1.1.8 Diagnostic Imaging Report (V3)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.5:2015-08-01 (open)]`

Table 31: Diagnostic Imaging Report (V3) Contexts

Contained By:	Contains:
	DICOM Object Catalog Section - DCM 121181 (optional) Findings Section (DIR) (required) Fetus Subject Context (optional) Observer Context (optional) Procedure Context (optional) SOP Instance Observation (optional) Text Observation (optional) Code Observations (optional) Quantity Measurement Observation (optional) US Realm Person Name (PN.US.FIELDED) (optional) Physician Reading Study Performer (V2) (optional) Physician of Record Participant (V2) (optional) US Realm Date and Time (DT.US.FIELDED) (optional)

A Diagnostic Imaging Report (DIR) is a document that contains a consulting specialist's interpretation of image data. It conveys the interpretation to the referring (ordering) physician and becomes part of the patient's medical record. It is for use in Radiology, Endoscopy, Cardiology, and other imaging specialties.

Table 32: Diagnostic Imaging Report (V3) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.5:2015-08-01)					
templateId	1..1	SHALL		1198-8404	
@root	1..1	SHALL		1198-10042	2.16.840.1.113883.10.20.22.1.5
@extension	1..1	SHALL		1198-32515	2015-08-01
id	1..1	SHALL		1198-30932	
@root	1..1	SHALL		1198-30933	
code	1..1	SHALL		1198-14833	
@code	1..1	SHALL		1198-14834	urn:oid:1.3.6.1.4.1.12009.10.2.5 (LOINC Imaging Document Codes)
informant	0..0	SHALL		1198-	

XPath	Card.	Verb	Data Type	CONF#	Value
		NOT		8410	
informationRecipient	0..*	MAY		1198-8411	
participant	0..1	MAY		1198-8414	
associatedEntity	1..1	SHALL		1198-31198	
associatedPerson	1..1	SHALL		1198-31199	
name	1..1	SHALL		1198-31200	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
inFulfillmentOf	0..*	MAY		1198-30936	
order	1..1	SHALL		1198-30937	
id	1..*	SHALL		1198-30938	
documentationOf	1..1	SHALL		1198-8416	
serviceEvent	1..1	SHALL		1198-8431	
@classCode	1..1	SHALL		1198-8430	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass) = ACT
id	0..*	SHOULD		1198-8418	
code	1..1	SHALL		1198-8419	
performer	0..*	SHOULD		1198-8422	Physician Reading Study Performer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.1:2014-06-09
relatedDocument	0..1	MAY		1198-8432	
parentDocument	1..1	SHALL		1198-32089	
id	1..1	SHALL		1198-32090	
componentOf	0..1	MAY		1198-30939	
encompassingEncounter	1..1	SHALL		1198-30940	
id	1..*	SHALL		1198-30941	
effectiveTime	1..1	SHALL		1198-	US Realm Date and Time

XPath	Card.	Verb	Data Type	CONF#	Value
				30943	(DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3
responsibleParty	0..1	MAY		1198-30945	
assignedEntity	1..1	SHALL		1198-30946	
encounterParticipant	0..1	SHOULD		1198-30948	Physician of Record Participant (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.2:2014-06-09
component	1..1	SHALL		1198-14907	
structuredBody	1..1	SHALL		1198-30695	
component	1..1	SHALL		1198-30696	
section	1..1	SHALL		1198-30697	Findings Section (DIR) (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.2
component	0..1	SHOULD		1198-30698	
section	1..1	SHALL		1198-30699	DICOM Object Catalog Section - DCM 121181 (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.1
component	0..*	MAY		1198-31055	
section	1..1	SHALL		1198-31056	
code	1..1	SHALL		1198-31057	
@code	1..1	SHALL		1198-31207	urn:oid:2.16.840.1.113883.11.20.9.59 (DIRSectionTypeCodes)
title	0..1	SHOULD		1198-31058	
text	0..1	SHOULD		1198-31059	
subject	0..1	MAY		1198-31215	
relatedSubject	1..1	SHALL		1198-31216	Fetus Subject Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.3
author	0..*	MAY		1198-	

XPath	Card.	Verb	Data Type	CONF#	Value
				31217	
assignedAuthor	1..1	SHALL		1198-31218	Observer Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.4
entry	0..*	MAY		1198-31213	
act	1..1	SHALL		1198-31214	Procedure Context (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.5
entry	0..*	MAY		1198-31357	
observation	1..1	SHALL		1198-31358	Text Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.12
entry	0..*	MAY		1198-31359	
observation	1..1	SHALL		1198-31360	Code Observations (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.13
entry	0..*	MAY		1198-31361	
observation	1..1	SHALL		1198-31362	Quantity Measurement Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.14
entry	0..*	MAY		1198-31363	
observation	1..1	SHALL		1198-31364	SOP Instance Observation (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8
component	0..*	MAY		1198-31208	

1.1.9 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:1198-8404) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.5" (CONF:1198-10042).
   b. **SHALL** contain exactly one [1..1] **@extension**="2015-08-01" (CONF:1198-32515).
   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:1198-32937).

