HL7 CDA® R2 Implementation Guide:
Public Health Case Report, Release 2 – US Realm
the Electronic Initial Case Report (eICR)

Standard for Trial Use
June 2016

Volume 2 – eICR CDA IG - C-CDA Templates Only

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<thead>
<tr>
<th>Terminology</th>
<th>Owner/Contact</th>
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<tr>
<td>SNOMED CT</td>
<td>International Healthcare Terminology Standards Development Organization (IHTSDO) <a href="http://www.ihtsdo.org/snomed-ct/get-snomed-ct">http://www.ihtsdo.org/snomed-ct/get-snomed-ct</a> or <a href="mailto:info@ihtsdo.org">info@ihtsdo.org</a></td>
</tr>
<tr>
<td>Logical Observation Identifiers Names &amp; Codes (LOINC)</td>
<td>Regenstrief Institute</td>
</tr>
<tr>
<td>International Classification of Diseases (ICD) codes</td>
<td>World Health Organization (WHO)</td>
</tr>
<tr>
<td>NUCC Health Care Provider Taxonomy code set</td>
<td>American Medical Association. Please see 222.nucc.org. AMA licensing contact: 312-464-5022 (AMA IP services)</td>
</tr>
</tbody>
</table>
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1 DOCUMENT

1.1 Initial Public Health Case Report Document (eICR)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.15.2:20160422 (open)]

Draft as part of eICR CDA IG - C-CDA Templates Only

<table>
<thead>
<tr>
<th>Table 1: Initial Public Health Case Report Document (eICR) Contexts</th>
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<tr>
<td><strong>Contained By:</strong></td>
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<tr>
<td>Encounters Section (entries required) (V3)</td>
</tr>
<tr>
<td>Immunizations Section (entries required) (V3)</td>
</tr>
<tr>
<td>Problem Section (entries required) (V3)</td>
</tr>
<tr>
<td>Results Section (entries required) (V3)</td>
</tr>
<tr>
<td>US Realm Address (AD.US.FIELDED)</td>
</tr>
<tr>
<td>US Realm Person Name (PN.US.FIELDED)</td>
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</tbody>
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The purpose of this implementation guide (IG) is to specify a standard for the creation of an electronic initial case report (eICR) in Clinical Document Architecture, Release 2 (CDA R2) US Realm format built upon Consolidated CDA (C-CDA) DSTU Release 2.1 templates. This document is volume 2 of the "HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2" Implementation Guide. The Initial Public Health Case Report Document (eICR) template is a specialization of the US Realm Header (2.16.840.1.113883.10.20.22.1.1:2015-08-01) from v3 of the C-CDA Implementation Guide. It contains all of the constraints of the US Realm Header in addition to constraints specific to initial public health case reporting. It describes the structure and content requirements for the initial Case Report such as document identification, header information, relationships to the eICR required C-CDA section and entry templates and codes systems/value sets. Most importantly it includes the data elements to be retrieved from the EHR to produce the core, electronic Initial Case Report (eICR).

The conformance verb keyword at the start of a constraint (SHALL, SHOULD, MAY, etc.) indicates usage conformance. SHALL is an indication that the constraint is to be enforced without exception; SHOULD is an indication that the constraint is optional but highly recommended; and MAY is an indication that the constraint is optional and that adherence to the constraint is at the discretion of the document creator. The constraint of “SHALL” has been applied to the majority of data elements identified in Volume 1 Section 3.4 of this specification. This allows the electronic Initial Case Reports to be transmitted with as much information as is known at the time of the triggering event within the encounter. As described in Volume 1 Section 3.2, a “@nullFlavor” attribute (such as the most general and default null flavor for no information ‘NI’) allows the sender to explicitly indicate that the information isn’t known or available. However, there is a small subset of data elements that the Public Health
Agency Information System requires in order to process a case report. This implementation guide uses “SHALL NOT contain 0..0] @nullFlavor” to indicate nullFlavor is not allowed for these elements.

1.1.1 Properties


2. **SHALL** contain exactly one [1..1] **templateId** (CONF:2218-94) such that it
   a. **SHALL** contain exactly one [1..1] @root="2.16.840.1.113883.10.20.15.2" eICR Initial Public Health Case Report Document (CONF:2218-95).
   b. **SHALL** contain exactly one [1..1] @extension="2015-11-28" (CONF:2218-96).


5. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:2218-141).
   Note: The effectiveTime indicates the date when the report was created and in almost all cases should correspond to the date when the public health case has been triggered.
   a. This effectiveTime **SHALL NOT** contain [0..0] @nullFlavor (CONF:2218-143).

6. **SHALL** contain exactly one [1..1] **recordTarget** (CONF:2218-103).
   a. This recordTarget **SHALL** contain exactly one [1..1] **patientRole** (CONF:2218-104).
      i. This patientRole **SHALL** contain at least one [1..*] **id** (CONF:2218-146).
         Note: If multiple identifiers are available, a medical record number, social security number, medicaid number, or all three SHOULD be provided in this field.
      ii. This patientRole **SHALL** contain at least one [1..*] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:2218-147).
         Note: For greatest utility to public health, a patient’s address should be a home address if available (PostalAddressUse = ‘H’ or ‘HP’); would also request a second address, preferably a work address, (PostalAddressUse = ‘WP’) if available.
      iii. This patientRole **SHALL** contain exactly one [1..1] **patient** (CONF:2218-105).
         1. This patient **SHALL** contain exactly one [1..1] **sdtc:deceasedTime** (CONF:2218-106).
         2. This patient **SHOULD** contain zero or more [0..*] **guardian** (CONF:2218-110).
            a. The guardian, if present, **SHALL** contain at least one [1..*] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:2218-115).
            b. The guardian, if present, **SHALL** contain at least one [1..*] **telecom** (CONF:2218-116).
            c. The guardian, if present, **SHALL** contain exactly one [1..1] **guardianPerson** (CONF:2218-129).
3. This patient **SHALL** contain at least one [1..*] languageCommunication (CONF:2218-130).

7. **SHALL** contain at least one [1..*] **author** (CONF:2218-127).
   Note: In a public health case report, the author may be the provider, software, or a person in the role of a public health reporter, such as an infection control professional (ICP), a medical assistant, an office administrator, or another staff person who assists a provider with public health reporting.
   a. Such authors **SHALL** contain exactly one [1..1] **US Realm Date and Time (DTM.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4) (CONF:2218-142).
      i. This time **SHALL NOT** contain [0..0] @nullFlavor (CONF:2218-144).
   b. Such authors **SHALL** contain exactly one [1..1] assignedAuthor (CONF:2218-128).

1.1.1.1 componentOf

Initial Public Health Case Report ComponentOf

The encompassing encounter represents the setting of the clinical encounter during which the document act(s) or ServiceEvent(s) occurred (CDA R2). For the public health case report, the provider in charge of care and the facility in which care was provided when the case was triggered are contained within this element.

8. **SHALL** contain exactly one [1..1] **componentOf** (CONF:2218-1).
   Note: eICR-ComponentOf
   a. This componentOf **SHALL** contain exactly one [1..1] encompassingEncounter (CONF:2218-2).
      i. This encompassingEncounter **SHALL** contain at least one [1..*] **id** (CONF:2218-3).
         Note: This identifier corresponds to the visit or encounter ID
      ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet ActEncounterCode 2.16.840.1.113883.1.11.13955 (CONF:2218-4).
         Note: PatientEncounter.typeCode
      iii. This encompassingEncounter **SHALL** contain exactly one [1..1] effectiveTime (CONF:2218-5).
         1. This effectiveTime **SHALL NOT** contain [0..0] @nullFlavor (CONF:2218-124).
         2. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:2218-20).
            Note: PatientEncounter.fromDateTime
         3. This effectiveTime **SHALL** contain exactly one [1..1] **high** (CONF:2218-21).
            Note: PatientEncounter.thruDateTime. This value is associated with the patient’s departure (e.g. discharge)
      iv. This encompassingEncounter **SHALL** contain exactly one [1..1] responsibleParty (CONF:2218-6).
1. This responsibleParty SHALL contain exactly one [1..1] assignedEntity (CONF:2218-7).
   Note: ResponsibleProvider
   a. This assignedEntity SHALL contain at least one [1..*] id (CONF:2218-8).
      Note: ResponsibleProvider.identifier. If available, the NPI Identifier SHALL be provided.
      i. Such ids SHALL contain exactly one [1..1] @root (CONF:2218-22).
      ii. Such ids MAY contain zero or one [0..1] @extension (CONF:2218-23).
   b. This assignedEntity SHALL contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:2218-125).
   c. This assignedEntity SHALL contain at least one [1..*] telecom (CONF:2218-24).
      Note: ResponsibleProvider.telecomAddress
   d. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:2218-9).
      i. This assignedPerson SHALL contain exactly one [1..1] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:2218-25).
         Note: ResponsibleProvider.name
   e. This assignedEntity SHALL contain exactly one [1..1] representedOrganization (CONF:2218-10).
      Note: ResponsibleProviderFacility
      i. This representedOrganization SHALL contain exactly one [1..1] name (CONF:2218-26).
         Note: ProviderFacility.name
      ii. This representedOrganization SHALL contain exactly one [1..1] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:2218-27).
         Note: ProviderFacility.postalAddress
   v. This encompassingEncounter SHALL contain exactly one [1..1] location (CONF:2218-11).
      1. This location SHALL contain exactly one [1..1] healthCareFacility (CONF:2218-12).
         a. This healthCareFacility SHALL contain exactly one [1..1] id (CONF:2218-13).
            Note: CareDeliveryFacility.identifier
i. This id **SHALL** contain exactly one [1..1] @root (CONF:2218-28).

ii. This id **MAY** contain zero or one [0..1] @extension (CONF:2218-29).

b. This healthCareFacility **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet `ServiceDeliveryLocationRoleType` urn:oid:2.16.840.1.113883.1.11.17660 (CONF:2218-14).

Note: CareFacility.typeCode

c. This healthCareFacility **SHALL** contain exactly one [1..1] **location** (CONF:2218-15).

   i. This location **SHALL** contain exactly one [1..1] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:2218-32).

Note: CareDeliveryFacility.postalAddress

d. This healthCareFacility **SHALL** contain exactly one [1..1] **serviceProviderOrganization** (CONF:2218-16).

   i. This serviceProviderOrganization **SHALL** contain exactly one [1..1] **name** (CONF:2218-33).

Note: CareDeliveryOrganization.name

   ii. This serviceProviderOrganization **SHALL** contain at least one [1..*] **telecom** (CONF:2218-34).

Note: CareDeliveryOrganization.telecomAddress

   iii. This serviceProviderOrganization **SHALL** contain exactly one [1..1] **US Realm Address (AD.US.FIELDED)** (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:2218-126).
**Figure 1: Initial Public Health Case Report ComponentOf**

```xml
<componentOf>
  <encompassingEncounter>
    <!--encounter ID-->
    <id root="2.16.840.1.113883.19" extension="9937012"/>
    <!--ActClassEncounterCodes - high level -->
    <code code="AMB" codeSystem="2.16.840.1.113883.5.4" displayName="Ambulatory" codeSystemName="HL7 ActEncounterCode"/>
    <effectiveTime>
      <low value="20151107"/>
      <high value="20151107"/>
    </effectiveTime>
    <!--provider in charge of care when case reported-->
    <responsibleParty>
      <assignedEntity>
        <id extension="6666666666666" root="2.16.840.1.113883.4.6"/>
        <addr>
          <streetAddressLine>1002 Healthcare Drive</streetAddressLine>
          <city>Ann Arbor</city>
          <state>MI</state>
          <postalCode>99999</postalCode>
          <country>US</country>
        </addr>
        <telecom use="WP" value="tel:+1(555)555-555"/>
      </assignedEntity>
      <responsibleOrganization>
        <name>HC Doctors</name>
        <addr>
          <streetAddressLine>4444 Healthcare Drive</streetAddressLine>
          <city>Ann Arbor</city>
          <state>MI</state>
          <postalCode>99999</postalCode>
          <country>US</country>
        </addr>
      </responsibleOrganization>
    </responsibleParty>
    <!-- Information about facility where care was provided when case reported-->
    <location>
      <id extension="77777777777" root="2.16.840.1.113883.4.6"/>
      <!-- facility type-->
      <code code="OF" codeSystem="2.16.840.1.113883.11.17660" displayName="Outpatient facility"/>
      <!-- facility location within larger healthcare organization e.g Kaiser Vacaville within Kaiser North-->
      <location>
        <addr>
          <streetAddressLine>11000 Lakeside Drive</streetAddressLine>
          <city>Ann Arbor</city>
        </addr>
      </location>
    </location>
  </encompassingEncounter>
</componentOf>
```
1.1.1.3 component

Encounters Section (entries required) (V3)

The Encounters section template lists and describes any healthcare encounters pertinent to the patient’s current health status or historical health history. The encounter section includes the Encounter Activity, Encounter Diagnosis, and Problem Observation entry templates. The eICR data elements included in this section are:

- Date of Diagnosis
- Date of Onset
- Diagnoses

  i. This structuredBody SHALL contain exactly one [1..1] component (CONF:2218-86) such that it

  Note: Encounters Section (entries required) (V3)

    1. SHALL contain exactly one [1..1] Encounters Section (entries required) (V3) (identifier:
       urn:hl7ii:2.16.840.1.113883.10.20.22.2.22.1:2015-08-01) (CONF:2218-90).
1.1.1.4 component

History of Present Illness Section

The History of Present Illness section template describes the historical details leading up to and pertaining to the patient’s current complaint or reason for seeking medical care. The section text element is used to capture the history of present illness narrative.

- History of Present Illness
  - This structuredBody SHALL contain exactly one [1..1] component (CONF:2218-97) such that it
    - Note: History of Present Illness Section
      - SHALL contain exactly one [1..1] History of Present Illness Section (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:2218-100).

1.1.1.5 component

Reason for Visit Section

The Reason for Visit Section template records the patient’s reason for the patient’s visit (as documented by the provider). The eICR data elements include in this section are:

- Reason for Visit
  - This structuredBody SHALL contain exactly one [1..1] component (CONF:2218-98) such that it
    - Note: Reason for Visit Section

1.1.1.6 component

Social History Section (V3)

The Social History Section template contains social history data that influence a patient’s physical, psychological or emotional health. The Social History Section includes the Social History Observation. The eICR data elements included in this section are:

- Occupation
  - This structuredBody SHALL contain exactly one [1..1] component (CONF:2218-87) such that it
    - Note: Social History Section (V3)
      - SHALL contain exactly one [1..1] Social History Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2015-08-01) (CONF:2218-91).
1.1.1.7 component

Problem Section (entries required) (V3)

The Problem Section template lists and describes all relevant clinical problems at the time the document is generated. The Problem Section includes the Problem Concern Act and Problem Observation entry templates. The eICR data elements included in this section are:

- Pregnancy Status
  
  **NOTE**: During the eICR CDA IG DSTU period, the use of the Problems Observation template to indicate pregnancy is being evaluated. The recommended SNOMED value codes are ‘60001007’ Not pregnant (finding), and ‘77386006’ Patient currently pregnant (finding).

- Symptoms (list)
  
  This structuredBody **SHALL** contain exactly one [1..1] component (CONF:2218-99) such that it

  Note: Problem Section (entries required) (V3)

  1. **SHALL** contain exactly one [1..1] **Problem Section (entries required) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.5.1:2015-08-01) (CONF:2218-102).

1.1.1.8 component

Medications Administered Section (V2)

The Medications Administered Section template defines medications (excluding anesthetic medications) and fluids administered during an encounter. The Medication Administered Section includes the Medication Activity and Medication Information entry templates. The eICR data elements mapped to this section are:

- Medications Administered (list)
  
  This structuredBody **SHALL** contain exactly one [1..1] component (CONF:2218-88) such that it

  Note: Medications Administered Section (V2)


1.1.1.9 component

Results Section (entries required) (V3)

The Results Section template contains the results of observations generated by laboratories, imaging and other procedures. The Results Section includes the Results Organizer and Result Observation entry templates. The eICR data elements mapped to this section are:

- Lab Order Code
o Lab Results

o Filler Order Number (Note: If available, the placing system order identifier (Placer Order number) as well)

  vii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:2218-89) such that it
      Note: Results Section (entries required) (V3)
      1. **SHALL** contain exactly one [1..1] **Results Section (entries required) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2015-08-01) (CONF:2218-93).

1.1.1.10 component

  The Immunization Section (entries required) (V3)

  The Immunization Section (entries required) (V3) template from C-CDA R2.1 should include current immunization status, and may contain the entire immunization history that is relevant to the period of time being summarized. The eICR data elements mapped to this section are:

  o Immunization Status

  viii. This structuredBody **SHOULD** contain zero or one [0..1] **component** (CONF:2218-148) such that it
      Note: The Immunization Section (entries required) (V3)
      1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries required) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.1:2015-08-01) (CONF:2218-149).
Figure 2: Initial Public Health Case Report Document Example

<?xml version="1.0" encoding="UTF-8"?>
<!-- Title: "Sample file for the PHCR Pertussis Report"

<ClinicalDocument xmlns="urn:hl7-org:v3" xmlns:voc="urn:hl7-org:v3/voc"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance" xmlns:sdtc="urn:hl7-org:sdtc">

<!-- ********************************************************
CDA Header
******************************************************** -->
<realmCode code="US"/>
<typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
<templateId root="2.16.840.1.113883.10.20.15.2" extension="2015-11-28"/>
<globally unique document ID (extension) is scoped by vendor/software -->
{id root="db734647-fc99-424c-a864-7e3da82e703"/>
<!-- Document Code -->
<code code="55751-2" codeSystem="2.16.840.1.113883.6.1"
displayName="Public Health Case report"/>
<title>Initial Public Health Case Report</title>
<effectiveTime value="20151107094421+0000"/>
<confidentialityCode code="N" displayName="Normal" codeSystem="2.16.840.1.113883.5.25"/>
<languageCode code="en-US"/>
<recordTarget>
<!-- Fake root for sample. -->
<patientRole>
<!-- SSN -->
<!-- Could have multiple addresses -->
<addr use="H">
<streetAddressLine>2222 Home Street</streetAddressLine>
<city>Ann Arbor</city>
<state>MI</state>
<postalCode>99999</postalCode>
<country>US</country>
</addr>
<telecom value="tel:+1-(555)555-2003" use="HP"/>
<telecom value="tel:+1(555)555-2004" use="WP"/>
</patient>
<!-- administrativeGenderCode code="M"
<administrativeGenderCode code="M" codeSystem="2.16.840.1.113883.5.1"/>
<birthTime value="19741124"/>
<administrativeGenderCode code="M" codeSystem="2.16.840.1.113883.5.1"/>
<birthTime value="19741124"/>
<deceasedInd value="false"/>
<deceasedTime value="20151128"/>
<raceCode code="2106-3" displayName="White" codeSystem="2.16.840.1.113883.6.238"
<raceCode code="2106-3" displayName="White" codeSystem="2.16.840.1.113883.6.238"
<raceCode code="2186-5" displayName="Not Hispanic or Latino"
codeSystem="2.16.840.1.113883.6.238" codeSystemName="Race &amp; Ethnicity - CDC"/>
<ethnicGroupCode code="2186-5" displayName="Not Hispanic or Latino"
codeSystem="2.16.840.1.113883.6.238" codeSystemName="Race &amp; Ethnicity - CDC"/>
<guardian>
  <addr use="H">
    <streetAddressLine>2222 Home Street</streetAddressLine>
    <city>Ann Arbor</city>
    <state_MI/>
    <postalCode>99999</postalCode>
    <country>US</country>
  </addr>
  <telecom value="tel:+1(555)555-2003" use="HP"/>
  <guardianPerson>
    <name use="L">
      <given>Eve</given>
      <given qualifier="IN">E</given>
      <family>Everywoman</family>
    </name>
  </guardianPerson>
</guardian>

<languageCommunication>
  <languageCode code="eng"/>
  <modeCode code="ESP" displayName="Expressed spoken" codeSystem="2.16.840.1.113883.5.60" codeSystemName="LanguageAbilityMode"/>
  <proficiencyLevelCode code="G" displayName="Good" codeSystem="2.16.840.1.113883.5.61" codeSystemName="LanguageAbilityProficiency"/>
</languageCommunication>

<languageCommunication>
</languageCommunication>

<author>
  <time value="20151107094421+0000"/>
  <assignedAuthor>
    <id root="2.16.840.1.113883.3.72.5.20"/>
    <addr>
      <streetAddressLine>1002 Healthcare Drive</streetAddressLine>
      <city>Ann Arbor</city>
      <state_MI/>
      <postalCode>99999</postalCode>
      <country>US</country>
    </addr>
    <telecom value="tel:+1-(555)555-1002 (ext=110)" use="WP"/>
    <assignedAuthoringDevice>
      <manufacturerModelName displayName="Acme"/>
      <softwareName displayName="Acme EHR"/>
    </assignedAuthoringDevice>
  </assignedAuthor>
</author>

<custodian>
</custodian>
<representedCustodianOrganization>
  <id extension="88888888" root="2.16.840.1.113883.4.6"/>
  <name>Level Seven Healthcare, Inc</name>
  <telecom use="WP" value="tel:+1(555)555-3001"/>
  <addr>
    <streetAddressLine>4444 Healthcare Drive</streetAddressLine>
    <city>Ann Arbor</city>
    <state>MI</state>
    <postalCode>99999</postalCode>
    <country>US</country>
  </addr>
</representedCustodianOrganization>
</assignedCustodian>
</custodian>

<componentOf>
  ...
</componentOf>

<component>
  <structuredBody>
    <component>
      <!--
      ********************************************************
      Encounters Section (entries required) (V3)
      ********************************************************
      -->
      <section>
        ...
      </section>
    </component>
    <component>
      <!--
      ********************************************************
      History of Present Illness Section
      ********************************************************
      -->
      <section>
        ...
      </section>
    </component>
    <component>
      <!--
      ********************************************************
      Medications Administered Section (V2)
      ********************************************************
      -->
      <section>
        ...
      </section>
    </component>
  </structuredBody>
</component>

<!--
********************************************************
ComponentOf - contains the provider and facility information for the case - see inline example above
********************************************************
-->
<!--
********************************************************
Problem Section (entries required) (V3)
********************************************************
-->  
  <section>  
    ...
  </section>
  <component>
  
  </component>
<!--
********************************************************
Reason for Visit Section
********************************************************
-->  
  <section>
    ...
  </section>
  <component>
  
  </component>
<!--
********************************************************
Results Section (entries required) (V3)
********************************************************
-->  
  <section>
    ...
  </section>
  <component>
  
  </component>
<!--
********************************************************
Social History Section (V3)
********************************************************
-->  
  <section>
    ...
  </section>
  <component>
  
  </component>
<!--
********************************************************
Immunizations Section (entries required) (V3)
********************************************************
-->  
  <section>
    ...
  </section>
  <component>
  </structuredBody>
  </component>
</ClinicalDocument>
1.2 **US Realm Header (V3)**

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2015-08-01 (open)]

Published as part of Consolidated CDA Templates for Clinical Notes (US Realm) DSTU R2.1

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>US Realm Address (AD.US.FIELDED)</td>
</tr>
<tr>
<td></td>
<td>US Realm Date and Time (DTM.US.FIELDED)</td>
</tr>
<tr>
<td></td>
<td>US Realm Person Name (PN.US.FIELDED)</td>
</tr>
</tbody>
</table>

This template defines constraints that represent common administrative and demographic concepts for US Realm CDA documents. Further specification, such as ClinicalDocument/code, are provided in document templates that conform to this template.

1.2.1 Properties

1.2.1.1 realmCode

1. **SHALL** contain exactly one [1..1] `realmCode`="US" (CONF:1198-16791).

2. **SHALL** contain exactly one [1..1] `typeId` (CONF:1198-5361).
   a. This `typeId` **SHALL** contain exactly one [1..1] `@root"2.16.840.1.113883.1.3"` (CONF:1198-5250).
   b. This `typeId` **SHALL** contain exactly one [1..1] `@extension"POCD_HD000040"` (CONF:1198-5251).

3. **SHALL** contain exactly one [1..1] `templateId` (CONF:1198-5252) such that it
   a. **SHALL** contain exactly one [1..1] `@root"2.16.840.1.113883.10.20.22.1.1"` (CONF:1198-10036).
   b. **SHALL** contain exactly one [1..1] `@extension"2015-08-01"` (CONF:1198-32503).

