1.1.4 Consultation Note (V3)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.4:2015-08-01 (open)]`

Table 26: Consultation Note (V3) Contexts

Contained By:	Contains:
	Assessment Section (optional) 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 (required) General Status Section (optional) Medications Section (entries required) (V2) (optional) Plan of Treatment Section (V2) (optional) Medical Equipment Section (V2) (optional) Nutrition Section (optional) Procedures Section (entries optional) (V2) (optional) Functional Status Section (V2) (optional) Assessment and Plan Section (V2) (optional) US Realm Date and Time (DT.US.FIELDED) (required) Mental Status Section (V2) (optional) Immunizations Section (entries optional) (V3) (optional) Results Section (entries required) (V3) (optional) Past Medical History (V3) (optional) Vital Signs Section (entries required) (V3) (optional) Problem Section (entries required) (V3) (required) Physical Exam Section (V3) (optional) Social History Section (V3) (optional) Advance Directives Section (entries optional) (V3) (optional) Family History Section (V3) (optional) Allergies and Intolerances Section (entries required) (V3) (required)

The Consultation Note is generated by a request from a clinician for an opinion or advice from another clinician. Consultations may involve face-to-face time with the patient or may fall under the auspices of telemedicine visits. Consultations may occur while the patient is inpatient or ambulatory. The Consultation Note should also be used to summarize an Emergency Room or Urgent Care encounter.

A Consultation Note includes the reason for the referral, history of present illness, physical examination, and decision-making components (Assessment and Plan).

Table 27: Consultation Note (V3) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.4:2015-08-01)					
templateId	1..1	SHALL		1198-8375	
@root	1..1	SHALL		1198-10040	2.16.840.1.113883.10.20.22.1.4
@extension	1..1	SHALL		1198-32502	2015-08-01
code	1..1	SHALL		1198-17176	
@code	1..1	SHALL		1198-32969	urn:oid:2.16.840.1.113883.11.20.9.31 (ConsultDocumentType)
participant	0..*	SHOULD		1198-31656	
@typeCode	1..1	SHALL		1198-31657	urn:oid:2.16.840.1.113883.5.90 (HL7ParticipationType) = CALLBCK
associatedEntity	1..1	SHALL		1198-31658	
@classCode	1..1	SHALL		1198-31659	urn:oid:2.16.840.1.113883.5.110 (HL7RoleClass) = ASSIGNED
id	1..*	SHALL		1198-31660	
addr	0..*	SHOULD		1198-31661	
telecom	1..*	SHALL		1198-31662	
associatedPerson	1..1	SHALL		1198-31663	
name	1..*	SHALL		1198-31664	
scopingOrganization	0..1	MAY		1198-31665	
inFulfillmentOf	1..*	SHALL		1198-8382	
order	1..1	SHALL		1198-29923	
id	1..*	SHALL		1198-29924	
componentOf	1..1	SHALL		1198-8386	
encompassingEncounter	1..1	SHALL		1198-8387	

XPath	Card.	Verb	Data Type	CONF#	Value
id	1..*	SHALL		1198-8388	
effectiveTime	1..1	SHALL		1198-8389	US Realm Date and Time (DT.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.3
responsibleParty	0..1	MAY		1198-8391	
assignedEntity	1..1	SHALL		1198-32904	
encounterParticipant	0..*	MAY		1198-8392	
assignedEntity	1..1	SHALL		1198-32902	
component	1..1	SHALL		1198-8397	
structuredBody	1..1	SHALL		1198-28895	
component	0..1	MAY		1198-28896	
section	1..1	SHALL		1198-28897	Assessment Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8
component	0..1	MAY		1198-28898	
section	1..1	SHALL		1198-28899	Assessment and Plan Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09
component	0..1	MAY		1198-28900	
section	1..1	SHALL		1198-28901	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		1198-28904	
section	1..1	SHALL		1198-28905	Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12
component	1..1	SHALL		1198-28906	
section	1..1	SHALL		1198-28907	History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4

