Integrating the Healthcare Enterprise

IHE PCC
Technical Framework Supplement

Paramedicine Summary of Care (PSC)

Revision 3.0 – Draft for Public Comment

For review and comment only.

DO NOT implement this public comment version.

Date: July 26, 2024

Author: Patient Care Coordination 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 July 26, 2024 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 August 26, 2024.

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 IHE.net.

Information about the IHE Patient Care Coordination domain can be found at IHE Domains.

Information about the organization of IHE Technical Frameworks and Supplements and the process used to create them can be found at Profiles and IHE Process.

The current version of the IHE Patient Care Coordination Technical Framework can be found at https://profiles.ihe.net/PCC/index.html.

CONTENTS

Introduction to this Supplement

When a paramedicine service is requested to care for a patient, that care is documented in a paramedicine record and reported, either to inform on the care that took place during the services provided to a patient or to communicate clinically relevant information to a receiving facility that the patient may be transported to. This profile defines a clinical document that can be shared to help inform care in a clinical subset of the ambulance report and it will define how the complete report that is generated by a paramedicine provider should be structured in CDA.

An Implementation Guide that defines the FHIR version of these documents is currently in process and will be published on a later date.

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 other viewpoints desire to explore what content might actually be included in the documents and notes.
2. See HL7 patient care work group discussion:
    a. *http://wiki.hl7.org/index.php?title=ClinicalNote_FHIR_Resource_Proposal*](http://wiki.hl7.org/index.php?title=ClinicalNote_FHIR_Resource_Proposal)
    b. See Monday Q2 HL7 WGM discussion related to this topic:
    c. [*http://wiki.hl7.org/index.php?title=January_2018_WGM_New_Orleans;_Jan_27_to_Feb_8*](http://wiki.hl7.org/index.php?title=January_2018_WGM_New_Orleans;_Jan_27_to_Feb_8)
3. There are a number of issues relating to the FHIR mapping and resources needed to support this profile.
4. Investigate the FHIR process for defining the resources required to fulfill NEMSIS.
5. The injury information may need to be more extensively modeled in FHIR.
6. There is no value set in FHIR relating to the level of care of ambulance units.
7. Extensions in FHIR need to me made to help include some of the needed attributes.
8. 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.
9. 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.

10. 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 the clauses of an advanced directives available in coded form.
11. 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?
12. 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.
13. The EMS Situation section contains observations around injuries, chief complaint, impressions, and additional observations on activity and last known well. This is not reflected in how EMS systems store or send these types of observations.
14. The EMS Medical Allergies and Environment/Food Allergies are used to populate the standard Allergies and Adverse Reactions Section.
15. The EMS Current Medications is used to populate the standard Medications Section.
16. The EMS Vital Signs is used to populate the standard Vital Signs Section. Note: This includes Body Weight which is documented in the EMS Physical Assessment Section.
17. The EMS Physical Assessment us used to populate the standard Physical Examination Section.
18. The EMS Medications Administered is used to populate the standard Medications Administered and Allergies and Adverse Reactions Sections.
19. The Pregnancy Status, Last Oral Intake and Last Known Well data elements have been populated to a new Review of Systems – EMS Section.
20. In consideration of reusable vital sign concepts IHE recommends the use of the following LOINC Codes for vital signs in place of the codes that are defined within the HL7 EMS Run report:
    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 modeled using the IHE PCC Vital Signs adding the additional vital sign observations.

21. 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 modeled and additional information needs to be documented on its use (what are the outputs that need to be captured?);

b. New information found in the United States, this seems to be a checklist that is used to determine if thrombolitic medication should be used. This seems to be an indicator for contraindications to thrombolitic use that is modeled elsewhere in this document;

c. 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?

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

22. 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. Medication Clinical Drug (2.16.840.1.113883.3.88.12.80.17);

b. Medication omission reason (2.16.840.1.113883.17.3.5.42).

23. 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's age (can be computed from birth date);

d. Barrier to care.

24. 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 code be to specify allergen (this should be an existing international value set)? Recommendation is to use the HL7 Allergen Type mapped to SNOMED CT.

25. 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.

26. 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.

27. Public Comment input is requested to review the EMS Cardiac Arrest Event Section to ensure there aren't any US Specific concepts.

28. Public Comment input is requested to review the transformation of the EMS Patient Care Report information for use in the Reason for Referral Section.

29. 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.

30. Should there be a special section to "vital signs obtained prior to EMS" that should be specially tagged?

31. Review the FHIR mapping for the Medications sections. There seem to be a combination of complex and simple uses for the FHIR structuring and we are unsure if it is appropriate to be mixing the two.

32. Review the FHIR mapping for the "protocol age category".

33. A complete example of the Paramedicine Summary of Care (PSC) Document Content Module should be made to be available.

34. The LOINC code more specific to the CDA documents will be requested.

35. 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.

36. This profile contains a reason for visit section and a chief complaints section as is used for Medical Summaries and discharge summaries. In the USA C-CDA has a combined Reason for Visit and Chief Complaint section. Should there be a section similar to this designed as well that holds Detailed values. There may be some confusion on the differences of use for the sections in the US Realm Vol4 constraints as NEMSIS has combined Chief complaints and others into one section similar to this proposed combined section. for now they have been modeled separately.

    a. For now the model requires the chief complaint to be documented in the chief complaint section and the secondary complaints to be documented in the reason for visit section.

    b. the Reason for Visit section has a constraint to include the Reason for encounter information, but in NEMSIS their reason for encounter is informed by elements in their chief complaint component. this may result in a duplication of data found. between the sections.

37. The chief complaint in many systems is usually a narrative section that describes the chief complaint with its details. The US Real Volume 4 is adding entries to document more granular data such as duration, and locations to reduce the loss of data coming in from NEMSIS. The HL7 EMS Run report mitigates this by making an observation with a text value and additional components. Is this something that should be modeled in IHE as well? How often are these details captured with these coded elements in EMRs?

38. NEMSIS Captures the duration of a complaint, but in the IHE templates, there is a way to document an effective time/low to indicate an onset time for a problem entry. Seeking comment on how to resolve this. Should there be an estimated onset date/time for the complaints. rather than a duration? would it be a user interface situation where the duration units should be calculated from the documentation time to produce an effective time/low that can fit into this element? is this a NEMSIS issue to change that data element to an onset time? This effects the Chief complaint and active problem elements of this profile and all NEMSIS complaints.

39. There is a potential for future work, to have a detailed Work Injury Description section.

40. Contraindications for thrombolytic use is not documented in this profile. Where would it go in a medical summary document? It seems like it is just a Boolean indicator, but it seems to be more like a Medication administration Status Reason for specifically medications labeled thrombolytic. Seeking comment on how to document this and if this is an international attribute.

41. NEMSIS eScene.01 - First EMS Unit on Scene should be a flag in the participant element. Seeking comment on how to model this for the US Realm Vol 4 Section.
42. NICTIZ has an indicator for if the patient was the driver of a vehicle in a collision. It might be more valuable to document who the driver was rather than if they were the driver or not. Additionally, the seat location of the patient may indicate if the patient is the driver or not. Future work should add a form of this element into the Collision organizer as it seems important to collect and note. Seeking comment on how to model this.
43. Future work to incorporate the NICTIZ Sections into the international specification:
    a. patient position
    b. consulting external professionals
    c. consents
44. How would you represent a software version concept for:
    a. <assignedAuthoringDevice>
    b. <manufacturerModelName>ACME EMT Device</manufacturerModelName>
    c. <softwareName>ACME EMT System 3.1</softwareName>
    d. </assignedAuthoringDevice>
45. For EMS, who would the legal authenticator be: the signing provider or the organization?
46. I have modeled a chief complaint section to allow the use for containing simple observations and a concern entry. It allows the additions of observations that may support the text entry for the chief complaint such as the chief complaint duration, anatomic location, organ system, etc. that may act as supporting information for the text portion of this section for the complaint. However, it looks like these are all elements that can be held in a concern entry element. Is there a way to have a concern entry with a code of 10154-3 Chief complaint that can have only a text value for the description of the complaint defined by the patient, the target site, and effective time period for this?
47. Seeking comment: NEMSIS has the ability to capture multiple complaints for the patient. The HL7 EMS Run Report creates a section to contain those multiple complaints. It is a general understanding that the EHRs and EMRs always have a separate section in place for the chief complaints. Seeking comment on how hospital systems document more than one complaint on the patient, if any. Would it be better to put it in the reason for visit section?
48. Seeking comment: We have an entry for injury severity modeled, but would that be documented better within a problem entry where severity is already a concept?
49. Open issues around NEMSIS Value sets and coded values:

a. Reason for visit section: NEMSIS 2301009 Automated Crash Notification seems like it is similar to transport accident.

50. Seeking comment on the granularity of the Active Problems entries. NEMSIS documents items as primary and secondary impressions. Primary and secondary impressions can be modeled as concern entries, but other than tying a specific name to the entry and the supporting information as symptoms is there a benefit to modeling these entries at this level?

51. The mental status assessment organizer has been modeled in this profile. Current work with the Post-Acute Care InterOperability (PACIO) Projects for transitions of care will affect this element in the future.

52. Many NEMSIS values have concepts bound to post-coordination, such as chest pain (non-traumatic). EMR is using CDA documentation. Do not document findings in this way. You are either having chest pain which is understood to be associated with physiological causes, or a chest injury. Would it be better to just transform those codes into the general concepts in SNOMED CT or is there a better way to document these pains associated with traumatic injuries?

53. Some NEMSIS Value Set codes may need to be more granular at the point of data entry.

54. seeking comment, How should the eVitals.02 Obtained Prior to this Unit's EMS Care indicator/flag be documented in the organizer?

55. NEMSIS LOINC Codes that need to be de constrained from their normative answer sets:

    a. 67515-7 "Barriers to patient care NEMSIS"

    b. 67490-3 "Mass casualty incident NEMSIS"

    c. 69463-8 "Suspected intentional or unintentional disaster NEMSIS"

    d. 67498-6 Location of patient in vehicle NEMSIS

    e. 67497-8 Location of impact on the vehicle NEMSIS

    f. 67500-9 Airbag deployment NEMSIS

    g. 67488-7 Emergency medical dispatch performed NEMSIS

56. NEMSIS Ranges for Pregnancy status ranges do not align with the recognized trimester ranges.

57. USA is using a clock reference for the Location of the Vehicle Impacted Entry, and SNOMED-CT does not have codes defining vehicle location sites. How do other countries document this?

58. The last known well entry seems to be the same as a concept for symptom onset time. Would including this, in the review of systems section encourage duplication? Should that concept be replaced with the illness/symptom onset time?

59. The Assessments Section is where we recommend that the Glasgow assessment and score, pain scale, and stroke assessments go, but currently they are bound to the vital signs section. Seeking comment on the feasibility of breaking their vital signs section apart to put the assessments here.
60. The Keep Vein open is not recognized as a valid rate of administration. Hospitals require that the rate still be documented in the their medication administration. Keep Vein Open should be used as a reason for why there are low rates are being used without errors being thrown. If this is to be documented it can only be represented within the note. KVO is often defined by the organization so the KVO rate SHOULD be documented.
61. The Chest_Physical_Findings_Target_Site_VS the terminology is used to describe the different regions that the findings are found. NEMSIS has more general terms for anterior, posterior, left side, right side etc. SNOMED-CT codes that can apply to these terms have been used, but this terminology seems more specific than the intended NEMSIS Use. Seeking comment on how to reconcile this.
62. The Paramedicine vital signs that are informed by the NEMSIS Data dictionary there are observations for pain scale score, stroke scale score, APGAR, and Glasgow scores. These are more traditionally documented using assessments observations in a nursing assessment panel. Either a new panel code should be defined or the observations should be broken into the separate sections.
63. The FHIR profiling in this document has been separated into a separate IG. When that IG has been published, a reference should be added in the cross profile considerations section of this profile.

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 PSC Profile leverages Sections/Entries from the HL7 EMS Patient Care Report which have US Realm Constraints, and used, were they exist, 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 PSC 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 will 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 matches the IHE PCC concept of List of Surgeries as a Procedure Entry. Committee moved 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 moved forward with the EMS Past Medical History Section from the HL7 specification. Even though there is currently 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 moved it forward anyway.
10. Committee determined that there were no international needs for the EMS Disposition Section Value Sets to be updated and moved forward with this value set. (7/18/18).
11. Committee determined that all additional EMS specific data elements/Sections need to be mapped into the patient medical record via the Paramedicine Summary of Care – Complete Report; however, the data in the Paramedicine Summary of Care – Clinical Subset should be limited to information which may be used for patient care.
12. OIDs were assigned and added into the profile.
13. The Advance Directive Type Vocabulary is not US Realm specific.
14. A new Mental Status Entry based upon the HL7 C-CDA R2 IG was created.
15. We are interpreting "return of spontaneous circulation" as a vital sign.
16. The Clinical subset was reduced to the entry level.

IHE Technical Frameworks General Introduction

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

9 Copyright Licenses

IHE technical documents refer to, and make use of, a number of standards developed and published by several standards development organizations. Please refer to the IHE Technical Frameworks General Introduction, Section 9 - Copyright Licenses for copyright license information for frequently referenced base standards. Information pertaining to the use of IHE International copyrighted materials is also available there.

10 Trademark

IHE® and the IHE logo are trademarks of the Healthcare Information Management Systems Society in the United States and trademarks of IHE Europe in the European Community. Please refer to the IHE Technical Frameworks General Introduction, Section 10 - Trademark for information on their use.

IHE Technical Frameworks General Introduction Appendices

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 – Actors

*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	

The table below lists *existing* actors that are utilized in this profile.

Complete List of Existing Actors Utilized in this Profile

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 – Transactions

*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

*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

Domain-specific additions

None

Add new Section X

X Paramedicine Summary of Care (PSC) Profile

Currently, patient interventions and assessments are written into an ambulance electronic Patient Care Report (ePCR) and are either manually entered by paramedicine services crew or collected from electronic devices (e.g., hemodynamic monitor). The ePCR is updated with treatments and interventions that are administered during the on-scene care and 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 system and only if it is requested by the hospital. In this profile, the prehospital paramedicine interventions, assessments, and known patient medical history attributes are made available to the hospital/emergency room IT system electronically when the patient arrives or in advance of patient arrival to the hospital as a clinical subset of the data. 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 as defined by this profile. The information available in the complete report can then be used to report to registries and quality reporting.

X.1 PSC 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 https://profiles.ihe.net/GeneralIntro/index.html.

Figure X.1-1 shows the actors directly involved in the PSC 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 (if any), are shown in conjoined boxes (see Section X.3).

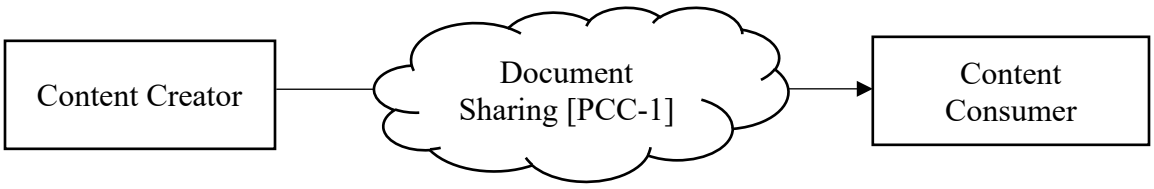

Figure X.1-1: PSC Actor Diagram

Table X.1-1 lists the transactions for each actor directly involved in this 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: PSC 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

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 this 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: PSC – Actors and Content Modules

Actors	Content Modules	Optionality	Reference
Content Creator	Paramedicine Summary of Care – Clinical Subset Document 1.3.6.1.4.1.19376.1.5.3.1.1.31.1	R	PCC TF-3: 6.3.1.D1
	Paramedicine Summary of Care – Complete Report Document 1.3.6.1.4.1.19376.1.5.3.1.1.32.1	R	PCC TF-3: 6.3.1.D2
Content Consumer	Paramedicine Summary of Care – Clinical Subset Document 1.3.6.1.4.1.19376.1.5.3.1.1.31.1	O Note1	PCC TF-3: 6.3.1.D1
	Paramedicine Summary of Care – Complete Report Document 1.3.6.1.4.1.19376.1.5.3.1.1.32.1	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 Summary of Care – Clinical Subset (PSC-CS) containing the data elements defined in PCC TF-3: 6.3.1.D1.
- Paramedicine Summary of Care – Complete Report (PSC-CR) containing the data elements defined in PCC TF-3: 6.3.1.D2.

