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An American National Standard

Standard Practice for Content and Structure of the Electronic Health Record (EHR)[1]

This standard is issued under the fixed designation E1384; the number immediately following the designation indicates the year of original adoption or, in the case of revision, the year of last revision. A number in parentheses indicates the year of last reapproval. A superscript epsilon (ε) indicates an editorial change since the last revision or reapproval.

1. Scope*

1.1 This practice covers all types of healthcare services, including those given in ambulatory care, hospitals, nursing homes, skilled nursing facilities, home healthcare, and specialty care environments. They apply both to short term contacts (for example, emergency rooms and emergency medical service units) and long term contacts (primary care physicians with long term patients). The vocabulary aims to encompass the continuum of care through all delivery models. This practice defines the persistent data needed to support Electronic Health Record system functionality.

1.2 This practice has four purposes:

1.2.1 Identify the content and logical data structure and organization of an Electronic Health Record (EHR) consistent with currently acknowledged patient record content. The record carries all health related information about a person over time. It may include history and physical, laboratory tests, diagnostic reports, orders and treatments documentation, patient identifying information, legal permissions, and so on. The content is presented and described as data elements or as clinical documents. This standard is consistent with eXtensible Markup Language (XML). See Document Type Definition (DTD) 2.1 and W3CXML Schema 1.0

1.2.2 Explain the relationship of data coming from diverse sources (for example, clinical laboratory information management systems, order entry systems, pharmacy information management systems, dictation systems), and other data in the Electronic Health Record as the primary repository for information from various sources.

1.2.3 Provide a common vocabulary for those developing, purchasing, and implementing EHR systems.

1.2.4 Provide sufficient content from which data extracts can be compiled to create unique setting "views."

1.2.5 Map the content to selected relevant biomedical and health informatics standards.

2. Referenced Documents

2.1 *ASTM Standards:*[2]

E1238 Specification for Transferring Clinical Observations Between Independent Computer Systems (Withdrawn 2002)[3]

E1239 Practice for Description of Reservation/Registration-Admission, Discharge, Transfer (R-ADT) Systems for Electronic Health Record (EHR) Systems

E1633 Specification for Coded Values Used in the Electronic Health Record

E1639 Guide for Functional Requirements of Clinical Laboratory Information Management Systems (Withdrawn 2002)[3]

E1714 Guide for Properties of a Universal Healthcare Identifier (UHID)

E1715 Practice for An Object-Oriented Model for Registration, Admitting, Discharge, and Transfer (RADT) Functions in Computer-Based Patient Record Systems

E1769 Guide for Properties of Electronic Health Records and Record Systems

E2118 Guide for Coordination of Clinical Laboratory Services within the Electronic Health Record Environment and Networked Architectures (Withdrawn 2002)[3]

E2369 Specification for Continuity of Care Record (CCR)

E2473 Practice for the Occupational/Environmental Health View of the Electronic Health Record

E2538 Practice for Defining and Implementing Pharmacotherapy Information Services within the Electronic Health Record (EHR) Environment and Networked Architectures

HL7

2.2 *Other Health Informatics Standards:*

HL7 Health Level Seven (HL7) Version 2.2 1994[4] (Version 2.4 and 2.5)

NCPDP National Council for Prescription Drug Programs

[1] This practice is under the jurisdiction of ASTM Committee E31 on Healthcare Informatics and is the direct responsibility of Subcommittee E31.25 on Healthcare Data Management, Security, Confidentiality, and Privacy.

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[2] For referenced ASTM standards, visit the ASTM website, www.astm.org, or contact ASTM Customer Service at service@astm.org. For *Annual Book of ASTM Standards* volume information, refer to the standard's Document Summary page on the ASTM website.

[3] The last approved version of this historical standard is referenced on www.astm.org.

[4] Available from HL7, Mark McDougall, Executive Director, 900 Victors Way, Suite 122, Ann Arbor, MI 48108.

***A Summary of Changes section appears at the end of this standard**

(NCPDP) Telecommunication Standard Format Version 3 Release 2, 1992[5]
ANSI ASC X12: Version 3, Release 3 (1992)[6]
X12.84 Healthcare Enrollment and Maintenance Transaction Set (834)[7]
X12.85 Healthcare Claim Payment Transaction Set (835)[7]
X12.87 Healthcare Claim Transaction Set (837)[7]

2.3 *ANSI Standards:*[7]
HL7 EHR TC Electronic Health Record-System Functional Model, Release 1 February, 2007
Health Information Management and Technology: Glossary, American Health Information Management Association, 2006

3. Terminology

3.1 *Definitions of Terms Specific to This Standard:*

3.1.1 *admitting diagnosis*—a provisional description of the reason why a patient requires care in an inpatient hospital setting.

3.1.2 *ambulatory care*—preventive or corrective healthcare services provided on a nonresident basis in a provider's office, clinic setting, or hospital outpatient setting. The term ambulatory usually implies that the patient has come to a location and has departed that same day. (Ambulatory care includes medicine such as acupuncture, specialty clinics for consultation services and retail care centers used for short term immediate services.)

3.1.3 *ancillary service visit*—appearance of an outpatient in a unit of a hospital or outpatient facility to receive service(s), test(s), or procedures; it is ordinarily not counted as an encounter for healthcare services.

3.1.4 *clinic*—an outpatient facility providing a limited range of healthcare services, and assuming overall healthcare responsibility for the patients. See also *ambulatory care*.

3.1.5 *clinic patient*—a patient who is registered for the purpose of diagnosis or treatment or follow-up on an ambulatory basis.

3.1.6 *continuing care retirement community*—an organization established to provide housing and services, including healthcare, to people of retirement age.

3.1.7 *electronic health record (EHR)*—an electronic health record is any information related to the past, present or future physical/mental health, or condition of an individual. The information resides in electronic system(s) used to capture, transmit, receive, store, retrieve, link and manipulate multimedia data for the primary purpose of providing health care and health related services.

3.1.8 *emergency patient*—a patient admitted to emergency room service of a hospital for diagnosis and therapy requiring immediate healthcare services.

3.1.9 *emergency services*—immediate evaluation and therapy rendered in urgent clinical conditions, sustained until the patient can be referred to his or her personal practitioner for further care.

3.1.10 *encounter*—(*1*) the direct personal contact between a patient and a physician or other person who is authorized by state licensure law and, if applicable, by medical staff bylaws to order or furnish healthcare services for the diagnosis or treatment of the patient. (*2*) A contact between a patient and a practitioner who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment. Contact may be via an electronic visit.

3.1.11 *episode*—one or more healthcare services received by an individual during a period of relatively continuous care by healthcare practitioners in relation to a particular clinical problem or situation.

3.1.11.1 *episode of care (EOC reimbursement)*—a category of payments made as lump sums to providers for all healthcare services delivered to a patient for a specific illness or over a specified time period or both; also called bundled payments because they include multiple services and may include multiple providers of care.

3.1.12 *free standing ambulatory surgery center*—a) A free standing outpatient surgical facility is a separate facility that exists primarily to provide services in connection with surgical procedures that do not require inpatient hospitalization. b) An outpatient surgical facility that has its own national identifier; is a separate entity with respect to its licensure, accreditation, governance, professional supervision, administrative functions, clinical services, record keeping, and financial and accounting systems; has as its sole purpose the provision of services in connection with surgical procedures that do not require inpatient hospitalization; and meets the conditions and requirements set forth in the Medicare Conditions of Participation.

3.1.13 *health maintenance organization*—an organization that provides health coverage to voluntary enrollees in return for prepayment of a set fee, regardless of the services used.

3.1.14 *home health*—a) An umbrella term that refers to the medical and non-medical services provided to patients and their families in their places of residence. b) The provision of medical and non-medical care in the home or place of residence to promote, maintain, or restore health or to minimize the effect of disease or disability.

3.1.15 *hospice*—an interdisciplinary program of palliative care and supportive services that addresses the physical, spiritual, social and economic needs of terminally ill patients and their families.

3.1.16 *hospital*—an establishment with an organized medical staff with permanent facilities that include inpatient beds and continuous medical/nursing services and that provides diagnostic and therapeutic services for patients as well as overnight accommodations and nutritional services.

3.1.17 *hospital-based outpatient care*—a subset of ambulatory care utilizing the hospital staff, equipment, and resources to render diagnostic, preventive or corrective healthcare, or both.

[5] Available from NCPDP, 4201 North 24th Street, Suite 365, Phoenix, AZ 85016.
[6] Available from DISA (Data Interchange Standards Association).
[7] Available from American National Standards Institute (ANSI), 25 W. 43rd St., 4th Floor, New York, NY 10036.

3.1.18 *inpatient admission*—the formal acceptance by a hospital of a patient who is to be provided with room, board, and continuous nursing service in an area of the hospital where patients generally stay overnight.

3.1.19 *intermediate care facility (ICF)*—an institution which primarily provides health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designated to provide, but who, because of their physical or mental condition, require care and services.

3.1.20 *length of stay (LOS)*—the total number of patient days for an inpatient episode, calculated by subtracting the date of admission from the date of discharge. If a patient is admitted and discharged on the same date, the LOS is one day.

3.1.21 *licensed practitioners*—an individual at any level of professional specialization who requires a public license/certification to practice the delivery of care to patients. A practitioner can also be a provider.

3.1.22 *longitudinal patient record*—a permanent, coordinated patient record of significant information, in chronological sequence. It may include all historical data collected or be retrieved as a user designated synopsis of significant demographic, genetic, clinical and environmental facts and events maintained within an automated system.

3.1.23 *long-term care*—healthcare rendered in a non-acute-care facility and to a patient in resident or nonresident status to chronically ill, aged, disabled or mentally handicapped individuals who are in need of continual supervision and assistance by healthcare practitioners.

3.1.24 *non-licensed practitioner*—an individual without a public license/certification who is supervised by a licensed/certified individual in delivering care to patients.

3.1.25 *outpatient care*—see *ambulatory care*.

3.1.26 *observation*—any aspect or attribute of a patient that can be described at a particular time. Examples include serum glucose finding, a chest x-ray impression, a bone density scan result, vital signs and a progress note.

3.1.27 *partial hospital program*—facilities of the hospital are regularly used on a scheduled basis for care during a substantial number of daytime or nighttime hours.

3.1.28 *patient health record*—the primary legal record documenting the healthcare services provided to a person, in any aspect of healthcare delivery. This term is synonymous with: medical record, health record, patient care record (primary patient record), client record, resident record. The term includes routine clinical or office records, records of care in any health-related setting, preventive care, life style evaluation, research protocols, special study records and various clinical databases.

3.1.28.1 *Discussion*—As the repository of information about a single patient, this information is generated by healthcare professionals as a direct result of interaction with a patient or with individuals who have personal knowledge of the patient (or with both). The record contains information about the patient and other individuals as they relate to the health of the patient, for example, family history, caregiver support.

3.1.28.1 *Personal health record*—An electronic or paper record of health information compiled and maintained by the patient or others for patient use (**5**) .

3.1.29 *patient record system*—the set of components that form the mechanism by which patient records are created, used, stored, and retrieved. A patient record system is usually located within a healthcare provider/practitioner setting. It includes people, data, rules and procedures, processing and storage devices (for example, paper and pen, hardware and software), and communications and support functions.

3.1.30 *primary diagnosis*—the diagnosis of the condition that is primarily responsible for the patient's symptoms and signs and has the greatest impact on the patient's health, or is the most resource-intensive to treat.

3.1.31 *principal diagnosis*—a statement of the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

3.1.32 *provider*—a business entity which furnishes healthcare to a consumer; it includes a professionally licensed practitioner who is authorized to operate a healthcare delivery facility.

3.1.33 *referred (patient)*—registered exclusively for special diagnostic/therapeutic service of the hospital for diagnosis/treatment on an ambulatory basis. Responsibility remains with the referring practitioner.

3.1.34 *resident care facility*—a residential facility that provides regular and emergency health services, when needed, and appropriate supporting services on a regular basis.

3.1.35 *school special education*—specifically designed instruction provided by qualified teachers within the context of school, aimed at the acquisition of academic, vocational, language, social, and self-care skills. Includes adapted physical education and use of specialized techniques to overcome intrinsic learning deficits.

3.1.36 *secondary diagnosis*—a statement of those conditions coexisting during an encounter that affect the treatment received or the length of stay.

3.1.37 *secondary patient record*—a record that is derived from the record used by healthcare practitioners while providing patient care services and it contains selected data elements to aid non-clinical persons (that is, persons not involved in direct patient care) in supporting, evaluating, or advancing patient care. Patient care support refers to administration, regulation, and payment functions. Patient care evaluation refers to quality assurance, utilization review and medical or legal audits. Patient care advancement refers to research. These records are often combined to form what the committee terms a secondary data base (for example, an insurance claims data base).

3.1.38 *sheltered employment*—employment provided in a special industry or workshop for the physically, mentally, emotionally, or developmentally handicapped.

3.1.39 *short stay ambulatory care*—a patient admitted to the hospital for an intended stay of less than 24 h, considered to be an outpatient and not included in inpatient hospital census statistics.

3.1.40 *skilled nursing facility*—a long term skilled facility with an organized professional staff and permanent facilities that provides continuous nursing and other health related services.

3.1.41 *UB-92 uniform bill*—a standardized uniform billing form required by federal authorities for Medicare claims and is used as an industry standard. It replaces the 1992 (UB-92) version.

3.1.42 *vocational rehabilitation*—evaluation and training aimed at assisting a person to enter or reenter the labor force.

4. Significance and Use

4.1 *This Guide has Four Parts:*

4.1.1 The first part (Section 5) identifies items of information carried in the traditional paper record organized by the source oriented structures common to paper records. The purpose of this section is to remind users of the spectrum of information that shall be accommodated by the logical structure of a EHR and to present a point of reference for the more abstract description of the patient record that follows.

4.1.2 The second part (Section 6) presents a number of operational principles, including such matters as privacy and security that should guide the implementation and operation of EHRs.

4.1.3 The third part (Section 7) describes a logical data organization and content (common data model) of an EHR. It is not a blueprint for constructing or implementing a EHR system. The model presents an organization according to the major informational structures and content of the EHR. The focus is on the structure required to store all clinically relevant patient information: those that describe the patient's state; the actions directed at the patient variables; and the actions initiated to diagnose, educate, or treat the patient. These are regarded as repository functions of the EHR. This standard does not describe all of the data structures required by applications that might use information contained in the EHR. In particular, the data structures used to control and guide the process of care such as utilization review or quality assurance, and the goals or thresholds (for example, mean length of stay) that might be used to judge the patient's care are not included.

4.1.3.1 There are many different ways to implement physical structures that could map into the model presented. It is emphasized that this standard should neither impede technical progress nor define the precise manner in which the EHR system is implemented.

4.1.3.2 The focus of this guide is on the kinds of information that should be included and upon a global description of the organization of that data within the EHR. This guide does not deal in detail with issues related to charges and billing for patient care, only the documentation required to support usual charging and administrative issues.

4.1.3.3 This standard deals with the health information as it would be stored in the EHR, not as it would be sent as a message to or from the EHR. Pains have been taken to be sure that the information content from existing healthcare informatics messages that lie within the scope of the EHR can be mapped into the EHR structure. Where mappings are one-to-one, the EHR data elements have been cross referenced with the message fields. However, the EHR is not just a collection of messages. It makes stronger assumptions about the context in which it exists, so there is not perfect correspondence between the structure and content of messages on the one hand and the EHR on the other.

4.1.3.4 This guide applies across a range of scales. Though the ultimate goal is a EHR that spans the entire nation and the lifetime of an individual, the reality is that EHRs are mostly of much smaller scope (for example, within institutions, communities, or states) and these can be implemented much sooner. This standard is intended to apply equally to all scopes of time and place. Within the scope of a EHR, all master tables and code systems (for example, service catalog, patient registry, patient identifier) will be held in common. It denotes extensions of text content for document format standards and references standard XML designation for document section tags.

4.1.4 The fourth part (Sections 8, 9, 10) describes some alternative views (subsets of information presented in various orderings) of the content and proposes the minimum data elements contained in the EHR. What has been described as the "Longitudinal Health Record" (a very short précis of the patient's entire history) falls into this category. A set of "views" will serve as the user interface to the EHR for various customers. When all of the data is available in a EHR, providing different views of that data to satisfy various user needs and perspectives will be facilitated. Further, the kinds of views that are "required" and their dependencies (differing by institution, by specialty, by health/medical problem, by practitioner) will evolve over time. Section 10 is a repository of data elements to be used as an electronic health record data dictionary (Annex A1) **(18)**.

4.2 *General—Healthcare Documentation:*

4.2.1 A patient's health record plays five unique roles: (*1*) It represents that patient's health history, that is, a record of the patient's health states and the health services provided, over time. (*2*) It provides a method for clinical communication and care planning among the individual healthcare practitioners serving the patient. (*3*) It serves as the legal document describing the healthcare services provided. (*4*) It is a source of data for clinical, health services, and outcomes research. (*5*) It serves as a major resource for healthcare practitioner education.

4.2.2 Keeping complete and accurate records is an essential part of patient care management. Increasing specialization in healthcare and population mobility have increased the fragmentation of the traditional health record. The EHR offers a unified, coordinated, complete repository of patient health information. It includes such things as treatments, prescriptions, test results, diagnostic impressions, and significant genetic, environmental, and clinical healthcare data.

4.2.3 The person's health record consists of the original documentation of their health information and of the associated health and clinical services provided at the various care sites including the results of tests and outcomes of treatments. Each care site will require basic data that may be common to all care sites, data specific to that particular type of care site, and data unique to the individual care site.

4.2.4 The EHR serves all of the functions of the traditional record but has many advantages.

4.2.4.1 It solves the logistic problems of easy access to the paper health/medical record. Information can be concurrently accessed from multiple locations.

4.2.4.2 It will provide efficient communication of information to support coordination of services between care practitioners (See Specification E2369).

4.2.4.3 It calls for data content to be stored so that it links to automatic reminders and alerts to avoid errors of omission and commission.

4.2.4.4 By providing cross-patient retrievals it will provide the statistics needed by clinical, outcomes, health services and policy researchers as well as administrators and managers, to define better policies and practices to improve the healthcare process and make it efficient.

4.2.5 The longitudinal healthcare record, which is the brief synopsis of the significant facts derived from the primary documentation, can be constructed from views of the elements described here.

4.3 *The Role of Standards in Healthcare Documentation:*

4.3.1 Healthcare informatics standards are essential for an efficient and affordable EHR. Even within a single institution, much of the information that should be stored in the EHR will come from other electronic sources. Message standards are needed to ensure that this data can be transmitted from a source system and received and stored with a EHR without requiring human intervention. The need for information from other healthcare facilities (the hospital would like nursing home records when the patient is admitted and vice versa when the patient is discharged) is even greater. Finally, standard terminology, codes, and formats are the sine qua non for aggregating many EHRs for research and policy purposes.

4.3.2 The model for an EHR described here provides a general guideline that describes the data and data organization for an EHR and recommends minimal content requirements. It promotes common approaches to documentation. The model should be flexible enough to permit the storage of any kind of patient information deemed important by an individual provider, ensure that a minimum set of patient data is maintained, as well as information required by diagnostic and therapeutic services of the future.

5. Catalog of Health Record Contents by Source

5.1 This section describes the content of the current paper oriented record by source of data. The purpose of this section is to depict the full range of data that will compose the EHR but described in familiar terms.

5.2 Within the traditional record of care we find the kinds of information shown in Table 1. As Table 1 shows, many categories of information exist, and they can often be broken down into ever more detailed categories depending upon who collects the information and how it is to be used. For example, the physical examination can be broken down into the traditional categories, but subcategories may be possible and, indeed, required. For example, the physical exam of the eye might be recorded as a family of procedures or as a single unit. While one ophthalmologist might break the exams into many subcategories; for example, lid and exterior muscles, conjunctiva, cornea, anterior chamber, and retina; another might not. When more completely structured, the granularity of such exams can be very fine.

5.3 In the traditional record the degree of granularity (expressed detail level) and the degree of structure may vary considerably depending upon specialty, the particular provider, the clinical problem, the kind of care (hospital, office visit, nursing home). The spectrum runs from complete free text (some visit notes) to free text broken down by subheadings of differing degrees (standards formats) of granularity to fully structured data collection instruments (where all questions have multiple choice, coded, or numeric answers). But the degree of granularity can vary among structured data collection instruments, and free text may or may not be allowed as an "escape." Thus, the EHR must also accommodate varying degrees of granularity in the recording of the same clinical information within one patient's record.

5.4 *Structured Data versus Free Text*—It is important to distinguish between two main ways of recording patient information. Some is recorded as free text (for example, the dictated visit note) and some structured data, that is, the information is broken into discrete data elements (single concept types) and the value(s) of each data element is recorded as discrete values (that is, terms codes, or surrogate codes such as multiple choice responses) or number values (for example, laboratory test results). Practically, the computer can "understand" structured data because it has a defined context, but it cannot easily understand free text because it has to determine a context. However, the computer can "process" free text and convert it into a structured form. Encoders that convert free text diagnostic phrases to specific ICD9-CM or CPT codes are examples. Professionally trained coders provide quality oversight of encoders.

5.5 Further complicating matters is the great variation among institutions, specialties, and practitioners in the degree to which they record patient information as free text versus structured responses. Some test results may be represented as structured. However, a formal standard for a fully structured representation for lab reports is complex and continues to be under development.

5.6 In some hospitals nursing notes are highly structured, with many separate questions calling for multiple choice options for recording patient's status; in other hospitals the notes are pure text. Major portions of obstetrical histories are recorded on multiple choice instruments in some institutions, as free text in others, and many of these documents originate in the physician's office. Radiologists break their reports of X-ray studies into description and impression, both of which are recorded as free text. Echocardiograms are usually reported as a set of discrete measurements (for example, left ventricular diameter, ejection fraction for echocardiograms).

5.7 There are many reasons for preferring structured to free text observations. (At the very least, the impressions of imaging studies diagnosis reported at visits and surgeries should be reported in structured forms.) However, rigorous structuring imposes time cost on the observer. In particular,

when reporting a patient's perceptions, anxieties, or other conversationally acquired information, it is impossible to predict what will be said. Forcing such information into a predetermined structure may degrade the richness of the content and could lead to erroneous interpretation of meaning. In some areas traditionally handled through free text, history and physical examinations, hospital discharge summaries, etc., standards are being developed to apply structure (formats). Yet, these areas are just underway. Given historical preferences, and the mass of existing free text information, the EHR must accommodate both structured and free text reporting for the foreseeable future. It may even have to accommodate structured or free text values, or both, for the same variable, depending upon who does the recording. In addition, the EHR must accommodate information from outside sources, such as lab work from a pervious admission at another facility. Free text processing is available through several approaches. The encoding of text into machine codes has been one approach. Term analysis, internal coding, and pattern mapping for clinical fact extraction also can be done. This area is in rapid development and should be monitored for application to EHR systems.

TABLE 1 Contents of the Traditional Patient Record

Category	Subcategory	Examples and Components
Patient registration information	Identifying information	Sex, birth date, race
	Locating information	Home address, home phone, work phone
	Insurance information	Name of plan
	Guarantor information	...
Patient problem list	...	Problem number
		Problem name
		Date of onset, status
Patient extended encounters	Hospitalization admission records	Insurance information (for current encounter), guarantor information (for current encounter), chief complaint, diagnoses, clinical variables (observations, tests, measurements), final diagnosis/problem, corrections to registration information, procedures performed, etc.
	Practitioner hospital notes	
	Practitioner visit notes	
	Home healthcare notes	
	Hospital discharge summary	
Encounters	Office/clinic visit	
	Home healthcare visit	
	Practitioner visit within extended stay	
	Emergency room visit	
Patient care plans	Clinical roadmaps	Assessment data
	Chronic disease management	Plans delineating therapy, education, scheduled appointments
	Plans for specific patient problems	
Orders	Medication orders/prescription	
	Test orders (Lab Tests)	(both continuing orders, for example, Hgb QAM, and point orders, for example, glucose stat)
	Diet orders	
	Other treatment orders	
	Physical therapy order	
	Occupational therapy order	
	Respiratory therapy order	
	Nursing treatments order	
	Other observation orders	
	Nursing observations (also independent of orders)	
	Consults (to variety of clinical specialists)	
	Nursing interventions	
Service Instances	Confirmation of receipt of orders	
	Documentation of completion of each step of process (for example, MAR report)	
Procedures	Surgical procedure	Pre-procedure orders, pre-operative diagnosis, procedure identifier, provider(s) performing procedures, permissions for procedure, procedure note, duration of procedure, medication used, immunizations, complications, final diagnosis, post-operative orders, after care plans
	Outpatient procedures	
	Invasive diagnostic studies	
	Bedside procedures	
	Imaging studies	Thyroid scan, chest X-ray, cardiac echoes, OB ultrasound, vascular dopplers, cardiac catheterizations
	Physiologic tracings	EEGs, EKGs, prenatal monitors, cardiac monitors
	Other special studies	Glaucoma fields, pulmonary function, sleep studies
	Practitioner notes	Physicians', nurses', physical therapists', etc., notes
	Provider discrete observation	Blood pressure, heart rate, skin fold thickness, eye tonometry, infant's head circumference
	Identifying information	Patient's name and identifying number
	Health history	Chief complaint

TABLE 1 *Continued*

Category	Subcategory	Examples and Components
		Source of history
		Present illness
		Family Hx
		Social Hx
		Functional status Hx
		Travel Hx
		Occupational Hx
		Childhood disease Hx
		Surgical procedures Hx
		Allergy Hx
		Medication Hx
		Review of systems
		Smoking Hx total
		Smoking Hx current, etc.
	Physical exam	General status Px
		Vital signs Px
		Skin Px
		Head Px
		Eyes Px
		Ears Px
		Nose Px
		Mouth/throat/teeth Px
		Thorax/lungs Px
		Breasts Px
		Heart Px, etc.
	Lab Data	
	Toxic exposures	
	Nursing assessments	
Legal documents		
	Surgical releases	...
	Organ donor permissions	
	Advance directives (release of documents)	
Schedules (surgery/clinic, etc.)	Requests for resource	Send patient to eye clinic
	Assignment of resource	
	Documentation of delivery to resource and return	
Supplies and equipment	Consumables (4×4's)	...
	Attachments	

6. Operational Considerations

6.1 Operational aspects that affect the record's structure and use need to be addressed in any approach to EHR development. These include: General Principles, Data Types, Identifiers, Initiation of the Record, Access to the Record, Essential Data Elements, Retention of the Record, and Referential or Master Tabular Data.

6.2 *General Principles*—In identifying and defining the general content and structure of the patient health record for the design of systems, certain operational principles apply.

6.2.1 Identify the patient health record as the main patient-specific clinical repository component of all health information systems and, as such, the primary repository source of all documentation of clinical care.

6.2.2 Establish standard minimal components of all patient records, and their content, in all healthcare delivery environments.

6.2.3 Accommodate compilation of data into views (synopses) of the patient care record, visits or episodes appropriate to each healthcare delivery setting, including a patient's personal health record, and which should be accessible locally and included in the unified longitudinal record.

6.2.4 Ensure that the standardized content conforms to the known health data standards.

6.2.5 Define the logical structure of the patient record which, when used for electronic health record systems, enables consistency in the data organization.

6.2.6 Specify data element definitions that conform to standard nomenclature and are mapped to related formally approved standards.

6.2.7 Identify and reference coding systems consistent with current health reporting retrieval, analysis, and reimbursement needs (See NCPDP, ANSI ASC X12, X12.84, X12.85, and X12.87).

6.2.8 Specify data security and confidentiality measures.

6.2.9 Identify the long-term and short-term clinical value of the data elements contained in the patient health record.

6.2.10 Ensure a patient role in contributing all reported data as appropriate for EHR content development and outcomes assessment.

6.3 *Data Types*—Each of the data elements identified have representations of their data values that fit into a limited number of classes called data types. Consistent with HL7 standards and Specification E1633, these include person names, addresses, text, phone numbers, numeric values, dates and times and "coded" (terms and their surrogate codes from a variety of systems). Table 2 is a list of data types found in HL7. Coded values, particularly, point to referential master tables. In those tables, the term that is human understandable may have

TABLE 2 Data Types

Value	Description
AD	Address
CE	Coded entry (for example, Test Ids, Dx codes)
CK	Composit ID with check digit
CM	Composit miscellaneous
CNA	Composit ID and person name
CQ	Composit quality with units <number> ^ <units>
ID	Identifier
MO	Money
NM	Numeric
PN	Person name
RP	Reference pointer
ST	String for short text and numerics
TN	Telephone number
TS	Time stamp (date and time)
TX	Bulk text

a number of code values from different coding systems associated with it, including different languages. When communicating with other systems using messages, a coding system identifier and the code value for that term in the identified system must all be associated with the value for the data element of interest. The date-time data type permits varying degrees of granularity from day, hours to even decimal seconds; a time zone offset from Greenwich Mean Time can also be used. One of these values sets will be used for each data element defined. Messaging standards may require additional subtypes which will be defined within those standards.

6.4 *Identifiers*— Identification of persons (patients, practitioners) and places (healthcare facilities, locations, and workstations) is an important component of the data collection process. The original source healthcare location information shall be captured for each event of care by using provider identification elements that are established for each setting. Check digits for the provider and patient record number should be included (See Guide E1714).

6.4.1 *National Patient Health Identifier*—Each individual patient should be assigned a unique healthcare code number. Fields for the identifiers for blood relatives and, where appropriate, spouses **(1)**[8] should be included in the patient record to allow these related records to be found when appropriate. The number attributes should be unique, permanent, atomic (a single data item), concise, controllable, assignable, universal, unambiguous, used solely for healthcare and compatible with current standards. It shall provide protection of confidentiality and privacy.

6.4.2 *Identification of the Healthcare Setting*—The healthcare location and setting information shall be captured by using specific synopsis data sets (Specification E1633) that are pre-established for each setting. Information technology can be used to facilitate the recording of these data sets. The system shall be capable of receiving and storing this data regardless of the medium but in conformance with the standard HL7 and ASTM transfer format.

6.5 *Initiation and Construction of the Patient Health Record:*

6.5.1 *Registration/Reservation Establishing the Patient Health Record*—Patients must be registered into an established EHR system by capturing the demographic information which identifies the patient and opens a formal patient record **(2)**. This information allows repeated and accurate identification of patients from one care setting to another and provides the link for additional healthcare information over time.

6.5.2 *Identification of Patients :*

6.5.2.1 The original source health care location information shall be captured for each event of care by using provider defined identification elements that are pre-established for each setting and stored as a longitudinal view of the original source record or transferred to a patient designated longitudinal health record system.

6.5.2.2 *Authentication of Data Entries*—All data entries will be authenticated by user identification, and date and time entries will be recorded automatically.

6.5.3 *Registration and Establishment of the EHR Record for Newborns*—At birth, a newborn record will be initiated as a patient health record. From the obstetric record of the mother the following data shall be transferred to the newborn's record:

6.5.3.1 Infant's full name,

6.5.3.2 Date of birth,

6.5.3.3 Sex,

6.5.3.4 Explicit identification of both parents,

6.5.3.5 Synopsis of abnormal prenatal findings and events,

6.5.3.6 Synopsis of perinatal abnormal events,

6.5.3.7 Genetic synopses of both parents, and

6.5.3.8 Significant socioeconomic facts on family circumstances.

6.6 *Access to Records*—Policies and procedures for access to electronic health records must comply with federal and state laws and be established within the organizational policy structure.

6.6.1 *Privacy of Patient Health Records*—Access to patient health records is controlled to maintain privacy. See Guide E1769 and other ASTM standards for confidentiality and privacy **(12)**.

6.6.2 *Release of Records for Clinical, Administrative and Research Purposes*—Records shall be released for clinical uses that provide direct care services to patients in line with Health Insurance Portability and Accountability Act (HIPAA), state statute and appropriate consent policies and procedures. Administrative needs for patient data to be drawn from the electronic health record shall be processed within appropriate legal guidelines and established health facility patient data confidentiality and security programs. Research use of patient data which is drawn from the EHR shall be provided as aggregate, unidentified data whenever possible. Research projects which seek the use of identified patient data shall be reviewed by the appropriate committee of the organization and shall conform to the patient data confidentiality and security program guidelines. Automated systems shall provide the necessary checks needed.

6.7 *Essential Data Elements:*

6.7.1 Minimum data sets for descriptive purposes have been determined from the health records in major clinical settings and these have been previously published. They are:

[8] The boldface numbers in parentheses refer to the list of references at the end of this standard.

6.7.1.1 Department of defense/composite healthcare system (3),
6.7.1.2 Uniform hospital discharge data set (4),
6.7.1.3 Basic ambulatory medical care data set (5, 6),
6.7.1.4 Minimum uniform data set for home care (6),
6.7.1.5 Minimum hospice data set (7),
6.7.1.6 Minimum data set for long-term care (8, 9),
6.7.1.7 Health record core data set (2),
6.7.1.8 Occupational health data set (10),
6.7.1.9 Emergency medical information data set (10),
6.7.1.10 Summarized health profile (13), and
6.7.1.11 The nursing minimum data set (1).

6.7.2 Recommended content of patient care records has also been developed and published by accrediting and certifying organizations and Medicare and Medicaid regulations. These include the Joint Commission on Accreditation of Healthcare Organization (JCAHO), the National Committee on Quality Assurance (NCQA) and others (11, 12).

6.8 *Retention of Records*—Patient health record retention criteria for both written and electronic records must be established to conform to the requirements of Federal and state statutes.

6.9 *Master Tables:*

6.9.1 A basic approach to defining EHR content is through master tables and data views. A master table is a list of variables that represent the range of attributes currently defined for a given subject. Table 3 is an example of an excerpt from a master table. Others are standard coding systems such as ICD9, a problem list directory, a catalogue of risk assessment questions organized as reference for patient reported status as well as short tables illustrated within this standard and discussed in Specification E1633. By using master tables we can provide both a short term and a long term approach to methodically addressing EHR content. By developing the master tables from these resources, users can apply the standard in diverse settings. Users would use this practice with the appropriate master tables to select standard recommended and optional vocabulary to define the EHR vocabulary in their organization. Overlap will occur among the tables. Master tables can be developed and refined as necessary. They also provide the means of proposing minimum content as well as the more detailed and comprehensive content by EHR areas. Master tables examples that reflect EHR content vocabulary are:

6.9.1.1 Complete patient health history variables,
6.9.1.2 Complete patient self reporting history questions catalogue,
6.9.1.3 Complete patient assessment/physical exam variables,
6.9.1.4 Patient self reporting functional status reporting items (for example, SF-36, Dartmouth 9),
6.9.1.5 Health outcomes variables,
6.9.1.6 Master table of vital signs variables,
6.9.1.7 Master table of instrument monitoring variables, and
6.9.1.8 Master table of laboratory tests, etc.

6.9.2 Tests, supplies and equipment have attributes when considered in the abstract (separately from results or use in a particular patient). These are attributes that would be listed in a catalogue of the available tests, supplies or equipment. The attributes of a test might be when it could be obtained, the preparation requirements for specimens, the price, the normal range, the units and so on. By maintaining a "catalogue" or definition table for items such as supplies, orders, observations and equipment, easy additions and extensions can be made. (New tests and observations can be created without having to redefine the universe, or rewrite programs.) More attributes can also be added to the item to give the universe of entities new behaviors with little or no effect on the previous version of the world. Most laboratory systems, pharmacy systems, billing systems, inventory systems and other systems that must deal with large numbers of discrete items use a general object, or file to carry context-insensitive attributes and "pointers," or indexes, to refer to the entry of interest. Tables are used by the long-surviving EHRs. For example, these attributes are now found in LOINC and SNOMED code systems.

6.9.3 An observation is a term that is used to mean any aspect of a patient that can be described at a particular time. It follows Allan Rector's idea of an observation (14) a serum glucose, a chest X-ray impression, a Glasgow coma score, each of the questions on a health or functional status, (for example, SF-36, D-9), a history of present illness, urine output and nurses notes are each an observation. An observation is an attribute of a patient, that is, an atomic unit or "chunk" in which clinical information is recorded. The observation, however, cannot stand alone. It has a context and general attributes that define that context that are independent of the particular patient's observation, such as: units of measure in which it is reported, its name and synonyms, its class, information about how it is grouped in reports or where it is stored and so forth. This context-independent data is stored in master tables. Tables accommodate different degrees of granularity and easily adapt to change. New entries are easily added to these tables since new concepts arise continually in patient care. It is again important to note that this document describes observations in an implementation independent fashion using a notation that depicts logical relationships but implies no implementation technique. Data element segments and grouping are used but other logical relationships could also be used. In any case master tables hold the context insensitive data

TABLE 3 Ophthalmology Exam Variables

Pupils	
OD pupil	OS cornea cannot be assessed
OS	OS shallow anterior chamber
	OS cornea cannot be assessed
Amsler Grid	
OD Amsler Grid	Anterior Chamber Findings
OS Amsler Grid	OD AC normal
	OD AC flare only
Corneal Examination	OD AC cells only
OD normal cornea	OD AC keratic precipitates
Guttata w/o edema	OD AC posterior synechiae
OD confluent guttata w/o edema	OD pupil mydriatis
OD corneal edema	OD pupil irregular
OD central corneal opacity	OD shallow AC
OD corneal dystrophy or degeneration	OD Transillumination defects, etc.

while the groupings of data elements deal with the context sensitive relationships that establish the observation's meaning.

6.9.4 When selected few observations are gathered in a particular setting, a simpler structure can be employed. For example, if a diabetes clinic wished to capture only 20 variables (for example, diastolic and systolic blood pressure, blood glucose, hemoglobin Alc, weight, pulse, foot lesions (present/absent) etc.) one record per visit might be created and specific fields defined for just those specific observations. A master term table would not be needed. But if other requirements arise, this approach is very rigid, limited and does not work well in the general case. A EHR may have 10 000, or more kinds of observations (there may be 5000 different laboratory tests that could be recorded, for example). Further, observations may be recorded multiple times by different providers during the same visit. The rigid structure cannot accommodate that situation.

7. The Overall Structure of the Electronic Health Record

7.1 The discussion of the structure of the EHR must relate the major entities (objects) of the record to the identified record segments. The clinical heart of the EHR is the core of the entities: patient, provider, problem, encounters, orders, services and observations. The record segments that relate to these entities are shown in Fig. 1. The focus of these relationships is the RADT object model, dealt with in Practice E1715 that provides the foundation for linking the entities in Fig. 1 to the detailed inventory of data elements given in Annex A1. Table 4 shows how the segments currently accommodate the entities.

7.1.1 Notice that most of the entities listed in Fig. 1 have their own attributes. For example, the patient has the attributes of sex, race, birth date, etc. Each order includes attributes that identify the item(s) ordered, the date of the order, the ordering provider, the urgency of the order (stat, now, routine, etc.), the ordering instructions can be further broken down into amount, frequency, duration, special conditions for many orders. These will all be presented in detail in Section 9.

7.1.2 For some of these entities, the industry has enough experience with them that the overall structure is well understood and easy to describe. In some information areas, especially those that are represented by free text in the traditional record, much is yet to be learned.

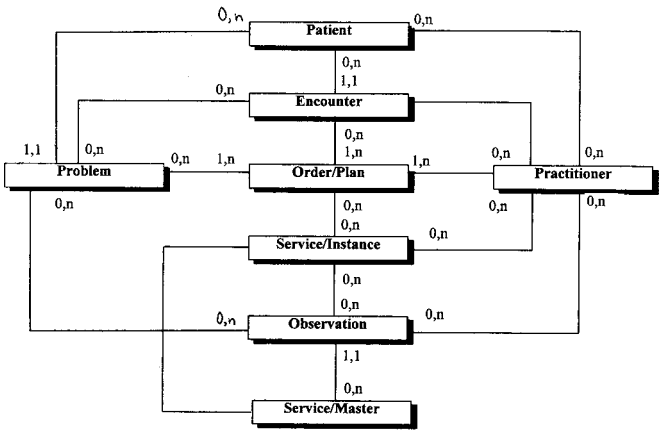

FIG. 1 Patient Record Object Model

TABLE 4 Patient Record Content Structure Data Categories, Segments and Entity Relationships

Data		Category and Segments	Entity
Administrative Data			
I		Demographics	Patient
II		Legal agreements	Patient
III		Financial information	Patient
IV		Provider/practitioner	Provider
Clinical Data: Problem/Diagnoses			
V		Problem list	Problem
Clinical Data: History			
VI		Immunization	Service instance
VII		Hazardous stressor exposure	Observation
VIII		Health history	Observation
Clinical Data: Assessments/Exams			
IX		Assessments	Observations
*		Patient reported data	Observation
Clinical Data: Care/Treatment Plans			
X		Clinical orders	Orders
Clinical Data: Services			
XI		Diagnostic tests	Observations
XII		Medications	Service instance
XIII		Scheduled appointment/ events	Encounter
Administrative Data: Encounters			
XIV	a	Administrative data	Patient
	f	Encounter disposition[A]	Encounter
Clinical Data: Encounters			
	b	Chief complaint/ diagnoses	Observation
	c	Clinical course	Observation
	d	Therapy/procedures	Service instance

[A] These are new concepts or reordered data, or both. Note that the clinical heart of the EHR is the core of the entities (Objects). The record segments that relate to these are shown.

7.2 *Perspective*—Representing the overall structure of the record is difficult since it is complex and has a number of dimensions. It also can be viewed from many perspectives. Four of these are: chronological, by encounter/episode, by problem, and by topic. Each of these views looks at the same stored data in a different way. There can be many perspectives and even more ways of displaying the same data. This guide must represent the complex storage structure in two dimensions. Therefore, in Appendix X1 several notational conventions are used. One of these is a "pointer" followed by a target segment or external master table. This allows data values in these tables to be referenced without clouding the basic structure being illustrated. These representations are not intended to imply implementation techniques but, rather, logical relationships. Another difficult task is that of representing the data needs of different settings in a manner that captures the diversity and complexity of the observations as they relate to service instances and requests. These aspects will be further expanded in the discussion of the appropriate segments.

7.3 *Segment Categories:*

7.3.1 In order to provide a comprehensive structure for the EHR record, it must be organized into major segments that are clearly identified and to which information can be consistently

added from one setting and episode to another over time. The segments were identified through analysis of the content of the existing data sets and each segment describes and represents a category or type of information that can be seen in all patient care records.

7.3.2 As noted in Table 4, these segments have been regrouped for a more universal understanding of administrative and clinical uses of the data. The following discussion deals with the essential data elements in each segment. The entire list is summarized in Appendix X1 and each element's attributes are detailed in Annex A1, which gives a definition and form of representation. These elements may be utilized in different constellations in different settings, but each element's meaning remains the same wherever it is used.

