritional status based on appearance, body build and habitus (e.g., muscular, cachectic, obese), developmental or other deformities, gait and mobility, personal hygiene, evidence of distress, and voice quality and speech.

1. SHALL contain exactly one [1..1] templateId (CONF:7985) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.2.5" (CONF:10457).
2. SHALL contain exactly one [1..1] code (CONF:15472).
   1. This code SHALL contain exactly one [1..1] @code="10210-3" General Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15473).
3. SHALL contain exactly one [1..1] title (CONF:7987).
4. SHALL contain exactly one [1..1] text (CONF:7988).
   1. History of Past Illness Section

[section: templateId 2.16.840.1.113883.10.20.22.2.20 (open)]

Table 31: History of Past Illness Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [History and Physical](#D_History_and_Physical) (required)  [Consultation Note](#D_Consultation_Note) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional)  [Procedure Note](#D_Procedure_Note) (optional) | [Problem Observation](#E_Problem_Observation) |

This section describes the history related to the patient’s past complaints, problems, or diagnoses. It records these details up until, and possibly pertinent to, the patient’s current complaint or reason for seeking medical care.

1. SHALL contain exactly one [1..1] templateId (CONF:7828) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.20" (CONF:10390).
2. SHALL contain exactly one [1..1] code (CONF:15474).
   1. This code SHALL contain exactly one [1..1] @code="11348-0" History of Past Illness (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15475).
3. SHALL contain exactly one [1..1] title (CONF:7830).
4. SHALL contain exactly one [1..1] text (CONF:7831).
5. MAY contain zero or more [0..\*] entry (CONF:8791) such that it
   1. SHALL contain exactly one [1..1] [Problem Observation](#E_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15476).
   2. History of Present Illness Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.4 (open)]

Table 32: History of Present Illness Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [History and Physical](#D_History_and_Physical) (optional)  [Consultation Note](#D_Consultation_Note) (required)  [Discharge Summary](#D_Discharge_Summary) (optional)  [Procedure Note](#D_Procedure_Note) (optional) |  |

The History of Present Illness section describes the history related to the reason for the encounter. It contains the historical details leading up to and pertaining to the patient’s current complaint or reason for seeking medical care.

1. SHALL contain exactly one [1..1] templateId (CONF:7848) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.4" (CONF:10458).
2. SHALL contain exactly one [1..1] code (CONF:15477).
   1. This code SHALL contain exactly one [1..1] @code="10164-2" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15478).
3. SHALL contain exactly one [1..1] title (CONF:7850).
4. SHALL contain exactly one [1..1] text (CONF:7851).
   1. Hospital Admission Diagnosis Section

[section: templateId 2.16.840.1.113883.10.20.22.2.43 (open)]

Table 33: Hospital Admission Diagnosis Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Discharge Summary](#D_Discharge_Summary) (optional) | [Hospital Admission Diagnosis](#E_Hospital_Admission_Diagnosis) |

The Hospital Admitting Diagnosis section contains a narrative description of the primary reason for admission to a hospital facility. The section includes an optional entry to record patient conditions.

1. SHALL contain exactly one [1..1] templateId (CONF:9930) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.43" (CONF:10391).
2. SHALL contain exactly one [1..1] code (CONF:15479).
   1. This code SHALL contain exactly one [1..1] @code="46241-6" Hospital Admission Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15480).
3. SHALL contain exactly one [1..1] title (CONF:9932).
4. SHALL contain exactly one [1..1] text (CONF:9933).
5. SHOULD contain zero or one [0..1] entry (CONF:9934).
   1. The entry, if present, SHALL contain exactly one [1..1] [Hospital Admission Diagnosis](#E_Hospital_Admission_Diagnosis) (templateId:2.16.840.1.113883.10.20.22.4.34) (CONF:15481).
   2. Hospital Admission Medications Section (entries optional)

[section: templateId 2.16.840.1.113883.10.20.22.2.44 (open)]

Table 34: Hospital Admission Medications Section (entries optional) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Discharge Summary](#D_Discharge_Summary) (optional) | [Admission Medication](#E_Admission_Medication) |

The Hospital Admission Medications section defines the relevant medications administered prior to admission to the facility. The currently active medications must be listed.

1. SHALL contain exactly one [1..1] templateId (CONF:10098) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.44" (CONF:10392).
2. SHALL contain exactly one [1..1] code (CONF:15482).
   1. This code SHALL contain exactly one [1..1] @code="42346-7" Medications on Admission (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15483).
3. SHALL contain exactly one [1..1] title (CONF:10100).
4. SHALL contain exactly one [1..1] text (CONF:10101).
5. SHOULD contain zero or more [0..\*] entry (CONF:10102) such that it
   1. SHALL contain exactly one [1..1] [Admission Medication](#E_Admission_Medication) (templateId:2.16.840.1.113883.10.20.22.4.36) (CONF:15484).
   2. Hospital Consultations Section

[section: templateId 2.16.840.1.113883.10.20.22.2.42 (open)]

Table 35: Hospital Consultations Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Discharge Summary](#D_Discharge_Summary) (optional) |  |

The Hospital Consultations section records consultations that occurred during the admission.

1. SHALL contain exactly one [1..1] templateId (CONF:9915) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.42" (CONF:10393).
2. SHALL contain exactly one [1..1] code (CONF:15485).
   1. This code SHALL contain exactly one [1..1] @code="18841-7" Hospital Consultations Section (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15486).
3. SHALL contain exactly one [1..1] title (CONF:9917).
4. SHALL contain exactly one [1..1] text (CONF:9918).
   1. Hospital Course Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.5 (open)]

Table 36: Hospital Course Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Discharge Summary](#D_Discharge_Summary) (required) |  |

The Hospital Course section describes the sequence of events from admission to discharge in a hospital facility.

1. SHALL contain exactly one [1..1] templateId (CONF:7852) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.5" (CONF:10459).
2. SHALL contain exactly one [1..1] code (CONF:15487).
   1. This code SHALL contain exactly one [1..1] @code="8648-8" Hospital Course (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15488).
3. SHALL contain exactly one [1..1] title (CONF:7854).
4. SHALL contain exactly one [1..1] text (CONF:7855).
   1. Hospital Discharge Diagnosis Section

[section: templateId 2.16.840.1.113883.10.20.22.2.24 (open)]

Table 37: Hospital Discharge Diagnosis Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Discharge Summary](#D_Discharge_Summary) (required) | [Hospital Discharge Diagnosis](#E_Hospital_Discharge_Diagnosis) |

The Hospital Discharge Diagnosis section describes the relevant problems or diagnoses at the time of discharge that occurred during the hospitalization or that need to be followed after hospitalization. This section includes an optional entry to record patient conditions.

1. SHALL contain exactly one [1..1] templateId (CONF:7979) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.24" (CONF:10394).
2. SHALL contain exactly one [1..1] code (CONF:15355).
   1. This code SHALL contain exactly one [1..1] @code="11535-2" Hospital Discharge Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15356).
3. SHALL contain exactly one [1..1] title (CONF:7981).
4. SHALL contain exactly one [1..1] text (CONF:7982).
5. SHOULD contain zero or one [0..1] entry (CONF:7983).
   1. The entry, if present, SHALL contain exactly one [1..1] [Hospital Discharge Diagnosis](#E_Hospital_Discharge_Diagnosis) (templateId:2.16.840.1.113883.10.20.22.4.33) (CONF:15489).
   2. Hospital Discharge Instructions Section

[section: templateId 2.16.840.1.113883.10.20.22.2.41 (open)]

Table 38: Hospital Discharge Instructions Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Discharge Summary](#D_Discharge_Summary) (optional) |  |

The Hospital Discharge Instructions section records instructions at discharge.

1. SHALL contain exactly one [1..1] templateId (CONF:9919) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.41" (CONF:10395).
2. SHALL contain exactly one [1..1] code (CONF:15357).
   1. This code SHALL contain exactly one [1..1] @code="8653-8" Hospital Discharge Instructions (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15358).
3. SHALL contain exactly one [1..1] title (CONF:9921).
4. SHALL contain exactly one [1..1] text (CONF:9922).
   1. Hospital Discharge Medications Section (entries optional)

[section: templateId 2.16.840.1.113883.10.20.22.2.11 (open)]

Table 39: Hospital Discharge Medications Section (entries optional) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Discharge Summary](#D_Discharge_Summary) (required) | [Discharge Medication](#E_Discharge_Medication) |

The Hospital Discharge Medications section defines the medications that the patient is intended to take (or stop) after discharge. The currently active medications must be listed. The section may also include a patient’s prescription history and indicate the source of the medication list, for example, from a pharmacy system versus from the patient.

1. SHALL contain exactly one [1..1] templateId (CONF:7816) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.11" (CONF:10396).
2. SHALL contain exactly one [1..1] code (CONF:15359).
   1. This code SHALL contain exactly one [1..1] @code="10183-2" Hospital Discharge Medications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15360).
3. SHALL contain exactly one [1..1] title (CONF:7818).
4. SHALL contain exactly one [1..1] text (CONF:7819).
5. SHOULD contain zero or more [0..\*] entry (CONF:7820) such that it
   1. SHALL contain exactly one [1..1] [Discharge Medication](#E_Discharge_Medication) (templateId:2.16.840.1.113883.10.20.22.4.35) (CONF:15490).
   2. Hospital Discharge Physical Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.26 (open)]

Table 40: Hospital Discharge Physical Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Discharge Summary](#D_Discharge_Summary) (optional) |  |

The Hospital Discharge Physical section records a narrative description of the patient’s physical findings.

1. SHALL contain exactly one [1..1] templateId (CONF:7971) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.26" (CONF:10460).
2. SHALL contain exactly one [1..1] code (CONF:15363).
   1. This code SHALL contain exactly one [1..1] @code="10184-0" Hospital Discharge Physical (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15364).
3. SHALL contain exactly one [1..1] title (CONF:7973).
4. SHALL contain exactly one [1..1] text (CONF:7974).
   1. Hospital Discharge Studies Summary Section

[section: templateId 2.16.840.1.113883.10.20.22.2.16 (open)]

Table 41: Hospital Discharge Studies Summary Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Discharge Summary](#D_Discharge_Summary) (optional) |  |

This section records the results of observations generated by laboratories, imaging procedures, and other procedures. The scope includes hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. This section often includes notable results such as abnormal values or relevant trends, and could record all results for the period of time being documented.

Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory.

Imaging results are typically generated by a clinician reviewing the output of an imaging procedure, such as where a cardiologist reports the left ventricular ejection fraction based on the review of an echocardiogram.

Procedure results are typically generated by a clinician wanting to provide more granular information about component observations made during the performance of a procedure, such as when a gastroenterologist reports the size of a polyp observed during a colonoscopy.

Note that there are discrepancies between CCD and the lab domain model, such as the effectiveTime in specimen collection.

1. SHALL contain exactly one [1..1] templateId (CONF:7910) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.16" (CONF:10398).
2. SHALL contain exactly one [1..1] code (CONF:15365).
   1. This code SHALL contain exactly one [1..1] @code="11493-4" Hospital Discharge Studies Summary (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15366).
3. SHALL contain exactly one [1..1] title (CONF:7912).
4. SHALL contain exactly one [1..1] text (CONF:7913).
   1. Immunizations Section (entries optional)

[section: templateId 2.16.840.1.113883.10.20.22.2.2 (open)]

Table 42: Immunizations Section (entries optional) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [History and Physical](#D_History_and_Physical) (optional)  [Consultation Note](#D_Consultation_Note) (optional)  [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional) | [Immunization Activity](#E_Immunization_Activity) |

The Immunizations section defines a patient's current immunization status and pertinent immunization history. The primary use case for the Immunization section is to enable communication of a patient's immunization status. The section should include current immunization status, and may contain the entire immunization history that is relevant to the period of time being summarized.

1. SHALL contain exactly one [1..1] templateId (CONF:7965) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.2" (CONF:10399).
2. SHALL contain exactly one [1..1] code (CONF:15367).
   1. This code SHALL contain exactly one [1..1] @code="11369-6" Immunizations (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15368).
3. SHALL contain exactly one [1..1] title (CONF:7967).
4. SHALL contain exactly one [1..1] text (CONF:7968).
5. SHOULD contain zero or more [0..\*] entry (CONF:7969) such that it
   1. SHALL contain exactly one [1..1] [Immunization Activity](#E_Immunization_Activity) (templateId:2.16.840.1.113883.10.20.22.4.52) (CONF:15494).
   2. Immunizations Section (entries required)

[section: templateId 2.16.840.1.113883.10.20.22.2.2.1 (open)]

Table 43: Immunizations Section (entries required) Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Immunization Activity](#E_Immunization_Activity) |

The Immunizations section defines a patient's current immunization status and pertinent immunization history. The primary use case for the Immunization section is to enable communication of a patient's immunization status. The section should include current immunization status, and may contain the entire immunization history that is relevant to the period of time being summarized.

1. Conforms to [Immunizations Section (entries optional)](#S_Immunizations_Section_entries_optional) template (2.16.840.1.113883.10.20.22.2.2).
2. SHALL contain exactly one [1..1] templateId (CONF:9015) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.2.1" (CONF:10400).
3. SHALL contain exactly one [1..1] code (CONF:15369).
   1. This code SHALL contain exactly one [1..1] @code="11369-6" Immunizations (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15370).
4. SHALL contain exactly one [1..1] title (CONF:9017).
5. SHALL contain exactly one [1..1] text (CONF:9018).
6. SHALL contain at least one [1..\*] entry (CONF:9019) such that it
   1. SHALL contain exactly one [1..1] [Immunization Activity](#E_Immunization_Activity) (templateId:2.16.840.1.113883.10.20.22.4.52) (CONF:15495).
   2. Implants Section

[section: templateId 2.16.840.1.113883.10.20.22.2.33 (open)]

Table 44: Implants Section Contexts

Replaced by template: 2.16.840.1.113883.10.20.22.2.40

Notes: Replaced by template: 2.16.840.1.113883.10.20.22.2.40

1. SHALL contain exactly one [1..1] templateId (CONF:8042) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.33" (CONF:10401).
2. SHALL contain exactly one [1..1] code (CONF:15371).
   1. This code SHALL contain exactly one [1..1] @code="55122-6" Implants (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15372).
3. SHALL contain exactly one [1..1] title (CONF:8044).
4. SHALL contain exactly one [1..1] text (CONF:8045).
   1. Instructions Section

[section: templateId 2.16.840.1.113883.10.20.22.2.45 (open)]

Table 45: Instructions Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (optional) | [Instructions](#E_Instructions) |

The Instructions section records instructions given to a patient. List patient decision aids here.

1. SHALL contain exactly one [1..1] templateId (CONF:10112) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.45" (CONF:10402).
2. SHALL contain exactly one [1..1] code (CONF:15375).
   1. This code SHALL contain exactly one [1..1] @code="69730-0" Instructions (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15376).
3. SHALL contain exactly one [1..1] title (CONF:10114).
4. SHALL contain exactly one [1..1] text (CONF:10115).
5. SHOULD contain zero or more [0..\*] entry (CONF:10116).
   1. The entry, if present, SHALL contain exactly one [1..1] [Instructions](#E_Instructions) (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:15496).
   2. Interventions Section

[section: templateId 2.16.840.1.113883.10.20.21.2.3 (open)]

Table 46: Interventions Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional) |  |

The Interventions section contains information about the specific interventions provided during the healthcare visit. Depending on the type of intervention(s) provided (procedural, education, application of assistive equipment, etc.), the details will vary but may include specification of frequency, intensity, and duration.

1. SHALL contain exactly one [1..1] templateId (CONF:8680) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.21.2.3" (CONF:10461).
2. SHALL contain exactly one [1..1] code (CONF:15377).
   1. This code SHALL contain exactly one [1..1] @code="62387-6" Interventions Provided (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15378).
3. SHALL contain exactly one [1..1] title (CONF:8682).
4. SHALL contain exactly one [1..1] text (CONF:8683).
   1. Medical (General) History Section

[section: templateId 2.16.840.1.113883.10.20.22.2.39 (open)]

Table 47: Medical (General) History Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Procedure Note](#D_Procedure_Note) (optional) |  |

The Medical History section describes all aspects of the medical history of the patient even if not pertinent to the current procedure, and may include chief complaint, past medical history, social history, family history, surgical or procedure history, medication history, and other history information. The history may be limited to information pertinent to the current procedure or may be more comprehensive. The history may be reported as a collection of random clinical statements or it may be reported categorically. Categorical report formats may be divided into multiple subsections including Past Medical History, Social History.

1. SHALL contain exactly one [1..1] templateId (CONF:8160) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.39" (CONF:10403).
2. SHALL contain exactly one [1..1] code (CONF:15379).
   1. This code SHALL contain exactly one [1..1] @code="11329-0" Medical (General) History (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15380).
3. SHALL contain exactly one [1..1] title (CONF:8162).
4. SHALL contain exactly one [1..1] text (CONF:8163).
   1. Medical Equipment Section

[section: templateId 2.16.840.1.113883.10.20.22.2.23 (open)]

Table 48: Medical Equipment Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (optional) | [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) |

The Medical Equipment section defines a patient’s implanted and external medical devices and equipment that their health status depends on, as well as any pertinent equipment or device history. This section is also used to itemize any pertinent current or historical durable medical equipment (DME) used to help maintain the patient’s health status. All pertinent equipment relevant to the diagnosis, care, and treatment of a patient should be included.

1. SHALL contain exactly one [1..1] templateId (CONF:7944) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.23" (CONF:10404).
2. SHALL contain exactly one [1..1] code (CONF:15381).
   1. This code SHALL contain exactly one [1..1] @code="46264-8" Medical Equipment (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15382).
3. SHALL contain exactly one [1..1] title (CONF:7946).
4. SHALL contain exactly one [1..1] text (CONF:7947).
5. SHOULD contain zero or more [0..\*] entry (CONF:7948) such that it
   1. SHALL contain exactly one [1..1] [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:15497).
   2. Medications Administered Section

[section: templateId 2.16.840.1.113883.10.20.22.2.38 (open)]

Table 49: Medications Administered Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Procedure Note](#D_Procedure_Note) (optional) | [Medication Activity](#E_Medication_Activity) |

The Medications Administered section defines medications and fluids administered during the procedure, encounter, or other activity excluding anesthetic medications. This guide recommends anesthesia medications be documented as described in the section on Anesthesia.

1. SHALL contain exactly one [1..1] templateId (CONF:8152) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.38" (CONF:10405).
2. SHALL contain exactly one [1..1] code (CONF:15383).
   1. This code SHALL contain exactly one [1..1] @code="29549-3" Medications Administered (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15384).
3. SHALL contain exactly one [1..1] title (CONF:8154).
4. SHALL contain exactly one [1..1] text (CONF:8155).
5. MAY contain zero or more [0..\*] entry (CONF:8156).
   1. The entry, if present, SHALL contain exactly one [1..1] [Medication Activity](#E_Medication_Activity) (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15499).
   2. Medications Section (entries optional)

[section: templateId 2.16.840.1.113883.10.20.22.2.1 (open)]

Table 50: Medications Section (entries optional) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (required)  [Consultation Note](#D_Consultation_Note) (optional)  [Procedure Note](#D_Procedure_Note) (optional) | [Medication Activity](#E_Medication_Activity) |

The Medications section defines a patient's current medications and pertinent medication history. At a minimum, the currently active medications are to be listed, with an entire medication history as an option. The section may also include a patient's prescription and dispense history.

This section requires that there be either an entry indicating the subject is not known to be on any medications, or that there be entries summarizing the subject's medications.

1. SHALL contain exactly one [1..1] templateId (CONF:7791) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.1" (CONF:10432).
2. SHALL contain exactly one [1..1] code (CONF:15385).
   1. This code SHALL contain exactly one [1..1] @code="10160-0" History of medication use (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15386).
3. SHALL contain exactly one [1..1] title (CONF:7793).
4. SHALL contain exactly one [1..1] text (CONF:7794).
5. SHOULD contain zero or more [0..\*] entry (CONF:7795) such that it
   1. SHALL contain exactly one [1..1] [Medication Activity](#E_Medication_Activity) (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15984).
   2. If medication use is unknown, the appropriate nullFlavor MAY be present (see unknown information in Section 1) (CONF:10076).
   3. Medications Section (entries required)

[section: templateId 2.16.840.1.113883.10.20.22.2.1.1 (open)]

Table 51: Medications Section (entries required) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (required) | [Medication Activity](#E_Medication_Activity) |

The Medications section defines a patient's current medications and pertinent medication history. At a minimum, the currently active medications are to be listed, with an entire medication history as an option. The section may also include a patient's prescription and dispense history.

This section requires that there be either an entry indicating the subject is not known to be on any medications, or that there be entries summarizing the subject's medications.

1. Conforms to [Medications Section (entries optional)](#S_Medications_Section_entries_optional) template (2.16.840.1.113883.10.20.22.2.1).
2. SHALL contain exactly one [1..1] templateId (CONF:7568) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.1.1" (CONF:10433).
3. SHALL contain exactly one [1..1] code (CONF:15387).
   1. This code SHALL contain exactly one [1..1] @code="10160-0" History of medication use (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15388).
4. SHALL contain exactly one [1..1] title (CONF:7570).
5. SHALL contain exactly one [1..1] text (CONF:7571).
6. SHALL contain at least one [1..\*] entry (CONF:7572) such that it
   1. SHALL contain exactly one [1..1] [Medication Activity](#E_Medication_Activity) (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15500).
   2. If medication use is unknown, the appropriate nullFlavor MAY be present (see unknown information in Section 1) (CONF:10077).
   3. Objective Section

[section: templateId 2.16.840.1.113883.10.20.21.2.1 (open)]

Table 52: Objective Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional) |  |

The Objective section contains data about the patient gathered through tests, measures, or observations that produce a quantified or categorized result. It includes important and relevant positive and negative test results, physical findings, review of systems, and other measurements and observations.

1. SHALL contain exactly one [1..1] templateId (CONF:7869) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.21.2.1" (CONF:10462).
2. SHALL contain exactly one [1..1] code (CONF:15389).
   1. This code SHALL contain exactly one [1..1] @code="61149-1" Objective (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15390).
3. SHALL contain exactly one [1..1] title (CONF:7871).
4. SHALL contain exactly one [1..1] text (CONF:7872).
   1. Observer Context

[assignedAuthor: templateId 2.16.840.1.113883.10.20.6.2.4 (open)]

Table 53: Observer Context Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Diagnostic Imaging Report](#D_Diagnostic_Imaging_Report) (optional) |  |

The Observer Context is used to override the author specified in the CDA Header. It is valid as a direct child element of a section.

1. SHALL contain exactly one [1..1] templateId (CONF:9194) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.4" (CONF:10536).

The id element contains the author's id or the DICOM device observer UID

1. SHALL contain at least one [1..\*] id (CONF:9196).
2. Either assignedPerson or assignedAuthoringDevice SHALL be present (CONF:9198).
   1. Operative Note Fluids Section

[section: templateId 2.16.840.1.113883.10.20.7.12 (open)]

Table 54: Operative Note Fluids Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (optional) |  |

The Operative Note Fluids section may be used to record fluids administered during the surgical procedure.

1. SHALL contain exactly one [1..1] templateId (CONF:8030) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.7.12" (CONF:10463).
2. SHALL contain exactly one [1..1] code (CONF:15391).
   1. This code SHALL contain exactly one [1..1] @code="10216-0" Operative Note Fluids (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15392).
3. SHALL contain exactly one [1..1] title (CONF:8032).
4. SHALL contain exactly one [1..1] text (CONF:8033).
5. If the Operative Note Fluids section is present, there SHALL be a statement providing details of the fluids administered or SHALL explicitly state there were no fluids administered (CONF:8052).
   1. Operative Note Surgical Procedure Section

[section: templateId 2.16.840.1.113883.10.20.7.14 (open)]

Table 55: Operative Note Surgical Procedure Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (optional) |  |

The Operative Note Surgical Procedure section can be used to restate the procedures performed if appropriate for an enterprise workflow. The procedure(s) performed associated with the Operative Note are formally modeled in the header using serviceEvent.

1. SHALL contain exactly one [1..1] templateId (CONF:8034) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.7.14" (CONF:10464).
2. SHALL contain exactly one [1..1] code (CONF:15393).
   1. This code SHALL contain exactly one [1..1] @code="10223-6" Operative Note Surgical Procedure (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15394).
3. SHALL contain exactly one [1..1] title (CONF:8036).
4. SHALL contain exactly one [1..1] text (CONF:8037).
5. If the surgical procedure section is present there SHALL be text indicating the procedure performed (CONF:8054).
   1. Payers Section

[section: templateId 2.16.840.1.113883.10.20.22.2.18 (open)]

Table 56: Payers Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (optional) | [Coverage Activity](#E_Coverage_Activity) |

The Payers section contains data on the patient’s payers, whether a ‘third party’ insurance, self-pay, other payer or guarantor, or some combination of payers, and is used to define which entity is the responsible fiduciary for the financial aspects of a patient’s care.

Each unique instance of a payer and all the pertinent data needed to contact, bill to, and collect from that payer should be included. Authorization information that can be used to define pertinent referral, authorization tracking number, procedure, therapy, intervention, device, or similar authorizations for the patient or provider, or both should be included. At a minimum, the patient’s pertinent current payment sources should be listed.

The sources of payment are represented as a Coverage Activity, which identifies all of the insurance policies or government or other programs that cover some or all of the patient's healthcare expenses. The policies or programs are sequenced by preference. The Coverage Activity has a sequence number that represents the preference order. Each policy or program identifies the covered party with respect to the payer, so that the identifiers can be recorded.

1. SHALL contain exactly one [1..1] templateId (CONF:7924) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.18" (CONF:10434).
2. SHALL contain exactly one [1..1] code (CONF:15395).
   1. This code SHALL contain exactly one [1..1] @code="48768-6" Payers (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15396).
3. SHALL contain exactly one [1..1] title (CONF:7926).
4. SHALL contain exactly one [1..1] text (CONF:7927).
5. SHOULD contain zero or more [0..\*] entry (CONF:7959) such that it
   1. SHALL contain exactly one [1..1] [Coverage Activity](#E_Coverage_Activity) (templateId:2.16.840.1.113883.10.20.22.4.60) (CONF:15501).
   2. Physical Exam Section

[section: templateId 2.16.840.1.113883.10.20.2.10 (open)]

Table 57: Physical Exam Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (required)  [Consultation Note](#D_Consultation_Note) (optional)  [Procedure Note](#D_Procedure_Note) (optional) | [Highest Pressure Ulcer Stage](#E_Highest_Pressure_Ulcer_Stage)  [Number of Pressure Ulcers Observation](#E_Number_of_Pressure_Ulcers_Observation)  [Pressure Ulcer Observation](#E_Pressure_Ulcer_Observation_) |

The Physical Exam section includes direct observations made by the clinician. The examination may include the use of simple instruments and may also describe simple maneuvers performed directly on the patient’s body. This section includes only observations made by the examining clinician using inspection, palpation, auscultation, and percussion; it does not include laboratory or imaging findings. The exam may be limited to pertinent body systems based on the patient’s chief complaint or it may include a comprehensive examination. The examination may be reported as a collection of random clinical statements or it may be reported categorically.

The Physical Exam section may contain multiple nested subsections: Vital Signs, General Status, and those listed in the Additional Physical Examination Subsections appendix.

1. SHALL contain exactly one [1..1] templateId (CONF:7806) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.2.10" (CONF:10465).
2. SHALL contain exactly one [1..1] code (CONF:15397).
   1. This code SHALL contain exactly one [1..1] @code="29545-1" Physical Findings (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15398).
3. SHALL contain exactly one [1..1] title (CONF:7808).
4. SHALL contain exactly one [1..1] text (CONF:7809).
5. MAY contain zero or more [0..\*] entry (CONF:17094) such that it
   1. SHALL contain exactly one [1..1] [Pressure Ulcer Observation](#E_Pressure_Ulcer_Observation_) (templateId:2.16.840.1.113883.10.20.22.4.70) (CONF:17095).
6. MAY contain zero or more [0..\*] entry (CONF:17096) such that it
   1. SHALL contain exactly one [1..1] [Number of Pressure Ulcers Observation](#E_Number_of_Pressure_Ulcers_Observation) (templateId:2.16.840.1.113883.10.20.22.4.76) (CONF:17097).
7. MAY contain zero or more [0..\*] entry (CONF:17098) such that it
   1. SHALL contain exactly one [1..1] [Highest Pressure Ulcer Stage](#E_Highest_Pressure_Ulcer_Stage) (templateId:2.16.840.1.113883.10.20.22.4.77) (CONF:17099).
   2. Plan of Care Section

[section: templateId 2.16.840.1.113883.10.20.22.2.10 (open)]

Table 58: Plan of Care Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (optional)  [Consultation Note](#D_Consultation_Note) (optional)  [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (optional)  [Discharge Summary](#D_Discharge_Summary) (required)  [Operative Note](#D_Operative_Note) (optional)  [Procedure Note](#D_Procedure_Note) (optional) | [Instructions](#E_Instructions)  [Plan of Care Activity Act](#E_Plan_of_Care_Activity_Act)  [Plan of Care Activity Encounter](#E_Plan_of_Care_Activity_Encounter)  [Plan of Care Activity Observation](#E_Plan_of_Care_Activity_Observation)  [Plan of Care Activity Procedure](#E_Plan_of_Care_Activity_Procedure)  [Plan of Care Activity Substance Administration](#E_Plan_of_Care_Activity_Substance_Admini)  [Plan of Care Activity Supply](#E_Plan_of_Care_Activity_Supply) |

The Plan of Care section contains data that defines pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only, which are indicated by the @moodCode of the entries within this section. All active, incomplete, or pending orders, appointments, referrals, procedures, services, or any other pending event of clinical significance to the current care of the patient should be listed unless constrained due to privacy issues. The plan may also contain information about ongoing care of the patient and information regarding goals and clinical reminders. Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and health-care quality improvements, including widely accepted performance measures. The plan may also indicate that patient education will be provided.

1. SHALL contain exactly one [1..1] templateId (CONF:7723) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.10" (CONF:10435).
2. SHALL contain exactly one [1..1] code (CONF:14749).
   1. This code SHALL contain exactly one [1..1] @code="18776-5" Plan of Care (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:14750).
3. SHALL contain exactly one [1..1] title (CONF:16986).
4. SHALL contain exactly one [1..1] text (CONF:7725).
5. MAY contain zero or more [0..\*] entry (CONF:7726) such that it
   1. SHALL contain exactly one [1..1] [Plan of Care Activity Act](#E_Plan_of_Care_Activity_Act) (templateId:2.16.840.1.113883.10.20.22.4.39) (CONF:14751).
6. MAY contain zero or more [0..\*] entry (CONF:8805) such that it
   1. SHALL contain exactly one [1..1] [Plan of Care Activity Encounter](#E_Plan_of_Care_Activity_Encounter) (templateId:2.16.840.1.113883.10.20.22.4.40) (CONF:14752).
7. MAY contain zero or more [0..\*] entry (CONF:8807) such that it
   1. SHALL contain exactly one [1..1] [Plan of Care Activity Observation](#E_Plan_of_Care_Activity_Observation) (templateId:2.16.840.1.113883.10.20.22.4.44) (CONF:14753).
8. MAY contain zero or more [0..\*] entry (CONF:8809) such that it
   1. SHALL contain exactly one [1..1] [Plan of Care Activity Procedure](#E_Plan_of_Care_Activity_Procedure) (templateId:2.16.840.1.113883.10.20.22.4.41) (CONF:14754).
9. MAY contain zero or more [0..\*] entry (CONF:8811) such that it
   1. SHALL contain exactly one [1..1] [Plan of Care Activity Substance Administration](#E_Plan_of_Care_Activity_Substance_Admini) (templateId:2.16.840.1.113883.10.20.22.4.42) (CONF:14755).
10. MAY contain zero or more [0..\*] entry (CONF:8813) such that it
    1. SHALL contain exactly one [1..1] [Plan of Care Activity Supply](#E_Plan_of_Care_Activity_Supply) (templateId:2.16.840.1.113883.10.20.22.4.43) (CONF:14756).
11. MAY contain zero or more [0..\*] entry (CONF:14695) such that it
    1. SHALL contain exactly one [1..1] [Instructions](#E_Instructions) (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:16751).
    2. Planned Procedure Section

[section: templateId 2.16.840.1.113883.10.20.22.2.30 (open)]

Table 59: Planned Procedure Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (optional)  [Procedure Note](#D_Procedure_Note) (optional) | [Plan of Care Activity Procedure](#E_Plan_of_Care_Activity_Procedure) |

The Planned Procedure section records the procedure(s) that a clinician thought would need to be done based on the preoperative assessment. It may be important to record the procedure(s) that were originally planned for, consented to, and perhaps pre-approved by the payer, particularly if different from the actual procedure(s) and procedure details, to provide evidence to various stakeholders that the providers are aware of the discrepancy and the justification can be found in the procedure details.

