b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32500).

2. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15385).
   a. This code **SHALL** contain exactly one [1..1] **@code**="10160-0" History of medication use (CONF:1098-15386).
   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:1098-30824).
3. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7793).
4. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7794).
5. **SHOULD** contain zero or more [0..*] **entry** (CONF:1098-7795) 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:1098-10076).

2.38.1 Medications Section (entries required) (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09 (open)]

Table 145: Medications Section (entries required) (V2) Contexts

Contained By:	Contains:
Consultation Note (V3) (optional) Continuity of Care Document (CCD) (V3) (required) Transfer Summary (V2) (required) Referral Note (V2) (required)	Medication Activity (V2) (required)

The Medications Section contains a patient's current medications and pertinent medication history. At a minimum, the currently active medications are listed. An entire medication history is an option. The section can describe a patient's prescription and dispense history and information about intended drug monitoring.

This section requires either an entry indicating the subject is not known to be on any medications or entries summarizing the subject's medications.

Table 146: Medications Section (entries required) (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09)					
@nullFlavor	0..1	MAY		1098-32845	urn:oid:2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		1098-7568	
@root	1..1	SHALL		1098-10433	2.16.840.1.113883.10.20.22.2.1.1
@extension	1..1	SHALL		1098-32499	2014-06-09
code	1..1	SHALL		1098-15387	
@code	1..1	SHALL		1098-15388	10160-0
@codeSystem	1..1	SHALL		1098-30825	urn:oid:2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		1098-7570	
text	1..1	SHALL		1098-7571	
entry	1..*	SHALL		1098-7572	
substanceAdministration	1..1	SHALL		1098-10077	Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09

1. Conforms to **Medications Section (entries optional) (V2)** template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2014-06-09).
2. **MAY** contain zero or one [0..1] **@nullFlavor**="NI" No information (CodeSystem: HL7NullFlavor urn:oid:2.16.840.1.113883.5.1008) (CONF:1098-32845).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:1098-7568) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.1.1" (CONF:1098-10433).
    b. **SHALL** contain exactly one [1..1] **@extension**="2014-06-09" (CONF:1098-32499).
4. **SHALL** contain exactly one [1..1] **code** (CONF:1098-15387).
    a. This code **SHALL** contain exactly one [1..1] **@code**="10160-0" History of medication use (CONF:1098-15388).
    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:1098-30825).
5. **SHALL** contain exactly one [1..1] **title** (CONF:1098-7570).
6. **SHALL** contain exactly one [1..1] **text** (CONF:1098-7571).

If section/@nullFlavor is not present:

7. **SHALL** contain at least one [1..*] **entry** (CONF:1098-7572) 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:1098-10077).

Figure 90: Medications Section (entries required) (V2) Example

```
<section>
    <!--**MEDICATION SECTION (coded entries required) ** -->
    <templateId root="2.16.840.1.113883.10.20.22.2.1.1" extension="2014-06-09" />
    <!-- Medications Section (entries optional) -->
    <templateId root="2.16.840.1.113883.10.20.22.2.1" extension="2014-06-09" />

    <code code="10160-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="HISTORY OF MEDICATION USE" />
    <title>MEDICATIONS</title>
    <text>
        Narrative Text
    </text>


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

2.39 Mental Status Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.56:2015-08-01 (open)]

Table 147: Mental Status Section (V2) Contexts

Contained By:	Contains:
Consultation Note (V3) (optional) Continuity of Care Document (CCD) (V3) (optional) Transfer Summary (V2) (optional) Referral Note (V2) (optional)	Assessment Scale Observation (optional) Mental Status Organizer (V3) (optional) Mental Status Observation (V3) (optional)

The Mental Status Section contains observations and evaluations related to a patient's psychological and mental competency and deficits including, but not limited to any of the following types of information:

- Appearance (e.g., unusual grooming, clothing or body modifications)
- Attitude (e.g., cooperative, guarded, hostile)
- Behavior/psychomotor (e.g., abnormal movements, eye contact, tics)