Figure 21: Care Plan relatedDocument Example

<!-- This document is the second in a set - relatedDocument describes the parent document-->
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1.1.4 Consultation Note (V3)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.4:2015-08-01 (open)]

Table 26: Consultation Note (V3) Contexts

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The Consultation Note is generated by a request from a clinician for an opinion or advice from another clinician. Consultations may involve face-to-face time with the patient or may fall under the auspices of telemedicine visits. Consultations may occur while the patient is inpatient or ambulatory. The Consultation Note should also be used to summarize an Emergency Room or Urgent Care encounter. A Consultation Note includes the reason for the referral, history of present illness, physical examination, and decision-making components (Assessment and Plan).

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### 1.1.5 Properties

2. **SHALL** contain exactly one [1..1] `templateId` (CONF:1198-8375) such that it
   a. **SHALL** contain exactly one [1..1] `@root"=2.16.840.1.113883.10.20.22.1.4"` (CONF:1198-10040).
   b. **SHALL** contain exactly one [1..1] `@extension"=2015-08-01"` (CONF:1198-32502).
   c. When asserting this templateId, all C-CDA 2.1 section and entry templates that had a previous version in C-CDA R1.1 **SHALL** include both the C-CDA 2.1 templateId and the C-CDA R1.1 templateId root without an extension. See C-CDA R2.1 Volume 1 - Design Considerations for additional detail (CONF:1198-32935).

The Consultation Note recommends use of the document type code 11488-4 "Consult Note", with further specification provided by author or performer, setting, or specialty. When pre-coordinated codes are used, any coded values describing the author or performer of the service act or the practice setting must be consistent with the LOINC document type.

3. **SHALL** contain exactly one [1..1] `code`, which **SHALL** be selected from ValueSet [ConsultDocumentType](urn:oid:2.16.840.1.113883.10.20.9.31 DYNAMIC (CONF:1198-17176)).

### 1.1.5.1 participant

This participant represents the person to contact for questions about the consult summary. This call back contact individual may be a different person than the individual(s) identified in the author or legalAuthenticator participant.
4. **SHOULD** contain zero or more [0..*] **participant** (CONF:1198-31656) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="CALLBCK" call back contact
      (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90
      **DYNAMIC** (CONF:1198-31657).
   b. **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:1198-31658).
      i. This **associatedEntity** **SHALL** contain exactly one [1..1]
         **@classCode**="ASSIGNED" assigned entity (CodeSystem: HL7RoleClass
         urn:oid:2.16.840.1.113883.5.110 **DYNAMIC** (CONF:1198-31659).
      ii. This **associatedEntity** **SHALL** contain at least one [1..*] **id** (CONF:1198-
          31660).
      iii. This **associatedEntity** **SHOULD** contain zero or more [0..*] **addr** (CONF:1198-
          31661).
      iv. This **associatedEntity** **SHALL** contain at least one [1..*] **telecom** (CONF:1198-
          31662).
      v. This **associatedEntity** **SHALL** contain exactly one [1..1] **associatedPerson**
         (CONF:1198-31663).
           1. This **associatedPerson** **SHALL** contain at least one [1..*] **name**
              (CONF:1198-31664).
      vi. This **associatedEntity** **MAY** contain zero or one [0..1] **scopingOrganization**
          (CONF:1198-31665).

1.1.5.2 inFulfillmentOf

The inFulfillmentOf element describes prior orders that are fulfilled (in whole or part) by the
service events described in the Consultation Note. For example, a prior order might be the
consultation that is being reported in the note.

5. **SHALL** contain at least one [1..*] **inFulfillmentOf** (CONF:1198-8382).
   a. Such inFulfillmentOfs **SHALL** contain exactly one [1..1] **order** (CONF:1198-29923).

Where a referral is being fulfilled by this consultation, this id would be the same as the id in
the Patient Referral Act template.

   i. This **order** **SHALL** contain at least one [1..*] **id** (CONF:1198-29924).

