

1.1.20 Referral Note (V2)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.14:2015-08-01 (open)]

Table 51: Referral Note (V2) Contexts

Contained By:	Contains:
	Assessment Section (optional) Review of Systems Section (optional) History of Present Illness Section (optional) General Status Section (optional) US Realm Person Name (PN.US.FIELDDED) (optional) US Realm Person Name (PN.US.FIELDDED) (required) Medications Section (entries required) (V2) (required) Plan of Treatment Section (V2) (optional) Medical Equipment Section (V2) (optional) Nutrition Section (optional) Procedures Section (entries optional) (V2) (optional) Functional Status Section (V2) (optional) Reason for Referral Section (V2) (required) Assessment and Plan Section (V2) (optional) Mental Status Section (V2) (optional) Immunizations Section (entries required) (V3) (optional) Results Section (entries required) (V3) (optional) Past Medical History (V3) (optional) Vital Signs Section (entries required) (V3) (optional) Problem Section (entries required) (V3) (required) Physical Exam Section (V3) (optional) Social History Section (V3) (optional) Advance Directives Section (entries optional) (V3) (optional) Family History Section (V3) (optional) Allergies and Intolerances Section (entries required) (V3) (required)

A Referral Note communicates pertinent information from a provider who is requesting services of another provider of clinical or non-clinical services. The information in this document includes the reason for the referral and additional information that would augment decision making and care delivery.

Examples of referral situations are when a patient is referred from a family physician to a cardiologist for cardiac evaluation or when patient is sent by a cardiologist to an emergency department for angina or when a patient is referred by a nurse practitioner to an audiologist for hearing screening or when a patient is referred by a hospitalist to social services.

Table 52: Referral Note (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.14:2015-08-01)					
templateId	1..1	SHALL		1198-28947	
@root	1..1	SHALL		1198-28948	2.16.840.1.113883.10.20.22.1.14
@extension	1..1	SHALL		1198-32911	2015-08-01
code	1..1	SHALL		1198-28949	
@code	1..1	SHALL		1198-32967	urn:oid:2.16.840.1.113883.1.11.20.2.3 (ReferralDocumentType)
informationRecipient	1..1	SHALL		1198-31589	
intendedRecipient	1..1	SHALL		1198-31590	
addr	0..*	SHOULD		1198-31591	
telecom	0..*	SHOULD		1198-31592	
informationRecipient	1..1	SHALL		1198-31593	
name	1..*	SHALL		1198-31594	US Realm Person Name (PN.US.FIELDDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)
participant	0..*	SHOULD		1198-31642	
@typeCode	1..1	SHALL		1198-31924	urn:oid:2.16.840.1.113883.5.90 (HL7ParticipationType) = IND
associatedEntity	1..1	SHALL		1198-31643	
@classCode	1..1	SHALL		1198-31925	urn:oid:2.16.840.1.113883.11.20.9.33 (INDRoleclassCodes)
associatedPerson	1..1	SHALL		1198-31644	
name	1..*	SHALL		1198-31645	US Realm Person Name (PN.US.FIELDDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)
participant	0..*	SHOULD		1198-31647	
@typeCode	1..1	SHALL		1198-31648	urn:oid:2.16.840.1.113883.5.90 (HL7ParticipationType) =

XPath	Card.	Verb	Data Type	CONF#	Value
					CALLBCK
associatedEntity	1..1	SHALL		1198-31649	
@classCode	1..1	SHALL		1198-32419	urn:oid:2.16.840.1.113883.5.110 (HL7RoleClass) = ASSIGNED
id	1..*	SHALL		1198-31650	
addr	0..*	SHOULD		1198-31651	
telecom	1..*	SHALL		1198-31652	
associatedPerson	1..1	SHALL		1198-31653	
name	1..*	SHALL		1198-31654	
scopingOrganization	0..1	MAY		1198-31655	
component	1..1	SHALL		1198-29062	
structuredBody	1..1	SHALL		1198-29063	
component	0..1	SHOULD		1198-29066	
section	1..1	SHALL		1198-29067	Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09)
component	0..1	MAY		1198-29068	
section	1..1	SHALL		1198-29069	Advance Directives Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2015-08-01)
component	0..1	MAY		1198-29074	
section	1..1	SHALL		1198-29075	History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4)
component	0..1	MAY		1198-29076	
section	1..1	SHALL		1198-29077	Family History Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2015-08-01)