3. **SHALL** contain exactly one [1..1] **id** (CONF:1198-30932).
    a. This id **SHALL** contain exactly one [1..1] **@root** (CONF:1198-30933).

OIDs SHALL be represented in dotted decimal notation, where each decimal number is either 0 or starts with a nonzero digit. More formally, an OID SHALL be in the form of the regular expression: ([0-2])(.([1-9][0-9]*|0))+

    i. The ClinicalDocument/id/@root attribute **SHALL** be a syntactically correct OID, and **SHALL NOT** be a UUID (CONF:1198-30934).
    ii. OIDs **SHALL** be no more than 64 characters in length (CONF:1198-30935).

Preferred code is 18748-4 LOINC Diagnostic Imaging Report

4. **SHALL** contain exactly one [1..1] **code** (CONF:1198-14833).
    a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHOULD** be selected from ValueSet **LOINC Imaging Document Codes** `urn:oid:1.3.6.1.4.1.12009.10.2.5` **DYNAMIC** (CONF:1198-14834).
5. **SHALL NOT** contain [0..0] **informant** (CONF:1198-8410).

1.1.9.1 informationRecipient

6. **MAY** contain zero or more [0..*] **informationRecipient** (CONF:1198-8411).
    a. The physician requesting the imaging procedure (ClinicalDocument/participant[@typeCode=REF]/associatedEntity), if present, **SHOULD** also be recorded as an informationRecipient, unless in the local setting another physician (such as the attending physician for an inpatient) is known to be the appropriate recipient of the report (CONF:1198-8412).
    b. When no referring physician is present, as in the case of self-referred screening examinations allowed by law, the intendedRecipient **MAY** be absent. The intendedRecipient **MAY** also be the health chart of the patient, in which case the receivedOrganization **SHALL** be the scoping organization of that chart (CONF:1198-8413).

1.1.9.2 participant

If participant is present, the associatedEntity/associatedPerson element SHALL be present and SHALL represent the physician requesting the imaging procedure (the referring physician AssociatedEntity that is the target of ClincalDocument/participant@typeCode=REF).

7. **MAY** contain zero or one [0..1] **participant** (CONF:1198-8414) such that it
    a. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1198-31198).
        i. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1198-31199).
            1. This associatedPerson **SHALL** contain exactly one [1..1] **US Realm Person Name (PN.US.FIELDED)** `(identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1)` (CONF:1198-31200).

1.1.9.3 inFulfillmentOf

An inFulfillmentOf element represents the Placer Order that is either a group of orders (modeled as PlacerGroup in the Placer Order RMIM of the Orders & Observations domain) or a single order item (modeled as ObservationRequest in the same RMIM). This optionality reflects two major approaches to the grouping of procedures as implemented in the installed base of imaging information systems. These approaches differ in their handling of grouped procedures and how they are mapped to identifiers in the Digital Imaging and Communications in Medicine (DICOM) image and structured reporting data. The example of a CT examination covering chest, abdomen, and pelvis will be used in the discussion below. In the IHE Scheduled Workflow model, the Chest CT, Abdomen CT, and Pelvis CT each represent a Requested Procedure, and all three procedures are grouped under a single Filler Order. The Filler Order number maps directly to the DICOM Accession Number in the DICOM imaging and report data. A widely deployed alternative approach maps the requested procedure identifiers directly to the DICOM Accession Number. The Requested Procedure ID in such implementations may or may not be different from the Accession Number, but is of little identifying importance because there is only one Requested Procedure per Accession Number. There is no identifier that formally connects the requested procedures ordered in this group.

