Integrating the Healthcare Enterprise

IHE Patient Care Coordination (PCC) Technical Framework Supplement

CDA Content Modules

Trial Implementation

Date: October 4, 2013

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Foreword

This is a supplement to the IHE Patient Care Coordination Technical Framework V9.0. Each supplement undergoes a process of public comment and trial implementation before being incorporated into the volumes of the Technical Frameworks.

This supplement is different than traditional IHE supplements. It serves as the trial implementation staging area for content modules. The content modules (section level, entry level) defined during trial implementation are gathered in this document to provide a central location for readers of supplements from PCC, QRPH and/or other domains that use the dictionary of content modules first defined by PCC. After individual modules are successfully tested and reviewed, they will be moved to final text. At that time, they are removed from this document. Thus, this supplement will continue to exist for some time as new content modules are defined and documented here. Likewise, content modules will be removed as they go to final text.

"Boxed" instructions like the sample below indicate to the Volume Editor how to integrate the relevant section(s) into the relevant Technical Framework volume.

Amend section X.X by the following:

Where the amendment adds text, make the added text **bold underline**. Where the amendment removes text, make the removed text **~~bold strikethrough~~**. When entire new sections are added, introduce with editor's instructions to "add new text" or similar, which for readability are not bolded or underlined.

General information about IHE can be found at: www.ihe.net.

Information about the IHE PCC domain and the IHE QRPH domain can be found at: http://www.ihe.net/IHE_Domains.

Information about the organization of IHE Technical Frameworks and Supplements and the process used to create them can be found at: http://www.ihe.net/IHE_Process and http://www.ihe.net/Profiles.

The current version of the IHE PCC Technical Framework and the IHE QRPH Technical Framework can be found at: http://www.ihe.net/Technical_Frameworks.

CONTENTS

Introduction

This supplement is written for trial implementation. It is written as changes to the latest revision of the documents listed below. The reader should have already read and understood these documents:

1. PCC Technical Framework Volume 1
2. PCC Technical Framework Volume 2

This supplement also references other documents[1]. The reader should have already read and understood these documents:

1. IT Infrastructure Technical Framework Volume 1
2. IT Infrastructure Technical Framework Volume 2
3. IT Infrastructure Technical Framework Volume 3
4. HL7 and other standards documents referenced in Volume 1 and Volume 2

This supplement defines a number of PCC and QRPH content modules that are shared between various content documents. These are provided for trial implementation and will be published in the same format for trial implementation. Upon completion, some content modules will be moved to final text; others may remain in trial implementation.

Profile Abstract

This supplement does not describe a profile.

Open Issues and Questions

None

Closed Issues

None

[1] The first three documents can be located on the IHE Website at http://www.ihe.net/Technical_Framework/index.cfm#IT. The remaining document can be obtained from its respective publisher.

Volume 1 – Integration Profiles

None

Glossary

Add the following terms to the Glossary:

None

2.5 History of Annual Changes

Add the following bullet to the end of the bullet list in Section 2.5

- Added a set of CDA Content Modules shared across several Integration Profiles for the 2010-2011 documentation cycle.
- In the 2011-2012 documentation cycle, the following CDA Section Content Modules were added as well as various Entry Content Modules and Value Sets:
    - PCC Transport Summary Profiles supplement
        - Sending Facility
        - Receiving Facility
        - Mass Causality Incident
        - Unit Response Level
        - Protocols Used
        - Extra Attendants Information
        - Invasive Airway
        - Isolation Status
        - Restraints
        - Ventilator Usage
        - Provider Level
    - QRPH EHCP Profile
        - Risk Indicators for Hearing Loss
        - Hearing Screening Coded Results
    - QRPH PRPH-Ca Profile
        - Cancer Diagnosis
- In the 2012-2013 documentation cycle, edits were made based on CPs. In addition, the following content modules were added:

- QRPH VRDR Section Content Modules
  - 6.3.3.10.1 VRDR Death Report Section
  - 6.3.3.10.2 Coded Hospital Course Section
- QRPH VRDR Entry Content Modules were added
  - 6.3.3.4.58 Death Pronouncement Entry Content Module
  - 6.3.3.4.59 Death Location Type Entry Content Module
- Some QRPH VRDR value sets were added
- QRPH HW Section Content Modules
  - 6.3.3.10.3 Resources to Support Goals Section
  - 6.3.3.10.4 Healthy Weight Care Plan Section
  - 6.3.3.10.5 Occupational Data for Health Section
- QRPH HW Entry Content Modules
  - 6.3.4.60 Occupational Data For Health Organizer
  - 6.3.4.61 Employment Status Organizer
  - 6.3.4.62 Usual Occupation and Industry Organizer
  - 6.3.4.63 History of Occupation Organizer
  - 6.3.4.64 Employment Status Observation
  - 6.3.4.65 Usual Occupation and Industry Observation Entry
  - 6.3.4.66 Occupation Observation Entry
  - 6.3.4.67 Work Shift Observation Entry
  - 6.3.4.68 Weekly Work Hours Observation Entry
  - 6.3.4.69 Usual Occupation Duration Entry
  - 6.3.4.70 Usual Industry Duration Entry

Volume 2 – Transactions and Content Modules

Please note that in December of 2012, a new supplement template was released. The new template separates *Transactions* (Volume 2) and *Content Modules (*Volume 3). As a result, in newer supplements you will find content module definitions in volume 3. The section numbering scheme, however, remains the same.

Add Section 6.1

6.1 Conventions

Various tables used in this section will further constrain the content. Within this volume, the follow conventions are used.

R

A "Required" data element is one that shall always be provided. If there is information available, the data element must be present. If there is no information available, or it cannot be transmitted, the data element must contain a value indicating the reason for omission of the data. (See PCC TF-2: 5.3.4.2 for a list of appropriate statements.)

R2

A "Required if data present" data element is one that shall be provided when a value exists. If the information cannot be transmitted, the data element shall contain a value indicating the reason for omission of the data. If no such information is available to the creator or if such information is not available in a well identified manner (e.g., buried in a free form narrative that contains additional information relevant to other sections) or if the creator requires that information be absent, the R2 section shall be entirely absent. (See Section PCC TF-2: 5.3.4.2 for a list of appropriate statements.)

O

An optional data element is one that may be provided, irrespective of whether the information is available or not. If the implementation elects to support this optional section, then its support shall meet the requirement set forth for the "Required if data present" or R2.

C

A conditional data element is one that is required, required if known, or optional depending upon other conditions. These will have further notes explaining when the data element is required, et cetera.

Note: The definitions of R, R2, and O differ slightly from other IHE profiles. This is due in part to the fact that local regulations and policies may in fact prohibit the transmission of certain information, and that a human decision to transmit the information may be required in many cases.

Add Section 6.2

6.2 Folder Content Modules

This section contains modules that describe the content requirements of Folders used with XDS, XDM or XDR. When workflows are completed normally, the folders will contain documents with the optionality specified in the tables shown below. Under certain circumstances, the folders will not meet the optionality requirements described below, for example, when the patient leaves before treatment is completed.

6.2.1 EDES Folder Specification

This section intentionally left blank.

6.2.2 APR Folder Specification

This section intentionally left blank.

6.2.3 LDR Folder Specification

This section intentionally left blank.

6.3 HL7 Version 3.0 Content Modules

This section contains content modules based upon the HL7 CDA Release 3.0 Standard, and related standards and/or implementation guides.

6.3.1 CDA Document Content Modules

Add Section 6.3.1.X

6.3.1.X History and Physical Specification 1.3.6.1.4.1.19376.1.5.3.1.1.16.1.4

The History and Physical document content module is a Medical Summary and inherits all header constraints from Medical Summary (1.3.6.1.4.1.19376.1.5.3.1.1.2). The intention of this document content module is to provide a base from which other document content modules may be derived. Future work may also result in a content profile for History and Physical.

6.3.1.x.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:pcc:hp:2008**

6.3.1.x.2 LOINC Code

The LOINC code for this document is **34117-2** HISTORY AND PHYSICAL

6.3.1.x.3 Standards

CDAR2	HL7 CDA Release 2.0
CDTHP	CDA for Common Document Types History and Physical Notes (DSTU)

6.3.1.x.4 Specification

This section references content modules using Template ID as the key identifier. Definitions of the modules are found in either:

- IHE Patient Care Coordination Volume 2: Final Text
- IHE PCC CDA Content Modules Supplement (this document, for Trial Implementation)

Table 6.3.1.x.4-1: History and Physical Data Elements

Data Element Name	Opt	Template ID
Chief Complaint	R	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1
History of Present Illness	R	1.3.6.1.4.1.19376.1.5.3.1.3.4
History of Past Illness	R	1.3.6.1.4.1.19376.1.5.3.1.3.8
Medications	R	1.3.6.1.4.1.19376.1.5.3.1.3.19
Allergies and Other Adverse Reactions Section	R	1.3.6.1.4.1.19376.1.5.3.1.3.13
Social History	R	1.3.6.1.4.1.19376.1.5.3.1.3.16
Family History	R	1.3.6.1.4.1.19376.1.5.3.1.3.14
Review of Systems	R	1.3.6.1.4.1.19376.1.5.3.1.3.18
Detailed Physical Examination This section SHALL include Vital Signs (1.3.6.1.4.1.19376.1.5.3.1.3.25) as a subsection.	R	1.3.6.1.4.1.19376.1.5.3.1.1.9.15
Results Diagnostic Findings; use this OR Coded Results	R	1.3.6.1.4.1.19376.1.5.3.1.3.27
Coded Results Diagnostic Findings; use this OR Results	R	1.3.6.1.4.1.19376.1.5.3.1.3.28
Assessment and Plan	R	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5

6.3.1.x.5 Conformance

CDA Release 2.0 documents that conform to the requirements of this content module shall indicate their conformance by the inclusion of the appropriate <templateId> elements in the header of the document. This is shown in the sample document below. A CDA Document may conform to more than one template. This content module inherits from the Medical Summaries content module, and so must conform to the requirements of that template as well, thus all <templateId> elements shown in the example below shall be included.

```
<ClinicalDocument xmlns='urn:hl7-org:v3'>
  <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3"/>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.2'/>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.1.4'/>
  <id root=' ' extension=' '/>
  <code code='34117-2' displayName='HISTORY AND PHYSICAL'
    codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
  <title>History and Physical</title>
  <effectiveTime value='20080601012005'/>
  <confidentialityCode code='N' displayName='Normal'
    codeSystem='2.16.840.1.113883.5.25' codeSystemName='Confidentiality' />
  <languageCode code='en-US'/>
     :
  <component><structuredBody>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1'/>
        <!-- Required Chief Complaint Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.4'/>
        <!-- Required History of Present Illness Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.8'/>
        <!-- Required History of Past Illness Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.19'/>
        <!-- Required Medications Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.13'/>
        <!-- Required Allergies and Other Adverse Reactions Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.16'/>
        <!-- Required Social History Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.14'/>
        <!-- Required Family History Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.18'/>
        <!-- Required Review of Systems Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15'/>
        <!-- Required Detailed Physical Examination Section content -->
      </section>
```

```
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.27'/>
        <!-- Required Results Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.28'/>
        <!-- Required Coded Results Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5'/>
        <!-- Required Assessment and Plan Section content -->
      </section>
    </component>
  </structuredBody></component>
</ClinicalDocument>
```

Figure 6.3.1.x.5-1: Sample History and Physical Document

Add Section 6.3.2

6.3.2 CDA Header Content Modules

Add Section 6.3.2.1

6.3.2.1 Language Communication 1.3.6.1.4.1.19376.1.5.3.1.2.1

Add Section 6.3.2.2

6.3.2.2 Employer and School Contacts 1.3.6.1.4.1.19376.1.5.3.1.2.2

Add Section 6.3.2.3

6.3.2.3 Healthcare Providers and Pharmacies 1.3.6.1.4.1.19376.1.5.3.1.2.3

Add Section 6.3.2.4

6.3.2.4 Patient Contacts 1.3.6.1.4.1.19376.1.5.3.1.2.4

Add Section 6.3.2.5

6.3.2.5 Spouse 1.3.6.1.4.1.19376.1.5.3.1.2.4.1

The spouse header element records the spouse of a patient, and inherits other constraints from the Patient Contacts entry. Items in bold in the example below show the additional constraints on this element.

This element SHALL be included as a participant in the header of the CDA document in the event of the pregnancy. If this does not apply to the patient this element SHALL use a null flavor.

6.3.2.5.1 Parent Template

The parent of this template is Patient Contacts.

6.3.2.5.2 Specification

```
<participant typeCode='IND'>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.2.4'/>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.2.4.1'/>
 <time value='20070213'/>
 <associatedEntity classCode='PRS'>
   <code code='xx-spouse|184142008' displayName=' ' codeSystem='2.16.840.1.113883.6.96'
codeSystemName='SNOMED CT'/>
   <addr></addr>
   <telecom value=' ' use=' '/>
   <assignedPerson><name></name></assignedPerson>
 </associatedEntity>
</participant>
```

6.3.2.5.3 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.2.4'/><templateId root='1.3.6.1.4.1.19376.1.5.3.1.2.4.1'/>

The <templateId> element identifies this person as a spouse and must be recorded exactly as shown above.

```
<rule context='hl7:templateId/@root="1.3.6.1.4.1.19376.1.5.3.1.2.4.1"]'>
  <assert test='hl7:templateId/@root="1.3.6.1.4.1.19376.1.5.3.1.2.4"'>
    A participant using template 1.3.6.1.4.1.19376.1.5.3.1.2.4.1 must also use template
1.3.6.1.4.1.19376.1.5.3.1.2.4.
  </assert>
</rule>
```

6.3.2.5.4 <associatedEntity classCode=’PRS’>

The classCode attribute of the <associatedEntity> element shall be PRS.

```
<rule context='hl7:templateId/@root="1.3.6.1.4.1.19376.1.5.3.1.2.4.1"]'>
  <assert test='../hl7:associatedEntity/@classCode = "PRS"'>
    The classCode attribute of the associated entity shall be PRS.
  </assert>
</rule>
```

6.3.2.5.5 <code code='127848009|184142008' displayName=' ' codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'/>

This element SHALL use127848009 to represent the patient's spouse or 184142008 to represent the patient's next of kin. The code system name is SNOMED CT.

6.3.2.5.6 Completed Example

```
  <!-- Husband/Domestic Partner -->
  <participant typeCode="IND">
    <associatedEntity classCode="NOK">
      <code code="184142008" displayName="patient's next of kin"
        codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"/>
      <addr>
        <streetAddressLine>45 Chunn Dr.</streetAddressLine>
        <city>Spring Hill</city>
        <state>TN</state>
        <postalCode>37174</postalCode>
        <country>USA</country>
      </addr>
      <telecom value="tel:(999)555-1212" use="WP"/>
      <associatedPerson>
        <name>
          <prefix>Mr.</prefix>
          <given>John</given>
          <family>Youngston</family>
        </name>
      </associatedPerson>
    </associatedEntity>
  </participant>
```

Add Section 6.3.2.6

6.3.2.6 Natural Father of Fetus 1.3.6.1.4.1.19376.1.5.3.1.2.4.2

This header element records the natural father of the fetus, and inherits other constraints from the Patient Contacts (1.3.6.1.4.1.19376.1.5.3.1.2.4) entry. Items in bold in the example below show the additional constraints on this element.

This element SHALL be included as a participant in the header of the CDA document in the event of the pregnancy. If the father of the baby is unknown this element SHALL use a null flavor.

6.3.2.6.1 Parent Template

The parent of this template is Patient Contacts (1.3.6.1.4.1.19376.1.5.3.1.2.4).

6.3.2.6.2 Specification

```
  <participant typeCode='IND'>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.2.4'/>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.2.4.1'/>
 <time value='20070213'/>
 <associatedEntity classCode='PRS'>
   <code code='xx-fatherofbaby' displayName=' ' codeSystem='2.16.840.1.113883.6.96'
codeSystemName='SNOMED CT'/>
   <addr></addr>
   <telecom value=' ' use=' '/>
   <assignedPerson><name></name></assignedPerson>
 </associatedEntity>
</participant>
```


6.3.2.6.3 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.2.4'/><templateId root='1.3.6.1.4.1.19376.1.5.3.1.2.4.2'/>

The <templateId> element identifies this person as the natural father and must be recorded exactly as shown above.

```
<rule context='hl7:templateId/@root="1.3.6.1.4.1.19376.1.5.3.1.2.4.2"]'>
  <assert test='hl7:templateId/@root="1.3.6.1.4.1.19376.1.5.3.1.2.4"'>
    A participant using template 1.3.6.1.4.1.19376.1.5.3.1.2.4.2 must also use template
1.3.6.1.4.1.19376.1.5.3.1.2.4.
  </assert>
</rule>
```

6.3.2.6.4 <associatedEntity classCode='PRS'>

The classCode attribute of the <associatedEntity> element SHALL be PRS.

```
<rule context='hl7:templateId/@root="1.3.6.1.4.1.19376.1.5.3.1.2.4.2"]'>
  <assert test='../hl7:associatedEntity/@classCode = "PRS"'>
    The classCode attribute of the associated entity shall be PRS.
  </assert>
</rule>
```

6.3.2.6.5 <code code='xx-fatherofbaby' displayName=' ' codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'/>

For father of baby the code SHALL be xx-fatherofbaby (requested). The code system name is SNOMED CT.

6.3.2.6.6 Completed Example

```
  <!-- Father of baby -->
  <participant typeCode="IND">
    <associatedEntity classCode="NOK">
      <code code="xx-fatherofbaby" displayName="Father of Baby"
        codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"/>
      <addr>
        <streetAddressLine>18 Oak Valley Dr.</streetAddressLine>
        <city>Monteagle</city>
        <state>TN</state>
        <postalCode>37205</postalCode>
        <country>USA</country>
      </addr>
      <telecom value="tel:(999)555-1212" use="WP"/>
      <associatedPerson>
        <name>
          <prefix>Mr.</prefix>
          <given>Thomas</given>
          <family>Caster</family>
        </name>
      </associatedPerson>
    </associatedEntity>
  </participant>
```

Add Section 6.3.2.7

6.3.2.7 Authorization 1.3.6.1.4.1.19376.1.5.3.1.2.5

Each <authorization> element in the CDA Header represents an informed consent. When the document being shared represents the informed consent to a policy expressed by the XDS Affinity Domain within the document, it shall do so in an <authorization> element. More than one <authorization> element may be present. The consent to share information shall have a unique identifier contained in the <id> element, representing the patient consent to that policy. The policy being consented to shall be represented in the <code> element. Note that other <authorization> elements may be present representing other sorts of consents associated with the document.

6.3.2.7.1 Parent Template

None

6.3.2.7.2 Specification

```
<authorization typeCode='AUTH'>
  <consent classCode='CONS' moodCode='EVN'>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.2.5'/>
    <id root=''/>
    <code code='' codeSystem='' codeSystemName='' displayName=''/>
    <statusCode code='completed'/>
  </consent>
</authorization>
```

6.3.2.7.3 <authorization typeCode='AUTH'>

At least one <authorization> element must be present in a consent medical document in documents shared by Document Source actors that implement the privacy option. The typeCode attribute shall be present and be valued with AUTH, indicating that this is an authorization act related to the document.

6.3.2.7.4 <consent classCode='CONS' moodCode='EVN'>

Each authorization element shall have one <consent> element. The classCode shall be present and be valued with CONS, indicating that the related act is an informed consent. The moodCode shall be EVN, indicating that this element represents and act that has occurred.

6.3.2.7.5 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.2.5'/>

The <templateId> element shall be recorded as shown above and identifies this consent as an authorization entry.

6.3.2.7.6 <id root=' '/>

The <consent> element shall have one identifier that is used to uniquely identify the consent act. This identifier shall contain a root attribute, and shall not contain an extension attribute.

6.3.2.7.7 <code code=' ' codeSystem=' ' codeSystemName=' ' displayName=' '/>

The <consent> element shall have one <code> element that is used to identify the consent policy that was agreed to by the patient.

Add Section 6.3.3

6.3.3 CDA Section Content Modules

Add Section 6.3.3.1

6.3.3.1 Reasons for Care

Add Section 6.3.3.1.1

6.3.3.1.1 Reason for Referral

Add Section 6.3.3.1.2

6.3.3.1.2 Coded Reason for Referral

Add Section 6.3.3.1.3

6.3.3.1.3 Chief Complaint

Add Section 6.3.3.1.4

6.3.3.1.4 Hospital Admission Diagnosis

Add Section 6.3.3.1.5

6.3.3.1.5 Proposed Procedure Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.1	
General Description	The proposed procedure section shall contain a description of the procedures for which a risk assessment is required including procedure names and codes, patient position, dates, and names of surgeons. It shall include entries for procedures as described in the Entry Content Modules and the required and optional subsections.	
LOINC Code	**Opt**	**Description**
29554-3	R	PROCEDURE
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.19	R	Procedure Entry
Subsections	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.9.4	R	Reason for Procedure
1.3.6.1.4.1.19376.1.5.3.1.1.9.3	R	Proposed Anesthesia
1.3.6.1.4.1.19376.1.5.3.1.1.9.2	R	Estimated Blood Loss

1.3.6.1.4.1.19376.1.5.3.1.1.9.40	R	Procedure Care Plan

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.1'/>
    <id root=' ' extension=' '/>
    <code code='29554-3' displayName='PROCEDURE'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
         :
      <!-- Required Procedure Entry  element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.19'/>
         :
    </entry>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.4'/>
        <!-- Required Reason for Procedure Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.3'/>
        <!-- Required Proposed Anesthesia Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.2'/>
        <!-- Required if known Estimated Blood Loss Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.40'/>
        <!-- Required if known Procedure Care Plan Section content -->
      </section>
    </component>
  </section>
</component>
```

Figure 6.3.3.1.5-1: Specification for Proposed Procedure Section

Add Section 6.3.3.1.6

6.3.3.1.6 EBS Estimated Blood Loss Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.2

Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.9.2
General Description		The estimated blood loss section shall contain a description of the blood loss for the procedure.
LOINC Code	**Opt**	**Description**
8717-1	R	OPERATIVE NOTE ESTIMATED BLOOD LOSS
Entries	**Opt**	**Description**

1.3.6.1.4.1.19376.1.5.3.1.4.13	R	Simple Observation

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.2'/>
    <id root=' ' extension=' '/>
    <code code='8717-1' displayName='OPERATIVE NOTE ESTIMATED BLOOD LOSS'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
         :
      <!-- Required Simple Observation element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
         :
    </entry>
  </section>
</component>
```

Figure 6.3.3.1.6-1: EBS Specification for Estimated Blood Loss Section

Add Section 6.3.3.1.7

6.3.3.1.7 Proposed Anesthesia Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.3

Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.9.3
General Description		The proposed anesthesia section shall contain a description of the anesthetic techniques for which a risk assessment is required. It shall include entries for anesthetic procedures as described in the Entry Content Modules.
LOINC Code	**Opt**	**Description**
10213-7	R	Surgical operation note anesthesia
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.19	R	Procedure Entry The procedure entries shall be in INT mood.

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.3'/>
    <id root=' ' extension=' '/>
    <code code='10213-7' displayName='Surgical operation note anesthesia'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
         :
      <!-- Required Procedure Entry element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.19'/>
         :
    </entry>
  </section>
</component>
```

Figure 6.3.3.1.7-1: Specification for Anesthesia Administered Section

Add Section 6.3.3.1.8

6.3.3.1.8 Reason for Procedure Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.4

Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.9.4
General Description		The reason for procedure section shall contain a description of the reason that the patient is receiving the procedure. It shall include entries for conditions as described in the Entry Content Module.
LOINC Code	**Opt**	**Description**
10217-8	R	OPERATIVE NOTE INDICATIONS
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.5	R2	Problem Entry

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.4'/>
    <id root=' ' extension=' '/>
    <code code='10217-8' displayName='OPERATIVE NOTE INDICATIONS'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
         :
      <!-- Required if known Problem Entry element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.5'/>
         :
    </entry>
  </section>
</component>
```

Figure 6.3.3.1.8-1: Specification for Reason for Procedure Section

Add Section 6.3.3.1.9

6.3.3.1.9 Reason for Visit Section 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1.1	
General Description	This contains a narrative description of the patient's reason for visit.	
LOINC Code	**Opt**	**Description**
29299-5	R	REASON FOR VISIT

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1.1'/>
    <id root=' ' extension=' '/>
    <code code='29299-5' displayName='REASON FOR VISIT'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>
</component>
```

Figure 6.3.3.1.9-1: Specification for Reason for Visit Section

Add Section 6.3.3.1.10

6.3.3.1.10 Injury Incident Description Section 1.3.6.1.4.1.19376.1.5.3.1.1.19.2.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.19.2.1	
General Description	This section shall include a description of the incident leading to the injury, including status of relevant safety equipment in use (e.g., safety belts, air bag, helmet).	
LOINC Code	**Opt**	**Description**
11374-6	R	Injury incident description

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.19.2.1'/>
    <id root=' ' extension=' '/>
    <code code='11374-6' displayName='Injury incident description'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>
</component>
```

Figure 6.3.3.1.10-1: Sample Injury Incident Description Section

Add Section 6.3.3.2

6.3.3.2 Other Condition Histories

Add Section 6.3.3.2.1

6.3.3.2.1 History of Present Illness

Add Section 6.3.3.2.2

6.3.3.2.2 Hospital Course

Add Section 6.3.3.2.3

6.3.3.2.3 Active Problems

Add Section 6.3.3.2.4

6.3.3.2.4 Discharge Diagnosis

Add Section 6.3.3.2.5

6.3.3.2.5 History of Past Illness

Add Section 6.3.3.2.6

6.3.3.2.6 Encounter Histories

Add Section 6.3.3.2.7

6.3.3.2.7 History of Outpatient Visits

Add Section 6.3.3.2.8

6.3.3.2.8 History of Inpatient Visits

Add Section 6.3.3.2.9

6.3.3.2.9 List of Surgeries

Add Section 6.3.3.2.10

6.3.3.2.10 Coded List of Surgeries

Add Section 6.3.3.2.11

6.3.3.2.11 Allergies and Other Adverse Reactions

Add Section 6.3.3.2.12

6.3.3.2.12 Family medical History

Add Section 6.3.3.2.13

6.3.3.2.13 Coded Family Medical History

Add Section 6.3.3.2.14

6.3.3.2.14 Social History Section

Add Section 6.3.3.2.15

6.3.3.2.15 Functional Status

Add Section 6.3.3.2.16

6.3.3.2.16 Review of Systems

Add Section 6.3.3.2.17

6.3.3.2.17 Hazardous Working Conditions

Add Section 6.3.3.2.18

6.3.3.2.18 Pregnancy History

Add Section 6.3.3.2.19

6.3.3.2.19 Medical Devices

Add Section 6.3.3.2.20

6.3.3.2.20 Foreign Travel

Add Section 6.3.3.2.21

6.3.3.2.21 Pre-procedure Family Medical History Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.5 (Deprecated)

Add Section 6.3.3.2.22

6.3.3.2.22 Coded Functional Status Assessment Section 1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1
Parent Template	Functional Status (1.3.6.1.4.1.19376.1.5.3.1.3.17, see PCC TF-2: 6.3.3.2.15)
General Description	The coded functional status assessment section provides a machine readable and narrative description of the patient's status of normal functioning at the time the document was created.

	Functional status includes information concerning: Ambulatory ability Mental status or competency Activities of Daily Living (ADL's) including bathing, dressing, feeding, grooming Home/living situation having an effect on the health status of the patient Ability to care for self Social activity, including issues with social cognition, participation with friends and acquaintances other than family members Occupation activity, including activities partly or directly related to working, housework or volunteering, family and home responsibilities or activities related to home and family Communication ability, including issues with speech, writing or cognition required for communication Perception, including sight, hearing, taste, skin sensation, kinesthetic sense, proprioception, or balance

LOINC Code	Opt	Description
47420-5	R	Functional Status Assessment
Subsections	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.12.2.2	R	Pain Scale Assessment
1.3.6.1.4.1.19376.1.5.3.1.1.12.2.3	O Note 1	Braden Score Assessment
1.3.6.1.4.1.19376.1.5.3.1.1.12.2.4	O Note 1	Geriatric Depression Scale
1.3.6.1.4.1.19376.1.5.3.1.1.12.2.5	O Note 1	Minimum Data Set

Note 1: At least one of the above optional subsections shall be present

6.3.3.2.22.1 Standards

CDAR2 HL7 CDA Release 2.0

CRS HL7 Care Record Summary

CCD ASTM/HL7 Continuity of Care Document

LOINC Logical Observation Identifier Names and Codes

SNOMED Systemitized Nomenclature of Medicine Clinical Terminology

6.3.3.2.22.2 Parent Template

The parent of this template is Functional Status (see PCC TF-2: 6.3.3.2.15).

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.17'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1'/>
    <id root=' ' extension=' '/>
    <code code='47420-5' displayName='Functional Status Assessment'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
   <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.2'/>
        <!-- Required Pain Scale Assessment Section content -->
      </section>
    </component>

   <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.3'/>
        <!-- Optional Braden Score Assessment Section content -->
      </section>
    </component>

   <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.4'/>
        <!-- Optional Geriatric Depression Scale Section content -->
      </section>
    </component>

   <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.5'/>
        <!-- Optional Minimum Data Set Section content -->
      </section>
    </component>


  </section>
</component>
```

Figure 6.3.3.2.22.2-1: Specification for Coded Functional Status Assessment Section

Add Section 6.3.3.2.23

6.3.3.2.23 Pain Scale Assessment Section 1.3.6.1.4.1.19376.1.5.3.1.1.12.2.2

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.12.2.2	
General Description	The Pain Scale Assessment contains a coded observation reflecting the patient's reported intensity of pain on a scale from 0 to 10.	
LOINC Code	**Opt**	**Description**
38208-5	R	Pain severity
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.12.3.1	R	Pain Score Observation

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.2'/>
    <id root=' ' extension=' '/>
    <code code='38208-5' displayName='Pain severity'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Required Pain Score Observation element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.3.1'/>
        :
    </entry>

  </section>
</component>
```

Figure 6.3.3.2.23-1: Specification for Pain Scale Assessment Section

Add Section 6.3.3.2.24

6.3.3.2.24 Braden Score Section 1.3.6.1.4.1.19376.1.5.3.1.1.12.2.3

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.12.2.3	
General Description	This section reports the Braden score and its related assessments in machine and human readable form.	
LOINC Code	**Opt**	**Description**
38228-3	R	BRADEN SCALE SKIN ASSESSMENT PANEL
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.12.3.2	R	Braden Score Observation

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.3'/>
    <id root=' ' extension=' '/>
    <code code='38228-3' displayName='BRADEN SCALE SKIN ASSESSMENT PANEL'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Required Braden Score Observation element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.3.2'/>
        :
    </entry>

  </section>
</component>
```

Figure 6.3.3.2.24-1: Specification for Braden Score Section

Add Section 6.3.3.2.25

6.3.3.2.25 Geriatric Depression Scale Section 1.3.6.1.4.1.19376.1.5.3.1.1.12.2.4

Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.12.2.4
General Description		This section reports the Geriatric Depression Scale score and its related assessments in machine and human readable form.
LOINC Code	**Opt**	**Description**
48542-5	R	Geriatric Depression Scale (GDS) Panel
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.12.3.4	R	Geriatric Depression Score Observation

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.4'/>
    <id root=' ' extension=' '/>
    <code code='48542-5' displayName='Geriatric Depression Scale (GDS) Panel'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Required Geriatric Depression Score Observation element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.3.4'/>
        :
    </entry>

  </section>
</component>
```

Figure 6.3.3.2.25-1: Specification for Geriatric Depression Scale Section

Add Section 6.3.3.2.26

6.3.3.2.26 Physical Function Section 1.3.6.1.4.1.19376.1.5.3.1.1.12.2.5

Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.12.2.5
General Description		This section reports scores from section G of the Minimum Data Set.
LOINC Code	**Opt**	**Description**
46006-3	R	Physical functioning and structural problems
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.12.3.7	O	Survey Panel At least one Survey Panel or Survey Observation shall be present.
1.3.6.1.4.1.19376.1.5.3.1.1.12.3.6	O	Survey Observation At least one Survey Panel or Survey Observation shall be present.