XPath	Card.	Verb	Data Type	CONF#	Value
component	0..1	SHOULD		1198-28908	
section	1..1	SHALL		1198-28909	Physical Exam Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2015-08-01
component	1..1	SHALL		1198-28910	
section	1..1	SHALL		1198-28911	Allergies and Intolerances Section (entries required) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2015-08-01
component	0..1	MAY		1198-28912	
section	1..1	SHALL		1198-28913	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		1198-28915	
section	1..1	SHALL		1198-28916	Chief Complaint and Reason for Visit Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13
component	0..1	MAY		1198-28917	
section	1..1	SHALL		1198-28918	Family History Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2015-08-01
component	0..1	MAY		1198-28919	
section	1..1	SHALL		1198-28920	General Status Section (identifier: urn:oid:2.16.840.1.113883.10.20.2.5
component	0..1	MAY		1198-28921	
section	1..1	SHALL		1198-28922	Past Medical History (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2015-08-01
component	0..1	MAY		1198-28923	
section	1..1	SHALL		1198-28924	Immunizations Section (entries optional) (V3) (identifier:

XPath	Card.	Verb	Data Type	CONF#	Value
					urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2015-08-01
component	0..1	SHOULD		1198-28925	
section	1..1	SHALL		1198-28926	Medications Section (entries required) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09
component	1..1	SHALL		1198-28928	
section	1..1	SHALL		1198-28929	Problem Section (entries required) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2015-08-01
component	0..1	MAY		1198-28930	
section	1..1	SHALL		1198-28931	Procedures Section (entries optional) (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09
component	0..1	SHOULD		1198-28932	
section	1..1	SHALL		1198-28933	Results Section (entries required) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2015-08-01
component	0..1	MAY		1198-28934	
section	1..1	SHALL		1198-28935	Social History Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2015-08-01
component	0..1	MAY		1198-28936	
section	1..1	SHALL		1198-28937	Vital Signs Section (entries required) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2015-08-01
component	0..1	MAY		1198-28942	
section	1..1	SHALL		1198-28943	Advance Directives Section (entries optional) (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2015-08-01
component	0..1	MAY		1198-28944	
section	1..1	SHALL		1198-	Functional Status Section (V2)

XPath	Card.	Verb	Data Type	CONF#	Value
				28945	(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.14:2014-06-09
component	0..1	MAY		1198-30237	
section	1..1	SHALL		1198-30238	Review of Systems Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18
component	0..1	MAY		1198-30904	
section	1..1	SHALL		1198-30905	Medical Equipment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09
component	0..1	MAY		1198-30906	
section	1..1	SHALL		1198-30907	Mental Status Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.56:2015-08-01
component	0..1	MAY		1198-30909	
section	1..1	SHALL		1198-30910	Nutrition Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57

1.1.5 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:1198-8375) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.4" (CONF:1198-10040).
    b. **SHALL** contain exactly one [1..1] **@extension**="2015-08-01" (CONF:1198-32502).
    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:1198-32935).
3. **SHALL** contain exactly one [1..1] **code** (CONF:1198-17176).

The Consultation Note recommends use of the document type code 11488-4 "Consult Note", 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.

a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **ConsultDocumentType** urn:oid:2.16.840.1.113883.11.20.9.31 **DYNAMIC** (CONF:1198-32969).

1.1.5.1 participant

This participant represents the person to contact for questions about the consult summary. This call back contact individual may be a different person than the individual(s) identified in the author or legalAuthenticator participant.

4. **SHOULD** contain zero or more [0..*] **participant** (CONF:1198-31656) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="CALLBCK" call back contact (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90 **DYNAMIC**) (CONF:1198-31657).
    b. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1198-31658).
        i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode**="ASSIGNED" assigned entity (CodeSystem: HL7RoleClass urn:oid:2.16.840.1.113883.5.110 **DYNAMIC**) (CONF:1198-31659).
        ii. This associatedEntity **SHALL** contain at least one [1..*] **id** (CONF:1198-31660).
        iii. This associatedEntity **SHOULD** contain zero or more [0..*] **addr** (CONF:1198-31661).
        iv. This associatedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:1198-31662).
        v. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1198-31663).
            1. This associatedPerson **SHALL** contain at least one [1..*] **name** (CONF:1198-31664).
        vi. This associatedEntity **MAY** contain zero or one [0..1] **scopingOrganization** (CONF:1198-31665).

1.1.5.2 inFulfillmentOf

The inFulfillmentOf element describes prior orders that are fulfilled (in whole or part) by the service events described in the Consultation Note. For example, a prior order might be the consultation that is being reported in the note.

5. **SHALL** contain at least one [1..*] **inFulfillmentOf** (CONF:1198-8382).
    a. Such inFulfillmentOfs **SHALL** contain exactly one [1..1] **order** (CONF:1198-29923).

