Integrating the Healthcare Enterprise

IHE PCC
Technical Framework Supplement

Paramedicine Care Summary
(PCS)

HL7® FHIR® STU 4

Using Resources at FMM Level 0-N

Revision 2.0 – Draft for Public Comment

For review and comment only.

DO NOT implement this public comment version.

Date: January 12, 2021

Author: PCC Technical Committee

Email: pcc@ihe.net

Please verify you have the most recent version of this document. See here for Trial Implementation and Final Text versions and here for Public Comment versions.

Foreword

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

This supplement is published on January 12, 2021 for Public Comment. Comments are invited and can be submitted at http://www.ihe.net/PCC_Public_Comments. In order to be considered in development of the Trial Implementation version of the supplement, comments must be received by February 11, 2021.

This supplement describes changes to the existing technical framework documents.

"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 Patient Care Coordination domain can be found at 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://ihe.net/IHE_Process and http://ihe.net/Profiles.

The current version of the IHE Patient Care Coordination Technical Framework can be found at http://ihe.net/Technical_Frameworks.

CONTENTS

Introduction to this Supplement

Whenever possible, IHE profiles are based on established and stable underlying standards. However, if an IHE domain determines that an emerging standard has high likelihood of industry adoption, and the standard offers significant benefits for the use cases it is attempting to address, the domain may develop IHE profiles based on such a standard. During Trial Implementation, the IHE domain will update and republish the IHE profile as the underlying standard evolves.

Product implementations and site deployments may need to be updated in order for them to remain interoperable and conformant with an updated IHE profile.

This IPS Profile incorporates content from Release 4 of the emerging HL7® FHIR® specification. HL7 describes FHIR Change Management and Versioning at https://www.hl7.org/fhir/versions.html.

HL7 provides a rating of the maturity of FHIR content based on the FHIR Maturity Model (FMM): level 0 (draft) through N (Normative). See http://hl7.org/fhir/versions.html#maturity.

The FMM levels for FHIR content used in this profile are listed in the following table.

FHIR Content (Resources, Value Sets, etc.)	FMM Level
Documents	3
Composition	2
Patient	N
Practitioner	3
MedicationStatement	3
Medication	3
AllergyIntolerance	3
Condition	3
Immunization	3
Procedure	3
Organization	3
DeviceUseStatement	0
Device	2
Observation	N
Specimen	2
Imaging Study	3
DiagnosticReport	3
CarePlan	2
Consent	2

FHIR Content (Resources, Value Sets, etc.)	FMM Level
VitalSigns	N/A
Encounter	N/A
MedicationAdministration	2
ServiceRequest	2

When a patient is transported for a medical emergency to a hospital, scene information, transfer information, patient assessments, and interventions are only verbally available to hospitals when the patient arrives. This results in inefficiencies and potential errors in the patient care process. This profile will map the flow of the patient information from the ambulance patient record, commonly known as the electronic Patient Care Record (ePCR), to the hospital Electronic Medical Record (EMR).

Open Issues and Questions

1. What are the implications to this profile of the current developments in HL7 related to supporting Document and/or Note sourcing, retrieval, creation, and consumption? There are ongoing conversations in the Patient Care Workgroup around coming up with a proposal for managing documents and notes within FHIR. Some viewpoints are focused on simply locating clinical documents and/or notes (i.e., metadata) whereas as other viewpoints desire to explore what content might actually be included in the documents and notes.
    a. See HL7 patient care work group discussion: *http://wiki.hl7.org/index.php?title=ClinicalNote_FHIR_Resource_Proposal* See Monday Q2 HL7 WGM discussion related to this topic: *http://wiki.hl7.org/index.php?title=January_2018_WGM_New_Orleans;_Jan_27_to_Feb_8*
2. There are a number of issues relating to the FHIR mapping and resources needed to support this profile:
    a. Investigate the FHIR process for defining the resources required to fulfill NEMSIS.
    b. The injury information may need to be more extensive modeling in FHIR.
    c. There is no value set in FHIR relating to the level of care of ambulance units.
    d. Extensions in FHIR need to me made to help include some of the needed attributes.
    e. IHE has filed a ticket against the FHIR specification #16237 to allow for EMS events to be recorded in a status history without the use of the extension
    f. IHE has filed a ticket against the FHIR specification #16238 to allow for there to be an outcome element for the end of the encounter.
    g. Document reference for Advanced Directives in the FHIR mapping table can support the use case as it exists today. Currently there are ongoing efforts within HL7 to make available the clauses of an advanced directives available in coded form.

3. Should there be a section which explicitly describes the differences in EMS PCR concepts as opposed to the IHE Medical Summary Sections. For example, the Advanced Directives Section in the Medical Summary allows for the inclusion of the Advanced Directive documentation (or links to the documentation). The EMS PCR provides coding as to the type of Advanced Directives which the EMS knows exists. OR do we just create a new Section in 6.3.1.D.5x and discuss the content.
    a. The EMS Situation Chief Complaint is used to populate the Reason for Referral as well as the Primary Symptoms, Other Associated Symptoms, and Provider's Primary and Secondary Impressions.
    b. The EMS Situation
    c. The EMS Medical Allergies and Environment/Food Allergies are used to populate the standard Allergies and Adverse Reactions Section.
    d. The EMS Current Medications is used to populate the standard Medications Section.
    e. The EMS Vital Signs are used to populate the standard Vital Signs Section. Note: This includes Body Weight which is documented in the EMS Physical Assessment Section.
    f. The EMS Physical Assessment us used to populate the standard Physical Examination Section.
    g. The EMS Medications Administered is used to populate the standard Medications Administered and Allergies and Adverse Reactions Sections.
    h. The Pregnancy Status, Last Oral Intake and Last Known Well data elements have been populated to a new Review of Systems – EMS Section.
4. In consideration of reusable vital sign concepts:
    a. 8884-9 Heart rate rhythm is used for the vital signs instead of 67519-9 Cardiac rhythm NEMSIS
    b. 72089-6 Total score [NIH Stroke Scale] is used for the vital signs instead of 67520-7 Stroke scale overall interpretation NEMSIS
    c. 11454-6 Responsiveness assessment at First encounter is used for the vital signs instead of 67775-7 Level of responsiveness NEMSIS
    d. 2710-2 Oxygen Saturation is used for the vital signs instead of 2708-6 Oxygen saturation in Arterial blood
    e. Also included in vital sign metrics is 80341-1 Respiratory effort, which is not in the EMS Run Report, but is part of the data dictionary for this specification
    f. The EMS VITAL SIGNS created a new Vital Signs Organizer to contain all of the additional Vital Signs collected. This has been modelled using the IHE PCC Vital Signs adding the additional vital sign observations
5. The following vital signs are not included in the specification:
    a. Reperfusion check list - This is a checklist and does not appear to be a vital sign. If it is required, it needs to be modelled and additional information needs to be (what are the outputs that need to be captured).
    b. The Respiratory Effort is not currently included in the EMS Patient Care Report. Are there any constraints that should be placed on the Respiratory Effort vocabulary?

c. Pulse Rhythm is not currently included in the EMS Patient Care Report. No definition exists in either the IHE or HL7 CDA specifications.

6. The following HL7 EMS Patient Care Report value sets are referenced, but no Value Sets have been defined. This information is needed so that the specification can be complete and decisions can be made on whether the value set needs to be internationalized.
   a. MedicationClinical Drug (2.16.840.1.113883.3.88.12.80.17)
   b. Medication omission reason (2.16.840.1.113883.17.3.5.42)
7. The following attributes are not modeled in this specification because this use case focuses on communicating relevant information from EMS into the hospital:
   a. Medication Response Observation
   b. Medication Prior Administration Observation
   c. Patient age (can be computed from birthdate)
   d. Barrier to care
8. In order to use the standard Medications Section from the Medical Summary, a number of the EMS Current Medication concepts were transformed. Public Comment is requesting that these transformations be verified.,
   a. we have the ability to document Drug Treatment Unknown and No Drug Therapy Prescribed
   b. There are currently no codes to indicate the Patient is on Anticoagulants (without specifying the substance).
   c. What should the SNOMED CT parent be to specify allergen (This should be an existing international value set). Recommendation is to use the HL7 Allergen Type mapped to SNOMED CT.
9. In order to use the standard Medications Administered Section from the Medical Summary, a number of the EMS Medications Administered concepts were transformed (and other were not). Public Comment is requesting that these transformations be reviewed.
   a. Reason for not Administering the Medication was moved forward.
   b. Medication Complications were moved to the standard Allergies and Adverse Reactions Section.
   c. Medication Response Observation was not moved forward.
   d. Medications Prior to Administration was not moved forward.
10. A new Review of Systems – EMS section has been created which includes information related to Pregnancy Status, Last Oral Intake, and Time Last Known Well.
11. Public Comment input is requested to review the EMS Cardiac Arrest Event Section to ensure there aren't any US Specific concepts.
12. Public Comment input is requested to review the transformation of the EMS Patient Care Report information for use in the Reason for Referral Section.
13. Public Comment input is requested to review whether the EMS Situation Section should be moved forward since most of the information is transformed to other Sections within the EMS Patient Care Medical Summary.
14. Should there be a special section to "vital signs obtained prior to EMS" that should be specially tagged?

15. Review the FHIR mapping for the Medications sections. There seem to have a combination of complex and simple uses for the FHIR structuring and we are unsure is it is appropriate to be mixing the two.
16. Review the FHIR mapping for the “protocol age category”.
17. A complete example of the Paramedicine Care Summary (PCS) Document Content Module should be made to be available on the IHE ftp server at: ftp://ftp.ihe.net/TF_Implementation_Material/PCC/PCS/.
18. The LOINC code more specific to the CDA documents will be requested.
19. The following data elements do not currently have FHIR resources that they can be mapped to. When they are created they will be added to the 6.6.X.3.2 FHIR Resource Data Specifications table.
    a. eSoftware Creator
    b. eSoftware Name
    c. eSoftware Version
    d. Standby Purpose
    e. Primary Role of the Unit
    f. Type of dispatch delay
    g. Type of response delay
    h. Type of scene delay
    i. Type of transport delay
    j. Type of turn-around delay
    k. EMS vehicle (unit) number
    l. EMS unit call sign
    m. Vehicle Dispatch GPS Location
    n. EMD Performed
    o. EMD Card Number
    p. Dispatch Center Name or ID
    q. Unit Dispatched CAD Record ID
    r. Response Urgency
    s. First EMS Unit on Scene
    t. Date/Time Initial Responder Arrived on Scene
    u. Numbers of Patients on Scene
    v. Scene GPS Location
    w. Incident Facility or Location Name
    x. Incident Street Address
    y. Incident Apartment, Suite, or Room
    z. Time Units of Duration of Complaint
    aa. Patient's Occupational Industry
    bb. Patient's Occupation
    cc. Presence of Emergency Information Form
    dd. Destination GPS Location
    ee. Type of Destination
    ff. Hospital In-Patient Destination
    gg. Date/Time of Destination Prearrival Alert or Activation

Closed Issues

1. (2/12/2018) Committee decided to use both CDA and FHIR. This is the same approach used in RIPT. CDA is more prevalent in "production" settings and is expected to remain so for the expected future and thus needs to be included. FHIR will help to "future-proof" by providing an implementation path for vendors that are newer to the market and not willing to invest in a full CDA supported infrastructure.
2. The PCS Profile leverages Sections/Entries from the HL7 EMS Patient Care Report which have US Realm Constraints, and used, were they exists, sections and entries that represent the information from the IHE CDA content modules so that discrete import and interpretation are able to be more readily used by EMRs that already support IHE Medical Summary.
3. The PCS Profile adds to the IHE Medical Summary constraints those identified by the HL7 EMS Patient Care Report that support the EMS concepts.
4. The EMS Advance Directives concept is different from the IHE PCC Advance Directive concept, so both are being maintained within the EMS Patient Care Medical Summary.
5. Only Header Data Elements that are constrained are listed in the Header Information Table. It is assumed that all the other header information is inherited from the Medical Summary.
6. Committee removed Billing section requirements from volume 3 and keep billing constraints in volume 4 and keep the codes the way that they are (7/16/2018).
7. Committee moved to add “Per EMS” to the element name for Hospital capability as seen by the EMS reporting. The Mapping will remain the same. (7/18/18).
8. Public Comment input was requested to review the EMS Procedures Performed. Currently the information in this Section does match the IHE PCC concept of List of Surgeries as a Procedure Entry. Committee moves forward using the procedure entry for IHE and using an extension to be able to continue with an IHE extension of the procedure entry that includes the concepts found in the Hl7 EMS Procedures Performed. (7/18/18).
9. Committee moves forward with the EMS Past Medical History Section from the HL7 spec. Even though there is currently there is not enough information in this Section (e.g., start/end dates, if the condition still exists) to transform it into a standard Past Medical History, committee moves forward anyway.
10. Committee has determined that there were no international needs for the EMS Disposition Section Value Sets to be updated for international needs and will move forward with this value set. (7/18/18).
11. Comment has determined that all additional EMS specific data elements/Sections which need to be mapped into the patient medical record via the Paramedicine Care Summary-Complete Report; however, the data in the Paramedicine Care Summary – Clinical subset should be limited to information which may be used for patient care.
12. OIDs have been assigned and added into the profile.
13. The Advance Direct Type Vocabulary is not US Realm specific.
14. A new Mental Status Entry based upon the HL7 C-CDA R2 IG has been created.
15. We are interpreting the “return of spontaneous circulation” as a vital sign.
16. The Clinical subset is reduced to the entry level.

17. We are interpreting the “Type of CPR provided” as the techniques used by those performing CPR prior to the EMS arrival. If this were to be used to describe the type of CPR provided by EMS it would be recorded as a procedure.

IHE Technical Frameworks General Introduction

The IHE Technical Framework General Introduction is shared by all of the IHE domain technical frameworks. Each technical framework volume contains links to this document where appropriate.

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The IHE Technical Framework General Introduction Appendices are components shared by all of the IHE domain technical frameworks. Each technical framework volume contains links to these documents where appropriate.

Update the following appendices to the General Introduction as indicated below. Note that these are not appendices to this domain's Technical Framework (TF-1, TF-2, TF-3 or TF-4) but rather, they are appendices to the IHE Technical Frameworks General Introduction located here.

Appendix A – Actor Summary Definitions

*Add the following **new or modified** actors to the IHE Technical Frameworks General Introduction Appendix A:*

New (or modified) Actor Name	Description
No new actors	

In addition to new actors (if any) the table below lists *existing* actors that are utilized in this profile.

List of Existing Actors Utilized in this Profile (as defined in Gazelle)

Existing Actor Name	Definition
Content Creator	The Content Creator Actor creates content and transmits to a Content Consumer.
Content Consumer	The Content Consumer Actor views, imports, or performs other processing of content created by a Content Creator Actor.

Appendix B – Transaction Summary Definitions

*Add the following **new or modified** transactions to the IHE Technical Frameworks General Introduction Appendix B:*

New (or modified) Transaction Name and Number	Definition
No new transactions	

Appendix D – Glossary

505 *Add the following **new or modified glossary** terms to the IHE Technical Frameworks General Introduction Appendix D.*

New (or modified) Glossary Term	Definition	Synonyms	Acronym/ Abbreviation
No new terms			

Volume 1 – Profiles

X Paramedicine Care Summary (PCS) Profile

Currently, patient interventions and assessments are written into an ambulance electronic Patient Care Record (ePCR), and are either manually updated by the Emergency Medical Services (EMS) crew, or collected from electronic devices (e.g., hemodynamic monitor). The ePCR is updated with treatments and interventions that are administered during the transport. The hospital will not typically have access to paper or electronic versions of this patient information until the report is finished and signed in the ePCR and only if it is requested by the hospital. In this profile, the prehospital and paramedicine interventions and patient assessments are made available to the hospital/emergency room IT system electronically when the patient arrives, or in advance of patient arrival to the hospital. This informs medical decision making during the hospital treatment to improve patient care and to save lives. Additional information that can be found in the completed report can be shared with the hospital in electronic and codable form. The information available can then be used to report to registries and quality reporting.

X.1 PCS Actors, Transactions, and Content Modules

This section defines the actors, transactions, and/or content modules in this profile. General definitions of actors are given in the Technical Frameworks General Introduction Appendix A. IHE Transactions can be found in the Technical Frameworks General Introduction Appendix B. Both appendices are located at http://ihe.net/Technical_Frameworks/#GenIntro

Figure X.1-1 shows the actors directly involved in the PCS Profile and the relevant transactions between them. If needed for context, other actors that may be indirectly involved due to their participation in other related profiles are shown in dotted lines. Actors which have a required grouping are shown in conjoined boxes (see Section X.3).

Figure X.1-1: PCS Actor Diagram

Table X.1-1 lists the transactions for each actor directly involved in the PCS Profile. To claim compliance with this profile, an actor shall support all required transactions (labeled "R") and may support the optional transactions (labeled "O").

Table X.1-1: PCS Profile – Actors and Transactions

Actors	Transactions	Initiator or Responder	Optionality	Reference
Content Creator	Document Sharing [PCC-1]	Initiator	R	PCC TF-2: 3.1
Content Consumer	Document Sharing [PCC-1]	Responder	R	PCC TF-2: 3.1

Figure X.1-1 shows the actors directly involved in the PCS Profile and the direction that the content is exchanged.

A product implementation using this profile may group actors from this profile with actors from a workflow or transport profile to be functional. The grouping of the content module described in this profile to specific actors is described in more detail in Required Actor Groupings PCC TF-1: X.3 or in Cross Profile Considerations PCC TF-1: X.6.

Table X.1-2 lists the content module(s) defined in the PCS Profile. To claim support with this profile, an actor shall support all required content modules (labeled "R") and may support optional content modules (labeled "O").

Table X.1-2: PCS – Actors and Content Modules

Actors	Content Modules	Optionality	Reference
Content Creator	Paramedicine Care Summary – Clinical Subset Document 1.3.6.1.4.1.19376.1.5.3.1.1.29.1	R	PCC TF-3: 6.3.1.D1
	Paramedicine Care Summary – Complete Report Document 1.3.6.1.4.1.19376.1.5.3.1.1.30.1	R	PCC TF-3: 6.3.1.D2
Content Consumer	Paramedicine Care Summary – Clinical Subset Document 1.3.6.1.4.1.19376.1.5.3.1.1.29.1	O Note1	PCC TF-3: 6.3.1.D1
	Paramedicine Care Summary – Complete Report Document 1.3.6.1.4.1.19376.1.5.3.1.1.30.1	O Note1	PCC TF-3: 6.3.1.D2

Note 1: The Content Consumer must be able to support at least one of these options.

X.1.1 Actor Descriptions and Actor Profile Requirements

Transactional requirements are documented in PCC TF-2 Transactions. This section documents any additional requirements on profile's actors.

Content module requirements are documented in PCC TF-2 Content Modules. This section documents any additional requirements on profile's actors.

X.1.1.1 Content Creator

- The Content Creator shall be responsible for the creation of content and sharing of two documents that summarize the emergency transport encounter Paramedicine Care

Summary – Clinical Subset (PCS-CS) containing the data elements defined in PCC TF-3: 6.3.1.D1 or, where the FHIR Option is used, containing the FHIR Composition bundle defined in PCC TF-3:6.6.x.2.1

- Paramedicine Care Summary – Complete Report (PCS-CR) containing the data elements defined in PCC TF-3: 6.3.1.D2, or, where the FHIR Option is used, containing the FHIR Composition bundle defined in PCC TF-3:6.6.x.2.1

X.1.1.1.1 Trigger Events

Upon patient handoff from the paramedicine care team to the receiving facility, a Paramedicine Care Summary – Clinical Subset will be shared with the receiving facility using the Document Sharing [PCC-1] transaction.

When the full Paramedicine Care Summary data is available, a Paramedicine Care Summary – Complete Report will be shared with the receiving facility using the Document Sharing [PCC-1] transactions.

X.1.1.2 Content Consumer

A Content Consumer is responsible for viewing, importing, or other processing options for Paramedicine Care Summary – Clinical Subset (1.3.6.1.4.1.19376.1.5.3.1.1.29.1) and Paramedicine Care Summary – Complete Report (1.3.6.1.4.1.19376.1.5.3.1.1.30.1) documents content created by a PCS Content Creator. This is specified in [PCC-1] document sharing transaction in PCC TF-2: 3.1

X.2 PCS Actor Options

Options that may be selected for each actor in this profile, if any, are listed in the Table X.2-1. Dependencies between options, when applicable, are specified in notes.

Table X.2-1: Paramedicine Care Summary – Actors and Options

Actor	Option Name	Reference
Content Creator	CDA Option [Note1]	Section X.2.1
	FHIR Option [Note1]	Section X.2.2
Content Consumer	View Option [Note2]	PCC TF-2: 3.1.1
	Document Import Option [Note2]	PCC TF-2: 3.1.2
	Section Import Option [Note2]	PCC TF-2: 3.1.3
	Discrete Data Import Option [Note2]	PCC TF-2: 3.1.4
	Clinical Subset Data Import Option [Note3]	Section X.2.5
	Quality Data Import Option [Note3]	Section X.2.3
	Trauma Data Import Option [Note3]	Section X.2.4

Note 1: The Content Creator must be able to support at least one of these options.

Note 2: The Content Consumer must implement at least one of these options.

Note 3: If the Content Consumer implements any of these options, it must also support the Discrete Data Import Option.

X.2.1 CDA Option

This option defines the processing requirements placed on the Content Creators for producing a CDA structured document version of the Paramedicine Care Summary documents. The CDA details are in Volume 3, Section 6.3.1

X.2.2 FHIR Option

This option defines the processing requirements placed on the Content Creators for producing a FHIR document bundle version of the Paramedicine Care Summary documents. The FHIR bundle details are in Volume 3, Section 6.6.x.2.

