Integrating the Healthcare Enterprise

IHE Technical Frameworks
General Introduction

Appendix D:
Glossary

Revision 2.0

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IHE Glossary

The following pages contain IHE Glossary terms from Final Text and Trial Implementation IHE Profiles. New terms from Public Comment Profiles are added once the profile is published for Trial Implementation.

Term	Definition
ACC NM Image Display	A display format for myocardial studies approved by the American College of Cardiology and the Society of Nuclear Medicine, as detailed in RAD TF-1: E5.3.3 and RAD TF-2: 4.16.4.2.2.
Access Decision Manager	A complex system that is responsible for access/creation/disclosure decisions performed according to Domain Policies, Consent Documents, etc. This actor can implement additional functionalities typical of a PDP (Policy Decision Point), PAP (Policy Administration Point) and a PIP (Policy Information Point).
Accession Number	The unique identifier assigned by the LIS of an Anatomic Pathology laboratory to an imaging Study. As expressed in DICOM Supplement 122: The concept of "accession" in Anatomic Pathology has been determined to be sufficiently equivalent to an "accession" in Radiology so that the existing Accession Number at the Study level may be reused for the same purpose and with essentially the existing definition. For Anatomic Pathology, like in Radiology, the Accession Number may correspond to the Order Filler Number, as specified in HL7 v2.x.
Accession Number	A user-friendly identifier, which identifies an instance of a filler order or imaging service request. It may group one or more requested procedures.
Accountability	The property that ensures that the actions of the entity may be traced uniquely to the entity.
Accountable Care Organization	Health care entity which supports an organization of health care providers that agrees to be accountable for improving the health and experience of care for individuals and improving the health of populations while reducing the rate of growth in health care spending.
ACO	See Accountable Care Organization.
ACR	American College of Radiology. See http://www.acr.org/.
Activity	A specific instance of an activity definition created in, and available from, an activity processor.
Activity	A specific instance of an activity created in, and available from, a task processor.
Activity Definition	A designed task which is deployable to a runtime activity processor, typically as part of a process definition.
Activity Definition	A definition of an individual task activity which is deployable to a runtime task processor. Typically an activity is defined as part of a process but standalone activities may also be defined.

Term	Definition
Actor	An entity within a use case diagram that can perform an action within a use case diagram. Possible actions are creation or consumption of a message
Actor	Information systems or components of information systems that produce, manage, or act on health information. Actors exchange information through standards-based transactions.
Actor	An actor in the Unified Modeling Language (UML) "specifies a role played by a user or any other system that interacts with the subject." "An Actor models a type of role played by an entity that interacts with the subject (e.g., by exchanging signals and data), but which is external to the subject."
Acuity Assessment	Also known as triage category, this is the acuity of the patient assigned during the process of ED triage. A number of evidenced based triage scales exist, including *Emergency Severity Index (ESI)* , *Canadian Triage and Acuity Scale (CTAS)* , the *Australian Triage Scale (ATS)* , and the *Manchester Triage System* . In many emergency departments, patients may simply be classified as *emergent, urgent, or non-urgent* .
Acute Care	Inpatient care designed to treat or cure a disease or injury that has a rapid onset and follows a short course or requires immediate attention in a hospital.
ADC	Apparent Diffusion Coefficient.
Administration Report	The information about an actual administration event or act. For example, a report that “1 tablet of paracetamol was given to patient X at 13:45”. The administration report is for one single administration act.
Administration Request	An instruction for a single medication administration event. For example, a request to “administer paracetamol to patient X on 1/7, at 13:00”. An administration request does not expect any further action (such as dispensing), only the administration. One event can also include several units at the same time (e.g., give paracetamol to patient X - 2 tablets at 3 pm”, even different medications (e.g., “give drug A and drug B mixed together to patient X – 1 each at 3 pm ”).
Admit, Discharge and Transfer	See HL7 version 2.3.1.
ADT	See Admit, Discharge and Transfer.

Term	Definition
Adverse Event	Any unfavorable and unintended diagnosis, symptom, sign (including an abnormal laboratory finding), syndrome or disease which either occurs during the study, having been absent at baseline, or if present at baseline, appears to worsen. (Adapted from the NINDS Glossary of Clinical Research Terms, Last updated November 24, 2008, retrieved from http://www.ninds.nih.gov/research/clinical_research/basics/glossary.htm.)
AE	See Adverse Event.
Aggregate-level Quality Report	A quality report that includes data computed from a set of patients across a set of encounters or another measured item.
AHD	See Application Hosting Device.
Alarm	A clinical alarm is an indication from a system or device, that when activated, indicates a condition requiring urgent clinical assessment and possible intervention.
Alert	A clinical alert is an indication from a system or device that a condition exists requiring clinical assessment and possible attention.
Aliquoter	An automated device which aliquots a parent specimen into one or more child specimen.
Ambulatory Care	All types of health services that do not require an overnight hospital stay.
American Academy of Ophthalmology	
American College of Cardiology	
American College of Clinical Engineering	American College of Clinical Engineering. See http://www.accenet.org/.
American Joint Commission on Cancer	Author of the TNM staging system (See TNM Stage.)
Analytical Work Order Step	A unit of work allocated from a Work Order, assigned to an analyzer, performed on a biological specimen, and producing observations characterizing this specimen.
Analytical Work Order Step	An analytical service to be performed by an analyzer on a specimen. The AWOS is ordered by means of a code representing this analytical service. The code may represent an elementary test or a panel of several elementary tests. In all cases the analytical service is expected to produce observations on the specimen.
Annotated Case Report Form	A case report form that includes the metadata associated with each data element on the form.

Term	Definition
Antigen	A component of a disease-causing agent that stimulates an immune response. More commonly, the disease which a vaccine is supposed to protect against. In the context of immunization, the latter is the meaning of interest.
Aperiodic	PCD data which occurs at irregular intervals such as a Cardiac Output measurement.
Application Hosting Device	In the context of home health care, an intermediary or gateway device which may act as a Device Observation Reporter on behalf of associated home health care devices.
Appropriate Use Criteria	Appropriate Use Criteria (AUC) is an algorithm, typically evidence-based, which specifies the appropriateness of medical procedure(s) or service(s) based on the patient's presenting clinical indication(s).
Arrest Disorder	Arrest of dilation: Condition in which there is no progress in cervical dilation for more than 2 hours. Arrest of descent: Condition in which the fetal head does not descend for more than 1 hour in primiparous woman and more than 0.5 hours in a multiparous woman.
ASE	American Society of Echocardiography. See http://www.asecho.org/.
Assembler	A system that faithfully combines available information and does not create new information in the process of assembling the available data.
Assessment	Collection of clinical health data.
Association	A relationship between two or more entities. Implies a connection of some type - for example one entity uses the services of another or one entity is connected to another over a network link.
Attestation	A personal assertion of the truth of the statement to which you are attesting.
Audit Message	A syslog message that complies with the DICOM PS3.15 schema.
Audit Record	A syslog message that complies with the DICOM PS3.15 schema.
Authenticator	Role played by a laboratory "Clinical Expert" (see Clinical Expert) when performing "Clinical Validation" (see Clinical Validation) of a set of results issued in a CDA® R2 laboratory report, by which this person authenticates and endorses the laboratory report or a subset of it.
Authoritative	Acknowledged to be reliable.
Authorization Decision	A security token that describes which documents can be accessed by a specific entity.

Term	Definition
Auto Program	A pump program in which some or all settings are received from another system such as an eMAR or BCMA system. When an auto-program is received on the pump, the clinician will enter any additional required settings, confirm them, and start the pump
Automatic Indentification and Data Capture	A technological solution like barcodes and RFIDs that allow information to be captured and entered into IT systems.
Autopopulate	This term is used in the Structured Data Capture (SDC) Profile to define content that is pulled into a form by a Form Filler. This contrasts against Prepopulate (RFD) and Querypopulate (mRFD)
Auto-population	When an EHR system automatically fills in form fields with data that are already available within the system's database.
AWOS	See Analytical Work Order Step.
Basic Text SR Storage SOP Class	See DICOM Supplement 23
Battery	A set of one or more laboratory tests, identified by a single name and code that can be ordered to a laboratory. Synonym: Panel. See HL7 version 2.
Bedside	The point of care, typically in an acute care environment.
Bedside Computer-assisted Medication Administration system.	Bedside Computer-assisted Medication Administration system. Also known as Barcode Medication Administration system.
Binding	Process of associating two related elements of information. In the PCD context this typically means the association of a Patient with a device or set of devices.
Biometric	Measurable, physical characteristic or personal behavioral trait used to recognize the identity, or verify the claimed identity.
BIRADS 0	The American College of Radiology defines an assessment system for Mammography image interpretation and reporting (Breast Imaging Reporting and Data System: BI-RADS). "Assessment 0" means that the Mammographic assessment is incomplete, and that additional images or prior studies are needed to finalize the assessment and report.
Blending Softcopy Presentation State SOP Class	See DICOM 2004 Final Text Supplement 100.
Blood Type	Test to determine blood group, i.e., A, B, AB or O.
BMI	See Body Mass Index.

Term	Definition
BMI z-score and percentiles	Among children and adolescents (ages, 2 to 18 years), BMI levels differ between boys and girls, and across ages. Therefore, for a BMI value to be interpretable among children and adolescents, it is necessary to express it as a z-score (standard deviation score) or as a percentile relative to children of the same sex and age in the CDC reference population. (This representative population consists of data collected from 1963 to 1980).
Body Mass Index	Body Mass Index (BMI) is a number calculated from weight and height: weight (kg)/[height (m)]^2
Bounded Waveform	A limited duration continuous block of waveform data which is bounded in time, synonymous with waveform snapshot or waveform snippet.
BPOC	Barcode Point of Care System.
BT	Classic Bluetooth (versus BTLE).
BTLE	Bluetooth Low Energy (also called Bluetooth Smart and denoted BLE).
CAD	Computer Aided Detection
Cancer Case	A summary of all submitted information. It contains the final best information regarding a patient and his or her cancer and includes patient demographic, medical, staging, treatment, and service information.
Cancer Control	Actions taken to reduce the frequency and impact of cancer, both financially and medically.
Cancer Reporting	Actions taken to notify a public health agency of a case of cancer.
Cancer Reporting Extract	A CDA document containing required and recommended information about a patient's cancer diagnosis and treatment, submitted by a physician to a public health cancer registry.
Candidate Standard Validation	Executing the Candidate Standard validation approach. HL7 will have a modified open approach to candidate standard validation. All those participants that made a non-binding commitment in step (5) will be included if they choose to honor the commitment. Others may be added to achieve a balance or for other necessities for validation. The previous notwithstanding, HL7 will limit the number of participants to ensure a manageable process and reasonable time frame.
Cardiac Device Programmer	A device used to noninvasively interrogate, monitor, and alter the operating parameters of an implantable pacemaker, defibrillator, or cardiac resynchronization device.
Care Delivery Organization	A Care Delivery Organization refers to a broad variety of healthcare facilities (private practice, nursing home, ambulatory clinic, acute care in-patient facility, hospitals etc.

Term	Definition
Care Plan	A patient has only one care plan. This is the patient-centered holistic view of all the various plans of care reconciled together, and adopted by the patient as what they actually agree they intend to do.
Care Plan (as used in DCP Profile)	Tool used by clinicians to plan and coordinate care for an individual patient. It aids in understanding and coordinating the actions that need to be performed for the target of care. The care plan is known by several similar and often interchangeable names such as the plan of care and treatment plan. See http://wiki.hl7.org/index.php?title=Care_Plan_Project_-_PCWG.
Care Plan Domain Analysis Model	A common reference used to support the development of implementable care plan models. See http://wiki.hl7.org/index.php?title=Care_Plan_Project_-_PCWG.
Care Transitions	When a patient is transferred or discharged to another phase of care. The destination of the care transition can be to the patient's home or the individual's specific living arrangements (half-way house), another nursing unit within a provider's organization, hospice or home health care, a long-term care facility (nursing home), a specialty hospital, a rehabilitation hospital, or a public facility (jail).
Case Report Form	A record of clinical study observations and other information that a study protocol designates must be completed for each subject.
Causes of Death	All those diseases, morbid conditions or injuries which either resulted in or contributed to death and the circumstances of the accident or violence which produced such injuries. (ref ICD-10 vol 2, section 4.1.1).
CCD	See Continuity of Care Document.
CCOW	See Clinical Context Object Working Group.
CD	Compact Disk.
CDA®	See Clinical Document Architecture.
CDASH	A standard from CDISC which defines those data elements common to case report forms.
CDEs	See Common Data Elements.
CDISC	A standards development organization which focuses on clinical research standards.
CDR	Clinical Data Repository.
CDS	See Clinical Decision Support
CEMS	See Clinical Equipment Management System.
Centers for Medicare & Medicaid Service	Centers for Medicare & Medicaid Service (CMS) is a department of the U.S. Health and Human Services (HHS).

Term	Definition
Centrifuge	An automated device which divides the blood into a serum ingredient and a blood cell ingredient by centrifugal separation. Acts as a Pre/Post-processor in LDA integration profile.
Certified Nurse Midwife	A nurse with specialized education and training in providing care to childbearing women during all stages of pregnancy including the postpartum period.
Certified Tumor Registrar	A nationally certified data collection and management expert with the training and specialized skills to provide the high quality data required in all avenues of cancer statistics and research.
Certifier	Person authorized by law (e.g., the physician who attended the deceased in his/her last illness; or the medical examiner/coroner for deaths of persons who were not attended during the last illness by a physician or for unnatural deaths due to violence or accident) who reports, on the prescribed form, stating to the best of his/her knowledge and belief, the cause of death and other facts related to the event for submission to the registrar (ref UN, Handbook of Vital Statistics Systems and Methods, Volume 1, Glossary)
Certifies	Process of reporting in the jurisdiction's prescribed format on the prescribed form, to the best of his/her knowledge and belief, the cause of death and other facts related to the event for submission to a registrar.
Chemotherapy regimen	A collection of drugs administered in a highly organized manner for treating cancer. It includes information on doses, scheduling, and duration of administration.
Chromosome abnormalities	Chromosome abnormalities consist of any change occurring in the structure or number of any of the chromosomes of a given species. In humans, a number of physical disabilities and disorders are directly associated with aberrations of both the autosomes and the sex chromosomes, including Down, Turner's, and Kleinfelter's syndromes.
CIS	Clinical Information System.
Class	A logical entity encapsulating data and behavior. A class is a template for an object - the class is the design, the object the runtime instance.
CLIA	See Clinical Laboratory Improvement Amendments.

