```
    </serviceEvent>
</documentationOf>
```

Figure 16: authorization Example

```
<authorization typeCode="AUTH">
    <consent classCode="CONS" moodCode="EVN">
        <id root="629deb70-5306-11df-9879-0800200c9a66" />
        <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="64293-4"
displayName="Procedure consent" />
        <statusCode code="completed" />
    </consent>
</authorization>
```

1.1.2 Care Plan (V2)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.15:2015-08-01 (open)]`

Table 22: Care Plan (V2) Contexts

Contained By:	Contains:
	US Realm Person Name (PN.US.FIELDED) (optional) US Realm Person Name (PN.US.FIELDED) (required) Health Status Evaluations and Outcomes Section (optional) Goals Section (required) Health Concerns Section (V2) (required) Interventions Section (V3) (optional)

CARE PLAN FRAMEWORK

A Care Plan (including Home Health Plan of Care (HHPoC)) is a consensus-driven dynamic plan that represents a patient's and Care Team Members' prioritized concerns, goals, and planned interventions. It serves as a blueprint shared by all Care Team Members (including the patient, their caregivers and providers), to guide the patient's care. A Care Plan integrates multiple interventions proposed by multiple providers and disciplines for multiple conditions.

A Care Plan represents one or more Plan(s) of Care and serves to reconcile and resolve conflicts between the various Plans of Care developed for a specific patient by different providers. While both a plan of care and a care plan include the patient's life goals and require Care Team Members (including patients) to prioritize goals and interventions, the reconciliation process becomes more complex as the number of plans of care increases. The Care Plan also serves to enable longitudinal coordination of care.

The CDA Care Plan represents an instance of this dynamic Care Plan at a point in time. The CDA document itself is NOT dynamic.

Key differentiators between a Care Plan CDA and CCD (another "snapshot in time" document):
There are 2 required sections:
o Health Concerns

o Goals
There are 2 optional sections:
o Interventions
o Outcomes
• Provides the ability to identify patient and provider priorities with each act
• Provides a header participant to indicate occurrences of Care Plan review
A care plan document can include entry references from the information in these sections to the information (entries) in other sections.

Please see Volume 1 of this guide to view a Care Plan Relationship diagram and story board.

Table 23: Care Plan (V2) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.15:2015-08-01)					
templateId	1..1	SHALL		1198-28741	
@root	1..1	SHALL		1198-28742	2.16.840.1.113883.10.20.22.1.15
@extension	1..1	SHALL		1198-32877	2015-08-01
code	1..1	SHALL		1198-28745	
@code	1..1	SHALL		1198-32959	urn:oid:2.16.840.1.113762.1.4.1099.10 (Care Plan Document Type)
setId	0..1	SHOULD		1198-32321	
versionNumber	0..1	SHOULD		1198-32322	
informationRecipient	0..*	SHOULD		1198-31993	
intendedRecipient	1..1	SHALL		1198-31994	
id	1..*	SHALL		1198-31996	
addr	0..*	SHOULD		1198-31997	
telecom	0..*	SHOULD		1198-31998	
informationRecipient	0..1	SHOULD		1198-31999	
name	1..1	SHALL		1198-32320	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
receivedOrganization	0..1	SHOULD		1198-32000	

XPath	Card.	Verb	Data Type	CONF#	Value
id	0..*	SHOULD		1198-32001	
name	1..*	SHALL		1198-32002	
standardIndustryClassCode	0..1	SHOULD		1198-32003	urn:oid:2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy)
authenticator	0..1	SHOULD		1198-31910	
time	1..1	SHALL		1198-31911	
signatureCode	1..1	SHALL		1198-31912	
sdtc:signatureText	0..1	MAY		1198-31913	
assignedEntity	1..1	SHALL		1198-31914	
id	1..*	SHALL		1198-31915	
code	1..1	SHALL		1198-31916	
@code	1..1	SHALL		1198-31917	ONESELF
@codeSystem	1..1	SHALL		1198-31918	urn:oid:2.16.840.1.113883.5.111 (HL7RoleCode) = 2.16.840.1.113883.5.111
participant	0..*	SHOULD		1198-31677	
@typeCode	1..1	SHALL		1198-31678	urn:oid:2.16.840.1.113883.5.90 (HL7ParticipationType) = VRF
functionCode	1..1	SHALL		1198-31679	
@code	1..1	SHALL		1198-31680	425268008
@codeSystem	1..1	SHALL		1198-31681	urn:oid:2.16.840.1.113883.6.96 (SNOMED CT) = 2.16.840.1.113883.6.96
time	1..1	SHALL		1198-31682	
associatedEntity	1..1	SHALL		1198-31683	
@classCode	1..1	SHALL		1198-31686	urn:oid:2.16.840.1.113883.5.110 (HL7RoleClass) = ASSIGNED
id	1..*	SHALL		1198-	