X.2.3 Quality Data Import Option

This option defines the processing requirements placed on the Content Consumers for providing access and importing quality data from selected sections of the Paramedicine Care Summary. The discrete data import data details are in Volume 3, Section 6.6.x.5.

X.2.4 Trauma Data Import Option

This option defines the processing requirements placed on the content consumers for providing access and importing trauma data from selected sections of the Paramedicine Care Summary. The discrete data import data details are in Volume 3, Section 6.6.x.6.

X.2.5 Clinical Subset Data Import Option

This option defines the processing requirements placed on the Content Consumers for providing access and importing the clinical subset data from selected sections of the Paramedicine Care Summary. The discrete data import data details are in Volume 3, Section 6.6.x.4.

X.3 PCS Required Actor Groupings

There are no required actor groupings for this profile.

X.4 PCS Overview

Transferring patient information from a Paramedicine ePCR using a send transaction can increase the efficiency of patient hand off between ambulance and hospitals.

X.4.1 Concepts

When a hospital is receiving a patient arriving in an emergency ambulance transport, the main source of the patient information is the ambulance crew that performed the emergency transport. This information is not typically electronically transferred and therefore this relay of information is usually verbal. This can draw away from the treatment of the patient. The use of an interoperable transfer of patient information can reduce the time spent relaying information and provide the hospital treatment team with patient information that can be used to make decisions on their treatment upon their arrival to the hospital.

X.4.2 Use Cases

X.4.2.1 Use Case #1: Emergency Response for Heart Attack

This use case describes how an emergency response for a heart attack is carried out and then how the information on interventions are recorded and provided to a hospital.

X.4.2.1.1 Emergency Response for Heart Attack Use Case Description

A fifty-year-old man develops heart attack symptoms. He calls 911 for an emergency transport to a hospital. The emergency transport team is able to retrieve some of the patient's medical history, current medications and allergies from the patient and inputs this information in their Electronic Patient Care Record (ePCR). The patient told EMTs that he had already taken his prescribed nitroglycerine thirty minutes before calling 911 when the chest pain first presented. A 12 lead EKG was established to monitor the patient's heart rhythm and the rhythm shows abnormalities indicative to a myocardial infarction. The EMT starts an intravenous line in the patient's left arm. During the transport the patient's chest pain increases and breathing is elevated. After ensuring that the patient is not on any blood thinners, the EMT administers aspirin to the patient. The patient felt relief after he was given aspirin. However, after feeling this relief, he falls into cardiac arrest. Compressions are started and maintained until arrival at the hospital. The patient information is made available to the hospital system and the hospital has full access to the EKG data, vitals, and interventions that were shared during the transport. The EMS ePCR is completed and then electronically shared with the hospital to be available for quality metrics. This sharing can be either directly or through a document sharing infrastructure.

X.4.2.1.2 Emergency Response for Heart Attack Patient Process Flow

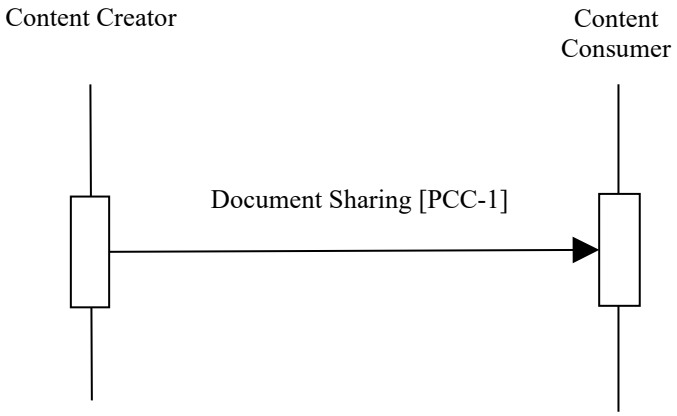

Figure X.4.2.1.2-1: Basic Process Flow in PCS Profile

Pre-conditions:

The person calling 911 is suffering from an emergent issue.

An EMS response team is sent out for the call.

Main Flow:

EMS provider arrives on scene and inputs the patient information into the ePCR.

Interventions are performed and documented during transport.

EMS, either directly or through a document sharing infrastructure, provides the information for the current patient condition and interventions that were performed to the hospital.

The patient care is transferred to the hospital staff.

Post-conditions:

The patient care is continued in the hospital.

The Paramedicine Care Summary – Complete, is completed and the full report is provided either directly or through a document sharing infrastructure, to the hospital.

X.5 PCS Security Considerations

See ITI TF-2.x: Appendix Z.8 "Mobile Security Considerations".

X.6 PCS Cross Profile Considerations

The information that is imported by the Paramedicine Care Summary (PCS) Content Consumer implementing the quality option may be leveraged to support content needed for the Quality Outcome Reporting for EMS (QORE) Profile.

The use of the IHE XD* family of transactions is encouraged to support standards-based interoperability between systems acting as the PCS Content Creator and PCS Content Consumer. However, this profile does not require any groupings with ITI XD* actors to facilitate transport of the content document it defines.

IHE transport transactions that MAY be utilized by systems playing the roles of PCS Content Creator or Content Consumer to support the standard use case defined in this profile:

A Document Source in XDS.b, a Portable Media Creator in XDM, or a Document Source in XDR might be grouped with the PCS Content Creator. A Document Consumer in XDS.b, a Portable Media Importer in XDM, or a Document Recipient in XDR might be grouped with the PCS Content Consumer. A registry/repository-based infrastructure is defined by the IHE Cross Enterprise Document Sharing (XDS.b) Profile that includes profile support that can be leveraged to facilitate retrieval of public health related information from a document sharing infrastructure: Multi-Patient Query (MPQ), and Document Metadata Subscription (DSUB).

A reliable messaging-based infrastructure is defined by the IHE Cross Enterprise Document Reliable Interchange (XDR) Profile. A Document Source in XDR might be grouped with the PCS Content Creator. A Document Recipient in XDR might be grouped with the PCS Content Consumer.

Detailed descriptions of these transactions can be found in the IHE IT Infrastructure Technical Framework.

Volume 1 Appendices

None

Volume 2 – Transactions

685

No new transactions.

Volume 2 Appendices

None

Volume 2 Namespace Additions

N/A

Volume 3 – Content Modules

5 IHE Namespaces, Concept Domains and Vocabularies

5.1 IHE Namespaces

No new namespaces.

5.2 IHE Concept Domains

No new concept domains.

5.3 IHE Format Codes and Vocabularies

5.3.1 IHE Format Codes

The following new Format Codes are introduced with the PCS Profile. A complete listing of IHE Format Codes can be found at http://wiki.ihe.net/index.php/IHE_Format_Codes.

Profile	Format Code	Media Type	Template ID
Paramedicine Care Summary – Clinical Subset (PCS-CS)	urn:ihe:pcc:pcs-cs:2018	text/xml	1.3.6.1.4.1.19376.1.5.3.1.1.29.1
Paramedicine Care Summary – Complete Report (PCS-CR)	urn:ihe:pcc:pcs-cr:2018	text/xml	1.3.6.1.4.1.19376.1.5.3.1.1.30.1

5.3.2 IHEActCode Vocabulary

NA

5.3.3 IHERoleCode Vocabulary

NA

6 Content Modules

6.3.1 CDA Document Content Modules

6.3.1.D1 Paramedicine Care Summary – Clinical Subset (PCS-CS) Document Content Module

The Paramedicine Care Summary – Clinical Subset document content module is a Medical Summary and inherits all header constraints from the International Patient Summary (2.16.840.1.113883.10.22.1.1). The intention of this document is to provide a clinical subset of the Paramedicine care report to an emergency department that does not include non-pertinent data.

6.3.1.D1.1 Format Code

The XDSDocumentEntry format code for this content is urn:ihe:pcc:pcs-cs:2018

6.3.1.D1.2 LOINC Code

The LOINC code for this document is 67796-3 -ParamedicineCareSummary.

6.3.1.D1.3 Referenced Standards

All standards which reference in this document are listed below with their common abbreviation, full title, and link to the standard.

Table 6.3.1.D1.3-1: Paramedicine Care Summary Document – Referenced Standards

Abbreviation	Title	URL
CDAR2	HL7 CDA Release 2.0	http://www.hl7.org/documentcenter/public/standards/dstu/CDAR2_IG_PROCNOTE_DSTU_R1_2010JUL.zip
HL7 IPS CDA	HL7 CDA® R2 Implementation Guide International Patient Summary STU Release 1	https://www.hl7.org/implement/standards/product_brief.cfm?product_id=483
SNOMED CT	SNOMED International	http://www.snomed.org/snomed-ct/get-snomed-ct
ISO/DIS 27269	ISO/DIS 27269 Health informatics — The international patient summary	https://www.iso.org/standard/79491.html
HL7 EMS DAM	HL7 Version 3 Domain Analysis Model, Emergency Medical Services, Release 1	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=421
HL7 EMS DIM	HL7 version 3 Domain Information Model; Emergency Model Services, release 1	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=302

6.3.1.D1.4 Data Element Requirement Mappings to CDA

This section identifies the mapping of data between referenced standards into the CDA implementation guide.

730 **Table 6.3.1.D1.4-1: Paramedicine Care Summary (PCS) – Data Element Requirement Mappings to CDA**

PCS Data Elements	IPS CDA
Patient Attributes	/ClinicalDocument/[IPS CDA recordTarget]
Patient's name	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/name
Address	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/addr
Telecoms	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/telecom
Administrative gender	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/administrativeGenderCode
Date of birth	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/birthTime
Patient's preferred language	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/languageCommunication/languageCode
Healthcare related identifiers	see below
Patient identifier	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/id
Insurance information	see below
Insurance identifier	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/id
Patient's Address Book	see below
Preferred healthcare providers	/ClinicalDocument/[IPS Patient Contacts]/code
Healthcare provider (person)	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson
Healthcare provider Name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson/name
Healthcare provider Role	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/code
Healthcare provider Telecoms	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/telecom
Healthcare provider (organization)	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/scopingOrganization
Organization's name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/scopingOrganization/name
Organization's Telecoms	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/telecom
Other's address details	see below
Addressee	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian
Addressee Role	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/code /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian
Addressee Name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson/name /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/guardianPerson/name
Addressee Address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/addr
Addressee Telecoms	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/telecom /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/telecom
Advance Directives Section	/ClinicalDocument/[IPS Advance Directives Section]
Advance Directives	/ClinicalDocument/[IPS Advance Directives Section]

PCS Data Elements	IPS CDA
Advance Directive	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer] /ClinicalDocument/[IPS Advance Directives Section]
Person Authorizing Directive	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/participant /ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/author
Person Authorizing Name	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/participant/participantRole/playingEntity/name /ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/author/assignedAuthor/assignedPerson/name
Person Authorizing Role	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/participant/participantRole/code /ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/author/assignedAuthor/code
Person Authorizing Telecoms	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/participant/participantRole/telecom /ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/author/assignedAuthor/telecom
Directive Category	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/code
Directive Description	/ClinicalDocument/[IPS Advance Directives Section]/text
Reference to Legal Document	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/reference/externalDocument
Allergies and Intolerances	/ClinicalDocument/[IPS Allergies and Intolerances Section]
Allergies/Intolerances content status	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/observation/code
Allergies and Intolerances	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance
Allergy/Intolerance	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]
Allergy/Intolerance description	/ClinicalDocument/[IPS Allergies and Intolerances Section]/text
Allergy/Intolerance Clinical status	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Allergy Status Observation]/value
Allergy/Intolerance Onset Date	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/observation/effectiveTime/low
Allergy/Intolerance End Date	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/observation/effectiveTime/high

PCS Data Elements	IPS CDA
Allergy/Intolerance Criticality	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Criticality Observation]
Allergy/Intolerance Certainty	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Allergy Certainty Observation]
Allergy/Intolerance Type of propensity	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/observation/code
Allergy/Intolerance Diagnosis	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/value
Allergy/Intolerance Reaction	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Reaction Manifestation]
Allergy/Intolerance Manifestation of the reaction	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Reaction Manifestation]/value
Allergy/Intolerance Severity	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Reaction Manifestation]/entryRelationship/[IPS Severity Observation]
Allergy/Intolerance Agent	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/participant
Allergy/Intolerance Agent code	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/participant/participantRole/playingEntity/code
Allergy/Intolerance Category	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/participant/participantRole/playingEntity/code
Functional Status Section	/ClinicalDocument/[IPS Functional Status Section]
Disabilities	/ClinicalDocument/[IPS Functional Status Section]
Disability	/ClinicalDocument/[IPS Functional Status Section]
Disability Description	/ClinicalDocument/[IPS Functional Status Section]/text
Disability Code	/ClinicalDocument/[IPS Functional Status Section]/entry/observation/value
Onset Date	/ClinicalDocument/[IPS Functional Status Section]/entry/observation/effectiveTime/low
Functional assessments (determines autonomy)	/ClinicalDocument/[IPS Functional Status Section]
Functional Assessment (type performed)	/ClinicalDocument/[IPS Functional Status Section]
Functional Assessment description	/ClinicalDocument/[IPS Functional Status Section]/text
Date of assessment	/ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/effectiveTime /ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/component/[IPS Survey Observation]/effectiveTime

PCS Data Elements	IPS CDA
Functional Assessment Type	/ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/code /ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/component/[IPS Survey Observation]/code
Functional Assessment Result	/ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/component/[IPS Survey Observation]/value
Functional Assessment	/ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/component/[IPS Survey Observation]
History of Past Problems	/ClinicalDocument/[IPS History of Past Illness Section]
Past problems	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]
Past problem	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]
Problem type	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/code
Problem Description	/ClinicalDocument/[IPS History of Past Illness Section]/text
Problem Diagnosis	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/value
Problem Severity	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/entryRelationship/[IPS Severity Observation]
Problem Onset Date	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/effectiveTime/low
Problem Status	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/entryRelationship/[IPS Problem Status Observation]
Date Problem Resolved	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/effectiveTime/high
Specialist Contact for problem	Not explicitly specified (see open issues #41)
History of Pregnancy Section	/ClinicalDocument/[IPS History of Pregnancy Section]
Current pregnancy status	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Status Observation]
Pregnancy description	/ClinicalDocument/[IPS History of Pregnancy Section]/text
Pregnancy details	see below
Date of observation	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Status Observation]/effectiveTime
Pregnancy state	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Status Observation]/value
Expected delivery date	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Status Observation]/entryRelationship/[IPS Pregnancy Expected Delivery Date Observation]/value
Specialist contact	Not explicitly specified (see open issues #41)
Previous history of pregnancies	/ClinicalDocument/[IPS History of Pregnancy Section]
Previous pregnancies status	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Observation]/value
Previous pregnancies description	/ClinicalDocument/[IPS History of Pregnancy Section]/text

PCS Data Elements	IPS CDA
Previous pregnancies	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Observation]
Previous pregnancy details	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Observation]
Outcome date	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Observation]/effectiveTime
Outcome	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Observation]/value
Specialist contact	Not explicitly specified (see open issues #41)
Summary metric	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Outcome Observation]
History of Procedures	/ClinicalDocument/[IPS History of Procedures Section]
Procedures content status	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]/code
Procedures	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]
Procedure	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]
Procedure code	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]/code
Procedure description	/ClinicalDocument/[IPS History of Procedures Section]/text
Body site	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]/targetSiteCode
Procedure date	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]/effectiveTime
Immunizations	/ClinicalDocument/[IPS Immunizations Section]
Immunizations content status	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/consumable/[IPS Immunization Medication Information]/manufacturedProduct/manufacturedMaterial/code
Immunizations	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]
Immunization	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]
Vaccine for type of disease	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/consumable/[IPS Immunization Medication Information]/manufacturedProduct/manufacturedMaterial/code
Target diseases	
Target disease	
Date of immunization	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/effectiveTime
Product administered	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/consumable/[IPS Immunization Medication Information]/manufacturedProduct/manufacturedMaterial/code
Brand name	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/consumable/[IPS Immunization Medication Information]/manufacturedProduct/manufacturedMaterial/code
Product administration process	see below

PCS Data Elements	IPS CDA
Performer	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/performer
Route of administration	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/routeCode
Medical Devices	/ClinicalDocument/[IPS Medical Devices Section]
Device content status	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]/participant/participantRole/playingDevice/code
Devices	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]
Device	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]
Device type	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]/participant/participantRole/playingDevice/code
Device identifier	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]/participant/participantRole/id
Use start date	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]/effectiveTime/low
Use end date	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]/effectiveTime/high
Medication Summary	/ClinicalDocument/[IPS Medication Summary Section]
Medication summary content status	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/code
Medications	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]
Medication	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]
Reason	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/entryRelationship/[Indication (V2)]
Medicinal product	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]
Product code	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/code
Product common name (and strength)	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/asSpecializedKind/name
Pharmaceutical dose form	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/formCode
Brand name	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/asContent/containerPackagedProduct/name
Active ingredients	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/ingredient
Active ingredient	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/ingredient

PCS Data Elements	IPS CDA
Substance code	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/ingredient/ingredientSubstance/code
Strength	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/ingredient/quantity
Administration instruction	see below
Instruction	/ClinicalDocument/[IPS Medication Summary Section]/text
Period of medication use	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/[UV Use Period]
Route of administration	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/routeCode
Dose instruction	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/entryRelationship/[IPS Subordinate SubstanceAdministration]
No. of units per intake	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/entryRelationship/[IPS Subordinate SubstanceAdministration]/doseQuantity
Frequency of intake	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/entryRelationship/[IPS Subordinate SubstanceAdministration]/effectiveTime
Plan of Care	/ClinicalDocument/[IPS Plan of Care Section]
Plans	/ClinicalDocument/[IPS Plan of Care Section]
Plan	/ClinicalDocument/[IPS Plan of Care Section]
Plan type	Not explicitly specified
Plan date	Not explicitly specified
Plan description	/ClinicalDocument/[IPS Plan of Care Section].text
Recommendations (Core Care Plan)	/ClinicalDocument/[IPS Plan of Care Section]/entry
Recommendation	/ClinicalDocument/[IPS Plan of Care Section]/entry/[…] (several templates)
Recommendation for treatment	depends on the template used
Given recommendation date	depends on the template used
Applicable date	depends on the template used
Extensive Plan	Not explicitly specified
Problems	/ClinicalDocument/[IPS Problems Section]
Problems content status	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/code
Problems	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]
Problem	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]
Problem type	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/code
Problem description	/ClinicalDocument/[IPS Problems Section]/text
Diagnosis	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/value
Severity	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/entryRelationship/[IPS Severity Observation]/value

PCS Data Elements	IPS CDA
Onset date	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/effectiveTime/low
Problem status	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/entryRelationship/[IPS Problem Status Observation]/value
Specialist contact	Not explicitly specified (see open issues #41)
Results	/ClinicalDocument/[IPS Results Section]
Observation results	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer] /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/[…] (several observation templates)
Observation result	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer] /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/[…] (several observation templates)
Date of observation	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/effectiveTime /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/effectiveTime
Observation type	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/code /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/code
Result description	/ClinicalDocument/[IPS Results Section]/text
Value	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/value
Observation result	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation
Performer	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/performer /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/performer
Observer	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/author
Social History	/ClinicalDocument/[IPS Social History Section]
Life style factors	/ClinicalDocument/[IPS Social History Section]/entry
Life style factor	/ClinicalDocument/[IPS Social History Section]/entry/[…] (several observation templates)
Life style factor description	/ClinicalDocument/[IPS Social History Section]/text
Life style factor details	/ClinicalDocument/[IPS Social History Section]/entry/observation/value
Reference date range	/ClinicalDocument/[IPS Social History Section]/entry/observation/effectiveTime
Vital Signs	/ClinicalDocument/[IPS Vital Signs Section]
Vital signs	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]
Vital sign	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]
Date of observation	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/effectiveTime
Observation type	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code
Result description	/ClinicalDocument/[IPS Vital Signs Section].text

PCS Data Elements	IPS CDA
Value	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Vital sign	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]
Physician Certification Statement	Reason for Referral
Date Physician Certification Statement Signed	Reason for Referral
Reason for Physician Certification Statement	Coded Reason for Referral
Healthcare Provider Type Signing Physician Certification Statement	Reason for Referral
Last Name of Individual Signing Physician Certification Statement	Reason for Referral
First Name of Individual Signing Physician Certification Statement	Reason for Referral

6.3.1.D1.5 Paramedicine Care Summary – Clinical Subset (PCS - CS) Document Content Module Specification

This section specifies the header, section, and entry content modules which comprise the Paramedicine Care Summary – Clinical Subset (PCS-CS) Document Content Module, using the Template ID as the key identifier.

Sections that are used according to the definitions in other specifications are identified with the relevant specification document. Additional constraints on vocabulary value sets, not specifically constrained within the section template, are also identified.

Note: The only header items that are mentioned are the items that are constrained.