XPath	Card.	Verb	Data Type	CONF#	Value
component	0..1	MAY		1198-29082	
section	1..1	SHALL		1198-29083	Immunizations Section (entries required) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.1.0.20.22.2.2.1:2015-08-01)
component	1..1	SHALL		1198-29086	
section	1..1	SHALL		1198-29087	Problem Section (entries required) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.1.0.20.22.2.5.1:2015-08-01)
component	0..1	MAY		1198-29088	
section	1..1	SHALL		1198-29089	Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.1.0.20.22.2.7:2014-06-09)
component	0..1	SHOULD		1198-29090	
section	1..1	SHALL		1198-29091	Results Section (entries required) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.1.0.20.22.2.3.1:2015-08-01)
component	0..1	MAY		1198-29092	
section	1..1	SHALL		1198-29093	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18)
component	0..1	MAY		1198-29094	
section	1..1	SHALL		1198-29095	Social History Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.1.0.20.22.2.17:2015-08-01)
component	0..1	MAY		1198-29096	
section	1..1	SHALL		1198-29097	Vital Signs Section (entries required) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.1.0.20.22.2.4.1:2015-08-01)
component	0..1	SHOULD		1198-29098	
section	1..1	SHALL		1198-29099	Functional Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.1

XPath	Card.	Verb	Data Type	CONF#	Value
					0.20.22.2.14:2014-06-09
component	0..1	MAY		1198-29100	
section	1..1	SHALL		1198-29101	Physical Exam Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.10:2015-08-01)
component	0..1	SHOULD		1198-30780	
section	1..1	SHALL		1198-30781	Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57)
component	0..1	SHOULD		1198-30796	
section	1..1	SHALL		1198-30926	Mental Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.56:2015-08-01)
component	0..1	MAY		1198-30798	
section	1..1	SHALL		1198-30799	Medical Equipment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09)
component	1..1	SHALL		1198-30911	
section	1..1	SHALL		1198-30912	Allergies and Intolerances Section (entries required) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2015-08-01)
component	0..1	MAY		1198-30913	
section	1..1	SHALL		1198-30914	Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8)
component	0..1	MAY		1198-30915	
section	1..1	SHALL		1198-30916	Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09)
component	0..1	MAY		1198-30917	
section	1..1	SHALL		1198-30918	Past Medical History (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2015-08-01)

XPath	Card.	Verb	Data Type	CONF#	Value
component	0..1	MAY		1198-30919	
section	1..1	SHALL		1198-30920	General Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.5)
component	1..1	SHALL		1198-30922	
section	1..1	SHALL		1198-30923	Medications Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.1.0.20.22.2.1.1:2014-06-09)
component	1..1	SHALL		1198-30924	
section	1..1	SHALL		1198-30925	Reason for Referral Section (V2) (identifier: urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.1:2014-06-09)

1. Conforms to [US Realm Header \(V3\)](#) template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2015-08-01).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:1198-28947) such that it
 - a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.14" (CONF:1198-28948).
 - b. **SHALL** contain exactly one [1..1] **@extension**="2015-08-01" (CONF:1198-32911).
 - c. When asserting this templateId, all C-CDA 2.1 section and entry templates that had a previous version in C-CDA R1.1 **SHALL** include both the C-CDA 2.1 templateId and the C-CDA R1.1 templateId root without an extension. See C-CDA R2.1 Volume 1 - Design Considerations for additional detail (CONF:1198-32943).

The Referral Note recommends use of the document type code 57133-1 "Referral Note", with further specification provided by author or performer, setting, or specialty. When pre-coordinated codes are used, any coded values describing the author or performer of the service act or the practice setting must be consistent with the LOINC document type. For example, an Obstetrics and Gynecology Referral note would not be authored by a Pediatric Cardiologist. The type of referral and the target of the referral are specified via the participant (and not via the author).

3. **SHALL** contain exactly one [1..1] **code** (CONF:1198-28949).
 - a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet [ReferralDocumentType](#) urn:oid:2.16.840.1.113883.1.11.20.2.3 **DYNAMIC** (CONF:1198-32967).
4. **SHALL** contain exactly one [1..1] **informationRecipient** (CONF:1198-31589).
 - a. This informationRecipient **SHALL** contain exactly one [1..1] **intendedRecipient** (CONF:1198-31590).