Term	Definition
Clinical Context Object Working Group	ANSI certified technology neutral specification for the Health Level Seven Context Management Architecture (CMA). This architecture enables multiple applications to be automatically coordinated and synchronized in clinically meaningful ways at the point of use. The architecture specified in this document establishes the basis for bringing interoperability among healthcare applications to point-of-use devices, such as a personal computer that serves as a clinical desktop.
Clinical Context Object Working Group	ANSI certified technology neutral specification for the Health Level Seven Context Management Architecture (CMA). This architecture enables multiple applications to be automatically coordinated and synchronized in clinically meaningful ways at the point of use.
Clinical Decision Support	The ability to use data to discover and/or justify the proper activities planned for a patient.
Clinical Decision Support	A clinical decision support (CDS) system is designed to assist physicians and other health care professionals with clinical decision making tasks. A CDS system implements an Appropriate Use Criteria (AUC) algorithm.
Clinical Document Architecture	An HL7 V3 standard for the electronic representation of clinical documents.
Clinical Document Architecture	An HL7 standard for the exchange for clinical documents. It specifies the structure and semantics of clinical documents. More information is available from http://www.hl7.org.
Clinical Document Architecture	The HL7® Version 3 Clinical Document Architecture (CDA®) is a document markup standard that specifies the structure and semantics of "clinical documents" for the purpose of exchange between healthcare providers and patients. It defines a clinical document as having the following six characteristics: 1) Persistence, 2) Stewardship, 3) Potential for authentication, 4) Context, 5) Wholeness and 6) Human readability.
Clinical Document Architecture	This term is used to describe conformance of an XML document against a variety of industry standards.
Clinical Equipment Management System	A clinical equipment specific variant of a Computerized Maintenance Management System (CMMS).
Clinical Expert	Also “Medical expert” or “Bio-medical scientist” or “Results principal interpreter”. The person who assumes the overall responsibility for the clinical validation and reporting of an order or an order group. HL7 V2.5 speaks of “Result principal interpreter”. In HL7 CDA R2 this actor is playing the role of “Authenticator” (AUTHEN) of the laboratory report or of a subset of this report.

Term	Definition
Clinical Laboratory Improvement Amendments	Quality standards regulating activities related to in vitro testing for laboratories in the US. See http://www.fda.gov/CDRH/clia/ and http://www.cms.hhs.gov/clia/.
Clinical Trial	A research investigation involving human subjects that is designed to answer specific questions about the safety and efficacy of a biomedical intervention
Clinical Validation	Also “Medical validation”. The process by which a clinical expert accepts and interprets the results of an order or an order group. Interpretation of the results considers the results together with the biological history, clinical and therapy information available for the patient. This step may sometimes be performed by an expert system that uses knowledge rules and emulates the reasoning of the bio-medical scientist, under its responsibility. In HL7 CDA R2 this process is recorded as “authentication” of the laboratory report or of a subset of this report.
Closed Loop Referral	A closed loop referral is a referral with a definite end-point, when the referral is considered complete. Closed Loop Referral is a subset of Transition of Care, where the cooperative provision of care is limited to the Referral Request and Referral Outcome between two providers. It includes bi-directional information exchange between the Referral Initiator and the Referral Recipient.
CLSI	The Clinical and Laboratory Standards Institute.
Code Set	A code set is any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis codes, or medical procedure codes. An example of international code set is LOINC™ (Logical Observation Identifier Names and Codes).
Cohort Specification	Defines the public health cohort by specifying inclusion and exclusion criteria. Inclusion criteria must be met for cohorts. Exclusion criteria are the characteristics in a cohort specification, any one of which may exclude a potential subject from participation in a cohort.
Combination Vaccine	A vaccine product containing antigens to more than one disease. Combination vaccines are commonly used to reduce the number of “needle sticks” required to give multiple vaccines at the same time. A combination vaccine is effectively the same thing as a Multiple Antigen Vaccine or a Poly-valent Vaccine.

Term	Definition
Common Data Elements	Standardized data element descriptions for collection and exchange of data of common interest to a particular community, and thus the community has agreed to share their definition, management and use. CDEs share a common set of attributes which facilitates their reuse in different settings, and are intended to aide in interoperability and data reuse.
Communication	A process for the transfer of information from one entity to another. The process can be verbal or written, but requires a sender, a message, and a recipient.
Community	A community is defined as a group of facilities/enterprises that have agreed to work together using a common set of policies for the purpose of sharing health information via an established mechanism. Membership of a facility/enterprise in one community does not preclude it from being a member in another community.
Community	A community is defined as a group of facilities/enterprises that have agreed to work together using a common set of policies for the purpose of sharing health information via an established mechanism. Facilities/enterprises may host any type of healthcare application such as EHR, PHR, etc. A community is identifiable by a globally unique id called the homeCommunityId. Membership of a facility/enterprise in one community does not preclude it from being a member in another community. Such communities may be XDS Affinity Domains which define document sharing using the XDS Profile or any other communities, no matter what their internal sharing structure.
Community Medication List	A Community Medication List is a collection of Medication Treatment Plan-, Prescription-, Dispense- and Medication Administration Items (and their related Pharmaceutical Advice Items) representing the Medication information of the patient at a certain point of time and according to business rules specified.
Co-morbidity	The presence of one or more disorders (or diseases) in addition to cancer.
Completed Form	A form where all the fields contain data – through a combination of pre-population, auto-population, and manual edits, and is ready for submission.
Complex Interval Administration	A specific case of continuous administration where the parameters of the administration are changed and those changes are considered relevant. For example, one administration that starts at one rate and then is changed to another rate, or when there is a change in the solvent and is important to capture that change.

Term	Definition
Complications	A list of current or past health problems a patient is experiencing or has overcome.
Composer	A system that creates new information about the patient. The new information may be introduced while assembling other available data.
Computerized Maintenance Management System.	This is the system which the hospital makes use of to maintain its inventory of medical devices, their identification, their status, their software, firmware, and hardware versioning information and history. This is a system for which reception of device location observation is well suited as a means of identifying the last known location of equipment in need of servicing, repairs, or version upgrades.
Confidentiality Code	A value from the value-set that indicates the sensitivity and/or confidentiality of an object (e.g., Document). This may be from the HL7 defined vocabulary or extension defined in the Security/Privacy Domain. The Confidentiality Code is used during access control to indicate the type of object as viewed by the security and/or privacy policies.
Conformance Statement	A conformance statement is a claim that the behavior of an application or application module agrees with the constraints stated in one or more profiles. A Conformance Statement is documentation of the degree to which a particular application conforms to the specification. Part of that document will be a profile expressing the requirements relevant to a particular standard. Standard Profiling is based upon the consistent application of constraints to a set of base specifications. This document outlines the processes that govern the definition of profiles and conformance statements.
Congenital Heart Defect	Congenital heart defect (CHD) is a defect in the structure of the heart and great vessels of a newborn. Obstruction defects. CHD can be classified as: -Obstruction defects occur when heart valves, arteries, or veins are abnormally narrow or blocked. -Septal defects, for defects concerning the separation between left heart and right heart. -Cyanotic defects, including persistent truncus arteriosus, total anomalous pulmonary venous connection, tetralogy of Fallot, transposition of the great vessels, and tricuspid atresia.
Connectathon	IHE testing process - a weeklong interoperability testing event where participating companies test their implementation of IHE capabilities with corresponding systems from industry peers.

Term	Definition
Containment Tree	The Domain Information Model for patient care devices defined in ISO/IEEE 11073 includes a hierarchy of objects representing the structure of a device: medical device system (MDS), virtual medical device (VMD), channel, and metric. An object in a device is described in terms of the objects containing it in this hierarchy, that is, its containment tree. See also "Dotted Notation".
Content Binding	A content binding describes how the payload used in an IHE transaction is related to and/or constrained by the data elements contained within the content sent or received in those transactions.
Context Management Registry	An HTTP technology specific service defined by the HL7 Context Management "CCOW" Standard to locate an instance of a context manager servicing a specific desktop.
Context Session	A collection of participant applications that are sharing context on one or more subjects.
Continuity of Care Document	An HL7 Clinical Document Architecture (CDA) implementation alternative to ASTM ADJE2369 for institutions or organizations committed to HL7 standards. This specification was developed as a collaborative effort between ASTM and HL7. See http://www.hl7.org.
Continuity of Care Document	Continuity of Care Document (CCD®) is document specification standard specified by HL7®/ASTM and commonly used for electronic document exchange. CCD® is based on HL7®'s Clinical Document Architecture (CDA®).
Continuous Administration	An administration that takes a measurable amount of time, for example an infusion.
Continuous Waveform	A continuous stream of waveform data terminated only on request, on patient disconnect or due to technical reasons.
Contraindication	Any medical, environmental, genetic, or other condition that makes a treatment inadvisable. Contraindications include increased likelihoods of a serious Adverse Events, reduced effectiveness of treatment, or duplicative therapies.
Conventional 2D Mammography	Refers to mammography images that have been acquired using FFDM.
Conveyor	An automated device which transports specimen to other devices. Acts as a Pre/Post-processor in LDA integration profile.
Coordination of Care Services Functional Model	Supports shared and coordinated care plans as well as support of multidisciplinary care team members to communicate changes resulting from care plan interventions and collaborate in removing barriers to care. See http://wiki.hl7.org/index.php?title=Care_Coordination_Capabilities.

Term	Definition
Cytology	Microscopic examination of cells.
D (Rh)	A blood screening test for presence of IgG antibodies to the Rh D antigen on red blood cells.
D (Rh) Sensitized	Rh negative mother is sensitized to the Rh D antigen. A sensitized mother produces IgG anti-D (antibody) that crosses the placenta and coats D-positive fetal red cells which are then destroyed in the fetal spleen.
DAM	See Domain Analysis Model.
DAP	Dose Area Product.
Data Element	A data element is a unit of data for which the definition, identification, representation, and permissible values are specified by a set of attributes and considered in context to be indivisible.
Data Element	A logical definition of data.
Data Field	A physical unit of storage in a record.
Data Item	An individual instance of a data element.
Data Set	A series of images or set of frames.
DBT	Digital Breast Tomosynthesis
DCM	See Detailed Clinical Model.
Decapper	An automated device which takes off the cap of the specimen container. Acts as a Pre/Post-processor in LDA integration profile.
Decision Support Service	Decision Support provided as a computerized web service. It is a basic component of Service Oriented Architecture (SOA) for Healthcare. When it is used to provide Clinical Decision Support, it is often called a CDS Service, or simply CDSS.
Defined Procedure Protocol Instance	A DICOM instance of a Defined Procedure Protocol SOP Class such as the CT Defined Procedure Protocol SOP Class.
Delivery	Expulsion or extraction of the infant, placenta and membranes at birth.
Delivery	The infusion pump mechanism for moving fluid into a patient is engaged.
Detached Signature	A Digital Signature approach that includes only references to the signed content (aka manifest) within the signature syntax. The signature is over content external to the Signature element, and can be identified via a URI or transform. Consequently, the signature is "detached" from the content it signs. This definition typically applies to separate data objects, but it also includes the instance where the Signature and data object reside within the same XML document but are sibling elements. [W3C XMLDSIG]

Term	Definition
Detailed Clinical Model	A Detailed Clinical Model (DCM) is an information model of a discrete set of precise clinical knowledge which can be used in a variety of contexts. Detailed Clinical Models (DCM) are descriptions of items of clinical information that include the clinical knowledge on the concept, the data specification, a model and where possible, technical implementation specifications. A DCM is a conceptual specification of the semantics of discrete structured clinical information. It provides the data elements and attributes, including the possible values and types of the attributes, needed to convey the clinical reality in a fashion that is understandable to both clinical domain experts and modelers. This includes the potential for use in health care information and communication technology, for example in EHR, Telehealth applications, messages, medical devices, computer algorithms, and deductive reasoning, decision support, among others. It provides unambiguous detail which is intended to be cross domain and cross discipline and standardized and reusable over domains, purposes, standards and implementations. DCM work currently includes clinical content analysis, quality assurance, information modeling, and repositories. DCM includes the structural model. Dynamic models are handled elsewhere, but some aspects of dynamics might be in the DCM. "Detailed Clinical Models are small items of clinical, preventive and care information that are well defined and for which knowledge, data definition, vocabulary binding, and information model for use in information and communication technology are standardized
Diagnoses	Analysis of patient assessment data.
DICOM	Digital Imaging and Communications in Medicine. See http://medical.nema.org/.
DICOM Encapsulated PDF	See DICOM PS 3.3.
DICOM Model of the Real World	See DICOM PS 3.3.
Digital Signature	A useful legal equivalent to facsimile signature that may be generated for a variety of entities, including human and machine sources. Based on digital certificates attributable to well-known healthcare oriented certificate authorities; incorporating cryptographically secure techniques for signature generation and validation.

Term	Definition
Digital Signature	Formally speaking, a value generated from the application of a private key to a message via a cryptographic algorithm such that it has the properties of integrity, message authentication and/or signer authentication. (However, we sometimes use the term signature generically such that it encompasses Authentication Code values as well, but we are careful to make the distinction when the property of signer authentication is relevant to the exposition.) A signature may be (non-exclusively) described as detached, enveloping, or enveloped. [W3C XMLDSIG]
Directory	A book containing the names and residences of the inhabitants of any place, or of classes of them; an address book; as, a business directory.
Dispense Item	A Dispense Item belongs to one Dispensation and represents one dispensed medication. It contains the dispensed medicinal product including information such as product code, brand name and packaging information.
Dispense/Dispensation	Dispensation is the act of assigning a medication to a patient, normally as indicated in the corresponding prescription. Since prescriptions can span long periods of time, a single prescription may result in medicines dispensed several times.
Dispensing	The act of assigning a medication to a patient, normally as indicated in the corresponding prescription. Since prescriptions can span long periods of time, a single prescription may result in medicines dispensed several times.
Dose Length Product	Dose Length Product.
Device Message Layer	Device Message Layer defined by the standard POCT1-A.
Date of Birth	Date of Birth.
Domain Analysis Model	A Domain Analysis Model (DAM) is an abstract representation of a subject area of interest designed to provide a generic representation of a class of system or capability and to suggest a set of approaches to implementation. In HL7 a DAM is complete enough to enable the development of downstream platform-independent models: HL7 RIM-based information and service models. A DAM may also be used to constrain other standards for use in healthcare (e.g., to constrain access control markup standards). The process used to create a DAM is documented in the HL7 Development Framework (HDF).
Dosage Instructions	Dosage Instructions are a set of data elements which together represent the dosage instructions to a medication such as duration of treatment, medication frequency, dose quantity and route of administration.