7.3.3 Segments 1 to 13 (see Table 4) contain elements that are widely used in all settings and apply to both patient record and the longitudinal précis regardless of setting. They are not specific to any one episode or encounter though they may be initiated or updated during an encounter. The way they reflect the relationships shown in Fig. 1 and Table 4 will be discussed in the following sections.

7.4 *Occurrence and Utilization of Record Segments in Different Settings*—Patient and client records across care sites include content in this model to some degree. Acute care, ambulatory care, long term care, home health care, emergency care and special alternative care settings all maintain legal patient or client records that contain required content consistent with this standard.

7.5 *Segment 1, Demographics*—These are personal data elements, sufficient to identify the patient, collected from the patient or patient representative and not related to health status or services provided. Some of these elements may require updating at each encounter or episode and must satisfy various national standards and regulations such as a Joint Commission Standard, conditions of participation for Medicare, uniform hospital discharge, ambulatory, and long term care data sets.

7.6 *Segment 2, Legal Agreements* —This includes data elements indicating legally binding directions or restraints on patient healthcare, release of information and disposal of body or body parts, or both, after death.

7.7 *Segment 3, Financial*—This segment contains the references to the financial bodies that will cover the cost of care. This segment may be referred to from within the record, as during encounters/episodes. Such reference would obviate the need for a redundant collection of such data during the visit.

7.8 *Segment 4, Provider/Practitioners :*

7.8.1 This segment contains in one place the descriptive data about each provider/practitioner and may then be referenced when recording data about the events of healthcare. This includes the provider identifying data on the primary organization, or establishment responsible for the availability of healthcare services for a specific episode or encounter.

7.8.2 Practitioner identifying data elements are those associated with the individuals licensed or certified to deliver care to patients, who had face-to-face contact with the patient, and provided care based on independent judgment.

7.9 *Segment 5, Problem List:*

7.9.1 This includes specified clinical problems, a diagnosis summary and stressor exposure, an ongoing list of clinically significant health status events and factors, resolved and unresolved, in a patient's life. This list should contain all past and existing diagnoses, pathophysiological states, potentially significant abnormal physical signs and laboratory findings, disabilities, and unusual conditions. Other factors such as social problems, psychiatric problems, risk factors, allergies, reactions to drugs or foods, behavioral problems or other health alerts may be included. The problem list is to be amended as more precise definitions of the problems become available. Controlled vocabulary for problem lists may be contained in a problem list directory master table.

7.9.2 This segment contains a master list of all of a patient's problems or diagnoses. It may be referenced, as noted in 7.18.2 in presenting the diagnostic summary beginning each encounter/episode. All problems or diagnoses initially recorded in a specific encounter/episode will also be entered in this master list. A permanent history of all problems associated with the patient should be maintained.

7.9.3 Whenever possible, identification of risk factors (health alerts) that should be known prior to implementing any health services should be included in this section. They can be considered to be instances of a special type of patient problem and include allergies, contagious conditions, and adverse reaction to specified treatments.

7.10 *Segment 6, Immunizations*—Considered a component of patient health history, this segment contains, chronologically, all immunizations administered to the patient and their current status. This synopsis may also be copied to an emergency record to accompany medical alert data. Acquired (active or passive) or induced immunity or resistance to particular pathogens produced by deliberate exposure to antigens is included.

7.11 *Segment 7, Exposure to Hazardous Substances:*

7.11.1 The what, where, when, and how data on actual or potential exposure to all biological, physical or chemical agents that might be associated with adverse health effects are listed in this segment. This segment should provide data for epidemiological studies to determine correlation of disease with exposure to environmental stressors.

7.11.2 Because of the potentially long latency period in exposure to hazardous substances before the appearance of effects, the chronological record of exposure—both in the workplace and out, where appropriate—to hazardous chemical, physical, biological, or radiological stressors to the body is contained in this segment. It has particular importance when accessed as part of the synoptic record because its completeness acts as a prompt to providers/practitioners long removed in time or space, or both, from the original entry that the signs and symptoms of health conditions may be due to previous exposure. Absence of such data does not rule out such exposure but presence provides direct clues needed to identify the possible causes of an observed condition.

7.12 *Segment 8, Family/Prenatal/Cumulative Health/Medical/Dental Nursing History*—The long term relevant

natural family and patient history and signs which would aid practitioners in predicting or diagnosing illness, or actual or potential alterations in health, or predicting outcome of the patient's care are all the focus of this segment. The historic record of previous signs and symptoms complements the problem list in itemizing, in an integral way, the manifestations of prior disease, illness or health status not yet documented in the problem. It characterizes those already present in that list and it takes the form of a categorized list of questions of the form: "Have you ever_____<If so, when>" During each encounter/episode this list may be updated by the preface: "Since the last visit have you ever_____<If so, when>" so that the most recent observations can be added to the growing list. This integral process then collects the most reliable observations from the patient, (historically categorized in patient records) review of systems, and nursing history or other method, and adds them to the historic body of (at the time) freshly collected data. Ideally, this process begins during gestation and the initial observations are transferred from the mother's record to that of the newborn at birth. Fresh observations are added throughout the patient's lifetime. If continuity can be maintained, the practitioner need not have to reconstitute the early record at each encounter. Recommended and optional attributes of patient history are included in a master table.

7.13 *Segment 9, Assessments/Exams :*

7.13.1 Assessments/exams characterizes the patient's health status in tandem with the history. Depending upon the setting, this segment may include a general or specialty medical or dental exam or assessments by nursing, dietary, social service, therapy or dental hygiene specialists, or all of these. The assessments may be all-inclusive or may relate only to hands-on care of very special problems (that is, particular body systems, psychosocial assessment, dental, vision communication, etc.). All data pertinent to pre- and perinatal care including monitoring during delivery are also included in a post-delivery exam assessment. Details of the actual delivery for the newborn are to be entered in the specific section containing health factors of the neonate. Recommended attributes of assessments/exams are identified in master tables.

7.13.2 This segment records the observations of the practitioner during structured and systematic examinations of the patient's body during encounters/episodes. It contains objective observations and measurements that quantify attributes of each body system (See 5.2.22 of Specification E1633). These are the same body systems about which patient questions are asked during the history. Such common categories allow characterization of expressed problems with observational evidence in explicit common terms and measures that, over time, allow practitioners to follow the course of illness and recovery. This focuses on the physical assessment of the patient and is combined with appropriate psychosocial assessment to compose overall patient assessment status. These observations complement the diagnostic terms described in 7.15. They also relate to the effects of therapeutic interventions, such as medications, as described in 7.16.

7.14 *Segment 10, Care/Treatment Plans and Orders:*

7.14.1 Data entries that direct a patient's treatment includes detail data on deliverance of orders and compliance with any diagnostic or therapeutic treatment plans, whether written, oral or standing.

7.14.2 A care treatment plan may be a broad perspective program that identifies planned clinical encounters, education and scheduled events related to specific diagnosis or set of problems (for example, diabetes). It may also be a short term tool applied, for instance, in acute care or other setting that arranges interdisciplinary roles to carry out therapies, nursing services and other activities. While not always explicitly defined, care plans are typically based on protocols and guidelines. In some cases, they are developed via consensus.

7.14.3 A clinical order is an action-oriented message describing an intervention in the health of a specific patient originated by, or under the supervision of, an authorized practitioner. A clinical order has legal implications regarding responsibilities for the ordered intervention as well as quality of care implications that may be assessed by supervisory bodies or clinical researchers, or both. It is therefore necessary to specify the logical structure of this message and to define the representations to be used for each constituent data element. The clinical order acts also as a communication and coordination mechanism for all of the practitioner and ancillary professionals who may participate in the actions set in motion by the order. The clinical order structure is complex and may be thought of as a network structure because of the complexity of relationships between specific data elements within the clinical order and other data elements located elsewhere in the care record. Because this complex structure is difficult to represent by means of two dimensional paper forms, there is no explicit manual-mode model for this kind of data structure. Paper records have relied on plain text representations in recording the order. In practice these relationships among the data elements have been implicit in the inculcated practices of professional training. This guide attempts to explicitly define this structure.

7.14.4 Since a clinical order is a message, it has a heading and a body. The heading specifies the originator, the object patient, the routing and the addressee(s). The body contains a structure that is greatly dependent upon the action addressee but does have commonality across all types of orders. Since the message objective is a specific patient, it serves as the legal business record and the original documentation of all orders for that patient and is a designated part of the patient's care record. Other copies may be stored for use by the action or information addressees, as appropriate. A given clinical order may be more appropriately created by means of pre-existing templates, or sets of templates, that contain pre-assigned data.

7.14.5 The data elements in each order are in the following functional groups:

7.14.5.1 Those that identify the patient,

7.14.5.2 Those that identify the action or ancillary service,

7.14.5.3 Those that identify the orderer(s),

7.14.5.4 Those that control the timing or delivery of services, or both,

7.14.5.5 Those that describe the requested service and conditions of delivery,

7.14.5.6 Those that document the delivery of results, and

7.14.5.7 Those that are used for quality assurance.

7.14.6 The logical structure in Appendix X1 lists these data elements showing their structural relationships within the message and the data elements to which they may be related in other segments of the clinical record.

7.14.7 *Orderer Group of Data Elements*—The elements in this group provide a means of tracking the initiation and responsibilities for each order. At the same time, these steps must, many times, be started in the absence of a practitioner having adequate authority to fully initiate the procedure or service ordered. In hospitals, the actions of the nursing staff and health practitioner students or those in training may require review and validation by co-signing for services having major health or cost implications from the aspect of accountability. Institutional policy must provide the criteria for expeditious action in identifying services needing higher permission levels from the responsible staff; this two-tier approach allows actions to be initiated in a timely fashion but yet rescinded, if appropriate. Therefore, the data elements in this group identify the needed information applying to a wide variety of situations. Nevertheless, not all elements may apply in a given situation.

7.14.8 *Action/Ancillary Service Data Elements*—The elements in this group identify the action performers and the type and priority of the order.

7.14.9 *Order Content Data Elements*—This group of data elements conveys the explicit service/actions desired for the patient. It may include patient data extracted from other segments of the record, as required to conduct the services or to carry out the action. Each ancillary service or treatment site must be able to define the data which will be required in this group in order to be able to carry out the ordered actions. Such data requirements will be found in appropriate subordinate files and will control, by prompting, the construction of the text of the order to meet these requirements. Modifications to the order shall be appended to the original text while other data elements shall document the course of each modification.

7.14.10 *Result Group*— This group of data elements documents the delivery of the result data from the service or action, as appropriate, while the results themselves are stored separately in the appropriate segments of the record.

7.14.11 *Quality Assurance Group of Data Elements*—This group of data elements documents the circumstances of actions that are exceptions to the routine process for each ordered action or service. They assume that a process is evaluating the specific criteria for each clinical order in order to establish the regular bounds. Because healthcare must deal with the unexpected and the unusual, recording of events that are unusual because they are outside the bounds of routine experience in no way implies that they are not required for treatment. Rather, these data elements flag such events so that they can be easily recognized for review. That they were reviewed is also documented in order to ensure that significant findings are not overlooked.

7.14.12 *Orders and Alerts*—Clinical orders may be designed to interact with clinical decision support functions which generate alerts or reminders or both that offer interventions to the orderer by analyzing the order and comparing it to specific criteria such as patient physical status (for example, lab results), drug contraindications or other situations and notifying the provider so that a recommended modification may be considered. Specific data from CDS application may or may not be included in the record.

7.15 *Segment 11, Diagnostic Tests*—Significant details of tests performed aid the practitioner in the diagnosis, management and treatment of the patient. Documentation of the results from the clinical laboratory, radiology, nuclear medicine, pulmonary function and any other diagnostic examinations would be included. This segment contains the chronological list of all diagnostic tests ordered and conducted on the patient. The attribute data about each such test reference the order, problem list, appropriate physical exam or medication segments, or all of these that may relate to the monitoring of therapeutic interventions to either measure therapeutic effects or detect adverse affects. It should be remembered that the problem list, encounters and physical exam segments may, likewise, contain references to specific dates and types of tests that are associated with those problems, encounters or examinations and which help document the full implications of the meaning of such tests.

7.16 *Segment 12, Medications:*

7.16.1 A list of all long term medications and significant details on all medications prescribed or administered, or both, in the course of, or as a consequence of, an encounter or episode.

7.16.2 This segment contains data about the therapeutic chemical substances and treatments that have been prescribed as interventions in the disease process. All of the attributes of the order described in 7.14 are linked to this record by reference to the orders segment. Additional attributes provided by the pharmacist are also added to the record, including adverse affects reported in the history or the physical exam segments, or both. The problem list that identifies the problem being treated may also be referenced.

7.17 *Segment 13, Scheduled Appointments/Events*—This segment includes the list of planned or scheduled appointments that implement a treatment plan. It includes attributes that characterize the planned services, location and practitioners that constitute the plan.

7.18 *Segment 14—Encounters/Episodes :*

7.18.1 The concept of an encounter is usually defined to be a face-to-face session of the patient with a practitioner during which information about the patient's health status is exchanged. The encounter record should capture the facts relating to the events that took place—whether they occur in an inpatient setting or an ambulatory care environment. Certain information that characterizes the time, place and circumstances of the initiation of the encounter are first required. Then the information characterizing the patient's condition and reason for seeking care must be recorded. Next, the identification and characterization of the patient's problem(s), including referencing the encounter to the problem list must be included. Finally, the interventions ordered, the response to the actions performed, the departure condition and the required follow-up actions must be recorded, including a record of the

services rendered. Because the circumstances leading to an encounter may be as direct as inpatient rounds by the attending physician to emergency room care (for example, traumatically injured patients), the data collected in the encounter may vary from brief to extensive. The collected data may not include all data elements identified, if these elements are not applicable to a given encounter. The logical structure shown in Appendix X1, however, identifies the minimal essential data elements that may comprise the ambulatory portion of the encounter record.

7.18.1.1 A discussion of this segment must first explain that the pointer arrows leading from the identified data elements to a logical file mnemonic is intended to portray that element is represented in a lexicon. The lexicon has associated attributes that are not dependent upon the context of the term in the encounter record, and the recorded element is the index into this lexicon. This notation enables discussion of the complexity of interrelationships among data elements of the record that occur across and within segment boundaries. In order to reflect how the structure of the record parallels the practitioner's thought processes, these logical interrelations must be depicted using a generic convention and the data that are global to the individual encounter must be so identified in order to foster data independence wherever possible. This means avoidance of recording redundant data when that data are independent of the context. It also means using a key identifier or term to represent that invariant data which is stored in a logical list that can be referenced from within the context. This procedure avoids a common error in forms design in which specific instances, or data values, of a given data element are identified as separate data elements. A specific instance of a class name, for example, might be a specific drug or a unique lab test name. Use the above notation to convey membership in a lexicon name class.

7.18.2 *Segment 14A, Administrative/Diagnostic Summary:*

7.18.2.1 These are the data elements clarifying time/date, location, type and source of encounter or episode as they differ from information already contained in the related major segments (7.5-7.17). These should include the problems and the list of admitting and all other diagnoses which are a factor in the patients care during the specific episode or encounter and which should be added to the patient's problem list in 7.9.

7.18.2.2 This sub segment contains all of the data that characterizes the origin of the episode and the manner of arrival at the provider's facility, including the condition of the patient. It also summarizes the administrative conditions concerning the termination of treatment, excepting the disposition that is contained in 7.18.6.

7.18.3 *Segment 14B—Chief Complaint Present Illness/ Trauma Care*—This contains health/medical/nursing dental history reference to Section 8 and history of chief complaint and reasons why the patient came in for care. This will include a review of systems as appropriate to the individual case and reference Section 9 as described in 7.13. It also includes reported pre-hospital care of emergency patients and assessment of the nature of traumatic injury and the results of stabilizing interventions.

To illustrate: Chief complaint is listed in Table A1.1 Number 14001.A023 as "The reason for the episode/encounter and patient's complaint and symptoms reflecting his/her own perceptions of his needs. The history taking clinician then frames this in the History of Present Illness which is a statement of the current state of the patient's health at the time of the health history updating.

7.18.4 *Segment 14C, Progress Notes/Clinical Course:*

7.18.4.1 This includes the components that form an ongoing chronological picture and analysis of the clinical course of the patient during an episode or encounter. This segment is applicable for any healthcare setting. These elements serve as a means of communication and interaction between members of the healthcare team. They may also occur as narrative or flow sheets. They constitute the record of patient response to therapies, procedures and other events.

This segment includes the content of electronic communications between patient and providers that document response to treatment or observations or both sent to providers by patients through web portals or through personal health records or both.

7.18.4.2 This subsection contains all those data elements that characterize the clinical course of care and the condition of the patient. They will link to tests, therapies and procedures and will be represented by test or flow sheets.

7.18.5 *Segment 14D, Therapies:*

7.18.5.1 This includes significant details on all preventive or therapeutic, or both, services performed at the time of the episode or encounter or scheduled to be performed before the next episode or encounter. This subsection would not include any surgery performed in an operating room or that could be documented under either Segment 12 (7.16) or 7.18.6. Transfusions, physical, occupational, nursing, respiratory, rehabilitative and mental health therapies would be included.

7.18.5.2 These elements are recorded to characterize all of the conditions of non-medication therapy, and they represent interdisciplinary therapy programs and results.

7.18.6 *Sub Segment 14E, Procedures :*

7.18.6.1 This includes significant details on all procedures performed in an operating room for diagnostic, exploratory, or definitive treatment purposes.

7.18.6.2 This subsection contains data that characterizes those procedural events that accompany treatment of the patient, exclusive of laboratory phases of diagnostic procedures, which are recorded in Segment 11.

7.18.7 *Segment 14F, Disposition:*

7.18.7.1 This subsection identifies the circumstances under which the patient terminated the encounter or episode and includes data about the length of stay, condition of patient on disposition, recommended treatment and other information necessary for follow-up care.

7.18.7.2 This subsection contains that data that characterizes the conditions under which the encounter or episode was completed and the arrangements for appropriate follow-up either by the current or by other providers. It contains information needed to maintain continuity of care over several episodes or multiple encounters.

8. Alternative Views of the Logical Structure

8.1 The EHR requires content depth and retrieval flexibility. The proposed approach expands the idea of user specific data

views to reflect the range of content from sparse to highly detailed. A data view is a specific collection of a set of data to meet user needs. This practice poses a minimum essential data view and a longitudinal précis view. The basic structure of this guide is expressed through the segments, now being adapted to the current perspective of objects. Content vocabulary is being assembled into master tables. Users are expected to begin with the standard as framework, build on the basic minimum data view and draw from the many master tables to specify their unique EHR requirements. As noted earlier in this guide, standard data views (such as uniform hospital discharge data, standard home health data set, etc.) were collected and incorporated into Annex A1. Additional views serve as ongoing resources to this work. Table 5 is a list of minimum essential data content or a minimum data view. It is organized according to currently proposed objects. Note that data items are intended for all EHR record sites unless marked as "conditional." This allows the variance between outpatient and inpatient as with a surgical procedure case. The "conditional" notation applies when the related events occur.

8.2 Just as master tables are a way in which to develop vocabulary depth within a framework, the data views provide the window for flexibility within a unified framework. This approach builds from the original work in this guide. Because the notation for conveying a common reference logical structure for the EHR depicts only a selected view of the complex interrelationships among the data elements, many readers may feel that their perspective is not represented. The selection of the notation used in Section 7 involved many compromises in selecting a reference representation. This section attempts to rectify the omission of many other valid representations of the same elements and their relationships. Since it cannot be comprehensive, it fails in representing all views. It is intended as a guide to those whose view is not adequately depicted to provide an illustration that can be developed to represent their perspective. There are many aspects that are involved. One is selecting the grouping of data elements that captures the data about the care of a patient involved in the user's setting. Another is understanding how these data are used and whether there is colloquial vernacular involved and, if so, which data elements are affected. A third aspect is how these data are desired to be viewed. These views control how the index hierarchy represented in Section 7 would be transformed to logically represent the index priority desired. The notation of Section 7 groups certain elements together and links them together with pointer notation. A new view can represent these linkages differently by moving groupings and indexing using different key data elements that lead to the same logical outcome as Section 7. These new structures can be displayed differently but have the same logical implications.

8.3 Data views can represent unique care areas, subsets of the data to meet specific care needs and alternative displays of data. For instance, clinical flow sheets show the clinical results and treatments as a matrix (spreadsheet) in which the individual observations and treatment events are recorded in the bins of the matrix and the row and column labels identify the date-time and the variable.

8.3.1 The following are examples of alternative data views (**16**, **17**) :

8.3.1.1 Clinical flow sheets,

8.3.1.2 Focused patient assessment/physical/mental exam data set by specialty/setting,

8.3.1.3 Prevention: risk factor data sets (pediatric, adolescent, adult, geriatric),

8.3.1.4 Healthcare outcomes data sets: diabetes care, obstetrical care, low back pain care, hypertension, benign prostatic hypertrophy,

8.3.1.5 Long term care data set,

8.3.1.6 Mental health data set,

8.3.1.7 Clinical program/clinical specialty data set (for example, breast cancer screening/monitoring),

8.3.1.8 Standard data elements for hospital drug surveillance,

8.3.1.9 Electronic health record for anesthesiology data set,

8.3.1.10 Electronic health record for emergency care data set,

8.3.1.11 National Committee on Quality Assurance patient record data set,

8.3.1.12 Longitudinal précis, and

8.3.1.13 Nursing minimum data set.

8.4 The EHR needs to be a reliable source of patient information in which a consistent base content can be found regardless of care setting. Work has been done to reduce the initial minimum content data items to reflect the basic essential data that should be present in the EHR. In Table 5, the general list is noted. The proposed content reflects the minimum required to serve as a guide for developers and clinicians. This serves as a basic content foundation for EHRs (**15**).

8.5 *The Longitudinal Précis* —One common and important view of the EHR containing all data recorded about a patient is what has been termed the longitudinal précis, or, in other terms, the longitudinal health record or other synonyms. Management of chronic diseases; recognition of occupational illnesses; the outcome of traumatic injuries; the tracking of persons who have been exposed to environments later recognized as hazardous; and a ready synopsis of previous healthcare for each new practitioner who provides services to a patient, all are examples of the need for a longitudinal perspective. All of these uses require an accurate contiguous summary record of the significant events of care received by each individual. The goal of the longitudinal précis is to provide this integrated summary record. The first purpose of a longitudinal précis is to assist the clinical practitioner in assessment of the patient's past clinical problems by summarizing the documented primary data of the conditions that may be used in clinical judgments. It serves as a unified, coordinated, synopsis of the clinically significant genetic, environmental and clinical healthcare data and events aggregated over a person's lifetime.

8.5.1 *Properties of a Longitudinal Précis*—The salient facts from the original EHR should be assembled systematically, summarized, ordered by clinical importance and indexed to the original EHR. A longitudinal précis should be brief. Positive patient identification and significant sociodemographic data should begin the longitudinal précis. It should next summarize the patient's family history and genetic profile and should

include hereditary and familial disorders potentially harmful family events such as childhood abuse, alcoholism and drug abuse. The patient's past health history should include past and current illnesses and surgeries, ranked by clinical significance as well as significant care problems experienced as a result of illness, injury or other health altering events. The genetic profile should name the finding(s) of specific laboratory studies and, if it represents an uncommon condition, an expanded description as part of the display of data. The longitudinal précis should link any past environmental exposure with potential or observed health problems. Exposure to environmental stressors should be named and followed briefly by quantitative details of the exposure and any suspected or clinical sequel. The longitudinal précis should next catalog past clinical episodes and diagnostic studies in order to facilitate retrieval of specific data such as EKG or laboratory tests.

TABLE 5 Minimum Essential Data Set—EHR Data View for All Settings

Entities	Data Elements	Segments	Conditional Status
Patient		Segments I, II, III	Conditional (c) notation for designated items conditional to the event occurring
	Patient name		
	Universal patient health number		
	Record holding location ID		
	Date of earliest held entry		
	Date of latest held entry		
	Date-time of birth		
	Birthplace		
	Sex (gender)		
	Race		
	Ethnic group		
	Religion		
	Marital status		
	Education level		
	Occupation		
	Family member name		
	Family member relationship		
	Patient permanent address		
	Consent signed/admit agreement		
	Patient rights acknowledgment		
	Directive to physician (primary healthcare practitioner)		(c)
	Release of information for protected health information (PHI) action date		
	Type of record action		
	Person authorizing release		
	Payment source		
	Payer group number		
	Payer ID number		
	Principal payment sponsor		
	Address of principal sponsor		
Encounter		Segments XIII, XIV	...
	Date time encounter/admission		
	Treatment facility name		
	Encounter type		
	Episode ID		(c)
	Encounter diagnosis(es)		
	Disposition date time		(c)
	Disposition type (master table)		(c)
	Disposition destination		(c)
	Disposition patient instructions		
	Text of note/report		
	Authentication/signature		
Problem		Segment V	...
	Problem number(s)		
	Problem name		
	Problem date of onset		
	Problem current status		
	Problem name @ encounter		
	Problem name @ care/treatment or plan/order		
Order-Care/treatment plan		Segment IV	...
	Treatment Plan		
	Treatment Plan Id		(c)
	Date-time		
	Care/treatment plan (text)		
	Clinical order(s) (full text)		
	Date-time of order		
Provider		Segment IV	...
	Provider/practitioner name		
	Provider address		
	Provider type		
	Provider ID number		
	Provider agency ID code		
	Practitioner name		

TABLE 5 *Continued*

Entities	Data Elements	Segments	Conditional Status
	Practitioner's universal ID number		
	Practitioner's profession		
	Practitioner's address		
	Practitioner's current role		
	Practitioner's authentication (signature)		
	Admission/encounter surgeon	Segments XIVA	(c)
	Admission/encounter surgeon role		(c)
	Therapy perf practitioner		(c)
	Anesthesiologist/Nurse anesthetist		
Observation—History			
	Health history—previous illnesses	Segment VIII	
	History taking event date		
	Source of history—contact name		
	History relationship source to patient		...
	History—social (text)		
	Current habits/oral health practices (master table)		
Observation—Assessment/ Exams		Segment IX	(c)
	Date-time of exam		
	Health assessment/exam present illness/inj history		
	Exam review of systems (Master table)		
	Exam finding(s)		...
	Exam finding comment(s)		
	Patient generated functional health status (Master table)		
	Exam summary (text)		
Observations—Diagnostic Tests		...	...
	Test requested (Master table)	Segment XI	
	Test/exam/spec-collection date-time		
	Test request ordering treatment facility		
	Test request performing facility		
	Test date-time result reported		
	Test report text		
	Numeric measurement/analyte name		
	Numeric measurement analyte value		
	Numeric measure/analyze interpretation		
	Test request microbial organism		(c)
	Microrg attribut		(c)
	Microbiol org resist patt		(c)
	Microbiol org spec comment		(c)
	Test comments		(c)
Observation—Encounter/ episode detail		Segment XIV	...
	Chief complaint (text)		
	Reason for visit (Master table)		
	Clinical progress note date-time (text)		
	Clinical progress note (encounter)		
	Authenticator/signature		
Service Instance		Segment VI, XII, XIVD/E	...
	Immunization name (Master table)		
	Immunization date		
	Medication pres/ord odate time		
	Medication name (Master table)		
	Medication prescriber		
	Medication dose		
	Medication vehicle/form (table)		
	Medication route (table)		
	Medication freq		
	Medication instructions (text)		
	Medication date of last refill		(c)
	Medication notes, for example, patient response (text)		
	Name of therapy/service (Master table)		
	Therapy start date-time		
	Therapy finish date-time		
	Therapists response assessment (text)		(c)
	Therapists recommendations		(c)
	Operation date-time		(c)
	Post-op diagnosis (Master table)		(c)
	Operative procedure name (Master table)		(c)
	Anesthetic agent (Master table)		(c)
	Post anesthesia assessment		(c)
	Operation complications		(c)

8.5.1.1 A longitudinal précis should be current, updated in a cost effective manner, and be an integral part of the EHR. Although it is a secondary record, it will require the same confidentiality and privacy protection as episodic patient records. Table 6 shows a sample general logical view of the précis according to the objects and segment's sources.

8.5.2 *Minimum Content and Data Categories*—The order of the categories of data utilized from the EHR by the longitudinal précis should begin with sociodemographic data and a list of long-term major health problems/risk factors which may then be directly accessed by practitioners to determine access to the remaining record. To provide a comprehensive structure for the longitudinal précis it must have access to all segments identified for the EHR in Section 7 and must organize that information in groupings optimized for its synoptic function. Table 6 summarizes these logical associations.

8.5.3 *Implementation*— A longitudinal précis could be a separate computer-based document or it could be the front part of the original source EHR. While the first level of presentation should be condensed and brief, an expanded presentation of selected data must be possible. Dates of service and clinical diagnoses/problems should serve as indexes to detailed data existing either in the longitudinal précis or the EHR itself.

9. Viewing the EHR from an Object Perspective

9.1 The purpose of this section is to represent how the data structure and terminology representations relate to the conceptual content of the EHR and to illustrate how that implementation of content can best be managed. Concepts are represented as "Objects" and these are organized into models using principles discussed in Practice E2145. This section organizes the basic information segments that have been explained in Section 7 into major objects and then it presents an object conceptual content model. This object model of the EHR can be further related to those general models developed for data flow (messaging) aspects of the implementation of this EHR model, as used in individual healthcare enterprise information architectures. HL7 and ASC X12N standards develop the modeling of these messaging aspects.

9.2 *Overall Objects in the EHR and the Model of Its Conceptual Content*—The major conceptual objects in the EHR model were previously noted in Table 4 and Table 6 in earlier sections. These tables relate the objects to the data segments and this linkage is expanded in Table 7. The object and segment inter-relationships from Table 4, Table 6, and Table 7 are shown in Fig. 2 with respect to the Patient Care Scenario. Additional detailed relationships are depicted in Practice E1715.

TABLE 6 Content and Data Categories

Object	Category	EHR Segment
Patient	Socio-demographic	I
Encounter	Episode/encounter index	XIV
Problem	Diagnoses/problems	V
Orders	Most recent treatment plan	X, XIII
Provider	Provider/practitioner	IV
Observation	(Health status and prevention risk)	VII, IX
	Environmental exposures	VII
	Patient health history	VIII
	Diagnostic test results	XI
Medication profile	Immunizations	VI

TABLE 7 Objects of EHR

EHR Object	EHRSegment
Patient (demographic)	1
Health Condition/Problem list	5
Clinical Orders	10
Treatment Plan	10
Financial	3
Immunizations	6
Environmental Stressors	7
Health History	8
Examination	9
Observation/Measurements	11
Encounters	14
Appointments	13
Medications	12
Legal agreements	2
Practitioner	4

9.3 *The Place of the EHR Model in the Health Information Domain*—The place of the EHR E1384 Practice structural models that are contained here lie within the Conceptual Content dimension (that is, Conceptual Content/Implementation, Data Structure/Data Representation, Patient Care/Resource Management) of Health Informatics because they are implementation independent. The models are intended to represent the essential EHR concepts (objects and their characterizing attributes), their interrelationships (Structure) and their associated value sets (Representation). This affords the maximum opportunity for Suppliers who market these concepts in products and services to use the existing technology and then validate, with objective data, that their implementations meet the necessary requirements implied by these models. They can then verify that their specific product provides the behavior implied by the implementation-independent model given in this standard Practice. Because this model is implementation independent, it provides the means for educating healthcare professional disciplines in the meaning without the influence of a specific product or service in the market. It enables professional disciplines to concentrate on the role that these concepts play in the practice of their discipline and their contribution to improved healthcare outcomes. Because the EHR is used to capture the observations made about an individual, and the practitioner judgments based upon those observations with respect to health, it is THE seminal record in healthcare and provides basic data for clinical care, analysis and administration purposes. It is important to note that the notation for representing the concepts that comprise the EHR may be any of a number of conventions but whichever notation is used, that notation should NEVER change the concept meaning. Thus the notation conventions used in this document may be changed to convey the same concepts in a different convention for either the same or different purpose or the same or different audiences, as may be judged appropriately by the presenter, as long as the concept representations and inter- relationships remain unchanged from that given in this standard Practice.

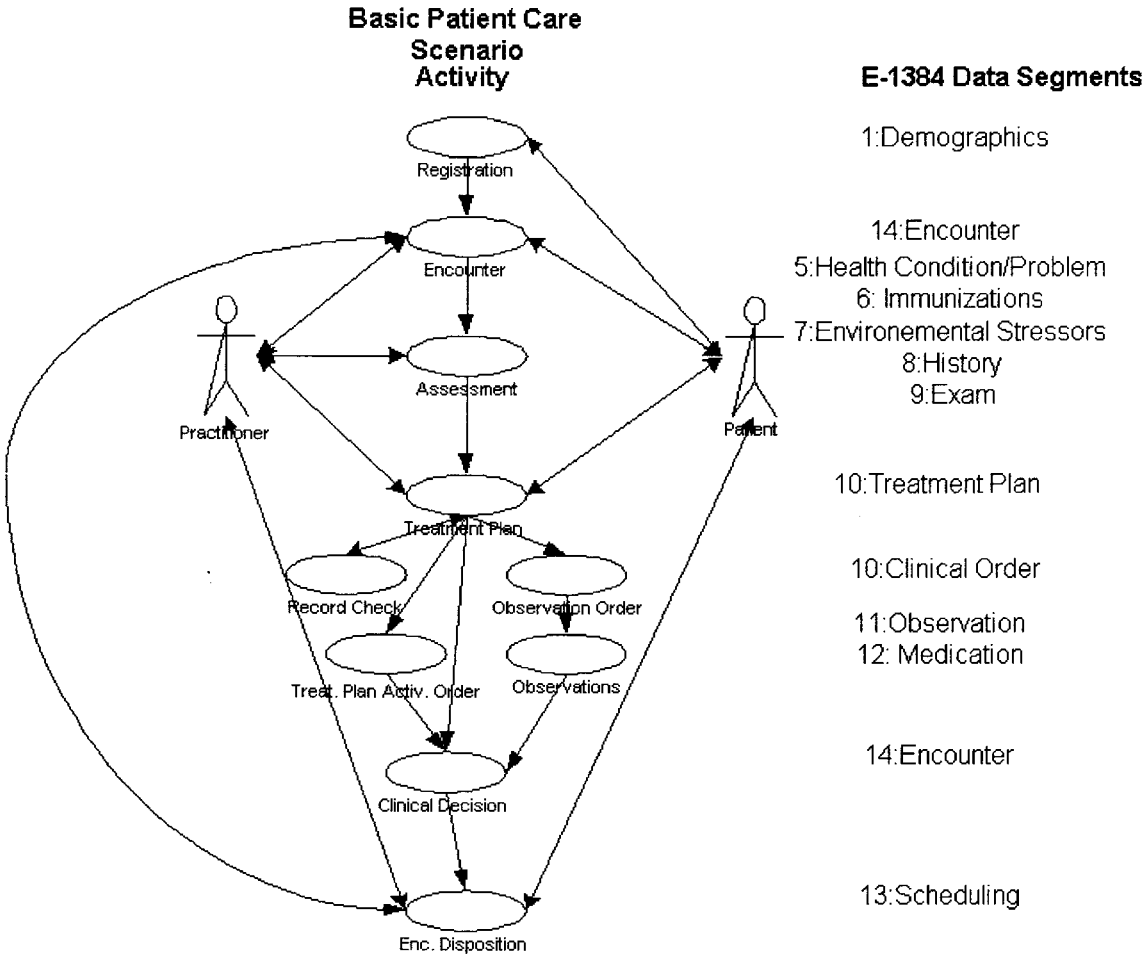

FIG. 2 Basic Patient Care Scenario Activity

9.4 *The Process of Patient Care that Uses the EHR Information*—A basic scenario for patient care that is setting-independent is shown in Fig. 2. The data objects given in Fig. 1 and the data segments given in Table 4 support this scenario. Note the cyclic nature of the process flow between Encounter receipt and Encounter Disposition. Depending upon the care setting and situation the detailed pathway may vary. Each of these processes is discussed in the following subsections.

9.4.1 *Registration*—The Registration (RADT) Process Model is given in Section 7 of Practice E1239, which also references the detail for the Master Patient Index subfunction. This process is common to all settings of care and it includes Admitting, Transfer and Discharge (ADT) for resident care settings; Reservation is another included ADT subfunction that is not only utilized in resident care settings for supporting the allocation of resources (such as rooms and beds but not limited to such resources) but also for non-resident care settings as well. Information architecture components that encapsulate this function can be appropriately invoked not only by EHR systems but also by supporting ancillary service modules that interoperate with EHR sub-functions. Practice E1239 develops a discussion of these interactions while CLSI LIS9A, as an example, places such interactions into a clinical laboratory service context while Practice E2538 deals with a pharmacotherapy context.

9.4.2 *Encounter*—The capture of attributes of each Encounter during its Receipt Phase and Disposition Phase, such as the data segment contents noted in Fig. 2, is covered in Practice E1715. These attributes characterize the nature of each healthcare event for an individual patient and the data are used collectively to understand the practice's patient population and the practice's mode of operation. Such encounter attributes, therefore, provide key reportable data that shape not only resource management but also healthcare policy.

9.4.3 *Assessment*—The Encounter Activity begins with assessment of the patient's health status and any new or continuing Health Conditions. The assessment includes an update of the Health History and an Examination which may result in attendant Clinical Orders for Diagnostic Test Procedures that produce explicit Observations/Measurements (note that measurements are observations having a magnitude). Once data has been collected completing the Assessment, the practitioner moves to the next step.

9.4.4 *Treatment Plan*—A Treatment Plan is often used in health care to outline the goals and objectives of treatment and the proposed treatment and may be a proposed alternative set of intervention actions based on the assessments of the patient's health status. The Treatment Plan may be the work of one individual or the work of several clinicians working as a team. Often the patient or client is part of the planning and agrees to take an active part in helping to achieve the objectives. The Treatment Plan contains specific actions which become the orders for treatment and it describes the intervention steps and those actions that enable health status to be monitored over time. It may include a series of phases, or sequential constellations of interventions that lead to a single intended target health status (outcome). Treatment Plan alternatives may be available. For example, a mental health client may agree to the objective of controlling his anger. One of the specific actions is to attend an anger management therapy group twice a week for the next 30 days. The specific action, that is, anger management therapy group twice a week is the "order for treatment." Treatment Plans are revised on a regular schedule. Treatment plans are typically designed according to the basic care setting. A Treatment Plan for a short hospital stay will be very focused on the target of recovery for discharge. In dental settings, the treatment plan is elected by the patient and practitioner jointly. In some settings the Plan may be a multidisciplinary treatment plan. For example, a Treatment Plan for a client who is mentally ill may cover a 90 day treatment span. At the end of the 90 days the Treatment Plan is evaluated. The Treatment Plan may be continued as is or modified based on the client's response to treatment. Organizations typically state who must sign a Treatment Plan. Some Treatment Plans contain multiple signatures - the clinician who put the plan together, the clinician empowered to order treatment, the patient/client. Each plan contains a series of associated Clinical Orders, which are action messages from the practitioner to the supporting ancillary clinical services that will contribute to the intervention. When a Treatment Plan is selected, the relevant Clinical Orders are then activated. Additional encounters may be scheduled as part of the overall iterative intervention process.

9.4.5 *Clinical Order*—A Clinical Order is an action directive to a supporting clinical service in, or contracted to, the healthcare enterprise that provides a specialty service to the practitioner for assessment or intervention activities that constitute the care process. It has several constituent sections that may or may not be applicable in a given instance. If maximum benefit is to result, each required clinical order attribute must be present in this directive and the Clinical Order creation process must ensure the presence of these required attributes.

9.4.6 *Observation*—An observation is the identifying of a characteristic of a patient and recording it as a persistent data item for the EHR. The scale of an observation determines whether it is a "measurement," which has magnitude. An "instrument" (such as a physical device) is one vehicle for capturing an observation and the activity may be either simple or complex. Classical observations are made from practitioner assessments as well as noted results of vital signs, lab results, etc.