8. **MAY** contain zero or more [0..*] **inFulfillmentOf** (CONF:1198-30936).
    a. The inFulfillmentOf, if present, **SHALL** contain exactly one [1..1] **order** (CONF:1198-30937).
        i. This order **SHALL** contain at least one [1..*] **id** (CONF:1198-30938).
        Note: DICOM Accession Number in the DICOM imaging and report data

1.1.9.4 documentationOf

Each serviceEvent indicates an imaging procedure that the provider describes and interprets in the content of the DIR. The main activity being described by this document is the interpretation of the imaging procedure. This is shown by setting the value of the @classCode attribute of the serviceEvent element to ACT, and indicating the duration over which care was provided in the effectiveTime element. Within each documentationOf element, there is one serviceEvent element. This event is the unit imaging procedure corresponding to a billable item. The type of imaging procedure may be further described in the serviceEvent/code element. This guide makes no specific recommendations about the vocabulary to use for describing this event. In IHE Scheduled Workflow environments, one serviceEvent/id element contains the DICOM Study Instance UID from the Modality Worklist, and the second serviceEvent/id element contains the DICOM Requested Procedure ID from the Modality Worklist. These two ids are in a single serviceEvent. The effectiveTime for the serviceEvent covers the duration of the imaging procedure being reported. This event should have one or more performers, which may participate at the same or different periods of time. Service events map to DICOM Requested Procedures. That is, serviceEvent/id is the ID of the Requested Procedure.

9. **SHALL** contain exactly one [1..1] **documentationOf** (CONF:1198-8416) such that it
    a. **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1198-8431) such that it
        i. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 **STATIC**) (CONF:1198-8430).
        ii. **SHOULD** contain zero or more [0..*] **id** (CONF:1198-8418).

iii. **SHALL** contain exactly one [1..1] **code** (CONF:1198-8419).

1. The value of serviceEvent/code **SHALL NOT** conflict with the ClininicalDocument/code. When transforming from DICOM SR documents that do not contain a procedure code, an appropriate nullFlavor **SHALL** be used on serviceEvent/code (CONF:1198-8420).

The performer is the Physician Reading Study Performer defined in serviceEvent and is usually different from the attending physician. The reading physician interprets the images and evidence of the study (DICOM Definition).

iv. **SHOULD** contain zero or more [0..*] **Physician Reading Study Performer (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.1:2014-06-09) (CONF:1198-8422).

1.1.9.5 relatedDocument

A DIR may have three types of parent document: • A superseded version that the present document wholly replaces (typeCode = RPLC). DIRs may go through stages of revision prior to being legally authenticated. Such early stages may be drafts from transcription, those created by residents, or other preliminary versions. Policies not covered by this specification may govern requirements for retention of such earlier versions. Except for forensic purposes, the latest version in a chain of revisions represents the complete and current report. • An original version that the present document appends (typeCode = APND). When a DIR is legally authenticated, it can be amended by a separate addendum document that references the original. • A source document from which the present document is transformed (typeCode = XFRM). A DIR may be created by transformation from a DICOM Structured Report (SR) document or from another DIR. An example of the latter case is the creation of a derived document for inclusion of imaging results in a clinical document.

10. **MAY** contain zero or one [0..1] **relatedDocument** (CONF:1198-8432).
    a. The relatedDocument, if present, **SHALL** contain exactly one [1..1] **parentDocument** (CONF:1198-32089).
        i. This parentDocument **SHALL** contain exactly one [1..1] **id** (CONF:1198-32090).
            1. OIDs **SHALL** be represented in dotted decimal notation, where each decimal number is either 0 or starts with a nonzero digit. More formally, an OID **SHALL** be in the form of the regular expression: ([0-2])(.([1-9][0-9][*]|0))+ (CONF:1198-10031).
            2. OIDs **SHALL** be no more than 64 characters in length (CONF:1198-10032).
    b. When a Diagnostic Imaging Report has been transformed from a DICOM SR document, relatedDocument/@typeCode **SHALL** be XFRM, and relatedDocument/parentDocument/id **SHALL** contain the SOP Instance UID of the original DICOM SR document (CONF:1198-8433).

1.1.9.6 componentOf

The id element of the encompassingEncounter represents the identifier for the encounter. When the diagnostic imaging procedure is performed in the context of a hospital stay or an outpatient visit for which there is an Encounter Number, that number should be present as the ID of the encompassingEncounter. The effectiveTime represents the time interval or point in time in which the encounter took place. The encompassing encounter might be that of the hospital or office visit in which the diagnostic imaging procedure was performed. If the effective time is unknown, a nullFlavor attribute can be used.

11. **MAY** contain zero or one [0..1] **componentOf** (CONF:1198-30939).

The id element of the encompassingEncounter represents the identifier for the encounter. When the diagnostic imaging procedure is performed in the context of a hospital stay or an outpatient visit for which there is an Encounter Number, that number should be present as the ID of the encompassingEncounter.

