Figure 34: Procedure Note serviceEvent Example

```
<documentationOf>
    <serviceEvent classCode="PROC">
       <code code="118155006" codeSystem="2.16.840.1.113883.6.96"
             codeSystemName="SNOMED CT" displayName="Gastrointestinal tract endoscopy" />
       <effectiveTime>
         <low value="201003292240" />
         <width value="15" unit="m" />
       </effectiveTime>
       ...
    </serviceEvent>
</documentationOf>
```

1.1.18 Progress Note (V3)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.9:2015-08-01 (open)]

Table 48: Progress Note (V3) Contexts

Contained By:	Contains:
	Assessment Section (optional) Review of Systems Section (optional) Chief Complaint Section (optional) Objective Section (optional) Subjective Section (optional) Medications Section (entries optional) (V2) (optional) Plan of Treatment Section (V2) (optional) Nutrition Section (optional) Assessment and Plan Section (V2) (optional) Instructions Section (V2) (optional) US Realm Date and Time (DT.US.FIELDED) (optional) US Realm Date and Time (DT.US.FIELDED) (required) Results Section (entries optional) (V3) (optional) Vital Signs Section (entries optional) (V3) (optional) Problem Section (entries optional) (V3) (optional) Physical Exam Section (V3) (optional) Interventions Section (V3) (optional) Allergies and Intolerances Section (entries optional) (V3) (optional)

This template represents a patient's clinical status during a hospitalization, outpatient visit, treatment with a LTPAC provider, or other healthcare 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.

Table 49: Progress Note (V3) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.9:2015-08-01)					
templateId	1..1	SHALL		1198-7588	
@root	1..1	SHALL		1198-10052	2.16.840.1.113883.10.20.22.1.9
@extension	1..1	SHALL		1198-32521	2015-08-01
code	1..1	SHALL		1198-17189	
@code	1..1	SHALL		1198-17190	urn:oid:2.16.840.1.113883.11.20.8.1 (ProgressNoteDocumentTypeCode)
documentationOf	0..1	SHOULD		1198-7603	
serviceEvent	1..1	SHALL		1198-7604	
@classCode	1..1	SHALL		1198-26420	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass) = PCPR
templateId	1..1	SHALL		1198-9480	
@root	1..1	SHALL		1198-10068	2.16.840.1.113883.10.20.21.3.1
effectiveTime	1..1	SHALL		1198-9481	US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3
low	1..1	SHALL		1198-32976	
componentOf	1..1	SHALL		1198-7595	
encompassingEncounter	1..1	SHALL		1198-7596	
id	1..*	SHALL		1198-7597	
effectiveTime	1..1	SHALL		1198-7598	US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3

XPath	Card.	Verb	Data Type	CONF#	Value
low	1..1	SHALL		1198-7599	
location	1..1	SHALL		1198-30879	
healthCareFacility	1..1	SHALL		1198-30880	
id	1..*	SHALL		1198-30881	
component	1..1	SHALL		1198-9591	
structuredBody	1..1	SHALL		1198-30617	
component	0..1	MAY		1198-30618	
section	1..1	SHALL		1198-30619	Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8
component	0..1	MAY		1198-30620	
section	1..1	SHALL		1198-30621	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		1198-30622	
section	1..1	SHALL		1198-30623	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		1198-30624	
section	1..1	SHALL		1198-30625	Allergies and Intolerances Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2015-08-01
component	0..1	MAY		1198-30626	
section	1..1	SHALL		1198-30627	Chief Complaint Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1
component	0..1	MAY		1198-30628	
section	1..1	SHALL		1198-30629	Interventions Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.1

XPath	Card.	Verb	Data Type	CONF#	Value
					0.20.21.2.3:2015-08-01
component	0..1	MAY		1198-30639	
section	1..1	SHALL		1198-31386	Instructions Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09
component	0..1	MAY		1198-30641	
section	1..1	SHALL		1198-30642	Medications Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09
component	0..1	MAY		1198-30643	
section	1..1	SHALL		1198-30644	Objective Section (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.1
component	0..1	MAY		1198-30645	
section	1..1	SHALL		1198-30646	Physical Exam Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2015-08-01
component	0..1	MAY		1198-30647	
section	1..1	SHALL		1198-30648	Problem Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2015-08-01
component	0..1	MAY		1198-30649	
section	1..1	SHALL		1198-30650	Results Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2015-08-01
component	0..1	MAY		1198-30651	
section	1..1	SHALL		1198-30652	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18
component	0..1	MAY		1198-30653	
section	1..1	SHALL		1198-30654	Subjective Section (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.2