Term	Definition
Dose Object	A persistent DICOM object (See DICOM PS 3.3: A.35.8 X-Ray Radiation Dose SR IOD) for recording details related to Irradiation Events. DICOM has defined Dose Objects for CT and Projection X-ray procedures.
Dose of Antigen / Vaccine Component	Immunization CDS will analyze an existing immunization history by vaccine component, or doses of antigen, in order to build a proposed immunization care plan (ICP).
Dose of Vaccine / Administered Dose	This is a quantity of medication or vaccine substance that is administered as a single shot. It will contain one *or more* doses of antigens. Immunization histories are typically recorded in terms of administered doses of vaccine, rather than doses of antigens.
Dose Registry	A system that collects dose information from multiple sites, generally to perform analysis of Population Dose and Dose Indicators.
Dosimetric Plan	An RT Plan object containing sufficient information to dosimetrically define a radiation therapy treatment. The Dosimetric Plan shall contain references to RT Structure Set and RT Dose objects. A Dosimetric Plan shall contain a Fraction Group Sequence (300A,0070) containing a single sequence item. Each beam in the Referenced Beam Sequence (300C,0004) shall have its Beam Meterset (300A,0086) defined.
Dotted Notation	A string in the form k.l.m.n[.o] (where k..o are integer ordinals mapping an object within a device: Medical Device System (MDS),Virtual Medical Device (VMD),Channel, Metric, and optional Facet), used in PCD -- specifically in the OBX-4 Sub-id field, to associate an observation with its unique ‘address’ within the device.
DSS	See Decision Support Service.
DVD	A trademark of the DVD Forum that is not an abbreviation.
ECG	Electrocardiogram
EDC	See Electronic Data Capture.
EDIS	See Emergency Department Information System.
EDRS	See Electronic Death Registration System.
EEG	Electroencephalogram.
EHR	Eye Care Electronic Health Record System or sometimes called Eye Care Electronic Medical Record System.
EHR	See Electronic Health Record.
EHR-CR	An EHR-CR or Care-delivery Record abstracts the patient information managed by the IT system or set of systems of a Care Delivery Organization, which may support a broad variety of healthcare facilities (private practice, nursing home, ambulatory clinic, acute care in-patient facility, etc.

Term	Definition
EHR-LR	The documents shared by the EHR-CR and tracked by the Registry form a Longitudinal Record for the patients that received care among the EHR-CRs of the XDS Affinity Domain. This is known as the EHR-LR.
Electronic Data Capture	The process of collecting clinical trial data into a permanent electronic form.
Electronic Death Registration System	A jurisdiction-based system used to create and register the legal death certificate.
Electronic Health Record	An electronic record derived from a computerized system used primarily for delivering patient care in a clinical setting
Electronic Health Record	This term is used to describe a system that maintains a longitudinal view of a patient's history. It contains comprehensive information on a patient's health.
Electronic Medical Record	This term is used to describe a system that maintains a narrow view of a patient's history. It is primarily used by providers to diagnose and treat conditions.
Electronic Medical Record	An Electronic Health Record system used within an enterprise to deliver care (also called EHR-CR by IHE-XDS).
Eligibility Criteria	Defines the study population by specifying inclusion and exclusion criteria. Inclusion criteria must be met for prospective subjects to be eligible for participation in a study. Exclusion criteria are the characteristics in a protocol, any one of which may exclude a potential subject from participation in a study.
eMAR	Electronic Medication Administration Record.
Emergency Department Information System	An extended EHR system used to manage data in support of emergency department patient care and operations. The functions of an EDIS may be provided by a single application or multiple applications.
eMPI	Enterprise Master Patient Index.
EMR	See Electronic Medical Record.
Encounter	An interaction between a patient and care provider(s) for the purpose of providing healthcare-related service(s). Healthcare services include health assessment. For example, outpatient visit to multiple departments, home health support (including physical therapy), inpatient hospital stay, emergency room visit, field visit (e.g., traffic accident), office visit, occupational therapy, telephone call.
Encounter	An encounter happens between a patient and a care provider who can be an individual or an organization.
End of Care	In the context of closed loop referral, the End of Care is determined by the Referral Recipient when no more care is needed to satisfy the reason for the referral; it is when the result of referral is sent to the Referral Initiator

Term	Definition
Enhanced Form Repository	A form repository with capability to pre-populate form with the data received from the Form Filler.
Enhanced SR Storage SOP Class	See DICOM PS 3.3.
Enveloping Signature	A Digital Signature approach that encapsulates the signed content within the signature syntax. The signature is over content found within an Object element of the signature itself. The Object (or its content) is identified via a Reference (via a URI fragment identifier or transform). [W3C XMLDSIG]
ePHI	Electronic Patient Healthcare Information.
Episodic	Occurring at unpredictable times. Similar in meaning to aperiodic, except that aperiodic is generally applied to observations and episodic can be applied to any sort of happening or event, including patient physiological and device technical alarms.
ESC	European Society of Cardiology
eSource Document	The electronic record used to keep together a collection of eSource data items for capture, transmission, storage, and/or display; and serving as a source document for a clinical investigation.
Estimated Time of Arrival	The time the patient being referred can be expected to arrive in the emergency department.
EUI-64	An 8-byte hexadecimal Extended Unique Identifier number defined by the IEEE, uniquely identifying a particular instance of a device. It begins with a 3- or 4-byte company id assigned to the manufacturer of a device by the IEEE Registration Authority. The rest of the bits are assigned by the manufacturer in such a way as to insure no two individual devices have the same EUI-64. It is one way used in PCD messaging to uniquely identify a device or system.
Event	In UML modeling, an occurrence at a definite time that is significant in the analysis of the system under study.
Event	An occurrence about which it is desired to communicate information between devices and information systems. Events include operational milestones and key parameter changes. Alarms are considered to be a subset of events.
Event	A real world activity has reached a well-defined state. Events can be organized in a hierarchy and event times can be ambiguous. For example, "Person flew from Boston to Chicago" could be defined as one event. Or, it could also be "Person arrived at parking lot", "person found parking place", "Person arrived at terminal", "person arrived at security line", "person cleared security", ….

Term	Definition
Event Report	A report describing an Event.
Evidence Documents	Evidence Documents represent the uninterpreted information that is primarily managed and used inside the imaging department, although distribution outside the imaging department is not precluded. Evidence documents are non-image information and include things such as measurements, CAD results, procedure logs, etc., and are to be encoded as DICOM SR documents.
Evidence Documents	Evidence Documents represent the non-interpreted information that is primarily managed and used inside the imaging department, although distribution outside the imaging department is not precluded. Evidence documents are non-image information and include things such as measurements, CAD results, procedure logs, etc. and are to be encoded as DICOM SR documents or Encapsulated PDF.
Evidence Objects	All objects generated as a result of performing procedure steps on systems in an imaging department. These objects are used by the reading healthcare provider in the process of creating a diagnostic report and are managed inside the imaging Department. Examples of evidence objects include Images, Presentation States, Key Image Notes and Evidence Documents.
Expanded Value Set	A set of concept representations that were in effect at a specific time for a particular version of a Value Set. See Value Set. The Value Set and the Expanded Value Set concepts are similar to the programming concepts of Class and Instance of Class. This may also be called a value set resolution or resolved value set.
Expected Actions	Actions which should occur as the result of a trigger event.
Export Source Document	A CDA document from which data will be drawn to send to an external system for secondary use.
Extends Relationship	A relationship between two use cases in which one use case 'extends' the behavior of another. Typically this represents optional behavior in a use case scenario - for example a user may optionally request a list or report at some point in a performing a business use case.
Extensional Value Set	A set of concepts that is specified in terms of a list of concepts.
External Data Repository	A database, outside of the EHR system, where completed forms data can be stored.

Term	Definition
External Quality Control	Tests performed on an identified control specimen whose target values are hidden, in order to control the proficiency of the organization. External QC specimens are provided by an external institution that controls and compares the results obtained by multiple healthcare enterprises. This is also called proficiency testing.
Extracted Data	Those data specified by the extraction specification.
Extraction Specification	An XSLT provided by a system external to the EHR which specifies which data elements of the CDA should be sent to the external system for secondary use.
Extraction Specification	A detailed map of data locations within an EHR, an EHR export document, or similar source used as a guide to extract data for re-use by a research, quality reporting, or public health system.
Extubation	This term is used to describe the removal of a device from a hollow organ.
Fast Health Interoperability Resources	The interoperability standard from HL7 which builds on HL7 version 2, version 3, the RIM and CDA. It can be used in conjunction with existing data exchange standards as well as a standalone standard
FDA	The United States Food and Drug Administration. See http://www.fda.gov/.
FFDM	Full Field Digital Mammography.
FHIR	See Fast Health Interoperable Resources.
FHIR Profile	A statement of use of one or more FHIR Resources. It may include constraints on Resources and Data Types, Terminology Binding Statements and Extension Definitions.
FHIR Provenance Resource	Describes the activity that led to the creation of a set of resources. This information can be used to help determine their reliability or trace where the information in them came from. The focus of the provenance resource is record keeping, audit and traceability, and not explicit statements of clinical significance
FHIR Resource List	Collection of resources in a list which is enumerated while providing features for managing the list.
FHIR Resources	The basic building block in FHIR. Used to define exchangeable content.
Filler	See HL7 version 2.3.1.
Filler Order Number	The unique reference assigned to an Order by the Order Filler Actor, which is expected to fulfill this Order.
FiO2	Fraction of inspired oxygen, a percentage of inhaled gas.

Term	Definition
First course of treatment	Includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence.
Fixed Wing	Any transport by airplane.
Fluid Management	The process of recording the patient's input and output of fluid. Fluids can be consumed via, but not limited to: oral, intravenous, or irrigation. Output of fluids include, but are not limited to: any expulsion of bodily liquid (blood, urine, feces, sputum, bile, vomitus, perspiration, pus) via oral or rectal cavities, wounds, drains, tubes, catheters, or other medical devices.
Foreign Key (FK)	A database key that is used as a reference to relate one entity to another entity. It may be a unique value, or used in conjunction with another Foreign Key to create a unique value.
Form	A form with data entry fields that will be filled out by an end user or provider.
Form Repository	An authoritative source for forms.
Frame of Reference (FoR)	Identifies the coordinate system that conveys spatial and or temporal information of composite instances in a series. The identified Coordinate System typically includes an origin, orientation and dimension scaling. Data with the same Frame of Reference are inherently using coordinate systems with the same origin, orientation and dimension scaling.
FSC	File-Set Creator.
FSR	File-Set Reader.
Functional Role	Role an individual is acting under when they are executing a function. See ISO 21298.
GBEA	Guide de Bonne Exécution des Analyses Médicales. Minimal regulatory set of quality standards regulating activities related to in vitro testing for laboratories in France.
General Purpose Infusion Pump	A pump used to infuse fluids intravenously in a wide variety of clinical settings. Differentiated from specialty infusion pumps, which are used for a specific purpose or in a specific setting, such as PCA (patient-controlled analgesia) or syringe pumps.
Geometric Plan	An RT Plan object containing a subset of information defining a radiation therapy treatment. The Geometric Plan shall contain a reference to an RT Structure Set. Further definition of a Geometric Plan can be found by review of the appendices of RO TF-2. A Geometric Plan is conceptually the state of an RT Plan object that might be stored by a CT-Simulation application (i.e., a Geometric Planner).
Gestational Age	Gestational age is the number of weeks elapsed between the first day of the last normal menstrual period and the date of delivery; weeks of amenorrhea.

Term	Definition
Global Positioning System	This is the system of orbiting satellites that are constantly broadcasting extremely high accuracy time information, combined with ubitiquous receivers and software associated with the receivers that upon correlation of the received data can identify with reasonably high accuracy the location of the receiver in 3D space by latitude, longitude, and altitude.
Globalized Distribution	A dispensing mode in which the pharmacy distributes the medication to the wards and the nurses then dispense the medication to each patient as needed.
Globally Unique Identifier	An identifier that has been generated by an algorithm guaranteeing its global uniqueness. The identifier is used to identify an entity, such as persistent document. See ITI TF-2x: Appendix B discussion of OIDs and UUIDs.
Goals	A defined outcome or condition to be achieved in the process of patient care. Goals include patient defined goals (e.g., prioritization of health concerns, interventions, longevity, function, comfort) and clinician specific goals to achieve desired and agreed upon outcomes.
Grayscale Softcopy Presentation State Storage SOP Class	See DICOM PS 3.4.
Grayscale Standard Display Function	See DICOM PS 3.14.
Grouping	Associating Actors together in one system such that information transferred between the actors is accomplished through direct application program interfaces, being out of scope to the IHE.
GSPS	Grayscale Softcopy Presentation State. See DICOM PS 3.4
GUID	See Globally Unique Identifier
Guidelines	Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. (Field MJ, Lohr KN. Guidelines for Clinical Practice: from development to use. Washington DC: National Academic Press, 1992. Retrieved from http://www.nap.edu/openbook.php?record_id=1863&page=27#p200063cf8960027001)
Hand-offs	A transfer of patient information during transitions of care to ensure safety and provide continuity of care for the patient. This transfer of information is provided internally, within the health care organization, or externally, outside the health care organization.
Hardcopy Import	The process of importing non-digital data into the Enterprise as DICOM Objects. The original data may be Films or Documents that are scanned and stored as DICOM Objects.