The effectiveTime represents the time interval or point in time in which the encounter took place. The encompassing encounter might be that of the hospital or office visit in which the diagnostic imaging procedure was performed. If the effective time is unknown, a nullFlavor attribute can be used.

a. The componentOf, if present, **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1198-30940).
    i. This encompassingEncounter **SHALL** contain at least one [1..*] **id** (CONF:1198-30941).
        1. In the case of transformed DICOM SR documents, an appropriate null flavor **MAY** be used if the id is unavailable (CONF:1198-30942).
    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:1198-30943).
    iii. This encompassingEncounter **MAY** contain zero or one [0..1] **responsibleParty** (CONF:1198-30945).
        1. The responsibleParty, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1198-30946).
            a. **SHOULD** contain zero or one [0..1] assignedPerson *OR* contain zero or one [0..1] representedOrganization (CONF:1198-30947).
    iv. This encompassingEncounter **SHOULD** contain zero or one [0..1] **Physician of Record Participant (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.6.2.2:2014-06-09) (CONF:1198-30948).

1.1.9.7 component

12. **SHALL** contain exactly one [1..1] **component** (CONF:1198-14907).
    a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1198-30695).
        i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-30696) such that it

1. **SHALL** contain exactly one [1..1] **Findings Section (DIR)** (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.2) (CONF:1198-30697).

ii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-30698) such that it

1. **SHALL** contain exactly one [1..1] **DICOM Object Catalog Section - DCM 121181** (identifier: urn:oid:2.16.840.1.113883.10.20.6.1.1) (CONF:1198-30699).

a. The DICOM Object Catalog section (templateId 2.16.840.1.113883.10.20.6.1.1), if present, **SHALL** be the first section in the document Body (CONF:1198-31206).

iii. This structuredBody **MAY** contain zero or more [0..*] **component** (CONF:1198-31055) such that it

1. **SHALL** contain exactly one [1..1] **section** (CONF:1198-31056).

a. This section **SHALL** contain exactly one [1..1] **code** (CONF:1198-31057).

For sections listed in the DIR Section Type Codes table, the code element must contain a LOINC code or DCM code for sections that have no LOINC equivalent

i. This code **SHALL** contain exactly one [1..1] **@code**, which **SHOULD** be selected from ValueSet **DIRSectionTypeCodes** urn:oid:2.16.840.1.113883.11.20.9.59 **DYNAMIC** (CONF:1198-31207).
Note: The section/code SHOULD be selected from LOINC or DICOM for sections not listed in the DIR Section Type Codes table

There is no equivalent to section/title in DICOM SR, so for a CDA to SR transformation, the section/code will be transferred and the title element will be dropped.

b. This section **SHOULD** contain zero or one [0..1] **title** (CONF:1198-31058).

c. This section **SHOULD** contain zero or one [0..1] **text** (CONF:1198-31059).

i. If clinical statements are present, the section/text **SHALL** represent faithfully all such statements and **MAY** contain additional text (CONF:1198-31060).

ii. All text elements **SHALL** contain content. Text elements **SHALL** contain PCDATA or child elements (CONF:1198-31061).

iii. The text elements (and their children) **MAY** contain Web Access to DICOM Persistent Object (WADO) references to DICOM objects by including a linkHtml element where @href is a valid WADO URL and the text content of linkHtml is the visible text of the hyperlink (CONF:1198-31062).

d. This section **MAY** contain zero or one [0..1] **subject** (CONF:1198-31215) such that it
    i. **SHALL** contain exactly one [1..1] **Fetus Subject Context** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.3) (CONF:1198-31216).

This author element is used when the author of a section is different from the author(s) listed in the Header

e. This section **MAY** contain zero or more [0..*] **author** (CONF:1198-31217) such that it
    i. **SHALL** contain exactly one [1..1] **Observer Context** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.4) (CONF:1198-31218).

If the service context of a section is different from the value specified in documentationOf/serviceEvent, then the section SHALL contain one or more entries containing Procedure Context (templateId 2.16.840.1.113883.10.20.6.2.5), which will reset the context for any clinical statements nested within those elements

f. This section **MAY** contain zero or more [0..*] **entry** (CONF:1198-31213) such that it
    i. **SHALL** contain exactly one [1..1] **Procedure Context** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.5) (CONF:1198-31214).
g. This section **MAY** contain zero or more [0..*] **entry** (CONF:1198-31357) such that it
    i. **SHALL** contain exactly one [1..1] **Text Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.12) (CONF:1198-31358).
h. This section **MAY** contain zero or more [0..*] **entry** (CONF:1198-31359) such that it
    i. **SHALL** contain exactly one [1..1] **Code Observations** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.13) (CONF:1198-31360).
i. This section **MAY** contain zero or more [0..*] **entry** (CONF:1198-31361) such that it
    i. **SHALL** contain exactly one [1..1] **Quantity Measurement Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.14) (CONF:1198-31362).
j. This section **MAY** contain zero or more [0..*] **entry** (CONF:1198-31363) such that it

i. **SHALL** contain exactly one [1..1] **SOP Instance Observation** (identifier: urn:oid:2.16.840.1.113883.10.20.6.2.8) (CONF:1198-31364).

