a. **SHALL** contain exactly one [1..1] **Procedure Activity Procedure (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.14:2014-06-09) (CONF:1098-15447).

6. **MAY** contain zero or more [0..*] **entry** (CONF:1098-8094) such that it
   a. **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:1098-31127).

Figure 60: Anesthesia Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.25" extension="2014-06-09" />
    <code code="59774-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName=" Anesthesia" />
    <title>Procedure Anesthesia</title>
    <text> Conscious sedation with propofol 200 mg IV </text>
    <entry>
        <procedure classCode="PROC" moodCode="EVN">
            <!-- Procedure activity procedure template -->
            <templateId root="2.16.840.1.113883.10.20.22.4.14" extension="2014-06-09" />
        ...


        </procedure>
    </entry>
    <entry>
        <substanceAdministration classCode="SBADM" moodCode="EVN">
            <!-- Medication activity template -->
            <templateId root="2.16.840.1.113883.10.20.22.4.16" extension="2014-06-09" />
        ...


        </substanceAdministration>
    </entry>
</section>
```

2.6 Assessment and Plan Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09 (open)]

Table 74: Assessment and Plan Section (V2) Contexts

Contained By:	Contains:
Consultation Note (V3) (optional) History and Physical (V3) (optional) Transfer Summary (V2) (optional) Referral Note (V2) (optional) Progress Note (V3) (optional) Procedure Note (V3) (optional)	Planned Act (V2) (optional)

This section represents the clinician's conclusions and working assumptions that will guide treatment of the patient. The Assessment and Plan Section may be combined or separated to meet local policy requirements.
See also the Assessment Section: templateId 2.16.840.1.113883.10.20.22.2.8 and Plan of Treatment Section (V2): templateId 2.16.840.1.113883.10.20.22.2.10:2014-06-09

Table 75: Assessment and Plan Section (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09)					
templateId	1..1	SHALL		1098-7705	
@root	1..1	SHALL		1098-10381	2.16.840.1.113883.10.20.22.2.9
@extension	1..1	SHALL		1098-32583	2014-06-09
code	1..1	SHALL		1098-15353	
@code	1..1	SHALL		1098-15354	51847-2
@codeSystem	1..1	SHALL		1098-32141	urn:oid:2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
text	1..1	SHALL		1098-7707	
entry	0..*	MAY		1098-7708	
act	1..1	SHALL		1098-15448	Planned Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7705) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.9" (CONF:1098-10381).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32583).
2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15353).
    a. This code **SHALL** contain exactly one [1..1] **@code**="51847-2" Assessment and Plan (CONF:1098-15354).
    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:1098-32141).
3. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7707).
4. **MAY** contain zero or more [0..*] **entry** (CONF:1098-7708) such that it
    a. **SHALL** contain exactly one [1..1] **Planned Act (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09) (CONF:1098-15448).

Figure 61: Assessment and Plan Section (V2) Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.9" extension="2014-06-09" />
    <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="51847-2"
displayName="ASSESSMENT AND PLAN" />
    <title>ASSESSMENT AND PLAN</title>
    <text>
      ...
   </text>
    <entry>
        <act moodCode="RQO" classCode="ACT">
            <templateId root="2.16.840.1.113883.10.20.22.4.39" />
            <!--   Planned Act  -->
         ...

        </act>
    </entry>
</section>
```

2.7 Assessment Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.8 (open)]

Table 76: Assessment Section Contexts

Contained By:	Contains:
Consultation Note (V3) (optional) History and Physical (V3) (optional) Transfer Summary (V2) (optional) Referral Note (V2) (optional) Progress Note (V3) (optional) Procedure Note (V3) (optional)	

The Assessment Section (also referred to as “impression” or “diagnoses” outside of the context of CDA) represents the clinician's conclusions and working assumptions that will guide treatment of the patient. The assessment may be a list of specific disease entities or a narrative block.