Term	Definition
Hash	A value uniquely calculated by using a well-known one way algorithm to create a digest of all the data constituting an electronic record.
Health Assessment	The screening/examining of an individual for their overall condition or optimal well-being (mind, body, and spirit).
Health Care Proxy	The legal appointment, power of attorney, of someone else, a proxy, other than yourself, to make healthcare decision for you when you are physically or cogitatively unable to. The person designates a trusted individual to make medical decisions in the event of inability to make such decisions. It is a vehicle for directing his/her own treatment in the event of serious illness and/or loss of mental ability to communicate those wishes; in an Advanced Directive, the person indicates in advance, how treatment decisions are to be made with regard to the use of artificial life support.
Health Concerns	The issues/current status and likely course identified by the patient or team members that require intervention(s) to achieve the patient's goals of care, any issue of concern to the individual or team member.
Health Data Locator	Health Data Locator is a function provided by a community or external entity that manages the locations of patient health data for a selected set of patients. A Health Data Locator keeps track of communities that know a patient and provides a list of these communities to a requesting community.
Health Device Profile	A transport profile defined for classic Bluetooth (BT)
Healthcare domain/ secondary use domain	The healthcare domain and its central system the EHR exist to provide medical care to patients. Data are created by the healthcare domain which are of value to the secondary use domains such as research, public health, and quality reporting. In general, only tightly specified data are permitted to be exported by the healthcare domain to a secondary use domain.
Healthcare Professional	A specially trained individual who provides healthcare services like a GP, specialist, nurse, midwife, dentist, physiotherapist, pharmacist etc.
Healthcare Provider	Medical information entities such as physicians, medical laboratories, hospitals, dentists, pharmacists, nurses, diagnostic imaging professionals etc. This includes both individuals as well as organizations.
Hearing Test	Any test that measures hearing or quantifies hearing loss; sound is perceived by intensity–loudness and by tone; both are measured in HTs, as is the ability to hear sound through air–air conduction and bone–bone conduction.
Heart Team	
Hematocrit (HCT)	The volume percentage of erythrocytes in whole blood.

Term	Definition
Hemoglobin (HGB)	Protein in red blood cells that carries oxygen; HGB measured by blood test.
Hemoglobin Disease	Hemoglobin is produced by genes that control the expression of the hemoglobin protein. Defects in these genes can produce abnormal hemoglobins and anemia, which are conditions termed "hemoglobinopathies". Abnormal hemoglobins appear in one of three basic circumstances: - Structural defects in the hemoglobin molecule. - Diminished production of one of the two subunits of the hemoglobin molecule. - Abnormal associations of otherwise normal subunits.
HIMSS	Healthcare Information and Management Systems Society. See http://www.himss.org.
HIS	Hospital Information System.
Histopathology	Microscopic examination of tissues.
HL7	Health Level Seven International. An international standards development organization in the domain of healthcare information exchange. See http://www.hl7.org/.
HL7	Health Level Seven is a not-for-profit, American National Standards Institute (ANSI)-accredited health care focused International and membership-driven Standard Development Organization (SDO) based in the United States with international affiliates.
HL7 Profile	An HL7 profile is an unambiguous specification of one or more HL7 standards that have been analyzed for a particular use case. It prescribes a set of precise constraints upon one or more standard HL7 artifacts. An HL7 profile is conformant, in all aspects, with the HL7 defined specification used in the profile according to the constraints or extension rules. It may specify constraints on the standard HL7 definition. An implementation profile fully describes an interoperability interaction between two or more systems through the combination of the following: a) one use case analysis, b) one or more dynamic definitions, and c) one or more static definitions.

Term	Definition
Home Care	Professional care (e.g., skilled nursing, physical therapy, speech-language pathology, occupational therapy, medical social work, home health aide) that an individual of any age with an acute or chronic condition, as well as a disability or a terminal illness, receives in the home. The professional will work with the patient and their families to teach them about their condition as well as how to care for themselves or the patient, so that the patient can be independent. A physician or a clinician with prescriptive authority is required to document or verbally communicate an order for the services to be provided.
homeCommunityId	A globally unique identifier for a community.
Hospital Cancer Registry	Collects information on all cancer patients who use the services of a hospital. It may be required to report cancer cases to the central registry, to respond to inquiries from the central registry, or to allow central registry access to its records.
HTML	Hyper Text Markup Language.
Human actor	Individual (physician, pharmacist, etc.) that usually makes use of a system actor to perform an activity in the e-pharmacy domain.
ICA	Intolerances, Contra-indications and Allergies. An ICA may be considered as a relationship between a Patient and a Medicine. A detected problem in a Pharmaceutical Advice may refer to an ICA.
ICE	Intracardiac Echocardiography.
ICRU	International Commission on Radiological Units.
IEC	International Electrotechnical Commission.
IEEE	Institute of Electrical and Electronics Engineers. See http://www.ieee.org.
IEEE-11073-20601	Optimized Exchange Protocol. A transport-agnostic packet-based protocol for exchanging health data. Currently used only over local transports (PHCD USB, ZigBee, HDP Bluetooth, NFC)
IETF	Internet Engineering Task Force. See http://www.ietf.org.
IHE	Integrating the Healthcare Enterprise. See http://www.ihe.net.
IHE PCD Data	PCHA sensor data expressed in the form of a PCHA-compliant IHE PCD-01 message.
IHI	See Institute for Healthcare Improvement.
IIS	See Immunization Information System.

Term	Definition
Image Fusion	The process of superimposing (overlaying) data sets for display. This is typically done so that corresponding features of the data sets can be seen at once. Fusion typically requires that the datasets be registered. This would normally involve two data sets- one underlying and one superimposed.
Image Registration	Spatially aligning datasets. This is done by mapping the pixel spatial coordinates of the Original Data Sets to the Registered Space and may include translations or rotations between the coordinate systems. The primary purpose is to support display of correlated features in two images. Typically the Registered Space is defined by one of the datasets, and the other is aligned with it.
Image Re-sampling	Synthesizing a new image dataset where the number of pixels, resolution, number of slices, slice locations and slice orientations may differ from the original, but the frame of reference is preserved (i.e., the pixel value at a given spatial location in the new dataset corresponds to the value at the same spatial location in the old dataset).
Imaging Service Request	See DICOM PS 3.3.
Immediate Cause of Death	Final disease or condition resulting in death, that is, one that is most proximate to time of death.
Immunization Information System	A software system designed to collect all information about immunizations given to a certain population. An IIS is typically funded or sponsored by a Public Health Department or Ministry.
Immunization Interval	A measure of the interval between doses of antigens. For maximum effectiveness against the targeted disease, many vaccines must have booster shots given after the initial dose. The recommended interval varies by vaccine. In most cases, administration of a vaccine with less than the minimum immunization interval reduces the effectiveness of the vaccine, and one that is substantially longer than the recommended interval exposes a person to a higher risk of contracting the disease during the period of delay.
Immunization Recommendation	A collection of proposed immunizations and encounters which a provider may use to develop an immunization care plan. Also known as an Immunization or Vaccine Forecast.
Immunization Recommendation	A set of proposed immunizations to be given to a patient, including the dates to give them. The recommendation may be general, or it may be focused on a particular disease (such as an influenza pandemic) or a particular risk situation (such as travel to places with high risk factors for certain diseases).
Immunization Registry	See Immunization Information System.

Term	Definition
Immunotherapy	Treatment that stimulates the body's immune system to fight tumors; also called biological response modifier (BRM) therapy.
Implantable Cardiac Monitor	An electronic device implanted beneath the skin used for monitoring/recording the electrical signals of the heart muscle.
Implantable Cardiac Resynchronization Therapy (CRT) Device	An electronic device implanted beneath the skin used to reestablish ventricular synchrony in an effort to improve left ventricular efficiency.
Implantable Defibrillator	An electronic device implanted beneath the skin used to counteract fibrillation of the heart muscle and restore normal heartbeat by applying an electric shock.
Implantable Medical Device	Any instrument, apparatus, implement, machine, appliance, implant, in vitro reagent or calibrator, software, material or other similar or related article:1) intended by the manufacturer to be used, alone or in combination, for human beings for one or more of the specific purpose(s) of: diagnosis, prevention, monitoring, treatment or alleviation of disease; diagnosis, monitoring, treatment, alleviation of or compensation for an injury; investigation, replacement, modification, or support of the anatomy or of a physiological process; supporting or sustaining life - control of conception; disinfections of medical devices; providing information for medical or diagnostic purposes by means of in vitro examination of specimens derived from the human body and: 2) which does not achieve its primary intended action in or on the human body by pharmacological, immunological or metabolic means, but which may be assisted in its intended function by such means. (Reference: GHT)
Implantable Pacemaker	An electronic device implanted beneath the skin for providing a normal heartbeat by electrical stimulation of the heart muscle, used in certain heart conditions.
Includes Relationship	A relationship between two use cases in which one use case 'includes' the behavior. This is indicated where there a specific business use cases which are used from many other places - for example updating a train record may be part of many larger business processes.
Industry Outreach	Depending on the goals of the project this may be as little as a set of announcements of work going on in HL7 targeted at the impacted stakeholder communities. For some projects it may involve scheduling out-of-cycle meetings, scheduling meetings jointly with other stakeholder organizations or some kind of “Town Hall” meetings similar to those used for the EHR Functional Requirements DSTU.

Term	Definition
Ineffective Dose	This is a dose of administered vaccine or vaccine component which may be predictably less effective than desired, due to inadequate immunization interval, expired vaccine, concurrent administration of antibiotics, vaccine recall, improper vaccine storage, or other issues.
inetOrgPerson	The inetOrgPerson [RFC 2798] object class is a general purpose object class that holds attributes about people. The attributes it holds were chosen to accommodate information requirements found in typical Internet and Intranet directory service deployments. The inetOrgPerson object class is designed to be used within directory services based on the LDAP v3 [RFC 2251] and the X.500 family of protocols, and it should be useful in other contexts as well.
Infobutton	A graphical user interface element which allows the user of an application to quickly obtain information about a specialized term or value found on application displays. It is typically represented as a lowercase letter "i" in a blue circle. The term may also be used to refer to the HL7 Context Aware Information Retrieval standard, which is often used to implement the information retrieval side of the interface.
Inpatient	A patient who is admitted to a hospital or clinic for treatment that requires at least one overnight stay.
Institute for Healthcare Improvement	An independent not-for-profit organization to improve health care throughout the world. See http://www.ihi.org.
Instructions	Information or directions to the patient and other providers including how to care for the individual's condition, what to do at home, when to call for help, any additional appointments, testing, and changes to the medication list or medication instructions, clinical guidelines and a summary of best practice. This is provided as a list of action steps given to a team member or patient to address health concerns.
Integrity	The property of the data has not been altered or destroyed in an unauthorized manner.
Integrity	The property of the data has not been altered, or destroyed in an unauthorized manner. "The property that data has not been changed, destroyed, or lost in an unauthorized or accidental manner." [SEC] A simple checksum can provide integrity from incidental changes in the data; message authentication is similar but also protects against an active attack to alter the data whereby a change in the checksum is introduced so as to match the change in the data. [W3C XMLDSIG]

Term	Definition
Intensional Value Set	A set of concepts that is specified in terms of the “intension” of use, for example “all concepts that are children of this node in a tree of concepts”. Intensional value sets often have some kind of algorithmic basis for selection of concepts.
Interaction Diagram	A diagram which depicts data flow and sequencing of events.
Interchange Media	A piece of data-bearing physical media, such as a CD or DVD. The term, which is used in the DICOM standard, is synonymous with "portable media" or "transfer media".
Internal Quality Control	Tests performed on an analyzer using an identified control specimen with usually known target values, in order to check the accuracy of the device.
Interoperable	The ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities.
Interval from onset to death	Minutes, hours, days, weeks, months, or years between the onset of each condition and the date of death (ref ICD-10 vol 2, section 4.1.3).
Interventions	Actions taken to maximize the prospects of achieving the patient’s or providers’ goals of care, including the removal of barriers to success. Instructions are a subset of instructions.
Invalid Dose	See Ineffective Dose.
IOD	Information Object Definitions. See DICOM PS 3.3
Irradiation Event	An irradiation event is one continuous occurrence of irradiation being applied to a patient. A pulsed fluoro X-Ray acquisition, or a multi-slice helical CT scan are examples of single events; while a CT scanogram and the helical scan, or two different presses of the fluoro pedal, or simultaneous irradiation from two X-ray tubes are examples of separate events. See RAD TF-3: 4.62.4.1.1 in Store Dose Information for a more detailed description.
ISO Reference Terminology Model	To establish a nursing reference terminology model consistent with the goals and objectives of other specific health terminology models in order to provide a more unified reference health model. This International Standard includes the development of reference terminology models for nursing diagnoses and nursing actions and relevant terminology and definitions for its implementation.
ISO/IEC 11179 metadata registry	A metadata registry is defined as “an information system for registering metadata” by ISO/IEC 11179. In particular, ISO/IEC 11179 defines a metadata registry is a database that manages the semantics of Data Elements.

Term	Definition
ISO/IEEE 11073-10101 Nomenclature	Within this standard nomenclature codes are defined, these give the possibility to clearly identify objects and attributes in relation to the so-called OID-Code). The nomenclature is divided in partitions, to demarcate codes with regards to content and functional.
IT	Information Technology.
IVD	In vitro diagnostic. This abbreviation is related to the processing of tests on in vitro specimens. A laboratory device (see term LD) is usually an IVD device and performs work order steps (see term WOS).
IVOCT	Intravascular Optical Coherence Tomography
IVUS	Intravascular Ultrasound.
JavaScript Object Notation	A textual representation of a serialized object from the JavaScript language.
JPEG	Joint Photographic Experts Group.
JSON	See JavaScript Object Notation
KDC	Key Distribution Center (the Kerberos server that issues Ticket Granting Tickets and service tickets. See RFC1510).
Keep Vein Open	A fluid delivery mode that may occur once the programmed volume has been infused.
Labeler	An automated device which affixes the bar code label to the specimen container.
Laboratory Performer	A laboratory who performed (all or some of) the tests documented in a laboratory report or reported in a results message. It is described with the laboratory's name and address and the laboratory director's identification
Laboratory Request	Synonym of "Order Group".
Language Proficiency	Family planning users who do not speak the national dominant language as their primary language and who have a limited ability to read, write, speak or understand the dominant language and therefore require language assistance services (interpretation or translation) in order to optimize their use of health services. Include users who receive services from multilingual staff in the user's preferred language, are assisted by a competent agency or contracted interpreter, or who opt to use a family member or friend as an interpreter after refusing the provider's offer of free language assistance services. Do not include users who are visually or hearing impaired or have other disabilities unless they also have a need for language assistance service.
LAS	Laboratory Automation System.