1. SHALL contain exactly one [1..1] templateId (CONF:8082) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.30" (CONF:10436).
2. SHALL contain exactly one [1..1] code (CONF:15399).
   1. This code SHALL contain exactly one [1..1] @code="59772-4" Planned Procedure (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15400).
3. SHALL contain exactly one [1..1] title (CONF:8084).
4. SHALL contain exactly one [1..1] text (CONF:8085).
5. MAY contain zero or more [0..\*] entry (CONF:8744) such that it
   1. SHALL contain exactly one [1..1] [Plan of Care Activity Procedure](#E_Plan_of_Care_Activity_Procedure) (templateId:2.16.840.1.113883.10.20.22.4.41) (CONF:15502).
   2. Postoperative Diagnosis Section

[section: templateId 2.16.840.1.113883.10.20.22.2.35 (open)]

Table 60: Postoperative Diagnosis Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (required) |  |

The Postoperative Diagnosis section records the diagnosis or diagnoses discovered or confirmed during the surgery. Often it is the same as the preoperative diagnosis.

1. SHALL contain exactly one [1..1] templateId (CONF:8101) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.35" (CONF:10437).
2. SHALL contain exactly one [1..1] code (CONF:15401).
   1. This code SHALL contain exactly one [1..1] @code="10218-6" Postoperative Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15402).
3. SHALL contain exactly one [1..1] title (CONF:8103).
4. SHALL contain exactly one [1..1] text (CONF:8104).
   1. Postprocedure Diagnosis Section

[section: templateId 2.16.840.1.113883.10.20.22.2.36 (open)]

Table 61: Postprocedure Diagnosis Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Procedure Note](#D_Procedure_Note) (required) | [Postprocedure Diagnosis](#E_Postprocedure_Diagnosis) |

The Postprocedure Diagnosis section records the diagnosis or diagnoses discovered or confirmed during the procedure. Often it is the same as the pre-procedure diagnosis or indication.

1. SHALL contain exactly one [1..1] templateId (CONF:8167) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.36" (CONF:10438).
2. SHALL contain exactly one [1..1] code (CONF:15403).
   1. This code SHALL contain exactly one [1..1] @code="59769-0" Postprocedure Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15404).
3. SHALL contain exactly one [1..1] title (CONF:8170).
4. SHALL contain exactly one [1..1] text (CONF:8171).
5. SHOULD contain zero or one [0..1] entry (CONF:8762) such that it
   1. SHALL contain exactly one [1..1] [Postprocedure Diagnosis](#E_Postprocedure_Diagnosis) (templateId:2.16.840.1.113883.10.20.22.4.51) (CONF:15503).
   2. Preoperative Diagnosis Section

[section: templateId 2.16.840.1.113883.10.20.22.2.34 (open)]

Table 62: Preoperative Diagnosis Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (required) | [Preoperative Diagnosis](#E_Preoperative_Diagnosis) |

The Preoperative Diagnosis section records the surgical diagnosis or diagnoses assigned to the patient before the surgical procedure and is the reason for the surgery. The preoperative diagnosis is, in the opinion of the surgeon, the diagnosis that will be confirmed during surgery.

1. SHALL contain exactly one [1..1] templateId (CONF:8097) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.34" (CONF:10439).
2. SHALL contain exactly one [1..1] code (CONF:15405).
   1. This code SHALL contain exactly one [1..1] @code="10219-4" Preoperative Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15406).
3. SHALL contain exactly one [1..1] title (CONF:8099).
4. SHALL contain exactly one [1..1] text (CONF:8100).
5. SHOULD contain zero or one [0..1] entry (CONF:10096) such that it
   1. SHALL contain exactly one [1..1] [Preoperative Diagnosis](#E_Preoperative_Diagnosis) (templateId:2.16.840.1.113883.10.20.22.4.65) (CONF:15504).
   2. Problem Section (entries optional)

[section: templateId 2.16.840.1.113883.10.20.22.2.5 (open)]

Table 63: Problem Section (entries optional) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (optional)  [Consultation Note](#D_Consultation_Note) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional) | [Problem Concern Act (Condition)](#E_Problem_Concern_Act_Condition) |

This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed.

1. SHALL contain exactly one [1..1] templateId (CONF:7877) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.5" (CONF:10440).
2. SHALL contain exactly one [1..1] code (CONF:15407).
   1. This code SHALL contain exactly one [1..1] @code="11450-4" Problem List (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15408).
3. SHALL contain exactly one [1..1] title (CONF:7879).
4. SHALL contain exactly one [1..1] text (CONF:7880).
5. SHOULD contain zero or more [0..\*] entry (CONF:7881).
   1. The entry, if present, SHALL contain exactly one [1..1] [Problem Concern Act (Condition)](#E_Problem_Concern_Act_Condition) (templateId:2.16.840.1.113883.10.20.22.4.3) (CONF:15505).
   2. Problem Section (entries required)

[section: templateId 2.16.840.1.113883.10.20.22.2.5.1 (open)]

Table 64: Problem Section (entries required) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (required) | [Problem Concern Act (Condition)](#E_Problem_Concern_Act_Condition) |

This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed.

1. Conforms to [Problem Section (entries optional)](#S_Problem_Section_entries_optional) template (2.16.840.1.113883.10.20.22.2.5).
2. SHALL contain exactly one [1..1] templateId (CONF:9179) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.5.1" (CONF:10441).
3. SHALL contain exactly one [1..1] code (CONF:15409).
   1. This code SHALL contain exactly one [1..1] @code="11450-4" Problem List (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15410).
4. SHALL contain exactly one [1..1] title (CONF:9181).
5. SHALL contain exactly one [1..1] text (CONF:9182).
6. SHALL contain at least one [1..\*] entry (CONF:9183).
   1. Such entries SHALL contain exactly one [1..1] [Problem Concern Act (Condition)](#E_Problem_Concern_Act_Condition) (templateId:2.16.840.1.113883.10.20.22.4.3) (CONF:15506).
   2. Procedure Description Section

[section: templateId 2.16.840.1.113883.10.20.22.2.27 (open)]

Table 65: Procedure Description Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (required)  [Procedure Note](#D_Procedure_Note) (required) |  |

The Procedure Description section records the particulars of the procedure and may include procedure site preparation, surgical site preparation, pertinent details related to sedation/anesthesia, pertinent details related to measurements and markings, procedure times, medications administered, estimated blood loss, specimens removed, implants, instrumentation, sponge counts, tissue manipulation, wound closure, sutures used, vital signs and other monitoring data. Local practice often identifies the level and type of detail required based on the procedure or specialty.

1. SHALL contain exactly one [1..1] templateId (CONF:8062) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.27" (CONF:10442).
2. SHALL contain exactly one [1..1] code (CONF:15411).
   1. This code SHALL contain exactly one [1..1] @code="29554-3" Procedure Description (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15412).
3. SHALL contain exactly one [1..1] title (CONF:8064).
4. SHALL contain exactly one [1..1] text (CONF:8065).
   1. Procedure Disposition Section

[section: templateId 2.16.840.1.113883.10.20.18.2.12 (open)]

Table 66: Procedure Disposition Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (optional)  [Procedure Note](#D_Procedure_Note) (optional) |  |

The Procedure Disposition section records the status and condition of the patient at the completion of the procedure or surgery. It often also states where the patent was transferred to for the next level of care.

1. SHALL contain exactly one [1..1] templateId (CONF:8070) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.18.2.12" (CONF:10466).
2. SHALL contain exactly one [1..1] code (CONF:15413).
   1. This code SHALL contain exactly one [1..1] @code="59775-7" Procedure Disposition (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15414).
3. SHALL contain exactly one [1..1] title (CONF:8072).
4. SHALL contain exactly one [1..1] text (CONF:8073).
   1. Procedure Estimated Blood Loss Section

[section: templateId 2.16.840.1.113883.10.20.18.2.9 (open)]

Table 67: Procedure Estimated Blood Loss Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (required)  [Procedure Note](#D_Procedure_Note) (optional) |  |

The Estimated Blood Loss section may be a subsection of another section such as the Procedure Description section. The Estimated Blood Loss section records the approximate amount of blood that the patient lost during the procedure or surgery. It may be an accurate quantitative amount, e.g., 250 milliliters, or it may be descriptive, e.g., “minimal” or “none”.

1. SHALL contain exactly one [1..1] templateId (CONF:8074) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.18.2.9" (CONF:10467).
2. SHALL contain exactly one [1..1] code (CONF:15415).
   1. This code SHALL contain exactly one [1..1] @code="59770-8" Procedure Estimated Blood Loss (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15416).
3. SHALL contain exactly one [1..1] title (CONF:8076).
4. SHALL contain exactly one [1..1] text (CONF:8077).
5. The Estimated Blood Loss section SHALL include a statement providing an estimate of the amount of blood lost during the procedure, even if the estimate is text, such as "minimal" or "none" (CONF:8741).
   1. Procedure Findings Section

[section: templateId 2.16.840.1.113883.10.20.22.2.28 (open)]

Table 68: Procedure Findings Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (required)  [Procedure Note](#D_Procedure_Note) (optional) | [Problem Observation](#E_Problem_Observation) |

The Procedure Findings section records clinically significant observations confirmed or discovered during the procedure or surgery.

1. SHALL contain exactly one [1..1] templateId (CONF:8078) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.28" (CONF:10443).
2. SHALL contain exactly one [1..1] code (CONF:15417).
   1. This code SHALL contain exactly one [1..1] @code="59776-5" Procedure Findings (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15418).
3. SHALL contain exactly one [1..1] title (CONF:8080).
4. SHALL contain exactly one [1..1] text (CONF:8081).
5. MAY contain zero or more [0..\*] entry (CONF:8090) such that it
   1. SHALL contain exactly one [1..1] [Problem Observation](#E_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15507).
   2. Procedure Implants Section

[section: templateId 2.16.840.1.113883.10.20.22.2.40 (open)]

Table 69: Procedure Implants Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (optional)  [Procedure Note](#D_Procedure_Note) (optional) |  |

The Procedure Implants section records any materials placed during the procedure including stents, tubes, and drains.

Notes: This section replaces: 2.16.840.1.113883.10.20.22.2.40

1. SHALL contain exactly one [1..1] templateId (CONF:8178) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.40" (CONF:10444).
2. SHALL contain exactly one [1..1] code (CONF:15373).
   1. This code SHALL contain exactly one [1..1] @code="59771-6" Procedure Implants (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15374).
3. SHALL contain exactly one [1..1] title (CONF:8180).
4. SHALL contain exactly one [1..1] text (CONF:8181).
5. The Implants section SHALL include a statement providing details of the implants placed, or assert no implants were placed (CONF:8769).
   1. Procedure Indications Section

[section: templateId 2.16.840.1.113883.10.20.22.2.29 (open)]

Table 70: Procedure Indications Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (optional)  [Procedure Note](#D_Procedure_Note) (required) | [Indication](#E_Indication) |

The Procedure Indications section records details about the reason for the procedure or surgery. This section may include the pre-procedure diagnosis or diagnoses as well as one or more symptoms that contribute to the reason the procedure is being performed.

1. SHALL contain exactly one [1..1] templateId (CONF:8058) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.29" (CONF:10445).
2. SHALL contain exactly one [1..1] code (CONF:15419).
   1. This code SHALL contain exactly one [1..1] @code="59768-2" Procedure Indications (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15420).
3. SHALL contain exactly one [1..1] title (CONF:8060).
4. SHALL contain exactly one [1..1] text (CONF:8061).
5. MAY contain zero or more [0..\*] entry (CONF:8743) such that it
   1. SHALL contain exactly one [1..1] [Indication](#E_Indication) (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:15508).
   2. Procedure Specimens Taken Section

[section: templateId 2.16.840.1.113883.10.20.22.2.31 (open)]

Table 71: Procedure Specimens Taken Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (required)  [Procedure Note](#D_Procedure_Note) (optional) |  |

The Procedure Specimens Taken section records the tissues, objects, or samples taken from the patient during the procedure including biopsies, aspiration fluid, or other samples sent for pathological analysis. The narrative may include a description of the specimens.

1. SHALL contain exactly one [1..1] templateId (CONF:8086) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.31" (CONF:10446).
2. SHALL contain exactly one [1..1] code (CONF:15421).
   1. This code SHALL contain exactly one [1..1] @code="59773-2" Procedure Specimens Taken (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15422).
3. SHALL contain exactly one [1..1] title (CONF:8088).
4. SHALL contain exactly one [1..1] text (CONF:8089).
5. The Procedure Specimens Taken section SHALL list all specimens removed or SHALL explicitly state that no specimens were taken (CONF:8742).
   1. Procedures Section (entries optional)

[section: templateId 2.16.840.1.113883.10.20.22.2.7 (open)]

Table 72: Procedures Section (entries optional) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [History and Physical](#D_History_and_Physical) (optional)  [Consultation Note](#D_Consultation_Note) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional)  [Procedure Note](#D_Procedure_Note) (optional) | [Procedure Activity Act](#E_Procedure_Activity_Act)  [Procedure Activity Observation](#E_Procedure_Activity_Observation)  [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) |

This section defines all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section is intended to include notable procedures, but can contain all procedures for the period of time being summarized. The common notion of ""procedure"" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore this section contains procedure templates represented with three RIM classes: Act. Observation, and Procedure. Procedure act is for procedures the alter that physical condition of a patient (Splenectomy). Observation act is for procedures that result in new information about a patient but do not cause physical alteration (EEG). Act is for all other types of procedures (dressing change).

The length of an encounter is documented in the documentationOf/encompassingEncounter/effectiveTime and length of service in documentationOf/ServiceEvent/effectiveTime.

1. SHALL contain exactly one [1..1] templateId (CONF:6270) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.7" (CONF:6271).
2. SHALL contain exactly one [1..1] code (CONF:15423).
   1. This code SHALL contain exactly one [1..1] @code="47519-4" History of Procedures (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15424).
3. SHALL contain exactly one [1..1] title (CONF:17184).
4. SHALL contain exactly one [1..1] text (CONF:6273).
5. MAY contain zero or more [0..\*] entry (CONF:6274) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) (templateId:2.16.840.1.113883.10.20.22.4.14) (CONF:15509).
6. MAY contain zero or one [0..1] entry (CONF:6278) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Observation](#E_Procedure_Activity_Observation) (templateId:2.16.840.1.113883.10.20.22.4.13) (CONF:15510).
7. MAY contain zero or one [0..1] entry (CONF:8533) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Act](#E_Procedure_Activity_Act) (templateId:2.16.840.1.113883.10.20.22.4.12) (CONF:15511).
   2. Procedures Section (entries required)

[section: templateId 2.16.840.1.113883.10.20.22.2.7.1 (open)]

Table 73: Procedures Section (entries required) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (optional) | [Procedure Activity Act](#E_Procedure_Activity_Act)  [Procedure Activity Observation](#E_Procedure_Activity_Observation)  [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) |

This section defines all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section may contain all procedures for the period of time being summarized, but should include notable procedures. The common notion of ""procedure"" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore this section contains procedure templates represented with three RIM classes: Act. Observation, and Procedure. Procedure act is for procedures the alter that physical condition of a patient (Splenectomy). Observation act is for procedures that result in new information about a patient but do not cause physical alteration (EEG). Act is for all other types of procedures (dressing change).

1. Conforms to [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional) template (2.16.840.1.113883.10.20.22.2.7).
2. SHALL contain exactly one [1..1] templateId (CONF:7891) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.7.1" (CONF:10447).
3. SHALL contain exactly one [1..1] code (CONF:15425).
   1. This code SHALL contain exactly one [1..1] @code="47519-4" History of Procedures (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15426).
4. SHALL contain exactly one [1..1] title (CONF:7893).
5. SHALL contain exactly one [1..1] text (CONF:7894).
6. MAY contain zero or more [0..\*] entry (CONF:7895) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) (templateId:2.16.840.1.113883.10.20.22.4.14) (CONF:15512).
7. MAY contain zero or more [0..\*] entry (CONF:8017) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Observation](#E_Procedure_Activity_Observation) (templateId:2.16.840.1.113883.10.20.22.4.13) (CONF:15513).
8. MAY contain zero or more [0..\*] entry (CONF:8019) such that it
   1. SHALL contain exactly one [1..1] [Procedure Activity Act](#E_Procedure_Activity_Act) (templateId:2.16.840.1.113883.10.20.22.4.12) (CONF:15514).
9. There SHALL be at least one procedure, observation or act entry conformant to Procedure Activity Procedure template, Procedure Activity Observation template or Procedure Activity Act template in the Procedure Section (CONF:8021).
   1. Reason for Referral Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.1 (open)]

Table 74: Reason for Referral Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Consultation Note](#D_Consultation_Note) (optional) |  |

A Reason for Referral section records the reason the patient is being referred for a consultation by a provider. An optional Chief Complaint section may capture the patient’s description of the reason for the consultation.

1. SHALL contain exactly one [1..1] templateId (CONF:7844) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.1" (CONF:10468).
2. SHALL contain exactly one [1..1] code (CONF:15427).
   1. This code SHALL contain exactly one [1..1] @code="42349-1" Reason for Referral (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15428).
3. SHALL contain exactly one [1..1] title (CONF:7846).
4. SHALL contain exactly one [1..1] text (CONF:7847).
   1. Reason for Visit Section

[section: templateId 2.16.840.1.113883.10.20.22.2.12 (open)]

Table 75: Reason for Visit Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [History and Physical](#D_History_and_Physical) (optional)  [Consultation Note](#D_Consultation_Note) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional)  [Procedure Note](#D_Procedure_Note) (optional) |  |

This section records the patient’s reason for the patient's visit (as documented by the provider). Local policy determines whether Reason for Visit and Chief Complaint are in separate or combined sections.

1. SHALL contain exactly one [1..1] templateId (CONF:7836) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.12" (CONF:10448).
2. SHALL contain exactly one [1..1] code (CONF:15429).
   1. This code SHALL contain exactly one [1..1] @code="29299-5" Reason for Visit (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15430).
3. SHALL contain exactly one [1..1] title (CONF:7838).
4. SHALL contain exactly one [1..1] text (CONF:7839).
   1. Results Section (entries optional)

[section: templateId 2.16.840.1.113883.10.20.22.2.3 (open)]

Table 76: Results Section (entries optional) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (required)  [Consultation Note](#D_Consultation_Note) (optional) | [Result Organizer](#E_Result_Organizer) |

The Results section contains the results of observations generated by laboratories, imaging procedures, and other procedures. The scope includes observations such as hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. The section often includes notable results such as abnormal values or relevant trends, and could contain all results for the period of time being documented.

Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory.

Imaging results are typically generated by a clinician reviewing the output of an imaging procedure, such as where a cardiologist reports the left ventricular ejection fraction based on the review of a cardiac echocardiogram.

Procedure results are typically generated by a clinician to provide more granular information about component observations made during a procedure, such as where a gastroenterologist reports the size of a polyp observed during a colonoscopy.

1. SHALL contain exactly one [1..1] templateId (CONF:7116) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.3" (CONF:9136).
2. SHALL contain exactly one [1..1] code (CONF:15431).
   1. This code SHALL contain exactly one [1..1] @code="30954-2" Relevant diagnostic tests and/or laboratory data (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15432).
3. SHALL contain exactly one [1..1] title (CONF:8891).
4. SHALL contain exactly one [1..1] text (CONF:7118).
5. SHOULD contain zero or more [0..\*] entry (CONF:7119) such that it
   1. SHALL contain exactly one [1..1] [Result Organizer](#E_Result_Organizer) (templateId:2.16.840.1.113883.10.20.22.4.1) (CONF:15515).
   2. Results Section (entries required)

[section: templateId 2.16.840.1.113883.10.20.22.2.3.1 (open)]

Table 77: Results Section (entries required) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (required) | [Result Organizer](#E_Result_Organizer) |

The Results section contains the results of observations generated by laboratories, imaging procedures, and other procedures. The scope includes observations such as hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. The section often includes notable results such as abnormal values or relevant trends, and could contain all results for the period of time being documented.

Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory.

Imaging results are typically generated by a clinician reviewing the output of an imaging procedure, such as where a cardiologist reports the left ventricular ejection fraction based on the review of a cardiac echocardiogram.

Procedure results are typically generated by a clinician to provide more granular information about component observations made during a procedure, such as where a gastroenterologist reports the size of a polyp observed during a colonoscopy.

1. Conforms to [Results Section (entries optional)](#S_Results_Section_entries_optional) template (2.16.840.1.113883.10.20.22.2.3).
2. SHALL contain exactly one [1..1] templateId (CONF:7108) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.3.1" (CONF:9137).
3. SHALL contain exactly one [1..1] code (CONF:15433).
   1. This code SHALL contain exactly one [1..1] @code="30954-2" Relevant diagnostic tests and/or laboratory data (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15434).
4. SHALL contain exactly one [1..1] title (CONF:8892).
5. SHALL contain exactly one [1..1] text (CONF:7111).
6. SHALL contain at least one [1..\*] entry (CONF:7112) such that it
   1. SHALL contain exactly one [1..1] [Result Organizer](#E_Result_Organizer) (templateId:2.16.840.1.113883.10.20.22.4.1) (CONF:15516).
   2. Review of Systems Section

[section: templateId 1.3.6.1.4.1.19376.1.5.3.1.3.18 (open)]

Table 78: Review of Systems Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (required)  [Consultation Note](#D_Consultation_Note) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional)  [Procedure Note](#D_Procedure_Note) (optional) |  |

The Review of Systems section contains a relevant collection of symptoms and functions systematically gathered by a clinician. It includes symptoms the patient is currently experiencing, some of which were not elicited during the history of present illness, as well as a potentially large number of pertinent negatives, for example, symptoms that the patient denied experiencing.

1. SHALL contain exactly one [1..1] templateId (CONF:7812) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.18" (CONF:10469).
2. SHALL contain exactly one [1..1] code (CONF:15435).
   1. This code SHALL contain exactly one [1..1] @code="10187-3" Review of Systems (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15436).
3. SHALL contain exactly one [1..1] title (CONF:7814).
4. SHALL contain exactly one [1..1] text (CONF:7815).
   1. Social History Section

[section: templateId 2.16.840.1.113883.10.20.22.2.17 (open)]

Table 79: Social History Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [History and Physical](#D_History_and_Physical) (required)  [Consultation Note](#D_Consultation_Note) (optional)  [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional)  [Procedure Note](#D_Procedure_Note) (optional) | [Pregnancy Observation](#E_Pregnancy_Observation)  [Smoking Status Observation](#E_Smoking_Status_Observation)  [Social History Observation](#E_Social_History_Observation)  [Tobacco Use](#E_Tobacco_Use) |

This section contains data defining the patient’s occupational, personal (e.g. lifestyle), social, and environmental history and health risk factors, as well as administrative data such as marital status, race, ethnicity and religious affiliation. Social history can have significant influence on a patient’s physical, psychological and emotional health and wellbeing so should be considered in the development of a complete record.

1. SHALL contain exactly one [1..1] templateId (CONF:7936) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.17" (CONF:10449).
2. SHALL contain exactly one [1..1] code (CONF:14819).
   1. This code SHALL contain exactly one [1..1] @code="29762-2" Social History (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:14820).
3. SHALL contain exactly one [1..1] title (CONF:7938).
4. SHALL contain exactly one [1..1] text (CONF:7939).
5. MAY contain zero or more [0..\*] entry (CONF:7953) such that it
   1. SHALL contain exactly one [1..1] [Social History Observation](#E_Social_History_Observation) (templateId:2.16.840.1.113883.10.20.22.4.38) (CONF:14821).
6. MAY contain zero or more [0..\*] entry (CONF:9132) such that it
   1. SHALL contain exactly one [1..1] [Pregnancy Observation](#E_Pregnancy_Observation) (templateId:2.16.840.1.113883.10.20.15.3.8) (CONF:14822).
7. SHOULD contain zero or more [0..\*] entry (CONF:14823) such that it
   1. SHALL contain exactly one [1..1] [Smoking Status Observation](#E_Smoking_Status_Observation) (templateId:2.16.840.1.113883.10.20.22.4.78) (CONF:14824).
8. MAY contain zero or more [0..\*] entry (CONF:16816) such that it
   1. SHALL contain exactly one [1..1] [Tobacco Use](#E_Tobacco_Use) (templateId:2.16.840.1.113883.10.20.22.4.85) (CONF:16817).
   2. Subjective Section

[section: templateId 2.16.840.1.113883.10.20.21.2.2 (open)]

Table 80: Subjective Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional) |  |

The Subjective section describes in a narrative format the patient’s current condition and/or interval changes as reported by the patient or by the patient’s guardian or another informant.

1. SHALL contain exactly one [1..1] templateId (CONF:7873) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.21.2.2" (CONF:10470).
2. SHALL contain exactly one [1..1] code (CONF:15437).
   1. This code SHALL contain exactly one [1..1] @code="61150-9" Subjective (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15438).
3. SHALL contain exactly one [1..1] title (CONF:7875).
4. SHALL contain exactly one [1..1] text (CONF:7876).
   1. Surgery Description Section

[section: templateId 2.16.840.1.113883.10.20.22.2.26 (open)]

Table 81: Surgery Description Section Contexts

replaced by 2.16.840.1.113883.10.20.22.2.27

1. SHALL contain exactly one [1..1] templateId (CONF:8022) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.26" (CONF:10450).
2. SHALL contain exactly one [1..1] code (CONF:15439).
   1. This code SHALL contain exactly one [1..1] @code="29554-3" Surgery Description (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15440).
3. SHALL contain exactly one [1..1] title (CONF:8024).
4. SHALL contain exactly one [1..1] text (CONF:8025).
   1. Surgical Drains Section

[section: templateId 2.16.840.1.113883.10.20.7.13 (open)]

Table 82: Surgical Drains Section Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Operative Note](#D_Operative_Note) (optional) |  |

The Surgical Drains section may be used to record drains placed during the surgical procedure. Optionally, surgical drain placement may be represented with a text element in the Procedure Description Section.

1. SHALL contain exactly one [1..1] templateId (CONF:8038) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.7.13" (CONF:10473).
2. SHALL contain exactly one [1..1] code (CONF:15441).
   1. This code SHALL contain exactly one [1..1] @code="11537-8" Surgical Drains (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15442).
3. SHALL contain exactly one [1..1] title (CONF:8040).
4. SHALL contain exactly one [1..1] text (CONF:8041).
5. If the Surgical Drains section is present, there SHALL be a statement providing details of the drains placed or SHALL explicitly state there were no drains placed (CONF:8056).
   1. Vital Signs Section (entries optional)

[section: templateId 2.16.840.1.113883.10.20.22.2.4 (open)]

Table 83: Vital Signs Section (entries optional) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Progress Note](#D_Progress_Note) (optional)  [History and Physical](#D_History_and_Physical) (required)  [Consultation Note](#D_Consultation_Note) (optional)  [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) (optional)  [Discharge Summary](#D_Discharge_Summary) (optional) | [Vital Signs Organizer](#E_Vital_Signs_Organizer) |

The Vital Signs section contains relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, and pulse oximetry. The section should include notable vital signs such as the most recent, maximum and/or minimum, baseline, or relevant trends.

Vital signs are represented in the same way as other results, but are aggregated into their own section to follow clinical conventions.

1. SHALL contain exactly one [1..1] templateId (CONF:7268) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.4" (CONF:10451).
2. SHALL contain exactly one [1..1] code (CONF:15242).
   1. This code SHALL contain exactly one [1..1] @code="8716-3" Vital Signs (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15243).
3. SHALL contain exactly one [1..1] title (CONF:9966).
4. SHALL contain exactly one [1..1] text (CONF:7270).
5. SHOULD contain zero or more [0..\*] entry (CONF:7271) such that it
   1. SHALL contain exactly one [1..1] [Vital Signs Organizer](#E_Vital_Signs_Organizer) (templateId:2.16.840.1.113883.10.20.22.4.26) (CONF:15517).
   2. Vital Signs Section (entries required)

[section: templateId 2.16.840.1.113883.10.20.22.2.4.1 (open)]

Table 84: Vital Signs Section (entries required) Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Vital Signs Organizer](#E_Vital_Signs_Organizer) |

The Vital Signs section contains current and historically relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, and pulse oximetry. The section should include notable vital signs such as the most recent, maximum and/or minimum, baseline, or relevant trends.

Vital signs are represented in the same way as other results, but are aggregated into their own section to follow clinical conventions.

1. Conforms to [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) template (2.16.840.1.113883.10.20.22.2.4).
2. SHALL contain exactly one [1..1] templateId (CONF:7273) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.4.1" (CONF:10452).
3. SHALL contain exactly one [1..1] code (CONF:15962).
   1. This code SHALL contain exactly one [1..1] @code="8716-3" Vital Signs (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15963).
4. SHALL contain exactly one [1..1] title (CONF:9967).
5. SHALL contain exactly one [1..1] text (CONF:7275).
6. SHALL contain at least one [1..\*] entry (CONF:7276) such that it
   1. SHALL contain exactly one [1..1] [Vital Signs Organizer](#E_Vital_Signs_Organizer) (templateId:2.16.840.1.113883.10.20.22.4.26) (CONF:15964).

# Entry-Level Templates

* 1. Admission Medication

[act: templateId 2.16.840.1.113883.10.20.22.4.36 (open)]

Table 85: Admission Medication Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Hospital Admission Medications Section (entries optional)](#S_Hospital_Admission_Medications_Section) (optional) | [Medication Activity](#E_Medication_Activity) |

The Admission Medications entry codes medications that the patient took prior to admission.

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7698).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7699).
3. SHALL contain exactly one [1..1] templateId (CONF:16758) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.36" (CONF:16759).
4. SHALL contain exactly one [1..1] code (CONF:15518).
   1. This code SHALL contain exactly one [1..1] @code="42346-7" Medications on Admission (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:15519).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:7701) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7702).
   2. SHALL contain exactly one [1..1] [Medication Activity](#E_Medication_Activity) (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15520).
   3. Advance Directive Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.48 (open)]

Table 86: Advance Directive Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Advance Directives Section (entries optional)](#S_Advance_Directives_Section_entries_opt) (optional)  [Advance Directives Section (entries required)](#S_Advance_Directives_Section_entries_req) (required) |  |

Advance Directives Observations assert findings (e.g., “resuscitation status is Full Code”) rather than orders, and should not be considered legal documents. A legal document can be referenced using the reference/externalReference construct.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8648).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8649).
3. SHALL contain exactly one [1..1] templateId (CONF:8655) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.48" (CONF:10485).
4. SHALL contain at least one [1..\*] id (CONF:8654).
5. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet AdvanceDirectiveTypeCode 2.16.840.1.113883.1.11.20.2 STATIC 2006-10-17 (CONF:8651).
6. SHALL contain exactly one [1..1] statusCode (CONF:8652).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19082).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:8656).
   1. This effectiveTime SHALL contain exactly one [1..1] high (CONF:15521).
8. SHOULD contain zero or more [0..\*] participant (CONF:8662) such that it
   1. SHALL contain exactly one [1..1] @typeCode="VRF" Verifier (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8663).
   2. SHALL contain exactly one [1..1] templateId (CONF:8664) such that it
      1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.1.58" (CONF:10486).
   3. SHOULD contain zero or one [0..1] time (CONF:8665).
      1. The data type of Observation/participant/time in a verification SHALL be TS (time stamp) (CONF:8666).
   4. SHALL contain exactly one [1..1] participantRole (CONF:8825).
9. SHOULD contain zero or one [0..1] participant (CONF:8667) such that it
   1. SHALL contain exactly one [1..1] @typeCode="CST" Custodian (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8668).
   2. SHALL contain exactly one [1..1] participantRole (CONF:8669).
      1. This participantRole SHALL contain exactly one [1..1] @classCode="AGNT" Agent (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:8670).
      2. This participantRole SHOULD contain zero or one [0..1] addr (CONF:8671).
      3. This participantRole SHOULD contain zero or one [0..1] telecom (CONF:8672).
      4. This participantRole SHALL contain exactly one [1..1] playingEntity (CONF:8824).
         1. This playingEntity SHALL contain exactly one [1..1] name (CONF:8673).
            1. The name of the agent who can provide a copy of the Advance Directive SHALL be recorded in the name element inside the playingEntity element (CONF:8674).
10. SHOULD contain zero or more [0..\*] reference (CONF:8692) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8694).
    2. SHALL contain exactly one [1..1] externalDocument (CONF:8693).
       1. This externalDocument SHALL contain at least one [1..\*] id (CONF:8695).
       2. This externalDocument MAY contain zero or one [0..1] text (CONF:8696).
          1. The text, if present, MAY contain zero or one [0..1] @mediaType="text/plain" (CONF:8703).
          2. The text, if present, MAY contain zero or one [0..1] reference (CONF:8697).
             1. The URL of a referenced advance directive document MAY be present, and SHALL be represented in Observation/reference/ExternalDocument/text/reference (CONF:8698).
             2. If a URL is referenced, then it SHOULD have a corresponding linkHTML element in narrative block (CONF:8699).
    3. Age Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.31 (open)]

Table 87: Age Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Problem Observation](#E_Problem_Observation) (optional)  [Family History Observation](#E_Family_History_Observation) (optional) |  |

This Age Observation represents the subject's age at onset of an event or observation. The age of a relative in a Family History Observation at the time of that observation could also be inferred by comparing RelatedSubject/subject/birthTime with Observation/effectiveTime. However, a common scenario is that a patient will know the age of a relative when the relative had a certain condition or when the relative died, but will not know the actual year (e.g., "grandpa died of a heart attack at the age of 50"). Often times, neither precise dates nor ages are known (e.g. "cousin died of congenital heart disease as an infant").