X.1.1.1.1 Trigger Events

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

When the full Paramedicine Summary data is available, a Paramedicine Summary of Care – 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 Summary of Care – Clinical Subset (1.3.6.1.4.1.19376.1.5.3.1.1.31.1) and Paramedicine Summary of Care – Complete Report (1.3.6.1.4.1.19376.1.5.3.1.1.32.1) documents content created by a PSC Content Creator. This is specified in [PCC-1] document sharing transaction in PCC TF-2: 3.1

X.2 PSC 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: <Profile Name> – Actors and Options

Actor	Option Name	Reference
Content Creator	Create Paramedicine Summary of Care – Clinical Subset Note1	Section X.2.1

Actor	Option Name	Reference
	Create Paramedicine Summary of Care – Complete Report 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 Create Paramedicine Summary of Care – Clinical Subset Option

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

X.2.2 Create Paramedicine Summary of Care – Complete Report Option

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

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 Summary. The discrete data import data details are in Volume 3, Section 6.6.x.5.

This applies to the import of airway management events and Cardiac events.

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 Summary of Care document. 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

Summary of Care document. The discrete data import data details are in Volume 3, Section 6.6.x.4.

X.3 PSC Required Actor Groupings

There are no required actor groupings for this profile.

X.4 PSC Overview

Transferring patient information from a Paramedicine care system to a receiving facility, using a send transaction can increase the efficiency of patient hand off between ambulances 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 the patient's 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 is 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 its Electronic Patient Care Report (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 of a myocardial infarction. An 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 feels 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

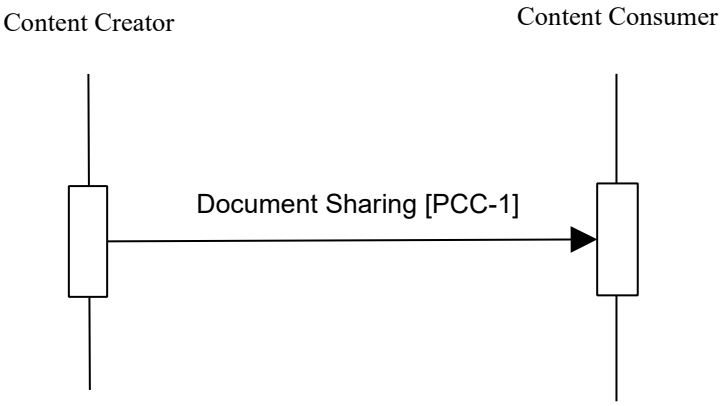

Figure X.4.2.1.2-1: Basic Process Flow in PSC Profile

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

X.4.2.2 Use Case #2: Emergency Death

This use case describes how Paramedicine Responds to an emergency that Results in a Death can report their documentation in support of coroner or medical examiner investigation documentation utilizing this profile.

X.4.2.2.1 Emergency Death Use Case Description

Emergency services are called when a motor vehicle crash takes place on a highway. A paramedicine team is dispatched to the accident along with the first responders activated for this event. When the paramedicine team arrives at the incident location they identify this as a mass casualty incident. When they arrived at the patient and evaluated their injuries, the patients were triaged as black and no resuscitation efforts were made. Once all other patients that were at the incident were evaluated and treated, the Paramedicine team completes their reporting for each of the patients. They submit the complete report to the Health Information Exchange. The Medical examiner queries the HIE as a document consumer and uses the information captured in this document to inform the cause of death determination.

X.4.2.2.2 Emergency Response for Heart Attack Patient Process Flow

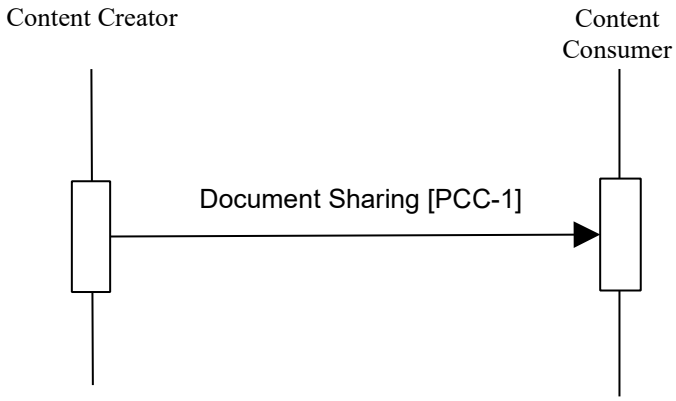

Figure X.4.2.2.2-1: Basic Process Flow in PSC Profile

Pre-conditions:

Emergency Services are called to request the first responders' services.

The first responder crews are activated and directed to the incident location.

Main Flow:

Paramedicine providers arrive on scene and evaluate the patient.

Resuscitation is determined to be futile.

The use of safety equipment, accident information, work information for an accident on the job, and vehicle information is included in the report content which will be used for accident report documentation. The paramedicine provider completes their Report and sends the document to the Health Information Exchange

Post-conditions:

The Medical examiner queries the HIE as a document consumer and uses the information captured in this document to inform the cause of death determination.

Parties responsible for accident reporting use the information to complete information that will be submitted to the national accident reporting system.

X.4.2.3 Use Case #3: Non Emergency Transport of a Patient to a Hospital

This use case describes how a Paramedicine Summary of Care can be utilized in a non-emergency Transport to a hospital.

X.4.2.3.1 Non Emergency Transport of a Patient to a Hospital Use Case Description

A patient is talking with their provider about seeking more specialized care at a hospital. Their Provider determines that the patient should be monitored on their way to the hospital. The provider reaches out to an ambulance service center to request a non-emergency medical transport to the hospital for their patient. The ambulance service center accepts this request, and the provider forwards the patient's pertinent medical information to the ambulance service center. The ambulance service activates their providers to carry out this request and forwards the patient medical information that was provided to them to this team. The Paramedicine providers are able to utilize the medical information to populate their report and inform themselves on the situation and care that may need to be provided to the patient. The paramedicine team arrives at the patient and collects their first assessments and patient status and begins their transport to the hospital. During the transport the patient is monitored and cared for as needed, and remains a non emergency transport. The care of the patient is transferred to the receiving hospital. When this care is transferred the clinical subset is sent to their system to continue the monitoring and informing the care of the patient. The paramedicine provider completes the Complete Report and forwards that document to the receiving hospital system for documentation of longitudinal care documents and to the Provider that made the request for the service to inform them of the care event and transport.

X.4.2.3.2 Non Emergency Transport of a Patient to a Hospital Process Flow

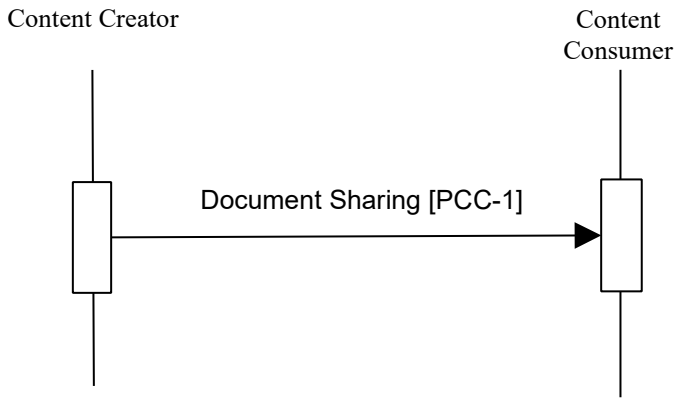

Figure X.4.2.3.2-1: Basic Process Flow in PSC Profile

Pre-conditions:

Provider calls an ambulance service to transfer the patient into a long-term care facility.

The control center accepts the request.

The provider forwards the Patient's pertinent medical information to the Ambulance service

The control center Activates the paramedicine team to carry out this transport, and forwards the patient's medical information while they are enroute.

Main Flow:

Paramedicine provider arrives at the patient's side and performs initial assessments and gathers the first vital signs.

The Patient's care is transferred to the Paramedicine providers

The Transport of the patient is carried out with the necessary information documented into the electronic system

EMS, either directly or through a document sharing infrastructure, provides the information for the current patient information and patient statuses that were monitored during the transport, to the receiving facility with the Clinical subset document.

The care of the patient was transferred to the providers in the receiving facility.

Post-conditions:

The Complete Report document is completed and the full report is provided, either directly or through a document sharing infrastructure, to the hospital and any other systems that are

responsible for the storing and maintenance of the patient's medical records and longitudinal care.

To close the loop of the request from the provider, a complete report is sent to the requesting provider.

X.4.2.4 Use Case #4: Opioid Care with no Transport

This use case describes how paramedicine services provides treatment to a patient but does not carry out a transport.

X.4.2.4.1 Opioid Care with no Transport Use Case Description

Emergency services are contacted for a request for paramedicine services for an unresponsive patient. A Paramedicine team is dispatched to the incident location. The paramedicine team makes contact with the patient. The team is able to evaluate the patient and obtain their medical history from their friend. Based on the information provided by the patient's friend the use of opioids was determined and the providers administered naloxone to the patient. When the medication took effect the patient became responsive. The patient refused to be transported against medical advice. The paramedicine team completes their care with the patient, documenting the events of the care and the administration of the medication, without transport and finishing their care with the patient. The paramedicine providers complete their documentation. As a participant of an HIE they send a Complete Report document, this ensures that the documentation of this event can be utilized for longitudinal care of this patient.

X.4.2.4.2 Opioid Care with no Transport Process Flow

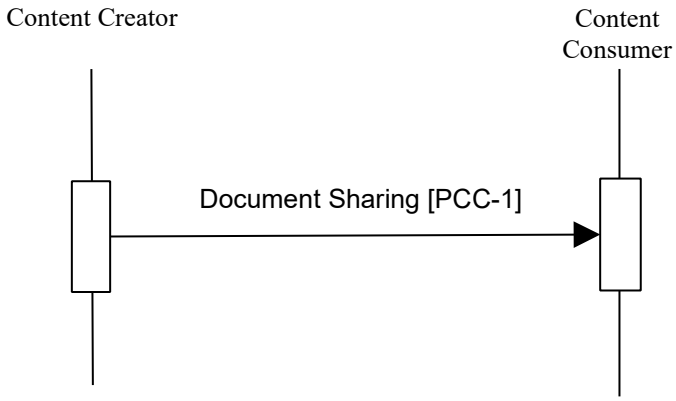

Figure X.4.2.4.2-1: Basic Process Flow in PSC Profile

Pre-conditions:

A request for emergency services is made.

An emergency service control room operator activates a care team to assess the patient for care

Any information that has been collected from the call is documented and forwarded to the activated paramedicine team

Main Flow:

The paramedicine providers arrive at the patient and get an identification and a general medical history from the patient's friend

The patient is assessed with the context of that information and the paramedicine providers administer naloxone to the patient and carry out other protocols used for overdose care.

The patient improves and becomes responsive. The paramedicine providers recommend that the patient should be transported to the hospital for continued care. The patient refuses the transport to the hospital against medical advice.

The Paramedicine providers document the refusal of care and complete their interactions with the patient.

Post-conditions:

The paramedicine providers complete their care report.

The Paramedicine Summary of Care – Complete Report is sent to an HIE.

X.5 PSC Security Considerations

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

The level of access to the patient records and information provided to control room operators, Paramedicine administrative providers, or other operations and non-Paramedicine first responder rolls, is out of scope of this profile. It is up to the local jurisdictions to determine the security access level of those people. Refer to the ITI TF-2.x: Appendix Z.8 "Mobile Security Considerations" to model those jurisdiction security rules on those ITI considerations.

X.6 PSC Cross Profile Considerations

The information that is imported by the Paramedicine Summary of Care (PSC) document 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* a family of transactions is encouraged to support standards-based interoperability between systems acting as the PSC Content Creator and PSC 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 PSC 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 PSC 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 PSC 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 PSC Content Creator. A Document Recipient in XDR might be grouped with the PSC Content Consumer.

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

Appendices to Volume 1

None

Volume 2 – Transactions

No new transactions.

Namespace Additions for Volume 2

<For Public Comment, please explicitly identify all new OIDs, UIDs, URNs, etc., defined specifically for this profile. These items should be collected from the sections above, and listed here as additions to the applicable domain OID Registry. This section will be deleted prior to inclusion into the Technical Framework as Final Text, but should be present for publication of Public Comment and Trial Implementation.>

*At Trial Implementation publication, the domain technical committee **must** ensure that all new OIDs, UIDs, URNs, etc., defined specifically for this profile have been recorded in their OID Registry. This section will be deleted prior to inclusion into the Technical Framework Volumes as Final Text but should be present for publication of Public Comment and Trial Implementation.>*

The <domain name> registry of OIDs is located at <link to your OID registry(ies)

Volume 2 additions to the <Domain Name> OID Registry are:

Volume 3 – Content Modules

5 IHE Namespaces, Concept Domains and Vocabularies

Add to Section 5 IHE Namespaces, Concept Domains and Vocabularies

5.1 IHE Patient Care Coordination Namespaces

No new namespaces..

The Patient Care Coordination registry of OIDs is located at https://wiki.ihe.net/index.php/PCC_Vocabulary_Registry_and_Data_Dictionary.

5.2 IHE Patient Care Coordination Concept Domains

For a listing of the Patient Care Coordination Concept Domains see *<enter location of the domains Concept Domains or NA if none>*

UV Concept Domain	Concept Domain Description
CD_ParamedicineProviderTypes	An extension of the general provider type value set to include the different types of providers that provide paramedicine care.
CD_ParamedicineProviderRoles	An extension of the general provider rolls value set to include a provider roll of a driver.

5.3 IHE Patient Care Coordination Format Codes and Vocabularies

5.3.1 IHE Format Codes

*List in the table below any **new** format codes to be added to the IHE Format Codes Implementation Guide at https://profiles.ihe.net/fhir/ihe.formatcode.fhir/index.html. For public comment, the additions must be listed in the table below. The domain technical committee must ensure any new codes are also added to the Implementation Guide prior to publication for trial implementation. See the process at https://github.com/IHE/FormatCode.*

The following new Format Codes are introduced with the PSC Profile. A complete listing of IHE Format Codes can be found at https://profiles.ihe.net/fhir/ihe.formatcode.fhir/index.html.

Profile	Format Code	Media Type	Template ID
Paramedicine Summary of Care– Clinical Subset (PSC-CS)	urn:ihe:pcc:psc-cs:2024	text/xml	1.3.6.1.4.1.19376.1.5.3.1.1.31.1
Paramedicine Summary of Care – Complete Report (PSC-CR)	urn:ihe:pcc:psc-cr:2024	text/xml	1.3.6.1.4.1.19376.1.5.3.1.1.32.1

5.3.2 IHEActCode Vocabulary

*List in the table below, any **new** additions to the IHEActCode Vocabulary wiki page at http://wiki.ihe.net/index.php/IHEActCode_Vocabulary. For public comment, the additions must be listed in the table below. The domain technical committee must ensure any new codes are also added to the wiki page prior to publication for trial implementation.*

Code	Description
No new codes	

5.3.3 IHERoleCode Vocabulary

*List in the table below any **new** additions to the IHERoleCode Vocabulary wiki page at http://wiki.ihe.net/index.php/IHERoleCode_Vocabulary. For public comment, the additions must be listed in the table below. The domain technical committee must ensure any new codes are also added to the wiki page prior to publication for trial implementation.*

Code	Description
No new codes	

6 Patient Care Coordination HL7 V3 CDA Content Modules

<Authors' notes: This section of the supplement template is only for HL7 v3 CDA Content Module definitions. Please delete the entire section 6.3.1 if the Content Module is based on DICOM or another standard.

Please note that the template for DICOM Content Definitions is defined in Section 7 but the content for other types of content modules (other than CDA or DICOM) has not yet been defined (although another type of content module would eventually go into Volume 3 Section 8, etc.).>

6.1 Conventions

HL7 V3 CDA Conventions are defined in Appendix E to the *IHE Technical Frameworks General Introduction*.