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.5'/>
    <id root=' ' extension=' '/>
    <code code='46006-3' displayName='Physical functioning and structural problems'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Optional Survey Panel element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.3.7'/>
        :
    </entry>
    <entry>
        :
      <!-- Optional Survey Observation element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.3.6'/>
        :
    </entry>

  </section>
</component>
```

Figure 6.3.3.2.26-1: Specification for Physical Function Section

6.3.3.2.26.1 Constraints

Survey Panel found in this section shall be identified using the panel codes found in the table below, and shall contain one or more survey observations from that panel.

Survey Observation found in this section shall use the LOINC codes from table 6.3.3.2.26.1 to express the answer to one or more questions from the Minimum Data Set Section G. The Survey Observations shall not contain a <methodCode> or <targetSiteCode> element, as these are not appropriate to the MDS Survey instrument.

Table 6.3.3.2.26.1-1: Panel Codes

Panel Code	Observation Code	Description	Data Type	Value Set
46007-1	Panel	ADL self-performance or support		
	45588-1	Bed mobility - self-performance	CO	2.16.840.1.113883.6.257.755
	45589-9	Bed mobility - support provided	CO	2.16.840.1.113883.6.257.768
	45590-7	Transfer - self-performance	CO	2.16.840.1.113883.6.257.755
	45591-5	Transfer - support provided	CO	2.16.840.1.113883.6.257.768
	45592-3	Walk in room - self-performance	CO	2.16.840.1.113883.6.257.755
	45593-1	Walk in room - support provided	CO	2.16.840.1.113883.6.257.768
	45594-9	Walk in corridor - self-performance	CO	2.16.840.1.113883.6.257.755
	45595-6	Walk in corridor - support provided	CO	2.16.840.1.113883.6.257.768
	45596-4	Locomotion on unit - self-performance	CO	2.16.840.1.113883.6.257.755
	45597-2	Locomotion on unit - support provided	CO	2.16.840.1.113883.6.257.768

Panel Code	Observation Code	Description	Data Type	Value Set
	45598-0	Locomotion off unit - self-performance	CO	2.16.840.1.113883.6.257.755
	45599-8	Locomotion off unit - support provided	CO	2.16.840.1.113883.6.257.768
	45600-4	Dressing - self-performance	CO	2.16.840.1.113883.6.257.755
	45601-2	Dressing - support provided	CO	2.16.840.1.113883.6.257.768
	45602-0	Eating - self-performance	CO	2.16.840.1.113883.6.257.755
	45603-8	Eating - support provided	CO	2.16.840.1.113883.6.257.768
	45604-6	Toilet use - self-performance	CO	2.16.840.1.113883.6.257.755
	45605-3	Toilet use - support provided	CO	2.16.840.1.113883.6.257.768
	45606-1	Personal hygiene - self-performance	CO	2.16.840.1.113883.6.257.755
	45607-9	Personal hygiene - support provided	CO	2.16.840.1.113883.6.257.768
46008-9	Panel	Bathing		
	45608-7	Bathing - self-performance	CO	2.16.840.1.113883.6.257.860
	45609-5	Bathing - support provided	CO	2.16.840.1.113883.6.257.768
46009-7	Panel	Test for balance		
	45610-3	Balance while standing	CO	2.16.840.1.113883.6.257.876
	45523-8	Balance while sitting	CO	2.16.840.1.113883.6.257.876
46010-5	Panel	Functional limitation in range of motion		
	45524-6	Range of motion^Neck	CO	2.16.840.1.113883.6.257.889
	45525-3	Voluntary movement^Neck	CO	2.16.840.1.113883.6.257.898
	45526-1	Range of motion^Upper Extremity	CO	2.16.840.1.113883.6.257.889
	45527-9	Voluntary movement^Upper Extremity	CO	2.16.840.1.113883.6.257.898
	45528-7	Range of motion^Hand	CO	2.16.840.1.113883.6.257.889
	45529-5	Voluntary movement^Hand	CO	2.16.840.1.113883.6.257.898
	45530-3	Range of motion^Lower Extremity	CO	2.16.840.1.113883.6.257.889
	45531-1	Voluntary movement^Lower Extremity	CO	2.16.840.1.113883.6.257.898
	45532-9	Range of motion^Foot	CO	2.16.840.1.113883.6.257.889
	45533-7	Voluntary movement^Foot	CO	2.16.840.1.113883.6.257.898
	45534-5	Other - range of motion	CO	2.16.840.1.113883.6.257.889
	45535-2	Other - voluntary movement	CO	2.16.840.1.113883.6.257.898
46011-3	Panel	Modes of locomotion		
	45536-0	Uses cane, walker or crutch	CO	2.16.840.1.113883.6.257.117
	45537-8	Wheeled self	CO	2.16.840.1.113883.6.257.117
	45538-6	Other person wheeled	CO	2.16.840.1.113883.6.257.117
	45539-4	Uses wheelchair for primary locomotion	CO	2.16.840.1.113883.6.257.117

Panel Code	Observation Code	Description	Data Type	Value Set
	45540-2	No modes of locomotion	CO	2.16.840.1.113883.6.257.117
46012-1	Panel	Modes of transfer		
	45541-0	Bedfast all or most of the time	CO	2.16.840.1.113883.6.257.117
	45542-8	Bed rails for bed mobility or transfer	CO	2.16.840.1.113883.6.257.117
	45543-6	Lifted manually	CO	2.16.840.1.113883.6.257.117
	45544-4	Lifted mechanically	CO	2.16.840.1.113883.6.257.117
	45545-1	Transfer aid	CO	2.16.840.1.113883.6.257.117
	45546-9	No mode of transfer	CO	2.16.840.1.113883.6.257.117
No Panel	45611-1	Task segmentation	CO	2.16.840.1.113883.6.257.117
46013-9	Panel	ADL functional rehabilitation potential		
	45612-9	Resident sees increased independence capability	CO	2.16.840.1.113883.6.257.117
	45613-7	Staff sees increased independence capability	CO	2.16.840.1.113883.6.257.117
	45614-5	Resident slow performing tasks or activity	CO	2.16.840.1.113883.6.257.117
	45615-2	Difference in morning to evening activities of daily living	CO	2.16.840.1.113883.6.257.117
	45616-0	Activities of daily living rehabilitation potential - none of above	CO	2.16.840.1.113883.6.257.117
	45617-8	Change in activities of daily living function	CO	2.16.840.1.113883.6.257.464

The coded original values used in the observations above are described in more detail in the table below.

Explanation	Coded Value
2.16.840.1.113883.6.257.755	
INDEPENDENT-No help or oversight -OR- Help/oversight provided only 1 or 2 times during last 7 days	0
SUPERVISION-Oversight, encouragement or cueing provided 3 or more times during last7 days -OR-Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days	1
LIMITED ASSISTANCE-Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times - OR-More help provided only 1 or 2 times during last 7 days	2
EXTENSIVE ASSISTANCE-While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: - Weight-bearing support - Full staff performance during part (but not all) of last 7 days	3
TOTAL DEPENDENCE-Full staff performance of activity during entire 7 days	4

Explanation	Coded Value
ACTIVITY DID NOT OCCUR during entire 7 days	8
2.16.840.1.113883.6.257.768	
No setup or physical help from staff	0
Setup help only	1
One person physical assist	2
ADL activity itself did not occur during entire 7 days	8
2.16.840.1.113883.6.257.860	
Independent-No help provided	0
Supervision-Oversight help only	1
Physical help limited to transfer only	2
Physical help in part of bathing activity	3
Total dependence	4
Activity itself did not occur during entire 7 days	8
2.16.840.1.113883.6.257.876	
Maintained position as required in test	0
Unsteady, but able to rebalance self without physical support	1
Partial physical support during test; or stands (sits) but does not follow directions for test	2
Not able to attempt test without physical help	3
2.16.840.1.113883.6.257.889	
No limitation	0
Limitation on one side	1
Limitation on both sides	2
2.16.840.1.113883.6.257.898	
No loss	0
Partial loss	1
Full loss	2
2.16.840.1.113883.6.257.117	
No	0
Yes	1
UTD	-
2.16.840.1.113883.6.257.464	
No change	0
Improved	1
Deteriorated	2

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Add Section 6.3.3.2.27

6.3.3.2.27 Preprocedure Review of Systems Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.13

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.13	
Parent Template	Review of Systems (1.3.6.1.4.1.19376.1.5.3.1.3.18)	
General Description	The pre-procedure review of systems section shall contain only required and optional subsections dealing with the responses the patient gave to a set of routine questions on body systems in general and specific risks of anesthesia not covered in general review of systems.	
LOINC Code	**Opt**	**Description**
10187-3	R	REVIEW OF SYSTEMS
Subsections	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.9.46	R	Implanted Medical Device Review
1.3.6.1.4.1.19376.1.5.3.1.1.9.47	R2	Pregnancy Status Review
1.3.6.1.4.1.19376.1.5.3.1.1.9.14	R	Anesthesia Risk Review of Systems

```
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    <id root=' ' extension=' '/>
    <code code='10187-3' displayName='REVIEW OF SYSTEMS'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.46'/>
        <!-- Required Implanted Medical Device Review Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.47'/>
        <!-- Required if known Pregnancy Status Review Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.14'/>
        <!-- Required Anesthesia Risk Review of Systems Section content -->
      </section>
    </component>


  </section>
</component>
```

Figure 6.3.3.2.27-1: Specification for Preprocedure Review of Systems Section

Add Section 6.3.3.2.28

6.3.3.2.28 Estimated Delivery Date Section 1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1	
General Description	This section contains the physician's best estimate of the patients due date. This is generally done both on an initial evaluation, and later confirmed at 18-20 weeks. The date is supported by evidence such as the patient's history of last menstrual period, a physical examination, or ultrasound measurements.	
LOINC Code	**Opt**	**Description**
57060-6	R	Estimated date of delivery
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.1	R	Estimated Delivery Date Observation This is a simple observation to represent the estimated due date with a supporting observation or observations that state the method used and date implied by that method. If one observation is present, then it is to be interpreted as the initial EDD. If the initial observation dates indicate the EDD is within the 18 to 20 weeks completed gestation, that observation will also populate the 18-20 week update. If the initial observation indicates an EDD of more than 20 weeks EGA, then no value will be placed in the 18-20 week update field.

```
<component>
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      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Required Estimated Due Date Observation element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.1'/>
        :
    </entry>
  </section>
</component>
```

Figure 6.3.3.2.28-1: Specification for Estimated Delivery Dates Section

Add Section 6.3.3.2.29

6.3.3.2.29 History of Tobacco Use Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.8

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.8	
General Description	The history of tobacco use section shall contain a description of the responses the patient gave to a set of routine questions on the history of tobacco use.	
LOINC Code	**Opt**	**Description**
11366-2	R	HISTORY OF TOBACCO USE

```
<component>

  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.8'/>
    <id root=' ' extension=' '/>
    <code code='11366-2' displayName='HISTORY OF TOBACCO USE'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>

</component>
```

Figure 6.3.3.2.29-1: Specification for History of Tobacco Use Section

Add Section 6.3.3.2.30

6.3.3.2.30 Current Alcohol/Substance Abuse Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.10

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.10	
General Description	The history of alcohol/substance abuse section shall contain a description of the responses the patient gave to a set of routine questions on the current abuse of alcohol or other substances.	
LOINC Code	**Opt**	**Description**
18663-5	R	HISTORY OF PRESENT ALCOHOL AND/OR SUBSTANCE ABUSE

```
<component>

  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.10'/>
    <id root=' ' extension=' '/>
    <code code='18663-5' displayName='HISTORY OF PRESENT ALCOHOL AND/OR SUBSTANCE ABUSE'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>

</component>
```

Figure 6.3.3.2.30-1: Specification for Current Alcohol/Substance Abuse Section

Add Section 6.3.3.2.31

6.3.3.2.31 History of Blood Transfusion Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.12

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.12
General Description	The History of Blood Transfusion section shall contain a narrative description of the blood products the patient has received in the past, including any reactions to blood

	products.	
LOINC Code	**Opt**	**Description**
56836-0	R	History of blood transfusion

```
<component>

  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.12'/>
    <id root=' ' extension=' '/>
    <code code='56836-0' displayName='History of blood transfusion'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>

</component>
```

Figure 6.3.3.2.31-1: Specification for History of Blood Transfusion Section

Add Section 6.3.3.2.32

6.3.3.2.32 Anesthesia Risk Review of Systems Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.14

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.14	
Parent Template	1.3.6.1.4.1.19376.1.5.3.1.3.18	
General Description	The anesthesia review of systems section shall contain a description of the responses the patient gave to a set of routine questions on specific risks of anesthesia not covered in general review of systems such as broken teeth, airway limitations, positioning limitations, recent infections, and history of personal anesthesia problems..	
LOINC Code	**Opt**	**Description**
57081-2	R	Anesthesia Risk Review of Systems

```
<component>

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    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.14'/>
    <id root=' ' extension=' '/>
    <code code='57081-2' displayName='Anesthesia Risk Review of Systems'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>

</component>
```

Figure 6.3.3.2.32-1: Specification for Anesthesia Risk Review of Systems Section

Add Section 6.3.3.2.33

6.3.3.2.33 Implanted Medical Device Review Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.46

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.46	
General Description	The implanted medical device review section shall contain a description of the medical devices that are inserted into the patient, whether internal or partially external.	
LOINC Code	**Opt**	**Description**
57080-4	R	Implanted medical device

```
<component>

  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.46'/>
    <id root=' ' extension=' '/>
    <code code='57080-4' displayName='Implanted medical device'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>

</component>
```

Figure 6.3.3.2.33-1: Specification for Implanted Medical Device Review Section

Add Section 6.3.3.2.34

6.3.3.2.34 Pregnancy Status Review Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.47

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.47	
General Description	The pregnancy status review section shall contain a description of the responses the patient gave to a set of routine questions regarding potential pregnancy in females of child-bearing-age.	
LOINC Code	**Opt**	**Description**
11449-6	R	Pregnancy Status-Reported

```
<component>

  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.47'/>
    <id root=' ' extension=' '/>
    <code code='11449-6' displayName='Pregnancy Status-Reported'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>
</component>
```

Figure 6.3.3.2.34-1: Specification for Pregnancy Status Review Section

Add Section 6.3.3.2.35

6.3.3.2.35 History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1	
General Description	The History of Infection section shall contain a narrative description of any infections the patient may have contracted prior to the patient's current visit or admission.	
LOINC Code	**Opt**	**Description**
56838-6	R	History of infectious disease

```
<component>
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    <id root=' ' extension=' '/>
    <code code='56838-6' displayName='History of infectious disease'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.2.35-1: Specification for History of Infection Section

Add Section 6.3.3.2.36

6.3.3.2.36 Coded Social History Section 1.3.6.1.4.1.19376.1.5.3.1.3.16.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.3.16.1	
Parent Template	Social History (1.3.6.1.4.1.19376.1.5.3.1.3.16)	
General Description	The social history section shall contain a narrative description of the person's beliefs, home life, community life, work life, hobbies, and risky habits. It shall include Social History Observations.	
LOINC Code	**Opt**	**Description**
29762-2	R	SOCIAL HISTORY
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.13.4	R	Social History Observation

```
<component>
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      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
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      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.2.36-1: Specification for Coded Social History Section

Add Section 6.3.3.2.37

6.3.3.2.37 Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	
Parent Template	History of Infection (1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1)	
General Description	The History of Infection section shall contain a narrative description of any infections the patient may have contracted prior to the patient's current condition. It shall include entries for problems as described in the Entry Content Modules.	
LOINC Code	**Opt**	**Description**
56838-6	R	History of infectious disease
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.5.2	R	Problem Concern Entry

```
<component>
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    <id root=' ' extension=' '/>
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      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.2.37-1: Specification for Coded History of Infection Section

Add Section 6.3.3.2.38

6.3.3.2.38 Prenatal Events Section 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.2

Template ID	1.3.6.1.4.1.19376.1.5.3..1.1.21.2.2
General Description	The Prenatal Events Section shall include narrative text describing pertinent prenatal information that has a direct impact on the process of labor and delivery. It shall also include subsections if known.

LOINC Code	Opt	Description
57073-9	R	Prenatal events
Subsections	**Opt**	**Description**
Coded Results This section SHOULD contain laboratory results and procedures as pertaining to the pregnancy , e.g., amniocentesis, cordocentesis, chorionic villus sampling.	R2	1.3.6.1.4.1.19376.1.5.3.1.3.28
Procedures and Interventions This section SHOULD contain procedures that took place during the prenatal period (i.e., prenatal care, prenatal complications, prenatal surgeries)	R2	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11
Event Outcomes This section contains event outcomes related to prenatal events e.g., miscarriage, infection.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9

```
<component>
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      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
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    </text>
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          <!-- Required if known Coded Results Section -->
        </section>
    </component>
    <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11'/>
          <!-- Required if known Procedures and Interventions Section -->
        </section>
    </component>
    <component>
        <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9'/>
          <!-- Required if known Event Outcomes Section -->
        </section>
    </component>
  </section>
</component>
```

Figure 6.3.3.2.38-1: Specification for Prenatal Events Section

Add Section 6.3.3.2.39

6.3.3.2.39 Labor and Delivery Events Section 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Parent Template		
General Description	The Labor and Delivery Events Section SHALL include a narrative text containing relevant information collected during the labor and delivery process.	
LOINC Code	**Opt**	**Description**
57074-7	R	Labor and delivery process
Subsections	**Opt**	**Description**
Procedures and Interventions The subsection SHALL contain procedures and interventions specific to labor and delivery events. These may include induction, the delivery type (e.g., vaginal, vaginal birth after cesarean section or cesarean section along with incision type), electronic fetal monitoring, etc.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11
Coded Event Outcomes This section SHOULD contain outcomes related to the labor and delivery process such as live birth or stillborn. The subsection shall include coded event outcomes such as live birth or stillborn and also including maternal death with date/time. Furthermore, Coded Event Outcomes section shall contain a simple Observation using LOINC Code 11636-8 that reports the number of births live or dead that occurred during the delivery event,.	R2	1.3.6.1.4.1.19376.1.7.3.1.1.13.7

```
<component>
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    <text>
      Text as described above
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    <component>
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          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11'/>
          <!-- Required if known Procedures and Interventions Section -->
        </section>
    </component>
    <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.7.3.1.1.13.7'/>
          <!-- Required if known Coded Event Outcomes Section -->
        </section>
    </component>
  </section>
</component>
```

Figure 6.3.3.2.39-1: Specification for Labor and Delivery Process Section

Add Section 6.3.3.2.40

6.3.3.2.40 Newborn Delivery Information Section 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4	
General Description	The Newborn Delivery Information Section SHALL include a narrative text containing information collected at the birth and up to the transfer of the infant from the birthing room to a post-natal unit.	
LOINC Code	**Opt**	**Description**
57075-4	R	Newborn delivery information from newborn
Subsections	**Opt**	**Description**
Coded Detailed Physical Examination Section This section SHALL include information about the newborn genitalia; weight; length; head circumference, size (AGA, SGA or LGA); Apgar score assessment ; vital signs, physical exam findings	R	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1
Active Problems This section SHALL describe problems that the newborn might have had during or immediately prior to delivery.	R2	1.3.6.1.4.1.19376.1.5.3.1.3.6
Procedures and Interventions This section SHALL include the procedures and interventions received by the newborn such as suction or resuscitation.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11
Medications Administered This section SHALL include the medication that was administered to the newborn while in the birthing suite such as: Vitamin K (Aquamephyton) injection; erythromycin eye ointment; and resuscitation medications (if any) including date, time, and route of administration.	R2	1.3.6.1.4.1.19376.1.5.3.1.3.21
Event Outcomes This section SHALL include the outcomes of the procedures and interventions such as a resuscitation event.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9
Coded Event Outcomes	C	1.3.6.1.4.1.19376.1.7.3.1.1.13.7
Coded Results	C	1.3.6.1.4.1.19376.1.5.3.1.3.28
Intake and Output This section SHALL include any intake and output while the newborn is in the delivery suite (excluding estimated blood loss) such as: first urine/void; stool; gastric output	C	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3

```
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      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <component>
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          <!-- Required Coded Detailed Physical Examination Section -->
        </section>
    </component>
    <component>
        <section>
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          <!-- Required if known Active Problems Section -->
        </section>
    </component>
    <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11'/>
          <!-- Required if known Procedures and Interventions Section -->
        </section>
    </component>
    <component>
        <section>
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          <!-- Required if known Medications Administered Section -->
        </section>
    </component>
    <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9'/>
          <!-- Required if known Event Outcomes Section -->
        </section>
    </component>
  </section>
</component>
```

Figure 6.3.3.2.40-1: Specification for Newborn Delivery Information Section

Add Section 6.3.3.2.41

6.3.3.2.41 Postpartum Hospitalization Treatment Section 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.7

1935

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.7	
Parent Template		
General Description	The Postpartum Treatment Section shall include a narrative description of the treatment delivered to the mother subsequent to the delivery.	
LOINC Code	**Opt**	**Description**
57076-2	R	Postpartum hospitalization TREATMENT
Subsections	**Opt**	**Description**
Immunizations This section SHOULD contain the immunization given to the mother prior to the discharge from the birthing facility.	O	1.3.6.1.4.1.19376.1.5.3.1.4.12
Medications Administered This SHOULD include commonly prescribed maternal medications including contraceptive medication.	R2	1.3.6.1.4.1.19376.1.5.3.1.3.21
Procedures and Interventions This section SHALL include the procedures and interventions received by the mother during the immediate post-partum period e.g., transfusion or curettage.	R	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11
Coded Results This section SHOULD contain laboratory results and procedures as pertaining to the mother while discharged such as the hemoglobin or the hematocrit level.	R2	1.3.6.1.4.1.19376.1.5.3.1.3.28
Care plan This section SHOULD include the plan of care for the mother upon her discharge such as the feeding method or the contraceptive plan	O	1.3.6.1.4.1.19376.1.5.3.1.3.31
Discharge Diet This section SHALL include the diet that the mother was recommended upon her discharge.	R	1.3.6.1.4.1.19376.1.5.3.1.3.33

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.7'/>
    <id root=' ' extension=' '/>
    <code code='57076-2' displayName='POST PARTUM HOSPITALIZATION TREATMENT'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.6'/>
          <!-- Required Active Problems Section -->
        </section>
    </component>
    <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.12'/>
          <!-- Optional Immunizations Section -->
        </section>
    </component>
    <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.22'/>
          <!-- Required if known Hospital Discharge Medication Section -->
        </section>
    </component>
    <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11'/>
          <!-- Required Procedures and Interventions Section -->
        </section>
    </component>
    <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.28'/>
          <!—Required if known Coded Results Section -->
        </section>
    </component>
    <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.31'/>
          <!-- Optional Care Plan Section -->
        </section>
    </component>
    <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.33'/>
          <!-- Required Discharge Diet Section -->
        </section>
    </component>
  </section>
</component>
```

Figure 6.3.3.2.41-1: Specification for Postpartum Treatment Section

Add Section 6.3.3.2.42

6.3.3.2.42 Event Outcomes Section 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9	
Parent Template		
General Description	The Event Outcome Section shall include a narrative description of the outcomes following a procedure, an intervention or a problem.	
LOINC Code	**Opt**	**Description**
42545-4	R	EVENT OUTCOME

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9'/>
    <id root=' ' extension=' '/>
    <code code='42545-4' displayName='EVENT OUTCOME'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
</component>
```

Figure 6.3.3.2.42-1: Specification for Event Outcomes Section

Add Section 6.3.3.2.43

6.3.3.2.43 Newborn Status at Maternal Discharge 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.8

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.8	
Parent Template		
General Description	The Newborn Status and Maternal Discharge section shall contain a narrative description of the status and disposition of the newborn at the time of maternal discharge.	
LOINC Code	**Opt**	**Description**
57077-0	R	Newborn status at maternal discharge from newborn

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.8'/>
    <id root=' ' extension=' '/>
    <code code='57077-0' displayName='Newborn status at maternal discharge from newborn'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
</component>
```

Figure 6.3.3.2.43-1: Specification for Newborn Status at Maternal Discharge Section

Add Section 6.3.3.2.44

6.3.3.2.44 History of Surgical Procedures Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2	
Parent Template		
General Description	The History of Surgical Procedures Section shall contain a narrative description of the surgical procedures performed on the patient.	
LOINC Code	**Opt**	**Description**
10167-5	R	History of surgical procedures

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2'/>
    <id root=' ' extension=' '/>
    <code code='10167-5' displayName='History of surgical procedures'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
</component>
```

Figure 6.3.3.2.44-1: Specification for History of Surgical Procedures Section

Add Section 6.3.3.2.45

6.3.3.2.45 Operative Note Section 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.6

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.6	
Parent Template		
General Description	The Operative Note Section shall contain a narrative description of the current operation or surgical procedure in detail.	
LOINC Code	**Opt**	**Description**
10223-6	R	Surgical operation note surgical procedure

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.6'/>
    <id root=' ' extension=' '/>
    <code code='10223-6' displayName='Surgical operation note surgical procedure'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
</component>
```

Figure 6.3.3.2.45-1: Specification for Operative Note Section

Add Section 6.3.3.2.46

6.3.3.2.46 Child Functional Status Assessment 1.3.6.1.4.1.19376.1.7.3.1.1.13.3

Template ID	1.3.6.1.4.1.19376.1.7.3.1.1.13.3	
General Description	This section provides a description of the child's status of normal functioning at the time the document was created. This section includes the psychomotor and the eating and sleeping assessments. This section shall include the Psychomotor Test Observation entry.	
LOINC Code	**Opt**	**Description**
47420-5	R	Functional Status Assessment
Subsections	**Opt**	**Description**
1.3.6.1.4.1.19376.1.7.3.1.1.13.4	O	Psychomotor Development
1.3.6.1.4.1.19376.1.7.3.1.1.13.5	O	Eating and sleeping assessment

Example

```
<component>
    <section>
        <templateId root="1.3.6.1.4.1.19376.1.7.3.1.1.13.3"/>
        <id root="16696797-f854-443d-8819-231ee09cad71"/>
        <code code="47420-5" displayName="Functional Status Assessment"
            codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
        <title/>
        <text/>
        <component>
            <section>
                <!-- Optional Psychomotor Development section -->
                <templateId root='1.3.6.1.4.1.19376.1.7.3.1.1.13.4'/>
                :
            </section>
        </component>

        <component>
            <section>
                <!-- Eating and sleeping assessment section -->
                <templateId root='1.3.6.1.4.1.19376.1.7.3.1.1.13.5'/>
                :
            </section>
        </component>
    </section>
</component>
```

Add Section 6.3.3.2.47

6.3.3.2.47 Psychomotor Development Section 1.3.6.1.4.1.19376.1.7.3.1.1.13.4

Template ID	1.3.6.1.4.1.19376.1.7.3.1.1.13.4	
General Description	This section describes a test battery in order to evaluate the psychomotricity of the newborn.	
LOINC Code	**Opt**	**Description**

xx-MCH-PsychoMDev	R	Psychomotor development
Entries	**Opt**	**Description**
Simple Observation	R	1.3.6.1.4.1.19376.1.5.3.1.4.13

```
<component>
  <section>
        <!– Psychomotor Development section templateId -->
        <templateId root='1.3.6.1.4.1.19376.1.7.3.1.1.13.4'/>
        <id root=' ' extension=' '/>
        <code code='47420-5' displayName=' Functional Status Assessment '
               codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />
               <text>
                :
               </text>
        <entry>
        :
        <!–Required simple Observation element -->
        <templateId root=1.3.6.1.4.1.19376.1.5.3.1.4.13>
               :
        </entry>
  </section>
</component>
```

Add Section 6.3.3.2.48

6.3.3.2.48 Eating and Sleeping Assessment Section 1.3.6.1.4.1.19376.1.7.3.1.1.13.5

Template ID		1.3.6.1.4.1.19376.1.7.3.1.1.13.5
General Description		This section describes a test battery in order to evaluate the psychomotricity of the newborn.
LOINC Code	**Opt**	**Description**
47420-5	R	Functional Status Assessment
Entries	**Opt**	**Description**
Simple Observation	R	1.3.6.1.4.1.19376.1.5.3.1.4.13

```
<component>
  <section>
        <!—Eating and Sleeping assessment section templateId -->
        <templateId root='1.3.6.1.4.1.19376.1.7.3.1.1.13.5'/>
        <id root=' ' extension=' '/>
        <code code='47420-5' displayName=' Functional Status Assessment '
               codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />
               <text>
                :
               </text>
        <entry>
        :
        <!— Required Simple Observation element -->
        <templateId root=1.3.6.1.4.1.19376.1.5.3.1.4.13/>
               :
        </entry>
  </section>
</component>
```

Add Section 6.3.3.2.49

6.3.3.2.49 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Template ID	1.3.6.1.4.1.19376.1.7.3.1.1.13.7	
Parent Template	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9	
General Description	The Coded Event Outcome Section shall include a narrative description of the outcomes following a procedure, an intervention or a problem, and outcomes related to the labor and delivery process such as live birth or stillborn. It shall include entries for observation as described in the Simple Observation entry.	
LOINC Code	**Opt**	**Description**
42545-4	R	EVENT OUTCOME
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.13	R	Simple Observation
1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1	R2	Patient Transfer

```
<component>
  <section>
        <!—Coded Event Outcomes assessment section templateId -->
        <templateId root='1.3.6.1.4.1.19376.1.7.3.1.1.13.7'/>
        <id root=' ' extension=' '/>
        <code code='42545-4' displayName='Event Outcome'
               codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />
               <text>
                :
               </text>
        <entry>
        :
        <!— Required Simple Observation element -->
        <templateId root=1.3.6.1.4.1.19376.1.5.3.1.4.13/>
               :
        </entry>
  </section>
</component>
```

Add Section 6.3.3.2.50 (Occupational History - removed 2011-09 at the request of QRPH)

6.3.3.2.50 Intentionally blank

Add Section 6.3.3.2.51 (Patient Status - removed 2011-09 at the request of QRPH)

6.3.3.2.51 Intentionally blank

Add Section 6.3.3.2.52 Cancer Control - removed 2011-09 at the request of QRPH)

6.3.3.2.52 Intentionally blank

Add Section 6.3.3.2.53

6.3.3.2.53 Notifications, Alerts, and Reminders Section 1.3.6.1.4.1.19376.1.5.3.1.1.20.2.1.x

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.1.x	
General Description	The Notifications, Reminders and Alerts section highlights areas of care plan non-conformance and directs the need for follow-up communications.	
LOINC Code	**Opt**	**Description**
XXX	R	Notifications, Alerts, and Reminders
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.7	C	Medications Medications entries shall appear for all pending medications when present. These entries shall be in intent mood.
1.3.6.1.4.1.19376.1.5.3.1.4.19	C	Procedure Procedure entries shall appear for all pending procedures when present. These entries shall be in intent mood.
1.3.6.1.4.1.19376.1.5.3.1.4.14	C	Encounter

		Encounter entries should appear for all pending follow-up encounters. These entries shall be in promise or appointment request mood.
1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1	C	Observation Request Observation request entries should appear for all pending follow-up observations. These entries shall appear in intent mood.

Add Section 6.3.3.2.54

6.3.3.2.54 Pain Assessment Panel Section 1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4	
General Description	This contains a narrative description of the patient's pain, including such items as severity, quality, location, time of onset, radiation, etc.	
LOINC Code	**Opt**	**Description**
38212-7	R	Pain Assessment Panel

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4'/>
    <id root=' ' extension=' '/>
    <code code='38212-7' displayName='Pain Assessment Panel'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>
</component>
```

Figure 6.3.2.54-1: Specification for Pain Assessment Panel Section

Add Section 6.3.3.2.55

6.3.3.2.55 History of Cognitive Function Section 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.11

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.11	
General Description	This contains a narrative description of a patient's mental status.	
LOINC Code	**Opt**	**Description**
11332-4	R	History of Cognitive Function

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.11'/>
    <id root=' ' extension=' '/>
    <code code='11332-4' displayName='History of Cognitive Function'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>
</component>
```

Figure 6.3.2.55-1: Specification for History of Cognitive Function Section

Add Section 6.3.3.2.56 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.2.56 Isolation Status Section 1.3.6.1.4.1.19376.1.5.3.1.1.25.2.8

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.25.2.8	
General Description	The Isolation Status section describes a patient with an active infectious disease requiring additional personal protective equipment for healthcare providers.	
LOINC Code	**Opt**	**Description**
55017-8	R	ISOLATION OR QUARANTINE FOR ACTIVE INFECTIOUS DISEASE

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.25.2.8'/>
    <id root=' ' extension=' '/>
    <code code='55017-8' displayName=' ISOLATION OR QUARANTINE FOR ACTIVE INFECTIOUS DISEASE '
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.2.56-1: Sample Isolation Status Section

Add Section 6.3.3.2.57 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.2.57 Restraints Section 1.3.6.1.4.1.19376.1.5.3.1.1.25.2.10

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.25.2.10	
General Description	The Restraints section describes the type of restraints currently in use on the patient to be transported.	
LOINC Code	**Opt**	**Description**
46067-5	R	DEVICES AND RESTRAINTS SET


```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.25.2.10'/>
    <id root=' ' extension=' '/>
    <code code='46067-5' displayName='DEVICES AND RESTRAINTS SET'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.2.57-1: Sample Restraints Section

Add Section 6.3.3.2.58. Added 2011-09 from QRPH EHCP profile

6.3.3.2.58 Risk Indicators for Hearing Loss

Template ID	1.3.6.1.4.1.19376.1.7.3.1.1.15.3.1	
General Description	This section SHALL include at least one entry describing hearing risk indicators for the subject	
LOINC® Code	**Opt**	**Description**
58232-0	R	HEARING LOSS RISK INDICATOR
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.7.3.1.1.15.5.1	R	Risk Indicators for Hearing Loss Entry

```
<component>
  <section>
    <templateId root=1.3.6.1.4.1.19376.1.7.3.1.1.15.3.1'/>
    <id root=' ' extension=' '/>
    <code code='58232-0' displayName= ‘HEARING LOSS RISK INDICATOR '
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Required Risk Indicators for Hearing Loss Entry element -->
        <templateId root='1.3.6.1.4.1.19376.1.7.3.1.1.15.5.1'/>
        :
    </entry>
  </section>
</component>
```

Figure 6.3.3.2.58-1: Sample Coded Risk Indicators for Hearing Loss Section

Add Section 6.3.3.2.58. Added 2011-09 from QRPH PRPH-Ca profile

6.3.3.2.59 Cancer Diagnosis Section 1.3.6.1.4.1.19376.1.7.3.1.3.14.1

Template ID	**1.3.6.1.4.1.19376.1.7.3.1.3.14.1**
Parent ID	PCC Active Problem Section 1.3.6.1.4.1.19376.1.5.3.1.3.6 CCD 3.5 2.16.840.1.113883.10.20.1.11

General Description	This section contains specific detailed information about cancer diagnosis(es) that are currently being monitored for the patient. A separate entry for each cancer diagnosis SHALL be provided.	
LOINC Code	**Opt**	**Description**
xxxxx-x	R	Cancer Diagnosis
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.7.3.1.4.14.1	R	Cancer Diagnosis Entry

```
<component>
  <section>
        <templateId root='1.3.6.1.4.1.19376.1.7.3.1.3.14.1/>
        <id root=' ' extension=' '/>
        <code code='xxxxx-x' displayName='Cancer Diagnosis'
        codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
        <text>
        Text as described above
        </text>
        <entry>
<!-- Required Cancer Diagnosis Entry element -->
               <templateId root='1.3.6.1.4.1.19376.1.7.3.1.4.14.1'/>
               :
        </entry>
</section>
</component>
```

Figure 6.3.2.59-1: Specification for Cancer Diagnosis Section

Add Section 6.3.3.3

6.3.3.3 Medications

Add Section 6.3.3.3.1

6.3.3.3.1 Medications Section

Add Section 6.3.3.3.2

6.3.3.3.2 Admission Medication History Section

Add Section 6.3.3.3.3

6.3.3.3.3 Medications Administered Section

Add Section 6.3.3.3.4

6.3.3.3.4 Hospital Discharge Medications Section

Add Section 6.3.3.3.5

6.3.3.3.5 Immunizations Section

Add Section 6.3.3.4

6.3.3.4 Physical Exams

Note: Sections 6.3.3.4.1 through 6.3.3.4.29 reside in IHE PCC TF-2:6.3.3.4

Add Section 6.3.3.4.30

6.3.3.4.30 Coded Detailed Physical Examination Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	
Parent Template	Detailed Physical Examination (1.3.6.1.4.1.19376.1.5.3.1.1.9.15)	
General Description	The Coded Detailed Physical Examination section shall contain a narrative description of the patient's physical findings. It shall include subsections, if known, for the exams that are performed.	
LOINC Code	**Opt**	**Description**
29545-1	R	PHYSICAL EXAMINATION
Subsections	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2	R2	Coded Vital Signs Vital signs may be a subsection of the physical examination or they may stand alone
1.3.6.1.4.1.19376.1.5.3.1.1.9.16	R2	General Appearance
1.3.6.1.4.1.19376.1.5.3.1.1.9.48	R2	Visible Implanted Medical Devices
1.3.6.1.4.1.19376.1.5.3.1.1.9.17	R2	Integumentary System
1.3.6.1.4.1.19376.1.5.3.1.1.9.18	R2	Head
1.3.6.1.4.1.19376.1.5.3.1.1.9.19	R2	Eyes
1.3.6.1.4.1.19376.1.5.3.1.1.9.20	R2	Ears, Nose, Mouth and Throat
1.3.6.1.4.1.19376.1.5.3.1.1.9.21	R2	Ears
1.3.6.1.4.1.19376.1.5.3.1.1.9.22	R2	Nose
1.3.6.1.4.1.19376.1.5.3.1.1.9.23	R2	Mouth, Throat, and Teeth
1.3.6.1.4.1.19376.1.5.3.1.1.9.24	R2	Neck
1.3.6.1.4.1.19376.1.5.3.1.1.9.25	R2	Endocrine System
1.3.6.1.4.1.19376.1.5.3.1.1.9.26	R2	Thorax and Lungs
1.3.6.1.4.1.19376.1.5.3.1.1.9.27	R2	Chest Wall
1.3.6.1.4.1.19376.1.5.3.1.1.9.28	R2	Breasts
1.3.6.1.4.1.19376.1.5.3.1.1.9.29	R2	Heart
1.3.6.1.4.1.19376.1.5.3.1.1.9.30	R2	Respiratory System

1.3.6.1.4.1.19376.1.5.3.1.1.9.31	R2	Abdomen
1.3.6.1.4.1.19376.1.5.3.1.1.9.32	R2	Lymphatic System
1.3.6.1.4.1.19376.1.5.3.1.1.9.33	R2	Vessels
1.3.6.1.4.1.19376.1.5.3.1.1.9.34	R2	Musculoskeletal System
1.3.6.1.4.1.19376.1.5.3.1.1.9.35	R2	Neurologic System
1.3.6.1.4.1.19376.1.5.3.1.1.9.36	R2	Genitalia
1.3.6.1.4.1.19376.1.5.3.1.1.9.37	R2	Rectum
1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1	R2	Extremities
1.3.6.1.4.1.19376.1.5.3.1.1.21.2.10	R2	Pelvis

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1'/>
    <id root=' ' extension=' '/>
    <code code='29545-1' displayName='PHYSICAL EXAMINATION'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.25'/>
          <!-- Optional Vital Signs Section content -->
      </section>
    </component>
  </section>
</component>
```

Figure 6.3.3.4.30-1: Coded Detailed Physical Examination Section

Add Section 6.3.3.4.31

6.3.3.4.31 Pelvis Section 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.10

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.10	
General Description	The Pelvis section shall include a narrative description of any type of exam of the reproductive organs.	
LOINC Code	**Opt**	**Description**
10204-6	R	PELVIS
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.5	O	Problem Entry

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.10'/>
    <id root=' ' extension=' '/>
    <code code='10204-6' displayName='PELVIS'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
       :
      <!-- Optional Problem Entry element -->
      <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.5'/>
       :
    </entry>
  </section>
</component>
```

Figure 6.3.3.4.31-1: Pelvis Section

Add Section 6.3.3.4.32

6.3.3.4.32 Admission Physical Exam Section 1.3.6.1.4.1.19376.1.5.3.1.1.22.1.1.2.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.22.1.1.2.1	
General Description	The Admission physical exam section shall include a narrative description of the physical exams given during the admission to a hospital or similar type of facility.	
LOINC Code	**Opt**	**Description**
XX-AdmissionPhysicalExam	R	Admission physical exam

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.22.1.1.2.1'/>
    <id root=' ' extension=' '/>
    <code code='XX-AdmissionPhysicalExam' displayName='Admission physical exam'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.4.32-1: Admission Physical Exam Section

Add Section 6.3.3.4.33

6.3.3.4.33 Discharge Status 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.12

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.12
Parent Template	
General Description	Discharge status should contain a narrative description of the status/condition of the patient at the time of discharge, such as stable, critical, etc.