Table 6.3.1.D1.5-1: Paramedicine Care Summary (PCS) Document Content Module Specification

Template Name		Paramedicine Care Summary – Clinical Subset (PCS-CS)			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.29.1			
Parent Template		International Patient Summary (2.16.840.1.113883.10.22.1.1)			
General Description		The Paramedicine Care Summary will contain the patient's paramedicine care information and interventions.			
Document Code		SHALL BE 67796-3Code System LOINC (CodeSystem: 2.16.840.1.113883.6.1 LOINC), "EMS Patient Care Report"			
Opt and Card	**Condition**	**Header Element or Section Name**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
Header Elements					
R [1..*]		author	2.16.840.1.113883.10.22.2.2	HL7 IPS CDA	
R [1..1]		custodian	2.16.840.1.113883.10.22.2.3	HL7 IPS CDA	
R [1..1]		documentationOf	2.16.840.1.113883.10.22.2.6	HL7 IPS CDA	6.3.2.H.7
RE [0..1]		legalAuthenticator	2.16.840.1.113883.10.22.2.4	HL7 IPS CDA	
R [1..1]		recordTarget	2.16.840.1.113883.10.22.2.1	HL7 IPS CDA	
RE [0..*]		relatedDocument	2.16.840.1.113883.10.22.2.7	HL7 IPS CDA	
RE [0..*]		IPS Patient Contacts	2.16.840.1.113883.10.22.2.5	HL7 IPS CDA	
RE [0..*]]		IPS CDA Organization	2.16.840.1.113883.10.22.9.1	HL7 IPS CDA	
O [0..1]		Personal Information: Race	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.1	6.3.2.H.3
O [0..1]		Personal Information: Ethnicity	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.1	6.3.2.H.1
R [1..1]		IPS CDA Person	2.16.840.1.113883.10.22.9.3	HL7 IPS CDA	
Sections					
RE [0..1]		IPS Advance Directives	2.16.840.1.113883.10.22.3.12	HL7 IPS CDA	6.3.D1.5.1
R [1..1]		IPS Allergies and Intolerances	2.16.840.1.113883.10.22.3.2	HL7 IPS CDA	6.3.D1.5.2
R [1..1]		IPS Medication Summary	2.16.840.1.113883.10.22.3.1	HL7 IPS CDA	6.3.D1.5.4

O [0..1]		Medications Administered Section	1.3.6.1.4.1.19376.1.5.3.1.3.21	PCC TF-2: 6.3.3.3.3, 6.3.3.2.11	6.3.D1.5.4, 6.3.D1.5.11
RE [0..1]		IPS History of Past Illness	2.16.840.1.113883.10.22.3.7	HL7 IPS CDA	6.3.D1.5.9
RE [1..N]		IPS Functional Status	2.16.840.1.113883.10.22.3.8	HL7 IPS CDA	6.3.D1.5.7
RE [0..1]		IPS History of Procedures	2.16.840.1.113883.10.22.3.4	HL7 IPS CDA	
O [0..1]		IPS Immunizations	2.16.840.1.113883.10.22.3.5	HL7 IPS CDA	
O [0..1]		IPS Medical Devices	2.16.840.1.113883.10.22.3.6	HL7 IPS CDA	
R [1..1]		IPS Problems	2.16.840.1.113883.10.22.3.3	HL7 IPS CDA	6.3.D1.5.10
O [0..1]		IPS Results	2.16.840.1.113883.10.22.3.14	HL7 IPS CDA	
RE [0..*]		IPS Vital Signs	2.16.840.113883.10.22.4.44	HL7 IPS CDA	6.3.D1.5.3 6.3.D1.5.7
RE [0..1]		IPS History of Pregnancy	2.16.840.1.113883.10.22.3.11	HL7 IPS CDA	
O[0..1]		Payor	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7	PCC TF-2: 6.3.3.7.1	

6.3.1.D1.5.1 Advance Directives Constraints

The Advance Directive Type shall be drawn from the Advance Directive Type concept domain as defined by local jurisdiction. The <value> element shall be encoded in the /value concept (e.g., In the US the value shall be drawn from the AdvanceDirectiveType - 2.16.840.1.113883.17.3.11.63 [HL7 EMS PCR] value set.).

6.3.1.D1.5.2 Allergies and Intolerances Constraint

The Drug Allergies allergen SHOULD be drawn from the RxNorm coding system 2.16.840.1.113883.6.88 unless otherwise specified by local jurisdiction. The <value> element SHALL be encoded in the participant/participantRole/playingEntity/code concept.

The Non-Drug Allergies allergen SHALL be drawn from the SNOMED CT coding system. The <value> element SHALL be encoded in the participant/participantRole/playingEntity/code concept.

In the case that the existence of the drug or non-drug allergy is known, but not the substance type, the allergen SHALL be coded using {6497000, SNOMED CT, Substance Type Unknown}. The <value> element SHALL be encoded in the participant/participantRole/playingEntity/code concept.

In the case that there are no known drug allergies the allergen SHALL be coded using {409137002, SNOMED CT, No Known Drug Allergies}. The <value> element SHALL be encoded in participant/participantRole/playingEntity/code concept.

6.3.1.D1.5.3 Vital Signs Section – Vital Signs Observation Constraints

765 The following additional vital sign observation entries SHALL be supported using the LOINC codes, with the specified data types and unit. The Coded Vital Signs Section SHALL include one or more Vital Signs Observation (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.13.2 [PCC TF-2]). For pain scale and stroke scale SHALL include the Type.

Table 6.3.1.D1.5.3-1: Vital Signs Descriptions and LOINC Codes

LOINC	Description	Units	Type
8478-0	MEAN ARTERIAL PRESSURE	mm[Hg]	PQ
19889-5	END TITLE CARBON DIOXIDE (ETCO2)	%	PQ
20563-3	CARBON MONOXIDE (CO)	%	PQ
2339-0	BLOOD GLUCOSE LEVEL	mg/dl	PQ
9267-6	GLASGOW COMA SCORE-EYE	n/a	PQ
9268-4	GLASGOW MOTOR	n/a	PQ
9270-0	GLASGOW COMA SCORE.VERBAL	n/a	PQ
9269-2	TOTAL GLASGOW COMA SCORE	n/a	PQ
9267-6	GLASCOW QUALIFIER	n/a	PQ
38208-5	PAIN SCALE SCORE	n/a	PQ
80316-3	PAIN SCALE TYPE	n/a	PQ
72089-6	STROKE SCALE SCORE	n/a	PQ
67521-5	STROKE SCALE TYPE	n/a	PQ
48334-7	APGAR 1 MINUTE	n/a	PQ
48333-9	APGAR 5 MINUTE	n/a	PQ
48332-1	APGAR 10 MINUTE	n/a	PQ
80341-1	RESPIRATORY EFFORT	n/a	PQ
11454-6	RESPONSIVENESS ASSESSMENT AT FIRST ENCOUNTER	n/a	PQ

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In addition, the following attributes will be supported for the additional LOINC definitions:

The Method of Measurement SHALL be included in the Vital Signs Observation for the following vital signs:

- Systolic Blood Pressure
775 • Diastolic Blood Pressure
- Mean Arterial Pressure
- Temperature
- Stroke Score

- and Heart Rate (if LOINC /value 8886-4 is designated).

The <methodCode>element SHALL be encoded in the /methodCode concept.

The Stroke Scale Type SHALL be drawn from the StrokeScale concept domain as defined by local jurisdiction. (e.g., In the US the value set SHALL be drawn from the StrokeScale (templateID 2.16.840.1.113883.17.3.11.88 [HL7 EMS PCR]) value set. The <value> element SHALL be encoded the in /methodCode concept.

The Glasgow Qualifier SHALL be drawn from the GlasgowComaScoreSpecialCircumstances (templateID 2.16.840.1.113883.17.3.11.89 [HL7 EMS PCR]) value set. The <value> element SHALL be encoded in the /value concept.

The Stroke Type SHALL be drawn from the Stroke Scale Interpretation concept domain as defined by local jurisdiction. (e.g., In the US the value set shall be Stroke (templateID 2.16.840.1.113883.17.3.11.93 [HL7 EMS PCR]) Value Set. The <value> element SHALL be encoded the /methodCode concept.

The Level of Responsiveness SHALL be drawn from the LevelOfResponsiveness (templateID 2.16.840.1.113883.17.3.11.21 [HL7 EMS PCR]) value set. The <value> element SHALL be encoded the concept in /value concept.

6.3.1.D1.5.4 Medication Summary Constraints

The following special cases exist for encoding the product medication:

- In the case that the patient is currently on anticoagulants and no medication details are provided for the anticoagulants, the product SHALL be coded using {81839001, SNOMED CT, Anticoagulant (product)}. The product SHALL be encoded in the Product Entry (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.7.2 [PCC TF-2]) /manufacturedProduct/manufacturedMaterial/code concept.
- In the case that the patient is currently on medications, but none of the medication details exist and the patient is not on anticoagulants, the Medications Section (templateIDs 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2]) SHALL be coded using {182904002, SNOMED CT, Drug Treatment Unknown}. The <code> element SHALL be encoded in the substanceAdminstration/act/code concept.
- In the case that the patient is currently not on medications, the Medications Section (template IDs 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2]) SHALL be coded using {182849000, SNOMED CT, No Drug Therapy Prescribed}. The <code> element SHALL be encoded in the substanceAdminstration/act/code concept.

The routeCode shall be drawn from the Medication Administration Route concept domain as defined by local jurisdiction. The <routeCode> element shall be encoded in the substanceAdminstration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2])/routeCode concept. (e.g., In the US the value set SHALL be drawn from the EMSLevelOfService – MedicationAdminstrationRoute 2.16.840.1.113883.17.3.11.43 [HL7 [HL7 EMS PCR] value set).

The manufacturedMaterial shall be drawn from the Manufactured Material concept domain as defined by local jurisdiction. The <code> element shall be encoded in the substanceAdminstration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2])/consumable/manufacturedProduct/manufacturedMaterial concept (e.g., In the US the value set shall be drawn from the RxNorm 2.16.840.1.113883.6.88 value set).

6.3.1.D1.5.5 Medications Administered –Constraints

In the case that the medication is not administered, this shall be reflected in the substanceAdministration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2]). The negationInd SHALL be set to "true", and an entryRelationship SHALL contain exactly one [1..1] @typeCode="RSON" drawn from the MedicationNotGiven Reason (2.16.840.1.113883.17.3.11.92 [HL7 EMS PCR]) value est and encoded in the /value concept.

The routeCode shall be drawn from the Medication Administration Route concept domain as defined by local jurisdiction. The <routeCode> Element SHALL be encoded in the substanceAdminstration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2])/routeCode concept (e.g., In the US the value set shall be drawn from the EMSLevelOfService – MedicationAdminstrationRoute 2.16.840.1.113883.17.3.11.43 [HL7 EMS PCR] value set).

The manufacturedMaterial shall be drawn from the Medical Clinical Drug concept domain as defined by the local jurisdiction. The <manufacturedMaterial> element SHALL be encoded the in the substanceAdminstration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2])/consumable/manufacturedProduct/manufactureredMaterial concept (e.g., In the US the value set shall be drawn from the MedicationClinicalDrug 2.16.840.1.113883.3.88.12.80.17 [HL7 EMS PCR] value set).

The assignedEntity shall be drawn from the Provider Role concept domain as defined by local jurisdiction. The <ProviderRole> element SHALL be encoded in the substanceAdminstration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2])/performer/assignedEntity/code concept (e.g., In the US the value set shall be drawn from the ProviderRole 2.16.840.1.113883.17.3.11.46 [HL7 EMS PCR] value set.).

If a complication is identified as part of the administration of a medication, the medication complication SHALL be documented in Allergies and Other Adverse Reaction Section (templateID 1.3.6.1.4.1.19376.1.5.3.1.3.13 [PCC TF-2]).

6.3.1.D1.5.7 Vital signs - Physical Examination Constraints

The physical examination assessment findings SHALL be drawn from the HL7 EMS PCR assessment value sets. The following table provides the mappings between the HL7 EMS PCR and [PCC TF-2] assessment concepts. The assessment <value> element shall be encoded in the /value concept.

Table 6.3.1.D1.5.7-1: Physical Examination Assessment Concepts

IHE Assessment Concept	IHE PCC templateID	HL7 EMS PCR Assessment Concept	HL7 EMS PCR Value Set
Integumentary System	1.3.6.1.4.1.19376.1.5.3.1.1.9.17	Skin	2.16.840.1.113883.17.3.11.25
Head Assessment	1.3.6.1.4.1.19376.1.5.3.1.1.9.18	Head	2.16.840.1.113883.17.3.11.26
Neurologic System	1.3.6.1.4.1.19376.1.5.3.1.1.9.35	Neurological	2.16.840.1.113883.17.3.11.40
Ears, Nose, Mouth and Throat	1.3.6.1.4.1.19376.1.5.3.1.1.9.20	Face	2.16.840.1.113883.17.3.11.27
Neck	1.3.6.1.4.1.19376.1.5.3.1.1.9.24	Neck	2.16.840.1.113883.17.3.11.28
Thorax and Lungs	1.3.6.1.4.1.19376.1.5.3.1.1.9.26	Chest And Lung	2.16.840.1.113883.17.3.11.29
Heart	1.3.6.1.4.1.19376.1.5.3.1.1.9.29	Heart	2.16.840.1.113883.17.3.11.30
Abdomen	1.3.6.1.4.1.19376.1.5.3.1.1.9.31	Abdomen	2.16.840.1.113883.17.3.11.32
Genitalia	1.3.6.1.4.1.19376.1.5.3.1.1.9.36	Pelvic And Genitourinary	2.16.840.1.113883.17.3.11.33
Musculoskeletal	1.3.6.1.4.1.19376.1.5.3.1.1.9.34	Back and Spine	2.16.840.1.113883.17.3.11.34
Extremities	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1	Extremities	2.16.840.1.113883.17.3.11.36
Eye	1.3.6.1.4.1.19376.1.5.3.1.1.1.9.1	Eye	2.16.840.1.113883.17.3.11.38
Mental Status Entry	1.3.6.1.4.1.19376.1.5.3.1.4.25	Mental	2.16.840.1.113883.17.3.11.84

Additionally, the following target site locations SHALL also be drawn from the HL7 EMS PCR finding location value sets and mapped into the [PCC TF-2] assessment target site. The target site location <value> element shall be encoded in the /targetSiteCode/code concept.

Table 6.3.1.D1.5.7-2: Physical Examination Target Site Locations

IHE Target Site Concept	IHE PCC templateID	HL7 EMS PCR Finding Location Concept	HL7 EMS PCR Value Set
Abdomen target site	1.3.6.1.4.1.19376.1.5.3.1.1.9.31	AbdominalFinding Location	2.16.840.1.113883.17.3.11.32
Back and Spine target site	1.3.6.1.4.1.19376.1.5.3.1.1.9.34	BackSpineFindingLocation	2.16.840.1.113883.17.3.11.35
Extremities	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1	ExtremityFinding Location	2.16.840.1.113883.17.3.11.37
Eye target site	1.3.6.1.4.1.19376.1.5.3.1.1.9.1	EyeFindingLocation	2.16.840.1.113883.17.3.11.39

6.3.1.D1.5.9 History of Present Illness Constraint

The Content Creator SHALL create a text entry within the History of Present Illness Section (templateID 1.3.6.1.4.1.19376.1.5.3.1.3.4 [PCC TF-2]) that contain the narrative description of EMS Patient Care Report Narrative the EMS encounter.

6.3.1.D1.5.10 Problems

The EMS Situation Provider's Primary Impression and Provider's Secondary Impression SHALL be documented in the Active Problems Section within the Active Problems Section (templateID 1.3.6.1.4.1.193796.1.5.3.1.3.1 [PCC TF-2]).

6.3.1.D1.5.11 Allergies and Other Adverse Reaction –Constraints

A complication associated with the EMS administration of a medication shall be documented as an Allergy and Other Adverse Reaction. The medication complication SHALL be documented in an Allergy and Intolerance Concern (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.5.3 [PCC TF-2]). The Allergy and Intolerance Concern SHALL contain exactly one [1..1] code/@code="67541-3" (Medication complication NEMSIS) and the <value> element shall be encoded in the /value concept. The value set SHALL be drawn from the MedicationComplication (2.16.840.1.113883.17.3.11.45 [EMS-PCR]) value set.

6.3.1.D2 Paramedicine Care Summary – Complete Report (PCS-CR) Document Content Module

The Paramedicine Care Summary – Complete Report document content module is a Medical Summary and inherits all header constraints from the International Patient Summary (2.16.840.1.113883.10.22.1.1). This document is extended in order to create a complete report that the Paramedicine services provided and can be utilized for quality and measure reports.

6.3.1.D2.1 Format Code

The XDSDocumentEntry format code for this content is urn:ihe:pcc:pcs-cr:2018

6.3.1.D2.2 LOINC Code

The LOINC code for this document 67796-3 ParamedicineCareSummary.

6.3.1.D2.3 Referenced Standards

All standards which reference in this document are listed below with their common abbreviation, full title, and link to the standard.

Table 6.3.1.D2.3-1: Paramedicine Care Summary – Complete Report Document – Referenced Standards

Abbreviation	Title	URL
CDAR2	HL7 CDA Release 2.0	http://www.hl7.org/documentcenter/public/standards/dstu/CDAR2_IG_PROCNOTE_DSTU_R1_2010JUL.zip

Abbreviation	Title	URL
HL7 IPS CDA	HL7 CDA® R2 Implementation Guide International Patient Summary STU Release 1	https://www.hl7.org/implement/standards/product_brief.cfm?product_id=483
SNOMED CT	SNOMED International	http://www.snomed.org/snomed-ct/get-snomed-ct
ISO/DIS 27269	ISO/DIS 27269 Health informatics — The international patient summary	https://www.iso.org/standard/79491.html
HL7 EMS DAM	HL7 Version 3 Domain Analysis Model, Emergency Medical Services, Release 1	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=421
HL7 EMS DIM	HL7 version 3 Domain Information Model; Emergency Model Services, release 1	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=302

6.3.1.D2.4 Data Element Requirement Mappings to CDA

This section identifies the mapping of data between referenced standards into the CDA implementation guide.

Table 6.3.1.D2.4-1: Paramedicine Care Summary – Complete Report (PCS-CR) – Data Element Requirement Mappings to CDA

PCS Data Elements	CDA
Patient Attributes	/ClinicalDocument/[IPS CDA recordTarget]
Patient's name	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/name
Address	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/addr
Telecoms	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/telecom
Administrative gender	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/administrativeGenderCode
Date of birth	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/birthTime
Patient's preferred language	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/languageCommunication/languageCode
Healthcare related identifiers	see below
Patient identifier	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/id
Insurance information	see below
Insurance identifier	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/id
Patient's Address Book	see below
Preferred healthcare providers	/ClinicalDocument/[IPS Patient Contacts]/code
Healthcare provider (person)	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson
Healthcare provider Name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson/name
Healthcare provider Role	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/code
Healthcare provider Telecoms	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/telecom
Healthcare provider (organization)	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/scopingOrganization
Organization's name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/scopingOrganization/name
Organization's Telecoms	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/telecom

PCS Data Elements	CDA
Other's address details	see below
Addressee	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian
Addressee Role	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/code /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian
Addressee Name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson/name /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/guardianPerson/name
Addressee Address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/addr
Addressee Telecoms	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/telecom /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/telecom
Advance Directives Section	/ClinicalDocument/[IPS Advance Directives Section]
Advance Directives	/ClinicalDocument/[IPS Advance Directives Section]
Advance Directive	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer] /ClinicalDocument/[IPS Advance Directives Section]
Person Authorizing Directive	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/participant /ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/author
Person Authorizing Name	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/participant/participantRole/playingEntity/name /ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/author/assignedAuthor/assignedPerson/name
Person Authorizing Role	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/participant/participantRole/code /ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/author/assignedAuthor/code
Person Authorizing Telecoms	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/participant/participantRole/telecom /ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/author/assignedAuthor/telecom
Directive Category	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/code
Directive Description	/ClinicalDocument/[IPS Advance Directives Section]/text
Reference to Legal Document	/ClinicalDocument/[IPS Advance Directives Section]/entry/[IPS Advance Directive Organizer]/component/[IPS Advance Directive Observation]/reference/externalDocument
Allergies and Intolerances	/ClinicalDocument/[IPS Allergies and Intolerances Section]

PCS Data Elements	CDA
Allergies/Intolerances content status	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/observation/code
Allergies and Intolerances	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance
Allergy/Intolerance	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]
Allergy/Intolerance description	/ClinicalDocument/[IPS Allergies and Intolerances Section]/text
Allergy/Intolerance Clinical status	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Allergy Status Observation]/value
Allergy/Intolerance Onset Date	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/observation/effectiveTime/low
Allergy/Intolerance End Date	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/observation/effectiveTime/high
Allergy/Intolerance Criticality	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Criticality Observation]
Allergy/Intolerance Certainty	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Allergy Certainty Observation]
Allergy/Intolerance Type of propensity	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/observation/code
Allergy/Intolerance Diagnosis	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/value
Allergy/Intolerance Reaction	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Reaction Manifestation]
Allergy/Intolerance Manifestation of the reaction	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Reaction Manifestation]/value
Allergy/Intolerance Severity	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/entryRelationship/[IPS Reaction Manifestation]/entryRelationship/[IPS Severity Observation]
Allergy/Intolerance Agent	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/participant
Allergy/Intolerance Agent code	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/participant/participantRole/playingEntity/code
Allergy/Intolerance Category	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance]/participant/participantRole/playingEntity/code
Functional Status Section	/ClinicalDocument/[IPS Functional Status Section]
Disabilities	/ClinicalDocument/[IPS Functional Status Section]