TABLE 8 EHR Tag-Value Synoptic View

Tag Value Global Model of EHR			
Tag	T-V Sect	E1238/ HL7	E1384 Seg
<Patient>			
<Demogr>	Sect 6	PID	Seg 1
<Pers>			
<Pers></>			
<Alt-IND -Name></>	6.1		
<IND-ID></>			
<Emplyr></>			
<Rec-Loc></>			
<Citizenship></>			
<Occup></>			
<Fam Mbr></>			
<FamMbrGene></>			
<Prev-Addr></>			
<Date-Rec-Chg></>			
</Demogr>			
<Legal-Agr></>			
<Release-of-Rcd></>			
<Financial>			
<W-Comp Clm></>			
<Ins-Clm></>			
</Financial>			
<Prov/Pract>			
<Prov-ID></>			
<Pract>			
<Pract-Lic></>			
<Pract-Cert></>			
<Pract-Role></>			
<Pract-Loc></>			
</Pract>			
</Prov/Pract>			
<Hlth-Cond/Prob>			
<HCP-Status></>			
<HCP-Bdy Sys></>			
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<MonitorVariable></>			
</HCP-Enc>			
</Hlth-Cond/Prob>			
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</Immuniz>			
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<Env-Haz-Test></>			
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<Newborn></>			
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<Perinatal-Hist></>			
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<ResponseDate></>			
</Hlt-Hist-Resp>			
</Individual-Hist>			
</Hlth-Hist>			
<Exam-Date>			
<Exam-Finding></>			
<ExamHlthStatus-Element></>			
<Tooth>			
<Tooth-Surf></>			
<Planned-Proc></>			
</Tooth>			

TABLE 8 *Continued*

Tag Value Global Model of EHR			
Tag	T-V Sect	E1238/ HL7	E1384 Seg
<Prosthesis></>			
</Exam-Date>			
<C-Order>	Sect 8.2	(E1238/ HL7 ORC/ OBR)	Seg 11
<ResultAck></>			
<C-OrdSpecimen></>			
<Q-A-Warn></>			
<Q-A-Rev></>			
<C-Ord-Query></>			
<C-Ord-Results></>			
</C-Order>			
<Treat-Plan>			
<Treat-Tm></>			
<Treat-Phase>			
<Treat-Appt>			
<Treat-Appt-Proc></>			
</Treat-Appt>			
</Treat-Phase			
</Treat-Plan>			
<Meas-Obs-Dtm>	Sect 10	(E1238/ HL7 OBX)	Seg 11
<Meas-Obs>			
<Meas-Obs-Value></>			
<Microbiol></>			
</Meas-Obs>			
</Meas-Obs-Dtm>			
<Medication>			
<Medication Refil></>			
</Medication>			
<Sched-Visit></>			
<Encounter>			
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<Encounter-Rec Hlth Sta></>			
<Encounter-Rec-Diag></>			
<Encounter-Src-Pay></>			
</Encounter-Receipt>			
<Encounter-Activities>			
<Encounter-Consult></>			
<Encounter-Inp_transfer></>			
<Encounter Clin-status></>			
<Encounter-PreH-Equip></>			
<Encounter-PreH-Crew-Action></>			
<Encounter-PreH-Obs></>			
<Encounter-Burns></>			
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<Encounter-Intens-Care-Summ></>			
<Encounter-Patient Profile></>			
<Encounter-Diet-Chng></>			
<Encounter-Dischg-Obj></>			
<Encounter-ROS></>			
<Encounter-Sched-Tests/ Procs></>			
<Encounter-Pat-Instructions></>			

TABLE 8 *Continued*

Tag Value Global Model of EHR			
Tag	T-V Sect	E1238/ HL7	E1384 Seg
<Encounter-Rehab></>			
<Encounter-Food-Intake>			
<Food></>			
<Nutrient></>			
</Encounter-Food-Intake>			
<Encounter-Progress-Note></>			
<Encounter-Therapy>			
<Encounter-Therapy-Dtm>			
<Encounter-Therapy-Prod></>			
</Encounter-Therapy-Dtm>			
</Encounter-Therapy>			
<Encounter-Oper-Proc>			
<Encounter-Organ-Donor></>			
<Encounter-Oper-Meas></>			
<Encounter-Premedication></>			
<Encounter-Surgeon></>			
<Encounter-OR-Staff></>			
<Encounter-Blood></>			
<Encounter-Surg-Proc></>			
<Encounter-Oper-Specimen></>			
<Encounter-Anesthetic></>			
<Encounter-Oper-Event></>			
<Encounter-Extra-OR-Supplies></>			
<Encounter-Tourniquet></>			
</Encounter-Oper-Proc>			
</Encounter-Activities>			
<Encounter-Disposition>			
<Encounter-Surgeon></>			
<Encounter-Etiol></>			
<Encounter-Disp-Op-Proc></>			
<Encounter-Disp-Diag></>			
<Encounter-Disp-Hlt-Sta></>			
</Encounter-Disposition>			
<Encounter-Chg-Item></>			
</Encounter>			
</Patient>			

9.5 *A Tag Value Notation Statement of the EHR Model*—Because the EHR is the seminal document about attributes of the care that a patient receives, other standards have used Tag-value notation (directly translatable into XML syntax) in documenting the supporting and intersecting concepts of the healthcare ancillary services, this Practice also states the EHR record attributes in this notation. Table 8 gives the group structure of this notation while the full reflection of the attributes given in Annex A1 is given in Annex A2 with mapping to the concepts given in the HL 7 v2.x and X12N administrative concepts used for the PL-104-191 HIPAA datasets. Practice E1715 on RADT and Practice E1744 on the Emergency Medical Care View of the EHR have associated subsets. A Clinical Laboratory Tag-value subset has also been developed.

10. Electronic Health Record Data Dictionary Resource

10.1 Additional recommended data elements within each segment category specified by individual source data sets are listed in Appendix X1 that contains a repository of historical and evolving elements proposed for the record, including primary and longitudinal records from multiple sources. They are listed as a visual summary only to aid perception of the

complete pattern of the record. Each data element is also listed and further detailed with attributes in Annex A1, that is a part of this practice. The reader is again reminded that, though each data element characterization is a part of this guide, it is not required if it is not to be used but, if used, it must have the same meaning and representation as given in Annex A1. Only conformance to that caveat will ensure reliable communication of the same concept across boundaries of time, setting and language. Work is underway to develop the master tables content and vocabulary to support this guide.

11. Keywords

11.1 data type; data views; EHR principles; electronic health record; master table; objects; segments

ANNEXES

(Mandatory Information)

A1. ELECTRONIC HEALTH RECORD DATA DICTIONARY RESOURCE

TABLE A1.1 Electronic Health Record Data Dictionary Resource

01001.	**PERSON NAME**	PersName	Person receiving health care services and about whom records containing data about those services are collected. ASTM E1633 PARA 4.2.1
01002.	PREVIOUSLY REGISTERED NAME (1996)	PersPrevRegName	A last name changed due to marriage or initiated by patient; a former name; a maiden name. ASTM E1633 PARA 4.2.1
01005.	PARENTAL MARITAL STATUS	PtParentMaritalStatusCode	A term expressing the current legal status of a pediatric patient's parents. ASTM E1633 PARA 4.2.6 (5.2.2)
01007.	ADOPTED<	PtAdoptionStatusCode	A term identifying that the patient's recorded parents are not the biological ones who may be needed in establishing family pedigrees. ASTM E1633 PARA 5.1 (4.2.6)
01010.	ALTERNATE INDIVIDUAL NAME	PersAltName	A name added to, or substituted for, the proper name of a person. An assumed name. ASTM E1633 PARA 4.2.6
01010.1.	ALTERNATE INDIVIDUAL NAME USAGE	PersAltNmUsageCode	Category of usage of this alternate individual name. ASTM E1633 PARA 4.2.1
01010.2.	ALTERNATE INDIVIDUAL NAME START DATE	PersAltNmStartDtm	Date usage of this alternate individual name became effective. ASTM E1633 PARA 4.2.4
01010.3.	ALTERNATE INDIVIDUAL NAME END DATE	PersAltNmEndDtm	Date usage of this alternate individual name ceased to be effective. ASTM E1633 PARA 4.2.4
01015.	INDIVIDUAL IDENTIFIER	PtId	Unique number assigned by the provider to: 1) distinguish the patient and his/her medical record from all others in the institution, 2) facilitate retrieval of the record and 3) facilitate posting of payment. ASTM E1633 PARA 4.2.6
01015.1.	INDIVIDUAL IDENTIFIER ORGANIZATION	PtIDIssuingAgCode	Identifier or name of the organization issuing the individual identifier. ASTM E1633 PARA 4.2.6
01015.2.	INDIVIDUAL IDENTIFIER TYPE	PtIDTypeCode	Category of the individual identifier. ASTM E1633 PARA 4.2.6
01015.3.	INDIVIDUAL IDENTIFIER START DATE	PtIDStartDtm	Date the identifier became effective within the issuing organization. ASTM E1633 PARA 4.2.4

01015.4.	INDIVIDUAL IDENTIFIER END DATE	PtIDEndDtm	Date the identifier ceased to be effective within the issuing organization. ASTM E1633 PARA 4.2.4
01015.5.	INDIVIDUAL IDENTIFIER STATUS	PtIDStatusCode	Status of the identifier within the issuing organization. ASTM E1633 PARA 4.2.6
01015.6.	IDENTIFIER PRIVACY KEY	IDPrivacyCode	Key for denoting the recognition of this identifer. ASTM E1633 PARA 4.2.6
01016.	**UNIVERSAL PATIENT HEALTH NO.**	PtUniversalHealthNum	Permanent, unique number used by all providers and third party payors in conjunction with establishing and using the longitudinal record. It will link services for the individual across care systems. ASTM E1633 PARA 4.2.5
01020.	SOCIAL SECURITY ACCOUNT NO. SSAN	PersSSANCode	A pseudo social security no. may be assigned if patient does not have an SSAN. ASTM E1633 PARA 4.2.6
01025.	ARCHIVE LOCATION	PtRecordArchiveLocText	The locations of linked fragmented records; it also identifies permanent storage locations of inactive archived records. ASTM E1633 PARA 4.2.6
01027.	**RECORD-HOLDING LOCATION ID**	PtRecHoldLocationId	Code identifier of a healthcare site which maintains a primary record of care about this patient. ASTM E1633 PARA 4.2.6 (5.1)
01027.1.	**DATE OF EARLIEST HELD ENTRY**	PtEarliestEntryDtm	The least recent date within the record of a datum about the patient. ASTM E1633 PARA 4.2.4 (01027.1)
01027.2.	**DATE OF LATEST HELD ENTRY**	PtLatestEntryDtm	The most recent date within the record of a datum about the patient. ASTM E1633 PARA 4.2.4
01030.	LOCATION OF CHART	PtPaperChartLocText	Location of the paper chart or the location of automated MR (original location prior to unitization via linkage). ASTM E1633 PARA 4.2.6
01032.	**DATE-TIME OF BIRTH**	PersBirthDtm	The exact time of birth event; age is generated from DOB if needed; time can be included for newborns. ASTM E1633 PARA 4.2.4
01033.	**BIRTHPLACE**	PersBirthplaceText	The City, State, Nation where the patient's birth records may be found. ASTM E1633 PARA 4.26
01035.	NUMBER OF CHILDREN IN BIRTH	PtMultBirthQty	A term to distinguish identical individuals produced in the same gestation period. ASTM E1633 PARA 4.2.5 (5.2.23)
01036.		PtDelBirthOrderQty	Integer representing the sequential order of birth during the delivery. ASTM E1633 PARA 4.2.5
01037.	BIRTH ORDER	PtFamBirthOrderQty	The order of birth of the patient in a given family; #__of__ children(pediatric use) ASTM E1633 PARA 4.2.5 (1996)
01040.	**GENDER**	PersGenderCode	Distinction of gender. ASTM E1633 PARA 5.2.20
01042.	**RACE**	PersRaceCode	The region of the world from which the patient's ancestors came generally indicating possible inherited biologic diversity. ASTM E1633 PARA 5.2.3

01045.	**ETHNIC GROUP**	PtEthnicGroupCode	That cultural group with which the patient identifies him/herself either by means of recorded family data or personal preference. A patient may belong to several such groups depending upon heritage, language, nationality or social association. ASTM E1633 PARA 5.2.4
01047.	**RELIGION**	PtReligionCode	A term denoting the current religious affiliation of the patient at the start of care. A particular system of faith or worship. ASTM E1633 PARA 5.2.7
01050.	MILITARY SVC/VETERAN STATUS	PtMilSvcCode	A term indicating whether the patient is eligible for veteran or military supported care. Y/N ASTM E1633 PARA 5.1 (4.2.6)
01052.	**MARITAL STATUS**	PersMaritalStatusCode	Marital status of the patient at the start of care. NEVER MARRIED: includes annulment of only marriage. MARRIED: includes common law. SEPARATED: married persons living apart except institutionalized. WIDOWED: spouse died and not remarried. DIVORCED: legally divorced and not remarried. ASTM E1633 PARA 5.2.2
01055.	CITIZENSHIP STATUS	PersCitizenshipCode	Position or status of an inhabitant (enfranchised) of a country, as opposed to an alien. ASTM E1633 PARA 5.2.6
01055.1A.	CITIZENSHIP STATUS	CitizenshipStatusCode	Status of identified patient citizenship. ASTM E1633 PARA 5.2.6
01057.	PATIENT'S LANGUAGE	PtLanguageCode	A term indicating the language most frequently spoken by the patient in communicating with health care practitioners; if more than one language is spoken, record the frequency with which each one is used in the health care setting. ASTM E1633 PARA 5.2.5
01058.	INTERPRETER REQ	PtLangInterpreterReqCode	This code merely indicates whether a language problem exists or not. Y/N ASTM E1633 PARA 5.1 (4.2.6)
01060.	**EDUCATIONAL LEVEL**	PersEducationalLevelCode	The highest level, in years, within each major (primary, secondary, college, postbaccalaureate) education system, irrespective of any certifications achieved. ASTM E1633 PARA 5.2.9
01062.	CURRENT WORK STATUS	PtWorkStatusCode	A term indicating level of employment: employed-full-time, employed-part-time, not employed, retired. ASTM E1633 PARA 4.26
01065.	**OCCUPATION**	OccOccupationText	The employment, business, or a course of action in which the patient is engaged (i.e. ″student″) ASTM E1633 PARA 4.2.6
01065.1.	OCCUPATION STATUS CODE	OccOccupationStatusCode	A list in reverse chronological order of all of the occupations which the patient held prior to the current one. A person can be considered to have only one primary occupation at one time - namely that activity in which the greatest amount of the working day is spent. Professional activities may span many diverse areas. Therefore the most significant should be considered. The status code should therefore identify the current active occupation and those that have been completed as well as those that are dormant but could be reactivated. ASTM E1633 PARA 5.2.11

01065.2.	DATE COMPLETED OCCUPATION	OccCompletedOccupationDtm	The date that an occupation was terminated. ASTM E1633 PARA 4.2.4
01065.3.	OCCUPATION STANDARD INDUSTRIAL CODE	OccupationSICode	The classification of this patient occupation. ASTM E1633 PARA 4.2.6
01067.	CURRENT VOCATION	PtVocationsStatusCode	ASTM E1633 PARA 5.1 (4.2.6)
010069	PERMANENT IMPAIRMENT	PermImpairmentCode	Patient permanent impairment. ASTM E1633 para 4.2.6
01075.	PRESENT EMPLOYER NAME (1996)	EmplrPresentEmployerText	Name of workplace (organization) or employer's full name. That part providing a position (and compensation) for an employee. ASTM E1633 PARA 4.2.6
01077.	WORK ADDRESS	EmplrWorkAddressText	The address of the employer at which the patient spends most of his/her day or that which is the location through which he/she can be contacted during working hours. ASTM E1633 PARA 4.2.2
01080.	WORK (BUSINESS) PHONE	EmplrBusinessPhonePhN	Current work phone no. of patient or guarantor, if applicable. ASTM E1633 PARA 4.2.3
01085.	USUAL LIVING ARRANGEMENT	PtUsualLivingArrangCode	A code which denotes whether the patient lives alone or with whom. LEXICON ASTM E1633 PARA 5.2.27 (4.2.6)
01087.	NUMBER OF PERSONS IN HOUSEHOLD	PtNumberinHouseholdQty	A value, which does not include patient, that denotes the number of individuals living in the patient's household. ASTM E1633 PARA 4.2.5
01090.	**FAMILY MEMBER NAME**	FAMMbrName	The name of each family member. ASTM E1633 PARA 4.2.1
01090.02.	FAMILY MEMBER DATE-OF-BIRTH	FAMMbrBirthDtm	The date of birth of the family member. ASTM E1633 PARA 4.2.4
01090.03.	FAMILY MEMBER GENDER	FAMMbrGenderCode	The biologic sex of the family member. ASTM E1633 PARA 5.2.20
01090.05.	FAMILY MEMBER SSAN	FAMMbrSSANId	The Social Security Account Number for each family member. ASTM E1633 PARA 4.2.5
01090.07.	**FAMILY MEMBER RELATIONSHIP**	FAMMbrRelationshipCode	A term denoting the relationship of the family member to the patient. ASTM E1633 PARA 5.2.10
01090.09.	FAMILY MEMBER MALE PARENT	FAMMbrMaleParentName	The name of the biologic male parent of the patient to be used for family pedigrees. ASTM E1633 PARA 4.2.1
01090.11.	FAMILY MEMBER FEMALE PARENT MAIDEN NAME	FAMMbrFemaleParentName	The name of the biologic female parent of the patient to be used for family pedigrees. It is the full current name of a newborn infant's mother. ASTM E1633 PARA 4.2.1
01090.13.	FAMILY MEMBER SPOUSE NAME	FAMMbrSpouseName	The full maiden name of a female spouse and the current name of a male spouse of the patient. ASTM E1633 PARA 4.2.1
01090.15.	FAMILY MEMBER DATE-OF-DEATH	FAMMbrDeathDtm	The date of death of the family member. ASTM E1633 PARA 4.2.4
01090.17.	FAMILY MEMBER HEAD OF HOUSEHOLD	FAMMbrHeadofHouseholdCode	A code used for arranging health services and indicates which family member is the head of the patient's household. Only one individual should be so designated at any one time. ASTM E1633 PARA 4.2.6

01090.19.	FAMILY MEMBER PRIMARY CAREGIVER STATUS	FAMMbrPrimCaregiverCode	A code denoting whether this person either acts as, or could act as, the primary giver of care in the home setting. ASTM E1633 PARA 4.2.6
01090.21.	FAMILY MEMBER LOCATION	FAMMrLocationText	The location where the member resides during non-working hours. ASTM E1633 PARA 4.2.6
01090.23.	FAMILY MEMBER OCCUPATION	FAMMbrOccupationCode	The current occupation of the family member. ASTM E1633 PARA 5.2.11
01090.25.	FAMILY MEMBER MAJOR DIAGNOSIS/CAUSE OF DEATH	FAMMbrMajDiagDeathCode	A list of diagnosed major illnesses or injuries suffered by the family member during his lifetime. It is used for family linkage in inherited conditions. ASTM E1633 PARA 4.2.6
01090.27.	FAMILY MEMBER INHERITED GENE ID	FAMMbrInheritedGeneCode	The McKusick number of the phenotype (Mendelian Inheritance in Man 9th Ed Johns Hopkins Press 1990) ASTM E1633 PARA 4.2.6
01090.27.01.	FAMILY MEMBER INHERITED GENE EXPRESSION	FAMMbrGeneExpressionCode	A term indicating Mendelian expression (dominant, Recessive, sex-linked); it is somewhat redundant as the McKusik number range also provides this data. ASTM E1633 PARA 4.2.6
01090.27.02.	FAMILY MEMBER INHERITED GENE EXTENT-OF-EXPRESSION	FAMMbrGeneExprExtentQty	This is an expression of the percentage of the expression. ASTM E1633 PARA 4.2.5: A FRACTION IN TWO DIGITS
01095.	**PERSON PERMANENT ADDRESS**	PersPermanentAddressText	The usual residence and/or address of the patient as defined by the payor organization. May be referred to as the ″Mailing Address″. ASTM E1633 PARA 4.2.2
01096.	PATIENT PRIOR ADDRESS	PtPriorAddressText	Address prior to the current one at which the patient resided. ASTM E1633 PARA 4.2.2
01096.1.	PRIOR ADDRESS BEGIN DATE	PtPriorAddrBeginDtm	The date on which a previous residence commenced. ASTM E1633 PARA 4.2.4
01096.2.	PRIOR ADDRESS END DATE	PtPriorAddressEndDtm	The date that a prior residence terminated. ASTM E1633 PARA 4.2.4
01097.	PERSON COUNTY/CENSUS TRACT	PersAddressCntyCensusCode	A code used by the US Bureau of Census to specify a geographic area. ASTM E1633 PARA 4.2.6
01099.	FOREIGN RESIDENCY STATUS	PersForeignResidencyCode	A code designating whether the patient regularly maintains a foreign residency. ASTM E1633 PARA 4.2.6
01100.	PATIENT HOME PHONE	PersHomePhonePhN	The phone numbers of both permanent and temporary addresses. ASTM E1633 PARA 4.2.3
01105.	PERSON'S TEMPORARY ADDRESS	PersTempAddressText	The address of hotel, school or vacation residence May be referred to as ″local address″. ASTM E1633 PARA 4.2.2
01108.	PATIENT TEMPORARY ADDRESS PHONE	PersTmpAddrPhN	The telephone at the temporary address. ASTM E1633 PARA 4.2.3
01110.	EMERG. CONT. (REL/FR.)	PtEmergContName	Person to be notified, if needed. ASTM E1633 PARA 4.2.1
01112.	EMERG. CONT. RELAT.	PtEmergContRelationCode	A code denoting the relationship of the emergency contact to the patient. ASTM E1633 PARA 5.2.10
01115.	EMERG. CONT. ADDRESS	PtEmergContAddressText	The address of the person to contact in any emergency situation. ASTM E1633 PARA 4.2.2

01117.	EMERG. CONT. H. PHONE	PtEmergContHPhonePhN	The most appropriate phone number of the emergency contact person. ASTM E1633 PARA 4.2.3
01119.	EMERG. CONT. B. PHONE	PtEmergContBPhonePhN	The telephone at which the named emergency contact can be reached during working hours if the contact is at work during these hours. ASTM E1633 PARA 4.2.3
01120.	PATIENT GUARDIAN NAME	PtGuardianName	Name of legal guardian. ASTM E1633 PARA 4.2.1
01125.	PATIENT GUARDIAN ADDRESS	PtGuardianAddressText	The current mailing address of the patient guardian. ASTM E1633 PARA 4.2.2
01130.	PATIENT GUARDIAN STATUS	PtGuardianStatusCode	Court appointed guardian: individuals or corporations appointed by the court to manage some or all of the affairs of adults whom the court has found unable to manage for themselves and their affairs with ordinary prudence, or of minors whose parents are not available or who have been found unfit. Includes limited and plenary guardians.
01135.	LNOK NAME	PtLegNxtofKinName	A name in the nuclear family first, then followed by closest relative or friend. ASTM E1633 PARA 4.2.1
01137.	LNOK RELATIONSHIP	PtLegNxtofKinRelationCode	This code denotes the relationship of the legal next-of-kin to the patient. ASTM E1633 PARA 5.2.10
01140.	LNOK ADDRESS	PtLegNxtofKinAddressText	The address for the person named as the Next-of-Kin. ASTM E1633 PARA 4.2.2
01142.	LNOK HOME PHONE	PtLegNxtofKinHPhonePhN	The home phone of the legal next of kin. ASTM E1633 PARA 4.2.3
01145.	LNOK B. PH.	PtLegNxtofKinBPhonePhN	The main business phone number of the legal next of kin. ASTM E1633 PARA 4.2.3
01150.	R/L HANDED<	HandednessCode	A code representing the patient's handedness ASTM E1633 PARA 4.2.6
01155.	COLOR EYES	PtEyeColorCode	The normal eye color in absence of contact lenses or other eyewear. ASTM E1633 PARA 4.2.6
01160.	COLOR HAIR	PtHairColorCode	The normal undyed hair color of the patient. ASTM E1633 PARA 4.2.6
01165.	BLOOD TYPE	PtBloodTypeCode	The code of the patient's blood type as determined by a laboratory testing procedure. ASTM E1633 PARA 4.2.6
010167	IDENTIFICATION PHOTO	PatientIDPhoto	An image of the patient for aid in unequivocal identification. ASTM E1633 para 4.2.6
01170.	HEIGHT FOR IDENTIFICATION	PtHeightQty(To include birth lengths)	Vertical measurement of the body. This is the most recent measured height standing in bare feet. ASTM E1633 PARA 4.2.5
01175.	BUILD FOR IDENTIFICATION	PtPhysiqueBuildCode	A code denoting the major class of patient body build. ASTM E1633 PARA 4.2.6
01180.	WEIGHT FOR IDENTIFICATION	PtWeightQty	A measurement of body mass; the most recent value. ASTM E1633 PARA 4.2.5
01185.	PATIENT RECORD ACTIVITY STATUS	PtRecrdActivStatusCode	This is the activity status of the current record. ACTIVE/INACTIVE/ARCHIVED/DEAD. ASTM E1633 PARA 4.2.6

01190.	CONFIDENTIALITY PROTECTION	PtConfidentialityCode	A code to protect privacy of the patient, to include unwed mothers, celebrities, provider employees, psych/drug/alcohol patients. TEXT ASTM E1633 PARA 5.2.1
01195.	DATE REGISTR RECORD INITIATED/UPDATED	HCRegRecordUpdateDtm	The date on which a change is made to the demographic segment of the primary record of care. ASTM E1633 PARA 4.2.4
01195.02.	PERSON INITIATING/UPDATING	HCRegInitUpdatePersName	The name of a member of a list of persons who change or update the primary record of care. ASTM E1633 PARA 4.2.1
01197.	REGISTRATION REVIEW DATE	HCRegRegistrReviewDtm	The date when the registration record was reviewed by a responsible official for its accuracy. ASTM E1633 PARA 4.2.4
01200.	REGISTRATION INFORMANT	HCRegRegistrInformantName	The name of the individual who provided the registration data on the latest update. ASTM E1633 PARA 4.2.1
01205.	REGISTRATION COMMENT	HCRegRegistrCommentText	A text containing any additional information that relates to the registration process. ASTM E1633 PARA 4.2.6
01210.	DATE RECORD TRANSF TO STORAGE	HCRegRecordTranstoStorageDtm	The date on which the record is removed from working storage and sent to archival storage because of death, inactivity or other knowledge that the patient will not return to active status. ASTM E1633 PARA 4.2.4
01220.	DATE-TIME OF DEATH	DCertDeathDtm	The recorded date and time of the patient's death; in cases where death was unobserved it is the best estimate of such date and time. ASTM E1633 PARA 4.2.4
01225.	PLACE OF DEATH	DCertDeathPlaceText	That location where the patient actually expired. If a health care facility, give its name. If at home give the address. If in the field give a location including an approximate address, optional city, county, state, and nation. TEXT ASTM E1633 PARA 4.2.6
01227.	AUTOPSY STATUS	DCertAutopsyStatusCode	A code denoting whether an autopsy was conducted after the patient's death. Y/N. ASTM E1633 PARA 4.2.6
01230.	RECORDER OF DEATH	DCertDeathRecorderName	The name of the person recording the patient's death. A physician must certify the patient's death. ASTM E1633 PARA 4.2.1
01235.	DATE DEATH RECORDED	DCertDeathRecordedDtm	The date that the patient's death was actually recorded, as differentiated from the time of its occurrence. ASTM E1633 PARA 4.2.4
01240.	DEATH CERTIFICATE NO.	DCertText	The state-of-death's actual identifier of the death certificate. ASTM E1633 PARA 4.2.5
01245.	STATE DEATH CERTIF RECORDED	DCertRecordeStateCode	The name of the state in which the death is actually recorded.
01250.	CAUSE OF DEATH	DCertDeathCauseCode	A list of codes or terms which together best describe either the immediate or the ultimate cause of death. LEXICON
01251.	UNDERLYING CAUSE OF DEATH (M)		Hospital Association: used only cause of death and did their own analysis without using traditional vital statistics methods and concluded that hospital discharge abstracts were sufficient information. APHSIS does not agree)

01255.	PATIENT'S MORTUARY PREF	DCertPtMortuaryPrefText	The stated preference, when known, of a terminally ill patient. It is noted in order to allow arrangements to be made on behalf of the survivors, should they not be available. ASTM E1633 PARA 4.2.6
01260.	BEREAVEMENT ASSESSMENT	PtBereavementAssessText	Textual assessment of the bereavement situation for this individual. ASTM E1633 PARA 4.2.6
01262.	CLERGYMAN'S NAME	PtClergymanName	The name of the patient's identified clergyman at the time of admission to a hospital or inpatient facility. ASTM E1633 PARA 4.2.6
01265.	CLERGYMAN'S ADDRESS	PtClergymanAddressText	The mailing address of the patient's clergyman. ASTM E1633 PARA 4.2.2
01267.	CLERGYMAN'S PHONE	PtClergymanPhonePhN	The telephone number at which the clergyman is most likely to be reached. ASTM E1633 PARA 4.2.3
02001.	**CONSENT SIGNED/ADMIT AGREEMENT**	CAgrmntPtSig	Patient indicates in writing that (s)he has been informed of the nature of the treatment, risks, complications, alternative forms of treatment and treatment consequences. TEXT ASTM E1633 PARA 4.2.7 (new) 4.2.6
02005.	**PATIENT RIGHTS ACKNOWLEDGEMENT**	CAgrmntPtRightsAcknSig	A text stating the patient's understanding of his/her rights and the rights associated with the information in the record of care. TEXT ASTM E1633 PARA 4.2.7 (new) 4.2.6
02010.	AUTHORITY FOR AUTOPSY	CAgrmntAutopsyAuthName	The name of the individual authorizing an autopsy. ASTM E1633 PARA 4.2.1
02015.	RELEASE OF BODY TO MORGUE	CAgrmntRelBodyMorgueText	Written notice that the body has been taken to the morgue. ASTM E1633 PARA 4.2.6
02020.	CONSENT FOR VIDEOTP/OBSERV	CAgrmntObsAgrmntText	The text of the agreement signed by the patient consenting to observation or videotaping. Text ASTM E1633 PARA 4.2.6
02025.	CONSENT TO RSCH PARTIC	RSCHAgrmntConsentText	A text agreeing to experimental therapies. Text ASTM E1633 PARA 4.2.6
02030.	**DIRECTIVE TO PHYSICIAN**	CAgrmntPhysDirectiveText	A living Will written by the patient to the physician in case of incapacitation to giver further instructions. Text ASTM E1633 PARA 4.2.6
02040.	ORGAN DONOR AGREEMENT	ORGDonorAgrText	An agreement text. Text should include: Donor Pt name (Transplant Recipient) Donor Pt no. (Transplant recipient) Recipient Pt no. (Transplant donor) Recipient Pt name (Transplant donor) Text ASTM E1633 PARA 4.2.6
02045.	COURT-ORDERED CARE	CAgrmntCourtOrderCareText	A description of care received by a child or adult as a result of a court order. ASTM E1633 PARA 4.2.6
02050.	LIVING WILL DESIGNEE	CAgrmntLivingWillText	Text of the Living will including identified individuals. ASTM E1633 PARA 4.2.6
02052.	DURABLE POWER-OF-ATTORNEY STATUS	PtDurPAttStatusCode	A code representing the values for the legal state of a Durable Power of Attorney. ASTM E1633 PARA 4.2.6
02053.	DURABLE POWER OF ATTORNEY FOR HEALTH CARE STATUS	PtDurHPAttStatusCode	A code representing the values for the legal state of a Durable Power of Attorney for health situations. ASTM E1633 PARA 4.2.6

02055.	POWER OF ATTORNEY NAME	PtPAttName	The full name of the individual acting as a Power of attorney for the patient. ASTM E1633 PARA 4.2.1
02056.	DURABLE POWER OF ATTORNEY FOR HEALTH CARE NAME	PtDurHPAttName	The full name of the individual acting as a Power of attorney for the patient for health situations. ASTM E1633 PARA 4.2.1
02057.	POWER OF ATTORNEY ADDRESS	PtPAtAddrText	The legal address of the individual acting as a Power of attorney for the patient. ASTM E1633 PARA 4.2.2
02058.	DURABLE POWER OF ATTORNEY FOR HEALTH CARE ADDRESS	PtDurHPAttAddtText	The legal address of the individual acting as a Power of attorney for the patient for health situations. ASTM E1633 PARA 4.2.2
02060.	POWER OF ATTORNEY PHONE	PtPAttPhonePhN	The telephone number of the individual acting as a Power of attorney for the patient. ASTM E1633 PARA 4.2.3
02061.	DURABLE POWER OF ATTORNEY FOR HEALTH CARE PHONE	PtDurHPAttPhn	The telephone number of the individual acting as a Power of attorney for the patient for health situations. ASTM E1633 PARA 4.2.3
02100.	**REL OF INFO RECRD ACT DATE**	RELINFRcrdRecordActionDtm	The date of each instance when any data from the patient record is released to other than authorized persons caring for the patient. ASTM E1633 PARA 4.2.4
02100.02.	**TYPE OF RECORD ACTION**	RELINFRcrdRelActTypeCode	A code that identifies the type of action involved in the release of information from the patient's record. ASTM E1633 PARA 4.2.6
02100.04.	REL OF INFO TYP OF INFO	RELINFRcrdInforTypeCode	A code that identifies the type of information released. ASTM E1633 PARA 4.2.6
02100.06.	REL OF INFO PERS RELEASING	RELINFRcrdReleasPersName	The name of the person who released information from the patient's record. ASTM E1633 PARA 4.2.1
02100.08.	REL OF INFO RELEASED TO	RELINFRcrdPersRelToName	The name of the person to whom the information from the patient's record was released. ASTM E1633 PARA 4.2.1
02100.10.	REL OF INFO PURPOSE	RELINFRcrdRelPurposeText	A text describing the purpose for which the released information will used. ASTM E1633 PARA 4.2.6
02100.12.	**PERSON AUTHORIZING RELEASE**	RELINFRcrdPersAuthRelName	The name or identifier of the individual authorizing the release of the type of information. ASTM E1633 PARA 4.2.1
03001.	WORKMANS COMP CLAIM DATE	WCClmClaimDtm	A narrative of the recorded claims for worker compensation, including data time, location, employer. ASTM E1633 PARA 4.2.4
03001.1.	WORKMANS COMP CLAIM NO.	BILLSvcsWrkCmpClaimId	The identifier string for a claim submitted under workman's compensation. ASTM E1633 PARA 4.2.6
03005.	INSURANCE CLAIM DATE	HCClmClaimDtm	The date of a recorded insurance claims for the patient. ASTM E1633 PARA 4.2.4
03005.02.	INSURANCE CLAIM ID	HCClmClaimId	The unique identifier for each insurance claim. ASTM E1633 PARA 4.2.6
03010.	**PAYMENT SOURCE**	HCClmPrimaryPaySourceCode	Responsible for largest % of patient's current bill. May include address. ASTM E1633 PARA 4.2.6, 5.2.21
03010.02.	PRIMARY PAYMENT CLASS	HCClmPrimaryPayClassCode	A code representing the class of payment. ASTM E1633 PARA 4.2.6

03010.04.	**PAYOR GROUP NO.**	HCClmPayorGroupId	An identification number, control no., or code assigned by the carrier or administrator, to identify the group under which the individual is covered. ASTM E1633 PARA 4.2.6
03010.06.	**PAYOR ID NO.**	HCClmPayorPolicyId	The identifier of the patient's insurance policy. ASTM E1633 PARA 4.2.5
03010.08.	**PAYMENT SPONSOR**	HCClmPaySponsorName	The name of the person responsible for bill or whose insurance plan provides coverage for the patient. ASTM E1633 PARA 4.2.1
03010.10.	**ADDRESS OF SPONSOR**	HCClmPaySponAddrText	The mailing address of the principal payment sponsor. ASTM E1633 PARA 4.2.2
03010.12.	PAYOR PRIORITY	HCClmPayorPriorityCode	The value indicating the sequence of priority of payors; it is an ordinal number. ASTM E1633 PARA 4.2.6
03017.	MEDICARE TO YR	ACCPtMedicareToYrDtm	The current terminal date for patient coverage under Medicare. ASTM E1633 PARA 4.2.4
03020.	MEDICARE A EFFECT. DATE	ACCPtMedicareAEffectDtm	The date that Part A of Medicare became effective for the patient. ASTM E1633 PARA 4.2.4
03022.	MEDICARE B EFFECT. DATE	ACCPtMedicareBEffectDtm	The date that Part B of Medicare became effective for the patient. ASTM E1633 PARA 4.2.4
03030.	BILLING ACCOUNT NO.	ACCPtBillingId	The identifier of the patient business account. ASTM E1633 PARA 4.2.6
04001.	**PROVIDER/PRACTITIONER NAME**	HCPrvProviderName	The name of the facility or practice submitting a bill. May be the same as practitioner name. (A business entity which furnishes health care). ASTM E1633 PARA 4.2.1
04001.01.	PROVIDER GROUP/ORGANIZATION TITLE	HCProvProviderOrgTitleText	The formal title of the organization or provider group. ASTM E1633 PARA 4.2.6
04001.03.	**PROVIDER ADDRESS**	HCPrvProviderAddressText	The complete address to which the provider wishes the payment sent. ASTM E1633 PARA 4.2.2
04001.05.	**PROVIDER TAXONOMY CATEGORY**	HCPrvProviderTypeCode	The code indicating the category of health care setting or practice type. Includes routine home care, respite, inpatient care, acute inpatient care, bereavement follow-up outpatient laboratory, short stay, etc. ASTM E1633 PARA 4.2.6
04001.07.	**PROVIDER ID NO.**	HCPrvProviderId	The numbers assigned by various payor agencies(e.g. Medicare, Medicaid, BlueCross/Blue Shield federal Tax no. (assigned by Federal Govt for tax report purposes). ASTM E1633 PARA 4.2.6
04001.07.01.	**PROVIDER AGENCY ID NUM**	HCPrvAgencyIDCode	The agency associated with this unique identifier of this provider ASTM E1633 PARA 4.2.6
04001.10.	**PRACTITIONER NAME**	HCPractPractitionerName	The name of the practitioner, structured in common person name format. ASTM E1633 PARA 4.2.1
04001.12.	PRACTITIONER SSAN	HCPractSSANId	The Social Security Account Number Identifier of the practitioner as a generic identifier code. ASTM E1633 PARA 4.2.5

04001.15.	PRACTITIONER'S NATIONAL PROVIDER IDENTIFIER	HCPractUniversalPractId	The universal numeric identifier which will be used to link services for a provider across care systems. A providers/practitioners will each have a unique number that identifies the practitioner from all others and is the same for the practitioner in all settings where he/she may practice. ASTM E1633 PARA 4.2.6
04001.20.	**PRACTITIONER'S PROFESSION/OCCUPATION/ SPECIALTY**	HCPractProfessionCode	The profession in which the practitioner is currently engaged. ASTM E1633 PARA 4.2.6, 5.1.16
04001.25.	**PRACTITIONER'S ADDRESS**	HCPractAddressText	The usual or principal place of practice. ASTM E1633 PARA 4.2.2
04001.30.	PRACTITIONER'S PHONE	HCPractPhonePhN	The number where the practitioner may most frequently be reached. ASTM E1633 PARA 4.2.3
04001.31.	PRACTITIONER'S FAX PHONE	PractFaxPhonePhN	Telephone attached to a FAX machine. ASTM E1633 PARA 4.2.3
04001.32.	PRACTITIONER'S E-MAIL ADDRESS	PractEMailAddrText	The electronic mail address string for the practitioner's office. ASTM E1633 PARA 4.2.2
04001.35.	PRACTITIONER'S LICENSE CATEGORY	HCPractLicenseId	The license identifying no. and state for the license authorizing the practitioner to practice. ASTM E1633 PARA 4.2.6
04001.35.01.	PRACTITIONER LICENSING STATE	HCPractLicenseStateCode	The code for the state of the practitioner's license. ASTM E1633 PARA 4.2.6
04001.35.02.	PRACTITIONER LICENSE CODE	HCPractLicenseCode	The code identifying the nature of the practitioner's license. ASTM E1633 PARA 4.2.6
04001.35.03.	PRACTITIONER LICENSE NUMBER	HCPractLicenseId	Identifier of the practitioner's license. ASTM E1633 PARA 4.2.6
04001.35.04.	PRACTITIONER LICENSE EFFECTIVE DATE	HCPractLicenseEffDtm	Time and date the license is effective. ASTM E1633 PARA 4.2.6
04001.35.05.	PRACTITIONER LICENSE EXPIRATION DATE	HCPractLicenseExpDtm	Time and Date the License expires. ASTM E1633 PARA 4.2.6
04001.35.06.	PRACTITIONER LICENSE TERMINATION DATE	HCPractLicenseTermDtm	Time and date license was terminated or expired. ASTM E1633 PARA 4.2.6
04001.40.	PRACTITIONER CERTIFICATION CATEGORY (M)	HCPractCertCatCode	The abbreviation for the state holding the practitioner's license. ASTM E1633 PARA 4.2.6
04001.40.1.	CERTIFICATION NUMBER	HCPractCertId	Identifier of Practitioner Certification. ASTM E1633 PARA 4.2.6
04001.40.2.	CERTIFICATION EFFECTIVE DATE	HCPractCertEffDtm	Time and Date Certification was effective. ASTM E1633 PARA 4.2.6
04001.40.3.	CERTIFICATION EXPIRATION DATE	HCPractCertExpDtm	Time and Date the Certification expires. ASTM E1633 PARA 4.2.6
04001.40.4.	CERTIFICATION TERMINATION DATE	HCPractCertTermDtm	Time and Date the Certification was terminated or expired. ASTM E1633 PARA 4.2.6
04001.40.5.	CERTIFICATION CODE	HCPractCertCode	Code identifying the nature of the Practitioner Certification. ASTM E1633 PARA 4.2.6
04001.40.6.	CERTIFICATION BOARD	HCPractCertBoardId	Identifier of the Certifying Board. ASTM E1633 PARA 4.2.6
04001.45.	PRACTITIONER CURRENT ROLE	HCPractCurrentRoleCode	The role (primary care practitioner, physician, consultant etc.) that the practitioner plays with this patient. ASTM E1633 PARA 4.2.6

04001.45.01.	PRACTITIONER DATE ROLE BEGAN	HCPractRoleBeganDtm	The date that this particular role was assumed by the practitioner for this patient. ASTM E1633 PARA 4.2.4
04001.45.02.	PRACTITIONER DATE ROLE ENDED	HCPractRoleEndedDtm	The date that this particular role by the practitioner has ended. ASTM E1633 PARA 4.2.4
04001.50.	PRACTITIONER SPECIALTY	HCPractSpecialtyCode	The particular branch of medicine, dentistry or surgery; by virtue of advanced training certifies individual to be qualified to so limit his/her practice. ASTM E1633 PARA 5.2.16
04001.50.		HCPractLocCode	Identifier of the Location where the Practitioner practices. ASTM E1633 PARA 4.2.6
04001.50.1.	DATE LOCATION EFFECTIVE	HCPractLocEffDtm	ASTM E1633 PARA 4.2.4
04001.50.2.	DATE LOCATION TERMINATED	HCPractLocTermDtm	ASTM E1633 PARA 4.2.4
04001.50.3.	LOCATION CODE	HCPractLoc	
04001.60.	**PRACTITIONER ELECTRONIC SIGNATURE**	HCPractPractitionerSig	The electronic signature of the practitioner. ASTM E1633 PARA 4.2.7
05001.	**PROBLEM NUMBER**	PHProbId	The problem identifier for this unique problem. Note: a systematic procedure for assigning these numbers across all practitioners has not been agreed upon. For the present, it should be considered a sequential integer number. ASTM E1633 PARA 4.2.6
05001.01.	**PROBLEM NAME**	PHProbTitleText	A term uniquely identifying the nature of the problem. ASTM E1633 PARA 4.2.6
05001.02.	PROBLEM CLINICAL INDICATION	PHProbIndicText	The reason for establishing a separate problem; the reason may be either a diagnosis or a pattern of symptoms. TEXT ASTM E1633 PARA 4.2.6
05001.03.	**PROBLEM ESTD DATE OF ONSET**	PHProbProbOnsetDtm	The estimated date that the problem first occurred. ASTM E1633 PARA 4.2.4
05001.05.	PROBLEM CAUSE/ETIOL.	PHProbCauseCode	The underlying disease, external cause, etc. ASTM E1633 PARA 4.2.6
05001.07.	PROBLEM DATE RECORDED	PHProbRecordedDtm	The date at which the problem was actually entered into the record. ASTM E1633 PARA 4.2.4
05001.09.	PROBLEM DIAGNOSIS	PHProbDiagnosisText	The term naming the established diagnosis for this problem. ASTM E1633 PARA 4.2.6
05001.10.	PROBLEM DATE DIAGNOSED	PHProbDiagnosisDtm	The date that the problem was clinically recognized. ASTM E1633 PARA 4.2.4
05001.12.	PROBLEM PROVIDER ASSIGNING DIAGNOSIS	PHProbDiagAssProvName	The name or identifier of the practitioner who assigns the diagnosis or recognizes the problem. ASTM E1633 PARA 4.2.1
05001.13.	PROBLEM, FACILITY WHERE DIAGNOSIS ASSIGNED	PHProbDiagFacId	The identifier of the facility at which the practitioner assigning the diagnosis for this problem conducts a practice. ASTM E1633 PARA 4.2.6
05001.15.	PROBLEM DATE RESOLVED	PHProbProbResolvedDtm	The date that this particular problem is considered resolved and no longer needs active consideration. ASTM E1633 PARA 4.2.4
05001.17.	PROBLEM RESPONSIBLE PRACTITIONER	PHProbResponPractName	The practitioner currently responsible for this problem.