LOINC Code	Opt	Description
52523-8	R2	Discharge Status

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.12'/>
    <id root=' ' extension=' '/>
    <code code='52323-8' displayName=Discharge status'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
</component>
```

Figure 6.3.3.4.33-1: Discharge Status Section

6.3.3.5 Relevant Studies

Add Section 6.3.3.3.5.1

6.3.3.5.1 Results

Add Section 6.3.3.3.5.2

6.3.3.5.2 Coded Results

Add Section 6.3.3.3.5.3

6.3.3.5.3 Hospital Studies Summary

Add Section 6.3.3.3.5.4

6.3.3.5.4 Coded Hospital Studies Summary

Add Section 6.3.3.3.5.5

6.3.3.5.5 Consultations 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.8

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.8	
General Description	**The ED Consultations section shall contain a narrative description of the consultations obtained during an encounter of care.**	
LOINC Code	**Opt**	**Description**
18693-2	R	ED CONSULTANT PRACTITIONER

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.8'/>
    <id root=' ' extension=' '/>
    <code code='18693-2' displayName='ED CONSULTANT PRACTITIONER'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.5.5-1: Specification for ED Consultations Section

Add Section 6.3.3.5.6

6.3.3.5.6 Antenatal Testing and Surveillance Section 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5	
Parent Template		
General Description	The Antenatal Testing and Surveillance section shall contain a narrative description of reports and data from tests and surveillance performed during the pregnancy (e.g., Ultrasound, Biophysical Profile, Non-Stress Test, Contraction Stress Test)	
LOINC Code	**Opt**	**Description**
57078-8	R	Antenatal testing and surveillance

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5'/>
    <id root=' ' extension=' '/>
    <code code='57078-8' displayName='ANTENATAL TESTING AND SURVEILLANCE'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
</component>
```

Figure 6.3.3.5.6-1: Specification for and Surveillance Section

Add Section 6.3.3.5.7

6.3.3.5.7 Coded Antenatal Testing and Surveillance Section 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1
Parent Template	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5
General Description	The Antenatal Testing and Surveillance section shall contain a narrative and coded description of reports and data from tests and surveillance performed during the pregnancy (e.g., Ultrasound, Biophysical Profile, Non-Stress Test, Contraction Stress Test). It shall contain an Antenatal Testing and

	Surveillance Battery.	
LOINC Code	**Opt**	**Description**
57078-8	R	ANTENATAL TESTING AND SURVEILLANCE
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.21.3.10	R	Antenatal Testing and Surveillance Battery

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1'/>
    <id root=' ' extension=' '/>
    <code code='57078-8' displayName='ANTENATAL TESTING AND SURVEILLANCE'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
       :
      <!-- Required Antenatal Testing and Surveillance Battery -->
      <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.3.10'/>
       :
    </entry>
</component>
```

Figure 6.3.3.5.7-1: Specification for Coded Antenatal Testing and Surveillance Section

Add Section 6.3.3.5.8 (Diagnosis - Removed 2011-09 at the request of QRPH)

6.3.3.5.8 Intentionally blank

Add Section 6.3.3.5.9 (TNM Stage – removed 2011-09 at the request of QRPH)

6.3.3.5.9 Intentionally blank

Add Section 6.3.3.5.10 (Cancer Supporting Documentation - removed 2011-09 at the request of QRPH)

6.3.3.5.10 Intentionally blank

Add Section 6.3.3.5.11. (Added 2011-09 from QRPH EHCP profile)

6.3.3.5.11 Hearing Screening Coded Results

The Hearing Screening Coded Results section SHALL contain the hearing screening results of pass or refer for the right ear and pass or refer for the left ear, expressed as LOINC® codes as well as the coded methodology to complete the screening. Coded methodology includes (LOINC 54106-0) Automated Auditory Brainstem Response, Auditory Brainstem Response, Otoacoustic

Emissions, Transient Otoacoustic Emissions, and Distortion Product Otoacoustic Emissions. If the methodology is unknown, the coded result of unknown method SHALL be used. Where the screening results are not available, the reason the results are not available SHALL be present. This could include unsuccessful, technical fail; not performed, not performed, medical exclusion. The Hearing Screening Coded Results section is required.

Template ID	1.3.6.1.4.1.19376.1.7.3.1.1.15.3.2	
Parent Template	Coded Results (1.3.6.1.4.1.19376.1.5.3.1.3.28)	
General Description	The Hearing Screening Code Results section SHALL include at least one observation entry describing the hearing screening results as described in the Entry Content Module. Where there are no hearing screening results performed, then the reason SHALL be indicated	
LOINC Code	**Opt**	**Description**
30954-2	R	Relevant diagnostic tests/laboratory data
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.19	R	Procedure Entry
1.3.6.1.4.1.19376.1.5.3.1.4.4	R2	References Entry
1.3.6.1.4.1.19376.1.5.3.1.4.13	R	Simple Observation

6.3.3.5.11.1 Parent Template

The parent of this template is Coded Results.

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.28'/>
    <id root=' ' extension=' '/>
    <code code='30954-2' displayName='Relevant diagnostic tests/laboratory data'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
         :
      <!-- Required Procedure Entry element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.19'/>
         :
    </entry>
    <entry>
         :
      <!-- Required if known References Entry element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.4'/>
         :
    </entry>
    <entry>
         :
      <!-- Optional Simple Observation element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
         :
    </entry>

  </section>
```

Figure 6.3.3.5.11-1: Hearing Screening Coded Results Section

Add Section 6.3.3.6

6.3.3.6 Plans of Care

Add Section 6.3.3.6.1

6.3.3.6.1 Care Plan

Add Section 6.3.3.6.2

6.3.3.6.2 Assessment and Plan

Add Section 6.3.3.6.3

6.3.3.6.3 Discharge Disposition

Add Section 6.3.3.6.4

6.3.3.6.4 Discharge Diet

Add Section 6.3.3.6.5

6.3.3.6.5 Advance Directives

Add Section 6.3.3.6.6

6.3.3.6.6 Coded Advance Directives

Add Section 6.3.3.6.7

6.3.3.6.7 Transport Mode

Add Section 6.3.3.6.8

6.3.3.6.8 Procedure Care Plan Status Report Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.45

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.45	
Parent Template	1.3.6.1.4.1.19376.1.5.3.1.1.9.40	
General Description	The procedure care plan status report section shall contain a description of the progress towards completing expectations for care including actions completed in fulfillment of proposals, goals, and order requests for monitoring, tracking, or improving the condition of the patient prior to the procedure.	
LOINC Code	**Opt**	**Description**
18776-5	R	TREATMENT PLAN

Sample Procedure Care Plan Status Report Section

```
<component>

  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.40'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.45'/>
    <id root=' ' extension=' '/>
    <code code='18776-5' displayName='TREATMENT PLAN'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>

</component>
```

Add Section 6.3.3.6.9

6.3.3.6.9 Health Maintenance Care Plan Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.50

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.50
Parent Template	1.3.6.1.4.1.19376.1.5.3.1.3.31

General Description	The health maintenance care plan section shall contain a description of the expectations for wellness care including proposals, goals, and order requests for monitoring, tracking, or improving the lifetime condition of the patient with goals of educating the patient on how to reduce the modifiable risks of the patient's genetic, behavioral, and environmental pre-conditions and otherwise optimizing lifetime outcomes.	
LOINC Code	**Opt**	**Description**
18776-5	R	TREATMENT PLAN

Sample Health Maintenance Care Plan Section

```
<component>

  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.31'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.50'/>
    <id root=' ' extension=' '/>
    <code code='18776-5' displayName='TREATMENT PLAN'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>

</component>
```

Add Section 6.3.3.6.10

6.3.3.6.10 Health Maintenance Care Plan Status Report Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.41

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.41	
Parent Template	1.3.6.1.4.1.19376.1.5.3.1.1.9.50	
General Description	The health maintenance status report section shall contain a description of the progress towards completing expectations for care including actions completed in fulfillment of proposals, goals, and order requests for monitoring, tracking, or improving the condition of the patient.	
LOINC Code	**Opt**	**Description**
18776-5	R	TREATMENT PLAN

Sample Health Maintenance Care Plan Status Report Section

```
<component>

  <section>    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.50'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.41'/>
    <id root=' ' extension=' '/>
    <code code='18776-5' displayName='TREATMENT PLAN'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>

</component>
```

Add Section 6.3.3.6.11

6.3.3.6.11 Provider Orders Section 1.3.6.1.4.1.19376.1.5.3.1.1.20.2.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.1	
General Description	The provider orders shall contain a list of all pertinent orders from healthcare providers.	
LOINC Code	**Opt**	**Description**
46209-3	R	PROVIDER ORDERS
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.7	C	Medications Medications entries shall appear for all ordered medications when present. These entries shall be in intent mood.
1.3.6.1.4.1.19376.1.5.3.1.4.19	C	Procedure Procedure entries shall appear for all ordered procedures when present. These entries shall be in intent mood.
1.3.6.1.4.1.19376.1.5.3.1.4.14	O	Encounter Encounter entries should appear for all ordered encounters. These entries shall be in promise or appointment request mood.
1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1	O	Observation Requests Observation request entries should appear for all ordered observations. These entries shall appear in intent mood.

Sample Provider Orders Section

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.2.1'/>
    <id root=' ' extension=' '/>
    <code code='46209-3' displayName='PROVIDER ORDERS'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Required if known Medications element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.7'/>
        :
    </entry>
    <entry>
        :
      <!-- Required if known Procedure element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.19'/>
        :
    </entry>
    <entry>
        :
      <!-- Optional Encounter element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.14'/>
        :
    </entry>
    <entry>
        :
      <!-- Optional Observation Requests element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1'/>
        :
    </entry>

  </section>
</component>
```

Add Section 6.3.3.6.12

6.3.3.6.12 Birth Plan Section 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.1	
Parent Template		
General Description	The Birth Plan section shall contain a narrative description of the patient's requests and expectations with respect to care she is expecting during the labor and delivery process.	
LOINC Code	**Opt**	**Description**
57079-6	R	Birth plan

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.1'/>
    <id root=' ' extension=' '/>
    <code code='57079-6' displayName='Birth plan'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
</component>
```

Figure 6.3.3.6.12-1: Specification for Birth Plan Section

Add Section 6.3.3.6.13

6.3.3.6.13 Immunization Recommendations 1.3.6.1.4.1.19376.1.5.3.1.1.18.3.1

Add Section 6.3.3.6.14

6.3.3.6.14 Patient Education Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.38

Template Id	1.3.6.1.4.1.19376.1.5.3.1.1.9.38	
General Description	The patient education section shall contain a description of the patient education the patient received as well as the results of the education.	
LOINC Code	**Opt**	**Description**
34895-3	R	EDUCATION NOTE
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.12.2	R	Immunization Recommendation Entry At least one Immunization Plan Entry shall be present in Proposal mood to indicate what the proposed care is for the patient. Other Immunization Plan entries may appear in intent mood to indicate the current plan.

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.38'/>
    <id root=' ' extension=' '/>
    <code code='34895-3' displayName='EDUCATION NOTE'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>
</component>
```

Figure 6.3.3.6.14-1: Specification for Patient Education and Consents Section

Add Section 6.3.3.6.15

6.3.3.6.15 Coded Care Plan Section 1.3.6.1.4.1.19376.1.5.3.1.3.36

Template ID	1.3.6.1.4.1.19376.1.5.3.1.3.31	
Parent Template	2.16.840.1.113883.10.20.1.10	
General Description	The care plan section shall contain a narrative description of the expectations for care including proposals, goals, and order requests for monitoring, tracking, or improving the condition of the patient.	
LOINC Code	**Opt**	**Description**
18776-5	R	TREATMENT PLAN
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1	O	Observation Requests The care plan may include observation requests in intent, goal or proposal mood to identify intended observations that are part of the care plan, goals of the plan, or proposed observations (e.g., from clinical decision support).
1.3.6.1.4.1.19376.1.5.3.1.4.7	O	Medication The care plan may include medication entries to identify those medications that are or are proposed to be part of the care plan.
1.3.6.1.4.1.19376.1.5.3.1.4.12	O	Immunization The care plan may include immunization entries to identify those immunizations that are or are proposed to be part of the care plan.
1.3.6.1.4.1.19376.1.5.3.1.4.19	O	Procedure The care plan may include procedure entries to identify those procedures that are or are proposed to be part of the care plan.
1.3.6.1.4.1.19376.1.5.3.1.4.14	O	Encounter The care plan may include encounter entries in to identify those encounters that are or are proposed to be part of the care plan.

```
<component>
  <section>
    <templateId root='2.16.840.1.113883.10.20.1.10'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.36'/>
    <id root=' ' extension=' '/>
    <code code='18776-5' displayName='TREATMENT PLAN'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
          :
      <!-- Optional Observation Requests element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1'/>
          :
    </entry>
    <entry>
          :
      <!-- Optional Medication element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.7'/>
          :
    </entry>
    <entry>
          :
      <!-- Optional Immunization element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.12'/>
          :
    </entry>
    <entry>
          :
      <!-- Optional Procedure element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.19'/>
          :
    </entry>
    <entry>
          :
      <!-- Optional Encounter element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.14'/>
          :
    </entry>

  </section>
</component>
```

Figure 6.3.3.6.15-1: Specification for Care Plan Section

6.3.3.6.16 Diet and Nutrition Section 1.3.6.1.4.1.19376.1.5.3.1.1.20.2.2

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.2	
General Description	This shall contain a narrative description of the diet restrictions necessary due to disease.	
LOINC Code	**Opt**	**Description**
XX-DietAndNutrition	R	Diet and nutrition

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.2.2'/>
    <id root=' ' extension=' '/>
    <code code='XXDiet-Restrictions' displayName='Diet and nutrition'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.6.16-1: Specification for Diet Restrictions Section

6.3.3.6.17 Intake and Output Section 1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3	
General Description	This section shall contain a narrative description of specific fluid inputs or fluid outputs for the patient.	
LOINC Code	**Opt**	**Description**
XX-IntakeAndOutput	R	Intake and output

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3'/>
    <id root=' ' extension=' '/>
    <code code='XX-FluidManagement' displayName='Intake and output'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.6.17-1: Specification for Fluid Management Section

Add Section 6.3.3.6.18 (Cancer Course of Treatment – removed 2011-09 at the request of QRPH)

6.3.3.6.18 Intentionally blank

Add Section 6.3.3.6.19 (Cancer Treatment Plan – removed 2011-09 at the request of QRPH)

6.3.3.6.19 Intentionally blank

Add section 6.3.3.6.20

6.3.3.6.20 Procedure Care Plan Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.40

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.40

Parent Template	1.3.6.1.4.1.19376.1.5.3.1.3.31 (1.3.6.1.4.1.19376.1.5.3.1.3.31)	
General Description	The procedure care plan section shall contain a description of the expectations for care including proposals, goals, and order requests for monitoring, tracking, or improving the condition of the patient prior, during and after a procedure with goals of educating the patient, reducing the modifiable risks of the procedure and anesthesia and otherwise optimizing the outcomes. The care plan will often be updated immediately following the addition of new impressions during the course of pre-procedure evaluation.	
LOINC Code	**Opt**	**Description**
18776-5	R	TREATMENT PLAN
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1	O	Observation Requests The care plan may include observation requests in intent, goal or proposal mood to identify intended observations that are part of the care plan, goals of the plan, or proposed observations (e.g., from clinical decision support).
1.3.6.1.4.1.19376.1.5.3.1.4.7	O	Medication The care plan may include medication entries to identify those medications that are or are proposed to be part of the care plan.
1.3.6.1.4.1.19376.1.5.3.1.4.12	O	Immunization The care plan may include immunization entries to identify those immunizations that are or are proposed to be part of the care plan.
1.3.6.1.4.1.19376.1.5.3.1.4.19	O	Procedure The care plan may include procedure entries to identify those procedures that are or are proposed to be part of the care plan.
1.3.6.1.4.1.19376.1.5.3.1.4.14	O	Encounter The care plan may include encounter entries in to identify those encounters that are or are proposed to be part of the care plan.

```
<component>

  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.31'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.40'/>
    <id root=' ' extension=' '/>
    <code code='18776-5' displayName='TREATMENT PLAN'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>

</component>
```

Figure 6.3.3.6.20-1: Sample Care Plan Section

Add section 6.3.3.6.21 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.6.21 Protocols Used Section 1.3.6.1.4.1.19376.1.5.3.1.1.25.2.5

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.25.2.5

General Description	The Protocols Used section describes the protocol used by EMS personnel to direct the clinical care of the patient.	
LOINC Code	**Opt**	**Description**
52019-7	R	DESCRIPTION OF SERVICES PERFORMED TO SUPPORT LEVEL OF SERVICE

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.25.2.5'/>
    <id root=' ' extension=' '/>
    <code code='52019-7' displayName='DESCRIPTION OF SERVICES PERFORMED TO SUPPORT LEVEL OF
SERVICE'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.6.21-1: Sample Protocols Used Section

Add section 6.3.3.6.22 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.6.22 Invasive Airway Section 1.3.6.1.4.1.19376.1.5.3.1.1.25.2.7

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.25.2.7	
General Description	The Invasive Airway section describes if, and what type, of advanced airway used.	
LOINC Code	**Opt**	**Description**
NEMSIS EProtocols.01 (1)	R	PROTOCOLS USED AIRWAY

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.25.2.7'/>
    <id root=' ' extension=' '/>
    <code code='NEMSIS EProtocols.01(1)' displayName='PROTOCOLS USED AIRWAY'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='NEMSIS'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.6.22-1: Sample Invasive Airway Section

Add section 6.3.3.6.23 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.6.23 Ventilator Usage Section 1.3.6.1.4.1.19376.1.5.3.1.1.25.2.11

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.25.2.11
General Description	The Ventilator Usage section describes

LOINC Code	Opt	Description
20124-4	R	VENTILATION MODE

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.25.2.11'/>
    <id root=' ' extension=' '/>
    <code code='2012404' displayName='VENTILATION MODE'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.6.23-1: Sample Ventilator Usage Section

Add Section 6.3.3.7

6.3.3.7 Administrative and Other Information

Add Section 6.3.3.7.1

6.3.3.7.1 Payers

Add Section 6.3.3.7.2

6.3.3.7.2 Referral Source

Add Section 6.3.3.7.3

6.3.3.7.3 Transport Mode

Add Section 6.3.3.7.4

6.3.3.7.4 ED Disposition

Add Section 6.3.3.7.5 (Cancer Payers – Removed 2011-09 at the request of QRPH)

6.3.3.7.5 Intentionally blank

Add Section 6.3.3.7.6 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.7.6 Sending Facility Section 1.3.6.1.4.1.19376.1.5.3.1.1.25.2.1

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.25.2.1
General Description	The Sending Facility section contains the name and address of the healthcare facility

	that is sending the patient for transport.	
LOINC Code	**Opt**	**Description**
52023-9	R	ORIGINATION SITE NAME AND ADDRESS

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.25.2.1'/>
    <id root=' ' extension=' '/>
    <code code='52023-9' displayName='ORIGINATION SITE NAME AND ADDRESS'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.7.6-1: Sample Sending Facility Section

Add Section 6.3.3.7.7 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.7.7 Receiving Facility Section 1.3.6.1.4.1.19376.1.5.3.1.1.25.2.2

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.25.2.2	
General Description	The Receiving Facility section contains the name and address of the healthcare facility that is receiving the transported patient.	
LOINC Code	**Opt**	**Description**
52026-2	R	DESTINATION SITE NAME & ADDRESS

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.25.2.2'/>
    <id root=' ' extension=' '/>
    <code code='52026-2' displayName='DESTINATION SITE NAME & ADDRESS'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.7.7-1: Sample Receiving Facility Section

Add Section 6.3.3.7.8 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.7.8 Mass Casualty Incident Section 1.3.6.1.4.1.19376.1.5.3.1.1.25.2.3

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.25.2.3
General Description	The Mass Casualty Incident Section indicates if this event would be considered a mass

	casualty incident overwhelming existing EMS and ED resources.	
LOINC Code	**Opt**	**Description**
NA – NEMSIS EScene.07	R2	MASS CASUALTY INCIDENT

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.25.2.3'/>
    <id root=' ' extension=' '/>
    <code code='NEMSIS Escene.07' displayName='MASS CASUALTY INCIDENT'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='NEMSIS'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.7.8-1: Sample Mass Casualty Incident Section

Add Section 6.3.3.7.9 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.7.9 Unit Response Level Section 1.3.6.1.4.1.19376.1.5.3.1.1.25.2.4

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.25.2.4	
General Description	The Unit Response Level section describes the level of service provided for this transport.	
LOINC Code	**Opt**	**Description**
51995-9	R	RATIONALE FOR TYPE OF TRANSPORT

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.25.2.4'/>
    <id root=' ' extension=' '/>
    <code code='51995-9' displayName='RATIONALE FOR TYPE OF TRANSPORT'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.7.9-1: Sample Unit Response Level Section

Add Section 6.3.3.7.10 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.7.10 Extra Attendants Information Section 1.3.6.1.4.1.19376.1.5.3.1.1.25.2.6

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.25.2.6
General Description	The Protocols Used section describes the protocol used by EMS personnel to direct the

	clinical care of the patient.	
LOINC Code	**Opt**	**Description**
52074-2	R2	EXTRA ATTENDANTS INFORMATION

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.25.2.6'/>
    <id root=' ' extension=' '/>
    <code code='52074-2' displayName='EXTRA ATTENDANTS INFORMATION'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.7.10-1: Sample Extra Attendants Information Section

Add Section 6.3.3.7.11 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.7.11 Provider Level Section 1.3.6.1.4.1.19376.1.5.3.1.1.25.2.9

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.25.2.9	
General Description	The Provider Level section describes the certification or licensure level of the healthcare provider.	
LOINC Code	**Opt**	**Description**
NEMSIS DConfiguration.02	R	STATE CERTIFICATION LICENSURE LEVELS

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.25.2.9'/>
    <id root=' ' extension=' '/>
    <code code='NEMSIS DConfiguration.02' displayName='STATE CERTIFICATION LICENSURE LEVELS'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='NEMSIS'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.7.11-1: Sample Provider Level Section

Add Section 6.3.3.8

6.3.3.8 Interventions

This section contains section content modules that describe interventions, procedures, therapeutic treatments, et cetera, performed on the patient.

Add Section 6.3.3.8.3

6.3.3.8.3 Procedures and Interventions Section 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11
General Description		The Procedures and Interventions section shall contain a narrative description of the actions performed by a clinician.
LOINC Code	**Opt**	**Description**
29554-3	R	PROCEDURE
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.19	R	Procedure This entry provides coded values for procedures performed during the encounter.

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11'/>
    <id root=' ' extension=' '/>
    <code code='X-PROC' displayName='PROCEDURES PERFORMED'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Required Procedure element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.19'/>
        :
    </entry>

  </section>
</component>
```

Figure 6.3.3.8.3-1: Specification for Procedures and Interventions Section

Add Section 6.3.3.8.4 (Added 2011-06 from the PCC Transport Record Summary Profiles supplement)

6.3.3.8.4 Intravenous Fluids Administered Section 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6

Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6
General Description		The intravenous fluids administered section shall contain a narrative description of fluids administered to a patient during the course of an encounter. It may include entries for IV fluid administration as described in the Entry Content Module.
LOINC Code	**Opt**	**Description**
57072-1	R	Intravenous fluids administered
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.13.3.2	R	Intravenous Fluids

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6'/>
    <id root=' ' extension=' '/>
    <code code='57072-1' displayName='Intravenous fluids administered'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Required Intravenous Fluids element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.3.2'/>
        :
    </entry>

  </section>
</component>
```

Figure 6.3.3.8.4-1: Specification for Intravenous Fluids Administered Section

Add Section 6.3.3.9

6.3.3.9 Impressions

This section contains section content modules that describe assessments, impressions, diagnoses, or other reporting of clinical opinions or judgment.

Add Section 6.3.3.9.1

6.3.3.9.1 Pre-procedure Impressions Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.42 (Deprecated)

Add Section 6.3.3.9.2

6.3.3.9.2 Pre-procedure Risk Assessment Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.44

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.9.44	
General Description	The pre-procedure risk section shall contain a description of the risks the patient faces because of the planned procedure and associated anesthesia, especially in the context of modifiable risks identified by patient findings. It shall include entries for patient risks as described in the Entry Content Module.	
LOINC Code	**Opt**	**Description**
11450-4	R	PROBLEM LIST
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.5	R	Problem Entry

The parent of this template is 1.3.6.1.4.1.19376.1.5.3.1.3.6

```
<component>

  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.6'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.44'/>
    <id root=' ' extension=' '/>
    <code code='11450-4' displayName='PROBLEM LIST'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
          :
      <!-- Required Problem Entry element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.5'/>
          :
    </entry>

  </section>

</component>
```

Figure 6.3.3.9.2-1: Specification for Pre-procedure Risk Assessment Section

Add Section 6.3.3.9.3

6.3.3.9.3 Antepartum Visit Summary Flowsheet Section 1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.2

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.2	
General Description	This section is a running history of the most important elements noted for a pregnant woman.	
LOINC Code	**Opt**	**Description**
57059-8	R	Pregnancy visit summary
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.13	R	Simple Observation The flowsheet contains one simple observation to represent the Prepregancy Weight. This observation SHALL be valued with the LOINC code 8348-5, BODY WEIGHT^PRE PREGNANCY-MASS-PT-QN-MEASURED. The value SHALL be of type PQ. The units may be either "lb_av" or "kg".
1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.2	R	Antepartum Flowsheet Panel Other entries on the flowsheet are "batteries" which represent a single visit.

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.2'/>
    <id root=' ' extension=' '/>
    <code code='57059-8' displayName='Pregnancy visit summary'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
         :
      <!-- Required Simple Observation element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
         :
    </entry>
    <entry>
         :
      <!-- Required Antepartum Flowsheet Panel element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.2'/>
         :
    </entry>

  </section>
</component>
```

Figure 6.3.3.9.3-1: Specification for Antepartum Visit Summary Flowsheet Section

Add Section 6.3.3.9.4

6.3.3.9.4 Progress Note Section 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.7

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.7	
General Description	The Progress Note section shall contain a narrative description of the sequence of events from initial assessment to discharge for an encounter.	
LOINC Code	**Opt**	**Description**
18733-6	R	SUBSEQUENT EVALUATION NOTE (ATTENDING PHYSICIAN)

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.7'/>
    <id root=' ' extension=' '/>
    <code code='18733-6' displayName='SUBSEQUENT EVALUATION NOTE (ATTENDING PHYSICIAN)'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>
</component>
```

Figure 6.3.3.9.4-1: Specification for Progress Note Section

Add Section 6.3.3.9.5

6.3.3.9.5 ED Diagnosis Section 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.9

Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.13.2.9
General Description		The ED diagnosis section shall contain a narrative description of the conditions that were diagnosed or addressed during the ED course, as well as those active conditions that modify the complexity of the patient encounter. It should include entries for patient conditions as described in the Entry Content Module.
LOINC Code	**Opt**	**Description**
11301-9	R	ED DIAGNOSIS
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.5	R	Problem Entry

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.9'/>
    <id root=' ' extension=' '/>
    <code code='11301-9' displayName='ED DIAGNOSIS'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Required Problem Entry element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.5'/>
        :
    </entry>

  </section>
</component>
```

Figure 6.3.3.9.5-1: Specification for ED Diagnosis Section

Add Section 6.3.3.9.6

6.3.3.9.6 Acuity Assessment Section 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.2

Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.13.2.2
General Description		The Acuity Assessment section contains a description of the acuity of the patient upon presentation to the Emergency department.
LOINC Code	**Opt**	**Description**
11283-9	R	ACUITY ASSESSMENT
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.13.3.1	R	Acuity This entry provides coded values giving the triage acuity.

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.2'/>
    <id root=' ' extension=' '/>
    <code code='11283-9' displayName='ACUITY ASSESSMENT'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Required Acuity element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.3.1'/>
        :
    </entry>

  </section>
</component>
```

Figure 6.3.3.9.6-1: Specification for Acuity Assessment Section

Add Section 6.3.3.9.7

6.3.3.9.7 Assessments Section 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.4

Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.4	
General Description	The assessments section contains narrative assessments of the patient status.	
LOINC Code	**Opt**	**Description**
51848-0	R	ASSESSMENT
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.1.13.3.4	O	Nursing Assessments Battery

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.4'/>
    <id root=' ' extension=' '/>
    <code code='51848-0' displayName='ASSESSMENT'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
        :
      <!-- Optional Nursing Assessments Battery element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.3.4'/>
        :
    </entry>

  </section>
</component>
```

Figure 6.3.3.9.7-1: Specification for Assessments Section

Add section 6.3.3.10

6.3.3.10 Section Content Modules-Non-categorized

Please note: As of 2013, section content modules are no longer being categorized into one of the nine existing categories (6.3.3.1 through 6.3.3.9). Instead, going forward, all section content modules will be placed under the 6.3.3.10 heading.

Add section 6.3.3.10.1. Added 2013-09 from QRPH VRDR supplement.

6.3.3.10.1 VRDR Death Report Section- Section Content Module (1.3.6.1.4.1.19376.1.7.3.1.3.23.2)

The sections and clinical statements which have additional implementation guidance further constrained are listed here showing their new IHE template ID.

Table 6.3.3.10.1-1 VRDR Death Report Section

Template Name		VRDR Death Report Section			
Template ID		1.3.6.1.4.1.19376.1.7.3.1.3.23.2			
Parent Template		Death Report Document Body (2.16.840.1.113883.10.20.24.1.2)			
General Description		The VRDR Death Report section shall contain a coded entries describing the decedent's death			
Section Code		64297-5, LOINC, "Death Certificate"			
Opt and Card	**Condition**	**Data Element or Section Name**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
Entries					
R[0..1]		Time of Death	2.16.840.1.113883.10.20.24.1.3	HL7 VRDR CDA CH4	
R[1..1]		Location of Death	2.16.840.1.113883.10.20.24.1.4	HL7 VRDR CDA CH4	
O[0..1]	QRPH 3:6.3.3.10.S1.3	Death Certification	2.16.840.1.113883.10.20.24.1.5	HL7 VRDR CDA CH4	
R[1..1]		Manner of Death	2.16.840.1.113883.10.20.24.1.7	HL7 VRDR CDA CH4	
C[0..1]	QRPH 3: 6.3.3.10.S1.1	Pregnancy Status	2.16.840.1.113883.10.20.24.1.8	HL7 VRDR CDA CH4	
R2[0..1]		Tobacco Use	2.16.840.1.113883.10.20.24.1.9	HL7 VRDR CDA CH4	
R2[0..1]		Injury	2.16.840.1.113883.10.20.24.1.10	HL7 VRDR CDA CH4	
R[1..1]	QRPH 3: 6.3.3.10.S1.4	Death Causal Information	2.16.840.1.113883.10.20.24.1.6	HL7 VRDR CDA CH4	
R[1..1]		Autopsy Performance	2.16.840.1.113883.10.20.24.1.	HL7 VRDR	

			11	CDA CH4	
C[0..1]	QRPH 3: 6.3.3.10.S1.2	Autopsy Results	2.16.840.1.113883.10.20.24.1.13	HL7 VRDR CDA CH4	
O[0..1]		Coroner Referral	2.16.840.1.113883.10.20.24.1.14	HL7 VRDR CDA CH4	
R[1..1]		Coroner Case Transfer	2.16.840.1.113883.10.20.24.1.12	HL7 VRDR CDA CH4	
R[1..1]		Death Location Type	1.3.6.1.4.1.19376.1.7.3.1.4.23.2	QRPH 3: 6.3.4.E2	
R[1..1]		Death Pronouncement	1.3.6.1.4.1.19376.1.7.3.1.4.23.1	QRPH 3: 6.3.4.E1	

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.5'/>
    <id root=' ' extension=' '/>
    <code code=’64297-5/displayName=’Death certificate’
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
         :
      <!-- Required Time of Death  -->
        <templateId root=’2.16.840.1.113883.10.20.24.1.3’/>
         :
    </entry>
    <entry>
         :
      <!-- Required Location of Death  -->
        <templateId root=’2.16.840.1.113883.10.20.24.1.4’/>
         :
    </entry>
    <entry>
         :
      <!—Optional Death Certification  -->
        <templateId root=’2.16.840.1.113883.10.20.24.1.5’/>
         :
    </entry>
    <entry>
         :
      <!—Required Manner of Death -->
        <templateId root=’2.16.840.1.113883.10.20.24.1.7’/>
         :
    </entry>
    <entry>
         :
      <!—Conditional Pregnancy Status  -->
        <templateId root=’2.16.840.1.113883.10.20.24.1.8’/>
         :
    </entry>
    <entry>
         :
      <!—Required if known Tobacco Use -->
        <templateId root=’2.16.840.1.113883.10.20.24.1.9’/>
         :
    </entry>
    <entry>
         :
      <!—Required if known Injury -->
```



```
        <templateId root='2.16.840.1.113883.10.20.24.1.10'/>
         :
    </entry>
    <entry>
         :
      <!–Required Death Causal Information -->
        <templateId root='2.16.840.1.113883.10.20.24.1.6'/>
         :
    </entry>
    <entry>
         :
      <!–Required Autopsy Performance -->
        <templateId root='2.16.840.1.113883.10.20.24.1.11'/>
         :
    </entry>
    <entry>
         :
      <!–Conditional Autopsy Results -->
        <templateId root='2.16.840.1.113883.10.20.24.1.13'/>
         :
    </entry>

          <entry>
        :
      <!–Optional Coroner Referral -->
        <templateId root='2.16.840.1.113883.10.20.24.1.14'/>
         :
    </entry>
    <entry>
         :
      <!–Required Coroner Case Transfer -->
        <templateId root='2.16.840.1.113883.10.20.24.1.12'/>
         :
    </entry>
    <entry>
         :
      <!–Required Death Location Type -->
        <templateId root=' 1.3.6.1.4.1.19376.1.7.3.1.4.23.2/>
         :
    </entry>
    <entry>
         :
      <!–Required Death Pronouncement-->
        <templateId root=' 1.3.6.1.4.1.19376.1.7.3.1.4.23.1'/>
         :
    </entry>


  </section>
</component>
```

Figure 6.3.3.10.1-1: Sample VRDR Death Report Section

6.3.3.10.1.1 Pregnancy Status Entry Condition

The Pregnancy Status clinical statement SHALL be Required if the person is female and in the age range 5 to75 years.

6.3.3.10.1.2 Autopsy Results Entry Condition

The Autopsy Results clinical statement SHALL be Required if autopsy performed.

6.3.3.10.1.3 Death Certification Entry Condition

The License Number of Person Certifying Death SHALL be reflected in Performer/assigned person.

6.3.3.10.1.4 Death Causal Information Entry Condition

The Name of person completing COD SHALL be reflected in author/assignedAuthor/name.

Add section 6.3.3.10 (added 2013-09 from QRPH VRDR supplement).

6.3.3.10.2 Coded Hospital Course Section 1.3.6.1.4.1.19376.1.7.3.1.3.23.1

Table 6.3.3.10.2-1 Coded Hospital Course Section

Template Name		Coded Hospital Course Section			
Template ID		1.3.6.1.4.1.19376.1.7.3.1.3.23.1			
Parent Template		Hospital Course Section (1.3.6.1.4.1.19376.1.5.3.1.3.5)			
General Description		The hospital course section shall contain a narrative description and coded entries describing the sequence of events from admission to discharge in a hospital facility.			
Section Code		8648-8, LOINC, HOSPITAL COURSE			
Opt and Card	**Condition**	**Data Element or Section Name**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
Entries					
R2[0..1]	HL7	Time of Death	2.16.840.1.113883.10.20.24.1.3		