6.2 Folder Modules

<This is a placeholder. If this domain is not using folders, enter "NA">

6.3 Content Modules

This section defines each IHE <Domain Name> Content Modules in detail, specifying the standards used and the information defined.

6.3.1 CDA Document Content Modules

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

The Paramedicine Summary of Care – Clinical Subset document content module is a Medical Document and inherits all header constraints from the Medical Documents Specification 1 (1.3.6.1.4.1.19376.1.5.3.1.1.1). 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:psc-cs:2024

6.3.1.D1.2 LOINC Code

The LOINC code for this document is 67796-3 - EMS patient care report - version 3.

6.3.1.D1.3 Referenced Standards

All standards referenced 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 Summary of Care Documents – 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
SNOMED CT	SNOMED International	http://www.snomed.org/snomed-ct/get-snomed-ct
LOINC	Logical Observation Identifiers Names and Codes	https://loinc.org
DEEDS	Data Elements for Emergency Department Systems (DEEDS), Release 1 - US Realm	https://www.hl7.org/implement/standards/product_brief.cfm?product_id=326
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
HL7 EMS Run Report	HL7 CDA® R2 Implementation Guide: Emergency Medical Services; Patient Care Report Release 3 - US Realm	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=438
NEMSIS	NEMSIS Data Dictionary v3.5.0	https://nemsis.org/media/nemsis_v3/release-3.5.0/DataDictionary/PDFHTML/EMSDEMSTATE/index.html
NICTIZ	NICTIZ Acute Data Set	https://decor.nictiz.nl/art-decor/decor-templates--acutezorg-?id=2.16.840.1.113883.2.4.3.11.60.55.10.9013&effectiveDate=2019-04-10T10%3A53%3A59

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.

Review the mappings of the specific elements that are documented in this profile in Appendix A.1 Data Elements Table of the volume 2.

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

This section specifies the header, section, and entry content modules which compose the Paramedicine Summary of Care – Clinical Subset (PSC-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.

Note: The sections indicated shall be sent, if the entries that should be there aren't there due to workflow limitations, than a Null flavor of NAV "Temporarily unavailable" SHALL be documented in the Required section entries.

Table 6.3.1.D1.5-1: Table 6.3.1.D1.5-1: Paramedicine Summary of Care – Clinical Subset (PSC-CS) Document Content Module Specification

Template Name		Paramedicine Summary of Care – Clinical Subset (PSC-CS)			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.31.1			
Parent Template		Medical Summary (1.3.6.1.4.1.19376.1.5.3.1.1.2)			
General Description		The Paramedicine Summary of Care – Clinical Subset contains the patient's medical history, paramedicine care information and interventions that are relevant to clinical care.			
Document Code		SHALL BE 67796-3 Code 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					
RE		authorInstitution			
RE		authorPerson			
RE		authorRole			
RE		authorSpecialty			
RE		AuthorDevice/application			
R		entryUUID			
O		eventCodeList			
R (if event Code is valued)		eventCodeDisplayNameList			
R		healthcareFacilityTypeCode			
R		healthcareFacility TypeCodeDisplay Name			
R		practiceSettingCode			

R		practiceSettingCodeDisplay Name			
R		Service Event			
RE		serviceStartTime			
R		sourcePatientId			
R		sourcePatientInfo / PatientRole			
R		uniqueId (ClinicalDocument/id)			
RE		Participating Providers and Roles	documentationOf/serviceEvent/performer	PCC TF-2: 6.3.1.5.6	
R [1..*]		Patient Administrative Identifiers	patientRole/id	PCC TF-2: 6.3.1.5.6	
R [1..*]		Personal Information	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
RE [0..1]		Personal Information: Name	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
RE [0..1]		Personal Information: Address	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
RE [0..*]		Personal Information: Patient Telecom	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.1	
R [1..*]		Personal Information: Personal Identification	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
O [0..1]		Personal Information: Administrative Gender	2.16.840.1.113883.1.11.1		
RE [0..1]		Personal Information: Patient Date of Birth	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
O [0..1]		Personal Information: Marital Status	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
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..*]		Personal Information: sDTCRaceCode	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 2.16.840.1.113883.1.11.15836	PCC TF-2: 6.3.1.1	6.3.2.H.1
O [0..1]		Employer and School Contacts	1.3.6.1.4.1.19376.1.5.3.1.2.2	PCC TF-2: 6.3.2.2	

O [0..1]		Language Communication	1.3.6.1.4.1.19376.1.5.3.1.2.1	PCC TF-2: 6.3.2.1	
RE [0..*]		Patient Contacts	1.3.6.1.4.1.19376.1.5.3.1.2.4	PCC TF-2: 6.3.2.4	
O [0..*]		IHE Healthcare Providers and Pharmacies	1.3.6.1.4.1.19376.1.5.3.1.2.3	PCC TF-2: 6.3.2.3	
RE [0..*]		IHE Authorization	1.3.6.1.4.1.19376.1.5.3.1.2.5	PCC CDA Content Modules: 6.3.2.7	
O [0..1]		Personal Information: ReligiousAffiliation	2.16.840.1.113883.1.11.19185		
RE [0..*]		Patient Guardian Person: *CDA Person*	2.16.840.1.113883.10.12.152		
RE [0..*]		Patient Guardian Organization: *CDA Organization*	2.16.840.1.113883.10.12.151		
RE [0..1]		Personal Information: Language Communication	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.1	6.3.2.H.5
RE [0..1]		Author Device: assignedAuthoringDevice	2.16.840.1.113883.10.12.315		
RE [0..1]		Author Organization: representedOrganization	2.16.840.1.113883.10.12.151		
O [0..*]		*CDA relatedDocument*	2.16.840.1.113883.10.12.111		
Sections					
R [1..1]		Coded Reason for Visit Section	1.3.6.1.4.1.19376.1.5.3.1.1.31.2.1	6.3.1.D1.5.S1	6.3.1.D1.5.1
R [1..1]		Detailed Chief Complaint	1.3.6.1.4.1.19376.1.5.3.1.1.31.2.2	6.3.1.D1.5.S2	6.3.1.D1.5.2
R [1..1]		Active Problems	1.3.6.1.4.1.19376.1.5.3.1.3.6	PCC TF-2: 6.3.3.2.3	6.3.1.D1.5.3

R [1..1]		Allergies and Other Adverse Reactions	1.3.6.1.4.1.19376.1.5.3.1.3.13	PCC TF-2: 6.3.3.2.11	6.3.1.D1.5.4
R [1..1]		Medication Section	1.3.6.1.4.1.19376.1.5.3.1.3.19	PCC TF-2: 6.3.3.3.1	6.3.1.D1.5.5
R [1..1]		Acuity Assessment Section	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.2	PCC CDA Content Modules: 6.3.3.9.6	6.3.1.D1.5.6
R [1..1]		Review of Systems-EMS	1.3.6.1.4.1.19376.1.5.3.1.3.39	6.3.1.D1.5.S3	6.3.1.D1.5.7
R [1..1]		Coded Detail Physical Examination	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	PCC TF-2: 6.3.3.4.30	6.3.1.D1.5.8
R [1..1]		Coded Vital Signs	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2	PCC TF-2: 6.3.3.4.5	6.3.1.D1.5.9
R [0..1]		Paramedicine Treatment	1.3.6.1.4.1.19376.1.5.3.1.1.31.2.3	6.3.1.D1.5.S5	6.3.1.D1.5.14 6.3.1.D1.5.15
RE [0..1]		Assessments	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.4	PCC CDA Content Modules: 6.3.3.9.7	
RE [0..1]		Paramedicine Incident	1.3.6.1.4.1.19376.1.5.3.1.1.31.2.4	6.3.1.D1.5.S6	
RE [0..1]		History of Present Illness	1.3.6.1.4.1.19376.1.5.3.1.3.4	PCC TF-2: 6.3.3.2.1	
RE [0..1]		History of Past illness	1.3.6.1.4.1.19376.1.5.3.1.3.8	PCC TF-2: 6.3.3.2.5	
RE [0..1]		History of Past Procedures	1.3.6.1.4.1.19376.1.5.3.1.3.11	PCC TF-2: 6.3.3.2.9	
RE [0..1]		Pregnancy History	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	PCC TF-2: 6.3.3.2.18	6.3.1.D1.5.10
RE [0..1]		Medical Devices	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.5	PCC TF-2: 6.3.3.2.19	6.3.1.D1.5.11

RE [0..1]		Social History	1.3.6.1.4.1.19376.1.5.3.1.3.16	PCC TF-2: 6.3.3.2.14	6.3.1.D1.5.12
RE [0..1]		Functional Status	1.3.6.1.4.1.19376.1.5.3.1.3.17	PCC TF-2: 6.3.3.2.15	
RE [0..1]		Coded Advance Directives Section	1.3.6.1.4.1.19376.1.5.3.1.3.35	PCC TF-2: 6.3.3.6.6	6.3.1.D1.5.13
O [0..1]		Immunizations	1.3.6.1.4.1.19376.1.5.3.1.3.23	PCC TF-2: 6.3.3.3.5	
O [0..1]		Coded Injury Incident Description	1.3.6.1.4.1.19376.1.5.3.1.1.31.2.5	6.3.1.D1.5.S7	
O [0..1]		Coded Results Section	1.3.6.1.4.1.19376.1.5.3.1.3.28	PCC TF-2: 6.3.3.5.2	
O [0..1]		Cardiac Arrest Event Section	2.16.840.1.1133883.17.3.10.1.14	HL7 EMS Run Report	
O [0..1]		Payers	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7	PCC TF-2: 6.3.3.7.1	
O [0..1]		Care plan	1.3.6.1.4.1.19376.1.5.3.1.3.31	PCC TF-2: 6.3.3.6.1	
O [0..1]		Provider Orders	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.1	PCC TF-2: 6.3.3.6.11	

Paramedicine Summary of Care – Complete Report (PSC-CR) Document Content Module Specification

Template Name		Paramedicine Summary of Care – Complete Report (PSC-CR)			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.32.1			
Parent Template		Paramedicine Summary of Care – Clinical Subset (PSC-CS) (1.3.6.1.4.1.19376.1.5.3.1.1.31.1)			
General Description		The Paramedicine Summary of Care – Complete Report contains the information available in the Clinical Subset and additional information around the paramedicine encounter used for providing additional context for quality calculation or registry reporting.			
Document Code		SHALL BE 67796-3 Code 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..*]		Participating Providers and Roles	documentationOf/serviceEvent/performer	PCC TF-2: 6.3.1.5.6	
R [1..*]		Patient Administrative Identifiers	patientRole/id	PCC TF-2: 6.3.1.5.6	
R [1..*]		Personal Information	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
		Personal Information: Name	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
		Personal Information: Address	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
RE [0..*]		Personal Information: Patient Telecom	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.1	
		Personal Information: Contact Information	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
		Personal Information: Personal Identification	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
RE [0..1]		Personal Information: Administrative Gender	2.16.840.1.113883.1.11.1		
RE [0..1]		Personal Information: Patient Date of Birth	1.3.6.1.4.1.19376.1.5.3.1.1.1	PCC TF-2: 6.3.1.5.6	
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..*]		Personal Information: sDTCRaceCode	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 2.16.840.1.113883.1.11.15836	PCC TF-2: 6.3.1.1	6.3.2.H.1
RE [0..1]		Employer and School Contacts	1.3.6.1.4.1.19376.1.5.3.1.2.2	PCC TF-2: 6.3.2.2	
		Language Communication	1.3.6.1.4.1.19376.1.5.3.1.2.1	PCC TF-2: 6.3.2.1	
RE [0..1]		Patient Contacts	1.3.6.1.4.1.19376.1.5.3.1.2.4	PCC TF-2: 6.3.2.4	
RE [0..*]		IHE Healthcare Providers and Pharmacies	1.3.6.1.4.1.19376.1.5.3.1.2.3	PCC TF-2: 6.3.2.3	
		IHE Spouse	1.3.6.1.4.1.19376.1.5.3.1.2.4.1	PCC CDA Content Modules: 6.3.2.5	
RE [1..*]		IHE Authorization	1.3.6.1.4.1.19376.1.5.3.1.2.5	PCC CDA Content Modules: 6.3.2.7	
R [1..1]		Author Device: assignedAuthoringDevice	2.16.840.1.113883.10.12.315		
R [1..1]		Author Organization: representedOrganization	2.16.840.1.113883.10.12.151		
RE [0..*]		*CDA relatedDocument*	2.16.840.1.113883.10.12.111		
Sections					
R [1..1]		EMS Times	2.16.840.1.1133883.17.3.10.1.10	HL7 EMS Run Report	
R [1..1]		*EMS Patient Care Narrative*	2.16.840.1.1133883.17.3.10.1.1	HL7 EMS Run Report	
R [1..1]		*Paramedicine Transport*	1.3.6.1.4.1.19376.1.5.3.1.1.32.2.1	6.3.1.D1.5.S9	
RE [0..1]		*EMS Response Section*	2.16.840.1.1133883.17.3.10.1.3	HL7 EMS Run Report	
O [0..1]		*Referral Source*	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.3	PCC TF-2: 6.3.3.7.2	

O [0..1]		*EMS Personnel Adverse Event Section*	2.16.840.1.1133883.17.3.10.1.6	HL7 EMS Run Report	
O [0..1]		*EMS Protocol*	2.16.840.1.1133883.17.3.10.1.7	HL7 EMS Run Report	

6.3.1.D1.5.1 Reason for Visit Section Constraints

The Reason for Visit SHOULD contain exactly [1..1] text entry documenting the reasons that the paramedicine visit or encounter took place.

The coded reason for visit entry MAY be drawn from a documented Service Request Reason or a complaint made by the patient. The observation <value> SHALL contain exactly one [1..1] value, which SHALL be selected from CodeSystem SNOMED CT (urn:oid:2.16.840.1.113883.6.96) OR CodeSystem ICD10 (urn:oid:2.16.840.1.113883.6.3).

The Coded Reason For Visit entry value MAY come from the Paramedicine_Emergency_Event_Sub_List_VS USA Volume 4 Constraint: Vol4 4.1.2.1.2.1

6.3.1.D1.5.2 Detailed Chief Complaint Constraints

The chief complaint SHALL be documented in the text entry portion of this section. The entries of this section SHALL be used to document additional details about the chief complaint such as the duration and the Target site.

USA Volume 4 Constraint: Vol4 4.1.2.1.2.2

6.3.1.D1.5.3 Active Problems Section Constraints

The Paramedicine Impressions, symptoms, and working diagnosis SHALL be documented within the Active Problems Section (templateID 1.3.6.1.4.1.19376.1.5.3.1.3.1 [PCC TF-2]) as Problem Concern Entries 1.3.6.1.4.1.19376.1.5.3.1.4.5.2.

An Problem with Symptoms Entry 1.3.6.1.4.1.19376.1.5.3.1.1.31.5.1 MAY be used to document a more detailed problem with associated symptoms.

USA Volume 4 Constraint: Vol4 4.1.2.1.2.3

6.3.1.D1.5.4 Allergies and Other Adverse Reactions Section 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.D1.5.5 Medication Section Constraints

The following special cases exist for encoding the medication product:

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.

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.D1.5.6 Acuity Assessment Section Constraints

The Acuity Assessment SHALL contain one or more [1..*] Acuity Observations 1.3.6.1.4.1.19376.1.5.3.1.1.31.5.23. The acuity observation may be used to document a LOINC

75615-5 Four level triage system or a 75616-3 Generic five level triage system. The <value> element MAY be encoded using values determined by local jurisdiction codes.

The Acuity Observation SHALL document the Acuity Criteria in the methodCodes entry. The Acuity Criteria value shall be drawn from the Acuity Criteria concept domain as defined by local jurisdiction.

USA Volume 4 Constraint: Vol4 4.1.2.1.2.4

6.3.1.D1.5.7 Review of Systems – EMS Section Constraints

The Review of Systems SHALL contain only the necessary Sections used for Paramedicine Care.

The estimated Age entry SHALL only be used to document the patients age when a birth date or partial birth date is not known.