05001.20.	**PROBLEM CURRENT STATUS**	PHProbStatusCode	The activity category of the problem e.g. Active,Inactive. ASTM E1633 PARA 4.2.6
05001.20.01.	PROBLEM DATE OF STATUS	PHProbStatusDtm	The date that the status code was assigned. ASTM E1633 PARA 4.2.4
05001.22.	PROBLEM SUBJECTIVE DATA	PHProbSubjectiveText	The textual synopsis of the subjective (e.g. symptoms) data for this problem. ASTM E1633 PARA 4.2.6
05001.23.	PROBLEM RANK	PHProbRankQty	Current numerical rank of importance for this patient problem. ASTM E1633 PARA 4.2.5
05001.25.	PROBLEM OBJECTIVE DATA	PHProbObjectiveText	The plain text description of the findings of examination by the practitioner. ASTM E1633 PARA 4.2.6
05001.30.	PROBLEM BODY SYSTEM	PHProbROSBdySysCode	The category name of the principal body system for this problem. ASTM E1633 PARA 5.2.22
05001.30.01.	PROBLEM BODY SYSTEM REVIEW TEXT	PHProbROSBdySysText	The textual summary text stating the status of the named body system.
05001.32.	PROBLEM ENCOUNTER DATES	PHProbEncDtm	The date of an encounter at which this problem was considered. ASTM E1633 PARA 4.2.4
05001.32.01.	PROBLEM MONITORING VARIABLE	PHProbMonitorVarCode	The measured parameter or variable to be monitored for tracking this problem. ASTM E1633 PARA 4.2.6
05001.32.01.01.	PROBLEM PARAMETER VALUE	PHProbParamValueQty	This value is the numeric continuous value of the indicated parameter. ASTM E1633 PARA 4.2.5
05001.35.	PROBLEM ASSESSMENT	PHProbAssessText	A statement of the problem current situation. TEXT ASTM E1633 PARA 4.2.6
05001.40.	PROBLEM PLAN	PHProbPlanText	Text describing the plan for dealing with this patient problem. TEXT ASTM E1633 PARA 4.2.6
05001.41.	PROBLEM TREATMENT PLAN ID	PHProbTrtPlId	Identifier of the Treatment Plan relating to this Health Condition/Problem. ASTM E1633 PARA 4.2.6
05001.45.	PROBLEM ORDERS	PHProbOrdersId	The codes that identify the orders in segment 10 of the record. ASTM E1633 PARA 4.2.6
06001.	**IMMUNIZATION NAME**	ImmText	The name or identifier of the immunization procedure conducted. ASTM E1633 PARA 4.2.6
06001.01.	**IMMUNIZATION DATE**	ImmDtm	The date the immunization procedure was conducted. ASTM E1633 PARA 4.2.4
06001.01.01.	IMMUNIZATION DOSE NUMBER IN SERIES	ImmDoseQty	The amount of immunizing agent administered. ASTM E1633 PARA 4.2.5
06001.01.02.	IMMUNIZATION BATCH (1996)	ImmBatchId	The identifier of the batch of an agent used to induce immunity. ASTM E1633 PARA 4.2.6
06001.01.03	IMMUNIZATION MANUFACTURER	ImmBatchMfrId	Identifier of the batch if immunizing agent. ASTM E1633 PARA 4.2.6
06001.01.04.	IMMUNIZATION EXPIRATION DATE	ImmBatchExpDtm	ASTM E1633 PARA 4.2.4
06001.01.05.	IMMUNIZATION LOT NO.	ImmLotIdCode	The individual lot number of the batch of an agent used to induce immunity. ASTM E1633 PARA 4.2.6 (1996)
06001.01.10.	IMMUNIZATION NUMBER OF UNITS	ImmUnitsQty	ASTM E1633 PARA 4.2.5

06001.01.11.	IMMUNIZATION INJECTION SITE	ImmInjSiteId	Body site where immunizing agent was injected. ASTM E1633 PARA 4.2.6
06001.01.12.	IMMUNIZATION ADMINISTERING TREATMENT FACILITY	ImmFacilId	The name or identifier of the treatment facility administering the agent. ASTM E1633 PARA 4.2.6
06001.01.15.	IMMUNIZATION REACTION/RESULT	ImmReactOrResultCode	Text describing the result of the immunization and any adverse reaction. ASTM E1633 PARA 4.2.6
06001.01.17.	IMMUNIZATION SEVERITY (1996)	ImmReactSevCode	A term classifying the severity of the reaction. ASTM E1633 PARA 4.2.6
06001.01.20.	IMMUNIZATION REMARKS	ImmRemarksText	Text amplifying the observations associated with the immunization procedure. ASTM E1633 PARA 4.2.2 (4.2.6)
06001.01.25.	PRACTITIONER IMMUNIZATION ADMINISTERING	HCPractPractitionerName	The name of the practitioner, structured in common person name format. ASTM E1633 PARA 4.2.1
07001.	HAZARDOUS AGENT NAME	EStrAgentText	The name or identifier of the environmental stressor. ASTM E1633 PARA 4.2.6
07001.01.	HAZARD TOTAL LIFETIME EXPOSURE	EStrTotLifeExpQty	The collective total lifetime exposure of the patient to this agent. ASTM E1633 PARA 4.2.5
07001.03.	HAZARD UNIT OF EXPOSURE (1996)	EStrUnitExpCode	The units of lifetime exposure in SI units. ASTM E1633 PARA 4.2.6
07001.05.	HAZARD EXPOSURE BEGIN DATE	EStrExposureBeginDtm	The date that the period of exposure began. ASTM E1633 PARA 4.2.4
07001.05.01.	HAZARD EXPOSURE TERMINATION DATE (1996)	EStrExposureTerminDtm	The date that this exposure period ceased. ASTM E1633 PARA 4.2.4
07001.05.02.	HAZARD EMPLOYER (1996)	EStrExposureEmployerText	The name of the employer associated with the exposure period. ASTM E1633 PARA 4.2.6
07001.05.03.	HAZARD SETTING OF EXPOSURE	EStrExposureWorkCntrText	The name of the employer's work area where this period of exposure occurred. ASTM E1633 PARA 4.2.6
07001.05.05.	HAZARD ROUTE OF EXPOSURE	EStrExposeWorkActyCode	The nature of the patient's activity at the name work area. ASTM E1633 PARA 4.2.6
07001.05.07.	HAZARD EXPOSURE INTERVAL DOSE	EStrExposureIntervDoseQty	The dose resulting from the exposure period. ASTM E1633 PARA 4.2.5
07001.05.09.	HAZARD PLANT PROCESS	EStrPlantProcessCode	The plant process related to the work area. ASTM E1633 PARA 4.2.6
07001.05.11.	HAZARD PLANT LOCATION	EStrPlantLocationCode	The location of the plant site. ASTM E1633 PARA 4.2.6
07001.05.13.	HAZARD WORK PERFORMED	EStrWorkPerformedText	The name of the hazardous work performed on the job. ASTM E1633 PARA 4.2.6
07001.05.15.	HAZARD PERSONAL PROTECTION USED	EStrPersProtectCode	The names of the personal protection clothing/devices used during this exposure period. ASTM E1633 PARA 4.2.6
07001.07.	HAZARD TEST DATE	EStrTestDtm	The testing date for measuring environmental levels of this agent. ASTM E1633 PARA 4.2.4
07001.07.01.	HAZARD NATURE AND FORM OF MEASURED AGENT	EStrNatFormAgentCode	A term identifying the nature and form of the stressor being measured. ASTM E1633 PARA 4.2.6 (1996)

07001.07.02.	HAZARD SAMPLE UNIT COLLECT	EStrSampleCollUnitCode	The unit of measure for the specimen collected. ASTM E1633 PARA 4.2.6 (1996)
07001.07.03.	HAZARD SAMPLE COLLECTION TIME	EStrCollTimeIntervQty	The time period over which the environmental specimen was collected. ASTM E1633 PARA 4.2.6
07001.07.05.	HAZARD SAMPLE COLLECT DEVICE	EStrCollectDeviceCode	The device by which the environmental specimen is obtained. ASTM E1633 PARA 4.2.6
07001.07.07.	HAZARD TEST SAMPLE METHOD (1996)	EStrTestSampleMethodCode	The method by which the sample is obtained. ASTM E1633 PARA 4.2.6
07001.07.09.	HAZARD TYPE OF DETERMINATION (1996)	EStrDeterTypeCode	The method by which the amount of stressor was measured.
07001.07.11.	HAZARD PEAK MEASUREMENT VALUE	EStrPeakMeasurmntQty	The value of the peak level measurement. ASTM E1633 PARA 4.2.5
07001.07.13.	HAZARD PEAK MEASUREMENT UNIT	EStrPeakMeasurmntUnitCode	The unit of the peak level measurement. ASTM E1633 PARA 4.2.6
08001.	NO. OF PREV PREGNANCIES	HHistPrevPregQty	The count of all pregnancies experienced regardless of outcome. ASTM E1633 PARA 4.2.5
08003.	NO. OF COMPLETED DELIVERIES	HHistCompletedDeliveryQty	The count of pregnancies which went to term with live births. ASTM E1633 PAR 4.2.5
08005.	ESTD DATE OF PREGNANCY BEGIN	PRHistPregnancyBeginDtm	The date on which it is estimated the current pregnancy began. ASTM E1633 PARA 4.2.4
08005.01.	PRENATAL & PERINATAL HISTORY	PRHistPregPerinatalHistText	A textual description of the current pregnancy. TEXT ASTM E1633 PARA 4.2.6
08005.03.	ESTIMATED DATE OF DELIVERY	PRHistEstDelDtm	The date on which it is estimated that delivery will occur. ASTM E1633 PARA 4.2.4
08005.05.	DATE FIRST SAW PRENATAL PRACT	PRHistInitPrenatPractDtm	The date the patient first consulted a healthcare practitioner about the current pregnancy. ASTM E1633 PARA 4.2.4
08005.07.	TYPE OF PRENATAL PRACTITIONER	PRHistPrenatPractTypeCode	The specialty of this practitioner. ASTM E1633 PARA 5.1 (5.2.9)
08005.09.	BIRTHING PLAN	PRHistBirthPlanText	The route of delivery selected for the current pregnancy. ASTM E1633 PARA 4.2.6
08005.11.	LENGTH OF GESTATION	PRHistGestLengthQty	The total length in days of completed pregnancies. ASTM E1633 PARA 4.2.5
08005.13.	GYNECOLOGIC ABNORMALITIES	PRHistGynecolAbnText	A textual description of abnormalities of the mother relating to the birth process. ASTM E1633 PARA 4.2.6
08005.15.	BIRTH METHOD	PRHistBirthMethodCode	A class term for the category of delivery method. ASTM E1633 PARA 4.2.6
08005.17.	DELIVERY COMPLICATIONS	PRHistDelivCompText	A textual description of the complications of each pregnancy, including the current one. ASTM E1633 PARA 4.2.6
08005.19.	NO. OF FETUSES IN PREGNANCY	PRHistFetusCountQty	A count of the total number of fetuses in the gestation period. ASTM E1633 PARA 4.2.5
08005.21.	BIRTH NAME	PRChildName	Unique name for this child of the identified gestation. ASTM E1633 PARA 4.2.1
08005.21.1.	BIRTH SEX	PRChildSexCode	Sex of the identified child an gestation. ASTM E1633 PARA 5.2.20

08010.	PATIENT NEWBORN BIRTHWT	HHistBirthWtQty	The weight at birth if the newborn infant, recorded at the time the record is initiated. ASTM E1633 PARA 4.2.5
08013.	PATIENT NEWBORN BIRTHLNGTH	HHistBirthLngthQty	The length of the newborn infant recorded at the time the record is initiated. ASTM E1633 PARA 4.2.5
08017.	ESTIMATE OF FETAL MATURITY AT BIRTH	HHistBirthMatCode	A class term for the category of maturity of newborns. ASTM E1633 PARA 4.2.6
08020.	PATIENT NEWBORN ABNORMALITIES	HHistBirthAbnCode	A textual description of the abnormalities observed at birth recorded when the record is first opened. ASTM E1633 PARA 4.2.6
08023.	ONSET OF RESPIRATION	HHistRespOnsetDtm	The date time post birth that respiration commenced. ASTM E1633 PARA 4.2.4
08027.	1 MIN APGAR	HHist1MApgarQty	The APGAR score computed at 1 minute post birth. ASTM E1633 PARA 4.2.5
08030.	5 MIN APGAR	HHist5MApgarQty	The APGAR score computed at 5 minutes post birth. ASTM E1633 PARA 4.2.5
08033.	NEWBORN HEAD CIRCUMFERENCE	HHistNbHeadCircQty	The measured circumference of the head recorded at birth when the record is opened. ASTM E1633 PARA 4.2.5
08037.	NEWBORN CHEST CIRCUMFERENCE	HHistNbChestCircQty	The measured circumference of the chest at birth when the record is opened. ASTM E1633 PARA 4.2.5
08050.	FAMILY HEALTH HISTORY	HHistFamilyHealthHistText	A textual summary of the health history of the parents and siblings of the patient. ASTM E1633 PARA 4.2.6
08052.	CHILD HEALTH HISTORY	HHistChildHealthHistText	A textual summary of the development of the infant through adolescence period. ASTM E1633 PARA 4.2.6
08054.	ADULT HEALTH HISTORY	HHistAdultHealthHistText	A textual summary of the significant health events from adolescence to current. ASTM E1633 PARA 4.2.6
08055.	PATIENT HEALTH EDUCATION HISTORY	HHistHealthEdHistText	A patient's self reported history including risk factors (may be a standard questionnaire) ASTM E1633 PARA 4.2.6
08056.	SEXUAL/REPRODUCTIVE HISTORY	HHistSexReprodHistText	A textual summary of the sexual history of both male and female patients. ASTM E1633 PARA 4.2.6
08058.	DATE OF LAST MENSTRUAL PERIOD	HHistLastMenstPerDtm	For a female only, the date of last menstrual period prior to a suspected pregnancy. ASTM E1633 PARA 4.2.4
08060.	AGE AT MENARCHE	HHistMenarcheAgeQty	The age at which menstruation began. ASTM E1633 PARA 4.2.5
08062.	MENSTRUAL STATUS	HHistMenstrualStatusCode	The category of current menstrual functioning. ASTM E1633 PARA 4.2.6
08064.	BIRTH CONTROL METHOD	HHistBirthContrMethCode	A textual description of the method of birth control for both male and female patients. ASTM E1633 PARA 4.2.6
08070.	JOB START DATE	JobStartDtm	The HIRE DATE for each chronological paid (or significant non-paid regular) position held by the patient. These are identified for the purpose of recognizing the timpacts of the work environment on the health status of the patient. ASTM E1633 PARA 4.2.4
08070.01.	JOB EMPLOYER	JobEmployerText	The name of the employing organization. ASTM E1633 PARA 4.2.6

08070.03.	JOB FULL/PARTIME STATUS	JobTime PresentStatusCode	A term categorizing the amount of time spent on the job. ASTM E1633 PARA 5.1 (4.2.6)
08070.05.	JOB STATUS	JobStatusCode	Code representing current priority of job. ASTM E1633 PARA 4.2.6
08070.07.	JOB TITLE	JobTitleText	The name of the position. ASTM E1633 PARA 4.2.6
08070.09.	JOB CODE	JobCode	Identifier for the nature of the job. ASTM E1633 PARA 4.2.6
08070.11.	JOB CLASSIFICATION	JobClassificationCode	Code representing the category of the job. ASTM E1633 PARA 4.2.6
08070.13.	JOB EMPLOYEE NUMBER	JobEmployeeId	A number assigned by the company to identify the employee. ASTM E1633 PARA 4.2.6
08070.14	OCCUPATIONAL CATEGORY	JobOccCategoryCode	Code for the category of occupation required for the job position. ASTM E1633 PARA 4.2.6
08070.15.	JOB PROCESS/ACTIVITY	JobProcessActivityCode	The category name of the work activity conducted. ASTM E1633 PARA 4.2.6
08070.16.	JOB STANDARD INDUSTRIAL CLASSIFICATION	JobStdIndCode	The USDOL Stand Industrial Class associated with the job. ASTM E1633 PARA 4.2.6
08070.17.	JOB TERMINATION DATE	JobTerminationDtm	The date this position terminated. ASTM E1633 PARA 4.2.4
08070.19.	JOB COMMENTS	JobCommentsText	Textual remarks about any aspect of this position. ASTM E1633 PARA 4.2.6
08070.20.	WORK LOCATION	JobworkLocCode	Code for the location at which the job primarily is carried out. ASTM E1633 PARA 4.2.6
08070.21.	JOB WORK ACTIVITY	JobWorkActivityCode	Code represzenting the nature of the work activity for this job position. ASTM E1633 PARA 4.2.6
08070.23.	JOB PROTECTIVE EQUIP	JobProtectiveEquipText	The textual name of any equipment, clothing or devices used to protect against the work environment. ASTM E1633 PARA 4.2.6
08070.25.	JOB STRESSORS EXPOSED TO	JobExposureStressorIDCode	The names or identifiers of chemical, physical, biological or radiological stressors exposed to in the workplace as a result of this position. ASTM E1633 PARA 4.2.6
08075.	**DATE OF HEALTH HISTORY**	HHistDtm	Time and Date of the Health History. ASTM E1633 PARA 4.2.4
08075.01.	PURPOSE	HHistPurposeText	Statement of the reason for recording Health History. ASTM E1633 PARA 4.2.6
08075.03.	HISTORY SITE OF EXAM	HHistSiteCode	The location where the health history is updated. ASTM E1633 PARA 4.2.6
08075.05	**SOURCE OF HISTORY: CONTACT NAME**	HExmHistSourceName	The name of an individual who relates the patient's history to the practitioner. ASTM E1633 PARA 4.2.1
08075.07.	**HISTORY RELAT SOURCE TO PT**	HExmHistSourceRelPtCode	The relationship of the source of data used in updating the health history to the patient, if it is not the patient. ASTM E1633 PARA 5.2.10
08075.09.	**HISTORY PRESENT HEALTH**	HExmPresentHlthText	A statement of the current state of the patient's health at the time of the health history updating. ASTM E1633 PARA 4.2.6

08075.10.	STATE OF ORAL HYGIENE	HExmOralHlthStatusText	Statement of the state of patient's health. ASTM E1633 PARA 4.2.6
08075.11.	**PAST HIST.-SOCIAL**	HEXmSocialHistText	A statement of the current social aspects of the patient's functioning. ASTM E1633 PARA 4.2.6
08075.13.	**CURRENT.-HABITS**	HExmHabitsText	A current statement of personal habits at the time of the health history updating. ASTM E1633 PARA 4.2.6
08075.15.	HISTORY CURRENT OCCUPATION	HxmCurrOccCode	A statement of the patient's occupation at the time of the history updating. ASTM E1633 PARA 4.2.6
08075.17.	PAST HIST.-PREV. ILLNESS	HExmPastHistPrevIllText	A statement of the illnesses experienced since the last history updating. ASTM E1633 PARA 4.2.6
08080.	PAST HIST.-SURGERY DATE	HHistPastSurgDtm	The date of a past surgical procedure. ASTM E1633 PARA 4.2.4
08080.01.	PAST HISTORY OPERATION IDENTIFIER	HHistPastHistOperId	The name of a surgical procedure. ASTM E1633 PARA 5.1 (4.2.6)
08083.	MEDICATION HISTORY	HHistMedcnIDText	A textual summary of past medications used by the patient. ASTM E1633 PARA 4.2.6
08085.	TRAUMA HISTORY	HHistTraumaText	A textual summary of trauma experienced by the patient during his lifetime. ASTM E1633 PARA 4.2.6
08088.	ALLERGY HISTORY	HHistAllDrgSensText	A textual description of prior allergies. ASTM E1633 PARA 4.2.6
08090.	DATE OF HISTORY GEN CMMENT	HHistCommentsDtm	The date of a textual remark. ASTM E1633 PARA 4.2.4
08090.1.	HISTORY GENERAL COMMENTS	HHistCommentsText	The statement of the remark. ASTM E1633 PARA 4.2.6
08095.	HEALTH HISTORY RESPONSE	HHistRespCode	A response term concerning a health history observation. ASTM E1633 PARA 4.2.6
08095.01.	HEALTH HISTORY RESPONSE DATE	HHistRespDtm	A list of dates when this response was given. ASTM E1633 PARA 4.2.4
08095.01.01.	HISTORY RESPONSE COMMENT	HHistRespCommentText	A remark amplifying a response about a patient's health history. ASTM E1633 PARA 4.2.6
09001.	**EXAM/HISTORY DATE**	HExmDtm	The date on which a physical examination and attendant history update was conducted. ASTM E1633 PARA 4.2.4
09001.01.	EXAM/HISTORY PURPOSE	HExmPurposeCode	The purpose for which the patient was being examined. ASTM E1633 PARA 4.2.6
09001.02.	EXAM RISK FACTORS	HExmRiskFactorCode	Code representing a value for factors of risk being considered during the examination. ASTM E1633 PARA 4.2.6
09001.03.	EXAM/HISTORY FACILITY	HExmFaciltyId	The location of the examination site. ASTM E1633 PARA 4.2.6
09001.04.	EXAM EXAMINERS NAME	HExmExaminerName	The name or identifier of the examiner. ASTM E1633 PARA 4.2.1
09001.09.	**SOURCE HISTORY OF PRESENT ILLNESS/STATUS OF PRESENT HEALTH**	HExmPresentIllnessText	A detailed chronological description of the development of the pt's illness from the appearance of the first symptom to the present time. Include data of onset. ASTM E1633 PARA 4.2.6

09001.11.	EXAM INITIAL IMPRESSIONS	HExmInitImpressionText	A textual statement of the examiner's initial observations. ASTM E1633 PARA 4.2.6
09001.12.	**EXAM REVIEW OF SYSTEMS**	HExmReviewSystemsText	This data element contains the textual summary of the systematic review of the status and functioning of the body's systems and regions. ASTM E1633 PARA 4.2.6
09001.13.	**EXAM FINDING**	HExmFindingCode	A term for an observation name made by the examiner. ASTM E1633 PARA 4.2.6
09001.13.01.	EXAM FINDING VALUE	HExmFindingValueQty	The number value for the measurement made by the examiner. ASTM E1633 PARA 4.2.5
09001.13.02	EXAM FINDING UNIT	HExmFindingUnitCode	The appropriate unit of measure for the observation. ASTM E1633 PARA 4.2.6
09001.13.03.	EXAM FINDING INTERP CODE	HExmFindingInterpCode	A remark about the observation made by the examiner. ASTM E1633 PARA 4.2.6
09001.13.04.	**EXAM FINDING COMMENT**	HExmFindingCommentText	A textual remark about the particular finding. ASTM E1633 PARA 4.2.2 (4.2.6)
09001.15.	**EXAM/HISTORY TEXT**	HExmText	A textual narrative of the observations made by the examiner. ASTM E1633 PARA 4.2.6
09001.16.	PATIENT HEALTH STATUS MEASURE NAME	HExmHlthStatTMeasText	Title of the Total Health Status Measure and Instrument. ASTM E1633 PARA 4.2.6
09001.17.	PATIENT HEALTH STATUS MEASURE TOTAL VALUE	HExmHlthStatTMeasQty	Numeric Value of the Health Status Measure Total magnitude. ASTM E1633 PARA 4.2.5
09001.19.	PATIENT HEALTH STATUS MEASURE ELEMENT NAME	HExmHlthStatMeasElCode	Code representing the identity of the Health Status Measure Element. ASTM E1633 PARA 4.2.6
09001.19.01.	PATIENT HEALTH STATUS MEASURE ELEMENT VALUE	HExmHlthStatMeasElQty	Numeric Value of the Magnitude of the Health Status measurement element. ASTM E1633 PARA 4.2.5
09001.21.	**EXAM SUMMARY**	HExmSummaryText	A textual synopsis of the narrative of the examination, if appropriate. ASTM E1633 PARA 4.2.6
09001.23.	EXAMINER/CONSULT RECOMMENDTN	HExmRecommdText	The examiner/consultant's opinion, diagnosis or impression. TEXT ASTM E1633 PARA 4.2.6
09001.25.	EXAM ASSESSSMENT OF NUTRITIONAL STATUS	HExmNutritionAssessText	A textual summary of the nutritional status of the patient at this examination. ASTM E1633 PARA 4.2.2 (4.2.6)
09001.30.	TOOTH (M)	HExmToothId	Tooth identifier code with ISO or ADA. ASTM E1633 PARA 4.2.6
09001.30.01.	TOOTH STATUS	HExmToothStatusCode	Status category code of the tooth. ASTM E1633 PARA 4.2.6
09001.30.03.	COMMENT	HExmToothCommentText	A textual comment observation or discussion about the identified tooth ASTM E1633 PARA 4.2.6
09001.30.05.	SURFACE (M)	HExmToothSurfaceId	The surface identifier code for the specified tooth. ASTM E1633 PARA 4.2.6
09001.30.05.1.	LEVEL OF DECAY	HExmToothSurfLevDecayCode	An ordinal code for increasing level of decay for the specified tooth and surface. ASTM E1633 PARA 4.2.6
09001.30.05.2.	RESTORATIVE MATERIAL	HExmToothSurfRestMatCode	Identifier of restorative material used for the specified tooth and surface restoration. ASTM E1633 PARA 4.2.6

09001.30.05.3.	PERIODONTAL TISSUE STATUS	HexmToothSurfPerioStatusCode	Status of the periodontal tissue adjacent to this tooth surface. ASTM E1633 PARA 4.2.6
09001.30.06.	TOOTH SENSITIVITY CODE	HExmToothSensCode	Code representing the patient perceived sensitivity to touch of this tooth. ASTM E1633 PARA 4.2.6
09001.30.07.	TOOTH MOBILITY CODE	HExmToothMobilityCode	Code representing the degree of mobility of this tooth. ASTM E1633 PARA 4.2.6
09001.30.08.	TOOTH LINGUAL POCKET DEPTH	HExmToothLingPocketDepthQty	A numeric value fore the depth of the lingual periodontal pocket. ASTM E1633 PARA 4.2.6
09001.30.09.	TOOTH BUCCAL POCKET DEPTH	HExmToothBucPocketDepthQty	A numeric value for the depth of the Buccal periodontal pocket. ASTM E1633 PARA 4.2.6
09001.30.11.	TOOTH IMPLANT MATERIAL CODE	HExmToothImplantMatlCode	Code denoting the nature of the the implant material. ASTM E1633 PARA 4.2.6
09001.30.07.	PERIODONTAL TISSUE STATUS (M)	HExmToothPerioStatusCode	Ordinal code for normal/abnormal condition of the specified tooth and region. ASTM E1633 PARA 4.2.6
09001.30.09.	IMPLANT STATUS (M)		Coded value for the category of implant condition in the specified tooth position. ASTM E1633 PARA 4.2.6
09001.30.13.	PLANNED PROCEDURE (M)	HExmToothPlannedProcIDCode	The identifier of the restorative procedure planned of the specified tooth. ASTM E1633 PARA 4.2.6
09001.30.13.1.	SCHEDULED DATE	HExmToothPlannedProcDtm	The date of the specified planned procedure and tooth. ASTM E1633 PARA 4.2.6
09001.40.	PROSTHESIS (M)	ProsthIDCode	The identifier of prosthesis installed with the patient mouth. ASTM E1633 PARA 4.2.6
09001.40.01.	PROSTHESIS TYPE	ProsthTypeCode	The coded category of the installed prosthesis. ASTM E1633 PARA 4.2.6
09001.40.03.	PROSTHESIS ABUTMENT (M)	ProsthAbutCode	The identifier of the tooth site where the abutment for the specified prosthesis is located. ASTM E1633 PARA 4.2.6
09001.40.05.	DATE OF TEMPORARY PROSTHESIS	ProsthTempDtm	Date of installation of a temporary prosthesis preceding the permanent prosthetic device. ASTM E1633 PARA 4.2.4
09001.40.07.	DATE OF PERMANENT PROSTHESIS	ProsthPermDtm	Date when the permanent restorative prosthetic device replaced to temporary device as the specified prosthesis. ASTM E1633 PARA 4.2.4
09001.40.09.	INSTALLING PRACTITIONER	ProsthInstalPractId	The identifier of the practitioner installing the prosthesis. ASTM E1633 PARA 4.2.6
09001.40.11.	OPPOSING ARCH STATUS	ProsthOpposArchStatusCode	Coded category for the condition of dental arch opposing the specified prosthesis. ASTM E1633 PARA 4.2.6
09001.40.13.	OCCUSAL SURFACE MATERIAL	ProsthOcclusSurfMatCode	Identifier of the material used on the occusal surface of the specified prosthesis. ASTM E1633 PARA 4.2.6
09001.40.15.	PATIENT SATISFACTION CODE	ProsthPatSatisCode	Ordinal code indicating the patient's satisfaction with the specified prosthesis. ASTM E1633 PARA 4.2.6
10001.	**CLIN ORDER ID NUMBER**	COrdIDId	The unique identifier for a clinical order. ASTM E1633 PARA 4.2.6

10001.001.	**CLIN ORDER ENCOUNTER DATETIME**	COrdEncDtm	The date and time of the Encounter that generated this clinical order. ASTM E1633 PARA 4.2.4
10001.002.	CLIN ORDER PATIENT STATUS	COrdPtStatusCode	The categorical term classifying the patient in terms of the health care setting under which treatment is being given such as: ambulatory, inpatient, home health, long term care, etc.).
10001.009.	CLIN ORDER DATE-TIME	COrdDtm	The date time point that the order was created by the originating practitioner. ASTM E1633 PARA 4.2.4
10001.010.	CLIN ORDER TYPE	COrdTypeCode	The categorical term classifying the action addressee and identifying the special data requirements of that addressee. ASTM E1633 PARA 4.2.6
10001.013.	CLIN ORDER ACTION	COrdActionCode	A code for the category of action to be taken on this order. ASTM E1633 PARA 4.2.6
10001.015.	CLIN ORDER PRIORITY	COrdPriorityCode	A categorical term classifying the urgency for carrying out his clinical order. ASTM E1633 PARA 4.2.6
10001.017.	CLIN ORDER PRE-ADMIT STATUS	COrdPreAdmStatusCode	A categorical term classifying whether the patient situation is a pre-admission one. ASTM E1633 PARA 4.2.6
10001.019.	CLIN ORDER ORIGIN	COrdOriginCode	The location from which the order was originated. ASTM E1633 PARA 4.2.6
10001.021.	CLIN ORDER PARENT ORDER	COrdParentOrdId	The identifier of the triggering order of a secondary order. ASTM E1633 PARA 4.2.6
10001.022.	CLIN ORDER MULTIPLE SEQ STATUS	COrdMultSeqStatusCode	The categorical terms classifying the actions of this clinical order as multiple and sequential in time.
10001.023.	CLIN ORDERS RELATED ORDERS	COrdRelatedOrdersIDCode	A list of order identifiers for clinical orders that are dependent upon or which are coordinated with the actions requested by this clinical order. ASTM E1633 PARA 4.2.6
10001.025.	CLIN ORDER USER	COrdUserName	The identity of the staff individual who entered the order on behalf of a practitioner. ASTM E1633 PARA 4.2.1
10001.027.	CLIN ORDER USER SIG	COrdUserSig	The electronic signature of the entering staff individual. ASTM E1633 PARA 4.2.7 (4.2.6)
10001.029.	CLIN ORDER NURSE ID	COrdNurseIDCode	The name or identifier of the nurse signing this clinical order. ASTM E1633 PARA 4.2.6
10001.031.	CLIN ORDER NURSE SIG	COrdNurseSig	The electronic signature of the nurse signing this clinical order. ASTM E1633 PARA 4.2.7 (4.2.6)
10001.033.	CLIN ORDER ORDERING PRACTITIONER NAME	COrdOrderingPractName	The name or identifier of the practitioner creating this clinical order. ASTM E1633 PARA 4.2.1
10001.034.	ORDERING PRACTITIONER ROLE	COrdOrdering PractRoleCode	Code representing the role of the ordering practitioner for this Clinical Order. ASTM E1633 PARA 4.2.6
10001.035.	CLIN ORDER ORDERING PRACTITIONER SIG	COrdOrderingPractSig	The electronic signature of the practitioner creating this clinical order.
10001.037.	CLIN ORDER COUNTERSIGNING PRACTITIONER NAME	COrdCSignPractName	The name or identifier of the duly authorized practitioner countersigning this clinical order. ASTM E1633 PARA 4.2.1

10001.039.	CLIN ORDER COUNTERSIGNING PRACTITIONER SIG	COrdCSignPractSig	The electronic signature of the duly authorized practitioner countersigning this clinical order. ASTM E1633 PARA 4.2.7
10001.041.	CLIN ORDER NURSE SIG NEEDED STATUS	COrdNursSigNeedStatusCode	The categorical term classifying the conditions under which a nurse signature is required on this clinical order. ASTM E1633 PARA 4.2.6
10001.043.	CLIN ORDER NURSE SIG NEEDED DATETIME	COrdNursSigNeedDtm	The date time point by which a nurse signature is required on this clinical order. ASTM E1633 PARA 4.2.4
10001.045.	CLIN ORDER PRACTITIONER SIG NEEDED STATUS	COrdPrctSigNeedStatusCode	A categorical term classifying the conditions under which a practitioner signature is required to activate this clinical order. ASTM E1633 PARA 4.2.6
10001.047.	CLIN ORDER PRACTITIONER SIG NEEDED DATETIME	COrdPrctSigNeedDtm	The date time by which the signature of an ordering practitioner is required for this clinical order. ASTM E1633 PARA 4.2.4
10001.049.	CLIN ORDER COUNTERSIG NEEDED STATUS	COrdCSigNeedDtm	The categorical term classifying the conditions under which a countersignature is required to activate this clinical order. ASTM E1633 PARA 4.2.4
10001.051.	CLIN ORDER COUNTERSIG NEEDED BY DATETIME	COrdCSigNeedStatusCode	The date time point by which a practitioner countersignature is required for this clinical order to be activated. ASTM E1633 PARA 4.2.6
10001.052.	CLIN ORDER DISCONTINUED BY PRACTITIONER NAME	COrdDisconbyPractName	The name or identifier of the practitioner who discontinues this clinical order. ASTM E1633 PARA 4.2.1
10001.053.	CLIN ORDER DISCONTINUED PRACTITIONER SIG	COrdDisconbyPractSig	The electronic signature of the practitioner who discontinues this clinical order. ASTM E1633 PARA 4.2.7
10001.055.	CLIN ORDER CONFIRMATION RECD CODE	COrdConfirmationRecdCode	Internal mechanism to ensure receipt of order. ASTM E1633 PARA 4.2.6
10001.057.	CLIN ORDER ACTIVE/PENDING FLAG	COrdActPendStatusCode	Code for the active/pending state of the Clinical Order. ASTM E1633 PARA 4.2.6
10001.058.	CLINICAL ORDER RESPONSE ACTION	COrdResponseActionCode	A code denoting the nature of responses to this clinical order. ASTM E1633 PARA 5.2.53
10001.059.	CLIN ORDER ACTIVE STATUS	COrdActiveStatusCode	Code for the completion state of the Clinical Order. ASTM E1633 PARA 4.2.6
10001.061.	CLIN ORDER PENDING STATUS	COrdPendingStatusCode	Code for the category characterizing the pending nature of the Clinical Order. ASTM E1633 PARA 4.2.6
10001.063.	CLIN ORDER INACTIVE STATUS FLAG	COrdInactiveStatusCode	Code denoting the nature and reason for inactivity of the Clinical Order. ASTM E1633 PARA 4.2.6
10001.065.	CLIN ORDER START STATUS	COrdStartStatusCode	Code denoting the conditions for starting the Clinical Order. ASTM E1633 PARA 4.2.6
10001.067.	CLIN ORDER EXECUTION FREQUENCY	COrdExecFreqQty	A textual statement of the frequency with which the requested action should be executed over the duration of this clinical order. ASTM E1633 PARA 4.2.5
10001.069.	CLIN ORDER DURATION OF SERVICE	COrdDurationText	The time period over which the service is to be performed, including start and stop times. ASTM E1633 PARA 4.2.6

10001.071.	CLIN ORDER LATEST STATUS CHG DATETIME	COrdLastStatusChgDtm	The date time associated with a change in the category of any of the control data elements. ASTM E1633 PARA 4.2.4
10001.073.	CLIN ORDER REACTIVATION DATETIME	COrdReactivationDtm	The date time of the point at which this clinical order was changed from inactive to active. ASTM E1633 PARA 4.2.4
10001.075.	CLIN ORDER REQ FM ANCILLARY	COrdReqFmAncillaryText	Statement of the identify of the Ancillary service which is to provide the ordered service. ASTM E1633 PARA 4.2.6
10001.077.	CLIN ORDER ANCILLARY ACTIV DATETIME	COrdAncillary ActivDtm	Time and Date the Ancillary was notified. ASTM E1633 PARA 4.2.4
10001.079.	CLIN ORDER RESULT EXPECTATION DATETIME	COrdRsltExpectDtm	The date time of the expected instant that a result from the actions requested in this clinical order might be available. ASTM E1633 PARA 4.2.4
10001.081.	CLIN ORDER TELEPHONE RESULT FLAG	COrdTeleRsltStatusCode	The categorical term classifying the situations in which the result requested as a result of the actions in this clinical order should be communicated by telephone to the designated location. ASTM E1633 PARA 4.2.6
10001.083.	CLIN ORDER TELEPHONE RESULT DESTINATION	COrdTelRsltDestinText	The name of the location to which a telephoned result which may be required should be returned. ASTM E1633 PARA 4.2.6
10001.085.	CLIN ORDER REQUEST SCHEDULED FLAG	COrdReqSchedStatusCode	The categorical term classifying the appointment request associated with this clinical order. ASTM E1633 PARA 4.2.6
10001.087.	CLIN ORDER REQUESTED APPT TIME	COrdReqApptDtm	The date time requested for the appointment associated with the services requested in this clinical order. ASTM E1633 PARA 4.2.4
10001.089.	CLIN ORDER REQ APPT TYPE	COrdReqApptTypeCode	The categorical term classifying the appointment associated with the services requested in this clinical order. ASTM E1633 PARA 4.2.6
10001.091.	CLIN ORDER APPT TRANSPORT STATUS	COrdApptTranspStatusCode	The categorical term classifying the transportation for the patient in conjunction with the appointment associated with delivering the services requested by this clinical order. ASTM E1633 PARA 4.2.6
10001.093.	CLIN ORDER APPT STATUS	COrdApptStatusCode	The categorical term classifying the current action in carrying out this clinical order. ASTM E1633 PARA 4.2.6
10001.095.	CLIN ORDER ASSIGNED APPT TIME	COrdAssignApptDtm	The date time of the appointment assigned by the delivering activity that is associated with the services requested in this clinical order. ASTM E1633 PARA 4.2.4
10001.097.	CLIN ORDER HEALTH SERVICE ORDERED	COrdServiceOrderedCode	The name or identifier of the health service requested by this clinical order. ASTM E1633 PARA 4.2.6
10001.098.	TREATMENT PLAN INVOLVED	COrdTrPInvId	Identifier of the Treatment Plan involved in this Clinical Order. ASTM E1633 PARA 4.2.6
10001.099.	PROBLEM NUMBER	PHProbId	The problem identifier for this unique problem. Note: a systematic procedure for assigning these numbers across all practitioners has not been agreed upon. For the present, it should be considered a sequential integer number. ASTM E1633 PARA 4.2.6

10001.100.	**CLIN ORDER FULL TEXT**	COrdOrderText	The textual content of the order detailing what action is to be taken and the means to go about it. ASTM E1633 PARA 4.2.6
10001.101.	CLINICAL ORDER SPECIMEN ID	COrdSpecimenId	A unique identifier character string for this specimen. ASTM E1633 PARA 4.2.6
10001.101.01.	CLINICAL ORDER SPECIMEN DATETIME	COrdSpecimenDtm	Time point that specimen collection began, if an interval or occurred if a time point. ASTM E1633 PARA 4.2.4
10001.101.02.	CLINICAL ORDER SPECIMEN COLLECTION END DATE-TIME	CordSpecimenEndDtm	Time point that an interval specimen collection was completed. ASTM E1633 PARA 4.2.4
10001.101.03.	CLINICAL ORDER SPECIMEN COLLECTION VOLUME	CordSpecimenVolumeQty	Total volume of the collected specimen in milliliters. ASTM E1633 PARA 4.2.5
10001.101.04.	CLINICAL ORDER SPECIMEN COLLECTOR	CordSpecimenCollecorId	Identifier of the individual collecting the specimen. ASTM E1633 PARA 4.2.6
10001.101.05.	CLINICAL ORDER SPECIMEN SOURCE	CordSpecimenSourceCode	Body location of the specimen.
10001.101.06.	CLINICAL ORDER SPECIMEN ADDITIVES CODE	CordSpecimenAdditiveCode	List of additives to the collected specimen. ASTM E1633 PARA 5.2.57
10001.101.07.	CLINICAL ORDER SPECIMEN ACTION	COrdSpecimenActionCode	Priority of action for the specimen. ASTM E1633 PARA 5.2.42
10001.101.08.	CLINICAL ORDER SPECIMEN COMMENTS	CordSpecimenCommentText	Text description relating to the specimen. ASTM E1633 PARA 4.2.6
10001.102.	CLIN ORDER LOCATION OF SERVICE	COrdServiceLocationId	The location at which the ordered service is to be delivered. ASTM E1633 PARA 4.2.6
10001.104.	CLIN ORDER FREQ ORDERED SVC	COrdOrderedSvcFeqQty	A term denoting how often the service is performed and the number of times it is performed. ASTM E1633 PARA 4.2.5
10001.106.	CLIN ORDER MODIFY STATUS	COrdModifyStatusCode	The categorical term classifying the conditions under which the order can be, or has been, modified. ASTM E1633 PARA 4.2.6
10001.108.	CLIN ORDER MODIFICATION REASON	COrdModifReasonText	The textual statement as to why the order has been modified. ASTM E1633 PARA 4.2.6
10001.110.	CLIN ORDER NON-MODIFY FLAG	COrdNonModifyStatusCode	The categorical term classifying the situation restricting modifications to this clinical order. ASTM E1633 PARA 4.2.6
10001.112.	CLIN ORDER INSTRUCTIONS	COrdInstructionsText	The text describing the conduct of the requested action, including criteria for D/C or other decisions to be made about conduct of the service. ASTM E1633 PARA 4.2.6
10001.114.	CLIN ORDER SECONDARY ORDERS	COrdSecondaryOrderListText	The list of identifiers of named clinical order types which are sequentially initiated when this clinical order is activated. ASTM E1633 PARA 4.2.6
10001.116.	CLIN ORDER MESSAGE	COrdMessageText	A textual comment sent to the performer of the requested action. ASTM E1633 PARA 4.2.6
10001.120.	CLIN ORDER RESULT ACKNOWL DATETIME	COrdRsltAcknDtm	The date time that the receipt of the result was acknowledged by the orderer. ASTM E1633 PARA 4.2.4
10001.120.01.	CLIN ORDER SHIFT CARE PLAN	COrdShiftCarePlanText	Identifier of the Shift Care Plan involved with this Clinical Order. ASTM E1633 PARA 4.2.6