```
<component>
  <section>
    <templateId root=' 1.3.6.1.4.1.19376.1.7.3.1.3.23.1'/>
    <id root=' ' extension=' '/>
    <code code='8648-8' displayName='HOSPITAL COURSE'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
    <entry>
         :
      <!-- Required if known Time of Death  element -->
        <templateId root='2.16.840.1.113883.10.20.24.1.3/>
         :
    </entry>

  </section>
</component>
```

Figure 6.3.3.10.2-1: Sample Coded Hospital Course Section

Add section 6.3.3.10.3 (added 2013-09 from the QRPH HW supplement).

6.3.3.10.3 Resources to Support Goals Section 1.3.6.1.4.1.19376.1.7.3.1.3.24.1

Table 6.3.3.10.3-1: Resources to Support Goals Section

Template ID	1.3.6.1.4.1.19376.1.7.3.1.3.24.1	
General Description	The Resources to Support Goals Section shall contain a narrative description of the community, health, and wellness resources available or provided to the patient to support their care plan goals.	
LOINC Code	**Opt**	**Description**
46802-5	R	Communication with community resources.knowledge

```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.7.3.1.3.24.1/>
    <id root=' ' extension=' '/>
    <code code='46802-5' displayName='Communication with community resources.knowledge'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>
</component
```

Figure 6.3.3.10.3-1: Sample Resources to Support Goals Section

Add section 6.3.3.10.4 (added 2013-09 from the QRPH HW supplement).

6.3.3.10.4 Healthy Weight Care Plan Section 1.3.6.1.4.1.19376.1.7.3.1.3.24.2

Table 6.3.3.10.4-1: Healthy Weight Care Plan Section

Template ID	1.3.6.1.4.1.19376.1.7.3.1.3.24.2	
Parent Template	1.3.6.1.4.1.19376.1.5.3.1.3.31	
General Description	The healthy weight care plan section shall contain a narrative description of the expectations for care for healthy weight management including proposals, goals, and order requests for monitoring, tracking, or improving the condition of the patient. The Healthy Weight care plan includes the following Goal Setting documentation: • Identification of goals for behavior change (increasing healthy behaviors and/or decreasing unhealthy behaviors) that are appropriate for the patient based on discussion during the visit and patient-reported readiness to change. • Messaging related to an ideal (targeted) level for the behavior • Goal selection may be selected from structured lists or selected in an open-ended manner • Documentation of barriers and supports to attaining selected goals, may be selected from structured lists or selected in an open-ended manner • Monitoring of progress against goals set during previous visits	
LOINC Code	**Opt**	**Description**
61145-9 R	R	PATIENT PLAN OF CARE

```
<component>
  <section>
    <templateId root='2.16.840.1.113883.10.20.1.10'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.31'/>
    <templateId root='1.3.6.1.4.1.19376.1.7.3.1.3.24.1'/>
    <id root=' ' extension=' '/>
    <code code='61145-9' displayName='PATIENT PLAN OF CARE'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>

  </section>
</component>
```

Figure 6.3.3.10.4-1: Sample Healthy Weight Care Plan Section

Add section 6.3.3.10.5 (added 2013-09 from the QRPH HW supplement).

6.3.3.10.5 Occupational Data for Health Section 1.3.6.1.4.1.19376.1.5.3.1.3.37

Table 6.3.3.10.5-1: Occupational Data for Health Section

Template Name	Occupational Data for Health
Template ID	1.3.6.1.4.1.19376.1.5.3.1.3.37
Parent Template	

General Description	The Occupational Data for Health section shall contain a narrative description of the person's employment status and usual occupation, as well as the person's history of employment. Employment information includes occupation and industry and may include the employer's name and the location where work was performed. When represented in a document containing a Social History section, the Occupational Data for Health section shall be encoded as a sub-section of the Social History section.				
Section Code	<LOINC-1, LOINC, "Occupational Data for Health">				
Author	If not the author from the encompassing context, include author. Role and entity must be specified if not inherited.				
Informant	If not the informant from the encompassing context, include informant. Role and entity must be specified if not inherited.				
Subject	If not the subject from the encompassing context, include subject. Role and entity must be specified if not inherited.				
Opt and Card	**Condition**	**Data Element or Section Name**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
Entries					
R2 [0..1]	PCC TF-3 6.3.3.2.36.X1	Occupational Data for Health Organizer	1.3.6.1.4.1.19376.1.5.3.1.4.20	PCC TF-3 6.3.3.2.S1.1	

6.3.3.10.5.1 Occupational Data for Health Section < 74166-0>

[`section: templateId` 1.3.6.1.4.1.19376.1.5.3.1.3.37 `(open)`]

The Occupational Data for Health section describes all aspects of the employment history. It may contain the current employment status, the usual occupation (longest held occupation) which may include the present duration for that job, or the employment history which may include the employer and places where the work was performed.

1. **SHALL** contain exactly one [1..1] **`templateId`** such that it
    a. **SHALL** contain exactly one [1..1] **`@root`**="1.3.6.1.4.1.19376.1.5.3.1.3.37".
2. **SHALL** contain exactly one [1..1] **`code/@code`**="`74166-0`" Occupational Data (CodeSystem: `LOINC 2.16.840.1.113883.6.1`).
3. **SHALL** contain exactly one [1..1] **`title`** .
4. **SHALL** contain exactly one [1..1] **`text`**.
5. **MAY** contain zero or one [0..1] **`entry`** such that it
    a. **SHALL** contain exactly one [1..1] 1.3.6.1.4.1.19376.1.5.3.1.4.20 **`Occupational Data For Health Organizer`**.


```
<section>
…
<!-- Sub section for Occupational Data For Health -->
<component>
       <section>
              <templateId root="2.16.840.1.113883.10.20.22.2.17"/>
              <!-- ODH SECTION TEMPLATE ID-->
              <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.37"/>
              <code code="74166-0" codeSystem="2.16.840.1.113883.6.1"
codeSystemVersion="0" codeSystemName="LOINC" displayName="Occupational Data for
Health"/>
              <text>...</text>
              <entry>
                     :
                     <!-- ODH ORGANIZER ENTRY TEMPLATE ID-->
                     <templateId root="1.3.6.1.4.1.19376.1.5.3.1.4.20"/>
                     <entry>
                           :
                           <!-- EMPLOYMENT STATUS ORGANIZER TEMPLATE ID-->
                           <templateId
root="1.3.6.1.4.1.19376.1.5.3.1.4.20.1"/>
                           :
                           <!-- USUAL OCCUPATION AND INDUSTRY ORGANIZER
TEMPLATE ID-->
                           <templateId
root="1.3.6.1.4.1.19376.1.5.3.1.4.20.2"/>
                           :
                           <!-- HISTORY OF OCCUPATION ORGANIZER TEMPLATE ID-->
                           <templateId
root="1.3.6.1.4.1.19376.1.5.3.1.4.20.3"/>
                     </entry>
              </entry>
       </section>
</component>
…
</section>
```

Figure 6.3.3.10.5-1: Occupational Data for Health Section example

6.3.4 CDA Entry Content Modules

Please note: Section 6.3.4.1 through 6.3.4.24 are defined in IHE PCC TF-2: 6.3.4.

Add Section 6.3.4.25

6.3.4.25 Family History Observation 1.3.6.1.4.19376.1.5.3.1.4.13.3

A family history observation is a Simple Observation that uses a specific vocabulary, and inherits constraints from CCD. Family history observations are found inside Family History Organizers.

6.3.4.25.1 Standards

CCD ASTM/HL7 Continuity of Care Document

6.3.4.25.2 Parent Template

The parent of this template is Simple Observation. This template is compatible with the ASTM/HL7 Continuity of Care Document template: 2.16.840.1.113883.10.20.1.22

6.3.4.25.3 Specification

```
<observation typeCode='OBS' moodCode='EVN'>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
 <templateId root='2.16.840.1.113883.10.20.1.22'/>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13.3'/>
 <id root=' ' extension=' '/>
 <code code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>
 <text><reference value='#xxx'/></text>
 <statusCode code='completed'/>
 <effectiveTime value=' '/>
 <repeatNumber value=' '/>
 <value xsi:type='CD' .../>
 <interpretationCode code=' ' codeSystem=' ' codeSystemName=' '/>
 <methodCode code=' ' codeSystem=' ' codeSystemName=' '/>
 <targetSiteCode code=' ' codeSystem=' ' codeSystemName=' '/>
</observation>
```

Figure 6.3.4.25.3-1: Family History Specification

6.3.4.25.4 <templateId root='2.16.840.1.113883.10.20.1.22'/> <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13.3'/>

The <templateId> elements identify this observation as a family history observation, and shall be present as shown above.

6.3.4.25.5 <code code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>

The <code> indicates the type of observation made (e.g., Diagnosis, et cetera). See the code element in the Problem Entry entry for suggested values.

6.3.4.25.6 <value xsi:type='CD' code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>

The <value> element indicates the information (e.g., diagnosis) of the family member. See the value element in the Problem Entry for suggested values.

Add Section 6.3.4.26

6.3.4.26 Pregnancy History Organizer 1.3.6.1.4.1.19376.1.5.3.1.4.13.5.1

Defined in IHE PCC TF-2.

Add Section 6.3.4.27

6.3.4.27 EDD Observation 1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.1

The EDD observation reflects the clinician's best judgment about the estimated delivery date of the patient. It can be supported by patient history (e.g., last menses or quickening), physical examination findings (uterine size), or Ultrasound. The observation is a Simple Observation with a supporting entryRelation of another Observation. The supporting observation may in turn have an entryRelation that gives the original observation as a gestational age or date from which the estimated due date is calculated.

6.3.4.27.1 Specification

```
<observation classCode='OBS' moodCode='EVN'>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.1'>
 <statusCode code='completed'/>
 <effectiveTime value=' '/>
 <author typeCode='AUT'>
   <time value=' '/>
   <assignedAuthor>
     <id root=' ' extension=' '/>
   </assignedAuthor>
 </author>
 <id root=' ' extension=' '/>
 <code code='11778-8'
       displayName='DELIVERY DATE-TMSTP-PT-^PATIENT-QN-CLINICAL.ESTIMATED'
       codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
 <text><reference value='id-foo'/></text>
 <value xsi:type='TS' value=' '/>
 <entryRelationship typeCode='SPRT'>
   <observation classCode='OBS' moodCode='EVN'>
     <id root=' ' extension=' '/>
     <statusCode code='completed'/>
     <effectiveTime value=' '/>
     <author typeCode='AUT'>
        <time value=' '/>
        <assignedAuthor classCode=' '>
          <id root=' ' extension=' '/>
        </assignedAuthor>
     </author>
     <code code='[11779-6|(xx-EDD-by-PE)|11781-2|(xx-EDD-by-Qck)|(xx-EDD-by-Fund)]'
           codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
     <value type='TS' value=' '>
     <entryRelationship typeCode='DRIV'>
       <observation  classCode='OBS' moodCode='EVN'>
         <id root=' ' extension=' '/>
         <statusCode code='completed'/>
         <effectiveTime value=' '/>
         <author typeCode='AUT'>
           <time value=' '/>
           <assignedAuthor>
             <id root=' ' extension=' '/>
           </assignedAuthor>
         </author>
         <informant typeCode='INF'>
           <relatedEntity classCode=' '>
             <id root=' ' extension=' '/>
           </relatedEntity>
         </informant>
         <code code='[8655-2|(xx-ga-by-pe)|11888-5|(xx-date-of-qck)|(xx-date-of-fund-umb) ]'
               codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
         <value type='[PQ|TS]' value=' ' units='week'/>
       </observation>
     </entryRelationship>
   </observation>
 </entryRelationship>
</observation>
```

6.3.4.27.2 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.1'/>

The <templateId> identifies the observation as a type of Estimated Delivery Date Observation. The root attribute SHALL be valued with '1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.1'.

6.3.4.27.3 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>

EDD observation SHALL comply with the restrictions of the Simple Observation entry. The observation SHALL NOT include repeatNumber, interpretationCode, methodCode, or targetSiteCode as listed below.

6.3.4.27.4 <code code='11778-8' codeSystem='2.16.840.1.113883.6.1'/>

The <code> element indicates that this is a "clinically estimated" estimated delivery date (for example, this code is used to represent the field on the last line of the EDD section of the ACOG form). This code SHALL be the LOINC code 11778-8. It is good style to include the displayName and codeSystemName to help debugging.

6.3.4.27.5 <value xsi:type='TS' value=' '>

The value of the EDD SHALL be represented as a point in time.

6.3.4.27.6 <author typeCode='AUT'><assignedAuthor><id root=' ' extension=' '/></assignedAuthor></author>

There may be multiple clinicians following the patient and authoring the overall document, however the EDD observation has an individual author. For CDA based content, this author SHALL be listed in the CDA header and referenced from the entry by including the id element of the assignedAuthor. For HL7 Version 3 Messages based content, the author SHALL be included in full through this element.

6.3.4.27.7 <author typeCode='AUT'><time value=' '/></author>

The author.time is used to record the time that the author recorded the observation. It SHALL be included.

6.3.4.27.8 <entryRelationship typeCode='SPRT'>

The <entryRelationship> element binds the clinicians estimated EDD to supporting observations by different methods. Supporting observations SHOULD be included. If included, the typeCode SHALL be 'SPRT'. For HL7 Version 3 Messages based content, the element name is <sourceOf> rather than <entryRelationship>, however the semantics, typeCode, and nested elements remain unchanged.

6.3.4.27.9 <observation>
<templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
:
</observation> [1st nesting]

Observations that support the clinical observation SHALL be included if known. These observations are the supporting calculated dates from various methods such as ultrasound dates or dates calculated from LMP (i.e., the left column of fields on the ACOG form). Supporting observations SHALL also conform to the simple observation template. Supporting observations MAY include a different effectiveTime, author, or informant. Supporting observations SHALL NOT include repeatNumber, interpretationCode, methodCode, or targetSiteCode. (Method is implied by the LOINC code). The templateId SHALL be valued as '1.3.6.1.4.1.19376.1.5.3.1.4.13'

6.3.4.27.10 <code code=' ' codeSystem='2.16.840.1.113883.6.1'/> [1st nesting]

Supporting observations SHALL include one of following LOINC values to indicate the method used to calculate the EDD.

Code	Description
11779-6	Delivery date Estimated from last menstrual period
(xx-EDD-by-PE)	DELIVERY DATE-TMSTP-PT-^PATIENT-QN-ESTIMATED FROM CLINICIANS PHYSICAL EXAM
11781-2	Delivery date composite estimate
57063-0	Delivery date Estimated from quickening date
57064-8	Delivery date Estimated from date fundal height reaches umb

6.3.4.27.11 <entryRelationship typeCode='DRIV'>

Observations of supporting EDD should provide observations from which they were derived such as the patient's last menses, or gestational age value at a point in time.

For HL7 Version 3 Messages based content, the element name is <sourceOf> rather than <entryRelationship>, however the semantics, typeCode, and nested elements remain unchanged.

6.3.4.27.12 <observation>
<templateId root=' '/>
:
</observation> [2st nesting]

Observations that support the calculation of supporting observation SHALL be included if known. These observations are the supporting dates or ages from various methods such as ultrasound gestational age or the date of last Menses (for example, the right column of fields on the ACOG form). Supporting observations SHALL also conform to the simple observation template. Supporting observations MAY include a different effectiveTime, author, or informant.

Supporting observations SHALL NOT include repeatNumber, interpretationCode, methodCode, or targetSiteCode. (Method is implied by the LOINC code)

6.3.4.27.13 <code code=' ' codeSystem='2.16.840.1.113883.6.1'/> [2nd nesting]

This code is used to represent the either the relevant date, or the gestational age observation from which the EDD is derived. The following table lists the relevant LOINC codes for methods used. For observations that record the gestational age the value is recorded as a physical quantity (PQ) with the units of weeks and the activity time should be recorded to indicate the date at which the gestational age was observed. For observations that simply record a date (e.g., LMP) the observation value is recorded as a point in time (TS).

Code	Description	Type
8655-2	DATE LAST MENSTRUAL PERIOD-TMSTP-PT-^PATIENT-QN-REPORTED	TS
11884-4	GESTATIONAL AGE-TIME-PT-^FETUS-QN-ESTIMATED FROM CLINICIANS PHYSICAL EXAM M	PQ
11888-5	Gestational age composite estimate	PQ
57065-5	Quickening date	TS
57066-3	Date fundal height reaches umbilicus	TS

6.3.4.27.14 <repeatNumber value=' '/> <interpretationCode code=' ' codeSystem=' '/> <targetSiteCode code=' ' codeSystem=' '/>

The <repeatNumber> <interpretationCode>, and <targetSiteCode> elements should not be present in an EDD observation.

Add Section 6.3.4.28

6.3.4.28 Antepartum Visit Summary Battery 1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.2

This entry describes a single row in the Antepartum Visit Summary Flowsheet. The single observation date and provider is applied to all other observations.

6.3.4.28.1 Specification

```
<entry>
  <organizer classCode='BATTERY' moodCode='EVN'>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.2'/>
    <id root=' ' extension=' '/>
    <code code='57061-4' displayName='Antepartum flowsheet panel'
          codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <statusCode code='completed'/>
    <author>
       <time value=' '/>
       <assignedAuthor>
          <id root=' ' extension=' '/>
       </assignedAuthor>
    </author>
    <component>
       <observation classCode='OBS' moodCode='EVN'>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
          :
       </observation>
    </component>
    <component>
       <observation classCode='OBS' moodCode='EVN'>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
           :
       </observation>
    </component>
    :
  </organizer>
</entry>
```

6.3.4.28.2 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.2'/>

The <templateId> element specifies that this organizer entry conforms to the APS profile Antepartum Visit Summary Flowsheet battery. The root attribute SHALL contain the value "1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.2"

6.3.4.28.3 <organizer classCode='BATTERY' moodCode='EVN'>

Each row in the visit Summary flowsheet of the Antepartum Summary SHALL be represented by an organizer with the classCode of 'BATTERY' and the moodCode of 'EVN'

6.3.4.28.4 <id root=' ' extension=' '/>

Each battery SHALL have a globally unique identifier.

6.3.4.28.5 <code code='(57061-4)' codeSystem='2.16.840.1.113883.6.1'/>

The <code> element specifies the LOINC code that represents the content of the battery. The codeSystem attribute SHALL contain the value '2.16.840.1.113883.6.1'. The code attribute SHALL contain the value='(57061-4)'. It is good practice to include displayName and codeSystemName for clarity and debugging. The corresponding values are 'ACOG VISIT SUMMARY BATTERY--PT--' and 'LOINC' respectively.

6.3.4.28.6 <author/><time/><assignedAuthor><id/></assignedAuthor></author>

The <author> relation element points at the author that records the visit battery. This assignedAuthor may be different than the author of the document. The time element is used to record when the assigned author recorded the battery.

6.3.4.28.7 <statusCode code='completed'/>

The status code for all batteries SHALL be 'completed'

6.3.4.28.8 <component>

The battery is made of several component simple observations. The following table lists the allowable LOINC codes, displayNames, and observation types, and unit of measures for these observations.

LOINC Code	displayName	xsi:type	units	value set
11884-4	Gestational age Clinical.estimate	PQ	week	
57067-1 or 11727-5 (by US)	Fetal Body weight Estimated by palpation or Fetal weight estimated by US	PQ	g, kg, lb_av, or oz_av	
11881-0	Uterus Fundal height Tape measure	PQ	cm	
11876-0 (by PE) or 11877-8 (by US)	Fetal presentation by palpitation or Fetal presentation US	CD		SNOMED CT Vertex (70028003) Breech (6096002) Transverse (73161006) Oblique (63750008) Compound (124736009) Brow (8014007) Face (21882006)
11948-7 or 57068-9	Fetal Heart rate US or Fetal Heart rate Auscultation	PQ	/min	
57088-7	Fetal Movement - Reported	CO		SNOMED CT fetal movement activity (finding) CID 364755008 baby kicks a lot (finding) CID 276368003 baby not moving (finding) CID 276370007 reduced fetal movement (finding) CID 276369006

LOINC Code	displayName	xsi:type	units	value set
				fetal movements present (finding) CID 289431008 fetal movements felt (finding) CID 268470003 fetal movements seen (finding) CID 169731002
57069-7	Preterm labor symptoms	BL		
11709-7 or 11785-3	DILATION-LEN-PT-CERVICAL CANAL.external os -QN-PALPATION or DILATION-LEN-PT-CERVICAL CANAL.external os-QN-US	PQ	cm	
11867-9	Effacement Cervix by palpitation	PQ	percent	
11961-0	Cervix [Length] US	PQ	cm	
8480-6	Systolic blood pressure	PQ	mmHg	
8462-4	Diastolic blood pressure	PQ	mmHg	
3141-9	Body weight Measured	PQ	g, kg, lb_av, or oz_av	
1753-3	Albumin [Presence] in Urine	CO		SNOMED CT Negative (finding) CID 167273002 Trace (finding) CID 167274008 1+ (finding) CID 167275009 2+ (finding) CID 167276005 3+ (finding) CID 167277001 4+ (finding) CID 167278006
2349-9 or 25428-4(test strip)	Glucose [Presence] in Urine or Glucose [Presence] in Urine by Test strip	CO		SNOMED CT Negative (finding) CID 167261002 Trace (finding) CID 167262009 1+ (finding) CID 167264005 2+ (finding) CID 167265006 3+ (finding) CID 167266007 4+ (finding) CID 167267003
44966-0	Edema	CO		SNOMED CT Trace 44996-0 1+ pitting edema 420829009 2+ pitting edema 421605005 3+ pitting edema 421346005 4+ pitting edema 421129002

LOINC Code	displayName	xsi:type	units	value set
38208-5	Pain severity - Reported	CO		0 (no pain) : 10 (worst possible pain) Note: This observation should correspond to the functional status pain score observation
57070-5	Date next clinic visit	PQ	day,week,mo	
48767-8	Annotation comment	ED		

Add Section 6.3.4.29

6.3.4.29 Advance Directive Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.7

An advance directive observation is a simple observation that uses a specific vocabulary, and inherits constraints from CCD.

6.3.4.29.1 Standards

CCD	ASTM/HL7 Continuity of Care Document

6.3.4.29.2 Specification

```
<observation typeCode='OBS' moodCode='EVN'>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
 <templateId root='2.16.840.1.113883.10.20.1.17'/>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13.7'/>
 <id root=' ' extension=' '/>
 <code code=' ' codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'/>
 <text><reference value='#xxx'/></text>
 <statusCode code='completed'/>
 <effectiveTime value=' '/>
  <value xsi:type='BL' value='true|false'/>
  <reference typeCode='REFR'>
   <templateId root='2.16.840.1.113883.10.20.1.36'/>
   <externalDocument classCode='DOC' moodCode='EVN'>
     <id root=' ' extension=' '/>
     <text><reference value=' '/></text>
   </externalDocument>
 </reference>
</observation>
```

An advanced directive <observation> shall be represented as shown above. They shall not contain any <repeatNumber>, <interpretationCode>, <methodCode> or <targetSiteCode> elements.

6.3.4.29.3 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/> <templateId root='2.16.840.1.113883.10.20.1.17'/> <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13.7'/>

The <templateId> elements shown above shall be present, and indicated that this is an Advance Directive entry.

6.3.4.29.4 <code code=' ' codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'/>

The <code> element records the type of advance directive. It should use one of the following SNOMED codes in the table below.

Code	Description	Data Type
304251008	Resuscitation	BL
52765003	Intubation	
225204009	IV Fluid and Support	
89666000	CPR	
281789004	Antibiotics	
78823007	Life Support	
61420007	Tube Feedings	
116859006	Transfusion of blood product	
71388002	Other Directive	<value> not permitted

6.3.4.29.5 <value xsi:type='BL' value='true|false'/>

The advance directive observation may include a <value> element using the Boolean (xsi:type='BL') data type to indicate simply whether the procedure described is permitted. Absence of the <value> element indicates that an advance directive of the specified type has been recorded, and must be examined to determine what type of treatment should be performed. The value element is not permitted when the <code> element describes an Other directive.

6.3.4.29.6 <reference typeCode='REFR'> <templateId root='2.16.840.1.113883.10.20.1.36'/> <externalDocument classCode='DOC' moodCode='EVN'> <id root=' ' extension=' '/> <text><reference value=' '/></text>

The advanced directive observation may contain a single reference to an external document. That reference shall be recorded as shown above. The <id> element shall contain the appropriate root and extension attributes to identify the document. The <text> element may be present to provide a URL link to the document in the value attribute of the <reference> element. If the <reference> element is present, the Advance Directive in the narrative shall contain a <linkHTML> element to the same URL found in the value attribute.

Add Section 6.3.4.30

6.3.4.30 Blood Type Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.6

The blood type observation is a Simple Observation of the patient's blood type. It conforms to the CCD Result observation template.

6.3.4.30.1 Standards

CCD ASTM/HL7 Continuity of Care Document

6.3.4.30.2 Specification

```
<observation typeCode='OBS' moodCode='EVN'>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13.6'/>
 <templateId root='2.16.840.1.113883.10.20.1.31'/>
 <id root=' ' extension=' '/>
 <code code='882-1' displayName='ABO+RH GROUP'
   codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
 <text><reference value='#xxx'/></text>
 <statusCode code='completed'/>
 <effectiveTime value=' '/>
 <repeatNumber value=' '/>
 <value xsi:type='CE' code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>
 <interpretationCode code=' ' codeSystem=' ' codeSystemName=' '/>
 <methodCode code=' ' codeSystem=' ' codeSystemName=' '/>
 <targetSiteCode code=' ' codeSystem=' ' codeSystemName=' '/>
<observation>
```

6.3.4.30.3 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/> <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13.6'/> <templateId root='2.16.840.1.113883.10.20.1.31'/>

These <templateId> elements identify this as a blood type observation. They shall be present in the <observation> element as shown above.

6.3.4.30.4 <code code='882-1' displayName='ABO+RH GROUP' codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>

The <code> element shall be present to represent this as a finding of the patient's composite blood type. It shall use the code and codeSystem attributes shown above.

6.3.4.30.5 ~~<repeatNumber value=' '/>~~

The <repeatNumber> element should not be present in a blood type observation.

6.3.4.30.6 <value xsi:type='CE' code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>

The <value> element shall be present and shall use the CE data type. The code attribute should be valued using a vocabulary that supports encoding of blood types. The table below shows some coding systems that may be used to encode blood type.

Coding System	OID
ISBT 128	2.16.840.1.113883.6.18
SNOMED CT	2.16.840.1.113883.6.96

.3.4.30.7 ~~<interpretationCode code=' ' codeSystem=' ' codeSystemName=' '/> <methodCode code=' ' codeSystem=' ' codeSystemName=' '/> <targetSiteCode code=' ' codeSystem=' ' codeSystemName=' '/>~~

The <interpretationCode>, <methodCode>, and <targetSiteCode> should not be present in a blood type observation.

Add Section 6.3.4.31

6.3.4.31 Encounters 1.3.6.1.4.1.19376.1.5.3.1.4.14

An Encounter is an interaction between a patient and care provider(s) for the purpose of providing healthcare-related service(s). Healthcare services include health assessment. Examples: outpatient visit to multiple departments, home health support (including physical therapy), inpatient hospital stay, emergency room visit, field visit (e.g., traffic accident), office visit, occupational therapy, or telephone call.

6.3.4.31.1 Standards

CCD ASTM/HL7 Continuity of Care Document

6.3.4.31.2 Specification

```
<encounter classCode='ENC' moodCode='PRMS|ARQ|EVN'>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.14'/>
 <templateId root='2.16.840.1.113883.10.20.1.21'/>
 <templateId root='2.16.840.1.113883.10.20.1.25'/>
 <id root='' extension=''/>
 <code code='' codeSystem='2.16.840.1.113883.5.4' codeSystemName='ActEncounterCode' />
 <text><reference value='#xxx'/></text>
 <effectiveTime>
   <low value=''/>
   <high value=''/>
 </effectiveTime>
 <priorityCode code=''/>
 <performer typeCode='PRF'>
   <time><low value=''/><high value=''/></time>
   <assignedEntity>...</assignedEntity>
 </performer>
 <author />
 <informant />
 <participant typeCode='LOC'>
   <participantRole classCode='SDLOC'>
     <id/>
     <code/>
     <addr>...</addr>
     <telecom value='' use=''/>
     <playingEntity classCode='PLC' determinerCode='INST'>
       <name></name>
     </playingEntity>
   </participantRole>
 </participant>
</encounter>
```

6.3.4.31.2.1 <encounter classCode='ENC' moodCode='APT|ARQ|EVN'>

This element is an encounter. The classCode shall be 'ENC'. The moodCode may be PRMS to indicate a scheduled appointment, ARQ to describe a request for an appointment that has been made but not yet scheduled by a provider, or EVN, to describe an encounter that has already occurred.

6.3.4.31.2.2 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.14'/>

The templateId indicates that this <encounter> entry conforms to the constraints of this content module. NOTE: When the encounter is in event mood (moodCode='EVN'), this entry conforms to the CCD template 2.16.840.1.113883.10.20.1.21, and when in other moods, this entry conforms to the CCD template 2.16.840.1.113883.10.20.1.25.

6.3.4.31.2.3 <id root='' extension=''/>

This required element shall contain an identifier for the encounter. More than one encounter identifier may be present.

6.3.4.31.2.4 <code code='' codeSystem='2.16.840.1.113883.5.4' codeSystemName='ActEncounterCode' />

This required element should contain a code from the HL7 ActEncounterCode vocabulary describing the type of encounter (e.g., inpatient, ambulatory, emergency, et cetera). Developers should take care to check that rational combinations of encounter.code and encounter.moodCode are used , but this Technical Framework does not restrict any combination.

6.3.4.31.2.5 <text><reference value='#xxx'/></text>

The <text> element shall contain a reference to the narrative text describing the encounter.

6.3.4.31.2.6 <effectiveTime><low value=''/><high value=''/></effectiveTime>

This element records the time over which the encounter occurred (in EVN mood), or the desired time of the encounter in ARQ or APT mood. In EVN or APT mood, the effectiveTime element should be present. In ARQ mood, the effectiveTime element may be present, and if not, the priorityCode may be present to indicate that a callback is required to schedule the appointment.

6.3.4.31.2.7 <priorityCode code='CS'/>

This element may be present in ARQ mood to indicate a callback is requested to schedule the appointment.

6.3.4.31.2.8 <performer>

For encounters in EVN mood, at least one performer should be present that identifies the provider of the service given during the encounter. More than one performer may be present. The <time> element should be used to indicate the duration of the participation of the performer when it is substantially different from that of the effectiveTime of the encounter. In ARQ mood, the performer may be present to indicate a preference for a specific provider. In APT mood, the performer may be present to indicate which provider is scheduled to perform the service.

6.3.4.31.2.9 <participant typeCode='LOC'> <participantRole classCode='SDLOC'>

A <participant> element with typeCode='LOC' may be present to provide information about the location where the encounter is to be or was performed. This element shall have a <participantRole> element with classCode='SDLOC' that describes the service delivery location.

6.3.4.31.2.10 <id/>

The <id> element may be present to identify the service delivery location.

6.3.4.31.2.11 <code/>

The <code> element may be present to classify the service delivery location.

6.3.4.31.2.12 <addr>...</addr>

The <addr> element should be present, and gives the address of the location.

6.3.4.31.2.13 <telecom value='' use=''/>

The <telecom> element should be present, and gives the telephone number of the location.

6.3.4.31.2.14 <playingEntity classCode='PLC'> <name>...</name> </playingEntity>

The <playingEntity> shall be present, and gives the name of the location in the required <name> element.

Add Section 6.3.4.32

6.3.4.32 Update Entry 1.3.6.1.4.1.19376.1.5.3.1.4.16

The update entry shall contain references to the entries or sections which are being replaced or updated. This reference shall not be present when the update entry is adding a new entries or sections.

Entries and sections can be added, updated, or removed from a PHR. An update entry indicates the entry in the original PHR Extract that should be replaced or updated with new information contained within the entry. Only one organizer of this type is allowed in a section, and if present, it must be the first entry in the section.

6.3.4.32.1 Specification

```
<entry>
  <organizer classCode='BATTERY' moodCode='EVN'>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.16'/>
    <reference typeCode='RPLC'>
      <externalAct classCode='ACT' moodCode='EVN'>
        <id root='' extension=''/>
      </externalAct>
    </reference>
  </organizer>
</entry>
```

6.3.4.32.2 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.16'/>

This templateId indicates that the organizer is used to update a PHR Extract.

6.3.4.32.3 <reference typeCode='RPLC'>

A reference element shall be present with typeCode RPLC. The reference element lists the acts that are affected by the update. It indicates that any referenced act is being replaced with new information. This element must be present, and may be repeated to replace more than one act at a time.

6.3.4.32.4 <externalAct classCode='ACT' moodCode='EVN'>

This element must appear as shown above. It indicates that the reference is to an external act (a section or entry contained in the parent document).

6.3.4.32.5 <id root=' ' extension=' '/>

This element identifies the information being replaced or updated. The identifier is of the entry or section being replaced. If the identifier is to a section being replaced, only one reference element is permitted.

Add Section 6.3.4.33

6.3.4.33 Procedure Entry 1.3.6.1.4.1.19376.1.5.3.1.4.19

The procedure entry is used to record procedures that have occurred, or which are planned for in the future.

6.3.4.33.1 Standards

CCD ASTM/HL7 Continuity of Care Document

6.3.4.33.2 Specification

