1.1.10 Discharge Summary (V3)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.8:2015-08-01 (open)]`

Table 35: Discharge Summary (V3) Contexts

Contained By:	Contains:
	Review of Systems Section (optional) Chief Complaint Section (optional) Reason for Visit Section (optional) Chief Complaint and Reason for Visit Section (optional) History of Present Illness Section (optional) Hospital Course Section (required) Hospital Discharge Studies Summary Section (optional) Hospital Discharge Physical Section (optional) Hospital Discharge Instructions Section (optional) Hospital Consultations Section (optional) Plan of Treatment Section (V2) (required) Nutrition Section (optional) Procedures Section (entries optional) (V2) (optional) Functional Status Section (V2) (optional) Admission Diagnosis Section (V3) (optional) Immunizations Section (entries optional) (V3) (optional) Discharge Diagnosis Section (V3) (required) Discharge Medications Section (entries optional) (V3) (optional) Discharge Medications Section (entries required) (V3) (optional) Admission Medications Section (entries optional) (V3) (optional) Past Medical History (V3) (optional) Vital Signs Section (entries optional) (V3) (optional) Problem Section (entries optional) (V3) (optional) Social History Section (V3) (optional) Family History Section (V3) (optional) Allergies and Intolerances Section (entries optional) (V3) (required)

The Discharge Summary is a document which synopsizes a patient's admission to a hospital, LTPAC provider, or other setting. It provides information for the continuation of care following discharge. The Joint Commission requires the following information to be included in the Discharge Summary (**http://www.jointcommission.org/**):

- The reason for hospitalization (the admission)
- The procedures performed, as applicable
- 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

The best practice for a Discharge Summary is to include the discharge disposition in the display of the header.

Table 36: Discharge Summary (V3) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.8:2015-08-01)					
templateId	1..1	SHALL		1198-8463	
@root	1..1	SHALL		1198-10044	2.16.840.1.113883.10.20.22.1.8
@extension	1..1	SHALL		1198-32517	2015-08-01
code	1..1	SHALL		1198-17178	
@code	1..1	SHALL		1198-17179	urn:oid:2.16.840.1.113883.11.20.4.1 (DischargeSummaryDocumentTypeCode)
participant	0..*	MAY		1198-8467	
componentOf	1..1	SHALL		1198-8471	
encompassingEncounter	1..1	SHALL		1198-8472	
effectiveTime	1..1	SHALL		1198-32611	
low	1..1	SHALL		1198-8473	
high	1..1	SHALL		1198-8475	
dischargeDispositionCode	1..1	SHALL		1198-8476	urn:oid:2.16.840.1.113883.3.88.12.80.33 (NUBC UB-04 FL17 Patient Status)
responsibleParty	0..1	MAY		1198-8479	
assignedEntity	1..1	SHALL		1198-32613	
encounterParticipant	0..*	MAY		1198-8478	
assignedEntity	1..1	SHALL		1198-32615	
component	1..1	SHALL		1198-9539	
structuredBody	1..1	SHALL		1198-	

XPath	Card.	Verb	Data Type	CONF#	Value
				30518	
component	1..1	SHALL		1198-30519	
section	1..1	SHALL		1198-30520	Allergies and Intolerances Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6:2015-08-01
component	1..1	SHALL		1198-30521	
section	1..1	SHALL		1198-30522	Hospital Course Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.5
component	1..1	SHALL		1198-30523	
section	1..1	SHALL		1198-30524	Discharge Diagnosis Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2015-08-01
component	0..1	SHOULD		1198-30525	
section	1..1	SHALL		1198-30526	Discharge Medications Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2015-08-01
component	1..1	SHALL		1198-30527	
section	1..1	SHALL		1198-30528	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		1198-30529	
section	1..1	SHALL		1198-30530	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		1198-30531	
section	1..1	SHALL		1198-30532	Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13
component	0..1	MAY		1198-30533	
section	1..1	SHALL		1198-	Nutrition Section (identifier:

XPath	Card.	Verb	Data Type	CONF#	Value
				30534	urn:oid:2.16.840.1.113883.10.20.22.2.57
component	0..1	MAY		1198-30535	
section	1..1	SHALL		1198-30536	Family History Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2015-08-01
component	0..1	MAY		1198-30537	
section	1..1	SHALL		1198-30538	Functional Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09
component	0..1	MAY		1198-30539	
section	1..1	SHALL		1198-30540	Past Medical History (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2015-08-01
component	0..1	MAY		1198-30541	
section	1..1	SHALL		1198-30542	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		1198-30543	
section	1..1	SHALL		1198-30544	Admission Diagnosis Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2015-08-01
component	0..1	MAY		1198-30545	
section	1..1	SHALL		1198-30546	Admission Medications Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2015-08-01
component	0..1	MAY		1198-30547	
section	1..1	SHALL		1198-30548	Hospital Consultations Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.42
component	0..1	MAY		1198-30549	
section	1..1	SHALL		1198-	Hospital Discharge

XPath	Card.	Verb	Data Type	CONF#	Value
				30550	Instructions Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.41
component	0..1	MAY		1198-30551	
section	1..1	SHALL		1198-30552	Hospital Discharge Physical Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.26
component	0..1	MAY		1198-30553	
section	1..1	SHALL		1198-30554	Hospital Discharge Studies Summary Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.16
component	0..1	MAY		1198-30555	
section	1..1	SHALL		1198-30556	Immunizations Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2015-08-01
component	0..1	MAY		1198-30557	
section	1..1	SHALL		1198-30558	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		1198-30559	
section	1..1	SHALL		1198-30560	Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09
component	0..1	MAY		1198-30561	
section	1..1	SHALL		1198-30562	Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12
component	0..1	MAY		1198-30563	
section	1..1	SHALL		1198-30564	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18
component	0..1	MAY		1198-30565	

XPath	Card.	Verb	Data Type	CONF#	Value
section	1..1	SHALL		1198-30566	Social History Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2015-08-01
component	0..1	MAY		1198-30567	
section	1..1	SHALL		1198-30568	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		1198-31586	
section	1..1	SHALL		1198-31587	Discharge Medications Section (entries required) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11.1:2015-08-01

1.1.11 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:1198-8463) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.8" (CONF:1198-10044).
   b. **SHALL** contain exactly one [1..1] **@extension**="2015-08-01" (CONF:1198-32517).
   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:1198-32938).

The Discharge Summary recommends use of a single document type code, 18842-5 "Discharge summary", 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:1198-17178).
   a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **DischargeSummaryDocumentTypeCode** urn:oid:2.16.840.1.113883.11.20.4.1 **DYNAMIC** (CONF:1198-17179).

1.1.11.1 participant

The participant element in the Discharge Summary header follows the General Header Constraints for participants. Discharge Summary does not specify any use for functionCode for participants. Local policies will determine how this element should be used in implementations.

4. **MAY** contain zero or more [0..*] **participant** (CONF:1198-8467).
    a. When participant/@typeCode is IND, associatedEntity/@classCode **SHALL** be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes **DYNAMIC** 2011-09-30 (CONF:1198-8469).

1.1.11.2 componentOf

The Discharge Summary is always associated with a Hospital Admission using the encompassingEncounter element in the header.

5. **SHALL** contain exactly one [1..1] **componentOf** (CONF:1198-8471).
    a. This componentOf **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1198-8472).
        i. This encompassingEncounter **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1198-32611).

The admission date is recorded in the componentOf/encompassingEncounter/effectiveTime/low.

1. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1198-8473).

The discharge date is recorded in the componentOf/encompassingEncounter/effectiveTime/high.

2. This effectiveTime **SHALL** contain exactly one [1..1] **high** (CONF:1198-8475).

The dischargeDispositionCode records the disposition of the patient at time of discharge. Access to the National Uniform Billing Committee (NUBC) code system requires a membership. The following conformance statement aligns with HITSP C80 requirements.
The dischargeDispositionCode, @displayName, or NUBC UB-04 Print Name, must be displayed when the document is rendered.

ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **dischargeDispositionCode**, which **SHOULD** be selected from ValueSet **NUBC UB-04 FL17 Patient Status** urn:oid:2.16.840.1.113883.3.88.12.80.33 **DYNAMIC** (CONF:1198-8476).

The responsibleParty element represents only the party responsible for the encounter, not necessarily the entire episode of care.

iii. This encompassingEncounter **MAY** contain zero or one [0..1] **responsibleParty** (CONF:1198-8479).
    1. The responsibleParty, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1198-32613).
        a. This assignedEntity **SHALL** contain an assignedPerson or a representedOrganization or both (CONF:1198-32898).