6.3.1.D1.5.8 Coded Detail Physical Examination Section Constraints

The Coded Detailed Physical Examination Section SHOULD contain the Subsections for the following subs section entries. The Implementor May choose to either document an entry for a combined physical findings of Back and Spine Entry or separate assessment entries for back and spine. The Same constraints apply to the Physical findings of Pelvis+Genitourinary entry.

The Assessment Findings Entries for these Assessments SHOULD contain zero or one [0..1] targetSite to capture the exam observation locations. The targetSiteCode SHALL use CodeSystem SNOMED CT (urn:oid:2.16.840.1.113883.6.96). The target site location <value> element shall be encoded in the /targetSiteCode/code concept.

The Physical Examination Assessment Findings MAY be drawn from the IHE Paramedicine Assessment value sets. The Examination Assessment findings <value> SHALL be

The following table provides the mappings between the IHE Paramedicine Assessment value sets and [PCC TF-2] assessment concepts. The assessment <value> element shall be encoded in the /value concept.

Table 6.3.1.D1.5.8-1: Physical Examination Assessment Sub Section Concepts

IHE Assessment Sub Section Concept	IHE PCC templateID	Section Entry LOINC Codes	Section Entry Name	Physical Examination Assessment Value Sets
Integumentary System	1.3.6.1.4.1.19376.1.5.3.1.1.9.17	8709-8	Physical findings of Skin	Paramedicine_Physical_Findings_of_Skin_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.3

IHE Assessment Sub Section Concept	IHE PCC templateID	Section Entry LOINC Codes	Section Entry Name	Physical Examination Assessment Value Sets
Head Assessment	1.3.6.1.4.1.19376.1.5.3.1.1.9.18	8701-5	Physical findings of Head	Paramedicine_Physical_Findings_of_Head_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.4
Neurologic System	1.3.6.1.4.1.19376.1.5.3.1.1.9.35	8705-6	Physical findings of Nervous system	Paramedicine_Physical_Findings_of_Nervous_System_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.5
Ears, Nose, Mouth and Throat	1.3.6.1.4.1.19376.1.5.3.1.1.9.20	32432-7	Physical findings of Face	Paramedicine_Physical_Findings_of_Face_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.6
Neck	1.3.6.1.4.1.19376.1.5.3.1.1.9.24	11442-1	Physical findings of Neck	Paramedicine_Physical_Findings_of_Neck_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.7
Thorax and Lungs	1.3.6.1.4.1.19376.1.5.3.1.1.9.26	32449-1	Physical findings of Lung	Paramedicine_Physical_Findings_of_Lung_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.8
		11422-3	Physical findings of Chest	Paramedicine_Physical_Findings_of_Chest_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.9
Heart	1.3.6.1.4.1.19376.1.5.3.1.1.9.29	8702-3	Physical findings of Heart	Paramedicine_Physical_Findings_of_Heart_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.10
Respiratory System Section	1.3.6.1.4.1.19376.1.5.3.1.1.9.30	11443-9	Physical findings of Respiratory system	Paramedicine_Physical_Findings_of_Respiratory_System_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.11
		32449-1	Physical findings of Lung	Paramedicine_Physical_Findings_of_Lung_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.22
Abdomen	1.3.6.1.4.1.19376.1.5.3.1.1.9.31	8694-2	Physical findings of Abdomen	Paramedicine_Physical_Findings_of_Abdomen_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.12
Genitalia	1.3.6.1.4.1.19376.1.5.3.1.1.9.36	67531-4	Physical findings of Pelvis+Genitourinary	Paramedicine_Physical_Findings_of_Pelvis_and_Genitourinary_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.13
		8707-2	Physical findings of Pelvis	Paramedicine_Physical_Findings_of_Pelvis_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.14

IHE Assessment Sub Section Concept	IHE PCC templateID	Section Entry LOINC Codes	Section Entry Name	Physical Examination Assessment Value Sets
		8700-7	Physical findings of Genitourinary tract	Paramedicine_Physical_Findings_of_Genitourinary_Tract_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.15
Musculoskeletal	1.3.6.1.4.1.19376.1.5.3.1.1.9.34	67532-2	Physical findings of Back and Spine	Paramedicine_Physical_Findings_of_Back_and_Spine_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.16
		8695-9	Physical findings of Back	Paramedicine_Physical_Findings_of_Back_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.17
		32476-4	Physical findings of Spine	Paramedicine_Physical_Findings_of_Spine_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.18
Extremities	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1	8703-1	Physical findings of Extremities	Paramedicine_Physical_Findings_of_Extremities_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.19
Eye	1.3.6.1.4.1.19376.1.5.3.1.1.9.19	8699-1	Physical findings of Eye	Paramedicine_Physical_Findings_of_Eye_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.20
		32466-5	Physical findings of Pupil	Paramedicine_Physical_Findings_of_Pupil_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.21
Mental Status assessment	1.3.6.1.4.1.19376.1.5.3.1.4.25	75275-8	Mental Status Organizer	2.16.840.1.113883.17.3.11.84

The following Assessments are further constrained, and SHALL contain exactly one [1..1] targetSiteCode and the /targetSiteCode/code concept MAY come from the indicated value set.

1130 **Table 6.3.1.D1.5.8-2: Physical Examination Target Site Locations**

IHE Target Site Concept	IHE PCC Physical Examination Target Site Value Set	IHE PCC Value Set OID
Abdomen Physical Findings Target Site	Abdomen_Physical_Findings_Target_Site_VS	1.3.6.1.4.1.19376.1.5.3.1.1.31.7.22
Back and Spine Physical Findings Target Site	Back_and_Spine_Physical_Findings_Target_Site_VS	1.3.6.1.4.1.19376.1.5.3.1.1.31.7.23
Extremities Physical Findings Target Site	Extremities_Physical_Findings_Target_Site_VS	1.3.6.1.4.1.19376.1.5.3.1.1.31.7.24

Eye Physical Findings Target Site	Eye_Physical_Findings_Target_Site_VS	1.3.6.1.4.1.19376.1.5.3.1.1.31.7.25
Chest Physical Findings Target Site	Chest_Physical_Findings_Target_Site_VS	1.3.6.1.4.1.19376.1.5.3.1.1.31.7.26

USA Volume 4 Constraint: Vol4 4.1.2.1.2.5.

6.3.1.D1.5.9 Coded Vital Signs Section Constraints

The Vital Signs organizer 1.3.6.1.4.1.19376.1.5.3.1.4.13.1 may use the LOINC code 34566-0 Vital signs with method details panel to document the panel for a panel of vital signs documented.

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]). SHALL be supported using the LOINC codes, with the specified data types and unit. IF there is no information provided in the Vital Signs Observation/value THEN there SHALL be NULL content documented.

Table 6.3.1.D1.5.9-1: Vital Signs Descriptions and LOINC Codes

LOINC	Description	Units	Type
8867-4	Heart Rate	/min	PQ
9279-1	Respiration Rate	/min	PQ
8480-6	Systolic Blood Pressure	mm[Hg]	PQ
8462-4	Diastolic Blood Pressure	mm[Hg]	PQ
8478-0	Mean Arterial Pressure	mm[Hg]	PQ
2339-0	Blood Glucose Level	mg/dl	PQ
2708-6	Oxygen Saturation	%	PQ
38208-5	Pain Scale Score	n/a	Nm
72089-6	Stroke Scale Score	n/a	PQ
67520-7	Stroke Scale Score Interpretation	n/a	PQ
35088-4	Glasgow Coma Scale	n/a	n/a
9267-6	Glasgow Coma Score-Eye	n/a	PQ
9268-4	Glasgow Coma Score-Motor	n/a	PQ

LOINC	Description	Units	Type
9270-0	Glasgow Coma Score-Verbal	n/a	PQ
9269-2	Glasgow Coma Score-Total Score	n/a	PQ
55285-1	Glasgow Coma Score-Qualifier	n/a	PQ
8884-9	Heart Rate Rhythm	n/a	Nom
8310-5	Body Temperature	Cel or [degF]	PQ
19889-5	End Title Carbon Dioxide (ETCO2)	%	PQ
19911-7	Carbon Monoxide (CO)	%	PQ
XXX	APGAR Generic	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
67775-7	Level of responsiveness	**n/a**	**PQ**
44969-4	Pulse Rhythm	n/a	Nom
80341-1	Respiratory Effort	n/a	PQ
3141-9	Body Weight (Measured)	kg, g, [lb_av] or [oz_av]	PQ
8302-2	Body Height (Measured)	m, cm,[in_us] or [in_uk]	PQ
8306-3	Body Height^Lying	m, cm,[in_us] or [in_uk]	PQ
8287-5	Circumference.Occipital-Frontal (Tape Measure)	m, cm,[in_us] or [in_uk]	PQ

1145

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

Table 6.3.1.D1.5.9-2: Vital Signs Descriptions and LOINC Codes

Observation	Method Concept
Systolic Blood Pressure	Measurement Device Type
Diastolic Blood Pressure	Measurement Device Type
Mean Arterial Pressure	Measurement Device Type
Heart Rate if LOINC value 8886-4 is designated	Physical Method/Device type
Heart Rate Rhythm	Interpretation Method

Observation	Method Concept
Blood Glucose Level	Measurement Device Type
Body Temperature	Physical Method/Body Site
Pain Scale Score	Pain Scale Type (80316-3)
Stroke Scale Score	Stroke Scale Type (67521-5)
Stroke Scale Score Interpretation	Stroke Scale Type (67521-5)

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

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. 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 Scale Score Interpretation SHALL be drawn from the Paramedicine_Observation_Interpretation_VS value set.

The Level of Responsiveness SHALL be drawn from the Level_Of_Responsiveness_AVPU_VS value set. The <value> element SHALL be encoded the concept in /value concept.

The Vital signs organizer MAY us the Glasgow organizer to document the Glascow score elements.

USA Volume 4 Constraint: Vol 4 4.1.2.1.2.6.

6.3.1.D1.5.11 Medical Devices Section Constraints

This Section SHALL be used to document the patient's personal Medical Devices.

Medical Devices used to interpret results, collect vital signs, etc. SHALL be Referenced using the Observation Method entry.

6.3.1.D1.5.10 Pregnancy History Section Constraints

The Pregnancy History Section SHALL contain a Pregnancy Observation using the 11449-6 Pregnancy Status code from LOINC to indicate whether the patient is pregnant. SHALL use the yes/no/unknown value set to document this

The Pregnancy History Section MAY contain a Pregnancy Observation using the 11884-4 Gestational age Estimated to indicate the timing of the pregnancy. This MAY be documented as quantity or a quantity range.

The Pregnancy History Section MAY contain a Pregnancy Observation using the EDD Observation 1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.1 to indicate the estimated due date of the fetus.

USA Volume 4 Constraint: Vol4 4.1.2.1.2.7

6.3.1.D1.5.12 Social History Section Constraints

If work information is known, this should be documented using the IHE Past or Present Occupation Observation (1.3.6.1.4.1.19376.1.7.3.1.4.24.19), including Employer in ../participant/participant, the Past or Present Industry Observation Entry (1.3.6.1.4.1.19376.1.7.3.1.4.24.3), and Occupational Hazard Observation (1.3.6.1.4.1.19376.1.7.3.1.4.24.27).

6.3.1.D1.5.13 Coded Advance Directives Section 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.

6.3.1.D1.5.14 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 SNOMED-CTvalue set 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 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

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 .

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]).

Medication negation where negation indicator of IND or True or false indicates that the procedure has not been done. Then the RSON would be associated would be the reason the procedure was not done

Negation is set to true when it did not happen.

A second reason can be added to indicate the reason the mediation has been suspended, or aborted.

6.3.1.D1.5.15 Procedures Performed Constraints

The Procedure negation where negation indicator of IND or True or false indicates that the procedure has not been done. Then the RSON would be associated would be the reason the procedure was not done

Negation is set to true when it did not happen.

A second reason can be added to indicate the reason the procedure has been suspended, aborted, or considered completed (airway confirmation).

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.2 Marital Status Vocabulary Constraint

The value for Marital status/ code SHALL be drawn from HL7 Marital Status value set 2.16.840.1.113883.1.11.12212 [HL7 EMS PCR] unless further extended by national extension.

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.4 Religious Affiliation Vocabulary Constraint

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

6.3.2.H.5 Language Communication Vocabulary Constraint

The value for Language Communication/ code SHALL be drawn from the ISO Language value set 639-2 unless further extended by national extension.

6.3.2.H.6 Participant Constraint

The Participant SHOULD contain an associatedEntity may be restricted by jurisdictions as constrained by national extension. When used, participant/associatedEntity/code SHALL use values from the DestinationType 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.

6.3.2.H.8 componentOf Vocabulary Constraint

The Health Care Facility may be restricted by jurisdictions as constrained by national extension. The componentOf/encompassingEncounter/location/healthCareFacility/code SHALL use values from the UnitResponseRole concept domain as specified by jurisdiction.

6.3.3 CDA Section Content Modules

6.3.3.10.S1 Coded Reason for Visit Section 1.3.6.1.4.1.19376.1.5.3.1.1.31.2.1

Title	Coded Reason for Visit Section	
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.2.1	
Parent Template	Reason for Visit Section 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1.1 [PCC CDA Content Modules 6.3.3.1.9]	
General Description	Contains entries that document the coded reasons for the patient to be at the patient care event/encounter. This may be informed by a reason for referral entry or a generic entry that documents a reason not initiated by someone other than a provider. This section SHALL Still use the Narrative <text> entry to document the reason for visit.	
LOINC Code	**Opt**	**Description**
29299-5	R	Reason For Visit

Entries	Opt	Description
1.3.6.1.4.1.19376.1.5.3.1.4.13	O [0..*]	Simple Observations
1.3.6.1.4.1.19376.1.5.3.1.4.5	O [0..*]	Condition Entry

6.3.3.10.S1.1 Parent Template

The parent of this template is Reason for Visit Section 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1.1

```
<component>
    <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.31.2.1'/>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1.1'/>
        <id root=' ' extension=' '/>
        <code code='29299-5' displayName='Reason For Visit'
codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
        Text as described above
    </text>
    <entry>
        <!-- Optional Simple Observations element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
    </entry>
    <entry>
        <!-- Condition Entry element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.5'/>
    </entry>
    </section>
</component>
```

Figure 6.3.3.10.S1.1-1 Sample Reason for Visit Section

6.3.3.10.S2 Detailed Chief Complaint Section 1.3.6.1.4.1.19376.1.5.3.1.1.31.2.2

Title	Detailed Chief Complaint	
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.2.2	
Parent Template	Chief Complaint Section 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1 [PCC TF-2: 6.3.3.1.3]	
General Description	Contains entries that document the coded reasons for the patient to be at the patient care event/encounter. This may be informed by a reason for referral entry or a generic entry that documents a reason not initiated by someone other than a provider. This section SHALL Still use the Narrative <text> entry to document the Chief Complaint.	
LOINC Code	Opt	Description
10154-3	R	Chief Complaint
Entries	**Opt**	**Description**
1.3.6.1.4.1.19376.1.5.3.1.4.13	O [0..*]	Simple Observations
1.3.6.1.4.1.19376.1.5.3.1.4.5.2	O [0..*]	Problem Concern Entry

6.3.3.10.S2.1 Parent Template

The parent of this template is Chief Complaint Section 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1

```
<component>
    <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.31.2.2'/>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1'/>
        <id root=' ' extension=' '/>
        <code code='29299-5' displayName='Reason For Visit'
codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
    <text>
        Text as described above
    </text>
    <entry>
        <!-- Optional Simple Observations element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.13'/>
    </entry>
```



```
    <entry>
        <!-- Condition Entry element -->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.5'/>
    </entry>
    </section>
</component>
```

Figure 6.3.3.10.S2.1-1: Sample Reason for Visit Section

6.3.3.10.S3 Review of Systems – EMS Section 1.3.6.1.4.1.19376.1.5.3.1.3.39

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) [PCC TF-2: 6.3.3.2.1.6]
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
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	
O [0..1]		Substance Use	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.2	6.3.4.E4	
R2 [0..1]		Patient Activity	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.3	6.3.4.E5	
R2 [0..1]		Patient estimated Age Observation	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.4	6.3.4.E6	