XPath	Card.	Verb	Data Type	CONF#	Value
				31684	
code	0..1	SHOULD		1198-31685	
@code	1..1	SHALL		1198-32367	urn:oid:2.16.840.1.113883.11.20.12.1 (Personal And Legal Relationship Role Type)
participant	0..*	SHOULD		1198-31895	
@typeCode	1..1	SHALL		1198-31896	urn:oid:2.16.840.1.113883.5.90 (HL7ParticipationType) = IND
associatedEntity	1..1	SHALL		1198-31897	
@classCode	1..1	SHALL		1198-31898	urn:oid:2.16.840.1.113883.11.20.9.33 (INDRoleclassCodes)
associatedPerson	1..1	SHALL		1198-31899	
name	1..*	SHALL		1198-31900	
documentationOf	1..1	SHALL		1198-31901	
serviceEvent	1..1	SHALL		1198-31902	
@classCode	1..1	SHALL		1198-31903	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass) = PCPR
effectiveTime	1..1	SHALL		1198-31904	
low	1..1	SHALL		1198-32330	
high	0..1	MAY		1198-32331	
performer	1..*	SHALL		1198-31905	
assignedEntity	1..1	SHALL		1198-31907	
id	1..*	SHALL		1198-31908	
code	0..1	MAY		1198-31909	
assignedPerson	1..1	SHALL		1198-32328	
name	1..1	SHALL		1198-32329	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
relatedDocument	0..*	MAY		1198-	

XPath	Card.	Verb	Data Type	CONF#	Value
				29893	
@typeCode	1..1	SHALL		1198-31889	urn:oid:2.16.840.1.113883.1.11.11610 (x_ActRelationshipDocument)
parentDocument	1..1	SHALL		1198-29894	
id	1..*	SHALL		1198-32949	
setId	1..1	SHALL		1198-29895	
versionNumber	1..1	SHALL		1198-29896	
componentOf	0..1	SHOULD		1198-32004	
encompassingEncounter	1..1	SHALL		1198-32005	
effectiveTime	1..1	SHALL		1198-32007	
component	1..1	SHALL		1198-28753	
structuredBody	1..1	SHALL		1198-28754	
component	1..1	SHALL		1198-28755	
section	1..1	SHALL		1198-28756	Health Concerns Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.58:2015-08-01
component	1..1	SHALL		1198-28761	
section	1..1	SHALL		1198-28762	Goals Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.60
component	0..1	SHOULD		1198-28763	
section	1..1	SHALL		1198-28764	Interventions Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2015-08-01
component	0..1	SHOULD		1198-29596	
section	1..1	SHALL		1198-29597	Health Status Evaluations and Outcomes Section (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.61

1.1.3 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:1198-28741) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.1.15" (CONF:1198-28742).
    b. **SHALL** contain exactly one [1..1] **@extension**="2015-08-01" (CONF:1198-32877).
    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:1198-32934).
3. **SHALL** contain exactly one [1..1] **code** (CONF:1198-28745).
    a. This code **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **Care Plan Document Type** urn:oid:2.16.840.1.113762.1.4.1099.10 **DYNAMIC** (CONF:1198-32959).
4. **SHOULD** contain zero or one [0..1] **setId** (CONF:1198-32321).
5. **SHOULD** contain zero or one [0..1] **versionNumber** (CONF:1198-32322).