4. **SHALL** contain exactly one [1..1] `id` (CONF:1198-5363).
   a. This `id` **SHALL** be a globally unique identifier for the document (CONF:1198-9991).

5. **SHALL** contain exactly one [1..1] `code` (CONF:1198-5253).
   a. This `code` **SHALL** specify the particular kind of document (e.g., History and Physical, Discharge Summary, Progress Note) (CONF:1198-9992).

6. **SHALL** contain exactly one [1..1] `title` (CONF:1198-5254).
   Note: The title can either be a locally defined name or the `displayName` corresponding to `clinicalDocument/code`

7. **SHALL** contain exactly one [1..1] `US Realm Date and Time (DTM.US.FIELDED)` (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4) (CONF:1198-5256).

8. **SHALL** contain exactly one [1..1] `confidentialityCode`, which **SHOULD** be selected from ValueSet [HL7 BasicConfidentialityKind](urn:oid:2.16.840.1.113883.1.11.16926) STATIC (CONF:1198-5259).
9. **SHALL** contain exactly one [1..1] `languageCode`, which **SHALL** be selected from ValueSet `Language` urn:oid:2.16.840.1.113883.1.11.11526 DYNAMIC (CONF:1198-5372).

10. **MAY** contain zero or one [0..1] `setId` (CONF:1198-5261).
   
a. If `setId` is present `versionNumber` **SHALL** be present (CONF:1198-6380).

11. **MAY** contain zero or one [0..1] `versionNumber` (CONF:1198-5264).
   
a. If `versionNumber` is present `setId` **SHALL** be present (CONF:1198-6387).

### 1.2.1.2 recordTarget

The `recordTarget` records the administrative and demographic data of the patient whose health information is described by the clinical document; each `recordTarget` must contain at least one `patientRole` element.

12. **SHALL** contain at least one [1..*] `recordTarget` (CONF:1198-5266).
   
a. Such `recordTargets` **SHALL** contain exactly one [1..1] `patientRole` (CONF:1198-5267).
   
   i. This `patientRole` **SHALL** contain at least one [1..*] `id` (CONF:1198-5268).
   
   ii. This `patientRole` **SHALL** contain at least one [1..*] `US Realm Address (AD.US.FIELDED)` (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1198-5271).
   
   iii. This `patientRole` **SHALL** contain at least one [1..*] `telecom` (CONF:1198-5280).

   1. Such `telecoms` **SHOULD** contain zero or one [0..1] `@use`, which **SHALL** be selected from ValueSet `Telecom Use (US Realm Header)` urn:oid:2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:1198-5375).

   iv. This `patientRole` **SHALL** contain exactly one [1..1] `patient` (CONF:1198-5283).

   1. This `patient` **SHALL** contain at least one [1..*] `US Realm Person Name (PN.US.FIELDED)` (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-5284).
   
   2. This `patient` **SHALL** contain exactly one [1..1] `administrativeGenderCode`, which **SHALL** be selected from ValueSet `Administrative Gender (HL7 V3)` urn:oid:2.16.840.1.113883.1.11.1 DYNAMIC (CONF:1198-6394).
   
   3. This `patient` **SHALL** contain exactly one [1..1] `birthTime` (CONF:1198-5298).

   a. **SHALL** be precise to year (CONF:1198-5299).
   
   b. **SHOULD** be precise to day (CONF:1198-5300).

For cases where information about newborn’s time of birth needs to be captured.

   c. **MAY** be precise to the minute (CONF:1198-32418).
   
   4. This `patient` **SHOULD** contain zero or one [0..1] `maritalStatusCode`, which **SHALL** be selected from ValueSet `Marital Status`
5. This patient **MAY** contain zero or one [0..1] 
   `religiousAffiliationCode`, which **SHALL** be selected from 
   ValueSet `Religious Affiliation` 
   urn:oid:2.16.840.1.113883.1.11.19185 **DYNAMIC** (CONF:1198-5317).

6. This patient **SHALL** contain exactly one [1..1] `raceCode`, which **SHALL** 
   be selected from ValueSet `Race Category Excluding Nulls` 
   urn:oid:2.16.840.1.113883.3.2074.1.1.3 **DYNAMIC** (CONF:1198-5322).

7. This patient **MAY** contain zero or more [0..*] `sdtc:raceCode`, which 
   **SHALL** be selected from ValueSet `Race` 
   urn:oid:2.16.840.1.113883.1.11.14914 **DYNAMIC** (CONF:1198-7263). 
   Note: The `sdtc:raceCode` is only used to record additional values 
   when the patient has indicated multiple races or additional race 
   detail beyond the five categories required for Meaningful Use Stage 2. 
   The prefix `sdtc:` **SHALL** be bound to the namespace “urn:hl7- 
   org:sdtc”. The use of the namespace provides a necessary extension 
   to CDA R2 for the use of the additional `raceCode` elements.
   a. If `sdtc:raceCode` is present, then the patient **SHALL** contain 
      [1..1] `raceCode` (CONF:1198-31347).

8. This patient **SHALL** contain exactly one [1..1] `ethnicGroupCode`, which 
   **SHALL** be selected from ValueSet `Ethnicity` 
   urn:oid:2.16.840.1.114222.4.11.837 **DYNAMIC** (CONF:1198-5323).

9. This patient **MAY** contain zero or more [0..*] `sdtc:ethnicGroupCode`, which 
   **SHALL** be selected from ValueSet `Detailed Ethnicity` 
   urn:oid:2.16.840.1.114222.4.11.877 **DYNAMIC** (CONF:1198-32901).

10. This patient **MAY** contain zero or more [0..*] `guardian` (CONF:1198-5325).
    a. The guardian, if present, **SHOULD** contain zero or one [0..1] `code`, which 
       **SHALL** be selected from ValueSet `Personal And Legal Relationship Role Type` 
       urn:oid:2.16.840.1.113883.11.20.12.1 **DYNAMIC** (CONF:1198-5326).
    b. The guardian, if present, **SHOULD** contain zero or more [0..*] `US Realm Address (AD.US.FIELDED)` (identifier: 
       urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1198-5359).
    c. The guardian, if present, **SHOULD** contain zero or more [0..*] `telecom` (CONF:1198-5382).
       i. The telecom, if present, **SHOULD** contain zero or one [0..1] @use, which **SHALL** be selected from ValueSet
Telecom Use (US Realm Header)
urn:oid:2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:1198-7993).

d. The guardian, if present, SHALL contain exactly one [1..1] guardianPerson (CONF:1198-5385).
   i. This guardianPerson SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-5386).

11. This patient MAY contain zero or one [0..1] birthplace (CONF:1198-5395).
   a. The birthplace, if present, SHALL contain exactly one [1..1] place (CONF:1198-5396).
      i. This place SHALL contain exactly one [1..1] addr (CONF:1198-5397).
         1. This addr SHOULD contain zero or one [0..1] country, which SHALL be selected from ValueSet Country urn:oid:2.16.840.1.113883.3.88.12.80.63 DYNAMIC (CONF:1198-5404).
         2. This addr MAY contain zero or one [0..1] postalCode, which SHALL be selected from ValueSet PostalCode urn:oid:2.16.840.1.113883.3.88.12.80.2 DYNAMIC (CONF:1198-5403).
         3. If country is US, this addr SHALL contain exactly one [1..1] state, which SHALL be selected from ValueSet StateValueSet 2.16.840.1.113883.3.88.12.80.1 DYNAMIC (CONF:1198-5402).
            Note: A nullFlavor of ' UNK' may be used if the state is unknown.

12. This patient SHOULD contain zero or more [0..*] languageCommunication (CONF:1198-5406).
   a. The languageCommunication, if present, SHALL contain exactly one [1..1] languageCode, which SHALL be selected from ValueSet Language urn:oid:2.16.840.1.113883.1.11.11526 DYNAMIC (CONF:1198-5407).
   b. The languageCommunication, if present, MAY contain zero or one [0..1] modeCode, which SHALL be selected from ValueSet LanguageAbilityMode urn:oid:2.16.840.1.113883.1.11.12249 DYNAMIC (CONF:1198-5409).
   c. The languageCommunication, if present, SHOULD contain zero or one [0..1] proficiencyLevelCode, which SHALL be selected from ValueSet LanguageAbilityProficiency
urn:oid:2.16.840.1.113883.1.11.12199 DYNAMIC (CONF:1198-9965).

d. The languageCommunication, if present, SHOULD contain zero or one [0..1] preferenceInd (CONF:1198-5414).

v. This patientRole MAY contain zero or one [0..1] providerOrganization (CONF:1198-5416).

1. The providerOrganization, if present, SHALL contain at least one [1..*] id (CONF:1198-5417).
   a. Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1198-16820).

2. The providerOrganization, if present, SHALL contain at least one [1..*] name (CONF:1198-5419).

3. The providerOrganization, if present, SHALL contain at least one [1..*] telecom (CONF:1198-5420).
   a. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) urn:oid:2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:1198-7994).

4. The providerOrganization, if present, SHALL contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1198-5422).

1.2.1.3 author

The author element represents the creator of the clinical document. The author may be a device or a person.

13. SHALL contain at least one [1..*] author (CONF:1198-5444).
   a. Such authors SHALL contain exactly one [1..1] US Realm Date and Time (DTM.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4) (CONF:1198-5445).

   b. Such authors SHALL contain exactly one [1..1] assignedAuthor (CONF:1198-5448).
      i. This assignedAuthor SHALL contain at least one [1..*] id (CONF:1198-5449).

      If this assignedAuthor is an assignedPerson
      ii. This assignedAuthor SHOULD contain zero or one [0..1] id (CONF:1198-32882) such that it

      If id with @root="2.16.840.1.113883.4.6" National Provider Identifier is unknown then

      1. MAY contain zero or one [0..1] @nullFlavor="UNK" Unknown (CodeSystem: HL7NullFlavor urn:oid:2.16.840.1.113883.5.1008) (CONF:1198-32883).

      2. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1198-32884).

      3. SHOULD contain zero or one [0..1] @extension (CONF:1198-32885).

      Only if this assignedAuthor is an assignedPerson should the assignedAuthor contain a code.
iii. This assignedAuthor **SHOULD** contain zero or one [0..1] `code` (CONF:1198-16787).
   1. The code, if present, **SHALL** contain exactly one [1..1] `@code`, which **SHOULD** be selected from ValueSet **Healthcare Provider Taxonomy (HIPAA)** `urn:oid:2.16.840.1.114222.4.11.1066 DYNAMIC` (CONF:1198-16788).

iv. This assignedAuthor **SHALL** contain at least one [1..*] **US Realm Address (AD.US.FIELDED)** (identifier: `urn:oid:2.16.840.1.113883.10.20.22.5.2`) (CONF:1198-5452).

v. This assignedAuthor **SHALL** contain at least one [1..*] `telecom` (CONF:1198-5428).
   1. Such telecoms **SHOULD** contain zero or one [0..1] `@use`, which **SHALL** be selected from ValueSet **Telecom Use (US Realm Header)** `urn:oid:2.16.840.1.113883.11.20.9.20 DYNAMIC` (CONF:1198-7995).

vi. This assignedAuthor **SHOULD** contain zero or one [0..1] `assignedPerson` (CONF:1198-5430).
   1. The assignedPerson, if present, **SHALL** contain at least one [1..*] **US Realm Person Name (PN.US.FIELDED)** (identifier: `urn:oid:2.16.840.1.113883.10.20.22.5.1.1`) (CONF:1198-16789).

vii. This assignedAuthor **SHOULD** contain zero or one [0..1] `assignedAuthoringDevice` (CONF:1198-16783).
   1. The assignedAuthoringDevice, if present, **SHALL** contain exactly one [1..1] `manufacturerModelName` (CONF:1198-16784).
   2. The assignedAuthoringDevice, if present, **SHALL** contain exactly one [1..1] `softwareName` (CONF:1198-16785).

viii. There **SHALL** be exactly one assignedAuthor/assignedPerson or exactly one assignedAuthor/assignedAuthoringDevice (CONF:1198-16790).

1.2.1.4 `dataEnterer`

The `dataEnterer` element represents the person who transferred the content, written or dictated, into the clinical document. To clarify, an author provides the content found within the header or body of a document, subject to their own interpretation; a dataEnterer adds an author's information to the electronic system.

14. **MAY** contain zero or one [0..1] `dataEnterer` (CONF:1198-5441).
   a. The `dataEnterer`, if present, **SHALL** contain exactly one [1..1] `assignedEntity` (CONF:1198-5442).
      i. This `assignedEntity` **SHALL** contain at least one [1..*] `id` (CONF:1198-5443).
         1. Such ids **SHOULD** contain zero or one [0..1] `@root="2.16.840.1.113883.4.6"` National Provider Identifier (CONF:1198-16821).
         ii. This `assignedEntity` **MAY** contain zero or one [0..1] `code`, which **SHOULD** be selected from ValueSet **Healthcare Provider Taxonomy (HIPAA)** `urn:oid:2.16.840.1.114222.4.11.1066 DYNAMIC` (CONF:1198-32173).
iii. This assignedEntity SHALL contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1198-5460).

iv. This assignedEntity SHALL contain at least one [1..*] telecom (CONF:1198-5466).
   1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) urn:oid:2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:1198-7996).

v. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:1198-5469).
   1. This assignedPerson SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-5470).

1.2.1.5 informant

The informant element describes an information source for any content within the clinical document. This informant is constrained for use when the source of information is an assigned health care provider for the patient.

15. MAY contain zero or more [0..*] informant (CONF:1198-8001) such that it
   a. SHALL contain exactly one [1..1] assignedEntity (CONF:1198-8002).
      i. This assignedEntity SHALL contain at least one [1..*] id (CONF:1198-9945).
         1. If assignedEntity/id is a provider then this id, SHOULD include zero or one [0..1] id where id/@root ="2.16.840.1.113883.4.6” National Provider Identifier (CONF:1198-9946).
      ii. This assignedEntity MAY contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) urn:oid:2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:1198-32174).
      iii. This assignedEntity SHALL contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1198-8220).
      iv. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:1198-8221).
         1. This assignedPerson SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-8222).

1.2.1.6 informant

The informant element describes an information source (who is not a provider) for any content within the clinical document. This informant would be used when the source of information has a personal relationship with the patient or is the patient.

16. MAY contain zero or more [0..*] informant (CONF:1198-31355) such that it
1.2.1.7 custodian

The custodian element represents the organization that is in charge of maintaining and is entrusted with the care of the document.

There is only one custodian per CDA document. Allowing that a CDA document may not represent the original form of the authenticated document, the custodian represents the steward of the original source document. The custodian may be the document originator, a health information exchange, or other responsible party.

17. SHALL contain exactly one [1..1] custodian (CONF:1198-5519).
   a. This custodian SHALL contain exactly one [1..1] assignedCustodian (CONF:1198-5520).
      i. This assignedCustodian SHALL contain exactly one [1..1] representedCustodianOrganization (CONF:1198-5521).
         1. This representedCustodianOrganization SHALL contain at least one [1..*] id (CONF:1198-5522).
            a. Such ids SHOULD contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1198-16822).
         2. This representedCustodianOrganization SHALL contain exactly one [1..1] name (CONF:1198-5524).
         3. This representedCustodianOrganization SHALL contain exactly one [1..1] telecom (CONF:1198-5525).
            a. This telecom SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) urn:oid:2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:1198-7998).
         4. This representedCustodianOrganization SHALL contain exactly one [1..1] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1198-5559).

1.2.1.8 informationRecipient

The informationRecipient element records the intended recipient of the information at the time the document was created. In cases where the intended recipient of the document is the patient's health chart, set the receivedOrganization to the scoping organization for that chart.

18. MAY contain zero or more [0..*] informationRecipient (CONF:1198-5565).
   a. The informationRecipient, if present, SHALL contain exactly one [1..1] intendedRecipient (CONF:1198-5566).
      i. This intendedRecipient MAY contain zero or more [0..*] id (CONF:1198-32399).
      ii. This intendedRecipient MAY contain zero or one [0..1] informationRecipient (CONF:1198-5567).
1. The informationRecipient, if present, **SHALL** contain at least one [1..*]
   **US Realm Person Name (PN.US.FIELDED)** (identifier:
   urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-5568).
   
   iii. This intendedRecipient **MAY** contain zero or one [0..1]
       **receivedOrganization** (CONF:1198-5577).

1. The receivedOrganization, if present, **SHALL** contain exactly one [1..1]
   **name** (CONF:1198-5578).

1.2.1.9 legalAuthenticator

The legalAuthenticator identifies the single person legally responsible for the document and must be present if the document has been legally authenticated. A clinical document that does not contain this element has not been legally authenticated.

The act of legal authentication requires a certain privilege be granted to the legal authenticator depending upon local policy. Based on local practice, clinical documents may be released before legal authentication.

All clinical documents have the potential for legal authentication, given the appropriate credentials.

Local policies **MAY** choose to delegate the function of legal authentication to a device or system that generates the clinical document. In these cases, the legal authenticator is a person accepting responsibility for the document, not the generating device or system.

Note that the legal authenticator, if present, must be a person.

19. **SHOULD** contain zero or one [0..1] **legalAuthenticator** (CONF:1198-5579).
   
   a. The legalAuthenticator, if present, **SHALL** contain exactly one [1..1]
      **US Realm Date and Time (DTM.US.FIELDED)** (identifier:
      urn:oid:2.16.840.1.113883.10.20.22.5.4) (CONF:1198-5580).
      
   b. The legalAuthenticator, if present, **SHALL** contain exactly one [1..1]
      **signatureCode** (CONF:1198-5583).
         
         i. This signatureCode **SHALL** contain exactly one [1..1] @code="S"
             **(CodeSystem:** ParticipationSignature
             urn:oid:2.16.840.1.113883.5.89 **STATIC**) (CONF:1198-5584).

1.2.1.10 sdtc:signatureText

The sdtc:signatureText extension provides a location in CDA for a textual or multimedia depiction of the signature by which the participant endorses and accepts responsibility for his or her participation in the Act as specified in the Participation.typeCode. Details of what goes in the field are described in the HL7 CDA Digital Signature Standard balloted in Fall 2013.

   c. The legalAuthenticator, if present, **MAY** contain zero or one [0..1]
      **sdtc:signatureText** (CONF:1198-30810).

      Note: The signature can be represented either inline or by reference according to the ED data type. Typical cases for CDA are:
      
      1) Electronic signature: this attribute can represent virtually any electronic signature scheme.
2) Digital signature: this attribute can represent digital signatures by reference to a signature data block that is constructed in accordance to a digital signature standard, such as XML-DSIG, PKCS#7, PGP, etc.

d. The legalAuthenticator, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:1198-5585).
   i. This assignedEntity SHALL contain at least one [1..*] id (CONF:1198-5586).
      1. Such ids MAY contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1198-16823).
   ii. This assignedEntity MAY contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) urn:oid:2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:1198-17000).
   iii. This assignedEntity SHALL contain at least one [1..*] US_Rule_Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1198-5589).
   iv. This assignedEntity SHALL contain at least one [1..*] telecom (CONF:1198-5595).
      1. Such telecoms SHOULD contain zero or one [0..1] @use, which SHALL be selected from ValueSet Telecom Use (US Realm Header) urn:oid:2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:1198-7999).
   v. This assignedEntity SHALL contain exactly one [1..1] assignedPerson (CONF:1198-5597).
      1. This assignedPerson SHALL contain at least one [1..*] US_Rule_Person_Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-5598).

1.2.1.11 authenticator

The authenticator identifies a participant or participants who attest to the accuracy of the information in the document.

20. MAY contain zero or more [0..*] authenticator (CONF:1198-5607) such that it
   a. SHALL contain exactly one [1..1] US_Rule_Date_and_Time (DTM.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4) (CONF:1198-5608).
   b. SHALL contain exactly one [1..1] signatureCode (CONF:1198-5610).
      i. This signatureCode SHALL contain exactly one [1..1] @code="S" (CodeSystem: Participationsignature urn:oid:2.16.840.1.113883.5.89 STATIC) (CONF:1198-5611).

The sdtc:signatureText extension provides a location in CDA for a textual or multimedia depiction of the signature by which the participant endorses and accepts responsibility for his or her participation in the Act as specified in the Participation.typeCode. Details of what goes in the field are described in the HL7 CDA Digital Signature Standard balloted in Fall of 2013.
c. **MAY** contain zero or one [0..1] `sdtc:signatureText` (CONF:1198-30811).
   Note: The signature can be represented either inline or by reference according to the ED data type. Typical cases for CDA are:
   1) Electronic signature: this attribute can represent virtually any electronic signature scheme.
   2) Digital signature: this attribute can represent digital signatures by reference to a signature data block that is constructed in accordance to a digital signature standard, such as XML-DSIG, PKCS#7, PGP, etc.

d. **SHALL** contain exactly one [1..1] `assignedEntity` (CONF:1198-5612).
   i. This `assignedEntity` **SHALL** contain at least one [1..*] `id` (CONF:1198-5613).
      1. Such ids **SHOULD** contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1198-16824).
   ii. This `assignedEntity` **MAY** contain zero or one [0..1] `code` (CONF:1198-16825).
      1. The code, if present, **MAY** contain zero or one [0..1] @code, which **SHOULD** be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) urn:oid:2.16.840.1.114222.4.11.1066 STATIC (CONF:1198-16826).
   iii. This `assignedEntity` **SHALL** contain at least one [1..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1198-5616).
   iv. This `assignedEntity` **SHALL** contain at least one [1..*] `telecom` (CONF:1198-5622).
      1. Such telecoms **SHOULD** contain zero or one [0..1] @use, which **SHALL** be selected from ValueSet Telecom Use (US Realm Header) urn:oid:2.16.840.1.113883.11.20.9.20 DYNAMIC (CONF:1198-8000).
   v. This `assignedEntity` **SHALL** contain exactly one [1..1] `assignedPerson` (CONF:1198-5624).
      1. This `assignedPerson` **SHALL** contain at least one [1..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-5625).

1.2.1.12 participant

The participant element identifies supporting entities, including parents, relatives, caregivers, insurance policyholders, guarantors, and others related in some way to the patient.

A supporting person or organization is an individual or an organization with a relationship to the patient. A supporting person who is playing multiple roles would be recorded in multiple participants (e.g., emergency contact and next-of-kin).

21. **MAY** contain zero or more [0..*] `participant` (CONF:1198-10003) such that it
   a. **MAY** contain zero or one [0..1] `time` (CONF:1198-10004).
   b. **SHALL** contain associatedEntity/associatedPerson **AND/OR** associatedEntity/scopingOrganization (CONF:1198-10006).
c. When participant/@typeCode is IND, associatedEntity/@classCode SHOULD be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:1198-10007).

1.2.1.13 inFulfillmentOf

The inFulfillmentOf element represents orders that are fulfilled by this document such as a radiologists’ report of an x-ray.

22. MAY contain zero or more [0..*] inFulfillmentOf (CONF:1198-9952).
   a. The inFulfillmentOf, if present, SHALL contain exactly one [1..1] order (CONF:1198-9953).
      i. This order SHALL contain at least one [1..*] id (CONF:1198-9954).

1.2.1.14 documentationOf

23. MAY contain zero or more [0..*] documentationOf (CONF:1198-14835).

A serviceEvent represents the main act being documented, such as a colonoscopy or a cardiac stress study. In a provision of healthcare serviceEvent, the care providers, PCP, or other longitudinal providers, are recorded within the serviceEvent. If the document is about a single encounter, the providers associated can be recorded in the componentOf/encompassingEncounter template.

   a. The documentationOf, if present, SHALL contain exactly one [1..1] serviceEvent (CONF:1198-14836).
      i. This serviceEvent SHALL contain exactly one [1..1] effectiveTime (CONF:1198-14837).
         1. This effectiveTime SHALL contain exactly one [1..1] low (CONF:1198-14838).

1.2.1.15 performer

The performer participant represents clinicians who actually and principally carry out the serviceEvent. In a transfer of care this represents the healthcare providers involved in the current or pertinent historical care of the patient. Preferably, the patient’s key healthcare care team members would be listed, particularly their primary physician and any active consulting physicians, therapists, and counselors.

   ii. This serviceEvent SHOULD contain zero or more [0..*] performer (CONF:1198-14839).
      1. The performer, if present, SHALL contain exactly one [1..1] @typeCode, which SHALL be selected from ValueSet x_ServiceEventPerformer urn:oid:2.16.840.1.113883.1.11.19601 STATIC (CONF:1198-14840).