10001.120.02.	CLIN ORDER RESULT RETURN FLAG	COrdRsltRetCode	A categorical term classifying the situation associated with this clinical order regarding whether a result is to be returned as part of the actions requested. ASTM E1633 PARA 4.2.6
10001.120.03.	CLIN ORDER RESULT RETURN STATUS	COrdResltRetStatusCode	The category of the situation where results from a clinical order are being awaited.
10001.120.04.	CLIN ORDER RESULT RETURN DATETIME	COrdRsltRetDtm	The date time of the instant that a result that may be associated with this clinical order is returned to the care record. ASTM E1633 PARA 4.2.4
10001.120.05.	CLIN ORDER RESULT RETURN ACKNL BY	COrdRsltRetAcknbyName	The identity of the individual who acknowledged the receipt of the results. ASTM E1633 PARA 4.2.1
10001.120.06.	CLIN ORDER RESULT RETURN COMMENT	COrdRsltRetCommentText	A textual remark associated with the result returned as requested by this clinical order. ASTM E1633 PARA 4.2.6
10001.123.	CLIN ORDER DATE-TIME COMPLETED	COrdOrderCompletionDtm	The date time of the point at which all requested actions have been completed on this clinical order. ASTM E1633 PARA 4.2.4
10001.140.	CLIN ORDER Q-A WARNING DATETIME	COrdQAWarnDtm	The date time of the point at which a warning about the actions associated with this clinical order was generated. ASTM E1633 PARA 4.2.4
10001.140.1.	CLIN ORDER Q-A WARNING TEXT	COrdQAWarnText	The textual content of the generated warning associated with this clinical order and date time. ASTM E1633 PARA 4.2.6
10001.140.2.	CLIN ORDER Q-A WARNING DISPOSITION	COrdQAWarnDispositionCode	The categorical term classifying the response to the warning. ASTM E1633 PARA 4.2.6
10001.140.3.	CLIN ORDER WARN OVERRIDE PRACTITIONER	COrdQAWarnOverrdPractName	The name or identifier of the practitioner overriding the warning associated with this clinical order. ASTM E1633 PARA 4.2.1
10001.140.4.	CLIN ORDER Q-A WARN OVERRIDE AUTH BY PRACTITIONER	COrdQAWarnOverrdAuthName	A textual statement of the actions overriding the warning issued in association with this clinical order. ASTM E1633 PARA 4.2.1
10001.140.5.	CLIN ORDER Q-A WARNING OVERRIDE JUSTIFICATION	COrdQAWarnOverrdJustText	A textual description of the reasons for overriding the warning associated with this clinical order. ASTM E1633 PARA 4.2.6
10001.160.	CLIN ORDER Q-A REVIEW DATE	COrdReviewDtm	The date upon which the situation leading to a warning on this clinical order was reviewed. ASTM E1633 PARA 4.2.4
10001.160.01.	CLIN ORDER Q-A REVIEW EVENT TYPE	COrdQAEventTypeCode	The categorical term classifying the review events for this clinical order. ASTM E1633 PARA 4.2.6
10010.	**TREATMENT PLAN ID (M)**	TPlId	Identifier of a specified treatment plan. ASTM E1633 PARA 4.2.6
10010.01.	TREATMENT PLAN NAME	TPlNameText	A human readable name of the treatment plan. ASTM E1633 PARA 4.2.6
10010.02.	**DESCRIPTION**	TPlDescrText	Textual description of the plan. ASTM E1633 PARA 4.2.6
10010.03.	PRIMARY PRACTITIONER	TPlPriPractId	Identifier of the practitioner who takes responsibility for the ideas stated in the plan over the interval specified in the plan. ASTM E1633 PARA 4.2.6

10010.04.	TEAM MEMBERS (M)	TPlTeamMbrId	Identifiers of the practitioners participating in the planning and execution of the specified plan. ASTM E1633 PARA 4.2.6
10010.04.01.	TEAM MEMBER ROLE	TPlTeamMbrRoleCode	The identifier code for the role the team member is specified to play in the specified plan. ASTM E1633 PARA 4.2.6
10010.05.	TOTAL OUTCOME MEASURE	TPlTotOutcomeMeasId	Identifier of the quantitative/ordinal measure of the global outcome of the treatment for which this plan was created. ASTM E1633 PARA 4.2.6
10010.06.	PLAN COMMENTS	TPlCommentsText	Textual discussion of the plan, its progress and effectiveness. ASTM E1633 PARA 4.2.6
10010.07.	PLAN COST	TPlCostQty	The estimated/measured overall cost of the planned treatment. ASTM E1633 PARA 4.2.5
10010.10.	**PHASE IDENTIFIER (M)**	TPlPhaseId	Identifier of specified phases declared in the planned treatment episode. ASTM E1633 PARA 4.2.6
10010.10.01.	**PROBLEM**	TPlPhaseHcondId	The identifier of the health condition(s) from the health condition list toward treatment in this phase is directed. ASTM E1633 PARA 4.2.6
10010.10.02.	CLINICAL ORDER ID	TPlCOrdId	The identifier of the clinical order(s) which potentially (when authenticated) implement(s) the specified treatment in a phase. ASTM E1633 PARA 4.2.6
10010.10.03.	CLINICAL ORDER STATUS	TPlCOrdStatusCode	Identifier code for the current status for the activating clinical order for the specified plan and phase. ASTM E1633 PARA 4.2.6
10010.10.04.	PHASE TARGET DATE	TPlPhaseTargetDtm	Date of the expected completion of this phase of the specified treatment plan and clinical order. ASTM E1633 PARA 4.2.4
10010.10.05.	OUTCOME GOAL	TPlPhaseOUtcomeGoalText	Textual statement of expected health condition status resulting from the specified treatment in this phase. ASTM E1633 PARA 4.2.6
10010.10.06.	OUTCOME MEASURE	TPlPhaseOutcomeMeasureCode	Identifier of the property which reflects the status of the outcome goal attainment of the specified treatment plan and phase. ASTM E1633 PARA 4.2.6
10010.10.07.	ACTUAL PHASE COST	TPlPhaseActualCostQty	The numerical value of the actual cost of the specified phase and treatment plan. ASTM E1633 PARA 4.2.5
10010.10.08.	TREATMENT PLAN STATUS	TPlStatusCode	Code representing the state of the treatment plan. ASTM E1633 PARA 4.2.6
10010.10.09.	TREATMENT PLAN PATIENT MANAGEMENT NEEDS	TPlPTMgtNeedText	Statement of the particular additional management steps needed to manage the patient using this treatment plan. ASTM E1633 PARA 4.2.6
10010.10.10.	TREATMENT EVENT DATE-TIME (M)	TPlTrtEvDtm	The time point of a specific scheduled encounter for execution of the proposed procedures for this phase and treatment plan. ASTM E1633 PARA 4.2.4
10010.10.10.01.	LOCATION	TPlTrtEvLocCode	The location of the scheduled encounter for the execution of the specified phase and treatment plan. ASTM E1633 PARA 4.2.6

10010.10.10.02.	PRACTITIONER	TPlTrtEvPractId	The identifier of the practitioner responsible for the scheduled encounter executing the specified phase and treatment plan. ASTM E1633 PARA 4.2.6
10010.10.10.03.	PROCEDURE (M)	TPlTrtEvProcIdCode	The identifier of the procedures to be executed during the scheduled encounter(s) for execution of the specified treatment event. ASTM E1633 PARA 4.2.6
10010.10.10.04.	APPOINTMENT COST	TPlTrtEvAppCostQty	The numeric value of the identified encounter scheduled to execute the specified treatment event. ASTM E1633 PARA 4.2.6
10010.10.09.	TREATMENT REGIMEN ID	TPRegimenId	Identifier of the specific regimen to be used in this treatement plan. ASTM E1633 PARA 4.2.6
10010.11.	DATE-TIME STARTED	TPlStarttm	The date the treatment plan was started using the initial phase. ASTM E1633 PARA 4.2.4
10010.12.	DATE-TIME EXPECTED COMPLETION	TPlExprComplDtm	The date that the entire treatment plan is expected to be complete. ASTM E1633 PARA 4.2.4
10010.13.	DATE-TIME ACTUAL COMPLETION	TPlActualComplDtm	The date that the entire treatment plan was actually completed. ASTM E1633 PARA 4.2.4
10010.14.	AUTHENTICATION	TPlAuthentCode	The practitioner authenticator for the scheduled encounter completion for the specified phase and treatment plan. ASTM E1633 PARA 4.2.6
11001.	**TEXT/EXAM/SPEC-COLLECTION DATETIME**	DXProcSpecExamDtm	The date and time when the specimen was collected from the patient or the measurement was made. ASTM E1633 PARA 4.2.4
11001.01.	**TEST REQUESTED**	DXProcTestId	The name of the diagnostic test. ASTM E1633 PARA 4.2.6
11001.01.03.	TEST REQ ENCOUNTER ID	DXProcTestEncIDCode	The name or identifier of the encounter from subsegment 14a during which the test/exam was conducted. The date and time when the specimen was collected from the patient or the measurement was made. ASTM E1633 PARA 4.2.4
11001.01.06.	**TEST REQ ORDERING TREAT FAC**	DXProcOrderingFacilCode	The name or identifier of the facility from which the test as requested in a clinical order. ASTM E1633 PARA 4.2.6
11001.01.09.	**TEST REQ PERFORMING FAC**	DXProcPerformFacilCode	The name or identifier of the facility performing the test or examination. ASTM E1633 PARA 4.2.4
11001.01.12.	ATTENDING PRACTITIONER NAME	DXProcAttPractName	The name or identifier of the practitioner ordering the test or exam. ASTM E1633 PARA 4.2.1
11001.01.15.	TEST REQ CLIN ORDER ID	DXProcClinOrderId	The identifier of the clinical order from segment 10 requesting the test or exam. ASTM E1633 PARA 4.2.6
11001.01.18.	RESIDENT PHYS. NAME	DXProcRes PractName	The name or identifier of the subordinate practitioner under supervision of the responsible practitioner. ASTM E1633 PARA 4.2.1
11001.01.21.	PROBLEM NUMBER	PHProbId	The problem identifier for this unique problem. Note: a systematic procedure for assigning these numbers across all practitioners has not been agreed upon. For the present, it should be considered a sequential integer number. ASTM E1633 PARA 4.2.6

11001.01.24.	TEST SPECIMEN SOURCE	DXProcSpecimenSourceCode	A term stating the specimen origin taken from the list of specimen categories. ASTM E1633 PARA 4.2.6
11001.01.27.	SPECIMEN/CYTOLOGY NO.	DXProcSpecimenId	A unique identifier assigned by the performer. ASTM E1633 PARA 4.2.6
11001.01.30.	SPECIMEN COLLECTION EMPLOYEE IDENTIFIER	DXProcSpecCollectorName	The name or identifier of the collector of the specimen to be used for the test or the examiner for other whole body tests. ASTM E1633 PARA 4.2.1
11001.01.33.	TEST SPECIMEN RECEIPT DATETIME	DXProcSpecReceiptDtm	The time that the specimen was actually received in the diagnostic facility. ASTM E1633 PARA 4.2.6
11001.01.36.	TEST SPECIMEN CONDITION	DXProcSpecConditionCode	A text statement of the state of the specimen following either harvesting from the patient or receipt in the testing facility. It may also include a statement of patient condition for a whole body test.
11001.01.39.	TEST SPECIMEN TOTAL VOLUME	DXProcSpecTotVolQty	The total volume of specimen collected. ASTM E1633 PARA 4.2.5
11001.01.42.	TEST SPECIMEN PREPARATIONS	DXProcSpecPrepText	A statement of the preparations required prior to the test or examination of the specimen. ASTM E1633 PARA 4.2.6
11001.01.45.	**TEST DATE-TIME RESULT REPTD**	DXProcResultReportedDtm	Date-time that the results were reported from the performing facility. ASTM E1633 PARA 4.2.4
11001.01.48.	TEST DATE OF REPORT DICTATION	DXProcReportDictationDtm	The date that the text of report was dictated for transcription. ASTM E1633 PARA 4.2.4
11001.01.51.	**TEST REPORT TEXT**	DXProcReportText	The body of the report on tests producing a narrative. ASTM E1633 PARA 4.2.6
11001.01.54.	DIAGNOSTIC REPORT DESTINATION	DXProcReportDestinCode	The location to which to send the reported results of testing or examination. ASTM E1633 PARA 4.2.6
11001.01.57.	**NUMERIC MEASUR/ANALYTE NAME**	DXProcNmeasAnalCode	The name of the exact measured species or measurement made during the test or examination. ASTM E1633 PARA 4.2.6
11001.01.57.01.	**NUMERIC MEASUR/ANALYTE VALUE**	DXProcNmeasAnalValQty	The numeric value of the measurement. ASTM E1633 PARA 4.2.5
11001.01.57.02.	NUMERIC MEASUR/ANALYTE UNITS	DXProcNmeasAnalUnitCode	The unit of measure for the measurement. ASTM E1633 PARA 4.2.6
11001.01.57.03.	**NUMERIC MEASUR/ANALYTE INTERP**	DXProcNmeasAnalInterpCode	A term of interpretation for the measurement. ASTM E1633 PARA 4.2.6
11001.01.57.04.	NUMERIC MEASUR/ANAL ABN BASIS	DXProcNmeasAnalAbnBasCode	The population basis term for the interpretation. ASTM E1633 PARA 4.2.6
11001.01.60.	**TEST REQ MICROBIOL ORGANISM**	DXProxMicroOrgCode	The name of the microobiological organism evaluated in the test. ASTM E1633 PARA 4.2.6
11001.01.60.01.	**MICRO ORG ATTRIBUTE**	DXProcMicroOrgAttrCode	A list of attributes for a microbiological organism. ASTM E1633 PARA 4.2.6
11001.01.60.02.	**MICRO BIOL ORG RESIST PATT**	DXProcMicroResistPattCode	A list of therapeutic agents for which the microbiologic organism is resistant. ASTM E1633 PARA 4.2.6
11001.01.60.02.01.	ANTIMICROBIAL RESISTANCE PATTERN DRUG MIC	MicroResistPattDrugMIC	Minimal concentration inhibiting this cultured organism and antimicrobial. ASTM E1633 PARA 4.2.5

11001.01.60.03.	**MICROBIOL ORG SPEC COMMENT**	DXProcMicroCommentText	A remark about the microbiologic organism tested. ASTM E1633 PARA 4.2.6
11001.01.63.	**TEST COMMENTS**	DXProcCommentText	Textual remarks on the test or examination. ASTM E1633 PARA 4.2.6
11001.01.66.	TEST PERFORMER/CYTOTEC HNOLOGIST	DXProcPerformerName	The name or identifier of the individual performing the test or examination. ASTM E1633 PARA 4.2.1
11001.01.67.	TRANSCRIPTIONIST	ProcTranscritionistId	Individual who transcribed this observation report. ASTM E1633 PARA 4.2.6
11001.01.68.	OBSERVATION INTERPRETER	ProcObsInterpreterId	Identifier of the individual who interpreted these observations. ASTM E1633 PARA 4.2.6
11001.01.69.	TEST DIAGNOSTIS/CYTO DIAG & CODES	DXProcDiagCode	A list of diagnostic codes associated with this test or examination, either prior to or subsequent to the test. ASTM E1633 PARA 4.2.6
12001.	**MEDICATION PRESC/ORD DATETIME**	MedcnOrdDtm	The date time the prescription or medication order was initiated. ASTM E1633 PARA 4.2.4
12001.03.	MEDICATION/PRESCRIPTION ENCOUNTER ID	MedcnEncIdentCode	A unique identifier for the encounter originating a prescription or medication order. ASTM E1633 PARA 4.2.6
12001.06.	**MEDICATION NAME**	MedcnNameText	Description of the current product. ASTM E1633 PARA 4.2.6
12001.09.	MEDICATION CLINICAL ORDER NO.	MedcnClinOrderId	The unique identifier of the prescription or medication order from segment 10. ASTM E1633 PARA 4.2.6 (4.2.5)
12001.12.	MEDICATION PRESCRIPTION NO.	MedcnPrescripId	Unique number assigned to identify each prescription. ASTM E1633 PARA 4.2.6
12001.15.	**MEDICATION PRESCRIBER**	MedcnPrescriberName	The identity of the person with prescribing authority who wrote the prescription/order. ASTM E1633 PARA 4.2.1
12001.18.	MEDICATION PRESCRIBER LOCATION	MedcnPrescriberLocCode	The location of the prescriber when the prescription/medication order was written. ASTM E1633 PARA 4.2.6
12001.21.	PROBLEM NUMBER	PHProbId	The problem identifier for this unique problem. Note: a systematic procedure for assigning these numbers across all practitioners has not been agreed upon. For the present, it should be considered a sequential integer number. ASTM E1633 PARA 4.2.6
12001.24.	MEDICATION REASON FOR ADMIN	MedcnAdminReasonText	The statement of the reason for this prescription/medication order. ASTM E1633 PARA 4.2.6
12001.27.	MEDICATION STATUS OF PRESC/ORD	MedcnPrescStatusCode	A status code of: Current, discontinued or PRN is used to focus on specific classes of orders.
12001.30.	**MEDICATION DOSE**	MedcnDoseQty	The strength, dosage or concentration ASTM E1633 PARA 4.2.5
12001.33.	MEDICATION DOSE UNIT	MedcnDoseUnitCode	The unit of measure of the dose. ASTM E1633 PARA 4.2.6
12001.36.	**MEDICATION VEHICLE/FORM**	MedcnVehicleFormCode	The form of the medication, including the vehicle. ASTM E1633 PARA 4.2.6
12001.39.	**MEDICATION ROUTE**	MedcnAdminRouteCode	A term identifying the route of administration. ASTM E1633 PARA 4.2.6

12001.40.A.	MEDICATION ADMINISTRATION DEVICE	MedcnAdminDeviceCode	Code name of the device used for medication administration. ASTM E1633 PARA 5.2.50
12001.40.B.	MEDICATION ADMINISTRATION METHOD	MedcnAdminMethodCode	Code name of the method used in medication administration. ASTM E1633 PARA 5.2.51
12001.42.	**MEDICATION FREQ.**	MedcnAdminFreqCode	The number of doses to be administered per day or the interval between doses. ASTM E1633 PARA 4.2.6
12001.45.	**MEDICATION INSTRUCTIONS**	MedcnInstructionText	Signature: prescription part that gives directions as to the taking of the medication. ASTM E1633 PARA 4.2.6
12001.48.	MEDICATION TOT NO. DOSES/REFILL	MedcnDosePerRefillQty	The number of doses to be issued at each filling. ASTM E1633 PARA 4.2.5 (1996)
12001.51.	MEDICATION NO. OF REFILLS	MedcnTotRefillQty	The number of times the prescription is authorized to be refilled. ASTM E1633 PARA 4.2.5
12001.54.	**MEDICATION DATE OF REFILL**	MedcnRefillDtm	The date of each refill of the prescription. ASTM E1633 PARA 4.2.4
12001.54.01.	MEDICATION REFILL DISP FACIL	MedcnRefilDispFacilCode	The name of the facility dispensing a refill of a specific prescription. ASTM E1633 PARA 4.2.6
12001.57.	MEDICATION START DATE-TIME	MedcnStartDtm	The date-time that an inpatient medication order is to be started. ASTM E1633 PARA 4.2.4
12001.60.	MEDICATION STOP DATE-TIME	MedcnStopDtm	The date-time that an inpatient medication order is to be stopped. ASTM E1633 PARA 4.2.4
12001.63.	**MEDICATION NOTES**	MedcnNoteText	The effects/results of medication administration, which include drug interactions, adverse effects, etc. or a change in the patient's clinical status and/or lab findings caused by drugs. ASTM E1633 4.2.6
13001.	SCHEDULED VISIT DATE-TIME	SCHPTApptDtm	The date and time of the appointed visit/encounter. ASTM E1633 PARA 4.2.4
13001.01.	SCHEDULED VISIT TREAT FACILITY	SCHPTApptTreatFacilText	The name of the facility where the appointed visit/encounter is to take place. ASTM E1633 PARA 4.2.6
13001.02.	SCHEDULED VISIT EXPECTED DURATION	SCHPTApptExpDurQty	Numeric value for the length of time for this appointment.
13001.03.	SCHEDULED VISIT CLINIC NAME	SCHPTApptClinicText	The name of the organizational unit within the facility where the visit/encounter will take place. ASTM E1633 PARA 4.2.6
13001.04.	SCHEDULED VISIT PREVIOUS ENC DATE	SCHPTApptPrevEncDtm	The date that the patient last had an encounter with this practitioner. ASTM E1633 PARA 4.2.4
130001.05.	SCHEDULED VISIT PRACTITIONER ID	SCHPTApptPractIDCode	The name or identifier of the practitioner who is to receive the patient. ASTM E1633 PARA 4.2.6
13001.06.	SCHEDULED VISIT	SCHPTApptRequestorId	Identifier of the individual requesting this appointment.
13001.07.	SCHEDULED VISIT PURPOSE	SCHPTApptPurposeText	The nature of the activities or focus of interest during the visit/encounter. ASTM E1633 PARA 4.2.6

13001.09.	SCHEDULED VISIT REMARKS	CHPTApptRemarksText	The text describing additional factors surrounding the visit/encounter ASTM E1633 PARA 4.2.6
13001.11.	SCHEDULED VISIT APPT STATUS	SCHPTApptStatus Code	Code representing the state of this appointment.
13001.12.	SCHEDULED VISIT EXPECTED SERVICES	SCHPTApptExp ServId	Identifier of the services the patient expects to receive.
13001.13.	SCHEDULED VISIT TYPE	SCHPTApptTypCode	Code for category of expected appointment.
13001.14.	SCHEDULED VISIT UGENCY	SCHPTApptUrgencyQty	Numeric value for the magnitude of the urgency for this appointment.
13001.15.	SCHEDULED VISIT CANCELLATION REASON	SCHPTApptReason Text	Statement of the reason given for this appointment.
13001.16.	SCHEDULED VISIT CANCELLATION DATETIME	SCHPTAppDtm	Time and Date for this appontment.
13001.17.	SCHEDULED VISITOVERBOOK STATUS	SCHPTApptStatusCode	Code denoting the stae of Overbooking for this appointment slot.
13001.18.	SCHEDULED VISIT ENCOUNTER DISPOSITION	SCHPTApptDispCode	Code denoting the category of disposition for this Appointment.
14001.	**DATE-TIME ENCOUNTER/ADMISSION**	HCFEncEncAdmDtm	The month, day, year and hour which patient began episode/encounter of care ASTM E1633 PARA 4.2.4
14001.A001.	**TREATMENT FACILITY NAME**	HCFEncTreatFacilText	The name of the facility at which treatment is rendered. It is applicable in any setting. This element identifies the PROVIDER ORGANIZATION, such as a private practice name. ASTM E1633 PARA 4.2.6
14001.A002.	**ENCOUNTER TYPE**	HCFEncEncounterTypeCode	Code representing the Category of the Encounter. ASTM E1633 PARA 5.2.17
14001.A003.	ENCOUNTER ID	HCFEncEncounterIDCode	A unique identifier for each encounter. ASTM E1633 PARA 4.2.6
14001.A0031.	**EPISODE ID**	HCEpiIDCode	An identifier code of the sequence of encounters relating to a single health problem. ASTM E1633 PARA 4.2.6
14001.A004.	ENCOUNTER SECURITY PROTECTION	HCFEncConfidentialityCode	The level of protection of confidentiality assigned to a patient because of special conditions e.g. (celebrity, unwed mothers, staff, mental health patient, etc.) ASTM E1633 PARA 5.2.1
14001.A010.	ENCOUNTER STATUS	HCFEncEncounterStatusCode	A term for the category denoting whether the encounter is complete, suspended, in progress or prematurely terminated. ASTM E1633 PARA 4.2.6
14001.A013.	TREATMENT FACILITY TYPE	HCFEncFacilTypeCode	The category of facility where the encounter/episode occurred. ASTM E1633 PARA 5.2.18
14001.A016.	**ENCOUNTER REASON FOR VISIT**	HCFEncReasonVisitCode	The purpose for which the encounter was sought by the patient. ASTM E1633 PARA 5.2.19
14001.A020.	ENCOUNTER PT ARRIVAL COND	HCFERecPtArrivCondCode	The severity condition of the patient on arrival for the encounter. ASTM E1633 PARA 4.2.6
14001.A021.	MODE OF ARRIVAL	HCFEPiIDCode	The mode of arrival. It may include a variety of land, water and aircraft in addition to walk-in or other mode. ASTM E1633 PARA 4.2.6

14001.A022.	ORIGIN FACILITY ID	IAdmOrigFacId	The identifier of the facility that transferred the patient to this facility. ASTM E1633 PARA 4.2.6
14001.A023.	**CHIEF COMPLAINT**	HCVRecChiefComplaintText	The reason for the episode/encounter and patient's complaints and symptoms reflecting his/her own perceptions of his needs. The nature and duration of symptoms that caused the patient to seek medical attention, as stated in the patient's own words. ASTM E1633 PARA 4.2.6 (1996)
14001.A027.	DATE-TIME OF INJURY	ERAdmInjDtm	The date-time injury to the patient actually occurred and which relates to this encounter. ASTM E1633 PARA 4.2.4
14001.A030.	ENCOUNTER NATURE OF INJURY	HCFERecNatInjCode	A list of terms describing the actual nature of injury. ASTM E1633 PARA 4.2.6
14001.A033.	ENCOUNTER MODE OF INJURY	HCFERecModeInjCode	A list of terms describing the causes (etiology) of the injury sustained. ASTM E1633 PARA 4.2.6
14001.A034.	PRODUCT OF INJURY	HCEncProdInjCode	Indentifier for the product causing the injury to the patient. ASTM E1633 PARA 4.2.6
14001.A036.	ENCOUNTER LOC WHERE INJURED	HCFERecInjGeogrLocCode	The geographic local where the injury took place. ASTM E1633 PARA 4.2.6
14001.A040.	INJURY ON THE JOB STATUS	HCFEncJobInjStatusCode	A code categorizing the injury on the job. ASTM E1633 PARA 4.2.6
14001.A043.	INJURY CIRCUMSTANCES	HCFERecInjCircumText	A textual description of the events surrounding the injury. ASTM E1633 PARA 4.2.6
14001.A044.	PROTECTIVE EQUIPMENT USED	HCFERecProtEqUsedCode	The name of the devices used for personal protection prior to injury, such as seat belts. ASTM E1633 PARA 4.2.6
14001.A046.	INJURY SEV SCORE	ERAdmInjSevScoreQty	The score calculated as the sum of squares of the three highest Abbreviated Injury Scale (1-6) from the list of injuries; it cannot exceed 75. ASTM E1633 PARA 4.2.5
14001.A050.	ENCOUNTER DATETIME OF PHYSICAL EXAM	HCFEncPhysExamDtm	The date time index of the physical examination from segment 9 associated with this encounter. ASTM E1633 PARA 4.2.4
14001.A053.	PROBLEM NUMBER	PHProbId	The problem identifier for this unique problem. Note: a systematic procedure for assigning these numbers across all practitioners has not been agreed upon. For the present, it should be considered a sequential integer number. ASTM E1633 PARA 4.2.6
14001.A056.	CURRENT LIVING ARRANGEMENT	IAdmLivingArrText	The environment in which the patient lives at home. ASTM E1633 PARA 4.2.6
14001.A060.	ENCOUNTER COMMENTS	HCFEncCommentText	Textual general remarks about this encounter. ASTM E1633 PARA 4.2.6 (1996)
14001.A063.	ADMISSION TYPE	HCFERecAdmissionTypeCode	The coded lexicon for the category of the admission. ASTM E1633 PARA 5.2.12
14001.A066.	ADMISSION AUTHORITY	IAdmAuthorityCode	The coded authority for the admission. ASTM E1633 PARA 4.2.6
14001.A070.	REFERRAL TYPE	IAdmReferralTypeCode	Referral source. ASTM E1633 PARA 4.2.6
14001.A073.	REFER. PROVIDER	IAdmReferProvName	SEE PRACTITIONER NAME. ASTM E1633 PARA 4.2.1

14001.A083.	PRIVATE PHYSICIAN NAME	IAdmPrivPractName	Practitioner(s) having the major responsibility of providing/coordinating the medical services to a patient. SEE PRACTITIONER NAME. ASTM E1633 PARA 4.2.1
14001.A093.	PRIV. PHYSICIAN NOTIFIED	IAdmPrivPractNotifCode	A code used at emergency facilities to record whether the patient's private practitioner has been notified. ASTM E1633 PARA 4.2.6
14001.A096.	ADMISSION HOSPITALIZATION TYPE CODE	IAdmHospTypeCode	Category of the Hospitalization component of the Admission. Code representing the category of the Hospital Admission. ASTM E1633 PARA 4.2.6
14001.A100.	PATIENT BOARD FROM	IAdmPatBdCode	ASTM E1633 PARA 4.2.6
14001.A103.	ADMISSION HOSP REGISTER NO.	IAdmHospitalRegisterText	The number that MAY be assigned for each new admission of a patient. It is not required and is not used in many facilities. ASTM E1633 PARA 4.2.6
14001.A106.	AGE	HCFEncPtAgeQty	The patient's age in years at the start of the encounter or episode. ASTM E1633 PARA 4.2.5
14001.A110.	ADMITTING SERVICE	IAdmAdmittingServiceCode	The clinical service within the resident treatment facility which accepts responsibility for the care of the patient during the stay. ASTM E1633 PARA 5.2.15
14001.A113.	ORIGIN SVC	IAdmOriginServiceCode	The clinical service that either originated the request for admission or which referred the patient to the service which admitted him. This element is not applicable when referred by a practitioner not a member of an institutional clinical service. ASTM E1633 PARA 5.2.15
14001.A116.	ADMISSION CONSULT SERVICE	IActAdmConsultSvcCode	The clinical service is one which is requested by the admitting service to provide advice regarding an aspect of the patient's health condition and who is being considered for admission to the facility. ASTM E1633 PARA 5.2.15
14001.A116.01.	CONSULT DATE	IActConsultDtm	The date on which the requested consultation was made. ASTM E1633 PARA 4.2.4
14001.A116.02.	CONSULT TEXT	IActConsultText	The text of the recommendations made by the consulting practitioner. ASTM E1633 PARA 4.2.6 (1996)
14001.A116.03.	CONSULTING PRACTITIONER NAME	IActConsultPractName	The name of the practitioner called in for advice and counsel. ASTM E1633 PARA 4.2.1
14001.A120.	ENC/ATTEND. PRACTITIONER NAME	IAdmAttendingPractName	An individual at any level of professional specialization who requires a public license/certification to practice the delivery of care to patients. A practitioner can also be a provider. The attending practitioner is that individual who is an established member of the admitting clinical service who accepts the responsibility for the care of the patient while assigned to that services's responsibility. ASTM E1633 PARA 4.2.1
14001.A123.	E-R/ADMITTING PHYSICIAN	ERAdmAdmPhysName	The practitioner authorizing the episode of care for the patient. ASTM E1633 PARA 4.2.1

14001.A126.	PATIENT CURRENT LOCATION	IActPtCurrentLocText	The location in terms of a care unit and physical location within that unit that the patient's residence is located. This may be the room and bed or a ward. ASTM E1633 PARA 4.2.6
14001.A130.	ADMITTING ROOM & BED	IAdmAdmitRoomBedText	The room and bed which is originally assigned and which may be different from the current location. The chronology of locations where the patient resided during this stay can be found in the intrafacility transfer date multiple data element. ASTM E1633 PARA 4.2.6 (1996)
14001.A133.	ADMISSION TYPE OF ACCOMMOD	IAdmAccommodationTypeCode	The type of the accommodation assigned to the patient when first admitted to the facility. This may change and the change can be found associated with the intrafacility transfer date list. ASTM E1633 PARA 5.2.15
14001.A136.	PRIMARY NURSING/THERAPY UNIT	IAdmPriNursinUnitText	The organizational title for the functional unit. ASTM E1633 PARA 4.2.6
14001.A140.	ADMITTING FLOOR	IAdmFloorText	The floor of the nursing unit to which the patient is admitted. ASTM E1633 PARA 4.2.6
14001.A143.	WARNINGS	IAdmWarningCode	A list of conditions that may be hazardous either to the patient or to the care staff that attend the patient upon admission to resident status. ASTM E1633 PARA 4.2.6
14001.A146.	ADMISSION RECORDS RECD	IAdmRecordsRecdCode	A code reflecting the nature of the records received during admitting that are from another site. ASTM E1633 PARA 4.2.6
14001.A150.	PERSONAL VALUABLES LEFT	IAdmValuableListText	A list containing names of the actual items left in custody of the facility. ASTM E1633 PARA 4.2.6 (1996)
14001.A151.	LOCATION OF PERSONAL VALUABLES	IadmPersVal LocCode	Institutional site where personal valuables are stored. ASTM E1633 PARA 4.2.6
14001.A153.	CURRENT TEMPORARY IMPAIRMENT (M)	TempImpairmentCode	Identifier of the Current encounter temporary patient impairments. ASTM E1633 PARA 4.2.6
14001.A154.	ADMITTING RANCHO SCORE	IAdmRANCHOScoreQty	A severity score calculated _____ at admission to resident status. ASTM E1633 PARA 4.2.5
14001.A154.	PATIENT RECEIPT HEALTH STATUS MEASURE NAME	IAdmHlthStatTMeasText	Title of the Total Health Status Measure and Instrument. ASTM E1633 PARA 4.2.6
14001.A156.	PATIENT RECEIPT HEALTH STATUS MEASURE TOTAL VALUE	IAdmHlthStatTMeasQty	Numeric Value of the Health Status Measure Total magnitude. ASTM E1633 PARA 4.2.5
14001.A160.	PATIENT RECEIPT HEALTH STATUS MEASURE ELEMENT NAME	IAdmHlthStatMeasElCode	Code representing the identity of the Health Status Measure Element. ASTM E1633 PARA 4.2.6
14001.A160.01.	PATIENT RECEIPT HEALTH STATUS MEASURE ELEMENT VALUE	IAdm	The value for the individual FIM element. ASTM E1633 PARA 4.2.5
14001.A163.	ADMISSION INTRA-FAC XFR DATE	ITrnsTransferDtm	The date upon which an intrafacility transfer took place. ASTM E1633 PARA 4.2.4
14001.A163.01.	ADMISSION INTRA-FAC XFR TYPE	ITrnsTransferTypeCode	A code that classifies the transfer into a discrete number of classes. ASTM E1633 PARA 5.2.13

14001.A163.02.	ADMISSION INTRA-FAC NURS UNIT	ITrnsNursingUnitId	The name of the nursing unit to which the patient is transferred. ASTM E1633 PARA 4.2.6
14001.A163.06.	ADMISSION INTRA-FAC CLIN SVC	ITrnsTransfServiceCode	The name of the clinical service assigned to the receiving unit in an intrafacility transfer. ASTM E1633 PARA 5.2.15.
14001.A163.10.	ADMISSION INTRA-FAC RM/BED	ITrnsTransfRoomBedName	The actual location of the functional nursing unit into which the patient is transferred. ASTM E1633 PARA 4.2.6
14001.A163.13.	ADMISSION INTRA-FAC DIAGNOSIS	ITrnsTransfDiagnosisCode	The diagnosis that characterizes the patient at the time the transfer is made. ASTM E1633 PARA 4.2.6
14001.A163.16.	ADMISSION INTRA-FAC PROVIDER	ITrnsTransfPractName	The name of the practitioner who actually orders the transfer. ASTM E1633 PARA 4.2.1
14001.A170.	**PATIENT DIAGNOSIS**	IAdmDiagnosisCode	A name or surrogate code for a diagnosis term in the list of diagnoses for this stay. ASTM E1633 PARA 4.2.6
14001.A170.01.	DIAGNOSIS TYPE	IAdmDiagnosisTypeCode	This element is a modifier for each term/code used to list the diagnoses for a patient, either concurrent with care or in discharge summary. Each diagnosis will have a single type that is its most important in any single list. ASTM E1633 PARA 4.2.6
14001.A170.02.	DIAGNOSIS STATUS	IAdmDiagnosisStatusCode	Major/minor-significant conditions vs. insignificant. R/O-diagnostic possibility to be considered. Inactive-not important at the present time, but could have implication for future care. Status post-condition no longer clinically relevant but historically important. ASTM E1633 PARA 4.2.6
14001.A170.03.	DIAGNOSIS NARRATIVE	IAdmDiagnosisNarrText	The diagnosis narrative in plain text. ASTM E1633 PARA 4.2.6 (1996)
14001.A173.	INDICATED SURGERY	IAdmIndSurgText	Description of anticipated surgery. ASTM E1633 PARA 4.2.6
14001.A186.	CURRENT PT STATUS DT	IActCurrPtStatusDtm	This date-time is that at which the status-code was assigned. ASTM E1633 PARA 4.2.4
14001.A186.01.	CURRENT PT STATUS	IActCurrPtStatusCode	This code classifies the patient's clinical status with respect to severity of illness. ASTM E1633 PARA 4.2.6
14001.A186.02.	CURRENT PROGNOSIS	IActCurrProgCode	The expected status or outcome of the resident stay at the time noted. ASTM E1633 PARA 4.2.6
14001.A195.	ADMISSION CUSTOD PERS EFF	IAdmCustPersEffName	The name of the person holding the patient's personal effects or valuables during the current stay. ASTM E1633 PARA 4.2.6
14001.A200.	NOTIFIED BY WHOM	IActNOKNotifiedbyName	The name of the facility staff members who notify the family or next-of-kin regarding the patient's death or major worsening of the patient's condition. ASTM E1633 PARA 4.2.1
14001.A203.	DATETIME NOTIFIED FAMILY/NOK	IActNOKNotifiedDtm	The time that the notifying person contacted the patient's family regarding the patient's death or major worsening of condition. ASTM E1633 PARA 4.2.4
14001.A206.	POLICE HOLD	IAdmPoliceHoldStatusCode	The code classifying the patient with respect to police holding status. ASTM E1633 PARA 4.2.6

14001.A210.	DATE-TIME NOTIFIED POLICE	IAdmPoliceHoldNotifDtm	The date-time that the police were notified regarding the need to hold the patient. ASTM E1633 PARA 4.2.4
14001.A213.	NOTIFIED MED. EXAMINER	IActMedexaminerNotifDtm	The class of the patient regarding notification of the medical examiner about the patient's death. Y/N ASTM E1633 PARA 4.2.4
14001.A216.	DATETIME CHAPLAIN NOTIFIED	IActChaplainNotifDtm	The time that the pastoral staff was notified of the severity or terminal status of a patient. ASTM E1633 PARA 4.2.4
14001.A220.	MINISTRATIONS ADMINISTERED	IActMinistrationsText	The text describing the nature of the pastoral care rendered. ASTM E1633 PARA 4.2.6
14001.A223.	ADMISS/ENC SOURCE OF PAYMENT	IAdmExpectPaySourceCode	The code identifying the class of payment mechanism by which the services rendered will be paid. ASTM E1633 PARA 4.2.6
14001.A223.01.	PAYMENT TYPE	IAdmExpectPayTypeCode	A category of payment list. ASTM E1633 PARA 4.2.6
14001.A223.02.	PAYMENT CARRIER	IAdmExpectPayCarrierId	The name of the insurance carrier providing the named category of payment. ASTM E1633 PARA 4.2.6
14001.A223.03.	PAYMENT MECHANISM	IAdmExpectPayMechCode	The means (funds transfer, check, cash, etc.) by which the payment will be made. ASTM E1633 PARA 4.2.6
14001.B0001.	PRE-HOSP DATETIME CALL RECEIVED	PREHospCallReceivedDtm	The date time the call was received at the dispatch center. ASTM E1633 PARA 4.2.4
14001.B0002.	PRE-HOSP DATETIME RUN DISPATCHED	PREHospRunDispatchDtm	The date time the provider was notified of the need to respond. ASTM E1633 PARA 4.2.4
14001.B0003.	PRE-HOSP DATETIME RUN ARRIVED AT SCENE	PREHospSceneArrivalDtm	The date time the provider's vehicle arrived at the scene. ASTM E1633 PARA 4.2.4
14001.B00031.	PRE-HOSP ORDER AGENCY ARRIVED	PREHospOrderAgencyArrQty	The sequence order that the responding agency arrived at the scene to administer pre-hospital care. ASTM E1633 PARA 4.2.5
14001.B0004.	PRE-HOSP DATETIME PATIENT LEFT THE SCENE	PREHospPtLeftSceneDtm	The date time that the provider's vehicle departed from the scene. ASTM E1633 PARA 4.2.4
14001.B0005.	PRE-HOSP DATETIME PATIENTARRIVED AT TREATMENT FACILITY	PREHospArrivTreatFacilDtm	The date time that the provider's vehicle arrived at the first health care facility destination. ASTM E1633 PARA 4.2.4
14001.B0006.	PRE-HOSP DATTIME UNIT RETURNED TO SERVICE	PREHospReturntoServiceDtm	The date time that the providers vehicle was ready to respond to a subsequent call. ASTM E1633 PARA 4.2.4
14001.B00061.	DATE-TIME TRAUMA SURGEON ARRIVED	ERAdmTraumaSurgArrDtm	The clock time that the trauma surgeon arrived in the Emergency Dept. in response to this case. ASTM E1633 PARA 4.2.4
14001.B00062.	DATE-TIME NEUROSURGEON ARRIVED	ERAdmNeuroSurgArrDtm	The time that the Neurosurgeon arrived in the Emergency Dept. in response to this case. ASTM E1633 PARA 4.2.4
14001.B001.	PRE-HOSPITAL EQUIPMENT/PROCEDURES	PREHospEquipProcedCode	The name of a treatment or procedure given to the patient during the pre-hospital care. ASTM E1633 PARA 4.2.6
14001.B001.01.	PRE-HOSPITAL PROCEDURE DATE-TIME	PREHospProcedureDtm	The date time that the treatment or procedure was conducted. ASTM E1633 PARA 4.2.4