The encounterParticipant element represents persons who participated in the encounter and not necessarily the entire episode of care.

iv. This encompassingEncounter **MAY** contain zero or more [0..*] **encounterParticipant** (CONF:1198-8478).

1. The encounterParticipant, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1198-32615).
    a. This assignedEntity **SHALL** contain an assignedPerson or a representedOrganization or both (CONF:1198-32899).

1.1.11.3 component

6. **SHALL** contain exactly one [1..1] **component** (CONF:1198-9539).

In this template (templateId 2.16.840.1.113883.10.20.22.1.8.2), coded entries are optional.

a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1198-30518).
    i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30519) 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:1198-30520).
    ii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30521) such that it
        1. **SHALL** contain exactly one [1..1] **Hospital Course Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.5) (CONF:1198-30522).
    iii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30523) such that it
        1. **SHALL** contain exactly one [1..1] **Discharge Diagnosis Section (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.24:2015-08-01) (CONF:1198-30524).
    iv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-30525) such that it
        1. **SHALL** contain exactly one [1..1] **Discharge Medications Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11:2015-08-01) (CONF:1198-30526).
    v. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30527) 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:1198-30528).
    vi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30529) 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:1198-30530).

vii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30531) such that it
    1. **SHALL** contain exactly one [1..1] **Chief Complaint and Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:1198-30532).

viii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30533) 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:1198-30534).

ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30535) 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:1198-30536).

x. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30537) 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:1198-30538).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30539) 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:1198-30540).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30541) 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:1198-30542).

xiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30543) such that it
    1. **SHALL** contain exactly one [1..1] **Admission Diagnosis Section (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.43:2015-08-01) (CONF:1198-30544).

xiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30545) such that it
    1. **SHALL** contain exactly one [1..1] **Admission Medications Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.44:2015-08-01) (CONF:1198-30546).

xv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30547) such that it
    1. **SHALL** contain exactly one [1..1] **Hospital Consultations Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.42) (CONF:1198-30548).

xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30549) such that it
    1. **SHALL** contain exactly one [1..1] **Hospital Discharge Instructions Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.41) (CONF:1198-30550).

xvii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30551) such that it
    1. **SHALL** contain exactly one [1..1] **Hospital Discharge Physical Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.26) (CONF:1198-30552).

xviii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30553) such that it
    1. **SHALL** contain exactly one [1..1] **Hospital Discharge Studies Summary Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.16) (CONF:1198-30554).

xix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30555) such that it
    1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2015-08-01) (CONF:1198-30556).

xx. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30557) 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:1198-30558).

xxi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30559) 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:1198-30560).

xxii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30561) such that it
    1. **SHALL** contain exactly one [1..1] **Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:1198-30562).

xxiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30563) 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:1198-30564).

xxiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30565) 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:1198-30566).

xxv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30567) 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:1198-30568).

xxvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-31586) such that it

1. **SHALL** contain exactly one [1..1] **Discharge Medications Section (entries required) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.11.1:2015-08-01) (CONF:1198-31587).

xxvii. This structuredBody **SHALL NOT** contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) is present (CONF:1198-30569).

Table 37: DischargeSummaryDocumentTypeCode

Value Set: DischargeSummaryDocumentTypeCode urn:oid:2.16.840.1.113883.11.20.4.1
(Clinical Focus: Kind of discharge summary document classified by author role),(Data Element Scope:),(Inclusion Criteria: A list of LOINC terms, intended to identify Discharge Summary Notes where component contains "Discharge Summary Note", Timing = "Patient", Property = Find" , scale = "Doc"),(Exclusion Criteria:)

This value set was imported on 6/24/2019 with a version of 20190425.
Value Set Source:
https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.4.1/expansion