- i. This intendedRecipient **SHOULD** contain zero or more [0..*] **addr** (CONF:1198-31591).
 - ii. This intendedRecipient **SHOULD** contain zero or more [0..*] **telecom** (CONF:1198-31592).
 - iii. This intendedRecipient **SHALL** contain exactly one [1..1] **informationRecipient** (CONF:1198-31593).
 - 1. This informationRecipient **SHALL** contain at least one [1..*] US Realm Person Name (PN.US.FIELDDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-31594).
- 5. **SHOULD** contain zero or more [0..*] **participant** (CONF:1198-31642) such that it
 - a. **SHALL** contain exactly one [1..1] **@typeCode="IND"** Indirect (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90) (CONF:1198-31924).
 - b. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1198-31643).
 - i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode**, which **SHALL** be selected from ValueSet INDRoleclassCodes urn:oid:2.16.840.1.113883.11.20.9.33 **DYNAMIC** (CONF:1198-31925).
 - ii. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1198-31644).
 - 1. This associatedPerson **SHALL** contain at least one [1..*] US Realm Person Name (PN.US.FIELDDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-31645).

This participant represents the clinician to contact for questions about the referral note. This call back contact individual may be a different person than the individual(s) identified in the author or legalAuthenticator participant.

- 6. **SHOULD** contain zero or more [0..*] **participant** (CONF:1198-31647) such that it
 - a. **SHALL** contain exactly one [1..1] **@typeCode="CALLBCK"** call back contact (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90 **DYNAMIC**) (CONF:1198-31648).
 - b. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1198-31649).
 - i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode="ASSIGNED"** assigned entity (CodeSystem: HL7RoleClass urn:oid:2.16.840.1.113883.5.110) (CONF:1198-32419).
 - ii. This associatedEntity **SHALL** contain at least one [1..*] **id** (CONF:1198-31650).
 - iii. This associatedEntity **SHOULD** contain zero or more [0..*] **addr** (CONF:1198-31651).
 - iv. This associatedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:1198-31652).
 - v. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1198-31653).
 - 1. This associatedPerson **SHALL** contain at least one [1..*] **name** (CONF:1198-31654).

- vi. This associatedEntity **MAY** contain zero or one [0..1] **scopingOrganization** (CONF:1198-31655).
- 7. **SHALL** contain exactly one [1..1] **component** (CONF:1198-29062).
 - a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1198-29063).
 - i. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-29066) such that it
 - 1. **SHALL** contain exactly one [1..1] [Plan of Treatment Section \(V2\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1198-29067).
 - ii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-29068) such that it
 - 1. **SHALL** contain exactly one [1..1] [Advance Directives Section \(entries optional\) \(V3\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2015-08-01) (CONF:1198-29069).
 - iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-29074) such that it
 - 1. **SHALL** contain exactly one [1..1] [History of Present Illness Section](#) (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1198-29075).
 - iv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-29076) such that it
 - 1. **SHALL** contain exactly one [1..1] [Family History Section \(V3\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2015-08-01) (CONF:1198-29077).
 - v. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-29082) such that it
 - 1. **SHALL** contain exactly one [1..1] [Immunizations Section \(entries required\) \(V3\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2015-08-01) (CONF:1198-29083).
 - vi. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-29086) such that it
 - 1. **SHALL** contain exactly one [1..1] [Problem Section \(entries required\) \(V3\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2015-08-01) (CONF:1198-29087).
 - vii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-29088) such that it
 - 1. **SHALL** contain exactly one [1..1] [Procedures Section \(entries optional\) \(V2\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09) (CONF:1198-29089).