14001.B003.	PRE-HOSP. CARE NARRATIVE	PREHospCareNarrativeText	The description of First Aid and other pre-arrival care delivered. ASTM E1633 PARA 4.2.2 (1996)
14001.B004.	SEVERITY AT DISPATCH	PREHospDispSeverityQty	The ordinal category of severity at the time of dispatch. ASTM E1633 PARA 4.2.5
14001.B005.	SEVERITY AT ARRIVAL ON SCENE	PREHospSceneSeverityQty	The ordinal category of severity at the time of arrival on scene. ASTM E1633 PARA 4.2.5
14001.B0051.	INCIDENT RUN NUMBER	PREHospIncidentRunId	A uniqe (preferable pre-numbered) alphanumeric sequence for each provider organization in a state to be assigned to each vehicle dispatch for each patient regardless of whether a patient was transported. ASTM E1633 PARA 4.2.6
14001.B006.	PRE-HOSPITAL AGENCY ID	PREHospAgencyId	A unique alphanumeric sequence assigned for identification by each state to first responder organizations. ASTM E1633 PARA 4.2.6
14001.B0065.	PRE-HOSP VEHICLE ID	PREHospVehicleId	The identification of the vehicle responding to the pre-hosp run. ASTM E1633 PARA 4.2.6
14001.B007.	PRE-HOSP DISPATCH NO.	PREHospDispatchId	A unique pre-numbered alphanumeric sequence for each request for service made to the dispatch center. ASTM E1633 PARA 4.2.6
14001.B0071.	TRAUMA NUMBER	PREHospTraumaId	An identifier for each Trauma incident in a region used for record linking. ASTM E1633 PARA 4.2.6
14001.B010.	PRE-HOSP SCENE DESCRIPTION	PREHospSceneDescriptText	A categorical term and code describing the scene in which the patient was first encountered. ASTM E1633 PARA 4.2.6
14001.B011.	PRE-HOSP CREW ID	PREHospCrewId	The state license number of the crew member which should be a unique alphanumeric sequence. ASTM E1633 PARA 4.2.6
14001.B011.01.	PRE-HOSP CREW MEMBER SKILL LEVEL	PREHospCrewSkillCode	A categorical term describing the highest level of certification. ASTM E1633 PARA 4.2.6
14001.B011.02.	PRE-HOSP CREW PROCEDURE PERFORMED	PREHospCrewProcedureId	The identifier of a procedure conducted or missed during pre-hospital care.
14001.B012.	PRE-HOSPITAL OBSERVATION	PREHospObservationCode	The name of an observation made during pre-hospital care. ASTM E1633 PARA 4.2.6
14001.B012.01.	PRE-HOSP OBSERVATION VALUE	PREHospObservationQty	The numeric value of the observation made during pre-hospital care. ASTM E1633 PARA 4.2.5
14001.B012.02.	PRE-HOSP OBSERVATION DATETIME	PREHospObsDtm	The time point at which an observation was made during pre-hospital care. ASTM E1633 PARA 4.2.4
14001.B015.	TIME OF TRIAGE	ERAdmTriageDtm	The time that the emergency department assigned priority to the patient for determining the nature and sequence of care. ASTM E1633 PARA 4.2.4
14001.B016.	CONDITION AT TRIAGE	ERAdmTRiageCondCode	A statement of the patient's physiologic state at the time triage was conducted. ASTM E1633 PARA 4.2.6
14001.B030.	BURNS-LOCATION	ERAdmBurnLocCode	The anatomic names of the ares of the body which are burned. ASTM E1633 PARA 4.2.6

14001.B030.01.	BURNS-PCT BODY	ERAdmBurnPctqty	The percent of the total body area that the burned area covers. ASTM E1633 PARA 4.2.5
14001.B030.02.	BURNS-DEGREE	ERAdmBurnDegreeCode	The severity of the area burned. ASTM E1633 PARA 4.2.6
14001.B033.	FRACTURES-LOCATION	ERAdmFractLocCode	The names of the bones which are fractured. ASTM E1633 PARA 4.2.6
14001.B033.01.	FRACTURES-TREATMENT	ERAdmFractTreatCode	The pre-hospital treatment of a fracture. ASTM E1633 PARA 4.2.6
14001.B036.	TOURNIQUET-DATETIME	ERAdmTournDtm	The date and time that each tourniquet is established. ASTM E1633 PARA 4.2.4
14001.B036.01.	TOURNIQUET LOC	ERAdmTournLocCode	The name of the location for each tourniquet established. ASTM E1633 PARA 4.2.6
14001.B039.	ER PROCEDURES	ERAdmERProcCode	The names of the diagnostic or therapeutic procedures conducted in the emergency department. ASTM E1633 PARA 4.2.6
14001.B042.	TUBE TYPE	ERAdmTubeTypeCode	The name of the device used to ensure a patient airway. ASTM E1633 PARA 4.2.6
14001.B045.	OXYGEN TIME STARTED	ERAdmOxyStartDtm	The time that oxygen therapy was commenced. ASTM E1633 PARA 4.2.4
14001.B048.	OXYGEN PERCENT	ERAdmOxyPctQty	The percent of oxygen in the administered breathing gasses. ASTM E1633 PARA 4.2.5
14001.B051.	XRAY LOCATION	ERAdmXrayLocCode	The body location for which a radiograph is taken. ASTM E1633 PARA 4.2.6
14001.B051.01.	XRAY VIEW	ERAdmXrayViewId	The view of the radiographed location. ASTM E1633 PARA 4.2.6
14001.B054.	PRE-HOSPITAL BLOOD RUN NO.	ERAdmPreHospBldRunId	The number of the specimen taken at the scene destined for the blood bank and tested to speed the availability of blood units at the receiving facility. ASTM E1633 PARA 4.2.6
14001.B057.	BLOOD PRODUCT ID	ERAdmBldProdId	The identifying number on each unit. ASTM E1633 PARA 4.2.6
14001.B057.01.	BLOOD DONOR ID	ERAdmBldDonorId	The identifier of the donor of the blood product unit. ASTM E1633 PARA 4.2.6
14001.B057.02.	BLOOD PRODUCT TYPE	ERAdmBldProdTypeCode	This is the product type (e.g. whole blood, packed red cells, fresh frozen plasma, etc.). ASTM E1633 PARA 4.2.6
14001.B057.03.	BLOOD PRODUCT TIME STARTED	ERAdmBldProdStartDtm	The time when administration was started. ASTM E1633 PARA 4.2.4
14001.B057.04.	BLOOD PRODUCT TIME FINISHED	ERAdmBldProdEndDtm	The time when administration was finished. ASTM E1633 PARA 4.2.4
14001.B057.05.	BLOOD PRODUCT BLOOD TYPE	ERAdmBldProdBldTypeCode	Code for Bld Type of product. ASTM E1633 PARA 4.2.6
14001.B057.06.	BLOOD PRODUCT CROSSMATCH	ERAdmBldProdCrosmatchText	This is the crossmatch data string. ASTM E1633 PARA 4.2.6
14001.B057.07.	BLOOD VOLUME TRANSFUSED	ERAdmBldVolTranf.Qty	Amount of each unit transfused in milliliters. ASTM E1633 PARA 4.2.5
14001.B057.08.	BLOOD PRODUCT CUMULATIVE VOLUME	ERAdmBldCumVolQty	The total volume of blood or blood products administered. ASTM E1633 PARA 4.2.5

14001.B057.09.	BLOOD PRODUCT COMMENTS	ERAdmBldProdCommentText	The textual remarks about blood product administration. ASTM E1633 PARA 4.2.6
14001.B060.	ADMITTING DIET ORDER	IAdmDietOrderId	Identifier of the Clinical order for the admitted patient's diet. ASTM E1633 PARA 4.2.6
14001.B063.	IV FLUID TYPE & ADDITIVES	IVFluidAddTypeCode	Name of the fluid and its additives. ASTM E1633 PARA 4.2.6
14001 B063.1.	DATE-TIME IV HUNG	IVFluidStartDtm	Time the IV Fluid container was started. ASTM E1633 PARA 4.2.4
14001.B063.2.	IV LINE NEW START DATE-TIME	IVFluidLineStartDtm	Time a new IV line was installed. ASTM E1633 PARA 4.2.4
14001.B063.3.	IV SITE	IVFluidLineSiteCode	Site of the Intravenous line. ASTM E1633 PARA 4.2.6
14001.B063.4.	IV LINE NEW START:GAUGE&LNGTH	IVFluidLineDescText	Size and length of the line when started. ASTM E1633 PARA 4.2.6
14001.B063.5.	IV FLUID INFUSION DATETIME	IVFluidInfusStartDtm	Time when the infusion commenced. ASTM E1633 PARA 4.2.4
14001.B063.5.01.	IV FLUID VOLUME INFUSED	IVFluidVolQty	Volume of fluid infused during this period. ASTM E1633 PARA 4.2.5
14001.B063.5.02.	IV FLUID BOTTLE ID	IVFluidContId	Identifier of the fluid container. ASTM E1633 PARA 4.2.6
14001.B063.6.	IV FLUID RATE	IVFluidInfRateQty	Rate of fluid infusion. ASTM E1633 PARA 4.2.5
14001.B063.7.	IV FLUID CUMULATIVE VOLUME INFUSED	IVFluidCumVolQty	Aggregate volume of fluid infused for this session. ASTM E1633 PARA 4.2.5
14001.B063.9.	IV CARE	IVFluidSiteCareText	Description of care at the body infusion site. ASTM E1633 PARA 4.2.6
14001.B069.	FLUID INTAKE IV SOURCE	FluidIntSourceCode	Name of source of fluid intake. ASTM E1633 PARA 4.2.6
14001.B069.01.	FLUID INTAKE VOL-TOTAL	Fluid IntTotQty	Volume of the total intake from the named source. ASTM E1633 PARA 4.2.5
14001.B069.02.	FLUID INTAKE DATE-TIME	FluidIntDtm	Time of fluid movement from the named source. ASTM E1633 PARA 4.2.4
14001.B069.02.01.	FLUID IN/OUT	FluidIntDirectionCode	Direction of fluid movement. ASTM E1633 PARA 4.2.6
14001.B069.02.02.	FLUID VOLUME	Fluid IntQty	Volume of fluid moving this period. ASTM E1633 PARA 4.2.5
14001.B070.	VITAL SIGNS TIMES	VitSignDtm	Time of measurement of vital signs. ASTM E1633 PARA 4.2.4
14001.B070.01.	VITAL SIGNS TRACKING VARIABLE	VitSignCode	Name of variable used for tracking physiologic state. ASTM E1633 PARA 4.2.6
14001.B070.01.01.	VITAL SIGNS TRACK VAR VALUE	VitSignQty	Value of the measuring variable. ASTM E1633 PARA 4.2.5
14001.B070.01.02.	VITAL SIGNS TRACK VAR UNIT	VitSignUnitCode	Name of the unit of measure. ASTM E1633 PARA 4.2.6
14001.B072.	MEDICATION ID	MedcnId	Identifier of the medication administered. ASTM E1633 PARA 4.2.6
14001.B072.01.	ADMISSION MEDICATION DATETIME ADMINISTERED	MedcnDtm	Time the medication was administered. ASTM E1633 PARA 4.2.4
14001.B072.01.01.	ADMISSION MEDICATION PERSON ADMINISTERING	MedcnAdminIndivId	Name of the person administering the medication. ASTM E1633 PARA 4.2.6
14001.B072.01.02.	ADMISSION MEDICATION CLINICAL ORDER ID	MedcnClinOrdId	Identifier of the clinical order for the medication. ASTM E1633 PARA 4.2.6

14001.B072.01.03.	ADMISSION MEDICATION DATETIME OF NEXT DOSE	MedcnNextAdminDtm	Tie of next expected administration of this medication during this admission. ASTM E1633 PARA 4.2.4
14001.B072.01.04.	ADMISSION MEDICATION ADMINISTRATION COMMENT	MednCommText	Comment about this dose administration. ASTM E1633 PARA 4.2.6
14001.B072.02.	ADMISSION MEDICATION NO. DOSES ADMINISTERED	MedcnTotDoseQty	Total count of doses administered during this admission. ASTM E1633 PARA 4.2.5
14001.B075.	ADMISSION DIAGNOSTIC TEST ID	DiagTestId	Identifier of a diagnostic test for this admission. ASTM E1633 PARA 4.2.6
14001.B075.01.	ADMISSION DIAGNOSTIC TEST DATETIME	DiagTestDtm	Time of the test or drawing of the specimen for the test attending this admission. ASTM E1633 PARA 4.2.4
14001.B075.01.01	ADMISSION DIAGNOSTIC TEST SPECIMEN ID	DiagTestSpecId	Identifier of the specimen for this diagnostic test. ASTM E1633 PARA 4.2.6
14001.B078.	INTENSIVE CARE SUMMARY DATETIME	IntensCareSummDtm	Narrative intensive care summary datetime for this admission. ASTM E1633 PARA 4.2.4
14001.B078.01.	INTENSIVE CARE SUMMARY TEXT	IntensCareSummText	Narrative text of intensive care summary. ASTM E1633 PARA 4.2.6
14001.B078.02.	INTENSIVE CARE SUMMARY PRACTITIONER ID	IntensCareSumPractNam	Name of the practitioner preparing the intensive care summary. ASTM E1633 PARA 4.2.1
14001.B081.	ADMISSION CLINICAL ORDER ID	IAdmClinOrdId	Identifier of the clinical for admission to the facility. ASTM E1633 PARA 4.2.6
14001.B084.	ADMISSION PROBLEM ID	Id	Identifier of the problem(s) causing admission to the facility. ASTM E1633 PARA 4.2.6
14001.C001.	PRIMARY NURSE THERAPIST	PrimNursTherapId	Identifier of the primary nurse therapist for the admission. ASTM E1633 PARA 4.2.6
14001.C003.	NURSING DIAGNOSIS/PAT. PROB.	NursDiagId	Identifier of nursing diagnosis/problem. ASTM E1633 PARA 4.2.6
14001.C006.	LONG TERM CARE GOALS	LongTerGoalText	Statement of long term patient care goals. ASTM E1633 PARA 4.2.6
14001.C009.	NURSING SHORT TERM GOAL	NursShortTermGoalText	Statement of short term nursing care goals. ASTM E1633 PARA 4.2.6
14001.C012.	NURS. SHORT TERM GOAL DEADLINE	NursShorTermGDeadDtm	Datetime of deadline for achieving short term nursing care goals. ASTM E1633 PARA 4.2.4
14001.C015.	NURSING REQUIREMENT CATEGORY	NursReqCatCode	Identifer of the nursing requirement category. ASTM E1633 PARA 4.2.6
14001.C018.	PATIENT PROFILE ATTRIBUTE	PatProfilAttrCode	Name of attribute of patient profile. ASTM E1633 PARA 4.2.6
14001.C018.01.	PATIENT PROFILE ATTRIBUTE VALUE	PatProfilAtrtrValQty	Values of the attribute from patient profile. ASTM E1633 PARA 4.2.5
14001.C021.	COMMUNITY SVCS USED	CommunSvcUsedText	Description of community services used in care plan. ASTM E1633 PARA 4.2.6
14001.C024.	NURSING APPROACH/ACT. PLAN	NursActPlanText	Text of nursing approach and action plan statement. ASTM E1633 PARA 4.2.6
14001.C027.	CLINICAL COURSE MEASUREMENT	ClinCourseMeasurCode	Name of clinical course measurement variable. ASTM E1633 PARA 4.2.6
14001.C027.01.	CLINICAL COURSE MEASUREMENT VALUE	ClinCourseMeasValQty	Value of clinical course measurement variable. ASTM E1633 PARA 4.2.5

14001.C027.02.	CLINICAL COURSE MEASUREMENT VALUE UNIT	ClinCourseMeasurUnitCode	Identifier of unit of measure for clinical course measurement variable. ASTM E1633 PARA 4.2.6
14001.C055.	DIET CHANGE DATE-TIME	DietChgDtm	Time of diet change assignment. ASTM E1633 PARA 4.2.4
14001.C055.01	DIET CHANGE DIET TYPE	DietChgTypeCode	Name of new diet assignment. ASTM E1633 PARA 4.2.6
14001.C058.	ADMISSION HYGIENE STATUS	IAdmHygiene StatusCode	Category of admission hygiene. ASTM E1633 PARA 4.2.6
14001.C060.	ADMISSION VITAL SIGN FREQUENCY	Iadm VitSiagn FreqCode	Category of admission vital sign frequency. ASTM E1633 PARA 4.2.6
14001.C062.	ADMISSION ALLERGIES	IAdmAllergiesText	Statement of allergies on admission. ASTM E1633 PARA 4.2.6
14001.C065.	ADMISSION DISCHARGE OBJECTIVE ID	IAdmDischObjId	Identifier of discharge objective for this admission. ASTM E1633 PARA 4.2.6
14001.C065.01.	ADMISSION DISCHARGE OBJECTIVE TEXT	IAdmDiscgObjText	Name of discharge objective for this admission. ASTM E1633 PARA 4.2.6
14001.C065.03.	ADMISSION FUNCTIONAL GOAL	IAdmFunctGoalText	Identifier of admission functional goal. ASTM E1633 PARA 4.2.6
14001.C065.06.	ADMISSION OBJECTIVE TARGET DATETIME	IAdmObjTargetDtm	Datetime of achievement of discharge objective. ASTM E1633 PARA 4.2.4
14001.C065.09.	ADMISSION DISCHG OBJECTIVE ACTION	IAdmDischObjActCode	Action to be taken to achieve discharge objective. ASTM E1633 PARA 4.2.6
14001.C068.	ANTIC. DIPSOSITION	IAdmAnticDispCode	Category of disposition expected. ASTM E1633 PARA 4.2.6
14001.C070.	ADMISSION ESTIMATED DISCHARGE DATETIME	IadmEstDischDtm	Estimated datetime of disposition for this admission. ASTM E1633 PARA 4.2.4
14001.C073.	DISCHARGE/AFTERCARE PLAN/PROBS	IAdmDischAftercarePlanCode	To provide reasonable assurance of continued care, developed with patient and family participation. ASTM E1633 PARA 4.2.6
14001.C075.	ADMISSION NURSING PROBLEM NUMBER	IADMNursProbId	ASTM E1633 PARA 4.2.6
14001.C078.	ADMISSION ROS BODY SYSTEM ID	IAdmROSSysCode	Identifier of body system. ASTM E1633 PARA 5.2.22
14001.C078.01.	ADMISSION ROS BODY SYSTEM REVIEW TEXT	IAdm ROSStatusText	Statement of status of admission ROS body system. ASTM E1633 PARA 4.2.6
14001.C080.	ADMISSION SCHEDULED TEST/CONSULT/SURGERY DATETIME	IAdmSchedEventDtm	Time test/consult/surgery scheduled at admission. ASTM E1633 PARA 4.2.4
14001.C080.01.	ADMISSION TEST/CONSULT/SURGERY TYPE	IAdmEventCatCode	Category of test/consult/surgery. ASTM E1633 PARA 4.2.6
14001.C080.02.	ADMISSION TEST/CONSULT/SURGERY LOC CONDUCTED	IAdmEventLocCode	Location identifier where test/consult/surgery was conducted. ASTM E1633 PARA 4.2.6
14001.C080.03.	ADMISSION TEST/CONSULT/SURGERY DATETIME ORDERED	IAdmEventOrderDtm	Datetime test/consult/surgery was ordered. ASTM E1633 PARA 4.2.4
14001.C080.04	ADMISSION TEST/CONSULT/SURGERY DATETIME COMPLETED	IAdmEventComplDtm	Datetime test/consult/surgery was completed. ASTM E1633 PARA 4.2.4
14001.C085.	ADMISSION TREATMENT	IAdmTreatId	Identifier of treatment given in this admission. ASTM E1633 PARA 4.2.6
14001.C085.01.	ADMISSION TREATMENT DATE ORDERED	IAdmTreatOrdDtm	The time that a treatment was ordered. ASTM E1633 PARA 4.2.4
14001.C085.02.	ADMISSION TREATMENT DATE SCHED	IAdmTreatSchedDtm	The time that an ordered treatment was scheduled. ASTM E1633 PARA 4.2.4

14001.C085.03.	ADMISSION TREATMENT DATE COMPLETE	IAdmTreatComplDtm	The time that an ordered treatment was completed. ASTM E1633 PARA 4.2.4
14001.C090.	ADMISSION PATIENT INSTRUCTION DATETIME	IAdmPatInstrDtm	Datetime instruction was given to the patient in this admission. ASTM E1633 PARA 4.2.4
14001.C090.01.	ADMISSION PATIENT INSTRUCTION TYPE	IAdmPatInstrTypeCode	Category of patient instruction. ASTM E1633 PARA 4.2.6
14001.C090.02	ADMISSION PATIENT INSTRUCTION TEXT	IAdmPatInstrText	Text of instruction given to the patient. ASTM E1633 PARA 4.2.6
14001.C090.03.	ADMISSION PATIENT INSTRUCTION VERIFICATION	IadmPatInstrPatSig	Signature of patient acknowledging instructure. ASTM E1633 PARA 4.2.7
14001.C110.		IAdmOrdRehabSvcId	Identifier of rehabilitative service ordered. ASTM E1633 PARA 4.2.6
14001.C110.01.		IAdmOrdRehabSvcUnitCode	Unit of measure of rehabilitative service ordered. ASTM E1633 PARA 4.2.6
14001.C110.02.		IAdmOrdRehabSvcDescText	Statement of rehabilitative service ordered. ASTM E1633 PARA 4.2.6
14001.C120.		IAdmFoodIntakeDtm	Datetime of food intake. ASTM E1633 PARA 4.2.4
14001.C120.01.		IAdmFoodId	Identifier of the food taken in. ASTM E1633 PARA 4.2.6
14001.C120.01.01.		IAdmFoodQty	Amount of food taken in. ASTM E1633 PARA 4.2.5
14001.C120.01.02.		IAdmFoodUnitCode	Unit of measure of food taken in. ASTM E1633 PARA 4.2.6
14001.C120.02.		IAdmNutrCode	Identifier of the nutrient resulting from food consumed. ASTM E1633 PARA 4.2.6
14001.C120.02.01.		IAdmNutrQty	Amount of nutrient from food consumed. ASTM E1633 PARA 4.2.5
14001.C120.02.02.		IAdmNutrUnitCode	Identifier of unit of measure of nutrient from consumed food. ASTM E1633 PARA 4.2.6
14001.C122.		IAdmNutritlAssessText	ASTM E1633 PARA 4.2.6
14001.C123.		IAdmDietRespText	ASTM E1633 PARA 4.2.6
14001.C125.		IAdmDietTypeCode	ASTM E1633 PARA 4.2.6
14001.C128.		IAdmDietCommentText	ASTM E1633 PARA 4.2.6
14001.C130.	**CLINICAL PROGRESS NOTE DATE-TIME**	IAdmClinProgrNoteDtm	The time point that the physicians textual assessment was composed or written. ASTM E1633 PARA 4.2.4
14001.C130.01.	**CLINICAL PROGRESS NOTE**	IAdmClinProgrNoteText	A textual description of the physician's observations, their interpretations and conclusions about the clinical course of the patient or the steps taken, or to be taken, in the care of the patient.
14001.C130.03.	**SIGNATURE/AUTHENTICATOR**	IAdm ClinProgrNotePractSig	An electronic unique signature of the physician identifying that individual. ASTM E1633 PARA 4.2.7
14001.C110.	REHABILITATIVE SERVICE ORDERED		
14001.C110.01.	REHABILITATIVE SVC UNIT		
14001.C110.02.	REHABILITATIVE SVC DESCRIPTION		
14001.C120.	FOOD INTAKE DATE-TIME		ASTM E1633 PARA 4.2.4

14001.C120.01.	FOOD ID		
1400.C120.01.01.	FOOD AMOUNT		ASTM E1633 PARA 4.2.5
14001.C120.01.02.	FOOD AMOUNT UNIT		
14001.C120.02.	NUTRIENT ID		
14001.C120.02.01.	NUTRIENT AMOUNT		ASTM E1633 PARA 4.2.5
14001.C120.02.02.	NUTRIENT UNIT		
14001.C122.	NUTRITIONAL ASSESSMENT		An overview of the nutritional status of the patient and the perceived nutritional needs that must be provided. TEXT
14001.C123.	RESPONSE TO DIET		A textual synopsis of the effects of a particular diet.
14001.C125.	DIET TYPE		A categorical term identifying a particular class of diet.
14001.C128.	DIET COMMENTS		A textual remark ampliyfing aspects of the patient's diet. ASTM E1633 PARA 4.2.6
14001.D001.	**NAME OF THERAPY/SVC**	TherapNameText	The identifier or name of the therapeutic service conducted. ASTM E1633 PARA 4.2.6
14001.D001.01.	**THERAPY START DATE-TIME**	TherapStartDtm	The time point that the service was commenced. ASTM E1633 PARA 4.2.4
14001.D001.01.01.	**THERAPY FINISH DATE-TIME**	TherapEndDtm	The time point that the therapy ceased. ASTM E1633 PARA 4.2.4
14001.D001.01.03.	THERAPY PROBLEM ID	TherapProbId	The identifier or name of the main problem associated with the therapy. ASTM E1633 PARA 4.2.6
14001.D001.01.05.	THERAPY CLINICAL ORDER ID	TherapClinOrdId	The identifier of the clinical order which requested the therapy. ASTM E1633 PARA 4.2.6
14001.D001.01.06.	THERAPY NAME OF ORDERING PRACTITIONER	TherapOrdPractName	Name of the Practitioner ordering the therapy. ASTM E1633 PARA 4.2.2
14001.D001.01.07.	THERAPY LOCATION DELIVERED	TherapDelLocId	The care facility location at which the therapeutic procedure was conducted. ASTM E1633 PARA 4.2.6
14001.D001.01.11.	THERAPY PATIENT BEGIN CONDIT	TherapPatBeginStatusCode	The beginning status of the patient, includes behavioral aspects. ASTM E1633 PARA 4.2.6
14001.D001.01.13.	THERAPY PATIENT END CONDIT	TherapPatEndStatusCode	The concluding status of the patient, including behavioral aspects. ASTM E1633 PARA 4.2.6
14001.D001.01.15.	THERAPY STATUS	TherapStatusCode	The category term describing the state of the therapeutic procedure. ASTM E1633 PARA 4.2.6
14001.D001.01.17.	THERAPY SPECIFIC PREPARATION	TherapSpecPrepText	The names of the preparative procedures required before the primary procedure can be conducted, such as positioning, procedures etc. ASTM E1633 PARA 4.2.6
14001.D001.01.18.	THERAPY PRODUCTS GIVEN	TherapProdGivenText	The name and attributes of the products utilized in the therapeutic procedure, including nature of product, dosages, ingredients. ASTM E1633 PARA 4.2.6
14001.D001.01.18.01.	AMT OF THERAP PRODUCT GIVEN	TherapProdAmtQty	The total dose or amount of the product, as opposed to dose rates. ASTM E1633 PARA 4.2.5

14001.D001.01.19.	THERAPY EQUIPMENT USED	TherapEquipUsedText	The names or identifiers of the devices used to deliver or conduct the therapeutic procedure. ASTM E1633 PARA 4.2.6
14001.D001.01.21.	**THERAPISTS RESPONSE ASSESSMENT**	TherapResponsAssText	Therapists documentation of pt's attitude toward the plan, including estimates of further therapeutic potential. ASTM E1633 PARA 4.2.6
14001.D001.01.22.	THERAPY RESULTS OF TREATMENT	TherapResultText	Text description of treatment outcome. ASTM E1633 PARA 4.2.6
14001.D001.01.23.	THERAPY RESULT EVALUATION	TherapEvalText	A textual judgment of the overall effect produced by the therapeutic procedure. ASTM E1633 PARA 4.2.6
14001.D001.01.25.	**THERAPY PERF PRACTITIONER**	TherapPractName	The name or identifier of the individual practitioner who administered the therapy. ASTM E1633 PARA 4.2.1
14001.D001.01.27.	**THERAPISTS RECOMMENDATIONS**	TherapRecommText	Further plans for continued treatment and/or services, including an assessment of patient's ability to improve and to what level. ASTM E1633 PARA 4.2.6
14001.E001.	**DATE-TIME PATIENT IN**	OpRepPatInDtm	The time point of the patient's arrival in the operating room complex. ASTM E1633 PARA 4.2.4
14001.E001.01.	CLINICAL ORDER ID	OpRepCOrdId	Identifier of the Clinical Order for this Operative session. ASTM E1633 PARA 4.2.6
14001.E001.02.	OPER PT ISOLATION STATUS	OpRepPatIsolStatusCode	The category term reflecting the nature of the procedures for isolating the patient from the environment or for protecting the environment from the patient with respect to infectious, or potentially infectious conditions. ASTM E1633 PARA 4.2.6
14001.E001.04.	OPER PT CATEGORY	OpRepOpPatCategCode	The category term for the class of operative procedure for this patient. ASTM E1633 PARA 4.2.6
14001.E001.06.	OPER PT CASE TYPE	OpRepOpPatCaseTypeCode	Category of Operative Case. ASTM E1633 PARA 4.2.6
14001.E001.08.	OPER PT CASE NO.	OpRepPatCaseId	The unique identifier for this operative case. ASTM E1633 PARA 4.2.6
14001.E001.10.	OR NO.	OpRepOpRmId	The name or identifier of the operating room in which this patient's procedures will be conducted. ASTM E1633 PARA 4.2.6
14001.E001.11.	PATIENT ISOLATION STATUS	OpRepPatIsolStatusCode	Identified for contagious disease condition state. ASTM E1633 PARA 4.2.6
14001.E001.12.	ORDERING STA NO.	OpRepOrdStaCode	The identifier of the location for which supplies or services are ordered for this operative event. ASTM E1633 PARA 4.2.6
14001.E001.14.	ORGAN DONOR TYPE	ORGDonorAgrTypeCode	The name of the individual donating tissue or organs to this recipient patient. ASTM E1633 PARA 4.2.6
14001.E001.14.01.	BLOOD/SKIN DONOR NAME	OpRepDonorName	The name of a blood or skin donor to this patient. ASTM E1633 PARA 4.2.1
14001.E001.17.	OPERATIVE POSITIONS	OpRepOpPosCode	The name of the position to be used to be used for the procedure to be conducted. ASTM E1633 PARA 4.2.6

14001.E001.20.	POSITIONAL AIDS	OpRepPosAidsCode	The nature of the devices used to aid the patient assume the body position required for the procedure to be conducted. ASTM E1633 PARA 4.2.6
14001.E001.22.	EVIDENCE REMOVED	OpRepEvidRemovdText	A textual description of the specimens or other material removed for legal purposes as evidence in judicial or administrative procedures. ASTM E1633 PARA 4.2.6
14001.E001.24.	DATE-TIME SEEN BY ANESTHESIOL	OpRepAnesthesiolSeenDtm	The time point of pre-anesthesia assessment. ASTM E1633 PARA 4.2.4
14001.E001.26.	ANESTHESIA START TIME	OpRepAnesthStartDtm	The date time when the procedure for administering all anesthetic agents is commenced. ASTM E1633 PARA 4.2.4
14001.E001.28.	ANESTHESIA RDY TIME	OpRepAnesthesRdyDtm	The date time when the anesthetic agents have produced their desired biological effect which will be maintained during the surgery. ASTM E1633 PARA 4.2.4
14001.E001.30.	OPERATION DATE-TIME	OpRepOperStartDtm	The date time at which the operative procedures commenced during this surgery. ASTM E1633 PARA 4.2.4
14001.E001.32.	OPERATION END TIME	OpRepOperEndDtm	The date time at which the operative procedures were completed during this surgery. ASTM E1633 PARA 4.2.4
14001.E001.34.	ANeSTHESIA END TIME	OpRepAnesthesEndDtm	The date time when the biologic effect of all anesthetic agents has disappeared. ASTM E1633 PARA 4.2.4
14001.E001.36.	PATIENT OUT TIME	OpRepPatOutDtm	The time point at which the patient leaves the operating room complex. ASTM E1633 PARA 4.2.4
14001.E001.38.	PATIENT PHYSICAL STATUS	OpRepPatPhysStatusCode	A textual description of the patient's overall physiological status. ASTM E1633 PARA 4.2.6
14001.E001.40.	OPERATION DESCRIPTION	OpRepOPerDescText	A textual description of the operation to be performed written before conduct of the procedures. ASTM E1633 PARA 4.2.6
14001.E001.42.	OPER PT PRE-OP COMMENT	OpRepPreOpCommentText	The textual remarks made before the surgical procedures begin. ASTM E1633 PARA 4.2.6
14001.E001.44.	OPERATION MEASUREMENT	OpRepOperMeasId	The name or identifier of the measurement or observation made during this surgery. ASTM E1633 PARA 4.2.6
14001.E001.44.01.	OPERATION MEASUREMENT VALUE	OpRepOperMeasValueQty	The numeric amount of the property to be measured during the surgery. ASTM E1633 PARA 4.2.5
14001.E001.46.	CHECK RECORD	OpRepRecordCheckCode	A category term for classifying the complete review of the care record and surgery request before commencing the surgery. ASTM E1633 PARA 4.2.6
14001.E001.48.	CHECK PATIENT	OpRepPatientCheckCode	A category term for classifying the complete review of the patient before commencing the surgery. ASTM E1633 PARA 4.2.6
14001.E001.50.	O-R NURSE ID	OpRepORNurseName	The name or identifier of the lead nurse in the operating room. ASTM E1633 PARA 4.2.1
14001.E001.51.	OPER PT RESP STATUS	OpRepPatRespStatusCode	The category term classifying the general respiratory condition of the patient. ASTM E1633 PARA 4.2.6

14001.E001.52.	OPER PT CIRC STATUS	OpRepPatCircStatusCode	The category term classifying the general circulatory condition of the patient. ASTM E1633 PARA 4.2.6
14001.E001.53.	OPER PT CNS STATUS	OpRepCNSStatusCode	The category term classifying the general central nervous system condition of the patient. ASTM E1633 PARA 4.2.6
14001.E001.54.	PREVIOUS ANESTHETIC COMPLIC.	OpRepPrevAnesComplicText	Textual description of prior difficulties the patient may have had with anesthesia. ASTM E1633 PARA 4.2.6
14001.E001.55.	PRE-OP MED NAME	OpRepPreOpMedId	Identifier of the Pre-operative Medication. ASTM E1633 PARA 4.2.6
14001.E001.55.01.	PRE-OP MED DOSE	OpRepPreOpMedDoseQty	The numerical measure of the amount of medicinal product given to the patient before surgery. ASTM E1633 PARA 4.2.5
14001.E001.55.02.	PRE-OP MED ROUTE	OpRepPreOpMedRiuteCode	The categorical term for the avenue by which the medicinal product given to the patient prior to surgery was introduced into the patient. ASTM E1633 PARA 4.2.6
14001.E001.55.03.	PRE-OP MED TIME	OpRepPreOpMedDtm	The date time point at which the medicinal product was administered to the patient. ASTM E1633 PARA 4.2.4
14001.E001.55.04.	PRE-OP MED EFFECT	OpRepPreOpMedEffectText	Textual description of the outcome of administering the medicinal product to the patient prior to surgery. ASTM E1633 PARA 4.2.6
14001.E001.56.	PRE-OP DIAGNOSIS	OpRepPreOpDiagCode	Determination of the case prior to operating. ASTM E1633 PARA 4.2.6
14001.E001.57.	POST-OP DIAGNOSIS	OpRepPostOpDiagnosisCode	Determination of the case after operating. ASTM E1633 PARA 4.2.6
14001.E001.58.	OPERATIVE EVENT SURGEON	OpRepOpEvSurgeonName	Clinicians who performed the principle procedure. These data are also needed for the operating practitioner in the episode summary (7170.) ASTM E1633 PARA 4.2.1
14001.E001.58.01.	SURGEON ROLE	OpRepOpEvSurgeonRoleCode	The category term for the role played by the named surgeon during this surgery. ASTM E1633 PARA 4.2.6
14001.E001.60.	**ANESTHESIOL/ANESTHETIST**	OpRepAnesthiolAnestName	The name of the practitioner responsible for the induction and maintenance of anesthesia during this surgery. ASTM E1633 PARA 4.2.1
14001.E001.61.	ANESTHESIOL. RESIDENT	OpRepAnesthesiolResName	The practitioner in training who assists the anesthesiologist responsible for this patient and this surgery. ASTM E1633 PARA 4.2.1
14001.E001.62.	ANESTHETIST	OpRepAnesthetName	The name or identifier of the nurse-anesthetist participating in the operation. ASTM E1633 PARA 4.2.1
14001.E001.63.	O-R STAFF POSITION	OpRepORStaffPosId	The unique name of the position staffed during this surgery. ASTM E1633 PARA 4.2.6
14001.E001.63.01.	O-R STAFF NAME	OpRepORStaffPosPersName	The name of the individual filling the O-R staff position. ASTM E1633 PARA 4.2.1
14001.E001.64.	ANESTHESIA INDUCTION	OpRepAnesthInductText	Description of the anesthesia induction period. ASTM E1633 PARA 4.2.6
14001.E001.65.	ANESTHETIC INDUCTION COMMENTS	OpRepAnesthesInductCommentText	The textual remarks relating to the induction of anesthesia in this patient. ASTM E1633 PARA 4.2.6

14001.E001.66.	ENDOTRACHEAL TUBE TYPE	OpRepETTubeTypeCode	The category of endotracheal tube used in this surgery and this patient. ASTM E1633 PARA 4.2.6
14001 E001.67.	ENDOTRACHEAL TUBE COMMENT	OpRepETTubeCommentText	The textual remarks concerning the endotracheal tube used in this surgery. ASTM E1633 PARA 4.2.6
14001.E001.68.	TIME OR BLOOD ORDERED	OpRepORBloodOrdDtm	The date time the request for blood units is to be used in the operating room was placed. ASTM E1633 PARA 4.2.4
14001.E001.68.01.	NO. UNITS BLOOD ORD IN O-R	OpRepUnitsORBloodOrdQty	The count of the units of blood ordered for the operating room to be used during this surgery. ASTM E1633 PARA 4.2.5
14001.E001.69.	**OPERATIVE PROCEDURE**	OpRepOperProcedCode	The unique name of the procedure conducted during surgery. ASTM E1633 PARA 4.2.6
14001.E001.69.001.	OPERATIVE PROCEDURE DATE-TIME	OpRepOperProcedDtm	The moment the surgical procedure commenced. ASTM E1633 PARA 4.2.4
14001.E001.69.002.	OPERATIVE PROCEDURE PRIORITY	OpRepOperProcedPriorCode	The order of importance of the operative procedure in the operating room stay. ASTM E1633 PARA 4.2.6
14001.E001.69.003.	OPERATIVE PROCEDURE DESCRIPTION	OpRepOPerProcedDescText	A narrative of what was done during the procedure. ASTM E1633 PARA 4.2.6
14001.E001.69.01.	OPERATIVE PROCEDURE EVAL.	OpRepOperProcEvalText	A textual report of the specific procedure conducted during surgery. ASTM E1633 PARA 4.2.6
14001.E001.69.02.	OPERATIVE PROCEDURE FINDINGS	OpRepOperProcedFindingsText	A narrative of what was observed as a result of the procedure. ASTM E1633 PARA 4.2.6
14001.E001.70.	SURGICAL SPECIMEN ID	OpRepSurgSpecId	The unique identifier for a specimen obtained during surgery. ASTM E1633 PARA 4.2.6
14001.E001.70.01.	SURGICAL SPECIMEN SITE	OpRepSurgSpecSiteCode	The anatomic location from which the specimen was obtained during surgery. ASTM E1633 PARA 4.2.6
14001.E001.70.02.	SURGICAL SPECIMEN PROCESSING	OpRepSurgSpecPocCode	The procedural steps taken to prepare a specimen obtained during surgery for examination. ASTM E1633 PARA 4.2.6
14001.E001.70.03.	SURGICAL SPECIMEN FINDINGS	OpRepSurgSpecFindingsText	A narrative of the observations on the specimen. ASTM E1633 PARA 4.2.6
14001.E001.71.	**ANESTHETIC AGENT**	OpRepAnesthetAgCode	Type of agent used to induce diminished, or loss of, feeling or sensation. ASTM E1633 PARA 4.2.6
14001.E001.71.01.	ANESTHETIC AGENT DOSE VALUE	OpRepAnesthetAgDoseQty	The numeric measure of the amount of anesthetic administered. ASTM E1633 PARA 4.2.5
14001.E001.71.02.	ANESTHETIC AGENT DOSE UNIT	OpRepAnesthetAgDoseUnitCode	The unit of measure associated with the anesthetic dose value. ASTM E1633 PARA 4.2.6
14001.E001.71.03.	ANESTHETIC TECHNIQUE	OpRepAnesthetTechTypeCode	The name of the technique(s) used to administer the anesthetics used in the operation. ASTM E1633 PARA 4.2.6
14001.E001.72.	**POST-ANESTHESIA ASSESSMENT**	OpRepPostAnesthesAssText	A textual synopsis of the effectiveness and adverse effects of the anesthesia. ASTM E1633 PARA 4.2.6
14001.E001.73.	**OPERATIVE EVENT DATE-TIME**	OpRepOpEvDtm	The time point for each operative event including temp, pulse, resp, BP from start of procedure through recovery. ASTM E1633 PARA 4.2.4

