## Figure 61: Assessment and Plan Section (V2) Example

## 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.

Table 77: Assessment Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value			
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8)								
templateId	11	SHALL		81-7711				
@root	11	SHALL		81-10382	2.16.840.1.113883.10.20.22.2 .8			
code	11	SHALL		81-14757				
@code	11	SHALL		81-14758	51848-0			
@codeSystem	11	SHALL		81-26472	urn:oid:2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1			
title	11	SHALL		81-16774				
text	11	SHALL		81-7713				

- 1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7711) such that it
  - a. **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.10.20.22.2.8" (CONF:81-10382).
- 2. **SHALL** contain exactly one [1..1] **code** (CONF:81-14757).
  - a. This code **SHALL** contain exactly one [1..1] **@code="**51848-0" Assessments (CONF:81-14758).
  - 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:81-26472).
- 3. **SHALL** contain exactly one [1..1] **title** (CONF:81-16774).
- 4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7713).

## Figure 62: Assessment Section Example

## 2.8 Chief Complaint and Reason for Visit Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.13 (open)]

Table 78: Chief Complaint and Reason for Visit Section Contexts

Contained By:	Contains:
Consultation Note (V3) (optional)	
Discharge Summary (V3) (optional)	
History and Physical (V3) (optional)	
Procedure Note (V3) (optional)	

This section records the patient's chief complaint (the patient's own description) and/or the reason for the patient's visit (the provider's description of the reason for visit). Local policy determines whether the information is divided into two sections or recorded in one section serving both purposes.

Table 79: Chief Complaint and Reason for Visit Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value			
section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13)								
templateId	11	SHALL		81-7840				
@root	11	SHALL		81-10383	2.16.840.1.113883.10.20.22.2 .13			
code	11	SHALL		81-15449				
@code	11	SHALL		81-15450	46239-0			
@codeSystem	11	SHALL		81-26473	urn:oid:2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1			
title	11	SHALL		81-7842				
text	11	SHALL		81-7843				

- 1. **SHALL** contain exactly one [1..1] **templateId** (CONF:81-7840) such that it
  - a. **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.10.20.22.2.13" (CONF:81-10383).
- 2. **SHALL** contain exactly one [1..1] **code** (CONF:81-15449).
  - a. This code **SHALL** contain exactly one [1..1] **@code="**46239-0" Chief Complaint and Reason for Visit (CONF:81-15450).
  - 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:81-26473).
- 3. **SHALL** contain exactly one [1..1] **title** (CONF:81-7842).
- 4. **SHALL** contain exactly one [1..1] **text** (CONF:81-7843).