Term	Definition
LDAP	Lightweight Directory Access Protocol is designed to provide access to directories supporting the X.500 models, while not incurring the resource requirements of the X.500 Directory Access Protocol (DAP).
LIS	Laboratory Information System.
Local Authentication	In the ATNA profile the term "local authentication" means that the user identification, authentication, and authorization method is chosen by the local system administration and does not necessarily comply with any IHE profile. It may be a local username password system, a secure token system, or any other system that is considered acceptable by the local security administration.
Location Services	This is a collection of software applications and services which utilize tag tracking information to provide the last known location of the tags as well as any environmental or operator interactions with the tags.
Logical Observation Identifiers Names and Codes	A vocabulary developed by the Regenstrief Institute aimed at standardizing laboratory and clinical codes for use in clinical care, outcomes management, and research. See http:/loinc.org.
LOINC	See Logical Observation Identifiers Names and Codes.
Long Term Signature	A signature that is intended to be valid for months or years later.
Long-term Care	A variety of services that help people, who have a chronic illness or disability, with medical or non-medical care needs and activities of daily living over a specified period of time. Long-term can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
LUT	Look Up Table.
MAC	Media Access Control – A unique identification/serial number associated with every device used in network communications.
Malpresentation	Abnormal position of fetus in birth canal. Natural delivery becomes difficult or impossible.
Manner of Death	Way the conditions reported as causes of death resulted in death, or for injuries, intent.
Master File	A common reference file used by one or more application systems. A code set can be considered a master file.
MCW	Multi-channel Waveform.
MDC	Medical Device Communication. The general name for the suite of standards in ISO/IEEE 11073 defining communications protocols for patient care devices.

Term	Definition
MDS	Medical Device System. The object in ISO/IEEE 11073 representing a whole medical device. It contains Virtual Medical Devices representing subsystems.
Medical Device	Any instrument, apparatus, implement, machine, appliance, implant, in vitro reagent or calibrator, software, material or other similar or related article: 1) intended by the manufacturer to be used, alone or in combination, for human beings for one or more of the specific purpose(s) of: - diagnosis, prevention, monitoring, treatment or alleviation of disease - diagnosis, monitoring, treatment, alleviation of or compensation for an injury - investigation, replacement, modification, or support of the anatomy or of a physiological process - supporting or sustaining life - control of conception - disinfections of medical devices - providing information for medical or diagnostic purposes by means of in vitro examination of specimens derived from the human body and: 2) which does not achieve its primary intended action in or on the human body by pharmacological, immunological or metabolic means, but which may be assisted in its intended function by such means. Reference: GHTF/SG1/N29R16:2005 published by the Global Harmonization Task Force (2005);
Medication	A medication is part of a prescription item and defines the actual prescribed drug. It contains the brand or generic name of the drug, national and/or regional drug codes, unit strength, active ingredients and packaging information.
Medication Administration	Medication Administration is the act of applying a medication to a patient (e.g., intake of tablet, injecting a syringe, applying an infusion, etc.), whether performed by the patient him- or herself or another person, such as a health care professional.
Medication Administration Item	A Medication Administration Item belongs to a Medication Administration and represents one administered medication. It contains the administered medicinal product including information such as product code, brand name, lot number as well as all other parameters describing the administering process, such as dose, drop-rate, etc.

Term	Definition
Medication Brand Name	The brand name is the name given to a medicine by the pharmaceutical company that makes it. This is also called the "proprietary name".
Medication Dispenser	In the domain of community pharmacy a Medication Dispenser is an abstract actor which dispenses prescribed medication to a patient (generally a healthcare professional, usually a pharmacist when the patient enters the pharmacy to get the prescribed medication).
Medication Generic/Scientific Name	The generic or scientific name is the term given to the active ingredient in the medicine that is decided by an expert committee and is understood internationally. This is also called the "non-proprietary name".
Medication Preparation	The act of making medication items available for a specific intended administration action.
Medication Record	A list of all medication-related data for a specific patient, including prescriptions (including (partially) fulfilled ones), dispenses and possibly administrations.
Medication Treatment Plan	The Medication Treatment Plan (MTP) of a patient is the collection of all medications the patient was planned to take in the past, presently or in the future. The Medication Treatment Plan is the complete set of all Medication Treatment Plan Items of the patient, i.e., not partitioned or grouped by pathology, planner, organization, etc.
Medication Treatment Plan Item	A Medication Treatment Plan Item is a single medication the patient was planned to take in the past or is planned to take presently or in the future, including its name, dosage, frequency of intake, etc. as well as other information such as patient- and fulfillment instructions and substitution handling. A Medication Treatment Plan Item triggers prescriptions and/or, dispenses in order to fulfill the medication treatment planned by the item.
Message Profile	An HL7 message profile is an unambiguous specification of one or more standard HL7 messages that have been analyzed for a particular use case. Each message profile may have a unique identifier as well as publish/subscribe topics
Metadata	Data that describe other data, particularly XML tags characterizing attributes of values in data fields, such as version, unique identifier, mappings.
MFI	Metamodel Framework for Interoperability (MFI) -- an ISO/IEC 19763 standard.
MFI-13	Metamodel Framework for Interoperability (MFI) – ISO/IEC 19763-13 Metamodel for Forms Registration

Term	Definition
Minimal Lower Layer Protocol	Used for transferring HL7 messages over Ethernet. It defines delimiters which identify the beginning and ends of the HL7 messages.
MLLP	See Minimal Lower Layer Protocol.
Mobility/Fall Risk	A screening, or assessment, of a patient's balance, mobility, muscle strength, cognitive status, sensory impairments, physiological parameters and sometimes home environment to identify the patient's risk for falling and implementation, if needed, fall prevention interventions.
Modality	See DICOM PS 3.3.
Modality Performed Procedure Step	See DICOM PS 3.3.
Modality Performed Procedure Step Information Module	See DICOM PS 3.3.
Modality Performed Procedure Step Relationship Module	See DICOM PS 3.3.
Modality Performed Procedure Step SOP Class	See DICOM PS 3.4.
Modality Worklist	A mechanism defined to support the imaging workflow, by which the LIS provides the attributes of the imaging subject to modalities. In radiology, the imaging subject is the patient; in anatomic pathology, the imaging subject is a specimen derived from the patient. The Modality Worklist provides patient, order (study) and specimen identification and description to be included in the acquired images. Therefore the LIS needs to provide the attributes of the Specimen Module for each specimen being imaged. Therefore, the attributes of the Specimen Module have been defined in a 'Macro' construct, and added to the Scheduled Procedure Step Module of Modality Worklist. Conceptually, then, the Procedure Step is scheduled for the imaging of one or more specimen containers. While the use of the specimen attributes is optional according to the Standard for any Modality Worklist implementation, the APW profile requires their use for effective interoperability.
Modality Worklist SOP Class	See DICOM PS 3.4.
Mode of Arrival	The method of transportation used to transport the patient to the emergency department.

Term	Definition
Movement	An event describing a change of the situation of the patient in the context of the encounter. This concept encompasses changes such as transfers of patient location, change of patient class, new attending doctor, new consulting doctor, new encounter starting, encounter closing, etc. The concept of Movement is a superset of the concept of "Transfer".
MPI	Master Patient Index. See eMPI.
MPPS	See Modality Performed Procedure Step.
MPR	Multi-Planar Reconstruction. Creating orthogonal images from a data set (e.g., creating coronal and sagittal images from a transverse data set).
MQSA	Mammography Quality Standards Act of 1992.
MRN	Medicare Record Number.
MRN	Medicare Record Number (US) or Medical Record Number.
Multiple Antigen Vaccine	See Combination Vaccine.
MWL	See Modality Worklist.
NAACCR	North American Association of Central Cancer Registries. A collaborative umbrella organization for cancer registries, governmental agencies, professional organizations, and private groups in North America interested in enhancing the quality and use of cancer registry data.
Negative Inspiratory Force	A measure of pulmonary mechanics used to assess readiness to wean.
NEMA	National Electrical Manufacturers Association. See http://nema.org
Network Time Protocol	This is the standard Internet protocol for synchronizing computer clocks. See http://www.ntp.org for extensive background documentation at the introductory and expert level on how to synchronize computers. Also see SNTP.
N-Event Report	See DICOM PS 3.7.
NFC	Near Field Communication wireless protocol (peer endpoints must almost ‘touch’ to communicate)
NICU	Neonatal intensive-care unit. Unit of a hospital specializing in the care of ill or premature newborn infants.
NIST Rosetta Terminology Mapping Management System	Specifies the IEEE 11073 nomenclature and co-constraints (units-of-measure, enumerated values and sites).
NMEA	National Marine Electronics Association
Nominative Distribution	A mode of distributing medication in which the pharmacy dispenses the medication to each patient.
Non-repudiation	This service that provides proof of the integrity and origin of data which can be verified by any party.

Term	Definition
Non-repudiation	The assurance that someone cannot deny something, such as the receipt of a message or the authenticity of a statement or contract. Typically, non-repudiation refers to the ability to ensure that a party to a contract or a communication cannot deny the authenticity of their signature on a document or the sending of a message that they originated.
Non-volunteer Resources	Beyond the routine support, HL7 headquarters provides for balloting, etc., additional support may be required to assess potential funding requirements. Hosted projects will be expected to provide associated funding.
Notification Broker	A system or a module in a publish/subscribe framework, the purpose of which is to process subscription/un-subscription requests, to keep track of existing subscriptions, to receive publish information, and based on the set of filters for each subscription, to send a notification about the published information to the appropriate notification recipients.
Notification Recipient	A system or a module in a publish/subscribe framework, the purpose of which is to receive and process notifications from the notification broker.
NPO	Nothing by Mouth.
NTP	See Network Time Protocol.
Object Identifier	An open-ended system with a hierarchical scheme of assigning authorities, with a dotted series of numbers where each number represents an assigning authority in the hierarchy – each assigning authority can assign numbers to another, lower-level authority. An example is 2.16.840.1.113883 (joint-iso-itu-t.country.us.organization.hl7). IHE PCD has assigns OIDs starting from 1.3.6.1.4.1.19376.1.6. The IEEE 11073 nomenclature has the OID 1.2.840.10004.1.1.1.0.0.1. OIDs are the preferred unique identification scheme in the HL7 organization and are widely used in HL7 and other healthcare IT contexts to provide a durable globally unique numeric identification scheme.
Observation	See HL7 version 2.3.1.
Observation	A measurement of a single variable or a single value derived logically and/or algebraically from other measured or derived values. A test result is an observation.

Term	Definition
Observation	In HL7 generally, patient-oriented clinical data. In IHE PCD, this category is enlarged to include, in addition to patient physiological data (clinical measurements), patient care device data supporting the communication of patient-oriented clinical data such as patient and device identifying data, device technical status data, alarms and device settings. These are all reported using HL7 communications patterns established for clinical data in HL7 version 2.6 Chapter 7, Observations.
OBXV	OBX Visibility. OBX visibility indicates whether an OBX must or may be sent or otherwise accounted for at a particular level in the OBX-4 "observation hierarchy". See the Rosetta Containment Hierarchy document for additional information.
OID	See Object Identifier.
ONC	The U.S. Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology.
Order	A battery or test ordered by a ward and/or a physician to a laboratory, to be performed on one or more specimens collected from a patient.
Order	A request to perform examination of a specimen or a set of specimens taken from a patient. The Order is the focal object of the transactions between Order Filler and Order Placer or Order Result Tracker. An Order may be standalone or belong to an Order Group. The anatomic pathology laboratory may reorganize the orders placed by a clinical unit, especially in cases where an order was received attached to a set of specimens, which will have to be analyzed separately by different pathologists. For this reason the Order Filler may replace, merge, or split orders received from the Order Placer. This process is accomplished through messages of transactions PAT-1 and PAT-2 initiated by the Order Filler.
Order	In the context of the EHDI-WD profile, an order is a request for one or more services to be performed. The services are likely a procedure to be performed, but they also could include other actions such as administering an assessment questionnaire, or making a diet change. In this profile, a referral causes an order to be placed and that order, when filled, completes the referral request.

Term	Definition
Order encoding	The Prescription Placer may fill in the prescription with a free-text description of the treatment details (as simple as Paracetamol 1000 mg oral, as needed, max 3 times a day). This description has to be translated (encoded) into products, and the quantities may have to be determined for the Pharmaceutical Analysis, Dispensing and Administration to take place. This is modeled as an “encoding” sub-task.
Order Group	Also called the “Laboratory Request”: A set of orders placed together by a ward and/or a physician to one or more laboratories for a patient, to be performed on one or more specimens collected from this patient.
Order Group	A set of orders ordered together to investigate or address a patient condition.
ORI	Observation Reporting Interface defined by the standard POCT1-A from CLSI.
Original Dataset	Either of the data sets that are to be transformed and blended.
Other contributing causes of death	Conditions that unfavorably influence the course of the morbid process and thus contributes to the fatal outcome, but which is not related to the disease or condition directly causing death (ref ICD-10, vol 2, section 4.1.3 and UN, Handbook of Vital Statistics Systems and Methods, Volume 1, Glossary).
Outcome	The status of the patient at one or more points in time in the future, related to the established care plan goals.
Outcome Report	An outcome report may consider multiple testing results and result interpretations into consideration. For example, if a newborn’s hearing is screened and the results for the left ear are interpreted as a “fail”, and the right ear’s result interpretation is a “pass”, then the outcome report may indicate to “Refer” the patient for further testing. If the newborn is retested, and the new result interpretation for the left ear is a “pass”, then the outcome report for the newborn would include two screening procedures and the aggregate hearing screening outcome may be a “Pass”. So the plan of care would follow normal well-baby hearing care guidelines.
Outpatient	A patient not hospitalized >24 hours or housed in an extended care facility, who is being treated in an office, clinic, or other ambulatory care facility (Reference: Perinatal Workflow)
PaCO2	Partial pressure of carbon dioxide in the blood. Critical in regulating breathing levels and maintaining body pH.
PACS	Picture Archive and Communication System.
PACU	Post Anesthesia Care Unit.
Panel	Synonym for "Battery" (see Battery).
PaO2	Partial pressure of oxygen in the blood.