14001.E001.73.01.	OPERATIVE EVENT CODE	OpRepOpEvCode	An identifier or name of the event occurring during the operation for which an attribute was observed. ASTM E1633 PARA 4.2.6
14001.E001.73.02.	OPERATIVE EVENT VALUE	OpRepOpEvValueQty	The value, either quantitative (numeric) or qualitative, associated with this operative event. ASTM E1633 PARA 4.2.5
14001.E001.73.03.	OPERATIVE EVENT FLUID TYPE	OpRepOpEvFluidTypeCode	The name or identifier of the fluid associated with this operative event. ASTM E1633 PARA 4.2.6
14001.E001.73.04.	OPERATIVE EVENT FLUID VOLUME	OpRepOpEvFluidVolQty	The measure of the fluid associated with this operative event. ASTM E1633 PARA 4.2.5
14001.E001.73.05.	OPERATIVE EVENT POSITION	OpRepOpEvPositCode	The name or identifier of the patient position associated with this event. ASTM E1633 PARA 4.2.6
14001.E001.73.06.	OPERATIVE EVENT POSITIONAL AID	OpRepOpEvPositAidCode	The name of a positional aid utilized during this operative event. ASTM E1633 PARA 4.2.6
14001.E001.74.	BLOOD LOSS, TOTAL	OpRepBloodLossQty	Total blood loss, in units of blood, during the operation. ASTM E1633 PARA 4.2.5
14001.E001.75.	EXTRA OR SUPPLIES	OpRepExtrSupplyCode	The name or identifier of supplies used in this operation that are additional to those regularly used. ASTM E1633 PARA 4.2.6
14001.E001.75.01.	EXTRA OR SUPPLIES-AMT	OpRepExtrSupplyAmtQty	The numeric quantity of those additional supplies. ASTM E1633 PARA 4.2.5
14001.E001.76.	K-THERMIA	OpRep	
14001.E001.78.	CAUTERY SITE	OpRepCauterySiteCode	The anatomic location of the site cauterized during surgery. ASTM E1633 PARA 4.2.6
14001.E001.80.	CASTS	OpRepCastCode	A description of the locations and types of casts applied during the operation. ASTM E1633 PARA 4.2.6
14001.E001.82.	IMPLANTS & DRAINS	OpRepImpDrainLocCode	A list of the locations and descriptions of any surgical implants or drains left in the patients at the conclusion of the operation. ASTM E1633 PARA 4.2.6
14001.E001.84.	TOURNIQUET TIMES	OpRepTournDtm	The list of times that tourniquets are established to control blood flow. ASTM E1633 PARA 4.2.4
14001.E001.84.01.	TOURNIQUET LOC	OpRepTournLocCode	The name of the location for each tourniquet established. ASTM E1633 PARA 4.2.6
14001.E001.85.	URINARY CATHET. PLACE DATETIME	OpRepUrCathPlaceDtm	The time point at which a catheter was placed in the urinary tract. ASTM E1633 PARA 4.2.4
14001.E001.86.	NEEDLE CTS-1ST:3RD	OpRepNeedleCtsQty	A sequence of numbers representing the visual counts of suturing needles at three time points. ASTM E1633 PARA 4.2.5
14001.E001.87.	INSTRUMENT CT-1ST:3RD	OpRepInstrumCtsQty	A sequence of numbers representing the visual counts of surgical instruments at three time points. ASTM E1633 PARA 4.2.5
14001.E001.88.	SPONGE CTS-1ST:3RD	OpRepSpongeCtsQty	A sequence of numbers representing the visual counts of surgical sponges at three time points. ASTM E1633 PARA 4.2.5

14001.E001.90.	RECOVERY NOTE TEXT	OpRepRecovNoteText	A textual account of the course of the patient's recovery following the operation. ASTM E1633 PARA 4.2.6
14001.E001.91.	**OPERATION COMPLICATIONS**	OpRepOperComplicText	A textual account of surgical misadventures, i.e., infections. ASTM E1633 PARA 4.2.6
14001.E001.92.	OPERATIVE COMMENTS	OpRepOperCommentsText	A textual remark during the operative event. ASTM E1633 PARA 4.2.6
14001.E001.93.	DISCH. OPER RPT DICT. DATE	OpRepDischOpRptDictDtm	The date the operating surgeon actually dictated the operative report. ASTM E1633 PARA 4.2.4
14001.E001.94.	OP-REPORT DICTATED BY	OpRepSurgeonName	The name or identifier of the surgeon dictating the operative report. ASTM E1633 PARA 4.2.1
14001.F006.	**ADMISSION ENCOUNTER SURGEON**	IDispSurgeonName	The surgeon participating in the principal operative procedure of this admission. ASTM E1633 PARA 4.2.1
14001.F006.1.	**ADMISSION ENCOUNTER SURGEON ROLE**	IDispSurgeonRoleCode	The role of the surgeon in the principal operative procedure of this admission. ASTM E1633 PARA 4.2.6
14001.F013.	ADMISS OPER PROCEDURE	IDispOperProcCode	The name of operative procedures other than the principal on conducted during this admission. ASTM E1633 PARA 4.2.6
14001.F013.01.	ADMISS OPER PROC DATE	IDispOperProcDtm	The date on which other operative procedures than the principal on was conducted. ASTM E1633 PARA 4.2.4
14001.F013.02.	ADMISS OPER PROC SURGEON	IDispOperProcSurgName	The name of the surgeon performing operative procedures other than the principal one. ASTM E1633 PARA 4.2.1
14001.F013.03.	ADMISS OPER PROCEDURE TYPE	IDispOperProcTypeCode	The code identifying the procedure type (e.g., principal, primary, secondary). ASTM E1633 PARA 4.2.6
14001.F014.	ENCOUNTER PROCEDURE	HCAVDispEncounterProcCode	A list of procedures conducted on the patient during this encounter/stay. ASTM E1633 PARA 4.2.6
14001.F030.	**ENCOUNTER DIAGNOSIS**	HCFEDispDiagICDCode	A list of all conditions co-existing at the time of the episode that effect the treatment received or LOS. A condition of sufficient signficance to warrant inclusion for investigative medical studies. No symbols or abbreviations. Complications are additional diagnoses describing conditions arising after the beginning of the episode and modifying the course of the patient's illness or the medical care required. Also describes undesired result and/or misadventure in the medical care of a patient. LEXICON ASTM E1633 PARA 4.2.6
14001.F030.01.	ENCOUNTER DIAGNOSIS TYPE	HCFEDispDiagTypeCode	A term identifying priority (e.g. secondary, tertiary etc.) of the diagnosis code. ASTM E1633 PARA 4.2.6
14001.F030.02.	ENCOUNTER DIAGNOSIS NARRATIVE	HCFEDispDiagNarrText	The narrative text of the diagnosis. ASTM E1633 PARA 4.2.6
14001.F030.03.	PATIENT DIAGNOSIS STATUS	DiagStatusCode	Code for the Status of this diagnosis in this encounter. ASTM E1633 PARA 4.2.6
14001.F036.	ENCOUNTER ETIOLOGY	HCFEDispEtiolCode	A name of causes of the conditions which led to this stay. ASTM E1633 PARA 4.2.6

14001.F036.1.	ENCOUNTER ETIOLOGY TYPE	HCFEDispEtiolTypeCode	The type of the cause of the patient's primary diagnosis for this stay. The name may refer to either illness or traumatic injury conditions. ASTM E1633 PARA 4.2.6
14001.F040.	**DISPOSITION DATE-TIME**	HCFEDispDispDtm	Date-time of formal release from, or termination of, an episode of care when discharged alive. ASTM E1633 PARA 4.2.4
14001.F043.	PHYSICIAN AUTHORIZ DISPOSITION	HCFEDispPrctAuthDischName	The responsible physician actually authorizing the patient's discharge. ASTM E1633 PARA 4.2.1
14001.F046.	**DISPOSITION TYPE**	HCFEDisposTypeCode	Code representing the term categorizing the Disposition. ASTM E1633 PARA 4.2.6
14001.F050.	DISCHG./ENCOUNTER DISPOSITION	HCFEDispDisposCode	The provider's statement of the next steps in the care of the patient. It applies to all encounters including inpatient stays and gives the basic cateory and subcategory of the disposition action (e.g. D/C to home, died, left AMA, follow-up, etc.). This lexicon is used in both the UACDS and the UHDDS of the NCHS. ASTM E1633 PARA 4.2.6
14001.F053.	ENCOUNTER DEPART DATETIME	HCAVDispDepartDtm	The date time the patient actually departed the facility. ASTM E1633 PARA 4.2.4
14001.F056.	ENCOUNTER FOLLOWUP ACTION	HCAVDispEncFolowupActCode	A description of any follow-up actions resulting from this encounter. ASTM E1633 PARA 4.2.6
14001.F060.	ENCOUNTER FOLLOWUP STATUS	HCAVDispEncFolowupStaCode	A list of terms depicting the current status of the follow-up action. ASTM E1633 PARA 4.2.6
14001.F063.	ENCOUNTER FOLLOWUP TARGET DATE	HCAVDispEncFollowTargDtm	The date by which the intended follow-up action is to be completed. ASTM E1633 PARA 4.2.4
14001.F066.	COND. ON DISCHG.	IDispCondonDischgCode	The health status upon discharge. Text. ASTM E1633 PARA 4.2.6
14001.F067.	PATIENT DISPOSITION HEALTH STATUS MEASURE NAME	IDispHlthStatTMeasText	Title of the Total Health Status Measure and Instrument. ASTM E1633 PARA 4.2.6
14001.F068.	PATIENT DISPOSITION HEALTH STATUS MEASURE TOTAL VALUE	IDispHlthStatTMeasQty	Numeric Value of the Health Status Measure Total magnitude. ASTM E1633 PARA 4.2.5
14001.F069.	PATIENT DISPOSITION HEALTH STATUS MEASURE ELEMENT NAME	IDispHlthStatMeasElCode	Code representing the identity of the Health Status Measure Element. ASTM E1633 PARA 4.2.6
14001.F069.01.	PATIENT DISPOSITION HEALTH STATUS MEASURE ELEMENT VALUE	IDispHlthStatMeasElQty	Numeric Value of the Magnitude of the Health Status measurement element. ASTM E1633 PARA 4.2.5
14001.F070.	REASON FOR DISCHARGE	IDispDischgReasonCode	The term categorizing the reason for terminating the patient's resident status such as: moved, died, no medical supervision needed, requested by family, referral elsewhere, lack of reimbursement, refusal of treatment, treatment goals met (maximum benefit achieved), left AMA. ASTM E1633 PARA 4.2.6
14001.F073.	PERSON ACCOMPANYING PATIENT FROM FACILITY	IDispPersonAccompPtName	The person who actually accompanies the patient from the facility after a discharge or encounter. ASTM E1633 PARA 4.2.1

14001.F076.	DISPOSITION TRANSPORT TYPE	IDispDisposTransTypeCode	A list of the categories of transport by which the patient left the facility. ASTM E1633 PARA 4.2.6
14001.F080.	**DISPOSITION DESTINATION**	IDispDisposDestText	A description of the actual destination of the patient upon leaving the facility. ASTM E1633 PARA 4.2.6
14001.F083.	**DISPOSITION PATIENT INSTRUCTIONS**	HCFEDispPtInstructText	The instructions for care or follow-up issued to a patient who left the facility. ASTM E1633 PARA 4.2.6
14001.F086.	PATIENT SIGNATURE	IDispPatientSig	Signature of the Patient to Instructions. ASTM E1633 PARA 4.2.7
14001.F090.	DISCHG SUMM DICT DATE-TIME	IDispDischgSummDictDtm	The date and time that the responsible physician actually dictated the text of the summary. ASTM E1633 PARA 4.2.4
14001.F093.	TOTAL ACUTE CARE LOS	IDispTotAcuteCarLOSDayQty	This period is the number of days calculated according to agreed upon formulae denoting the period of inpatient residence in the facility. The period of rehabilitative care is calculated separately, if conducted in the same faciity and residence period. ASTM E1633 PARA 4.2.5
14001.F096.	LENGTH OF REHAB SERVICES	IDispRehabSvcDayCnt	The number of days denoting the period of residence in a rehabilitative status. ASTM E1633 PARA 4.2.5
14001.F100.	TOTAL ICU DAYS	IDispTotalICUDayCnt	ASTM E1633 PARA 4.2.5
14001.F101.	DATE-TIME OF DISPOSITION NOTE	HCFEDispDispNoteDtm	The date and time of the note describing the care rendered in the emergency department. ASTM E1633 PARA 4.2.4
14001.F105.	**TEXT OF NOTE/REPORT**	HCFEDispNoteText	The textual content of the report. ASTM E1633 PARA 4.2.6
14001.F110.	**SIGNATURE/AUTHENTICATOR**	HCPractSig	An electronic unique signature of the physician identifying that individual. ASTM E1633 PARA 4.2.7
14001.G001.	CHARGE ITEM NAME	BILLItmText	The name for a reimbursement, for D/C DRG charge-all charges for procedures and services rendered by the provider or his/her associates, during or in conjunction with the episode. It includes procedures occurring subsequent to the episode but ordered during the episode, and a facility fee, if billed separately from the professional fee. NUMERIC. ASTM E1633 PARA 4.2.6
14001.G001.01.	MEDICAL SERVICE CODE	BILLItmServiceCode	The identifying character string for a service rendered during this encounter. ASTM E1633 PARA 4.2.6
14001.G001.02.	MEDICAL SERVICE DATE	BILLItmServiceDtm	The date of the service rendered, which may be different from the encounter data-time, conducted off-site. ASTM E1633 PARA 4.2.4
14001.G001.03.	MEDICAL SERVICE COMMENT	BILLItmCommentText	The notation associated with this Service Code. ASTM E1633 PARA 4.2.6
14001.G001.04.	MEDICAL SERVICE CHARGE VALUE	BILLItmChargeValue	The monetary value associated with the Service Code. ASTM E1633 PARA 4.2.5
14001.G002.	ENCOUNTER TOTAL CHARGES	BillSvcsTotChgQty	Total Charge Value for this encounter. ASTM E1633 PARA 4.2.5
14001.G003.	WORKMANS COMP CLAIM FILING STATUS	BILLSvcsWrkCmpFilStatCode	The code for the status of any claim filed for Workman's Compensation at either the state or federal level associated with this visit/encounter. ASTM E1633 PARA 4.2.6

14001.G006.	WORKMANS COMP CLAIM NO.	BILLSvcsWrkCmpClaimId	The identifier string for a claim submitted under workman's compensation. ASTM E1633 PARA 4.2.6

A2. TAG VALUE MODEL OF EHR: DETAIL

TABLE A2.1 EHR Patient Care Record

Sources:
= DOD/CHCS Registration data element
+ = Uniform Discharge Dataset
& = Uniform Ambulatory Minimum Dataset
M = Master Patient Index
% = VA Data Dictionary
$ = VA March AFB Data Dictionary Additions
*(post) = USMC FMF reqd elements
38 = E-1238 data elements
E = EMS Data Elements
C = NCVHS Core Data Elements
7 = HL7 Data Elements
12 = X12N Data Elements

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01002.		Previously Registered Name		
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01032.	%&M+#EC7	Date-time of Birth *38	00110	1251
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01033.	%127	Birthplace	00126	
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01040.	%&M+#EC127	Sex *38	00111	1068
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01045.	EC127	Ethnic Group(M) 38	00125	1109
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01052.	EC127%	Marital Status 38	00119	1067
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01099.		Foreign Residency Status		
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01010.3.		End date		
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04001.10.		Practitioner Name (M)----->PROVIDER/PRACTITIONER NAME		
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04001.31.	%	Practitioner FAX Phone		
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04001.32	7	Practitioner E-mail Address	01160	
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04001.45.	7	Practitioner Current role for this patient (M)	01155/01197	
<RoleBeginDtm>				
04001.45.01.	7	Date role began	01163/01199	
<RoleEndDtm>				
04001.45.02.	7	Date role ended	01164/01200	
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04001.50.01.		Date Location Began		
<PractLocEndDtm>				
04001.50.02		Date Location Ended		
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5. Health Condition/Problem List

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<PHProbProbOnsetDtm>				
05001.03.	%7	Health Cond/Prob Date of Onset	00851	1251
<PHProbDescText>				
05001.04.	7	Health Cond/Prob Onset Description	00852	
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05001.07.	%7	Health Cond/Prob Date Recorded	00842	
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05001.09.	%7	Health Cond/Prob Diagnosis	00575	
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05001.10.	7	Health Cond/Prob Date Diagnosed	00379	1251
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05001.13.	%	Health Cond/Prob Facility Where Diagnosed		
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05001.15.	%7	Health Cond/Prob Date Resolved	00844	
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05001.32.01.		Health Cond/Prob Monitoring Variable/service (M)		

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<PHProbOrdersId>		
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</Hlth-Cond/Prob>		

6. Immunizations

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<ImmBatchMfrId>		
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<ImmBatchExprDtm>		
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<ImmUnitsQty>		
06001.01.10.		Immunization No of Units
<ImmInjsiteId>		
06001.01.11		Immunization Injection Site
<ImmFacId>		
06001.01.12.	%	Immunization Administering Treatment Facility
<ImmReactOrResultCode>		
06001.01.15.	%	Immunization Reaction/Result
<ImmRectSevCode>		
06001.01.17.	%	Immunization Severity
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06001.01.20.	%	Immunization Remarks
<ImmAdminPractId>		
06001.01.25.	%	Immunization Administering Practitioner-ID----->PRACTITIONER SEGMENT
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7. Record of Exposure to Environmental Stressors

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<EStrExposureBeginDtm>		
07001.05.		Hazard Exposure Begin Date-time (M)
<EStrExposureTermDtm>		
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<EStrWorkCenterText>		
07001.05.03.		Hazard Setting of Exposure
<EStrExposureWorkActyCode>		
07001.05.05.		Hazard Route of Exposure
<EStrExposureIntervDoseQty>		
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07001.05.13.		Hazard Work Performed

<EStrPersProtectCode>
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</Env-Haz-Agent>
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<EStrTestDtm>
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<EStrSampleCollUnitCode>
07001.07.02. Hazard Unit of Hazard Sample Collected
<EStrCllTimeIntervQty>
07001.07.03. Hazard Sample Collection Time
<EStrCollectDeviceCode>
07001.07.05. Hazard Sample Collection Device
<EStrTestSampleMethoidCode>
07001.07.07. Hazard Test Sample Method
<EStrDeterTypeCode>
07001.07.09. Hazard Type of Determination
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07001.07.11. Hazard Peak Measurement Value
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07001.07.13. Hazard Peak Measurement Unit
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8. Health History

Prenatal

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<PRHistEstDelDtm>
08005.03. Estimated/Actual Date of Delivery
<PRHistInitPrenatPractDtm>
08005.05. Date First Saw Pre-natal Practitioner
<PRHistPrenatPractTypeCode>
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08005.09. Birthing Plan
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<PRHistGynecolAbnText>
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<Newborn>
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<PRHistSex>
08005.21.1. Sex
</Newborn>
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Perinatal

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08013. Patient newborn Birth Length
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08017. Estimate of Patient Fetal Maturity at Birth
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08020. Patient Newborn Abnormalities
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08027.		1 min Apgar		
<HHist5MApgarQty>				
08030.		5 min Apgar		
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<HHistNbChestCircQty>				
08037.		Newborn Chest Circumference (cm)		
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Individual

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08070.07.	7	Job Title	00785	
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08070.09.	7	Job Code	00786	
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08070.17.	7	Termination Date	00783	
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08070.19.		Comments		
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08075.05.		Source of History: Contact Name		

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08075.07.		History Relationship of Source to Patient	
<HistoryPresentHealthText>			
08075.09.		History of Present Health	
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08075.10.		State of Oral Hygiene	
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08075.15.		Current Occupation	
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9. Examinations

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09001.11.	%	Initial Impression	
<HExmReviewSystemsText>			
09001.12.		Review of Systems (text)	
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09001.13.04.	%	Comment on Finding	
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09001.14.		Exam Procedure	
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09001.15.	%	Exam/History Comments	
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09001.23.		Recommendations	
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<Tooth>			
<HExmToothId>			
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09001.30.01.	12	Tooth Status	1368
<HExmToothCommentText>			
09001.30.03.		Comment	
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<HExmToothSurfRestMatCode>			
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09001.30.05.3.		Periodontal Tissue Status	
</Tooth-Surf>			
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09001.30.06.		Sensitivity	
<HExmToothMobilityCode>			
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<HExmTooth BuccPocket DepthQty>			
09001.30.09.		Periodontal Buccal Pocket Depth	
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09001.30.10.	12	Implant Type	1403
<HExmTooth ImplantMatlCode>			
09001.30.11.		Implant Material	
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10. Clinical Orders/Treatment Plans—Clinical Orders

<C-Order>	Sect 8	(E-1238/HI7 ORC/OBR)	Segment 10	
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10001.	%7	CLIN ORDER Order ID # (M) 38	00216/00217	

Patient/Subject

<COrdEncDtm>				
10001.001.		CLIN ORDER Encounter date-time/ID (M)----->ENCOUNTER SEGMENT		
<COrdPtStatus>				
10001.002.		CLIN ORDER Patient Status		

Type/Addressee

<COrdDtm>				
10001.009.	12%7	CLIN ORDER Date-time 38	00229	0373
<COrdType>				
10001.010.	12%	CLIN ORDER Order type (ancillary service ID)----->ANCIL SER LEX		1251,0373
<COrdAction>				
10001.013.	%7	CLIN ORDER Order Action 38	00245	
<COrdPriority>				
10001.015.	7	CLIN ORDER Priority of order 38	00239	
<COrdPreAdmitStatus>				
10001.017.		CLIN ORDER Pre-admit order		
<COrdOrigin>				
10001.019.	%7	CLIN ORDER Origin of order(verbal/phone etc)	00227	
<COrdParentOrd>				
10001.021.	%7	CLIN ORDER Parent order- if secondary 38	00222/00261	
<COrdMultSeqStatus>				
10001.022		CLIN ORDER Is order multiple sequential		
<COrdRelatedOrders>				
10001.023.	%7	CLIN ORDER Related Orders (M) 38----->ORDER SEGMENT		

Orderer/Originator

<COrdUser>				
10001.025.	%7	CLIN ORDER User	00224	
<COrdUserISig>				
10001.027.	%	CLIN ORDER User SIG		
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10001.029.		CLIN ORDER Nurse		
<COrdNurseSig>				
10001.031.	%	CLIN ORDER Nurse SIG		
<COrdOrderingPract>				
10001.033.	7	CLIN ORDER Ordering Practitioner 38----- >PRACTITIONER SEG	00226	
<COrdOrderingPractRole>				
10001.034.	7	CLIN ORDER Ordering Practitioner Role 38 xxxx		
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10001.035.	%	CLIN ORDER Ordering Practitioner SIG		
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10001.037.		CLIN ORDER Countersigning Practitioner----- >PRACTITIONER SEGMENT	00225	
<COrdCsignPractSig>				
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10001.047.		CLIN ORDER Time Practitioner SIG Needed		
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10001.049.		CLIN ORDER Countersignature Needed		
<COrdCSigNeedDtm>				
10001.051		CLIN ORDER Time Countersignature Needed		
<COrdDisconbyPract>				
10001.052.		CLIN ORDER Order D/Ced by----->PRACTITIONER SEG	00233	
<COrdDisconbyPractSig>				
10001.053.		CLIN ORDER D/C SIG		
<COrdConfirmationRecd>				
10001.055.		CLIN ORDER Date-time Order Confirmed by Addressee		

Control

<COrdActPendStatus>				
10001.057.	7	CLIN ORDER Active/Pending Flag	00219	
<COrdResponseActionCode>				
10001.058.	7	CLIN ORDER Response Action Code	00220	0121
<COrdActiveStatus>				
10001.059.		CLIN ORDER Active Status		
<COrdPendingStatus>				
10001.061.		CLIN ORDER Pending Status		
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10001.063.		CLIN ORDER Inactive Status flag		
<COrdStartStatus>				
10001.065.		CLIN ORDER Start Today/Tomorrow		
<COrdExecFreq>				
10001.067.	%7	CLIN ORDER Order Timing-Every or Every nth Day 38	00221	
<COrdDuration>				
10001.069.	%	CLIN ORDER Duration Order in Effect		
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10001.079		CLIN ORDER Time to Expect Stat Result		
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10001.081.		CLIN ORDER Telephone Result Flag		
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10001.083.	7	CLIN ORDER Telephone Result to Other Than Location Ordered From 38	00228	
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10001.085.		CLIN ORDER Request Scheduled		
<COrdReqApptDtm>				
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10001.091.	7	CLIN ORDER Transport Needed 38	01032	
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10001.093.		CLIN ORDER Appointment Status		
<COrdAssineApptDtm>				
10001.095.		CLIN ORDER Assigned Appt Time		

Text

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10001.097.	7	CLIN ORDER Health Service Ordered 38----->HLTH SERVICE TERM	00238	
<COrdTrPInv>				
10001.098.		CLIN ORDER Treatment Plan Involved----->TREATMENT PLAN		
<COrdProb>				
10001.099.	7	CLIN ORDER Principal Health Condition Affected 38----->HLTH COND LIST SEGMENT		
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10001.100.	%	CLIN ORDER Full Text of Order		
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10001.102.	7	CLIN ORDER Location of Service	01311	
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Treatment Plan

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11. Observation/Diagnostic Tests

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11001.01.09.	7	Performing Facility	00583
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11001.01.12.	7	Attending Specialist ID 38	00137
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11001.01.15.	7	Clinical Order ID----->ORDERS SEGMENT	00216/00217
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11001.01.18.	7	Requesting Provider ID 38	00226
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11001.01.33.	%7	Date-time Specimen Received 38	00248	
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11001.01.57.04.	7	Abnormality Basis 38	00576/01348	
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12. Medications

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13. Scheduled Visits

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13001.03.	%	Clinic Name		
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14. Encounters

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14001.A005.		Encounter Detailed Location		

A. Administrative/Diagnostic Summary

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14001.A040.	EC7	Injury. on Job Status	00716	
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14001.A130.	7%	Admitting Room & Bed 38	00133/00209	
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14001.A170.03.		Narrative		
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14001.A163.02.		Transferred to Nursing Unit	
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14001.A163.06.		Clinical Service	
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14001.A163.10.		Room/Bed	
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14001.A163.13.		Transfer Diagnosis	
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14001.A163.16.		Provider----->PRACTITIONER SEGMENT	
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14001.A186.2.	#	Prognosis	
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B. Trauma Care/History of Present Illness

Pre-hospital Care

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14001.B0003.		Date-time Run Arrived at the Scene	
<PREHospOrderAgencyArrQty>			
14001.B00031.		Order Agency Arrived at Scene	
<PREHospPtLeftSceneDtm>			
14001.B0004.		Date-time Patient Left the Scene	
<PREHospArrTreatFacilDtm>			
14001.B0005.	E	Date-time Patient Arrived at the Treatment Facility	
<PREHospReturntoServiceDtm>			
14001.B0006.		Date-time Returned to Service	
<PREHospTraumaSurgArrDtm>			
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<PREHospNeuroSurgArrDtm>			
14001.B00062.		Date-time Neurosurgeon Arrived	
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<PREHospDispSeverityQty>			

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<PREHospSceneSeverityQty>		
14001.B005.		Severity at Arrival on Scene
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14001.B0051.		Run Number
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14001.B006.		Agency ID
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14001.B0065.		Vehicle ID
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Emergency Room Care

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14001.B015.		Time of Triage *
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Critical Care

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14001.B063.3.		IV Site
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14001.B063.4.		IV Line New Start:Guage&Lngth
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14001.B063.5.2.		IV Fluid Bottle ID
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C. Clin Course/Nursing Care Plan

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14001.C012. Nursing Short Term Goal Deadline
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14001.C070.		Est Discharge Date	
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14001.C073.		Aftercare Plan	
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14001.C080.		Date-time Sched. tests/consults/Surgery (M)	
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14001.C080.01.		Type	
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14001.C080.02.		Place to be Conducted	
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C. Clin Course/Rehabilitative Care Section

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C. Clin Course Dietetics/Nutritional Care Plan

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14001.C125.	7	Diet type	00168
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14001.C128.	%	Diet/Nutrition Comments	

C. Clin Course/Progress Notes

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D. Therapies

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14001.D001.01.13.		Ending Patient Condition	
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E. Operative Procedures

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14001.E001.26.	%	Anesthesia Start Time
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14001.E001.28.		Anesthesia Ready Time
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14001.E001.30.	%E	Operation Start Time
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14001.E001.32.	%E	Operation Complete Time
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14001.E001.65.	%	Induction Comments
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14001.E001.73.04.	%	Fluid Volume *	
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14001.E001.82.		Implants/Drains/Ligatures (M)	
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14001.E001.88.		Sponge Counts(M)	
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14001.E001.91.		Complications	
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14001.E001.92.		Post Operative Remarks *	
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14001.E001.93.		Operative Report Dictation date	
<OpRepDictSurgeonName>			
14001.E001.94.		Operative Report Dictated By----->PRACTITIONER SEGMENT	
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F. Disposition

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14001.F013.02.	12	Surgeon----->PRACTITIONER SEGMENT		1035,1036,1037,1039
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14001.F013.03.		Type (pri,sec,etc)		
</Encounter-Disp-Op-Proc>				
<Encounter-Disp-Diag>				
<DiagICD>				
14001.F030.	5+C12	Patient Diagnosis (M)----->DIAGN TERM/CODE	00378	1328/1271
<DiagType>				
14001.F030.01.	127	Type (pri,sec,etc)	00380	1220
<DiagStatus>				
14001.F030.02	7	Narrative		
<DiagNarr>				
14001.F030.03.		Diagnosis Status	00389	
</Encounter Disp-Diag>				
<Encounter Etiology>				
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14001.F036.		Encounter Etiology (M)----->ETIOLOGY TERM/CODE		
<EtiolType>				
14001.F036.1.		Type (pri,sec,etc)		
</Encounter Etiology>				
<Encounter-Disp-Hlth-Sta>				
<HlthStatMeasEl>				
14001.F069.		Patient Disposition Health Status Measure Element Name(M)		
<HlthStatMeasElQty>				
14001.F069.01.		Patient Disposition Health Status Measure Element Value		
</Encounter-Disp-Hlth-Sta>				
<EncounterProc>				
14001.F014.	%E12	Encounter Procedure (M)----->PROCEDURE TERM/CODE		1137
<DisposDtm>				
14001.F040.	%+#E7	Disposition Datetime *	00175	
<PrctAuthDischg>				
14001.F043.		Physician Authorizing Discharge----->PRACTITIONER SEGMENT		
<DisposType>				
14001.F046.	#%	Disposition Type		
<Dispos>				
14001.F050.	&EC7	Disposition	00166	
<DepartDtm>				
14001.F053.	E	Departure Date/time		
<EncFollowupAction>				
14001.F056.	E	Followup Action		
<EncFollowupStatus>				
14001.F060.		Followup Status		
<EncFollowTargDtm>				
14001.F063.		Followup Target date		
<CondonDischg>				
14001.F066.		Condition on Discharge/Departure		
<DispHlthStatusTotMeas>				
14001.F067.		Patient Disposition Health Status Measure Name		
<DispHlthStatusTotMeasValue>				
14001.F068.	E	Patient Disposition Health Status Measure Total Value		
<DischgReason>				
14001.F070.		Reason for Discharge		
<PersonAccompPt>				
14001.F073.		Person Accompanying patient from facility		
<DisposTransportType>				
14001.F076		Disposition Transport Type		
<DispDest>				
14001.F080.	#$E7	Disposition Destination	00167	
<DispPtInstruct>				
14001.F083.		Patient Disposition Instructions		
<PatientSig>				
14001.F086.		Patient Signature		
<DischSummDictDtm>				
14001.F090.		Disposition Summary Dictation Date		
<TotAcute CareLOS>				

14001.F093. <RehabSvcDays>	7	Length of Acute Care Stay	00712
14001.F096. <TotlCUDays>		Length of Rehabilitation Services	
14001.F100. <DispDtm>		Total ICU Days	
14001.F101. <DispNote>	%	Dischg Summary Date	
14001.F105. <NarrSig>	E	Narrative Discharge Summary	
14001.F110. </Enc-Disposition>	%#E	Practitioner ID----->PRACTITIONER SEGMENT	

G. Charges

<Encounter-Chg-Item>			
<BillItemName>			
14001.G001. <BillItem>	E	Charge Item Name (M)	
14001.G001.01. <ServiceCode>		Medical Service Code	
14001.G001.02. <ItemComment>		Medical Service Date	
14001.G001.03. <ChargeValue>		Medical Service Comment	
14001.G001.04. </Encounter-Chg-Item>		Charge Value	
<BillTotalChargeQty>			
14001.G002. <BillWCompClaim FilStatuCode>	7EC	Total Encounter Billed Charges	00177
14001.G003. <BillWCompClaimId>	12	Workmans Comp Claim Filing Status	
14001.G006. </Encounter>	%	Workmans Comp Claim ID	
</Patient>			

APPENDIXES

(Nonmandatory Information)

X1. MEDICAL DENTAL RECORD OF CARE STRUCTURE

TABLE X1.1 EHR Vocabulary Content Master List

Electronic Health Record Summary List of Content
= DOD/CHCS Registration data element
+ = Uniform Discharge Dataset
& = Uniform Ambulatory Minimum Dataset
M = Master Patient Index
% = VA Data Dictionary
$ = VA March AFB Data Dictionary Additions
* (post) = FMF reqd elements

I. Demographic/Administrative

01001.	%+&M#Patient Name *
01002.	Previous Name - Previously Registered Name
01005.	Parental Marital Status
01007.	Adoption status
01010.	% Alias - Individual Alternate Name (M)
01010.1.	Usage
01010.2.	Start date
01010.3.	End date
01015.	&M+Unique Personal Identifier/Facility Unit Number - Individual Identifier (M)
01015.1.	Organization
01015.2.	Type
01015.3.	Start date
01015.4.	End date
01015.5.	Status
01015.6.	Identifier Privacy Key
01025.	MArchive data (M)
01027.	Record Holding Location ID (M)→Facility Data File
01027.1.	Date of earliest held entry
01027.2.	Date of latest held entry
01030.	%MLocation of paper chart (chartbase)
01032.	%&M+#Date-time of Birth *
01033.	%Birthplace
01035.	Multiple Birth Market—Number of Children in the birth
01036.	Delivery Birth Order
01037.	Family Birth order
01040.	%&M+#Sex *
01042.	%+#Race *
01045.	Ethnic Group(M)
01047.	%#Religion *
01050.	Military Service/Veteran Status
01052.	%Marital Status
01055.	Citizenship Status
01057.	Patient's Language
01058.	Enabling Interpreter Reqd
01060.	Education level
01062.	%Current work Status
01065.	%Occupation (M)
01065.1.	Occupation Status Code
01065.2.	Date completed occupation
01065.3.	Occupation Std Industrial Code
01067.	Current Vocational Status
01069.	Permanent Impairment
01075.	Patient current workplace - Present employer name
01077.	Work Address
01080.	%#Work Phone
01085.	Usual living arrangement

01087.	No. persons in household
01090.	Family member's name (M)
01090.02.	SSAN
01090.03.	Relationship
01090.05.	Male parent name
01090.07.	Female parent maiden (birth) name - Female parent name
01090.11.	Sex
01090.13.	Date of birth
01090.15.	Date of Death
01090.17.	Head of Household Status
01090.19.	Principal Caregiver Status
01090.21.	Location
01090.23.	Occupation
01090.25.	Major Diagnosis/Cause of Death (M)
01090.27.	Inherited Gene ID (M)
01090.27.01.	Expression
01090.27.02.	Extent
01095.	%&+Patient. Home Address
01096.	Patient Previous Address (M)
01096.1.	Previous address begin date
01096.2.	Previous address end date
01097.	Patient County/Census tract
01099.	Foreign residency status
01100.	%&+Patient Home Phone
01105.	Patient Temporary Address
01108.	Patient Temporary Address Phone
01110.	%Emergency Contact name
01112.	%Emergency Contact relationship
01115.	%Emergency Contact Addr.
01117.	%Emergency Contact phone
01119.	Emergency Contact Business phone
01120.	Patient Legal Guardian Name
01125.	Patient Legal Guardian Address
01130.	Patient Guardian Status
01135.	%#Next of Kin (NOK) Name
01137.	%#NOK Relationship
01140.	%#NOK Address
01142.	%#NOK H. Phone
01145.	NOK B. Phone
01150.	Handedness Code
01155.	Color Eyes
01160.	Color Hair
01165.	Blood Type
01167.	Identification Photo
01170.	%Height for identification
01175.	Build for identification
01180.	%Weight for identification *
01185.	%Patient Record-Activity Status
01190.	Confidentiality Protection
01195.	Date Record Initiated or Updated(M)
01195.02.	Person initiating/updating
01197.	Record review date
01200.	Registration Informant
01205.	Registration Comment
01210.	Date Record transferred to Storage
01220.	Date-time of Death
01225.	Place of Death
01227.	Autopsy Status
01230.	Recorder of death
01235.	Date recorded
01240.	Death Certif. no.
01245.	State recorded
01250.	Cause of Death (M)
01251.	Underlying Cause of Death
01255.	Mortuary preference/internment
01260.	Bereavement assessment
01262.	Clergyman Name
01265.	Clergyman Address
01267.	Clergyman phone

II. Legal Agreements

02001.	Admit agreements/Consent to care
02005.	Patients rights Acknowledgement
02010.	Authority for Autopsy
02015.	Body release to Morgue
02020.	Consent for video tape/observation
02025.	Consent to Research participation
02030.	Directive to Physician
02040.	Organ Donor Consent
02045.	Court-ordered care
02050.	Living Will Designee
02052.	Durable Power of Attorney status
02053.	Durable Power of Attorney for health care status
02055.	Power of Attorney Name
02056.	Durable Power of Attorney for health care name
02057.	Power of Attorney Address
02058.	Durable Power of Attorney for health care address
02060.	Power of Attorney Phone
02061.	Durable Power of Attorney for health care phone

IIA. Release of Information Record

02100.	Record action date (M)
02100.02.	Type of action
02100.04.	Type of information
02100.06.	Person releasing
02100.08.	Released to
02100.10.	Purpose of release
02100.12.	Person Authorizing

III. Financial

03001.	Workman Comp Claim Date (M)
03001.1.	Workman Comp Claim ID
03005.	Insurance Claim Date (M)
03005.02.	Claim ID
03010.	Payer (M)
03010.02.	Payer type/class
03010.04.	Patient Insurance Group no.
03010.06.	Insurance Subscriber ID
03010.08.	Payment Sponsor
03010.10.	Address of Sponsor
03010.12.	Payer Priority
03010.15.	(MEDICARE NO.)
03017.	Medicare to yr
03020.	Medicare A eff date
03022.	Medicare B eff date
03030.	Billing Account no.