```
<procedure classCode='PROC' moodCode='EVN|INT'>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.19'/>
  <templateId root='2.16.840.1.113883.10.20.1.29'/><!-- see text of section 0 -->
  <templateId root='2.16.840.1.113883.10.20.1.25'/><!-- see text of section 0 -->
  <id root='' extension=''/>
  <code code='' codeSystem='2.16.840.1.113883.5.4' codeSystemName='ActCode' />
  <text><reference value='#xxx'/></text>
  <statusCode code='completed|active|aborted|cancelled'/>
  <effectiveTime>
    <low value=''/>
    <high value=''/>
  </effectiveTime>
  <priorityCode code=''/>
  <approachSiteCode code='' displayName='' codeSystem='' codeSystemName=''/>
  <targetSiteCode code='' displayName='' codeSystem='' codeSystemName=''/>
  <author />
  <informant />
  <entryRelationship typeCode='COMP' inversionInd='true'>
    <act classCode='ACT' moodCode=''>
      <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.4.1'/>
      <id root='' extension=''/>
    </act>
  </entryRelationship>
  <entryRelationship typeCode='RSON'>
    <act classCode='ACT' moodCode='EVN'>
      <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.4.1'/>
      <id root='' extension=''/>
    </act>
  </entryRelationship>
</procedure>
```

6.3.4.33.2.1 <procedure classCode='PROC' moodCode='EVN|INT'>

This element is a procedure. The classCode shall be 'PROC'. The moodCode may be INT to indicate a planned procedure or EVN, to describe a procedure that has already occurred.

6.3.4.33.2.2 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.19'/>

The templateId indicates that this <procedure> entry conforms to the constraints of this content module. NOTE: When the procedure is in event mood (moodCode='EVN'), this entry conforms to the CCD template 2.16.840.1.113883.10.20.1.29, and when in intent mood, this entry conforms to the CCD template 2.16.840.1.113883.10.20.1.25.

6.3.4.33.2.3 <id root='' extension=''/>

This required element shall contain an identifier for the procedure. More than one procedure identifier may be present.

6.3.4.33.2.4 <code code='' displayName='' codeSystem='' codeSystemName='' />

This element shall be present, and should contain a code describing the type of procedure.

6.3.4.33.2.5 <text><reference value='#xxx'/></text>

The <text> element shall contain a reference to the narrative text describing the procedure.

6.3.4.33.2.6 <statusCode code='completed|active|aborted|cancelled'/>

The <statusCode> element shall be present when used to describe a procedure event. It shall have the value 'completed' for procedures that have been completed, and 'active' for procedures that are still in progress. Procedures that were stopped prior to completion shall use the value 'aborted', and procedures that were cancelled before being started shall use the value 'cancelled'.

6.3.4.33.2.7 <effectiveTime><low value=''/><high value=''/></effectiveTime>

This element should be present, and records the time at which the procedure occurred (in EVN mood), or the desired time of the procedure in INT mood.

6.3.4.33.2.8 <priorityCode code=''/>

This element shall be present in INT mood when effectiveTime is not provided, it may be present in other moods. It indicates the priority of the procedure.

6.3.4.33.2.9 <approachSiteCode code='' displayName='' codeSystem='' codeSystemName=''/>

This element may be present to indicate the procedure approach.

6.3.4.33.2.10 <targetSiteCode code='' displayName='' codeSystem='' codeSystemName=''/>

This element may be present to indicate the target site of the procedure.

6.3.4.33.2.11 <entryRelationship typeCode='COMP' inversionInd='true'>

This element may be present to point the encounter in which the procedure was performed, and shall contain an internal reference to the encounter. See PCC TF-2: 6.3.4.10 Internal References for more details.

6.3.4.33.2.12 <entryRelationship typeCode='RSON'>

A <procedure> act may indicate one or more reasons for the procedure. These reasons identify the concern that was the reason for the procedure via an Internal Reference (see PCC TF-2: 6.3.4.10 Internal References) to the concern. The extension and root of each observation present must match the identifier of a concern entry contained elsewhere within the CDA document.

Add Section 6.3.4.34

6.3.4.34 Transport 1.3.6.1.4.1.19376.1.5.3.1.1.10.4.1

Defined in IHE PCC TF-2:6.3.4.34

Add Section 6.3.4.35

6.3.4.35 Encounter Disposition 1.3.6.1.4.1.19376.1.5.3.1.1.10.4.2

This element records the intended or actual disposition for the patient (e.g., admit, discharge home after treatment, et cetera).

6.3.4.35.1 Specification

```
<act classCode='ACT' moodCode='INT|EVN'>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.10.4.2'/>
  <id root='' extension=''/>
  <code code='' displayName='' codeSystem='' codeSystemName='' />
  <text><reference value='#xxx'/></text>
  <statusCode code='normal|completed'/>
  <effectiveTime value=''/>
  <performer typeCode='PRF'>
    <assignedEntity>
      <id root='' extension=''/>
      <addr></addr>
      <telecom value='' use=''/>
      <assignedPerson>
        <name></name>
      </assignedPerson>
    </assignedEntity>
  </performer>
  <participant typeCode='RCV'>
    <time value=''/>
    <participantRole classCode='ROL'>
      <id root='' extension=''/>
      <addr></addr>
      <telecom value='' use=''/>
      <playingEntity>
        <name></name>
      </playingEntity>
    </participantRole>
  </participant>
  <entryRelationship typeCode='COMP'>
    <act classCode='ACT'>
      <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.10.4.1'/>
       :
    </act>
  </entryRelationship>
</act>
```

6.3.4.35.1.1 <act classCode='ACT' moodCode='INT|EVN'>

The disposition is recorded in an act element, to describe the disposition action taken during the encounter[1] . In intent mood (moodCode='INT'), this records the expected disposition of the patient. In event mood (moodCode='EVN'), this records the actual disposition.

[1] The HL7 RIM allows this portion of the encounter to be recorded in the dischargeDispositionCode RIM Attribute of the Encounter class, but the Encounter class is constrained within CDA. To record the disposition act therefore requires the use of the Act class.

6.3.4.35.1.2 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.10.4.2'/>

The templateId indicates that this <encounter> entry conforms to the constraints of this content module.

6.3.4.35.1.3 <id root='' extension=''/>

This required element shall contain an identifier.

6.3.4.35.1.4 <code code='' displayName='' codeSystem='' codeSystemName='' />

This required element indicates the disposition of the patient. The code shall come from a coding system that is able to record common patient dispositions (e.g., Discharged, Transferred, Admitted). The "Administrative Procedure" concept (14734007) of SNOMED CT contains several code values that cover a wide variety of dispositions routinely recorded. Other vocabularies that are commonly in use to describe discharge disposition codes are DEEDS (see section 8.02), and in the US, the Uniform National Billing Code.

6.3.4.35.1.5 <text><reference value='#xxx'/></text>

The <text> element shall contain a reference to the narrative text describing the disposition of the patient. <statusCode code='normal|completed'/> When the disposition act has occurred (moodCode='EVN'), the statusCode element shall be present, and shall contain the value 'completed'. When the disposition act is intended (moodCode='EVN') the statusCode element shall contain the value 'normal'.

6.3.4.35.1.6 <effectiveTime><low value=''/><high value=''/><effectiveTime/>

When the disposition has occurred, this element shall be sent, and indicates the effective time for the disposition process. This element may be sent to record when the disposition act is intended to occur. The <low> element records the time at which the disposition process was started. The <high> value records the time at which the disposition process was completed.

6.3.4.35.1.7 <performer typeCode='PRF'>

The <performer> element provides information about the person that performs the discharge, admission or transfer of the patient. When the disposition is in intent mood, this element describes any expectations with respect to the performer, and is optional. When the disposition is in event mood, this element is required.

6.3.4.35.1.8 <assignedEntity>

The <assignedEntity> element identifies the performer of the disposition.

6.3.4.35.1.9 <id root='' extension=''/>

The <id> element shall be sent when the disposition has occurred, and identifies the performer of the act.

6.3.4.35.1.10 <addr></addr>

The <addr> element may be sent to provide a contact postal address for the performer of the disposition.

6.3.4.35.1.11 <telecom value='' use=''/>

The <telecom> element may be sent to provide a contact postal address for the performer of the disposition.

6.3.4.35.1.12 <assignedPerson><name/></assignedPerson>

The <assignedPerson> element shall be sent to identify the person who performed the disposition of the patient.

6.3.4.35.1.13 <participant typeCode='RCV'> <time value=''/> <participantRole classCode='ROL'> <id root='' extension=''/> <addr></addr> <telecom value='' use=''/> <playingEntity><name/></playingEntity>

This element identifies the person or organization that is receiving the patient. ===== <entryRelationship typeCode='COMP'> <act classCode='ACT'> <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.10.4.1'/> If the disposition of the patient requires transport to another location, this information shall be recorded in a subordinate act that conforms to the Transport template described above.

Add Section 6.3.4.36

6.3.4.36 Coverage Entry 1.3.6.1.4.1.19376.1.5.3.1.4.17

Payers shall be recorded as described in CCD: 3.1.2.1.1.

6.3.4.36.1 Standards

CCD ASTM/HL7 Continuity of Care Document

6.3.4.36.2 Specification

Coverage Entry Example

```
<act classCode='ACT' moodCode='DEF'>
  <templateId root='2.16.840.1.113883.10.20.1.20'/>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.17'/>
  <id root='' extension='' />
  <code code='48768-6' displayName='Payment Sources'
    codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
  <statusCode code='completed'/>
  <entryRelationship typeCode='COMP'>
    <sequenceNumber value=''/>
      :
  </entryRelationship>
</act>
```

6.3.4.36.3 <act classCode='ACT' moodCode='DEF'>

Coverage shall be recorded in an <act> that groups all patient coverage together, and defines (moodCode='DEF') the payers.

6.3.4.36.4 <templateId root='2.16.840.1.113883.10.20.1.20'/> <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.17'/>

The <act> conforms to CCD: 3.1.2.1.1 as well as this specification. This shall be reflected by including the <templateId> elements shown above.

6.3.4.36.5 <id root=' ' extension=' '/>

The <id> element shall be present.

6.3.4.36.6 <code code='48768-6' displayName='PAYMENT SOURCES' codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>

The <code> element shall be recorded exactly as shown above.

6.3.4.36.7 <statusCode code='completed'/>

The <statusCode> element shall be present exactly as shown above.

6.3.4.36.8 <entryRelationship typeCode='COMP'>

The coverage <act> shall have one or more <entryRelationship> elements. These elements define the coverage. The entry relationships must contain Payer Entries.

6.3.4.36.9 <sequenceNumber value=' '/>

The <sequenceNumber> element may be present. If present, it shall contain a value attribute that indicates the priority of the payment source.

Add Section 6.3.4.37

6.3.4.37 Payer Entry 1.3.6.1.4.1.19376.1.5.3.1.4.18

The payer entry allows information about the patient's sources of payment to be recorded.

6.3.4.37.1 Standards

CCD ASTM/HL7 Continuity of Care Document

6.3.4.37.2 Specification

Payer Entry Example

```
<act classCode='ACT' moodCode='EVN'>
  <templateId root='2.16.840.1.113883.10.20.1.26'/>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.18'/>
  <id root='' extension=''/>
  <code code='' displayName='' codeSystem='' codeSystemName=''/>
  <statusCode code='completed'/>
  <performer typeCode='PRF'><!-- payer -->
    <assignedEntity classCode='ASSIGNED'>
      <id root='' extension=''/>
      <code code='PAYOR|GUAR|PAT' displayName=''
        codeSystem='2.16.840.1.113883.5.110' codeSystemName='RoleClass'/>
      <addr></addr>
      <telecom value='' use=''/>
      <representedOrganization typeCode='ORG'>
        <name></name>
      </representedOrganization>
    </assignedEntity>
  </performer>
  <participant typeCode='COV'><!-- member -->
    <participantRole classCode='PAT'>
      <id root='' extension=''/>
      <code code='' displayName=''
        codeSystem='2.16.840.1.113883.5.111' codeSystemName='RoleCode'/>
      <addr></addr>
      <telecom value='' use=''/>
      <playingEntity><name></name></playingEntity>
    </participantRole>
  </participant>
  <participant typeCode='HLD'><!-- subscriber -->
    <participantRole classCode='PAT'>
      <id root='' extension=''/>
      <playingEntity><name></name></playingEntity>
    </participantRole>
  </participant>
  <entryRelationship typeCode='REFR'>
    <act classCode='ACT' moodCode='DEF'>
      <id root='' extension=''/>
      <code code='' displayName='' codeSystem='' codeSystemName=''/>
      <text><reference value=''/></text>
    </act>
  </entryRelationship>
</act>
```

6.3.4.37.3 <act classCode='ACT' moodCode='EVN'>

The policy entry <act> describes the policy or program that has agreed to pay (moodCode='EVN') for the patient's treatment.

6.3.4.37.4 <templateId root='2.16.840.1.113883.10.20.1.26'/> <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.18'/>

The <act> conforms to CCD: 3.1.2.1.2 and this guide. This shall be reflected by including the <templateId> elements shown above.

6.3.4.37.5 <id root=' ' extension=' '/>

The <act> shall contain at least one <id> element that represents the policy or group number of the coverage. That identifier shall appear in the extension attribute.

6.3.4.37.6 <code code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>

The <code> element should be present, and represents the type of coverage provided by the payer. Potential vocabularies to use include:

Table 6.3.4.37.6-1: Payer Type Vocabularies

Vocabulary	Description	OID
HL7 ActCoverageType	The HL7 ActCoverageType vocabulary describes payers and programs. Note that HL7 does not have a specific code to identify an individual payer, e.g., in the role of a guarantor or patient.	2.16.840.1.113883.5.4
X12 Data Element 1336	The X12N 271 implementation guide includes various types of payers. This code set does include a code to identify individual payers.	2.16.840.1.113883.6.255.1336

6.3.4.37.7 <statusCode code='completed'/>

The <statusCode> element shall be present, and should be recorded exactly as shown above.

6.3.4.37.8 <performer typeCode='PRF'> <assignedEntity classCode='ASSIGNED'>

The <performer> element shall be present to represent the payer of the coverage.

6.3.4.37.9 <id root=' ' extension=' '/>

The identity of the performer should be recorded in the <id> element.

6.3.4.37.10 <code code='PAYOR|GUAR|PAT' displayName=' ' codeSystem='2.16.840.1.113883.5.110' codeSystemName='RoleClass'/>

The <code> element describes the role of the payer. It shall contain one of the values listed in the table below.

Table 6.3.4.37.10-1 Payer Role Codes

Coding System	OID
ISBT 128	2.16.840.1.113883.6.18
SNOMED CT	2.16.840.1.113883.6.96

6.3.4.37.11 <addr></addr>

The <addr> element shall be used to record the address of the payer. This information will usually come from the back of an insurance card.

6.3.4.37.12 <telecom value=' ' use=' '/>

The <telecom> element shall be used to record the phone number of the payer. This information will usually come from the back of an insurance card.

6.3.4.37.13 <representedOrganization typeCode='ORG'> <name></name>

The name of the payer organization shall be provided in the <name> element contained within the <representedOrganization> element.

6.3.4.37.14 <participant typeCode='COV'> <participantRole classCode='PAT'>

Information about the patient with respect to the policy or program shall be recorded in the <participantRole> element shown above. This element shall be present when the patient is a member of a policy or program.

6.3.4.37.15 <id root=' ' extension=' '/>

The <id> element should contain the identifier of the patient with respect to the payer (the subscriber or member id).

6.3.4.37.16 <code code= displayName= codeSystem='2.16.840.1.113883.5.111' codeSystemName='RoleCode'/>

The <code> element shall indicate the covered party's relationship to the subscriber, and should come from the HL7 CoverageRoleType value set.

6.3.4.37.17 <addr></addr>

The <addr> element should be used to record the address of the patient as known to the payer when different from that recorded in the <patientRole> element.

6.3.4.37.18 <telecom value=' ' use=' '/>

The <telecom> element should be used to record the phone number of the patient when different from that recorded in the <patientRole> element.

6.3.4.37.19 <playingEntity><name></name></playingEntity>

The <name> element should be used to record the member name when it is different from that recorded in the <patient> element.

6.3.4.37.20 <participant typeCode='HLD'> <participantRole classCode='IND'>

Information about subscriber to the policy or program shall be recorded in the <participantRole> element shown above. This element shall be present when the subscriber is different from the patient.

6.3.4.37.21 <id root=' ' extension=' '/>

The <id> element shall contain the identifier of the subscriber when the subscriber is not the patient.

6.3.4.37.22 <addr></addr>

The <addr> element shall be used to record the address of the subscriber when the subscriber is not the patient.

6.3.4.37.23 <telecom value=' ' use=' '/>

The <telecom> element shall be used to record the phone number of the subscriber when the subscriber is not the patient.

6.3.4.37.24 <playingEntity><name></name></playingEntity>

The name of the subscriber shall be recorded in the <name> element of the <playingEntity>.

6.3.4.37.25 <entryRelationship typeCode='REFR'> <act classCode='ACT' moodCode='DEF'>

The plan information may be provided in the elements described above.

6.3.4.37.26 <id root=' ' extension=' '/>

The health plan identifier is recorded in the <id> element.

6.3.4.37.27 <text><reference value=' '/></text>

This <reference> element shown above should be present and the value attribute should point to the name of the plan contained in the narrative of the document.

Add Section 6.3.4.38

6.3.4.38 Pain Score Observation 1.3.6.1.4.1.19376.1.5.3.1.1.12.3.1

The pain score observation is a Simple Observation that records the patient's assessment of their pain on a scale from 0 to 10.

6.3.4.38.1 Parent Template

The parent of this template is Simple Observation.

6.3.4.38.2 Specification

```
<observation typeCode='OBS' moodCode='EVN'>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
 <templateId root=1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
 <id root=' ' extension=' '/>
 <code code='38208-5|38221-8|38214-3' codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'>
   <translation code='406127006' displayName='Pain intensity'
     codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'/>
 </code>
 <text><reference value='#xxx'/></text>
 <statusCode code='completed'/>
 <effectiveTime value=' '/>
 <repeatNumber value=' '/>
 <value xsi:type='CO|REAL' />
 <interpretationCode code= codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'/>
 <methodCode code=' ' codeSystem=' ' codeSystemName=' '/>
 <targetSiteCode code=' ' codeSystem=' ' codeSystemName=' '/>
</observation>
```

6.3.4.38.3 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>

The <templateId> identifies this as a Pain Score Observation, and shall be present as shown above.

6.3.4.38.4 <code code='38208 5' codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'> <translation code='406127006' displayName='Pain intensity' codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'/>

The <code> element indicates what kind of pain observation was made. It shall contain the code and codeSystem attribute values shown above. The <translation> element may be present, and provides a mapping to SNOMED CT of the observation. If present, is shall have the code and codeSystem attribute values shown above.

Code	Data Type	Description
38208-5	CO	A Pain Score made using the Numerical Rating Scale (NRS), where pain is assessed on a scale from 0 to 10. -->>The code system to use for this observation<<--

6.3.4.38.5 <value xsi:type='CO' value=' ' />

The <value> element records the assessed pain score. If using the NRS the pain is assessed using coded ordinal values that range from 0 to 10. The use of the coded ordinal type is required because while pain assessments are ordered values, and can be compared, the differences

between two pain assessment values cannot be compared, and so these values are not really numbers.

6.3.4.38.6<interpretationCode code='301379001|40196000|76948002|67849003' codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'/>

The <interpretationCode> element should be present to provide an interpretation of the pain scale assessment using SNOMED CT. When the <interpretationCode> element is present, the <translation> element described above shall be present. These interpretations are provided to assist decision support systems that are making secondary use of the assessment information, and are not intended to replace the score values.

Pain Score Range	Code	Description
0	301379001	No Present Pain
1-3	40196000	Mild Pain
4-6	50415004	Moderate Pain
7-9	76948002	Severe Pain
10	67849003	Excruciating Pain

6.3.4.38.7 ~~<methodCode code=' ' codeSystem=' ' codeSystemName=' '/>~~

The <methodCode> should not be present in a Pain Score Observation, as the method is implied by the <code> element.

6.3.4.38.8 <targetSiteCode code=' ' codeSystem=' ' codeSystemName=' '/>

The <targetSiteCode> element should be present, and shall indicate the location of the pain being assessed.

Add Section 6.3.4.39

6.3.4.39 Braden Score Observation 1.3.6.1.4.1.19376.1.5.3.1.1.12.3.2

Add Section 6.3.4.40

6.3.4.40 Braden Score Component 1.3.6.1.4.1.19376.1.5.3.1.1.12.3.3

Add Section 6.3.4.41

6.3.4.41 Geriatric Depression Score Observation 1.3.6.1.4.1.19376.1.5.3.1.1.12.3.4

Add Section 6.3.4.42

6.3.4.42 Geriatric Depression Score Component 1.3.6.1.4.1.19376.1.5.3.1.1.12.3.5

4285

Add Section 6.3.4.43

6.3.4.43 Survey Panel 1.3.6.1.4.1.19376.1.5.3.1.1.12.3.7

A survey panel collects related survey observations.

6.3.4.43.1 Parent Template

4290 This template is compatible with the ASTM/HL7 Continuity of Care Document template: 2.16.840.1.113883.10.20.1.32

6.3.4.43.2 Uses

See Templates using Survey Panel.

6.3.4.43.3 Specification

4295

```
<organizer classCode='CLUSTER' moodCode='EVN'>
  <templateId root='2.16.840.1.113883.10.20.1.32'/>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.3.7'/>
  <id root='' extension=''/>
  <code code=' ' displayName=' '
    codeSystem=' ' codeSystemName=' '/>
  <statusCode code='completed'/>
  <effectiveTime value=''/>
  <!-- one or more survey observations -->
  <component typeCode='COMP'>
    <observation classCode='OBS' moodCode='EVN'>
      <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.3.6'/>
        :
    </observation>
  </component>
</organizer>
```

6.3.4.43.3.1 <organizer classCode='CLUSTER' moodCode='EVN'>

The survey panel is a cluster of related survey observations.

6.3.4.43.3.2 <templateId root='2.16.840.1.113883.10.20.1.32'/> <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.3.7'/>

The survey panel shall have the <templateId> elements shown above to indicate that it inherits constraints from the ASTM/HL7 CCD Specification for results organizers, and the constraints of this specification.

6.3.4.43.3.3 <id root=' ' extension=' '/>

The organizer shall have an <id> element.

6.3.4.43.3.4 <code code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>

The <code> element shall be present, and identifies the survey panel.

6.3.4.43.3.5 <statusCode code='completed'/>

The observations have all been completed.

6.3.4.43.3.6 <effectiveTime value=' '/>

The effective time element shall be present to indicate when the survey panel was taken.

6.3.4.43.3.7 <!-- one or more survey observations --> <component typeCode='COMP'>

The organizer shall have one or more <component> elements that are <observation> elements using the Survey Observation template.

Add Section 6.3.4.44

6.3.4.44 Survey Observation 1.3.6.1.4.1.19376.1.5.3.1.1.12.3.6

Survey observations are used to record responses to assessment instruments. They are simple observations conforming to the CCD Result template. The vocabulary and data type constraints on survey observations is specified elsewhere, either in the specializations of the survey observation template, or by the template that makes use of it.

6.3.4.44.1 Parent Template

The parent of this template is Simple Observation. This template is compatible with the ASTM/HL7 Continuity of Care Document template: 2.16.840.1.113883.10.20.1.31

6.3.4.44.2 Uses

See Templates using Survey Observation.

6.3.4.44.3 Specification

```
<observation classCode='OBS' moodCode='EVN'>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
 <templateId root='2.16.840.1.113883.10.20.1.31'/>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.3.6'/>
 <id root=' ' extension=' '/>
 <code code=' ' codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
 <text><reference value='#xxx'/></text>
 <statusCode code='completed'/>
 <effectiveTime value=' '/>
 <repeatNumber value=' '/>
 <value xsi:type='CO|CD|INT|PQ' />
 <interpretationCode code=' ' codeSystem=' ' codeSystemName=' '/>
 <methodCode code=' ' codeSystem=' ' codeSystemName=' '/>
 <targetSiteCode code=' ' codeSystem=' ' codeSystemName=' '/>
</observation>
```

6.3.4.44.3.1 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/> <templateId root='2.16.840.1.113883.10.20.1.31'/> <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.3.6'/>

A survey observation shall have the <templateId> elements shown above to indicate that it inherits constraints from the ASTM/HL7 CCD Specification for results, and the constraints of this specification.

6.3.4.44.3.2 <code code=' ' codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>

A survey observation entry shall contain a code identifying the observation made.

6.3.4.44.3.3 <value xsi:type='CO|CD|INT|PQ' .../>

The <value> element shall be present, and shall be of the appropriate data type specified for the observation.

6.3.4.44.3.4 <interpretationCode code=' ' codeSystem=' ' codeSystemName=' '/>

An interpretation code may be present to provide an interpretation of the observation.

6.3.4.44.3.5 <methodCode code=' ' codeSystem=' ' codeSystemName=' '/> <targetSiteCode code=' ' codeSystem=' ' codeSystemName=' '/>

The <methodCode> and <targetSiteCode> element shall not be present, as these are not relevant to survey responses.

Add Section 6.3.4.45

6.3.4.45 Acuity 1.3.6.1.4.1.19376.1.5.3.1.1.13.3.1

An acuity entry indicates the triage acuity entry and the triage time of the patient.

6.3.4.45.1 Specification

```
<entry>
  <!-- Acuity Event  -->
  <observation classCode='OBS' moodCode='EVN'>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.3.1'/>
    <id root='' extension=''/>
    <code code='' displayName=''
          <code code='273887006' displayName='Triage index'
           codeSystem='2.16.840.1.113883.6.96'
           codeSystemName='SNOMED CT'/> <!-- Triage index (assessment scale) FullySpecifiedName -
->
      <originalText><reference value='#(ID of text coded)/></orginalText>
    </code>
    <text><reference value='#text/></text>
    <!-- effectiveTime
    <effectiveTime>
      <low value=''/> <!-- start of triage, may be sent -->
      <high value=''/><!-- end of triage should be sent -->
    </effectiveTime>
  </observation>
</entry>
```

6.3.4.45.1.1 <observation classCode='OBS' moodCode='EVN'>

This element indicates that the entry is an observation regarding the event of triage assessment. This entry records the observation and the time of the observation.

6.3.4.45.1.2 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.3.1'/>

The <templateId> element identifies this <act> as about Acuity Assessment of the patient. The templateId must have root='1.3.6.1.4.1.19376.1.5.3.1.1.13.3.1'.

6.3.4.45.1.3 <id root='' extension=''/>

The entry must have an identifier.

6.3.4.45.1.4 <code code='' displayName='' codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'>

The code describes the triage acuity scale. IHE recommends the use the Emergency Severity Index (ESI). However, the vocabulary used within an affinity domain may be determined by a policy agreement within the domain.

6.3.4.45.1.5 <originalText><reference value='#xxx'/><orginalText>

This is a reference to the narrative text within the section that describes the acuity description.

6.3.4.45.1.6 <text><reference value='#text/></text>

This is a reference to the narrative text corresponding to the Observation act.

6.3.4.45.1.7 <effectiveTime>

The effectiveTime element shall be sent. It records the interval of time over which triage occurs. The use case for this information requires that the ending time of triage be recorded. However, the <low value=''> element may be sent by systems that capture the beginning and end of the triage process.

6.3.4.45.1.8 <high value=''/>

This element records the time of completion of triage, and is required. If unknown, it must be recorded using a flavor of null. This element may be sent using the TS data type, as shown above. If there is uncertainty about the time of completion of triage, the sender may record the time using the IVL_TS data type, as shown below.

```
<high xsi:type='IVL_TS'>
  <low value=''/>
  <high value=''/>
</high>
```

Add Section 6.3.4.46

6.3.4.46 Intravenous Fluids 1.3.6.1.4.1.19376.1.5.3.1.1.13.3.2

This content module describes the general structure for intravenous fluids. All intravenous fluid administration acts should be derived from this content module.

6.3.4.46.1 Specification

```
<substanceAdministration classCode='SBADM' moodCode='INT|EVN'>
  <templateId root='2.16.840.1.113883.10.20.1.24'/>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.7'/>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.7.1'/>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.3.2'/>
  <id root='' extension=''/>
  <code code='' codeSystem='' displayName='' codeSystemName=''/>
  <text><reference value='#med-1'/></text>
  <statusCode code='completed|active'/>
  <effectiveTime xsi:type='IVL_TS'>
      <low value=''/>
      <high value=''/>
  </effectiveTime>
  <effectiveTime operator='A' xsi:type='TS|PIVL_TS|EIVL_TS|PIVL_PPD_TS|SXPR_TS'>
   :
  </effectiveTime>
  <routeCode code='' codeSystem='' displayName='' codeSystemName=''/>
  <doseQuantity value='' unit=''/>
  <approachSiteCode code='' codeSystem='' displayName='' codeSystemName=''/>
  <rateQuantity value='' unit=''/>
  <consumable>
   :
    .
  </consumable>
  <!-- 0..* entries describing the components -->
  <entryRelationship typeCode='COMP' >
      <sequenceNumber value=''/>
  </entryRelationship>
  <!-- An optional entry relationship that indicates the reason for use -->
  <entryRelationship typeCode='RSON'>
    <act classCode='ACT' moodCode='EVN'>
      <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.4.1'/>
      <id root='' extension=''/>
    </act>
  </entryRelationship>
  <!-- An optional entry relationship that provides prescription activity -->
  <entryRelationship typeCode='REFR'>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.7.3'/>
     :
      .
  </entryRelationship>
  <precondition>
    <criterion>
      <text><reference value=''/></text>
    </criterion>
  </precondition>
</substanceAdministration>
```

This content module is derived from the Medication content module to specifically and more easily describe the necessary details of intravenous fluid administration. For the purpose of EDER and other profiles employing this content module, the table below identifies and describes the fields and constraints on whether or not they are required to be sent. The fields are listed in the order that they appear in the CDA XML content.

6.3.4.46.1.1 Medication Fields

Field	Opt.	CDA Tag	Description
Start and Stop Date	R2	<effectiveTime>	The date and time when the fluid regimen began and is expected to finish. The first component of the <effectiveTime> encodes the lower and upper bounds over which the <substanceAdministration> occurs, and the start time is determined from the lower bound. If the fluid has been known to be stopped, the high value must be present, but expressed as a flavor of null (e.g., Unknown).
Dose	R2	<doseQuantity>	The amount of fluid given. This should be in some known and measurable fluid unit, such as milliliters, or may be measured in "administration" units (such "units" of blood or "packs" of platelets).
Site	O	<approachSiteCode>	The site where the fluid is administered (i.e., "Left Antecubital", or "Central Line").
Rate	R2	<rateQuantity>	The rate is a measurement of how fast the fluid is given to the patient over time (e.g., .5 liter / 1 hr).
Product	R	<consumable> <name> </consumable>	The name of the substance or product. This should be sufficient for a provider to identify the type of fluid. It may be a trade name (Plasmalyte®)or a generic name. This information is required in all fluid entries. The name should not include packaging, strength or dosing information.
Code	R2	<consumable> <code/> </consumable>	A code describing the product from a controlled vocabulary, such as RxNorm, First DataBank, et cetera.

6.3.4.46.1.2 <substanceAdministration classCode='SBADM' moodCode='INT|EVN'>

The general model is to record each fluid administered in a <substanceAdministration> intent (moodCode='INT'). Fluids that have been started but not completely administered should be recorded in a <substanceAdministration> intent (moodCode='INT'). Fluids that have been completed should be recorded as an event (moodCode='EVN').

6.3.4.46.1.3 <templateId root='2.16.840.1.113883.10.20.1.24'/> <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.7'/> <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.7.1' />

All intravenous fluid entries use the <templateId> elements specified above to indicate that they are IV fluid administration acts. This element is required.

6.3.4.46.1.4 <id root='' extension=''/>

The <substanceAdministration> element must be uniquely identified. If there is no explicit identifier for this observation in the source EMR system, a GUID may be used for the root attribute, and the extension may be omitted. Although HL7 allows for multiple identifiers, this Technical Framework profile requires that one and only one be used.

6.3.4.46.1.5 <code code='' displayName='' codeSystem='' codeSystemName=''>

The <code> element is required, and is used to supply a code that describes the act of fluid administration, not the fluid being administered. This may be a procedure code, such as those found in CPT-4 (and often used for billing), or may describe the method of administration, such as by intravenous injection.

6.3.4.46.1.6 <text><reference value=''/></text>

The URI given in the value attribute of the <reference> element points to an element in the narrative content that contains the complete text describing the fluid administration.

6.3.4.46.1.7 <statusCode code='completed|active'/>

The status of all <substanceAdministration> elements must be "completed" or "active". If "completed", then the administration has occurred, or the request or order has been placed. If "active", then at the time recorded, the fluid was still being administered.

6.3.4.1.46.8 <effectiveTime xsi:type='IVL_TS'>

The first <effectiveTime> element encodes the start and stop time of the administration. This is an interval of time (xsi:type='IVL_TS'), and must be specified as shown. This is an additional constraint placed upon CDA Release 2.0 by this Technical Framework profile, and simplifies the exchange of start/stop and frequency information between EMR systems.

6.3.4.46.1.9 <low value=''/><high value=''/>

The <low> and <high> values of the first <effectiveTime> element represent the start and stop times for the fluid administration. The <low> value represents the start time, and the <high> value represents the stop time. If either the <low> or the <high> value is unknown, this shall be recorded by setting the nullFlavor attribute to UNK. The <high> value records the end of the fluid administration according to the information provided in the initial fluid order or RN documentation. For example, if the fluid order is for one liter, and the fluid is to be delivered at 250 mL/hr, then the high value should contain a datetime that is 4 hours later then the <low> value. The rationale is that a provider, seeing a discontinued fluid could normally assume that the fluid has been stopped, even if the intent of the treatment plan is to continue the fluid continuously.

6.3.4.46.1.10 <approachSiteCode code='' codeSystem=''> originalText><reference value=''/></originalText> </approachSiteCode>

The <approachSiteCode> element contains a URI in the value attribute of the <reference> that points to the text in the narrative identifying the site. It may be coded to a controlled vocabulary that lists such sites (e.g., SNOMED-CT).

6.3.4.46.1.11 <doseQuantity><low value='' unit=''/><high value='' unit=''/> </doseQuantity>

The dose is specified if the <doseQuantity> element. If a dose range is given (e.g., 125-250 mL/hr [i.e., to replace fluid losses]), then the <low> and <high> bounds are specified in their respective elements, otherwise both <low> and <high> have the same value. The unit attribute should be derived from the HL7 UnitsOfMeasureCaseSensitive vocabulary .

6.3.4.46.1.12 <low|high value=''> <translation> <originalText><reference value=''/></originalText> </translation></low|high >

Any <low> and <high> elements used for <doseQuantity> or <rateQuantity> should contain a <translation> element that provides a <reference> to the <originalText> found in the narrative body of the document .

6.3.4.46.1.13 <rateQuantity><low value='' unit=''/><high value='' unit=''/></rateQuantity>

The rate is specified in the <rateQuantity> element. The rate is given in units that have measure over time. In this case, the units should be specified as a string made up of a unit of measure (see doseQuantity above), followed by a slash (/), followed by a time unit (s, min, h or d) (i.e., mL/hr).

Again, if a range is given, then the <low> and <high> elements contain the lower and upper bound of the range, otherwise, they contain the same value.

6.3.4.46.1.14 <consumable>

The <consumable> element shall be present, and shall contain a <manufacturedProduct> entry conforming to the Product Entry template (see PCC TF-2: 6.3.4.19).

Add Section 6.3.4.47

6.3.4.47 Nursing Assessments Battery 1.3.6.1.4.1.19376.1.5.3.1.1.13.3.4

This entry describes a single row in the Nursing Assessment flowsheet. The single observation date/time and provider is applied to all other observations.

6.3.4.47.1 Specification

```
<entry>
  <organizer classCode='BATTERY' moodCode='EVN'>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.3.4'/>
    <id root=' ' extension=' '/>
    <code code='XX-ASSESS' displayName='Nursing Assessments Battery'
          codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <statusCode code='completed'/>
    <author>
       <time value=' '/>
       <assignedAuthor>
          <id root=' ' extension=' '/>
       </assignedAuthor>
    </author>
    <component>
       <observation classCode='OBS' moodCode='EVN'>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
         :
       </observation>
    </component>
    <component>
       <observation classCode='OBS' moodCode='EVN'>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
          :
       </observation>
    </component>
   :
  </organizer>
</entry>
```

6.3.4.47.1.1 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.3.4'/>

The <templateId> element specifies that this organizer entry conforms to the Nursing Interventions battery. The root attribute SHALL contain the value "1.3.6.1.4.1.19376.1.5.3.1.1.13.3.4"

6.3.4.47.1.2 <organizer classCode='BATTERY' moodCode='EVN'>

Each row in the Nursing Interventions battery SHALL be represented by an organizer with the classCode of 'BATTERY' and the moodCode of 'EVN'

6.3.4.47.1.3 <id root=' ' extension=' '/>

Each battery SHALL have a globally unique identifier.

6.3.4.47.1.4 <code code='X-ASSESS' codeSystem='2.16.840.1.113883.6.1'/>

The <code> element specifies the LOINC code that represents the content of the battery. The codeSystem attribute SHALL contain the value '2.16.840.1.113883.6.1'. The code attribute SHALL contain the value='X-ASSESS'. It is good practice to include displayName and codeSystemName for clarity and debugging. The corresponding values are 'Nursing Assessments battery' and 'LOINC' respectively.

6.3.4.47.1.5 <author/><time/><assignedAuthor><id/></assignedAuthor></author>

The <author> relation element points at the author that records the visit battery. This assignedAuthor may be different than the author of the document. The time element is used to record when the assigned author recorded the battery.

6.3.4.47.1.6 <statusCode code='completed'/>

The status code for all batteries SHALL be 'completed'

6.3.4.47.1.7 <component>

The battery is made of several component Simple Observations (see PCC TF-2: 6.3.4.20). The following table lists the allowable LOINC codes, displayNames, and observation types, and unit of measures for these observations.

LOINC Code	displayName	xsi:type	value set
9269-2	GLASGOW COMA CORE.TOTAL	CO	3..15
9268-4	GLASGOW COMA SCORE.MOTOR	CO	1..6
11454-6	LEVEL OF RESPONSIVENESS	CO	ALERT VERBAL RESPONSE PAINFUL RESPONSE UNRESPONSIVE
38208-5	PAIN SEVERITY	CO	0-10
48767-8	(COMMENT FIELD)	ED	

Add Section 6.3.4.48

6.3.4.48 Antenatal Testing and Surveillance Battery 1.3.6.1.4.1.19376.1.5.3.1.1.21.3.10

This entry describes a single row in the Antenatal Testing and Surveillance Section. The single observation date/time and provider is applied to all other observations.

6.3.4.48.1 Specification