XPath	Card.	Verb	Data Type	CONF#	Value
component	0..1	MAY		1198-30655	
section	1..1	SHALL		1198-30656	Vital Signs Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2015-08-01
component	0..1	MAY		1198-32626	
section	1..1	SHALL		1198-32627	Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57

1.1.19 Properties

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:1198-7588) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.9" (CONF:1198-10052).
    b. **SHALL** contain exactly one [1..1] **@extension**="2015-08-01" (CONF:1198-32521).
    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:1198-32942).

The Progress Note recommends use of a single document type code, 11506-3 "Subsequent evaluation 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.

3. **SHALL** contain exactly one [1..1] **code** (CONF:1198-17189).
    a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ProgressNoteDocumentTypeCode** urn:oid:2.16.840.1.113883.11.20.8.1 **DYNAMIC** (CONF:1198-17190).

1.1.19.1 documentationOf

A documentationOf can contain a serviceEvent to further specialize the act inherent in the ClinicalDocument/code. In a Progress Note, a serviceEvent can represent the event of writing the Progress Note. The serviceEvent/effectiveTime is the time period the note documents.

4. **SHOULD** contain zero or one [0..1] **documentationOf** (CONF:1198-7603).
    a. The documentationOf, if present, **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1198-7604).

i. This serviceEvent **SHALL** contain exactly one [1..1] **@classCode**="PCPR" Care Provision (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 **STATIC**) (CONF:1198-26420).

ii. This serviceEvent **SHALL** contain exactly one [1..1] **templateId** (CONF:1198-9480) such that it

1. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.21.3.1" (CONF:1198-10068).

iii. This serviceEvent **SHALL** contain exactly one [1..1] **US Realm Date and Time (DT.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1198-9481).

1. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1198-32976).
2. If a width element is not present, the serviceEvent **SHALL** include effectiveTime/high (CONF:1198-10066).

1.1.19.2 componentOf

The Progress Note is always associated with an encounter by the componentOf/encompassingEncounter element in the header. The effectiveTime element for an encompassingEncounter represents the time or time interval in which the encounter took place. A single encounter may contain multiple Progress Notes; hence the effectiveTime elements for a Progress Note (recorded in serviceEvent) and for an encounter (recorded in encompassingEncounter) represent different time intervals. For outpatient encounters that are a point in time, set effectiveTime/high, effectiveTime/low, and effectiveTime/@value to the same time. All visits take place at a specific location. When available, the location ID is included in the encompassingEncounter/location/healthCareFacility/id element.

5. **SHALL** contain exactly one [1..1] **componentOf** (CONF:1198-7595).
    a. This componentOf **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1198-7596).
        i. This encompassingEncounter **SHALL** contain at least one [1..*] **id** (CONF:1198-7597).
        ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **US Realm Date and Time (DT.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1198-7598).
            1. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1198-7599).
        iii. This encompassingEncounter **SHALL** contain exactly one [1..1] **location** (CONF:1198-30879).
            1. This location **SHALL** contain exactly one [1..1] **healthCareFacility** (CONF:1198-30880).
                a. This healthCareFacility **SHALL** contain at least one [1..*] **id** (CONF:1198-30881).

1.1.19.3 component

6. **SHALL** contain exactly one [1..1] **component** (CONF:1198-9591).

In this template (templateId 2.16.840.1.113883.10.20.22.1.9.2), coded entries are optional

a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1198-30617).
    i. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30618) 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:1198-30619).
    ii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30620) 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:1198-30621).
    iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30622) 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:1198-30623).
    iv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30624) such that it
        1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2015-08-01) (CONF:1198-30625).
    v. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30626) such that it
        1. **SHALL** contain exactly one [1..1] **Chief Complaint Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1198-30627).
    vi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30628) such that it
        1. **SHALL** contain exactly one [1..1] **Interventions Section (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2015-08-01) (CONF:1198-30629).
    vii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30639) such that it
        1. **SHALL** contain exactly one [1..1] **Instructions Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.45:2014-06-09) (CONF:1198-31386).
    viii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30641) such that it

1. **SHALL** contain exactly one [1..1] **Medications Section (entries optional) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09) (CONF:1198-30642).

ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30643) such that it
    1. **SHALL** contain exactly one [1..1] **Objective Section** (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.1) (CONF:1198-30644).

x. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30645) such that it
    1. **SHALL** contain exactly one [1..1] **Physical Exam Section (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2015-08-01) (CONF:1198-30646).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30647) such that it
    1. **SHALL** contain exactly one [1..1] **Problem Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5:2015-08-01) (CONF:1198-30648).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30649) such that it
    1. **SHALL** contain exactly one [1..1] **Results Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3:2015-08-01) (CONF:1198-30650).

xiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30651) 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:1198-30652).

xiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30653) such that it
    1. **SHALL** contain exactly one [1..1] **Subjective Section** (identifier: urn:oid:2.16.840.1.113883.10.20.21.2.2) (CONF:1198-30654).

xv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30655) such that it
    1. **SHALL** contain exactly one [1..1] **Vital Signs Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4:2015-08-01) (CONF:1198-30656).

xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-32626) 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:1198-32627).

xvii. 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:1198-30657).

xviii. 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:1198-30658).

Table 50: ProgressNoteDocumentTypeCode

Value Set: ProgressNoteDocumentTypeCode urn:oid:2.16.840.1.113883.11.20.8.1

(Clinical Focus: Progress note kind classified by setting, author role, and author specialization),(Data Element Scope: ClinicalDocument.code@code in Progress Note Document template in C-CDA R2.1),(Inclusion Criteria: LOINC document concepts representing a transfer summary where component = 'progress note' and scale = 'DOC'),(Exclusion Criteria:)

This value set was imported on 6/29/2019 with a version of 20190516.

Value Set Source: https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.8.1/expansion

Code	Code System	Code System OID	Print Name
11506-3	LOINC	urn:oid:2.16.840.1.113883.6.1	Progress note
11507-1	LOINC	urn:oid:2.16.840.1.113883.6.1	Occupational therapy Progress note
11508-9	LOINC	urn:oid:2.16.840.1.113883.6.1	Physical therapy Progress note
11509-7	LOINC	urn:oid:2.16.840.1.113883.6.1	Podiatry Progress note
11510-5	LOINC	urn:oid:2.16.840.1.113883.6.1	Psychology Progress note
11512-1	LOINC	urn:oid:2.16.840.1.113883.6.1	Speech-language pathology Progress note
15507-7	LOINC	urn:oid:2.16.840.1.113883.6.1	Emergency department Progress note
18733-6	LOINC	urn:oid:2.16.840.1.113883.6.1	Attending Progress note
28569-2	LOINC	urn:oid:2.16.840.1.113883.6.1	Consultant Progress note
28575-9	LOINC	urn:oid:2.16.840.1.113883.6.1	Nurse practitioner Progress note
…			

Figure 35: Progress Note serviceEvent Example

```
<documentationOf>
  <serviceEvent classCode="PCPR">
    <templateId root="2.16.840.1.113883.10.20.21.3.1" />
    <effectiveTime>
      <low value="200503291200" />
      <high value="200503291400" />
    </effectiveTime>
   ...
  </serviceEvent>
</documentationOf>
```

Figure 36: Progress Note encompassingEncounter Example

```
<componentOf>
    <encompassingEncounter>
        <id extension="9937012" root="2.16.840.1.113883.19" />
        <code codeSystem="2.16.840.1.113883.6.12" codeSystemName="CPT" code="99213"
               displayName="Evaluation and Management" />
        <effectiveTime>
            <low value="20090227130000+0500" />
            <high value="20090227130000+0500" />
        </effectiveTime>
        <location>
            <healthCareFacility>
                <id root="2.16.540.1.113883.19.2" />
            </healthCareFacility>
        </location>
    </encompassingEncounter>
</componentOf>
```

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.FIELDED) (optional) US Realm Person Name (PN.US.FIELDED) (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.