IV. Providers

04001.	Provider/Practitioner name (M)
04001.01.	Provider Group/Organization title
04001.03.	Provider Address
04001.05.	Provider Taxonomic Category
04001.07.	Provider ID# (M)
04001.07.01.	ID Agency
04001.10.	Practitioner Name (M)→PROVIDER/PRACTITIONER NAME
04001.12.	Practitioner SSAN
04001.15.	Practitioner number ID - Practitioner National Provider ID (NPI)
04001.20.	Practitioner Profession - Practitioner profession/ occupation/specialty (M)
04001.25.	Practitioner Office Address
04001.30.	Practitioner Office Phone
04001.31.	Practitioner FAX Phone
04001.32.	Practitioner E-mail Address
04001.35.	Practitioner License Number - Practitioner License Category (M)
04001.35.01.	Practitioner Licensing State
04001.35.02.	Practitioner License Code
04001.35.03.	Practitioner License Number
04001.35.04.	Practitioner License Effective Date
04001.35.05.	Practitioner License Expiration Date
04001.35.06.	Practitioner License Termination Date
04001.40.	Practitioner Licensing State - Practitioner Certification Category (M)
04001.40.01.	Certification Number
04001.40.02.	Certification Effective date
04001.40.03.	Certification Expiration date
04001.40.04.	Certification Termination Date
04001.40.05.	Certification Code
04001.40.06.	Certification Board
04001.45.	Practitioner Current role for this patient (M)
04001.45.01.	Date role began

04001.45.02.	Date role ended
04001.50.	Practitioner Location (M)
04001.50.01.	Date Location Effective
04001.50.02.	Date Location Terminated
04001.50.03.	Location Code
04001.60.	Practitioner Signature - Practitioner Electronic Signature

V. Problem List - Health Condition List

05001.	Problem ID (M)
05001.01.	Problem Name
05001.02.	Problem Indication
05001.03.	Problem Date of Onset
05001.05.	Problem Cause
05001.07.	Problem Date Recorded
05001.09.	Problem Diagnosis
05001.10.	Problem Date Diagnosed
05001.12.	Problem Provider Assigning Diagnosis→PRACTITIONER SEGMENT
05001.13.	Problem Facility Where Diagnosed
05001.15.	Problem Date Resolved
05001.17.	Problem Responsible Practitioner→PRACTITIONER SEGMENT
05001.20.	Problem - Status (active, suspended, nactive, resolved,alert) (M)
05001.20.01.	Problem Date of Status
05001.22.	Problem - Subjective (text)
05001.25.	Problem - Objective (text)
05001.30.	Problem - Body System (M)→BODY SYSTEM TERM
05001.30.01.	Problem - Review text
05001.32.	Problem - Encounter date-times (M)→ENCOUNTER SEGMENT
05001.32.01.	Problem - Monitoring variable/service (M)
05001.32.01.01.	Problem—Value
05001.35.	Problem - Assessment (text)
05001.40.	Problem - Plan (text)
05001.41.	Problem Treatment Plan ID
05001.45.	Problem - Health Condition Order ID (M)→ORDERS SEGMENT

VI. Immunizations

06001.	Type of procedure(vaccine,test or Toxoid name, including blood type) (M) *
06001.01.	Immunization Date (M)
06001.01.01.	Dose - Immunization Dose number in series
06001.01.02.	Batch - Immunization Batch
06001.01.03.	Immunization Manufacturer
06001.01.04.	Immunization Expiration date
06001.01.05.	Lot No. - Immunization Lot no
06001.01.10.	No of Units - Immunization No of Units
06001.01.11.	Immunization Injection site
06001.01.12.	Administering Treatment Facility - Immunization Administering Treatment Facility
06001.01.15.	Reaction/Result - Immunization Reaction/Result
06001.01.17.	Severity - Immunization Severity
06001.01.20.	Immunization Remarks
06001.01.25.	Provider - Immunization Administering Practitioner-ID→PRACTITIONER SEGMENT

VII. Record of Exposure to Environmental Stressors

07001.	Hazardous Agent Name (M)→STRESSOR FILE
07001.01.	Total Lifetime Exposure - Hazard Total Lifetime Exposure
07001.03.	Unit of Exposure - Hazard Unit of Exposure
07001.05.	Hazard Exposure begin date-time (M)
07001.05.1.	Termination date - Hazard Exposure Termination Date
07001.05.02.	Employer - Hazard Employer→EMPLOYER SUBSEGMENT OF MED HIST
07001.05.03.	Work Center - Hazard Setting of Exposure
07001.05.05.	Work Activity - Hazard Route of Exposure
07001.05.07.	Interval Dose - Hazard Interval Dose
07001.05.09.	Plant Process - Hazard Plant Process Code
07001.05.11.	Plant Location - Hazard Plant Location Code
07001.05.13.	Work Performed—Name of Hazard Work Performed
07001.05.15.	Protection Practice Used - Hazard Personal Protection Used (M)
07001.07.	Hazard Test Date (M)
07001.07.01.	Nature and Form of Measured Agent - Hazard Nature and Form of Measured Agent
07001.07.02.	Hazard Unit of Hazard Sample collected
07001.07.03.	Collection Time - Hazard Sample Collection Time
07001.07.05.	Collection Device - Hazard Sample Collection Device
07001.07.07.	Sample Method - Hazard Test Sample method
07001.07.09.	Measurement Method - Hazard Type of Determination
07001.07.11.	Peak Value - Hazard Peak Measurement Value
07001.07.13.	Measurement Unit - Hazard Peak Measurement Unit

VIII. Health History

Prenatal

08001.	No. prev pregnancies
08003.	No. completed deliveries
08005.	Est date of beginning of pregnancy (M)
08005.01.	Prenatal/perinatal history
08005.03.	Estimated/Actual Date of Delivery
08005.05.	Date first saw pre-natal practitioner
08005.07.	Type of prenatal practitioner seen
08005.09.	Birthing plan
08005.11.	Length of Gestation (Wks)
08005.13.	Gynecologic Abnormalities
08005.15.	Birth method
08005.17.	Delivery complications
08005.19.	No. of fetuses in pregnancy

Perinatal

08010.	Patient newborn birth weight
08013.	Patient newborn birth length
08017.	Estimate of patient fetal maturity at birth
08020.	Patient newborn abnormalities
08023.	Onset of respiration
08027.	1 min Apgar
08030.	5 min Apgar
08033.	Newborn Head circumference (cm)
08037.	Newborn Chest circumference (cm)

Individual

08050.	Family History (text)
08052.	Child History (text)
08054.	Adult History (text)
08055.	Patient Reported Health History - Health Education History
08056.	Sexual/Reproductive History (text)
08058.	Date of last missed menstrual period
08060.	Age at menarche
08062.	Current Menstrual Status
08064.	Birth Control Method
08070.	Job Hire date (M)
08070.01.	Employer
08070.03.	Full/Part-time
08070.05.	Job Status(primary,secondary)
08070.07.	Job title
08070.09.	Job code
08070.11.	Job classification
08070.13.	Employee no.
08070.14.	Occupational Category
08070.15.	Job Process/activity
08070.16.	Job Std Industrial Category
08070.17.	Termination date
08070.19.	Comments
08070.20.	Work Location
08070.21.	Work activity (M)
08070.23.	Protective equipment (M)
08070.25.	Stressors exposed to (M)
8075.	Date of history
8076.	Purpose
08075.3.	History site/location
08075.5.	Source of history
08075.7.	Source of history data name
08075.9.	State of present health
08075.10.	State of oral hygiene

08075.11.	Social history
08075.13.	Current Habits - smoking, alcohol, etc.
08075.15.	Current occupation
08075.17.	History of present illness since last visit
08080.	Operation date (M)
08080.01.	Name
08083.	Past medications(M)
08085.	Trauma History (text)
08088.	Drug Sensitivities/Allergies (text)
08090.	General Comments Date (M)
08090.1.	Text
08095.	Health History Question Response (M)
08095.01.	Date (M)
08095.01.01.	Comment
IX Examination	
09001.	Exam Date (M)
09001.01.	Purpose
09001.02.	Risk Factors (M)
09001.03.	Treatment Facility
09001.04.	Examiner's name→PRACTITIONER SEGMENT
09001.05.	History of Present Illness/Status of Present Health - Source of History data:name
09001.11.	Initial impression
09001.12.	Review of Systems(text)
09001.13.	Exam Finding (M)
09001.13.01.	Finding value
09001.13.02.	Finding Units
09001.13.03.	Finding Interpretation Code
09001.13.04.	Comment on Finding
09001.14.	Exam Procedure
09001.15.	Comments on Exam
09001.16.	Patient Health Status Measure Name
09001.17.	Patient Health Status Measure Total Value
09001.19.	Patient health Status Measure Element name (M)
09001.19.1.	Patient Health Status Measure Element value
09001.21.	Exam Summary
09001.23.	Examiner/Consult Recommendations
09001.25.	Assessment of nutritional status
09001.26.	Patient Generated Functional Health Status
09001.30.	Tooth (M)
09001.30.01.	Tooth Status
09001.30.03.	Comment
09001.30.05.	Surface (M)
09001.30.05.1.	Level of Decay
09001.30.05.2.	Restorative Material
09001.30.05.3.	Periodontal Tissue Status
09001.30.06.	Sensitivity
09001.30.07.	Mobility
09001.30.08.	Periodontal Lingual Pocket Depth
09001.30.09.	Periodontal Buccal Pocket Depth
09001.30.10.	Implant Type
09001.30.11.	Implant material
09001.30.13.	Planned Procedure
09001.30.13.1.	Scheduled Date
09001.40.	Prosthesis (M)
09001.40.01.	Prosthesis Type
09001.40.03.	Prosthesis Abutment(M)
09001.40.05.	Date of Temporary Prosthesis
09001.40.07.	Date of Permanent Prosthesis
09001.40.09.	Installing Practitioner
09001.40.11.	Opposing Arch Status
09001.40.13.	Occusal Surface Material
09001.40.15.	Patient Satisfaction Code
X. Orders/Treatment Plans	
10001.	Order ID # (M)
	Patient /Subject
10001.001.	Encounter date-time/ID (M)→ENCOUNTER SEGMENT
10001.002.	Patient Residential Status
	Type/Addressee
10001.009.	Order Date-time
10001.010.	Order type (ancillary service ID)→ANCILLARY SERVICE LEXICON
10001.013.	Order Action
10001.015.	Priority of order
10001.017.	Pre-admit order
10001.019.	Origin of order(verbal/phone etc)
10001.021.	Parent order- if secondary
10001.022.	Is order multiple sequential
10001.023.	Related Orders (M)→ORDER SEGMENT
	Orderer/Originator
10001.025.	User→Personnel list
10001.027.	User SIG
10001.029.	Nurse
10001.031.	Nurse SIG
10001.033.	Ordering Practitioner→PRACTITIONER SEGMENT
10001.034.	Ordering Practitioner Role
10001.035.	Ordering Practitioner SIG
10001.037.	Countersigning Practitioner→PRACTITIONER SEGMENT
10001.039.	Countersigning Practitioner SIG
10001.041.	Nurse SIG needed
10001.043.	Time Nurse SIG needed
10001.045.	Practitioner SIG needed
10001.047.	Time Practitioner SIG needed
10001.049.	Countersignature needed
10001.051.	Time countersignature needed
10001.052.	Order D/Ced by→PRACTITIONER SEGMENT
10001.053.	D/C SIG
10001.055.	Date-time Order confirmed by addressee
	Control
10001.057.	Active/pending flag
10001.058.	Response Action Code
10001.059.	Active status
10001.061.	Pending status
10001.063.	Inactive status flag
10001.065.	Start today/tomorrow
10001.067.	Order timing-every or every nth day
10001.069.	Duration order in effect
10001.071.	Last status change
10001.073.	Reactivation date
10001.075.	Ask from ancillary
10001.077.	Time of ancillary activ.
10001.079.	Time to expect stat result
10001.081.	Telephone result flag
10001.083.	Telephone result to other than location ordered from
10001.085.	Request scheduled
10001.087.	Requested appt time
10001.089.	Requested Appointment type
10001.091.	Transport needed
10001.093.	Appointment status
10001.095.	Assigned appt time
	Text
10001.097.	Health Service Ordered→HEALTH SERVICE TERM
10001.098.	Treatment Plan Involved→TREATMENT PLAN
10001.099.	Principal Problem - Health Condition Affected→PROBLEM LIST SEGMENT
10001.100.	Full text of order
10001.101.	Clinical Order Specimen ID
10001.101.01.	Clinical Order Specimen Datetime
10001.101.02.	Clinical Order Specimen Collection End Datetime
10001.101.03.	Clinical Order Specimen Collection Volume
10001.101.04.	Clinical Order Specimen Collector
10001.101.05.	Clinical Order Specimen Source
10001.101.06.	Clinical Order Specimen Additives Code
10001.101.07.	Clinical Order Specimen Action
10001.101.08.	Clinical Order Specimen Comments
10001.102.	Location of Service
10001.104.	Daily frequency
10001.106.	Order modified<
10001.108.	Reason for Modification
10001.110.	Non-modifiable flag
10001.112.	Instructions for the order (Including D/C Criteria)
10001.114.	Secondary orders→Order ID #(ORDER/TREATMENT PLAN SEGMENT)
10001.116.	Message (M)
	Results
10001.120.	Result acknowledgement date-time (M)
10001.120.01.	Shift care plan date
10001.120.02.	Result return flag
10001.120.03.	Result status
10001.120.04.	Result date-time

10001.120.05.	Acknowledged by→PRACTITIONER SEGMENT
10001.120.06.	Comment
10001.123.	Date-time order completed
	Quality Assurance
10001.140.	Q-A Warning date-time (M)
10001.140.1.	Text of warning
10001.140.2.	Disposition of warning
10001.140.3.	Over-ridden by practitioner→PRACTITIONER SEGMENT
10001.140.4.	Authorized by practitioner→PRACTITIONER SEGMENT
10001.140.5.	Justification
10001.160.	Q-A Review date (M)
10001.160.01.	Event Type
10001.170.	Care/treatment plans
10001.170.1.	Care plan goals
10001.170.2.	Date-time care plan started
10001.170.3.	(AUTHORIZED BY PRACTITIONER)
	Treatment plan
10010.	Treatment Plan ID (M)
10010.01.	Treatment Plan Name
10010.02.	Description
10010.03.	Primary Practitioner ID
10010.04.	Team Members(M)
10010.04.01.	Team Member Role
10010.05.	Total Outcome measure
10010.06.	Plan Comments
10010.07.	Plan Cost
10010.08.	Treatment Plan Status
10010.09.	Patient Management Needs (M)
10010.10.	Phase Identifier (M)
10010.10.01.	Problem - Health Condition (M)
10010.10.02.	Clinical Order ID
10010.10.03.	Clinical Order Status
10010.10.04.	Target Date
10010.10.05.	Outcome Goal
10010.10.06.	Outcome Measure
10010.10.07.	Phase Cost
10010.10.09.	Treatment Regimen ID
10010.10.10.	Appointment Date-time (M)
10010.10.10.01.	Location
10010.10.10.02.	Practitioner→PRACTITIONER SEGMENT
10010.10.10.03.	Procedure (M)
10010.10.10.03.01.	Problem - Health Condition ID
10010.10.10.04.	Appointment Cost
10010.11.	Date-time Started
10010.12.	Date-time expected completion
10010.13.	Date-time actual completion
10010.14.	Authentication

XI. Diagnostic Tests

11001.	Speciment Collection Datetime (M)
11001.01.	Test Requested (M)
11001.01.03.	Encounter ID→ENCOUNTER SEGMENT
11001.01.06.	Treatment facility ordering
11001.01.09.	Performing facility
11001.01.12.	Attending Specialist ID
11001.01.15.	Clinical Order ID→ORDERS SEGMENT
11001.01.18.	Requesting Provider ID
11001.01.21.	Problem/Diagnosis→PROBLEM LIST SEGMENT
11001.01.24.	Source of specimen
11001.01.27.	Specimen ID
11001.01.30.	Collection Employee Identifier
11001.01.33.	Data-time specimen received
11001.01.36.	Condition of specimen
11001.01.39.	Specimen volume
11001.01.42.	Specimen Information/Preparations reqd
11001.01.45.	Date-time result returned to requester
11001.01.48.	Report dictation date-time
11001.01.51.	Report Text
11001.01.54.	Report Destination (M)
11001.01.57.	Numeric Measurement/Analyte name (M)
11001.01.57.01.	Value
11001.01.57.02.	Units
11001.01.57.03.	Interpretation
11001.01.57.04.	Abnormality Basis
11001.01.60.	Microbiologic organism (M)
11001.01.60.01.	Attribute pattern
11001.01.60.02.	Resistance pattern
11001.01.60.02.01.	Antimicrobial Resistance Pattern Drug MIC
11001.01.60.03.	Specific Comments
11001.01.63.	General Comments
11001.01.66.	Performer/Technologist
11001.01.67.	Transcriptionist
11001.01.68.	Observation Interpreter
11001.01.69.	Diagnosis Terms/Codes (M)

XII. Medications

12001.	Date-time of Prescription/Medication Order (M)
12001.03.	Encounter ID→ENCOUNTER SEGMENT
12001.06.	Medication name→MEDICATION PROPERTIES
12001.09.	Clinical Order ID→ORDERS SEGMENT
12001.12.	Prescription no.
12001.15.	Prescriber ID→PRACTITIONER SEGMENT
12001.18.	Prescriber location
12001.21.	Problem ID→PROBLEM LIST SEGMENT
12001.24.	Reason for administration
12001.27.	Status of Prescription/Order
12001.30.	Dose
12001.33.	Unit
12001.36.	Form
12001.39.	Route
12001.40A.	Medication Administration Device
12001.40B.	Medication Administration Method
12001.42.	Interval/Frequency
12001.45.	Instructions for use (SIG)
12001.48.	Total Dose prescribed/refill
12001.51.	No. refills authorized
12001.54.	Date of refill (M)
12001.54.01.	Refill dispensing facility
12001.57.	Medication Start date-time
12001.60.	Medication Stop date-time
12001.63.	Medication Notes

XIII. Scheduled Visits

13001.	% Date-time (M)
13001.01.	Treatment Facility
13001.02.	Scheduled Visit Expected Duration
13001.03.	% Clinic Name
13001.04.	Previous Encounter date-time→ENCOUNTER SEGMENT
13001.05.	Provider ID→PRACTITIONER SEGMENT
13001.06.	Scheduled Visit ID
13001.07.	% Purpose/Chief Complaint
13001.09.	Remarks
13001.11.	Scheduled Visit Appt Status
13001.12.	Scheduled Visit Expected Services
13001.13.	Scheduled Visit Type
13001.14.	Scheduled Visit Urgency
13001.15.	Scheduled Visit Cancellation Reason
13001.16.	Scheduled Visit Cancellation Date-time
13001.17.	Scheduled Visit Overbook Status
13001.18.	Scheduled Visit Encounter Disposition

XIV. Encounter/Episodes

14001.	%+#Date-time of encounter/admission (M) *
14001.A001.	# Name of Treatment Facility *
14001.A002.	Type of Encounter (Patient Type)
14001.A003.	Encounter ID
14001.A004.	Confidentiality Status

A. Administrative/Diagnostic Summary

14001.A010.	Encounter Status Amb Care
14001.A013.	& Treatment facility type
14001.A016.	&Reason for visit
14001.A020.	Encounter Patient Arrival Condition
14001.A021.	Mode of Arrival (M)
14001.A022.	Origin Facility ID
14001.A023.	& Chief Complaint
14001.A027.	Date-time of injury Trauma

14001.A030.	Encounter Nature of Injury/Illness (M)
14001.A033.	Encounter Mode of Injury/illness (M) [See also F003/F036]
14001.A034.	Product of Injury
14001.A036.	Location where injured/ill
14001.A040.	Inj. on Job Status
14001.A043.	Injury circumstances
14001.A044.	Protective equipment used (M)
14001.A046.	Injury Severity Score
14001.A050.	Date of Phys Exam→PHYS EXAM SEGMENT
14001.A053.	Problems (M)→PROBLEM LIST SEGMENT
14001.A056.	Current Living arrangements
14001.A060.	Comments
14001.A063.	% Admission type
14001.A066.	Admission authority
14001.A070.	%# Location Admitted/Referred/Sent from
14001.A073.	Referring Practitioner name→PROVIDER SEGMENT
14001.A083.	Private Practitioner name→PROVIDER SEGMENT
14001.A093.	Private Practitioner Notified<
14001.A096.	Hospitalization type
14001.A100.	Patient Board from
14001.A103.	# Hospital Register no
14001.A106.	$ Age
14001.A110.	#Admitting Service
14001.A113.	Referring Service
14001.A116.	% Consulting Service (M)
14001.A116.01.	Date assigned
14001.A116.02.	Consult text
14001.A116.03.	Consult Practitioner →PRACTITIONER SEGMENT
14001.A120.	Provider/Attending physician (M)→PRACTITIONER SEGMENT
14001.A123.	% E-R/Admitting physician→PRACTITIONER SEGMENT
14001.A126.	%Patient Current Location
14001.A130.	%Location admitted to
14001.A133.	Type of Accommodation
14001.A136.	Current Nursing Unit Assigned
14001.A140.	%Floor Assigned
14001.A143.	Warnings
14001.A146.	Records received
14001.A150.	Personal Valuables left
14001.A151.	Location of Personal Valuables
14001.A153.	Current Temporay Impairment
14001.A154.	Patient Receipt Health Status Name
14001.A156.	Patient Receipt Health Status MeasureTotal Value
14001.A160.	Patient Receipt Measure Element name (M)
14001.A160.01.	Patient Receipt Measure Element value
14001.A163.	%Transfer date (M)
14001.A163.01.	% Transfer type
14001.A613.02.	% Transferred to Nursing unit
14001.A163.06.	Clinical service
14001.A163.10.	% Room/Bed
14001.A163.13.	% Transfer diagnosis
14001.A163.16.	Provider→PRACTITIONER SEGMENT
14001.A170.	Diagnosis/Problem (M)→DIAGNOSIS TERM
14001.A170.01.	Type(Admitting,pri,sec)
14001.A170.02.	Status(Major,Minor,R/O,Inact,S/P)
14001.A170.03.	Narrative
14001.A173.	Indicated surgery
14001.A183	Current Status SI/VSI
14001.A186.	#Date-time of Clinical Status (M)
14001.A186.1.	# Status (SI/VSI)
14001.A186.2.	# Prognosis
14001.A195.	Custodian of Personal Effects
14001.A200.	NOK notified by whom
14001.A203.	#Date-time NOK notified
14001.A206.	Police hold
14001.A210.	Date-time Notif. police
14001.A213.	Date-time Notif med. examiner
14001.A216.	Date-time Chaplain notified
14001.A220.	Ministrations administered *
14001.A223.	+Source of payment (M)
14001.A223.01.	Type(primary, secondary,other)
14001.A223.02.	Carrier
14001.A223.03.	Mechanism
B. Trauma Care/History of Present Illness	
	Pre-hospital care
14001.B0001.	Date-time Call Received
14001.B0002.	Date-time Run Dispatched
14001.B0003.	Date-time Run Arrived at the Scene
14001.B00031.	Order Agency Arrived at Scene
14001.B0004.	Date-time Patient Left the Scene
14001.B0005.	Date-time Patient arrived at the Treatment Facility
14001.B0006.	Date-time Returned to Service
14001.B00061.	Date-time Trauma Surgeon arrived
14001.B00062.	Date-time Neurosurgeon arrived
14001.B001.	Pre-hospital Equipment/procedures (M)
14001.B001.01	Procedure date-time
14001.B003.	Narrative
14001.B004.	Severity in Dispatch
14001.B005.	Severity at Arrival on Scene
14001.B0051.	Run Number
14001.B006.	Agency ID
14001.B0065.	Vehicle ID
14001.B007.	Dispatch Number
14001.B0071.	Trauma Number
14001.B010.	Scene Description
14001.B011.	Crew ID (M)
14001.B011.1.	Skill level
14001.B011.2.	Procedure Performed (M)
14001.B012.	Observation (M)→Consciousness
14001.B012.01.	Observation value
14001.B012.02.	Observation date-time
14001.B015.	Time of Triage *
14001.B016.	Condition at Triage
14001.B030.	Burns/location (M)
14001.B030.01.	%Body
14001.B030.02.	Degree
14001.B033.	Fracture/location (M)
14001.B033.01.	Treatment
14001.B036.	Tourniquet date-time (M)
14001.B036.01.	Location
14001.B039.	ER Procedures (M)
14001.B039.01	Procedure Date-time
14001.B042.	Tube Type (M)
14001.B045.	Oxygen time started
14001.B048.	Oxygen %
14001.B051.	Xray-location (M)
14001.B051.01.	View (M)
14001.B054.	Blood Run No.
	Critical Care
14001.B057.	Blood product Unit ID (M)
14001.B057.01.	Donor ID
14001.B057.02.	Product Type
14001.B057.03.	Time started
14001.B057.04.	Time completed
14001.B057.05	Blood type
14001.B057.06	Crossmatch Data
14001.B057.07.	Volume
14001.B057.08.	Cumulative volume
14001.B057.09.	Comments
14001.B060.	Current Diet-type
14001.B063.	IV Solution/Fluid type (M)
14001.B063.1.	Date-time IV Hung
14001.B063.2.	IV Line Newstart Date-time
14001.B063.3.	IV Site
14001.B063.4.	IV Line New Start:: Gauge & Lngth
14001.B063.5.	IV Fluid Infusion Date-time (M)
14001.B063.5.1.	IV Fluid Volume Infused
14001.B063.5.2.	IV Fluid Bottle ID
14001.B063.6.	IV Fluid rate
14001.B063.7.	IV Fluid Cumulative Volume Infused
14001.B063.9.	IV care
14001.B069.	Fluid intake source (M)
14001.B069.1	Total vol
14001.B069.2.	Time (M)
14001.B069.21.	IN/OUT
14001.B069.22.	Volume
14001.B070.	Vital Signs/Tracking Variable Date-time (M) *
14001.B070.01.	Vital Signs Tracking variable name (M)→Body Wt
14001.B070.01.1.	Vital Signs Value
14001.B072.	Medication ID (M)→MEDICATION/PRESCRIPTION SEGMENT
14001.B072.01.	Date-time administered (M)

14001.B072.01.01. Person administering
14001.B072.01.02. Clinical Order ID→ORDERS SEGMENT
14001.B072.01.03 Time next dose
14001.B072.01.04. Comments
14001.B072.02. No. doses administered
14001.B075. Lab test ID (M)→DIAGNOSTIC TEST SEGMENT
14001.B075.01. Date-time (M)
14001.B075.01.01. Specimen ID
14001.B078. Intensive Care date-time (M)
14001.B078.01. Summary text
14001.B078.02. Practitioner ID→PRACTITIONER SEGMENT
14001.B081. Order ID (M)→ORDERS SEGMENT
14001.B084. Problem ID (M)→PROBLEM LIST SEGMENT

C. Clin Course/Nursing Care Plan

14001.C001. Primary Nurse/Therapist
14001.C003. Nursing Diagnosis
14001.C006. Long Term Care goals
14001.C009. Nursing Short Term Goals
14001.C012. Nursing Short Term Goal Deadline
14001.C015. Nursing Requirement Category (Acuity)
14001.C018. Patient Profile Attribute (M)
14001.C018.1. Attribute Value
14001.C021. Community Services Used
14001.C024. Nursing Approach
14001.C027. Clinical Course Measurement
14001.C027.1. Clinical Course Measurement Value
14001.C027.2. Clinical Course Measurement Unit
14001.C055. Diet chg date-time (M)
14001.C055.1. Type
14001.C058. Hygiene (oral & general) (M)
14001.C060. Vital sign frequency
14001.C062. Allergies (M)
14001.C065. Discharge objective ID (M)
14001.C065.01. Objective text
14001.C065.03. Functional Goal (M)
14001.C065.06. Objective Date
14001.C065.09. Actions
14001.C068. Anticipated Disposition
14001.C070. Est Discharge date
14001.C073. Aftercare Plan
14001.C075. Nursing Problem no (M)→PROBLEM SEGMENT
14001.C078. General Review of Systems (M)
14001.C078.01. Text
14001.C080. Date-time sched. tests/consults/Surgery (M)
14001.C080.01. Type
14001.C080.02. Place to be conducted
14001.C080.03. Date-time ordered
14001.C080.04. Date-time completed
14001.C085. Treatment types (M)
14001.C085.01. Date-time ordered
14001.C085.02. Date-time scheduled
14001.C085.03. Date-time completed
14001.C090. Patient Instruction date (M)
14001.C090.01. Type
14001.C090.02. Text
14001.C090.03. Verification

C. Clin Course/Rehabilitative Care Section
14001.C110. Rehabilitative Service ordered (M)
14001.C110.01. Unit
14001.C110.02. Description
C. Clin Course Dietetics/Nutritional Care Plan
14001.C120. Food intake date-time (M)
14001.C120.01. Food ID (M)
14001.C120.01.01. Amt
14001.C120.01.02. Unit
14001.C120.02. Nutrient (M)
14001.C120.02.01. Level/day
14001.C120.02.02. Unit
14001.C122. Nutritional Status
14001.C123. Response to Diet
14001.C125. Diet type
14001.C128. Diet/Nutrition Comments

C. Clin course/Progress Notes

14001.C130. Progress Notes date-time (M)
14001.C130.01. Text
14001.C130.03. Authenticator ID→PRACTITIONER SEGMENT

D. Therapies

14001.D001. Therapy type (M)
14001.D001.01. Date-time commenced (M)
14001.D001.01.01. Date-time completed
14001.D001.01.03. Problem ID→PROBLEM LIST SEGMENT
14001.D001.01.05. Clinical Order ID→ORDERS SEGMENT
14001.D001.01.07. Location delivered
14001.D001.01.11. Beginning patient condition
14001.D001.01.13. Ending patient condition
14001.D001.01.15. Status of Therapy
14001.D001.01.17. Specific preparation for therapy
14001.D001.01.18. Type of Product/Service (M)
14001.D001.01.18.01. Amount of product
14001.D001.01.19. Durable Equipment Used
14001.D001.01.21. Progress Assessment
14001.D001.01.22. Results of Treatment
14001.D001.01.23. Clinical Evaluation of results
14001.D001.01.25. Performing Practitioner name→PRACTITIONER SEGMENT
14001.D001.01.27. Recommendations

E. Operative Procedures

14001.E001. Operation Patient arrival Date-time (M) *
14001.E001.01. Clinical Order ID
14001.E001.02. Isolation
14001.E001.04. Category
14001.E001.06. Case type
14001.E001.08. Case no.
14001.E001.10. O.R. no.
14001.E001.12. Ordering station no.
14001.E001.14. Donor type (M)
14001.E001.14.01. Name
14001.E001.17. Operative Positions
14001.E001.20. Positional aids
14001.E001.22. Was evidence removed from patient<
14001.E001.24. Patient seen by anesthesiol. date-time
14001.E001.26. Anesthesia start time
14001.E001.28. Anesthesia ready time
14001.E001.30. Operation start time
14001.E001.32. Operation complete time
14001.E001.34. Anesthesia end time
14001.E001.36. Patient depart time
14001.E001.38. Physical status
14001.E001.40. Operation description *
14001.E001.42. Pre-operative Comment
14001.E001.44. Operation Measurement (M)→Vitals(T,P,R,BP,Wt)
14001.E001.44.1. Measurement value HGB
14001.E001.46. Check Record
14001.E001.48. Check Patient
14001.E001.50. OR Nurse ID
14001.E001.51. Resp status (text)
14001.E001.52. Circulatory status (text)
14001.E001.53. CNS status (text)
14001.E001.54. Prev. anesth. complications (text) *
14001.E001.55. Premedication name (M) *
14001.E001.55.01 Dose
14001.E001.55.02 Route
14001.E001.55.03. Time
14001.E001.55.04. Effect
14001.E001.56. Preoperat. diagnosis *
14001.E001.57. Postoperative diagnosis *
14001.E001.58. Surgeon (M) *→PRACTITIONER SEGMENT
14001.E001.58.01. Role (Primary,Assistant,Resident)
14001.E001.60. Anesthesiologist→PRACTITIONER SEGMENT
14001.E001.61. Anesthesiology Resident→PRACTITIONER SEGMENT
14001.E001.62. Anesthetist→PRACTITIONER SEGMENT
14001.E001.63. O.R. Staff position (M)
14001.E001.63.01. Name
14001.E001.64. Induction (Sat/Unsat) *
14001.E001.65. Induction comments

14001.E001.66.	Endotracheal tube type *
14001.E001.67.	E.T. tube comments
14001.E001.68.	Time blood ordered for O.R. (M)
14001.E001.68.01.	No units
14001.E001.69.	Operative procedure (M) *
14001.E001.69.001.	Operative Procedure Date-time
14001.E001.69.002.	Operative Procedure Priority
14001.E001.69.003.	Operative Procedure Description
14001.E001.69.01.	Operative Procedure Evaluation
14001.E001.69.02.	Operative Procedure Findings
14001.E001.70	Specimen ID (M)
14001.E001.70.01.	Site
14001.E001.70.02.	Processing
14001.E001.70.03	Findings
14001.E001.71.	Anesthetic agent (M) *
14001.E001.71.01.	Dose
14001.E001.71.02.	Unit
14001.E001.71.03.	Anesthetic technique
14001.E001.72.	Post anesthesia assessment
14001.E001.73.	Event-time (M)
14001.E001.73.01	Event code
14001.E001.73.02	Value
14001.E001.73.03	Fluid type *
14001.E001.73.04	Fluid volume *
14001.E001.73.05.	Position
14001.E001.73.06.	Positional aid
14001.E001.74.	Blood loss tital (No units used)
14001.E001.75.	Extra supplies name (M)
14001.E001.75.01.	Amount
14001.E001.78.	Cautery site
14001.E001.80.	Casts applied
14001.E001.82.	Implants/Drains/Ligatures (M)
14001.E001.84.	Tourniquet time (M)
14001.E001.84.01.	Tourniquet location
14001.E001.85.	Urinary catheter place time
14001.E001.86.	Needle counts(M)
14001.E001.87.	Instrument counts(M)
14001.E001.88.	Sponge counts(M)
14001.E001.90.	Recovery (text)
14001.E001.91.	Complications
14001.E001.92.	Post operative Remarks *
14001.E001.93.	Operative Report dictation date
14001.E001.94.	Operative Report dictated by→PRACTITIONER SEGMENT
14001.E001.95.	Operative report text
F. Disposition	
14001.F006.	Assistant Surgeon - Surgeon (M)→PRACTITIONER SEGMENT
14001.F006.1.	Encounter Surgeon Role
14001.F013.	+ Operative procedure (M) *→PROCEDURE TERM/CODE
14001.F013.01.	Date
14001.F013.02.	Surgeon→PRACTITIONER SEGMENT
14001.F013.03.	Type (pri,sec,etc)
14001.F014.	Encounter Procedure (M)→PROCEDURE TERM/CODE
14001.F030.	+ Patient Diagnosis (M)→DIAGNOSIS TERM/CODE
14001.F030.01.	Type (pri,sec,etc)
14001.F030.02.	Narrative
14001.F030.03.	Patient Diagnosis Status
14001.F036.	Encounter Etiology (M)→ETIOLOGY TERM/CODE)
14001.F036.1.	Encounter Etiology Type
14001.F040.	+#Disposition Date-time *
14001.F043.	Physician Authorizing Discharge→PRACTITIONER SEGMENT
14001.F046.	#%Disposition type
14001.F050.	& Disposition
14001.F053.	Departure Date/time
14001.F056.	Followup action
14001.F060.	Follow-up status
14001.F063.	Follow-up target date
14001.F066.	Condition on discharge/departure
14001.F067.	Patient Disposition Health Status Measure Name
14001.F068.	Patient Disposition Health Status Measure total Value
14001.F069.	Patient Disposition Health Status Measure Element Name
14001.F069.1.	Patient Disposition Health Status Measure Element Value
14001.F070.	Reason for discharge
14001.F073.	Person Accompanying patient from facility
14001.F076.	Disposition transport type
14001.F080.	#$ Disposition Destination
14001.F083.	Patient Disposition Instructions
14001.F086.	Patient signature
14001.F090.	Discharge Summary Dictation date
14001.F093.	Length of acute care stay
14001.F096.	Length of Rehabilitation services
14001.F100.	Total ICU days
14001.F101.	% Dischg Summary date
14001.F105.	Narrative Discharge Summary
14001.F110.	# Physician ID→PRACTITIONER SEGMENT
G. Charges	
14001.G001.	Charge Item Name (M)
14001.G001.01.	Medical Service Code
14001.G001.02.	Medical Service date
14001.G001.03.	Medical Service Comment
14001.G001.04.	Charge Value
14001.G02.	Encounter Total Charges
14001.G003.	Workman's Comp Claim filing status
14001.G006.	Workman's Comp Claim ID

X2.

X2.1 Using Life Cycle Principles in Implementing the EHR Conceptual Content

X2.1.1 Implementing the EHR content involves the application of basic Software Life Cycle Principles. Both Supplier/Developer and Acquirer/Users for Healthcare Enterprises follow this process (See Fig. X2.1). The Acquiring Healthcare Enterprise must ensure that its patient care and resource management functions, and the information needed for those functions, are analyzed and documented in user requirements. The terms of the healthcare common conventions for those concepts, as documented in the various health informatics standards, should be used. Practice E2473, for example, describes how to use the Information Systems Architecture (ISA) Framework to identify and document those standards that apply both to the EHR component of the Enterprise Information Architecture and to its usage within the enterprise in meeting information system requirements. The observations recorded in the EHR in support of patient care functions also provide information for management of the logistic, financial and human resources needed for support of that care. This standard Practice points to other standards that refer to the practices for incorporating the EHR component into the full healthcare enterprise information architecture. For the Supplier/Developer, this document presents the basic data according to uses that support common EHR functions that have established healthcare professional specialty consensus. The Supplier's design of the general functional component modules to be used by healthcare enterprises can provide an information architecture that is clear and unambiguous. The

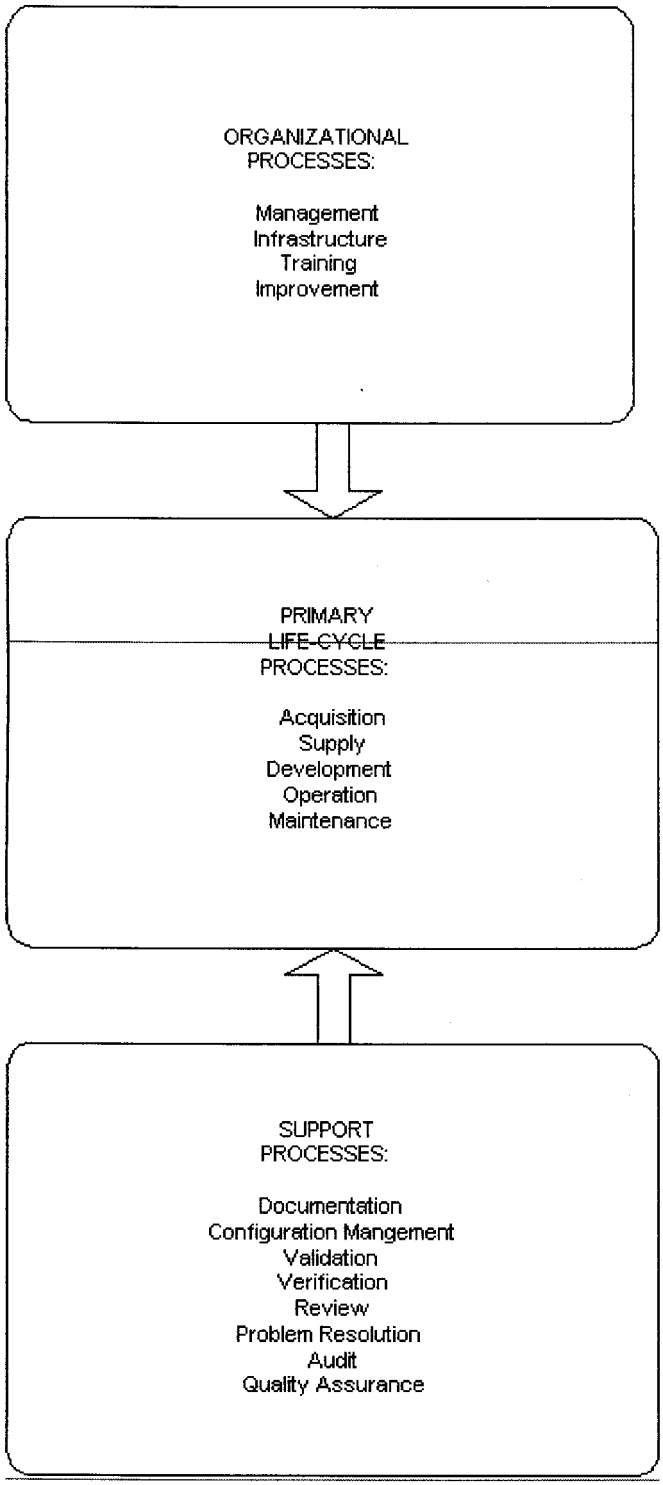

FIG. X2.1 Life Cycle Processes in Healthcare

general standards that are needed by the Acquiring Healthcare Enterprise are those of IEEE 1362, 830, 1058, which can be used at all levels of conceptualization from that of strategic planning to detailed project management. A more extensive set of documents will be needed by Suppliers in order to provide documentation to Acquirers of their use of best recommended information systems engineering practices that lead to those EHR components.

X2.2 Uses of the EHR Model by Healthcare Enterprise Acquirers

X2.2.1 The basic EHR Model given in this document is intended to offer Healthcare Enterprises a comprehensive picture to use in developing an Enterprise View of patient care data is captured in a fashion consistent with the data needed for resource management within and beyond the enterprise. As noted in section X2.1, the uses of the EHR model through application of Life Cycle Principles by the Acquirer will be different than those of a Supplier organization whose activities are primarily developmental. Nevertheless, there is considerable overlap of Supplier and Acquirer uses of the Processes with the Life Cycle, particularly in those Processes that relate to establishment of the information needs for an enterprise and its requirements for architectural components. Practice E1384 considers the differences in perspective, particularly in Needs/Requirements determination. An application of these principles in Guide E2118, which expounds the Clinical Laboratory use the common RADT functions and Core model that is given in both Practice E1715 and in Requirements for Clinical Laboratory Information Management Systems (CLIMS) stated in Practice E1639. Because RADT is a foundation stone for both the EHR and the clinical lab supporting functions, both Practices E1715 and E1639 use the RADT core function as a common point for the integration and interoperability of the EHR and CLIMS Information Domains. Additionally, the RADT model portion of the full EHR model will be required in documentation of the Pharmacotherapy Information Domain as it becomes more fully defined. The difference in notation regarding the "Record Segments," as stated in Section 7 of this Practice, and the notation describing associated "Objects" stated in this section should be used in developing different "Views" of the full model for conducting dialog within the enterprise about the enterprise's conceptual entities and the attributes that characterize each of them in the documentation of Requirements. By relating these attributes to the data items appearing on traditional forms, and in the "fields" that characterize those messages that may be currently used with respect to the EHR model given here together with those that may be used by other healthcare informatics standards, the Acquiring Healthcare Enterprise will be able to identify not only the common concepts that will be needed in its enterprise information architecture but also how the different standards identified in the ISA matrix noted in section X2.1 should be used in crafting the interoperability of the enterprise's information architecture to support the enterprise's business purpose.

X2.3 Uses of the EHR Model by Healthcare Professional Specialty Disciplines

X2.3.1 Professional Specialty Disciplines need to mutually use the EHR model here to ensure that the identification of the essential concepts and their characterization and interrelationships is accurate. It should represent the processes used in patient care first and in resource management second. This EHR model is independent of implementing information technology. Realizing that even though a clear unambiguous statement of the conceptual framework may influence, and even constrain, implementers, it is an essential first condition to the development of any working system. Implementers will then be challenged to find ways to use the available technology to produce an implemented system that behaves as closely as possible to those properties defined through the model for the system. Even though the EHR, and its related model, are central to healthcare because of the primacy of the patient care dimension, each setting for a healthcare enterprise has a different balance of requirements and so too does each specialty discipline. It is the responsibility of each healthcare professional specialty discipline to ensure that its requirements are met in a consistent fashion with those articulated by all other disciplines. It is this usage of the EHR model which must be addressed by the specialty discipline societies and which is recognized in this section of the practice.

X2.4 Uses of the EHR Model by Suppliers of Products and Services to the Healthcare Market

X2.4.1

X2.5 Using the EHR Content and Structure Standard Practice

X2.5.1 This Practice should be used both by the individuals within a given healthcare enterprise in understanding the underlying common concepts that relate to their discipline and by the healthcare enterprise's internal organizations to organize the application of these ideas into management documents that tap the insights and expertise of the individuals within that organization who are using these hard-won recognized principles in supporting the lifetime of the information components that comprise the enterprise's information architecture. Guide E2118, focuses on the clinical laboratory but its principles are generally applicable. The modeling activities for depicting the conceptual entities in healthcare have also been used in assembling the conceptual entities noted in this Practice and in other standards referenced within. This document does not address the allied resource management concepts but does provide a mapping to them in Annex A2 that is discussed in section 9.5. Likewise this Practice refers messaging issues within the domain of interest to other standards, as noted for example in CLSI LIS-9A.

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ADDITIONAL MATERIAL

(1) Guide E1869 for Confidentiality, Privacy, Access and Data Security Principles for Health Information Including Computer Based Patient Records[9]

(2) Guide E1985 for User Authentication and Authorization[9]

(3) Guide E1986 for Information Access Privileges to Health Information[9]

(4) Guide E1987 for Individual Rights Regarding Health Information[9]

(5) Guide E1988 for Training of Persons who have Access to Health Information[9]

(6) Guide E2017 for Amendments to Health Information[9]

(7) Specification E2084 for Authentication of Healthcare Information Using Digital Signatures[9]

(8) Guide E2085 on Security Framework for Healthcare Information[9]

(9) Guide E2086 for Internet and Intranet Healthcare Security[9]

(10) Specification E2147 for Audit and Disclosure Logs for Use in Health Information Systems[9]

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SUMMARY OF CHANGES

Committee E31 has identified the location of selected changes to this practice since the last issue, E1384 – 02a, that may impact the use of this practice. (Approved October 15, 2007)

(*1*) The text of the standard was revised throughout.