```
<entry>
  <organizer classCode='BATTERY' moodCode='EVN'>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.3.10'/>
    <id root=' ' extension=' '/>
    <code code='XX-ANTENATALTESTINGBATTERY' displayName='ANTENATAL TESTING AND SURVEILLANCE
BATTERY'
          codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <statusCode code='completed'/>
    <author>
       <time value=' '/>
       <assignedAuthor>
          <id root=' ' extension=' '/>
       </assignedAuthor>
    </author>
    <component>
       <observation classCode='OBS' moodCode='EVN'>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
         :
       </observation>
    </component>
    <component>
       <observation classCode='OBS' moodCode='EVN'>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
          :
       </observation>
    </component>
   :
  </organizer>
</entry>
```

6.3.4.48.1.1 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.3.10'/>

The <templateId> element specifies that this organizer entry conforms to the Antenatal Testing and Surveillance Battery. The root attribute SHALL contain the value "1.3.6.1.4.1.19376.1.5.3.1.1.21.3.10"

6.3.4.48.1.2 <organizer classCode='BATTERY' moodCode='EVN'>

Each row in the Antenatal Testing and Surveillance Battery SHALL be represented by an organizer with the classCode of 'BATTERY' and the moodCode of 'EVN'

6.3.4.48.1.3 <id root=' ' extension=' '/>

Each battery SHALL have a globally unique identifier.

6.3.4.48.1.4 <code code='XX- XX-ANTENATALTESTINGBATTERY' codeSystem='2.16.840.1.113883.6.1'/>

The <code> element specifies the LOINC code that represents the content of the battery. The codeSystem attribute SHALL contain the value '2.16.840.1.113883.6.1'. The code attribute SHALL contain the value='XX-ANTENATALTESTINGBATTERY'. It is good practice to include displayName and codeSystemName for clarity and debugging. The corresponding values are 'ANTENATAL TESTING AND SURVEILLANCE BATTERY' and 'LOINC' respectively.

6.3.4.48.1.5 <author/><time/><assignedAuthor><id/></assignedAuthor></author>

The <author> relation element points at the author that records the visit battery. This assignedAuthor may be different than the author of the document. The time element is used to record when the assigned author recorded the battery.

6.3.4.48.1.6 <statusCode code='completed'/>

The status code for all batteries SHALL be 'completed'

6.3.4.48.1.7 <component>

The battery is made of several component Simple Observations (see PCC TF-2: 6.3.4.20). The following table lists the allowable LOINC codes, displayNames, and observation types, and unit of measures for these observations.

LOINC Code	displayName	xsi:type
11630-1	Biophysical profile.amniotic fluid volume	ED
11631-9	Biophysical profile.body movement	ED
11632-7	Biophysical profile.breathing movement	ED
11633-5	Biophysical profile.heart rate reactivity	ED
11635-0	Biophysical profile.tone	ED
11634-3	Biophysical profile.sum	ED
35096-7	**Ultrasound morphologic**	**ED**
49086-2	**Nuchal translucency screening**	**ED**
51659-1	**Hbs1 Antigen**	**ED**

Add Section 6.3.4.49

6.3.4.49 Immunization Recommendation

Defined in IHE PCC TF-2:6.3.4

Add Section 6.3.4.50

6.3.4.50 Alert Entry

Defined in IHE PCC TF-2:6.3.4

Add Section 6.3.4.51

6.3.4.51 Antigen Dose

Defined in IHE PCC TF-2:6.3.4

Add Section 6.3.4.52 (Occupation Observation – removed 2011-09 at the request of QRPH)

6.3.4.52 Intentionally blank

Add Section 6.3.4.53 (Industry Observation removed 2011-09 at the request of QRPH)

6.3.4.53 Intentionally blank

Add Section 6.3.4.54

6.3.4.54 Observation Request 1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1

The observation request entry is used to record goals, plans or intention for an observation to be performed (e.g., assessment, laboratory test, imaging study, et cetera).

6.3.4.54.1 Uses

See Templates using Observation Request.

6.3.4.54.2 Specification

```
<observation classCode='OBS' moodCode='INT|PRP|GOL'>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1'/>
  <templateId root=''2.16.840.1.113883.10.20.1.25'/>
  <id root='' extension=''/>
  <code code='' displayName='' codeSystem='' codeSystemName=''/>
  <!-- for CDA -->
  <text><reference value='#xxx'/></text>
  <!-- For HL7 Version 3 Messages
  <text>text</text>
  -->
  <statusCode code='active'/>
  <effectiveTime value=''/>
  <repeatNumber value=''/>
  <value xsi:type='' …/>
  <interpretationCode code='' codeSystem='' codeSystemName=''/>
  <methodCode code='' codeSystem='' codeSystemName=''/>
  <targetSiteCode code='' codeSystem='' codeSystemName=''/>
```



```
  <author typeCode='AUT'>
    <assignedAuthor typeCode='ASSIGNED'><id ... /></assignedAuthor> <!-- for CDA --
>
    <!-- For HL7 Version 3 Messages
    <assignedEntity typeCode='ASSIGNED'>
       <Person classCode='PSN'>
          <determinerCode root=''>
          <name>…</name>
       </Person>
    <assignedEntity>
     -->
  </author>
</observation>
```

Figure 6.3.4.54.2-1: Observation Request Example

6.3.4.54.2.1 <observation classCode='OBS' moodCode='INT|PRP|GOL'>

These acts are observations that form the care plan or which can be used in decision support. In intent mood (moodCode='INT') these are what is intended to be performed as part of the care plan. In proposal mood (moodCode='PRP'), these observations are being proposed, for example, as the output of a clinical decision support system. In goal mood (moodCode='GOL'), these observations described the intended goal of a treatment plan.

6.3.4.54.2.2 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1'/>

The <templateId> element identifies this <observation> as an observation request, allowing for validation of the content. The templateId must appear as shown above.

6.3.4.54.2.3 <templateId root=2.16.840.1.113883.10.20.1.25'/>

The IHE Observation Request template conforms to the Plan of care activity defined by the HL7 Continuity of Care Document. This template id must be present to indicate conformance.

6.3.4.54.2.4 <id root=' ' extension=' '/>

Each observation shall have an identifier.

6.3.4.54.2.5 <code code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>

Observations shall have a code describing what is to be measured. The code system used is determined by the vocabulary constraints on the types of measurements that might be recorded in a section. Modules that are derived from this one may restrict the code system and code values used for the observation.

6.3.4.54.2.6 <text><reference value='#xxx'/></text> -OR- <text>text</text>

Each observation request entry may contain a <text> element providing the free text that provides the same information as the observation within the narrative portion of the document with a <text> element. For CDA based uses of Observation Requests, this element SHALL be present, and SHALL contain a <reference> element that points to the related string in the

narrative portion of the document. For HL7 Version 3 based uses, the <text> element MAY be included.

6.3.4.54.2.7 <statusCode code='active'/>

The <statusCode> element shall be present and shall describe the current state of the observation. Goals, intents and proposals that are available for action shall have an 'active' status, but other status values are permitted.

6.3.4.54.2.8 <effectiveTime value=' '/>

The <effectiveTime> element shall be present in observation requests to indicate the date and time when the measurement should be taken.

6.3.4.54.2.9 <value xsi:type=' ' …/>

The value of the observation may be recorded using a data type appropriate to the observation to indicate the desired value (e.g., in GOL or PRP mood).

6.3.4.54.2.10 <methodCode code=' ' codeSystem=' ' codeSystemName=' '/>

The methodCode element may be used to record the specific method used to make an observation when this information is not already pre-coordinated with the observation code.

6.3.4.54.2.11 <targetSiteCode code=' ' codeSystem=' ' codeSystemName=' '/>

The targetSiteCode may be used to record the target site where the observation should be made when this information is not already pre-coordinated with the observation code.

6.3.4.54.2.12 <author><assignedAuthor classCode='ASSIGNED'>...<assignedAuthor></author>

In CDA uses, the observation request is assumed to be authored by the same author as the document through context conduction. However, observation requests would often be used to record orders, and in these cases, the author of the order shall be recorded in the author element.

For HL7 Version 3 purposes, the <author> element SHOULD be present unless it can be determined by conduction from organizers or higher level structures. When used for HL7 Version 3 the role element name is <assignedEntity> and the author is represented as <assignedPerson> element.

Add Section 6.3.4.55 (Added 2011-09 from QRPH EHCP profile)

6.3.4.55 Risk Indicators for Hearing Loss Entry 1.3.6.1.4.1.19376.1.7.3.1.1.15.5.1

This entry describes the Risk Indicators for Hearing Loss.

6.3.4.55.1 Specification

```
<entry>
  <organizer classCode='BATTERY' moodCode='EVN'>
    <templateId root='1.3.6.1.4.1.19376.1.7.3.1.1.15.5.1'/>
    <id root=' ' extension=' '/>
    <code code='58232-0’ displayName='Hearing Loss Risk
Indicators'
          codeSystem='2.16.840.1.113883.6.1'
codeSystemName='LOINC'/>
    <statusCode code='completed'/>
    <author>
       <time value=' '/>
       <assignedAuthor>
          <id root=' ' extension=' '/>
       </assignedAuthor>
    </author>
    <component>
       <observation classCode='OBS' moodCode='EVN'>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
          :
       </observation>
    </component>
    <component>
       <observation classCode='OBS' moodCode='EVN'>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
           :
       </observation>
    </component>
    :
  </organizer>
</entry>
```

Figure 6.3.4.55.1-1: Sample Risk Indicators for Hearing Loss Entry

6.3.4.55.2 <templateId root='1.3.6.1.4.1.19376.1.7.3.1.1.15.5.1'/>

The <templateId> element specifies that this organizer entry conforms to the Nursing Interventions battery. The root attribute SHALL contain the value '"1.3.6.1.4.1.19376.1.7.3.1.1.15.5.1”

6.3.4.55.3 <organizer classCode='BATTERY' moodCode='EVN'>

Each row in the Nursing Interventions battery SHALL be represented by an organizer with the classCode of 'BATTERY' and the moodCode of 'EVN'

6.3.4.55.4 <id root=' ' extension=' '/>

Each battery SHALL have a globally unique identifier.

6.3.4.55.5 <code code=’58232-0’ codeSystem='2.16.840.1.113883.6.1'/>

The <code> element specifies the LOINC® code that represents the content of the battery. The codeSystem attribute SHALL contain the value '2.16.840.1.113883.6.1'. The code attribute SHALL contain the value='58232-0’. It is good practice to include displayName and codeSystemName for clarity and debugging. The corresponding values are 'Hearing Loss Risk Indicators’ and 'LOINC®' respectively.

6.3.4.55.6 <author/><time/><assignedAuthor><id/></assignedAuthor></author>

The <author> relation element points at the author that records the visit battery. This assignedAuthor MAY be different than the author of the document. The time element is used to record when the assigned author recorded the battery.

6.3.4.55.7 <statusCode code='completed'/>

The status code for all batteries SHALL be 'completed'

6.4.4.55.8 <component>

The battery is made of several component Simple Observations. The observation values SHALL be constrained to those coded values and descriptions described by the JCIH-EHDI Risk Indicators for Hearing Loss (LOINC®) Value Set (1.3.6.1.4.1.19376.1.7.3.1.1.15.2.24).

Add Section 6.3.4.56. (Added 2011-09 from QRPH PRPH-Ca profile.)

6.3.4.56 Cancer Diagnosis Entry 1.3.6.1.4.1.19376.1.7.3.1.4.14.1

A Cancer Diagnosis entry collects details of the patient’s cancer diagnosis, including histology, behavior, primary site, laterality, diagnosis date, TNM Stage, and Best Method of Confirmation.

6.3.4.56.1 Parent Template

The parent of this templ**l**ate is Problem Concern Entry (1.3.6.1.4.1.19376.1.5.3.1.4.5.2).

6.3.4.56.2 Specification

```
<section>
       <templateId root="2.16.840.1.113883.10.20.1.11"/>
       <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.6"/>
  <templateId root="1.3.6.1.4.1.19376.1.7.3.1.3.14.1"/>
       <title>"Cancer Diagnosis"</title>
       <text>"Malignant melanoma of the left leg, Stage 1"</text>
       <entry>
              <act classCode='ACT' moodCode='EVN'>
              <templateId root='2.16.840.1.113883.10.20.1.27'/>
              <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.5.2'/>
              <code nullFlavor='NA'/>
              <statusCode code='active'/>
              <effectiveTime>
                     <low value='20110101'/>
                     <high nullFlavor="NA" />
              </effectiveTime>
              <entryRelationship typeCode="SUBJ" inversionInd="false" >
                     <observation classCode='OBS' moodCode='EVN' negationInd="false">
                     <templateId root='2.16.840.1.113883.10.20.1.28'/>
                     <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.5'/>
                     <templateId root="1.3.6.1.4.1.19376.1.7.3.1.4.14.1"/>
                     <code code="282291009" codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT" displayName="Diagnosis"/>
                     <text><reference value="" ></reference></text>
                     <statusCode code="completed"/>
                     <effectiveTime>
                            <low value="20110101"/>
                            <high nullFlavor="NI"/>
                     </effectiveTime>
<!--The <value> is the condition that was found.-->
                     <value xsi:type="CD" code="8742" codeSystem="2.16.840.1.113883.3.520.3.2"
codeSystemName="NAACCR Histologic Type" displayName="Lentigo Maligna" >

<!--Behavior Qualifier-->
                                   <qualifier>
                                   <name code="31206-6" codeSystem="2.16.840.1.113883.6.1"
codeSystemName="LOINC" displayName="Behavior ICD-O-3"/>
                                   <value code="2" codeSystem="2.16.840.1.113883.3.520.3.14"
codeSystemName="NAACCR Behavior Code" displayName="In Situ"/>
                                   </qualifier>
                                   <qualifier>

<!--Best Method of Diagnosis Qualifier-->
                                   <name code="21861-0" codeSystem="2.16.840.1.113883.6.1"
codeSystemName="LOINC" displayName="Diagnostic Confirmation"/>
                                   <value xsi:type="CD" code="2"
codeSystem="2.16.840.1.113883.3.520.3.3" codeSystemName="NAACCR Diagnostic Confirmation"
displayName="Positive cytology, no positive histology"/>
                                   </qualifier>
                            </value>

<!--Primary Site -->
                            <targetSiteCode code="C447" codeSystem="2.16.840.1.113883.6.43.1"
codeSystemName="ICD-O-3 (Topography Section)" displayName="Leg">

<!--Laterality-->
                                   <qualifier>
                                   <name code="20228-3" codeSystem="2.16.840.1.113883.6.1"
codeSystemName="LOINC" displayName="Anatomic part Laterality"/>
                                   <value code="1" codeSystem="2.16.840.1.113883.3.520.3.1"
codeSystemName="NAACCR Laterality at Diagnosis" displayName="origin of primary: right"/>
                                   </qualifier>
                            </targetSiteCode>
                            <entryRelationship typeCode="SUBJ" inversionInd="true">
<!--TNM Stage Information-->
```



```
                                    <observation classCode="OBS" moodCode="EVN">
                                        <templateId
root="1.3.6.1.4.1.19376.1.7.3.1.4.14.2"/>
                                        <code code="21908-9" displayName="TNM Clinical Stage
Group" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
<!-- Narrative TNM Clinical Stage -->
                                        <text> Stage 0 TisN0M0 </text>
                                        <statusCode code="completed"/>
                                        <value xsi:type="CD" code="0"
codeSystem="2.16.840.1.113883.3.520.3.9" codeSystemName="NAACCR TNM Clinical Stage Group"
displayName="In Situ">
                                        <qualifier>

<!--TNM Clinical Stage Descriptor Observation -->
                                            <name code="21909-7" displayName="TNM
Clinical Stage Descriptor" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
                                            <value xsi:type="CD" code="0"
codeSystem="2.16.840.1.113883.3.520.3.10" codeSystemName="NAACCR TNM Clinical Stage Descriptor"
displayName="None"/>
                                        </qualifier>
<!--AJCC TNM Edition Number.-->
                                        <qualifier>
                                            <name code="21917-0" displayName="TNM
Edition Number" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
                                            <value xsi:type="CD" code="7"
codeSystem="2.16.840.1.113883.3.520.3.5" codeSystemName="NAACCR TNM Edition Number"
displayName="7th Edition"/>
                                        </qualifier>
                                    </value>
                                    <participant typeCode="PPRF">
                                        <participantRole>
                                        <code code="21910-5"
codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Stager.clinical Cancer"/>
                                            <playingEntity nullFlavor="NA">
                                            <code xsi:type="CE" code="1"
codeSystem="2.16.840.1.113883.3.520.3.4" codeSystemName="TNM Clinical Staged By"
displayName="Managing Physician"/>
                                            </playingEntity>
                                        </participantRole>
                                    </participant>
                                    <entryRelationship typeCode="COMP">

<!-- 6.3.4.62 TNM Clinical Tumor Observation-->
                                        <observation classCode="OBS" moodCode="EVN">
                                        <templateId root="1.3.6.1.4.1.19376.1.5.3.1.4.13"/>
                                        <code code="21905-5" displayName="TNM Clinical T"
codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
                                        <statusCode code="completed"/>
                                        <value xsi:type="CD" code="Tis"
codeSystem="2.16.840.1.113883.3.520.3.6" codeSystemName="NAACCR TNM Clinical Tumor"
displayName="In Situ"/>
                                        </observation>
                                    </entryRelationship>

<!--6.3.4.63 TNM Clinical Nodes Observation -->
                                    <entryRelationship typeCode="COMP">
                                        <observation classCode="OBS" moodCode="EVN">
                                        <templateId root="1.3.6.1.4.1.19376.1.5.3.1.4.13"/>
                                        <code code="21906-3" displayName="TNM Clinical N"
codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
                                        <statusCode code="completed"/>
                                        <value xsi:type="CD" code="N0"
codeSystem="2.16.840.1.113883.3.520.3.7" codeSystemName="NAACCR TNM Clinical Nodes"
displayName="None"/>
                                        </observation>
                                    </entryRelationship>
```



```
<!--6.3.4.64 TNM Clinical Metastases Observation-->
                                        <entryRelationship typeCode="COMP">
                                                <observation classCode="OBS" moodCode="EVN">
                                                <templateId root="1.3.6.1.4.1.19376.1.5.3.1.4.13"/>
                <code code="21907-1" displayName="TNM Clinical M"
codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
                                                <statusCode code="completed"/>
                                                <value xsi:type="CD"
codeSystem="2.16.840.1.113883.3.520.3.8" codeSystemName="NAACCR TNM Clinical Metastases"
code="M0" displayName="None"/>
                                                </observation>
                                        </entryRelationship>
                                </observation>
                        </entryRelationship>
                </observation>
        </entryRelationship>
  </act>
</entry>
</section>
```

Figure 6.3.4.56.2-1: Sample Cancer Diagnosis Entry

6.3.4.56.3 <act classCode='ACT' moodCode='EVN'>

All concerns reflect the act of recording (<act classCode='ACT'>) the event (moodCode='EVN') of being concerned about a problem, allergy or other issue about the patient condition.

6.3.4.56.4 <templateId root='2.16.840.1.113883.10.20.1.27'/> <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.5.2/>

These template identifiers indicates this entry conforms to the concern content module. This content module inherits constraints from the HL7 CCD Template for problem acts, and so also includes that template identifier.

6.3.4.56.5 <!-- 1..* entry relationships identifying problems of concern --><entryRelationship type='SUBJ'><observation classCode='OBS' moodCode='EVN'><templateIDroot='1.3.6.1.4.1.19376.1.5.3.1.4.5'/>…</observation>

This entry shall contain one or more problem entries that conform to the Problem Entry template 1.3.6.1.4.1.19376.1.5.3.1.4.5. The typeCode SHALL be “SUBJ” and inversionInd SHALL be “false”.

6.3.4.56.6 <observation classCode="OBS" moodCode="EVN">

The <observation> classCode and moodCode SHALL be recorded as shown above.

6.3.4.56.7 <templateId root=’1.3.6.1.4.1.19376.1.5.3.1.4.5'/> <templateId root='1.3.6.1.4.1.19376.1.7.3.1.4.14.1'/>

These <templateId> elements identify this <entry> as a cancer diagnosis entry and its parent, Problem Entry, allowing for validation of the content. The <templateId> elements shall be recorded as shown above.

6.3.4.56.8 <code code="282291009" codeSystem=" 2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Diagnosis"/>

The <code> element indicates that this is the Diagnosis information. This code SHALL be the SNOMED CT code “282291009” for “Diagnosis”. It is good style to include the displayName and codeSystemName to help debugging.

6.3.4.56.9 <statusCode code='completed'/>

The status code for all Cancer Diagnosis Entries SHALL be ‘completed’.

6.3.4.56.10 <effectiveTime value="xxx"/>

This element records the date of initial diagnosis by a recognized medical practitioner for the cancer being reported.

6.3.4.56.11 <value xsi:type='CD' code=' ' codeSystem=' ' codeSystemName=' ' displayName=' '>

The <value> records the Histologic Type, which is the cell type of the tumor/cancer (e.g., carcinoma, melanoma, sarcoma, lymphoma, leukemia). This element is required. It is always represented using the CD datatype (xsi:type='CD'), even though the value may be a coded or uncoded string. If coded, it SHALL follow the appropriate realm constraints for vocabulary. (See Volume 4 in the QRPH PRPH-Ca profile found at http://www.ihe.net.)

6.3.4.56.12 <qualifier><name code="31206-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName=" Behavior ICD-O-3 Cancer"/><value code="" codeSystem="" codeSystemName=" " displayName=" "/> </qualifier>

This <qualifier> provides Behavior information, indicating whether the tumor is benign, in situ, malignant or metastatic. The code and codeSystem attributes SHALL be recorded exactly as shown above. If coded, it SHALL follow the appropriate realm constraints for vocabulary. (See Volume 4 in the QRPH PRPH-Ca profile found at http://www.ihe.net.)

6.3.4.56.13 <qualifier><name code="21861-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Dx confirmed by Cancer"/><value xsi:type="CD" code="" codeSystem="" codeSystemName=" " displayName=" "/></qualifier>

This <qualifier> provides Best Method of Diagnosis information, indicating the best method used to confirm the presence of the cancer being reported. The code and codeSystem attributes SHALL be recorded exactly as shown above. The <value> records the best method of diagnosis, and if coded, it SHALL follow the appropriate realm constraints for vocabulary. (See Volume 4 in the QRPH PRPH-Ca profile found at http://www.ihe.net.)

6.3.4.56.14 <targetSiteCode code=" " codeSystem="" codeSystemName=" " displayName=" ">

The <targetSiteCode> element SHALL be present and shall indicate the anatomic location where the primary tumor originated. Vocabulary used SHALL follow the appropriate realm constraints. (See Volume 4 in the QRPH PRPH-Ca profile found at http://www.ihe.net.)

6.3.4.56.15 <qualifier><name code="20228-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Anatomic part Laterality"/> <value code="" codeSystem="" codeSystemName=" " displayName=" "/></qualifier>

This <qualifier> provides the laterality, which indicates the side of a paired organ or side of the body on which the reportable tumor originated. The code and codeSystem attributes SHALL be recorded exactly as shown above. The <value> records the laterality, if coded, it SHALL follow the appropriate realm constraints for vocabulary. (See Volume 4 in the QRPH PRPH-Ca profile found at http://www.ihe.net.)

6.3.4.56.16 <entryRelationship typeCode="SUBJ" inversionInd="false">

One <entryRelationship> element should be present providing information on the TNM Clinical Stage.

When present, this <entryRelationship> element SHALL contain an observation conforming to the TNM Stage Information (1.3.6.1.4.1.19376.1.7.3.1.4.14.2) template. The typeCode SHALL be “SUBJ” and inversionInd SHALL be “false”.

6.3.4.56.17 <observation classCode="OBS" moodCode="EVN"> <templateId root="1.3.6.1.4.1.19376.1.7.3.1.4.14.2"/> [1st nesting]

Observations that describe the TNM Stage Information SHALL be included if known.

6.3.4.56.18 <code code="xxxxx-x" displayName="TNM Clinical Stage Information" codeSystem="2.16.840.1.113883.6.1"codeSystemName="LOINC"/> [1st nesting]

The <code> element indicates that this observation is the TNM Clinical Stage Information. This code SHALL be the LOINC code xxxxx-x. It is good style to include the displayName and codeSystemName to help debugging.

6.3.4.56.19 <statusCode code="completed"/> [1st nesting]

The status code for all TNM Clinical Stage Information observations SHALL be ‘completed’.

6.3.4.56.20 <value xsi:type="CD" code="" codeSystem="" codeSystemName="" displayName=" "> [1st nesting]

The <value> records the TNM Clinical Stage Group, which is a detailed site-specific code for the clinical stage group as defined by AJCC and recorded by the physician. This element is required. It is always represented using the CD datatype (xsi:type='CD'), even though the value

may be a coded or uncoded string. If coded, it SHALL follow the appropriate realm constraints for vocabulary. (See Volume 4 in the QRPH PRPH-Ca profile found at http://www.ihe.net.)

6.3.4.56.21 <qualifier><name code="21909-7" displayName=" Descriptor.clinical Cancer" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/> <value xsi:type="CD" code="" codeSystem="" codeSystemName=" " displayName=" "/></qualifier> [1st nesting]

This <qualifier> provides TNM Clinical Stage Descriptor information, indicating The AJCC clinical stage prefix/suffix recorded by the physician. AJCC stage descriptors identify special cases that require separate analysis. The code and codeSystem attributes SHALL be recorded exactly as shown above. The <value> records the TNM Clinical Stage Descriptor, and if coded, it SHALL follow the appropriate realm constraints for vocabulary. (See Volume 4 in the QRPH PRPH-Ca profile found at http://www.ihe.net.)

6.3.4.56.22 <qualifier><name code="21917-0" displayName="Version TNM Classification" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/><value xsi:type="CD" code="" codeSystem="" codeSystemName=" " displayName=""/></qualifier> [1st nesting]

This <qualifier> provides TNM Edition Number information, indicating the edition number of the AJCC Staging Manual. The code and codeSystem attributes of <name> SHALL be recorded exactly as shown above. If coded, it SHALL follow the appropriate realm constraints for vocabulary. (See Volume 4 in the QRPH PRPH-Ca profile found at http://www.ihe.net.)

6.3.4.56.23 <participant typeCode="PPRF"> <participantRole> <code code="21910-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Stager.clinical Cancer"/><playingEntity nullFlavor="NA"> <code xsi:type="CE" code="" codeSystem="" codeSystemName=" " displayName=" "/> [1st nesting]

This <participant> element should specify the person who recorded the AJCC staging elements and stage group in the patient's medical record. The code and codeSystem attributes for <participantRole> SHALL be recorded exactly as shown above. The <code> attribute of <playingEntity> identifies the person who recorded the staging elements, and SHALL follow the appropriate realm constraints for vocabulary. (See Volume 4 in the QRPH PRPH-Ca profile found at http://www.ihe.net.)

6.3.4.56.24 <!-- 0..3 entryRelationships identifying simple observations for TNM Clinic Tumor, TNM Clinical Nodes, and TNM Clinical Metastases--><entryRelationship typeCode="COMP" inversionInd="false"><observation classCode='OBS'moodCode='EVN'><templateIDroot='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>…</observation>[2nd nesting]

Each <entryRelationship> element should contain a simple observation that specifies the TNM Clinic Tumor, TNM Clinical Nodes, and TNM Clinical Metastases, each of which is a

component of the TNM Stage Group. Simple observations that describe the TNM Clinic Tumor, TNM Clinical Nodes, and TNM Clinical Metastases SHALL be included if known and inversionInd SHALL be “false”.

6.3.4.56.25 <code code="" displayName=" " codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/> [2nd nesting]

Observations SHALL include one of following LOINC values to indicate the component of TNM Stage Group represented in the Observation.

LOINC Code	Display Name	Description
21905-5	TNM Clinical T	A detailed site-specific code for the clinical tumor (T) as defined by AJCC and recorded by the physician.
21906-3	TNM Clinical N	A detailed site-specific code for the clinical nodes (N) as defined by AJCC and recorded by the physician.
21907-1	TNM Clinical M	A detailed site-specific staging code for the clinical metastases (M) as defined by AJCC and recorded by the physician.

6.3.4.56.26 <value xsi:type="CD" code="" codeSystem="" codeSystemName=" " displayName=" "/>

The <value> of the observation SHALL be recorded using the vocabulary appropriate to the coded observation according to the table above and SHALL follow the appropriate realm constraints for vocabulary. (See Volume 4 in the QRPH PRPH-Ca profile found at http://www.ihe.net.)

6.3.4.57 Patient Transfer 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1

The Patient Transfer entry shall record the transfer of the patient to an internal department or external entity such as a different hospital or skilled nursing facility.

6.3.4.57.1 Parent Template

The parent of this template is Problem Concern Entry (1.3.6.1.4.1.19376.1.5.3.1.4.5.2).

6.3.4.57.2 Specification

```
  <act classCode='ACT' moodCode='EVN'>
  <templateId root='PatientTransferAct'/>
  <id/>
  <!-- code is fixed -->
  <code code='107724000' displayName='patient transfer' codeSystem='2.16.840.1.113883.6.96'/>
  <effectiveTime value=''/>
  <participant typeCode='DST'>
    <templateId root='destinationLocation'/>
   <participantRole classCode='SDLOC'>
      <id/>
      <code/>
      <addr/>
      <telecom/>
      <playingEntity classCode='ENT'>
        <name/>
      </playingEntity>
    </participantRole>
  </participant>
</act>
```

Figure 6.3.4.57.2-1: Sample Cancer Diagnosis Entry

6.3.4.57.3 <act classCode='ACT' moodCode='INT|EVN'>

The transfer is recorded in an act element, to describe a patient transfer. In intent mood (moodCode='INT'), this records the expected transfer of the patient. In event mood (moodCode='EVN'), this records the actual transfer.

6.3.4.57.4 <templateId root='TBD'/>

The templateId indicates that this transfer entry conforms to the constraints of this content module.

6.3.4.57.5 <id root='' extension=''/>

This required element shall contain an identifier.

6.3.4.57.6 <code code='' displayName='' codeSystem='' codeSystemName='' />

The code shall be code='107724000' displayName='patient transfer' codeSystem='2.16.840.1.113883.6.96'/>

6.3.4.57.7 <text><reference value='#xxx'/></text>

The <text> element shall contain a reference to the narrative text describing the transfer of the patient.

6.3.4.57.8 statusCode

<statusCode code='normal|completed'/> When the transfer act has occurred (moodCode='EVN'), the statusCode element shall be present, and shall contain the value 'completed'. When the transfer act is intended (moodCode='EVN') the statusCode element shall contain the value 'normal'.

6.3.4.57.9 <effectiveTime><low value="/><high value="/><effectiveTime/>

When the transfer has occurred, this element shall be sent, and indicates the effective time for the transfer. This element may be sent to record when the transfer act is intended to occur. The <low> element records the time at which the transfer process was started. The <high> value records the time at which the transfer was completed.

6.3.4.57.10 participant

The <participant> element encodes the destination with a typeCode of DST

<participant typeCode='DST'>

6.3.4.57.11 templateId

The template id identifies the facility or department which is the transfer destination.

<templateId root='destinationLocation'/>

6.3.457.12 participantRole

The participant role is fixed to <participantRole classCode='SDLOC'>

6.3.4.57.13 <id root=" extension="/>

The <id> element shall be sent when the transfer has occurred, and identifies the performer of the act.

6.3.4.57.14 <code>

The code shall indicate the type of healthcare service location for the transfer destination.

6.3.4.57.15 <addr></addr>

The <addr> element may be sent to provide a contact postal address for the performer of the disposition.

6.3.4.57.16 <telecom>

The <telecom> element may be sent to provide a contact postal address for the performer of the disposition.

6.3.4.57.17 playingEntity

The playing entity classCode shall be ENT <playingEntity classCode='ENT'>

6.3.4.57.18 name

The name element of the playing entity shall record the name of the facility or departmental destination.

Add section 6.3.4.58 (added 2013-09 from the QRPH VRDR supplement.)

6.3.4.58 Death Pronouncement Entry Content Module (1.3.6.1.4.1.19376.1.7.3.1.4.23.1)

[observation: templateId 1.3.6.1.4.1.19376.1.7.3.1.4.23.1]

The template contains information on the pronouncement of death on the death certificate.

1. **SHALL** contain exactly one [1..1] **@classCode**
2. **SHALL** contain exactly one [1..1] **@moodCode**
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:7136) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.2" (CONF:9138) SHALL contain exactly one [1..1] code/@code="58325-2" Provider witnessed decedent's death (CodeSystem: 2.16.840.1.113883.6.1 LOINC).
4. **SHALL** contain zero or one [1..1] **effectiveTime**

Provide the date and time at which the decedent was pronounced dead. The first id represents this specific globally unique result observation.

5. **SHALL** contain exactly one [1..1] **performer**
    a. This performer **SHALL** contain exactly one [1..1] **@typeCode**="PRF"
    b. This performer **SHALL** contain exactly one [1..1] **assignedEntity**
    c. This assignedEntity **SHALL** contain exactly one [1..1] **@classCode**="ASSIGNED"
    d. This assignedEntity **SHALL** contain exactly one [1..1] **addr**

    The postal address used to locate the clinician or pronouncing the death at the time of death certification.
6. This assignedEntity **SHALL** contain exactly one [1..1] assignedPerson
    a. This assignedPerson **SHALL** contain exactly one [1..1] **@classCode**="PSN"
    b. This assignedPerson **SHALL** contain exactly one [1..1] **determinerCode**="INSTANCE"
    c. This assignedPerson **SHALL** contain exactly one [1..1] **ID**

    This field shall contain the License Number of Person Pronouncing Death
    d. This assignedPerson **SHALL** contain exactly one [1..1] **name**

    This field is valued with the person who pronounced the death. The full name of the pronouncer is required.

```
<entry>
  <observation classCode=”OBS” moodCode=”EVN”>
     <templateId root="1.3.6.1.4.1.19376.1.7.3.1.4.23.1"/>
     <id root=""/>
     <code code="58325-2" codeSystem="2.16.840.1.113883.6.1"
     codeSystemName="LOINC" displayName=" Provider witnessed decedent's death "/>
     <effectiveTime>
     <low value="201311141201"/>
```



```
      <high value="201311141201"/>
      </effectiveTime>
    </observation>
  </entry>
```

Figure 6.3.4.58-1: Death Pronouncement Entry Content Module example

Add section 6.3.4.59 (added 2013-09 from the QRPH VRDR supplement.)

6.3.4.59 Death Location Type Entry Content Module

[Observation: templateId 1.3.6.1.4.1.19376.1.7.3.1.4.23.2]

This template makes it possible to record the type of location (e.g., hospital inpatient room) at which the person died.

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass)
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: 2.16.840.1.113883.5.1001 HL7ActMood)
3. **SHALL** contain exactly one [1..1] **code/@code**=" 58332-8" (CodeSystem: 2.16.840.1.113883.6.1 LOINC)
4. **SHALL** contain exactly one [1..1] **value**, which **SHALL** be selected from ValueSet
5. Death Location Type Codes (1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4) STATIC, where its data type is CE
6. A code value to indicate the type of location where the patient died.