6.3.3.10.S4 Mental Status Organizer Section [1.3.6.1.4.1.19376.1.5.3.1.3.38]

Template Name		Mental Status Organizer			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.3.38			
Parent Template		N/A			
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.E7	

1315

6.3.3.10.S5 Paramedicine Treatment Section 1.3.6.1.4.1.19376.1.5.3.1.1.31.2.3

Template Name		Paramedicine Treatment			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.31.2.3			
Parent Template		Procedures and Interventions (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11)			
General Description		The Paramedicine Treatment Section shall contain a narrative description of the patient's treatments carried out during paramedicine care. It shall include subsections, if known, for the procedures performed, medications Administered, and the event outcomes of the treatment procedure or medication.			
Section Code		29554-3[AF2] , LOINC, "Paramedicine Treatment"			
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					
RE [0..*]		Detailed Procedure	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.5	6.3.4.E8	
RE [0..*]		Detailed Medication Administration	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.6	6.3.4.E9	
RE [0..*]		Intravenous Fluids	1.3.6.1.4.1.19376.1.5.3.1.1.13.3.2	PCC CDA Content Modules: 6.3.4.46	
O [0..*]		Immunizations	1.3.6.1.4.1.19376.1.5.3.1.4.12	PCC TF-2: 6.3.4.17	
O [0..*]		Barriers to Care	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.7	6.3.4.E10	Vol4 4.1.2.1.2.8

6.3.3.10.S6 Paramedicine Incident Section 1.3.6.1.4.1.19376.1.5.3.1.1.31.2.4

Template Name	Paramedicine Incident
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.2.4
Parent Template	N/A
General Description	This section SHALL contain descriptions and observations that relate to an incident that a patient is involved in that utilizes paramedicine care.
Section Code	272379006, SNOMED CT, "Event"
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					
RE [0..*]		Incident Event	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.8	6.3.4.E11	
RE [0..1]		Work-Related Illness/Injury indicator	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.9	6.3.4.E12	
RE [0..1		Mass Casualty Incident Indicator	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.10	6.3.4.E13	
RE [0..1]		Number of Affected People	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.11	6.3.4.E14	
O [0..*]		Disaster Type	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.12	6.3.4.E15	
O [0..*]		Simple Observations	1.3.6.1.4.1.19376.1.5.3.1.4.13	PCC TF-2: 6.3.4.20	

6.3.3.10.S7 Coded Injury Incident Description Section 1.3.6.1.4.1.19376.1.5.3.1.1.31.2.5

Template Name	Coded Injury Incident Description				
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.2.5				
Parent Template	Injury Incident Description Section 1.3.6.1.4.1.19376.1.5.3.1.1.19.2.1				
General Description	The Coded elements of this system are used to support the documentation of coded values supporting information describing an Injury Incident.				
Section Code	11374-6, LOINC, "Injury incident description"				
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					
RE [0..*]		Mechanism of Injury	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.13	6.3.4.E16	
RE [0..*]		Cause of Injury	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.14	6.3.4.E17	
RE [0..*]		Safety Equipment Used	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.15	6.3.4.E18	
RE [0..*]		Protective Equipment Used	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.16	6.3.4.E19	
O [0..1]		Height of Fall	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.17	6.3.4.E20	
O [0..1]		Collision Data Organizer	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.18	6.3.4.E21	
O [0..*]		Simple Observations	1.3.6.1.4.1.19376.1.5.3.1.4.13	PCC TF-2: 6.3.4.20	

6.3.3.10.S9 Paramedicine Transportation Section 1.3.6.1.4.1.19376.1.5.3.1.1.32.2.1

Template Name		Transportation			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.32.2.1			
Parent Template		Transport Mode Section 1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2			
General Description		Paramedicine Transport section contains the transport event along with the supporting observations for the event.			
Section Code		11459-5, LOINC, “Transport Mode”			
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					
RE [0..1]		Patient Transported Indicator	1.3.6.1.4.1.19376.1.5.3.1.1.32.5.1	6.3.4.E28	
RE [0..1]		Paramedicine Transport	11.3.6.1.4.1.19376.1.5.3.1.1.32.5.2	6.3.4.E29	
RE [0..1]		Number of Patients Transported	1.3.6.1.4.1.19376.1.5.3.1.1.32.5.3	6.3.4.E30	
O [0..1]		Activation of the destination healthcare facility team	1.3.6.1.4.1.19376.1.5.3.1.1.32.5.4	6.3.4.E31	
O [0..*]		Simple Observations	1.3.6.1.4.1.19376.1.5.3.1.4.13	PCC TF-2: 6.3.4.20	

6.3.3.10.S10 Emergency Notification Section 1.3.6.1.4.1.19376.1.5.3.1.1.31.2.7

Template Name	Emergency Notification				
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.32.2.2				
Parent Template	N/A				
General Description	The documentation of the Notification that activates a healthcare team to start a healthcare service event.				
Section Code	67660-1 LOINC "EMS dispatch"				
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]		Dispatch Event	1.3.6.1.4.1.19376.1.5.3.1.1.32.5.5	6.3.4.E32	
O [0..1]		Emergency Medical Dispatch Performed Indicator	1.3.6.1.4.1.19376.1.5.3.1.1.32.5.6	6.3.4.E33	
O [0..*]		External References	1.3.6.1.4.1.19376.1.5.3.1.4.4	PCC TF-2: 6.3.4.9	

6.3.4 CDA Entry Content Modules

6.3.4.E1 Problem with Symptoms Entry Content Module

Table 6.3.4.E1-1: Symptom Entry

Template Name	Problem with Symptoms
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.1
Parent Template	Problem Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5 [PCC TF-2: 6.3.4.14]
General Description	A problem entry that is documented to contain associated symptoms.

This element inherits all constraints from the problem Entry template.

A required if known <entryRelationship> may be present indicating the symptoms associated with the problem entry being documented. <entryRelationship typeCode='REFR' inversionInd='false'>. When present, this <entryRelationship> element shall contain a symptom observation conforming to the Problem Entry observation template 1.3.6.1.4.1.19376.1.5.3.1.4.5 and have a code of <code code='418799008' displayName='Symptom' codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'>

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	Simple Observation 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 EMS 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	11368-8 LOINC	TS	NA

6.3.4.E4 Substance Use Entry Content Module

Table 6.3.4.E4-1: Substance Use Entry

Template Name	Substance Use				
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.2				
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13				
General Description	The documentation of an indication that the patient has used drugs, alcohol, or other controlled substances.				
Class/ Mood	**Code**		**Data Type**	**Value**	
OBS/EVN	XXX, LOINC		CE	ValueSet Yes No Unknown (YNU) urn:oid:2.16.840.1.114222.4.11.888	
Opt and Card	**entryRelationship**	**Description**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
RE [0..*]	Evidence	Simple Observation	1.3.6.1.4.1.19376.1.5.3.1.4.13		MAY use Substance_Use_Evidence_VS

1345

6.3.4.E5 Patient Activity Entry Content Module

Table 6.3.4.E5-1: Patient Activity Entry

Template Name	Patient Activity Entry		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.3		
Parent Template	1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The activity the patient was engaging prior to onset of symptoms or injury,		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	XXX LOINC	TS	NA

6.3.4.E6 Patient Estimated Age Observation Entry

Table 6.3.4.E6-1: Patient Age Observation Entry

Template Name	Patient Age Observation		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.4		
Parent Template	Simple Observations 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The Age of the patient either reported to or assumed by a provider in an event when a full birthdate is unavailable or unknown. For situations where birthdate is unknown; age is estimated by third party on basis of physical evidence		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	21611-9 Age estimated (LOINC)	QTY	NA

6.3.4.E7 Mental Status Entry

Table 6.3.4.E7-1: 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	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	Qualitative assessment of condition of patient's mental status.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	75275-8, LOINC, Cognitive Function	CE	SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96)

6.3.4.E8 Detailed Procedure Entry Content Module

Table 6.3.4.E8-1: Detailed Procedure Entry

Template Name	Detailed Procedure
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.5
Parent Template	Procedure Entry 1.3.6.1.4.1.19376.1.5.3.1.4.19 [PCC CDA Content Modules: 6.3.4.33]
General Description	A procedure entry that contains more detailed information on elements such as, outcomes, and complications.

Class/Mood	Code	Data Type	Value
OBS/EVN	This element shall be present, and should contain a code describing the type of procedure.	CE	SNOMED or ICD-10-PCS

Opt and Card	entryRelationship	Description	Template ID	Specification Document	Vocabulary Constraint
R2 0..*	<entryRelationship typeCode='COMP' inversionInd='true'>	Event Outcome Observation	1.3.6.1.4.1.19376.1.5.3.1.4.13 (Simple Observation)		SHOULD use Response_VS
R2 0..*	<entryRelationship typeCode='COMP' inversionInd='true'>	Complication	1.3.6.1.4.1.19376.1.5.3.1.4.5 (Problem entry)		ICD-10 SNOMED-CT

6.3.4.E9 Detailed Medication Entry Content Module

1360 **Table 6.3.4.E9-1: Detailed Medication Entry**

Template Name	Detailed Medication
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.6
Parent Template	Medications 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2: 6.3.4.16]
General Description	A medication entry that contains more detailed information on elements such as devices, outcome, and complications.

Class/Mood	Code	Data Type	Value
ACT/EVN	This element shall be present, and should contain a code describing the type of medication or substance that this element is about.	CE	SNOMED-CT or RxNorm

Opt and Card	entry	Description	Template ID	Specification Document	Vocabulary Constraint
R [1..1]	<entryRelationship typeCode='COMP' inversionInd='true'>	Event Outcome Observation	1.3.6.1.4.1.19376.1.5.3.1.4.13 (Simple Observation)		SHOULD use Response_VS
R2 0..*	<entryRelationship typeCode='COMP' inversionInd='true'>	Complication	1.3.6.1.4.1.19376.1.5.3.1.4.5 (Problem entry)		ICD-10 SNOMED-CT

6.3.4.E10 Barriers to Care

Table 6.3.4.E10-1: Barriers to Care Entry

Template Name	Barriers to Care		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.7		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The conditions, situations, personal beliefs, or physical barriers that may have acted as an impediment to the treatment of the patient.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	67515-7, Barriers to patient care	CE	ValueSet Barriers_To_Care_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.2

6.3.4.E11 Incident Event Entry

Table 6.3.4.E11-1: Incident Event Entry

Template Name	Incident Event				
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.8				
Parent Template	NA				
General Description	An entry that defines the Incident times, Participants, participant rolls, and locations of an incident event.				
Class/Mood	**Code**		**Data Type**	**Value**	
Act/EVN	272379006 Event If the specific type of incident event wants to be defined, then this value can be any value from the defined value ser.		N/A	MAY come from Paramedicine_Emergency_Event_Sub_List_VS	
Opt and Card	**Element**	**Description**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
R 1..1		Effective time			

	< effectiveTime>				
R 1..1	participant	Incident Location	SHALL contain @typeCode="LOC"		
RE 0..1	participant/ participantRole/class		SHOULD contain @classCode="EXLOC"		
RE 0..*	participant/ participantRole/id	Location ID			
R 1..1	participant/ participantRole/code	Location Type			SHALL be selected from CodeSystem ICD10 (urn:oid:2.16.840.1.113883.6.3) OR SNOMED-CT ()
R 1..1	participant/ participantRole/addr	Location Address			
RE 0..1	participant/ participantRole/ playingEntity/	Location facility	SHOULD contain zero or one [0..1] @classCode to reflect the facility type/capability		SHALL be selected from CodeSystem HL7EntityClass (urn:oid:2.16.840.1.113883.5.41) STATIC
RE 0..1	participant/ participantRole/ playingEntity/code	Location Facility code	SHOULD contain zero or one [0..1] code to reflect the location in the facility (e.g., ICU, Cath Lab, etc.)		IHE_PCC_Facility_Ward_VS
RE 0..1	participant/ participantRole/ playingEntity/name	Location Name			
R 1..*	participant	Performer			
O 0..1	participant/time	Performer effective time			

R 1..1	participant/ participantRole	Performer Role			
RE 0..*	participant/ participantRole/id	Performer ID			
RE 0..*	participant/ participantRole/code	Performer role			Paramedicine_Provider_Roles_VS
R 1..*	participant/ participantRole/code	Performer Type			TBD Paramedicine_Provider_Types_VS
RE 0..*	participant/ participantRole/ playingEntity	Performer Person/organization			
RE 0..*	<entryRelationship typeCode='RSON'>	Refusal Reason	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		

6.3.4.E12 Work-Related Illness/Injury Entry

Table 6.3.4.E12 -1: Work-Related Illness/Injury Entry

Template Name	Work-Related Illness/Injury		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.9		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	Indication of whether or not the illness or injury of a patient is work related.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	XXX (LOINC)	BL	N/A

6.3.4.E13 Mass Casualty Incident Entry

Table 6.3.4.E13-1: Mass Casualty Incident Entry

Template Name	Mass Casualty Incident		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.10		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The indication of weather an incident is considered a mass casualty. A mass casualty incident describes an incident in which emergency medical services resources, such as personnel and equipment, are overwhelmed by the number and severity of casualties.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	67490-3 Mass casualty incident (LOINC)	BL	NA

6.3.4.E14 Number of Affected People Entry

Table 6.3.4.E14-1: Number of Affected People Entry

Template Name	Number of Affected People		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.11		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The General mechanism of the forces which caused the injury.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	XXX (LOINC)	INT	NA

6.3.4.E15 Disaster Type Entry

Table 6.3.4.E15-1: Disaster Type Entry

Template Name	Disaster Type		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.12		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	Event caused by natural forces or Suspected and Intentional/Unintentional Disasters.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	69463-8 (LOINC)	CE	SHOULD come from Paramedicine_Emergency_Event_Sub_List_VS

6.3.4.E16 Mechanism of Injury Entry

1380 **Table 6.3.4.E16-1: Mechanism of Injury Entry**

Template Name	Mechanism of Injury		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.13		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The General mechanism of the forces which caused the injury.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	67494-5 (LOINC)	CE	SHOULD come from Mechanism_Of_Injury_VS

6.3.4.E17 Cause of Injury

Table 6.3.4.E17-1: Cause of Injury Entry

Template Name	Cause of Injury		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.14		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The category or type of mechanism used to describe how an injury was caused, e.g., animal bite, self harm, assault, etc. This entry may be documented as narrative text or a coded value.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	11373-8, Injury cause	CE	SNOMED-CT or ICD-10

1385 ### 6.3.4.E18 Safety Equipment Used Entry

Table 6.3.4.E18 -1: Safety Equipment Used Entry

Template Name	Safety Equipment Used		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.15		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	Safety Equipment that has been used.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	11457-9 Safety equipment used (LOINC)	CE	SHOULD come from Safety_Equipment_VS

6.3.4.E19 Protective Equipment Used Entry

Table 6.3.4.E19 -1: Protective Equipment Used Entry

Template Name	Protective Equipment Used		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.16		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The Protective equipment that was used.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	XXX (LOINC)	CE	SHOULD come from Protective_Equipment_VS

1390

6.3.4.E20 Height of Fall Entry

Table 6.3.4.E20-1: Height of Fall Entry

Template Name	Height of Fall		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.17		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The high the patient has fallen. Measured from the lowest point of the patient to the position of the patient at the end of the fall.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	67501-7 Height of fall	QTY	NA

6.3.4.E21 Collision Data Entry Content Module

Table 6.3.4.E21-1: Collision Data Entry Content Module

Template Name	Collision Data				
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.18				
Parent Template	NA				
General Description	Observations specific to a collision incident or injury event.				
Class/Mood	**Code**		**Data Type**	**Value**	
CLUSTER /EVN	XXX, LOINC		N/A	N/A	
Opt and Card	**Element**	**Description**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
RE [0..1]		Vehicle Type	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.19	6.3.4.E22	
O [0..1]		Location of Patient in Vehicle	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.20	6.3.4.E23	
O [0..*]		Location of the Vehicle Impacted	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.21	6.3.4.E24	
RE [0..1]		Airbag Deployment	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.22	6.3.4.E25	
O [0..*]		Collision Object	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.23	6.3.4.E26	
O [0..1]		Seatbelt used indicator	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.24	6.3.4.E27	
O [0..*]		Simple Observations	1.3.6.1.4.1.19376.1.5.3.1.4.13	PCC TF-2: 6.3.4.20	

6.3.4.E22 Vehicle Type Entry

Table 6.3.4.E22 -1: Vehicle Type Entry

Template Name	Vehicle Type		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.19		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The Type of vehicle that has crashed		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	261324000, SNOMED-CT	CE	SHOULD come from Vehicle_Type_VS, CodeSystem SNOMED CT (urn:oid:2.16.840.1.113883.6.96)

1400

6.3.4.E23 Location of Patient in Vehicle Entry

Table 6.3.4.E23-1: Location of Patient in Vehicle Entry

Template Name	Location of Patient in Vehicle		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.20		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The location of the patient in the vehicle during a collision incident.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	67498-6 Location of patient in vehicle (LOINC)	CE	SHOULD conf from Location_In_Vehicle_VS

6.3.4.E24 Location of the Vehicle Impacted Entry

1405 **Table 6.3.4.E24-1: Location of the Vehicle Impacted Entry**

Template Name	Location of the Vehicle Impacted		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.21		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The location of a vehicle that has been impacted in a collision		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	67497-8 Location of impact on the vehicle (LOINC)	CE	

6.3.4.E25 Airbag Deployment Entry

Table 6.3.4.E25-1: Airbag Deployment Impacted Entry

Template Name	Airbag Deployment Entry				
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.22				
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13				
General Description	The indication that the airbags were deployed in the vehicle during a collision.				
Class/ Mood	**Code**		**Data Type**	**Value**	
OBS/EVN	67500-9 Airbag Deployment		BL	NA	
Opt and Card	**entryRelationship**	**Description**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
R [1..1]	102384007 SNOMED-CT	Simple Observation	1.3.6.1.4.1.19376.1.5.3.1.4.13		SHOULD come from Airbag_Type_VS

If the Indication is True, then the airbag type shall be documented.