      2. The performer, if present, MAY contain zero or one [0..1] functionCode (CONF:1198-16818).
         a. The functionCode, if present, SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet
3. The performer, if present, **SHALL** contain exactly one [1..1] \textit{assignedEntity} (CONF:1198-14841).
   a. This \textit{assignedEntity} **SHALL** contain at least one [1..*] \textit{id} (CONF:1198-14846).
      i. Such ids **SHOULD** contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider Identifier (CONF:1198-14847).
   b. This \textit{assignedEntity} **SHOULD** contain zero or one [0..1] \textit{code}, which **SHOULD** be selected from ValueSet \textit{Healthcare Provider Taxonomy (HIPAA)} urn:oid:2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:1198-14842).

### 1.2.1.16 authorization

The authorization element represents information about the patient’s consent.

The type of consent is conveyed in \textit{consent/code}. Consents in the header have been finalized (\textit{consent/statusCode} must equal Completed) and should be on file. This specification does not address how 'Privacy Consent' is represented, but does not preclude the inclusion of 'Privacy Consent'.

The authorization consent is used for referring to consents that are documented elsewhere in the EHR or medical record for a health condition and/or treatment that is described in the CDA document.

24. **MAY** contain zero or more [0..*] \textit{authorization} (CONF:1198-16792) such that it
   a. **SHALL** contain exactly one [1..1] \textit{consent} (CONF:1198-16793).
      i. This \textit{consent} **MAY** contain zero or more [0..*] \textit{id} (CONF:1198-16794).
      ii. This \textit{consent} **MAY** contain zero or one [0..1] \textit{code} (CONF:1198-16795).
          Note: The type of consent (e.g., a consent to perform the related serviceEvent) is conveyed in \textit{consent/code}.
      iii. This \textit{consent} **SHALL** contain exactly one [1..1] \textit{statusCode} (CONF:1198-16797).
          1. This \textit{statusCode} **SHALL** contain exactly one [1..1] @code="completed" Completed (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6) (CONF:1198-16798).

### 1.2.1.17 componentOf

The encompassing encounter represents the setting of the clinical encounter during which the document act(s) or ServiceEvent(s) occurred. In order to represent providers associated with a specific encounter, they are recorded within the encompassingEncounter as participants. In a CCD, the encompassingEncounter may be used when documenting a specific encounter and its participants. All relevant encounters in a CCD may be listed in the encounters section.
25. **MAY** contain zero or one [0..1] **componentOf** (CONF:1198-9955).
   a. The componentOf, if present, **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:1198-9956).
      i. This encompassingEncounter **SHALL** contain at least one [1..*] **id** (CONF:1198-9959).
      ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1198-9958).

**Figure 3: US Realm Header (V3) Example**

```xml
<ClinicalDocument>
  <realmCode code="US" />
  <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3" />
  <!-- CCD template -->
  <templateId root="2.16.840.1.113883.10.20.22.1.1" extension="2015-08-01" />
  <!-- Globally unique identifier for the document -->
  <id extension="TT988" root="2.16.840.1.113883.19.5.99999.1" />
  <code code="34133-9" displayName="Summarization of Episode Note" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />
  <!-- Title of the document -->
  <title>Patient Chart Summary</title>
  <effectiveTime value="201209151030-0800" />
  <confidentialityCode code="N" displayName="normal" codeSystem="2.16.840.1.113883.5.25" codeSystemName="Confidentiality" />
  <languageCode code="en-US" />
  <setId extension="sTT988" root="2.16.840.1.113883.19.5.99999.19" />
  <!-- Version of the document -->
  <versionNumber value="1" />
  . . .
</ClinicalDocument>
```
Figure 4: recordTarget Example

<recordTarget>
  <patientRole>
    <id extension="444-22-2222" root="2.16.840.1.113883.4.1" />
    <!-- Example Social Security Number using the actual SSN OID. -->
    <addr use="HP">
      <!-- HP is "primary home" from codeSystem 2.16.840.1.113883.5.1119 -->
      <streetAddressLine>2222 Home Street</streetAddressLine>
      <city>Beaverton</city>
      <state>OR</state>
      <postalCode>97867</postalCode>
      <country>US</country>
      <!-- US is "United States" from ISO 3166-1 Country Codes: 1.0.3166.1 -->
    </addr>
    <telecom value="tel:+1(555)555-2003" use="HP" />
    <!-- HP is "primary home" from HL7 AddressUse 2.16.840.1.113883.5.1119 -->
  </patientRole>
  <!-- The first name element represents what the patient is known as -->
  <name use="L">
    <given>Eve</given>
    <!-- The "SP" is "Spouse" from HL7 Code System EntityNamePartQualifier 2.16.840.1.113883.5.43 -->
    <family qualifier="SP">Betterhalf</family>
  </name>
  <!-- The second name element represents another name associated with the patient -->
  <name>
    <given>Eve</given>
    <!-- The "BR" is "Birth" from HL7 Code System EntityNamePartQualifier 2.16.840.1.113883.5.43 -->
    <family qualifier="BR">Everywoman</family>
  </name>
  <administrativeGenderCode code="F" displayName="Female" codeSystem="2.16.840.1.113883.5.1" codeSystemName="AdministrativeGender" />
  <!-- Date of birth need only be precise to the day -->
  <birthTime value="19750501" />
  <maritalStatusCode code="M" displayName="Married" codeSystem="2.16.840.1.113883.5.2" codeSystemName="MaritalStatusCode" />
  <religiousAffiliationCode code="1013" displayName="Christian (non-Catholic, non-specific)" codeSystem="2.16.840.1.113883.5.1076" codeSystemName="HL7 Religious Affiliation" />
    <!-- CDC Race and Ethnicity code set contains the five minimum race and ethnicity categories defined by OMB Standards -->
    <raceCode code="2106-3" displayName="White" codeSystem="2.16.840.1.113883.6.238" codeSystemName="Race & Ethnicity - CDC" />
    <!-- The raceCode extension is only used if raceCode is valued -->
    <sdtc:raceCode code="2076-8" displayName="Hawaiian or Other Pacific Islander" codeSystem="2.16.840.1.113883.6.238" codeSystemName="Race & Ethnicity - CDC" />
    <ethnicGroupCode code="2186-5" displayName="Not Hispanic or Latino" codeSystem="2.16.840.1.113883.6.238" codeSystemName="Race & Ethnicity - CDC" />
  <guardian>
    <code code="POWATT" displayName="Power of Attorney" codeSystem="2.16.840.1.113883.1.11.19830" codeSystemName="ResponsibleParty" />
    <addr use="HP">
      <streetAddressLine>2222 Home Street</streetAddressLine>
      <city>Beaverton</city>
    </addr>
  </guardian>
</recordTarget>
<state>OR</state>
<postalCode>97867</postalCode>
<country>US</country>
</addr>
<telecom value="tel:+1(555)555-2008" use="MC" />
<guardianPerson>
  <name>
    <given>Boris</given>
    <given qualifier="CL">Bo</given>
    <family>Betterhalf</family>
  </name>
</guardianPerson>
</guardian>
<birthplace>
  <place>
    <addr>
      <streetAddressLine>4444 Home Street</streetAddressLine>
      <city>Beaverton</city>
      <state>OR</state>
      <postalCode>97867</postalCode>
      <country>US</country>
    </addr>
  </place>
</birthplace>
<languageCommunication>
  <languageCode code="eng" />
</languageCommunication>
</patient>
<providerOrganization>
  <id extension="219BX" root="1.1.1.1.1.1.1.1.2" />
  <name>The DoctorsTogether Physician Group</name>
  <telecom use="WP" value="tel: +(555)-555-5000" />
  <addr>
    <streetAddressLine>1007 Health Drive</streetAddressLine>
    <city>Portland</city>
    <state>OR</state>
    <postalCode>99123</postalCode>
    <country>US</country>
  </addr>
</providerOrganization>
</patientRole>
</recordTarget>
Figure 5: author Example

```xml
<author>
  <time value="201209151030-0800"/>
  <assignedAuthor>
    <id extension="5555555555" root="2.16.840.1.113883.4.6"/>
    <code code="163W00000X" displayName="Registered nurse"
      codeSystem="2.16.840.1.113883.5.53" codeSystemName="Health Care Provider Taxonomy"/>
    <addr>
      <streetAddressLine>1004 Healthcare Drive</streetAddressLine>
      <city>Portland</city>
      <state>OR</state>
      <postalCode>99123</postalCode>
      <country>US</country>
    </addr>
    <telecom use="WP" value="tel:+1(555)555-1004"/>
  </assignedAuthor>
</author>
```

Figure 6: dateEnterer Example

```xml
<dataEnterer>
  <assignedEntity>
    <id extension="3337777777" root="2.16.840.1.113883.4.6"/>
    <addr>
      <streetAddressLine>1007 Healthcare Drive</streetAddressLine>
      <city>Portland</city>
      <state>OR</state>
      <postalCode>99123</postalCode>
      <country>US</country>
    </addr>
    <telecom use="WP" value="tel:+1(555)555-1050"/>
  </assignedEntity>
</dataEnterer>
```
Figure 7: Assigned Health Care Provider informant Example

```xml
<informant>
  <assignedEntity>
    <id extension="888888888" root="1.1.1.1.1.1.1.3"/>
    <addr>
      <streetAddressLine>1007 Healthcare Drive</streetAddressLine>
      <city>Portland</city>
      <state>OR</state>
      <postalCode>99123</postalCode>
      <country>US</country>
    </addr>
    <telecom use="WP" value="tel:+1(555)555-1003"/>
    <assignedPerson>
      <name>
        <given>Harold</given>
        <family>Hippocrates</family>
        <suffix qualifier="AC">M.D.</suffix>
      </name>
    </assignedPerson>
    <representedOrganization>
      <name>The DoctorsApart Physician Group</name>
    </representedOrganization>
  </assignedEntity>
</informant>
```

Figure 8: Personal Relation informant Example

```xml
<informant>
  <relatedEntity classCode="PRS">
    <!-- classCode "PRS" represents a person with personal relationship with the patient -->
    <code code="SPS" displayName="SPOUSE" codeSystem="2.16.840.1.113883.1.11.19563"
      codeSystemName="Personal Relationship Role Type Value Set"/>
    <relatedPerson>
      <name>
        <given>Boris</given>
        <given qualifier="CL">Bo</given>
        <family>Betterhalf</family>
      </name>
    </relatedPerson>
  </relatedEntity>
</informant>
```
Figure 9: custodian Example

```
<custodian>
  <assignedCustodian>
    <representedCustodianOrganization>
      <id extension="321CX" root="1.1.1.1.1.1.1.1.3" />
      <name>Good Health HIE</name>
      <telecom use="WP" value="tel:+1(555)555-1009" />
      <addr use="WP">
        <streetAddressLine>1009 Healthcare Drive</streetAddressLine>
        <city>Portland</city>
        <state>OR</state>
        <postalCode>99123</postalCode>
        <country>US</country>
      </addr>
    </representedCustodianOrganization>
  </assignedCustodian>
</custodian>
```

Figure 10: informationRecipient Example

```
<informationRecipient>
  <intendedRecipient>
    <informationRecipient>
      <name>
        <given>Sara</given>
        <family>Specialize</family>
        <suffix qualifier="AC">M.D.</suffix>
      </name>
    </informationRecipient>
  </intendedRecipient>
  <receivedOrganization>
    <name>The DoctorsApart Physician Group</name>
  </receivedOrganization>
</informationRecipient>
```

Figure 11: Digital signature Example

```
<sdtc:signatureText mediaType="text/xml" representation="B64">omSJUEdmde9j44zmMiromSJUEdmde9j44zmMirdMDSsWdIJdksIJR3373jeu836edjzMMIjdMDSsWdIJdksIJR3373jeu83MNYD83jmMdomSJUEdmde9j44zmMir...
  MNYD83jmMdomSJUEdmde9j44zmMir6edjzMMIjdMDSsWdIJdksIJR3373jeu834zmMir6edjzMMIjdMDSsWdIJdksIJR3373jeu83==</sdtc:signatureText>
```
Figure 12: legalAuthenticator Example

<legalAuthenticator>
  <time value="20120915223615-0800" />
  <signatureCode code="S" />
  <assignedEntity>
    <id extension="5555555555" root="2.16.840.1.113883.4.6" />
    <code code="207QA0505X" displayName="Adult Medicine" codeSystem="2.16.840.1.113883.5.53" codeSystemName="Health Care Provider Taxonomy" />
    <addr>
      <streetAddressLine>1004 Healthcare Drive</streetAddressLine>
      <city>Portland</city>
      <state>OR</state>
      <postalCode>99123</postalCode>
      <country>US</country>
    </addr>
    <telecom use="WP" value="tel:+1(555)555-1004" />
    <assignedPerson>
      <name>
        <given>Patricia</given>
        <given qualifier="CL">Patty</given>
        <family>Primary</family>
        <suffix qualifier="AC">M.D.</suffix>
      </name>
    </assignedPerson>
  </assignedEntity>
</legalAuthenticator>
Figure 13: authenticator Example

```xml
<authenticator>
  <time value="201209151030-0800" />
  <signatureCode code="S" />
  <assignedEntity>
    <id extension="5555555555" root="2.16.840.1.113883.4.6" />
    <code code="207QA0505X" displayName="Adult Medicine"
          codeSystem="2.16.840.1.113883.5.53" codeSystemName="Health Care Provider Taxonomy" />
    <addr>
      <streetAddressLine>1004 Healthcare Drive</streetAddressLine>
      <city>Portland</city>
      <state>OR</state>
      <postalCode>99123</postalCode>
      <country>US</country>
    </addr>
    <telecom use="WP" value="tel:+1(555)555-1004" />
  </assignedEntity>
  <assignedPerson>
    <name>
      <given>Patricia</given>
      <given qualifier="CL">Patty</given>
      <family>Primary</family>
      <suffix qualifier="AC">M.D.</suffix>
    </name>
  </assignedPerson>
</authenticator>
```
Figure 14: Supporting Person participant Example

```xml
<participant typeCode="IND">
  <!-- typeCode "IND" represents an individual -->
  <associatedEntity classCode="NOK">
    <!-- classCode "NOK" represents the patient's next of kin-->
    <addr use="HP">
      <streetAddressLine>2222 Home Street</streetAddressLine>
      <city>Beaverton</city>
      <state>OR</state>
      <postalCode>97867</postalCode>
      <country>US</country>
    </addr>
    <telecom value="tel:+1(555)555-2008" use="MC" />
    <associatedPerson>
      <name>
        <given>Boris</given>
        <given qualifier="CL">Bo</given>
        <family>Betterhalf</family>
      </name>
    </associatedPerson>
  </associatedEntity>
</participant>

<!-- Entities playing multiple roles are recorded in multiple participants -->
<participant typeCode="IND">
  <!-- classCode "ECON" represents an emergency contact -->
  <addr use="HP">
    <streetAddressLine>2222 Home Street</streetAddressLine>
    <city>Beaverton</city>
    <state>OR</state>
    <postalCode>97867</postalCode>
    <country>US</country>
  </addr>
  <telecom value="tel:+1(555)555-2008" use="MC" />
  <associatedPerson>
    <name>
      <given>Boris</given>
      <given qualifier="CL">Bo</given>
      <family>Betterhalf</family>
    </name>
  </associatedPerson>
</participant>

Figure 15: inFulfillmentOf Example

```xml
<inFulfillmentOf typeCode="FLFS">
  <order classCode="ACT" moodCode="RQ0">
    <id root="2.16.840.1.113883.6.96" extension="1298989898" />
    <code code="388975008" displayName="Weight Reduction Consultation" codeSystem="2.16.840.1.113883.6.96" codeSystemName="CPT4" />
  </order>
</inFulfillmentOf>
**Figure 16: performer Example**

```xml
<performer typeCode="PRF">
  <functionCode code="PCP">
    <displayName>Primary Care Provider</displayName>
    <originalText>Primary Care Provider</originalText>
  </functionCode>
  <assignedEntity>
    <id extension="5555555555" root="2.16.840.1.113883.4.6"/>
    <code code="207QA0505X" display="Adult Medicine" codeSystem="2.16.840.1.113883.5.53" codeSystemName="Health Care Provider Taxonomy"/>
    <addr>
      <streetAddressLine>1004 Healthcare Drive</streetAddressLine>
      <city>Portland</city>
      <state>OR</state>
      <postalCode>99123</postalCode>
      <country>US</country>
    </addr>
    <telecom use="WP" value="tel:+1(555)555-1004"/>
    <assignedPerson>
      <name>
        <given>Patricia</given>
        <given qualifier="CL">Patty</given>
        <family>Primary</family>
        <suffix qualifier="AC">M.D.</suffix>
      </name>
    </assignedPerson>
    <representedOrganization>
      <id extension="219BX" root="1.1.1.1.1.1.1.2"/>
      <name>The DoctorsTogether Physician Group</name>
      <telecom use="WP" value="tel: +(555)-555-5000"/>
      <addr>
        <streetAddressLine>1004 Health Drive</streetAddressLine>
        <city>Portland</city>
        <state>OR</state>
        <postalCode>99123</postalCode>
        <country>US</country>
      </addr>
    </representedOrganization>
  </assignedEntity>
</performer>
```
Figure 17: documentationOf Example

```xml
<documentationOf>
  <serviceEvent classCode="PCPR">
    <!-- The effectiveTime reflects the provision of care summarized in the document. In this scenario, the provision of care summarized is the lifetime for the patient -->
    <effectiveTime>
      <low value="19750501" />
      <!-- The low value represents when the summarized provision of care began. In this scenario, the patient's date of birth -->
      <high value="20120915" />
      <!-- The high value represents when the summarized provision of care being ended. In this scenario, when chart summary was created -->
    </effectiveTime>
    <performer typeCode="PRF">
      <functionCode code="PCP">
        <originalText>Primary Care Provider</originalText>
      </functionCode>
      <assignedEntity>
        <id extension="5555555555" root="2.16.840.1.113883.4.6" />
        <code code="207QA0505X" displayName="Adult Medicine" codeSystem="2.16.840.1.113883.5.53" codeSystemName="Health Care Provider Taxonomy" />
        <addr>
          <streetAddressLine>1004 Healthcare Drive</streetAddressLine>
          <city>Portland</city>
          <state>OR</state>
          <postalCode>99123</postalCode>
          <country>US</country>
        </addr>
        <telecom use="WP" value="tel:+1(555)555-1004" />
        <assignedPerson>
          <name>
            <given>Patricia</given>
            <given qualifier="CL">Patty</given>
            <family>Primary</family>
            <suffix qualifier="AC">M.D.</suffix>
          </name>
        </assignedPerson>
        <representedOrganization>
          <id extension="219BX" root="1.1.1.1.1.1.1.1.2" />
          <name>The DoctorsTogether Physician Group</name>
          <telecom use="WP" value="tel: +(555)-555-5000" />
          <addr>
            <streetAddressLine>1004 Health Drive</streetAddressLine>
            <city>Portland</city>
            <state>OR</state>
            <postalCode>99123</postalCode>
            <country>US</country>
          </addr>
        </representedOrganization>
      </assignedEntity>
    </performer>
  </serviceEvent>
</documentationOf>
```
Figure 18: authorization Example

```xml
<authorization typeCode="AUTH">
  <consent classCode="CONS" moodCode="EVN">
    <id root="629deb70-5306-11df-9879-0800200c9a66" />
    <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="64293-4" displayName="Procedure consent" />
    <statusCode code="completed" />
  </consent>
</authorization>
```
2 SECTION

2.1 Encounters Section (entries required) (V3)

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Table 3: Encounters Section (entries required) (V3) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Public Health Case Report Document (eICR)</td>
<td>Encounter Activity (V3)</td>
</tr>
</tbody>
</table>

This section lists and describes any healthcare encounters pertinent to the patient’s current health status or historical health history. An encounter is an interaction, regardless of the setting, between a patient and a practitioner who is vested with primary responsibility for diagnosing, evaluating, or treating the patient’s condition. It may include visits, appointments, as well as non-face-to-face interactions. It is also a contact between a patient and a practitioner who has primary responsibility (exercising independent judgment) for assessing and treating the patient at a given contact. This section may contain all encounters for the time period being summarized, but should include notable encounters.

2. MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor urn:oid:2.16.840.1.113883.5.1008) (CONF:1198-32815).
3. SHALL contain exactly one [1..1] templateId (CONF:1198-8705) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.22.1" (CONF:1198-10387).
   b. SHALL contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32548).
4. SHALL contain exactly one [1..1] code (CONF:1198-15466).
   a. This code SHALL contain exactly one [1..1] @code="46240-8" Encounters (CONF:1198-15467).
   b. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1 STATIC) (CONF:1198-31137).
5. SHALL contain exactly one [1..1] title (CONF:1198-8707).
6. SHALL contain exactly one [1..1] text (CONF:1198-8708).

If section/@nullFlavor is not present:

7. SHALL contain at least one [1..*] entry (CONF:1198-8709) such that it
Figure 19: Encounters Section (entries required) (V3) Example

```xml
<section>
  <templateId root="2.16.840.1.113883.10.20.22.2.22.1" extension="2015-08-01" />
  <!-- Encounters Section - Entries required -->
  <code code="46240-8" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
        displayName="History of encounters" />
  <title>Encounters</title>
  <text>
    ...
  </text>
  <entry typeCode="DRIV">
    <encounter classCode="ENC" moodCode="EVN">
      <!-- Encounter Activities -->
      ...
    </encounter>
  </entry>
</section>
```

2.2 History of Present Illness Section

[section: identifier urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4 (open)]

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<table>
<thead>
<tr>
<th>Table 4: History of Present Illness Section Contexts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contained By:</td>
</tr>
<tr>
<td>Initial Public Health Case Report Document (eICR)</td>
</tr>
</tbody>
</table>

The History of Present Illness section describes the history related to the reason for the encounter. It contains the historical details leading up to and pertaining to the patient’s current complaint or reason for seeking medical care.

1. SHALL contain exactly one [1..1] templateId (CONF:81-7848) such that it
   a. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.5.3.1.3.4"
      (CONF:81-10458).
2. SHALL contain exactly one [1..1] code (CONF:81-15477).
   a. This code SHALL contain exactly one [1..1] @code="10164-2"
      (CONF:81-15478).
   b. This code SHALL contain exactly one [1..1]
      @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC
3. SHALL contain exactly one [1..1] title (CONF:81-7850).
4. SHALL contain exactly one [1..1] text (CONF:81-7851).
Figure 20: History of Present Illness Section Example

<section>
  <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.4.2"/>
  <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
    code="10164-2"
    displayName="HISTORY OF PRESENT ILLNESS"/>
  <title>HISTORY OF PRESENT ILLNESS</title>
  <text>
    <paragraph>This patient was only recently discharged for a recurrent
    GI bleed as described below.</paragraph>
    <paragraph>He presented to the ER today c/o a dark stool yesterday
    but a normal brown stool today. On exam he was hypotensive in the
    80s resolved after .... .... ....</paragraph>
    <paragraph>Lab at discharge: Glucose 112, BUN 16, creatinine 1.1,
    electrolytes normal. H. pylori antibody pending. Admission
    hematocrit 16%, discharge hematocrit 29%. WBC 7300, platelet
    count 256,000. Urinalysis normal. Urine culture: No growth. INR
    1.1, PTT 40.</paragraph>
    <paragraph>He was transfused with 6 units of packed red blood cells
    with .... .... ....</paragraph>
    <paragraph>GI evaluation 12 September: Colonoscopy showed single red
    clot in .... .... ....</paragraph>
  </text>
</section>

2.3 Immunizations Section (entries required) (V3)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2015-08-01
(open)]

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DSTU R2.1

Table 5: Immunizations Section (entries required) (V3) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Public Health Case Report Document (eICR) (optional)</td>
<td></td>
</tr>
</tbody>
</table>

The Immunizations Section defines a patient's current immunization status and pertinent
immunization history. The primary use case for the Immunization Section is to enable
communication of a patient's immunization status. The section should include current
immunization status, and may contain the entire immunization history that is relevant to the
period of time being summarized.

1. Conforms to Immunizations Section (entries optional) (V3) template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2015-08-01).
2. MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor urn:oid:2.16.840.1.113883.5.1008) (CONF:1198-32833).
3. SHALL contain exactly one [1..1] templateId (CONF:1198-9015) such that it
a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.2.1" (CONF:1198-10400).
   
b. SHALL contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32530).

4. SHALL contain exactly one [1..1] code (CONF:1198-15369).
   a. This code SHALL contain exactly one [1..1] @code="11369-6" Immunizations (CONF:1198-15370).
   b. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:1198-32147).