Term	Definition
Partially Completed Form	A pre-populated and/or auto-populated form served by the EHR to the provider that contains data for most fields.
Patient	See DICOM PS 3.3.
Patient	See DICOM PS 3.3
Patient	(When used in the context of ATNA) RFC 3881 defines the means of identifying the person who is a patient. The patient information in audit event records corresponds to the information available to identify a patient at the time the audit record was generated, and does not reflect later updates (e.g., patient reconciliation).
Patient Care Plan	The synthesis and reconciliation of the multiple Plans of Care produced by each provider to address specific health concerns of the patient. See below Plan of Care definition.
Patient Identification Module	See DICOM PS 3.3.
Patient Identifier Cross-reference Domain	Consists of a set of Patient Identifier Domains known and managed by a Patient Identifier Cross-reference Manager Actor. The Patient Identifier Cross-reference Manager Actor is responsible for providing lists of "alias" identifiers from different Patient Identifier Domains.
Patient Identifier Domain	A single system or a set of interconnected systems that all share a common identification scheme for patients. Such a scheme includes: (1) a single identifier-issuing authority, (2) an assignment process of an identifier to a patient, (3) a permanent record of issued patient identifiers with associated traits, and (4) a maintenance process over time. The goal of Patient Identification is to reduce errors.
Patient Mapping Agent	The CCOW defined component that provides for the mapping of patient identifiers across disparate patient identity domains.
Patient Privacy Policy	A Patient Privacy Policy explains appropriate use of data/documents in a way that provides choices to the patient. The BPPC Profile places no requirements on the content of these policies nor the method used to develop these policies (See ITI TF-1 Appendix P for some guidance on developing these policies). A Patient Privacy Policy will identify who has access to information, and what information is governed by the policy (e.g., under what conditions will a document be marked as containing that type of information). The Patient Privacy Policy may be a consent policy, dissent policy, authorization policy, etc.

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Patient Privacy Policy Acknowledgement Document	A document that follows the BPPC Content Profile and captures the act of the patient acknowledging a specific Patient Privacy Policy Domain defined Patient Privacy Policy.
Patient Privacy Policy Identifier	A Patient Privacy Policy Domain assigned identifier (OID) that uniquely identifies the Affinity Domain Patient Privacy Policy. There is one unique identifier (OID) for each Privacy Policy within the Patient Privacy Policy Domain.
Patient Privacy Policy Identifier	A Patient Privacy Policy Domain assigned identifier (OID) that uniquely identifies the Affinity Domain Patient Privacy Policy. There is one unique identifier (OID) for each Privacy Policy within the Patient Privacy Policy Domain. A Patient Privacy Policy Domain-assigned globally unique identifier that uniquely identifies the Patient Privacy Policy.
Patient Subject	The PSA defined subject that supports sharing the currently selected patient identifier amongst disparate applications running on the desktop.
PatientID	(When used in the context of ATNA) A free text that holds the system-internal patient identifier being unique within that system domain. The patient identifier domain is that assigned to the system that generated the audit event record. The patient information in audit event records corresponds to the information available to identify a patient at the time the audit record was generated and does not reflect later updates (e.g. patient reconciliation)
Patient-level Quality Report	A quality report that includes data about a single patient.
PBE	Password Based Encryption

Term	Definition
PCHA	Personal Connected Health Alliance (Formally Continua).
PCHA Data	Data arriving over the Continua-specified PCHA Transaction from PHD devices. This data is typically provided by sensors and contains sufficient information to generate the non-demographic components of and enterprise time requirements for the IHE PCD-01 or PHMR modules.
PDF	Portable Document Format.
Personal Health Device Class	A transport profile defined for USB.
Personal Health Monitoring Report	A C-CDA document designed primarily to record medical measurements taken on a patient by a sensor device.
Personnel White Pages	Information on human workforce members within the authority of the PWP directory. This information has broad use among many clinical and non-clinical applications across the healthcare enterprise. The information can be used to enhance the clinical workflow (contact information), enhance the user interface (user friendly names and titles), and ensure identity.
Pharmaceutical Advice	The outcome of the pharmaceutical analysis.
Pharmaceutical Advice	A Pharmaceutical Advice document is the outcome of the validation or review of one Prescription- or Dispense Item. It contains the overall result of the validation or review which affects the further processing as well as additional information such as Intolerances, Contra-indications and Allergies (ICAs) and all other information which was discovered during validation. A Pharmaceutical Advice document is also used to manage Prescription- or Dispensation Items (e.g., change, cancel, etc.) as well as to document Medication Interaction Checking Issues and their resolutions.
Pharmaceutical Advice Concern Item	A Pharmaceutical Advice Concern Item belongs to one Pharmaceutical Advice Item and represents the information to concerns (e.g., problems, allergies, etc.) which the Prescription- or Dispense Item referenced by the underlying Pharmaceutical Advice Item causes.
Pharmaceutical Advice Item	A Pharmaceutical Advice Item belongs to one Pharmaceutical Advice and represents the validation outcome or management command regarding the referenced Prescription- or Dispense Item (e.g., change, cancel, etc.). It may also carry Medication Interaction Checking Issue information regarding the referenced item.
Pharmaceutical Adviser	A pharmaceutical adviser is an abstract actor which validates prescription items issued on a prescription (generally a healthcare professional, usually a pharmacist when the patient enters the pharmacy to get the prescribed medication).

Term	Definition
Pharmaceutical Analysis	The action performed by a pharmacist to approve/modify or reject a prescription before it is given out to the patient.
Pharmacy Medication List	A Pharmacy Medication list is a collection of Medication Treatment Plan-, Prescription- and Dispense Items (and their related Pharmaceutical Advice Items) representing the Medication information of the patient at a certain point of time and according to business rules specified.
Pharmacy Validated Order	This term is used to indicate that a medication order (in the current case, a medication prescription) is considered valid after some pharmaceutical analysis. This may require (or not) some review by one or more healthcare professionals, e.g., pharmacists or physicians.
PHD	Personal Health Device such as a pedometer, glucometer, blood pressure cuff, thermometer, etc.
PHDC	See Personal Health Device Class.
PHI	See Protected Health Information.
PHMR	See Personal Healthcare Monitoring Report.
PHR	Personal Health Record
Physiologic	Mechanical, physical, and biochemical functions of living organisms.
Physiological Alarm	An alarm reflecting the physiological state of the patient (such as a heart rate above or below a caregiver-specified safe range for the patient).
Piggyback	A medication, typically administered intermittently in a small volume of fluid that runs into a maintenance line. While a piggyback is infusing, the maintenance fluid is stopped. When the piggyback has completed, the pump will automatically restart the maintenance fluid. The advantage to piggyback administration is that it does not require the patient to have multiple IV sites
PKI	Public Key Infrastructure.
Placer	See HL7 version 2.3.1.
Placer Group Number	The unique pair of identifiers assigned to an Order Group by the Order Placer Actor on the ward side and by the Order Filler Actor on the lab side. Either of the two identifiers may be present, or both may be present.
Placer Order Number	The unique reference assigned to an Order by the Order Placer Actor.
Plan of Care	A concept some clinicians use to focus on discrete problems, the specific interventions to address the problem, and achieve a certain goal related to the problem.

Term	Definition
Plan of Care	A plan of care is “specialty focused”. A patient may have multiple plans of care: one from a cardiologist, another from a hearing specialist, another from a nutritionist, etc. These plans of care are developed from the point of view of the specialty or sub-specialty. They are not necessarily reconciled to take other plans of care into consideration.
PM Store	Persistent Metric (PM) data Storage. An IEEE 11073 20601 means of persistently storing measurement data and exposing it to a peer.
PMA	Patient Mapping Agent component as defined by CCOW.
PMS	Practice Management System.
PnP	Plug and Play.
PO	A Latin term "per os", meaning by mouth.
POCT1-A	Interoperability Standard supporting point of care testing, produced by CLSI
Point of Care	Physical area in close proximity to the patient under clinical care. Usually the vicinity around the patient bedside and may include adjacent areas.
Post-Acute Care	The recuperative or rehabilitative care needed to recover from a serious injury or illness.
PPS	Performed Procedure Step.
Precaution	A statement indicating any medical, environmental, genetic, or other condition that may increase the likelihood of an Adverse Event, or reduce the effectiveness of the medication or immunization. A clinician should review the risks and weigh them against the benefits of the vaccine before deciding whether or not to proceed with the immunization.
Pre-fetch	The activity of fetching images or other information objects from previously completed procedures to near-term storage for review of those data.
Pregnancy Intention	A client’s plan or desire to either become pregnant or have a child in the near future or to prevent a future pregnancy.
Pre-op	A phase of care that occurs immediately prior to admitting the patient into the operating room or procedure room.
Prepopulate	This term is used in the Retrieve Form for Data Capture (RFD) Profile to define content that is submitted by a Form Filler and used to populate a form before an end user needs to fill in data. This contrasts against Autopopulate (SDC) and Querypopulate (mRFD)

Term	Definition
Pre-Population	When an Enhanced Form Repository fills in form fields using data sent by the Form Filler along with the retrieve request. This activity is distinguished from Auto-population in that Pre-population is performed by the Form Manager using an Enhanced Form Repository, whereas Auto-population is always performed by Form Filler.
Prescription	A prescription is an order given by a clinician (usually physicians and in some particular cases pharmacists, nurses, etc.), for a medication to be dispensed to the patient according to an established pattern. The prescription includes the name of the drugs, their dosages, instructions to the patient for the intake, etc.
Prescription	A prescription is issued by one ordering healthcare professional for one patient, in the context of zero or one administrative encounter (between the patient and the ordering physician and/or the healthcare institution).
Prescription Item	A prescription item belongs to one prescription and represents one prescribed medication. It may be associated with one or more observations. Prescription Item is the atomic entity for logistics, distribution and billing.
Prescription Item	A Prescription Item belongs to one prescription and represents one prescribed medication. It may be associated with one or more observations. Prescription Item is the atomic entity for logistics, distribution and billing. It contains the prescribed medicine and dosage information as well as other information to the prescribed item such as patient- and fulfillment instructions and substitution handling.
Presentation	Presentation is the part of the fetus lying over the pelvic inlet; the presenting body part of the fetus.
Presriber	A prescriber is an abstract actor who issues a prescription to a patient (generally a healthcare professional, usually a physician during treatment of a patient).
Primary Alarm System	The patient care device itself provides visual and aural indications of alarms that can be seen and heard in the immediate patient vicinity, and that are the authoritative primary indicators of alarms resulting from monitoring the patient. It is understood that caregivers shall be in a position to take immediate action based on these primary alarm indications and shall not rely exclusively on secondary alarm systems for alarm notifications.

Term	Definition
Principal	An end user, an application, a machine, or any other type of entity that may act as a requester in a transaction. A principal is typically represented in a transaction with a digital identity and the principal may have multiple valid digital identities to use with different transactions
Print Presentation LUT SOP Class	See DICOM PS 3.4.
Privacy Consent Document	The document containing a structured policy used to express patients' privacy preference.
Private Key	A key in an asymmetric cryptographic algorithm; the possession of this key is restricted, usually to one entity.
Pro Re Nata	Medication that should be administered as needed or as the situation arises. It represents an administration of prescribed medication whose timing is left to the patient, nurse or caregiver, as opposed to medication that is to be taken according to a fixed schedule. This does not imply that the patient may take as much of the medicine as desired, but rather that the medicine may be taken in the prescribed dosage if needed.
Procedure	A surgery or an invasive examination of a patient that is required by quality review organizations to be preceded by a pre-procedure assessment of procedure risk and anesthesia risk. This assessment is typically referred to as a "Pre-operative" or "Pre-procedure History and Physical."
Procedure	In the context of a "Pre-procedure History and Physical," the "procedure" is a surgery or an invasive examination of a patient that is required by quality review organizations to be preceded by a pre-procedure assessment of procedure risk and anesthesia risk. This assessment is typically referred to as a "Pre-operative" or "Pre-procedure History and Physical."
Procedure Plan	See DICOM PS 3.3.
Procedure Step	A Procedure Step is the smallest unit of work in the workflow that is scheduled (work to do) and/or performed (work done) by a person or machine (automatons, image acquisition modality, etc.) on an object (specimen, tissue sample, tissue section, etc.).
Procedure Type	See DICOM PS 3.3.
Process	A specific instance of a process definition running in a process engine.
Process	A specific instance of a process definition running in a process consumer.

Term	Definition
Process Definition	A designed flow of activities involving one or more role-based activity performers, implemented in XML and deployable to a runtime process consumer.
Process Definition	A design definition of a process flow of activities involving one or more role-based activity performers. A process definition is implemented in XML and deployable to a runtime process engine.
Process Flow Diagram	A graphical illustration of the flow of processes and interactions among the actors involved in a particular example.
Program	Settings used to control the operation of the pump. A program typically initiated by the clinician and entered manually on the device. Once the settings are confirmed, the clinician can then start the infusion.
Projection Dataset	A collection of images which do not have a completely defined location in space and whose pixels may not represent an exact location in the patient body. Although each image can have a normal vector describing the orientation of the image plane, they are not strictly planar since the “depth” of each pixel is undetermined. The image represents the (parallel or non-parallel) projection of volume data onto the image plane. Typical examples of projection data include Maximum Intensity Projection (MIP) images, projection images from an NM Gamma camera, most x-rays, mammograms, angio or fluoro series.
Pronouncer	When physician responsible for completing the medical certification of cause of death is not available at the time of death and the jurisdiction has a law providing for a pronouncer, person who determines that the decedent is legally dead but who was not in charge of the patient’s care for the illness or condition that resulted in death.(ref Medical Examiners’ and Coroners’ Handbook on Death Registration and Fetal Death Reporting).
Pronouncing	Process of determining and reporting, in the prescribed format, that the decedent is legally dead.
Protected Health Information	Protected Health Information, as defined in the United States Code of Federal Regulations (Part 45 CFR 160.103) and, as referenced in Section 13400 of Subtitle D (’Privacy’) of the HITECH Act.
Protected Health Information	Information that could be used to identify a patient linked with health data.
Protocol Code	See DICOM PS 3.3.