Code	Code System	Code System OID	Print Name
11490-0	LOINC	urn:oid:2.16.840.1.113883.6.1	Physician Discharge summary
18842-5	LOINC	urn:oid:2.16.840.1.113883.6.1	Discharge summary
28655-9	LOINC	urn:oid:2.16.840.1.113883.6.1	Attending Discharge summary
29761-4	LOINC	urn:oid:2.16.840.1.113883.6.1	Dentistry Discharge summary
34105-7	LOINC	urn:oid:2.16.840.1.113883.6.1	Hospital Discharge summary
34106-5	LOINC	urn:oid:2.16.840.1.113883.6.1	Physician Hospital Discharge summary
34745-0	LOINC	urn:oid:2.16.840.1.113883.6.1	Nurse Discharge summary
57058-0	LOINC	urn:oid:2.16.840.1.113883.6.1	Maternal discharge summary note
59258-4	LOINC	urn:oid:2.16.840.1.113883.6.1	Emergency department Discharge summary
59259-2	LOINC	urn:oid:2.16.840.1.113883.6.1	Psychiatry Discharge summary
…			

Table 38: NUBC UB-04 FL17 Patient Status

Value Set: NUBC UB-04 FL17 Patient Status urn:oid:2.16.840.1.113883.3.88.12.80.33 National Uniform Billing Committee (NUBC) code system. Value Set Source: **http://www.nubc.org**			
Code	**Code System**	**Code System OID**	**Print Name**
01	NUBC UB-04 Patient Discharge Status code set	urn:oid:2.16.840.1.113883.6.301.5	Discharged to Home or Self Care (Routine Discharge)
02	NUBC UB-04 Patient Discharge Status code set	urn:oid:2.16.840.1.113883.6.301.5	Discharged/transferred to a Short-Term General Hospital for Inpatient Care
03	NUBC UB-04 Patient Discharge Status code set	urn:oid:2.16.840.1.113883.6.301.5	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care
04	NUBC UB-04 Patient Discharge Status code set	urn:oid:2.16.840.1.113883.6.301.5	Discharged/transferred to a Facility that Provides Custodial or Supportive Care
05	NUBC UB-04 Patient Discharge Status code set	urn:oid:2.16.840.1.113883.6.301.5	Discharged/transferred to a Designated Cancer Center or Children's Hospital
06	NUBC UB-04 Patient Discharge Status code set	urn:oid:2.16.840.1.113883.6.301.5	Discharged/transferred to Home Under Care of an Organized Home Health Service Organization in Anticipation of Covered Skilled Care
07	NUBC UB-04 Patient Discharge Status code set	urn:oid:2.16.840.1.113883.6.301.5	Left Against Medical Advice or Discontinued Care
08	NUBC UB-04 Patient Discharge Status code set	urn:oid:2.16.840.1.113883.6.301.5	Reserved for Assignment by the NUBC
09	NUBC UB-04 Patient Discharge Status code set	urn:oid:2.16.840.1.113883.6.301.5	Admitted as an Inpatient to this Hospital
20	NUBC UB-04 Patient Discharge Status code set	urn:oid:2.16.840.1.113883.6.301.5	Expired
…			

Figure 29: Discharge Summary 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>
        <dischargeDispositionCode code="01" codeSystem="2.16.840.1.113883.12.112"
displayName="Routine Discharge" codeSystemName="HL7 Discharge Disposition" />
        <location>
            <healthCareFacility>
                <id root="2.16.540.1.113883.19.2" />
            </healthCareFacility>
        </location>
    </encompassingEncounter>
</componentOf>
```

1.1.12 History and Physical (V3)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.3:2015-08-01 (open)]`

Table 39: History and Physical (V3) Contexts

Contained By:	Contains:
	Assessment Section (optional) Review of Systems Section (required) Chief Complaint Section (optional) Reason for Visit Section (optional) Chief Complaint and Reason for Visit Section (optional) History of Present Illness Section (optional) General Status Section (required) Medications Section (entries optional) (V2) (required) Plan of Treatment Section (V2) (optional) Procedures Section (entries optional) (V2) (optional) Assessment and Plan Section (V2) (optional) Instructions Section (V2) (optional) US Realm Date and Time (DT.US.FIELDED) (required) Immunizations Section (entries optional) (V3) (optional) Results Section (entries optional) (V3) (required) Past Medical History (V3) (required) Vital Signs Section (entries optional) (V3) (required) Problem Section (entries optional) (V3) (optional) Physical Exam Section (V3) (required) Social History Section (V3) (required) Family History Section (V3) (required) Allergies and Intolerances Section (entries optional) (V3) (required)

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. This is typically supplied by the patient or the caregiver, concerning 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.