5. SHALL contain exactly one [1..1] title (CONF:1198-9017).

6. SHALL contain exactly one [1..1] text (CONF:1198-9018).

If section/@nullFlavor is not present:

7. SHALL contain at least one [1..*] entry (CONF:1198-9019) such that it
   a. SHALL contain exactly one [1..1] Immunization Activity (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.52:2015-08-01) (CONF:1198-15495).
Figure 21: Immunizations Section (entries required) (V3) Example

```
<section>
  <templateId root="2.16.840.1.113883.10.20.22.2.1" extension="2015-08-01" />
  <!-- ******* Immunizations section template ******* -->
  <code code="11369-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="History of immunizations" />
  <title>Immunizations</title>
  <text>
    <table border="1" width="100%">
      <thead>
        <tr>
          <th>Vaccine</th>
          <th>Date</th>
          <th>Status</th>
        </tr>
      </thead>
      <tbody>
        <tr>
          <td>
            <content ID="immun1" />
            Influenza virus vaccine, IM
          </td>
          <td>Nov 1999</td>
          <td>Completed</td>
        </tr>
        <tr>
          <td>
            <content ID="immun2" />
            Influenza virus vaccine, IM
          </td>
          <td>Dec 1998</td>
          <td>Completed</td>
        </tr>
        <tr>
          <td>
            <content ID="immun3" />
            Pneumococcal polysaccharide vaccine, IM
          </td>
          <td>Dec 1998</td>
          <td>Completed</td>
        </tr>
        <tr>
          <td>
            <content ID="immun4" />
            Tetanus and diphtheria toxoids, IM
          </td>
          <td>1997</td>
          <td>Refused</td>
        </tr>
      </tbody>
    </table>
  </text>
</section>
```

2.4 Medications Administered Section (V2)

The Medications Administered Section usually resides inside a Procedure Note describing a procedure. This section defines medications and fluids administered during the procedure, its related encounter, or other procedure related activity excluding anesthetic medications. Anesthesia medications should be documented as described in the Anesthesia Section templateId 2.16.840.1.113883.10.20.22.2.25.

1. SHALL contain exactly one [1..1] templateId (CONF:1098-8152) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.38" (CONF:1098-10405).
   b. SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32525).
2. SHALL contain exactly one [1..1] code (CONF:1098-15383).
   a. This code SHALL contain exactly one [1..1] @code="29549-3" Medications Administered (CONF:1098-15384).
   b. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:1098-30829).
3. SHALL contain exactly one [1..1] title (CONF:1098-8154).
4. SHALL contain exactly one [1..1] text (CONF:1098-8155).
5. MAY contain zero or more [0..*] entry (CONF:1098-8156).
Figure 22: Medications Administered Section (V2) Example

```
<section>
  <templateId root="2.16.840.1.113883.10.20.22.2.38" extension="2014-06-09" />
  <code code="29549-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" display="MEDICATIONS ADMINISTERED" />
  <title>MEDICATIONS ADMINISTERED</title>
  <text>
    <table border="1" width="100%">
      <thead>
        <tr>
          <th>Medication</th>
          <th>Directions</th>
          <th>Start Date</th>
          <th>Status</th>
          <th>Indications</th>
          <th>Fill Instructions</th>
        </tr>
      </thead>
      <tbody>
        <tr>
          <td>
            <content ID="MedAdministered_1">
              Proventil 0.09 MG/ACTUAT inhalant solution
            </content>
          </td>
          <td>0.09 MG/ACTUAT inhalant solution, 2 puffs QID PRN wheezing</td>
          <td>20070103</td>
          <td>Active</td>
          <td>Pneumonia (233604007 SNOMED CT)</td>
          <td>Generic Substitution Allowed</td>
        </tr>
      </tbody>
    </table>
  </text>
  <entry typeCode="DRIV">
    <substanceAdministration classCode="SBADM" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.16" extension="2014-06-09" />
    </substanceAdministration>
  </entry>
</section>
```
2.5 **Problem Section (entries required) (V3)**

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2015-08-01 (open)]

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<table>
<thead>
<tr>
<th><strong>Table 7: Problem Section (entries required) (V3) Contexts</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contained By:</strong></td>
</tr>
<tr>
<td>Initial Public Health Case Report Document (eICR) (required)</td>
</tr>
</tbody>
</table>

This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed. Overall health status may be represented in this section.

1. Conforms to Problem Section (entries optional) (V3) template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2015-08-01).
2. **MAY** contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor urn:oid:2.16.840.1.113883.5.1008) (CONF:1198-32864).
3. **SHALL** contain exactly one [1..1] templateId (CONF:1198-9179) such that it
   a. **SHALL** contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.5.1" (CONF:1198-10441).
   b. **SHALL** contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32510).
4. **SHALL** contain exactly one [1..1] code (CONF:1198-15409).
   a. This code **SHALL** contain exactly one [1..1] @code="11450-4" Problem List (CONF:1198-15410).
   b. This code **SHALL** contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:1198-31142).
5. **SHALL** contain exactly one [1..1] title (CONF:1198-9181).
6. **SHALL** contain exactly one [1..1] text (CONF:1198-9182).

If section/@nullFlavor is not present:

7. **SHALL** contain at least one [1..*] entry (CONF:1198-9183) such that it
   a. **SHALL** contain exactly one [1..1] **Problem Concern Act (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2015-08-01) (CONF:1198-15506).
8. **MAY** contain zero or one [0..1] entry (CONF:1198-30479) such that it
Figure 23: Problem Section (entries required) (V3) Example

<section>
   <templateId root="2.16.840.1.113883.10.20.22.2.5.1"
            extension="2015-08-01" />
   <code code="11450-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
        displayName="PROBLEM LIST" />
   <title>PROBLEMS</title>
   <text>
      <item listType="ordered">
         <item>Pneumonia: Resolved in March 1998</item>
         <item>...</item>
      </item>
   </text>
   <entry typeCode="DRIV">
      <act classCode="ACT" moodCode="EVN">
         <templateId root="2.16.840.1.113883.10.20.22.4.3" extension="2014-06-09" />
         <!-- Problem Concern Act template -->
         ...
      </act>
   </entry>
</section>
**Figure 24: No Known Problems Section Example**

```xml
<section>
  <templateId root="2.16.840.1.113883.10.20.22.2.5"
    extension="2014-06-09" />
  <!-- Problem Section with Coded Entries Optional -->
  <templateId root="2.16.840.1.113883.10.20.22.5.1"/>
  <!-- Problem Section with Coded Entries Required -->
  <code code="11450-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
    displayName="Problem List"/>
  <title>PROBLEMS</title>
  <text ID="Concern_1">
    Problem Concern:
    <br/>
    Concern Tracker Start Date: 06/07/2013 16:05:06
    <br/>
    Concern Tracker End Date:
    <br/>
    Concern Status: Active
    <br/>
    <content ID="problems1">No known</content>
    <content ID="problemType1">problems</content>.
  </text>
</section>

<entry typeCode="DRIV">
  <!-- Problem Concern Act -->
  <act classCode="ACT" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.3"/>
    <id root="36e3e930-7b14-11db-9fe1-0800200c9a66"/>
    <!-- SDWG supports 48765-2 or CONC in the code element -->
    <code code="CONC" codeSystem="2.16.840.1.113883.5.6"/>
    <text>
      <reference value="#Concern_1"></reference>
    </text>
    <statusCode code="active"/>
    <!-- The concern is not active, in terms of there being an active condition to
    be managed.--> 
    <effectiveTime>
      <low value="20130607160506"/>
    </effectiveTime>
    <!-- Time at which THIS "concern" began being tracked.--> 
    <effectiveTime>
      <!-- status is active so high is not applicable. If high is present it should
      have nullFlavor of NA-->
    </effectiveTime>
    <!-- Optional Author Element-->
    <author>
      <time value="20130607160506"/>
      <assignedAuthor>
        <id extension="66666" root="2.16.840.1.113883.4.6"/>
        <code code="207RC0000X" codeSystem="2.16.840.1.113883.6.101"
          codeSystemName="NUCC"
          displayName="Cardiovascular Disease"/>
      </assignedAuthor>
    </author>
  </act>
</entry>
```
<streetAddressLine>6666 StreetName St.</streetAddressLine>
<city>Silver Spring</city>
<state>MD</state>
<postalCode>20901</postalCode>
<country>US</country>
</addr>
<telecom value="tel:+1(301)666-6666" use="WP"/>
<assignedPerson>
  <name>
    <given>Heartly</given>
    <family>Sixer</family>
    <suffix>MD</suffix>
  </name>
</assignedPerson>
</author>
<entryRelationship typeCode="SUBJ">
  <observation classCode="OBS" moodCode="EVN" negationInd="true">
    <!-- Model of Meaning for No Problems -->
    <!-- This is more consistent with how we did no known allergies. -->
    <!-- The use of negationInd corresponds with the newer Observation.ValueNegationInd -->
    <!-- The negationInd = true negates the value element. -->
    <!-- problem observation template -->
    <templateId root="2.16.840.1.113883.10.20.22.4.4"/>
    <id root="4adc1021-7b14-11db-9fe1-0800200c9a67"/>
    <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>
    <text>
      <reference value="#problems1"></reference>
    </text>
    <statusCode code="completed"/>
    <effectiveTime>
      <low value="20130607160506"/>
    </effectiveTime>
    <!-- The time when this was biologically relevant ie True for the patient. -->
    <!-- As a minimum time interval over which this is true, populate the effectiveTime/low with the current time. -->
    <!-- It would be equally valid to have a longer range of time over which this statement was represented as being true. -->
    <!-- As a maximum, you would never indicate an effectiveTime/high that was greater than the current point in time. -->
    <!-- This idea assumes that the value element could come from the Problem value set, or -->
    <!-- when negationInd was true, is could also come from the ProblemType value set (and code would be ASSERTION). -->
    <value xsi:type="CD" code="55607006" displayName="Problem"
      codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT">
      <originalText>
        <reference value="#problemType1"></reference>
      </originalText>
    </value>
  </observation>
</entryRelationship>
2.6  Reason for Visit Section

[section: identifier urn:oid:2.16.840.1.113883.10.20.22.2.12 (open)]

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Table 8: Reason for Visit Section Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Public Health Case Report Document (eICR) (required)</td>
<td></td>
</tr>
</tbody>
</table>

This section records the patient’s reason for the patient’s visit (as documented by the provider). Local policy determines whether Reason for Visit and Chief Complaint are in separate or combined sections.

1. **SHALL** contain exactly one [1..1] `templateId` (CONF:81-7836) such that it
   a. **SHALL** contain exactly one [1..1] `@root"=2.16.840.1.113883.10.20.22.2.12"`
      (CONF:81-10448).

2. **SHALL** contain exactly one [1..1] `code` (CONF:81-15429).
   a. This code **SHALL** contain exactly one [1..1] `@code"=29299-5"` Reason for Visit
      (CONF:81-15430).
   b. This code **SHALL** contain exactly one [1..1]
      `@codeSystem"=2.16.840.1.113883.6.1"` (CodeSystem: LOINC

3. **SHALL** contain exactly one [1..1] `title` (CONF:81-7838).

4. **SHALL** contain exactly one [1..1] `text` (CONF:81-7839).

**Figure 25: Reason for Visit Section Example**

```
<section>
  <templateId root="2.16.840.1.113883.10.20.22.2.12"/>
  <code code="29299-5"
        codeSystem="2.16.840.1.113883.6.1"
        codeSystemName="LOINC"
        displayName="REASON FOR VISIT"/>
  <title>REASON FOR VISIT</title>
  <text>
    <paragraph>Dark stools.</paragraph>
  </text>
</section>
```
2.7 **Results Section (entries required) (V3)**

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2015-08-01 (open)]

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<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Public Health Case Report Document (eICR) (required)</td>
<td>Result Organizer (V3)</td>
</tr>
</tbody>
</table>

The Results Section contains observations of results generated by laboratories, imaging procedures, and other procedures. These coded result observations are contained within a Results Organizer in the Results Section. The scope includes observations such as hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. The section often includes notable results such as abnormal values or relevant trends, and could contain all results for the period of time being documented.

Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory.

Imaging results are typically generated by a clinician reviewing the output of an imaging procedure, such as where a cardiologist reports the left ventricular ejection fraction based on the review of a cardiac echocardiogram.

Procedure results are typically generated by a clinician to provide more granular information about component observations made during a procedure, such as where a gastroenterologist reports the size of a polyp observed during a colonoscopy.

1. Conforms to Results Section (entries optional) (V3) template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2015-08-01).

2. MAY contain zero or one [0..1] @nullFlavor="NI" No information (CodeSystem: HL7NullFlavor urn:oid:2.16.840.1.113883.5.1008) (CONF:1198-32875).

3. SHALL contain exactly one [1..1] templateId (CONF:1198-7108) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.3.1" (CONF:1198-9137).
   b. SHALL contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32592).

4. SHALL contain exactly one [1..1] code (CONF:1198-15433).
   a. This code SHALL contain exactly one [1..1] @code="30954-2" Relevant diagnostic tests and/or laboratory data (CONF:1198-15434).
   b. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:1198-31040).

5. SHALL contain exactly one [1..1] title (CONF:1198-8892).
6. **SHALL** contain exactly one [1..1] **text** (CONF:1198-7111).

If section/@nullFlavor is not present:

7. **SHALL** contain at least one [1..*] **entry** (CONF:1198-7112) such that it
   a. **SHALL** contain exactly one [1..1] **Result Organizer (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2015-08-01) (CONF:1198-15516).

---

**Figure 26: Results Section (entries required) (V3) Example**

```xml
<section>
  <templateId root="2.16.840.1.113883.10.20.22.2.3.1" extension="2015-08-01" />
  <code code="30954-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" display="RELEVANT DIAGNOSTIC TESTS AND/OR LABORATORY DATA" />
  <title>Results</title>
  <text />
  <entry typeCode="DRIV">
    <organizer classCode="BATTERY" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.1" extension="2014-06-09" />
      ...
    </organizer>
  </entry>
</section>
```

---

### 2.8 Social History Section (V3)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2015-08-01 (open)]

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**Table 10: Social History Section (V3) Contexts**

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Public Health Case Report Document (eICR) (required)</td>
<td>Social History Observation (V3)</td>
</tr>
</tbody>
</table>
This section contains social history data that influence a patient’s physical, psychological or emotional health (e.g., smoking status, pregnancy). Demographic data, such as marital status, race, ethnicity, and religious affiliation, is captured in the header.

1. **SHALL** contain exactly one [1..1] `templateId` (CONF:1198-7936) such that it
   a. **SHALL** contain exactly one [1..1] `@root`="2.16.840.1.113883.10.20.22.2.17" (CONF:1198-10449).
   b. **SHALL** contain exactly one [1..1] `@extension"="2015-08-01"` (CONF:1198-32494).
2. **SHALL** contain exactly one [1..1] `code` (CONF:1198-14819).
   a. This code **SHALL** contain exactly one [1..1] `@code"=29762-2"` Social History (CONF:1198-14820).
   b. This code **SHALL** contain exactly one [1..1] `@codeSystem="2.16.840.1.113883.6.1"` (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:1198-30814).
3. **SHALL** contain exactly one [1..1] `title` (CONF:1198-7938).
4. **SHALL** contain exactly one [1..1] `text` (CONF:1198-7939).
5. **MAY** contain zero or more [0..*] `entry` (CONF:1198-7953) such that it
   a. **SHALL** contain exactly one [1..1] Social History Observation (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2015-08-01) (CONF:1198-14821).
6. **MAY** contain zero or more [0..*] `entry` (CONF:1198-9132) such that it
   a. **SHALL** contain exactly one [1..1] Pregnancy Observation (identifier: urn:oid:2.16.840.1.113883.10.20.15.3.8) (CONF:1198-14822).
7. **SHOULD** contain zero or more [0..*] `entry` (CONF:1198-14823) such that it
8. **MAY** contain zero or more [0..*] `entry` (CONF:1198-16816) such that it
9. **MAY** contain zero or more [0..*] `entry` (CONF:1198-28361) such that it
   a. **SHALL** contain exactly one [1..1] Caregiver Characteristics (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.72) (CONF:1198-28362).
10. **MAY** contain zero or more [0..*] `entry` (CONF:1198-28366) such that it
11. **MAY** contain zero or more [0..*] `entry` (CONF:1198-28825) such that it
Figure 27: Social History Section (V3) Example

```xml
<component>
  <section>
    <templateId root="2.16.840.1.113883.10.20.22.2.17" extension="2015-08-01" />
    <code code="29762-2" codeSystem="2.16.840.1.113883.6.1" displayName="Social History" />
    <title>SOCIAL HISTORY</title>
    <text>
      ...
    </text>
    <entry>
      <observation classCode="OBS" moodCode="EVN">
        <!-- Social history observation V2 -->
        <templateId root="2.16.840.1.113883.10.20.22.4.38" extension="2015-08-01" />
      </observation>
      ...
    </entry>
    <entry>
      <observation classCode="OBS" moodCode="EVN">
        <!-- ** Current smoking status observation ** -->
        <templateId root="2.16.840.1.113883.10.20.22.4.78" extension="2014-06-09" />
      </observation>
      ...
    </entry>
    <entry>
      <observation classCode="OBS" moodCode="EVN">
        <!-- Caregiver Characteristics -->
        <templateId root="2.16.840.1.113883.10.20.22.4.72" />
      </observation>
      ...
    </entry>
    <entry>
      <observation classCode="OBS" moodCode="EVN">
        <!-- ** Cultural and Religious Observations (NEW) ** -->
        <templateId root="2.16.840.1.113883.10.20.22.4.111" />
      </observation>
      ...
    </entry>
    <entry>
      <observation classCode="OBS" moodCode="EVN">
        <!-- ** Characteristics of Care Environment ** -->
        <templateId root="2.16.840.1.113883.10.20.22.4.109" />
      </observation>
      ...
    </entry>
  </section>
</component>
```
</observation>
</entry>
</section>
</component>
3 ENTRY

3.1 Encounter Activity (V3)

[encounter: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2015-08-01 (open)]

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Table 11: Encounter Activity (V3) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounters Section (entries required)</td>
<td>Encounter Diagnosis (V3)</td>
</tr>
</tbody>
</table>

This clinical statement describes an interaction between a patient and clinician. Interactions may include in-person encounters, telephone conversations, and email exchanges.

1. SHALL contain exactly one [1..1] @classCode="ENC" (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 STATIC) (CONF:1198-8710).
2. SHALL contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood urn:oid:2.16.840.1.113883.5.1001 STATIC) (CONF:1198-8711).
3. SHALL contain exactly one [1..1] templateId (CONF:1198-8712) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.49" (CONF:1198-26353).
   b. SHALL contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32546).
4. SHALL contain at least one [1..*] id (CONF:1198-8713).
5. SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet EncounterTypeCode urn:oid:2.16.840.1.113883.3.88.12.80.32 DYNAMIC (CONF:1198-8714).
   a. This code SHOULD contain zero or one [0..1] originalText (CONF:1198-8719).
      i. The originalText, if present, SHOULD contain zero or one [0..1] reference (CONF:1198-15970).
         1. The reference, if present, SHOULD contain zero or one [0..1] @value (CONF:1198-15971).
            a. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:1198-15972).
   b. This code MAY contain zero or one [0..1] translation (CONF:1198-32323).
6. SHALL contain exactly one [1..1] effectiveTime (CONF:1198-8715).

The translation may exist to map the code of EncounterTypeCode (2.16.840.1.113883.3.88.12.80.32) value set to the code of Encounter Planned (2.16.840.1.113883.11.20.9.52) value set.

   a. This code MAY contain zero or one [0..1] translation (CONF:1198-32323).
6. SHALL contain exactly one [1..1] effectiveTime (CONF:1198-8715).
7. **MAY** contain zero or one [0..1] `sdtc:dischargeDispositionCode` (CONF:1198-32176).
   Note: The prefix sdtc: SHALL be bound to the namespace “urn:hl7-org:sdtc”. The use of the namespace provides a necessary extension to CDA R2 for the use of the dischargeDispositionCode element
   a. This sdtc:dischargeDispositionCode **SHOULD** contain exactly [1..1] `@code`, which **SHOULD** be selected from ValueSet 2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status (code system 2.16.840.1.113883.6.301.5) **DYNAMIC** or, if access to NUBC is unavailable, from CodeSystem 2.16.840.1.113883.12.112 HL7 Discharge Disposition (CONF:1198-32177).
   b. This sdtc:dischargeDispositionCode **SHOULD** contain exactly [1..1] `@codeSystem`, which **SHOULD** be either CodeSystem: NUBC 2.16.840.1.113883.6.301.5 OR CodeSystem: HL7 Discharge Disposition 2.16.840.1.113883.12.112 (CONF:1198-32377).

8. **MAY** contain zero or more [0..∗] `performer` (CONF:1198-8725).
   a. The performer, if present, **SHALL** contain exactly one [1..1] `assignedEntity` (CONF:1198-8726).
      i. This assignedEntity **MAY** contain zero or one [0..1] `code`, which **SHOULD** be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) urn:oid:2.16.840.1.114222.4.11.1066 **DYNAMIC** (CONF:1198-8727).

9. **SHOULD** contain zero or more [0..∗] `participant` (CONF:1198-8738) such that it
   a. **SHALL** contain exactly one [1..1] `@typeCode`="LOC" Location (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 **STATIC**) (CONF:1198-8740).
   b. **SHALL** contain exactly one [1..1] Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32) (CONF:1198-14903).

10. **MAY** contain zero or more [0..∗] `entryRelationship` (CONF:1198-8722) such that it
    a. **SHALL** contain exactly one [1..1] `@typeCode"="RSON" Has Reason (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 **STATIC**) (CONF:1198-8723).

11. **MAY** contain zero or more [0..∗] `entryRelationship` (CONF:1198-15492) such that it
    a. **SHALL** contain exactly one [1..1] **Encounter Diagnosis (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2015-08-01) (CONF:1198-15973).
3.2 **Encounter Diagnosis (V3)**

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2015-08-01 (open)]

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**Table 12: Encounter Diagnosis (V3) Contexts**

<table>
<thead>
<tr>
<th>Contained By</th>
<th>Contains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter Activity (V3) (optional)</td>
<td>Problem Observation (V3)</td>
</tr>
</tbody>
</table>

This template wraps relevant problems or diagnoses at the close of a visit or that need to be followed after the visit. If the encounter is associated with a Hospital Discharge, the Hospital Discharge Diagnosis must be used. This entry requires at least one Problem Observation entry.

1. **SHALL** contain exactly one [1..1] @classCode="ACT" (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 STATIC) (CONF:1198-14889).
2. **SHALL** contain exactly one [1..1] @moodCode="EVN" (CodeSystem: ActMood urn:oid:2.16.840.1.113883.5.1001 STATIC) (CONF:1198-14890).

3. **SHALL** contain exactly one [1..1] templateId (CONF:1198-14895) such that it
   a. **SHALL** contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.80" (CONF:1198-14896).
   b. **SHALL** contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32542).

4. **SHALL** contain exactly one [1..1] code (CONF:1198-19182).
   a. This code **SHALL** contain exactly one [1..1] @code="29308-4" Diagnosis (CONF:1198-19183).
   b. This code **SHALL** contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:1198-32160).

5. **SHALL** contain at least one [1..*] entryRelationship (CONF:1198-14892) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="SUBJ" (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 STATIC) (CONF:1198-14893).
   b. **SHALL** contain exactly one [1..1] Problem Observation (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2015-08-01) (CONF:1198-14898).

---

**Figure 29: Encounter Diagnosis (V3) Example**

```xml
<act classCode="ACT" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.22.4.80" extension="2015-08-01"/>
  <code code="29308-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" display="DIAGNOSIS"/>
  <statusCode code="active"/>
  <effectiveTime>
    <low value="20903003"/>
  </effectiveTime>
  <entryRelationship typeCode="SUBJ">
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.4" extension="2015-08-01"/>
      <!-- Problem Observation -->
    </observation>
  </entryRelationship>
</act>
```
3.3 Medication Activity (V2)

A Medication Activity describes substance administrations that have actually occurred (e.g., pills ingested or injections given) or are intended to occur (e.g., "take 2 tablets twice a day for the next 10 days"). Medication activities in "INT" mood are reflections of what a clinician intends a patient to be taking. For example, a clinician may intend that a patient to be administered Lisinopril 20 mg PO for blood pressure control. If what was actually administered was Lisinopril 10 mg., then the Medication activities in the "EVN" mood would reflect actual use.