PCS Data Elements	CDA
Disability	/ClinicalDocument/[IPS Functional Status Section]
Disability Description	/ClinicalDocument/[IPS Functional Status Section]/text
Disability Code	/ClinicalDocument/[IPS Functional Status Section]/entry/observation/value
Onset Date	/ClinicalDocument/[IPS Functional Status Section]/entry/observation/effectiveTime/low
Functional assessments (determines autonomy)	/ClinicalDocument/[IPS Functional Status Section]
Functional Assessment (type performed)	/ClinicalDocument/[IPS Functional Status Section]
Functional Assessment description	/ClinicalDocument/[IPS Functional Status Section]/text
Date of assessment	/ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/effectiveTime /ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/component/[IPS Survey Observation]/effectiveTime
Functional Assessment Type	/ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/code /ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/component/[IPS Survey Observation]/code
Functional Assessment Result	/ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/component/[IPS Survey Observation]/value
Functional Assessment	/ClinicalDocument/[IPS Functional Status Section]/entry/[IPS Survey Panel]/component/[IPS Survey Observation]
History of Past Problems	/ClinicalDocument/[IPS History of Past Illness Section]
Past problems	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]
Past problem	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]
Problem type	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/code
Problem Description	/ClinicalDocument/[IPS History of Past Illness Section]/text
Problem Diagnosis	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/value
Problem Severity	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/entryRelationship/[IPS Severity Observation]
Problem Onset Date	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/effectiveTime/low
Problem Status	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/entryRelationship/[IPS Problem Status Observation]
Date Problem Resolved	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/effectiveTime/high
Specialist Contact for problem	Not explicitly specified (see open issues #41)
History of Pregnancy Section	/ClinicalDocument/[IPS History of Pregnancy Section]
Current pregnancy status	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Status Observation]
Pregnancy description	/ClinicalDocument/[IPS History of Pregnancy Section]/text

PCS Data Elements	CDA
Pregnancy details	see below
Date of observation	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Status Observation]/effectiveTime
Pregnancy state	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Status Observation]/value
Expected delivery date	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Status Observation]/entryRelationship/[IPS Pregnancy Expected Delivery Date Observation]/value
Specialist contact	Not explicitly specified (see open issues #41)
Previous history of pregnancies	/ClinicalDocument/[IPS History of Pregnancy Section]
Previous pregnancies status	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Observation]/value
Previous pregnancies description	/ClinicalDocument/[IPS History of Pregnancy Section]/text
Previous pregnancies	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Observation]
Previous pregnancy details	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Observation]
Outcome date	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Observation]/effectiveTime
Outcome	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Observation]/value
Specialist contact	Not explicitly specified (see open issues #41)
Summary metric	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Outcome Observation]
History of Procedures	/ClinicalDocument/[IPS History of Procedures Section]
Procedures content status	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]/code
Procedures	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]
Procedure	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]
Procedure code	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]/code
Procedure description	/ClinicalDocument/[IPS History of Procedures Section]/text
Body site	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]/targetSiteCode
Procedure date	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]/effectiveTime
Immunizations	/ClinicalDocument/[IPS Immunizations Section]
Immunizations content status	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/consumable/[IPS Immunization Medication Information]/manufacturedProduct/manufacturedMaterial/code
Immunizations	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]
Immunization	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]

PCS Data Elements	CDA
Vaccine for type of disease	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/consumable/[IPS Immunization Medication Information]/manufacturedProduct/manufacturedMaterial/code
Target diseases	
Target disease	
Date of immunization	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/effectiveTime
Product administered	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/consumable/[IPS Immunization Medication Information]/manufacturedProduct/manufacturedMaterial/code
Brand name	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/consumable/[IPS Immunization Medication Information]/manufacturedProduct/manufacturedMaterial/code
Product administration process	see below
Performer	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/performer
Route of administration	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/routeCode
Medical Devices	/ClinicalDocument/[IPS Medical Devices Section]
Device content status	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]/participant/participantRole/playingDevice/code
Devices	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]
Device	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]
Device type	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]/participant/participantRole/playingDevice/code
Device identifier	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]/participant/participantRole/id
Use start date	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]/effectiveTime/low
Use end date	/ClinicalDocument/[IPS Medical Devices Section]/entry/[IPS Medical Device]/effectiveTime/high
Medication Summary	/ClinicalDocument/[IPS Medication Summary Section]
Medication summary content status	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/code
Medications	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]
Medication	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]
Reason	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/entryRelationship/[Indication (V2)]
Medicinal product	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]
Product code	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/code

PCS Data Elements	CDA
Product common name (and strength)	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/asSpecializedKind/name
Pharmaceutical dose form	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/formCode
Brand name	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/asContent/containerPackagedProduct/name
Active ingredients	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/ingredient
Active ingredient	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/ingredient
Substance code	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/ingredient/ingredientSubstance/code
Strength	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/consumable/[IPS Medication Information]/manufacturedMaterial/ingredient/quantity
Administration instruction	see below
Instruction	/ClinicalDocument/[IPS Medication Summary Section]/text
Period of medication use	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/[UV Use Period]
Route of administration	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/routeCode
Dose instruction	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/entryRelationship/[IPS Subordinate SubstanceAdministration]
No. of units per intake	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/entryRelationship/[IPS Subordinate SubstanceAdministration]/doseQuantity
Frequency of intake	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/entryRelationship/[IPS Subordinate SubstanceAdministration]/effectiveTime
Plan of Care	/ClinicalDocument/[IPS Plan of Care Section]
Plans	/ClinicalDocument/[IPS Plan of Care Section]
Plan	/ClinicalDocument/[IPS Plan of Care Section]
Plan type	Not explicitly specified
Plan date	Not explicitly specified
Plan description	/ClinicalDocument/[IPS Plan of Care Section].text
Recommendations (Core Care Plan)	/ClinicalDocument/[IPS Plan of Care Section]/entry
Recommendation	/ClinicalDocument/[IPS Plan of Care Section]/entry/[…] (several templates)
Recommendation for treatment	depends on the template used
Given recommendation date	depends on the template used
Applicable date	depends on the template used

PCS Data Elements	CDA
Extensive Plan	Not explicitly specified
Problems	/ClinicalDocument/[IPS Problems Section]
Problems content status	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/code
Problems	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]
Problem	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]
Problem type	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/code
Problem description	/ClinicalDocument/[IPS Problems Section]/text
Diagnosis	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/value
Severity	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/entryRelationship/[IPS Severity Observation]/value
Onset date	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/effectiveTime/low
Problem status	/ClinicalDocument/[IPS Problems Section]/entry/[IPS Problem Concern Entry]/entryRelationship/[IPS Problem Entry]/entryRelationship/[IPS Problem Status Observation]/value
Specialist contact	Not explicitly specified (see open issues #41)
Results	/ClinicalDocument/[IPS Results Section]
Observation results	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer] /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/[…] (several observation templates)
Observation result	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer] /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/[…] (several observation templates)
Date of observation	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/effectiveTime /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/effectiveTime
Observation type	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/code /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/code
Result description	/ClinicalDocument/[IPS Results Section]/text
Value	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/value
Observation result	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation
Performer	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/performer /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/performer
Observer	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/author
Social History	/ClinicalDocument/[IPS Social History Section]
Life style factors	/ClinicalDocument/[IPS Social History Section]/entry

PCS Data Elements	CDA
Life style factor	/ClinicalDocument/[IPS Social History Section]/entry/[…] (several observation templates)
Life style factor description	/ClinicalDocument/[IPS Social History Section]/text
Life style factor details	/ClinicalDocument/[IPS Social History Section]/entry/observation/value
Reference date range	/ClinicalDocument/[IPS Social History Section]/entry/observation/effectiveTime
Vital Signs	/ClinicalDocument/[IPS Vital Signs Section]
Vital signs	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]
Vital sign	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]
Date of observation	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/effectiveTime
Observation type	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code
Result description	/ClinicalDocument/[IPS Vital Signs Section].text
Value	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Vital sign	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]
Physician Certification Statement	Reason for Referral
Date Physician Certification Statement Signed	Reason for Referral
Reason for Physician Certification Statement	Coded Reason for Referral
Healthcare Provider Type Signing Physician Certification Statement	Reason for Referral
Last Name of Individual Signing Physician Certification Statement	Reason for Referral
First Name of Individual Signing Physician Certification Statement	Reason for Referral

6.3.1.D2.5 Paramedicine Care Summary – Complete Report (PCS-CR) Document Content Module Specification

This section specifies the header, section, and entry content modules which comprise the Paramedicine Care Summary – Complete Report (PCS-CR) Document Content Module, using the 1.3.6.1.4.1.19376.1.5.3.1.1.30.1 as the key identifier.

Sections that are used according to the definitions in other specifications are identified with the relevant specification document. Additional constraints on vocabulary value sets, not specifically constrained within the section template, are also identified.

Note: The only header items that are mentioned are the items that are constrained.

910 **Table 6.3.1.D2.5-1: Paramedicine Care Summary – Complete Report (PCS-CR) Document Content Module Specification**

Template Name	Paramedicine Care Summary – Complete Report (PCS-CR)				
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.30.1				
Parent Template	International Patient Summary (2.16.840.1.113883.10.22.1.1).				
General Description	The Paramedicine Care Summary will contain the patient's paramedicine care information and interventions.				
Document Code	SHALL BE 67796-3 EMS patient care report Code System LOINC (CodeSystem: 2.16.840.1.113883.6.1 LOINC), "ParamedicineCareSummary"				
Opt and Card	**Condition**	**Header Element or Section Name**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
Header Elements					
R [1..*]		author	2.16.840.1.113883.10.22.2.2	HL7 IPS CDA	
R [1..1]		custodian	2.16.840.1.113883.10.22.2.3	HL7 IPS CDA	
R [1..1]		documentationOf	2.16.840.1.113883.10.22.2.6	HL7 IPS CDA	6.3.2.H.7
RE [0..1]		legalAuthenticator	2.16.840.1.113883.10.22.2.4	HL7 IPS CDA	
R [1..1]		recordTarget	2.16.840.1.113883.10.22.2.1	HL7 IPS CDA	
RE [0..*]		relatedDocument	2.16.840.1.113883.10.22.2.7	HL7 IPS CDA	
RE [0..*]		IPS Patient Contacts	2.16.840.1.113883.10.22.2.5	HL7 IPS CDA	
RE [0..*]]		IPS CDA Organization	2.16.840.1.113883.10.22.9.1	HL7 IPS CDA	
O [0..1]		Personal Information: Race	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.1	6.3.2.H.3
O [0..1]		Personal Information: Ethnicity	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.1	6.3.2.H.1
R [1..1]		IPS CDA Person	2.16.840.1.113883.10.22.9.3	HL7 IPS CDA	
R [1..*]		author	2.16.840.1.113883.10.22.2.2	HL7 IPS CDA	
R [1..1]		custodian	2.16.840.1.113883.10.22.2.3	HL7 IPS CDA	
R [1..1]		documentationOf	2.16.840.1.113883.10.22.2.6	HL7 IPS CDA	6.3.2.H.7

RE [0..1]		legalAuthenticator	2.16.840.1.113883.10.22.2.4	HL7 IPS CDA	
R [1..1]		recordTarget	2.16.840.1.113883.10.22.2.1	HL7 IPS CDA	
Sections					
RE [0..1]		IPS Advance Directives	2.16.840.1.113883.10.22.3.12	HL7 IPS CDA	6.3.D2.5.1
R [1..1]		IPS Allergies and Intolerances	2.16.840.1.113883.10.22.3.2	HL7 IPS CDA	6.3.D2.5.2 6.3.D2.5.12
R [1..1]		IPS Medication Summary	2.16.840.1.113883.10.22.3.1	HL7 IPS CDA	
O [0..1]		Medications Administered Section	1.3.6.1.4.1.19376.1.5.3.1.3.21	PCC TF-2: 6.3.3.3.3, 6.3.3.2.11	6.3.D2.5.5
RE [0..1]		IPS History of Past Illness	2.16.840.1.113883.10.22.3.7	HL7 IPS CDA	6.3.D2.5.10
RE [1..N]		IPS Functional Status	2.16.840.1.113883.10.22.3.8	HL7 IPS CDA	6.3.D2.5.8
RE [0..1]		IPS History of Procedures	2.16.840.1.113883.10.22.3.4	HL7 IPS CDA	
O [0..1]		IPS Immunizations	2.16.840.1.113883.10.22.3.5	HL7 IPS CDA	
O [0..1]		IPS Medical Devices	2.16.840.1.113883.10.22.3.6	HL7 IPS CDA	,
R [1..1]		IPS Problems	2.16.840.1.113883.10.22.3.3	HL7 IPS CDA	6.3.D2.5.11
O [0..1]		IPS Results	2.16.840.1.113883.10.22.3.14	HL7 IPS CDA	
RE [0..*]		IPS Vital Signs	2.16.840.113883.10.22.4.44	HL7 IPS CDA	6.3.D2.5.4 6.3.1.D2.5.8
RE [0..1]		IPS History of Pregnancy	2.16.840.1.113883.10.22.3.11	HL7 IPS CDA	
O[0..1]		Payor	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7	PCC TF-2: 6.3.3.7.1	6.3.D2.5.3
RE [0..1]		Cause of Injury			
R [1..1]		Chief Complaint	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1		
R [1..1]		Impressions			
RE [0..1]		Triage note	1.3.6.1.4.1.19376.1.5.3.1.1.13.1.1		6.3.1.D2.5.13
RE [1..1]		EMS Protocol Section	2.16.840.1.113883.17.3.10.1.7	HL7 EMS Run Report R2	
R [1..1]		Paramedicine Note	xxxxxx		

R [1..1]		EMS Response Section	2.16.840.1.113883.17.3.10.1.3	HL7 EMS Run Report R2	6.3.D2.5.9
RE [0..1]		EMS Times Section	2.16.840.1.113883.17.3.10.1.10	HL7 EMS Run Report R2	

6.3.1.D2.5.1 Advance Directives Observation Constraints

The Advance Directive Type shall be drawn from the Advance Directive Type concept domain as defined by local jurisdiction. The <value> element shall be encoded in the /value concept (e.g., In the US the value shall be drawn from the AdvanceDirectiveType - 2.16.840.1.113883.17.3.11.63 [HL7 EMS PCR] value set.).

6.3.1.D2.5.2 Allergy and Intolerance Concern Constraint

The Drug Allergies allergen SHOULD be drawn from the RxNorm coding system 2.16.840.1.113883.6.88 unless otherwise specified by local jurisdiction. The <value> element SHALL be encoded in the participant/participantRole/playingEntity/code concept.

The Non-Drug Allergies allergen SHALL be drawn from the SNOMED CT coding system. The <value> element SHALL be encoded in the participant/participantRole/playingEntity/code concept.

In the case that the existence of the drug or non-drug allergy is known, but not the substance type, the allergen SHALL be coded using {6497000, SNOMED CT, Substance Type Unknown}. The <value> element SHALL be encoded in the participant/participantRole/playingEntity/code concept.

In the case that there are no known drug allergies the allergen SHALL be coded using {409137002, SNOMED CT, No Known Drug Allergies}. The <value> element SHALL be encoded in participant/participantRole/playingEntity/code concept.

6.3.1.D2.5.4 Vital Signs Section – Vital Signs Observation Constraints

The following additional vital sign observation entries SHALL be supported using the LOINC codes, with the specified data types and unit. The Coded Vital Signs Section SHALL include one or more Vital Signs Observation (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.13.2 [PCC TF-2]).

LOINC	Description	Units	Type
8478-0	MEAN ARTERIAL PRESSURE	mm[Hg]	PQ
19889-5	END TITLE CARBON DIOXIDE (ETCO2)	%	PQ
20563-3	CARBON MONOXIDE (CO)	%	PQ
2339-0	BLOOD GLUCOSE LEVEL	mg/dl	PQ
9267-6	GLASGOW COMA SCORE-EYE	n/a	PQ
9268-4	GLASGOW MOTOR	n/a	PQ
9270-0	GLASGOW COMA SCORE.VERBAL	n/a	PQ
9269-2	TOTAL GLASGOW COMA SCORE	n/a	PQ

LOINC	Description	Units	Type
9267-6	GLASCOW QUALIFIER	n/a	PQ
38208-5	PAIN SCALE SCORE	n/a	PQ
80316-3	PAIN SCALE TYPE	n/a	PQ
72089-6	STROKE SCALE SCORE	n/a	PQ
67521-5	STROKE SCALE TYPE	n/a	PQ
48334-7	APGAR 1 MINUTE	n/a	PQ
48333-9	APGAR 5 MINUTE	n/a	PQ
48332-1	APGAR 10 MINUTE	n/a	PQ
80341-1	RESPIRATORY EFFORT	n/a	PQ
11454-6	RESPONSIVENESS ASSESSMENT AT FIRST ENCOUNTER	n/a	PQ

In addition, the following attributes will be supported for the additional LOINC definitions:

The Method of Measurement SHALL be included in the Vital Signs Observation for the following vital signs:

- Systolic Blood Pressure
- Diastolic Blood Pressure
- Mean Arterial Pressure
- Temperature
- Stroke Score
- and Heart Rate (if LOINC /value 8886-4 is designated).

The <methodCode>element SHALL be encoded in the /methodCode concept.

The Stroke Scale Type SHALL be drawn from the StrokeScale concept domain as defined by local jurisdiction. (e.g., In the US the value set SHALL be drawn from the StrokeScale (templateID 2.16.840.1.113883.17.3.11.88 [HL7 EMS PCR]) value set. The <value> element SHALL be encoded the in /methodCode concept.

The Glasgow Qualifier SHALL be drawn from the GlasgowComaScoreSpecialCircumstances (templateID 2.16.840.1.113883.17.3.11.89 [HL7 EMS PCR]) value set. The <value> element SHALL be encoded in the /value concept.

The Stroke Type SHALL be drawn from the Stroke Scale Interpretation concept domain as defined by local jurisdiction. (e.g., In the US the value set shall be Stroke (templateID 2.16.840.1.113883.17.3.11.93 [HL7 EMS PCR]) Value Set. The <value> element SHALL be encoded the /methodCode concept.

The Level of Responsiveness SHALL be drawn from the LevelOfResponsiveness (templateID 2.16.840.1.113883.17.3.11.21 [HL7 EMS PCR]) value set. The <value> element SHALL be encoded the concept in /value concept.

6.3.1.D2.5.5 Current Medications –Constraints

The following special cases exist for encoding the product medication:

- In the case that the patient is currently on anticoagulants and no medication details are provided for the anticoagulants, the product SHALL be coded using {81839001, SNOMED CT, Anticoagulant (product)}. The product SHALL be encoded in the Product Entry (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.7.2[PCC TF-2]) /manufacturedProduct/manufacturedMaterial/code concept.
- In the case that the patient is currently on medications, but none of the medication details exist and the patient is not on anticoagulants, the Medications Section (templateIDs 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2]) SHALL be coded using {182904002, SNOMED CT, Drug Treatment Unknown}. The <code> element SHALL be encoded in the substanceAdminstration/act/code concept.
- In the case that the patient is currently not on medications, the Medications Section (template IDs 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2]) SHALL be coded using {182849000, SNOMED CT, No Drug Therapy Prescribed}. The <code> element SHALL be encoded in the substanceAdminstration/act/code concept.

The routeCode shall be drawn from the Medication Administration Route concept domain as defined by local jurisdiction. The <routeCode> element shall be encoded in the substanceAdminstration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2])/routeCode concept. (e.g., In the US the value set SHALL be drawn from the EMSLevelOfService – MedicationAdminstrationRoute 2.16.840.1.113883.17.3.11.43 [HL7 [HL7 EMS PCR] value set).

The manufacturedMaterial shall be drawn from the Manufactured Material concept domain as defined by local jurisdiction. The <code> element shall be encoded in the substanceAdminstration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2])/consumable/manufacturedProduct/manufacturedMaterial concept (e.g., In the US the value set shall be drawn from the RxNorm 2.16.840.1.113883.6.88 value set).

6.3.1.D2.5.6 Medications Administered –Constraints

In the case that the medication is not administered, this shall be reflected in the substanceAdministration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2]). The negationInd SHALL be set to "true", and an entryRelationship SHALL contain exactly one [1..1] @typeCode="RSON" drawn from the MedicationNotGiven Reason (2.16.840.1.113883.17.3.11.92 [HL7 EMS PCR]) value est and encoded in the /value concept.

The routeCode shall be drawn from the Medication Administration Route concept domain as defined by local jurisdiction. The <routeCode> Element SHALL be encoded in the substanceAdminstration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2])/routeCode concept (e.g., In the US the value set shall

be drawn from the EMSLevelOfService – MedicationAdminstrationRoute 2.16.840.1.113883.17.3.11.43 [HL7 EMS PCR] value set).

The manufacturedMaterial shall be drawn from the Medical Clinical Drug concept domain as defined by the local jurisdiction. The <manufacturedMaterial> element SHALL be encoded the in the substanceAdminstration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2])/consumable/manufacturedProduct/manufactureredMaterial concept (e.g., In the US the value set shall be drawn from the MedicationClinicalDrug 2.16.840.1.113883.3.88.12.80.17 [HL7 EMS PCR] value set).

The assignedEntity shall be drawn from the Provider Role concept domain as defined by local jurisdiction. The <ProviderRole> element SHALL be encoded in the substanceAdminstration (templateID 2.16.840.1.113883.10.20.1.24 and 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2])/performer/assignedEntity/code concept (e.g., In the US the value set shall be drawn from the ProviderRole 2.16.840.1.113883.17.3.11.46 [HL7 EMS PCR] value set.).

If a complication is identified as part of the administration of a medication, the medication complication SHALL be documented in Allergies and Other Adverse Reaction Section (templateID 1.3.6.1.4.1.19376.1.5.3.1.3.13 [PCC TF-2]).

6.3.1.D2.5.8 Vital Signs - Physical Examination Entries Constraints

The physical examination assessment findings SHALL be drawn from the HL7 EMS PCR assessment value sets. The following table provides the mappings between the HL7 EMS PCR and [PCC TF-2] assessment concepts. The assessment <value> element shall be encoded in the /value concept.