1.1.5.3 componentOf

A Consultation Note is always associated with an encounter; the id element of the
encompassingEncounter is required to be present and represents the identifier for the
encounter.

6. **SHALL** contain exactly one [1..1] **componentOf** (CONF:1198-8386).
   a. This componentOf **SHALL** contain exactly one [1..1] **encompassingEncounter**
      (CONF:1198-8387).
      i. This encompassingEncounter **SHALL** contain at least one [1..*] **id**
          (CONF:1198-8388).
      ii. This encompassingEncounter **SHALL** contain exactly one [1..1] **US Realm
          Date and Time (DT.US.FIELDED)** (identifier:
          urn:oid:2.16.840.1.113883.10.20.22.5.3) (CONF:1198-8389).
iii. This encompassing encounter **MAY** contain zero or one [0..1] responsibleParty (CONF:1198-8391).
   1. The responsibleParty, if present, **SHALL** contain exactly one [1..1] assignedEntity (CONF:1198-32904).
      a. This assignedEntity **SHALL** contain an assignedPerson or a representedOrganization or both (CONF:1198-32905).

The encounterParticipant element represents persons who participated in the encounter and not necessarily the entire episode of care.

iv. This encompassing encounter **MAY** contain zero or more [0..*] encounterParticipant (CONF:1198-8392).
   1. The encounterParticipant, if present, **SHALL** contain exactly one [1..1] assignedEntity (CONF:1198-32902).
      a. This assignedEntity **SHALL** contain an assignedPerson or a representedOrganization or both (CONF:1198-32906).

1.1.5.4 component

7. **SHALL** contain exactly one [1..1] **component** (CONF:1198-8397).
   a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:1198-28895).
      i. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28896) such that it
         1. **SHALL** contain exactly one [1..1] **Assessment Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.8) (CONF:1198-28897).
      ii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28898) such that it
         1. **SHALL** contain exactly one [1..1] **Assessment and Plan Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.9:2014-06-09) (CONF:1198-28899).
      iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28900) such that it
         1. **SHALL** contain exactly one [1..1] **Plan of Treatment Section (V2)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1198-28901).
      iv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:1198-28904) such that it
         1. **SHALL** contain exactly one [1..1] **Reason for Visit Section** (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.12) (CONF:1198-28905).
      v. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:1198-28906) such that it
         1. **SHALL** contain exactly one [1..1] **History of Present Illness Section** (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.4) (CONF:1198-28907).
vi. This structuredBody **SHOULD** contain zero or one [0..1] component (CONF:1198-28908) such that it
   1. **SHALL** contain exactly one [1..1] **Physical Exam Section (V3)**
      (identifier: urn:hl7ii:2.16.840.1.113883.10.20.2.10:2015-08-01)
      (CONF:1198-28909).

vii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:1198-28910) such that it
    1. **SHALL** contain exactly one [1..1] **Allergies and Intolerances Section (entries required) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.6.1:2015-08-01) (CONF:1198-28911).

viii. This structuredBody **MAY** contain zero or one [0..1] component (CONF:1198-28912) such that it
    1. **SHALL** contain exactly one [1..1] **Chief Complaint Section**
       (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:1198-28913).

ix. This structuredBody **MAY** contain zero or one [0..1] component (CONF:1198-28915) such that it
    1. **SHALL** contain exactly one [1..1] **Chief Complaint and Reason for Visit Section**
       (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.13) (CONF:1198-28916).

x. This structuredBody **MAY** contain zero or one [0..1] component (CONF:1198-28917) such that it
    1. **SHALL** contain exactly one [1..1] **Family History Section (V3)**
       (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.15:2015-08-01) (CONF:1198-28918).

xi. This structuredBody **MAY** contain zero or one [0..1] component (CONF:1198-28919) such that it
    1. **SHALL** contain exactly one [1..1] **General Status Section**
       (identifier: urn:oid:2.16.840.1.113883.10.20.2.2.5) (CONF:1198-28920).