k. This section **MAY** contain zero or more [0..*] **component** (CONF:1198-31208).
   i. **SHALL** contain child elements (CONF:1198-31210).

l. All sections defined in the DIR Section Type Codes table **SHALL** be top-level sections (CONF:1198-31211).

m. **SHALL** contain at least one text element or one or more component elements (CONF:1198-31212).

Table 33: LOINC Imaging Document Codes

Value Set: LOINC Imaging Document Codes urn:oid:1.3.6.1.4.1.12009.10.2.5

(Clinical Focus: The subset of document codes in LOINC that represent imaging procedures/reports. Such documents contain a consulting specialist's interpretation of image data and are used in Radiology, Endoscopy, Cardiology, and other imaging specialties.),(Data Element Scope: Document type),(Inclusion Criteria: As Defined and managed by LOINC at https://loinc.org/oids/1.3.6.1.4.1.12009.10.2.5/),(Exclusion Criteria: Only codes in inclusion criteria)

This value set was imported on 6/25/2019 with a version of 20190517.

Value Set Source: **https://vsac.nlm.nih.gov/valueset/1.3.6.1.4.1.12009.10.2.5/expansion**

Code	Code System	Code System OID	Print Name
11525-3	LOINC	urn:oid:2.16.840.1.113883.6.1	US Pelvis Fetus for pregnancy
18742-7	LOINC	urn:oid:2.16.840.1.113883.6.1	Arthroscopy study
18744-3	LOINC	urn:oid:2.16.840.1.113883.6.1	Bronchoscopy study
18745-0	LOINC	urn:oid:2.16.840.1.113883.6.1	Cardiac catheterization study
18746-8	LOINC	urn:oid:2.16.840.1.113883.6.1	Colonoscopy study
18748-4	LOINC	urn:oid:2.16.840.1.113883.6.1	Diagnostic imaging study
18751-8	LOINC	urn:oid:2.16.840.1.113883.6.1	Endoscopy study
18753-4	LOINC	urn:oid:2.16.840.1.113883.6.1	Flexible sigmoidoscopy study
18756-7	LOINC	urn:oid:2.16.840.1.113883.6.1	MR Spine study
24531-6	LOINC	urn:oid:2.16.840.1.113883.6.1	US Retroperitoneum
…			

Table 34: DIRSectionTypeCodes

Value Set: DIRSectionTypeCodes urn:oid:2.16.840.1.113883.11.20.9.59 The Section Type codes used by DIR are all narrative document sections. The codes in this table are drawn from LOINC (http://www.loinc.org/) and DICOM (http://medical.nema.org/). The section/code should be selected from LOINC or DICOM for sections not listed in this table. Value Set Source: **http://www.loinc.org/**			
Code	**Code System**	**Code System OID**	**Print Name**
121181	DCM	urn:oid:1.2.840.10008.2.16.4	DICOM Object Catalog
121060	DCM	urn:oid:1.2.840.10008.2.16.4	History
121062	DCM	urn:oid:1.2.840.10008.2.16.4	Request
121064	DCM	urn:oid:1.2.840.10008.2.16.4	Current Procedure Descriptions
121066	DCM	urn:oid:1.2.840.10008.2.16.4	Prior Procedure Descriptions
121068	DCM	urn:oid:1.2.840.10008.2.16.4	Previous Findings
121070	DCM	urn:oid:1.2.840.10008.2.16.4	Findings (DIR)
121072	DCM	urn:oid:1.2.840.10008.2.16.4	Impressions
121074	DCM	urn:oid:1.2.840.10008.2.16.4	Recommendations
121076	DCM	urn:oid:1.2.840.10008.2.16.4	Conclusions
...			

Figure 28: DIR Participant Example

```
<participant typeCode="REF">
    <associatedEntity classCode="PROV">
        <id nullFlavor="NI" />
        <addr nullFlavor="NI" />
        <telecom nullFlavor="NI" />
        <associatedPerson>
            <name>
                <given>Amanda</given>
                <family>Assigned</family>
                <suffix>MD</suffix>
            </name>
        </associatedPerson>
    </associatedEntity>
</participant>
```

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