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7613).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7614).
3. SHALL contain exactly one [1..1] templateId (CONF:7899) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.31" (CONF:10487).
4. SHALL contain exactly one [1..1] code (CONF:7615).
   1. This code SHALL contain exactly one [1..1] @code="445518008" Age At Onset (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:16776).
5. SHALL contain exactly one [1..1] statusCode (CONF:15965).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:15966).
6. SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:7617).
   1. This value SHALL contain exactly one [1..1] @unit, which SHALL be selected from ValueSet AgePQ\_UCUM 2.16.840.1.113883.11.20.9.21 DYNAMIC (CONF:7618).
   2. Allergy - Intolerance Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.7 (open)]

Table 88: Allergy - Intolerance Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Allergy Problem Act](#E_Allergy_Problem_Act) (required) | [Allergy Status Observation](#E_Allergy_Status_Observation)  [Reaction Observation](#E_Reaction_Observation)  [Severity Observation](#E_Severity_Observation) |

This clinical statement represents that an allergy or adverse reaction exists or does not exist. The agent that is the cause of the allergy or adverse reaction is represented as a manufactured material participant playing entity in the allergy observation. While the agent is often implicit in the alert observation (e.g. ""allergy to penicillin""), it should also be asserted explicitly as an entity. The manufactured material participant is used to represent natural and non-natural occurring substances.

NOTE: The agent responsible for an allergy or adverse reaction is not always a manufactured material (for example, food allergies), nor is it necessarily consumed. The following constraints reflect limitations in the base CDA R2 specification, and should be used to represent any type of responsible agent.

1. Conforms to [Substance or Device Allergy - Intolerance Observation](#E_Substance_or_Device_Allergy__Intolera) template (2.16.840.1.113883.10.20.24.3.90).
2. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7379).
3. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7380).
4. SHALL contain exactly one [1..1] templateId (CONF:7381) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.7" (CONF:10488).
5. SHALL contain at least one [1..\*] id (CONF:7382).
6. SHALL contain exactly one [1..1] code (CONF:15947).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:15948).
7. SHALL contain exactly one [1..1] statusCode (CONF:19084).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19085).
8. SHALL contain exactly one [1..1] effectiveTime (CONF:7387).
   1. If it is unknown when the allergy began, this effectiveTime SHALL contain low/@nullFLavor="UNK" (CONF:9103).
   2. If the allergy is no longer a concern, this effectiveTime MAY contain zero or one [0..1] high (CONF:10082).
9. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:7390).
   1. This value SHOULD contain zero or one [0..1] originalText (CONF:7422).
      1. The originalText, if present, MAY contain zero or one [0..1] reference (CONF:15949).
         1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15950).
            1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15951).
   2. This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Allergy/Adverse Event Type Value Set 2.16.840.1.113883.3.88.12.3221.6.2 DYNAMIC (CONF:9139).
10. SHOULD contain zero or one [0..1] participant (CONF:7402) such that it
    1. SHALL contain exactly one [1..1] @typeCode="CSM" Consumable (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:7403).
    2. SHALL contain exactly one [1..1] participantRole (CONF:7404).
       1. This participantRole SHALL contain exactly one [1..1] @classCode="MANU" Manufactured Product (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:7405).
       2. This participantRole SHALL contain exactly one [1..1] playingEntity (CONF:7406).
          1. This playingEntity SHALL contain exactly one [1..1] @classCode="MMAT" Manufactured Material (CodeSystem: EntityClass 2.16.840.1.113883.5.41 STATIC) (CONF:7407).
          2. This playingEntity SHALL contain exactly one [1..1] code (CONF:7419).
             1. This code SHOULD contain zero or one [0..1] originalText (CONF:7424).

The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:7425).

The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15952).

This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15953).

* + - * 1. This code MAY contain zero or more [0..\*] translation (CONF:7431).
        2. In an allergy to a specific medication the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.16 Medication Brand Name DYNAMIC or the ValueSet 2.16.840.1.113883.3.88.12.80.17 Medication Clinical Drug DYNAMIC (CONF:7421).
        3. In an allergy to a class of medications the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.18 Medication Drug Class DYNAMIC (CONF:10083).
        4. In an allergy to a food or other substance the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.20 Ingredient Name DYNAMIC (CONF:10084).

1. MAY contain zero or one [0..1] entryRelationship (CONF:7440) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7906).
   2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7446).
   3. SHALL contain exactly one [1..1] [Allergy Status Observation](#E_Allergy_Status_Observation) (templateId:2.16.840.1.113883.10.20.22.4.28) (CONF:15954).
2. SHOULD contain zero or more [0..\*] entryRelationship (CONF:7447) such that it
   1. SHALL contain exactly one [1..1] @typeCode="MFST" Is Manifestation of (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7907).
   2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7449).
   3. SHALL contain exactly one [1..1] [Reaction Observation](#E_Reaction_Observation) (templateId:2.16.840.1.113883.10.20.22.4.9) (CONF:15955).
3. SHOULD contain zero or one [0..1] entryRelationship (CONF:9961) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9962).
   2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:9964).
   3. SHALL contain exactly one [1..1] [Severity Observation](#E_Severity_Observation) (templateId:2.16.840.1.113883.10.20.22.4.8) (CONF:15956).
   4. Allergy Problem Act

[act: templateId 2.16.840.1.113883.10.20.22.4.30 (open)]

Table 89: Allergy Problem Act Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Allergies Section (entries required)](#S_Allergies_Section_entries_required) (required)  [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional) (optional) | [Allergy - Intolerance Observation](#E_Allergy__Intolerance_Observation) |

This clinical statement act represents a concern relating to a patient's allergies or adverse events. A concern is a term used when referring to patient's problems that are related to one another. Observations of problems or other clinical statements captured at a point in time are wrapped in a Allergy Problem Act, or ""Concern"" act, which represents the ongoing process tracked over time. This outer Allergy Problem Act (representing the ""Concern"") can contain nested problem observations or other nested clinical statements relevant to the allergy concern.

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7469).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7470).
3. SHALL contain exactly one [1..1] templateId (CONF:7471) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.30" (CONF:10489).
4. SHALL contain at least one [1..\*] id (CONF:7472).
5. SHALL contain exactly one [1..1] code (CONF:7477).
   1. This code SHALL contain exactly one [1..1] @code="48765-2" Allergies, adverse reactions, alerts (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19158).
6. SHALL contain exactly one [1..1] statusCode (CONF:7485).
   1. This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet ProblemAct statusCode 2.16.840.1.113883.11.20.9.19 STATIC 2011-09-09 (CONF:19086).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:7498).
   1. If statusCode/@code="active" Active, then effectiveTime SHALL contain [1..1] low (CONF:7504).
   2. If statusCode/@code="completed" Completed, then effectiveTime SHALL contain [1..1] high (CONF:10085).
8. SHALL contain at least one [1..\*] entryRelationship (CONF:7509) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7915).
   2. SHALL contain exactly one [1..1] [Allergy - Intolerance Observation](#E_Allergy__Intolerance_Observation) (templateId:2.16.840.1.113883.10.20.22.4.7) (CONF:14925).
   3. Allergy Status Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.28 (open)]

Table 90: Allergy Status Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Allergy - Intolerance Observation](#E_Allergy__Intolerance_Observation) (optional)  [Substance or Device Allergy - Intolerance Observation](#E_Substance_or_Device_Allergy__Intolera) (optional) |  |

This template represents the status of the allergy indicating whether it is active, no longer active, or is an historic allergy. There can be only one allergy status observation per alert observation.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7318).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7319).
3. SHALL contain exactly one [1..1] templateId (CONF:7317) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.28" (CONF:10490).
4. SHALL contain exactly one [1..1] code (CONF:7320).
   1. This code SHALL contain exactly one [1..1] @code="33999-4" Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19131).
5. SHALL contain exactly one [1..1] statusCode (CONF:7321).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19087).
6. SHALL contain exactly one [1..1] value with @xsi:type="CE", where the @code SHALL be selected from ValueSet Problem Status Value Set 2.16.840.1.113883.3.88.12.80.68 DYNAMIC (CONF:7322).
   1. Assessment Scale Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.69 (open)]

Table 91: Assessment Scale Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Functional Status Section](#S_Functional_Status_Section) (optional)  [Functional Status Result Observation](#E_Functional_Status_Result_Observation) (optional)  [Cognitive Status Result Observation](#E_Cognitive_Status_Result_Observation) (optional)  [Functional Status Problem Observation](#E_Functional_Status_Problem_Observation) (optional)  [Cognitive Status Problem Observation](#E_Cognitive_Status_Problem_Observation) (optional) | [Assessment Scale Supporting Observation](#E_Assessment_Scale_Supporting_Observati) |

An assessment scale is a collection of observations that together yield a summary evaluation of a particular condition. Examples include the Braden Scale (assesses pressure ulcer risk), APACHE Score (estimates mortality in critically ill patients), Mini-Mental Status Exam (assesses cognitive function), APGAR Score (assesses the health of a newborn), and Glasgow Coma Scale (assesses coma and impaired consciousness.)

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14434).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14435).
3. SHALL contain exactly one [1..1] templateId (CONF:14436) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.69" (CONF:14437).
4. SHALL contain at least one [1..\*] id (CONF:14438).
5. SHALL contain exactly one [1..1] code (CONF:14439).
   1. SHOULD be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) identifying the assessment scale (CONF:14440).

Such derivation expression can contain a text calculation of how the components total up to the summed score

1. MAY contain zero or one [0..1] derivationExpr (CONF:14637).
2. SHALL contain exactly one [1..1] statusCode (CONF:14444).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19088).

Represents clinically effective time of the measurement, which may be when the measurement was performed (e.g., a BP measurement), or may be when sample was taken (and measured some time afterwards)

1. SHALL contain exactly one [1..1] effectiveTime (CONF:14445).
2. SHALL contain exactly one [1..1] value (CONF:14450).
3. MAY contain zero or more [0..\*] interpretationCode (CONF:14459).
   1. The interpretationCode, if present, MAY contain zero or more [0..\*] translation (CONF:14888).
4. MAY contain zero or more [0..\*] author (CONF:14460).
5. SHOULD contain zero or more [0..\*] entryRelationship (CONF:14451) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" has component (CONF:16741).
   2. SHALL contain exactly one [1..1] [Assessment Scale Supporting Observation](#E_Assessment_Scale_Supporting_Observati) (templateId:2.16.840.1.113883.10.20.22.4.86) (CONF:16742).

The referenceRange/observationRange/text, if present, MAY contain a description of the scale (e.g. for a Pain Scale 1 to 10: 1 to 3 = little pain, 4 to 7= moderate pain, 8 to 10 = severe pain)

1. MAY contain zero or more [0..\*] referenceRange (CONF:16799).
   1. The referenceRange, if present, SHALL contain exactly one [1..1] observationRange (CONF:16800).
      1. This observationRange SHOULD contain zero or one [0..1] text (CONF:16801).
         1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:16802).
            1. The reference, if present, MAY contain zero or one [0..1] @value (CONF:16803).

This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:16804).

* 1. Assessment Scale Supporting Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.86 (open)]

Table 92: Assessment Scale Supporting Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Assessment Scale Observation](#E_Assessment_Scale_Observation) (optional) |  |

An Assessment Scale Supporting observation represents the components of a scale used in an Assessment Scale Observation. The individual parts that make up the component may be a group of cognitive or functional status observations.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:16715).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:16716).
3. SHALL contain exactly one [1..1] templateId (CONF:16722) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.86" (CONF:16723).
4. SHALL contain at least one [1..\*] id (CONF:16724).
5. SHALL contain exactly one [1..1] code (CONF:19178).
   1. This code SHALL contain exactly one [1..1] @code (CONF:19179).
      1. Such that the @code SHALL be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) and represents components of the scale (CONF:19180).
6. SHALL contain exactly one [1..1] statusCode (CONF:16720).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19089).
7. SHALL contain at least one [1..\*] value (CONF:16754).
   1. If xsi:type="CD" , MAY have a translation code to further specify the source if the instrument has an applicable code system and valueSet for the integer (CONF:14639) (CONF:16755).
   2. Authorization Activity

[act: templateId 2.16.840.1.113883.10.20.1.19 (open)]

Table 93: Authorization Activity Contexts

An Authorization Activity represents authorizations or pre-authorizations currently active for the patient for the particular payer.

Authorizations are represented using an act subordinate to the policy or program that provided it. The authorization refers to the policy or program. Authorized treatments can be grouped into an organizer class, where common properties, such as the reason for the authorization, can be expressed. Subordinate acts represent what was authorized.

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8944).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8945).
3. SHALL contain exactly one [1..1] templateId (CONF:8946) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.1.19" (CONF:10529).
4. SHALL contain exactly one [1..1] id (CONF:8947).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:8948) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8949).
   2. The target of an authorization activity with act/entryRelationship/@typeCode="SUBJ" SHALL be a clinical statement with moodCode="PRMS" Promise (CONF:8951).
   3. The target of an authorization activity MAY contain one or more performer, to indicate the providers that have been authorized to provide treatment (CONF:8952).
   4. Boundary Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.11 (open)]

Table 94: Boundary Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Referenced Frames Observation](#E_Referenced_Frames_Observation) (required) |  |

A Boundary Observation contains a list of integer values for the referenced frames of a DICOM multiframe image SOP instance. It identifies the frame numbers within the referenced SOP instance to which the reference applies. The CDA Boundary Observation numbers frames using the same convention as DICOM, with the first frame in the referenced object being Frame 1. A Boundary Observation must be used if a referenced DICOM SOP instance is a multiframe image and the reference does not apply to all frames.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9282).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9283).
3. SHALL contain exactly one [1..1] code (CONF:9284).
   1. This code SHALL contain exactly one [1..1] @code="113036" Frames for Display (CodeSystem: DCM 1.2.840.10008.2.16.4 STATIC) (CONF:19157).

Each number represents a frame for display.

1. SHALL contain at least one [1..\*] value with @xsi:type="INT" (CONF:9285).
   1. Caregiver Characteristics

[observation: templateId 2.16.840.1.113883.10.20.22.4.72 (open)]

Table 95: Caregiver Characteristics Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Functional Status Section](#S_Functional_Status_Section) (optional)  [Functional Status Result Observation](#E_Functional_Status_Result_Observation) (optional)  [Cognitive Status Result Observation](#E_Cognitive_Status_Result_Observation) (optional)  [Functional Status Problem Observation](#E_Functional_Status_Problem_Observation) (optional)  [Cognitive Status Problem Observation](#E_Cognitive_Status_Problem_Observation) (optional) |  |

This clinical statement represents a caregiver’s willingness to provide care and the abilities of that caregiver to provide assistance to a patient in relation to a specific need.

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14219).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14220).
3. SHALL contain exactly one [1..1] templateId (CONF:14221) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.72" (CONF:14222).
4. SHALL contain at least one [1..\*] id (CONF:14223).
5. SHALL contain exactly one [1..1] code (CONF:14230).
6. SHALL contain exactly one [1..1] statusCode (CONF:14233).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19090).
7. SHALL contain exactly one [1..1] value (CONF:14599).
   1. Where the @code SHALL be selected from LOINC (codeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:14600).
8. SHALL contain at least one [1..\*] participant (CONF:14227).
   1. Such participants MAY contain zero or one [0..1] time (CONF:14830).
      1. The time, if present, SHALL contain exactly one [1..1] low (CONF:14831).
      2. The time, if present, MAY contain zero or one [0..1] high (CONF:14832).
   2. Such participants SHALL contain exactly one [1..1] participantRole (CONF:14228).
      1. This participantRole SHALL contain exactly one [1..1] @classCode="IND" (CONF:14229).
   3. Code Observations

[observation: templateId 2.16.840.1.113883.10.20.6.2.13 (open)]

Table 96: Code Observations Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Quantity Measurement Observation](#E_Quantity_Measurement_Observation)  [SOP Instance Observation](#E_SOP_Instance_Observation) |

DICOM Template 2000 specifies that Imaging Report Elements of Value Type Code are contained in sections. The Imaging Report Elements are inferred from Basic Diagnostic Imaging Report Observations that consist of image references and measurements (linear, area, volume, and numeric). Coded DICOM Imaging Report Elements in this context are mapped to CDA-coded observations that are section components and are related to the SOP Instance Observations (templateId 2.16.840.1.113883.10.20.6.2.8) or Quantity Measurement Observations (templateId 2.16.840.1.113883.10.20.6.2.14) by the SPRT (Support) act relationship.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9304).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9305).
3. SHALL contain exactly one [1..1] templateId (CONF:15523).
   1. This templateId SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.13" (CONF:15524).
4. SHALL contain exactly one [1..1] code (CONF:19181).
5. SHOULD contain zero or one [0..1] effectiveTime (CONF:9309).
6. SHALL contain exactly one [1..1] value (CONF:9308).
7. MAY contain zero or more [0..\*] entryRelationship (CONF:9311) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9312).
   2. SHALL contain exactly one [1..1] [SOP Instance Observation](#E_SOP_Instance_Observation) (templateId:2.16.840.1.113883.10.20.6.2.8) (CONF:16083).
8. MAY contain zero or more [0..\*] entryRelationship (CONF:9314) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9315).
   2. SHALL contain exactly one [1..1] [Quantity Measurement Observation](#E_Quantity_Measurement_Observation) (templateId:2.16.840.1.113883.10.20.6.2.14) (CONF:16084).
9. Code Observations SHALL be rendered into section/text in separate paragraphs (CONF:9310).
   1. Cognitive Status Problem Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.73 (open)]

Table 97: Cognitive Status Problem Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Functional Status Section](#S_Functional_Status_Section) (optional) | [Assessment Scale Observation](#E_Assessment_Scale_Observation)  [Caregiver Characteristics](#E_Caregiver_Characteristics)  [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) |

A cognitive status problem observation is a clinical statement that describes a patient's cognitive condition, findings, or symptoms. Examples of cognitive problem observations are inability to recall, amnesia, dementia, and aggressive behavior.

A cognitive problem observation is a finding or medical condition. This is different from a cognitive result observation, which is a response to a question that provides insight into the patient's cognitive status, judgment, comprehension ability, or response speed.

1. Conforms to [Problem Observation](#E_Problem_Observation) template (2.16.840.1.113883.10.20.22.4.4).
2. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14319).
3. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14320).

Use negationInd="true" to indicate that the problem was not observed.

1. MAY contain zero or one [0..1] @negationInd (CONF:14344).
2. SHALL contain exactly one [1..1] templateId (CONF:14346) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.73" (CONF:14347).
3. SHALL contain at least one [1..\*] id (CONF:14321).
4. SHALL contain exactly one [1..1] code (CONF:14804).
   1. This code SHOULD contain zero or one [0..1] @code="373930000" Cognitive function finding (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:14805).
5. SHOULD contain zero or one [0..1] text (CONF:14341).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15532).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15533).
         1. SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15534).
6. SHALL contain exactly one [1..1] statusCode (CONF:14323).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19091).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:14324).
   1. The onset date SHALL be recorded in the low element of the effectiveTime element when known (CONF:14325).
   2. The resolution date SHALL be recorded in the high element of the effectiveTime element when known (CONF:14326).
   3. If the problem is known to be resolved, but the date of resolution is not known, then the high element SHALL be present, and the nullFlavor attribute SHALL be set to 'UNK'. Therefore, the existence of a high element within a problem does indicate that the problem has been resolved (CONF:14327).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the @code SHOULD be selected from ValueSet Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:14349).
9. MAY contain zero or more [0..\*] methodCode (CONF:14693).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:14331) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14588).
    2. SHALL contain exactly one [1..1] [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:14351).
11. MAY contain zero or more [0..\*] entryRelationship (CONF:14335) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14589).
    2. SHALL contain exactly one [1..1] [Caregiver Characteristics](#E_Caregiver_Characteristics) (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:14352).
12. MAY contain zero or more [0..\*] entryRelationship (CONF:14467) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14590).
    2. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:14468).
    3. Cognitive Status Result Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.74 (open)]

Table 98: Cognitive Status Result Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Functional Status Section](#S_Functional_Status_Section) (optional)  [Cognitive Status Result Organizer](#E_Cognitive_Status_Result_Organizer) (required) | [Assessment Scale Observation](#E_Assessment_Scale_Observation)  [Caregiver Characteristics](#E_Caregiver_Characteristics)  [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) |

This clinical statement contains details of an evaluation or assessment of a patient’s cognitive status. The evaluation may include assessment of a patient's mood, memory, and ability to make decisions. The statement, if present, will include supporting caregivers, non-medical devices, and the time period for which the evaluation and assessment were performed.

This is different from a cognitive status problem observation, which is a clinical statement that describes a patient's cognitive condition, findings, or symptoms. Examples of cognitive problem observations are inability to recall, amnesia, dementia, and aggressive behavior.

1. Conforms to [Result Observation](#E_Result_Observation) template (2.16.840.1.113883.10.20.22.4.2).
2. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14249).
3. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14250).
4. SHALL contain exactly one [1..1] templateId (CONF:14255) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.74" (CONF:14256).
5. SHALL contain at least one [1..\*] id (CONF:14257).
6. SHALL contain exactly one [1..1] code (CONF:14591).
   1. This code SHOULD contain zero or one [0..1] @code="373930000" Cognitive function finding (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:14592).
7. SHOULD contain zero or one [0..1] text (CONF:14258).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15549).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15550).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15551).
8. SHALL contain exactly one [1..1] statusCode (CONF:14254).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19092).

Represents clinically effective time of the measurement, which may be the time the measurement was performed (e.g., a BP measurement), or may be the time the sample was taken (and measured some time afterwards).

1. SHALL contain exactly one [1..1] effectiveTime (CONF:14261).
2. SHALL contain exactly one [1..1] value (CONF:14263).
   1. If xsi:type=“CD”, SHOULD contain a code from SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:14271).
3. SHOULD contain zero or more [0..\*] interpretationCode (CONF:14264).
4. MAY contain zero or one [0..1] methodCode (CONF:14265).
5. MAY contain zero or one [0..1] targetSiteCode (CONF:14270).
6. MAY contain zero or one [0..1] author (CONF:14266).
7. MAY contain zero or more [0..\*] entryRelationship (CONF:14272) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14593).
   2. SHALL contain exactly one [1..1] [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:14273).
8. MAY contain zero or more [0..\*] entryRelationship (CONF:14276) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14594).
   2. SHALL contain exactly one [1..1] [Caregiver Characteristics](#E_Caregiver_Characteristics) (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:14277).
9. MAY contain zero or more [0..\*] entryRelationship (CONF:14469) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14595).
   2. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:14470).
10. SHOULD contain zero or more [0..\*] referenceRange (CONF:14267).
    1. The referenceRange, if present, SHALL contain exactly one [1..1] observationRange (CONF:14268).
       1. This observationRange SHALL NOT contain [0..0] code (CONF:14269).
    2. Cognitive Status Result Organizer

[organizer: templateId 2.16.840.1.113883.10.20.22.4.75 (open)]

Table 99: Cognitive Status Result Organizer Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Functional Status Section](#S_Functional_Status_Section) (optional) | [Cognitive Status Result Observation](#E_Cognitive_Status_Result_Observation) |

This clinical statement identifies a set of cognitive status result observations. It contains information applicable to all of the contained cognitive status result observations. A result organizer may be used to group questions in a Patient Health Questionnaire (PHQ).

An appropriate nullFlavor can be used when the organizer/code or organizer/id is unknown.

1. Conforms to [Result Organizer](#E_Result_Organizer) template (2.16.840.1.113883.10.20.22.4.1).
2. SHALL contain exactly one [1..1] @classCode="CLUSTER", which SHALL be selected from CodeSystem HL7ActClass (2.16.840.1.113883.5.6) STATIC (CONF:14369).
3. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14371).
4. SHALL contain exactly one [1..1] templateId (CONF:14375) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.75" (CONF:14376).
5. SHALL contain at least one [1..\*] id (CONF:14377).
6. SHALL contain exactly one [1..1] code (CONF:14378).
   1. This code SHOULD contain zero or one [0..1] @code (CONF:14697).
      1. Should be selected from ICF (codeSystem 2.16.840.1.113883.6.254) or SNOMED CT (codeSystem 2.16.840.1.113883.6.96) (CONF:14698).
7. SHALL contain exactly one [1..1] statusCode (CONF:14372).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19093).
8. SHALL contain at least one [1..\*] component (CONF:14373) such that it
   1. SHALL contain exactly one [1..1] [Cognitive Status Result Observation](#E_Cognitive_Status_Result_Observation) (templateId:2.16.840.1.113883.10.20.22.4.74) (CONF:14381).
   2. Comment Activity

[act: templateId 2.16.840.1.113883.10.20.22.4.64 (open)]

Table 100: Comment Activity Contexts

Comments are free text data that cannot otherwise be recorded using data elements already defined by this specification. They are not to be used to record information that can be recorded elsewhere. For example, a free text description of the severity of an allergic reaction would not be recorded in a comment.

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9425).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9426).
3. SHALL contain exactly one [1..1] templateId (CONF:9427) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.64" (CONF:10491).
4. SHALL contain exactly one [1..1] code (CONF:9428).
   1. This code SHALL contain exactly one [1..1] @code="48767-8" Annotation Comment (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19159).
5. SHALL contain exactly one [1..1] text (CONF:9430).
   1. This text SHALL contain exactly one [1..1] reference (CONF:15967).
      1. This reference SHALL contain exactly one [1..1] @value (CONF:15968).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15969).
   2. This text SHALL contain exactly one [1..1] reference/@value (CONF:9431).
6. MAY contain zero or one [0..1] author (CONF:9433).
   1. The author, if present, SHALL contain exactly one [1..1] time (CONF:9434).
   2. The author, if present, SHALL contain exactly one [1..1] assignedAuthor (CONF:9435).
      1. This assignedAuthor SHALL contain exactly one [1..1] id (CONF:9436).
      2. This assignedAuthor SHALL contain exactly one [1..1] addr (CONF:9437).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10480).
      3. SHALL include assignedPerson/name or representedOrganization/name (CONF:9438).
      4. An assignedPerson/name SHALL be a conformant US Realm Person Name (PN.US.FIELDED) (2.16.840.1.113883.10.20.22.5.1.1) (CONF:9439).
7. Data elements defined elsewhere in the specification SHALL NOT be recorded using the Comment Activity (CONF:9429).
   1. Coverage Activity

[act: templateId 2.16.840.1.113883.10.20.22.4.60 (open)]

Table 101: Coverage Activity Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Payers Section](#S_Payers_Section) (optional) | [Policy Activity](#E_Policy_Activity) |

A Coverage Activity groups the policy and authorization acts within a Payers Section to order the payment sources. A Coverage Activity contains one or more policy activities, each of which contains zero or more authorization activities. The Coverage Activity id is the Id from the patient's insurance card. The sequenceNumber/@value shows the policy order of preference.

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8872).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8873).
3. SHALL contain exactly one [1..1] templateId (CONF:8897) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.60" (CONF:10492).
4. SHALL contain at least one [1..\*] id (CONF:8874).
5. SHALL contain exactly one [1..1] code (CONF:8876).
   1. This code SHALL contain exactly one [1..1] @code="48768-6" Payment sources (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19160).
6. SHALL contain exactly one [1..1] statusCode (CONF:8875).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19094).
7. SHALL contain at least one [1..\*] entryRelationship (CONF:8878) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8879).
   2. MAY contain zero or one [0..1] sequenceNumber (CONF:17174).
      1. The sequenceNumber, if present, SHALL contain exactly one [1..1] @value (CONF:17175).
   3. SHALL contain exactly one [1..1] [Policy Activity](#E_Policy_Activity) (templateId:2.16.840.1.113883.10.20.22.4.61) (CONF:15528).
   4. Deceased Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.79 (open)]

Table 102: Deceased Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Problem Observation](#E_Problem_Observation) |

This clinical statement represents the observation that a patient has expired. It also represents the cause of death, indicated by an entryRelationship type of “CAUS”.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14851).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14852).
3. SHALL contain exactly one [1..1] templateId (CONF:14871) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.79" (CONF:14872).
4. SHALL contain at least one [1..\*] id (CONF:14873).
5. SHALL contain exactly one [1..1] code (CONF:14853).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19135).
6. SHALL contain exactly one [1..1] statusCode (CONF:14854).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19095).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:14855).
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:14874).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:14857).
   1. This value SHALL contain exactly one [1..1] @code="419099009" Dead (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:15142).
9. SHOULD contain zero or one [0..1] entryRelationship (CONF:14868) such that it
   1. SHALL contain exactly one [1..1] @typeCode="CAUS" Is etiology for (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14875).
   2. SHALL contain exactly one [1..1] [Problem Observation](#E_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:14870).
   3. Discharge Medication

[act: templateId 2.16.840.1.113883.10.20.22.4.35 (open)]

Table 103: Discharge Medication Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Hospital Discharge Medications Section (entries optional)](#S_Hospital_Discharge_Medications_ent_opt) (optional) | [Medication Activity](#E_Medication_Activity) |

The Discharge Medications entry codes medications that the patient is intended to take (or stop) after discharge.

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7689).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7690).
3. SHALL contain exactly one [1..1] templateId (CONF:16760) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.35" (CONF:16761).
4. SHALL contain exactly one [1..1] code (CONF:7691).
   1. This code SHALL contain exactly one [1..1] @code="10183-2" Discharge medication (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19161).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:7692) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7693).
   2. SHALL contain exactly one [1..1] [Medication Activity](#E_Medication_Activity) (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15525).
   3. Drug Vehicle

[participantRole: templateId 2.16.840.1.113883.10.20.22.4.24 (open)]

Table 104: Drug Vehicle Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Medication Activity](#E_Medication_Activity) (optional)  [Immunization Activity](#E_Immunization_Activity) (optional) |  |

This template represents the vehicle (e.g. saline, dextrose) for administering a medication.

1. SHALL contain exactly one [1..1] @classCode="MANU" (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:7490).
2. SHALL contain exactly one [1..1] templateId (CONF:7495) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.24" (CONF:10493).
3. SHALL contain exactly one [1..1] code (CONF:19137).
   1. This code SHALL contain exactly one [1..1] @code="412307009" Drug Vehicle (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:19138).
4. SHALL contain exactly one [1..1] playingEntity (CONF:7492).

This playingEntity/code is used to supply a coded term for the drug vehicle.

* 1. This playingEntity SHALL contain exactly one [1..1] code (CONF:7493).
  2. This playingEntity MAY contain zero or one [0..1] name (CONF:7494).
     1. This playingEntity/name MAY be used for the vehicle name in text, such as Normal Saline (CONF:10087).
  3. Encounter Activities

[encounter: templateId 2.16.840.1.113883.10.20.22.4.49 (open)]

Table 105: Encounter Activities Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Encounters Section (entries optional)](#S_Encounters_Section_entries_optional) (optional)  [Encounters Section (entries required)](#S_Encounters_Section_entries_required) (required) | [Encounter Diagnosis](#E_Encounter_Diagnosis)  [Indication](#E_Indication)  [Service Delivery Location](#E_Service_Delivery_Location) |

This clinical statement describes the interactions between the patient and clinicians. Interactions include in-person encounters, telephone conversations, and email exchanges.