1.1.3.1 informationRecipient

6. **SHOULD** contain zero or more [0..*] **informationRecipient** (CONF:1198-31993) such that it
    a. **SHALL** contain exactly one [1..1] **intendedRecipient** (CONF:1198-31994).
        i. This intendedRecipient **SHALL** contain at least one [1..*] **id** (CONF:1198-31996).
        ii. This intendedRecipient **SHOULD** contain zero or more [0..*] **addr** (CONF:1198-31997).
        iii. This intendedRecipient **SHOULD** contain zero or more [0..*] **telecom** (CONF:1198-31998).
        iv. This intendedRecipient **SHOULD** contain zero or one [0..1] **informationRecipient** (CONF:1198-31999).
            1. The informationRecipient, if present, **SHALL** contain exactly one [1..1] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-32320).
        v. This intendedRecipient **SHOULD** contain zero or one [0..1] **receivedOrganization** (CONF:1198-32000).
            1. The receivedOrganization, if present, **SHOULD** contain zero or more [0..*] **id** (CONF:1198-32001).
            2. The receivedOrganization, if present, **SHALL** contain at least one [1..*] **name** (CONF:1198-32002).
            3. The receivedOrganization, if present, **SHOULD** contain zero or one [0..1] **standardIndustryClassCode**, which **SHALL** be selected from ValueSet **Healthcare Provider Taxonomy** urn:oid:2.16.840.1.114222.4.11.1066 **DYNAMIC** (CONF:1198-32003).

1.1.3.2 authenticator

7. **SHOULD** contain zero or one [0..1] **authenticator** (CONF:1198-31910) such that it
    a. **SHALL** contain exactly one [1..1] **time** (CONF:1198-31911).
    b. **SHALL** contain exactly one [1..1] **signatureCode** (CONF:1198-31912).
    c. **MAY** contain zero or one [0..1] **sdtc:signatureText** (CONF:1198-31913).
    d. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1198-31914).
        i. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1198-31915).
        ii. This assignedEntity **SHALL** contain exactly one [1..1] **code** (CONF:1198-31916).
            1. This code **SHALL** contain exactly one [1..1] **@code**="ONESELF" Self (CONF:1198-31917).
            2. This code **SHALL** contain exactly one [1..1] **@codeSystem**="2.16.840.1.113883.5.111" (CodeSystem: HL7RoleCode urn:oid:2.16.840.1.113883.5.111) (CONF:1198-31918).

1.1.3.3 participant

8. **SHOULD** contain zero or more [0..*] **participant** (CONF:1198-31677) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="VRF" Verifier (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90) (CONF:1198-31678).
    b. **SHALL** contain exactly one [1..1] **functionCode** (CONF:1198-31679).
        i. This functionCode **SHALL** contain exactly one [1..1] **@code**="425268008" Review of Care Plan (CONF:1198-31680).
        ii. This functionCode **SHALL** contain exactly one [1..1] **@codeSystem**="2.16.840.1.113883.6.96" (CodeSystem: SNOMED CT urn:oid:2.16.840.1.113883.6.96) (CONF:1198-31681).
    c. **SHALL** contain exactly one [1..1] **time** (CONF:1198-31682).
    d. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1198-31683).
        i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode**="ASSIGNED" (CodeSystem: HL7RoleClass urn:oid:2.16.840.1.113883.5.110) (CONF:1198-31686).
        ii. This associatedEntity **SHALL** contain at least one [1..*] **id** (CONF:1198-31684).
        iii. This associatedEntity **SHOULD** contain zero or one [0..1] **code** (CONF:1198-31685).
            1. The code, if present, **SHALL** contain exactly one [1..1] **@code**, which **SHOULD** be selected from ValueSet **Personal And Legal Relationship Role Type** urn:oid:2.16.840.1.113883.11.20.12.1 **DYNAMIC** (CONF:1198-32367).

1.1.3.4 participant

9. **SHOULD** contain zero or more [0..*] **participant** (CONF:1198-31895) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="IND" Indirect (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90) (CONF:1198-31896).
b. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1198-31897).
    i. This associatedEntity **SHALL** contain exactly one [1..1] **@classCode**, which **SHALL** be selected from ValueSet **INDRoleclassCodes** urn:oid:2.16.840.1.113883.11.20.9.33 **DYNAMIC** (CONF:1198-31898).
    ii. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:1198-31899).
        1. This associatedPerson **SHALL** contain at least one [1..*] **name** (CONF:1198-31900).

1.1.3.5 documentationOf

The serviceEvent describes the provision of healthcare over a period of time. The duration over which care was provided is indicated in serviceEvent/effectiveTime. Additional data from outside this duration may also be included if it is relevant to care provided during that time range (e.g., reviewed during the stated time range).

