If section/@nullFlavor is not present:

7. **SHALL** contain at least one [1..*] **entry** (CONF:1198-8709) such that it
   a. **SHALL** contain exactly one [1..1] **Encounter Activity (V3)** (identifier:
      urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2015-08-01) (CONF:1198-
      15468).

Figure 70: Encounters Section (entries required) (V3) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.22.1" extension="2015-08-01" />
    <!-- Encounters Section - Entries required -->
    <code code="46240-8" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="History of encounters" />
    <title>Encounters</title>
    <text>
    ...
  </text>
    <entry typeCode="DRIV">
        <encounter classCode="ENC" moodCode="EVN">
            <!-- Encounter Activities -->
            ...

        </encounter>
    </entry>
</section>
```

2.17 Family History Section (V3)

```
[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2015-08-01
(open)]
```

Table 100: Family History Section (V3) Contexts

Contained By:	Contains:
Consultation Note (V3) (optional)	Family History Organizer (V3) (optional)
Continuity of Care Document (CCD) (V3) (optional)	
Discharge Summary (V3) (optional)	
History and Physical (V3) (required)	
Transfer Summary (V2) (optional)	
Referral Note (V2) (optional)	
Procedure Note (V3) (optional)	

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.

Table 101: Family History Section (V3) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2015-08-01)					
templateId	1..1	SHALL		1198-7932	
@root	1..1	SHALL		1198-10388	2.16.840.1.113883.10.20.22.2.15
@extension	1..1	SHALL		1198-32607	2015-08-01
code	1..1	SHALL		1198-15469	
@code	1..1	SHALL		1198-15470	10157-6
@codeSystem	1..1	SHALL		1198-32481	urn:oid:2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1198-7934	
text	1..1	SHALL		1198-7935	
entry	0..*	MAY		1198-32430	
organizer	1..1	SHALL		1198-32431	Family History Organizer (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2015-08-01)

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1198-7932) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.15" (CONF:1198-10388).
   b. **SHALL** contain exactly one [1..1] **@extension**="2015-08-01" (CONF:1198-32607).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1198-15469).
   a. This code **SHALL** contain exactly one [1..1] **@code**="10157-6" Family History (CONF:1198-15470).
   b. This code **SHALL** contain exactly one [1..1] **@codeSystem**="2.16.840.1.113883.6.1" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:1198-32481).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1198-7934).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1198-7935).
5. **MAY** contain zero or more [0..*] **entry** (CONF:1198-32430) such that it
   a. **SHALL** contain exactly one [1..1] **Family History Organizer (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.45:2015-08-01) (CONF:1198-32431).

Figure 71: Family History Section (V3) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.15" extension="2015-08-01" />
    <!-- Family history section template -->
    <code code="10157-6" codeSystem="2.16.840.1.113883.6.1" />
    <title>Family history</title>
    <text>
    ...
  </text>
    <entry typeCode="DRIV">
        <organizer moodCode="EVN" classCode="CLUSTER">
            <templateId root="2.16.840.1.113883.10.20.22.4.45" />
            <!--    Family history organizer template   -->
        ...


        </organizer>
    </entry>
</section>
```

2.18 Fetus Subject Context

[relatedSubject: identifier urn:oid:2.16.840.1.113883.10.20.6.2.3 (open)]

Table 102: Fetus Subject Context Contexts

Contained By:	Contains:
Diagnostic Imaging Report (V3) (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.