1. SHALL contain exactly one [1..1] @classCode="ENC" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8710).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8711).
3. SHALL contain exactly one [1..1] templateId (CONF:8712) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.49" (CONF:26353).
4. SHALL contain at least one [1..\*] id (CONF:8713).
5. SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet EncounterTypeCode 2.16.840.1.113883.3.88.12.80.32 DYNAMIC (CONF:8714).
   1. The code, if present, SHOULD contain zero or one [0..1] originalText (CONF:8719).
      1. The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:15970).
         1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15971).
            1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15972).
      2. The originalText, if present, SHOULD contain zero or one [0..1] reference/@value (CONF:8720).
6. SHALL contain exactly one [1..1] effectiveTime (CONF:8715).
7. MAY contain zero or more [0..\*] performer (CONF:8725).
   1. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:8726).
      1. This assignedEntity MAY contain zero or one [0..1] code (CONF:8727).
8. MAY contain zero or more [0..\*] participant (CONF:8738) such that it
   1. SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8740).
   2. SHALL contain exactly one [1..1] [Service Delivery Location](#E_Service_Delivery_Location) (templateId:2.16.840.1.113883.10.20.22.4.32) (CONF:14903).
9. MAY contain zero or more [0..\*] entryRelationship (CONF:8722) such that it
   1. SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8723).
   2. SHALL contain exactly one [1..1] [Indication](#E_Indication) (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:14899).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:15492) such that it
    1. SHALL contain exactly one [1..1] [Encounter Diagnosis](#E_Encounter_Diagnosis) (templateId:2.16.840.1.113883.10.20.22.4.80) (CONF:15973).
11. MAY contain zero or one [0..1] sdtc:dischargeDispositionCode, which SHALL be selected from ValueSet 2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status DYNAMIC or, if access to NUBC is unavailable, from CodeSystem 2.16.840.1.113883.12.112 HL7 Discharge Disposition. The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the dischargeDispositionCode element (CONF:9929).
    1. Encounter Diagnosis

[act: templateId 2.16.840.1.113883.10.20.22.4.80 (open)]

Table 106: Encounter Diagnosis Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Encounter Activities](#E_Encounter_Activities) (optional) | [Problem Observation](#E_Problem_Observation) |

This template wraps relevant problems or diagnoses at the close of a visit or that need to be followed after the visit. If the encounter is associated with a Hospital Discharge, the Hospital Discharge Diagnosis must be used. This entry requires at least one Problem Observation entry.

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14889).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14890).
3. SHALL contain exactly one [1..1] templateId (CONF:14895) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.80" (CONF:14896).
4. SHALL contain exactly one [1..1] code (CONF:19182).
   1. This code SHALL contain exactly one [1..1] @code="29308-4" Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19183).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:14892) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14893).
   2. SHALL contain exactly one [1..1] [Problem Observation](#E_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:14898).
   3. Estimated Date of Delivery

[observation: templateId 2.16.840.1.113883.10.20.15.3.1 (closed)]

Table 107: Estimated Date of Delivery Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Pregnancy Observation](#E_Pregnancy_Observation) (optional) |  |

This clinical statement represents the anticipated date when a woman will give birth.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:444).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:445).
3. SHALL contain exactly one [1..1] templateId (CONF:16762) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.15.3.1" (CONF:16763).
4. SHALL contain exactly one [1..1] code (CONF:19139).
   1. This code SHALL contain exactly one [1..1] @code="11778-8" Estimated date of delivery (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19140).
5. SHALL contain exactly one [1..1] statusCode (CONF:448).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19096).
6. SHALL contain exactly one [1..1] value with @xsi:type="TS" (CONF:450).
   1. Family History Death Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.47 (open)]

Table 108: Family History Death Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Family History Observation](#E_Family_History_Observation) (optional) |  |

This clinical statement records whether the family member is deceased.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8621).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8622).
3. SHALL contain exactly one [1..1] templateId (CONF:8623) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.47" (CONF:10495).
4. SHALL contain exactly one [1..1] code (CONF:19141).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19142).
5. SHALL contain exactly one [1..1] statusCode (CONF:8625).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19097).
6. SHALL contain exactly one [1..1] value="419099009" Dead with @xsi:type="CD" (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:8626).
   1. Family History Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.46 (open)]

Table 109: Family History Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Family History Organizer](#E_Family_History_Organizer) (required) | [Age Observation](#E_Age_Observation)  [Family History Death Observation](#E_Family_History_Death_Observation) |

Family History Observations related to a particular family member are contained within a Family History Organizer. The effectiveTime in the Family History Observation is the biologically or clinically relevant time of the observation. The biologically or clinically relevant time is the time at which the observation holds (is effective) for the family member (the subject of the observation).

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8586).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8587).
3. SHALL contain exactly one [1..1] templateId (CONF:8599) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.46" (CONF:10496).
4. SHALL contain at least one [1..\*] id (CONF:8592).
5. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet Problem Type 2.16.840.1.113883.3.88.12.3221.7.2 STATIC 2012-06-01 (CONF:8589).
6. SHALL contain exactly one [1..1] statusCode (CONF:8590).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19098).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:8593).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the @code SHALL be selected from ValueSet Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:8591).
9. MAY contain zero or one [0..1] entryRelationship (CONF:8675) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Subject (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8676).
   2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:8677).
   3. SHALL contain exactly one [1..1] [Age Observation](#E_Age_Observation) (templateId:2.16.840.1.113883.10.20.22.4.31) (CONF:15526).
10. MAY contain zero or one [0..1] entryRelationship (CONF:8678) such that it
    1. SHALL contain exactly one [1..1] @typeCode="CAUS" Causal or Contributory (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8679).
    2. SHALL contain exactly one [1..1] [Family History Death Observation](#E_Family_History_Death_Observation) (templateId:2.16.840.1.113883.10.20.22.4.47) (CONF:15527).
    3. Family History Organizer

[organizer: templateId 2.16.840.1.113883.10.20.22.4.45 (open)]

Table 110: Family History Organizer Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Family History Section](#S_Family_History_Section) (optional) | [Family History Observation](#E_Family_History_Observation) |

The Family History Organizer associates a set of observations with a family member. For example, the Family History Organizer can group a set of observations about the patient’s father.

1. SHALL contain exactly one [1..1] @classCode="CLUSTER" Cluster (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8600).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8601).
3. SHALL contain exactly one [1..1] templateId (CONF:8604) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.45" (CONF:10497).
4. SHALL contain exactly one [1..1] statusCode (CONF:8602).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19099).
5. SHALL contain exactly one [1..1] subject (CONF:8609).
   1. This subject SHALL contain exactly one [1..1] relatedSubject (CONF:15244).
      1. This relatedSubject SHALL contain exactly one [1..1] @classCode="PRS" Person (CodeSystem: EntityClass 2.16.840.1.113883.5.41 STATIC) (CONF:15245).
      2. This relatedSubject SHALL contain exactly one [1..1] code (CONF:15246).
         1. This code SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet Family Member Value Set 2.16.840.1.113883.1.11.19579 DYNAMIC (CONF:15247).
      3. This relatedSubject SHOULD contain zero or one [0..1] subject (CONF:15248).
         1. The subject, if present, SHALL contain exactly one [1..1] administrativeGenderCode (CONF:15974).
            1. This administrativeGenderCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Administrative Gender (HL7 V3) 2.16.840.1.113883.1.11.1 STATIC (CONF:15975).
         2. The subject, if present, SHOULD contain zero or one [0..1] birthTime (CONF:15976).
         3. The subject SHOULD contain zero or more [0..\*] sdtc:id. The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the id element (CONF:15249).
         4. The subject MAY contain zero or one sdtc:deceasedInd. The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the deceasedInd element (CONF:15981).
         5. The subject MAY contain zero or one sdtc:deceasedTime. The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the deceasedTime element (CONF:15982).
         6. The age of a relative at the time of a family history observation SHOULD be inferred by comparing RelatedSubject/subject/birthTime with Observation/effectiveTime (CONF:15983).
6. SHALL contain at least one [1..\*] component (CONF:8607).
   1. Such components SHALL contain exactly one [1..1] [Family History Observation](#E_Family_History_Observation) (templateId:2.16.840.1.113883.10.20.22.4.46) (CONF:16888).
   2. Functional Status Problem Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.68 (open)]

Table 111: Functional Status Problem Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Functional Status Section](#S_Functional_Status_Section) (optional) | [Assessment Scale Observation](#E_Assessment_Scale_Observation)  [Caregiver Characteristics](#E_Caregiver_Characteristics)  [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) |

A functional status problem observation is a clinical statement that represents a patient’s functional performance and ability.

1. Conforms to [Problem Observation](#E_Problem_Observation) template (2.16.840.1.113883.10.20.22.4.4).
2. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14282).
3. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14283).

Use negationInd="true" to indicate that the problem was not observed.

1. MAY contain zero or one [0..1] @negationInd (CONF:14307).
2. SHALL contain exactly one [1..1] templateId (CONF:14312) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.68" (CONF:14313).
3. SHALL contain at least one [1..\*] id (CONF:14284).
4. SHALL contain exactly one [1..1] code (CONF:14314).
   1. This code SHOULD contain zero or one [0..1] @code="248536006" finding of functional performance and activity (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:14315).
5. SHOULD contain zero or one [0..1] text (CONF:14304).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15552).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15553).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15554).
6. SHALL contain exactly one [1..1] statusCode (CONF:14286).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19100).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:14287).
   1. The onset date SHALL be recorded in the low element of the effectiveTime element when known (CONF:14288).
   2. The resolution date SHALL be recorded in the high element of the effectiveTime element when known (CONF:14289).
   3. If the problem is known to be resolved, but the date of resolution is not known, then the high element SHALL be present, and the nullFlavor attribute SHALL be set to 'UNK'. Therefore, the existence of an high element within a problem does indicate that the problem has been resolved (CONF:14290).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the @code SHOULD be selected from ValueSet Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:14291).
   1. This value MAY contain zero or one [0..1] @nullFlavor (CONF:14292).
      1. If the diagnosis is unknown or the SNOMED code is unknown, @nullFlavor SHOULD be “UNK”. If the code is something other than SNOMED, @nullFlavor SHOULD be “OTH” and the other code SHOULD be placed in the translation element (CONF:14293).
9. MAY contain zero or one [0..1] methodCode (CONF:14316).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:14294) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14584).
    2. SHALL contain exactly one [1..1] [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:14317).
11. MAY contain zero or more [0..\*] entryRelationship (CONF:14298) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14586).
    2. SHALL contain exactly one [1..1] [Caregiver Characteristics](#E_Caregiver_Characteristics) (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:14318).
12. MAY contain zero or more [0..\*] entryRelationship (CONF:14463) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" has component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14587).
    2. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:14464).
    3. Functional Status Result Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.67 (open)]

Table 112: Functional Status Result Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Functional Status Section](#S_Functional_Status_Section) (optional)  [Functional Status Result Organizer](#E_Functional_Status_Result_Organizer) (required) | [Assessment Scale Observation](#E_Assessment_Scale_Observation)  [Caregiver Characteristics](#E_Caregiver_Characteristics)  [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) |

This clinical statement represents details of an evaluation or assessment of a patient's functional status. The evaluation may include assessment of a patient's language, vision, hearing, activities of daily living, behavior, general function, mobility, and self-care status. The statement, if present, will include supporting caregivers, non-medical devices, and the time period for which the evaluation and assessment were performed.

1. Conforms to [Result Observation](#E_Result_Observation) template (2.16.840.1.113883.10.20.22.4.2).
2. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:13905).
3. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:13906).
4. SHALL contain exactly one [1..1] templateId (CONF:13889) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.67" (CONF:13890).
5. SHALL contain at least one [1..\*] id (CONF:13907).
6. SHALL contain exactly one [1..1] code (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:13908).
   1. This code SHALL contain zero or one [0..1] @code, which SHOULD be selected from CodeSystem LOINC (2.16.840.1.113883.6.1) STATIC (CONF:26448).
7. SHOULD contain zero or one [0..1] text (CONF:13926).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:13927).
      1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:13928).
8. SHALL contain exactly one [1..1] statusCode (CONF:13929).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19101).

Represents clinically effective time of the measurement, which may be when the measurement was performed (e.g., a BP measurement), or may be when sample was taken (and measured some time afterwards)

1. SHALL contain exactly one [1..1] effectiveTime (CONF:13930).
2. SHALL contain exactly one [1..1] value (CONF:13932).
   1. If xsi:type=“CD”, SHOULD contain a code from SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:14234).
3. SHOULD contain zero or more [0..\*] interpretationCode (CONF:13933).
4. MAY contain zero or one [0..1] methodCode (CONF:13934).
5. MAY contain zero or one [0..1] targetSiteCode (CONF:13935).
6. MAY contain zero or one [0..1] author (CONF:13936).
7. MAY contain zero or one [0..1] entryRelationship (CONF:13892) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CONF:14596).
   2. SHALL contain exactly one [1..1] [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) (templateId:2.16.840.1.113883.10.20.22.4.50) (CONF:14218).
8. MAY contain zero or one [0..1] entryRelationship (CONF:13895) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CONF:14597).
   2. SHALL contain exactly one [1..1] [Caregiver Characteristics](#E_Caregiver_Characteristics) (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:13897).
9. MAY contain zero or one [0..1] entryRelationship (CONF:14465) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" has component (CONF:14598).
   2. SHALL contain exactly one [1..1] [Assessment Scale Observation](#E_Assessment_Scale_Observation) (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:14466).
10. SHOULD contain zero or more [0..\*] referenceRange (CONF:13937).
    1. The referenceRange, if present, SHALL contain exactly one [1..1] observationRange (CONF:13938).
       1. This observationRange SHALL NOT contain [0..0] code (CONF:13939).
    2. Functional Status Result Organizer

[organizer: templateId 2.16.840.1.113883.10.20.22.4.66 (open)]

Table 113: Functional Status Result Organizer Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Functional Status Section](#S_Functional_Status_Section) (optional) | [Functional Status Result Observation](#E_Functional_Status_Result_Observation) |

This clinical statement identifies a set of functional status result observations. It contains information applicable to all of the contained functional status result observations. A functional status organizer may group self-care observations related to a patient's ability to feed, bathe, and dress.

An appropriate nullFlavor can be used when the organizer/code or organizer/id is unknown.

1. Conforms to [Result Organizer](#E_Result_Organizer) template (2.16.840.1.113883.10.20.22.4.1).
2. SHALL contain exactly one [1..1] @classCode="CLUSTER", which SHALL be selected from CodeSystem HL7ActClass (2.16.840.1.113883.5.6) STATIC (CONF:14355).
3. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14357).
4. SHALL contain exactly one [1..1] templateId (CONF:14361) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.66" (CONF:14362).
5. SHALL contain at least one [1..\*] id (CONF:14363).
6. SHALL contain exactly one [1..1] code (CONF:14364).
   1. This code SHOULD contain zero or one [0..1] @code (CONF:14747).
      1. SHOULD be selected from ICF (codeSystem 2.16.840.1.113883.6.254) or SNOMED CT (codeSystem 2.16.840.1.113883.6.96) (CONF:14748).
7. SHALL contain exactly one [1..1] statusCode (CONF:14358).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19102).
8. SHALL contain at least one [1..\*] component (CONF:14359) such that it
   1. SHALL contain exactly one [1..1] [Functional Status Result Observation](#E_Functional_Status_Result_Observation) (templateId:2.16.840.1.113883.10.20.22.4.67) (CONF:14368).
   2. Health Status Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.5 (closed)]

Table 114: Health Status Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Problem Observation](#E_Problem_Observation) (optional) |  |

The Health Status Observation records information about the current health status of the patient.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9057).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9072).
3. SHALL contain exactly one [1..1] templateId (CONF:16756) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.5" (CONF:16757).
4. SHALL contain exactly one [1..1] code (CONF:19143).
   1. This code SHALL contain exactly one [1..1] @code="11323-3" Health status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19144).
5. SHOULD contain zero or one [0..1] text (CONF:9270).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15529).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15530).
         1. SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15531).
6. SHALL contain exactly one [1..1] statusCode (CONF:9074).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19103).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the @code SHALL be selected from ValueSet HealthStatus 2.16.840.1.113883.1.11.20.12 DYNAMIC (CONF:9075).
   1. Highest Pressure Ulcer Stage

[observation: templateId 2.16.840.1.113883.10.20.22.4.77 (open)]

Table 115: Highest Pressure Ulcer Stage Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Physical Exam Section](#S_Physical_Exam_Section) (optional)  [Functional Status Section](#S_Functional_Status_Section) (optional) |  |

This observation contains a description of the wound tissue of the most severe or highest staged pressure ulcer observed on a patient.

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14726).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14727).
3. SHALL contain exactly one [1..1] templateId (CONF:14728) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.77" (CONF:14729).
4. SHALL contain at least one [1..\*] id (CONF:14730).
5. SHALL contain exactly one [1..1] code (CONF:14731).
   1. This code SHALL contain exactly one [1..1] @code="420905001" Highest Pressure Ulcer Stage (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:14732).
6. SHALL contain exactly one [1..1] value (CONF:14733).
   1. Hospital Admission Diagnosis

[act: templateId 2.16.840.1.113883.10.20.22.4.34 (open)]

Table 116: Hospital Admission Diagnosis Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Hospital Admission Diagnosis Section](#S_Hospital_Admission_Diagnosis_Section) (optional) | [Problem Observation](#E_Problem_Observation) |

The Hospital Admission Diagnosis entry describes the relevant problems or diagnoses at the time of admission.

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7671).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7672).
3. SHALL contain exactly one [1..1] templateId (CONF:16747) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.34" (CONF:16748).
4. SHALL contain exactly one [1..1] code (CONF:19145).
   1. This code SHALL contain exactly one [1..1] @code="46241-6" Admission diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19146).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:7674) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7675).
   2. SHALL contain exactly one [1..1] [Problem Observation](#E_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15535).
   3. Hospital Discharge Diagnosis

[act: templateId 2.16.840.1.113883.10.20.22.4.33 (open)]

Table 117: Hospital Discharge Diagnosis Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Hospital Discharge Diagnosis Section](#S_Hospital_Discharge_Diagnosis_Section) (optional) | [Problem Observation](#E_Problem_Observation) |

The Hospital Discharge Diagnosis act wraps relevant problems or diagnoses at the time of discharge that occurred during the hospitalization or that need to be followed after hospitalization. This entry requires at least one Problem Observation entry.

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7663).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7664).
3. SHALL contain exactly one [1..1] templateId (CONF:16764) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.33" (CONF:16765).
4. SHALL contain exactly one [1..1] code (CONF:19147).
   1. This code SHALL contain exactly one [1..1] @code="11535-2" Hospital discharge diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19148).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:7666) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7667).
   2. SHALL contain exactly one [1..1] [Problem Observation](#E_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15536).
   3. Immunization Activity

[substanceAdministration: templateId 2.16.840.1.113883.10.20.22.4.52 (open)]

Table 118: Immunization Activity Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Immunizations Section (entries optional)](#S_Immunizations_Section_entries_optional) (optional)  [Immunizations Section (entries required)](#S_Immunizations_Section_entries_required) (required) | [Drug Vehicle](#E_Drug_Vehicle)  [Immunization Medication Information](#E_Immunization_Medication_Information)  [Immunization Refusal Reason](#E_Immunization_Refusal_Reason)  [Indication](#E_Indication)  [Instructions](#E_Instructions)  [Medication Dispense](#E_Medication_Dispense)  [Medication Supply Order](#E_Medication_Supply_Order)  [Precondition for Substance Administration](#E_Precondition_for_Substance_Administrat)  [Reaction Observation](#E_Reaction_Observation) |

An Immunization Activity describes immunization substance administrations that have actually occurred or are intended to occur. Immunization Activities in ""INT"" mood are reflections of immunizations a clinician intends a patient to receive. Immunization Activities in ""EVN"" mood reflect immunizations actually received.

An Immunization Activity is very similar to a Medication Activity with some key differentiators. The drug code system is constrained to CVX codes. Administration timing is less complex. Patient refusal reasons should be captured. All vaccines administered should be fully documented in the patient's permanent medical record. Healthcare providers who administer vaccines covered by the National Childhood Vaccine Injury Act are required to ensure that the permanent medical record of the recipient indicates:

1) Date of administration

2) Vaccine manufacturer

3) Vaccine lot number

4) Name and title of the person who administered the vaccine and the address of the clinic or facility where the permanent record will reside

5) Vaccine information statement (VIS)

a. date printed on the VIS

b. date VIS given to patient or parent/guardian.

This information should be included in an Immunization Activity when available.

1. SHALL contain exactly one [1..1] @classCode="SBADM" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8826).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 STATIC (CONF:8827).

Use negationInd="true" to indicate that the immunization was not given.

1. SHALL contain exactly one [1..1] @negationInd (CONF:8985).
2. SHALL contain exactly one [1..1] templateId (CONF:8828) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.52" (CONF:10498).
3. SHALL contain at least one [1..\*] id (CONF:8829).
4. MAY contain zero or one [0..1] code (CONF:8830).
5. SHOULD contain zero or one [0..1] text (CONF:8831).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15543).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15544).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1 (CONF:15545).
6. SHALL contain exactly one [1..1] statusCode (CONF:8833).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:8834).

In "INT" (intent) mood, the repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times. In "EVN" (event) mood, the repeatNumber is the number of occurrences. For example, a repeatNumber of "3" in a dispense act means that the current dispensation is the 3rd. A repeatNumber of "3" in a substance administration event means that the current administration is the 3rd in a series.

1. MAY contain zero or one [0..1] repeatNumber (CONF:8838).
2. MAY contain zero or one [0..1] routeCode, which SHALL be selected from ValueSet Medication Route FDA Value Set 2.16.840.1.113883.3.88.12.3221.8.7 DYNAMIC (CONF:8839).
3. MAY contain zero or one [0..1] approachSiteCode, where the @code SHALL be selected from ValueSet Body Site Value Set 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:8840).
4. SHOULD contain zero or one [0..1] doseQuantity (CONF:8841).
   1. The doseQuantity, if present, SHOULD contain zero or one [0..1] @unit, which SHALL be selected from ValueSet UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 DYNAMIC (CONF:8842).
5. MAY contain zero or one [0..1] administrationUnitCode, which SHALL be selected from ValueSet Medication Product Form Value Set 2.16.840.1.113883.3.88.12.3221.8.11 DYNAMIC (CONF:8846).
6. SHALL contain exactly one [1..1] consumable (CONF:8847).
   1. This consumable SHALL contain exactly one [1..1] [Immunization Medication Information](#E_Immunization_Medication_Information) (templateId:2.16.840.1.113883.10.20.22.4.54) (CONF:15546).
7. SHOULD contain zero or one [0..1] performer (CONF:8849).
8. MAY contain zero or more [0..\*] participant (CONF:8850).
   1. The participant, if present, SHALL contain exactly one [1..1] @typeCode="CSM" (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8851).
   2. The participant, if present, SHALL contain exactly one [1..1] [Drug Vehicle](#E_Drug_Vehicle) (templateId:2.16.840.1.113883.10.20.22.4.24) (CONF:15547).
9. MAY contain zero or more [0..\*] entryRelationship (CONF:8853) such that it
   1. SHALL contain exactly one [1..1] @typeCode="RSON" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8854).
   2. SHALL contain exactly one [1..1] [Indication](#E_Indication) (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:15537).
10. MAY contain zero or one [0..1] entryRelationship (CONF:8856) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8857).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:8858).
    3. SHALL contain exactly one [1..1] [Instructions](#E_Instructions) (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:15538).
11. MAY contain zero or one [0..1] entryRelationship (CONF:8860) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8861).
    2. SHALL contain exactly one [1..1] [Medication Supply Order](#E_Medication_Supply_Order) (templateId:2.16.840.1.113883.10.20.22.4.17) (CONF:15539).
12. MAY contain zero or one [0..1] entryRelationship (CONF:8863) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8864).
    2. SHALL contain exactly one [1..1] [Medication Dispense](#E_Medication_Dispense) (templateId:2.16.840.1.113883.10.20.22.4.18) (CONF:15540).
13. MAY contain zero or one [0..1] entryRelationship (CONF:8866) such that it
    1. SHALL contain exactly one [1..1] @typeCode="CAUS" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8867).
    2. SHALL contain exactly one [1..1] [Reaction Observation](#E_Reaction_Observation) (templateId:2.16.840.1.113883.10.20.22.4.9) (CONF:15541).
14. MAY contain zero or one [0..1] entryRelationship (CONF:8988) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8989).
    2. SHALL contain exactly one [1..1] [Immunization Refusal Reason](#E_Immunization_Refusal_Reason) (templateId:2.16.840.1.113883.10.20.22.4.53) (CONF:15542).
15. MAY contain zero or more [0..\*] precondition (CONF:8869) such that it
    1. SHALL contain exactly one [1..1] @typeCode="PRCN" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8870).
    2. SHALL contain exactly one [1..1] [Precondition for Substance Administration](#E_Precondition_for_Substance_Administrat) (templateId:2.16.840.1.113883.10.20.22.4.25) (CONF:15548).
    3. Immunization Medication Information

[manufacturedProduct: templateId 2.16.840.1.113883.10.20.22.4.54 (open)]

Table 119: Immunization Medication Information Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Medication Supply Order](#E_Medication_Supply_Order) (optional)  [Medication Dispense](#E_Medication_Dispense) (optional)  [Immunization Activity](#E_Immunization_Activity) (required) |  |

The Immunization Medication Information represents product information about the immunization substance. The vaccine manufacturer and vaccine lot number are typically recorded in the medical record and should be included if known.

1. SHALL contain exactly one [1..1] @classCode="MANU" (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:9002).
2. SHALL contain exactly one [1..1] templateId (CONF:9004) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.54" (CONF:10499).
3. MAY contain zero or more [0..\*] id (CONF:9005).
4. SHALL contain exactly one [1..1] manufacturedMaterial (CONF:9006).
   1. This manufacturedMaterial SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Vaccine Administered Value Set 2.16.840.1.113883.3.88.12.80.22 DYNAMIC (CONF:9007).
      1. This code SHOULD contain zero or one [0..1] originalText (CONF:9008).
         1. The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:15555).
            1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15556).

This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15557).

* + 1. This code MAY contain zero or more [0..\*] translation (CONF:9011).
       1. Translations can be used to represent generic product name, packaged product code, etc. (CONF:16887).
  1. This manufacturedMaterial SHOULD contain zero or one [0..1] lotNumberText (CONF:9014).

1. SHOULD contain zero or one [0..1] manufacturerOrganization (CONF:9012).
   1. Immunization Refusal Reason

[observation: templateId 2.16.840.1.113883.10.20.22.4.53 (open)]

Table 120: Immunization Refusal Reason Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Immunization Activity](#E_Immunization_Activity) (optional) |  |

The Immunization Refusal Reason Observation documents the rationale for the patient declining an immunization.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8991).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8992).
3. SHALL contain exactly one [1..1] templateId (CONF:8993) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.53" (CONF:10500).
4. SHALL contain at least one [1..\*] id (CONF:8994).
5. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet No Immunization Reason Value Set 2.16.840.1.113883.1.11.19717 DYNAMIC (CONF:8995).
6. SHALL contain exactly one [1..1] statusCode (CONF:8996).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19104).
   2. Indication

[observation: templateId 2.16.840.1.113883.10.20.22.4.19 (open)]

Table 121: Indication Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Medication Activity](#E_Medication_Activity) (optional)  [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) (optional)  [Procedure Activity Act](#E_Procedure_Activity_Act) (optional)  [Procedure Activity Observation](#E_Procedure_Activity_Observation) (optional)  [Procedure Indications Section](#S_Procedure_Indications_Section) (optional)  [Encounter Activities](#E_Encounter_Activities) (optional)  [Immunization Activity](#E_Immunization_Activity) (optional) |  |

The Indication Observation documents the rationale for an activity. It can do this with the id element to reference a problem recorded elsewhere in the document or with a code and value to record the problem type and problem within the Indication. For example, the indication for a prescription of a painkiller might be a headache that is documented in the Problems Section.

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7480).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7481).
3. SHALL contain exactly one [1..1] templateId (CONF:7482) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.19" (CONF:10502).
4. SHALL contain exactly one [1..1] id (CONF:7483).
   1. Set the observation/id equal to an ID on the problem list to signify that problem as an indication (CONF:16885).
5. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet Problem Type 2.16.840.1.113883.3.88.12.3221.7.2 STATIC 2012-06-01 (CONF:16886).
6. SHALL contain exactly one [1..1] statusCode (CONF:7487).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19105).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:7488).
8. SHOULD contain zero or one [0..1] value with @xsi:type="CD" (CONF:7489).
   1. The value, if present, MAY contain zero or one [0..1] @nullFlavor (CONF:15990).
      1. If the diagnosis is unknown or the SNOMED code is unknown, @nullFlavor SHOULD be “UNK”. If the code is something other than SNOMED, @nullFlavor SHOULD be “OTH” and the other code SHOULD be placed in the translation element (CONF:15991).
   2. The value, if present, SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:15985).
   3. Instructions

[act: templateId 2.16.840.1.113883.10.20.22.4.20 (open)]

Table 122: Instructions Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Medication Activity](#E_Medication_Activity) (optional)  [Medication Supply Order](#E_Medication_Supply_Order) (optional)  [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) (optional)  [Plan of Care Section](#S_Plan_of_Care_Section) (optional)  [Procedure Activity Act](#E_Procedure_Activity_Act) (optional)  [Procedure Activity Observation](#E_Procedure_Activity_Observation) (optional)  [Immunization Activity](#E_Immunization_Activity) (optional)  [Instructions Section](#S_Instructions_Section) (optional) |  |

The Instructions template can be used in several ways, such as to record patient instructions within a Medication Activity or to record fill instructions within a supply order. The act/code defines the type of instruction. Though not defined in this template, a Vaccine Information Statement (VIS) document could be referenced through act/reference/externalDocument, and patient awareness of the instructions can be represented with the generic participant and the participant/awarenessCode.

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7391).
2. SHALL contain exactly one [1..1] @moodCode="INT" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7392).
3. SHALL contain exactly one [1..1] templateId (CONF:7393) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.20" (CONF:10503).
4. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet Patient Education 2.16.840.1.113883.11.20.9.34 DYNAMIC (CONF:16884).
5. SHOULD contain zero or one [0..1] text (CONF:7395).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15577).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15578).
         1. This @value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15579).
6. SHALL contain exactly one [1..1] statusCode (CONF:7396).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19106).
   2. Medication Activity

[substanceAdministration: templateId 2.16.840.1.113883.10.20.22.4.16 (open)]

Table 123: Medication Activity Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Reaction Observation](#E_Reaction_Observation) (optional)  [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) (optional)  [Medications Section (entries required)](#S_Medications_Section_entries_required) (required)  [Discharge Medication](#E_Discharge_Medication) (required)  [Admission Medication](#E_Admission_Medication) (required)  [Medications Section (entries optional)](#S_Medications_Section_entries_optional) (optional)  [Procedure Activity Act](#E_Procedure_Activity_Act) (optional)  [Procedure Activity Observation](#E_Procedure_Activity_Observation) (optional)  [Medications Administered Section](#S_Medications_Administered_Section) (optional) | [Drug Vehicle](#E_Drug_Vehicle)  [Indication](#E_Indication)  [Instructions](#E_Instructions)  [Medication Dispense](#E_Medication_Dispense)  [Medication Information](#E_Medication_Information)  [Medication Supply Order](#E_Medication_Supply_Order)  [Precondition for Substance Administration](#E_Precondition_for_Substance_Administrat)  [Reaction Observation](#E_Reaction_Observation) |

A medication activity describes substance administrations that have actually occurred (e.g. pills ingested or injections given) or are intended to occur (e.g. ""take 2 tablets twice a day for the next 10 days""). Medication activities in ""INT"" mood are reflections of what a clinician intends a patient to be taking. Medication activities in ""EVN"" mood reflect actual use.

Medication timing is complex. This template requires that there be a substanceAdministration/effectiveTime valued with a time interval, representing the start and stop dates. Additional effectiveTime elements are optional, and can be used to represent frequency and other aspects of more detailed dosing regimens.