- viii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-29090) such that it
 - 1. **SHALL** contain exactly one [1..1] [Results Section \(entries required\) \(V3\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2015-08-01) (CONF:1198-29091).
- ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-29092) such that it
 - 1. **SHALL** contain exactly one [1..1] [Review of Systems Section](#) (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1198-29093).
- x. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-29094) such that it
 - 1. **SHALL** contain exactly one [1..1] [Social History Section \(V3\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2015-08-01) (CONF:1198-29095).
- xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-29096) such that it
 - 1. **SHALL** contain exactly one [1..1] [Vital Signs Section \(entries required\) \(V3\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2015-08-01) (CONF:1198-29097).
- xii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-29098) such that it
 - 1. **SHALL** contain exactly one [1..1] [Functional Status Section \(V2\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09) (CONF:1198-29099).
- xiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-29100) such that it
 - 1. **SHALL** contain exactly one [1..1] [Physical Exam Section \(V3\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2015-08-01) (CONF:1198-29101).
- xiv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-30780) such that it
 - 1. **SHALL** contain exactly one [1..1] [Nutrition Section](#) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1198-30781).
- xv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-30796) such that it
 - 1. **SHALL** contain exactly one [1..1] [Mental Status Section \(V2\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.56:2015-08-01) (CONF:1198-30926).

- xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30798) such that it
1. **SHALL** contain exactly one [1..1] [Medical Equipment Section \(V2\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09) (CONF:1198-30799).
- xvii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30911) such that it
1. **SHALL** contain exactly one [1..1] [Allergies and Intolerances Section \(entries required\) \(V3\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2015-08-01) (CONF:1198-30912).
- xviii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30913) such that it
1. **SHALL** contain exactly one [1..1] [Assessment Section](#) (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1198-30914).
- xix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30915) such that it
1. **SHALL** contain exactly one [1..1] [Assessment and Plan Section \(V2\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1198-30916).
- xx. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30917) such that it
1. **SHALL** contain exactly one [1..1] [Past Medical History \(V3\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2015-08-01) (CONF:1198-30918).
- xxi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30919) such that it
1. **SHALL** contain exactly one [1..1] [General Status Section](#) (identifier: urn:oid:2.16.840.1.113883.10.20.2.5) (CONF:1198-30920).
- xxii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30922) such that it
1. **SHALL** contain exactly one [1..1] [Medications Section \(entries required\) \(V2\)](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09) (CONF:1198-30923).
- xxiii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30924) such that it
1. **SHALL** contain exactly one [1..1] [Reason for Referral Section \(V2\)](#) (identifier: urn:hl7ii:1.3.6.1.4.1.19376.1.5.3.1.3.1:2014-06-09) (CONF:1198-30925).

- xxiv. This structuredBody **SHALL** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09), or an Assessment Section (2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1198-29102).
- xxv. This structuredBody **SHALL NOT** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1198-29103).

Table 53: ReferralDocumentType

Value Set: ReferralDocumentType urn:oid:2.16.840.1.113883.1.11.20.2.3 (Clinical Focus: A LOINC concept that indicates the focus of the referral note),(Data Element Scope: C-CDA r2.1 @code in ReferralNote(V2) [ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.14:2015- 08-01 (open)] DYNAMIC),(Inclusion Criteria: LOINC document concepts for referral notes),(Exclusion Criteria: only those in the inclusion criteria) This value set was imported on 6/29/2019 with a version of 20190516. Value Set Source: https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.1.11.20.2.3/expansion			
Code	Code System	Code System OID	Print Name
57133-1	LOINC	urn:oid:2.16.840.1.113883.6.1	Referral note
57134-9	LOINC	urn:oid:2.16.840.1.113883.6.1	Dentistry Referral note
57135-6	LOINC	urn:oid:2.16.840.1.113883.6.1	Dermatology Referral note
57136-4	LOINC	urn:oid:2.16.840.1.113883.6.1	Diabetology Referral note
57137-2	LOINC	urn:oid:2.16.840.1.113883.6.1	Endocrinology Referral note
57138-0	LOINC	urn:oid:2.16.840.1.113883.6.1	Gastroenterology Referral note
57139-8	LOINC	urn:oid:2.16.840.1.113883.6.1	General medicine Referral note
57141-4	LOINC	urn:oid:2.16.840.1.113883.6.1	Infectious disease Referral note
57142-2	LOINC	urn:oid:2.16.840.1.113883.6.1	Kinesiotherapy Referral note
57143-0	LOINC	urn:oid:2.16.840.1.113883.6.1	Mental health Referral note
...			

