Imaging examination result UK

Entity: OBSERVATION

Concept description:				Identification:		
Record the findings and interpretation of an imaging examination, or series of examinations, performed.				*Id*: openEHR-EHR-OBSERVATION.imaging_exam_uk.v0 *Reference model*: openEHR_EHR		
Purpose	**Use**	**Misuse**	**Copyright**	**References**	**Contact**	
To record the findings and interpretation of an imaging examination, or series of examinations, performed.	Use to record all results related to the diagnostic imaging aspects of any imaging examinations performed. Use to record the imaging examination components (only) of a more complex procedure, including those that may have been undertaken under imaging guidance. More complex procedures (such as echocardiaograms or Bone density scans) may be represented using templates or	Not to be used to record non-imaging examination findings or activities. For example when imaging is performed as part of a procedure the information related to the procedure must be recorded using the ACTION.procedure archetype or an OBSERVATION for the operative findings. This archetype will only be used to record the findings from the imaging. Not to be used to record details about any parallel procedure undertaken. Use the specific procedure-related archetypes, for	© openEHR Foundation	IHE.net Technical Frameworks - Radiology [Internet]. [date unknown];[cited 2011 Jan 2] Available from: http://www.ihe.net/Technical_Framework/index.cfm#radiology RSNA.org: Radiology Reporting [Internet]. [date unknown]; [cited 2011 Jan 2] Available from: http://www.rsna.org/Informatics/radreports.cfm Radiology Written Report Guideline Project (Draft Consultation); December 2010. Diagnostic Imaging data specifications; NEHTA, version 1.0, 2007 Jun 29. Imaging examination result, draft archetype, NEHTA Clinical Knowledge Manager [Internet]. London: NEHTA. Authored: 11 Feb 2007. Available at: http://dcm.nehta.org.au/ckm/#showArchetype_1013.1.943_6 (accessed 16 Sep 2013).	

specialised archetypes where additional report content is appropriate. Will normally be reported back to the requesting clinician as one component within the context of an overall COMPOSITION-based report.	example ACTION.procedure. Not to be used to record details about medications administered during the imaging test. Use specific medication-related archetypes, for example ACTION.medication.

Data

Structure: Tree

Concept	Description	Constraints	Values
T Examination result name	Identification of the imaging examination or procedure performed, typically including modality and anatomical location (including laterality). Coding with a terminology, potientially a pre-coordinated term specifying both modality and anatomical location, is desirable where possible. Possible candidate terminologies: LOINC, SNOMED CT or RadLex.	*Text* 0..1	Text;
T Modality	The imaging method used to perform the examination e.g Ultrasound, CT, X-ray. Coding with a terminology is desirable, where possible. If the modality is specified	*Text* 0..1	Text;

	by a code in the Examination result name, then this field is not required.		
T **Submodality**	Imaging submodality where further classification of imaging modality is required.	*Text* 0..1	Text;
(A)	Slot Anatomical site [Cluster]	Include : Cluster anatomical_location(-[a-zA-Z0-9_]+)*\.v1	Exclude : Cluster
T **Overall result status**	The status of the examination result as a whole.	*Text* 0..1	Internal; 'Registered', 'Interim', 'Final', 'Amended', 'Cancelled / Aborted'
DateTime result issued	The date and/or time that the result was issued for the recorded 'Examination result status'.	*DateTime* 0..1	Allow all
T **Clinical information provided**	Description of clinical information available at the time of interpretation of results, and which may a link to the original clinical information provided in the examination request.	*Text* 0..1	Text;
T **Findings**	Narrative description of findings, including comparative findings.	*Text* 0..1	Text;
(A)	Slot Result details [Cluster]	Include : Cluster	Exclude : Cluster
T **Radiological diagnosis**	Single word, phrase or brief description representing the 'Conclusion'. Coding with a terminology is preferred, where possible.	*Text* 0..*	Text;
T **Conclusion**	Concise and clinically contextualised narrative interpretation of the imaging examination findings.	*Text* 0..1	Text;
Examination result representation	Rich text representation of the entire result as issued by the diagnostic service. Multiple formats	*MultiMedia* 0..*	