Where a referral is being fulfilled by this consultation, this id would be the same as the id in the Patient Referral Act template.

        i. This order **SHALL** contain at least one [1..*] **id** (CONF:1198-29924).

1.1.5.3 componentOf

A Consultation Note is always associated with an encounter; the id element of the encompassingEncounter is required to be present and represents the identifier for the encounter.

6. **SHALL** contain exactly one [1..1] **componentOf** (CONF:1198-8386).
    a. This componentOf **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1198-8387).
        i. This encompassingEncounter **SHALL** contain at least one [1..*] **id** (CONF:1198-8388).
        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:1198-8389).
        iii. This encompassingEncounter **MAY** contain zero or one [0..1] **responsibleParty** (CONF:1198-8391).
            1. The responsibleParty, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1198-32904).
                a. This assignedEntity **SHALL** contain an assignedPerson or a representedOrganization or both (CONF:1198-32905).

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:1198-8392).
            1. The encounterParticipant, if present, **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1198-32902).
                a. This assignedEntity **SHALL** contain an assignedPerson or a representedOrganization or both (CONF:1198-32906).

1.1.5.4 component

7. **SHALL** contain exactly one [1..1] **component** (CONF:1198-8397).
    a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1198-28895).
        i. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28896) such that it
            1. **SHALL** contain exactly one [1..1] **Assessment Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1198-28897).
        ii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28898) such that it
            1. **SHALL** contain exactly one [1..1] **Assessment and Plan Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1198-28899).
        iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28900) 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:1198-28901).

iv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28904) 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:1198-28905).

v. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-28906) 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:1198-28907).

vi. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-28908) such that it
    1. **SHALL** contain exactly one [1..1] **Physical Exam Section (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2015-08-01) (CONF:1198-28909).

vii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-28910) such that it
    1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries required) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2015-08-01) (CONF:1198-28911).

viii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28912) 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:1198-28913).

ix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28915) 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:1198-28916).

x. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28917) 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:1198-28918).

xi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28919) such that it

1. **SHALL** contain exactly one [1..1] **General Status Section** (identifier: urn:oid:2.16.840.1.113883.10.20.2.5) (CONF:1198-28920).

xii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28921) 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:1198-28922).

xiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28923) 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:1198-28924).

xiv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-28925) such that it

1. **SHALL** contain exactly one [1..1] **Medications Section (entries required) (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09) (CONF:1198-28926).

xv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-28928) such that it

1. **SHALL** contain exactly one [1..1] **Problem Section (entries required) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2015-08-01) (CONF:1198-28929).

xvi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28930) 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:1198-28931).

xvii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-28932) such that it

1. **SHALL** contain exactly one [1..1] **Results Section (entries required) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2015-08-01) (CONF:1198-28933).

xviii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28934) 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:1198-28935).

xix. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28936) such that it

1. **SHALL** contain exactly one [1..1] **Vital Signs Section (entries required) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2015-08-01) (CONF:1198-28937).

xx. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28942) such that it

1. **SHALL** contain exactly one [1..1] **Advance Directives Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2015-08-01) (CONF:1198-28943).

xxi. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28944) 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:1198-28945).

xxii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30237) 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:1198-30238).

xxiii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30904) such that it

1. **SHALL** contain exactly one [1..1] **Medical Equipment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.23:2014-06-09) (CONF:1198-30905).

xxiv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30906) such that it

1. **SHALL** contain exactly one [1..1] **Mental Status Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.56:2015-08-01) (CONF:1198-30907).

xxv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-30909) 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:1198-30910).

xxvi. This structuredBody **SHALL NOT** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1198-28939).

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:1198-28940).

xxviii. **SHALL** include a Reason for Referral or Reason for Visit section (CONF:1198-9504).

xxix. **SHALL** include an Assessment and Plan Section, or both an Assessment Section and a Plan of Treatment Section (CONF:1198-9501).