Figure 37: Referral Note informationRecipient Example

```
<informationRecipient>
  <intendedRecipient>
    <informationRecipient>
      <name>
        <given>Nancy</given>
        <family>Nightingale</family>
        <suffix qualifier="AC">RN</suffix>
      </name>
    </informationRecipient>
  </intendedRecipient>
  <receivedOrganization>
    <name>Community Health and Hospitals</name>
    <telecom value="tel:+1(555)-555-1002" use="WP" />
    <addr use="WP">
      <streetAddressLine>Cardiac Stepdown Unit, 4B </streetAddressLine>
      <streetAddressLine>1002 Healthcare Drive </streetAddressLine>
      <city>Ann Arbor</city>
      <state>MI</state>
      <postalCode>97857</postalCode>
      <country>US</country>
    </addr>
  </receivedOrganization>
</intendedRecipient>
</informationRecipient>
```

Figure 38: Referral Note Caregiver Example

```
<participant typeCode="IND">
  <functionCode code="407543004" displayName="Primary Carer"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED-CT" />
  <!-- Caregiver -->
  <associatedEntity classCode="CAREGIVER">
    <code code="MTH" codeSystem="2.16.840.1.113883.5.111" />
    <addr>
      <streetAddressLine>17 Daws Rd.</streetAddressLine>
      <city>Ann Arbor</city>
      <state>MI</state>
      <postalCode>97857</postalCode>
      <country>US</country>
    </addr>
    <telecom value="tel: 1+(555)555-1212" use="WP" />
    <associatedPerson>
      <name>
        <prefix>Mrs.</prefix>
        <given>Martha</given>
        <family>Jones</family>
      </name>
    </associatedPerson>
  </associatedEntity>
</participant>
```

Figure 39: Referral Note Callback Contact Example

```
<participant typeCode="CALLBCK">
  <time value="20050329224411+0500" />
  <associatedEntity classCode="ASSIGNED">
    <id extension="99999999" root="2.16.840.1.113883.4.6" />
    <code code="200000000X" codeSystem="2.16.840.1.113883.6.101"
displayName="Allopathic & Osteopathic Physicians" />
    <addr>
      <streetAddressLine>1002 Healthcare Drive </streetAddressLine>
      <city>Ann Arbor</city>
      <state>MI</state>
      <postalCode>97857</postalCode>
      <country>US</country>
    </addr>
    <telecom use="WP" value="tel:555-555-1002" />
    <associatedPerson>
      <name>
        <given>Henry</given>
        <family>Seven</family>
        <suffix>DO</suffix>
      </name>
    </associatedPerson>
  </associatedEntity>
</participant>
```

1.1.21 Transfer Summary (V2)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.13:2015-08-01 (open)]

Table 54: Transfer Summary (V2) Contexts

Contained By:	Contains:
	Assessment Section (optional) Review of Systems Section (optional) History of Present Illness Section (optional) General Status Section (optional) Medications Section (entries required) (V2) (required) Plan of Treatment Section (V2) (optional) Medical Equipment Section (V2) (optional) Nutrition Section (optional) Procedures Section (entries required) (V2) (optional) Functional Status Section (V2) (optional) Reason for Referral Section (V2) (required) Assessment and Plan Section (V2) (optional) Course of Care Section (optional) Admission Diagnosis Section (V3) (optional) Mental Status Section (V2) (optional) Immunizations Section (entries optional) (V3) (optional) Discharge Diagnosis Section (V3) (optional) Results Section (entries required) (V3) (required) Admission Medications Section (entries optional) (V3) (optional) Past Medical History (V3) (optional) Vital Signs Section (entries required) (V3) (required) Problem Section (entries required) (V3) (required) Physical Exam Section (V3) (optional) Payers Section (V3) (optional) Social History Section (V3) (optional) Advance Directives Section (entries required) (V3) (optional) Family History Section (V3) (optional) Allergies and Intolerances Section (entries required) (V3) (required) Encounters Section (entries required) (V3) (optional)

This document describes constraints on the Clinical Document Architecture (CDA) header and body elements for a Transfer Summary. The Transfer Summary standardizes critical information for exchange of information between providers of care when a patient moves between health care settings. Standardization of information used in this form will promote interoperability; create information suitable for reuse in quality measurement, public health, research, and for reimbursement.