10. **SHALL** contain exactly one [1..1] **documentationOf** (CONF:1198-31901) such that it
    a. **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:1198-31902).
        i. This serviceEvent **SHALL** contain exactly one [1..1] **@classCode**="PCPR" Care Provision (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6) (CONF:1198-31903).
        ii. This serviceEvent **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1198-31904).
            1. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1198-32330).
            2. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:1198-32331).
        iii. This serviceEvent **SHALL** contain at least one [1..*] **performer** (CONF:1198-31905) such that it
            1. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:1198-31907).
                a. This assignedEntity **SHALL** contain at least one [1..*] **id** (CONF:1198-31908).
                b. This assignedEntity **MAY** contain zero or one [0..1] **code** (CONF:1198-31909).
                c. This assignedEntity **SHALL** contain exactly one [1..1] **assignedPerson** (CONF:1198-32328).
                    i. This assignedPerson **SHALL** contain exactly one [1..1] **US Realm Person Name (PN.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-32329).

1.1.3.6 relatedDocument

11. **MAY** contain zero or more [0..*] **relatedDocument** (CONF:1198-29893) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**, which **SHALL** be selected from ValueSet **x_ActRelationshipDocument** urn:oid:2.16.840.1.113883.1.11.11610 **STATIC** (CONF:1198-31889).
    b. **SHALL** contain exactly one [1..1] **parentDocument** (CONF:1198-29894).
        i. This parentDocument **SHALL** contain at least one [1..*] **id** (CONF:1198-32949).
        ii. This parentDocument **SHALL** contain exactly one [1..1] **setId** (CONF:1198-29895).
        iii. This parentDocument **SHALL** contain exactly one [1..1] **versionNumber** (CONF:1198-29896).

1.1.3.7 componentOf

12. **SHOULD** contain zero or one [0..1] **componentOf** (CONF:1198-32004) such that it
    a. **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1198-32005).
        i. This encompassingEncounter **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1198-32007).

1.1.3.8 component

13. **SHALL** contain exactly one [1..1] **component** (CONF:1198-28753).
    a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1198-28754).
        i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-28755) such that it
            1. **SHALL** contain exactly one [1..1] **Health Concerns Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.58:2015-08-01) (CONF:1198-28756).
        ii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-28761) such that it
            1. **SHALL** contain exactly one [1..1] **Goals Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.60) (CONF:1198-28762).
        iii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-28763) such that it
            1. **SHALL** contain exactly one [1..1] **Interventions Section (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.21.2.3:2015-08-01) (CONF:1198-28764).
        iv. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:1198-29596) such that it
            1. **SHALL** contain exactly one [1..1] **Health Status Evaluations and Outcomes Section** (identifier:

urn:oid:2.16.840.1.113883.10.20.22.2.61) (CONF:1198-29597).

v. This structuredBody **SHALL NOT** contain a Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1198-31044).

Table 24: x_ActRelationshipDocument

Value Set: x_ActRelationshipDocument urn:oid:2.16.840.1.113883.1.11.11610 Used to enumerate the relationships between two clinical documents for document management.			
Code	**Code System**	**Code System OID**	**Print Name**
RPLC	HL7ActRelationshipType	urn:oid:2.16.840.1.113883.5.1002	Replaces
APND	HL7ActRelationshipType	urn:oid:2.16.840.1.113883.5.1002	Is appendage
XFRM	HL7ActRelationshipType	urn:oid:2.16.840.1.113883.5.1002	Transformation

Table 25: Care Plan Document Type

Value Set: Care Plan Document Type urn:oid:2.16.840.1.113762.1.4.1099.10

(Clinical Focus: Terms used to identify documents that represent a Care Plan),(Data Element Scope:),(Inclusion Criteria: This value set expansion is currently missing two pending LOINC concepts:
93023-0 Pharmacist Plan of care note
and 93024-8 Pharmacist Consult Note.),(Exclusion Criteria:)

This value set was imported on 6/24/2019 with a version of 20190425.

Value Set Source:
https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1099.10/expansion

Code	Code System	Code System OID	Print Name
18776-5	LOINC	urn:oid:2.16.840.1.113883.6.1	Plan of care note
64295-9	LOINC	urn:oid:2.16.840.1.113883.6.1	Nurse Plan of care note
74156-1	LOINC	urn:oid:2.16.840.1.113883.6.1	Oncology Plan of care and summary note
77442-2	LOINC	urn:oid:2.16.840.1.113883.6.1	Cardiology Plan of care note
77443-0	LOINC	urn:oid:2.16.840.1.113883.6.1	Allergy and immunology Plan of care note
77444-8	LOINC	urn:oid:2.16.840.1.113883.6.1	Audiology Plan of care note
77445-5	LOINC	urn:oid:2.16.840.1.113883.6.1	Critical care medicine Plan of care note
77446-3	LOINC	urn:oid:2.16.840.1.113883.6.1	Child and adolescent psychiatry Plan of care note
80739-6	LOINC	urn:oid:2.16.840.1.113883.6.1	Infectious disease Plan of care note
80740-4	LOINC	urn:oid:2.16.840.1.113883.6.1	Hematology Plan of care note
…			