Table 28: ConsultDocumentType

Value Set: ConsultDocumentType urn:oid:2.16.840.1.113883.11.20.9.31
(Clinical Focus: A classification of a document by the author's specialty, role, setting, or some combination of these properties to find documents that are consider a consultation.),(Data Element Scope:),(Inclusion Criteria:),(Exclusion Criteria:)

This value set was imported on 6/24/2019 with a version of 20190516.
Value Set Source:
https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.31/expansion

Code	Code System	Code System OID	Print Name
11488-4	LOINC	urn:oid:2.16.840.1.113883.6.1	Consult note
34099-2	LOINC	urn:oid:2.16.840.1.113883.6.1	Cardiology Consult note
34100-8	LOINC	urn:oid:2.16.840.1.113883.6.1	Intensive care unit Consult note
34101-6	LOINC	urn:oid:2.16.840.1.113883.6.1	General medicine Outpatient Consult note
34102-4	LOINC	urn:oid:2.16.840.1.113883.6.1	Psychiatry Hospital Consult note
34103-2	LOINC	urn:oid:2.16.840.1.113883.6.1	Pulmonary Consult note
34104-0	LOINC	urn:oid:2.16.840.1.113883.6.1	Hospital Consult note
34749-2	LOINC	urn:oid:2.16.840.1.113883.6.1	Anesthesiology Outpatient Consult note
34756-7	LOINC	urn:oid:2.16.840.1.113883.6.1	Dentistry Consult note
34758-3	LOINC	urn:oid:2.16.840.1.113883.6.1	Dermatology Consult note
...			

Figure 22: Consultation Note Callback participant Example

```
<participant typeCode="CALLBCK">
    <time value="20050329224411+0500" />
    <associatedEntity classCode="ASSIGNED">
        <id extension="99999999" root="2.16.840.1.113883.4.6" />
        <code code="200000000X" codeSystem="2.16.840.1.113883.6.101"
displayName="Allopathic & Osteopathic Physicians" />
        <addr>
            <streetAddressLine>1002 Healthcare Drive </streetAddressLine>
            <city>Ann Arbor</city>
            <state>MI</state>
            <postalCode>97857</postalCode>
            <country>US</country>
        </addr>
        <telecom use="WP" value="tel:555-555-1002" />
        <associatedPerson>
            <name>
                <given>Henry</given>
                <family>Seven</family>
                <suffix>DO</suffix>
            </name>
        </associatedPerson>
    </associatedEntity>
</participant>
```

Figure 23: Consultation Note (V2) inFulfillmentOf Example

```
<inFulfillmentOf typeCode="FLFS">
    <order classCode="ACT" moodCode="RQO">
        <id root="629deb70-5306-11df-9879-0800200c9a66" extension="1298989898" />
        <code code="1011220" displayName="Clinical pathology consultation"
codeSystem="2.16.840.1.113883.6.12" codeSystemName="CPT" />
    </order>
</inFulfillmentOf>
```