1. SHALL contain exactly one [1..1] @classCode="SBADM" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7496).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03 (CONF:7497).
3. SHALL contain exactly one [1..1] templateId (CONF:7499) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.16" (CONF:10504).
4. SHALL contain at least one [1..\*] id (CONF:7500).
5. MAY contain zero or one [0..1] code (CONF:7506).
6. SHOULD contain zero or one [0..1] text (CONF:7501).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15977).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15978).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15979).
7. SHALL contain exactly one [1..1] statusCode (CONF:7507).
8. SHALL contain exactly one [1..1] effectiveTime (CONF:7508) such that it
   1. SHALL contain exactly one [1..1] low (CONF:7511).
   2. SHALL contain exactly one [1..1] high (CONF:7512).
9. SHOULD contain zero or one [0..1] effectiveTime (CONF:7513) such that it
   1. SHALL contain exactly one [1..1] @operator="A" (CONF:9106).
   2. SHALL contain exactly one [1..1] @xsi:type=”PIVL\_TS” or “EIVL\_TS” (CONF:9105).
10. MAY contain zero or one [0..1] repeatNumber (CONF:7555).
    1. In "INT" (intent) mood, the repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times.In "EVN" (event) mood, the repeatNumber is the number of occurrences. For example, a repeatNumber of "3" in a substance administration event means that the current administration is the 3rd in a series (CONF:16877).
11. MAY contain zero or one [0..1] routeCode, which SHALL be selected from ValueSet Medication Route FDA Value Set 2.16.840.1.113883.3.88.12.3221.8.7 DYNAMIC (CONF:7514).
12. MAY contain zero or one [0..1] approachSiteCode, where the @code SHALL be selected from ValueSet Body Site Value Set 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:7515).
13. SHOULD contain zero or one [0..1] doseQuantity (CONF:7516).
    1. The doseQuantity, if present, SHOULD contain zero or one [0..1] @unit, which SHALL be selected from ValueSet UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 DYNAMIC (CONF:7526).
    2. Pre-coordinated consumable: If the consumable code is a pre-coordinated unit dose (e.g. "metoprolol 25mg tablet") then doseQuantity is a unitless number that indicates the number of products given per administration (e.g. "2", meaning 2 x "metoprolol 25mg tablet") (CONF:16878).
    3. Not pre-coordinated consumable: If the consumable code is not pre-coordinated (e.g. is simply "metoprolol"), then doseQuantity must represent a physical quantity with @unit, e.g. "25" and "mg", specifying the amount of product given per administration (CONF:16879).
14. MAY contain zero or one [0..1] rateQuantity (CONF:7517).
    1. The rateQuantity, if present, SHALL contain exactly one [1..1] @unit, which SHALL be selected from ValueSet UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.11.12839 DYNAMIC (CONF:7525).
15. MAY contain zero or one [0..1] maxDoseQuantity (CONF:7518).
16. MAY contain zero or one [0..1] administrationUnitCode, which SHALL be selected from ValueSet Medication Product Form Value Set 2.16.840.1.113883.3.88.12.3221.8.11 DYNAMIC (CONF:7519).
17. SHALL contain exactly one [1..1] consumable (CONF:7520).
    1. This consumable SHALL contain exactly one [1..1] [Medication Information](#E_Medication_Information) (templateId:2.16.840.1.113883.10.20.22.4.23) (CONF:16085).
18. MAY contain zero or one [0..1] performer (CONF:7522).
19. MAY contain zero or more [0..\*] participant (CONF:7523) such that it
    1. SHALL contain exactly one [1..1] @typeCode="CSM" (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:7524).
    2. SHALL contain exactly one [1..1] [Drug Vehicle](#E_Drug_Vehicle) (templateId:2.16.840.1.113883.10.20.22.4.24) (CONF:16086).
20. MAY contain zero or more [0..\*] entryRelationship (CONF:7536) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7537).
    2. SHALL contain exactly one [1..1] [Indication](#E_Indication) (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:16087).
21. MAY contain zero or one [0..1] entryRelationship (CONF:7539) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7540).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7542).
    3. SHALL contain exactly one [1..1] [Instructions](#E_Instructions) (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:16088).
22. MAY contain zero or one [0..1] entryRelationship (CONF:7543) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7547).
    2. SHALL contain exactly one [1..1] [Medication Supply Order](#E_Medication_Supply_Order) (templateId:2.16.840.1.113883.10.20.22.4.17) (CONF:16089).
23. MAY contain zero or more [0..\*] entryRelationship (CONF:7549) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7553).
    2. SHALL contain exactly one [1..1] [Medication Dispense](#E_Medication_Dispense) (templateId:2.16.840.1.113883.10.20.22.4.18) (CONF:16090).
24. MAY contain zero or one [0..1] entryRelationship (CONF:7552) such that it
    1. SHALL contain exactly one [1..1] @typeCode="CAUS" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7544).
    2. SHALL contain exactly one [1..1] [Reaction Observation](#E_Reaction_Observation) (templateId:2.16.840.1.113883.10.20.22.4.9) (CONF:16091).
25. MAY contain zero or more [0..\*] precondition (CONF:7546) such that it
    1. SHALL contain exactly one [1..1] @typeCode="PRCN" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7550).
    2. SHALL contain exactly one [1..1] [Precondition for Substance Administration](#E_Precondition_for_Substance_Administrat) (templateId:2.16.840.1.113883.10.20.22.4.25) (CONF:16092).
26. Medication Activity SHOULD include doseQuantity OR rateQuantity (CONF:7529).
    1. Medication Dispense

[supply: templateId 2.16.840.1.113883.10.20.22.4.18 (open)]

Table 124: Medication Dispense Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Medication Activity](#E_Medication_Activity) (optional)  [Immunization Activity](#E_Immunization_Activity) (optional) | [Immunization Medication Information](#E_Immunization_Medication_Information)  [Medication Information](#E_Medication_Information)  [Medication Supply Order](#E_Medication_Supply_Order) |

This template records the act of supplying medications (i.e., dispensing).

1. SHALL contain exactly one [1..1] @classCode="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7451).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7452).
3. SHALL contain exactly one [1..1] templateId (CONF:7453) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.18" (CONF:10505).
4. SHALL contain at least one [1..\*] id (CONF:7454).
5. SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet Medication Fill Status 2.16.840.1.113883.3.88.12.80.64 DYNAMIC (CONF:7455).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:7456).
7. SHOULD contain zero or one [0..1] repeatNumber (CONF:7457).
   1. In "EVN" (event) mood, the repeatNumber is the number of occurrences. For example, a repeatNumber of "3" in a dispense act means that the current dispensation is the 3rd (CONF:16876).
8. SHOULD contain zero or one [0..1] quantity (CONF:7458).
9. MAY contain zero or one [0..1] product (CONF:7459) such that it
   1. SHALL contain exactly one [1..1] [Medication Information](#E_Medication_Information) (templateId:2.16.840.1.113883.10.20.22.4.23) (CONF:15607).
10. MAY contain zero or one [0..1] product (CONF:9331) such that it
    1. SHALL contain exactly one [1..1] [Immunization Medication Information](#E_Immunization_Medication_Information) (templateId:2.16.840.1.113883.10.20.22.4.54) (CONF:15608).
11. MAY contain zero or one [0..1] performer (CONF:7461).
    1. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:7467).
       1. This assignedEntity SHOULD contain zero or one [0..1] addr (CONF:7468).
          1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10565).
12. MAY contain zero or one [0..1] entryRelationship (CONF:7473) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7474).
    2. SHALL contain exactly one [1..1] [Medication Supply Order](#E_Medication_Supply_Order) (templateId:2.16.840.1.113883.10.20.22.4.17) (CONF:15606).
13. A supply act SHALL contain one product/Medication Information or one product/Immunization Medication Information template (CONF:9333).
    1. Medication Information

[manufacturedProduct: templateId 2.16.840.1.113883.10.20.22.4.23 (open)]

Table 125: Medication Information Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Medication Activity](#E_Medication_Activity) (required)  [Medication Supply Order](#E_Medication_Supply_Order) (optional)  [Medication Dispense](#E_Medication_Dispense) (optional) |  |

The medication can be recorded as a pre-coordinated product strength, product form, or product concentration (e.g., ""metoprolol 25mg tablet"", ""amoxicillin 400mg/5mL suspension""); or not pre-coordinated (e.g., ""metoprolol product"").

1. SHALL contain exactly one [1..1] @classCode="MANU" (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:7408).
2. SHALL contain exactly one [1..1] templateId (CONF:7409) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.23" (CONF:10506).
3. MAY contain zero or more [0..\*] id (CONF:7410).
4. SHALL contain exactly one [1..1] manufacturedMaterial (CONF:7411).
   1. This manufacturedMaterial SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet Medication Clinical Drug Name Value Set 2.16.840.1.113883.3.88.12.80.17 DYNAMIC (CONF:7412).
      1. This code SHOULD contain zero or one [0..1] originalText (CONF:7413).
         1. The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:15986).
            1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15987).

This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15988).

* + 1. This code MAY contain zero or more [0..\*] translation (CONF:7414).
       1. Translations can be used to represent generic product name, packaged product code, etc (CONF:16875).

1. MAY contain zero or one [0..1] manufacturerOrganization (CONF:7416).
   1. Medication Supply Order

[supply: templateId 2.16.840.1.113883.10.20.22.4.17 (open)]

Table 126: Medication Supply Order Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Medication Activity](#E_Medication_Activity) (optional)  [Medication Dispense](#E_Medication_Dispense) (optional)  [Immunization Activity](#E_Immunization_Activity) (optional) | [Immunization Medication Information](#E_Immunization_Medication_Information)  [Instructions](#E_Instructions)  [Medication Information](#E_Medication_Information) |

This template records the intent to supply a patient with medications.

1. SHALL contain exactly one [1..1] @classCode="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7427).
2. SHALL contain exactly one [1..1] @moodCode="INT" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7428).
3. SHALL contain exactly one [1..1] templateId (CONF:7429) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.17" (CONF:10507).
4. SHALL contain at least one [1..\*] id (CONF:7430).
5. SHALL contain exactly one [1..1] statusCode (CONF:7432).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:15143) such that it
   1. SHALL contain exactly one [1..1] high (CONF:15144).
7. SHOULD contain zero or one [0..1] repeatNumber (CONF:7434).
   1. In "INT" (intent) mood, the repeatNumber defines the number of allowed fills. For example, a repeatNumber of "3" means that the substance can be supplied up to 3 times (or, can be dispensed, with 2 refills) (CONF:16869).
8. SHOULD contain zero or one [0..1] quantity (CONF:7436).
9. MAY contain zero or one [0..1] product (CONF:7439) such that it
   1. SHALL contain exactly one [1..1] [Medication Information](#E_Medication_Information) (templateId:2.16.840.1.113883.10.20.22.4.23) (CONF:16093).
10. MAY contain zero or one [0..1] product (CONF:9334) such that it
    1. SHALL contain exactly one [1..1] [Immunization Medication Information](#E_Immunization_Medication_Information) (templateId:2.16.840.1.113883.10.20.22.4.54) (CONF:16094).
       1. A supply act SHALL contain one product/Medication Information or one product/Immunization Medication Information template (CONF:16870).
11. MAY contain zero or one [0..1] author (CONF:7438).
12. MAY contain zero or one [0..1] entryRelationship (CONF:7442).
    1. The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="SUBJ" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7444).
    2. The entryRelationship, if present, SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7445).
    3. The entryRelationship, if present, SHALL contain exactly one [1..1] [Instructions](#E_Instructions) (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:16095).
    4. Medication Use - None Known (deprecated)

[observation: templateId 2.16.840.1.113883.10.20.22.4.29 (open)]

Table 127: Medication Use - None Known (deprecated) Contexts

The recommended approach to stating no known medications is to use the appropriate nullFlavor instead of this template.

See ""Unknown Information"" in Section 1.

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7557).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7558).
3. SHALL contain exactly one [1..1] templateId (CONF:7559) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.29" (CONF:10508).
4. SHALL contain at least one [1..\*] id (CONF:7560).
5. SHALL contain exactly one [1..1] code (CONF:19149).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19150).
6. MAY contain zero or one [0..1] text (CONF:7565).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15580).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15581).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15582).
7. SHALL contain exactly one [1..1] statusCode (CONF:7562).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19107).
8. SHOULD contain zero or one [0..1] effectiveTime (CONF:7563).
9. SHALL contain exactly one [1..1] value="182904002" Drug treatment unknown (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:7564).
   1. Non-Medicinal Supply Activity

[supply: templateId 2.16.840.1.113883.10.20.22.4.50 (open)]

Table 128: Non-Medicinal Supply Activity Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Functional Status Section](#S_Functional_Status_Section) (optional)  [Medical Equipment Section](#S_Medical_Equipment_Section) (optional)  [Functional Status Result Observation](#E_Functional_Status_Result_Observation) (optional)  [Cognitive Status Result Observation](#E_Cognitive_Status_Result_Observation) (optional)  [Functional Status Problem Observation](#E_Functional_Status_Problem_Observation) (optional)  [Cognitive Status Problem Observation](#E_Cognitive_Status_Problem_Observation) (optional) | [Product Instance](#E_Product_Instance) |

This template records non-medicinal supplies provided, such as medical equipment

1. SHALL contain exactly one [1..1] @classCode="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8745).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03 (CONF:8746).
3. SHALL contain exactly one [1..1] templateId (CONF:8747) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.50" (CONF:10509).
4. SHALL contain at least one [1..\*] id (CONF:8748).
5. SHALL contain exactly one [1..1] statusCode (CONF:8749).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:15498).
   1. The effectiveTime, if present, SHOULD contain zero or one [0..1] high (CONF:16867).
7. SHOULD contain zero or one [0..1] quantity (CONF:8751).
8. MAY contain zero or one [0..1] participant (CONF:8752) such that it
   1. SHALL contain exactly one [1..1] @typeCode="PRD" Product (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8754).
   2. SHALL contain exactly one [1..1] [Product Instance](#E_Product_Instance) (templateId:2.16.840.1.113883.10.20.22.4.37) (CONF:15900).
   3. Number of Pressure Ulcers Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.76 (open)]

Table 129: Number of Pressure Ulcers Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Physical Exam Section](#S_Physical_Exam_Section) (optional)  [Functional Status Section](#S_Functional_Status_Section) (optional) |  |

This clinical statement enumerates the number of pressure ulcers observed in a particular stage.

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14705).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14706).
3. SHALL contain exactly one [1..1] templateId (CONF:14707) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.76" (CONF:14708).
4. SHALL contain at least one [1..\*] id (CONF:14709).
5. SHALL contain exactly one [1..1] code (CONF:14767).
   1. This code SHALL contain exactly one [1..1] @code="2264892003" number of pressure ulcers (CONF:14768).
6. SHALL contain exactly one [1..1] statusCode (CONF:14714).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19108).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:14715).
8. SHALL contain exactly one [1..1] value with @xsi:type="INT" (CONF:14771).
9. MAY contain zero or one [0..1] author (CONF:14717).
10. SHALL contain exactly one [1..1] entryRelationship (CONF:14718).
    1. This entryRelationship SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14719).
    2. This entryRelationship SHALL contain exactly one [1..1] observation (CONF:14720).
       1. This observation SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14721).
       2. This observation SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14722).
       3. This observation SHALL contain exactly one [1..1] value with @xsi:type="CD", where the @code SHOULD be selected from ValueSet Pressure Ulcer Stage 2.16.840.1.113883.11.20.9.35 STATIC (CONF:14725).
    3. Plan of Care Activity Act

[act: templateId 2.16.840.1.113883.10.20.22.4.39 (open)]

Table 130: Plan of Care Activity Act Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Assessment and Plan Section](#S_Assessment_and_Plan_Section) (optional)  [Plan of Care Section](#S_Plan_of_Care_Section) (optional) |  |

This is the generic template for the Plan of Care Activity.

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8538).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet Plan of Care moodCode (Act/Encounter/Procedure) 2.16.840.1.113883.11.20.9.23 STATIC 2011-09-30 (CONF:8539).
3. SHALL contain exactly one [1..1] templateId (CONF:8544) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.39" (CONF:10510).
4. SHALL contain at least one [1..\*] id (CONF:8546).
   1. Plan of Care Activity Encounter

[encounter: templateId 2.16.840.1.113883.10.20.22.4.40 (open)]

Table 131: Plan of Care Activity Encounter Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Plan of Care Section](#S_Plan_of_Care_Section) (optional) |  |

This is the template for the Plan of Care Activity Encounter.

1. SHALL contain exactly one [1..1] @classCode="ENC" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8564).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet Plan of Care moodCode (Act/Encounter/Procedure) 2.16.840.1.113883.11.20.9.23 STATIC 2011-09-30 (CONF:8565).
3. SHALL contain exactly one [1..1] templateId (CONF:8566) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.40" (CONF:10511).
4. SHALL contain at least one [1..\*] id (CONF:8567).
   1. Plan of Care Activity Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.44 (open)]

Table 132: Plan of Care Activity Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Plan of Care Section](#S_Plan_of_Care_Section) (optional) |  |

This is the template for the Plan of Care Activity Observation.

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8581).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet Plan of Care moodCode (Observation) 2.16.840.1.113883.11.20.9.25 STATIC 2011-09-30 (CONF:8582).
3. SHALL contain exactly one [1..1] templateId (CONF:8583) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.44" (CONF:10512).
4. SHALL contain at least one [1..\*] id (CONF:8584).
   1. Plan of Care Activity Procedure

[procedure: templateId 2.16.840.1.113883.10.20.22.4.41 (open)]

Table 133: Plan of Care Activity Procedure Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Plan of Care Section](#S_Plan_of_Care_Section) (optional)  [Planned Procedure Section](#S_Planned_Procedure_Section) (optional) |  |

This is the template for the Plan of Care Activity Procedure.

1. SHALL contain exactly one [1..1] @classCode="PROC" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8568).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet Plan of Care moodCode (Act/Encounter/Procedure) 2.16.840.1.113883.11.20.9.23 STATIC 2011-09-30 (CONF:8569).
3. SHALL contain exactly one [1..1] templateId (CONF:8570) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.41" (CONF:10513).
4. SHALL contain at least one [1..\*] id (CONF:8571).
   1. Plan of Care Activity Substance Administration

[substanceAdministration: templateId 2.16.840.1.113883.10.20.22.4.42 (open)]

Table 134: Plan of Care Activity Substance Administration Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Plan of Care Section](#S_Plan_of_Care_Section) (optional) |  |

This is the template for the Plan of Care Activity Substance Administration

1. SHALL contain exactly one [1..1] @classCode="SBADM" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8572).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet Plan of Care moodCode (SubstanceAdministration/Supply) 2.16.840.1.113883.11.20.9.24 STATIC 2011-09-30 (CONF:8573).
3. SHALL contain exactly one [1..1] templateId (CONF:8574) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.42" (CONF:10514).
4. SHALL contain at least one [1..\*] id (CONF:8575).
   1. Plan of Care Activity Supply

[supply: templateId 2.16.840.1.113883.10.20.22.4.43 (open)]

Table 135: Plan of Care Activity Supply Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Plan of Care Section](#S_Plan_of_Care_Section) (optional) |  |

This is the template for the Plan of Care Activity Supply.

1. SHALL contain exactly one [1..1] @classCode="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8577).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet Plan of Care moodCode (SubstanceAdministration/Supply) 2.16.840.1.113883.11.20.9.24 STATIC 2011-09-30 (CONF:8578).
3. SHALL contain exactly one [1..1] templateId (CONF:8579) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.43" (CONF:10515).
4. SHALL contain at least one [1..\*] id (CONF:8580).
   1. Policy Activity

[act: templateId 2.16.840.1.113883.10.20.22.4.61 (closed)]

Table 136: Policy Activity Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Coverage Activity](#E_Coverage_Activity) (required) |  |

A policy activity represents the policy or program providing the coverage. The person for whom payment is being provided (i.e., the patient) is the covered party. The subscriber of the policy or program is represented as a participant that is the holder the coverage. The payer is represented as the performer of the policy activity.

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8898).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8899).
3. SHALL contain exactly one [1..1] templateId (CONF:8900) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.61" (CONF:10516).

This id is a unique identifier for the policy or program providing the coverage

1. SHALL contain at least one [1..\*] id (CONF:8901).
2. SHALL contain exactly one [1..1] code (CONF:8903).
   1. This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Health Insurance Type Value Set 2.16.840.1.113883.3.88.12.3221.5.2 DYNAMIC (CONF:19185).
3. SHALL contain exactly one [1..1] statusCode (CONF:8902).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19109).

This performer represents the Payer.

1. SHALL contain exactly one [1..1] performer (CONF:8906) such that it
   1. SHALL contain exactly one [1..1] @typeCode="PRF" Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8907).
   2. SHALL contain exactly one [1..1] templateId (CONF:16808) such that it
      1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.87" Payer Performer (CONF:16809).
   3. SHALL contain exactly one [1..1] assignedEntity (CONF:8908).
      1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:8909).
      2. This assignedEntity SHOULD contain zero or one [0..1] code (CONF:8914).
         1. The code, if present, SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet HL7FinanciallyResponsiblePartyType 2.16.840.1.113883.1.11.10416 DYNAMIC (CONF:15992).
      3. This assignedEntity MAY contain zero or one [0..1] addr (CONF:8910).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10481).
      4. This assignedEntity MAY contain zero or one [0..1] telecom (CONF:8911).
      5. This assignedEntity SHOULD contain zero or one [0..1] representedOrganization (CONF:8912).
         1. The representedOrganization, if present, SHOULD contain zero or one [0..1] name (CONF:8913).

This performer represents the Guarantor.

1. SHOULD contain zero or one [0..1] performer="PRF" Performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8961) such that it
   1. SHALL contain exactly one [1..1] templateId (CONF:16810) such that it
      1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.88" Guarantor Performer (CONF:16811).
   2. SHOULD contain zero or one [0..1] time (CONF:8963).
   3. SHALL contain exactly one [1..1] assignedEntity (CONF:8962).
      1. This assignedEntity SHALL contain exactly one [1..1] code (CONF:8968).
         1. This code SHALL contain exactly one [1..1] @code="GUAR" Guarantor (CodeSystem: RoleCode 2.16.840.1.113883.5.111 STATIC) (CONF:16096).
      2. This assignedEntity SHOULD contain zero or one [0..1] addr (CONF:8964).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10482).
      3. This assignedEntity SHOULD contain zero or one [0..1] telecom (CONF:8965).
      4. SHOULD include assignedEntity/assignedPerson/name AND/OR assignedEntity/representedOrganization/name (CONF:8967).
2. SHALL contain exactly one [1..1] participant (CONF:8916) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COV" Coverage target (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8917).
   2. SHALL contain exactly one [1..1] templateId (CONF:16812) such that it
      1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.89" Covered Party Participant (CONF:16814).
   3. SHOULD contain zero or one [0..1] time (CONF:8918).
      1. The time, if present, SHOULD contain zero or one [0..1] low (CONF:8919).
      2. The time, if present, SHOULD contain zero or one [0..1] high (CONF:8920).
   4. SHALL contain exactly one [1..1] participantRole (CONF:8921).
      1. This participantRole SHALL contain at least one [1..\*] id (CONF:8922).
         1. This id is a unique identifier for the covered party member. Implementers SHOULD use the same GUID for each instance of a member identifier from the same health plan (CONF:8984).
      2. This participantRole SHALL contain exactly one [1..1] code (CONF:8923).
         1. This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Coverage Role Type Value Set 2.16.840.1.113883.1.11.18877 DYNAMIC (CONF:16078).
      3. This participantRole SHOULD contain zero or one [0..1] addr (CONF:8956).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10484).
      4. This participantRole SHOULD contain zero or one [0..1] playingEntity (CONF:8932).

If the covered party’s name is recorded differently in the health plan and in the registration/medication summary (due to marriage or for other reasons), use the name as it is recorded in the health plan.

* + - 1. The playingEntity, if present, SHALL contain exactly one [1..1] name (CONF:8930).
      2. If the member date of birth as recorded by the health plan differs from the patient date of birth as recorded in the registration/medication summary, then the member date of birth SHALL be recorded in sdtc:birthTime. The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the birthTime element (CONF:8933).

1. SHOULD contain zero or one [0..1] participant (CONF:8934) such that it
   1. SHALL contain exactly one [1..1] @typeCode="HLD" Holder (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8935).
   2. SHALL contain exactly one [1..1] templateId (CONF:16813) such that it
      1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.90" Policy Holder Participant (CONF:16815).
   3. MAY contain zero or one [0..1] time (CONF:8938).
   4. SHALL contain exactly one [1..1] participantRole (CONF:8936).
      1. This participantRole SHALL contain at least one [1..\*] id (CONF:8937).
         1. This id is a unique identifier for the subscriber of the coverage (CONF:10120).
      2. This participantRole SHOULD contain zero or one [0..1] addr (CONF:8925).
         1. The content of addr SHALL be a conformant US Realm Address (AD.US.FIELDED) (2.16.840.1.113883.10.20.22.5.2) (CONF:10483).
   5. When the Subscriber is the patient, the participant element describing the subscriber SHALL NOT be present. This information will be recorded instead in the data elements used to record member information (CONF:17139).
2. SHALL contain at least one [1..\*] entryRelationship (CONF:8939) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8940).
   2. The target of a policy activity with act/entryRelationship/@typeCode="REFR" SHALL be an authorization activity (templateId 2.16.840.1.113883.10.20.1.19) OR an act, with act[@classCode="ACT"] and act[@moodCode="DEF"], representing a description of the coverage plan (CONF:8942).
   3. A description of the coverage plan SHALL contain one or more act/id, to represent the plan identifier, and an act/text with the name of the plan (CONF:8943).
   4. Postprocedure Diagnosis

[act: templateId 2.16.840.1.113883.10.20.22.4.51 (open)]

Table 137: Postprocedure Diagnosis Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Postprocedure Diagnosis Section](#S_Postprocedure_Diagnosis_Section) (optional) | [Problem Observation](#E_Problem_Observation) |

The Postprocedure Diagnosis entry encodes the diagnosis or diagnoses discovered or confirmed during the procedure. Often it is the same as the pre-procedure diagnosis or indication.

1. SHALL contain exactly one [1..1] @classCode="ACT" (CONF:8756).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CONF:8757).
3. SHALL contain exactly one [1..1] templateId (CONF:16766) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.51" (CONF:16767).
4. SHALL contain exactly one [1..1] code (CONF:19151).
   1. This code SHALL contain exactly one [1..1] @code="59769-0" Postprocedure diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19152).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:8759).
   1. Such entryRelationships SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8760).
   2. Such entryRelationships SHALL contain exactly one [1..1] [Problem Observation](#E_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15583).
   3. Precondition for Substance Administration

[criterion: templateId 2.16.840.1.113883.10.20.22.4.25 (open)]

Table 138: Precondition for Substance Administration Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Medication Activity](#E_Medication_Activity) (optional)  [Immunization Activity](#E_Immunization_Activity) (optional) |  |

A criterion for administration can be used to record that the medication is to be administered only when the associated criteria are met.

1. SHALL contain exactly one [1..1] templateId (CONF:7372) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.25" (CONF:10517).
2. SHOULD contain zero or one [0..1] code (CONF:16854).
3. MAY contain zero or one [0..1] text (CONF:7373).
4. SHOULD contain zero or one [0..1] value with @xsi:type="CD" (CONF:7369).
   1. Pregnancy Observation

[observation: templateId 2.16.840.1.113883.10.20.15.3.8 (open)]

Table 139: Pregnancy Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Social History Section](#S_Social_History_Section) (optional) | [Estimated Date of Delivery](#E_Estimated_Date_of_Delivery) |

This clinical statement represents current and/or prior pregnancy dates enabling investigators to determine if the subject of the case report was pregnant during the course of a condition.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:451).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:452).
3. SHALL contain exactly one [1..1] templateId (CONF:16768) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.15.3.8" (CONF:16868).
4. SHALL contain exactly one [1..1] code (CONF:19153).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19154).
5. SHALL contain exactly one [1..1] statusCode (CONF:455).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19110).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:2018).
7. SHALL contain exactly one [1..1] value="77386006" Pregnant with @xsi:type="CD" (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:457).
8. MAY contain zero or one [0..1] entryRelationship (CONF:458) such that it
   1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:459).
   2. SHALL contain exactly one [1..1] [Estimated Date of Delivery](#E_Estimated_Date_of_Delivery) (templateId:2.16.840.1.113883.10.20.15.3.1) (CONF:15584).
   3. Preoperative Diagnosis

[act: templateId 2.16.840.1.113883.10.20.22.4.65 (open)]

Table 140: Preoperative Diagnosis Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Preoperative Diagnosis Section](#S_Preoperative_Diagnosis_Section) (optional) | [Problem Observation](#E_Problem_Observation) |

The Preoperative Diagnosis entry encodes the surgical diagnosis or diagnoses assigned to the patient before the surgical procedure and is the reason for the surgery. The preoperative diagnosis is, in the opinion of the surgeon, the diagnosis that will be confirmed during surgery.

1. SHALL contain exactly one [1..1] @classCode="ACT" (CONF:10090).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CONF:10091).
3. SHALL contain exactly one [1..1] templateId (CONF:16770) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.65" (CONF:16771).
4. SHALL contain exactly one [1..1] code (CONF:19155).
   1. This code SHALL contain exactly one [1..1] @code="10219-4" Preoperative Diagnosis (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19156).
5. SHALL contain at least one [1..\*] entryRelationship (CONF:10093).
   1. Such entryRelationships SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:10094).
   2. Such entryRelationships SHALL contain exactly one [1..1] [Problem Observation](#E_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15605).
   3. Pressure Ulcer Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.70 (open)]

Table 141: Pressure Ulcer Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Physical Exam Section](#S_Physical_Exam_Section) (optional)  [Functional Status Section](#S_Functional_Status_Section) (optional) |  |

The pressure ulcer observation contains details about the pressure ulcer such as the stage of the ulcer, location, and dimensions. If the pressure ulcer is a diagnosis, you may find this on the problem list. An example of how this would appear is in the Problem Section.

1. SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14383).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14384).

Use negationInd="true" to indicate that the problem was not observed.

1. MAY contain zero or one [0..1] @negationInd (CONF:14385).
2. SHALL contain exactly one [1..1] templateId (CONF:14387) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.70" (CONF:14388).
3. SHALL contain at least one [1..\*] id (CONF:14389).
4. SHALL contain exactly one [1..1] code (CONF:14759).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:14760).
5. SHOULD contain zero or one [0..1] text (CONF:14391).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:14392).
      1. The reference, if present, SHALL contain exactly one [1..1] @value (CONF:15585).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15586).
6. SHALL contain exactly one [1..1] statusCode (CONF:14394).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19111).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:14395).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the @code SHOULD be selected from ValueSet Pressure Ulcer Stage 2.16.840.1.113883.11.20.9.35 STATIC (CONF:14396).
   1. This value MAY contain zero or one [0..1] @nullFlavor (CONF:14397).
      1. If the stage unknown or the SNOMED code is unknown, @nullFlavor SHOULD be “UNK”. If the code is something other than SNOMED, @nullFlavor SHOULD be “OTH” and the other code SHOULD be placed in the translation element (CONF:14398).
9. SHOULD contain zero or more [0..\*] targetSiteCode (CONF:14797).
   1. The targetSiteCode, if present, SHALL contain exactly one [1..1] @code, which SHOULD be selected from ValueSet Pressure Point 2.16.840.1.113883.11.20.9.36 STATIC (CONF:14798).
   2. The targetSiteCode, if present, SHOULD contain zero or one [0..1] qualifier (CONF:14799).
      1. The qualifier, if present, SHALL contain exactly one [1..1] name (CONF:14800).
         1. This name SHOULD contain zero or one [0..1] @code="272741003" laterality (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:14801).
      2. The qualifier, if present, SHALL contain exactly one [1..1] value (CONF:14802).
         1. This value SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet TargetSite Qualifiers 2.16.840.1.113883.11.20.9.37 STATIC (CONF:14803).
10. SHOULD contain zero or one [0..1] entryRelationship (CONF:14410) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:14411).
    2. SHALL contain exactly one [1..1] observation (CONF:14619).
       1. This observation SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14685).
       2. This observation SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14686).
       3. This observation SHALL contain exactly one [1..1] code (CONF:14620).
          1. This code SHALL contain exactly one [1..1] @code="401238003" Length of Wound (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:14621).
       4. This observation SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:14622).
11. SHOULD contain zero or one [0..1] entryRelationship (CONF:14601) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" (CONF:14602).
    2. SHALL contain exactly one [1..1] observation (CONF:14623).
       1. This observation SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14687).
       2. This observation SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14688).
       3. This observation SHALL contain exactly one [1..1] code (CONF:14624).
          1. This code SHALL contain exactly one [1..1] @code="401239006" Width of Wound (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:14625).
       4. This observation SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:14626).
12. SHOULD contain zero or one [0..1] entryRelationship (CONF:14605) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" (CONF:14606).
    2. SHALL contain exactly one [1..1] observation (CONF:14627).
       1. This observation SHALL contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14689).
       2. This observation SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14690).
       3. This observation SHALL contain exactly one [1..1] code (CONF:14628).
          1. This code SHALL contain exactly one [1..1] @code="425094009" Depth of Wound (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:14629).
       4. This observation SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:14630).
    3. Problem Concern Act (Condition)

[act: templateId 2.16.840.1.113883.10.20.22.4.3 (open)]

Table 142: Problem Concern Act (Condition) Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Problem Section (entries required)](#S_Problem_Section_entries_required) (required)  [Problem Section (entries optional)](#S_Problem_Section_entries_optional) (optional) | [Problem Observation](#E_Problem_Observation) |

Observations of problems or other clinical statements captured at a point in time are wrapped in a ""Concern"" act, which represents the ongoing process tracked over time. This allows for binding related observations of problems. For example, the observation of ""Acute MI"" in 2004 can be related to the observation of ""History of MI"" in 2006 because they are the same concern. The conformance statements in this section define an outer ""problem act"" (representing the ""Concern"") that can contain a nested ""problem observation"" or other nested clinical statements.