Term	Definition
Protocol Specifications	Protocol specifications encompass the following work products developed and supported by HL7: all versions of the HL7 messaging standard; the Clinical Document Architecture (CDA); Arden Syntax; CCOW specifications; Service Oriented Architecture (SOA) standards; any other normative standards subsequently released by HL7; various functional models, implementation guides, and Implementation Technology Specifications (ITS); the Reference Information Model (RIM); and those informative documents initiated and balloted by the various Work Groups.
Provider	An individual or any category of health care providers who deliver medical or health services and any other person or organization that supplies, bills, or is paid for health care. Including but not limited to: a doctor of medicine, osteopathy, optometry, dental science, podiatry, chiropractic, pharmacist, certified midwife, a registered nurse, a nursing home, a birthing center, or a hospital.
PSD	Peak Skin Dose.
Public Health Cancer Registry	A registry for a defined geographic location that collects cancer information from more than one facility and consolidates multiple reports into one record.
Public Key	A key in an asymmetric algorithm that is publicly available.
Publisher	A system or a module in a publish/subscribe framework, the purpose of which is to publish information to the notification broker about events for which there may be existing subscriptions.
Pull Point Resource	A resource managed by the Pull Point that allows the storing of notification targeted to a specific recipient.
QA	Quality Assurance.
QC	Quality Control.
Quality Criteria	A project commitment to a measure of the quality for each step of the project cycle. It is expected that most projects will use or possibly adapt boiler-plate quality criteria developed as part of HL7's methodology.
Quality Review	An evaluation of whether the work products of a step meet the pre-established quality criteria. At most steps the project team will self-assess against these criteria and take a vote (not a ballot) to move ahead to the next step.
Querypopulate	This term is used in this profile to define content that is populated into a form via use of RESTful queries to systems that may contain that discrete information. This contrasts against Autopopulate (SDC) and Prepopulate (RFD).

Term	Definition
Radio Frequency Identification	A technology that uses radio waves to transfer data from an electronic tag, called RFID tag or label, attached to an object, through a reader for the purpose of identifying and tracking the object.
Radio Frequency Identification	This is the technology whereby tags will transmit their unique identification either periodically (active) or when energized by an energy field (passive). This identification transmission can be correlated by multiple receives to identify the location of the tag.
Radiopharmaceutical Radiation Dose SR Object (RRDSR)	A DICOM Structured Report object conforming to the Radiopharmaceutical Radiation Dose SR IOD.
Real Time Location Services	This is an aspect of Location Services whereby the last known location of devices or people can be communicated to other systems.
Recapper	An automated device which puts back the cap on a specimen container. Acts as a Pre/Post-processor in LDA integration profile.
Reconciliation	The process of merging and adjudicating conflicts between electronically accessed clinical information from multiple sources. It occurs during transfers or transitions of care from one healthcare practice setting or level of care to another, and can occur at other times as needed.
Redacted Document	A document that contains extracted data from the export source document which will be sent to the external system for secondary use.
Referral	In the context of the EHDI-WD profile, a referral is a request for a treatment action to be taken. The treatment could involve performing a procedure or following some other set of instructions. A referral initiates one or more orders to be placed.
Referral Outcome	In the context of closed loop referral, the Referral Outcome extends the Result of Referral to include situations where the requisite care was not rendered or was ended before completion. Possible Referral Outcomes include: -The Referral Initiator cancels the referral request (a) before care began or (b) while care was being rendered, but before the care is completed. -The Referral Recipient declines the referral request (a) before beginning to render care or (b) before care has been completed. -The Referral Recipient completes the care and submits the Result of Referral.

Term	Definition
Referral Request	Referral Request is defined as a request from one provider (Referral Initiator) to another provider (Referral Recipient). The request includes a description of the services the Referral Initiator wants for a patient (i.e., the reason for referral and the specific questions asked).
Registered Space	The space to which the datasets are being registered. Typically this will be the space of one of the Original Data Sets. The Registered Space is identified by the Frame of Reference UID of the Spatial Registration object.
Related Health Information	In the context of closed loop referral, related health information is the patient information that is relevant to the referral request, interim findings, or the referral outcome.
Requested Procedure	See DICOM PS 3.3
Requested Procedure ID	See DICOM PS 3.3.
Requested Procedure Module	See DICOM PS 3.3.
Requester Entity	The entity identified within the identity assertion. This entity asks for resources (documents). This entity performs query to the registry and try to retrieve documents from repositories. Authorization Decisions are created and associated with the Requester Entity.
Research Eligibility Criteria	Defines the study population by specifying inclusion and exclusion criteria. Inclusion criteria must be met for prospective subjects to be eligible for participation in a study. Exclusion criteria are the characteristics in a protocol, any one of which may exclude a potential subject from participation in a study.
Research Management System	This term is used to describe a system that manages research information related to clinical trials or studies.
REST	Representational State Transfer. An integration paradigm whereby data is exchanged with remote hosts by operating on HTTP resources using HTTP verbs such as GET, PUT, POST, etc.
Result Interpretation	A categorization of a result to map actual measures or test observations to a set of possible meanings associated with the test, for example, in a hearing screening test, a measure of lower than 20 dBHL could be interpreted as a “Pass” while a measure of higher than 20 dBHL could be interpreted as a “Fail”. Results are what they are, but interpretations could vary by device, or by jurisdiction, for example, in some cases, the cut off between normal and abnormal could be30 dBHL.

Term	Definition
Result of Referral	In the context of closed loop referral, the Result of Referral encompasses the Referral Recipient's findings, conclusions, interpretations, and/or impressions of the service performed for the patient. The results are sent from the Referral Recipient to the Referral Initiator at the End of Care.
Resulting Dataset	The data set created by applying a Registration Transformation to an Original Dataset.
Results	Information measured or produced by a test. This is observable data.
Results Information Object Definition	See DICOM PS 3.3.
RFC	Request for comment. See http://www.rfc-editor.org/.
RFID	See Radio Frequency Identification.
RGB	Stands for "Red Green Blue." It refers to the three hues of light (red, green, and blue) that can mix together to form any color. When the highest intensity (255) of each color is mixed together, white light is created. When each hue is set to zero intensity, the result is black. Software specifies the specific R, G and B levels to generate specific colors per displayed pixel.
RID	Retrieve Information for Display
RIS	Radiology Information System.
Role	The actions of an actor in a use case.
Rosetta Terminology Mapping	The Rosetta Terminology Mapping (RTM)) IHE PCD Profile is focused on identifying a core set of semantics that are shared between multiple devices within the same modality (e.g., physiological monitors, ventilators, infusion pumps, etc.) and then mapping them to a standard terminology. The RTM mapping effort will initially include numeric parameters and their associated units of measurement and enumerated values. http://wiki.ihe.net/index.php?title=PCD_Profile_Rosetta_Terminology_Mapping References: ISO/IEEE 11073-10101 Health informatics — Point-of-care medical device communication — Part 10101: Nomenclature, First edition, 2004-12-15. ISO and IEEE, 2004. The 'Unified Code for Units of Measure' (UCUM).
Rotor Wing	Any transport by helicopter.
RPR	Rapid Plasma Reagin.
RR	Respiration rate in breaths per minute.
RRDSR	See Radiopharmaceutical Radiation Dose SR object.

Term	Definition
RSNA	Radiological Society of North America. See http://www.rsna.org/.
RTM	See Rosetta Terminology Mapping.
Run	A “run” is a set of documents to be processed. There can be a run of summary of care documents or a run of patient-level quality report documents. When validating a document produced from a run of documents, the content in that resulting document must demonstrate proper processing of the content in all documents with the run of incoming.
S&I	Standards and Interoperability Framework is an open forum sponsored by ONC’s Office of Standards & Interoperability (OSI) to advance harmonization and implementation of specifications that support national healthcare priorities. SDC is an S&I Framework initiative.
Safety Infusion System (Smart Pump System)	Infusion devices designed to reduce the error rates associated with infusions through the use of one or more of the following “smart” features: -Ability to check programmed doses against pre-configured limits in an onboard drug library. -Ability to read infusion parameters from RFID tags or bar codes. -Ability to send and receive infusion parameters via a wired or wireless network. -Ability to communicate through a server or gateway.
SAML	Security Assertion Markup Language is an Extensible Markup Language standard that allows a user to log on once for affiliated but separate Web sites.
SaO2	The saturation level of oxygen in hemoglobin, as measured by samples obtained from arterial puncture.
Scheduled Procedure Step	See DICOM PS 3.3.
Scheduled Procedure Step Module	See DICOM PS 3.3
SCO	Source Cardinality. Indicates the cardinality for a particular observation, for example: 0..1, 0..*, 1..1, 1..*, etc.)
Scope	A brief description of the transaction.
Scope	A brief description of the extent of identified profiles' transaction capacity.
SCP	Service Class Provider. See DICOM PS 3.3
SCU	Service Class User. See DICOM PS 3.3

Term	Definition
SDC Form Definition	A standardized set of attributes describing the semantics and syntax of a form design so that it may be rendered consistently in any suitable information system and can be validated using SDC Schema. Based on ISO/IEC 19763-13 with SDC extensions. This is not a fillable form.
SDC HTML Package	A collection of files that contains an HTML form instance derived from an SDC Form Definition, along with (optional) mapping information, (optional) administrative information, and (optional) supplemental data. The package is represented in SDC Content modules and may also be persisted as a collection of files. The HTML form instance is a fillable form.
SDC Schema	A W3C schema for an ISO/IEC 19763-13 compliant form, with SDC extensions.
SDC XML Package	A collection of XML data, meeting the SDC Schema, that includes the particular SDC Form Definition represented as a set of standardized XML elements, along with mapping information, administrative information including submission and compliance instructions, and (optional) supplemental data. The package is represented in SDC Content modules and may also be persisted as a collection of files.
Secondary Alarm System	A system intended to give "best effort" notification of alarms at additional locations, to additional persons, or for additional purposes such as archiving, but not intended to take the place of a primary alarm system as the authoritative primary indicator of alarms resulting from monitoring the patient.
Secure Domain	A network, hardware systems, secure nodes, and physical environment for which a single set of security policies is defined and enforced for access to its addressable objects.
Secure Node	A network-addressable system that conforms to a secure domain's access policies and management. A secure node often supports IHE actors.
Sequence	Term refers to two or more conditions entered on successive lines of Part I of the cause-of-death statement, each condition being an acceptable cause of the one entered on the line above it (ref ICD-10, vol 2, section 4.1.5).
Sequence Diagram	UML Sequence diagrams are a dynamic modeling technique, as are collaboration diagrams and activity diagrams.
Series	A subset of an imaging Study (see this entry) acquired from a single specimen by a single acquisition modality. Whenever an image is acquired from a new specimen or involves a new acquisition modality a new Series is created. A new series is also created when an image is acquired for an existing study after the original order has been fulfilled.

Term	Definition
Service Interface	System interfaces are also known as "application roles" or "service interfaces".
Settings	Device operational options that may be reported through the device's communications interface and in some cases may be changed through the communications interface.
Signature Ceremony	An instance of an entity creating a digital signature document.
Signature Purpose	An indication of the reason an entity signs a document. This may be explicitly included as part of the signed information and can be used when determining accountability for various actions concerning the document. Examples include: author, transcriptionist/recorder, and witness.
Signature Purpose	An indication of the reason that an entity signed a document. This may be explicitly included as part of the signature information and can be used when determining accountability for various actions concerning the document. Examples include attesting to: authorship, correct transcription, and witness of specific event. Also known as a "Commitment Type Indication"
Signature Time	The date and time of a signature ceremony.
Signature Time	The date and time that a signature was created.
Simple Network Time Protocol	This is a reduced accuracy version of NTP. The protocol fields are the same, but the data values and algorithms used are greatly reduced accuracy so that it can be implemented on limited capacity systems.
Single Interval Administration	A specific case of continuous administration where the parameters of the administration remain constant (or are changes are not considered relevant) during the entire interval. For example, one administration at a fixed rate for a given amount of time.
Single Point In Time Administration	An administration that happens in one single point in time, i.e., instantaneously, or that does not take a measurable amount of time. For example, giving or taking a tablet.
Slab	A thick slice tomosynthesis reconstruction (e.g., greater than 1mm).
SME	Subject Matter Expert or Domain Expert. A person with domain knowledge that represent the users of IT systems and their business needs.
SMTP Aether	The interconnected e-mail infrastructure of the Internet. The entry point into the SMTP Aether is an SMTP Server.

Term	Definition
SNOMED-CT®	A comprehensive clinical terminology, originally created by the College of American Pathologists (CAP) and, as of April 2007, owned, maintained, and distributed by the International Health Terminology Standards Development Organization (IHTSDO), a non-for-profit association in Denmark. The CAP continues to support SNOMED CT operations under contract to the IHTSDO and provides SNOMED-related products and services as a licensee of the terminology. More information available from http://www.ihtsdo.org/ or the United States National Library of Medicine at http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html.
SOAP	Simple Object Access Protocol: An XML-based messaging protocol.
Sorter	An automated device which sorts the specimen according to their process type. Acts as a Pre/Post-processor in LDA integration profile.
Spatial Registration SOP Class	See DICOM PS 3.3, section A.39.
Specimen Work Order Step	A single non-analytical operation to be performed on a specimen by an automated peri-analytical device.
SpO2	The saturation level of oxygen in hemoglobin; can be determined by noninvasive method of pulse oximetry.
SPS	See Scheduled Procedure Step.
SR	Structured Report.
Stage	The extent of involvement of organs and tissues by tumor (e.g., how far the cancer has spread in the body.
Stakeholder	A person or a company that requests a new standard, a technical correction to an existing standard, or an enhancement.
Standardized Functional Status Assessments	A series of specific, objective, and standardized tests, which include interview questions and/or a physical examination, of an individual, to determine their level or their strengths or weaknesses related, but not limited to fine and gross motor skills, visual perception, sensory processing, social skills, or comfort level. The assessment is used to confirm the individual's current level of functional ability for activities of daily living.