Figure 24: Consultation Note structuredBody Example

```
<component>
    <structuredBody>
        <component>
            <section>
                <templateId root="2.16.840.1.113883.10.20.22.2.6.1"
                    extension="2015-08-01" />
                <!-- Allergies section template -->
                <code code="48765-2" codeSystem="2.16.840.1.113883.6.1"
                      displayName="Allergies, adverse reactions, alerts"
codeSystemName="LOINC" />
                <title>Allergies, Adverse Reactions, Alerts</title>
                ...


            </section>
        </component>
        <component>
            <section>
                <templateId root="2.16.840.1.113883.10.20.22.2.8" />
                <!-- Assessment-->
                <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
                      code="51848-0" displayName="ASSESSMENT" />
                <title>ASSESSMENT</title>
                ...


            </section>
        </component>
        <component>
            <section>
                <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.4" />
                <!-- History of Present Illness -->
                <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
                      code="10164-2" displayName="HISTORY OF PRESENT ILLNESS" />
                <title>HISTORY OF PRESENT ILLNESS</title>
                ...


            </section>
        </component>
        <component>
            <section>
                <!--MEDICATION SECTION (V2) (coded entries required) -->
                <templateId root="2.16.840.1.113883.10.20.22.2.1.1" 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>
                ...


            </section>
        </component>
        <component>
            <section>
```

```
                <templateId root="2.16.840.1.113883.10.20.2.10" extension="2015-08-01" />
                <!-- Physical Exam (V3) -->
                <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
                      code="29545-1" displayName="PHYSICAL FINDINGS" />
                <title>PHYSICAL EXAMINATION</title>
                ...


            </section>
        </component>
        <component>
            <section>
                <templateId root="2.16.840.1.113883.10.20.22.2.10"
                    extension="2014-06-09" />
                <!--  Plan of Treatment Section (V2) template  -->
                <code code="18776-5" codeSystem="2.16.840.1.113883.6.1"
                      codeSystemName="LOINC" displayName="Treatment plan" />
                <title>PLAN OF CARE</title>
                ...


            </section>
        </component>
        <component>
            <section>
                <!-- Problem Section (entries required) (V3) -->
                <templateId root="2.16.840.1.113883.10.20.22.2.5.1" extension="2015-08-01"
/>
                <code code="11450-4" codeSystem="2.16.840.1.113883.6.1"
                      codeSystemName="LOINC" displayName="PROBLEM LIST" />
                <title>PROBLEMS</title>
                ...


            </section>
        </component>
        <component>
            <section>
                <templateId root="2.16.840.1.113883.10.20.22.2.7"
                    extension="2014-06-09" />
                <!-- Procedures Section (entries optional) (V2) -->
                <code code="47519-4" codeSystem="2.16.840.1.113883.6.1"
                      codeSystemName="LOINC" displayName="HISTORY OF PROCEDURES" />
                <title>PROCEDURES</title>
                ...


            </section>
        </component>
        <component>
            <section>
                <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.1"
                    extension="2014-06-09" />
                <!-- Reason for Referral Section V2  -->
                <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
                      code="42349-1" displayName="REASON FOR REFERRAL" />
                <title>REASON FOR REFERRAL</title>
```

```
                ...


            </section>
        </component>
        <component>
            <section>
                <templateId root="2.16.840.1.113883.10.20.22.2.3.1" extension="2015-08-01"
/>
                <!-- Results Section (entries required) (V3) -->
                <code code="30954-2" codeSystem="2.16.840.1.113883.6.1"
                      codeSystemName="LOINC" displayName="RESULTS" />
                <title>RESULTS</title>
                ...


            </section>
        </component>
        <component>
            <section>
                <templateId root="2.16.840.1.113883.10.20.22.2.17" extension="2015-08-01"
/>
                <!-- Social history section (V3)-->
                <code code="29762-2" codeSystem="2.16.840.1.113883.6.1"
                      displayName="Social History" />
                <title>SOCIAL HISTORY</title>
                ...


            </section>
        </component>
        <component>
            <section>
                <templateId root="2.16.840.1.113883.10.20.22.2.4.1" extension="2015-08-01"
/>
                <!-- Vital Signs Section (V3)-->
                <code code="8716-3" codeSystem="2.16.840.1.113883.6.1"
                      codeSystemName="LOINC" displayName="VITAL SIGNS" />
                <title>VITAL SIGNS</title>
                        ...


            </section>
        </component>
    </structuredBody>
</component>
```

1.1.6 Continuity of Care Document (CCD) (V3)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.2:2015-08-01 (open)]`

Table 29: Continuity of Care Document (CCD) (V3) Contexts

Contained By:	Contains:
	Medications Section (entries required) (V2) (required) Plan of Treatment Section (V2) (optional) Medical Equipment Section (V2) (optional) Nutrition Section (optional) Procedures Section (entries required) (V2) (optional) Functional Status Section (V2) (optional) Mental Status Section (V2) (optional) Immunizations Section (entries required) (V3) (optional) Results Section (entries required) (V3) (required) Vital Signs Section (entries required) (V3) (required) Problem Section (entries required) (V3) (required) Payers Section (V3) (optional) Social History Section (V3) (required) Advance Directives Section (entries optional) (V3) (optional) Family History Section (V3) (optional) Allergies and Intolerances Section (entries required) (V3) (required) Encounters Section (entries optional) (V3) (optional)

This document type was originally based on the Continuity of Care Document (CCD) Release 1.1 which itself was derived from HITSP C32 and CCD Release 1.0.

The Continuity of Care Document (CCD) represents a core data set of the most relevant administrative, demographic, and clinical information facts about a patient's healthcare, covering one or more healthcare encounters. It provides a means for one healthcare practitioner, system, or setting to aggregate all of the pertinent data about a patient and forward it to another to support the continuity of care.

The primary use case for the CCD is to provide a snapshot in time containing the germane clinical, demographic, and administrative data for a specific patient. The key characteristic of a CCD is that the ServiceEvent is constrained to "PCPR". This means it does not function to report new ServiceEvents associated with performing care. It reports on care that has already been provided. The CCD provides a historical tally of the care over a range of time and is not a record of new services delivered.

More specific use cases, such as a Discharge Summary, Transfer Summary, Referral Note, Consultation Note, or Progress Note, are available as alternative documents in this guide.

Table 30: Continuity of Care Document (CCD) (V3) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.2:2015-08-01)					