A moodCode of INT is allowed, but it is recommended that the Planned Medication Activity (V2) template be used for moodCodes other than EVN if the document type contains a section that includes Planned Medication Activity (V2) (for example a Care Plan document with Plan of Treatment, Intervention, or Goal sections).

At a minimum, a Medication Activity shall include an effectiveTime indicating the duration of the administration (or single-administration timestamp). Ambulatory medication lists generally provide a summary of use for a given medication over time - a medication activity in event mood with the duration reflecting when the medication started and stopped. Ongoing medications will not have a stop date (or will have a stop date with a suitable NULL value). Ambulatory medication lists will generally also have a frequency (e.g., a medication is being taken twice a day). Inpatient medications generally record each administration as a separate act.

The dose (doseQuantity) represents how many of the consumables are to be administered at each administration event. As a result, the dose is always relative to the consumable and the interval of administration. Thus, a patient consuming a single “metoprolol 25mg tablet” per administration will have a doseQuantity of "1", whereas a patient consuming "metoprolol" will have a dose of "25 mg".

1. SHALL contain exactly one [1..1] @classCode="SBADM" (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 STATIC) (CONF:1098-7496).
2. SHALL contain exactly one [1..1] @moodCode, which SHALL be selected from ValueSet MoodCodeEvnInt urn:oid:2.16.840.1.113883.11.20.9.18 STATIC 2011-04-03 (CONF:1098-7497).
3. SHALL contain exactly one [1..1] templateId (CONF:1098-7499) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.16" (CONF:1098-10504).
   b. SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32498).
4. SHALL contain at least one [1..*] id (CONF:1098-7500).
5. **MAY** contain zero or one [0..1] **code** (CONF:1098-7506).
   Note: SubstanceAdministration.code is an optional field. Per HL7 Pharmacy Committee, “this is intended to further specify the nature of the substance administration act. To date the committee has made no use of this attribute”. Because the type of substance administration is generally implicit in the routeCode, in the consumable participant, etc., the field is generally not used, and there is no defined value set.

6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1098-7507).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet ActStatus urn:oid:2.16.840.1.113883.1.11.159331 DYNAMIC (CONF:1098-32360).

The substance administration effectiveTime field can repeat, in order to represent varying levels of complex dosing. effectiveTime can be used to represent the duration of administration (e.g., "10 days"), the frequency of administration (e.g., "every 8 hours"), and more. Here, we require that there **SHALL** be an effectiveTime documentation of the duration (or single-administration timestamp), and that there **SHOULD** be an effectiveTime documentation of the frequency. Other timing nuances, supported by the base CDA R2 standard, may also be included.

7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1098-7508) such that it
   a. **SHOULD** contain zero or one [0..1] **@value** (CONF:1098-32775).
      Note: indicates a single-administration timestamp
   b. **SHOULD** contain zero or one [0..1] **low** (CONF:1098-32776).
      Note: indicates when medication started
   c. **MAY** contain zero or one [0..1] **high** (CONF:1098-32777).
      Note: indicates when medication stopped
   d. This effectiveTime **SHALL** contain either a low or a @value but not both (CONF:1098-32890).

8. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:1098-7513) such that it
   a. **SHALL** contain exactly one [1..1] **@operator** = "A" (CONF:1098-9106).
   b. **SHALL** contain exactly one [1..1] **@xsi:type** = "PIVL_TS" or "EIVL_TS" (CONF:1098-28499).

In "INT" (intent) mood, the repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times. In "EVN" (event) mood, the repeatNumber is the number of occurrences. For example, a repeatNumber of "3" in a substance administration event means that the current administration is the 3rd in a series.

9. **MAY** contain zero or one [0..1] **repeatNumber** (CONF:1098-7555).

10. **SHOULD** contain zero or one [0..1] **routeCode**, which **SHALL** be selected from ValueSet Medication Route FDA urn:oid:2.16.840.1.113883.3.88.12.3221.8.7 DYNAMIC (CONF:1098-7514).
11. **MAY** contain zero or one [0..1] `approachSiteCode`, where the code **SHALL** be selected from ValueSet **Body Site** urn:oid:2.16.840.1.113883.3.88.12.3221.8.9 **DYNAMIC** (CONF:1098-7515).

12. **SHALL** contain exactly one [1..1] `doseQuantity` (CONF:1098-7516).
   a. This `doseQuantity` **SHOULD** contain zero or one [0..1] `@unit`, which **SHALL** be selected from ValueSet **UnitsOfMeasureCaseSensitive** urn:oid:2.16.840.1.113883.1.11.12839 **DYNAMIC** (CONF:1098-7526).
   b. Pre-coordinated consumable: If the consumable code is a pre-coordinated unit dose (e.g., "metoprolol 25mg tablet") then `doseQuantity` is a unitless number that indicates the number of products given per administration (e.g., "2", meaning 2 x "metoprolol 25mg tablet" per administration) (CONF:1098-16878).
   c. Not pre-coordinated consumable: If the consumable code is not pre-coordinated (e.g., is simply "metoprolol"), then `doseQuantity` must represent a physical quantity with `@unit`, e.g., "25" and "mg", specifying the amount of product given per administration (CONF:1098-16879).

13. **MAY** contain zero or one [0..1] `rateQuantity` (CONF:1098-7517).
   a. The `rateQuantity`, if present, **SHALL** contain exactly one [1..1] `@unit`, which **SHALL** be selected from ValueSet **UnitsOfMeasureCaseSensitive** urn:oid:2.16.840.1.113883.1.11.12839 **DYNAMIC** (CONF:1098-7525).

14. **MAY** contain zero or one [0..1] `maxDoseQuantity` (CONF:1098-7518).

15. **MAY** contain zero or one [0..1] `administrationUnitCode`, which **SHALL** be selected from ValueSet **AdministrationUnitDoseForm** urn:oid:2.16.840.1.113762.1.4.1021.30 **DYNAMIC** (CONF:1098-7519).

16. **SHALL** contain exactly one [1..1] `consumable` (CONF:1098-7520).
   a. This consumable **SHALL** contain exactly one [1..1] **Medication Information (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09) (CONF:1098-16085).

17. **MAY** contain zero or one [0..1] `performer` (CONF:1098-7522).

18. **SHOULD** contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1098-31150).

19. **MAY** contain zero or more [0..*] `participant` (CONF:1098-7523) such that it
   a. **SHALL** contain exactly one [1..1] `@typeCode`="CSM" (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90 **STATIC**) (CONF:1098-7524).

20. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:1098-7536) such that it...
a. **SHALL** contain exactly one [1..1] `@typeCode`="RSON" (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 STATIC) (CONF:1098-7537).


21. **MAY** contain zero or one [0..1] `entryRelationship` (CONF:1098-7539) such that it

a. **SHALL** contain exactly one [1..1] `@typeCode`="SUBJ" (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 STATIC) (CONF:1098-7540).


22. **MAY** contain zero or one [0..1] `entryRelationship` (CONF:1098-7543) such that it

a. **SHALL** contain exactly one [1..1] `@typeCode`="REFR" (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 STATIC) (CONF:1098-7547).


23. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:1098-7549) such that it

a. **SHALL** contain exactly one [1..1] `@typeCode`="REFR" (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 STATIC) (CONF:1098-7553).


24. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:1098-7552) such that it

a. **SHALL** contain exactly one [1..1] `@typeCode`="CAUS" (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 STATIC) (CONF:1098-7544).


25. **MAY** contain zero or one [0..1] `entryRelationship` (CONF:1098-30820) such that it

a. **SHALL** contain exactly one [1..1] `@typeCode`="COMP" Has component (CONF:1098-30821).

b. **SHALL** contain exactly one [1..1] Drug Monitoring Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.123) (CONF:1098-30822).

The following `entryRelationship` is used to indicate a given medication's order in a series. The nested Substance Administered Act identifies an administration in the series. The `entryRelationship/sequenceNumber` shows the order of this particular administration in that series.

26. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:1098-31515) such that it
a. SHALL contain exactly one [1..1] @typeCode="COMP" Component (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002) (CONF:1098-31516).

b. SHALL contain exactly one [1..1] @inversionInd="true" (CONF:1098-31517).

c. MAY contain zero or one [0..1] sequenceNumber (CONF:1098-31518).

d. SHALL contain exactly one [1..1] Substance Administered Act (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.118) (CONF:1098-31519).

27. MAY contain zero or more [0..*] entryRelationship (CONF:1098-32907) such that it

a. SHALL contain exactly one [1..1] @typeCode="COMP" Has component (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002) (CONF:1098-32908).

b. SHALL contain exactly one [1..1] Medication Free Text Sig (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.147) (CONF:1098-32909).

28. MAY contain zero or more [0..*] precondition (CONF:1098-31520).

a. The precondition, if present, SHALL contain exactly one [1..1] @typeCode="PRCN" (CONF:1098-31882).


29. Medication Activity SHOULD include doseQuantity OR rateQuantity (CONF:1098-30800).
Figure 30: Medication Activity (V2) Example

```
<substanceAdministration classCode="SBADM" moodCode="E VN">  
  <!-- ** Medication Activity (V2) ** -->
  <templateId root="2.16.840.1.113883.10.20.22.4.16"
    extension="2014-06-09"/>
  <id root="6c844c75-aa34-411c-b7bd-5e4a9f206e29"/>
  <statusCode code="active"/>
  <effectiveTime xsi:type="IVL_TS">
    <low value="20120318"/>
  </effectiveTime>
  <effectiveTime xsi:type="PIVL_TS" institutionSpecified="true" operator="A">
    <period value="12" unit="h"/>
  </effectiveTime>
  <routeCode code="C38288"
    codeSystem="2.16.840.1.113883.3.26.1.1"
    codeSystemName="NCI Thesaurus"
    displayName="ORAL"/>
  <doseQuantity value="1"/>
  <consumable>
    <manufacturedProduct classCode="MANU">
      <!-- ** Medication information ** -->
      <templateId root="2.16.840.1.113883.10.20.22.4.23"
        extension="2014-06-09"/>
      <id root="2a620155-9d11-439e-92b3-5d9815ff4ee9"/>
      <manufacturedMaterial>
        <code code="197380"
          displayName="Atenolol 25 MG Oral Tablet"
          codeSystem="2.16.840.1.113883.6.88" codeSystemName="RxNorm"/>
      </manufacturedMaterial>
    </manufacturedProduct>
  </consumable>
  <entryRelationship typeCode="RSON">
    <observation classCode="OBS" moodCode="E VN">
      <!-- ** Indication ** -->
      <templateId root="2.16.840.1.113883.10.20.22.4.19"
        extension="2014-06-09"/>
      <id root="e63166c7-6482-4a44-83a1-37ccdbde725b"/>
      <code code="75321-0"
        codeSystem="2.16.840.1.113883.6.1"
        codeSystemName="LOINC"
        displayName="Clinical finding"/>
      <statusCode code="completed"/>
      <value xsi:type="CD"
        code="38341003"
        displayName="Hypertension"
        codeSystem="2.16.840.1.113883.6.96"/>
    </observation>
  </entryRelationship>
</substanceAdministration>
```
3.4 Medication Information (V2)

A medication should be recorded as a pre-coordinated ingredient + strength + dose form (e.g., “metoprolol 25mg tablet”, “amoxicillin 400mg/5mL suspension”) where possible. This includes RxNorm codes whose Term Type is SCD (semantic clinical drug), SBD (semantic brand drug), GPCK (generic pack), BPCK (brand pack).

The dose (doseQuantity) represents how many of the consumables are to be administered at each administration event. As a result, the dose is always relative to the consumable. Thus, a patient consuming a single "metoprolol 25mg tablet" per administration will have a doseQuantity of "1", whereas a patient consuming "metoprolol" will have a dose of "25 mg".

1. SHALL contain exactly one [1..1] @classCode="MANU" (CodeSystem: RoleClass urn:oid:2.16.840.1.113883.5.110 STATIC) (CONF:1098-7408).
2. SHALL contain exactly one [1..1] templateId (CONF:1098-7409) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.23" (CONF:1098-10506).
b. **SHALL** contain exactly one \[1..1\] @extension="2014-06-09" (CONF:1098-32579).

3. **MAY** contain zero or more \[0..*\] id (CONF:1098-7410).

4. **SHALL** contain exactly one \[1..1\] manufacturedMaterial (CONF:1098-7411).
   
   Note: A medication should be recorded as a pre-coordinated ingredient + strength + dose form (e.g., “metoprolol 25mg tablet”, “amoxicillin 400mg/5mL suspension”) where possible. This includes RxNorm codes whose Term Type is SCD (semantic clinical drug), SBD (semantic brand drug), GPCK (generic pack), BPCK (brand pack).

   a. This manufacturedMaterial **SHALL** contain exactly one \[1..1\] code, which **SHALL** be selected from ValueSet Medication Clinical Drug urn:oid:2.16.840.1.113762.1.4.1010.4 DYNAMIC (CONF:1098-7412).

   i. This code **MAY** contain zero or more \[0..*\] translation, which **MAY** be selected from ValueSet Clinical Substance urn:oid:2.16.840.1.113762.1.4.1010.2 DYNAMIC (CONF:1098-31884).

5. **MAY** contain zero or one \[0..1\] manufacturerOrganization (CONF:1098-7416).

---

**Figure 32: Medication Information (V2) Example**

```xml
<manufacturedProduct classCode="MANU">
  <!-- ** Medication information ** -->
  <templateId root="2.16.840.1.113883.10.20.22.4.23" extension="2014-06-09" />
  <id root="2a620155-9d11-439e-92b3-5d9815ff4ee8" />
  <manufacturedMaterial>
    <code code="573621" displayName="Proventil 0.09 MG/ACTUAT inhalant solution" codeSystem="2.16.840.1.113883.6.88" codeSystemName="RxNorm" />
  </manufacturedMaterial>
  <manufacturerOrganization>
    <name>Medication Factory Inc.</name>
  </manufacturerOrganization>
</manufacturedProduct>
```

3.5 **Problem Concern Act (V3)**

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.3:2015-08-01 (open)]

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**Table 15: Problem Concern Act (V3) Contexts**

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Section (entries required) (V3) (required)</td>
<td>Problem Observation (V3)</td>
</tr>
</tbody>
</table>

This template reflects an ongoing concern on behalf of the provider that placed the concern on a patient’s problem list. So long as the underlying condition is of concern to the provider (i.e., as long as the condition, whether active or resolved, is of ongoing concern and interest to the provider), the statusCode is “active”. Only when the underlying condition is no longer of concern is the statusCode set to “completed”. The effectiveTime reflects the time that the underlying condition was felt to be a concern; it may or may not correspond to the
effectiveTime of the condition (e.g., even five years later, the clinician may remain concerned about a prior heart attack).

The statusCode of the Problem Concern Act is the definitive indication of the status of the concern, whereas the effectiveTime of the nested Problem Observation is the definitive indication of whether or not the underlying condition is resolved.

The effectiveTime/low of the Problem Concern Act asserts when the concern became active. This equates to the time the concern was authored in the patient’s chart. The effectiveTime/high asserts when the concern was completed (e.g., when the clinician deemed there is no longer any need to track the underlying condition).

A Problem Concern Act can contain many Problem Observations (templateId 2.16.840.1.113883.10.20.22.4.4). Each Problem Observation is a discrete observation of a condition, and therefore will have a statusCode of “completed”. The many Problem Observations nested under a Problem Concern Act reflect the change in the clinical understanding of a condition over time. For instance, a Concern may initially contain a Problem Observation of “chest pain”:

- Problem Concern 1
  --- Problem Observation: Chest Pain

Later, a new Problem Observation of “esophagitis” will be added, reflecting a better understanding of the nature of the chest pain. The later problem observation will have a more recent author time stamp.

- Problem Concern 1
  --- Problem Observation (author/time Jan 3, 2012): Chest Pain
  --- Problem Observation (author/time Jan 6, 2012): Esophagitis

Many systems display the nested Problem Observation with the most recent author time stamp, and provide a mechanism for viewing prior observations.

1. SHALL contain exactly one [1..1] @classCode="ACT" Act (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 STATIC) (CONF:1198-9024).
3. SHALL contain exactly one [1..1] templateId (CONF:1198-16772) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.3" (CONF:1198-16773).
   b. SHALL contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32509).
4. SHALL contain at least one [1..*] id (CONF:1198-9026).
5. SHALL contain exactly one [1..1] code (CONF:1198-9027).
   a. This code SHALL contain exactly one [1..1] @code="CONC" Concern (CONF:1198-19184).
   b. This code SHALL contain exactly one [1..1]
      @codeSystem="2.16.840.1.113883.5.6" (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6) (CONF:1198-32168).
6. SHALL contain exactly one [1..1] statusCode (CONF:1198-9029).
The statusCode of the Problem Concern Act is the definitive indication of the status of the concern, whereas the effectiveTime of the nested Problem Observation is the definitive indication of whether or not the underlying condition is resolved.

a. This statusCode **SHALL** contain exactly one [1..1] @code, which **SHALL** be selected from ValueSet **ProblemAct statusCode**
   urn:oid:2.16.840.1.113883.11.20.9.19 **STATIC** (CONF:1198-31525).

7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1198-9030).
   a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:1198-9032).  
      Note: The effectiveTime/low asserts when the concern became active. This equates to the time the concern was authored in the patient's chart.
   b. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:1198-9033).  
      Note: The effectiveTime/high asserts when the concern was completed (e.g., when the clinician deemed there is no longer any need to track the underlying condition).

8. **SHOULD** contain zero or more [0..*] Author Participation (identifier: 
   urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1198-31146).

9. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:1198-9034) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: 
      HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 **STATIC**) 
      (CONF:1198-9035).
   b. **SHALL** contain exactly one [1..1] **Problem Observation (V3)** (identifier: 
      urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2015-08-01) (CONF:1198-15980).

The following entryRelationship represents the importance of the concern to a provider.

10. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1198-31638) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: 
      HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002) (CONF:1198-31639).
   b. **SHALL** contain exactly one [1..1] Priority Preference (identifier: 
      urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1198-31640).
Figure 33: Problem Concern Act (V3) Example

<act classCode="ACT" moodCode="EVN">
  <!-- ** Problem Concern Act (V2) ** -->
  <templateId root="2.16.840.1.113883.10.20.22.4.3" extension="2015-08-01" />
  <id root="ecc8a6ff8-ed4b-4f7e-82c3-e98e58b45de7" />
  <code code="CONC" codeSystem="2.16.840.1.113883.5.6" displayName="Concern" />
  <!-- The statusCode represents the need to continue tracking the problem -->
  <!-- This is of ongoing concern to the provider -->
  <statusCode code="active" />
  <effectiveTime>
    <!-- The low value represents when the problem was first recorded in the patient's chart -->
    <!-- Concern was documented on July 6, 2013 -->
    <low value="201307061145-0800" />
  </effectiveTime>
  <author typeCode="AUT">
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    <!-- Same as Concern effectiveTime/low -->
    <time value="201307061145-0800" />
    <assignedAuthor>
      <id extension="555555555" root="2.16.840.1.113883.4.6" />
      <code code="207QA0505X" displayName="Adult Medicine" codeSystem="2.16.840.1.113883.6.101" codeSystemName="Healthcare Provider Taxonomy (HIPAA)" />
    </assignedAuthor>
  </author>
</act>

<observation classCode="OBS" moodCode="EVN">
  <!-- ** Problem Observation (V2) ** -->
  <templateId root="2.16.840.1.113883.10.20.22.4.4" extension="2015-08-01" />
  <id root="ab1791b0-5c71-11db-b0de-0800200c9a66" />
  <code code="75323-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Condition" />
  <!-- The statusCode reflects the status of the observation itself -->
  <statusCode code="completed" />
  <effectiveTime>
    <!-- The low value reflects the date of onset -->
    <!-- Based on patient symptoms, presumed onset is July 3, 2013 -->
    <low value="20130703" />
    <!-- The high value reflects when the problem was known to be resolved -->
    <!-- Based on signs and symptoms, appears to be resolved on Aug 14, 2013 -->
    <high value="20080814" />
  </effectiveTime>
  <value xsi:type="CD" code="233604007" codeSystem="2.16.840.1.113883.6.96" displayName="Pneumonia" />
  <author typeCode="AUT">
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    <time value="200808141030-0800" />
    <assignedAuthor>
      <id extension="555555555" root="2.16.840.1.113883.4.6" />
      <code code="207QA0505X" displayName="Adult Medicine" />
    </assignedAuthor>
  </author>
</observation>
3.6 **Problem Observation (V3)**

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2015-08-01 (open)]

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**Table 16: Problem Observation (V3) Contexts**

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Encounter Diagnosis (V3)</strong> (required)</td>
<td></td>
</tr>
<tr>
<td><strong>Problem Concern Act (V3)</strong> (required)</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** During the eICR CDA IG DSTU period, the use of the Problems Observation template to indicate pregnancy is being evaluated. The recommended SNOMED value codes are ‘60001007’ Not pregnant (finding), and ‘77386006’ Patient currently pregnant (finding). An eICR Example is provided for a pregnant patient.

This template reflects a discrete observation about a patient's problem. Because it is a discrete observation, it will have a statusCode of "completed". The effectiveTime, also referred to as the “biologically relevant time” is the time at which the observation holds for the patient. For a provider seeing a patient in the clinic today, observing a history of heart attack that occurred five years ago, the effectiveTime is five years ago.

The effectiveTime of the Problem Observation is the definitive indication of whether or not the underlying condition is resolved. If the problem is known to be resolved, then an effectiveTime/high would be present. If the date of resolution is not known, then effectiveTime/high will be present with a nullFlavor of "UNK".

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 STATIC) (CONF:1198-9041).


The negationInd is used to indicate the absence of the condition in observation/value. A negationInd of “true” coupled with an observation/value of SNOMED code 64572001 “Disease (disorder)” indicates that the patient has no known conditions.

3. MAY contain zero or one [0..1] @negationInd (CONF:1198-10139).

4. SHALL contain exactly one [1..1] templateId (CONF:1198-14926) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.4" (CONF:1198-14927).
b. **SHALL** contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32508).

5. **SHALL** contain at least one [1..*] id (CONF:1198-9043).

6. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **Problem Type** urn:oid:2.16.840.1.113883.3.88.12.3221.7.2 **STATIC** 2012-06-01 (CONF:1198-9045).
   a. This code **SHALL** contain at least one [1..*] **translation**, which **SHOULD** be selected from ValueSet **Problem Type** urn:oid:2.16.840.1.113883.3.88.12.3221.7.2 2014-09-02 (CONF:1198-32848).

7. **SHALL** contain exactly one [1..1] **statusCode** (CONF:1198-9049).
   a. This **statusCode** **SHALL** contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus urn:oid:2.16.840.1.113883.5.14 **STATIC**) (CONF:1198-19112).

If the problem is known to be resolved, but the date of resolution is not known, then the high element **SHALL** be present, and the nullFlavor attribute **SHALL** be set to 'UNK'. Therefore, the existence of an high element within a problem does indicate that the problem has been resolved.

8. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1198-9050).

   The **effectiveTime**/low (a.k.a. "onset date") asserts when the condition became biologically active.
   a. This **effectiveTime** **SHALL** contain exactly one [1..1] **low** (CONF:1198-15603).

   The **effectiveTime**/high (a.k.a. "resolution date") asserts when the condition became biologically resolved.
   b. This **effectiveTime** **MAY** contain zero or one [0..1] **high** (CONF:1198-15604).

9. **SHALL** contain exactly one [1..1] **value** with @xsi:type="CD", where the code **SHOULD** be selected from ValueSet **Problem** urn:oid:2.16.840.1.113883.3.88.12.3221.7.4 **DYNAMIC** (CONF:1198-9058).

The observation/value and all the qualifiers together (often referred to as a post-coordinated expression) make up one concept. Qualifiers constrain the meaning of the primary code, and cannot negate it or change its meaning. Qualifiers can only be used according to well-defined rules of post-coordination and only if the underlying code system defines the use of such qualifiers or if there is a third code system that specifies how other code systems may be combined.