Table 6.3.1.D2.5.8-1: Physical Examination Assessment Concepts

IHE Assessment Concept	IHE PCC templateID	HL7 EMS PCR Assessment Concept	HL7 EMS PCR Value Set
Integumentary System	1.3.6.1.4.1.19376.1.5.3.1.1.9.17	Skin	2.16.840.1.113883.17.3.11.25
Head Assessment	1.3.6.1.4.1.19376.1.5.3.1.1.9.18	Head	2.16.840.1.113883.17.3.11.26
Neurologic System	1.3.6.1.4.1.19376.1.5.3.1.1.9.35	Neurological	2.16.840.1.113883.17.3.11.40
Ears, Nose, Mouth and Throat	1.3.6.1.4.1.19376.1.5.3.1.1.9.20	Face	2.16.840.1.113883.17.3.11.27
Neck	1.3.6.1.4.1.19376.1.5.3.1.1.9.24	Neck	2.16.840.1.113883.17.3.11.28
Thorax and Lungs	1.3.6.1.4.1.19376.1.5.3.1.1.9.26	Chest And Lung	2.16.840.1.113883.17.3.11.29
Heart	1.3.6.1.4.1.19376.1.5.3.1.1.9.29	Heart	2.16.840.1.113883.17.3.11.30
Abdomen	1.3.6.1.4.1.19376.1.5.3.1.1.9.31	Abdomen	2.16.840.1.113883.17.3.11.32
Genitalia	1.3.6.1.4.1.19376.1.5.3.1.1.9.36	Pelvic And Genitourinary	2.16.840.1.113883.17.3.11.33
Musculoskeletal	1.3.6.1.4.1.19376.1.5.3.1.1.9.34	Back and Spine	2.16.840.1.113883.17.3.11.34
Extremities	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1	Extremities	2.16.840.1.113883.17.3.11.36

IHE Assessment Concept	IHE PCC templateID	HL7 EMS PCR Assessment Concept	HL7 EMS PCR Value Set
Eye	1.3.6.1.4.1.19376.1.5.3.1.1.1.9.1	Eye	2.16.840.1.113883.17.3.11.38
Mental Status Entry	1.3.6.1.4.1.19376.1.5.3.1.4.25	Mental	2.16.840.1.113883.17.3.11.84

Additionally, the following target site locations SHALL also be drawn from the HL7 EMS PCR finding location value sets and mapped into the [PCCTF-2] assessment target site. The target site location <value> element shall be encoded in the /targetSiteCode/code concept.

Table 6.3.1.D2.5.8-2: Physical Examination Target Site Locations

IHE Target Site Concept	IHE PCC templateID	HL7 EMS PCR Finding Location Concept	HL7 EMS PCR Value Set
Abdomen target site	1.3.6.1.4.1.19376.1.5.3.1.1.9.31	AbdominalFinding Location	2.16.840.1.113883.17.3.11.32
Back and Spine target site	1.3.6.1.4.1.19376.1.5.3.1.1.9.34	BackSpineFindingLocation	2.16.840.1.113883.17.3.11.35
Extremities	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1	ExtremityFinding Location	2.16.840.1.113883.17.3.11.37
Eye target site	1.3.6.1.4.1.19376.1.5.3.1.1.9.1	EyeFindingLocation	2.16.840.1.113883.17.3.11.39

6.3.1.D2.5.10 History of Present Illness Constraint

The Content Creator SHALL create a text entry within the History of Present Illness Section (templateID 1.3.6.1.4.1.19376.1.5.3.1.3.4 [PCC TF-2]) that contain the narrative description of EMS Patient Care Report Narrative the EMS encounter.

6.3.1.D2.5.11 Problems Constraint

The EMS Situation Provider's Primary Impression and Provider's Secondary Impression SHALL be documented in the Active Problems Section within the Active Problems Section (templateID 1.3.6.1.4.1.193796.1.5.3.1.3.1 [PCC TF-2]).

6.3.1.D2.5.12 Allergies and Other Adverse Reaction –Constraints

A complication associated with the EMS administration of a medication shall be documented as an Allergy and Other Adverse Reaction. The medication complication SHALL be documented in an Allergy and Intolerance Concern (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.5.3 [PCC TF-2]). The Allergy and Intolerance Concern SHALL contain exactly one [1..1] code/@code="67541-3" (Medication complication NEMSIS) and the <value> element shall be encoded in the /value concept. The value set SHALL be drawn from the MedicationComplication (2.16.840.1.113883.17.3.11.45 [EMS-PCR]) value set.

6.3.1.D2.5.13 EMS Injury Incident Description Section

The Trauma Center Criteria value shall be drawn from the Trauma Center Criteria concept domain as defined by local jurisdiction. The <value> element shall be eEncoded in the concept in the /value concept (e.g., in the US the value set shall be drawn from the TraumaCenterCriteria 2.16.840.1.113883.17.3.11.3 [HL7 EMS PCR] value set.).

6.3.1.D2.6 PCS Conformance and Example

CDA Release 2.0 documents that conform to the requirements of this document content module shall indicate their conformance by the inclusion of the <templateId> XML elements in the header of the document.

A CDA Document may conform to more than one template. This content module inherits from the Medical Summary 1.3.6.1.4.1.19376.1.5.3.1.1.2 and so must conform to the requirements of those templates as well this document specification, PCS-CR 1.3.6.1.4.1.19376.1.5.3.1.1.29.1 PCS *templateID*.

Note that this is an example and is meant to be informative and not normative. This example shows the PCS-CR 1.3.6.1.4.1.19376.1.5.3.1.1.29.1 elements for all of the specified templates.

6.3.2 CDA Header Content Modules

6.3.2.H CDA Header Content Module

6.3.2.H.1 Ethnicity Vocabulary Constraints

Collection of Ethnicity information may be restricted by some jurisdictions as constrained by national extension. When used, ethnicity SHALL use values from the Ethnicity concept domain as specified by jurisdiction.

6.3.2.H.3 Race Vocabulary Constraint

Collection of Race information may be restricted by some jurisdictions as constrained by national extension. When used, race SHALL use values from the Race concept domain as specified by jurisdiction.

6.3.2.H.7 documentationOf Vocabulary Constraint

The serviceEvent may be restricted by jurisdictions as constrained by national extension. The documentationOf/serviceEvent/code SHALL use values from the ServiceType concept domain as specified by jurisdiction.

The serviceEvent performer may be restricted by jurisdictions as constrained by national extension. The documentationOf/serviceEvent/performer/functionCode/code SHALL use values from the ProviderResponseRole concept domain as specified by jurisdiction.

The serviceEvent performer assignedEntity may be restricted by jurisdictions as constrained by national extension. The documentationOf/serviceEvent/performer/assignedEntity/code SHALL use values from the CrewRoleLevel concept domain as specified by jurisdiction.

6.3.3 CDA Section Content Modules

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	M 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
1.3.6.1.4.1.19376.1.5.3.1.3.38	**R2**	**Mental Status Organizer**

Add to Section 6.3.3.10 Section Content Modules

6.3.3.10.S1 Mental Status Organizer- Section Content Module

Table 6.3.3.10.S1-1: Mental Status Organizer Section

Template Name		Mental Status Organizer Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.3.38			
Parent Template		None			
General Description		The Mental Status Organizer template may be used to group related Mental Status Observations (e.g., results of mental tests) and associated Assessment Scale Observations into subcategories and/or groupings by time. Subcategories can be things such as Mood and Affect, Behavior, Thought Process, Perception, Cognition, etc. NOTE: This is modelled to be consistent with HL7 C-CDA R2, for consistency, but re-defining for international use.			
Section Code		75275-8, LOINC, "Cognitive Function"			
Author		May vary			
Informant		May vary			
Subject		current recordTarget			
Opt and Card	**Condition**	**Data Element or Section Name**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
Entries					
R [1..*]		Mental Status Observation entry	1.3.6.1.4.1.19376.1.5.3.1.4.25	6.3.4.E1	

```
<component>
  <section>
    <templateId root=' 1.3.6.1.4.1.19376.1.5.3.1.3.38'/>
    <id root=' ' extension=' '/>
    <code code=' 75275-8' displayName='Cognitive Function'
      codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
      Text as described above
    </text>
  </section>
</component>
```

Figure 6.3.3.10.S1-1: Specification for Mental Status Organizer Section

6.3.3.10.S2 Review of Systems - EMS - Section Content Module

Table 6.3.3.10.S2-1: Review of Systems - EMS Section

Template Name		Review of Systems - EMS			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.3.39			
Parent Template		Review of Systems (1.3.6.1.4.1.19376.1.5.3.1.3.18)			
General Description		The EMS 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 not covered in general review of systems.			
Section Code		10187-3, LOINC, “Review of Systems”			
Author		May vary			
Informant		May vary			
Subject		current recordTarget			
Opt and Card	**Condition**	**Data Element or Section Name**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
Subsections					
R2 [0..1]		Pregnancy Status Review	1.3.6.1.4.1.19376.1.5.3.1.1.9.47	PCC TF-3:6.3.3.2.34	6.3.3.10.S.1
Entries					
R2 [0..1]		Last Oral Intake	1.3.6.1.4.1.19376.1.5.3.1.4.26	6.3.4.E2	
R2 [0..1]		Last Known Well	1.3.6.1.4.1.19376.1.5.3.1.4.27	6.3.4.E3	

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```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.18'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.39'/>
    <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='1.3.6.1.4.1.19376.1.5.3.1.1.9.47'/>
        <!-- Required if known Pregnancy Status Review Section content -->
      </section>
    </component>
    <entry>
         :
      <!-- Required if known Last Oral Intake Entry element -->
        <templateId root='TBD'/>
         :
    </entry>
    <entry>
         :
      <!-- Required if known Last Known Well Entry element -->
        <templateId root='TBD'/>
         :
    </entry>
  </section>
</component>
```

Figure 6.3.3.10.S2-1: Specification for Review of Systems - EMS Section

6.3.3.10.S2.1 Pregnancy Status Vocabulary Constraint

The value for Pregnancy Status/ code SHALL be drawn from the Pregnancy value set 2.16.840.1.113883.17.3.11.42 [HL7 EMS PCR] unless further extended by national extension.

6.3.3.10.S3 EMS Procedures and Interventions Section Content Module

Table 6.3.3.10.S3-1: EMS Procedures and Interventions Section

Template Name		EMS Procedures and Interventions Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.13.2.14			
Parent Template		Procedures and Interventions Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11)			
General Description		The EMS Procedures and Interventions Section shall contain coded procedures performed during Pre-hospital paramedical care including information related to the success, unsuccessful attempts, and patient response as documented by the paramedicine care provider.			
Section Code		29554-3, LOINC, "Procedure"			
Author		May vary			
Informant		May vary			
Subject		current recordTarget			
Opt and Card	**Condition**	**Data Element or Section Name**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
Entries					
R [1..1]		Procedure	1.3.6.1.4.1.19376.1.5.3.1.4.19	PCC TF-2: 6.3.4.33	
R2 [0..1]		Abandoned Procedure Reason Observation	2.16.840.1.1133883.17.3.10.1.130	HL7 EMS Run Report R2	
R2 [0..1]		Procedure Prior Indicator	2.16.840.1.1133883.17.3.10.1.131	HL7 EMS Run Report R2	
R2 [0..1]		Procedure Number Of Attempts Observation	2.16.840.1.1133883.17.3.10.1.132	HL7 EMS Run Report R2	
R2 [0..1]		Procedure Successful Observation	2.16.840.1.1133883.17.3.10.1.133	HL7 EMS Run Report R2	
R2 [0..1]		Procedure Complications Observation	2.16.840.1.1133883.17.3.10.1.179	HL7 EMS Run Report R2	
R2 [0..1]		Procedure Patient Response Observation	2.16.840.1.1133883.17.3.10.1.135	HL7 EMS Run Report R2	
R2 [0..1]		Airway Confirmation Observation	2.16.840.1.1133883.17.3.10.1.175	HL7 EMS Run Report R2	

6.3.3.10.S3.1 <effectiveTime><low value="/><high value="/></effectiveTime>

This element should be present, and records the time at which the procedure occurred (in EVN mood), the desired time of the procedure in INT mood. If an abandoned time is recorded, the time it is abandoned is reflected in effectiveTime(high).

6.3.3.10.S3.2 <approachSiteCode code=" displayName=" codeSystem=" codeSystemName="/>

This element may be present to indicate the procedure approach. Required conditionally if procedure code is intravenous catheterization, using valueSet IVSite - 2.16.840.1.113883.17.3.11.56 unless otherwise constrained by jurisdiction.

6.3.3.10.S3.3 <performer>

For procedures in EVN mood, at least one performer should be present that identifies the provider of the service given. 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 procedure.

Such performers **SHALL** contain exactly one [1..1] **`assignedEntity`**

a. This assignedEntity **SHALL** contain exactly one [1..1] **`id`** indicating the performer's jurisdiction license number as defined by the jurisdiction
b. This assignedEntity **SHALL** contain exactly one [1..1] **`code`** which **SHALL** use values from the Provider Role concept domain as specified by jurisdiction.

6.3.3.10.S3.4 @negationInd

Required to document a procedure not performed, with required entryRelationship typeCode=RSON

6.3.3.10.S3.5 <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. For procedures not performed, this is used to document the "reason not performed", documenting the reason using valueSet Reason Procedure not Performed Superset - 2.16.840.1.113883.17.3.11.100 unless otherwise specified by jurisdiction.


```
<component>
  <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11'/>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.14'/>
    <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>
    <entry>
         :
      <!-- Required if known Abandoned Procedure Reason Observation Entry
element -->
        <templateId root='2.16.840.1.1133883.17.3.10.1.130'/>
         :
    </entry>
    <entry>
         :
      <!-- Required if known Procedure Prior Indicator Entry element -->
        <templateId root='2.16.840.1.1133883.17.3.10.1.131'/>
         :
    </entry>
    <entry>
         :
      <!-- Required if known Procedure Number Of Attempts Observation Entry
element -->
        <templateId root='2.16.840.1.1133883.17.3.10.1.132'/>
         :
    </entry>
    <entry>
         :
      <!-- Required if known Procedure Successful Observation Entry element -
->
        <templateId root='2.16.840.1.1133883.17.3.10.1.133'/>
         :
    </entry>
    <entry>
         :
      <!-- Required if known Procedure Complications Observation Entry
element -->
        <templateId root='2.16.840.1.1133883.17.3.10.1.179'/>
         :
    </entry>
    <entry>
         :
      <!-- Required if known Procedure Patient Response Observation Entry
element -->
```