```
<observation xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xmlns="urn:hl7-org:v3" xsi:schemaLocation="urn:hl7-org:v3 CDA.xsd"
classCode="OBS" moodCode="EVN">
<id root="1536492804"/>
<code code="58332-8" codeSystem="2.16.840.1.113883.6.1"
codeSystemName="LOINC"/>
<effectiveTime>
<low value="2012"/>
<high value="2012"/>
</effectiveTime>
<value xsi:type="CE" code="Value"/>
</observation>
```

Figure 6.3.4.59-1: Death Location Type Entry Content Module example

Add section 6.3.4.60 (added 2013-09 from the QRPH HW supplement.).

Table 6.3.4.60-1: Occupational Data For Health Organizer Entry 1.3.6.1.4.1.19376.1.5.3.1.4.20

Template Name	Occupational Data For Health Organizer		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.20		
Parent Template			
General Description	This organizer holds information about a person's occupation. It organizes the employment status, usual occupation and usual industry along with durations, and history of occupation information (which includes occupation and employer with industry, and work hours and workshift) into a standard structure.		
Class/Mood	**Code**	**Data Type**	**Value**
ClassCode= "CLUSTER" MoodCode= "EVN"	Code = LOINC-1 Display Name = Occupational Data for Health CodeSystem = 2.16.840.1.113883.6.1 CodeSystemName=LOINC	Organizer	

6.3.4.60 Occupational Data For Health Organizer

`[organizer: templateId` 1.3.6.1.4.1.19376.1.5.3.1.4.20 `(open)]`

An Occupational Data for Health Organizer is a clinical statement about the subject's employment status, usual occupation and history of occupations.

1. **SHALL** contain exactly one [1..1] **`@classCode`**`="CLUSTER"` CLUSTER (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass).
2. **SHALL** contain exactly one [1..1] **`@moodCode`**`="EVN"` Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001`).
3. **SHALL** contain exactly one [1..1] **`templateId`** such that it
   a. **SHALL** contain exactly one [1..1] **`@root`**`="` 1.3.6.1.4.1.19376.1.5.3.1.4.20`".`
4. **SHALL** contain at least one [1..*] **`id`**.
   a. The first id represents this specific globally unique occupational data for health organizer.
5. **SHALL** contain exactly one [1..1] **`code`**.
   a. **SHALL** be LOINC-1 (Occupational Data for Health) from LOINC (codeSystem 2.16.840.1.113883.6.1).
6. **SHALL** contain exactly one [1..1] **`statusCode`**`="completed"` Completed (CodeSystem: `ActStatus 2.16.840.1.113883.5.14`).
7. **SHALL** contain exactly one [1..1] **`effectiveTime`**.

a. Where EffectiveTime/low SHALL represent the earliest point in time for any occupation data in the organizer.
b. Where effectiveTime/high SHALL represent the latest point in time for any occupation data in the organizer, consequently the last point in time when information in the organizer was updated.

8. **SHOULD** contain zero or one [0..1] **component**.
   a. The component/@typeCode **SHALL** be "COMP".
   b. The sequenceNumber **SHALL** be 1.
   c. **SHALL** contain exactly one [1..1] **Employment Status Organizer** (1.3.6.1.4.1.19376.1.5.3.1.4.20.1).
9. **SHOULD** contain zero or one [0..1] **component**.
   a. The component/@typeCode **SHALL** be "COMP".
   b. The sequenceNumber **SHALL** be 2.
   c. **SHALL** contain exactly one [1..1] **Usual Occupation and Industry Organizer** (1.3.6.1.4.1.19376.1.5.3.1.4.20.2).
10. **MAY** contain zero or one [0..1] **component**.
    a. The component/@typeCode **SHALL** be "COMP".
    b. The sequenceNumber **SHALL** be 3.
    c. **SHALL** contain exactly one [1..1] **History of Occupation and Industry Organizer** (1.3.6.1.4.1.19376.1.5.3.1.4.20.3).

Add section 6.3.4.61 Employment Status Organizer (added 2013-09 from the QRPH HW supplement.).

Table 6.3.4.61-1: Employment Status Organizer Entry 1.3.6.1.4.1.19376.1.5.3.1.4.20.1

Template Name	Employment Status Organizer		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.20.1		
Parent Template			
General Description	This organizer holds information about a person's employment status over time. It may hold current as well as prior employment status entries.		
Class/Mood	**Code**	**Data Type**	**Value**
ClassCode= "CLUSTER" MoodCode= "EVN"	Code = LOINC-2 Display Name = History of Employment Status CodeSystem = 2.16.840.1.113883.6.1 CodeSystemName=LOINC	Organizer	

6.3.461 Employment Status Organizer

`[organizer: templateId` 1.3.6.1.4.1.19376.1.5.3.1.4.20.1 `(open)]`

An Employment Status Organizer holds clinical statements about the subject's employment status over time.

1. **SHALL** contain exactly one [1..1] **`@classCode`**`="CLUSTER"` CLUSTER (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass).
2. **SHALL** contain exactly one [1..1] **`@moodCode`**`="EVN"` Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001`).
3. **SHALL** contain exactly one [1..1] **`templateId`** such that it
   a. **SHALL** contain exactly one [1..1] **`@root`**`="` 1.3.6.1.4.1.19376.1.5.3.1.4.20.1`".`
4. **SHALL** contain at least one [1..*] **`id`**.
   a. The first id represents this specific globally unique employment status organizer.
5. **SHALL** contain exactly one [1..1] **`code`**.
   a. **SHALL** be LOINC-2 (History of Employment Status) from LOINC (codeSystem 2.16.840.1.113883.6.1).
6. **SHALL** contain exactly one [1..1] **`statusCode`**`="completed"` Completed (CodeSystem: `ActStatus 2.16.840.1.113883.5.14`).
7. **SHALL** contain exactly one [1..1] **`effectiveTime`**.
   a. Where EffectiveTime/low SHALL represent the earliest point in time for any data in the organizer.
   b. Where effectiveTime/high SHALL represent the latest point in time for any data in the organizer, consequently the last point in time when information in the organizer was updated.
8. **SHALL** contain one or more [1..*] **`component`**.
   a. The component/@typeCode **SHALL** be "COMP".
   b. **SHALL** contain exactly one [1..1] Employment Status Observation `(1.3.6.1.4.1.19376.1.5.3.1.4.20.4)`.

Add section 6.3.4.62 Usual Occupation and Industry Organizer (added 2013-09 from the QRPH HW supplement.).

Table 6.3.4.62-1: Usual Occupation and Industry Organizer Entry 1.3.6.1.4.1.19376.1.5.3.1.4.20.2

Template Name	Usual Occupation and Industry Organizer
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.20.2
Parent Template	
General Description	This organizer holds information about a person's usual occupation, usual industry and the

	durations associated with each. A person's usual occupation is the occupation they have held for the longest combined duration of time over the person's history of employment. The usual industry is the industry where they have been employed for the longest combined duration of time over the person's history of employment. This organizer may hold current as well as prior observations about their usual occupation and usual industry.		
Class/Mood	**Code**	**Data Type**	**Value**
ClassCode= "CLUSTER" MoodCode= "EVN"	Code = LOINC-3 Display Name = History of Usual Occupation and Usual Industry CodeSystem = 2.16.840.1.113883.6.1 CodeSystemName=LOINC	Organizer	

6.3.4.62 Usual Occupation and Industry Organizer

`[organizer: templateId` 1.3.6.1.4.1.19376.1.5.3.1.4.20.2 `(open)]`

A Usual Occupation Organizer holds clinical statements about the subject's usual occupation and usual industry.

1. **SHALL** contain exactly one [1..1] **`@classCode`**="CLUSTER" CLUSTER `(CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass)`.
2. **SHALL** contain exactly one [1..1] **`@moodCode`**="EVN" Event `(CodeSystem: ActMood 2.16.840.1.113883.5.1001)`.
3. **SHALL** contain exactly one [1..1] **`templateId`** such that it
   a. **SHALL** contain exactly one [1..1] **`@root`**="1.3.6.1.4.1.19376.1.5.3.1.4.20.2".
4. **SHALL** contain at least one [1..*] **`id`**.
5. **SHALL** contain exactly one [1..1] **`code`**.
   a. **SHALL** be LOINC-3 (History of Usual Occupation) from LOINC.
6. **SHALL** contain exactly one [1..1] **`statusCode`**="completed" `(CodeSystem: ActStatus 2.16.840.1.113883.5.14)`.
7. **SHALL** contain exactly one [1..1] **`effectiveTime`**.
   a. Where EffectiveTime/low SHALL represent the earliest point in time for any data in the organizer.
   b. Where effectiveTime/high SHALL represent the latest point in time for any data in the organizer, consequently the last point in time when information in the organizer was updated.
8. **SHALL** contain one or more [1..*] **`component`**.
   a. The component/@typeCode **SHALL** be "COMP".
   b. **SHALL** contain exactly one or more [1..*] Usual Occupation and Industry Observation `(1.3.6.1.4.1.19376.1.5.3.1.4.20.5)`.

Add section 6.3.4.63 History of Occupation Organizer (added 2013-09 from the QRPH HW supplement.).

Table 6.3.4.63-1: History of Occupation Organizer Entry 1.3.6.1.4.1.19376.1.5.3.1.4.20.3

Template Name	History of Occupation Organizer
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.20.3
Parent Template	
General Description	This organizer holds information about a person's various specific occupations over time. It may hold current as well as prior observations about occupations which may include details about the employer and places where work was performed. A person's occupation also includes industry information which is used to more precisely specify the occupation.

Class/Mood	Code	Data Type	Value
ClassCode= "CLUSTER" MoodCode= "EVN"	Code = LOINC-6 Display Name = History of Usual Occupation CodeSystem = 2.16.840.1.113883.6.1 CodeSystemName=LOINC	Organizer	

Opt and Card	entryRelationship	Description	Template ID	Specification Document	Vocabulary Constraint

6.3.4.63 History of Occupation Organizer

`[organizer: templateId 1.3.6.1.4.1.19376.1.5.3.1.4.20.3 (open)]`

A History of Occupation Organizer holds clinical statements about the subject's specific occupations over time.

1. **SHALL** contain exactly one [1..1] **`@classCode`**="`CLUSTER`" CLUSTER (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass).
2. **SHALL** contain exactly one [1..1] **`@moodCode`**="`EVN`" Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001`).
3. **SHALL** contain exactly one [1..1] **`templateId`** such that it
   a. **SHALL** contain exactly one [1..1] **`@root`**=" 1.3.6.1.4.1.19376.1.5.3.1.4.20.3".
4. **SHALL** contain at least one [1..*] **`id`**.
   a. The first id represents this specific globally unique History of Occupation organizer.
5. **SHALL** contain exactly one [1..1] **`code`**.
   a. **SHALL** be LOINC-6 (History of Occupation) from LOINC.

6. **SHALL** contain exactly one [1..1] **statusCode**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14).
7. **SHALL** contain exactly one [1..1] **effectiveTime**.
    a. represents the point in time that the most recent Occupation Observation component entry was added.
8. **SHALL** contain one or more [1..*] **component**.
    a. The component/@typeCode **SHALL** be "COMP".
    b. **SHALL** contain exactly one [1..1] Occupation Observation (1.3.6.1.4.1.19376.1.5.3.1.4.20.6).

Add section 6.3.4.64 Employment Status Observation Entry (added 2013-09 from the QRPH HW supplement.).

Table 6.3.4.64-1: Employment Status Observation Entry 1.3.6.1.4.1.19376.1.5.3.1.4.20.4

Template Name	Employment Status Observation Entry
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.20.4
Parent Template	
General Description	An employment status observation entry is a clinical statement about a person's employment status at a point in time. An employment status observation recorded two years ago represents the person's employment status at that time. An employment status observation recorded today represents the person's employment status at this more current point in time.

Class/Mood	Code	Data Type	Value
ClassCode= "OBS" MoodCode= "EVN"	Code = LOINC-2 Display Name = History of Employment Status CodeSystem = 2.16.840.1.113883.6.1 CodeSystemName=LOINC Should this be LOINC or SNOMED CT?	Observation	Value datatype=CD From Value Set PHVS_EmploymentStatus_ODH 2.16.840.1.114222.4.11.7129

Opt and Card	entryRelationship	Description	Template ID	Specification Document	Vocabulary Constraint

6.3.4.64 Employment Status Observation

[observation: templateId 1.3.6.1.4.1.19376.1.5.3.1.4.20.4 (open)]

An Employment Status Entry is a clinical statement about the subject's employment status at the point in time the statement is recorded.

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001).
3. **SHALL** contain exactly one [1..1] **templateId** such that it
    a. **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.4.20.4".
4. **SHALL** contain at least one [1..*] **id**.
5. **SHALL** contain exactly one [1..1] **code**.
    a. **SHALL** be LOINC-2 (History of Employment Status) from LOINC (codeSystem 2.16.840.1.113883.6.1).
6. **SHALL** contain exactly one [1..1] **statusCode**="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14).
7. **SHALL** contain exactly one [1..1] **effectiveTime**.
    a. This effectiveTime **MAY** contain exactly one [1..1] **low**.
        i. If the starting time is unknown, the <low> element **SHALL** have the nullFlavor attribute set to UNK.
    b. This effectiveTime **SHALL** contain exactly one [1..1] **high**.
        i. The ending time <high> element **SHALL** not be greater than the time the observation is made.
8. This observation **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the @code **SHOULD** be selected from ValueSet PHVS_EmploymentStatus_ODH 2.16.840.1.114222.4.11.7129 **DYNAMIC**

Add section 6.3.4.65 Usual Occupation and Industry Observation (added 2013-09 from the QRPH HW supplement.).

Table 6.3.4.65-1: Usual Occupation and Usual Industry Observation Entry 1.3.6.1.4.1.19376.1.5.3.1.4.20.5

Template Name	Usual Occupation and Usual Industry Observation Entry		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.20.5		
Parent Template			
General Description	A Usual Occupation and Industry Observation entry is a clinical statement about a person's usual employment and Usual Industry, which is defined to be the occupation held for the longest period of time over the course of a person's career and the industry in which the person has worked for the longest. The entry represents the person's usual occupation and usual industry at the point in time when the observation is recorded.		
Class/Mood	**Code**	**Data Type**	**Value**
ClassCode= "OBS"	Code = LOINC-3 Display Name = Usual Occupation and	Observation	Value xsi:type = "CD" from value set PHVS_Occupation_Census

MoodCode= "EVN"	Industry Hx CodeSystem = 2.16.840.1.113883.6.1 CodeSystemName=LOINC Should this be LOINC or SNOMED CT		2.16.840.1.114222.4.11.6036

Opt and Card	entryRelationship	Description	Template ID	Specification Document	Vocabulary Constraint

6.3.4.65 Usual Occupation and Industry Observation Entry

`[observation: templateId 1.3.6.1.4.1.19376.1.5.3.1.4.20.5 (open)]`

A Usual Occupation and Industry Observation Entry is a clinical statement about the type of occupation which the subject has held for the longest duration through his or her working history, at the point in time the statement is recorded, and the industry in which the subject has been employed the longest. It optionally includes the duration for each.

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001).
3. **SHALL** contain exactly one [1..1] **templateId** such that it
   a. **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.4.20.5".
4. **SHALL** contain at least one [1..*] **id**.
5. **SHALL** contain exactly one [1..1] **code**.
   a. **SHALL** be LOINC-3 (Usual Occupation and Industry Hx) from LOINC (codeSystem 2.16.840.1.113883.6.1).
6. **SHALL** contain exactly one [1..1] **statusCode**="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14).
7. **SHALL** contain exactly one [1..1] **effectiveTime**.
   a. Such that the effectiveTime **SHALL** be used to represent the date that the observation is collected.
8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD".
   a. This value **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet Bureau of Census Occupation Codes 2.16.840.1.114222.4.11.6036 **DYNAMIC**
9. **SHALL** contain exactly one [1..1] **participant** such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="IND"
   b. **SHALL** contain exactly one [1..1] **participantRole**

i. Which **SHALL** contain exactly one [1..1] **@classCode**="ROL" (CodeSystem: RoleCode 2.16.840.1.113883.5.111 **STATIC**).
ii. Which **SHALL** contain exactly one [1..1] **id**
    1. Such that the id **SHALL** reference the id of a participant/AssociatedEntity in the header which **SHALL** contain exactly one [1..1] **templateId** such that it **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.2.2" (IHE Employer and School Contacts template).
    2. The AssociatedEntity/scopingOrganization shall contain exactly one [1..1] standardIndustryClassCode which **SHALL** be selected from ValueSet Bureau of Census Industry Codes 2.16.840.1.114222.4.11.6037 **DYNAMIC**

10. **SHOULD** contain zero or one [0..1] **entryRelationship** such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**).
    b. **SHALL** contain exactly one [1..1] Usual Occupation Duration Observation (1.3.6.1.4.1.19376.1.5.3.1.4.20.9).

11. **SHOULD** contain zero or one [0..1] **entryRelationship** such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**).
    b. **SHALL** contain exactly one [1..1] Usual Industry Duration Observation (1.3.6.1.4.1.19376.1.5.3.1.4.20.10).

Add section 6.3.4.66 Occupation Observation (added 2013-09 from the QRPH HW supplement.).

Table 6.3.4.66-1: Occupation Observation Entry 1.3.6.1.4.1.19376.1.5.3.1.4.20.6

Template Name	Occupation Observation Entry		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.20.6		
Parent Template			
General Description	An Occupation Observation entry is a clinical statement about a person's specific employment situation includes the occupation and the industry which is required to determine the precise occupation held. The entry may also include information about the employer and locations where work has been performed.		
Class/Mood	**Code**	**Data Type**	**Value**
ClassCode= "OBS" MoodCode=	Code = LOINC-6 Display Name = History of Occupation CodeSystem = 2.16.840.1.113883.6.1	Observation	Value xsi:type = "CD" from value set PHVS_Occupation_Census 2.16.840.1.114222.4.11.6036

"EVN"	CodeSystemName=LOINC		

Opt and Card	entryRelationship	Description	Template ID	Specification Document	Vocabulary Constraint

6.3.4.66 Occupation Observation Entry

`[observation: templateId 1.3.6.1.4.1.19376.1.5.3.1.4.20.6 (open)]`

An Occupation Observation Entry is a clinical statement about the type of occupation which the subject currently holds or has held in the past.

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001).
3. **SHALL** contain exactly one [1..1] **templateId** such that it
   a. **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.4.20.6".
4. **SHALL** contain at least one [1..*] **id**.
5. **SHALL** contain exactly one [1..1] **code**.
   a. **SHALL** be LOINC-6 (History of Occupation) from LOINC (codeSystem 2.16.840.1.113883.6.1).
6. **SHALL** contain exactly one [1..1] **statusCode**="completed" (CodeSystem: ActStatus 2.16.840.1.113883.5.14).
7. **SHALL** contain exactly one [1..1] **effectiveTime**.
   a. This effectiveTime **SHOULD** contain exactly one [1..1] **low**.
      i. If the starting time is unknown, the <low> element **SHALL** have the nullFlavor attribute set to UNK.
   b. This effectiveTime **SHALL** contain exactly one [1..1] **high**.
      i. The ending time <high> element **SHALL** not be greater than the time the observation is made.
8. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD".
   a. This value **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet PHVS_Occupation_Census 2.16.840.1.114222.4.11.6036 **DYNAMIC**
9. **SHALL** contain exactly one [1..1] **participant** such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="IND"
   b. **SHALL** contain exactly one [1..1] **participantRole**
      i. Which **SHALL** contain exactly one [1..1] **@classCode**="ROL" (CodeSystem: RoleCode 2.16.840.1.113883.5.111 **STATIC**).

ii. Which **SHALL** contain exactly one [1..1] **id**

1. Such that the id **SHALL** reference the id of an AssociatedEntity in the header which **SHALL** contain exactly one [1..1] **templateId** such that it **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.2.2" (IHE Employer and School Contacts template).
2. The AssociatedEntity **SHALL** contain exactly one [1..1] name.
3. The AssociatedEntity **SHALL** contain exactly one [1..1] addr.
4. The AssociatedEntity/scopingOrganization **SHALL** contain exactly one [1..1] standardIndustryClassCode which **SHALL** be selected from ValueSet Bureau of Census Industry Codes 2.16.840.1.114222.4.11.6037 **DYNAMIC**

10. **SHOULD** contain zero or one [0..1] **entryRelationship** such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**).
    b. **SHALL** contain exactly one [1..1] Work Shift Observation (1.3.6.1.4.1.19376.1.5.3.1.4.20.7).

11. **SHOULD** contain zero or one [0..1] **entryRelationship** such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002 **STATIC**).
    b. **SHALL** contain exactly one [1..1] Weekly Work Hours Observation (1.3.6.1.4.1.19376.1.5.3.1.3.16.1.1.11).

Add section 6.3.4.67 Work Shift Observation (added 2013-09 from the QRPH HW supplement.).

Table 6.3.4.67-1: Work Shift Observation Entry 1.3.6.1.4.1.19376.1.5.3.1.4.20.7

Template Name	Work Shift Observation Entry			
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.20.7			
Parent Template				
General Description	The "shift" or typical time within a work-day in which a person is scheduled to perform their duties.			
Class/Mood	**Code**		**Data Type**	**Value**
ClassCode= "OBS" MoodCode= "EVN"	Code = LOINC-7 Display Name = Work Shift CodeSystem = 2.16.840.1.113883.6.1 CodeSystemName=LOINC		Observation	Value xsi:type = "CD" from value set PHVS_EmploymentWorkShift_ODH 2.16.840.1.114222.4.11.7130
Opt and	**entryRelatio**	**Description**	**Template ID**	**Specificati on** / **Vocabulary**

Card	nship			Document	Constraint

6.3.4.67 Work Shift Observation Entry

`[observation: templateId 1.3.6.1.4.1.19376.1.5.3.1.4.20.7 (open)]`

A clinical statement about the "shift" or typical time within a work-day in which a person is scheduled to perform their duties.

1. **SHALL** contain exactly one [1..1] **`@classCode`**="OBS" (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass).
2. **SHALL** contain exactly one [1..1] **`@moodCode`**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001).
3. **SHALL** contain exactly one [1..1] **`templateId`** such that it
   a. **SHALL** contain exactly one [1..1] **`@root`**=" 1.3.6.1.4.1.19376.1.5.3.1.4.20.7".
4. **SHALL** contain at least one [1..*] **`id`**.
5. **SHALL** contain exactly one [1..1] **`code`**.
   a. **SHALL** be LOINC-7 (Workshift) from LOINC.
6. **SHALL** contain exactly one [1..1] **`statusCode`**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14).
7. **SHALL** contain exactly one [1..1] **`value`** with @xsi:type="CD".
   a. This value **SHALL** contain exactly one [1..1] **`@code`**, which **SHALL** come from value set Value Set PHVS_EmploymentWorkShift_ODH 2.16.840.1.114222.4.11.7130.

Add section 6.3.4.68 Weekly Work Hours Observation (added 2013-09 from the QRPH HW supplement.).

Table 6.3.4.68-1: Weekly Work Hours Observation Entry 1.3.6.1.4.1.19376.1.5.3.1.4.20.8

Template Name	Weekly Work Hours Observation Entry
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.20.8
Parent Template	
General Description	The typical hours per week that a person spends working.

Class/Mood	Code	Data Type	Value
ClassCode= "OBS" MoodCode= "EVN"	Code = LOINC-8 Display Name = Weekly Work Hours CodeSystem = 2.16.840.1.113883.6.1 CodeSystemName=LOINC	Observation	**`value`** with @xsi:type="INT"

Opt	entryRelatio	Description	Template ID	Specificati	Vocabulary

and Card	nship			on Document	Constraint

6.3.4.68 Weekly Work Hours Observation Entry

`[observation: templateId 1.3.6.1.4.1.19376.1.5.3.1.4.20.8 (open)]`

A clinical statement about the typical number of hours per week that a person spends performing their duties for work.

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001).
3. **SHALL** contain exactly one [1..1] **templateId** such that it
   a. **SHALL** contain exactly one [1..1] **@root**=" 1.3.6.1.4.1.19376.1.5.3.1.4.20.8".
4. **SHALL** contain at least one [1..*] **id**.
5. **SHALL** contain exactly one [1..1] **code**.
   a. **SHALL** be LOINC-8 (Weekly Work Hours) from LOINC.
6. **SHALL** contain exactly one [1..1] **statusCode**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14).
7. **SHALL** contain exactly one [1..1] **value** with @xsi:type="INT".
   a. This value **SHALL** contain exactly one [1..1] **@value**, which represents the number of hours in a week that a person usually works.

Add section 6.3.4.69 Usual Occupation Duration (added 2013-09 from the QRPH HW supplement.).

Table 6.3.4.69-1: Usual Occupation Duration Entry (1.3.6.1.4.1.19376.1.5.3.1.4.20.9)

Template Name	Usual Occupation Duration Entry		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.20.9		
Parent Template			
General Description	A Usual Occupation Duration entry is a clinical statement about a quantity of time.		
Class/Mood	**Code**	**Data Type**	**Value**
ClassCode= "OBS" MoodCode= "EVN"	Code = LOINC-5 Display Name = Usual Occupation Duration CodeSystem = 2.16.840.1.113883.6.1	Observation	Value xsi:type=PQ representing the number of years of months. Units shall be expressed in UCUM.

	CodeSystemName=LOINC		

Opt and Card	entryRelationship	Description	Template ID	Specification Document	Vocabulary Constraint

6.3.4.69 Usual Occupation Duration Entry

`[observation: templateId 1.3.6.1.4.1.19376.1.5.3.1.4.20.9 (open)]`

A Usual Occupation Duration Entry is a clinical statement about the quantity of time a person spent in the occupation they held the longest over the course of their career.

1. **SHALL** contain exactly one [1..1] **`@classCode`**`="OBS" (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass)`.
2. **SHALL** contain exactly one [1..1] **`@moodCode`**`="EVN"` Event (CodeSystem: `ActMood 2.16.840.1.113883.5.1001`).
3. **SHALL** contain exactly one [1..1] **`templateId`** such that it
   a. **SHALL** contain exactly one [1..1] **`@root`**`="1.3.6.1.4.1.19376.1.5.3.1.4.20.9"`.
4. **SHALL** contain at least one [1..*] **`id`**.
5. **SHALL** contain exactly one [1..1] **`code`**.
   a. **SHALL** be LOINC-5 (Usual Occupation Duration) from LOINC.
6. **SHALL** contain exactly one [1..1] **`statusCode`**`="completed"` Completed (CodeSystem: `ActStatus 2.16.840.1.113883.5.14`).
7. **SHALL** contain exactly one [1..1] **`value`** with @xsi:type="PQ".
   a. This value **SHALL** contain exactly one [1..1] **`@unit`**, which **SHALL** include duration-related units from value set `UCUM 2.16.840.1.113883.1.11.12839`.

Add section 6.3.4.70 Usual Industry Duration (added 2013-09 from the QRPH HW supplement.).

Table 6.3.4.70-1: Usual Industry Duration Entry 1.3.6.1.4.1.19376.1.5.3.1.4.20.10

Template Name	Usual Industry Duration Entry		
Template ID	`1.3.6.1.4.1.19376.1.5.3.1.4.20.10`		
Parent Template			
General Description	A Usual Industry Duration entry is a clinical statement about a quantity of time in which a person was employed in an industry.		
Class/Mood	**Code**	**Data Type**	**Value**

ClassCode= "OBS" MoodCode= "EVN"	Code = LOINC-5 Display Name = Usual Occupation Duration CodeSystem = 2.16.840.1.113883.6.1 CodeSystemName=LOINC	Observation	Value xsi:type=PQ representing the number of years of months. Units shall be expressed in UCUM.

Opt and Card	entryRelationship	Description	Template ID	Specification Document	Vocabulary Constraint

6.3.4.70 Usual Industry Duration Entry

`[observation: templateId 1.3.6.1.4.1.19376.1.5.3.1.4.20.10 (open)]`

A Usual Industry Duration Entry is a clinical statement about the quantity of time a person spent in a particular industry in which they worked for the longest over the course of their career.

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" (CodeSystem: 2.16.840.1.113883.5.6 HL7ActClass).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001).
3. **SHALL** contain exactly one [1..1] **templateId** such that it
   a. **SHALL** contain exactly one [1..1] **@root**="1.3.6.1.4.1.19376.1.5.3.1.4.20.10".
4. **SHALL** contain at least one [1..*] **id** .
5. **SHALL** contain exactly one [1..1] **code**.
   a. **SHALL** be LOINC-5 (Usual Industry Duration) from LOINC.
6. **SHALL** contain exactly one [1..1] **statusCode**="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14).
7. **SHALL** contain exactly one [1..1] **value** with @xsi:type="PQ".
   a. This value **SHALL** contain exactly one [1..1] **@unit**, which **SHALL** include duration-related units from value set UCUM 2.16.840.1.113883.1.11.12839.

Add Section 6.4

6.4 HL7 Version 2.0 Content Modules

This section contains content modules based upon the HL7 Version 2 Standard, and related standards and/or implementation guides.

Add Section 6.5

6.5 PCC Value Sets

This section contains value sets used by Content Modules. The value sets listed here may be used by other domains (e.g., QRPH) in addition to the PCC domain.

Note: Although some tables in this section include a column for "Units", units may not be applicable to all table entries and the cell will remain blank.

Add Section 6.5.A

6.5.A Antepartum History of Past Illness Value Set 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.1

Name	Opt	Type	Units	SNOMED CT
Diabetes	R2	CD		73211009
Hypertension	R2	CD		38341003
Heart Disease	R2	CD		56265001
Autoimmune Disorder	R2	CD		85828009
Kidney Disease	R2	CD		90708001
UTI	R2	CD		68566005
Neurologic	R2	CD		118940003
Epilepsy	R2	CD		84757009
Psychiatric	R2	CD		74732009
Depression	R2	CD		41006004
Postpartum Depression	R2	CD		58703003
Hepatitis	R2	CD		128241005
Liver Disease	R2	CD		235856003
Varicosities	R2	CD		276504003
Phlebitis	R2	CD		61599003
Thyroid Dysfunction	R2	CD		14304000
Trauma	R2	CD		417746004
Violence	R2	CD		225818009
History of Blood Transfusion	R2	CD		116859006
D(Rh) Sensitized	R2	CD		3885002
Pulmonary	R2	CD		19829001
Seasonal Allergies	R2	CD		367498001
Drug Allergy	R2	CD		416098002
Latex Allergy	R2	CD		300916003
Food Allergy	R2	CD		414285001
Breast	R2	CD		79604008
Hospitalizations	R2	CD		32485007

Name	Opt	Type	Units	SNOMED CT
Anesthetic Complications	R2	CD		33211000
History of Abnormal Pap	R2	CD		274688009
Uterine Anomaly/DES	R2	CD		37849005
DES Exposure	R2	CD		413340008 of fetus
Infertility	R2	CD		8619003
Artificial Reproductive Therapy (ART) Treatment	R2	CD		63487001
History of Gestational Diabetes	R2	CD		
History of Incompetent Cervix	R2	CD		17382005 Code is for incompetent cervix rather than history of. Given this condition this should be okay.
History of Infant with Intrauterine Growth Restriction	R2	CD		Need Code for history of.
History of Infant with Macrosomia	R2	CD		Need Code for history of.
History of Pregnancy Induced Hypertension	R2	CD		Need code for history of.
History of Placenta Previa/Abruption	R2	CD		Need Code for history of.
History of Preterm labor	R2	CD		441493008
History of Premature Rupture of Membranes	R2	CD		Need Code for history of.
Previous Cesarean Section	R2	CD		161805006
History of Stillbirth	R2	CD		161743003
History of Neonatal Death	R2	CD		Need code for history of.
History of Postpartum Hemorrhage	R2	CD		161809000

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Add Section 6.5.C

6.5.C Antepartum Family History and Genetic Screening Value Set 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.4

Name	Opt	Type	Units	SNOMED CT	LOINC
Autism	R2	CD		408856003	
Blood Disorders	R2	CD		414022008	
Canavan Disease	R2	CD		80544005	
Chromosomal Disorder Includes any inherited genetic or chromosomal disorders	R2	CD		409709004	
Congenital Heart Defect	R2	CD		13213009	
Cystic Fibrosis	R2	CD		190905008	
Dysmorphism (Birth Defect) Patient or baby's father has a child with birth defects	R2	CD		276720006	

Name	Opt	Type	Units	SNOMED CT	LOINC
Down Syndrome	R2	CD		41040004	
Familial Dysautonomia	R2	CD		29159009	
Hemophilia	R2	CD		90935002	
Huntington's Chorea	R2	CD		58756001	
Maternal Metabolic Disorder	R2	CD		75934005	
Mental Retardation	R2	CD		91138005	
Muscular Dystrophy	R2	CD		73297009	
Neural Tube Defect	R2	CD		253098009	
Recurrent pregnancy loss/stillbirth	R2	CD		102878001	
Sickle Cell Disease	R2	CD		417357006	
Sickle Cell Trait	R2	CD		16402000	
Tay-Sachs	R2	CD		111385000	
Thalassemia	R2	CD		40108008	

Add Section 6.5.D

6.5.D Antepartum Review of Systems Menstrual History Value Set 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.5

Name	Opt	Type	Units	SNOMED CT	LOINC
Date of Last Menstrual Period	R	TS		21840007	
Menses Monthly	R	BL		364307006	
Prior Menses Date	R	TS		21840007	
Duration of Menstrual Flow	R	PQ	days	364306002	
Frequency of Menstrual Cycles	R	PQ	days	289887006	
On Birth Control Pills at conception	R	BL		10036567	
Menarche	R	PQ		398700009	
hCG+	R	TS		250423000	

Add Section 6.5.E

6.5.E Antepartum History of Infection Value Set 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.6

Name	Opt	Type	Units	SNOMED CT	LOINC
Live with someone with TB or exposed to TB	R2	CD		170464005	

Name	Opt	Type	Units	SNOMED CT	LOINC
History of Genital Herpes	R2	CD		402888002	
Exposed to Genital Herpes	R2	CD		240480009	
Rash since LMP	R2	CD		49882001	
Viral illness since LMP	R2	CD		34014006	
Rash or viral illness since LMP	R2	CD		49882001	
Hepatitis B	R2	CD		235871004	
Hepatitis C	R2	CD		235872006	
History of STD	R2	CD		8098009	
History of Gonorrhea	R2	CD		15628003	
History of Chlamydia	R2	CD		312099009	
History of HPV	R2	CD		302812006	
History of HIV	R2	CD		165816005	
History of Syphilis	R2	CD		76272004	

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Add Section 6.5.F

6.5.F Antepartum Laboratory Value Set 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.7

Lab	LOINC Code	Comments
Antibody Screen (AB)	890-4 Ab Screen	
Blood Type (ABO Group)	883-9 ABO Group	
Rh	10331-7 Rh	
Hepatitis B virus (HBV) surface Antigen (Ag)	5196-1 HBV surface Ag (EIA) 5195-3 HBV surface Ag 5197-9 HBV surface Ag (RIA) 7905-3 HBV surface Ag (Neut)	
Hemoglobin (Hgb)/Hematocrit (Hct)	718-7 Hgb 4544-3 Hct (Automated count) 30350-3 Hgb	
Hemoglobin (Hgb) Electrophoresis	13514-5 Hemoglobin pattern [interpretation] in Blood by Electrophoresis Narrative	Appropriate code appears to be 13514-5
Aneuploidy Screening (Ultrasound)	XX-ASU Aneuploidy Screening (Ultrasound)	XX-ASU: A LOINC profile code will be requested

Lab	LOINC Code	Comments
Pap Test/Human papilloma virus (HPV)	21440-3 HPV I/H Risk DNA Cervix (Probe) 21441-1 HPV Low Risk DNA Cervix (Probe) 10524-7 Cytology Cervix 18500-9 Thin Prep Cervix 19765-7 Cytology Cervix/Vaginal (Nominal) 19766-5 Cytology Cervix/Vaginal (Narrative)	
Rubella Virus (RUBV) Antibody (Ab)	5334-8 RUBV Ab IgG (EIA) 20458-6 RUBV Ab IgG 40667-8 RUBV Ab IgG (EIA) 8014-3 RUBV Ab IgG	
Urine Culture Screen	630-4 Bacteria Urine Culture	
Purified protein derivative (PPD)	1647-7 Purified protein derivative skin test	
Chlamydia	6347-9 Chlamydia Ag 14510-2 Chlamydia trachomatis Ag (Vaginal) 14474-1 Chlamydia trachomatis Ag (Urine) 6349-5 Chlamydia trachomatis (Unspecified specimen)	
Gonorrhea	691-6 Neisseria Gonorrhoeae (genital specimen) 9568-7 Neisseria Gonorrhoeaea Ab	
Chlamydia Trachomatis/ Neisseria Gonorrhoeae	45067-6 Chlamydia Trachomatis Neisseria Gonorrhoeae (Cervix) 45074-2 Chlamydia Trachomatis Neisseria Gonorrhoeae (Urine)	
Ultrasound	35096-7 OB Ultrasound Panel	
Alpha-Feto Protein (Maternal) (Profile)	30525-0 Age 29463-7 Body Weight 18185-9 Gestational Age 20450-3 Alpha-1-Fetoprotein 48803-1 Neural Tube Defect Risk	