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9024).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9025).
3. SHALL contain exactly one [1..1] templateId (CONF:16772) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.3" (CONF:16773).
4. SHALL contain at least one [1..\*] id (CONF:9026).
5. SHALL contain exactly one [1..1] code (CONF:9027).
   1. This code SHALL contain exactly one [1..1] @code="CONC" Concern (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:19184).
6. SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet ProblemAct statusCode 2.16.840.1.113883.11.20.9.19 STATIC 2011-09-09 (CONF:9029).

The effectiveTime element records the starting and ending times during which the concern was active on the Problem List.

1. SHALL contain exactly one [1..1] effectiveTime (CONF:9030).
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:9032).
   2. This effectiveTime SHOULD contain zero or one [0..1] high (CONF:9033).
2. SHALL contain at least one [1..\*] entryRelationship (CONF:9034) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9035).
   2. SHALL contain exactly one [1..1] [Problem Observation](#E_Problem_Observation) (templateId:2.16.840.1.113883.10.20.22.4.4) (CONF:15980).
   3. Problem Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.4 (open)]

Table 143: Problem Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Problem Concern Act (Condition)](#E_Problem_Concern_Act_Condition) (required)  [Hospital Discharge Diagnosis](#E_Hospital_Discharge_Diagnosis) (required)  [Hospital Admission Diagnosis](#E_Hospital_Admission_Diagnosis) (required)  [History of Past Illness Section](#S_History_of_Past_Illness_Section) (optional)  [Complications (OpNote)](#S_Complications_(OpNote)) (optional)  [Procedure Findings Section](#S_Procedure_Findings_Section) (optional)  [Complications Section](#S_Complications_Section) (optional)  [Postprocedure Diagnosis](#E_Postprocedure_Diagnosis) (required)  [Preoperative Diagnosis](#E_Preoperative_Diagnosis) (required)  [Deceased Observation](#E_Deceased_Observation) (optional)  [Encounter Diagnosis](#E_Encounter_Diagnosis) (required) | [Age Observation](#E_Age_Observation)  [Health Status Observation](#E_Health_Status_Observation)  [Problem Status](#E_Problem_Status) |

A problem is a clinical statement that a clinician has noted. In health care it is a condition that requires monitoring or diagnostic, therapeutic, or educational action. It also refers to any unmet or partially met basic human need.

A Problem Observation is required to be wrapped in an act wrapper in locations such as the Problem Section, Allergies Section, and Hospital Discharge Diagnosis Section, where the type of problem needs to be identified or the condition tracked.

A Problem Observation can be a valid ""standalone"" template instance in cases where a simple problem observation is to be sent.

The negationInd attribute, if true, specifies that the problem indicated was observed to not have occurred (which is subtly but importantly different from having not been observed). NegationInd='true' is an acceptable way to make a clinical assertion that something did not occur, for example, 'no diabetes'.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9041).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9042).
3. MAY contain zero or one [0..1] @negationInd (CONF:10139).
   1. Use negationInd="true" to indicate that the problem was not observed (CONF:16880).
4. SHALL contain exactly one [1..1] templateId (CONF:14926) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.4" (CONF:14927).
5. SHALL contain at least one [1..\*] id (CONF:9043).
6. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet Problem Type 2.16.840.1.113883.3.88.12.3221.7.2 STATIC 2012-06-01 (CONF:9045).
7. SHOULD contain zero or one [0..1] text (CONF:9185).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15587).
      1. The reference, if present, SHALL contain exactly one [1..1] @value (CONF:15588).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15589).
8. SHALL contain exactly one [1..1] statusCode (CONF:9049).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19112).
9. SHOULD contain zero or one [0..1] effectiveTime (CONF:9050).
   1. The effectiveTime, if present, SHALL contain exactly one [1..1] low (CONF:15603).
      1. This field represents the onset date (CONF:16882).
   2. The effectiveTime, if present, SHOULD contain zero or one [0..1] high (CONF:15604).
      1. This field represents the resolution date (CONF:16883).
   3. If the problem is known to be resolved, but the date of resolution is not known, then the high element SHALL be present, and the nullFlavor attribute SHALL be set to 'UNK'. Therefore, the existence of an high element within a problem does indicate that the problem has been resolved (CONF:16881).
10. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the @code SHOULD be selected from ValueSet Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:9058).
    1. This value MAY contain zero or more [0..\*] translation (CONF:16749).
       1. The translation, if present, MAY contain zero or one [0..1] @code (CodeSystem: ICD10CM 2.16.840.1.113883.6.90 STATIC) (CONF:16750).
    2. This value MAY contain zero or one [0..1] @nullFlavor (CONF:10141).
       1. If the diagnosis is unknown or the SNOMED code is unknown, @nullFlavor SHOULD be “UNK”. If the code is something other than SNOMED, @nullFlavor SHOULD be “OTH” and the other code SHOULD be placed in the translation element (CONF:10142).
11. MAY contain zero or one [0..1] entryRelationship (CONF:9059) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9060).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:9069).
    3. SHALL contain exactly one [1..1] [Age Observation](#E_Age_Observation) (templateId:2.16.840.1.113883.10.20.22.4.31) (CONF:15590).
12. MAY contain zero or one [0..1] entryRelationship (CONF:9063) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9068).
    2. SHALL contain exactly one [1..1] [Problem Status](#E_Problem_Status) (templateId:2.16.840.1.113883.10.20.22.4.6) (CONF:15591).
13. MAY contain zero or one [0..1] entryRelationship (CONF:9067) such that it
    1. SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9064).
    2. SHALL contain exactly one [1..1] [Health Status Observation](#E_Health_Status_Observation) (templateId:2.16.840.1.113883.10.20.22.4.5) (CONF:15592).
    3. Problem Status

[observation: templateId 2.16.840.1.113883.10.20.22.4.6 (open)]

Table 144: Problem Status Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Problem Observation](#E_Problem_Observation) (optional) |  |

The Problem Status records whether the indicated problem is active, inactive, or resolved.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7357).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7358).
3. SHALL contain exactly one [1..1] templateId (CONF:7359) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.6" (CONF:10518).
4. SHALL contain exactly one [1..1] code (CONF:19162).
   1. This code SHALL contain exactly one [1..1] @code="33999-4" Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:19163).
5. SHOULD contain zero or one [0..1] text (CONF:7362).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15593).
      1. The reference, if present, SHALL contain exactly one [1..1] @value (CONF:15594).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15595).
6. SHALL contain exactly one [1..1] statusCode (CONF:7364).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19113).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the @code SHALL be selected from ValueSet Problem Status Value Set 2.16.840.1.113883.3.88.12.80.68 DYNAMIC (CONF:7365).
   1. Procedure Activity Act

[act: templateId 2.16.840.1.113883.10.20.22.4.12 (open)]

Table 145: Procedure Activity Act Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Procedures Section (entries required)](#S_Procedures_Section_entries_required) (optional)  [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional) (optional) | [Indication](#E_Indication)  [Instructions](#E_Instructions)  [Medication Activity](#E_Medication_Activity)  [Service Delivery Location](#E_Service_Delivery_Location) |

The common notion of ""procedure"" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g., splenectomy).

This clinical statement represents any procedure that cannot be classified as an observation or a procedure according to the HL7 RIM. Examples of these procedures are a dressing change, teaching or feeding a patient or providing comfort measures.

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8289).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03 (CONF:8290).
3. SHALL contain exactly one [1..1] templateId (CONF:8291) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.12" (CONF:10519).
4. SHALL contain at least one [1..\*] id (CONF:8292).
5. SHALL contain exactly one [1..1] code (CONF:8293).
   1. This code SHOULD contain zero or one [0..1] originalText (CONF:19186).
      1. The originalText, if present, MAY contain zero or one [0..1] reference (CONF:19187).
         1. The reference, if present, MAY contain zero or one [0..1] @value (CONF:19188).
            1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:19189).
   2. This code in a procedure activity act SHOULD be selected from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:19190).
6. SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22 DYNAMIC (CONF:8298).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:8299).
8. MAY contain zero or one [0..1] priorityCode, which SHALL be selected from ValueSet Act Priority Value Set 2.16.840.1.113883.1.11.16866 DYNAMIC (CONF:8300).
9. SHOULD contain zero or more [0..\*] performer (CONF:8301).
   1. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:8302).
      1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:8303).
      2. This assignedEntity SHALL contain exactly one [1..1] addr (CONF:8304).
      3. This assignedEntity SHALL contain exactly one [1..1] telecom (CONF:8305).
      4. This assignedEntity SHOULD contain zero or one [0..1] representedOrganization (CONF:8306).
         1. The representedOrganization, if present, SHOULD contain zero or more [0..\*] id (CONF:8307).
         2. The representedOrganization, if present, MAY contain zero or more [0..\*] name (CONF:8308).
         3. The representedOrganization, if present, SHALL contain exactly one [1..1] telecom (CONF:8310).
         4. The representedOrganization, if present, SHALL contain exactly one [1..1] addr (CONF:8309).
10. MAY contain zero or more [0..\*] participant (CONF:8311).
    1. The participant, if present, SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8312).
    2. The participant, if present, SHALL contain exactly one [1..1] [Service Delivery Location](#E_Service_Delivery_Location) (templateId:2.16.840.1.113883.10.20.22.4.32) (CONF:15599).
11. MAY contain zero or more [0..\*] entryRelationship (CONF:8314).
    1. The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8315).
    2. The entryRelationship, if present, SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8316).
    3. The entryRelationship, if present, SHALL contain exactly one [1..1] encounter (CONF:8317).
       1. This encounter SHALL contain exactly one [1..1] @classCode="ENC" Encounter (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8318).
       2. This encounter SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8319).
       3. This encounter SHALL contain exactly one [1..1] id (CONF:8320).
          1. Set the encounter ID to the ID of an encounter in another section to signify they are the same encounter (CONF:16849).
12. MAY contain zero or one [0..1] entryRelationship (CONF:8322).
    1. The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8323).
    2. The entryRelationship, if present, SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8324).
    3. The entryRelationship, if present, SHALL contain exactly one [1..1] [Instructions](#E_Instructions) (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:15600).
13. MAY contain zero or more [0..\*] entryRelationship (CONF:8326).
    1. The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8327).
    2. The entryRelationship, if present, SHALL contain exactly one [1..1] [Indication](#E_Indication) (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:15601).
14. MAY contain zero or more [0..\*] entryRelationship (CONF:8329).
    1. The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8330).
    2. The entryRelationship, if present, SHALL contain exactly one [1..1] [Medication Activity](#E_Medication_Activity) (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15602).
    3. Procedure Activity Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.13 (open)]

Table 146: Procedure Activity Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Procedures Section (entries required)](#S_Procedures_Section_entries_required) (optional)  [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional) (optional) | [Indication](#E_Indication)  [Instructions](#E_Instructions)  [Medication Activity](#E_Medication_Activity)  [Service Delivery Location](#E_Service_Delivery_Location) |

The common notion of ""procedure"" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g. splenectomy).

This clinical statement represents procedures that result in new information about the patient that cannot be classified as a procedure according to the HL7 RIM. Examples of these procedures are diagnostic imaging procedures, EEGs and EKGs.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8282).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03 (CONF:8237).
3. SHALL contain exactly one [1..1] templateId (CONF:8238) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.13" (CONF:10520).
4. SHALL contain at least one [1..\*] id (CONF:8239).
5. SHALL contain exactly one [1..1] code (CONF:19197).
   1. This code SHOULD contain zero or one [0..1] originalText (CONF:19198).
      1. The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:19199).
         1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:19200).
            1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:19201).
   2. This @code SHOULD be selected from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96), and MAY be selected from CPT-4 (CodeSystem: 2.16.840.1.113883.6.12), ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) (CONF:19202).
6. SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22 DYNAMIC (CONF:8245).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:8246).
8. MAY contain zero or one [0..1] priorityCode, which SHALL be selected from ValueSet Act Priority Value Set 2.16.840.1.113883.1.11.16866 DYNAMIC (CONF:8247).
9. SHALL contain exactly one [1..1] value (CONF:16846).
10. MAY contain zero or one [0..1] methodCode (CONF:8248).
    1. MethodCode SHALL NOT conflict with the method inherent in Observation / code (CONF:8249).
11. SHOULD contain zero or more [0..\*] targetSiteCode (CONF:8250).
    1. The targetSiteCode, if present, SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Body Site Value Set 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:16071).
12. SHOULD contain zero or more [0..\*] performer (CONF:8251).
    1. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:8252).
       1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:8253).
       2. This assignedEntity SHALL contain exactly one [1..1] addr (CONF:8254).
       3. This assignedEntity SHALL contain exactly one [1..1] telecom (CONF:8255).
       4. This assignedEntity SHOULD contain zero or one [0..1] representedOrganization (CONF:8256).
          1. The representedOrganization, if present, SHOULD contain zero or more [0..\*] id (CONF:8257).
          2. The representedOrganization, if present, MAY contain zero or more [0..\*] name (CONF:8258).
          3. The representedOrganization, if present, SHALL contain exactly one [1..1] telecom (CONF:8260).
          4. The representedOrganization, if present, SHALL contain exactly one [1..1] addr (CONF:8259).
13. MAY contain zero or more [0..\*] participant (CONF:8261).
    1. The participant, if present, SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8262).
    2. The participant, if present, SHALL contain exactly one [1..1] [Service Delivery Location](#E_Service_Delivery_Location) (templateId:2.16.840.1.113883.10.20.22.4.32) (CONF:15904).
14. MAY contain zero or more [0..\*] entryRelationship (CONF:8264).
    1. The entryRelationship, if present, SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8265).
    2. The entryRelationship, if present, SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8266).
    3. The entryRelationship, if present, SHALL contain exactly one [1..1] encounter (CONF:8267).
       1. This encounter SHALL contain exactly one [1..1] @classCode="ENC" Encounter (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8268).
       2. This encounter SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8269).
       3. This encounter SHALL contain exactly one [1..1] id (CONF:8270).
          1. Set encounter/id to the id of an encounter in another section to signify they are the same encounter (CONF:16847).
15. MAY contain zero or one [0..1] entryRelationship (CONF:8272) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8273).
    2. SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8274).
    3. SHALL contain exactly one [1..1] [Instructions](#E_Instructions) (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:15905).
16. MAY contain zero or more [0..\*] entryRelationship (CONF:8276) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8277).
    2. SHALL contain exactly one [1..1] [Indication](#E_Indication) (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:15906).
17. MAY contain zero or more [0..\*] entryRelationship (CONF:8279) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:8280).
    2. SHALL contain exactly one [1..1] [Medication Activity](#E_Medication_Activity) (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15907).
    3. Procedure Activity Procedure

[procedure: templateId 2.16.840.1.113883.10.20.22.4.14 (open)]

Table 147: Procedure Activity Procedure Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Procedures Section (entries required)](#S_Procedures_Section_entries_required) (optional)  [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional) (optional)  [Reaction Observation](#E_Reaction_Observation) (optional)  [Anesthesia Section](#S_Anesthesia_Section) (optional) | [Indication](#E_Indication)  [Instructions](#E_Instructions)  [Medication Activity](#E_Medication_Activity)  [Product Instance](#E_Product_Instance)  [Service Delivery Location](#E_Service_Delivery_Location) |

The common notion of ""procedure"" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore procedure templates can be represented with various RIM classes: act (e.g., dressing change), observation (e.g., EEG), procedure (e.g. splenectomy).

This clinical statement represents procedures whose immediate and primary outcome (post-condition) is the alteration of the physical condition of the patient. Examples of these procedures are an appendectomy, hip replacement and a creation of a gastrostomy.

1. SHALL contain exactly one [1..1] @classCode="PROC" Procedure (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7652).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt 2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03 (CONF:7653).
3. SHALL contain exactly one [1..1] templateId (CONF:7654) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.14" (CONF:10521).
4. SHALL contain at least one [1..\*] id (CONF:7655).
5. SHALL contain exactly one [1..1] code (CONF:7656).
   1. This code SHOULD contain zero or one [0..1] originalText (CONF:19203).
      1. The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:19204).
         1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:19205).
            1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:19206).
   2. This code in a procedure activity SHOULD be selected from LOINC (codeSystem 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96), and MAY be selected from CPT-4 (CodeSystem: 2.16.840.1.113883.6.12) or ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) (CONF:19207).
6. SHALL contain exactly one [1..1] statusCode, which SHALL be selected from ValueSet ProcedureAct statusCode 2.16.840.1.113883.11.20.9.22 DYNAMIC (CONF:7661).
7. SHOULD contain zero or one [0..1] effectiveTime (CONF:7662).
8. MAY contain zero or one [0..1] priorityCode, which SHALL be selected from ValueSet Act Priority Value Set 2.16.840.1.113883.1.11.16866 DYNAMIC (CONF:7668).
9. MAY contain zero or one [0..1] methodCode (CONF:7670).
   1. MethodCode SHALL NOT conflict with the method inherent in Procedure / code (CONF:7890).
10. SHOULD contain zero or more [0..\*] targetSiteCode (CONF:7683).
    1. The targetSiteCode, if present, SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Body Site Value Set 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:16082).
11. MAY contain zero or more [0..\*] specimen (CONF:7697).
    1. The specimen, if present, SHALL contain exactly one [1..1] specimenRole (CONF:7704).
       1. This specimenRole SHOULD contain zero or more [0..\*] id (CONF:7716).
          1. If you want to indicate that the Procedure and the Results are referring to the same specimen, the Procedure/specimen/specimenRole/id SHOULD be set to equal an Organizer/specimen/ specimenRole/id (CONF:7717).
    2. This specimen is for representing specimens obtained from a procedure (CONF:16842).
12. SHOULD contain zero or more [0..\*] performer (CONF:7718) such that it
    1. SHALL contain exactly one [1..1] assignedEntity (CONF:7720).
       1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:7722).
       2. This assignedEntity SHALL contain exactly one [1..1] addr (CONF:7731).
       3. This assignedEntity SHALL contain exactly one [1..1] telecom (CONF:7732).
       4. This assignedEntity SHOULD contain zero or one [0..1] representedOrganization (CONF:7733).
          1. The representedOrganization, if present, SHOULD contain zero or more [0..\*] id (CONF:7734).
          2. The representedOrganization, if present, MAY contain zero or more [0..\*] name (CONF:7735).
          3. The representedOrganization, if present, SHALL contain exactly one [1..1] telecom (CONF:7737).
          4. The representedOrganization, if present, SHALL contain exactly one [1..1] addr (CONF:7736).
13. MAY contain zero or more [0..\*] participant (CONF:7751) such that it
    1. SHALL contain exactly one [1..1] @typeCode="DEV" Device (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7752).
    2. SHALL contain exactly one [1..1] [Product Instance](#E_Product_Instance) (templateId:2.16.840.1.113883.10.20.22.4.37) (CONF:15911).
14. MAY contain zero or more [0..\*] participant (CONF:7765) such that it
    1. SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:7766).
    2. SHALL contain exactly one [1..1] [Service Delivery Location](#E_Service_Delivery_Location) (templateId:2.16.840.1.113883.10.20.22.4.32) (CONF:15912).
15. MAY contain zero or more [0..\*] entryRelationship (CONF:7768) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7769).
    2. SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:8009).
    3. SHALL contain exactly one [1..1] encounter (CONF:7770).
       1. This encounter SHALL contain exactly one [1..1] @classCode="ENC" Encounter (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7771).
       2. This encounter SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7772).
       3. This encounter SHALL contain exactly one [1..1] id (CONF:7773).
          1. Set the encounter ID to the ID of an encounter in another section to signify they are the same encounter (CONF:16843).
16. MAY contain zero or one [0..1] entryRelationship (CONF:7775) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7776).
    2. SHALL contain exactly one [1..1] @inversionInd="true" true (CONF:7777).
    3. SHALL contain exactly one [1..1] [Instructions](#E_Instructions) (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:15913).
17. MAY contain zero or more [0..\*] entryRelationship (CONF:7779) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7780).
    2. SHALL contain exactly one [1..1] [Indication](#E_Indication) (templateId:2.16.840.1.113883.10.20.22.4.19) (CONF:15914).
18. MAY contain zero or more [0..\*] entryRelationship (CONF:7886) such that it
    1. SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7887).
    2. SHALL contain exactly one [1..1] [Medication Activity](#E_Medication_Activity) (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15915).
    3. Procedure Context

[act: templateId 2.16.840.1.113883.10.20.6.2.5 (open)]

Table 148: Procedure Context Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Diagnostic Imaging Report](#D_Diagnostic_Imaging_Report) (optional) |  |

The ServiceEvent Procedure Context of the document header may be overridden in the CDA structured body if there is a need to refer to multiple imaging procedures or acts. The selection of the Procedure or Act entry from the clinical statement choice box depends on the nature of the imaging service that has been performed. The Procedure entry shall be used for image-guided interventions and minimal invasive imaging services, whereas the Act entry shall be used for diagnostic imaging services.

1. SHALL contain exactly one [1..1] templateId (CONF:9200) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.5" (CONF:10530).
2. SHALL contain exactly one [1..1] code (CONF:9201).
3. SHOULD contain zero or one [0..1] effectiveTime (CONF:9203).
   1. The effectiveTime, if present, SHALL contain exactly one [1..1] @value (CONF:17173).
4. Procedure Context SHALL be represented with the procedure or act elements depending on the nature of the procedure (CONF:9199).
   1. Product Instance

[participantRole: templateId 2.16.840.1.113883.10.20.22.4.37 (open)]

Table 149: Product Instance Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) (optional)  [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) (optional) |  |

This clinical statement represents a particular device that was placed in or used as part of a procedure or other act. This provides a record of the identifier and other details about the given product that was used. For example, it is important to have a record that indicates not just that a hip prostheses was placed in a patient but that it was a particular hip prostheses number with a unique identifier.

The FDA Amendments Act specifies the creation of a Unique Device Identification (UDI) System that requires the label of devices to bear a unique identifier that will standardize device identification and identify the device through distribution and use.

The UDI should be sent in the participantRole/id.

1. SHALL contain exactly one [1..1] @classCode="MANU" Manufactured Product (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:7900).
2. SHALL contain exactly one [1..1] templateId (CONF:7901) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.37" (CONF:10522).
3. SHALL contain at least one [1..\*] id (CONF:7902).
4. SHALL contain exactly one [1..1] playingDevice (CONF:7903).
   1. This playingDevice SHOULD contain zero or one [0..1] code (CONF:16837).
5. SHALL contain exactly one [1..1] scopingEntity (CONF:7905).
   1. This scopingEntity SHALL contain at least one [1..\*] id (CONF:7908).
   2. Purpose of Reference Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.9 (open)]

Table 150: Purpose of Reference Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [SOP Instance Observation](#E_SOP_Instance_Observation) (optional) |  |

A Purpose of Reference Observation describes the purpose of the DICOM composite object reference. Appropriate codes, such as externally defined DICOM codes, may be used to specify the semantics of the purpose of reference. When this observation is absent, it implies that the reason for the reference is unknown.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9264).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9265).
3. SHALL contain exactly one [1..1] templateId (CONF:9266) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.9" (CONF:10531).
4. SHALL contain exactly one [1..1] code (CONF:9267).
   1. This code SHOULD contain zero or one [0..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19208).
   2. For backwards compatibility with the DICOM CMET, the code MAY be drawn from ValueSet 2.16.840.1.113883.11.20.9.28 DICOMPurposeOfReference DYNAMIC (CONF:19209).

The value element is a SHOULD to allow backwards compatibility with the DICOM CMET. Note that the use of ASSERTION for the code differs from the DICOM CMET. This is intentional. The DICOM CMET was created before the Term Info guidelines describing the use of the assertion pattern were released. It was determined that this IG should follow the latest Term Info guidelines. Implementers using both this IG and the DICOM CMET should be aware of this difference and apply appropriate transformations.

1. SHOULD contain zero or one [0..1] value with @xsi:type="CD", where the @code SHOULD be selected from ValueSet DICOMPurposeOfReference 2.16.840.1.113883.11.20.9.28 DYNAMIC (CONF:9273).
   1. Quantity Measurement Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.14 (open)]

Table 151: Quantity Measurement Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Text Observation](#E_Text_Observation) (optional)  [Code Observations](#E_Code_Observations) (optional) | [SOP Instance Observation](#E_SOP_Instance_Observation) |

A Quantity Measurement Observation records quantity measurements based on image data such as linear, area, volume, and numeric measurements. The codes in DIRQuantityMeasurementTypeCodes (ValueSet: 2.16.840.1.113883.11.20.9.29) are from the qualifier hierarchy of SNOMED CT and are not valid for observation/code according to the Term Info guidelines. These codes can be used for backwards compatibility, but going forward, codes from the observable entity hierarchy will be requested and used.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9317).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9318).
3. SHALL contain exactly one [1..1] templateId (CONF:9319) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.14" (CONF:10532).

The value set of the observation/code includes numeric measurement types for linear dimensions, areas, volumes, and other numeric measurements. This value set is extensible and comprises the union of SNOMED codes for observable entities as reproduced in DIRQuantityMeasurementTypeCodes (ValueSet: 2.16.840.1.113883.11.20.9.29) and DICOM Codes in DICOMQuantityMeasurementTypeCodes (ValueSet: 2.16.840.1.113883.11.20.9.30).

1. SHALL contain exactly one [1..1] code (CONF:9320).
   1. This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet DIRQuantityMeasurementTypeCodes 2.16.840.1.113883.11.20.9.29 DYNAMIC (CONF:19210).
2. SHOULD contain zero or one [0..1] effectiveTime (CONF:9326).
3. SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:9324).
4. MAY contain zero or more [0..\*] entryRelationship (CONF:9327) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9328).
   2. SHALL contain exactly one [1..1] [SOP Instance Observation](#E_SOP_Instance_Observation) (templateId:2.16.840.1.113883.10.20.6.2.8) (CONF:15916).
   3. Reaction Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.9 (open)]

Table 152: Reaction Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Medication Activity](#E_Medication_Activity) (optional)  [Allergy - Intolerance Observation](#E_Allergy__Intolerance_Observation) (optional)  [Immunization Activity](#E_Immunization_Activity) (optional)  [Substance or Device Allergy - Intolerance Observation](#E_Substance_or_Device_Allergy__Intolera) (optional) | [Medication Activity](#E_Medication_Activity)  [Procedure Activity Procedure](#E_Procedure_Activity_Procedure)  [Severity Observation](#E_Severity_Observation) |

This clinical statement represents an undesired symptom, finding, etc., due to an administered or exposed substance. A reaction can be defined with respect to its severity, and can have been treated by one or more interventions.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7325).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7326).
3. SHALL contain exactly one [1..1] templateId (CONF:7323) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.9" (CONF:10523).
4. SHALL contain exactly one [1..1] id (CONF:7329).
5. SHALL contain exactly one [1..1] code (CONF:16851).
   1. The value set for this code element has not been specified. Implementers are allowed to use any code system, such as SNOMED CT, a locally determined code, or a nullFlavor (CONF:16852).
6. SHOULD contain zero or one [0..1] text (CONF:7330).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15917).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15918).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15919).
7. SHALL contain exactly one [1..1] statusCode (CONF:7328).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19114).
8. SHOULD contain zero or one [0..1] effectiveTime (CONF:7332).
   1. The effectiveTime, if present, SHOULD contain zero or one [0..1] low (CONF:7333).
   2. The effectiveTime, if present, SHOULD contain zero or one [0..1] high (CONF:7334).
9. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the @code SHALL be selected from ValueSet Problem Value Set 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (CONF:7335).
10. MAY contain zero or more [0..\*] entryRelationship (CONF:7337) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7338).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7343).
    3. SHALL contain exactly one [1..1] [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) (templateId:2.16.840.1.113883.10.20.22.4.14) (CONF:15920).
       1. This procedure activity is intended to contain information about procedures that were performed in response to an allergy reaction (CONF:16853).
11. MAY contain zero or more [0..\*] entryRelationship (CONF:7340) such that it
    1. SHALL contain exactly one [1..1] @typeCode="RSON" Has reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7341).
    2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:7344).
    3. SHALL contain exactly one [1..1] [Medication Activity](#E_Medication_Activity) (templateId:2.16.840.1.113883.10.20.22.4.16) (CONF:15921).
       1. This medication activity is intended to contain information about medications that were administered in response to an allergy reaction (CONF:16840).
12. SHOULD contain zero or one [0..1] entryRelationship (CONF:7580) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:7581).
    2. SHALL contain exactly one [1..1] @inversionInd="true" TRUE (CONF:10375).
    3. SHALL contain exactly one [1..1] [Severity Observation](#E_Severity_Observation) (templateId:2.16.840.1.113883.10.20.22.4.8) (CONF:15922).
    4. Referenced Frames Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.10 (open)]

Table 153: Referenced Frames Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [SOP Instance Observation](#E_SOP_Instance_Observation) (optional) | [Boundary Observation](#E_Boundary_Observation) |

A Referenced Frames Observation is used if the referenced DICOM SOP instance is a multiframe image and the reference does not apply to all frames. The list of integer values for the referenced frames of a DICOM multiframe image SOP instance is contained in a Boundary Observation nested inside this class.

1. SHALL contain exactly one [1..1] @classCode="ROIBND" Bounded Region of Interest (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9276).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9277).
3. SHALL contain exactly one [1..1] code (CONF:19164).
   1. This code MAY contain zero or one [0..1] @code="121190" Referenced Frames (CodeSystem: DCM 1.2.840.10008.2.16.4 STATIC) (CONF:19165).
4. SHALL contain exactly one [1..1] entryRelationship (CONF:9279).
   1. This entryRelationship SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9280).
   2. This entryRelationship SHALL contain exactly one [1..1] [Boundary Observation](#E_Boundary_Observation) (templateId:2.16.840.1.113883.10.20.6.2.11) (CONF:15923).
   3. Result Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.2 (open)]

Table 154: Result Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Result Organizer](#E_Result_Organizer) (required) |  |

This clinical statement represents details of a lab, radiology, or other study performed on a patient.

The result observation includes a statusCode to allow recording the status of an observation. If a Result Observation is not completed, the Result Organizer must include corresponding statusCode. “Pending” results (e.g., a test has been run but results have not been reported yet) should be represented as “active” ActStatus.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7130).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7131).
3. SHALL contain exactly one [1..1] templateId (CONF:7136) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.2" (CONF:9138).
4. SHALL contain at least one [1..\*] id (CONF:7137).
5. SHALL contain exactly one [1..1] code (CONF:7133).
   1. SHOULD be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:19211).
   2. Laboratory results SHOULD be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or other constrained terminology named by the US Department of Health and Human Services Office of National Coordinator or other federal agency. Local and/or regional codes for laboratory results are allowed. The Local and/or regional codes SHOULD be sent in the translation element. See the Local code example figure (CONF:19212).
6. SHOULD contain zero or one [0..1] text (CONF:7138).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15924).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15925).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15926).
7. SHALL contain exactly one [1..1] statusCode (CONF:7134).
   1. This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Result Status 2.16.840.1.113883.11.20.9.39 STATIC (CONF:14849).
8. SHALL contain exactly one [1..1] effectiveTime (CONF:7140).
   1. Represents clinically effective time of the measurement, which may be when the measurement was performed (e.g., a BP measurement), or may be when sample was taken (and measured some time afterwards) (CONF:16838).
9. SHALL contain exactly one [1..1] value (CONF:7143).
10. SHOULD contain zero or more [0..\*] interpretationCode (CONF:7147).
11. MAY contain zero or one [0..1] methodCode (CONF:7148).
12. MAY contain zero or one [0..1] targetSiteCode (CONF:7153).
13. MAY contain zero or one [0..1] author (CONF:7149).
14. SHOULD contain zero or more [0..\*] referenceRange (CONF:7150).
    1. The referenceRange, if present, SHALL contain exactly one [1..1] observationRange (CONF:7151).
       1. This observationRange SHALL NOT contain [0..0] code (CONF:7152).
    2. Result Organizer

[organizer: templateId 2.16.840.1.113883.10.20.22.4.1 (open)]

Table 155: Result Organizer Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Results Section (entries required)](#S_Results_Section_entries_required) (required)  [Results Section (entries optional)](#S_Results_Section_entries_optional) (optional) | [Result Observation](#E_Result_Observation) |

This clinical statement identifies set of result observations. It contains information applicable to all of the contained result observations. Result type codes categorize a result into one of several commonly accepted values (e.g., “Hematology”, “Chemistry”, “Nuclear Medicine”). These values are often implicit in the Organizer/code (e.g., an Organizer/code of “complete blood count” implies a ResultTypeCode of “Hematology”). This template requires Organizer/code to include a ResultTypeCode either directly or as a translation of a code from some other code system.

An appropriate nullFlavor can be used when the organizer/code or organizer/id is unknown.