Term	Definition
Standards of Practice	The American Nurses Association defines Standards of Practice as follows (from American Nurses Association (2004). Standards of Clinical Nursing Practice. Washington, DC: ANA): Standard 1: Assessment: The registered nurse collects comprehensive data pertinent to the patient's health or the situation. Standard 2: Diagnosis: The registered nurse analyzes the assessment data to determine the diagnoses or issues. Standard 3: Outcomes Identification: The registered nurse identifies expected outcomes for a plan individualized to the patient and situation. Standard 4: Planning: The registered nurse develops a plan then prescribes strategies and alternatives to attain expected outcomes. Standard 5: Implementation: The Registered nurse implements the identified plan. from Standard 6: Evaluation: The registered nurse evaluates the progress toward attainment of outcomes.
Storage Commitment SOP Class	See DICOM PS 3.4.
Stored Print SOP Class	See DICOM PS 3.4
Structured Policy	A machine-processable set of access rules that enables the receiving system to enforce the patients' privacy preferences without requiring human interpretation.
Structured Reporting Information Object Definitions	See DICOM PS 3.3.
Structured Reporting SOP Classes	See DICOM PS 3.4.
Structured Reporting Templates	See DICOM PS 3.16.
Study	A study, in this context, is a test ordered by a clinician to gain information which helps to diagnose a patient's condition. A screening is a type of test which may include a very simple result interpretation, like pass or fail, normal or abnormal. In the context of this profile, the three concepts: study, test and screening can be classified a synonymous.
Study Coordinator	Person who handles most of the administrative responsibilities of a clinical trial on behalf of a site investigator, acts as liaison between investigative site and sponsor, and reviews all data and records before a monitor's visit.
Study Protocol	A document that describes the objective(s), design, methodology, statistical considerations, and organization of a trial.

Term	Definition
Subject	An individual who participates in a clinical trial, either as recipient of the investigational product(s) or as a control.
Submission Set	A set of XDS documents registered together to a Document Repository concerning information related to one care event of a single patient, provided by an EHR system.
Sub-order	A part of an Order or of an Order Group, which the current laboratory subcontracts to another laboratory.
Subscribe	Make a request that only messages satisfying specific predicates be sent to the subscriber.
Subscriber	A system or a module in a publish/subscribe framework, the purpose of which is to send subscribe and unsubscribe requests to the notification broker on the behalf of a notification recipient. The subscribe request contains a set of filters to determine the information for which the subscription applies.
SUID	The Study Instance UID from a DICOM SOP instance, or collection of SOP instances.
SWOS	Specimen Work Order Step: A WOS performed by Pre/Post-processor in LDA integration profile.
Syslog Message	Any message that complies with RFC-5424, regardless of the format of the message body. An ATNA audit log message is a specific kind of syslog message that has a specific format for the message body.
Syslog Metadata	Attributes that classifies the audit message defining: severity of the event, facility and application that sent the message. These are defined in RFC-5424.
System Actor	Information system that supports a particular function in the pharmacy domain.
Systemic Therapy	Treatment that affects the entire body, rather than a localized area. Types of systemic therapy include chemotherapy, hormone therapy, and biological therapy. Systemic therapy enters the bloodstream to destroy or control cancer throughout the body.
Team Member	Parties who manage and/or provide care or service as specified and agreed to in the care plan, including clinicians, other paid and informal caregivers, and the patient.
Technical Alarm	An alarm reflecting the state of the patient care device themselves that may require action from caregivers (such as ECG leads off the patient).

Term	Definition
Technical Validation	The process by which a laboratory technician accepts a single observation or a set of observations that have been produced either with a manual technique or an automated one, generally under his control. Technical validation ensures that observations have been obtained in conformance with defined laboratory procedures and have satisfied quality control and other technical validation criteria.
TEE	Transesophageal Echocardiography.
Test	An operation performed in laboratory or on the point of care, manually or on an analyzer or with the help of a device, instrument or system, to produce one or more observations (aka results). The observations can be obtained by measurement of a quantity on an in-vitro specimen, finding on this specimen, calculation from other observations and data, or any other means
TF	Technical Framework
TGT	Ticket Granting Ticket. The initial credentials that verify that the user has been authenticated. It is used to avoid repeated user authentication events and as a token to request access to services.
The Joint Commission	An independent, not-for-profit organization, which accredits and certifies health care organizations and programs in the United States. See https://www.jointcommission.org/.
The Joint Commission	Formerly "The Joint Commission on Accreditation of Healthcare Organizations" (JCAHO).
Tiers of Effective Contraception	Three tiers of effectiveness for available contraceptive methods have been established based upon efficacy of use and typical failure rates, per USAID and WHO recommendations. The tier 1 methods (such as the intrauterine device, implants, and sterilization) are rated the most highly effective because they are long-acting and independent from coitus, user motivation, or adherence and therefore have failure of rates of <1%. The lower tier methods are more highly dependent upon correct and consistent usage at every coital episode and thus susceptible to user failure with rates greater than 9%. Data elements that present contraceptive options should be ordered by these tiers.

Term	Definition
Tissue microarray	Tissue microarrays (TMA) consist of paraffin blocks in which up to 1000 separate tissue cores coming from different donor blocks, different parts and different patients, are assembled in array fashion to allow simultaneous processing and histological analysis.
TMA	See Tissue Micro Array.
TNM Stage	Tumor/Nodes/Metastasis – A system to classify the extent of disease based mostly on anatomic information on the extent of the primary tumor, regional lymph nodes and distant metastasis.
Transclusion	An inclusion within a template design makes use of another template by “virtually” copying the included template definitions, also known as transclusion. In essence this means that template definitions are included by reference and shown as-is on demand, i.e., at time of displaying the template or using it for the creation of validation scripts. Inclusion is automatic and transparent to the user.
Transfer of Care	Any transfer of care involving the exchange of patient care information between or across systems.
Transistion of Care	Transition of Care is defined as the cooperative provision of care by multiple providers, where each provider has part of the responsibility for the patient's wellness.
Transitions	Often referred to as a "hand-offs". Transfer of patient and their care to another similarly licensed care provider. This occurs during a change in acuity, care site, or a different provider.
Transport Medicine	Any field of medicine dealing specifically with an out of care setting environment or restructured to apply to an out of care setting environment.
Transport Mode	The method the patient employs, or is provided to get to the emergency department.
Treatment or Medication Regime	A treatment or medication regime is a series of medications intended to heal the patient or to improve the health status or to diagnose a disease.
Treatment Plan	A concept developed by a provider in collaboration with the individual to address an individual’s health concern under the purview of a single provider.
Trigger Event	An event such as the reception of a message or completion of a process, which causes another action to occur.
TTE	Transthoracic Echocardiography.

Term	Definition
Tubal Sterilization	To make sterile by ligation of the fallopian tubes. Irving Tubal Ligation - A surgical method of fallopian tube occlusion that excises a small portion of Fallopian tubes and then embeds the end of the cut fallopian tube below the serosa, or peritoneal, surface of the uterus. Modified Pomeroy Tubal Sterilization - A surgical method of fallopian tube occlusion that excises a small loop of Fallopian tube that has been tied firmly. Parkland Tubal ligation - A surgical method of fallopian tube occlusion that excises a small portion of Fallopian tubes after ligation proximally and distally. Uchida Tubal Ligation - A surgical method of fallopian tube occlusion that excises a small portion of Fallopian tubes then embeds the end of the cut fallopian tube below the mesosalpinx resulting in female sterilization
UCUM	The Unified Code for Units of Measure is a code system intended to include all units of measures being contemporarily used in international science. See www.unitsofmeasure.org/.
UID	See Unique Identifier (see also Globally Unique Identifier).
UML	See Unified Modeling Language.
Unbinding	Disassociation of a patient from a device.
Underlying Cause of Death	The disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury (ref ICD-10, vol 2, section 4.1.2).
Unfixed Dataset	A set of images which are planar, with a defined “depth”, but due to the nature of the modality the relative positions of each frame in the set is undetermined and so they do not technically define a volume. The most typical example of an unfixed dataset is a set of conventional ultrasound images.
Unified Modeling Language	A standardized general-purpose modeling language in the field of software engineering. The standard is managed, and was created by, the Object Management Group. UML includes a set of graphic notation techniques to create visual models of software-intensive systems.
Unique Identifier	See DICOM PS 3.5.
Universal ID	Unique identifier over time within the UID type. Each UID must belong to one of specifically enumerated species. Universal ID must follow syntactic rules of its scheme.
Universal Service ID	See HL7 version 2.3.1.

Term	Definition
Unsolicited	Within the context of HL7 when the transfer of information in initiated by the application system that deals with the triggering event, the transaction is termed an unsolicited update.
Unverified	Results that are flagged to be reviewed by a user prior to being incorporated into the information system.
USB	Universal Serial Bus.
Use Case	A graphical depiction of the actors and operation of a system.
Use Case	A Use Case represents a discrete unit of interaction between a user (human or machine) and the system. A Use Case is a single unit of meaningful work; for example creating a train, modifying a train and creating orders are all Use Cases. Each Use Case has a description which describes the functionality that will be built in the proposed system. A Use Case may 'include' another Use Case's functionality or 'extend' another Use Case with its own behavior. Use Cases are typically related to 'actors'. An actor is a human or machine entity that interacts with the system to perform meaningful work.
User Assertion	A set of claims about an authenticated principal (user, application, system...) that is issued by an identity provider.
User Subject	The PSA defined subject that supports sharing the user identity of the currently logged in to the applications on the desktop.
Username	A sequence of characters, different from a password, that is used as identification and is required when logging on to a multi-user computer system, LAN, bulletin board system, or online service. Also called user ID, or uid.
UTC	Universal Coordinated Time. This is the replacement for GMT. It defines a reference time base that is internationally recognized and supported.
UUID	Universally Unique Identifier
Vaccine	This is a substance designed to be administered to a person in order provide protection against future disease. See also Combination Vaccine.
Validated	PCD data which has been marked as correct by caregiver.
Validator	Synonym of “Clinical Expert” (see Clinical Expert).

Term	Definition
Value Set	A uniquely identifiable set of valid concept representations where any concept representation can be tested to determine whether or not it is a member of the value set. A value set may be a simple flat list of concept codes drawn from a single code system, or it might be an unbounded hierarchical set of possibly post-coordinated expressions drawn from multiple code systems. Also known as a list of valid concept codes. A valid concept is a concept that would be logically representative of the Value Set that it belongs to, for example for the Value Set "Colours of the rainbow", "yellow" would be a valid concept.
VDRL	Venereal Disease Research Laboratories. A blood test.
Verified	Results that are stored in the information system because they were marked as Verified (by device configuration) and did not require user review, or because they were selected at the point of care and reviewed by a user prior to being incorporated into the information system.
Verifier	This term is used in HL7 CDA R2 standard. A laboratory staff who performed "Technical Validation" (see Technical Validation).
Volumetric Dataset	A collection of planar (cross-sectional) images which spans a volume and each image has a defined location in space. Typical examples include a set of CT transversal slices, MR slice stacks, reconstructed tomographic NM or PET volumes or volumes re-constructed from projection X-ray images.
W3C	World Wide Web Consortium. See http://www/w3.org
W3C	A trademark of the World Wide Web Consortium that is not an abbreviation.
WADO-RS	Web Access to DICOM Objects by RESTful Services.
Waveform Snapshot	A limited duration continuous block of waveform data; typically less than one minute in duration.
Web-Viewable	Browsable using a web browser (e.g., XHTML files and JPEG images).
Weight-for-Length z-score and percentiles	For children less than 2 years (24 months) of age, weight-for-length, rather than BMI, is the preferred indicator. The reference population is the WHO Multicentre Growth Reference Study.
Wet Signature	Ink on paper signature.
WNL	Within Normal Limits.
Work Order	A test or battery to be performed on one or more biological specimens in the work area of a clinical laboratory.
Work Order Step	A battery or test requested by the Order Filler Actor to the Automation Manager Actor.
WOS	See Work Order Step.

Term	Definition
WSI	Whole Slide Image.
XA	X-ray Angiography.
XAD-PID	XDS Affinity Domain Patient Identifier.
XAD-PID - XDS Affinity Domain Patient Identifier	XDS assumes that the XDS Affinity Domain will establish common means to create a unique patient identifier for persons involved in the domain and allow Document Sources to find the appropriate patient identifier prior to publishing documents to the XDS infrastructure. This identifier is called the XDS Affinity Domain Patient Identifier.
X-Assertion Provider	This is an SAML Identity Provider (IDP) or WS-Trust Security Token Service (STS), and is not further specified by IHE.
XDS Affinity Domain	A group of healthcare enterprises that have agreed to work together using a common set of policies and which share a common infrastructure of repositories and a registry.
XDS Affinity Domain Policy	XDS Affinity Domain Policy that clearly defines the appropriate uses of the XDS Affinity Domain. Within this policy is a defined set of acceptable use Privacy Consent Policies that are published and understood.
XDS Document	An XDS Document is the smallest unit of information that may be provided to a Document Repository and registered in a Document Registry. An XDS Document may contain simple text, formatted text (e.g., HL7 CDA Release 1), images (e.g., DICOM) or structured and vocabulary coded clinical information (e.g., CDA Release 2, CCR), or may be made up of a mixture of the above types of content.
XDS Folder	An XDS Folder allows document sources to group the documents they submit with other related documents. What constitutes a Folder and the vocabulary associated with the specific Folders used by an EHR-CR is decided by an agreement between the care delivery organization members of an XDS Affinity Domain.
XDS Imaging Document	An XDS Imaging Document is the smallest unit of imaging related information that may be provided to a Document Repository and registered in a Document Registry. An XDS Imaging Document may contain a manifest of images (e.g., DICOM Key Object Selection document) or a radiology report provided either as a PDF document or as structured and vocabulary coded clinical information (e.g., CDA Release 2).
XHTML	eXtensible Hypertext Markup Language.
XSD	W3C Schema, when referencing xs:integer and other datatypes.

Term	Definition
ZigBee	Zigbee is an IEEE 802.15.4-based specification for a suite of high-level communication protocols used to create personal area networks with small, low-power digital radios, such as for home automation, medical device data collection, and other low-power low-bandwidth needs, designed for small scale projects which need wireless connection. Hence, Zigbee is a low-power, low data rate, and close proximity (i.e., personal area) wireless ad hoc network.