xii. This structuredBody **MAY** contain zero or one [0..1] component (CONF:1198-28921) such that it
    1. **SHALL** contain exactly one [1..1] **Past Medical History (V3)**
       (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.20:2015-08-01) (CONF:1198-28922).

xiii. This structuredBody **MAY** contain zero or one [0..1] component (CONF:1198-28923) such that it
    1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries optional) (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.2:2015-08-01) (CONF:1198-28924).
xiv. This structuredBody **SHOULD** contain zero or one [0..1] component (CONF:1198-28925) such that it
   1. **SHALL** contain exactly one [1..1] Medications Section (entries required) (V2) (identifier:
      urn:hl7ii:2.16.840.1.113883.10.20.22.2.1.1:2014-06-09)
      (CONF:1198-28926).

xv. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:1198-28928) such that it
   1. **SHALL** contain exactly one [1..1] Problem Section (entries required) (V3) (identifier:
      urn:hl7ii:2.16.840.1.113883.10.20.22.2.5.1:2015-08-01)
      (CONF:1198-28929).

xvi. This structuredBody **MAY** contain zero or one [0..1] component (CONF:1198-28930) such that it
   1. **SHALL** contain exactly one [1..1] Procedures Section (entries optional) (V2) (identifier:
      urn:hl7ii:2.16.840.1.113883.10.20.22.2.7:2014-06-09)
      (CONF:1198-28931).

xvii. This structuredBody **SHOULD** contain zero or one [0..1] component (CONF:1198-28932) such that it
   1. **SHALL** contain exactly one [1..1] Results Section (entries required) (V3) (identifier:
      urn:hl7ii:2.16.840.1.113883.10.20.22.2.3.1:2015-08-01)
      (CONF:1198-28933).

xviii. This structuredBody **MAY** contain zero or one [0..1] component (CONF:1198-28934) such that it
   1. **SHALL** contain exactly one [1..1] Social History Section (V3)
      (identifier:
      urn:hl7ii:2.16.840.1.113883.10.20.22.2.17:2015-08-01)
      (CONF:1198-28935).

xix. This structuredBody **MAY** contain zero or one [0..1] component (CONF:1198-28936) such that it
   1. **SHALL** contain exactly one [1..1] Vital Signs Section (entries required) (V3) (identifier:
      urn:hl7ii:2.16.840.1.113883.10.20.22.2.4.1:2015-08-01)
      (CONF:1198-28937).

xx. This structuredBody **MAY** contain zero or one [0..1] component (CONF:1198-28942) such that it
   1. **SHALL** contain exactly one [1..1] Advance Directives Section (entries optional) (V3) (identifier:
      urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2015-08-01)
      (CONF:1198-28943).

xxi. This structuredBody **MAY** contain zero or one [0..1] component (CONF:1198-28944) such that it
   1. **SHALL** contain exactly one [1..1] Functional Status Section (V2) (identifier:
xxii. This structuredBody *MAY* contain zero or one [0..1] component (CONF:1198-30237) such that it

1. **SHALL** contain exactly one [1..1] *Review of Systems Section*
   (identifier: urn:oid:1.3.6.1.4.1.19376.1.5.3.1.3.18) (CONF:1198-30238).

xxiii. This structuredBody *MAY* contain zero or one [0..1] component (CONF:1198-30904) such that it

1. **SHALL** contain exactly one [1..1] *Medical Equipment Section (V2)*

xxiv. This structuredBody *MAY* contain zero or one [0..1] component (CONF:1198-30906) such that it

1. **SHALL** contain exactly one [1..1] *Mental Status Section (V2)*
   (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.56:2015-08-01) (CONF:1198-30907).

xxv. This structuredBody *MAY* contain zero or one [0..1] component (CONF:1198-30909) such that it

1. **SHALL** contain exactly one [1..1] *Nutrition Section*
   (identifier: urn:oid:2.16.840.1.113883.10.20.22.2.57) (CONF:1198-30910).