If any Result Observation within the organizer has a statusCode of ‘active’, the Result Organizer must also have as statusCode of ‘active.

1. SHALL contain exactly one [1..1] @classCode (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7121).
   1. SHOULD contain zero or one [0..1] @classCode="CLUSTER" Cluster (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass) OR SHOULD contain zero or one [0..1] @classCode="BATTERY" Battery (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass) (CONF:7165).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7122).
3. SHALL contain exactly one [1..1] templateId (CONF:7126) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.1" (CONF:9134).
4. SHALL contain at least one [1..\*] id (CONF:7127).
5. SHALL contain exactly one [1..1] code (CONF:7128).
   1. SHOULD be selected from LOINC (codeSystem 2.16.840.1.113883.6.1) or SNOMED CT (codeSystem 2.16.840.1.113883.6.96), and MAY be selected from CPT-4 (codeSystem 2.16.840.1.113883.6.12) (CONF:19218).
   2. Laboratory results SHOULD be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or other constrained terminology named by the US Department of Health and Human Services Office of National Coordinator or other federal agency. Local and/or regional codes for laboratory results SHOULD also be allowed (CONF:19219).
6. SHALL contain exactly one [1..1] statusCode (CONF:7123).
   1. This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Result Status 2.16.840.1.113883.11.20.9.39 STATIC (CONF:14848).
7. SHALL contain at least one [1..\*] component (CONF:7124) such that it
   1. SHALL contain exactly one [1..1] [Result Observation](#E_Result_Observation) (templateId:2.16.840.1.113883.10.20.22.4.2) (CONF:14850).
   2. Series Act

[act: templateId 2.16.840.1.113883.10.20.22.4.63 (open)]

Table 156: Series Act Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Study Act](#E_Study_Act) (required) | [SOP Instance Observation](#E_SOP_Instance_Observation) |

A Series Act contains the DICOM series information for referenced DICOM composite objects. The series information defines the attributes that are used to group composite instances into distinct logical sets. Each series is associated with exactly one study. Series Act clinical statements are only instantiated in the DICOM Object Catalog section inside a Study Act, and thus do not require a separate templateId; in other sections, the SOP Instance Observation is included directly.

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9222).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9223).
3. SHALL contain exactly one [1..1] templateId (CONF:10918) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.63" (CONF:10919).
4. SHALL contain at least one [1..\*] id (CONF:9224).

The @root contains the OID of the study instance UID since DICOM study ids consist only of an OID

* 1. Such ids SHALL contain exactly one [1..1] @root (CONF:9225).
  2. Such ids SHALL NOT contain [0..0] @extension (CONF:9226).

1. SHALL contain exactly one [1..1] code (CONF:19166).
   1. This code SHALL contain exactly one [1..1] @code="113015" (CodeSystem: DCM 1.2.840.10008.2.16.4 STATIC) (CONF:19167).

If present, the text element contains the description of the series

1. MAY contain zero or one [0..1] text (CONF:9233).

If present, the effectiveTime contains the time the series was started

1. SHOULD contain zero or one [0..1] effectiveTime (CONF:9235).
2. SHALL contain at least one [1..\*] entryRelationship (CONF:9237) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9238).
   2. SHALL contain exactly one [1..1] [SOP Instance Observation](#E_SOP_Instance_Observation) (templateId:2.16.840.1.113883.10.20.6.2.8) (CONF:15927).
   3. Service Delivery Location

[participantRole: templateId 2.16.840.1.113883.10.20.22.4.32 (open)]

Table 157: Service Delivery Location Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) (optional)  [Procedure Activity Act](#E_Procedure_Activity_Act) (optional)  [Procedure Activity Observation](#E_Procedure_Activity_Observation) (optional)  [Encounter Activities](#E_Encounter_Activities) (optional) |  |

This clinical statement represents the location of a service event where an act, observation or procedure took place.

1. SHALL contain exactly one [1..1] @classCode="SDLOC" (CodeSystem: RoleCode 2.16.840.1.113883.5.111 STATIC) (CONF:7758).
2. SHALL contain exactly one [1..1] templateId (CONF:7635) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.32" (CONF:10524).
3. SHALL contain exactly one [1..1] code, which SHALL be selected from ValueSet HealthcareServiceLocation 2.16.840.1.113883.1.11.20275 STATIC (CONF:16850).
4. SHOULD contain zero or more [0..\*] addr (CONF:7760).
5. SHOULD contain zero or more [0..\*] telecom (CONF:7761).
6. MAY contain zero or one [0..1] playingEntity (CONF:7762).
   1. The playingEntity, if present, SHALL contain exactly one [1..1] @classCode="PLC" (CodeSystem: EntityClass 2.16.840.1.113883.5.41 STATIC) (CONF:7763).
   2. The playingEntity, if present, MAY contain zero or one [0..1] name (CONF:16037).
   3. Severity Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.8 (open)]

Table 158: Severity Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Reaction Observation](#E_Reaction_Observation) (optional)  [Allergy - Intolerance Observation](#E_Allergy__Intolerance_Observation) (optional)  [Substance or Device Allergy - Intolerance Observation](#E_Substance_or_Device_Allergy__Intolera) (required) |  |

This clinical statement represents the gravity of the problem, such as allergy or reaction, in terms of its actual or potential impact on the patient. The Severity Observation can be associated with an Allergy Observation, Reaction Observation or both. When the Severity Observation is associated directly with an Allergy it characterizes the Allergy. When the Severity Observation is associated with a Reaction Observation it characterizes a Reaction. A person may manifest many symptoms in a reaction to a single substance, and each reaction to the substance can be represented. However, each reaction observation can have only one severity observation associated with it. For example, someone may have a rash reaction observation as well as an itching reaction observation, but each can have only one level of severity.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7345).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7346).
3. SHALL contain exactly one [1..1] templateId (CONF:7347) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.8" (CONF:10525).
4. SHALL contain exactly one [1..1] code (CONF:19168).
   1. This code SHALL contain exactly one [1..1] @code="SEV" (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19169).
5. SHOULD contain zero or one [0..1] text (CONF:7350).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15928).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15929).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15930).
6. SHALL contain exactly one [1..1] statusCode (CONF:7352).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19115).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD", where the @code SHALL be selected from ValueSet Problem Severity 2.16.840.1.113883.3.88.12.3221.6.8 DYNAMIC (CONF:7356).
8. SHOULD contain zero or more [0..\*] interpretationCode (CONF:9117).
   1. The interpretationCode, if present, SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Observation Interpretation (HL7) 2.16.840.1.113883.1.11.78 DYNAMIC (CONF:16038).
   2. Smoking Status Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.78 (open)]

Table 159: Smoking Status Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Social History Section](#S_Social_History_Section) (optional) |  |

This clinical statement represents a patient’s current smoking status. The vocabulary selected for this clinical statement is the best approximation of the statuses in Meaningful Use (MU) Stage 1.

If the patient is a smoker (77176002), the effectiveTime/low element must be present. If the patient is an ex-smoker (8517006), both the effectiveTime/low and effectiveTime/high element must be present.

The smoking status value set includes a special code to communicate if the smoking status is unknown which is different from how Consolidated CDA generally communicates unknown information.

1. Conforms to [Tobacco Use](#E_Tobacco_Use) template (2.16.840.1.113883.10.20.22.4.85).
2. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:14806).
3. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:14807).
4. SHALL contain exactly one [1..1] templateId (CONF:14815) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.78" (CONF:14816).
5. SHALL contain exactly one [1..1] code (CONF:19170).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19171).
6. SHALL contain exactly one [1..1] statusCode (CONF:14809).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19116).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:14814).
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:14818).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:14810).
   1. This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Smoking Status 2.16.840.1.113883.11.20.9.38 STATIC (CONF:14817).
   2. Social History Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.38 (open)]

Table 160: Social History Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Social History Section](#S_Social_History_Section) (optional) |  |

This Social History Observation defines the patient’s occupational, personal (e.g., lifestyle), social, and environmental history and health risk factors, as well as administrative data such as marital status, race, ethnicity, and religious affiliation.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8548).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:8549).
3. SHALL contain exactly one [1..1] templateId (CONF:8550) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.38" (CONF:10526).
4. SHALL contain at least one [1..\*] id (CONF:8551).
5. SHALL contain exactly one [1..1] code (CONF:8558).
   1. This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Social History Type Value Set 2.16.840.1.113883.3.88.12.80.60 STATIC (CONF:19220).
   2. This code SHOULD contain zero or one [0..1] originalText (CONF:19221).
      1. The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:19222).
         1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:19223).
            1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:19224).
6. SHALL contain exactly one [1..1] statusCode (CONF:8553).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19117).
7. SHOULD contain zero or one [0..1] value (CONF:8559).
   1. Observation/value can be any data type. Where Observation/value is a physical quantity, the unit of measure SHALL be expressed using a valid Unified Code for Units of Measure (UCUM) expression (CONF:8555).
   2. SOP Instance Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.8 (open)]

Table 161: SOP Instance Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Series Act](#E_Series_Act) (required)  [Text Observation](#E_Text_Observation) (optional)  [Code Observations](#E_Code_Observations) (optional)  [Quantity Measurement Observation](#E_Quantity_Measurement_Observation) (optional) | [Purpose of Reference Observation](#E_Purpose_of_Reference_Observation)  [Referenced Frames Observation](#E_Referenced_Frames_Observation) |

A SOP Instance Observation contains the DICOM Service Object Pair (SOP) Instance information for referenced DICOM composite objects. The SOP Instance act class is used to reference both image and non-image DICOM instances. The text attribute contains the DICOM WADO reference.

1. SHALL contain exactly one [1..1] @classCode="DGIMG" Diagnostic Image (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9240).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9241).

The @root contains an OID representing the DICOM SOP Instance UID

1. SHALL contain at least one [1..\*] id (CONF:9242).
2. SHALL contain exactly one [1..1] code (CONF:9244).
   1. This code SHALL contain exactly one [1..1] @code (CONF:19225).
      1. @code is an OID for a valid SOP class name UID (CONF:19226).
   2. This code SHALL contain exactly one [1..1] @codeSystem="1.2.840.10008.2.6.1" DCMUID (CONF:19227).
3. SHOULD contain zero or one [0..1] text (CONF:9246).
   1. The text, if present, SHALL contain exactly one [1..1] @mediaType="application/dicom" (CONF:9247).
   2. The text, if present, SHALL contain exactly one [1..1] reference (CONF:9248).
      1. SHALL contain a @value that contains a WADO reference as a URI (CONF:9249).
4. SHOULD contain zero or one [0..1] effectiveTime (CONF:9250).
   1. The effectiveTime, if present, SHALL contain exactly one [1..1] @value (CONF:9251).
   2. The effectiveTime, if present, SHALL NOT contain [0..0] low (CONF:9252).
   3. The effectiveTime, if present, SHALL NOT contain [0..0] high (CONF:9253).
5. MAY contain zero or more [0..\*] entryRelationship (CONF:9254) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9255).
6. MAY contain zero or more [0..\*] entryRelationship (CONF:9257) such that it
   1. SHALL contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9258).
   2. SHALL contain exactly one [1..1] [Purpose of Reference Observation](#E_Purpose_of_Reference_Observation) (templateId:2.16.840.1.113883.10.20.6.2.9) (CONF:15935).
7. MAY contain zero or more [0..\*] entryRelationship (CONF:9260) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9261).
   2. SHALL contain exactly one [1..1] [Referenced Frames Observation](#E_Referenced_Frames_Observation) (templateId:2.16.840.1.113883.10.20.6.2.10) (CONF:15936).
   3. This entryRelationship SHALL be present if the referenced DICOM object is a multiframe object and the reference does not apply to all frames (CONF:9263).
   4. Study Act

[act: templateId 2.16.840.1.113883.10.20.6.2.6 (open)]

Table 162: Study Act Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [DICOM Object Catalog Section - DCM 121181](#S_DICOM_Object_Catalog_Section__DCM_121) (required) | [Series Act](#E_Series_Act) |

A Study Act contains the DICOM study information that defines the characteristics of a referenced medical study performed on a patient. A study is a collection of one or more series of medical images, presentation states, SR documents, overlays, and/or curves that are logically related for the purpose of diagnosing a patient. Each study is associated with exactly one patient. A study may include composite instances that are created by a single modality, multiple modalities, or by multiple devices of the same modality. The study information is modality-independent. Study Act clinical statements are only instantiated in the DICOM Object Catalog section; in other sections, the SOP Instance Observation is included directly.

1. SHALL contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:9207).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9208).
3. SHALL contain exactly one [1..1] templateId (CONF:9209) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.6" (CONF:10533).
4. SHALL contain at least one [1..\*] id (CONF:9210).

The @root contains the OID of the study instance UID since DICOM study ids consist only of an OID

* 1. Such ids SHALL contain exactly one [1..1] @root (CONF:9213).
  2. Such ids SHALL NOT contain [0..0] @extension (CONF:9211).

1. SHALL contain exactly one [1..1] code (CONF:19172).
   1. This code SHALL contain exactly one [1..1] @code="113014" (CodeSystem: DCM 1.2.840.10008.2.16.4 STATIC) (CONF:19173).

If present, the text element contains the description of the study.

1. MAY contain zero or one [0..1] text (CONF:9215).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15995).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15996).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15997).

If present, the effectiveTime contains the time the study was started

1. SHOULD contain zero or one [0..1] effectiveTime (CONF:9216).
2. SHALL contain at least one [1..\*] entryRelationship (CONF:9219) such that it
   1. SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9220).
   2. SHALL contain exactly one [1..1] [Series Act](#E_Series_Act) (templateId:2.16.840.1.113883.10.20.22.4.63) (CONF:15937).
   3. Substance or Device Allergy - Intolerance Observation

[observation: templateId 2.16.840.1.113883.10.20.24.3.90 (open)]

Table 163: Substance or Device Allergy - Intolerance Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Allergy Status Observation](#E_Allergy_Status_Observation)  [Reaction Observation](#E_Reaction_Observation)  [Severity Observation](#E_Severity_Observation) |

This clinical statement represents that an allergy or adverse reaction to a substance or device exists or does not exist. The agent that is the cause of the allergy or adverse reaction is represented as a participant in the observation.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:16303).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:16304).
3. SHALL contain exactly one [1..1] templateId (CONF:16305) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.24.3.90" (CONF:16306).
4. SHALL contain at least one [1..\*] id (CONF:16307).
5. SHALL contain exactly one [1..1] code (CONF:16345).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:16346).
6. SHALL contain exactly one [1..1] statusCode (CONF:16308).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:26354).
7. SHALL contain exactly one [1..1] effectiveTime (CONF:16309).
8. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:16312).
   1. This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Allergy/Adverse Event Type Value Set 2.16.840.1.113883.3.88.12.3221.6.2 DYNAMIC (CONF:16317).
9. SHOULD contain zero or more [0..\*] participant (CONF:16318).
   1. The participant, if present, SHALL contain exactly one [1..1] @typeCode="CSM" Consumable (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:16319).
   2. The participant, if present, SHALL contain exactly one [1..1] participantRole (CONF:16320).
      1. This participantRole SHALL contain exactly one [1..1] @classCode="MANU" Manufactured Product (CodeSystem: RoleClass 2.16.840.1.113883.5.110 STATIC) (CONF:16321).
      2. This participantRole SHALL contain exactly one [1..1] playingEntity (CONF:16322).
         1. This playingEntity SHALL contain exactly one [1..1] @classCode="MMAT" Manufactured Material (CodeSystem: EntityClass 2.16.840.1.113883.5.41 STATIC) (CONF:16323).
         2. This playingEntity SHALL contain exactly one [1..1] code (CONF:16324).
            1. This code SHOULD contain zero or one [0..1] originalText (CONF:16326).

The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:16327).

The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:16328).

This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:16329).

* + - * 1. This code MAY contain zero or more [0..\*] translation (CONF:16330).
        2. In an allergy to a specific medication the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.16 Medication Brand Name DYNAMIC or the ValueSet 2.16.840.1.113883.3.88.12.80.17 Medication Clinical Drug DYNAMIC (CONF:16325).
        3. In an allergy to a class of medications the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.18 Medication Drug Class DYNAMIC (CONF:16331).
        4. In an allergy to a food or other substance the code SHALL be selected from the ValueSet 2.16.840.1.113883.3.88.12.80.20 Ingredient Name DYNAMIC (CONF:16332).

1. MAY contain zero or one [0..1] entryRelationship (CONF:16333) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:16335).
   2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:16334).
   3. SHALL contain exactly one [1..1] [Allergy Status Observation](#E_Allergy_Status_Observation) (templateId:2.16.840.1.113883.10.20.22.4.28) (CONF:16336).
2. SHOULD contain zero or more [0..\*] entryRelationship (CONF:16337) such that it
   1. SHALL contain exactly one [1..1] @typeCode="MFST" Is Manifestation of (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:16339).
   2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:16338).
   3. SHALL contain exactly one [1..1] [Reaction Observation](#E_Reaction_Observation) (templateId:2.16.840.1.113883.10.20.22.4.9) (CONF:16340).
3. SHALL contain exactly one [1..1] entryRelationship (CONF:16341) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:16342).
   2. SHALL contain exactly one [1..1] @inversionInd="true" True (CONF:16343).
   3. SHALL contain exactly one [1..1] [Severity Observation](#E_Severity_Observation) (templateId:2.16.840.1.113883.10.20.22.4.8) (CONF:16344).
   4. Text Observation

[observation: templateId 2.16.840.1.113883.10.20.6.2.12 (open)]

Table 164: Text Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
|  | [Quantity Measurement Observation](#E_Quantity_Measurement_Observation)  [SOP Instance Observation](#E_SOP_Instance_Observation) |

DICOM Template 2000 specifies that Imaging Report Elements of Value Type Text are contained in sections. The Imaging Report Elements are inferred from Basic Diagnostic Imaging Report Observations that consist of image references and measurements (linear, area, volume, and numeric). Text DICOM Imaging Report Elements in this context are mapped to CDA text observations that are section components and are related to the SOP Instance Observations (templateId 2.16.840.1.113883.10.20.6.2.8) or Quantity Measurement Observations (templateId 2.16.840.1.113883.10.20.6.2.14) by the SPRT (Support) act relationship.

A Text Observation is required if the findings in the section text are represented as inferred from SOP Instance Observations.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:9288).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:9289).
3. SHALL contain exactly one [1..1] templateId (CONF:9290) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.6.2.12" (CONF:10534).
4. SHALL contain exactly one [1..1] code (CONF:9291).
5. MAY contain zero or one [0..1] text (CONF:9295).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15938).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15939).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15940).
6. SHOULD contain zero or one [0..1] effectiveTime (CONF:9294).
7. SHALL contain exactly one [1..1] value with @xsi:type="ED" (CONF:9292).
8. MAY contain zero or more [0..\*] entryRelationship (CONF:9298) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9299).
   2. SHALL contain exactly one [1..1] [SOP Instance Observation](#E_SOP_Instance_Observation) (templateId:2.16.840.1.113883.10.20.6.2.8) (CONF:15941).
9. MAY contain zero or more [0..\*] entryRelationship (CONF:9301) such that it
   1. SHALL contain exactly one [1..1] @typeCode="SPRT" Has Support (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 STATIC) (CONF:9302).
   2. SHALL contain exactly one [1..1] [Quantity Measurement Observation](#E_Quantity_Measurement_Observation) (templateId:2.16.840.1.113883.10.20.6.2.14) (CONF:15942).
   3. Tobacco Use

[observation: templateId 2.16.840.1.113883.10.20.22.4.85 (open)]

Table 165: Tobacco Use Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Social History Section](#S_Social_History_Section) (optional) |  |

This clinical statement represents a patient’s tobacco use. All types of tobacco use are represented using the codes from the tobacco use and exposure - finding hierarchy in SNOMED CT.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:16558).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:16559).
3. SHALL contain exactly one [1..1] templateId (CONF:16566) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.85" (CONF:16567).
4. SHALL contain exactly one [1..1] code (CONF:19174).
   1. This code SHALL contain exactly one [1..1] @code="ASSERTION" Assertion (CodeSystem: ActCode 2.16.840.1.113883.5.4 STATIC) (CONF:19175).
5. SHALL contain exactly one [1..1] statusCode (CONF:16561).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19118).
6. SHALL contain exactly one [1..1] effectiveTime (CONF:16564).
   1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:16565).
7. SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:16562).
   1. This value SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Tobacco Use 2.16.840.1.113883.11.20.9.41 DYNAMIC (CONF:16563).
   2. Vital Sign Observation

[observation: templateId 2.16.840.1.113883.10.20.22.4.27 (open)]

Table 166: Vital Sign Observation Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Vital Signs Organizer](#E_Vital_Signs_Organizer) (required) |  |

Vital signs are represented as are other results, with additional vocabulary constraints.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7297).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7298).
3. SHALL contain exactly one [1..1] templateId (CONF:7299) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.27" (CONF:10527).
4. SHALL contain at least one [1..\*] id (CONF:7300).
5. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet Vital Sign Result Value Set 2.16.840.1.113883.3.88.12.80.62 DYNAMIC (CONF:7301).
6. SHOULD contain zero or one [0..1] text (CONF:7302).
   1. The text, if present, SHOULD contain zero or one [0..1] reference (CONF:15943).
      1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:15944).
         1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:15945).
7. SHALL contain exactly one [1..1] statusCode (CONF:7303).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19119).
8. SHALL contain exactly one [1..1] effectiveTime (CONF:7304).
9. SHALL contain exactly one [1..1] value with @xsi:type="PQ" (CONF:7305).
10. MAY contain zero or one [0..1] interpretationCode (CONF:7307).
11. MAY contain zero or one [0..1] methodCode (CONF:7308).
12. MAY contain zero or one [0..1] targetSiteCode (CONF:7309).
13. MAY contain zero or one [0..1] author (CONF:7310).
    1. Vital Signs Organizer

[organizer: templateId 2.16.840.1.113883.10.20.22.4.26 (open)]

Table 167: Vital Signs Organizer Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Vital Signs Section (entries required)](#S_Vital_Signs_Section_entries_required) (required)  [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) (optional) | [Vital Sign Observation](#E_Vital_Sign_Observation) |

The Vital Signs Organizer groups vital signs, which is similar to the Result Organizer, but with further constraints.

An appropriate nullFlavor can be used when the organizer/code or organizer/id is unknown.

1. SHALL contain exactly one [1..1] @classCode="CLUSTER" CLUSTER (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:7279).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 STATIC) (CONF:7280).
3. SHALL contain exactly one [1..1] templateId (CONF:7281) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.26" (CONF:10528).
4. SHALL contain at least one [1..\*] id (CONF:7282).
5. SHALL contain exactly one [1..1] code (CONF:19176).
   1. This code SHALL contain exactly one [1..1] @code="46680005" Vital signs (CodeSystem: SNOMED-CT 2.16.840.1.113883.6.96 STATIC) (CONF:19177).
6. SHALL contain exactly one [1..1] statusCode (CONF:7284).
   1. This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14 STATIC) (CONF:19120).

The effectiveTime represents clinically effective time of the measurement, which is most likely when the measurement was performed (e.g., a BP measurement).

1. SHALL contain exactly one [1..1] effectiveTime (CONF:7288).
2. SHALL contain at least one [1..\*] component (CONF:7285) such that it
   1. SHALL contain exactly one [1..1] [Vital Sign Observation](#E_Vital_Sign_Observation) (templateId:2.16.840.1.113883.10.20.22.4.27) (CONF:15946).

# Datatypes and Sub-entry Templates

* 1. Physician of Record Participant

[encounterParticipant: templateId 2.16.840.1.113883.10.20.6.2.2 (open)]

Table 168: Physician of Record Participant Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Diagnostic Imaging Report](#D_Diagnostic_Imaging_Report) (optional) |  |

This encounterParticipant is the attending physician and is usually different from the Physician Reading Study Performer defined in documentationOf/serviceEvent.

1. SHALL contain exactly one [1..1] @typeCode="ATND" Attender (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:8881).
2. MAY contain zero or more [0..\*] templateId (CONF:16072).
   1. The templateId, if present, MAY contain zero or one [0..1] @root="2.16.840.1.113883.10.20.6.2.2" (CONF:16073).
3. SHALL contain exactly one [1..1] assignedEntity (CONF:8886).
   1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:8887).
      1. The id SHOULD include zero or one [0..1] id where id/@root ="2.16.840.1.113883.4.6" National Provider Identifier (CONF:10035).
   2. This assignedEntity SHALL contain exactly one [1..1] code (CONF:8888).
      1. SHALL contain a valid DICOM Organizational Role from DICOM CID 7452 (Value Set 1.2.840.10008.6.1.516)(@codeSystem is 1.2.840.10008.2.16.4) or an appropriate national health care provider coding system (e.g., NUCC in the U.S., where @codeSystem is 2.16.840.1.113883.6.101)Footnote: DICOM Part 16 (NEMA PS3.16), page 631 in the 2011 edition. See ftp://medical.nema.org/medical/dicom/2011/11\_16pu.pdf (CONF:8889).
   3. This assignedEntity MAY contain zero or one [0..1] representedOrganization (CONF:16074).
      1. The representedOrganization, if present, SHOULD contain zero or one [0..1] name (CONF:16075).
   4. This assignedEntity SHOULD contain zero or one [0..1] name (CONF:8890).
4. SHALL contain exactly one [1..1] templateId/@root="2.16.840.1.113883.10.20.6.2.2" (CONF:8440).
   1. Physician Reading Study Performer

[Performer1: templateId 2.16.840.1.113883.10.20.6.2.1 (open)]

Table 169: Physician Reading Study Performer Contexts

| Used By: | Contains Entries: |
| --- | --- |
| [Diagnostic Imaging Report](#D_Diagnostic_Imaging_Report) (optional) |  |

This performer is the Physician Reading Study Performer and is usually different from the attending physician (Physician of Record Participant) in componentOf/encompassingEncounter.

1. SHALL contain exactly one [1..1] @typeCode="PRF" Performer (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:8424).
2. MAY contain zero or one [0..1] time (CONF:8425).
   1. The content of time SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.3) (CONF:10134).
3. SHALL contain exactly one [1..1] assignedEntity (CONF:8426).
   1. This assignedEntity SHALL contain at least one [1..\*] id (CONF:10033).
      1. The id SHOULD include zero or one [0..1] id where id/@root ="2.16.840.1.113883.4.6" National Provider Identifier (CONF:10034).
   2. This assignedEntity SHALL contain exactly one [1..1] code (CONF:8427).
      1. SHALL contain a valid DICOM personal identification code sequence (@codeSystem is 1.2.840.10008.2.16.4) or an appropriate national health care provider coding system (e.g., NUCC in the U.S., where @codeSystem is 2.16.840.1.113883.6.101) (CONF:8428).
   3. Every assignedEntity element SHALL have at least one assignedPerson or representedOrganization (CONF:8429).
4. SHALL contain exactly one [1..1] templateId/@root="2.16.840.1.113883.10.20.6.2.1" (CONF:8423).
   1. US Realm Address (AD.US.FIELDED)

[AD: templateId 2.16.840.1.113883.10.20.22.5.2 (open)]

Table 170: US Realm Address (AD.US.FIELDED) Contexts

Reusable address template, for use in US Realm CDA Header.

1. SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet PostalAddressUse 2.16.840.1.113883.1.11.10637 STATIC 2005-05-01 (CONF:7290).
2. SHOULD contain zero or one [0..1] country, which SHALL be selected from ValueSet CountryValueSet 2.16.840.1.113883.3.88.12.80.63 DYNAMIC (CONF:7295).
3. SHOULD contain zero or one [0..1] state (ValueSet: StateValueSet 2.16.840.1.113883.3.88.12.80.1 DYNAMIC) (CONF:7293).
   1. State is required if the country is US. If country is not specified, it is assumed to be US. If country is something other than US, the state MAY be present but MAY be bound to different vocabularies (CONF:10024).
4. SHALL contain exactly one [1..1] city (CONF:7292).
5. SHOULD contain zero or one [0..1] postalCode, which SHOULD be selected from ValueSet PostalCodeValueSet 2.16.840.1.113883.3.88.12.80.2 DYNAMIC (CONF:7294).
   1. PostalCode is required if the country is US. If country is not specified, it is assumed to be US. If country is something other than US, the postalCode MAY be present but MAY be bound to different vocabularies (CONF:10025).
6. SHALL contain at least one and not more than 4 streetAddressLine (CONF:7291).
7. SHALL NOT have mixed content except for white space (CONF:7296).
   1. US Realm Date and Time (DT.US.FIELDED) [DEPRECATED]

[IVL\_TS: templateId 2.16.840.1.113883.10.20.22.5.3 (open)]

Table 171: US Realm Date and Time (DT.US.FIELDED) [DEPRECATED] Contexts

The US Realm Clinical Document Date and Time datatype flavor records date and time information. If no time zone offset is provided, you can make no assumption about time, unless you have made a local exchange agreement.

This data type uses the same rules as US Realm Date and Time (DTM.US.FIELDED), but is used with the effectiveTime element.

Notes: This template is a duplicate, and has been deprecated. Use 2.16.840.1.113883.10.20.22.5.4 instead.

1. SHALL be precise to the day (CONF:10078).
2. SHOULD be precise to the minute (CONF:10079).
3. MAY be precise to the second (CONF:10080).
4. If more precise than day, SHOULD include time-zone offset (CONF:10081).
   1. US Realm Date and Time (DTM.US.FIELDED)

[TS: templateId 2.16.840.1.113883.10.20.22.5.4 (open)]

Table 172: US Realm Date and Time (DTM.US.FIELDED) Contexts

The US Realm Clinical Document Date and Time datatype flavor records date and time information. If no time zone offset is provided, you can make no assumption about time, unless you have made a local exchange agreement.

1. SHALL be precise to the day (CONF:10127).
2. SHOULD be precise to the minute (CONF:10128).
3. MAY be precise to the second (CONF:10129).
4. If more precise than day, SHOULD include time-zone offset (CONF:10130).
   1. US Realm Patient Name (PTN.US.FIELDED)

[PN: templateId 2.16.840.1.113883.10.20.22.5.1 (open)]

Table 173: US Realm Patient Name (PTN.US.FIELDED) Contexts

The US Realm Patient Name datatype flavor is a set of reusable constraints that can be used for the patient or any other person. It requires a first (given) and last (family) name. If a patient or person has only one name part (e.g., patient with first name only) place the name part in the field required by the organization. Use the appropriate nullFlavor, ""Not Applicable"" (NA), in the other field.

For information on mixed content see the Extensible Markup Language reference (http://www.w3c.org/TR/2008/REC-xml-20081126/).

1. MAY contain zero or one [0..1] @use, which SHALL be selected from ValueSet EntityNameUse 2.16.840.1.113883.1.11.15913 STATIC 2005-05-01 (CONF:7154).
2. SHALL contain exactly one [1..1] family (CONF:7159).
   1. This family MAY contain zero or one [0..1] @qualifier, which SHALL be selected from ValueSet EntityPersonNamePartQualifier 2.16.840.1.113883.11.20.9.26 STATIC 2011-09-30 (CONF:7160).
3. SHALL contain at least one [1..\*] given (CONF:7157).
   1. Such givens MAY contain zero or one [0..1] @qualifier, which SHALL be selected from ValueSet EntityPersonNamePartQualifier 2.16.840.1.113883.11.20.9.26 STATIC 2011-09-30 (CONF:7158).
   2. The second occurrence of given (given[2]) if provided, SHALL include middle name or middle initial (CONF:7163).
4. MAY contain zero or more [0..\*] prefix (CONF:7155).
   1. The prefix, if present, MAY contain zero or one [0..1] @qualifier, which SHALL be selected from ValueSet EntityPersonNamePartQualifier 2.16.840.1.113883.11.20.9.26 STATIC 2011-09-30 (CONF:7156).
5. MAY contain zero or one [0..1] suffix (CONF:7161).
   1. The suffix, if present, MAY contain zero or one [0..1] @qualifier, which SHALL be selected from ValueSet EntityPersonNamePartQualifier 2.16.840.1.113883.11.20.9.26 STATIC 2011-09-30 (CONF:7162).
6. SHALL NOT have mixed content except for white space (CONF:7278).
   1. US Realm Person Name (PN.US.FIELDED)

[PN: templateId 2.16.840.1.113883.10.20.22.5.1.1 (open)]

Table 174: US Realm Person Name (PN.US.FIELDED) Contexts

The US Realm Clinical Document Person Name datatype flavor is a set of reusable constraints that can be used for Persons.

1. SHALL contain exactly one [1..1] name (CONF:9368).
   1. The content of name SHALL be either a conformant Patient Name (PTN.US.FIELDED), or a string (CONF:9371).
   2. The string SHALL NOT contain name parts (CONF:9372).