6.3.4.E26 Collision Object Entry

Table 6.3.4.E26-1: Collision Object Entry

Template Name	Collision Object		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.23		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The object/person or type of object/person that was hit in a collision.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	260787004 SNOMED-CT	CE	SNOMED CT Concept SHOULD use Collision_Object_VS

6.3.4.E27 Seatbelt Used Indicator Content Module

Table 6.3.4.E1-1: Mental Status Entry

Template Name	Seatbelt Used Indicator		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.24		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The indication on if a seatbelt was used by the patient		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	XXX LOINC	BL	ValueSet Yes No Unknown (YNU) urn:oid:2.16.840.1.114222.4.11.888

6.3.4.E28 Patient Transported Indicator Content Module

Table 6.3.4.28-1: Mental Status Entry

Template Name	Seatbelt Used Indicator		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.32.5.1		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The indication on if the patient was transported or not.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	XXX LOINC	BL	ValueSet Yes No Unknown (YNU) urn:oid:2.16.840.1.114222.4.11.888

6.3.4.E29 Transport Event Entry

1420 **Table 6.3.4.E11-1: Incident Event Entry**

Template Name	Incident Event				
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.32.5.2				
Parent Template	Transport 1.3.6.1.4.1.19376.1.5.3.1.1.10.4.1 [PCC TF-2: 6.3.4.34]				
General Description	An entry that defines the Transport times, Participants, participant rolls, and locations of an incident event.				
Class/Mood	**Code**		**Data Type**	**Value**	
Act/EVN	SHALL be used to indicate the mode/method of transport.		CE	SHOULD come from Transport_Method_VS	
Opt and Card	**Element**	**Description**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
R 1..1		Effective time			
	< effectiveTime>				
R 1..1	participant	Source Location	SHALL contain @typeCode="LOC"		

RE 0..1	participant/ participantRole/class		SHOULD contain @classCode="EXLOC"		
RE 0..*	participant/ participantRole/id	Location ID			
R 1..1	participant/ participantRole/code	Location Type			SHALL be selected from CodeSystem ICD10 (urn:oid:2.16.840.1.113883.6.3) OR SNOMED-CT ()
R 1..1	participant/ participantRole/addr	Location Address			
RE 0..1	participant/ participantRole/ playingEntity/	Location facility	SHOULD contain zero or one [0..1] @classCode to reflect the facility type/capability		SHALL be selected from CodeSystem HL7EntityClass (urn:oid:2.16.840.1.113883.5.41) STATIC
RE 0..1	participant/ participantRole/ playingEntity/code	Location Facility code	SHOULD contain zero or one [0..1] code to reflect the location in the facility (e.g., ICU, Cath Lab, etc.)		TBD IHE_PCC_Facility_Ward_VS
RE 0..1	participant/ participantRole/ playingEntity/name	Location Name			
R 1..1	participant	Destination Location	SHALL contain @typeCode="LOC"		
RE 0..1	participant/ participantRole/class		SHOULD contain @classCode="EXLOC"		
RE 0..*	participant/ participantRole/id	Location ID			
R 1..1	participant/ participantRole/code	Location Type			SHALL be selected from CodeSystem ICD10 (urn:oid:2.16.840.1.113883.6.3) OR SNOMED-CT ()

R 1..1	participant/ participantRole/addr	Location Address			
RE 0..1	participant/ participantRole/ playingEntity/	Location facility	SHOULD contain zero or one [0..1] @classCode to reflect the facility type/capability		SHALL be selected from CodeSystem HL7EntityClass (urn:oid:2.16.840.1.113883.5.41) STATIC
RE 0..1	participant/ participantRole/ playingEntity/code	Location Facility code	SHOULD contain zero or one [0..1] code to reflect the location in the facility (e.g., ICU, Cath Lab, etc.)		TBD IHE_PCC_Facility_Ward_VS
RE 0..1	participant/ participantRole/ playingEntity/name	Location Name			
R 1..*	participant	Performer			
O 0..1	participant/time	Performer effective time			
R 1..1	participant/ participantRole	Performer Role			
RE 0..*	participant/ participantRole/id	Performer ID			
RE 0..*	participant/ participantRole/code	Performer role			
R 1..*	participant/ participantRole/code	Performer Type			
RE 0..*	participant/ participantRole/ playingEntity	Performer Person/organization			
R 1..1	<statusCode code='completed|active|aborted|cancelled'/>				
R1..1	<priorityCode code=''/>				
RE 0..*	<entryRelationship typeCode='RSON'>	Transport Reason Code	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		SNOMED-CT
RE 0..*	<entryRelationship typeCode='RSON'>	Destination Reason	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		SNOMED-CT
RE 0..*	<entryRelationship typeCode='REFR'>	Additional Transport Descriptors	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		

6.3.4.E30 Number of Patients Transported Entry

Table 6.3.4.E30-1: Number of Patients Transported Entry

Template Name	Number of Patients Transported		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.32.5.3		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The Number of patients that are being transported in the Paramedicine vehicle.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	67547-0" Patients transported in EMS unit (LOINC)	INT	NA

1425 ### 6.3.4.E31 Activation of the Destination Facility Team Entry

Table 6.3.4.E31-1: Activation of the Destination Facility Team Entry

Template Name	Activation of the Destination Facility Team		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.32.5.4		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	Indication that an alert (or activation) was called by the Paramedicine providers to the appropriate destination healthcare facility team. The alert (or activation) should occur prior to the Paramedicine Unit arrival at the destination with the patient.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	69462-0, Activation of the destination healthcare facility team	BL	ValueSet Yes No Unknown (YNU) urn:oid:2.16.840.1.114222.4.11.888

6.3.4.E32 Dispatch Event Entry

Table 6.3.4.E32-1: Dispatch Event Entry

Template Name	Dispatch Event
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.32.5.5
Parent Template	N/A
General Description	An entry that defines the Dispatch times, Participants, participant rolls, and locations of and reasons for a dispatch event.

Class/Mood	Code	Data Type	Value
Act/EVN	SHALL be used to indicate the mode/method of transport.	CE	SHOULD come from Transport_Method_VS

Opt and Card	Element	Description	Template ID	Specification Document	Vocabulary Constraint
R.1..1	<effectiveTime>	Effective time			
R 1..1	participant	Dispatch Location	SHALL contain @typeCode="LOC"		
RE 0..1	participant/ participantRole/class		SHOULD contain @classCode="EXLOC"		
RE 0..*	participant/ participantRole/id	Location ID			
R 1..1	participant/ participantRole/code	Location Type			SHALL be selected from CodeSystem ICD10 (urn:oid:2.16.840.1.113883.6.3) OR SNOMED-CT ()
R 1..1	participant/ participantRole/addr	Location Address			
RE 0..1	participant/ participantRole/ playingEntity/	Location facility	SHOULD contain zero or one [0..1] @classCode to reflect the facility type/capability		SHALL be selected from CodeSystem HL7EntityClass (urn:oid:2.16.840.1.113883.5.41) STATIC
RE 0..1	participant/ participantRole/ playingEntity/code	Location Facility code	SHOULD contain zero or one [0..1] code to reflect the location in the facility (e.g., ICU, Cath Lab, etc.)		IHE_PCC_Facility_Wards_VS

RE 0..1	participant/ participantRole/ playingEntity/name	Location Name			
R 1..*	participant	Performer			
O 0..1	participant/time	Performer effective time			
R 1..1	participant/ participantRole	Performer Role			
RE 0..*	participant/ participantRole/id	Performer ID			
RE 0..*	participant/ participantRole/code	Performer role			Paramedicine_Provider_Roles_VS
R 1..*	participant/ participantRole/code	Performer Type			Paramedicine_Provider_Types_VS
RE 0..*	participant/ participantRole/ playingEntity	Performer Person/organization			
R 1..1	<statusCode code='completed|active|aborted|cancelled' />				
R1..1	<priorityCode code="/>				TBD
RE 0..*	<entryRelationship typeCode='RSON'>	Reason Code	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		SNOMED-CT

6.3.4.E33 Emergency medical dispatch performed Indicator Entry Content Module

Table 6.3.4.E33-1: Emergency medical dispatch performed Indicator Entry

Template Name	Emergency medical dispatch performed Indicator		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.32.5.6		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	Emergency medical dispatch performed		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	67488-7, LOINC, Emergency medical dispatch performed	BL	SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96)

6.3.4.E34 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	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13
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.E35 Acuity Assessment Observation Entry

Table 6.3.4.E5-1: Acuity Assessment Observation Entry

Template Name	Acuity Assessment Observation Entry
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.25
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13
General Description	Contains the urgency category as determined by the triage nurse/observer, whether or not this deviates from the urgency category generated by the system

Class/Mood	Code	Data Type	Value
OBS/EVN	11283-9, Acuity assessment	CE	NA

6.3.4.E36 Possible injury Entry

Table 6.3.4.E23-1: Procedure with Outcome Entry

Template Name	Procedure with Outcome		
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.31.5.26		
Parent Template	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
General Description	The indication if there is an injury involved in the incident. provides documentation to classify the incident as either injury or non-injury related.		
Class/Mood	**Code**	**Data Type**	**Value**
OBS/EVN	69467-9 Possible injury (LOINC)	CE	ValueSet Yes No Unknown (YNU) 2.16.840.1.114222.4.11.888

1440

6.3.4.E37 Glasgow Scale Organizer

Table 6.3.4.E35 -1: Glasgow Scale Organizer

Template Name		Glasgow Assessment Organizer			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.31.5.27			
Parent Template		Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13			
General Description		The Glasgow Coma Scale is a neurological scale for assessing a person's level of consciousness, both for initial as well as continuing assessment. A patient is assessed against the criteria of the scale, and the resulting points give the Glasgow Coma Score (or GCS).			
Section Code		LOINC 35088-4 “Glasgow coma scale”			
Author		May vary			
Informant		May vary			
Subject		current recordTarget			
Opt and Card	**LOINC**	**Data Element or Section Name**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
Entries					
R	9267-6	Glasgow coma score eye opening	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
R	9268-4	Glasgow coma score motor	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
R	9270-0	Glasgow coma score verbal	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
R	9269-2	Glasgow coma score total	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		
O	55285-1	Glasgow coma score special circumstances	Simple Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13		SNOMED-CT

6.4 Section not applicable

Not applicable

1445

Add to Section 6.5 Value Sets

6.5 PCC Value Sets and Concept Domains

6.5.X Paramedicine Summary of Care Concept Domains

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

Paramedicine Summary of Care	Value Set OID
HL7NullFlavor	urn:oid:2.16.840.1.113883.5.1008
Yes No Unknown (YNU)	urn:oid:2.16.840.1.114222.4.11.888

Appendices to Volume 3

Appendix A

A.1 Data Elements Table

NEMSIS Data Element	CDA Location
Last Name	ClinicalDocument/recordTarget/patientRole/patient/name
First Name	ClinicalDocument/recordTarget/patientRole/patient/name
Middle Initial/Name	ClinicalDocument/recordTarget/patientRole/patient/name
Patient's Home Address	ClinicalDocument/recordTarget/patientRole/addr
Patient's Home City	ClinicalDocument/recordTarget/patientRole/addr
Patient's Home Country	ClinicalDocument/recordTarget/patientRole/addr
Patient's Home State	ClinicalDocument/recordTarget/patientRole/addr
Patient's Home ZIP Code	ClinicalDocument/recordTarget/patientRole/addr
Patient's Country of Residence	ClinicalDocument/recordTarget/patientRole/addr
Patient Id	ClinicalDocument/recordTarget/patientRole/id
Gender	ClinicalDocument/recordTarget/patientRole/patient/administrativeGenderCode
Race	ClinicalDocument/recordTarget/patientRole/race
Date of Birth	ClinicalDocument/recordTarget/patientRole/patient/birthTime
Patient's Phone Number	ClinicalDocument/recordTarget/patientRole/telecom
Patient's Email Address	ClinicalDocument/recordTarget/patientRole/telecom
State Issuing Driver's License	ClinicalDocument/recordTarget/patientRole/id
Driver's License Number	ClinicalDocument/recordTarget/patientRole/id

NEMSIS Data Element	CDA Location
Primary Method of Payment	ClinicalDocument/component/structuredBody/component/Payer
Insurance Company ID	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/organization/id
Insurance Company Name	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/organization/name
Insurance Company Address	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/addr
Insurance Company City	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/addr
Insurance Company State	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/addr
Insurance Company ZIP Code	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/addr
Insurance Company Country	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/addr
Insurance Group ID	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/organization/id
Insurance Policy ID Number	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/organization/id
Last Name of the Insured	ClinicalDocument/component/structuredBody/component/Payer/beneficiary/name
First Name of the Insured	ClinicalDocument/component/structuredBody/component/Payer/beneficiary/name
Middle Initial/Name of the Insured	ClinicalDocument/component/structuredBody/component/Payer/beneficiary/name
Relationship to the Insured	ClinicalDocument/component/structuredBody/component/Payer
Insurance Group Name	ClinicalDocument/component/structuredBody/component/Payer
Date of Birth of the Insured	ClinicalDocument/component/structuredBody/component/Payer/beneficiary/birthTime
Closest Relative/Guardian Last Name	ClinicalDocument/participant/associatedEntity[Pt Contact]/name
Closest Relative/ Guardian First Name	ClinicalDocument/participant/associatedEntity[Pt Contact]/name
Closest Relative/ Guardian Middle Initial/Name	ClinicalDocument/participant/associatedEntity[Pt Contact]/name