Concept	Description	Constraints	Values
	are allowed but they must be semantically equivalent.		
T **Examination comment**	Additional narrative about the examination not captured in other fields. For example, recommendations for future examinations; a comment on appropriateness of the examination or on quality of images, if separate to findings; or a note that the film was given to the patient.	*Text* 0..1	Text;

State

Structure: Tree

Concept	Description	Constraints	Values
T **Confounding factors**	Record any issues or factors that may impact on the result or interpretation.	*Text* 0..*	Text;

Event Series

Events	Description	Constraints
Point in time	**A specific date and/or time which may be explicitly defined in a template or at run-time.**	PointEvent

Protocol

Structure: Tree

Concept	Description	Constraints	Values
A	Slot Receiving imaging service [Cluster]	Include : Cluster	Exclude : Cluster
Examination request details	Details concerning a single examination requested. Note: Usually there is one examination request for each result, however in some circumstances multiple examination requests may be represented using a single Imaging examination result archetype.	*Cluster* 0..*	
Requester order identifier	The local identifier assigned to the order by the order requester. Equivalent to the HL7 Placer Order Identifier.	*Identifier* 0..1	
T Examination requested name	Identification of imaging examination or procedure requested, where the examination requested differs from the examination actually performed.	*Text* 0..*	Text;
A	Slot Requester [Cluster]	Include : Cluster	Exclude : Cluster
Receiver order identifier	The local identifier assigned to the examination order by the order filler, usually by the Radiology Information System (RIS). Usually equivalent to the HL7 Filler Order Number.	*Identifier* 0..1	
www DICOM study identifier	Unique identifier of this study allocated by the imaging service.	*URI* 0..1	
Report identifier	The local identifier given to the imaging examination report.	*Identifier* 0..1	
Image details	Images referred to, or provided, to assist clinical understanding of the examination. If attached image is in	*Cluster* 0..*	

	DICOM format, all the fields below should be populated so the values are available to software that does not process DICOM images.		
☐ **Image identifier**	Unique identifier of this image allocated by the imaging service (often the DICOM image instance UID).	*Identifier* 0..1	
☐ **DICOM series identifier**	Unique identifier of this series allocated by the imaging service.	*Identifier* 0..1	
T View	The name of the imaging view e.g Lateral or Antero-posterior (AP). Coding using a terminology is desirable, where possible.	*Text* 0..1	Text;
T Position	Description of the subject of care's positon when the image was performed.	*Text* 0..1	Text;
Image DateTime	Specific date/time the imaging examination was performed.	*DateTime* 0..1	Allow all
Image	An attached or referenced image of a current view.	*MultiMedia* 0..1	
A	Slot Examination procedure [Cluster]	Include : Cluster	Exclude : Cluster
Compared image details	Details of previous images used for comparison.	*Cluster* 0..*	
☐ **Requester order identifier**	The local identifier assigned to the order by the order requester. Equivalent to the HL7 Placer Order Identifier.	*Identifier* 0..1	
www**DICOM study identifier**	Unique identifier of this study allocated by the imaging service.	*URI* 0..1	
☐ **Image identifier**	Unique identifier of this image allocated by the imaging service	*Identifier* 0..1	

	(often the DICOM image instance UID).		
☐ **DICOM series identifier**	Unique identifier of this series allocated by the imaging service.	*Identifier* 0..1	
T **View**	The name of the imaging view e.g Lateral or Antero-posterior (AP). Coding using a terminology is desirable, where possible.	*Text* 0..1	Text;
T **Position**	Description of the subject of care's positon when the image was performed.	*Text* 0..1	Text;
Image DateTime	Specific date/time the imaging examination was performed.	*DateTime* 0..1	Allow all
Image	An attached or referenced image of a current view.	*MultiMedia* 0..1	
A	Slot Extension [Cluster]	Include : Cluster	Exclude : Cluster