|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Result of a Consultation –( comparison to CDA Consultation Report)** | | | | | | |
| **S&I Data Element Set** | **Clinical Summary for Specialist Note** | [**CIM Priority**](http://wiki.siframework.org/ToC+Classification+of+Data+Elements) | **Comments** | **CDA Data Element Section** | **Consultation Report (CDA Guide)**  LOINC - 11488-4  2.16.840.1.113883.10.20.22.1.4  Definition - a Consultation Note must be generated as a result of a request for an opinion or advice | **Comments** |
| Person Information | R | A - demographics |  | Record Target | R |  |
| Contact Information | R | A - demographics | patient contact information (phone number, address, etc) | Address, Phone number, etc | R | Included in PatientRole Constraints |
| Insurance Information | R | A - demographics |  | Participant | O | See Section 3.2.1.3 |
| Healthcare Provider | R | A – PCP and Designated Providers |  | Participant | O | See Section 3.2.1.3 |
| Allergies and Other Adverse Reactions | R | A – meds, envt, food |  | Allergies | O |  |
| Problem List | R | A – Active problems |  | Problem List | O |  |
| History of Past Illness | R | B – Medical History |  | History of Past Illness (Past Medical History) | O |  |
| Chief Complaint | R | ???Not listed |  | Chief Complaint | O |  |
| Reason for Transition of Care | R | B – Reason for Consult Request |  | Reason for Referral/Reason for Visit | R |  |
| History of Present Illness | R | B |  | History of Present Illness | R |  |
| List of Surgeries | R | B – Surgical/ Procedure History |  | Procedures (List of Surgeries) (History of Procedures) | O |  |
| Medications | R | A |  | Medications | O | Include medication administration act |
| Medications Administered | R – if relevant to referral | A – if changed during encounter, Reconciled |  |  |  |  |
| Advanced Directives | R | A – Existence of AD - Yes/No if signed |  |  |  |  |
| Pregnancy | R – only if relevant | ??? Include with problems |  |  |  |  |
| Immunizations | R – administered or recommended | B – Immunization History |  | Immunizations | O |  |
| Physical Exam | R – pertinent findings | B – Physical Exam |  | Physical Exam | R |  |
| Vital Signs | R – pertinent findings | B – Vital Signs |  | Vital Signs | O |  |
| Review of Systems | R – pertinent findings | B – Review od Systems |  | Review of Systems | O |  |
| Diagnostic Results | R | B - Results |  | Results | O |  |
| Assessment and Plan | R | B – Consultant Assessment and Plan Recommendations |  | Assessment and Plan\* | R |  |
| Plan of Care | R | ??? Not listed by itself - | interventions and procedures for patient e.g. list of orders | Plan\* | R |  |
| Orders | Blank |  | For LRI and future use cases |  |  |  |
| Medical Equipment | R | B - Equipment |  |  |  |  |
| Family History | Blank | B – Family History |  | Family History | O |  |
|  |  | C – Health Maintenance ??? |  | General Status | O |  |
| Social History | Blank | B – Social History |  | Social History | O |  |
| Encounters | Blank | C - F/U appointments???? | Current and Historical; dates |  |  |  |
| Condition (Preoperative Diagnosis) | Blank | A - Problems |  |  |  |  |
| Condition (Postoperative Diagnosis) | Blank | B – Surgical/Procedure History ?? |  |  |  |  |
| Surgery Description | Blank | B – Operative Summary | Narrative text, Images |  |  |  |
| Surgical Operation Note Findings | Blank | B – Operative Summary |  |  |  |  |
| Complications Section | Blank | A - Problems | Known risks or unidentified problems |  |  |  |
| Operative Note Surgical Procedure | Blank | B – Operative Summary |  |  |  |  |
| Clinical research Information | Blank | ??? | For LRI and future use cases |  |  |  |
| Specimen | Blank | ??? | For LRI and future use cases |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Request for Consultation – (Comparison to CDA Progress Note)** | | | | | | |
| **S&I Data Element Set** | **Clinical Summary (Specialist Consultation Referral)** | [**CIM Priority**](http://wiki.siframework.org/ToC+Classification+of+Data+Elements) | **Comments** | **CDA Data Element Section** | **Progress Note (CDA Guide)**  Definition - A Progress Note documents a patient’s clinical status during a hospitalization or outpatient visit; thus, it is associated with an encounter | **Comments** |
| Person Information | R | A - demographics |  | Record Target | R |  |
| Contact Information | R | A - demographics | patient contact information (phone number, address, etc) | Address, Phone number, etc | R | Included in PatientRole Constraints |
| Insurance Information | R | A - demographics |  | Participant | O | See Section 3.2.1.3 |
| Healthcare Provider | R | A – PCP and Designated Providers |  | Participant | O | See Section 3.2.1.3 |
| Allergies and Other Adverse Reactions | R | A – meds, envt, food |  | Allergies | O |  |
| Problem List | R | A – Active problems |  | Problem List | O |  |
| History of Past Illness | R | B – Medical History |  |  |  |  |
| Chief Complaint | R | ???Not listed |  | Chief Complaint | O |  |
| Reason for Transition of Care | R | B – Reason for Consult Request |  |  |  |  |
| History of Present Illness | R | B |  |  |  |  |
| List of Surgeries | R | R | B – Surgical/ Procedure History |  |  |  |
| Medications | R | R | A | Medications | O |  |
| Medications Administered | R – if relevant to referral | R – if relevant to referral | A – if changed during encounter, Reconciled |  |  |  |
| Advanced Directives | R | R | A – Existence of AD - Yes/No if signed |  |  |  |
| Pregnancy | R – only if relevant | R – only if relevant | ??? Include with problems |  |  |  |
| Immunizations | R – administered or recommended | B – Immunization History |  |  |  |  |
| Physical Exam | R – pertinent findings | B – Physical Exam |  | Physical Exam | O |  |
| Vital Signs | R – pertinent findings | B – Vital Signs |  | Vital Signs | O |  |
| Review of Systems | R – pertinent findings | B – Review od Systems |  | Review of Systems | O |  |
| Diagnostic Results | R | B - Results |  | Results | O |  |
| Assessment and Plan | R | B – Consultant Assessment and Plan Recommendations |  | Assessment and Plan\* | R |  |
| Plan of Care | R | ??? Not listed by itself - | interventions and procedures for patient e.g. list of orders | Plan\* | R |  |
| Orders | Blank |  |  |  |  |  |
| Medical Equipment | R |  |  |  |  |  |
| Family History | Blank |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Social History | Blank | B – Social History |  |  |  |  |
| Encounters | Blank | C - F/U appointments???? | Current and Historical; dates |  |  |  |
| Condition (Preoperative Diagnosis) | Blank | A - Problems |  |  |  |  |
| Condition (Postoperative Diagnosis) | Blank | B – Surgical/Procedure History ?? |  |  |  |  |
| Surgery Description | Blank | B – Operative Summary | Narrative text, Images |  |  |  |
| Surgical Operation Note Findings | Blank | B – Operative Summary |  |  |  |  |
| Complications Section | Blank | A - Problems | Known risks or unidentified problems |  |  |  |
| Operative Note Surgical Procedure | Blank | B – Operative Summary |  |  |  |  |
| Clinical research Information | Blank | ??? | For LRI and future use cases |  |  |  |
| Specimen | Blank | ??? | For LRI and future use cases |  |  |  |
|  |  |  |  | Interventions | O |  |
|  |  |  |  | Objective | O |  |
|  |  |  |  | Subjective | O |  |