NEMSIS Data Element	CDA Location
Closest Relative/ Guardian Street Address	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr
Closest Relative/ Guardian City	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr
Closest Relative/ Guardian State	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr
Closest Relative/ Guardian ZIP Code	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr
Closest Relative/ Guardian Country	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr
Closest Relative/ Guardian Phone Number	ClinicalDocument/participant/associatedEntity[Pt Contact]/telecom
Closest Relative/ Guardian Relationship	ClinicalDocument/participant/associatedEntity[Pt Contact]/telecom
Patient's Employer	ClinicalDocument/participant/associatedEntity[Pt Contact]/name
Patient's Employer's Address	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr
Patient's Employer's City	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr
Patient's Employer's State	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr
Patient's Employer's ZIP Code	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr
Patient's Employer's Country	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr
Patient's Employer's Primary Phone Number	ClinicalDocument/participant/associatedEntity[Pt Contact]/telecom
Last Name of Patient's Practitioner	ClinicalDocument/participant/associatedEntity/associatedPerson [Pt General Practitioner Name]
First Name of Patient's Practitioner	ClinicalDocument/participant/associatedEntity/associatedPerson [Pt General Practitioner Name]
Middle Initial/Name of Patient's Practitioner	ClinicalDocument/participant/associatedEntity/associatedPerson [Pt General Practitioner Name]
Advance Directives	ClinicalDocument/component/structuredBody/component/AdvanceDiretives
Medication Allergies	ClinicalDocument/component/structuredBody/component/AllergiesandIntolerances
Environmental/Food Allergies	ClinicalDocument/component/structuredBody/component/AllergiesandIntolerances

NEMSIS Data Element	CDA Location
Medical/Surgical History	ClinicalDocument/component/structuredBody/component/HistoryOfProcedures
The Patient's Type of Immunization	ClinicalDocument/component/structuredBody/component/Immunization/entry/immunization/code
Immunization Year	ClinicalDocument/component/structuredBody/component/Immunization/entry/immunization/effectiveTime
Current Medications	ClinicalDocument/component/structuredBody/component/medications
Current Medication Dose	ClinicalDocument/component/structuredBody/component/medications/dose
Current Medication Dosage Unit	ClinicalDocument/component/structuredBody/component/medications/dose/doseUnits
Current Medication Administration Route	ClinicalDocument/component/structuredBody/component/medication/medicationAdministration/Administration route
Current Medication Frequency	ClinicalDocument/component/structuredBody/component/medication/medicationAdministration/frequency
Presence of Emergency Information Form	N/A
Alcohol/Drug Use Indicators	ClinicalDocument/component/structuredBody/component/ReviewOfSystems/entry/substanceUseIndicator
Last Oral Intake	ClinicalDocument/component/structuredBody/component/ReviewOfSystems/entry/LastOralIntake
Pregnancy	ClinicalDocument/component/structuredBody/component/PregnancyHistory/entry/PregnancyStatus
Date/Time Vital Signs Taken	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/effectiveTime
Cardiac Rhythm / Electrocardiography (ECG)	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
ECG Type	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/particiapnt/device/type
Method of ECG Interpretation	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method
SBP (Systolic Blood Pressure)	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
DBP (Diastolic Blood Pressure)	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Method of Blood Pressure Measurement	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method
Mean Arterial Pressure	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Heart Rate	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code

NEMSIS Data Element	CDA Location
Method of Heart Rate Measurement	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method
Pulse Oximetry	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Pulse Rhythm	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Respiratory Rate	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Respiratory Effort	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
End Title Carbon Dioxide (ETCO2)	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Carbon Monoxide (CO)	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Blood Glucose Level	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Glasgow Coma Score-Eye	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/GlasgowComaScore/GlasgowComaScore-eye
Glasgow Coma Score-Verbal	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/GlasgowComaScore/GlasgowComaScore-verbal
Glasgow Coma Score-Motor	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/GlasgowComaScore/GlasgowComaScore-motor
Glasgow Coma Score-Qualifier	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/GlasgowComaScore/GlasgowComaScore-qualifyer
Total Glasgow Coma Score	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code/value ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/GlasgowComaScore/value
Temperature	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Temperature Method	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method
Level of Responsiveness (AVPU)	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code

NEMSIS Data Element	CDA Location
Pain Scale Score	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/PainScaleScore
Pain Scale Type	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/method
Stroke Scale Score	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/StrokeScaleScore
Stroke Scale Type	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/method
Reperfusion Checklist	N/A
APGAR	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Revised Trauma Score	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Date/Time of Laboratory or Imaging Result	ClinicalDocument/component/structuredBody/component/CodedResults/entry/effectiveDateTime
Laboratory Result Type	ClinicalDocument/component/structuredBody/component/CodedResults/entry/code
Laboratory Result	ClinicalDocument/component/structuredBody/component/CodedResults/entry/value
Imaging Study Type	ClinicalDocument/component/structuredBody/component/CodedResults/entry/code
Imaging Study Results	ClinicalDocument/component/structuredBody/component/CodedResults/entry/value
Imaging Study File or Waveform Graphic Type	ClinicalDocument/component/structuredBody/component/CodedResults/entry/code
Imaging Study File or Waveform Graphic	ClinicalDocument/component/structuredBody/component/CodedResults/entry/value
Estimated Body Weight in Kilograms	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Length Based Tape Measure	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Date/Time of Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/effectiveTime
Skin Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Head Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value

NEMSIS Data Element	CDA Location
Face Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Neck Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Heart Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Abdominal Assessment Finding Location	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Abdomen Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Pelvis/Genitourinary Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Back and Spine Assessment Finding Location	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Back and Spine Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Extremity Assessment Finding Location	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Extremities Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Eye Assessment Finding Location	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Eye Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Mental Status Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Neurological Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Lung Assessment Finding Location	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Lung Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Chest Assessment Finding Location	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Chest Assessment	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Stroke/CVA Symptoms Resolved	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Date/Time Procedure Performed	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/ Paramedicine Treatment/Procedure/effectiveTime
Procedure	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/ Paramedicine Treatment/Procedure
Destination/Transferred To, Name	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/code
Destination Street Address	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/line

NEMSIS Data Element	CDA Location
Destination City	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/city
Destination State	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/state
Destination County	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/district
Destination ZIP Code	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/postalCode
Destination Country	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/Country
Dispatch Reason	ClinicalDocument/component/structuredBody/component/ParamedicineDispatch/reason
Dispatch Priority	ClinicalDocument/component/structuredBody/component/ParamedicineDispatch/prirority
Transport Priority	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/priority
Consents	ClinicalDocument/component/structuredBody/component/Authorizations
Consent Document Type	ClinicalDocument/component/structuredBody/component/Authorizations/code
Consents Signature	ClinicalDocument/component/structuredBody/component/Authorizations/ Digital Signature/Consent Signature
Consents Signature Date Time	ClinicalDocument/component/structuredBody/component/Authorizations/effectiveTime
Patient Age	ClinicalDocument/component/struct uredBody/component/ReviewOfSystems/estimated age

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 Summary of Care Summary PSC

4.I.2.1 PSC US Volume 3 Constraints

4.I.2.1.1 PSC US Volume 3 Attribute Constraints

The following attribute cardinality 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]

4.I.2.1.2 PS 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 Summary (PSC) Document Content Module Specification

Table 4.I.2.1.2-1: PSC 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	

4.1.2.1.2.1 Reason for Visit Section Constraints US Realm

The Coded Reason For Visit <text> SHALL be informed by NEMSIS eSituation.19 Justification for Transfer/Encounter and eSituation.20 Reason for Interfacility Transfer/Medical Transport

The Coded Reason For Visit SHALL have a Possible Injury entry [2.16.840.1.113883.17.3.10.1.64] that SHALL be informed by eSituation.02 Possible Injury observation.

4.1.2.1.2.2 Detailed Chief Complaint Constraints US Realm

The Chief Complaint entry, Simple observation 1.3.6.1.4.1.19376.1.5.3.1.4.13, SHALL be used to document the following entries:

- SHALL include Time Duration of the Healthcare Complaint (LOINC 67491-1) where <value xsi:type='Qn' …/>; The value code SHALL come from ucum.
- The Chief Complaint entry SHALL include Chief Complaint Location (LOINC 71588-8) where value SHALL be from code system SNOMED-CT; the value SHALL be drawn from the ChiefComplaint_Anatomic_Location_VS;
- The Chief Complaint entry SHALL include Chief Complaint Organ System (LOINC 69468-7) where value SHALL be from code system SNOMED-CT; the value SHALL be drawn from the ChiefComplaint_Organ_System_VS.

See open issue.

4.1.2.1.2.3 Active Problems Section Constraints US Realm

The Active Problems section SHALL have a Problem Concern Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 used to document the following attributes:

- Additional complaints that the patient has
  - The entry SHALL have a code of <code code='409586006' displayName='Complaint' codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'>
  - The <effectiveTime><low value=' ' > SHALL be used to indicate the time of the onset of the complaint being documented.
  - The entry <value> SHALL be an un-coded string. The entry value SHALL be informed by the NEMSIS eSituation.04 – Complaint element, where the complaint type does not = Chief complaint

The Active Problems Sections SHALL have a Problem with Symptoms Entry 1.3.6.1.4.1.19376.1.5.3.1.1.31.5.1 to document the following attributes:

- Provider Primary Impressions

- The entry SHALL Have a code of <code code='55607006' displayName='Problem' codeSystem='2.16.840.1.113883.6.96' codeSystemName='SNOMED CT'>
- The <effectiveTime><low value=' ' > SHALL be used to indicate the time of the onset of the problem being documented. This SHALL be informed by NEMSIS eSituation.01 - Date/Time of Symptom Onset
- The entry <value> SHALL be coded using ICD-10 CM. The entry value SHALL be informed by the NEMSIS sSituation.11 – Provider's primary Impression or eSituation.12 – Provider's Secondary impression.
- The Symptoms of this problem SHALL be documented in an <entryRelationship typeCode='REFR' inversionInd='false'> to link to additional problem entries. This SHALL be informed by NEMSIS eSituation.09 - Primary Symptom and eSituation.10 - Other Associated Symptoms.

4.1.2.1.2.4 Acuity Assessment Section Constraints US Realm

This section SHALL be used to document the Patient Condition at Destination observation (LOINC 77941-3). This SHALL be informed by NEMSIS eDisposition.19 element.

This section SHALL be used to document the Initial Patient Acuity (LOINC 67493-7). This SHALL be informed by NEMSIS eDisposition.13 element.

The LOINC 75616-3 Generic five level triage system SHALL be used to document eScene.08 Triage Classification for Mass Casualty Incident Patients.

4.1.2.1.2.5 Coded Detail Physical Examination Section Constraints US Realm

The Physical Examination Assessment value SHALL come from the associated value set.

Table 4.1.2.1.2.5-1: PSC Value Set Binding for Physical Exams US Realm

LOINC	Entry Name	Value Set
8709-8	Physical findings of Skin	Paramedicine_Physical_Findings_of_Skin_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.3
8701-5	Physical findings of Head	Paramedicine_Physical_Findings_of_Head_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.4
32432-7	Physical findings of Face	Paramedicine_Physical_Findings_of_Face_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.6
11442-1	Physical findings of Neck	Paramedicine_Physical_Findings_of_Neck_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.7
8702-3	Physical findings of Heart	Paramedicine_Physical_Findings_of_Heart_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.10
8694-2	Physical findings of Abdomen	Paramedicine_Physical_Findings_of_Abdomen_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.12

LOINC	Entry Name	Value Set
67531-4	Physical findings of Pelvis+Genitourinary	Paramedicine_Physical_Findings_of_Pelvis_and_Genitourinary_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.13
67532-2	Physical findings of Back and Spine	Paramedicine_Physical_Findings_of_Back_and_Spine_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.16
8703-1	Physical findings of Extremities	Paramedicine_Physical_Findings_of_Extremities_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.19
8699-1	Physical findings of Eye	Paramedicine_Physical_Findings_of_Eye_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.20
8705-6	Physical findings of Nervous system	Paramedicine_Physical_Findings_of_Nervous_System_VS 1.3.6.1.4.1.19376.1.5.3.1.1.31.7.5
75275-8	Mental Status Organizer	2.16.840.1.113883.17.3.11.84

The following target site code value sets are required:

Table 4.1.2.1.2.5-2: PSC Value Set Binding for Physical Exams target Site Location US Realm

LOINC	Value Set	Value Set OID
Abdomen Physical Findings Target Site	Abdomen_Physical_Findings_Target_Site_VS	1.3.6.1.4.1.19376.1.5.3.1.1.31.7.22
Back and Spine Physical Findings Target Site	Back_and_Spine_Physical_Findings_Target_Site_VS	1.3.6.1.4.1.19376.1.5.3.1.1.31.7.23
Extremities Physical Findings Target Site	Extremities_Physical_Findings_Target_Site_VS	1.3.6.1.4.1.19376.1.5.3.1.1.31.7.24
Eye Physical Findings Target Site	Eye_Physical_Findings_Target_Site_VS	1.3.6.1.4.1.19376.1.5.3.1.1.31.7.25
Chest Physical Findings Target Site	Chest_Physical_Findings_Target_Site_VS	1.3.6.1.4.1.19376.1.5.3.1.1.31.7.26

4.1.2.1.2.6 Coded Vital Signs Section Constraints US Realm

This Vital Signs Organizer SHALL Have an <effectiveTime value=' '/> informed by NEMSIS eVitals.01 - Date/Time Vital Signs Taken element.

The <assignedEntity1> SHOULD document the provider taking the vital signs in the organizer.

The Vital Signs organizer MAY include an HL7 EMS Run report Prior Aid Vitals [2.16.840.1.1133883.17.3.10.1.29] entry, informed by NEMSIS eVitals.02 - Obtained Prior to this Unit's EMS Care element. See Open Issue.

The Vital Signs organizer SHALL Contain entries for the following observations:

- cardiac Rhythm:
- ECG type;
- method of ECG interpretation;
- blood pressure panel:
  - systolic;
- heart rate;
- respiratory rate;
- glucose;
- ETC02P;
- pulse Ox;
- Glasgow score;
- pain scale;
- stroke scale;
- AVPU.

The following elements are required, if known:

- diastolic blood pressure;
- method of blood pressure measurement;
- CO;
- total Glasgow coma score;
- temperature;
- pain scale type.

The following elements are optional:

- mean arterial pressure;
- method of heart rate measurement;
- pulse rhythm;
- respiratory effort;
- temperature method;
- APGAR scores;
- revised trauma score;

- body weight.

4.1.2.1.2.7 Pregnancy History Section Constraints US Realm

The Pregnancy History Pregnancy Status entry SHALL be informed by NEMSIS eHistory.18. If this element contains the following codes - 3118005, 3118007, 3118009, or 3118011, then the status is YES. If the NEMSIS code is 3118001, then the status is NO. If the NEMSIS code is 3118003 is documented, then the status SHALL be UNK.

See open issues. Until open issue is resolved, implementors SHALL document both Pregnancy Status and Estimated Gestational Age in the Pregnancy History.

The Pregnancy History section SHALL have a Estimated Gestational Age Stated (LOINC 11884-4). If NEMSIS code 3118005 is present, then the value Quantity SHALL be represented as a quantity range WHERE range.low = 12 [weeks] and range.high = 20 [weeks]

If NEMSIS code 3118007 is present, then the value Quantity SHALL be represented as a quantity range WHERE range.low = 20 [weeks] and range.high = 36 [weeks]

If NEMSIS code 3118009 is present, then the value Quantity SHALL be represented as a quantity range WHERE range.low = 0 [weeks] and range.high = 12 [weeks]

4.1.2.1.2.8 Paramedicine Treatment Section Constraints US Realm

The Barriers to Care Observations SHALL be documented with value codeable concept from Barrier_To_Care_VS.

4.1.2.1.2.9 Paramedicine Incident Section Constraints US Realm

The work related injury Indicator SHALL be informed by NEMSIS eSituation.14 - Work-Related Illness/Injury

The Number of affected people SHALL be documented as a quantity. It SHALL be informed by the NEMSIS eScene.06 - Number of Patients at Scene element. If NEMSIS code 2707003 is documented then the Quantity shall equal 0, If NEMSIS code 2707005 is documented then Quantity SHALL equal 1, and if NEMSIS code 2707001 is documented then the Quantity Shall have a comparator code of > with a quantity of 1.

The Mass Casualty Incident Indicator SHALL be documented and informed by NEMSIS eScene.07 - Mass Casualty Incident.

4.1.2.1.2.10 Detailed Injury Incident Description Section Constraints US Realm

The Cause of Injury SHALL be documented using ICD-10-CM and SHALL be informed by NEMSIS eInjury.01 - Cause of Injury.

The Safety Equipment Used value SHALL come from the Safety_Equipment_VS. This observation SHALL be informed by NEMSIS eInjury.07 - Use of Occupant Safety Equipment element.