For example, SNOMED CT allows constructing concepts as a combination of multiple codes. SNOMED CT defines a concept "pneumonia (disorder)” (233604007) an attribute "finding site” (363698007) and another concept "left lower lobe of lung (body structure)” (41224006). SNOMED CT allows one to combine these codes in a code phrase, as shown in the sample XML.

   a. This value **MAY** contain zero or more [0..*] **qualifier** (CONF:1198-31870).
   b. This value **MAY** contain zero or more [0..*] **translation** (CONF:1198-16749) such that it
      i. **MAY** contain zero or one [0..1] @code (CodeSystem: ICD-10-CM
         urn:oid:2.16.840.1.113883.6.90 **STATIC**) (CONF:1198-16750).
A negationInd of "true" coupled with an observation/value/@code of SNOMED code 64572001 "Disease (disorder)" indicates that the patient has no known conditions.

c. This value **MAY** contain zero or one [0..1] @code (CONF:1198-31871).

10. **SHOULD** contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1198-31147).

11. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1198-9059) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 STATIC) (CONF:1198-9060).
   b. **SHALL** contain exactly one [1..1] @inversionInd="true" True (CONF:1198-9069).
   c. **SHALL** contain exactly one [1..1] Age Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.31) (CONF:1198-15590).

12. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1198-29951) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002) (CONF:1198-31531).
   b. **SHALL** contain exactly one [1..1] Prognosis Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.113) (CONF:1198-29952).

13. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:1198-31063) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002) (CONF:1198-31532).
   b. **SHALL** contain exactly one [1..1] Priority Preference (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.143) (CONF:1198-31064).

14. **MAY** contain zero or one [0..1] **entryRelationship** (CONF:1198-9063) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002) (CONF:1198-9068).
Figure 34: Problem Observation (V3) Example

```xml
<observation classCode="OBS" moodCode="EVN">
  <!-- ** Problem Observation (V3) ** -->
  <templateId root="2.16.840.1.113883.10.20.22.4.4" extension="2015-08-01" />
  <id root="ab1791b0-5c71-11db-b0de-0800200c9a66" />
  <code code="64572001" displayName="Condition"
    codeSystem="2.16.840.1.113883.6.96"
    codeSystemName="SNOMED CT">
    <translation code="75323-6"
      codeSystem="2.16.840.1.113883.6.1"
      codeSystemName="LOINC"
      displayName="Condition" />
  </code>
  <!-- The statusCode reflects the status of the observation itself -->
  <statusCode code="completed" />
  <effectiveTime>
    <!-- The low value reflects the date of onset -->
    <!-- Based on patient symptoms, presumed onset is July 3, 2013 -->
    <low value="20130703" />
    <!-- The high value reflects when the problem was known to be resolved -->
    <!-- Based on signs and symptoms, appears to be resolved on Aug 14, 2013 -->
    <high value="20080814" />
  </effectiveTime>
  <value xsi:type="CD"
    code="233604007"
    codeSystem="2.16.840.1.113883.6.96"
    displayName="Pneumonia" />
  <author typeCode="AUT">
    <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    <time value="200808141030-0800" />
    <assignedAuthor>
      <id extension="555555555" root="2.16.840.1.113883.4.6" />
      <code code="207QA0505X"
        displayName="Adult Medicine"
        codeSystem="2.16.840.1.113883.6.101"
        codeSystemName="Healthcare Provider Taxonomy (HIPAA)" />
    </assignedAuthor>
  </author>
</observation>
```

### 3.7 Result Observation (V3)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2015-08-01 (open)]

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<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Result Organizer (V3) (required)</td>
<td></td>
</tr>
</tbody>
</table>
This template represents the results of a laboratory, radiology, or other study performed on a patient.

The result observation includes a statusCode to allow recording the status of an observation. “Pending” results (e.g., a test has been run but results have not been reported yet) should be represented as “active” ActStatus.

1. **SHALL** contain exactly one [1..1] @classCode = "OBS" Observation (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 STATIC) (CONF:1198-7130).


3. **SHALL** contain exactly one [1..1] templateId (CONF:1198-7136) such that it
   a. **SHALL** contain exactly one [1..1] @root = "2.16.840.1.113883.10.20.22.4.2" (CONF:1198-9138).
   b. **SHALL** contain exactly one [1..1] @extension = "2015-08-01" (CONF:1198-32575).

4. **SHALL** contain at least one [1..*] id (CONF:1198-7137).

5. **SHALL** contain exactly one [1..1] code, which **SHOULD** be selected from CodeSystem LOINC (urn:oid:2.16.840.1.113883.6.1) (CONF:1198-7133).
   a. This code **SHOULD** be a code from the LOINC that identifies the result observation. If an appropriate LOINC code does not exist, then the local code for this result **SHALL** be sent (CONF:1198-19212).

6. **SHALL** contain exactly one [1..1] statusCode (CONF:1198-7134).
   a. This statusCode **SHALL** contain exactly one [1..1] @code, which **SHALL** be selected from ValueSet Result Status urn:oid:2.16.840.1.113883.11.20.9.39 STATIC (CONF:1198-14849).

7. **SHALL** contain exactly one [1..1] effectiveTime (CONF:1198-7140).
   Note: Represents the biologically relevant time of the measurement (e.g., the time a blood pressure reading is obtained, the time the blood sample was obtained for a chemistry test).

8. **SHALL** contain exactly one [1..1] value (CONF:1198-7143).
   a. If Observation/value is a physical quantity (xsi:type = "PQ"), the unit of measure **SHALL** be selected from ValueSet UnitsOfMeasureCaseSensitive 2.16.840.1.113883.1.12.2839 DYNAMIC (CONF:1198-31484).
   b. A coded or physical quantity value **MAY** contain zero or more [0..*] translations, which can be used to represent the original results as output by the lab (CONF:1198-31866).
   c. If Observation/value is a CD (xsi:type = "CD") the value **SHOULD** be SNOMED-CT (CONF:1198-32610).

9. **SHOULD** contain zero or more [0..*] interpretationCode (CONF:1198-7147).
   a. The interpretationCode, if present, **SHALL** contain exactly one [1..1] @code, which **SHALL** be selected from ValueSet Observation Interpretation (HL7) urn:oid:2.16.840.1.113883.11.78 STATIC (CONF:1198-32476).

10. **MAY** contain zero or one [0..1] methodCode (CONF:1198-7148).

11. **MAY** contain zero or one [0..1] targetSiteCode (CONF:1198-7153).

12. **SHOULD** contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1198-7149).
13. **SHOULD** contain zero or more [0..*] **referenceRange** (CONF:1198-7150).
   a. The **referenceRange**, if present, **SHALL** contain exactly one [1..1] **observationRange** (CONF:1198-7151).
      i. This **observationRange** **SHALL NOT** contain [0..0] **code** (CONF:1198-7152).
      ii. This **observationRange** **SHALL** contain exactly one [1..1] **value** (CONF:1198-32175).

**Figure 35: Result Observation (V3) Example**

```
<observation classCode="OBS" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.22.4.2" extension="2015-08-01" />
  <id root="7c0704bb-9c40-41b5-9c7d-26b2d9e234f" />
  <code code="20570-8" displayName="Hematocrit" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />
  <statusCode code="completed" />
  <effectiveTime value="200803190830-0800" />
  <value xsi:type="PQ" value="35.3" unit="%" />
  <interpretationCode code="L" codeSystem="2.16.840.1.113883.5.83" />
  <author>
    <time value="200803190830-0800" />
    <assignedAuthor>
      <id extension="333444444" root="1.1.1.1.1.1.1.4" />
      <addr>
        <streetAddressLine>1017 Health Drive</streetAddressLine>
        <city>Portland</city>
        <state>OR</state>
        <postalCode>99123</postalCode>
        <country>US</country>
      </addr>
      <telecom use="WP" value="tel:+1(555)555-1017" />
      <assignedPerson>
        <given>William</given>
        <given qualifier="CL">Bill</given>
        <family>Beaker</family>
      </assignedPerson>
      <representedOrganization>
        <name>Good Health Laboratory</name>
      </representedOrganization>
    </assignedAuthor>
  </author>
  <referenceRange>
    <observationRange>
      <text>Low</text>
      <value xsi:type="IVL_PQ">
        <low value="34.9" unit="%" />
        <high value="44.5" unit="%" />
      </value>
      <interpretationCode code="L" codeSystem="2.16.840.1.113883.5.83"/>
    </observationRange>
  </referenceRange>
</observation>
```
3.8 Result Organizer (V3)

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Table 18: Result Organizer (V3) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results Section (entries required) (V3) (required)</td>
<td>Result Observation (V3)</td>
</tr>
</tbody>
</table>

This template provides a mechanism for grouping result observations. It contains information applicable to all of the contained result observations. The Result Organizer code categorizes the contained results into one of several commonly accepted values (e.g., “Hematology”, “Chemistry”, “Nuclear Medicine”).

If any Result Observation within the organizer has a statusCode of "active", the Result Organizer must also have a statusCode of "active".

1. SHALL contain exactly one [1..1] @classCode (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 STATIC) (CONF:1198-7121).
3. SHALL contain exactly one [1..1] templateId (CONF:1198-7126) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.1" (CONF:1198-9134).
   b. SHALL contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32588).
4. SHALL contain at least one [1..*] id (CONF:1198-7127).
5. SHALL contain exactly one [1..1] code (CONF:1198-7128).
   a. SHOULD be selected from LOINC (codeSystem 2.16.840.1.113883.6.1) OR SNOMED CT (codeSystem 2.16.840.1.113883.6.96), and MAY be selected from CPT-4 (codeSystem 2.16.840.1.113883.6.12) (CONF:1198-19218).
   b. Laboratory results SHOULD be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or other constrained terminology named by the US Department of Health and Human Services Office of National Coordinator or other federal agency (CONF:1198-19219).
6. SHALL contain exactly one [1..1] statusCode (CONF:1198-7123).
   a. This statusCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Result Status urn:oid:2.16.840.1.113883.11.20.9.39 STATIC (CONF:1198-14848).
7. MAY contain zero or one [0..1] effectiveTime (CONF:1198-31865).
   Note: The effectiveTime is an interval that spans the effectiveTimes of the contained result observations. Because all contained result observations have a required time stamp, it is not required that this effectiveTime be populated.
   a. The effectiveTime, if present, SHALL contain exactly one [1..1] low (CONF:1198-32488).
b. The effectiveTime, if present, **SHALL** contain exactly one [1..1] **high** (CONF:1198-32489).

8. **SHOULD** contain zero or more [0..*] Author Participation *(identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1198-31149).

9. **SHALL** contain at least one [1..*] **component** (CONF:1198-7124) such that it
   a. **SHALL** contain exactly one [1..1] **Result Observation (V3)** *(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2015-08-01) (CONF:1198-14850).

   **Figure 36: Result Organizer (V3) Example**

   

```
<organizer classCode="BATTERY" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.22.4.1" extension="2015-08-01" />
  <id root="7d5a02b0-67a4-11db-bd13-0800200c9a66" />
  <code code="57021-8" displayName="CBC W Auto Differential panel in Blood" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" />
  <statusCode code="completed" />
  <effectiveTime>
    <low value="200803190830-0800" />
    <high value="200803190830-0800" />
  </effectiveTime>
  <author>...
  </author>
  <component>
    <observation classCode="OBS" moodCode="EVN">
      <!-- ** Result observation ** -->
      <templateId root="2.16.840.1.113883.10.20.22.4.2" extension="2015-08-01" />
      ...
    </observation>
  </component>
</organizer>
```

### 3.9 Social History Observation (V3)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.38:2015-08-01 (open)]

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#### Table 19: Social History Observation (V3) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social History Section (V3) (optional)</td>
<td></td>
</tr>
</tbody>
</table>

This template represents a patient's occupations, lifestyle, and environmental health risk factors. Demographic data (e.g., marital status, race, ethnicity, religious affiliation) are captured in the header. Though tobacco use and exposure may be represented with a Social
History Observation, it is recommended to use the Current Smoking Status template or the Tobacco Use template instead, to represent smoking or tobacco habits.

1. **SHALL** contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 **STATIC** (CONF:1198-8548)).

2. **SHALL** contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood urn:oid:2.16.840.1.113883.5.1001 **STATIC** (CONF:1198-8549)).

3. **SHALL** contain exactly one [1..1] `templateId` (CONF:1198-8550) such that it
   a. **SHALL** contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.38" (CONF:1198-10526).
   b. **SHALL** contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32495).

4. **SHALL** contain at least one [1..*] `id` (CONF:1198-8551).

5. **SHALL** contain exactly one [1..1] `code`, which **SHOULD** be selected from ValueSet **Social History Type** urn:oid:2.16.840.1.113883.3.88.12.80.60 **STATIC** 2008-12-18 (CONF:1198-8558).
   a. This code **SHALL** contain at least one [1..*] `translation`, which **SHOULD** be selected from CodeSystem LOINC (urn:oid:2.16.840.1.113883.6.1) (CONF:1198-32853).

6. **SHALL** contain exactly one [1..1] `statusCode` (CONF:1198-8553).
   a. This statusCode **SHALL** contain exactly one [1..1] @code="completed" Completed (CodeSystem: ActStatus urn:oid:2.16.840.1.113883.5.14 **STATIC** (CONF:1198-19117)).

7. **SHALL** contain exactly one [1..1] `effectiveTime` (CONF:1198-31868).

8. **SHOULD** contain zero or one [0..1] `value` (CONF:1198-8559).
   a. If Observation/value is a physical quantity (xsi:type="PQ"), the unit of measure **SHALL** be selected from ValueSet UnitsOfMeasureCaseSensitive (2.16.840.1.113883.1.11.12839) **DYNAMIC** (CONF:1198-8555).

9. **SHOULD** contain zero or more [0..*] `Author Participation` (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1198-31869).
Figure 37: Social History Observation (V3) Example

```xml
<observation classCode="OBS" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.22.4.38" extension="2015-08-01" />
  <id root="37f76c51-6411-4e1d-8a37-957fd49d2cef" />
  <code code="160573003" displayName="Alcohol intake" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT">
    <translation code="74013-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Alcoholic drinks per day"></translation>
    <statusCode code="completed" />
    <effectiveTime>
      <low value="20120215" />
    </effectiveTime>
    <value xsi:type="PQ" value="12" />
    <author typeCode="AUT">
      <templateId root="2.16.840.1.113883.10.20.22.4.119" />
    </author>
  </code>
</observation>
```
4 UNSPECIFIED

4.1 US Realm Address (AD.US.FIELDED)

Table 20: US Realm Address (AD.US.FIELDED) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Realm Header (V3) (required)</td>
<td></td>
</tr>
<tr>
<td>Initial Public Health Case Report Document (eICR)</td>
<td></td>
</tr>
<tr>
<td>[required]</td>
<td></td>
</tr>
</tbody>
</table>

Reusable address template, for use in US Realm CDA Header.

1. **SHOULD** contain zero or one [0..1] @use, which **SHALL** be selected from ValueSet PostalAddressUse urn:oid:2.16.840.1.113883.1.11.10637 STATIC 2005-05-01 (CONF:81-7290).

2. **SHOULD** contain zero or one [0..1] country, which **SHALL** be selected from ValueSet Country urn:oid:2.16.840.1.113883.3.88.12.80.63 DYNAMIC (CONF:81-7295).

3. **SHOULD** contain zero or one [0..1] state (ValueSet: StateValueSet urn:oid:2.16.840.1.113883.3.88.12.80.1 DYNAMIC) (CONF:81-7293).
   a. State is required if the country is US. If country is not specified, it’s assumed to be US. If country is something other than US, the state **MAY** be present but **MAY** be bound to different vocabularies (CONF:81-10024).

4. **SHALL** contain exactly one [1..1] city (CONF:81-7292).

5. **SHOULD** contain zero or one [0..1] postalCode, which **SHOULD** be selected from ValueSet PostalCode urn:oid:2.16.840.1.113883.3.88.12.80.2 DYNAMIC (CONF:81-7294).
   a. PostalCode is required if the country is US. If country is not specified, it’s assumed to be US. If country is something other than US, the postalCode **MAY** be present but **MAY** be bound to different vocabularies (CONF:81-10025).

6. **SHALL** contain exactly one [1..1] streetAddressLine (CONF:81-7291).

7. **SHALL NOT** have mixed content except for white space (CONF:81-7296).

Figure 38: US Realm Address Example

```xml
<addr use="HP">
  <streetAddressLine>22 Sample Street</streetAddressLine>
  <city>Beaverton</city>
  <state>OR</state>
  <postalCode>97867</postalCode>
  <country>US</country>
</addr>
```
4.2 US Realm Date and Time (DTM.US.FIELDED)

[effectiveTime: identifier urn:oid:2.16.840.1.113883.10.20.22.5.4 (open)]

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<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Realm Header (V3) (required)</td>
<td></td>
</tr>
<tr>
<td>Initial Public Health Case Report Document (eICR) (required)</td>
<td></td>
</tr>
</tbody>
</table>

The US Realm Clinical Document Date and Time datatype flavor records date and time information. If no time zone offset is provided, you can make no assumption about time, unless you have made a local exchange agreement.

This data type uses the same rules as US Realm Date and Time (DT.US.FIELDED), but is used with elements having a datatype of TS.

1. **SHALL** be precise to the day (CONF:81-10127).
2. **SHOULD** be precise to the minute (CONF:81-10128).
3. **MAY** be precise to the second (CONF:81-10129).
4. If more precise than day, **SHOULD** include time-zone offset (CONF:81-10130).

**Figure 39: US Realm Date and Time Example**

```xml
<time value="19800531"/>
<effectiveTime>
    <low value="20110706122735-0000"/>
    <high value="20110706122815-0000"/>
</effectiveTime>
```

4.3 US Realm Patient Name (PTN.US.FIELDED)

[name: identifier urn:oid:2.16.840.1.113883.10.20.22.5.1 (open)]

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The US Realm Patient Name datatype flavor is a set of reusable constraints that can be used for the patient or any other person. It requires a first (given) and last (family) name. If a patient or person has only one name part (e.g., patient with first name only) place the name part in the field required by the organization. Use the appropriate nullFlavor, "Not Applicable" (NA), in the other field.
For information on mixed content see the Extensible Markup Language reference (http://www.w3c.org/TR/2008/REC-xml-20081126/).

1. **MAY** contain zero or one [0..1] @use, which **SHALL** be selected from ValueSet **EntityNameUse**

2. **SHALL** contain exactly one [1..1] family (CONF:81-7159).
   a. This family **MAY** contain zero or one [0..1] @qualifier, which **SHALL** be selected from ValueSet **EntityPersonNamePartQualifier**

3. **SHALL** contain at least one [1..*] given (CONF:81-7157).
   a. Such givens **MAY** contain zero or one [0..1] @qualifier, which **SHALL** be selected from ValueSet **EntityPersonNamePartQualifier**
   b. The second occurrence of given [given2] if provided, **SHALL** include middle name or middle initial (CONF:81-7163).

4. **MAY** contain zero or more [0..*] prefix (CONF:81-7155).
   a. The prefix, if present, **MAY** contain zero or one [0..1] @qualifier, which **SHALL** be selected from ValueSet **EntityPersonNamePartQualifier**

5. **MAY** contain zero or one [0..1] suffix (CONF:81-7161).
   a. The suffix, if present, **MAY** contain zero or one [0..1] @qualifier, which **SHALL** be selected from ValueSet **EntityPersonNamePartQualifier**

6. **SHALL NOT** have mixed content except for white space (CONF:81-7278).

**Figure 40: US Realm Patient Name Example**

```
<name use="L">
  <prefix qualifier="TITLE">Rep</prefix>
  <given>Evelyn</given>
  <given qualifier="CL">Eve</given>
  <family qualifier="BR">Everywoman</family>
  <suffix qualifier="AC">J.D.</suffix>
</name>
```
4.4 **US Realm Person Name (PN.US.FIELDED)**

[name: identifier urn:oid:2.16.840.1.113883.10.20.22.5.1.1 (open)]

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<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Realm Header (V3) (required)</td>
<td></td>
</tr>
<tr>
<td>Initial Public Health Case Report Document (eICR) (required)</td>
<td></td>
</tr>
</tbody>
</table>

Table 22: US Realm Person Name (PN.US.FIELDED) Contexts

The US Realm Clinical Document Person Name datatype flavor is a set of reusable constraints that can be used for Persons.

1. **SHALL** contain exactly one [1..1] name (CONF:81-9368).
   a. The content of name **SHALL** be either a conformant Patient Name (PTN.US.FIELDED), or a string (CONF:81-9371).
   b. The string **SHALL NOT** contain name parts (CONF:81-9372).
## 5 Template IDs In This Guide

### Table 23: Template Containments

<table>
<thead>
<tr>
<th>Template Title</th>
<th>Template Type</th>
<th>templateId</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Public Health Case Report Document (eICR)</td>
<td>document</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.15.2:20160422</td>
</tr>
<tr>
<td>Encounters Section (entries required) [V3]</td>
<td>section</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2015-08-01</td>
</tr>
<tr>
<td>Encounter Activity [V3]</td>
<td>entry</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2015-08-01</td>
</tr>
<tr>
<td>Encounter Diagnosis [V3]</td>
<td>entry</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2015-08-01</td>
</tr>
<tr>
<td>Problem Observation [V3]</td>
<td>entry</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.4.4:2015-08-01</td>
</tr>
<tr>
<td>History of Present Illness Section</td>
<td>section</td>
<td>urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4</td>
</tr>
<tr>
<td>Immunizations Section (entries required) [V3]</td>
<td>section</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.2.2.1:2015-08-01</td>
</tr>
<tr>
<td>Medications Administered Section [V2]</td>
<td>section</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.2.38:2014-06-09</td>
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<tr>
<td>Medication Activity [V2]</td>
<td>entry</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.4.16:2014-06-09</td>
</tr>
<tr>
<td>Medication Information [V2]</td>
<td>entry</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.4.23:2014-06-09</td>
</tr>
<tr>
<td>Problem Section (entries required) [V3]</td>
<td>section</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2015-08-01</td>
</tr>
<tr>
<td>Problem Concern Act [V3]</td>
<td>entry</td>
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</tr>
<tr>
<td>Problem Observation [V3]</td>
<td>entry</td>
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</tr>
<tr>
<td>Reason for Visit Section</td>
<td>section</td>
<td>urn:oid:2.16.840.1.113883.10.20.22.2.12</td>
</tr>
<tr>
<td>Results Section (entries required) [V3]</td>
<td>section</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2015-08-01</td>
</tr>
<tr>
<td>Result Organizer [V3]</td>
<td>entry</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.4.1:2015-08-01</td>
</tr>
<tr>
<td>Result Observation [V3]</td>
<td>entry</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.4.2:2015-08-01</td>
</tr>
<tr>
<td>Social History Section [V3]</td>
<td>section</td>
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</tr>
<tr>
<td>Social History Observation [V3]</td>
<td>entry</td>
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<tr>
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</tr>
<tr>
<td>US Realm Date and Time</td>
<td>unspecified</td>
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</tr>
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<td>Template Title</td>
<td>Template Type</td>
<td>templateId</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>(DTM.US.FIELDED)</td>
<td></td>
<td>2.5.4</td>
</tr>
<tr>
<td>US Realm Person Name</td>
<td>unspecified</td>
<td>urn:oid:2.16.840.1.113883.10.20.2</td>
</tr>
<tr>
<td>(PN.US.FIELDED)</td>
<td></td>
<td>2.5.1.1</td>
</tr>
<tr>
<td>US Realm Header (V3)</td>
<td>document</td>
<td>urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2015-08-01</td>
</tr>
<tr>
<td>US Realm Address (AD.US.FIELDED)</td>
<td>unspecified</td>
<td>urn:oid:2.16.840.1.113883.10.20.2</td>
</tr>
<tr>
<td>US Realm Date and Time (DTM.US.FIELDED)</td>
<td>unspecified</td>
<td>urn:oid:2.16.840.1.113883.10.20.2</td>
</tr>
<tr>
<td>US Realm Person Name</td>
<td>unspecified</td>
<td>urn:oid:2.16.840.1.113883.10.20.2</td>
</tr>
<tr>
<td>(PN.US.FIELDED)</td>
<td></td>
<td>2.5.1.1</td>
</tr>
</tbody>
</table>
## Value Sets in This Guide

*Table 24: ActEncounterCode*

Value Set: ActEncounterCode 2.16.840.1.113883.1.11.13955  
Domain provides codes that qualify the ActEncounterClass  
Value Set Source: [http://www.hl7.org](http://www.hl7.org)

<table>
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<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
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<td>AMB</td>
<td>ActCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>ambulatory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.4</td>
<td></td>
</tr>
<tr>
<td>FLD</td>
<td>ActCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>field</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.4</td>
<td></td>
</tr>
<tr>
<td>HH</td>
<td>ActCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>home health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.4</td>
<td></td>
</tr>
<tr>
<td>EMER</td>
<td>ActCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>emergency</td>
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<td></td>
<td></td>
<td>3.5.4</td>
<td></td>
</tr>
<tr>
<td>IMP</td>
<td>ActCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>inpatient encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.4</td>
<td></td>
</tr>
<tr>
<td>ACUTE</td>
<td>ActCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>inpatient acute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.4</td>
<td></td>
</tr>
<tr>
<td>NONAC</td>
<td>ActCode</td>
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<td>inpatient non-acute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.4</td>
<td></td>
</tr>
<tr>
<td>PRENC</td>
<td>ActCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>pre-admission</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.4</td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>ActCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>short stay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.4</td>
<td></td>
</tr>
<tr>
<td>VR</td>
<td>ActCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Virtual</td>
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<tr>
<td></td>
<td></td>
<td>3.5.4</td>
<td></td>
</tr>
</tbody>
</table>
Table 25: ServiceDeliveryLocationRoleType

Value Set: Personal And Legal Relationship Role Type urn:oid:2.16.840.1.11388.11.20.12.1
A personal or legal relationship records the role of a person in relation to another person, or a person to himself or herself. This value set is to be used when recording relationships based on personal or family ties or through legal assignment of responsibility.