Figure 17: Care Plan Patient authenticator Example

```
<!-- This authenticator represents patient agreement or
  sign-off of the Care Plan-->
<authenticator>
    <time value="20130802" />
    <signatureCode code="S" />
    <sdtc:signatureText mediaType="text/xml"
representation="B64">omSJUEdmde9j44zmMiromSJUEdmde9j44zmMirdMDSsWdIJdksIJR3373jeu83
    6edjzMMIjdMDSsWdIJdksIJR3373jeu83MNYD83jmMdomSJUEdmde9j44zmMir ...
    MNYD83jmMdomSJUEdmde9j44zmMir6edjzMMIjdMDSsWdIJdksIJR3373jeu83
    4zmMir6edjzMMIjdMDSsWdIJdksIJR3373jeu83==</sdtc:signatureText>
    <assignedEntity>
        <id extension="996-756-495" root="2.16.840.1.113883.19.5" />
        <code code="ONESELF" displayName="Self" codeSystem="2.16.840.1.113883.5.111"
codeSystemName="HL7 Role code" />
    </assignedEntity>
</authenticator>
```

Figure 18: Care Plan Review Example

```
<!-- This participant represents the Care Plan review.
  If the date in the time element is in the past,
  then this review has already taken place.
  If the date in the time element is in the future,
  then this is the date of the next scheduled review. -->
<!-- This example shows a Care Plan Review that has already taken place -->
<participant typeCode="IND">
    <functionCode code="425268008" codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT" displayName="Review of Care Plan" />
    <time value="20130801" />
    <associatedEntity classCode="ASSIGNED">
        <id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c" />
    </associatedEntity>
</participant>
```

Figure 19: Care Plan Caregiver participant Example

```
<participant typeCode="IND">
    <functionCode code="407543004" displayName="Primary Carer"
codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED-CT" />
    <!-- Caregiver -->
    <associatedEntity classCode="CAREGIVER">
        <code code="MTH" codeSystem="2.16.840.1.113883.5.111" />
        <addr>
            <streetAddressLine>17 Daws Rd.</streetAddressLine>
            <city>Ann Arbor</city>
            <state>MI</state>
            <postalCode>97857</postalCode>
            <country>US</country>
        </addr>
        <telecom value="tel:(999)555-1212" use="WP" />
        <associatedPerson>
            <name>
                <prefix>Mrs.</prefix>
                <given>Martha</given>
                <family>Jones</family>
            </name>
        </associatedPerson>
    </associatedEntity>
</participant>
```

Figure 20: Care Plan performer Example

```
<performer typeCode="PRF">
    <time value="20130715223615-0800" />
    <assignedEntity>
        <id extension="5555555555" root="2.16.840.1.113883.4.6" />
        <code code="59058001" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED
CT" displayName="General Physician" />
        <addr>
            <streetAddressLine>1004 Healthcare Drive </streetAddressLine>
            <city>Portland</city>
            <state>OR</state>
            <postalCode>99123</postalCode>
            <country>US</country>
        </addr>
        <telecom use="WP" value="tel:+1(555)-1004" />
        <assignedPerson>
            <name>
                <given>Patricia</given>
                <given qualifier="CL">Patty</given>
                <family>Primary</family>
                <suffix qualifier="AC">M.D.</suffix>
            </name>
        </assignedPerson>
    </assignedEntity>
</performer>
```

Figure 21: Care Plan relatedDocument Example

```
<!-- This document is the second in a set - relatedDocument
  describes the parent document-->
<relatedDocument typeCode="RPLC">
  <parentDocument>
    <id root="223769be-f6ee-4b04-a0ce-b56ae998c880" />
    <code code="18776-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Care Plan" />
    <setId root="004bb033-b948-4f4c-b5bf-a8dbd7d8dd40" />
    <versionNumber value="1" />
  </parentDocument>
</relatedDocument>
```

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).