```
        <templateId root='2.16.840.1.1133883.17.3.10.1.135'/>
         :
    </entry>
    <entry>
         :
      <!-- Required if known Airway Confirmation Observation Entry element --
>
        <templateId root='2.16.840.1.1133883.17.3.10.1.175'/>
         :
    </entry>
  </section>
</component>
```

Figure 6.3.3.10.S3.5-1: EMS Procedures and Interventions Section

6.3.3.10.S4 EMS Injury Incident Description Clinical Section Content Module

Table 6.3.3.10.S4-1: EMS Injury Incident Description Clinical Section

Template Name		EMS Injury Incident Description Clinical Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.3.40			
Parent Template		EMS Injury Incident Description Section (2.16.840.1.113883.17.3.10.1.17 HL7 EMS Run Report R2)			
General Description		The EMS Injury Incident Description Clinical Section shall contain injury information where the Pre-hospital paramedical care was in response to an injury.			
Section Code		67800-3, LOINC, "EMS injury incident description Narrative"			
Author		May vary			
Informant		May vary			
Subject		current recordTarget			
Opt and Card	**Condition**	**Data Element or Section Name**	**Template ID**	**Specification Document**	**Constraint**
Entries					
R [1..1]		Injury Cause Category	2.16.840.1.1133883.17.3.10.1.50	HL7 EMS Run Report R2	
RE [0..1]		Injury Mechanism	2.16.840.1.1133883.17.3.10.1.51	HL7 EMS Run Report R2	
R [1..1]		Trauma Center Criteria	2.16.840.1.1133883.17.3.10.1.52	HL7 EMS Run Report R2	6.3.3.10.S4.1
R [1..1]		Injury Risk Factor	2.16.840.1.1133883.17.3.10.1.53	HL7 EMS Run Report R2	
O [0..1]		Vehicle Impact Area	2.16.840.1.1133883.17.3.10.1.54	HL7 EMS Run Report R2	6.3.3.10.S4.2
O [0..1]		Patient Location In Vehicle	2.16.840.1.1133883.17.3.10.1.55	HL7 EMS Run Report R2	6.3.3.10.S4.3

O [0..1]		Vehicle Occupant Safety Equipment	2.16.840.1.1133883.17.3.10.1.56	HL7 EMS Run Report R2	
O [0..1]		Airbag Deployment Status	2.16.840.1.1133883.17.3.10.1.57	HL7 EMS Run Report R2	
O [0..1]		Height Of Fall	2.16.840.1.1133883.17.3.10.1.58	HL7 EMS Run Report R2	
O [0..1]		Disaster Type	2.16.840.1.1133883.17.3.10.1.59	HL7 EMS Run Report R2	

6.3.3.10.S4.1 Trauma Center Criteria

This entry is required by the parent section, but SHALL be NULL as this information is not relevant to clinical care.

6.3.3.10.S4.2 Vehicle Impact Area

This entry is optional in the parent section, but SHALL be omitted or NULL as this information is not relevant to clinical care.

6.3.3.10.S4.3 Patient Location In Vehicle

This entry is optional in the parent section, but SHALL be omitted or NULL as this information is not relevant to clinical care.

6.3.3.10.S5 EMS Procedures and Interventions Clinical Section Content Module

Table 6.3.3.10.S5-1: EMS Procedures and Interventions Clinical Section

Template Name		EMS Procedures and Interventions Clinical Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.13.2.14			
Parent Template		Procedures and Interventions Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11) EMS Procedures and Interventions Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.14)			
General Description		The EMS Procedures and Interventions Clinical Section shall contain coded procedures performed during Pre-hospital paramedical care including information related to the success, unsuccessful attempts, and patient response as documented by the paramedicine care provider. This section is limited to the information needed for continued clinical care at the receiving facility.			
Section Code		29554-3, LOINC, "Procedure"			
Author		May vary			
Informant		May vary			
Subject		current recordTarget			
Opt and Card	**Condition**	**Data Element or Section Name**	**Template ID**	**Specification Document**	**Constraint**
Entries					
R [1..1]		Procedure	1.3.6.1.4.1.19376.1.5.3.1.4.19	PCC TF-2: 6.3.4.33	
R2 [0..1]		Abandoned Procedure Reason Observation	2.16.840.1.1133883.17.3.10.1.130	HL7 EMS Run Report R2	
R2 [0..1]		Procedure Prior Indicator	2.16.840.1.1133883.17.3.10.1.131	HL7 EMS Run Report R2	
R2 [0..1]		Procedure Number Of Attempts Observation	2.16.840.1.1133883.17.3.10.1.132	HL7 EMS Run Report R2	
O [0..1]		Procedure Successful Observation	2.16.840.1.1133883.17.3.10.1.133	HL7 EMS Run Report R2	6.3.3.10.S5.1
R2 [0..1]		Procedure Complications Observation	2.16.840.1.1133883.17.3.10.1.179	HL7 EMS Run Report R2	
O [0..1]		Procedure Patient Response Observation	2.16.840.1.1133883.17.3.10.1.135	HL7 EMS Run Report R2	6.3.3.10.S5.2
R2 [0..1]		Airway Confirmation Observation	2.16.840.1.1133883.17.3.10.1.175	HL7 EMS Run Report R2	6.3.3.10.S5.3

6.3.3.10.S5.1 Procedure Successful Observation

This entry is R2 in the parent section, but SHALL be omitted or NULL as this information is not relevant to clinical care.

6.3.3.10.S5.2 Procedure Patient Response Observation

This entry is Optional in the parent section, but SHALL be omitted or NULL as this information is not relevant to clinical care.

6.3.3.10.S5.3 Procedure Patient Response Observation

This entry is R2 in the parent section, but SHALL be omitted or NULL as this information is not relevant to clinical care.

6.3.3.10.S6 EMS Scene Clinical Section Content Module

Table 6.3.3.10.S6-1: EMS Scene Clinical Section

Template Name		EMS Scene Clinical Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.3.41			
Parent Template		EMS Scene Section 2.16.840.1.113883.17.3.10.1.8 (HL7 EMS Run Report R2)			
General Description		The EMS Scene Clinical Section shall contain information about the environment in which the patient is found for the Pre-hospital paramedical care.			
Section Code		67665-0, LOINC, " EMS scene Narrative"			
Author		May vary			
Informant		May vary			
Subject		current recordTarget			
Opt and Card	**Condition**	**Data Element or Section Name**	**Template ID**	**Specification Document**	**Constraint**
Entries					
R [1..1]		First Unit Indicator	2.16.840.1.1133883.17.3.10.1.84	HL7 EMS Run Report R2	6.3.3.10.S6.1
R [1..1]		Scene Patient Count	2.16.840.1.1133883.17.3.10.1.86	HL7 EMS Run Report R2	6.3.3.10.S6.2
R [1..1]		Mass Casualty Indicator	2.16.840.1.1133883.17.3.10.1.87	HL7 EMS Run Report R2	
R [1..1]		Location Type Observation	2.16.840.1.1133883.17.3.10.1.88	HL7 EMS Run Report R2	

6.3.3.10.S6.1 First Unit Indicator

This entry is R in the parent section, but SHALL be omitted or NULL as this information is not relevant to clinical care.

6.3.3.10.S2.2 Procedure Patient Response Observation

This entry is R in the parent section, but SHALL be omitted or NULL as this information is not relevant to clinical care.

6.3.3.10.S7 EMS Situation Clinical Section Content Module

Table 6.3.3.10.S7-1: EMS Situation Clinical Section

Template Name		EMS Situation Clinical Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.3.42			
Parent Template		EMS Situation Section 2.16.840.1.113883.17.3.10.1.9 (HL7 EMS Run Report R2)			
General Description		The EMS Situation Clinical Section shall contain information about patient symptoms and complaints during the Pre-hospital paramedical care.			
Section Code		67666-8, LOINC, "EMS situation Narrative"			
Author		May vary			
Informant		May vary			
Subject		current recordTarget			
Opt and Card	**Condition**	**Data Element or Section Name**	**Template ID**	**Specification Document**	**Constraint**
Entries					
R [1..1]		Complaint	2.16.840.1.1133883.17.3.10.1.63	HL7 EMS Run Report R2	
R [1..1]		Possible Injury	2.16.840.1.1133883.17.3.10.1.64	HL7 EMS Run Report R2	
R [1..1]		Provider Primary Impression	2.16.840.1.1133883.17.3.10.1.65	HL7 EMS Run Report R2	
R [1..1]		Primary Symptom	2.16.840.1.1133883.17.3.10.1.66	HL7 EMS Run Report R2	
R [1..1]		Other Symptoms	2.16.840.1.1133883.17.3.10.1.67	HL7 EMS Run Report R2	
R [1..1]		Provider Secondary Impressions	2.16.840.1.1133883.17.3.10.1.68	HL7 EMS Run Report R2	
R [1..1]		Initial Patient Acuity	2.16.840.1.1133883.17.3.10.1.69	HL7 EMS Run Report R2	6.3.3.10.S7.1

6.3.3.10.S7.1 Initial Patient Acuity

This entry is R in the parent section, but SHALL be omitted or NULL as this information is not relevant to clinical care.

6.3.4 CDA Entry Content Modules

Add to Section 6.3.4.E Entry Content Modules

6.3.4.E1 Mental Status Entry Content Module

Table 6.3.4.E1-1: Mental Status Entry

Template Name	Mental Status Entry		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.25		
Parent Template	NA		
General Description	Qualitative assessment of condition of patient's mental status.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	75275-8, LOINC, Cognitive Function	CD	SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96)

Opt and Card	entryRelationship	Description	Template ID	Specification Document	Vocabulary Constraint
R [1..1]		Simple Observation	1.3.6.1.4.1.19376.1.5.3.1.4.13		Concept Domain Mental Status

6.3.4.E2 Last Oral Intake Entry Content Module

Table 6.3.4.E2-1: Last Oral Intake Entry

Template Name	Last Oral Intake Entry		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.26		
Parent Template	1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	Time of patient's last oral intake		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	67517-3, LOINC, Last oral intake [Date and time] NEMSIS	TS	NA

Opt and Card	entryRelationship	Description	Template ID	Specification Document	Vocabulary Constraint
R [1..1]		Simple Observation	1.3.6.1.4.1.19376.1.5.3.1.4.13		NA

6.3.4.E3 Last Known Well Entry Content Module

Table 6.3.4.E3-1: Last Known Well Entry

Template Name	Last Known Well Entry		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.4.27		
Parent Template	1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The time prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current condition or at his or her baseline state of health.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	1.3.6.1.4.1.19376.1.5.3.1.4.27, LOINC, Time last known well [Date and time]	TS	NA

6.5 PCC Value Sets and Concept Domains

6.5.X Paramedicine Care Summary Concept Domains

The Concept Domains below are used in the Paramedicine Care Summary.

Paramedicine Care Summary
Ethnicity
Marital Status
Race
Religious Affiliation
Language Communication
Data Enterer
Confidentiality code
Destination
Service Type
advanced directives
Allergen
EMS Level of Service
Medications Administration route
UnitLevelOfCare
UnitResponseRole
Manufactured Material
Destination type
ProviderResponseRole
CrewRoleLevel

ProviderRole

6.6 HL7 FHIR Content Module

6.6.X Transport Content

6.6.X.1 Referenced Standards

Title	URL
HL7 Version 3 Domain Analysis Model: Emergency Medical Services, Release 1	<http://www.hl7.org/implement/standards/product_brief.cfm?product_id=39>
HL7 Version 3 Domain Information Model; Emergency Medical Services, Release 1	<http://www.hl7.org/implement/standards/product_brief.cfm?product_id=302>
HL7 Version 3 Implementation Guide for CDA Release 2 - Level 3: Emergency Medical Services; Patient Care Report, Release 2 - US Realm	<http://www.hl7.org/implement/standards/product_brief.cfm?product_id=438>
HL7 Version 3 Domain Analysis Model: Trauma Registry Data Submission,	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=363
HL7 CDA® R2 Implementation Guide: Trauma Registry Data Submission, Release 1 - US Realm	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=355
HL7 Version 2.7.1 Implementation Guide: Message Transformations with OASIS Tracking of Emergency Patients (TEP), Release 1	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=439
National Trauma Data Standard Data Dictionary	https://www.facs.org/~/media/files/quality%20programs/trauma/ntdb/ntds/data%20dictionaries/ntds%20data%20dictionary%202018.ashx
HL7 FHIR standard STU3	http://hl7.org/fhir/STU3/index.html

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6.6.X.2.1 FHIR Resource Bundle Content

The first column of this table refers to the options that these structure definitions apply to, e.g., complete report (CR), Clinical Subset (CS), Quality (Q), Trauma (T).

Table 6.6.X.2.1-1: FHIR Resource Bundle Structure Definitions

Found In	FHIR Resource location	Optionality	Cardinality	Structured Definition
CR, CS, Q, T	Composition	R	1..1	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.Composition
CR, Q	Patient	R	1..1	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.Patinet
T, CS	Patient	RE	0..1	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS-CS.Patinet
CR, CS, Q, T	Condition	RE	0..*	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.Condition
CR, CS, Q, T	Procedure	RE	0..*	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.Procedure
CR, CS, Q, T	Medication Administration	RE	0..*	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.MedicationAdministration

Found In	FHIR Resource location	Optionality	Cardinality	Structured Definition
CR, CS, Q,	Medication Statement	RE	0..*	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.MedicationStatement
CR, CS, Q, T	Observation	R	1..*	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.Observation
CR, Q	Encounter	R	1..*	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.Encounter
CS, T	Encounter	RE	0..*	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS-CS.Encounter
CR, Q	Location	R	1..1	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.Location
CS, T	Location	RE	0..1	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS-CS.Location
CR, CS,	Related Person	RE	0..*	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.RelatedPerson
CR, CS, Q, T	Allergy Intolerance	RE	0..*	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.AllergyIntolerance
CR, CS, Q, T	Adverse Event	RE	0..1	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.AdverseEvent
CR, CS, Q, T	Clinical Impression	R	1..*	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.ClinicalImpression
CR, CS, Q, T	Device	RE	0..1*	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.Device
CR, CS, Q, T	Document Reference	RE	0.1	http://ihe.net/fhir/StructureDefinition/IHE.PCC.PCS.DocumentReference

6.6.X.2.2 FHIR Resource Data Specifications

1300 The following table shows the mapping of the FHIR Resources supporting the content for EMS Data Elements/Attributes. The Content Creator SHALL support the Resources identified by this table. Content Consumer SHALL receive paramedicine content from the specified resource for each attribute.

Table 6.6.X.2.2-1: FHIR Resource Data Specification Data Elements

Data Element	Cardinality	FHIR Resource location	Constraint
Last name	RE [0..1]	Patient:PatientUvIps.identifier	
First name	RE [0..1]	Patient:PatientUvIps.name	
middle initial	RE [0..1]	Patient:PatientUvIps.name	
home address	RE [0..1]	Patient:PatientUvIps.name	
home city	RE [0..1]	Patient:PatientUvIps.address	
home country	RE [0..1]	Patient:PatientUvIps.address	
home state	RE [0..1]	Patient:PatientUvIps.address	
home zip code	RE [0..1]	Patient:PatientUvIps.address	
country of residence	RE [0..1]	Patient:PatientUvIps.address	

Data Element	Cardinality	FHIR Resource location	Constraint
home census tract	O [0..1]	Patient:PatientUvIps.address	
social security number	O [0..1]	Patient:PatientUvIps.identifier	
gender	RE [0..1]	Patient:PatientUvIps.gender	
race	O [0..1]	Patient.extension(us-core-race)	When used in the Unites States this element is required if known
Age	RE [0..1]	Patient:PatientUvIps.birthDate	
Age Units	RE [0..1]	Patient:PatientUvIps.birthDate	
Date of Birth	RE [0..1]	Patient:PatientUvIps.birthDate	
Patient's Phone Number	O [0..1]	Patient:PatientUvIps.telecom	
Patient's email	O [0..1]	Patient:PatientUvIps.telecom	
State Issuing Driver's License	O [0..1]	Patient:PatientUvIps.identifier	
Driver's License Number	O [0..1]	Patient:PatientUvIps.identifier	
Alternate Home Residence	O [0..1]	Patient:PatientUvIps.	
Primary Method of Payment	RE [0..1]	Coverage.type	
Document type: Certificate of medical necessity (CMN)	RE [0..1]	Servicerequest.reasonRefrence: DocumentReference	Where code is LOINC = 52016-3 Ambulance transport, Physician certification for transport Information set)
Physician Certification Statement Signed	RE [0..1]	Servicerequest.reasonRefrence: DocumentReference.content.attachment	Where code is LOINC = 52017-1 Ambulance transport, Physician certification for transport statement (narrative)Ambulance transport
Date Physician Certification Statement Signed	RE [0..1]	Servicerequest.reasonRefrence: DocumentReference.context.period	
Reason for Physician Certification Statement	RE [0..*]	Servicerequest.reasonCode	
Healthcare Provider Type Signing Physician Certification Statement	RE [0..1]	Servicerequest.reasonRefrence: DocumentReference.context.related: PractitionerRole.code	
Last Name of Individual Signing Physician Certification Statement	RE [0..1]	Servicerequest.reasonRefrence: DocumentReference.context.related: Practitioner.name	

Data Element	Cardinality	FHIR Resource location	Constraint
First Name of Individual Signing Physician Certification Statement	RE [0..1]	Servicerequest.reasonRefrence: DocumentReference.context.related: Practitioner.name	
Insurance Company ID	RE [0..1]	Coverage.payor:Organization.idetifier	
Insurance Company Name	RE [0..1]	Coverage.payor:Organization.name	
Insurance Company Billing Priority	RE [0..1]	Coverage.type	
Insurance Company Address	RE [0..1]	Coverage.payor:Organization.address	
Insurance Company City	RE [0..1]	Coverage.payor:Organization.address	
Insurance Company State	RE [0..1]	Coverage.payor:Organization.address	
Insurance Company Zipcode	RE [0..1]	Coverage.payor:Organization.address	
Insurance Company Country	RE [0..1]	Coverage.payor:Organization.address	
Insurance Group ID	RE [0..1]	Coverage.class.value	
Insurance Policy ID Number	RE [0..1]	Coverage.class.value	
Last Name of the Insured	RE [0..1]	Coverage.policyHolder:Patient.name Coverage.policyHolder:RelatedPerson.name	When policyholder name is not the same as the patient then SHALL use the Related person name resource
First Name of the Insured	RE [0..1]	Coverage.policyHolder:Patient.name Coverage.policyHolder:RelatedPerson.name	When policyholder name is not the same as the patient then SHALL use the Related person name resource
Middle initial/name of the Insured	RE [0..1]	Coverage.policyHolder:Patient.name Coverage.policyHolder:RelatedPerson.name	When policyholder name is not the same as the patient then SHALL use the Related person name resource
Relationship to the Insured	RE [0..1]	Coverage.relationship	
Insurance Group Name	RE [0..1]	Coverage.class.name	
Closest Relative/Guardian Last Name	RE [0..1]	Patient:PatientUvIps.contact.name	

Data Element	Cardinality	FHIR Resource location	Constraint
Closest Relative/Guardian First Name	RE [0..1]	Patient:PatientUvIps.contact.name	
Closest Relative/Guardian Middle Initial/Name	RE [0..1]	Patient:PatientUvIps.contact.name	
Closest Relative/Guardian Street Address	RE [0..1]	Patient:PatientUvIps.contact.address	
Closest Relative/Guardian City	RE [0..1]	Patient:PatientUvIps.contact.address	
Closest Relative/Guardian State	RE [0..1]	Patient:PatientUvIps.contact.address	
Closest Relative/Guardian Zip Code	RE [0..1]	Patient:PatientUvIps.contact.address	
Closest Relative/Guardian Country	RE [0..1]	Patient:PatientUvIps.contact.address	
Closest Relative/Guardian Phone Number	RE [0..1]	Patient:PatientUvIps.contact.telecom	
Closest Relative/Guardian Relationship	RE [0..1]	Patient:PatientUvIps.contact.relationship	
Patient's Employer	O [0..1]	Patient:PatientUvIps.contact.name	
Patient's Employer's Address	O [0..1]	Patient:PatientUvIps.contact.address	
Patient's Employer's City	O [0..1]	Patient:PatientUvIps.contact.address	
Patient's Employer's State	O [0..1]	Patient:PatientUvIps.contact.address	
Patient's Employer's Zip Code	O [0..1]	Patient:PatientUvIps.contact.address	
Patient's Employer's Country	O [0..1]	Patient:PatientUvIps.contact.address	
Patient's Employer's Primary Phone Number	O [0..1]	Patient:PatientUvIps.contact.telecom	
Last Name of Patient's Practitioner	RE [0..1]	Patient:PatientUvIps.generalPractitioner.name	
First Name of Patient's Practitioner	RE [0..1]	Patient:PatientUvIps.generalPractitioner.name	
Middle Initial/Name of Patient's Practitioner	RE [0..1]	Patient:PatientUvIps.generalPractitioner.name	
Advanced Directives	RE [0..1]	Composition.section:sectionAdvanceDirectives	
Medication Allergies	RE [0..*]	Composition.section:sectionAllergies.entry:allergyOrIntolerance	

Data Element	Cardinality	FHIR Resource location	Constraint
Environmental/Food Allergies	RE [0..*]	Composition.section:sectionAllergies.entry:allergyOrIntolerance	
Medical/Surgical History	RE [0..*]	"Composition.section:sectionPastIllnessHx.entry:pastProblem Composition.section:sectionProceduresHx.entry:procedure"	
The Patient's Type of Immunization	O [0..1]	Composition.section:sectionImmunizations.entry:immunization.vaccineCode	
Immunization Year	O [0..1]	Composition.section:sectionImmunizations.entry:immunization.occurrenceDateTime	
Current Medications	RE [0..1]	Composition.section:sectionMedications.entry:medicationStatement	
Current Medication Dose	RE [0..1]	Composition.section:sectionMedications.entry:medicationStatement.dosage.doseAndRate.dose[x]	
Current Medication Dosage Unit	RE [0..1]	Composition.section:sectionMedications.entry:medicationStatement.dosage.doseAndRate.dose[x]	
Current Medication Administration Route	RE [0..1]	Composition.section:sectionMedications.entry:medicationStatement.dosage.route	
Current Medication Frequency	RE [0..1]	Composition.section:sectionMedications.entry:medicationStatement.dosage.timing	
Presence of Emergency Information Form	O [0..1]	Encounter ←Observation.value[x]	
Alcohol/Drug Use Indicators	O [0..1]	Encounter ←Observation.value[x]	
Last Oral Intake	O [0..1]	Encounter ←Observation.value[x]	
Pregnancy	RE [0..1]	Composition.section:sectionPregnancyHx.entry:pregnancyStatus	
Date/Time Vital Signs Taken	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.effective[x]	
Cardiac Rhythm / Electrocardiography (ECG)	RE [0..1]	"Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	
ECG Type	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]"	
Method of ECG Interpretation	RE [0..1]	N/A	
SBP (Systolic Blood Pressure)	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code	
DBP (Diastolic Blood Pressure)	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	
Method of Blood Pressure Measurement	RE [0..1]	N/A	
Mean Arterial Pressure	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code	
Heart Rate	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	

Data Element	Cardinality	FHIR Resource location	Constraint
Method of Heart Rate Measurement	RE [0..1]	N/A	
Pulse Oximetry	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code	
Pulse Rhythm	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	
Respiratory Rate	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Respiratory Effort	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code	
End Title Carbon Dioxide (ETCO2)	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	
Carbon Monoxide (CO)	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Blood Glucose Level	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code	
Glasgow Coma Score-Eye	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	
Glasgow Coma Score-Verbal	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Glasgow Coma Score-Motor	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Glasgow Coma Score-Qualifier	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Total Glasgow Coma Score	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Temperature	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Temperature Method	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	

Data Element	Cardinality	FHIR Resource location	Constraint
Level of Responsiveness (AVPU)	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Pain Scale Score	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Pain Scale Type	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Stroke Scale Score	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Stroke Scale Type	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Reperfusion Checklist	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
APGAR	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Revised Trauma Score	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	

Data Element	Cardinality	FHIR Resource location	Constraint
Date/Time of Laboratory or Imaging Result	RE [0..1]	Composition.section:sectionResults.entry:Observation.effective[x] Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.effective[x]	
Study/Result Prior to this Unit's EMS Care	RE [0..1]	Composition.section:sectionResults.entry:Observation.effective[x] Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.effective[x]	
Laboratory Result Type	RE [0..1]	Composition.section:sectionResults.entry:results-observation.category Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.code	
Laboratory Result	RE [0..1]	Composition.section:sectionResults.text Composition.section:sectionResults.entry:Observation.text Composition.section:sectionResults.entry:results-observation.value[x] Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.value[x]	
Imaging Study Type	RE [0..1]	Composition.section:sectionResults.entry:results-observation.category Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.code	
Imaging Study Results	RE [0..1]	Composition.section:sectionResults.text Composition.section:sectionResults.entry:Observation.text Composition.section:sectionResults.entry:results-observation.value[x] Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.value[x]	
Imaging Study File or Waveform Graphic Type	RE [0..1]	N/A	
Imaging Study File or Waveform Graphic	RE [0..1]	N/A	
Estimated Body Weight in Kilograms	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Length Based Tape Measure	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	