# References

* CDC, *Epidemiology and Prevention of Vaccine-Preventable Diseases (The Pink Book), Appendix D: Vaccine Administration Guidelines.* <http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/D/vacc_admin.pdf>
* *Extensible Markup Language (XML) 1.0* (Fifth Edition), <http://www.w3c.org/TR/2008/REC-xml-20081126/>
* HITSP, *Summary Documents Using HL7 Continuity of Care Document (CCD) Component* (HITSP/C32); Versions 2.1, 2.2, 2.3, 2.5; December 13, 2007 - July 8, 2009
* *HL7 Clinical Document Architecture (CDA Release 2)*. http://www.hl7.org/implement/standards/cda.cfm
* *HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation, DSTU Release 1.1 - US Realm.* July 2012. http://www.hl7.org/documentcenter/public/standards/dstu/CDAR2\_IG\_IHE\_CONSOL\_DSTU\_R1dot1\_2012JUL.zip
* *HL7 Implementation Guide: CDA Release 2 – Continuity of Care Document (CCD)* A CDA implementation of ASTM E2369-05 Standard Specification for Continuity of Care Record© (CCR), April 01, 2007
* *HL7 Version 3 Interoperability Standards,* Normative Edition 2010. [http://www.hl7.org/memonly/downloads/v3edition.cfm - V32010](http://www.hl7.org/memonly/downloads/v3edition.cfm#V32010)
* *Joint Commission Requirements for Discharge Summary* (JCAHO IM.6.10 EP7). See [http://www.jointcommission.org/NR/rdonlyres/C9298DD0-6726-4105-A007-FE2C65F77075/0/CMS\_New\_Revised\_HAP\_FINAL\_withScoring.pdf (page 26](http://www.jointcommission.org/NR/rdonlyres/C9298DD0-6726-4105-A007-FE2C65F77075/0/CMS_New_Revised_HAP_FINAL_withScoring.pdf)).
* *Mosby's Medical Dictionary*, 8th edition. © 2009, Elsevier.
* NEMA, *Digital Imaging and Communications in Medicine (DICO Part 16: Content Mapping Resource.* NEMA PS3.16-2011, page 631. <ftp://medical.nema.org/medical/dicom/2011/11_16pu.pdf>
* Term Info. <http://www.hl7.org/special/committees/terminfo/index.cfm>

1. Acronyms and Abbreviations

AMA American Medical Association

C-CDA Consolidated Clinical Document Architecture

CCD Continuity of Care Document

CDC Centers for Disease Control and Prevention

DICOM Digital Imaging and Communications in Medicine

DIR Diagnostic Imaging Report

DSTU Draft Standard for Trial Use

H&P History and Physical

HITSP Health Information Technology Standards Panel

HL7 Health Level Seven

HTML Hypertext Markup Language

IG implementation guide

IHE Integrating the Healthcare Enterprise

IHTSDO International Health Terminology Standard Development Organisation

LOINC Logical Observation Identifiers Names and Codes

NPP non-physician providers

NUCC Healthcare Provider Taxonomy Code

PCP primary care provider

PDF portable document format

PHQ Patient Health Questionnaire

PHR personal health record

PPRF primary performers

RIM Reference Information Model

SDWG Structured Documents Working Group

SNOMED CT Systemized Nomenclature for Medicine – Clinical Terms

SOP Service Object Pair

SR Structured Report

UCUM Unified Code for Units of Measure

UD Unstructured Document

UDI Unique Device Identification

URL Uniform Resource Locator

VIS Vaccine Information Statement

WADO Web Access to Persistent DICOM Objects

1. Template Ids in This Guide

Table 175: Template List

| Template Title | Template Type | templateId |
| --- | --- | --- |
| [Consultation Note](#D_Consultation_Note) | document | 2.16.840.1.113883.10.20.22.1.4 |
| [Continuity of Care Document (CCD)](#D_Continuity_of_Care_Document_CCD) | document | 2.16.840.1.113883.10.20.22.1.2 |
| [Diagnostic Imaging Report](#D_Diagnostic_Imaging_Report) | document | 2.16.840.1.113883.10.20.22.1.5 |
| [Discharge Summary](#D_Discharge_Summary) | document | 2.16.840.1.113883.10.20.22.1.8 |
| [History and Physical](#D_History_and_Physical) | document | 2.16.840.1.113883.10.20.22.1.3 |
| [Operative Note](#D_Operative_Note) | document | 2.16.840.1.113883.10.20.22.1.7 |
| [Procedure Note](#D_Procedure_Note) | document | 2.16.840.1.113883.10.20.22.1.6 |
| [Progress Note](#D_Progress_Note) | document | 2.16.840.1.113883.10.20.22.1.9 |
| [Unstructured Document](#D_Unstructured_Document) | document | 2.16.840.1.113883.10.20.22.1.10 |
| [US Realm Header](#D_US_Realm_Header) | document | 2.16.840.1.113883.10.20.22.1.1 |
| [Advance Directives Section (entries optional)](#S_Advance_Directives_Section_entries_opt) | section | 2.16.840.1.113883.10.20.22.2.21 |
| [Advance Directives Section (entries required)](#S_Advance_Directives_Section_entries_req) | section | 2.16.840.1.113883.10.20.22.2.21.1 |
| [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional) | section | 2.16.840.1.113883.10.20.22.2.6 |
| [Allergies Section (entries required)](#S_Allergies_Section_entries_required) | section | 2.16.840.1.113883.10.20.22.2.6.1 |
| [Anesthesia Section](#S_Anesthesia_Section) | section | 2.16.840.1.113883.10.20.22.2.25 |
| [Assessment and Plan Section](#S_Assessment_and_Plan_Section) | section | 2.16.840.1.113883.10.20.22.2.9 |
| [Assessment Section](#S_Assessment_Section) | section | 2.16.840.1.113883.10.20.22.2.8 |
| [Chief Complaint and Reason for Visit Section](#S_Chief_Complaint_and_Reason_for_Visit_S) | section | 2.16.840.1.113883.10.20.22.2.13 |
| [Chief Complaint Section](#S_Chief_Complaint_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1 |
| [Complications (OpNote)](#S_Complications_(OpNote)) | section | 2.16.840.1.113883.10.20.22.2.32 |
| [Complications Section](#S_Complications_Section) | section | 2.16.840.1.113883.10.20.22.2.37 |
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| [Discharge Diet Section](#S_Discharge_Diet_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.33 |
| [Encounters Section (entries optional)](#S_Encounters_Section_entries_optional) | section | 2.16.840.1.113883.10.20.22.2.22 |
| [Encounters Section (entries required)](#S_Encounters_Section_entries_required) | section | 2.16.840.1.113883.10.20.22.2.22.1 |
| [Family History Section](#S_Family_History_Section) | section | 2.16.840.1.113883.10.20.22.2.15 |
| [Fetus Subject Context](#S_Fetus_Subject_Context) | section | 2.16.840.1.113883.10.20.6.2.3 |
| [Findings Section (DIR)](#S_Findings_Section_DIR) | section | 2.16.840.1.113883.10.20.6.1.2 |
| [Functional Status Section](#S_Functional_Status_Section) | section | 2.16.840.1.113883.10.20.22.2.14 |
| [General Status Section](#S_General_Status_Section) | section | 2.16.840.1.113883.10.20.2.5 |
| [History of Past Illness Section](#S_History_of_Past_Illness_Section) | section | 2.16.840.1.113883.10.20.22.2.20 |
| [History of Present Illness Section](#S_History_of_Present_Illness_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.4 |
| [Hospital Admission Diagnosis Section](#S_Hospital_Admission_Diagnosis_Section) | section | 2.16.840.1.113883.10.20.22.2.43 |
| [Hospital Admission Medications Section (entries optional)](#S_Hospital_Admission_Medications_Section) | section | 2.16.840.1.113883.10.20.22.2.44 |
| [Hospital Consultations Section](#S_Hospital_Consultations_Section) | section | 2.16.840.1.113883.10.20.22.2.42 |
| [Hospital Course Section](#S_Hospital_Course_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.5 |
| [Hospital Discharge Diagnosis Section](#S_Hospital_Discharge_Diagnosis_Section) | section | 2.16.840.1.113883.10.20.22.2.24 |
| [Hospital Discharge Instructions Section](#S_Hospital_Discharge_Instructions_Sectio) | section | 2.16.840.1.113883.10.20.22.2.41 |
| [Hospital Discharge Medications Section (entries optional)](#S_Hospital_Discharge_Medications_ent_opt) | section | 2.16.840.1.113883.10.20.22.2.11 |
| [Hospital Discharge Physical Section](#S_Hospital_Discharge_Physical_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.26 |
| [Hospital Discharge Studies Summary Section](#S_Hospital_Discharge_Studies_Summary_Sec) | section | 2.16.840.1.113883.10.20.22.2.16 |
| [Immunizations Section (entries optional)](#S_Immunizations_Section_entries_optional) | section | 2.16.840.1.113883.10.20.22.2.2 |
| [Immunizations Section (entries required)](#S_Immunizations_Section_entries_required) | section | 2.16.840.1.113883.10.20.22.2.2.1 |
| [Implants Section](#S_Implants_Section) | section | 2.16.840.1.113883.10.20.22.2.33 |
| [Instructions Section](#S_Instructions_Section) | section | 2.16.840.1.113883.10.20.22.2.45 |
| [Interventions Section](#S_Interventions_Section) | section | 2.16.840.1.113883.10.20.21.2.3 |
| [Medical (General) History Section](#S_Medical_General_History_Section) | section | 2.16.840.1.113883.10.20.22.2.39 |
| [Medical Equipment Section](#S_Medical_Equipment_Section) | section | 2.16.840.1.113883.10.20.22.2.23 |
| [Medications Administered Section](#S_Medications_Administered_Section) | section | 2.16.840.1.113883.10.20.22.2.38 |
| [Medications Section (entries optional)](#S_Medications_Section_entries_optional) | section | 2.16.840.1.113883.10.20.22.2.1 |
| [Medications Section (entries required)](#S_Medications_Section_entries_required) | section | 2.16.840.1.113883.10.20.22.2.1.1 |
| [Objective Section](#S_Objective_Section) | section | 2.16.840.1.113883.10.20.21.2.1 |
| [Observer Context](#S_Observer_Context) | section | 2.16.840.1.113883.10.20.6.2.4 |
| [Operative Note Fluids Section](#S_Operative_Note_Fluids_Section) | section | 2.16.840.1.113883.10.20.7.12 |
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| [Planned Procedure Section](#S_Planned_Procedure_Section) | section | 2.16.840.1.113883.10.20.22.2.30 |
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| [Problem Section (entries optional)](#S_Problem_Section_entries_optional) | section | 2.16.840.1.113883.10.20.22.2.5 |
| [Problem Section (entries required)](#S_Problem_Section_entries_required) | section | 2.16.840.1.113883.10.20.22.2.5.1 |
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| [Procedure Specimens Taken Section](#S_Procedure_Specimens_Taken_Section) | section | 2.16.840.1.113883.10.20.22.2.31 |
| [Procedures Section (entries optional)](#S_Procedures_Section_entries_optional) | section | 2.16.840.1.113883.10.20.22.2.7 |
| [Procedures Section (entries required)](#S_Procedures_Section_entries_required) | section | 2.16.840.1.113883.10.20.22.2.7.1 |
| [Reason for Referral Section](#S_Reason_for_Referral_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.1 |
| [Reason for Visit Section](#S_Reason_for_Visit_Section) | section | 2.16.840.1.113883.10.20.22.2.12 |
| [Results Section (entries optional)](#S_Results_Section_entries_optional) | section | 2.16.840.1.113883.10.20.22.2.3 |
| [Results Section (entries required)](#S_Results_Section_entries_required) | section | 2.16.840.1.113883.10.20.22.2.3.1 |
| [Review of Systems Section](#S_Review_of_Systems_Section) | section | 1.3.6.1.4.1.19376.1.5.3.1.3.18 |
| [Social History Section](#S_Social_History_Section) | section | 2.16.840.1.113883.10.20.22.2.17 |
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| [Surgical Drains Section](#S_Surgical_Drains_Section) | section | 2.16.840.1.113883.10.20.7.13 |
| [Vital Signs Section (entries optional)](#S_Vital_Signs_Section_entries_optional) | section | 2.16.840.1.113883.10.20.22.2.4 |
| [Vital Signs Section (entries required)](#S_Vital_Signs_Section_entries_required) | section | 2.16.840.1.113883.10.20.22.2.4.1 |
| [Admission Medication](#E_Admission_Medication) | entry | 2.16.840.1.113883.10.20.22.4.36 |
| [Advance Directive Observation](#E_Advance_Directive_Observation) | entry | 2.16.840.1.113883.10.20.22.4.48 |
| [Age Observation](#E_Age_Observation) | entry | 2.16.840.1.113883.10.20.22.4.31 |
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| [Allergy Problem Act](#E_Allergy_Problem_Act) | entry | 2.16.840.1.113883.10.20.22.4.30 |
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| [Assessment Scale Observation](#E_Assessment_Scale_Observation) | entry | 2.16.840.1.113883.10.20.22.4.69 |
| [Assessment Scale Supporting Observation](#E_Assessment_Scale_Supporting_Observati) | entry | 2.16.840.1.113883.10.20.22.4.86 |
| [Authorization Activity](#E_Authorization_Activity) | entry | 2.16.840.1.113883.10.20.1.19 |
| [Boundary Observation](#E_Boundary_Observation) | entry | 2.16.840.1.113883.10.20.6.2.11 |
| [Caregiver Characteristics](#E_Caregiver_Characteristics) | entry | 2.16.840.1.113883.10.20.22.4.72 |
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| [Cognitive Status Result Observation](#E_Cognitive_Status_Result_Observation) | entry | 2.16.840.1.113883.10.20.22.4.74 |
| [Cognitive Status Result Organizer](#E_Cognitive_Status_Result_Organizer) | entry | 2.16.840.1.113883.10.20.22.4.75 |
| [Comment Activity](#E_Comment_Activity) | entry | 2.16.840.1.113883.10.20.22.4.64 |
| [Coverage Activity](#E_Coverage_Activity) | entry | 2.16.840.1.113883.10.20.22.4.60 |
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| [Discharge Medication](#E_Discharge_Medication) | entry | 2.16.840.1.113883.10.20.22.4.35 |
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| [Encounter Activities](#E_Encounter_Activities) | entry | 2.16.840.1.113883.10.20.22.4.49 |
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| [Family History Death Observation](#E_Family_History_Death_Observation) | entry | 2.16.840.1.113883.10.20.22.4.47 |
| [Family History Observation](#E_Family_History_Observation) | entry | 2.16.840.1.113883.10.20.22.4.46 |
| [Family History Organizer](#E_Family_History_Organizer) | entry | 2.16.840.1.113883.10.20.22.4.45 |
| [Functional Status Problem Observation](#E_Functional_Status_Problem_Observation) | entry | 2.16.840.1.113883.10.20.22.4.68 |
| [Functional Status Result Observation](#E_Functional_Status_Result_Observation) | entry | 2.16.840.1.113883.10.20.22.4.67 |
| [Functional Status Result Organizer](#E_Functional_Status_Result_Organizer) | entry | 2.16.840.1.113883.10.20.22.4.66 |
| [Health Status Observation](#E_Health_Status_Observation) | entry | 2.16.840.1.113883.10.20.22.4.5 |
| [Highest Pressure Ulcer Stage](#E_Highest_Pressure_Ulcer_Stage) | entry | 2.16.840.1.113883.10.20.22.4.77 |
| [Hospital Admission Diagnosis](#E_Hospital_Admission_Diagnosis) | entry | 2.16.840.1.113883.10.20.22.4.34 |
| [Hospital Discharge Diagnosis](#E_Hospital_Discharge_Diagnosis) | entry | 2.16.840.1.113883.10.20.22.4.33 |
| [Immunization Activity](#E_Immunization_Activity) | entry | 2.16.840.1.113883.10.20.22.4.52 |
| [Immunization Medication Information](#E_Immunization_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.54 |
| [Immunization Refusal Reason](#E_Immunization_Refusal_Reason) | entry | 2.16.840.1.113883.10.20.22.4.53 |
| [Indication](#E_Indication) | entry | 2.16.840.1.113883.10.20.22.4.19 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Activity](#E_Medication_Activity) | entry | 2.16.840.1.113883.10.20.22.4.16 |
| [Medication Dispense](#E_Medication_Dispense) | entry | 2.16.840.1.113883.10.20.22.4.18 |
| [Medication Information](#E_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.23 |
| [Medication Supply Order](#E_Medication_Supply_Order) | entry | 2.16.840.1.113883.10.20.22.4.17 |
| [Medication Use - None Known (deprecated)](#E_Medication_Use__None_Known_deprecated) | entry | 2.16.840.1.113883.10.20.22.4.29 |
| [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) | entry | 2.16.840.1.113883.10.20.22.4.50 |
| [Number of Pressure Ulcers Observation](#E_Number_of_Pressure_Ulcers_Observation) | entry | 2.16.840.1.113883.10.20.22.4.76 |
| [Plan of Care Activity Act](#E_Plan_of_Care_Activity_Act) | entry | 2.16.840.1.113883.10.20.22.4.39 |
| [Plan of Care Activity Encounter](#E_Plan_of_Care_Activity_Encounter) | entry | 2.16.840.1.113883.10.20.22.4.40 |
| [Plan of Care Activity Observation](#E_Plan_of_Care_Activity_Observation) | entry | 2.16.840.1.113883.10.20.22.4.44 |
| [Plan of Care Activity Procedure](#E_Plan_of_Care_Activity_Procedure) | entry | 2.16.840.1.113883.10.20.22.4.41 |
| [Plan of Care Activity Substance Administration](#E_Plan_of_Care_Activity_Substance_Admini) | entry | 2.16.840.1.113883.10.20.22.4.42 |
| [Plan of Care Activity Supply](#E_Plan_of_Care_Activity_Supply) | entry | 2.16.840.1.113883.10.20.22.4.43 |
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| [Postprocedure Diagnosis](#E_Postprocedure_Diagnosis) | entry | 2.16.840.1.113883.10.20.22.4.51 |
| [Precondition for Substance Administration](#E_Precondition_for_Substance_Administrat) | entry | 2.16.840.1.113883.10.20.22.4.25 |
| [Pregnancy Observation](#E_Pregnancy_Observation) | entry | 2.16.840.1.113883.10.20.15.3.8 |
| [Preoperative Diagnosis](#E_Preoperative_Diagnosis) | entry | 2.16.840.1.113883.10.20.22.4.65 |
| [Pressure Ulcer Observation](#E_Pressure_Ulcer_Observation_) | entry | 2.16.840.1.113883.10.20.22.4.70 |
| [Problem Concern Act (Condition)](#E_Problem_Concern_Act_Condition) | entry | 2.16.840.1.113883.10.20.22.4.3 |
| [Problem Observation](#E_Problem_Observation) | entry | 2.16.840.1.113883.10.20.22.4.4 |
| [Problem Status](#E_Problem_Status) | entry | 2.16.840.1.113883.10.20.22.4.6 |
| [Procedure Activity Act](#E_Procedure_Activity_Act) | entry | 2.16.840.1.113883.10.20.22.4.12 |
| [Procedure Activity Observation](#E_Procedure_Activity_Observation) | entry | 2.16.840.1.113883.10.20.22.4.13 |
| [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) | entry | 2.16.840.1.113883.10.20.22.4.14 |
| [Procedure Context](#E_Procedure_Context) | entry | 2.16.840.1.113883.10.20.6.2.5 |
| [Product Instance](#E_Product_Instance) | entry | 2.16.840.1.113883.10.20.22.4.37 |
| [Purpose of Reference Observation](#E_Purpose_of_Reference_Observation) | entry | 2.16.840.1.113883.10.20.6.2.9 |
| [Quantity Measurement Observation](#E_Quantity_Measurement_Observation) | entry | 2.16.840.1.113883.10.20.6.2.14 |
| [Reaction Observation](#E_Reaction_Observation) | entry | 2.16.840.1.113883.10.20.22.4.9 |
| [Referenced Frames Observation](#E_Referenced_Frames_Observation) | entry | 2.16.840.1.113883.10.20.6.2.10 |
| [Result Observation](#E_Result_Observation) | entry | 2.16.840.1.113883.10.20.22.4.2 |
| [Result Organizer](#E_Result_Organizer) | entry | 2.16.840.1.113883.10.20.22.4.1 |
| [Series Act](#E_Series_Act) | entry | 2.16.840.1.113883.10.20.22.4.63 |
| [Service Delivery Location](#E_Service_Delivery_Location) | entry | 2.16.840.1.113883.10.20.22.4.32 |
| [Severity Observation](#E_Severity_Observation) | entry | 2.16.840.1.113883.10.20.22.4.8 |
| [Smoking Status Observation](#E_Smoking_Status_Observation) | entry | 2.16.840.1.113883.10.20.22.4.78 |
| [Social History Observation](#E_Social_History_Observation) | entry | 2.16.840.1.113883.10.20.22.4.38 |
| [SOP Instance Observation](#E_SOP_Instance_Observation) | entry | 2.16.840.1.113883.10.20.6.2.8 |
| [Study Act](#E_Study_Act) | entry | 2.16.840.1.113883.10.20.6.2.6 |
| [Substance or Device Allergy - Intolerance Observation](#E_Substance_or_Device_Allergy__Intolera) | entry | 2.16.840.1.113883.10.20.24.3.90 |
| [Text Observation](#E_Text_Observation) | entry | 2.16.840.1.113883.10.20.6.2.12 |
| [Tobacco Use](#E_Tobacco_Use) | entry | 2.16.840.1.113883.10.20.22.4.85 |
| [Vital Sign Observation](#E_Vital_Sign_Observation) | entry | 2.16.840.1.113883.10.20.22.4.27 |
| [Vital Signs Organizer](#E_Vital_Signs_Organizer) | entry | 2.16.840.1.113883.10.20.22.4.26 |
| [Physician of Record Participant](#U_Physician_of_Record_Participant) | unspecified | 2.16.840.1.113883.10.20.6.2.2 |
| [Physician Reading Study Performer](#U_Physician_Reading_Study_Performer) | unspecified | 2.16.840.1.113883.10.20.6.2.1 |
| [US Realm Address (AD.US.FIELDED)](#U_US_Realm_Address_ADUSFIELDED) | unspecified | 2.16.840.1.113883.10.20.22.5.2 |
| [US Realm Date and Time (DT.US.FIELDED) [DEPRECATED]](#U_US_Realm_Date_and_Time_DTUSFIELDED_DE) | unspecified | 2.16.840.1.113883.10.20.22.5.3 |
| [US Realm Date and Time (DTM.US.FIELDED)](#U_US_Realm_Date_and_Time_DTMUSFIELDED) | unspecified | 2.16.840.1.113883.10.20.22.5.4 |
| [US Realm Patient Name (PTN.US.FIELDED)](#U_US_Realm_Patient_Name_PTNUSFIELDED) | unspecified | 2.16.840.1.113883.10.20.22.5.1 |
| [US Realm Person Name (PN.US.FIELDED)](#U_US_Realm_Person_Name_PNUSFIELDED) | unspecified | 2.16.840.1.113883.10.20.22.5.1.1 |

Table 176: Template Containments

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| --- | --- | --- |
| [Consultation Note](#D_Consultation_Note) | document | 2.16.840.1.113883.10.20.22.1.4 |
| [Allergies Section (entries optional)](#S_Allergies_Section_entries_optional) | section | 2.16.840.1.113883.10.20.22.2.6 |
| [Allergy Problem Act](#E_Allergy_Problem_Act) | entry | 2.16.840.1.113883.10.20.22.4.30 |
| [Allergy - Intolerance Observation](#E_Allergy__Intolerance_Observation) | entry | 2.16.840.1.113883.10.20.22.4.7 |
| [Allergy Status Observation](#E_Allergy_Status_Observation) | entry | 2.16.840.1.113883.10.20.22.4.28 |
| [Reaction Observation](#E_Reaction_Observation) | entry | 2.16.840.1.113883.10.20.22.4.9 |
| [Medication Activity](#E_Medication_Activity) | entry | 2.16.840.1.113883.10.20.22.4.16 |
| [Drug Vehicle](#E_Drug_Vehicle) | entry | 2.16.840.1.113883.10.20.22.4.24 |
| [Indication](#E_Indication) | entry | 2.16.840.1.113883.10.20.22.4.19 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Dispense](#E_Medication_Dispense) | entry | 2.16.840.1.113883.10.20.22.4.18 |
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| [Immunization Medication Information](#E_Immunization_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.54 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Information](#E_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.23 |
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| [Medication Supply Order](#E_Medication_Supply_Order) | entry | 2.16.840.1.113883.10.20.22.4.17 |
| [Immunization Medication Information](#E_Immunization_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.54 |
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| [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) | entry | 2.16.840.1.113883.10.20.22.4.14 |
| [Indication](#E_Indication) | entry | 2.16.840.1.113883.10.20.22.4.19 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
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| [Severity Observation](#E_Severity_Observation) | entry | 2.16.840.1.113883.10.20.22.4.8 |
| [Service Delivery Location](#E_Service_Delivery_Location) | entry | 2.16.840.1.113883.10.20.22.4.32 |
| [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) | entry | 2.16.840.1.113883.10.20.22.4.14 |
| [Indication](#E_Indication) | entry | 2.16.840.1.113883.10.20.22.4.19 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Activity](#E_Medication_Activity) | entry | 2.16.840.1.113883.10.20.22.4.16 |
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| [Indication](#E_Indication) | entry | 2.16.840.1.113883.10.20.22.4.19 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
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| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Information](#E_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.23 |
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| [Medication Supply Order](#E_Medication_Supply_Order) | entry | 2.16.840.1.113883.10.20.22.4.17 |
| [Immunization Medication Information](#E_Immunization_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.54 |
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| [Reaction Observation](#E_Reaction_Observation) | entry | 2.16.840.1.113883.10.20.22.4.9 |
| [Severity Observation](#E_Severity_Observation) | entry | 2.16.840.1.113883.10.20.22.4.8 |
| [Product Instance](#E_Product_Instance) | entry | 2.16.840.1.113883.10.20.22.4.37 |
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| [Caregiver Characteristics](#E_Caregiver_Characteristics) | entry | 2.16.840.1.113883.10.20.22.4.72 |
| [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) | entry | 2.16.840.1.113883.10.20.22.4.50 |
| [Product Instance](#E_Product_Instance) | entry | 2.16.840.1.113883.10.20.22.4.37 |
| [Functional Status Problem Observation](#E_Functional_Status_Problem_Observation) | entry | 2.16.840.1.113883.10.20.22.4.68 |
| [Assessment Scale Observation](#E_Assessment_Scale_Observation) | entry | 2.16.840.1.113883.10.20.22.4.69 |
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| [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) | entry | 2.16.840.1.113883.10.20.22.4.50 |
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| [Non-Medicinal Supply Activity](#E_NonMedicinal_Supply_Activity) | entry | 2.16.840.1.113883.10.20.22.4.50 |
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| [Medication Activity](#E_Medication_Activity) | entry | 2.16.840.1.113883.10.20.22.4.16 |
| [Drug Vehicle](#E_Drug_Vehicle) | entry | 2.16.840.1.113883.10.20.22.4.24 |
| [Indication](#E_Indication) | entry | 2.16.840.1.113883.10.20.22.4.19 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Dispense](#E_Medication_Dispense) | entry | 2.16.840.1.113883.10.20.22.4.18 |
| [Immunization Medication Information](#E_Immunization_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.54 |
| [Medication Information](#E_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.23 |
| [Medication Supply Order](#E_Medication_Supply_Order) | entry | 2.16.840.1.113883.10.20.22.4.17 |
| [Immunization Medication Information](#E_Immunization_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.54 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Information](#E_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.23 |
| [Medication Information](#E_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.23 |
| [Medication Supply Order](#E_Medication_Supply_Order) | entry | 2.16.840.1.113883.10.20.22.4.17 |
| [Immunization Medication Information](#E_Immunization_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.54 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Information](#E_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.23 |
| [Precondition for Substance Administration](#E_Precondition_for_Substance_Administrat) | entry | 2.16.840.1.113883.10.20.22.4.25 |
| [Procedure Activity Procedure](#E_Procedure_Activity_Procedure) | entry | 2.16.840.1.113883.10.20.22.4.14 |
| [Indication](#E_Indication) | entry | 2.16.840.1.113883.10.20.22.4.19 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Activity](#E_Medication_Activity) | entry | 2.16.840.1.113883.10.20.22.4.16 |
| [Drug Vehicle](#E_Drug_Vehicle) | entry | 2.16.840.1.113883.10.20.22.4.24 |
| [Indication](#E_Indication) | entry | 2.16.840.1.113883.10.20.22.4.19 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Dispense](#E_Medication_Dispense) | entry | 2.16.840.1.113883.10.20.22.4.18 |
| [Immunization Medication Information](#E_Immunization_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.54 |
| [Medication Information](#E_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.23 |
| [Medication Supply Order](#E_Medication_Supply_Order) | entry | 2.16.840.1.113883.10.20.22.4.17 |
| [Immunization Medication Information](#E_Immunization_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.54 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Information](#E_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.23 |
| [Medication Information](#E_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.23 |
| [Medication Supply Order](#E_Medication_Supply_Order) | entry | 2.16.840.1.113883.10.20.22.4.17 |
| [Immunization Medication Information](#E_Immunization_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.54 |
| [Instructions](#E_Instructions) | entry | 2.16.840.1.113883.10.20.22.4.20 |
| [Medication Information](#E_Medication_Information) | entry | 2.16.840.1.113883.10.20.22.4.23 |
| [Precondition for Substance Administration](#E_Precondition_for_Substance_Administrat) | entry | 2.16.840.1.113883.10.20.22.4.25 |
| [Product Instance](#E_Product_Instance) | entry | 2.16.840.1.113883.10.20.22.4.37 |
| [Service Delivery Location](#E_Service_Delivery_Location) | entry | 2.16.840.1.113883.10.20.22.4.32 |
| [Severity Observation](#E_Severity_Observation) | entry | 2.16.840.1.113883.10.20.22.4.8 |
| [Severity Observation](#E_Severity_Observation) | entry | 2.16.840.1.113883.10.20.22.4.8 |
| [Text Observation](#E_Text_Observation) | entry | 2.16.840.1.113883.10.20.6.2.12 |
| [Quantity Measurement Observation](#E_Quantity_Measurement_Observation) | entry | 2.16.840.1.113883.10.20.6.2.14 |
| [SOP Instance Observation](#E_SOP_Instance_Observation) | entry | 2.16.840.1.113883.10.20.6.2.8 |
| [Purpose of Reference Observation](#E_Purpose_of_Reference_Observation) | entry | 2.16.840.1.113883.10.20.6.2.9 |
| [Referenced Frames Observation](#E_Referenced_Frames_Observation) | entry | 2.16.840.1.113883.10.20.6.2.10 |
| [Boundary Observation](#E_Boundary_Observation) | entry | 2.16.840.1.113883.10.20.6.2.11 |
| [SOP Instance Observation](#E_SOP_Instance_Observation) | entry | 2.16.840.1.113883.10.20.6.2.8 |
| [Purpose of Reference Observation](#E_Purpose_of_Reference_Observation) | entry | 2.16.840.1.113883.10.20.6.2.9 |
| [Referenced Frames Observation](#E_Referenced_Frames_Observation) | entry | 2.16.840.1.113883.10.20.6.2.10 |
| [Boundary Observation](#E_Boundary_Observation) | entry | 2.16.840.1.113883.10.20.6.2.11 |
| [US Realm Address (AD.US.FIELDED)](#U_US_Realm_Address_ADUSFIELDED) | unspecified | 2.16.840.1.113883.10.20.22.5.2 |
| [US Realm Date and Time (DT.US.FIELDED) [DEPRECATED]](#U_US_Realm_Date_and_Time_DTUSFIELDED_DE) | unspecified | 2.16.840.1.113883.10.20.22.5.3 |
| [US Realm Date and Time (DTM.US.FIELDED)](#U_US_Realm_Date_and_Time_DTMUSFIELDED) | unspecified | 2.16.840.1.113883.10.20.22.5.4 |
| [US Realm Patient Name (PTN.US.FIELDED)](#U_US_Realm_Patient_Name_PTNUSFIELDED) | unspecified | 2.16.840.1.113883.10.20.22.5.1 |
| [US Realm Person Name (PN.US.FIELDED)](#U_US_Realm_Person_Name_PNUSFIELDED) | unspecified | 2.16.840.1.113883.10.20.22.5.1.1 |

1. <http://www.hl7.org/documentcenter/public/standards/dstu/CDAR2_IG_IHE_CONSOL_DSTU_R1dot1_2012JUL.zip> [↑](#footnote-ref-1)