xxvi. This structuredBody **SHALL NOT** contain an Assessment and Plan Section (V2) (2.16.840.1.113883.10.20.22.2.9:2014-06-09) when either an Assessment Section (2.16.840.1.113883.10.20.22.2.8) or a Plan of Treatment Section (V2) (2.16.840.1.113883.10.20.22.2.10:2014-06-09) is present (CONF:1198-28939).

xxvii. This structuredBody **SHALL NOT** contain a Chief Complaint and Reason for Visit Section (2.16.840.1.113883.10.20.22.2.13) when either a Chief Complaint Section (1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) or a Reason for Visit Section (2.16.840.1.113883.10.20.22.2.12) is present (CONF:1198-28940).

xxviii. **SHALL** include a Reason for Referral or Reason for Visit section (CONF:1198-9504).

xxix. **SHALL** include an Assessment and Plan Section, or both an Assessment Section and a Plan of Treatment Section (CONF:1198-9501).
Table 28: ConsultDocumentType

Value Set: ConsultDocumentType urn:oid:2.16.840.1.113883.11.20.9.31
(Clinical Focus: A classification of a document by the author's specialty, role, setting, or some combination of these properties to find documents that are considered a consultation.), (Data Element Scope: ), (Inclusion Criteria: ), (Exclusion Criteria: )

This value set was imported on 6/24/2019 with a version of 20190516.
Value Set Source: [https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.31/expansion](https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.31/expansion)

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Code System OID</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>11488-4</td>
<td>LOINC</td>
<td>urn:oid:2.16.840.1.113883.6.1</td>
<td>Consult note</td>
</tr>
<tr>
<td>34099-2</td>
<td>LOINC</td>
<td>urn:oid:2.16.840.1.113883.6.1</td>
<td>Cardiology Consult note</td>
</tr>
<tr>
<td>34100-8</td>
<td>LOINC</td>
<td>urn:oid:2.16.840.1.113883.6.1</td>
<td>Intensive care unit Consult note</td>
</tr>
<tr>
<td>34101-6</td>
<td>LOINC</td>
<td>urn:oid:2.16.840.1.113883.6.1</td>
<td>General medicine Outpatient Consult note</td>
</tr>
<tr>
<td>34102-4</td>
<td>LOINC</td>
<td>urn:oid:2.16.840.1.113883.6.1</td>
<td>Psychiatry Hospital Consult note</td>
</tr>
<tr>
<td>34103-2</td>
<td>LOINC</td>
<td>urn:oid:2.16.840.1.113883.6.1</td>
<td>Pulmonary Consult note</td>
</tr>
<tr>
<td>34104-0</td>
<td>LOINC</td>
<td>urn:oid:2.16.840.1.113883.6.1</td>
<td>Hospital Consult note</td>
</tr>
<tr>
<td>34749-2</td>
<td>LOINC</td>
<td>urn:oid:2.16.840.1.113883.6.1</td>
<td>Anesthesiology Outpatient Consult note</td>
</tr>
<tr>
<td>34756-7</td>
<td>LOINC</td>
<td>urn:oid:2.16.840.1.113883.6.1</td>
<td>Dentistry Consult note</td>
</tr>
<tr>
<td>34758-3</td>
<td>LOINC</td>
<td>urn:oid:2.16.840.1.113883.6.1</td>
<td>Dermatology Consult note</td>
</tr>
</tbody>
</table>

...
Figure 22: Consultation Note Callback participant Example

```
<participant typeCode="CALLBCK">
  <time value="20050329224411+0500" />
  <associatedEntity classCode="ASSIGNED">
    <id extension="99999999" root="2.16.840.1.113883.4.6" />
    <code code="200000000X" codeSystem="2.16.840.1.113883.6.101" displayName="Allopathic & Osteopathic Physicians" />
    <addr>
      <streetAddressLine>1002 Healthcare Drive</streetAddressLine>
      <city>Ann Arbor</city>
      <state>MI</state>
      <postalCode>97857</postalCode>
      <country>US</country>
    </addr>
    <telecom use="WP" value="tel:555-555-1002" />
    <associatedPerson>
      <name>
        <given>Henry</given>
        <family>Seven</family>
        <suffix>DO</suffix>
      </name>
    </associatedPerson>
  </associatedEntity>
</participant>
```