Data Element	Cardinality	FHIR Resource location	Constraint
Date/Time of Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Skin Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Head Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Face Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Neck Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Chest/Lungs Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Heart Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Abdominal Assessment Finding Location	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	

Data Element	Cardinality	FHIR Resource location	Constraint
Abdominal Assessment Finding Location	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Abdomen Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Pelvis/Genitourinary Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Back and Spine Assessment Finding Location	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Back and Spine Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Extremity Assessment Finding Location	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Extremities Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Eye Assessment Finding Location	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	

Data Element	Cardinality	FHIR Resource location	Constraint
Eye Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Mental Status Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Neurological Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Lung Assessment Finding Location	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Lung Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Chest Assessment Finding Location	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Chest Assessment	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	
Stroke/CVA Symptoms Resolved	RE [0..1]	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	Where condition is stroke/CVA symptoms where clinicalStatus is resolved
Date/Time Procedure Performed	RE [0..1]	Composition.section:sectionProceduresHx.entry:procedure.performedDateTime	

Data Element	Cardinality	FHIR Resource location	Constraint
Procedure Performed Prior to this Unit's EMS Care	RE [0..1]	Composition.section:sectionProceduresHx.entry: procedure.performedDateTime	
Procedure	RE [0..1]	Composition.section:sectionProceduresHx.entry: procedure	
Destination/Transferred To, Name	R [1..1]	ServiceRequest.locationReference: Location.name	
Destination Street Address	R [1..1]	ServiceRequest.locationReference: Location.address	Patient destination street address
Destination City	R [1..1]	ServiceRequest.locationReference: Location.address	
Destination State	R [1..1]	ServiceRequest.locationReference: Location.address	
Destination County	RE [0..1]	ServiceRequest.locationReference: Location.address	
Destination ZIP Code	RE [0..1]	ServiceRequest.locationReference: Location.address	
Destination Country	RE [0..1]	ServiceRequest.locationReference: Location.address	

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6.6.X.4 Clinical Subset Data Import Option

The Content Consumer supporting the Clinical Subset Data Import Option SHALL require receiving system to import the discrete data elements identified in the following table.

Table 6.6.X.4-1: Clinical Subset Data Import Option FHIR and CDA Mapping

Paramedicine Data Element	FHIR Resource location	CDA Location
Patient Care Report Number	Resource.Composition	Header
Complaint Reported by Dispatch	Encounter.reason	Reason for Referral
PSAP Call Date/Time	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Time Section

Paramedicine Data Element	FHIR Resource location	CDA Location
Unit Arrived on Scene Date/Time	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Time Section
Arrived at Patient Date/Time	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Time Section
Arrival at Destination Landing Area Date/Time	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Time Section
Patient Arrived at Destination Date/Time	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Time Section
EMS Patient ID	Encounter.subject (Patient.identifier)	Header
Last name	Encounter.subject (Patient.name)	Header
First name	Encounter.subject (Patient.name)	Header
middle initial	Encounter.subject (Patient.name)	Header
home address	Encounter.subject (Patient.address)	Header
home city	Encounter.subject (Patient.address)	Header
home country	Encounter.subject (Patient.address)	Header
home state	Encounter.subject (Patient.address)	Header
home postal code	Encounter.subject (Patient.address)	Header
gender	Encounter.subject (Patient.gender)	Header
Race	Encounter.subject (Patient.race (US extension))	Header
Age	Encounter.subject (Patient.identifier)	Header
Age Units	Encounter.subject (Patient.identifier)	Header
Date of Birth	Encounter.subject (Patient.birthDate)	Header
Patient's Phone Number	Encounter.subject (Patient.telecom)	Header
Closest Relative/Guardian Last Name	Encounter.subject (RelatedPerson.name)	Header

Paramedicine Data Element	FHIR Resource location	CDA Location
Closest Relative/Guardian First Name	Encounter.subject (RelatedPerson.name)	Header
Closest Relative/Guardian Middle Initial/Name	Encounter.subject (RelatedPerson.name)	Header
Closest Relative/Guardian Street Address	Encounter.subject (RelatedPerson.address)	Header
Closest Relative/Guardian City	Encounter.subject (RelatedPerson.address)	Header
Closest Relative/Guardian State	Encounter.subject (RelatedPerson.address)	Header
Closest Relative/Guardian postal code	Encounter.subject (RelatedPerson.address)	Header
Closest Relative/Guardian Country	Encounter.subject (RelatedPerson.address)	Header
Closest Relative/Guardian Phone Number	Encounter.subject (RelatedPerson.telecom)	Header
Closest Relative/Guardian Relationship	Encounter.subject (RelatedPerson.relationship)	Header
Mass Casualty Incident	Encounter.encounter- massCasualty **IHE extension**	EMS Scene Section
Triage Classification for MCI Patient	Encounter.priority Encounter.priority.code	EMS Scene Section
Incident Location Type	Encounter.encounter-incidentLocationType **IHE extension**	EMS Scene Section
Incident Facility Code	Encounter.encounter-incidentFacilityCode **IHE extension**	EMS Scene Section
Date/Time of Symptom Onset	Encounter.diagnosis.condition(condition. onsetDateTime)	EMS Situation Section
Possible Injury	Encounter.diagnosis.condition(condition.code)	EMS Situation Section
Complaint Type	Encounter.diagnosis.condition(Condition.category)	EMS Situation Section
Complaint	Encounter.diagnosis.condition(Condition.note)	EMS Situation Section
Duration of Complaint	Encounter.diagnosis.condition(Condition.abatemetDateTime)	EMS Situation Section

Paramedicine Data Element	FHIR Resource location	CDA Location
Chief complaint Anatomic Location	Encounter.diagnosis.condition(Condition.bodySite)	EMS Situation Section
Chief Complain organ system	Encounter.diagnosis.condition(Condition.bodySite)	EMS Situation Section
Primary Symptom	Encounter.diagnosis.condition(Condition.evidence.code)	EMS Situation Section / Reason for Referral
Other Associated symptoms	Encounter.diagnosis.condition(Condition.evidence.code)	EMS Situation Section / Reason for Referral
Provider's Primary Impressions	Encounter←Observation.value[x]	EMS Situation Section / Reason for Referral
Provider's Secondary Impressions	Encounter←Observation.value[x]	EMS Situation Section / Reason for Referral
Initial Patient Acuity	Encounter←Observation.interpretation	EMS Situation Section
Work-related Illness/Injury	Encounter←Observation.note	EMS Situation Section
Patient's Occupational Industry	N/A	EMS Situation Section
Patient's Occupation	N/A	EMS Situation Section
Patient Activity	Encounter←Observation.value[x]	EMS Situation Section
Date/Time Last Known Well	Encounter←Observation.value[x]	EMS Situation Section /Review of Systems-EMS Section
Cause of Injury	Encounter←Observation.value[x]	EMS Injury Incident Description Section
Mechanism of Injury	No mapping available	EMS Injury Incident Description Section
Location of Patient in Vehicle	Encounter←Observation.value[x]	EMS Injury Incident Description Section
Use of Occupant Safety Equipment	Encounter←Observation.value[x]	EMS Injury Incident Description Section
Height of Fall (feet)	Encounter←Observation.value[x]	EMS Injury Incident Description Section
Cardiac Arrest	Encounter←Observation.value[x]	EMS Cardiac Arrest Event Section
Cardiac Arrest Etiology	Encounter←Observation.value[x]	EMS Cardiac Arrest Event Section
Resuscitation Attempted By EMS	Encounter←Procedure.code	EMS Cardiac Arrest Event Section
Arrest Witnessed By	Encounter.encounter – witness (Person) **IHE Extension**	EMS Cardiac Arrest Event Section
CPR Care Provided Prior to EMS Arrival	Encounter.encounter – priorCprProvided **IHE Extension**	EMS Cardiac Arrest Event Section
Who Provided CPR Prior to EMS Arrival	Encounter.encounter – priorCprProvidedRole **IHE Extension**	EMS Cardiac Arrest Event Section

Paramedicine Data Element	FHIR Resource location	CDA Location
AED Use Prior to EMS Arrival	Encounter.encounter – priorAedProvided **IHE Extension**	EMS Cardiac Arrest Event Section
Who Used AED Prior to EMS Arrival	Encounter.encounter – priorAedProvidedRole **IHE Extension**	EMS Cardiac Arrest Event Section
Type of CPR Provided	Encounter.encounter – CprProvidedType **IHE Extension**	EMS Cardiac Arrest Event Section
First Monitored Arrest Rhythm of the Patient	Encounter←Observation.value[x]	EMS Cardiac Arrest Event Section
Any Return of Spontaneous Circulation	Encounter←Procedure.outcome	EMS Cardiac Arrest Event Section
Date/Time of Cardiac Arrest	Encounter←Observation.effective[x]	EMS Cardiac Arrest Event Section
Date/Time Resuscitation Discontinued	Encounter←Procedure.performedPeriod.end	EMS Cardiac Arrest Event Section
Reason CPR/Resuscitation Discontinued	Encounter←Procedure - resuscitationDiscontinuedReason **IHE Extension**	EMS Cardiac Arrest Event Section
Cardiac Rhythm on Arrival at Destination	Encounter←Observation.value[x]	EMS Cardiac Arrest Event Section
End of EMS Cardiac Arrest Event	Encounter←Procedure – **IHE Extension**	EMS Cardiac Arrest Event Section
Date/Time of Initial CPR	Encounter←Procedure.performedPeriod.start	EMS Cardiac Arrest Event Section
Barriers to Pt care	Encounter←Observation.value[x]	N/A
Advanced Directives	DocumentReference	EMS Advance Directives Section
Medication Allergies	AllergyIntolerance.substance	Allergy and Intolerances Concern Entry
Environmental/Food Allergies	AllergyIntolerance.substance	Allergy and Intolerances Concern Entry
Medical/Surgical History	Encounter.diagnosis.condition(ClinicalImpression.finding)	EMS Past Medical History Section
Medical/Surgical History	Encounter.diagnosis.condition(ClinicalImpression.date)	EMS Past Medical History Section
Medical/Surgical History	Encounter.diagnosis.condition(Condition.code)	EMS Past Medical History Section
Medical/Surgical History	Encounter.diagnosis.condition(Condition.onset[x])	EMS Past Medical History Section
Medical/Surgical History	Encounter.diagnosis.condition(Procedure.performed[x])	EMS Past Medical History Section

Paramedicine Data Element	FHIR Resource location	CDA Location
Medical/Surgical History	Encounter.diagnosis.condition(Procedure.code)	EMS Past Medical History Section
Current Medications	MedicationStatement.medication[x]	Medication Section
Current Medication Dose	MedicationStatement.dosage	Medication Section
Current Medication Dosage Unit	MedicationStatement.dosage	Medication Section
Current Medication Administration Route	MedicationStatement.dosage.route	Medication Section
Alcohol/Drug Use Indicators	Encounter←Observation.value[x]	EMS Social History Section
Pregnancy	Encounter.diagnosis.condition(Condition.code)	Review of Systems - EMS Section
Last Oral Intake	Encounter←Observation.value[x]	Review of Systems-EMS Section
Date/Time Vital Signs Taken	Encounter←Observation.issued	Coded Vital Signs Section
Vitals Obtained Prior to this Unit's EMS Care	Encounter←Observation.value[x]	N/A
Cardiac Rhythm / Electrocardiography (ECG)	Encounter←Observation.value[x]	EMS Cardiac Arrest Event Section
ECG Type	Encounter←Observatio.type	EMS Cardiac Arrest Event Section
Method of ECG Interpretation	Encounter←Observation.method	EMS Cardiac Arrest Event Section
SBP (Systolic Blood Pressure)	Encounter←Observation.value[x]	Coded Vital Signs Section
DBP (Diastolic Blood Pressure)	Encounter←Observation.value[x]	Coded Vital Signs Section
Method of Blood Pressure Measurement	Encounter←Observation.method	Coded Vital Signs Section
Mean Arterial Pressure	Encounter←Observation.value[x]	Coded Vital Signs Section
Heart Rate	Encounter←Observation.value[x]	Coded Vital Signs Section
Method of Heart Rate Measurement	Encounter←Observation.method	Coded Vital Signs Section
Pulse Oximetry	Encounter←Observation.value[x]	Coded Vital Signs Section
Pulse Rhythm	Encounter←Observation.value[x]	N/A
Respiratory Rate	Encounter←Observation.value[x]	Coded Vital Signs Section
Respiratory Effort	Encounter←Observation.value[x]	N/A
End Title Carbon Dioxide (ETCO2)	Encounter←Observation.value[x]	Coded Vital Signs Section

Paramedicine Data Element	FHIR Resource location	CDA Location
Carbon Monoxide (CO)	Encounter←Observation.value[x]	Coded Vital Signs Section
Blood Glucose Level	Encounter←Observation.value[x]	Coded Vital Signs Section
Glasgow Coma Score-Eye	Encounter←Observation.value[x]	Coded Vital Signs Section
Glasgow Coma Score-Verbal	Encounter←Observation.value[x]	Coded Vital Signs Section
Glasgow Coma Score-Motor	Encounter←Observation.value[x]	Coded Vital Signs Section
Glasgow Coma Score-Qualifier	Encounter←Observation.value[x]	Coded Vital Signs Section
Total Glasgow Coma Score	Encounter←Observation.value[x]	Coded Vital Signs Section
Temperature	Encounter←Observation.value[x]	Coded Vital Signs Section
Temperature Method	Encounter←Observation.value[x]	Coded Vital Signs Section
Level of Responsiveness (AVPU)	Encounter←Observation.value[x]	Coded Vital Signs Section
Pain Scale Score	Encounter←Observation.value[x]	Coded Vital Signs Section
Pain Scale Type	Encounter←Observation.value[x]	Coded Vital Signs Section
Stroke Scale Score	Encounter←Observation.value[x]	Coded Vital Signs Section
Stroke Scale Type	Encounter←Observation.value[x]	Coded Vital Signs Section
Reperfusion Checklist	Encounter←Observation.value[x]	Coded Vital Signs Section
APGAR	Encounter←Observation.value[x]	Coded Vital Signs Section
Revised Trauma Score	Encounter←Observation.value[x]	Coded Vital Signs Section
Estimated Body Weight in Kilograms	Encounter←Observation.interpretation	Coded Vital Signs Section
Length Based Tape Measure	Encounter←Observation.interpretation	Coded Vital Signs Section
Date/Time of Assessment	Encounter←Observation.issued	Coded Detail Physical Examination Section
Skin Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Head Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Face Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Neck Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Chest/Lungs Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Heart Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Abdominal Assessment Finding Location	Encounter←Observation.bodySite	Coded Detail Physical Assessment Section

Paramedicine Data Element	FHIR Resource location	CDA Location
Abdominal Assessment Finding Location	Encounter←Observation.bodySite	Coded Detail Physical Assessment Section
Abdomen Assessment	Encounter←Observation.interpretation	Coded Detail Physical Assessment Section
Pelvis/Genitourinary Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Back and Spine Assessment Finding Location	Encounter←Observation.bodySite	Coded Detail Physical Examination Section
Back and Spine Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Extremity Assessment Finding Location	Encounter←Observation.bodySite	Coded Detail Physical Examination Section
Extremities Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Eye Assessment Finding Location	Encounter←Observation.bodySite	Coded Detail Physical Examination Section
Eye Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Mental Status Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Neurological Assessment	Encounter←Observation.interpretation	Coded Detail Physical Examination Section
Stroke/CVA Symptoms Resolved	Encounter.diagnosis.condition(Condition.clinicalStatus)	Coded Detail Physical Examination Section
Date/Time Medication Administered	Encounter←MedicationAdministration.effective[x] Encounter←MedicationAdministration.effective.date/time	Medications Administered Section
Medication Administered Prior to this Unit's EMS Care	Encounter←MedicationAdministration.effective[x] Encounter←MedicationAdministration.effective.date/time	N/A
Medication Given	Encounter←MedicationAdministration.resource	Medications Administered Section
Medication Administered Route	Encounter←MedicationAdministration.dosage.route	Medications Administered Section
Medication Dosage	Encounter←MedicationAdministration.dosage	Medications Administered Section
Medication Dosage Units	Encounter←MedicationAdministration.dosage.dose	Medications Administered Section
Response to Medication	Encounter←MedicationAdministration.note	N/A

Paramedicine Data Element	FHIR Resource location	CDA Location
Medication Complication	Encounter←AdverseEvent.reaction Encounter←AdverseEvent.Description	Allergy and Intolerances Concern Entry
Date/Time Procedure Performed	Encounter←Procedure.performed[x].performed.dateTime	EMS Procedures Performed Section
Procedure Performed Prior to this Unit's EMS Care	Encounter←Procedure.performed[x].performed.dateTime	EMS Procedures Performed Section
Procedure	Encounter←Procedure.code	EMS Procedures Performed Section
Number of Procedure Attempts	Encounter←Procedure.partOf.observation.value[x]	EMS Procedures Performed Section
Procedure Successful	Encounter←Procedure Procedure.outcome	EMS Procedures Performed Section
Procedure Complication	Encounter←Procedure Procedure.status	EMS Procedures Performed Section
Response to Procedure	Encounter←Procedure Procedure.outcome	EMS Procedures Performed Section
Vascular Access Location	Encounter←Procedure Procedure.bodySite	EMS Procedures Performed Section
Indications for Invasive Airway	Encounter←Procedure Procedure.ReasonReference Encounter←Procedure Procedure.ReasonCode	EMS Procedures Performed Section
Date/Time Airway Device Placement Confirmation	Encounter←Procedure Procedure.performedDateTime	EMS Procedures Performed Section
Airway Device Being Confirmed	Encounter←Procedure Procedure.outcome Procedure.code	EMS Procedures Performed Section
Crew Member ID	Encounter←Procedure Procedure.performer	EMS Procedures Performed Section
Airway Complications Encountered	Encounter←Procedure Procedure.status	EMS Procedures Performed Section
Suspected Reasons for Failed Airway Management	Encounter←Procedure Procedure.outcome	EMS Procedures Performed Section
Date/Time Decision to Manage the Patient with an Invasive Airway	Encounter←Procedure Procedure.outcome.note	EMS Procedures Performed Section
Date/Time Invasive Airway Placement Attempts Abandoned	Encounter←Procedure Procedure.outcome	EMS Procedures Performed Section
Date/Time of Event (per Medical Device)	Encounter←Device.TimeDate	EMS Cardiac Arrest Event Section

Paramedicine Data Element	FHIR Resource location	CDA Location
Medical Device Event Type	Encounter←Observation.value[x]	EMS Cardiac Arrest Event Section
Medical Device Waveform Graphic Type	Encounter←Observation.value[x]	EMS Cardiac Arrest Event Section
Medical Device Waveform Graphic	Encounter←Observation.value[x]	EMS Cardiac Arrest Event Section
Medical Device Mode (Manual, AED, Pacing, CO2, O2, etc.)	Encounter.device – MedicalDeviceMode **IHE Extension**	EMS Cardiac Arrest Event Section
Medical Device ECG Lead	Encounter←Device.type	EMS Cardiac Arrest Event Section
Medical Device ECG Interpretation	Encounter←Observation.Interpretation	EMS Cardiac Arrest Event Section
Type of Shock	Encounter←Procedure – DeviceShockType **IHE Extension**	EMS Cardiac Arrest Event Section
Shock or Pacing Energy	Encounter←Procedure – DeviceShockPacingEnergy **IHE Extension**	EMS Cardiac Arrest Event Section
Total Number of Shocks Delivered	Encounter←Procedure – DeviceNumberOfShocksDelivered **IHE Extension**	EMS Cardiac Arrest Event Section
Pacing Rate	Encounter←Procedure – DeviceRate **IHE Extension**	EMS Cardiac Arrest Event Section

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6.6.X.5 Quality Data Import Option

The Content Consumer supporting the Quality Data Import Option SHALL require receiving system to import the discrete data elements identified in the following table.

Table 6.6.X.5-1: Quality Data Import Option FHIR and CDA Mapping

Paramedicine Data Element	FHIR Resource Location	CDA Location
Patient Care Report Number type	Resource.composition.type	Header
Patient Care Report Number	Resource.composition.type	Header
EMS Organization Identifier	Organization.Identifier	Header
Type of service requested	Encounter.type	Header

Paramedicine Data Element	FHIR Resource Location	CDA Location
Level of care for this unit	HealthService.characteristic	Header
Additional Response Mode Descriptors	Encounter.encounter-responseModeDescriptor **IHE extension**	EMS Response Section
Date/Time Procedure Performed	Encounter←Procedure.performed[x].performed.dateTime	EMS Procedures and Interventions Section
Procedure	Encounter←Procedure.code	EMS Procedures and Interventions Section
PSAP Call Date/Time	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Response Section
Unit Arrived on Scene Date/Time	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Response Section
Patient Contact Date/time	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Response Section
Complaint	Encounter.diagnosis.condition(Condition.note)	EMS Situation Section
Primary Symptom	Encounter.diagnosis.condition(Condition.evidence.code)	EMS Situation Section / Reason for Referral
Other Associated symptoms	Encounter.diagnosis.condition(Condition.evidence.code)	EMS Situation Section / Reason for Referral
Provider's Primary Impressions	Encounter←Observation.value[x]	EMS Situation Section / Reason for Referral
Provider's Secondary Impressions	Encounter←Observation.value[x]	EMS Situation Section / Reason for Referral
Date/Time Last Known Well	Encounter←Observation.value[x]	EMS Situation Section /Review of Systems-EMS Section
Destination/Transferred To, Name	Encounter.encounter- destinationName **IHE extension**	EMS Situation
Destination/Transferred To, Code	Encounter.encounter-destinationIdentifier **IHE extension**	EMS Situation

Paramedicine Data Element	FHIR Resource Location	CDA Location
Incident/Patient Disposition	Encounter.encounter- treatment **IHE extension**	EMS Disposition Section
Type of Destination	Encounter.encounter- destinationType **IHE extension**	EMS Disposition Section
Hospital Capability Per EMS	HealthService.characteristic	EMS Disposition Section
Destination Team Pre-Arrival Alert or Activation	Encounter.encounter- Pre-arrivalAlertActivated **IHE extension**	EMS Disposition Section
Resuscitation Attempted By EMS	Encounter←Procedure.code	EMS Cardiac Arrest Event Section
Arrest Witnessed By	Encounter.encounter – witness (Person) **IHE Extension**	EMS Cardiac Arrest Event Section
CPR Care Provided Prior to EMS Arrival	Encounter.encounter – priorCprProvided **IHE Extension**	EMS Cardiac Arrest Event Section
Who Provided CPR Prior to EMS Arrival	Encounter.encounter – priorCprProvidedRole **IHE Extension**	EMS Cardiac Arrest Event Section
AED Use Prior to EMS Arrival	Encounter.encounter – priorAedProvided **IHE Extension**	EMS Cardiac Arrest Event Section
Who Used AED Prior to EMS Arrival	Encounter.encounter – priorAedProvidedRole **IHE Extension**	EMS Cardiac Arrest Event Section
Type of CPR Provided	Encounter.encounter – priorCprProvidedType **IHE Extension**	EMS Cardiac Arrest Event Section
Any Return of Spontaneous Circulation	Encounter←Procedure.outcome	EMS Cardiac Arrest Event Section
Date/Time of Initial CPR	Encounter←Procedure.performedPeriod.start	EMS Cardiac Arrest Event Section
Advanced Directives	DocumentReference	EMS Advance Directives Section
SBP (Systolic Blood Pressure)	Encounter←Observation.value[x]	Coded Vital Signs Section
DBP (Diastolic Blood Pressure)	Encounter←Observation.value[x]	Coded Vital Signs Section
Heart Rate	Encounter←Observation.value[x]	Coded Vital Signs Section
Pulse Oximetry	Encounter←Observation.value[x]	Coded Vital Signs Section
Respiratory Rate	Encounter←Observation.value[x]	Coded Vital Signs Section
Blood Glucose Level	Encounter←Observation.value[x]	Coded Vital Signs Section

Paramedicine Data Element	FHIR Resource Location	CDA Location
Cardiac Rhythm / Electrocardiography (ECG)	Encounter←Observation.value[x]	EMS Cardiac Arrest Event Section
Stroke Scale Score	Encounter←Observation.value[x]	Coded Vital Signs Section
Pain Scale Score	Encounter←Observation.value[x]	Coded Vital Signs Section
Medication Given	Encounter←MedicationAdministration.resource	Medications Administered Section
Age	Encounter.subject (Patient.identifier)	Header
Age Units	Encounter.subject (Patient.identifier)	Header
Date of Birth	Encounter.subject (Patient.birthDate)	Header
Cause of Injury	Encounter.Observation.value	EMS Injury Incident Description Section
Mass Casualty	Encounter.encounter- massCasualty **IHE extension**	EMS Scene Section
Mechanism of Injury	No Mapping Available	EMS Injury Incident Description Section

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6.6.X.6 Trauma Data Import Option

The Content Consumer supporting the Trauma Data Import Option SHALL support discrete import of the data elements identified in the following table.