Chorionic Villus Sampling (CVS)	33774-1 Karotype	
Amniotic Fluid (Karotype)	33773-3 Karyotype (Amino Fluid)	
Amniotic Fluid (AFP)	41273-4 Alpha-1-Fetoprotein, Amniotic Fluid Semi-Quantitative 1832-5 Alpha-1-Fetoprotein [Multiple of the median] in Amniotic	

Lab	LOINC Code	Comments
	Fluid 29595-6 Alpha-1-Fetoprotein [Mass/volume] in Amniotic Fluid	
Diabetes Screen	1557-8 Fasting Blood Glucose-Venous 14770-2 Fasting Blood Glucose-Capillary	
Glucose Tolerance Test (GTT)	1507-3 Glucose 1HR post 75 g glucose 14995-5 Glucose 2HR post 75 g glucose 20437-0 Glucose 3HR post 75 g glucose	
Rapid Plasma Reagin (RPR)	31147-2 Reagin Ab 20508-8 Reagin Ab by RPR	
Venereal Disease Research Laboratory (VDRL)	5292-8 Reagin Ab by VDRL	
Group B Strep	48683-7 Beta Strep Group B (PCR) 11267-2 Strep Group B	
Beta Human Chorionic Gonadotropin (HCG)	21198-7 Beta HCG	
Varicella zoster virus Ab.IgG	15410-4 Varicella zoster virus Ab.IgG (EIA) 17763-4 Varicella zoster virus Ab.IgG (IF)	
Maternal Serum Triple Screen	30525-0 Age, Patient Quantitative 20450-3 Alpha-1-Fetoprotein Multiple of the Median, Serum Quantitative Calculated 20465-1 Choriogonadotropin/Choriogonatotropin, Control Serum Quantitative 20466-9 Estriol/Estriol, Control Serum Quantitative	
Urinalysis (Urine Screen)	20406-5 Glucose 20505-4 Bilirubin 5797-6 Ketones 5811-5 Specific Gravity 5803-2 pH 5804-0 Protein 20405-7 Urobilinogen 20407-3 Nitrite 5794-3 Hemoglobin 5799-2 Leukocyte	

Lab	LOINC Code	Comments
	esterase 5767-9 Appearance 5778-6 Color 9842-6 Casts 5787-7 Epithelial cells 13945-1 Erythrocytes 5769-5 Bacteria	
First Trimester Maternal Serum Screening with Nuchal Translucency	49588-7 First trimester maternal screen with nuchal translucency [interpretation] Narrative	
Thyroid Stimulating Hormone (TSH)	11580-8 Thyrotropin (3rd generation) 3016-3 TSH 5385-0 Thyrotropin Receptor Ab 27975-2 TSH (serum)	
Triiodothyronine (T3)	3051-0 T3 Free 3052-8 T3 Reverse 3054-4 T3 True 3050-2 T3 Resin Uptake	

Add Section 6.5.G

6.5.G Antepartum Education Value Set 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.8

Name	Opt	Type	units	SNOMED CT	LOINC
First Trimester					
Risk factors identified by prenatal history	R2	CD		440047008	
Anticipated course of prenatal care	R2	CD		17629007	
Special Diet	R2	CD		171054004	
Nutrition and weight gain counseling	R2	CD		171054004	
Toxoplasmosis precautions (cats/raw meat)	R2	CD		439733009	
Sexual activity	R2	CD		162169002	
Exercise	R2	CD		171056002	
Influenza vaccine	R2	CD		xx-edu-influenza need code closest is	

Name	Opt	Type	units	SNOMED CT	LOINC
				vaccine education 171044003	
Smoking/tobacco counseling	R2	CD		171055003	
Environmental/work hazards	R2	CD		385872009	
Travel	R2	CD		439816006	
Alcohol	R2	CD		171057006	
Illicit/recreational drugs	R2	CD		425014005	
Use of any medications	R2	CD		171058001	
Indications for ultrasound	R2	CD		440227005	
Domestic violence	R2	CD		413457006	
Seatbelt use	R2	CD		440638004	
Childbirth classes/hospital facilities	R2	CD		66961001	
Second Trimester					
Childbirth classes/hospital facilities	R2	CD		66961001	
Signs and symptoms of preterm labor	R2	CD		440669000	
Abnormal Lab Values	R2	CD		410299006	
Influenza vaccine	R2	CD		xx-edu-fluvaccine need code. Closest is vaccine education 171044003	
Selecting a newborn care provider	R2	CD		439908001	
Postpartum family planning	R2	CD		54070000	
Tubal sterilization	R2	CD		243064009	
Third Trimester					
Anesthesia/analgesia plans	R2	CD		243062008	
Intended Facility for Delivery plan				310585007	
Fetal movement monitoring	R2	CD		440309009	
Labor signs	R2	CD		440671000	

Name	Opt	Type	units	SNOMED CT	LOINC
VBAC counseling	R2	CD		440073003	
Signs & Symptoms of Pregnancy-induced hypertension	R2	CD		xx-edu-sspreclampsia need to request code	
Postterm counseling	R2	CD		xx-edu-postterm need to request code	
Circumcision	R2	CD		184002001	
Bottle feeding	R2	CD		169644004	
Breast feeding	R2	CD		169643005	
Postpartum depression	R2	CD		439366005	
Newborn education (Newborn screening, jaundice, SIDS, car seat)	R2	CD		75461000	
Family medical leave or disability forms	R2	CD		40791000	
Tubal sterilization consent signed	R2	CD		408835000	

Add section 6.5.H. (Added 2011-09 from QRPH EHCP profile)

The value subsets provided in this section are used both to constrain the CDA content, and to assert measure logic. These MAY be supported by the Value Set Repository actor for value set management as defined by the IHE ITI TF Sharing of Value Sets (SVS) profile.

6.5.H JCIH-EHDI Risk Indicators for Hearing Loss (LOINC®) Value Set

6.5.H.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.24
Name	name of the value set	JCIH-EHDI Risk Indicators for Hearing Loss (LOINC®) Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Risk Indicators for Hearing Loss associated with hearing loss using LOINC® concepts
Definition	A text definition describing how concepts in the value set were selected	**Extensional definition:** The value set was constructed by enumerating the codes from LOINC®

Metadata Element	Description	Mandatory
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.H.2 JCIH-EHDI Risk Indicators for Hearing Loss (LOINC®) Value Set Value Set

LOINC® 58232-0 Hearing Loss Risk Indicator

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.24
	Vocabulary:	2.16.840.1.113883.6.1
Sequence	LOINC® Code	Description
1	LA137-2	None
2	LA12667-4	Caregiver concern about hearing
3	LA12668-2	Family Hx of hearing loss
4	LA12669-0	NICU stay > 5 days
5	LA12670-8	ECMO
6	LA12671-6	Assisted ventilation
7	LA12672-4	Ototoxic medication use
8	LA12673-2	Exchange transfusion for Hyperbilirubinemia
9	LA12674-0	In utero infection(s)
10	LA12675-7	Craniofacial anomalies
11	LA12681-5	Physical findings of syndromes that include hearing loss
12	LA12676-5	Syndromes associated with hearing loss
13	LA12677-3	Neurodegenerative disorders
14	LA12678-1	Postnatal infections
15	LA12679-9	Head trauma

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.24
	Vocabulary:	2.16.840.1.113883.6.1
Sequence	LOINC® Code	Description
16	LA6172-6	Chemotherapy

Add section 6.5.I. (Added 2011-09 from QRPH EHCP profile)

6.5.I JCIH-EHDI Risk Indicators for Hearing Loss Codes

6.5.I.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.11
Name	name of the value set	JCIH-EHDI Risk Indicators for Hearing Loss Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the risk indicators for hearing loss associated with hearing loss using SNOMED-CT Finding/Situation concepts
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.I.2 JCIH-EHDI Risk Indicators for Hearing Loss Value Set

SNOMED-CT Risk Indicators for Hearing Loss Value Set

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.11
	Vocabulary:	2.16.840.1.113883.6.96
Sequence	SNOMED-CT Code	Description
1	439750006	Family history of hearing loss (situation)
2	441899004	History of therapy with ototoxic medication (situation)
3	276687002	Conjugated hyperbilirubinemia in infancy (disorder)
4	281610001	Neonatal hyperbilirubinemia (disorder)
5	281612009	Neonatal conjugated hyperbilirubinemia (disorder)
6	281611002	Neonatal unconjugated hyperbilirubinemia (disorder)
7	206363004	Intra-amniotic fetal infection (disorder) (Deprecated, replaced by 11618000)
8	206331005	Infections specific to perinatal period (disorder)
9	206005002	Fetus or neonate affected by maternal infection (disorder)
10	80690008	Degenerative disease of the central nervous system (disorder)
11	178280004	Postnatal infection (disorder)
12	312972009	Neonatal extracranial head trauma (disorder)
13	161653008	History of - chemotherapy (situation)
14	11618000	Intra-amniotic infection of fetus (disorder) (Replaces 206363004)

6.5.I.3 Pending Codes for SNOMED-CT Findings/Situation to support Risk Indicators for Hearing Loss

Note that additional specificity for this value set is under way and will result in an update to this value set. Further coded values are sought to represent the following:

None
Caregiver concern about hearing
Craniofacial anomalies
Physical findings of syndromes that include hearing loss
Syndromes associated with hearing loss

Add section 6.5.J. (Added 2011-09 from QRPH EHCP profile)

6.5.J JCIH-EHDI Risk Indicators for Hearing Loss - Procedures Codes

6.5.J.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.12
Name	name of the value set	JCIH-EHDI Risk Indicators for Hearing Loss - Procedures Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the risk indicators for hearing loss Procedures associated with hearing loss using SNOMED-CT
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.J.2 JCIH-EHDI Risk Indicators for Hearing Loss - Procedures Value

Risk Indicators for Hearing Loss - Procedures Set

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.12
	Vocabulary:	2.16.840.1.113883.6.96
Sequence	SNOMED-CT Code	Description
1	266700009	Assisted breathing (procedure)
2	233573008	Extracorporeal membrane oxygenation (procedure)

Add section 6.5.K. (Added 2011-09 from QRPH EHCP profile)

6.5.K Newborn Hearing Procedure Codes

6.5.K.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.17
Name	name of the value set	JCIH-EHDI Newborn Hearing Procedure Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the type of newborn hearing procedure identified using SNOMED-CT Procedure codes (includes both screening and other tests and examinations)
Definition	A text definition describing how concepts in the value set were selected	**Extensional definition:** The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

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6.5.K.2 JCIH-EHDI Newborn Hearing Procedure Value Set

Newborn Hearing Procedure Value Set:

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.17
	Vocabulary:	2.16.840.1.113883.6.96
Sequence	SNOMED-CT Code	Description
3	417491009	Neonatal hearing test (procedure)

Add section 6.5.L. (Added 2011-09 from QRPH EHCP profile)

6.5.L JCIH-EHDI Newborn Hearing Screening Method Codes

6.5.L.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.4
Name	name of the value set	JCIH-EHDI Newborn Hearing Screening Method Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the type of newborn hearing screening procedure identified using LOINC® answer codes
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC®
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.L.2 JCIH-EHDI Newborn Hearing Screening Method Value Set

Newborn Hearing Screening Method Value Set:

LOINC® 54106-0

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.4	
	Vocabulary:	2.16.840.1.113883.6.1	
Sequence	**LOINC® Code**	**Answer Code**	**Description**
1	LA10387-1	AABR	Automated auditory brainstem response
2	LA10388-9	ABR	Auditory brain stem response
3	LA10389-7	OAE	Otoacoustic emissions
4	LA10390-5	DPOAE	Distortion product otoacoustic emissions
5	LA10391-3	TOAE	Transient otoacoustic emissions
6	LA12406-7		Methodology unknown

Add section 6.5.M. (Added 2011-09 from QRPH EHCP profile)

6.5.M JCIH-EHDI Hearing Screen Right Codes– Right

6.5.M.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.9
Name	name of the value set	JCIH-EHDI Hearing Screen Right Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the right ear EHDI screening using LOINC® in result type
Definition	A text definition describing how concepts in the value set were selected	**Extensional definition:** The value set was constructed by enumerating the codes from LOINC®
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is	8/1/2010

Metadata Element	Description	Mandatory
	expected to be effective	
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.M.2 JCIH-EHDI Hearing Screen Right Value Set

NB hearing scn –R:Result Type

Hearing Screen Right Value Set

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.9
	Vocabulary:	2.16.840.1.113883.6.1
Sequence	LOINC® Code	Description
1	53109-4	Newborn Hearing Screen Right

Add section 6.5.N. (Added 2011-09 from QRPH EHCP profile)

6.5.N JCIH-EHDI Hearing Screen Left Codes

6.5.N.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.8
Name	name of the value set	JCIH-EHDI Hearing Screen Left Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the left ear EHDI hearing screening result type using LOINC®
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC®
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific	Version 1.0

Metadata Element	Description	Mandatory
	version of the value set.	
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.N.2 JCIH-EHDI Hearing Screen Left Value Set

Hearing Screen Left Value Set

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.8
	Vocabulary:	2.16.840.1.113883.6.1
Sequence	LOINC® Code	Description
1	53108-6	Newborn Hearing Screen Left

Add section 6.5.O. (Added 2011-09 from QRPH EHCP profile)

6.5.O JCIH-EHDI Reason for no Hearing Loss Diagnosis or Screening Codes(SNOMED)

6.5.O.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.15
Name	name of the value set	JCIH-EHDI Reason for no Hearing Loss Diagnosis or Screening Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Reason for no hearing loss diagnosis coded with SNOMED-CT.

Metadata Element	Description	Mandatory
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.O.2 JCIH-EHDI Reason for no Hearing Loss Diagnosis or Screening Value Set

Reason for no Hearing Loss Diagnosis

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.15	
	Vocabulary:	2.16.840.1.113883.6.96	
Sequence	SNOMED Code	Description	EHDI Concept
1	397709008	Patient died (finding)	No screening or diagnosis: Infant died
2	360885002	Change of residence status (finding)	No diagnosis: Moved or gone elsewhere
3	184112005	Patient address unknown (finding)	No diagnosis: Unable to Contact Family
4	184118009	Patient telephone number unknown (finding)	No diagnosis: Unable to Contact Family
5	183638004	Follow-up refused	No screening diagnosis: Parents Declined Services - Follow-up refused
6	183946001	Procedure refused-uncooperative	No diagnosis: Parents Declined Services -Procedure refused - uncooperative
7	413319007	Persistent non-attender	No diagnosis: Unresponsive - Persistent non-attender
8	399307001	Loss to follow-up	No diagnosis: Unknown - Loss

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.15	
	Vocabulary:	2.16.840.1.113883.6.96	
Sequence	SNOMED Code	Description	EHDI Concept
			to follow-up
9	419984006	Inconclusive (qualifier value)	No diagnosis: Audiologic Diagnosis in Process
10	185332005	Appointment cancelled by patient (finding)	No diagnosis: Audiologic Diagnosis in Process - Rescheduled appointment
11	185333000	Appointment cancelled by doctor (finding)	No diagnosis: Audiologic Diagnosis in Process - Rescheduled appointment
12	281399006	Did not attend	No diagnosis: Audiologic Diagnosis in Process - Did not attend

Add section 6.5.P. (Added 2011-09 from QRPH EHCP profile)

6.5.P JCIH-EHDI Newborn Hearing Loss Referrals Codes

6.5.P.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.16
Name	name of the value set	JCIH-EHDI Newborn Hearing Loss Referrals Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect EHDI referrals coded with SNOMED-CT and as a response to care plan recommendations (entered on a list of referrals in a medical summary)
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active

Metadata Element	Description	Mandatory
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.P.2 JCIH-EHDI Newborn Hearing Loss Referrals Value Set

EHDI Newborn Hearing Loss Referrals Value Set

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.16	
	Vocabulary:	2.16.840.1.113883.6.96	
Sequence	**SNOMED Code**	**Description**	**EHDI Concept**
1	306210008	Referral to pediatric diagnostic audiology service (procedure)	Referral to audiologist
2	415271004	Referral to education service (procedure)	Referral to Early Intervention (Part C/non Part C)

5800 *Add section 6.5.Q. (Added 2011-09 from QRPH EHCP profile)*

6.5.Q JCIH-EHDI Newborn Hearing Loss Reason for no Follow-up – Patient Reason Codes

6.5.Q.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.7
Name	name of the value set	JCIH-EHDI Newborn Hearing Loss Reason for no Follow-up – Patient Reason Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the reason that no follow-up is conducted in the case of hearing

Metadata Element	Description	Mandatory
		loss using SNOMED-CT reflected in negation of an intent to order the referral.
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

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6.5.Q2 JCIH-EHDI Newborn Hearing Loss Reason for no Follow-up – Patient Reason Value Set

EHDI Newborn Hearing Loss Reason for no Follow-up Value Set

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.7	
	Vocabulary:	2.16.840.1.113883.6.96	
Sequence	**SNOMED Code**	**Description**	**EHDI Concept**
1	397709008	Patient died (finding)	Incomplete outpatient screen: Infant died
2	360885002	Change of residence status (finding)	Incomplete outpatient screen: Moved or gone elsewhere
3	184112005	Patient address unknown (finding)	Incomplete outpatient screen: Unable to contact family
4	184118009	Patient telephone number unknown (finding)	Incomplete outpatient screen: Unable to contact family
5	183638004	Follow-up refused	Incomplete outpatient screen: Follow-up refused
6	183946001	Procedure refused-uncooperative	Incomplete outpatient screen: Procedure refused-uncooperative
7	413319007	Persistent non-attender	Incomplete outpatient screen:

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.7	
	Vocabulary:	2.16.840.1.113883.6.96	
Sequence	SNOMED Code	Description	EHDI Concept
			Persistent non-attender
8	399307001	Loss to follow-up	Incomplete outpatient screen: Loss to follow-up
9	185332005	Appointment cancelled by patient (finding)	Incomplete outpatient screen: Rescheduled appointment
10	185333000	Appointment cancelled by doctor (finding)	Incomplete outpatient screen: Rescheduled appointment
11	281399006	Did not attend	Incomplete outpatient screen: Did not attend

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Add section 6.5.R. (Added 2011-09 from QRPH EHCP profile)

6.5.R Joint Commission Medical Reason Codes

6.5.R.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.33895.1.3.0.75
Name	name of the value set	Joint Commission Medical Reason Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	The Joint Commission value set is used to reflect medical reason why a test was not performed
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.R.2 Joint Commission Medical Reason Value Set

EHDI specifies the re-use of the existing Medical Reason Value Set used by the Joint Commission measures.

	Value Set :	1.3.6.1.4.1.33895.1.3.0.75
	Vocabulary:	2.16.840.1.113883.6.96
Sequence	SNOMED-CT Code	Description
1	397745006	Medical contraindication (finding)
2	397773008	Surgical contraindication (finding)

Add section 6.5.S. (Added 2011-09 from QRPH EHCP profile)

6.5.S JCIH-EHDI Inpatient Screening Results not Performed Codes

6.5.S.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.10
Name	name of the value set	JCIH-EHDI Inpatient Screening Results not Performed Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the right ear EHDI results reported using LOINC® answer lists
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC®
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.S.2 JCIH-EHDI Inpatient Screening Results not Performed Value Set

5830

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.10		
	Vocabulary:	2.16.840.1.113883.6.1		
Sequence	**LOINC® Code**	**Description**	**Global ID**	**Global ID Code System**
1	LA12408-3	Attempted, but unsuccessful - technical fail	103709008	SN
2	LA7304-4	Not performed	262008008	SN
3	LA12409-1	Not performed, medical exclusion - not indicated	410534003	SN

Add section 6.5.T. (Added 2011-09 from QRPH EHCP profile)

6.5.T JCIH-EHDI Evidence of Hearing Screening Performed Codes

6.5.T.1 Metadata

5835

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.18
Name	name of the value set	JCIH-EHDI Evidence of Hearing Screening Performed Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Evidence of Hearing Screening Performed through the result values of pass-Left, pass-Right, or Refer. This excludes unsuccessful results.
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC®
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010

Metadata Element	Description	Mandatory
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.T.2 JCIH-EHDI Evidence of Hearing Screening Performed Value Set

Evidence of Hearing Screening Performed Value Set

		Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.18		
		Vocabulary:	2.16.840.1.113883.6.1		
Sequence	LOINC® Code	Answer Code	Description	Global ID	Global ID Code System
1	LA10392-1	164059009	Pass		
2	LA10393-9	183924009	Refer		

5840 *Add section 6.5.U. (Added 2011-09 from QRPH EHCP profile)*

6.5.U JCIH-EHDI Procedure Declined Value Set Codes

6.5.U.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.20
Name	name of the value set	JCIH-EHDI Procedure Declined Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that the hearing screening procedure was not performed due to the patient/parent declining the procedure

Metadata Element	Description	Mandatory
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.U.2 JCIH-EHDI JCIH-EHDI Procedure Declined Value Set Value Set

JCIH-EHDI Procedure Declined Value Set:

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.20
	Vocabulary:	2.16.840.1.113883.6.96
Sequence	SNOMED-CT Code	Description
1	183949008	Assessment examination refused (situation)
2	183945002	Procedure refused - religion (situation)
3	183948000	Refused procedure - parent's wish (situation)
4	397709008	Patient died (finding)

Add section 6.5.V. (Added 2011-09 from QRPH EHCP profile)

6.5.V JCIH-EHDI Newborn Hearing Screening Abnormal Results Value Set Codes

6.5.V.1 Metadata

Metadata Element	Description	Mandatory
Identifier	unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.23
Name	name of the value set	JCIH-EHDI Newborn Hearing

Metadata Element	Description	Mandatory
		Screening Abnormal Results Value Set
Source	source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect abnormal results from the hearing screening procedure
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group MAY also have an OID assigned.	IHE EHDI

6.5.V.2 JCIH-EHDI Newborn Hearing Screening Abnormal Results Value Set

JCIH-EHDI Newborn Hearing Screening Abnormal Results Value Set:

	Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.15.2.23
	Vocabulary:	2.16.840.1.113883.6.96
Sequence	SNOMED-CT Code	Description
1	313203003	Hearing test abnormal (finding)
2	308409008	Child hearing screening failure (finding)
3	185577006	Child hearing screening first failure (finding)
4	185579009	Child hearing screening second failure (finding)
5	185580007	Child hearing screening failure referred to specialist (finding)

5855 *Add section 6.5.W. (Added 2011-09 from QRPH PRPH-Ca profile)*

6.5.W Primary Site Value Set

LOINC = 22035-0	
Code System: ICD-O-3 2.16.840.1.113883.6.43.1	
Code	**Meaning**
	A code from ICD-O-3 (Topography Section)

Add section 6.5.X (Added 2011-09 from QRPH PRPH-Ca profile)

6.5.X Histologic Type Value Set

LOINC = 31205-8	
Code System: ICD-O-3 2.16.840.1.113883.6.43.1	
Code	**Meaning**
	An ICD-O-3 code (Morphology Section)

5860

Add section 6.5.Y (Added 2011-09 from QRPH PRPH-Ca profile)

6.5.Y Derived AJCC Descriptor (T,N,M) Value Set

LOINC = 21908-9	
Code System: 2.16.840.1.113883.15.6	
Code	**Meaning**
c	clinical
p	pathologic
a	Autopsy classification
yc or yp	Posttherapy classification “y” prefex to utilize with “c: or “p” for denoting extent of cancer after neoadjuvant or primary systemic and/or radiation therapy
r	Retreatment Classification

Add section 6.5.Z (Added 2011-09 from QRPH PRPH-Ca profile)

5865 **6.5.Z TNM Edition Value Set**

LOINC = 21917-0	
Code System: 2.16.840.1.113883.15.6	
Code	**Meaning**
5	AJCC Staging Manual, 5th Edition
6	AJCC Staging Manual, 6th Edition
7	AJCC Staging Manual, 7th Edition

Add section 6.5.AA (Added 2011-09 from QRPH PRPH-Ca profile)

6.5.AA TNM Stage Group Value Set

Note: The AJCC Staging Manual TNM system is propriety and its definitions cannot be included in other documents without permission.

LOINC = 21908-9	
Code System: TNM 5. Edition: 2.16.840.1.113883.15.8 - tnm5 TNM 6. Edition: 2.16.840.1.113883.15.7 - tnm6 TNM 7. Edition: 2.16.840.1.113883.15.6 - tnm7	
Code	**Description: Site specific descriptions prevent listing of text equivalents.**
0	Site specific descriptions prevent listing of text equivalents.
0a	“
0is	“
I	“
IA	“
IA1	“
IA2	“
IB	“
IB1	“
IB2	“
IC	“
II	“
IIA	“
IIA1	“
IIA2	“
IIB	“
IIC	“
III	“
IIIA	“
IIIB	“
IIIC	“
IS	“
IV	“
IVA	“
IVB	“
IVC	“

Add section 6.5.BB (Added 2011-09 from QRPH PRPH-Ca profile)

6.5.BB TNM Stage Descriptor Value Set

Note: The AJCC Staging Manual TNM system is propriety and its definitions cannot be included in other documents without permission.

LOINC = 21909-7	
Code System: TNM 5. Edition: 2.16.840.1.113883.15.8 - tnm5 TNM 6. Edition: 2.16.840.1.113883.15.7 - tnm6 TNM 7. Edition: 2.16.840.1.113883.15.6 - tnm7	
Code	**Meaning**
0	None
1	E (Extranodal, lymphomas only)
2	S (Spleen, lymphomas only)
3	M (Multiple primary tumors in a single site)
4	Y (Classification during or after initial multimodality therapy)—pathologic staging only
5	E & S (Extranodal and spleen, lymphomas only)
6	M & Y (Multiple primary tumors and initial multimodality therapy)

Add section 6.5.CC (Added 2011-09 from QRPH PRPH-Ca profile)

6.5.CC TNM Tumor Value Set

Note: The AJCC Staging Manual TNM system is propriety and its definitions cannot be included in other documents without permission.

LOINC = 21905-5	
Code System: TNM 5. Edition: 2.16.840.1.113883.15.8 - tnm5 TNM 6. Edition: 2.16.840.1.113883.15.7 - tnm6 TNM 7. Edition: 2.16.840.1.113883.15.6 - tnm7	
Code	**Description: Site specific descriptions prevent listing of text equivalents.**
Ta	Site specific descriptions prevent listing of text equivalents.
Tis	“
T0	“
T1	“
T1mic	“
T1a	“
T1a1	“
T1a2	“
T1b	“
T1b1	“
T1b2	“
T1c	“

T1d	“
T2	“
T2a	“
T2a1	“
T2a2	“
T2b	“
T2c	“
T2d	“
T3	“
T3a	“
T3b	“
T3c	“
T3d	“
T4	“
T4a	“
T4b	“
T4c	“
T4d	“
T4e	“
Tx	“

Add section 6.5.DD (Added 2011-09 from QRPH PRPH-Ca profile)

6.5.DD TNM Node Value Set

Note: The AJCC Staging Manual TNM system is propriety and its definitions cannot be included in other documents without permission.

LOINC = 21906-3	
Code System: TNM 5. Edition: 2.16.840.1.113883.15.8 - tnm5 TNM 6. Edition: 2.16.840.1.113883.15.7 - tnm6 TNM 7. Edition: 2.16.840.1.113883.15.6 - tnm7	
Code	**Description: Site specific descriptions prevent listing of text equivalents.**
N0	Site specific descriptions prevent listing of text equivalents.
N1	“
N1mi	“
N1a	“
N1b	“
N1b1	“
N1b2	“
N1b3	“
N1b4	“
N1c	“

N2	“
N2a	“
N2b	“
N2c	“
N3	“
N3a	“
N3b	“
N3c	“
N	“

Add section 6.5.EE (Added 2011-09 from QRPH PRPH-Ca profile)

6.5.EE TNM Metastasis Value Set

Note: The AJCC Staging Manual TNM system is propriety and its definitions cannot be included in other documents without permission.

LOINC = 21907-1	
Code System: TNM 5. Edition: 2.16.840.1.113883.15.8 - tnm5 TNM 6. Edition: 2.16.840.1.113883.15.7 - tnm6 TNM 7. Edition: 2.16.840.1.113883.15.6 - tnm7	
Code	**Description: Site specific descriptions prevent listing of text equivalents.**
M0	Site specific descriptions prevent listing of text equivalents.
M1	“
M1a	“
M1b	“
M1c	“
M1d	“
M1e	“
Mx	“

Add section 6.5.FF (Added 2013-09 for the QRPH VRDR supplement)

6.5.FF QRPH VRDR Autopsy Procedure Performed Codes

6.5.FF.1 Metadata

Autopsy Procedure Performed Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.1

Metadata Element	Description	Mandatory
Name	This is the name of the value set	VRDR Autopsy Procedure Performed Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect that there was an Autopsy Procedure Performed
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2013
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	4/3/2013
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE VRDR

6.5.FF.2 VRDR Autopsy Procedure Performed Value Set

VRDR Autopsy Procedure Performed Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.1
Vocabulary:	**2.16.840.1.113883.6.96**
SNOMED-CT Code	**SNOMED-CT Description**
9427006	Autopsy review
16521010	Autopsy review
16522015	Autopsy review, NOS
68184000	Autopsy review, consultation and report
60864000	Autopsy review for conference (procedure)
86693001	Autopsy review for teaching (procedure)
5785009	Forensic autopsy (procedure)
61501008	Forensic autopsy, extensive (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.1
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
29240004	Autopsy examination (procedure)
48926013	Autopsy examination
48930011	Autopsy
48927016	Autopsy examination, NOS
48928014	Autopsy, NOS
41770000	Autopsy, gross and microscopic examination (procedure)
56417000	Autopsy, gross and microscopic examination with brain (procedure)
41554000	Autopsy, gross and microscopic examination with brain and spinal cord (procedure)
74348008	Autopsy, gross and microscopic examination, limited (procedure)
57438004	Autopsy, gross and microscopic examination, regional (procedure)
16361008	Autopsy, gross and microscopic examination, stillborn or newborn (procedure)
4447001	Autopsy, gross and microscopic examination, stillborn or newborn without CNS (procedure)
82823006	Autopsy, gross examination with brain (procedure)
47197006	Autopsy, gross examination with brain and spinal cord (procedure)
72598009	Autopsy, gross examination, limited (procedure)
47847005	Autopsy, gross examination, limited, regional (procedure)
50333006	Autopsy, gross examination, macerated stillborn (procedure)
35459000	Autopsy, gross examination, stillborn or newborn (procedure)
26762004	Autopsy, gross examination, teaching, complete (procedure)
22677004	Autopsy, gross examination, teaching, limited (procedure)
5785009	Forensic autopsy (procedure)
430339001	Pediatric autopsy (procedure)
90864005	Special autopsy procedure, explain by report (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.1
Vocabulary:	**2.16.840.1.113883.6.96**
SNOMED-CT Code	**SNOMED-CT Description**
43939005	Autopsy service by diener (procedure)
71604005	Forensic autopsy, coroner's call (procedure)
108259003	Autopsy pathology procedure AND/OR service (procedure)
59543001	Autopsy, clerical procedure (procedure)
29915004	Autopsy, clerical with coding procedure (procedure)
3133002	Patient discharge, deceased, autopsy (procedure)

Add section 6.5.GG (Added 2013-09 form the QRPH VRDR supplement.)

6.5.GG QRPH VRDR Autopsy Not Performed Codes

6.5.GG.1 Metadata

Autopsy Not Performed Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.2
Name	This is the name of the value set	VRDR Autopsy Not Performed Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect that there was an Autopsy was not performed
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2013
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	4/3/2013

Metadata Element	Description	Mandatory
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE VRDR

6.5.GG.2 VRDR Autopsy Not Performed Value Set

VRDR Autopsy Not Performed Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.2
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
44551000009109	Autopsy not performed (finding)
76231000009111	No post performed
76241000009117	Post mortem examination not performed
76221000009114	Autopsy not performed
408775001	Consent for postmortem declined (finding)
2470636019	Consent for postmortem declined
2477187017	Consent for autopsy declined
79779006	Patient discharge, deceased, no autopsy (procedure)

Add section 6.5.HH (Added 2013-09 form the QRPH VRDR supplement.)

6.5.HH VRDR Discharge Death Codes

6.5.HH.1 Metadata

Discharge Death Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3 .1.1.23.8.3
Name	This is the name of the value set	VRDR Discharge Death Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Discharge disposition of death

Metadata Element	Description	Mandatory
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from UB04
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	www.nubc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2013
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2013
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE VRDR

6.5.HH.2 VRDR Discharge DeathValue Set

Discharge Death Value Set will use the UB-04/NUBC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Section Template :	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.3
Vocabulary:	UB04 OID
UB-04/NUBC Code	Description
20	Expired

Add section 6.5.II (Added 2013-09 form the QRPH VRDR supplement.)

6.5.II VRDR Death Location Type Codes

6.5.II.1 Metadata

Death Location Type Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3 .1.1.23.8.4
Name	This is the name of the value set	Death Location Type

Metadata Element	Description	Mandatory
		Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the location where the decedent died
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from the HL7 VRDR CDA Death Location Types
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	www.HL7.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2013
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2013
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE VRDR

6.5.II.2 VRDR Death Location Type Value Set

5930 Death Location Type Value Set will use the HL7 Death Location Type code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set:	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.4
Vocabulary:	**2.16.840.1.113883**
HL7 Death Location Type Code	**HL7DeathLocationType**
H-IN	Hospital Inpatient
H-ER/ OP	Hospital Emergency Department or Outpatient
H-DOA	Hospital Dead on Arrival
NH	Nursing Home

RES	Residence
OTH	Other

Add section 6.5.JJ (Added 2013-09 form the QRPH VRDR supplement.)

6.5.JJ VRDR Death Certification Procedure Codes

6.5.JJ.1 Metadata

Death Certification Procedure Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.6
Name	This is the name of the value set	VRDR Death Certification Procedure Performed Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect that there was a Death Certification Procedure Performed
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2013
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	4/3/2013
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE VRDR

6.5.JJ.2 VRDR Death Certification Procedure Performed Value Set

Death Certification Procedure Performed Value Set will use the HL7 Transportation Relationship Type code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.6
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
308646001	Death certification (procedure)

Add section 6.5.KK (Added 2013-09 form the QRPH VRDR supplement.)

6.5.KK VRDR Death Pronouncement Procedure Codes

6.5.KK.1 Metadata

Death Pronouncement Procedure Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.7
Name	This is the name of the value set	VRDR Death Pronouncement Procedure Performed Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect that there was a Death Pronouncement Procedure Performed
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0

Metadata Element	Description	Mandatory
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2013
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	4/3/2013
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE VRDR

6.5.KK.2 VRDR Death Pronouncement Procedure Performed Value Set

Death Pronouncement Procedure Performed Value Set will use the HL7 Transportation Relationship Type code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.23.8.7
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
428413005	Death verification (procedure)

Add Appendix Q

APPENDIX Q: Document Construction

Describe document construction.