Figure 23: Consultation Note (V2) inFulfillmentOf Example

```
<inFulfillmentOf typeCode="FLFS">
  <order classCode="ACT" moodCode="RQO">
    <id root="2.16.840.1.113883.6.96" extension="1298989898" />
    <code code="388975008" displayName="Weight Reduction Consultation" codeSystem="2.16.840.1.113883.6.96" codeSystemName="CPT4" />
  </order>
</inFulfillmentOf>
```
Figure 24: Consultation Note structuredBody Example

```xml
<component>
  <structuredBody>
    <component>
      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.6.1"
                   extension="2015-08-01" />
        <!-- Allergies section template -->
        <code code="48765-2" codeSystem="2.16.840.1.113883.6.1"
              codeSystemName="LOINC" />
        <title>Allergies, Adverse Reactions, Alerts</title>
        ...
      </section>
    </component>
    <component>
      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.8"
                   extension="2015-08-01" />
        <!-- Assessment -->
        <code codeSystem="2.16.840.1.113883.6.1"
              codeSystemName="LOINC"
              code="51848-0" displayName="ASSESSMENT" />
        <title>ASSESSMENT</title>
        ...
      </section>
    </component>
    <component>
      <section>
        <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.4"
                   extension="2015-08-01" />
        <!-- History of Present Illness -->
        <code codeSystem="2.16.840.1.113883.6.1"
              codeSystemName="LOINC"
              code="10164-2" displayName="HISTORY OF PRESENT ILLNESS" />
        <title>HISTORY OF PRESENT ILLNESS</title>
        ...
      </section>
    </component>
    <component>
      <section>
        <!-- MEDICATION SECTION (V2) (coded entries required) -->
        <templateId root="2.16.840.1.113883.10.20.22.2.1.1"
                   extension="2014-06-09" />
        <code codeSystem="2.16.840.1.113883.6.1"
              codeSystemName="LOINC"
              code="10160-0" displayName="HISTORY OF MEDICATION USE" />
        <title>MEDICATIONS</title>
        ...
      </section>
    </component>
    <component>
      <section>
        <!-- Physical Exam (V3) -->
        <templateId root="2.16.840.1.113883.10.20.2.10"
                   extension="2015-08-01" />
        <!-- Physical Exam -->
        <templateId root="2.16.840.1.113883.10.20.2.10"
                   extension="2015-08-01" />
        <title>PHYSICAL EXAM</title>
        ...
      </section>
    </component>
  </structuredBody>
</component>
```
<component>
  <section>
    <templateId root="2.16.840.1.113883.10.20.22.2.7"
      extension="2014-06-09" />
    <!-- Procedures Section (entries optional) (V2) -->
    <code codeSystem="2.16.840.1.113883.6.1"
      codeSystemName="LOINC" displayName="HISTORY OF PROCEDURES" />
    <title>PROCEDURES</title>
    ...
  </section>
</component>

<component>
  <section>
    <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.1"
      extension="2014-06-09" />
    <!-- Reason for Referral Section V2 -->
    <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
      code="42349-1" displayName="REASON FOR REFERRAL" />
    <title>REASON FOR REFERRAL</title>
    ...
  </section>
</component>
1.1.6 Continuity of Care Document (CCD) (V3)

[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.1.2:2015-08-01 (open)]

Table 29: Continuity of Care Document (CCD) (V3) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications Section (V2)</td>
<td>(required)</td>
</tr>
<tr>
<td>Plan of Treatment Section (V2)</td>
<td>(optional)</td>
</tr>
<tr>
<td>Medical Equipment Section (V2)</td>
<td>(optional)</td>
</tr>
</tbody>
</table>