3 ENTRY-LEVEL TEMPLATES

This chapter describes the clinical statement entry templates used within the sections of the document types of this consolidated guide. Entry templates contain constraints that are required for conformance.
Entry-level templates are always in sections.
Each entry-level template description contains the following information:
• Key template metadata (e.g., template identifier, etc.)
• Description and explanatory narrative.
• Required CDA acts, participants and vocabularies.
• Optional CDA acts, participants and vocabularies.
Several entry-level templates require an effectiveTime:
The effectiveTime of an observation is the time interval over which the observation is known to be true. The low and high values should be as precise as possible, but no more precise than known. While CDA has multiple mechanisms to record this time interval (e.g., by low and high values, low and width, high and width, or center point and width), this guide constrains most to use only the low/high form. The low value is the earliest point for which the condition is known to have existed. The high value, when present, indicates the time at which the observation was no longer known to be true. The full description of effectiveTime and time intervals is contained in the CDA R2 normative edition.
Provenance in entry templates:
In this version of Consolidated CDA (C-CDA), we have added a “SHOULD” Author constraint on several entry-level templates. Authorship and Author timestamps must be explicitly asserted in these cases, unless the values propagated from the document header hold true.
ID in entry templates:
Entry-level templates may also describe an id element, which is an identifier for that entry. This id may be referenced within the document, or by the system receiving the document. The id assigned must be globally unique.

3.1 Admission Medication (V2)

`[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.36:2014-06-09 (open)]`

Table 218: Admission Medication (V2) Contexts

Contained By:	Contains:
Admission Medications Section (entries optional) (V3) (optional)	Medication Activity (V2) (required)

This template represents the medications taken by the patient prior to and at the time of admission.

Table 219: Admission Medication (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.36:2014-06-09)					
@classCode	1..1	SHALL		1098-7698	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		1098-7699	urn:oid:2.16.840.1.113883.5.1001 (HL7ActMood) = EVN
templateId	1..1	SHALL		1098-16758	
@root	1..1	SHALL		1098-16759	2.16.840.1.113883.10.20.22.4.36
@extension	1..1	SHALL		1098-32524	2014-06-09
code	1..1	SHALL		1098-15518	
@code	1..1	SHALL		1098-15519	42346-7
@codeSystem	1..1	SHALL		1098-32152	urn:oid:2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
entryRelationship	1..*	SHALL		1098-7701	
@typeCode	1..1	SHALL		1098-7702	urn:oid:2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
substanceAdministration	1..1	SHALL		1098-15520	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 **STATIC**) (CONF:1098-7698).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" (CodeSystem: HL7ActMood urn:oid:2.16.840.1.113883.5.1001 **STATIC**) (CONF:1098-7699).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-16758) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.36" (CONF:1098-16759).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32524).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15518).
    a. This code **SHALL** contain exactly one [1..1] **@code**="42346-7" Medications on Admission (CONF:1098-15519).
    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:1098-32152).
5. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1098-7701) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="SUBJ" (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 **STATIC**) (CONF:1098-7702).
b. **SHALL** contain exactly one [1..1] **Medication Activity (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09) (CONF:1098-15520).

Figure 123: Admission Medication (V2) Example

```
<act classCode="ACT" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.22.4.36" extension="2014-06-09" />
  <code code="42346-7" />
  <entryRelationship typeCode="SUBJ">
    <substanceAdministration classCode="SBADM" moodCode="EVN">
      <!-- ** MEDICATION ACTIVITY V2 ** -->
      <templateId root="2.16.840.1.113883.10.20.22.4.16" extension="2014-06-09" />
        ...
    </substanceAdministration>
  </entryRelationship>
</act>
```

3.2 Advance Directive Observation (V3)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2015-08-01 (open)]

Table 220: Advance Directive Observation (V3) Contexts

Contained By:	Contains:
Advance Directive Organizer (V2) (required) Planned Intervention Act (V2) (optional) Intervention Act (V2) (optional) Advance Directives Section (entries optional) (V3) (optional) Advance Directives Section (entries required) (V3) (optional)	US Realm Address (AD.US.FIELDED) (optional) US Realm Person Name (PN.US.FIELDED) (optional) Author Participation (optional)

This clinical statement represents Advance Directive Observation findings (e.g., “resuscitation status is Full Code”) rather than orders. It should not be considered a legal document or a substitute for the actual Advance Directive document. The related legal documents are referenced using the reference/externalReference element.
The Advance Directive Observation describes the patient’s directives, including but not limited to:
• Medications
• Transfer of Care to Hospital
• Treatment
• Procedures
• Intubation and Ventilation
• Diagnostic Tests
• Tests