Table 6.6.X.6-1: Trauma Data Import Option FHIR and CDA Mapping

Paramedicine Data Element	FHIR Resource Location	CDA Location
EMS Dispatch Date	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Response Section
Ems Dispatch Time	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Response Section
Ems Unit Arrival Date At Scene Or Transferring Facility	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Response Section

Paramedicine Data Element	FHIR Resource Location	CDA Location
Ems Unit Arrival Time At Scene Or Transferring Facility	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Response Section
Ems Unit Departure Date From Scene Or Transferring Facility	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Response Section
Ems Unit Departure Time From Scene Or Transferring Facility	Encounter.statusHistory.code Encounter.statusHistory.period.start Encounter.statusHistory – Type **IHE Extension*	EMS Response Section
Transport Mode	Encounter.encounter- transportMode **IHE extension**	EMS Disposition Section
Other Transport Mode	Encounter.encounter- transportMode **IHE extension**	EMS Disposition Section
Initial Field Systolic Blood Pressure	Encounter←Observation.value[x]	Coded Vital Signs Section
Initial Field Pulse Rate	Encounter←Observation.value[x]	Coded Vital Signs Section
Initial Field Respiratory Rate	Encounter←Observation.value[x]	Coded Vital Signs Section
Initial Field Oxygen Saturation	Encounter←Observation.value[x]	Coded Vital Signs Section
Initial Field Gcs – Eye	Encounter←Observation.value[x]	Coded Vital Signs Section
Initial Field Gcs – Verbal	Encounter←Observation.value[x]	Coded Vital Signs Section
Initial Field Gcs – Motor	Encounter←Observation.value[x]	Coded Vital Signs Section
Initial Field Gcs – Total	Encounter←Observation.value[x]	Coded Vital Signs Section
Inter-Facility Transfer	Encounter.encounter- transportMode **IHE extension**	EMS Disposition Section
Trauma Center Criteria	Encounter←Observation.value[x]	EMS Injury Incident Description Section
Vehicular, Pedestrian, Other Risk Injury	No Mapping Available	EMS Injury Incident Description Section

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Volume 3 Appendices

Appendix A

A.1 Data Elements Table

The list of data elements are informed by https://nemsis.org/.

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NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Last name	ePatient.02	Patient:PatientUvIps.identifier	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/name
First name	ePatient.03	Patient:PatientUvIps.name	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/name
middle initial	ePatient.04	Patient:PatientUvIps.name	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/name
home address	ePatient.05	Patient:PatientUvIps.name	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/addr
home city	ePatient.06	Patient:PatientUvIps.address	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/addr
home country	ePatient.07	Patient:PatientUvIps.address	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/addr
home state	ePatient.08	Patient:PatientUvIps.address	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/addr
home zip code	ePatient.09	Patient:PatientUvIps.address	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/addr
country of residence	ePatient.10	Patient:PatientUvIps.address	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/addr
home census tract	ePatient.11	N/A	N/A
social security number	ePatient.12	Patient:PatientUvIps.identifier	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/id
gender	ePatient.13	Patient:PatientUvIps.gender	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/administrativeGenderCode
race	ePatient.14	Patient.extension(us-core-race)	N/A
Age	ePatient.15	Patient:PatientUvIps.birthDate	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/birthTime
Age Units	ePatient.16	Patient:PatientUvIps.birthDate	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/birthTime
Date of Birth	ePatient.17	Patient:PatientUvIps.birthDate	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/patient/birthTime
Patient's Phone Number	ePatient.18	Patient:PatientUvIps.telecom	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/telecom
Patient's email	ePatient.19	Patient:PatientUvIps.telecom	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/telecom

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
State Issuing Driver's License	ePatient.20	Patient:PatientUvIps.identifier	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/id
Driver's License Number	ePatient.21	Patient:PatientUvIps.identifier	/ClinicalDocument/[IPS CDA recordTarget]/patientRole/id
Alternate Home Residence	ePatient.22	Patient:PatientUvIps.address	N/A
Primary Method of Payment	ePayment. 01	Coverage.type	N/A
Certificate of medical necessity (CMN)	ePayment. 02	Servicerequest.reasonRefrence: DocumentReference	N/A
Physician Certification Statement Signed	eOther.15	Servicerequest.reasonRefrence: DocumentReference.content.attachment	N/A
Date Physician Certification Statement Signed	ePayment. 03	Servicerequest.reasonRefrence: DocumentReference.context.period	N/A
Reason for Physician Certification Statement	ePayment. 04	Servicerequest.reasonCode	N/A
Healthcare Provider Type Signing Physician Certification Statement	ePayment. 05	Servicerequest.reasonRefrence: DocumentReference.context.related: PractitionerRole.code	N/A
Last Name of Individual Signing Physician Certification Statement	ePayment. 06	Servicerequest.reasonRefrence: DocumentReference.context.related: Practitioner.name	N/A
First Name of Individual Signing Physician Certification Statement	ePayment. 07	Servicerequest.reasonRefrence: DocumentReference.context.related: Practitioner.name	N/A
Insurance Company ID	ePayment. 09	Coverage.payor:Organization.idetifier	N/A

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Insurance Company Name	ePayment.10	Coverage.payor:Organization.name	N/A
Insurance Company Billing Priority	ePayment.11	Coverage.type	N/A
Insurance Company Address	ePayment.12	Coverage.payor:Organization.address	N/A
Insurance Company City	ePayment.13	Coverage.payor:Organization.address	N/A
Insurance Company State	ePayment.14	Coverage.payor:Organization.address	N/A
Insurance Company Zipcode	ePayment.15	Coverage.payor:Organization.address	N/A
Insurance Company Country	ePayment.16	Coverage.payor:Organization.address	N/A
Insurance Group ID	ePayment.17	Coverage.class.value	N/A
Insurance Policy ID Number	ePayment.18	Coverage.class.value	N/A
Last Name of the Insured	ePayment.19	Coverage.policyHolder:Patient.name Coverage.policyHolder:RelatedPerson.name	N/A
First Name of the Insured	ePayment.20	Coverage.policyHolder:Patient.name Coverage.policyHolder:RelatedPerson.name	N/A
Middle initial/name of the Insured	ePayment.21	Coverage.policyHolder:Patient.name Coverage.policyHolder:RelatedPerson.name	N/A
Relationship to the Insured	ePayment.22	Coverage.relationship	N/A
Insurance Group Name	ePayment.58	Coverage.class.name	N/A
Date of Birth of the Insured	ePayment.59	Coverage.benificiary:patient.birthdate	N/A
Closest Relative/Guardian Last Name	ePayment.23	Patient:PatientUvIps.contact.name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson/name /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/guardianPerson/name

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Closest Relative/Guardian First Name	ePayment.24	Patient:PatientUvIps.contact.name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson/name /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/guardianPerson/name
Closest Relative/Guardian Middle Initial/Name	ePayment.25	Patient:PatientUvIps.contact.name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson/name /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/guardianPerson/name
Closest Relative/Guardian Street Address	ePayment.26	Patient:PatientUvIps.contact.address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/addr
Closest Relative/Guardian City	ePayment.27	Patient:PatientUvIps.contact.address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/addr
Closest Relative/Guardian State	ePayment.28	Patient:PatientUvIps.contact.address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/addr
Closest Relative/Guardian Zip Code	ePayment.29	Patient:PatientUvIps.contact.address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/addr
Closest Relative/Guardian Country	ePayment.30	Patient:PatientUvIps.contact.address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/addr
Closest Relative/Guardian Phone Number	ePayment.31	Patient:PatientUvIps.contact.telecom	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/telecom /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian/telecom
Closest Relative/Guardian Relationship	ePayment.32	Patient:PatientUvIps.contact.relationship	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/code /ClinicalDocument/[IPS CDA recordTarget]/patientRole/guardian
Patient's Employer	ePayment.33	Patient:PatientUvIps.contact.name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson/name
Patient's Employer's Address	ePayment.34	Patient:PatientUvIps.contact.address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr
Patient's Employer's City	ePayment.35	Patient:PatientUvIps.contact.address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr
Patient's Employer's State	ePayment.36	Patient:PatientUvIps.contact.address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Patient's Employer's Zip Code	ePayment.37	Patient:PatientUvIps.contact.address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr
Patient's Employer's Country	ePayment.38	Patient:PatientUvIps.contact.address	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/addr
Patient's Employer's Primary Phone Number	ePayment.39	Patient:PatientUvIps.contact.telecom	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/telecom
Last Name of Patient's Practitioner	eHistory.02	Patient:PatientUvIps.generalPractitioner.name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson/name
First Name of Patient's Practitioner	eHistory.03	Patient:PatientUvIps.generalPractitioner.name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson/name
Middle Initial/Name of Patient's Practitioner	eHistory.04	Patient:PatientUvIps.generalPractitioner.name	/ClinicalDocument/[IPS Patient Contacts]/associatedEntity/associatedPerson/name
Advanced Directives	eHistory.05	Composition.section:sectionAdvanceDirectives	/ClinicalDocument/[IPS Advance Directives Section]
Medication Allergies	eHistory.06	Composition.section:sectionAllergies.entry:allergyOrIntolerance	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance
Environmental/ Food Allergies	eHistory.07	Composition.section:sectionAllergies.entry:allergyOrIntolerance	/ClinicalDocument/[IPS Allergies and Intolerances Section]/entry/[IPS Allergy and Intolerance Concern]/entryRelationship/[IPS Allergy or Intolerance
Medical/Surgical History	eHistory.08	"Composition.section:sectionPastIllnessHx.entry:pastProblem Composition.section:sectionProceduresHx.entry:procedure"	/ClinicalDocument/[IPS History of Past Illness Section]/entry/[IPS Problem Concern Entry] /ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]/code
The Patient's Type of Immunization	eHistory.10	Composition.section:sectionImmunizations.entry:immunization.vaccineCode	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/consumable/[IPS Immunization Medication Information]/manufacturedProduct/manufacturedMaterial/code
Immunization Year	eHistory.11	Composition.section:sectionImmunizations.entry:immunization.occurrenceDateTime	/ClinicalDocument/[IPS Immunizations Section]/entry/[IPS Immunization]/effectiveTime
Current Medications	eHistory.12	Composition.section:sectionMedications.entry:medicationStatement	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]
Current Medication Dose	eHistory.13	Composition.section:sectionMedications.entry:medicationStatement.dosage.doseAndRate.dose[x]	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/entryRelationship/[IPS Subordinate SubstanceAdministration]/doseQuantity

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Current Medication Dosage Unit	eHistory.14	Composition.section:sectionMedications.entry:medicationStatement.dosage.doseAndRate.dose[x]	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/entryRelationship/[IPS Subordinate SubstanceAdministration]/doseQuantity
Current Medication Administration Route	eHistory.15	Composition.section:sectionMedications.entry:medicationStatement.dosage.route	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/routeCode
Current Medication Frequency	eHistory.20	Composition.section:sectionMedications.entry:medicationStatement.dosage.timing	/ClinicalDocument/[IPS Medication Summary Section]/entry/[IPS Medication Statement]/entryRelationship/[IPS Subordinate SubstanceAdministration]/effectiveTime
Presence of Emergency Information Form	eHistory.16	Encounter ←Observation.value[x]	N/A
Alcohol/Drug Use Indicators	eHistory.17	Encounter ←Observation.value[x]	N/A
Last Oral Intake	eHistory.19	Encounter ←Observation.value[x]	N/A
Pregnancy	eHistory.18	Composition.section:sectionPregnancyHx.entry:pregnancyStatus	/ClinicalDocument/[IPS History of Pregnancy Section]/entry/[IPS Pregnancy Status Observation]
Date/Time Vital Signs Taken	eVitals.01	Composition.section:sectionVitalSigns.entry:vitalSign.effective[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/effectiveTime
Cardiac Rhythm / Electrocardiography (ECG)	eVitals.03	"Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
ECG Type	eVitals.04	Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]"	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Method of ECG Interpretation	eVitals.05	N/A	N/A
SBP (Systolic Blood Pressure)	eVitals.06	Composition.section:sectionVitalSigns.entry:vitalSign.code	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
DBP (Diastolic Blood Pressure)	eVitals.07	Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Method of Blood Pressure Measurement	eVitals.08	N/A	N/A
Mean Arterial Pressure	eVitals.09	Composition.section:sectionVitalSigns.entry:vitalSign.code	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Heart Rate	eVitals.10	Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Method of Heart Rate Measurement	eVitals.11	N/A	N/A
Pulse Oximetry	eVitals.12	Composition.section:sectionVitalSigns.entry:vitalSign.code	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Pulse Rhythm	eVitals.13	Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Respiratory Rate	eVitals.14	Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Respiratory Effort	eVitals.15	Composition.section:sectionVitalSigns.entry:vitalSign.code	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
End Title Carbon Dioxide (ETCO2)	eVitals.16	Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Carbon Monoxide (CO)	eVitals.17	Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Blood Glucose Level	eVitals.18	Composition.section:sectionVitalSigns.entry:vitalSign.code	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Glasgow Coma Score-Eye	eVitals.19	Composition.section:sectionVitalSigns.entry:vitalSign.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Glasgow Coma Score-Verbal	eVitals.20	Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Glasgow Coma Score-Motor	eVitals.21	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Glasgow Coma Score-Qualifier	eVitals.22	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Total Glasgow Coma Score	eVitals.23	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Temperature	eVitals.24	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Temperature Method	eVitals.25	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Level of Responsiveness (AVPU)	eVitals.26	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Pain Scale Score	eVitals.27	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Pain Scale Type	eVitals.28	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Stroke Scale Score	eVitals.29	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Stroke Scale Type	eVitals.30	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Reperfusion Checklist	eVitals.31	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
APGAR	eVitals.32	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Revised Trauma Score	eVitals.33	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Date/Time of Laboratory or Imaging Result	eLabs.01	Composition.section:sectionResults.entry:Observation.effective[x] Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.effective[x]	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/effectiveTime /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/effectiveTime
Study/Result Prior to this Unit's EMS Care	eLabs.02	Composition.section:sectionResults.entry:Observation.effective[x] Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.effective[x]	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/effectiveTime /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/effectiveTime

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Laboratory Result Type	eLabs.03	Composition.section:sectionResults.entry:results-observation.category Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.code	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/code /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/code
Laboratory Result	eLabs.04	Composition.section:sectionResults.text Composition.section:sectionResults.entry:Observation.text Composition.section:sectionResults.entry:results-observation.value[x] Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.value[x]	/ClinicalDocument/[IPS Results Section]/text /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/value
Imaging Study Type	eLabs.05	Composition.section:sectionResults.entry:results-observation.category Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.code	/ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/code /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/code
Imaging Study Results	eLabs.06	Composition.section:sectionResults.text Composition.section:sectionResults.entry:Observation.text Composition.section:sectionResults.entry:results-observation.value[x] Composition.section:sectionResults.entry:results-diagnosticReport.result:observation-results.value[x]	/ClinicalDocument/[IPS Results Section]/text /ClinicalDocument/[IPS Results Section]/entry/[IPS Result Organizer]/component/observation/value
Imaging Study File or Waveform Graphic Type	eLabs.07	N/A	N/A
Imaging Study File or Waveform Graphic	eLabs.08	N/A	N/A
Estimated Body Weight in Kilograms	eExam.01	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Length Based Tape Measure	eExam.02	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Date/Time of Assessment	eExam.03	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Skin Assessment	eExam.04	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Head Assessment	eExam.05	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Face Assessment	eExam.06	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Neck Assessment	eExam.07	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Heart Assessment	eExam.09	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Abdominal Assessment Finding Location	eExam.10	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Abdomen Assessment	eExam.11	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Pelvis/Genitourinary Assessment	eExam.12	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Back and Spine Assessment Finding Location	eExam.13	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Back and Spine Assessment	eExam.14	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Extremity Assessment Finding Location	eExam.15	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Extremities Assessment	eExam.16	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Eye Assessment Finding Location	eExam.17	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Eye Assessment	eExam.18	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Mental Status Assessment	eExam.19	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Neurological Assessment	eExam.20	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Lung Assessment Finding Location	eExam.22	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Lung Assessment	eExam.23	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Chest Assessment Finding Location	eExam.24	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Chest Assessment	eExam.25	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Stroke/CVA Symptoms Resolved	eExam.21	Composition.section:sectionVitalSigns.entry:vitalSign.code Composition.section:sectionVitalSigns.entry:vitalSign.value[x] Composition.section:sectionVitalSigns.entry:vitalSign.component.value[x]	/ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/code /ClinicalDocument/[IPS Vital Signs Section]/entry/[IPS Vital Signs Organizer]/component/[IPS Vital Signs Observation]/value
Date/Time Procedure Performed	eProcedures.01	Composition.section:sectionProceduresHx.entry:procedure.performedDateTime	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]/effectiveTime
Procedure Performed Prior to this Unit's EMS Care	eProcedures.02	Composition.section:sectionProceduresHx.entry:procedure.performedDateTime	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]/effectiveTime
Procedure	eProcedures.03	Composition.section:sectionProceduresHx.entry:procedure	/ClinicalDocument/[IPS History of Procedures Section]/entry/[IPS Procedure Entry]

NEMSIS Data Element	NEMSIS v3.5.0	FHIR Resource location	CDA Location
Destination/Transferred To, Name	eDisposition.01	ServiceRequest.locationReference: Location.name	/ClinicalDocument/[CDA documentationof]
Destination Street Address	eDisposition.03	ServiceRequest.locationReference: Location.address	/ClinicalDocument/[CDA documentationof]
Destination City	eDisposition.04	ServiceRequest.locationReference: Location.address	/ClinicalDocument/[CDA documentationof]
Destination State	eDisposition.05	ServiceRequest.locationReference: Location.address	/ClinicalDocument/[CDA documentationof]
Destination County	eDisposition.06	ServiceRequest.locationReference: Location.address	/ClinicalDocument/[CDA documentationof]
Destination ZIP Code	eDisposition.07	ServiceRequest.locationReference: Location.address	/ClinicalDocument/[CDA documentationof]
Destination Country	eDisposition.08	ServiceRequest.locationReference: Location.address	/ClinicalDocument/[CDA documentationof]

Volume 4 – National Extensions

Add appropriate Country section

4 National Extensions

4.I National Extensions for IHE USA

4.I.1 Comment Submission

This national extension document was authored under the sponsorship and supervision of the IHE Patient Care Coordination Technical Committee who welcome comments on this document and the IHE USA initiative. Comments should be directed to: http://www.ihe.net/PCC_Public_Comments.

4.I.2 Paramedicine Care Summary PCS

4.I.2.1 PCS US Volume 3 Constraints

4.I.2.1.1 PCS US Volume 3 Attribute Constraints

The following attribute cardinalities constraints apply in the US.

Table 4.I.2.1.1-1: US Attribute Cardinality Constraints

Attribute	Cardinality
Race	RE [0..*]
Ethnicity	RE [0..1]
Religious Affiliation	RE [0..*]

4.I.2.1.2 PCS US Volume 3 Section Constraints

The following additional cardinality constraints apply to the Paramedicine Care document specification and entries in Table 6.3.1.D.5-1 Paramedicine Care Summary (PCS) Document Content Module Specification

Table 4.I.2.1.2-1: PCS US Section Constraints

Cardinality	Section Element	Value Set OID	Specification Document	Vocabulary Constraint
R [1..1]	EMS Protocol Section	2.16.840.1.113883.17.3.10.1.7	HL7 EMS Run Report R2	
RE [0..1]	EMS Billing Section	2.16.840.1.113883.17.3.10.1.5	HL7 EMS Run Report R2	6.3.D.5.3

4.I.2.2 PCS Value Set Binding for US Realm Concept Domains

This section defines the actual value sets and code systems for any coded concepts that were described by concept domains in the main profile and binds the value set to the coded concepts.

Table 4.I.2.2-1: PCS Value Set Binding for US Realm Concept Domains

UV Concept Domain	US Realm Vocabulary Binding or Single Code Binding	Value Set OID
Ethnicity	Ethnicity Group	2.16.840.1.114222.4.11.837
Marital Status	HL7 Marital Status	2.16.840.1.113883.1.11.12212
Race	RaceCategory	2.16.840.1.114222.4.11.836
sDTCRaceCode	Race	2.16.840.1.113883.1.11.14914
Religious Affiliation	HL7 Religious Affiliation	2.16.840.1.113883.1.11.19185
Language Communication	Language	2.16.840.1.113883.1.11.11526
Data Enterer	Assigned entity	2.16.840.1.113883.4.6
Confidentiality code	HL7 BasicConfidentialityKind	2.16.840.1.113883.1.11.16926
Provider role	ProviderRole	2.16.840.1.113883.17.3.11.46
Destination	associatedEntity	2.16.840.1.113883.11.20.9.33
DestinationType	DestinationType	2.16.840.1.113883.17.3.11.69
Service Type	Service Type	2.16.840.1.113883.17.3.11.79
advanced directives	AdvanceDirectiveType	2.16.840.1.113883.17.3.11.63
Allergen	RxNorm	2.16.840.1.113883.6.88
UnitLevelOfCare	UnitLevelOfCare	2.16.840.1.113883.17.3.11.105
Medications Administration route	FDA Route of Administration	2.16.840.1.113883.17.3.11.43
Manufactured Material	RxNorm	2.16.840.1.113883.6.88
ProviderResponseRole	ProviderResponseRole	2.16.840.1.113883.17.3.11.80
CrewRoleLevel	CrewRoleLevel	2.16.840.1.113883.17.3.11.81
UnitResponseRole	UnitResponseRole	2.16.840.1.113883.17.3.11.82
StrokeScale	StrokeScale	2.16.840.1.113883.17.3.11.88
Trauma Center Criteria	TraumaCenterCriteria	2.16.840.1.113883.17.3.11.3
EMS Level Of Service	EMSLevelOfService	2.16.840.1.113883.17.3.11.70

Volume 4 Appendices

N/A