The Airbag use indicator SHALL be true if the following NEMSIS Codes are documented: 2908001, 2908003, or 2908005.

The Indicator SHALL be false if the following NEMSIS codes are documented: 2908007 or 2908009

The Airbag Type SHALL be documented with codes from the Airbag_Type_VS. this observation SHALL be informed by the NEMSIS eInjury.08 - Airbag Deployment element.

4.I.2.2 PSC US Volume 3 Entry Constraints

4.I.2.3 PSC US Volume 3 Header Constraints

This section documents the header constraints of this profile in relation to US Core and NEMSIS Requirements.

4.I.2.3.1 ClinicalDocument/[CDA Header]/custodian/assignedCustodian/representedCustodianOrganization/id…

In the NEMSIS Data Set, dAgency.01, dAgency.02, and dAgency.03 are Mandatory 1..1 fields used to document agency information. In US Core the organization IDs are RE 0..*. The NEMSIS Data Set indicates that more than one ID may be associated with an Agency ID or Number indicating that the data elements should be 0..*

For all PSC documents generated in the US Realm Content Creators **SHALL** have one or more **[1..*]** custodian/assignedCustodian/representedCustodianOrganization/id = "..." where one providerOrganization/id/codeSystem = "2.16.840.1.113883.4.6" codeSystemName="National Provider Identifier (NPI)".

The dAgency.01 **SHOULD** document the National Provider ID (NPI) for the Paramedicine Agency. The US CORE standards indicate that an organization **SHOULD** have zero or more **[0..*]** NPI numbers.

The dAgency.02 **MAY** document an additional NPI number [id/type = NPI] OR a State License [id/type = SL] OR Provider Number [id/type = PRN], etc.

The id/type **SHALL** be documented and **SHOULD** be documented using the codes defined in the HL7 v2.0203 Value Set

4.I.2.4 PSC 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: PSC 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
CD_ParamedicineProviderTypes		
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	MedicationAdministrationRoute	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

Appendices to Volume 4

Appendix A – NEMSIS Data Elements

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

NEMSIS Data Element	NEMSIS v3.5.0	CDA Location
Last Name	ePatient.02	ClinicalDocument/recordTarget/patientRole/patient/name/family
First Name	ePatient.03	ClinicalDocument/recordTarget/patientRole/patient/name/given
Middle Initial/Name	ePatient.04	ClinicalDocument/recordTarget/patientRole/patient/name/given
Patient's Home Address	ePatient.05	ClinicalDocument/recordTarget/patientRole/addr/line
Patient's Home City	ePatient.06	ClinicalDocument/recordTarget/patientRole/addr/city
Patient's Home Country	ePatient.07	ClinicalDocument/recordTarget/patientRole/addr/country
Patient's Home State	ePatient.08	ClinicalDocument/recordTarget/patientRole/addr/state
Patient's Home ZIP Code	ePatient.09	ClinicalDocument/recordTarget/patientRole/addr/postalCode
Patient's Country of Residence	ePatient.10	ClinicalDocument/recordTarget/patientRole/addr/country
Patient Home Census Tract	ePatient.11	n/a
Social Security Number	ePatient.12	ClinicalDocument/recordTarget/patientRole/identifier
Gender	ePatient.13	ClinicalDocument/recordTarget/patientRole/patient/administrativeGenderCode
Race	ePatient.14	ClinicalDocument/recordTarget/patientRole/race
Age	ePatient.15	ClinicalDocument/component/structuredBody/component/ReviewOfSystems/estimatedAge
Age Units	ePatient.16	ClinicalDocument/component/structuredBody/component/ReviewOfSystems/estimatedAge
Date of Birth	ePatient.17	ClinicalDocument/recordTarget/patientRole/patient/birthTime
Patient's Phone Number	ePatient.18	ClinicalDocument/recordTarget/patientRole/telecom
Patient's Email Address	ePatient.19	ClinicalDocument/recordTarget/patientRole/telecom

NEMSIS Data Element	NEMSIS v3.5.0	CDA Location
State Issuing Driver's License	ePatient.20	ClinicalDocument/recordTarget/patientRole/id/assigningAuthority
Driver's License Number	ePatient.21	ClinicalDocument/recordTarget/patientRole/id
Alternate Home Residence	ePatient.22	n/a
Primary Method of Payment	ePayment.01	ClinicalDocument/component/structuredBody/component/Payer/playingEntity
Physician Certification Statement	ePayment.02	ClinicalDocument/component/Authorizations
Date Physician Certification Statement Signed	ePayment.03	ClinicalDocument/component/Authorizations/digital signature/dateTime
Reason for Physician Certification Statement	ePayment.04	ClinicalDocument/component/Authorizations/reason
Healthcare Provider Type Signing Physician Certification Statement	ePayment.05	ClinicalDocument/component/Authorizations/digital signature/author/providerRole
Last Name of Individual Signing Physician Certification Statement	ePayment.06	ClinicalDocument/component/Authorizations/digital signature/author/name/family
First Name of Individual Signing Physician Certification Statement	ePayment.07	ClinicalDocument/component/Authorizations/digital signature/author/name/given
Insurance Company ID	ePayment.09	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/organization/id
Insurance Company Name	ePayment.10	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/organization/name

NEMSIS Data Element	NEMSIS v3.5.0	CDA Location
Insurance Company Billing Priority	ePayment.11	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/addr
Insurance Company Address	ePayment.12	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/addr
Insurance Company City	ePayment.13	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/addr
Insurance Company State	ePayment.14	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/addr
Insurance Company ZIP Code	ePayment.15	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/addr
Insurance Company Country	ePayment.16	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/organization/id
Insurance Group ID	ePayment.17	ClinicalDocument/component/structuredBody/component/Payer/playingEntity/organization/id
Insurance Policy ID Number	ePayment.18	ClinicalDocument/component/structuredBody/component/Payer/beneficiary/name
Last Name of the Insured	ePayment.19	ClinicalDocument/component/structuredBody/component/Payer/beneficiary/name/family
First Name of the Insured	ePayment.20	ClinicalDocument/component/structuredBody/component/Payer/beneficiary/name/given
Middle Initial/Name of the Insured	ePayment.21	ClinicalDocument/component/structuredBody/component/Payer/beneficiary/name/given
Relationship to the Insured	ePayment.22	ClinicalDocument/component/structuredBody/component/Payer beneficiary/relationship
Insurance Group Name	ePayment.58	n/a
Date of Birth of the Insured	ePayment.59	ClinicalDocument/component/structuredBody/component/Payer/beneficiary/birthTime
Closest Relative/Guardian Last Name	ePayment.23	ClinicalDocument/participant/associatedEntity[Pt Contact]/name/family
Closest Relative/ Guardian First Name	ePayment.24	ClinicalDocument/participant/associatedEntity[Pt Contact]/name/given

NEMSIS Data Element	NEMSIS v3.5.0	CDA Location
Closest Relative/ Guardian Middle Initial/Name	ePayment.25	ClinicalDocument/participant/associatedEntity[Pt Contact]/name/given
Closest Relative/ Guardian Street Address	ePayment.26	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr/line
Closest Relative/ Guardian City	ePayment.27	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr/city
Closest Relative/ Guardian State	ePayment.28	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr/state
Closest Relative/ Guardian ZIP Code	ePayment.29	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr/postalCode
Closest Relative/ Guardian Country	ePayment.30	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr/country
Closest Relative/ Guardian Phone Number	ePayment.31	ClinicalDocument/participant/associatedEntity[Pt Contact]/telecom
Closest Relative/ Guardian Relationship	ePayment.32	ClinicalDocument/participant/associatedEntity[Pt Contact]/telecom
Patient's Employer	ePayment.33	ClinicalDocument/participant/associatedEntity[Pt Contact]/name
Patient's Employer's Address	ePayment.34	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr/line
Patient's Employer's City	ePayment.35	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr/city
Patient's Employer's State	ePayment.36	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr/state
Patient's Employer's ZIP Code	ePayment.37	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr/postalCode

NEMSIS Data Element	NEMSIS v3.5.0	CDA Location
Patient's Employer's Country	ePayment.38	ClinicalDocument/participant/associatedEntity[Pt Contact]/addr/country
Patient's Employer's Primary Phone Number	ePayment.39	ClinicalDocument/participant/associatedEntity[Pt Contact]/telecom
Last Name of Patient's Practitioner	eHistory.02	ClinicalDocument/participant/associatedEntity/associatedPerson [Pt General Practitioner Name]
First Name of Patient's Practitioner	eHistory.03	ClinicalDocument/participant/associatedEntity/associatedPerson [Pt General Practitioner Name]
Middle Initial/Name of Patient's Practitioner	eHistory.04	ClinicalDocument/participant/associatedEntity/associatedPerson [Pt General Practitioner Name]
Advance Directives	eHistory.05	ClinicalDocument/component/structuredBody/component/AdvanceDiretives
Medication Allergies	eHistory.06	ClinicalDocument/component/structuredBody/component/AllergiesandIntolerances
Environmental/ Food Allergies	eHistory.07	ClinicalDocument/component/structuredBody/component/AllergiesandIntolerances
Medical/Surgical History	eHistory.08	ClinicalDocument/component/structuredBody/component/HistoryOfProcedures
The Patient's Type of Immunization	eHistory.10	ClinicalDocument/component/structuredBody/component/Immunization/entry/immunization/code
Immunization Year	eHistory.11	ClinicalDocument/component/structuredBody/component/Immunization/entry/immunization/effectiveTime
Current Medications	eHistory.12	ClinicalDocument/component/structuredBody/component/medications
Current Medication Dose	eHistory.13	ClinicalDocument/component/structuredBody/component/medications/dose
Current Medication Dosage Unit	eHistory.14	ClinicalDocument/component/structuredBody/component/medications/dose/doseUnits
Current Medication Administration Route	eHistory.15	ClinicalDocument/component/structuredBody/component/medication/medicationAdministration/Administration route

NEMSIS Data Element	NEMSIS v3.5.0	CDA Location
Current Medication Frequency	eHistory.20	ClinicalDocument/component/structuredBody/component/medication/medicationAdministration/frequency
Presence of Emergency Information Form	eHistory.16	N/A
Alcohol/Drug Use Indicators	eHistory.17	ClinicalDocument/component/structuredBody/component/ReviewOfSystems/entry/substanceUseIndicator
Last Oral Intake	eHistory.19	ClinicalDocument/component/structuredBody/component/ReviewOfSystems/entry/LastOralIntake
Pregnancy	eHistory.18	ClinicalDocument/component/structuredBody/component/PregnancyHistory/entry/PregnancyStatus
Date/Time Vital Signs Taken	eVitals.01	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/effectiveTime
Cardiac Rhythm / Electrocardiography (ECG)	eVitals.03	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
ECG Type	eVitals.04	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/particiapnt/device/type
Method of ECG Interpretation	eVitals.05	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method
SBP (Systolic Blood Pressure)	eVitals.06	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
DBP (Diastolic Blood Pressure)	eVitals.07	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Method of Blood Pressure Measurement	eVitals.08	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method
Mean Arterial Pressure	eVitals.09	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Heart Rate	eVitals.10	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Method of Heart Rate Measurement	eVitals.11	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method
Pulse Oximetry	eVitals.12	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code

NEMSIS Data Element	NEMSIS v3.5.0	CDA Location
Pulse Rhythm	eVitals.13	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Respiratory Rate	eVitals.14	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Respiratory Effort	eVitals.15	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
End Title Carbon Dioxide (ETCO2)	eVitals.16	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Carbon Monoxide (CO)	eVitals.17	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Blood Glucose Level	eVitals.18	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Glasgow Coma Score-Eye	eVitals.19	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/GlasgowComaScore/GlasgowComaScore-eye
Glasgow Coma Score-Verbal	eVitals.20	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/GlasgowComaScore/GlasgowComaScore-verbal
Glasgow Coma Score-Motor	eVitals.21	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/GlasgowComaScore/GlasgowComaScore-motor
Glasgow Coma Score-Qualifier	eVitals.22	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/GlasgowComaScore/GlasgowComaScore-qualifyer
Total Glasgow Coma Score	eVitals.23	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code/value ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/GlasgowComaScore/value
Temperature	eVitals.24	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Temperature Method	eVitals.25	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method
Level of Responsiveness (AVPU)	eVitals.26	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code

NEMSIS Data Element	NEMSIS v3.5.0	CDA Location
Pain Scale Score	eVitals.27	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/PainScaleScore
Pain Scale Type	eVitals.28	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/method
Stroke Scale Score	eVitals.29	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/StrokeScaleScore
Stroke Scale Type	eVitals.30	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/method ClinicalDocument/component/structuredBody/component/Assessments/entry/assessment/method
Reperfusion Checklist	eVitals.31	N/A
APGAR	eVitals.32	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Revised Trauma Score	eVitals.33	ClinicalDocument/component/structuredBody/component/CodedVitalSigns/entry/vitalsign/code
Date/Time of Laboratory or Imaging Result	eLabs.01	ClinicalDocument/component/structuredBody/component/CodedResults/entry/effectiveDateTime
Study/Result Prior to this Unit's EMS Care	eLabs.02	ClinicalDocument/component/structuredBody/component/CodedResults/entry/code
Laboratory Result Type	eLabs.03	ClinicalDocument/component/structuredBody/component/CodedResults/entry/value
Laboratory Result	eLabs.04	ClinicalDocument/component/structuredBody/component/CodedResults/entry/code
Imaging Study Type	eLabs.05	ClinicalDocument/component/structuredBody/component/CodedResults/entry/value
Imaging Study Results	eLabs.06	ClinicalDocument/component/structuredBody/component/CodedResults/entry/code
Imaging Study File or Waveform Graphic Type	eLabs.07	ClinicalDocument/component/structuredBody/component/CodedResults/entry/value

NEMSIS Data Element	NEMSIS v3.5.0	CDA Location
Imaging Study File or Waveform Graphic	eLabs.08	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Estimated Body Weight in Kilograms	eExam.01	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Length Based Tape Measure	eExam.02	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/effectiveTime
Date/Time of Assessment	eExam.03	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Skin Assessment	eExam.04	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Head Assessment	eExam.05	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Face Assessment	eExam.06	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Neck Assessment	eExam.07	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Heart Assessment	eExam.09	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Abdominal Assessment Finding Location	eExam.10	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Abdomen Assessment	eExam.11	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Pelvis/Genitourinary Assessment	eExam.12	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Back and Spine Assessment Finding Location	eExam.13	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Back and Spine Assessment	eExam.14	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Extremity Assessment Finding Location	eExam.15	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value

NEMSIS Data Element	NEMSIS v3.5.0	CDA Location
Extremities Assessment	eExam.16	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Eye Assessment Finding Location	eExam.17	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Eye Assessment	eExam.18	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Mental Status Assessment	eExam.19	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Neurological Assessment	eExam.20	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Lung Assessment Finding Location	eExam.22	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Lung Assessment	eExam.23	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/targetSite
Chest Assessment Finding Location	eExam.24	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Chest Assessment	eExam.25	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/value
Stroke/CVA Symptoms Resolved	eExam.21	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/ Paramedicine Treatment/Procedure/effectiveTime
Date/Time Procedure Performed	eProcedures.01	ClinicalDocument/component/structuredBody/component/PhysicalExams/entry/ Paramedicine Treatment/Procedure
Procedure Performed Prior to this Unit's EMS Care	eProcedures.02	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/code
Procedure	eProcedures.03	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/line
Destination/Transferred To, Name	eDisposition.01	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/city
Destination Street Address	eDisposition.03	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/state

NEMSIS Data Element	NEMSIS v3.5.0	CDA Location
Destination City	eDisposition.04	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/district
Destination State	eDisposition.05	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/postalCode
Destination County	eDisposition.06	ClinicalDocument/component/structuredBody/component/Transport/Transportation/ Transport Event Entry/ participant/ participantRole/playingEntity/addr/Country
Destination ZIP Code	eDisposition.07	ClinicalDocument/component/structuredBody/component/ParamedicineDispatch/reason
Destination Country	eDisposition.08	ClinicalDocument/component/structuredBody/component/ParamedicineDispatch/priority