<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>DX</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388 3.5.111</td>
<td>Diagnostics or therapeutics unit</td>
</tr>
<tr>
<td>CVDX</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388 3.5.111</td>
<td>Cardiovascular diagnostics or therapeutics unit</td>
</tr>
<tr>
<td>CATH</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388 3.5.111</td>
<td>Cardiac catheterization lab</td>
</tr>
<tr>
<td>ECHO</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388 3.5.111</td>
<td>Echocardiography lab</td>
</tr>
<tr>
<td>GIDX</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388 3.5.111</td>
<td>Gastroenterology diagnostics or therapeutics lab</td>
</tr>
<tr>
<td>ENDOS</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388 3.5.111</td>
<td>Endoscopy lab</td>
</tr>
<tr>
<td>RADDX</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388 3.5.111</td>
<td>Radiology diagnostics or therapeutics unit</td>
</tr>
<tr>
<td>RADO</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388 3.5.111</td>
<td>Radiation oncology unit</td>
</tr>
<tr>
<td>RNEU</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388 3.5.111</td>
<td>Neuroradiology unit</td>
</tr>
<tr>
<td>HOSP</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388 3.5.111</td>
<td>Hospital</td>
</tr>
</tbody>
</table>

...
### Table 26: Race

Concepts in the race value set include the 5 minimum categories for race specified by OMB along with a more detailed set of race categories used by the Bureau of Census.


<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1002-5</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>American Indian or Alaska Native</td>
</tr>
<tr>
<td>2028-9</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Asian</td>
</tr>
<tr>
<td>2054-5</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Black or African American</td>
</tr>
<tr>
<td>2076-8</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Native Hawaiian or Other Pacific Islander</td>
</tr>
<tr>
<td>2106-3</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>White</td>
</tr>
<tr>
<td>1006-6</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Abenaki</td>
</tr>
<tr>
<td>1579-2</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Absentee Shawnee</td>
</tr>
<tr>
<td>1490-2</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Acoma</td>
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<tr>
<td>2126-1</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Afghanistani</td>
</tr>
<tr>
<td>1740-0</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Ahtna</td>
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</table>

### Table 27: HL7 BasicConfidentialityKind

A value set of HL7 Code indication the level of confidentiality an act.


<table>
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<th>Code System OID</th>
<th>Print Name</th>
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<tr>
<td>N</td>
<td>ConfidentialityCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>normal</td>
</tr>
<tr>
<td>R</td>
<td>ConfidentialityCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>restricted</td>
</tr>
<tr>
<td>V</td>
<td>ConfidentialityCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>very restricted</td>
</tr>
</tbody>
</table>
### Table 28: Language

<table>
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<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
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<td>Language</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Afar</td>
</tr>
<tr>
<td>ab</td>
<td>Language</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Abkhazian</td>
</tr>
<tr>
<td>ace</td>
<td>Language</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Achinese</td>
</tr>
<tr>
<td>ach</td>
<td>Language</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Acoli</td>
</tr>
<tr>
<td>ada</td>
<td>Language</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Adangme</td>
</tr>
<tr>
<td>ady</td>
<td>Language</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Adyghe; Adygei</td>
</tr>
<tr>
<td>ae</td>
<td>Language</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Avestan</td>
</tr>
<tr>
<td>af</td>
<td>Language</td>
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<td>Afrikaans</td>
</tr>
<tr>
<td>afa</td>
<td>Language</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Afro-Asiatic (Other)</td>
</tr>
<tr>
<td>afh</td>
<td>Language</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
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### Table 29: Telecom Use (US Realm Header)

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</tr>
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<td>HP</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Primary home</td>
</tr>
<tr>
<td>HV</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Vacation home</td>
</tr>
<tr>
<td>WP</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Work place</td>
</tr>
<tr>
<td>MC</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.113883.11.11526</td>
<td>Mobile contact</td>
</tr>
</tbody>
</table>
### Table 30: Administrative Gender (HL7 V3)

Value Set: Administrative Gender (HL7 V3) urn:oid:2.16.840.1.113883.1.11.1

Administrative Gender based upon HL7 V3 vocabulary. This value set contains only male, female and undifferentiated concepts.


<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>AdministrativeGender</td>
<td>urn:oid:2.16.840.1.11388 3.5.1</td>
<td>Female</td>
</tr>
<tr>
<td>M</td>
<td>AdministrativeGender</td>
<td>urn:oid:2.16.840.1.11388 3.5.1</td>
<td>Male</td>
</tr>
<tr>
<td>UN</td>
<td>AdministrativeGender</td>
<td>urn:oid:2.16.840.1.11388 3.5.1</td>
<td>Undifferentiated</td>
</tr>
</tbody>
</table>

### Table 31: Marital Status

Value Set: Marital Status urn:oid:2.16.840.1.113883.1.11.12212

Marital Status is the domestic partnership status of a person.


<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>MaritalStatus</td>
<td>urn:oid:2.16.840.1.11388 3.5.2</td>
<td>Annulled</td>
</tr>
<tr>
<td>D</td>
<td>MaritalStatus</td>
<td>urn:oid:2.16.840.1.11388 3.5.2</td>
<td>Divorced</td>
</tr>
<tr>
<td>T</td>
<td>MaritalStatus</td>
<td>urn:oid:2.16.840.1.11388 3.5.2</td>
<td>Domestic partner</td>
</tr>
<tr>
<td>I</td>
<td>MaritalStatus</td>
<td>urn:oid:2.16.840.1.11388 3.5.2</td>
<td>Interlocutory</td>
</tr>
<tr>
<td>L</td>
<td>MaritalStatus</td>
<td>urn:oid:2.16.840.1.11388 3.5.2</td>
<td>Legally Separated</td>
</tr>
<tr>
<td>M</td>
<td>MaritalStatus</td>
<td>urn:oid:2.16.840.1.11388 3.5.2</td>
<td>Married</td>
</tr>
<tr>
<td>S</td>
<td>MaritalStatus</td>
<td>urn:oid:2.16.840.1.11388 3.5.2</td>
<td>Never Married</td>
</tr>
<tr>
<td>P</td>
<td>MaritalStatus</td>
<td>urn:oid:2.16.840.1.11388 3.5.2</td>
<td>Polygamous</td>
</tr>
<tr>
<td>W</td>
<td>MaritalStatus</td>
<td>urn:oid:2.16.840.1.11388 3.5.2</td>
<td>Widowed</td>
</tr>
</tbody>
</table>
### Table 32: Religious Affiliation

A value set of codes that reflect spiritual faith affiliation.

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1001</td>
<td>ReligiousAffiliation</td>
<td>urn:oid:2.16.840.1.11388 3.5.1076</td>
<td>Adventist</td>
</tr>
<tr>
<td>1002</td>
<td>ReligiousAffiliation</td>
<td>urn:oid:2.16.840.1.11388 3.5.1076</td>
<td>African Religions</td>
</tr>
<tr>
<td>1003</td>
<td>ReligiousAffiliation</td>
<td>urn:oid:2.16.840.1.11388 3.5.1076</td>
<td>Afro-Caribbean Religions</td>
</tr>
<tr>
<td>1004</td>
<td>ReligiousAffiliation</td>
<td>urn:oid:2.16.840.1.11388 3.5.1076</td>
<td>Agnosticism</td>
</tr>
<tr>
<td>1005</td>
<td>ReligiousAffiliation</td>
<td>urn:oid:2.16.840.1.11388 3.5.1076</td>
<td>Anglican</td>
</tr>
<tr>
<td>1006</td>
<td>ReligiousAffiliation</td>
<td>urn:oid:2.16.840.1.11388 3.5.1076</td>
<td>Animism</td>
</tr>
<tr>
<td>1007</td>
<td>ReligiousAffiliation</td>
<td>urn:oid:2.16.840.1.11388 3.5.1076</td>
<td>Atheism</td>
</tr>
<tr>
<td>1008</td>
<td>ReligiousAffiliation</td>
<td>urn:oid:2.16.840.1.11388 3.5.1076</td>
<td>Babi &amp; Baha'I faiths</td>
</tr>
<tr>
<td>1009</td>
<td>ReligiousAffiliation</td>
<td>urn:oid:2.16.840.1.11388 3.5.1076</td>
<td>Baptist</td>
</tr>
<tr>
<td>1010</td>
<td>ReligiousAffiliation</td>
<td>urn:oid:2.16.840.1.11388 3.5.1076</td>
<td>Bon</td>
</tr>
</tbody>
</table>

### Table 33: Race Category Excluding Nulls


<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1002-5</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>American Indian or Alaska Native</td>
</tr>
<tr>
<td>2028-9</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Asian</td>
</tr>
<tr>
<td>2054-5</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Black or African American</td>
</tr>
<tr>
<td>2076-8</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Native Hawaiian or Other Pacific Islander</td>
</tr>
<tr>
<td>2106-3</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>White</td>
</tr>
</tbody>
</table>
### Table 34: Ethnicity

Value Set: Ethnicity urn:oid:2.16.840.1.114222.4.11.837  
Code System: Race & Ethnicity - CDC 2.16.840.1.113883.6.238  

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>2135-2</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Hispanic or Latino</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.238</td>
<td></td>
</tr>
<tr>
<td>2186-5</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Not Hispanic or Latino</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.238</td>
<td></td>
</tr>
</tbody>
</table>

### Table 35: Personal And Legal Relationship Role Type

Value Set: Personal And Legal Relationship Role Type urn:oid:2.16.840.1.113883.11.20.12.1  
A personal or legal relationship records the role of a person in relation to another person, or a person to himself or herself. This value set is to be used when recording relationships based on personal or family ties or through legal assignment of responsibility.  

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>self</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.111</td>
<td></td>
</tr>
<tr>
<td>MTH</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>mother</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.111</td>
<td></td>
</tr>
<tr>
<td>FTH</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>father</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.111</td>
<td></td>
</tr>
<tr>
<td>DAU</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>natural daughter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.111</td>
<td></td>
</tr>
<tr>
<td>SON</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>natural son</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.111</td>
<td></td>
</tr>
<tr>
<td>DAUINLAW</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>daughter in-law</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.111</td>
<td></td>
</tr>
<tr>
<td>SONINLAW</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>son in-law</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.111</td>
<td></td>
</tr>
<tr>
<td>GUARD</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>guardian</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.111</td>
<td></td>
</tr>
<tr>
<td>HPOWATT</td>
<td>RoleCode</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>healthcare power of attorney</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.111</td>
<td></td>
</tr>
<tr>
<td>...</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 36: Country

Value Set: Country urn:oid:2.16.840.1.113883.3.88.12.80.63  
This identifies the codes for the representation of names of countries, territories and areas of geographical interest.  
Value Set Source: [http://www.iso.org/iso/country_codes/iso_3166_code_lists.htm](http://www.iso.org/iso/country_codes/iso_3166_code_lists.htm)

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>AW</td>
<td>Country</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.80.63</td>
<td>Aruba</td>
</tr>
<tr>
<td>IL</td>
<td>Country</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.80.63</td>
<td>Israel</td>
</tr>
</tbody>
</table>

### Table 37: PostalCode

Value Set: PostalCode urn:oid:2.16.840.1.113883.3.88.12.80.2  
A value set of postal (ZIP) Code of an address in the United States  
Value Set Source: [http://ushik.ahrq.gov/ViewItemDetails?system=mdr&itemKey=86671000](http://ushik.ahrq.gov/ViewItemDetails?system=mdr&itemKey=86671000)

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>19009</td>
<td>USPostalCodes</td>
<td>urn:oid:2.16.840.1.113883.3.6.231</td>
<td>Bryn Athyn</td>
</tr>
<tr>
<td>92869-1736</td>
<td>USPostalCodes</td>
<td>urn:oid:2.16.840.1.113883.3.6.231</td>
<td>Orange, CA</td>
</tr>
<tr>
<td>32830-8413</td>
<td>USPostalCodes</td>
<td>urn:oid:2.16.840.1.113883.3.6.231</td>
<td>Lake Buena Vista, FL</td>
</tr>
</tbody>
</table>

...
### Table 38: LanguageAbilityMode

Value Set: LanguageAbilityMode urn:oid:2.16.840.1.113883.1.11.12249

This identifies the language ability of the individual. A value representing the method of expression of the language.


<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESGN</td>
<td>LanguageAbilityMode</td>
<td>urn:oid:2.16.840.1.113883.1.11.12249</td>
<td>Expressed signed</td>
</tr>
<tr>
<td>ESP</td>
<td>LanguageAbilityMode</td>
<td>urn:oid:2.16.840.1.113883.1.11.12249</td>
<td>Expressed spoken</td>
</tr>
<tr>
<td>EWR</td>
<td>LanguageAbilityMode</td>
<td>urn:oid:2.16.840.1.113883.1.11.12249</td>
<td>Expressed written</td>
</tr>
<tr>
<td>RSGN</td>
<td>LanguageAbilityMode</td>
<td>urn:oid:2.16.840.1.113883.1.11.12249</td>
<td>Received signed</td>
</tr>
<tr>
<td>RSP</td>
<td>LanguageAbilityMode</td>
<td>urn:oid:2.16.840.1.113883.1.11.12249</td>
<td>Received spoken</td>
</tr>
<tr>
<td>RWR</td>
<td>LanguageAbilityMode</td>
<td>urn:oid:2.16.840.1.113883.1.11.12249</td>
<td>Received written</td>
</tr>
</tbody>
</table>

### Table 39: LanguageAbilityProficiency

Value Set: LanguageAbilityProficiency urn:oid:2.16.840.1.113883.1.11.12199


<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>LanguageAbilityProficiency</td>
<td>urn:oid:2.16.840.1.113883.1.11.12199</td>
<td>Excellent</td>
</tr>
<tr>
<td>F</td>
<td>LanguageAbilityProficiency</td>
<td>urn:oid:2.16.840.1.113883.1.11.12199</td>
<td>Fair</td>
</tr>
<tr>
<td>G</td>
<td>LanguageAbilityProficiency</td>
<td>urn:oid:2.16.840.1.113883.1.11.12199</td>
<td>Good</td>
</tr>
<tr>
<td>P</td>
<td>LanguageAbilityProficiency</td>
<td>urn:oid:2.16.840.1.113883.1.11.12199</td>
<td>Poor</td>
</tr>
</tbody>
</table>
### Table 40: Detailed Ethnicity

Value Set: Detailed Ethnicity urn:oid:2.16.840.1.114222.4.11.877
List of detailed ethnicity codes reported on a limited basis

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>2138-6</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Andalusian</td>
</tr>
<tr>
<td>2166-7</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Argentinean</td>
</tr>
<tr>
<td>2139-4</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Asturian</td>
</tr>
<tr>
<td>2142-8</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Belearic Islander</td>
</tr>
<tr>
<td>2167-5</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Bolivian</td>
</tr>
<tr>
<td>2163-4</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Canal Zone</td>
</tr>
<tr>
<td>2145-1</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Canarian</td>
</tr>
<tr>
<td>2140-2</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Castilllan</td>
</tr>
<tr>
<td>2141-0</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Catalonian</td>
</tr>
<tr>
<td>2155-0</td>
<td>Race &amp; Ethnicity - CDC</td>
<td>urn:oid:2.16.840.1.11388 3.6.238</td>
<td>Central American</td>
</tr>
</tbody>
</table>

...
The Health Care Provider Taxonomy value set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct Levels including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category. Providers may have one or more than one value associated to them. When determining what value or values to associate with a provider, the user needs to review the requirements of the trading partner with which the value(s) are being used.

Value Set Source:

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>171100000X</td>
<td>Healthcare Provider Taxonomy (HIPAA)</td>
<td>urn:oid:2.16.840.1.11388 3.6.101</td>
<td>Acupuncturist</td>
</tr>
<tr>
<td>363LA2100X</td>
<td>Healthcare Provider Taxonomy (HIPAA)</td>
<td>urn:oid:2.16.840.1.11388 3.6.101</td>
<td>Nurse Practitioner - Acute Care</td>
</tr>
<tr>
<td>364SA2100X</td>
<td>Healthcare Provider Taxonomy (HIPAA)</td>
<td>urn:oid:2.16.840.1.11388 3.6.101</td>
<td>Clinical Nurse Specialist - Acute Care</td>
</tr>
<tr>
<td>101YA0400X</td>
<td>Healthcare Provider Taxonomy (HIPAA)</td>
<td>urn:oid:2.16.840.1.11388 3.6.101</td>
<td>Counselor - Addiction (Substance Use Disorder)</td>
</tr>
<tr>
<td>103TA0400X</td>
<td>Healthcare Provider Taxonomy (HIPAA)</td>
<td>urn:oid:2.16.840.1.11388 3.6.101</td>
<td>Psychologist - Addiction (Substance Use Disorder)</td>
</tr>
<tr>
<td>163WA0400X</td>
<td>Healthcare Provider Taxonomy (HIPAA)</td>
<td>urn:oid:2.16.840.1.11388 3.6.101</td>
<td>Registered Nurse - Addiction (Substance Use Disorder)</td>
</tr>
<tr>
<td>207LA0401X</td>
<td>Healthcare Provider Taxonomy (HIPAA)</td>
<td>urn:oid:2.16.840.1.11388 3.6.101</td>
<td>Anesthesiology - Addiction Medicine</td>
</tr>
<tr>
<td>207QA0401X</td>
<td>Healthcare Provider Taxonomy (HIPAA)</td>
<td>urn:oid:2.16.840.1.11388 3.6.101</td>
<td>Family Medicine - Addiction Medicine</td>
</tr>
<tr>
<td>207RA0401X</td>
<td>Healthcare Provider Taxonomy (HIPAA)</td>
<td>urn:oid:2.16.840.1.11388 3.6.101</td>
<td>Internal Medicine - Addiction Medicine</td>
</tr>
</tbody>
</table>
**Table 42: INDRoleclassCodes**

Value Set: INDRoleclassCodes urn:oid:2.16.840.1.113883.11.20.9.33
Value Set Source:  

<table>
<thead>
<tr>
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<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRS</td>
<td>RoleClass</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>personal relationship</td>
</tr>
<tr>
<td>NOK</td>
<td>RoleClass</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>next of kin</td>
</tr>
<tr>
<td>CAREGIVER</td>
<td>RoleClass</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>caregiver</td>
</tr>
<tr>
<td>AGNT</td>
<td>RoleClass</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>agent</td>
</tr>
<tr>
<td>GUAR</td>
<td>RoleClass</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>guarantor</td>
</tr>
<tr>
<td>ECON</td>
<td>RoleClass</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>emergency contact</td>
</tr>
</tbody>
</table>

**Table 43: x_ServiceEventPerformer**

Value Set: x_ServiceEventPerformer urn:oid:2.16.840.1.113883.1.7.19601
Value Set Source:  

<table>
<thead>
<tr>
<th>Code</th>
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<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRF</td>
<td>HL7ParticipationType</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>performer</td>
</tr>
<tr>
<td>SPRF</td>
<td>HL7ParticipationType</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>secondary performer</td>
</tr>
<tr>
<td>PPRF</td>
<td>HL7ParticipationType</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>primary performer</td>
</tr>
</tbody>
</table>
Table 44: ParticipationFunction

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNRS</td>
<td>participationFunction</td>
<td>urn:oid:2.16.840.1.11388.3.5.88</td>
<td>Scrub nurse</td>
</tr>
<tr>
<td>SASST</td>
<td>participationFunction</td>
<td>urn:oid:2.16.840.1.11388.3.5.88</td>
<td>Second assistant surgeon</td>
</tr>
<tr>
<td>_AuthorizedParticipationFunction</td>
<td>participationFunction</td>
<td>urn:oid:2.16.840.1.11388.3.5.88</td>
<td>AuthorizedParticipationFunction</td>
</tr>
<tr>
<td>_AuthorizedReceiverParticipationFunction</td>
<td>participationFunction</td>
<td>urn:oid:2.16.840.1.11388.3.5.88</td>
<td>AuthorizedReceiverParticipationFunction</td>
</tr>
<tr>
<td>AUCG</td>
<td>participationFunction</td>
<td>urn:oid:2.16.840.1.11388.3.5.88</td>
<td>caregiver information receiver</td>
</tr>
<tr>
<td>AULR</td>
<td>participationFunction</td>
<td>urn:oid:2.16.840.1.11388.3.5.88</td>
<td>legitimate relationship information receiver</td>
</tr>
<tr>
<td>AUTM</td>
<td>participationFunction</td>
<td>urn:oid:2.16.840.1.11388.3.5.88</td>
<td>care team information receiver</td>
</tr>
<tr>
<td>AUWA</td>
<td>participationFunction</td>
<td>urn:oid:2.16.840.1.11388.3.5.88</td>
<td>work area information receiver</td>
</tr>
<tr>
<td>_ConsenterParticipationFunction</td>
<td>participationFunction</td>
<td>urn:oid:2.16.840.1.11388.3.5.88</td>
<td>ConsenterParticipationFunction</td>
</tr>
<tr>
<td>GRDCON</td>
<td>participationFunction</td>
<td>urn:oid:2.16.840.1.11388.3.5.88</td>
<td>legal guardian consent author</td>
</tr>
</tbody>
</table>

Value Set: ParticipationFunction urn:oid:2.16.840.1.11388.3.11.10267

This HL7-defined value set can be used to specify the exact function an actor had in a service in all necessary detail.

Table 45: EncounterTypeCode

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>CPT4</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Office or other outpatient visit (problem focused)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.12</td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td>CPT4</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Office or other outpatient visit (expanded problem)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.12</td>
<td></td>
</tr>
<tr>
<td>99203</td>
<td>CPT4</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Office or other outpatient visit (detailed)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.12</td>
<td></td>
</tr>
<tr>
<td>99204</td>
<td>CPT4</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Office or other outpatient visit (comprehensive, (comprehensive-moderate)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.12</td>
<td></td>
</tr>
<tr>
<td>99205</td>
<td>CPT4</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Office or other outpatient visit (comprehensive, comprehensive-high)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.12</td>
<td></td>
</tr>
<tr>
<td>19681004</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Nursing evaluation of patient and report (procedure)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.96</td>
<td></td>
</tr>
<tr>
<td>207195004</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>History and physical examination with evaluation and management of nursing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.96</td>
<td>facility patient (procedure)</td>
</tr>
<tr>
<td>209099002</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>History and physical examination with management of domiciliary or rest home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.96</td>
<td>patient (procedure)</td>
</tr>
<tr>
<td>210098006</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Domiciliary or rest home patient evaluation and management (procedure)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.96</td>
<td></td>
</tr>
<tr>
<td>225929007</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Joint home visit (procedure)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.6.96</td>
<td></td>
</tr>
</tbody>
</table>

Value Set: EncounterTypeCode urn:oid:2.16.840.1.113883.388.12.80.32
This value set includes only the codes of the Current Procedure and Terminology designated for Evaluation and Management (99200 – 99607) (subscription to AMA Required)
### Table 46: MoodCodeEvnInt

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVN</td>
<td>ActMood</td>
<td>urn:oid:2.16.840.1.113883.11.20.9.18</td>
<td>Event</td>
</tr>
<tr>
<td>INT</td>
<td>ActMood</td>
<td>urn:oid:2.16.840.1.113883.11.20.9.18</td>
<td>Intent</td>
</tr>
</tbody>
</table>

Value Set: MoodCodeEvnInt urn:oid:2.16.840.1.113883.11.20.9.18
Contains moodCode EVN and INT

### Table 47: Medication Route FDA

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>C38192</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.8.7</td>
<td>AURICULAR (OTIC)</td>
</tr>
<tr>
<td>C38193</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.8.7</td>
<td>BUCCAL</td>
</tr>
<tr>
<td>C38194</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.8.7</td>
<td>CONJUNCTIVAL</td>
</tr>
<tr>
<td>C38675</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.8.7</td>
<td>CUTANEOUS</td>
</tr>
<tr>
<td>C38197</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.8.7</td>
<td>DENTAL</td>
</tr>
<tr>
<td>C38633</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.8.7</td>
<td>ELECTRO-OSMOSIS</td>
</tr>
<tr>
<td>C38205</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.8.7</td>
<td>ENDOCERVICAL</td>
</tr>
<tr>
<td>C38206</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.8.7</td>
<td>ENDOSINUSIAL</td>
</tr>
<tr>
<td>C38208</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.8.7</td>
<td>ENDOTRACHEAL</td>
</tr>
<tr>
<td>C38209</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.8.7</td>
<td>ENTERAL</td>
</tr>
</tbody>
</table>

Value Set: Medication Route FDA urn:oid:2.16.840.1.113883.3.88.12.3221.8.7
Route of Administration value set is based upon FDA Drug Registration and Listing Database (FDA Orange Book) which are used in FDA Structured Product Labeling (SPL).
Table 48: Body Site

| Code         | Code System | Code System OID       | Print Name                                                      |
|--------------|-------------|-----------------------|                                                               |
| 362783006    | SNOMED CT   | urn:oid:2.16.840.1.113883.3.6.96 | entire medial surface of lower extremity (body structure)        |
| 302539009    | SNOMED CT   | urn:oid:2.16.840.1.113883.3.6.96 | entire hand (body structure)                                   |
| 287679003    | SNOMED CT   | urn:oid:2.16.840.1.113883.3.6.96 | left hip region structure (body structure)                     |
| 3341006      | SNOMED CT   | urn:oid:2.16.840.1.113883.3.6.96 | right lung structure (body structure)                          |
| 87878005     | SNOMED CT   | urn:oid:2.16.840.1.113883.3.6.96 | left ventricular structure (body structure)                    |
| 49848007     | SNOMED CT   | urn:oid:2.16.840.1.113883.3.6.96 | structure of myocardium of left ventricle (body structure)      |
| 38033009     | SNOMED CT   | urn:oid:2.16.840.1.113883.3.6.96 | amputation stump (body structure)                               |
| 305005006    | SNOMED CT   | urn:oid:2.16.840.1.113883.3.6.96 | 6/7 interchondral joint (body structure)                       |
| 28726007     | SNOMED CT   | urn:oid:2.16.840.1.113883.3.6.96 | corneal structure (body structure)                             |
| 75324005     | SNOMED CT   | urn:oid:2.16.840.1.113883.3.6.96 | 70 to 79 percent of body surface (body structure)              |

Value Set: Body Site urn:oid:2.16.840.1.113883.3.88.12.3221.8.9
Contains values descending from the SNOMED CT® Anatomical Structure (91723000) hierarchy or Acquired body structure (body structure) (280115004) or Anatomical site notations for tumor staging (body structure) (258331007) or Body structure, altered from its original anatomical structure (morphologic abnormality) (118956008) or Physical anatomical entity (body structure) (91722005) This indicates the anatomical site.
Value Set Source:
## Table 49: UnitsOfMeasureCaseSensitive

The UCUM code system provides a set of structural units from which working codes are built. There is an unlimited number of possible valid UCUM codes.

Value Set Source: [http://unitsofmeasure.org/ucum.html](http://unitsofmeasure.org/ucum.html)

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>min</td>
<td>UCUM</td>
<td>urn:oid:2.16.840.1.11388.3.6.8</td>
<td>minute</td>
</tr>
<tr>
<td>hour</td>
<td>UCUM</td>
<td>urn:oid:2.16.840.1.11388.3.6.8</td>
<td>hr</td>
</tr>
<tr>
<td>%</td>
<td>UCUM</td>
<td>urn:oid:2.16.840.1.11388.3.6.8</td>
<td>percent</td>
</tr>
<tr>
<td>cm</td>
<td>UCUM</td>
<td>urn:oid:2.16.840.1.11388.3.6.8</td>
<td>centimeter</td>
</tr>
<tr>
<td>g</td>
<td>UCUM</td>
<td>urn:oid:2.16.840.1.11388.3.6.8</td>
<td>gram</td>
</tr>
<tr>
<td>g/(12.h)</td>
<td>UCUM</td>
<td>urn:oid:2.16.840.1.11388.3.6.8</td>
<td>gram per 12 hour</td>
</tr>
<tr>
<td>g/L</td>
<td>UCUM</td>
<td>urn:oid:2.16.840.1.11388.3.6.8</td>
<td>gram per liter</td>
</tr>
<tr>
<td>mol</td>
<td>UCUM</td>
<td>urn:oid:2.16.840.1.11388.3.6.8</td>
<td>mole</td>
</tr>
<tr>
<td>[IU]</td>
<td>UCUM</td>
<td>urn:oid:2.16.840.1.11388.3.6.8</td>
<td>international unit</td>
</tr>
<tr>
<td>Hz</td>
<td>UCUM</td>
<td>urn:oid:2.16.840.1.11388.3.6.8</td>
<td>Hertz</td>
</tr>
</tbody>
</table>

...
Table 50: AdministrationUnitDoseForm

Values that are similar to a drug "form" but limited to those used as units when describing drug administration when the drug item is a physical form that is continuous and therefore not administered as an "each" of the physical form, or is not using standard measurement units (inch, ounce, gram, etc.) This set does not include unit concepts that mimic "physical form" concepts that can be counted using "each", such as tablet, bar, lozenge, packet, etc.


<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>C122629</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Actuation Dosing Unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.26.1.1</td>
<td></td>
</tr>
<tr>
<td>C25397</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Application Unit</td>
</tr>
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<td></td>
<td>3.3.26.1.1</td>
<td></td>
</tr>
<tr>
<td>C102405</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Capful Dosing Unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.26.1.1</td>
<td></td>
</tr>
<tr>
<td>C122631</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Dropperful Dosing Unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.26.1.1</td>
<td></td>
</tr>
<tr>
<td>C48501</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Inhalation Dosing Unit</td>
</tr>
<tr>
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<td></td>
<td>3.3.26.1.1</td>
<td></td>
</tr>
<tr>
<td>C48491</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Metric Drop</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.26.1.1</td>
<td></td>
</tr>
<tr>
<td>C71204</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Nebule Dosing Unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.26.1.1</td>
<td></td>
</tr>
<tr>
<td>C65060</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Puff Dosing Unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.26.1.1</td>
<td></td>
</tr>
<tr>
<td>C48536</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Scoopful Dosing Unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.26.1.1</td>
<td></td>
</tr>
<tr>
<td>C48537</td>
<td>NCI Thesaurus (NCIt)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Spray Dosing Unit</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>...</td>
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<td></td>
</tr>
</tbody>
</table>
**Table 51: ActStatus**

Value Set: ActStatus urn:oid:2.16.840.1.113883.1.11.159331
Contains the names (codes) for each of the states in the state-machine of the RIM Act class.

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>normal</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.1.11.159331</td>
<td>normal</td>
</tr>
<tr>
<td>aborted</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.1.11.159331</td>
<td>aborted</td>
</tr>
<tr>
<td>active</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.1.11.159331</td>
<td>active</td>
</tr>
<tr>
<td>cancelled</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.1.11.159331</td>
<td>cancelled</td>
</tr>
<tr>
<td>completed</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.1.11.159331</td>
<td>completed</td>
</tr>
<tr>
<td>held</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.1.11.159331</td>
<td>held</td>
</tr>
<tr>
<td>new</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.1.11.159331</td>
<td>new</td>
</tr>
<tr>
<td>suspended</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.1.11.159331</td>
<td>suspended</td>
</tr>
<tr>
<td>nullified</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.1.11.159331</td>
<td>nullified</td>
</tr>
<tr>
<td>obsolete</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.1.11.159331</td>
<td>obsolete</td>
</tr>
</tbody>
</table>
**Table 52: Medication Clinical Drug**

All prescribable medication formulations represented using either a "generic" or "brand-specific" concept. This includes RxNorm codes whose Term Type is SCD (semantic clinical drug), SBD (semantic brand drug), GPCK (generic pack), BPCK (brand pack), SCDG (semantic clinical drug group), SBDG (semantic brand drug group), SCDF (semantic clinical drug form), or SBDF (semantic brand drug form).

Value set intentionally defined as a GROUPING made up of: Value Set: Medication Clinical General Drug (2.16.840.1.113883.3.88.12.80.17) (RxNorm Generic Drugs); Value Set: Medication Clinical Brand-specific Drug (2.16.840.1.113762.1.4.1010.5) (RxNorm Branded Drugs).


<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>978727</td>
<td>RxNorm</td>
<td>urn:oid:2.16.840.1.11388 3.6.88</td>
<td>0.2 ML Dalteparin Sodium 12500 UNT/ML Prefilled Syringe [Fragmin]</td>
</tr>
<tr>
<td>827318</td>
<td>RxNorm</td>
<td>urn:oid:2.16.840.1.11388 3.6.88</td>
<td>Acetaminophen 250 MG / Aspirin 250 MG / Caffeine 65 MG Oral Capsule</td>
</tr>
<tr>
<td>199274</td>
<td>RxNorm</td>
<td>urn:oid:2.16.840.1.11388 3.6.88</td>
<td>Aspirin 300 MG Oral Capsule</td>
</tr>
<tr>
<td>362867</td>
<td>RxNorm</td>
<td>urn:oid:2.16.840.1.11388 3.6.88</td>
<td>Cefotetan Injectable Solution [Cefotan]</td>
</tr>
<tr>
<td>...</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 53: Clinical Substance

All substances that may need to be represented in the context of health care related activities. This value set is quite broad in coverage and includes concepts that may never be needed in a health care activity event, particularly the included SNOMED CT concepts. The code system-specific value sets in this grouping value set are intended to provide broad coverage of all kinds of agents, but the expectation for use is that the chosen concept identifier for a substance should be appropriately specific and drawn from the appropriate code system as noted: prescribable medications should use RXNORM concepts, more specific drugs and chemicals should be represented using UNII concepts, and any substances not found in either of those two code systems, should use the appropriate SNOMED CT concept. This overarching grouping value set is intended to support identification of prescribable medications, foods, general substances and environmental entities.

Value set intensionally defined as a GROUPING made up of: Value Set: Medication Clinical Drug (2.16.840.1.113762.1.4.1010.4) (RxNorm generic and brand codes); Value Set: Unique Ingredient Identifier - Complete Set (2.16.840.1.113883.3.88.12.80.20) (UNII codes); Value Set: Substance Other Than Clinical Drug (2.16.840.1.113762.1.4.1010.9) (SNOMED CT codes).


<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>369436</td>
<td>RxNorm</td>
<td>urn:oid:2.16.840.1.11388 3.6.88</td>
<td>6-Aminocaproic Acid Oral Tablet [Amicar]</td>
</tr>
<tr>
<td>1116447</td>
<td>RxNorm</td>
<td>urn:oid:2.16.840.1.11388 3.6.88</td>
<td>Acepromazine Oral Tablet</td>
</tr>
<tr>
<td>9042592173</td>
<td>Unique Ingredient Identifier (UNII)</td>
<td>urn:oid:2.16.840.1.11388 3.4.9</td>
<td>ATROMEPINE</td>
</tr>
<tr>
<td>7673326042</td>
<td>Unique Ingredient Identifier (UNII)</td>
<td>urn:oid:2.16.840.1.11388 3.4.9</td>
<td>IRINOTECAN</td>
</tr>
<tr>
<td>413480003</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Almond product (substance)</td>
</tr>
<tr>
<td>256915001</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Aluminum hydroxide absorbed plasma (substance)</td>
</tr>
<tr>
<td>10020007</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Biperiden hydrochloride (substance)</td>
</tr>
<tr>
<td>10133003</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Cyclizine lactate (substance)</td>
</tr>
<tr>
<td>10174003</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Procarbazine hydrochloride (substance)</td>
</tr>
<tr>
<td>102259006</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Citrus fruit (substance)</td>
</tr>
</tbody>
</table>

...
**Table 54: ProblemAct statusCode**

Value Set: ProblemAct statusCode urn:oid:2.16.840.1.113883.11.20.9.19
A ValueSet of HL7 actStatus codes for use on the concern act

<table>
<thead>
<tr>
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<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>completed</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.14</td>
<td></td>
</tr>
<tr>
<td>aborted</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Aborted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.14</td>
<td></td>
</tr>
<tr>
<td>active</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Active</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.14</td>
<td></td>
</tr>
<tr>
<td>suspended</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Suspended</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5.14</td>
<td></td>
</tr>
</tbody>
</table>
Table 55: Problem

Value Set: Problem urn:oid:2.16.840.1.113883.3.88.12.3221.7.4
A value set of SNOMED-CT codes limited to terms descending from the Clinical Findings (404684003) or Situation with Explicit Context (243796009) hierarchies.

Specific URL Pending

Value Set Source: http://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.113883.3.88.12.3221.7.4

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>46635009</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.7.4</td>
<td>diabetes mellitus type 1</td>
</tr>
<tr>
<td>234422006</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.7.4</td>
<td>acute intermittent porphyria</td>
</tr>
<tr>
<td>31712002</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.7.4</td>
<td>primary biliary cirrhosis</td>
</tr>
<tr>
<td>302002000</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.7.4</td>
<td>difficulty moving</td>
</tr>
<tr>
<td>15188001</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.7.4</td>
<td>hearing loss</td>
</tr>
<tr>
<td>129851009</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.7.4</td>
<td>alteration in bowel elimination</td>
</tr>
<tr>
<td>247472004</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.7.4</td>
<td>hives</td>
</tr>
<tr>
<td>39579001</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.7.4</td>
<td>anaphylaxis</td>
</tr>
<tr>
<td>274945004</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.7.4</td>
<td>AA amyloidosis (disorder)</td>
</tr>
<tr>
<td>129851009</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.113883.3.88.12.3221.7.4</td>
<td>alteration in comfort: pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Table 56: Problem Type**

Value Set: Problem Type 2.16.840.1.113883.3.88.12.3221.7.2 STATIC 2012-06-01
This value set indicates the level of medical judgment used to determine the existence of a problem.

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
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<tbody>
<tr>
<td>404684003</td>
<td>SNOMED CT</td>
<td>2.16.840.1.113883.6.96</td>
<td>Finding</td>
</tr>
<tr>
<td>409586006</td>
<td>SNOMED CT</td>
<td>2.16.840.1.113883.6.96</td>
<td>Complaint</td>
</tr>
<tr>
<td>282291009</td>
<td>SNOMED CT</td>
<td>2.16.840.1.113883.6.96</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>64572001</td>
<td>SNOMED CT</td>
<td>2.16.840.1.113883.6.96</td>
<td>Condition</td>
</tr>
<tr>
<td>248536006</td>
<td>SNOMED CT</td>
<td>2.16.840.1.113883.6.96</td>
<td>Finding of functional performance and activity</td>
</tr>
<tr>
<td>418799008</td>
<td>SNOMED CT</td>
<td>2.16.840.1.113883.6.96</td>
<td>Symptom</td>
</tr>
<tr>
<td>55607006</td>
<td>SNOMED CT</td>
<td>2.16.840.1.113883.6.96</td>
<td>Problem</td>
</tr>
<tr>
<td>373930000</td>
<td>SNOMED CT</td>
<td>2.16.840.1.113883.6.96</td>
<td>Cognitive function finding</td>
</tr>
</tbody>
</table>

Value Set: Problem Type 2.16.840.1.113883.3.88.12.3221.7.2 STATIC 2014-09-02
This value set indicates the level of medical judgment used to determine the existence of a problem.

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<th>Code System OID</th>
<th>Print Name</th>
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<tbody>
<tr>
<td>75326-9</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Problem HL7.CCDAR2</td>
</tr>
<tr>
<td>75325-1</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Symptom HL7.CCDAR2</td>
</tr>
<tr>
<td>75324-4</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Functional performance HL7.CCDAR2</td>
</tr>
<tr>
<td>75323-6</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Condition HL7.CCDAR2</td>
</tr>
<tr>
<td>29308-4</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>75322-8</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Complaint HL7.CCDAR2</td>
</tr>
<tr>
<td>75275-8</td>
<td>LOINC</td>
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<td>Cognitive Function HL7.CCDAR2</td>
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<td>75321-0</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Clinical finding HL7.CCDAR2</td>
</tr>
<tr>
<td>75319-4</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Cognitive function family member HL7.CCDAR2</td>
</tr>
<tr>
<td>75318-6</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Problem family member HL7.CCDAR2</td>
</tr>
<tr>
<td>75317-8</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Symptom family member HL7.CCDAR2</td>
</tr>
<tr>
<td>75316-0</td>
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<td>Functional performance family member HL7.CCDAR2</td>
</tr>
<tr>
<td>75315-2</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Condition family member HL7.CCDAR2</td>
</tr>
<tr>
<td>75314-5</td>
<td>LOINC</td>
<td>2.16.840.1.113883.6.96</td>
<td>Diagnosis family member HL7.CCDAR2</td>
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</tbody>
</table>
Table 57: Result Status

<table>
<thead>
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<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
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<tbody>
<tr>
<td>aborted</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.11.20.9.39 aborted</td>
<td></td>
</tr>
<tr>
<td>active</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.11.20.9.39 active</td>
<td></td>
</tr>
<tr>
<td>cancelled</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.11.20.9.39 cancelled</td>
<td></td>
</tr>
<tr>
<td>completed</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.11.20.9.39 completed</td>
<td></td>
</tr>
<tr>
<td>held</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.11.20.9.39 held</td>
<td></td>
</tr>
<tr>
<td>suspended</td>
<td>ActStatus</td>
<td>urn:oid:2.16.840.1.113883.11.20.9.39 suspended</td>
<td></td>
</tr>
</tbody>
</table>

Value Set: Result Status urn:oid:2.16.840.1.113883.11.20.9.39
### Table 58: Observation Interpretation (HL7)

Value Set: Observation Interpretation (HL7) urn:oid:2.16.840.1.113883.1.11.78


<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>HITSP-CS-83</td>
<td>urn:oid:2.16.840.1.113883.1.11.78</td>
<td>abnormal</td>
</tr>
<tr>
<td>B</td>
<td>HITSP-CS-83</td>
<td>urn:oid:2.16.840.1.113883.1.11.78</td>
<td>better</td>
</tr>
<tr>
<td>Carrier</td>
<td>HITSP-CS-83</td>
<td>urn:oid:2.16.840.1.113883.1.11.78</td>
<td>carrier</td>
</tr>
<tr>
<td>D</td>
<td>HITSP-CS-83</td>
<td>urn:oid:2.16.840.1.113883.1.11.78</td>
<td>decreased</td>
</tr>
<tr>
<td>HX</td>
<td>HITSP-CS-83</td>
<td>urn:oid:2.16.840.1.113883.1.11.78</td>
<td>above high threshold</td>
</tr>
<tr>
<td>I</td>
<td>HITSP-CS-83</td>
<td>urn:oid:2.16.840.1.113883.1.11.78</td>
<td>intermediate</td>
</tr>
<tr>
<td>IND</td>
<td>HITSP-CS-83</td>
<td>urn:oid:2.16.840.1.113883.1.11.78</td>
<td>indeterminate</td>
</tr>
<tr>
<td>LX</td>
<td>HITSP-CS-83</td>
<td>urn:oid:2.16.840.1.113883.1.11.78</td>
<td>below low threshold</td>
</tr>
<tr>
<td>MS</td>
<td>HITSP-CS-83</td>
<td>urn:oid:2.16.840.1.113883.1.11.78</td>
<td>moderately susceptible</td>
</tr>
<tr>
<td>N</td>
<td>HITSP-CS-83</td>
<td>urn:oid:2.16.840.1.113883.1.11.78</td>
<td>normal</td>
</tr>
</tbody>
</table>

...
**Table 59: Social History Type**

Value Set: Social History Type  urn:oid:2.16.840.1.113883.3.88.12.80.60

A value set of SNOMED-CT observable entity codes containing common social history observables. Though Tobacco Use and Exposure exists in this value set, it is recommended to use the Current Smoking Status template or the Tobacco Use template to represent smoking or tobacco habits.


<table>
<thead>
<tr>
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<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>160573003</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Alcohol intake (observable entity)</td>
</tr>
<tr>
<td>363908000</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Details of drug misuse behavior (observable entity)</td>
</tr>
<tr>
<td>364703007</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Employment detail (observable entity)</td>
</tr>
<tr>
<td>256235009</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Exercise (observable entity)</td>
</tr>
<tr>
<td>228272008</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Health-related behavior (observable entity)</td>
</tr>
<tr>
<td>364393001</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Nutritional observable (observable entity)</td>
</tr>
<tr>
<td>425400000</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Toxic exposure status (observable entity)</td>
</tr>
<tr>
<td>105421008</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Educational achievement (observable entity)</td>
</tr>
<tr>
<td>302160007</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Household, family and support network detail (observable entity)</td>
</tr>
<tr>
<td>423514004</td>
<td>SNOMED CT</td>
<td>urn:oid:2.16.840.1.11388 3.6.96</td>
<td>Community resource details (observable entity)</td>
</tr>
</tbody>
</table>

...
### Table 60: PostalAddressUse

Value Set: PostalAddressUse urn:oid:2.16.840.1.113883.1.11.10637
A value set of HL7 Codes for address use.

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
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</thead>
<tbody>
<tr>
<td>BAD</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.11388.3.5.1119</td>
<td>bad address</td>
</tr>
<tr>
<td>CONF</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.11388.3.5.1119</td>
<td>confidential</td>
</tr>
<tr>
<td>DIR</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.11388.3.5.1119</td>
<td>direct</td>
</tr>
<tr>
<td>H</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.11388.3.5.1119</td>
<td>home address</td>
</tr>
<tr>
<td>HP</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.11388.3.5.1119</td>
<td>primary home</td>
</tr>
<tr>
<td>HV</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.11388.3.5.1119</td>
<td>vacation home</td>
</tr>
<tr>
<td>PHYS</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.11388.3.5.1119</td>
<td>physical visit address</td>
</tr>
<tr>
<td>PST</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.11388.3.5.1119</td>
<td>postal address</td>
</tr>
<tr>
<td>PUB</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.11388.3.5.1119</td>
<td>public</td>
</tr>
<tr>
<td>TMP</td>
<td>AddressUse</td>
<td>urn:oid:2.16.840.1.11388.3.5.1119</td>
<td>temporary</td>
</tr>
</tbody>
</table>

...
**Table 61: StateValueSet**

Identifies addresses within the United States are recorded using the FIPS 5-2 two-letter alphabetic codes for the State, District of Columbia, or an outlying area of the United States or associated area.

Value Set Source: [http://www.census.gov/geo/reference/ansi_statetables.html](http://www.census.gov/geo/reference/ansi_statetables.html)

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL</td>
<td>FIPS 5-2 (State)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Alabama</td>
</tr>
<tr>
<td>AK</td>
<td>FIPS 5-2 (State)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Alaska</td>
</tr>
<tr>
<td>AZ</td>
<td>FIPS 5-2 (State)</td>
<td>urn:oid:2.16.840.1.11388</td>
<td>Arizona</td>
</tr>
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<tr>
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<tr>
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<tr>
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...
### Table 62: EntityNameUse

Value Set: EntityNameUse urn:oid:2.16.840.1.113883.1.11.15913  

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<th>Code System OID</th>
<th>Print Name</th>
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<tbody>
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<td>Artist/Stage</td>
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<tr>
<td>ABC</td>
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<tr>
<td>ASGN</td>
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<td>Assigned</td>
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<td>urn:oid:2.16.840.1.11388 3.5.45</td>
<td>License</td>
</tr>
<tr>
<td>I</td>
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<td>Indigenous/Tribal</td>
</tr>
<tr>
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Table 63: EntityPersonNamePartQualifier

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Value Set: EntityPersonNamePartQualifier urn:oid:2.16.840.1.113883.11.20.9.26
Value Set Source:
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