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# HL7 Version 3 Specification: Data Elements for Emergency Department Systems (DEEDS),

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#### **FORWARD**

#### 2 **Introduction**

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- 3 Hospital emergency departments (EDs) and their functional equivalents (e.g. military field
- 4 hospital set up for civil emergencies and to care for injured service members abroad) provide a
- 5 vast array of services to sick and injured people 24 hours a day, 7 days a week. Services range
- 6 from providing the sole source of care to indigent and migrant populations, being the social and
- 7 clinical safety net, and care for the acute and severely injured, ill or poisoned<sup>1</sup>.
- 8 Although the need has been recognized for much longer, the awareness of the importance for
- 9 accurate, automated and interoperable information collection and exchange for both continuity
- of care and public health reporting has grown dramatically since the events of September 11,
- 11 2001 and Hurricane Katrina in 2005.
- 12 Detailed data specifications and information models are required if healthcare IT is to provide a
- 13 foundational tool for managing the complexity of the health care system. The promise of
- improved quality of care, cost reduction, and a safer health care system will not be achieved
- 15 without general use of data collection and clinical decision support systems that engage in a
- 16 "virtuous cycle" where clinical experience, best practices, and validated evidence are
- 17 continuously fed back into a "learning healthcare system."
- 18 In 2012 the United States and other developed countries still face fundamental shortcomings in
- 19 available data which limit the ability to appropriately influence basic clinical, epidemiologic and
- 20 healthcare operations.

#### 21 Background

- 22 Data Elements for Emergency Department Systems (DEEDS)<sup>2</sup> was initially published by the US
- 23 Center for Disease Control and Prevention (CDC) National Center for Injury Prevention and
- 24 Control (NCIPC) in 1997. This represented one of the first detailed clinical content standards
- created for general use by the public. The methodology was exemplary. Existing standards
- 26 (HL7 v2.3, ASTEM E1238-94, LOINC) were used as the framework and starting point for the
- 27 data element definitions.
- 28 Participation in DEEDS r1.0 involved 35 professional organizations, 12 federal agencies and
- 29 over 160 individual participants. While not balloted by any currently recognized SDOs, the
- 30 broad outreach and subsequent adoption and reuse in various public health reporting systems
- 31 is a model for standards development.
- 32 During early development of the X12N/HL7 claims attachment specifications (1997) in response
- 33 to HIPAA, DEEDS was recognized as an example of work potentially leading the way to

<sup>1</sup> Committee on the Future of Emergency Care in the United States Health System. Institute of Medicine. *Hospital-Based Emergency Care: At the Breaking Point*. 2007 National Academies Press. <a href="download.nap.edu/catalog.php?record\_id=11621">download.nap.edu/catalog.php?record\_id=11621</a>

<sup>2</sup> National Center for Injury Prevention and Control. *Data elements for emergency department systems, release 1.0.* Atlanta, GA: Centers for Disease Control and Prevention, 1997. www.cdc.gov/ncipc/pub-res/deedspage.htm

- 34 automated claims adjudication. As the time course for adoption of these specifications changed
- with the notice of intended rule-making as part of the HIPAA Administrative Simplification [45]
- 36 CFR 162], and other CDA r1 specifications and collections of LOINC codes evolved, the need
- 37 for a separate claims attachment for emergency departments was reviewed.
- 38 Working with the Claims Attachment SIG, the Emergency Care SIG reviewed the existing
- 39 DEEDS specification based CDA r1 specification, and suggested its withdrawal, as it was felt
- 40 that the needs for ED records was likely met by subsequently developed specifications with
- 41 more general scope. This reflected needs addressed in a consensus conference on emergency
- 42 medicine informatics<sup>3</sup>.
- 43 The review surfaced the need to update the DEEDS specification to accommodate changes in
- 44 the practice of clinical informatics, availability of HL7 v3 based standards, the recognized
- 45 changes in the scope of emergency care in the United States, and the need for specifications
- 46 with the details needed for Emergency Department Information Systems (EDIS) vendor
- 47 implementation.
- The purpose of DEEDS has been to provide a shared specification for "voluntary adoption by
- 49 individual and organizations responsible for maintaining or improving record systems in 24-hour,
- 50 hospital-based EDs.4"
- 51 The objective of the HL7 DEEDS specification is to update and revise the original DEEDS
- 52 Release 1.0. This ballot is intended to telegraph the plan of future updates to the DEEDS
- 53 specification by making recommendations for replacing the HL7 v2.3 based data types and
- modeling approach with a more modern treatment, suggesting data elements for deprecation,
- 55 identifying mappings of limited utility data elements, and identifying new data elements required
- 56 for further development. This revised version will be referred to in this ballot document as
- 57 DEEDS 1.1.
- In addition, considerable effort has been invested in harmonization with other groups working in
- the same space (e.g. IHE<sup>5</sup> and HL7). In particular, LOINC codes have been changed to reflect
- 60 use in other specifications to facilitate future harmonization.

#### Scope

- This HL7 DEEDS specification is intentionally limited in scope and depth. Other countries
- have similar programs, some of which were informed by the early DEEDS work, and the
- benefits of working with colleges in Canada<sup>6</sup>, the UK, Australia<sup>7</sup> and elsewhere are obvious.
- 65 Given the universality of the content internationalization of the specification is desirable.

<sup>3</sup> Barthell ED, Coonan, KM, Finnell, JT, Pollock DA, Cochrane D. Disparate Systems, Disparate Data: Integration, Interfaces, and Standards in Emergency Medicine Information Technology. *Academic Emergency Medicine* 2004;11:1142-48.

<sup>4</sup> DEEDS Writing Committee Data Elements for Emergency Department Systems, Release 1.0 (DEEDS): A Summary Report. Academic Emergency Medicine, 1998; 5(2):185-193.

<sup>&</sup>lt;sup>5</sup> Integrating the Healthcare Enterprise www.ihe.net

<sup>6</sup> Grant Innes, Michael Murray, Eric Grafstein, A consensus-based process to define standard national data elements for a Canadian emergency department information system. *CJEM* 2001;3(4):277-284. See <a href="http://caep.ca/resources/ctas/cedis">http://caep.ca/resources/ctas/cedis</a>

<sup>7</sup> www.health.vic.gov.au/hdss/vemd/index.htm

- The HL7 DEEDS specification is not intended for implementation. It is an enumeration of
- 67 changes with information needed for domain experts to review the update for coverage. While
- 68 HL7 and LOINC are used as frequent references, DEEDS specifications are NOT a simple
- 69 enumeration of LOINC codes as a value set or LOINC panels, nor are it intended as a HL7
- 70 standard. Rather, these are used to help orient existing users and align standards development
- 71 with the DEEDS effort.

#### <u>Methodology</u>

- 73 DEEDS is in the United States public domain. It has been updated and revised over the last 5
- 74 years by the DEEDS Update and Revision Work Group, and the resulting document; DEEDS
- 1.1 remains a public domain work product of this non-HL7 effort. There historically has been a
- great deal of overlap between this work group and the HL7 Emergency Care WG. The decision
- 77 to ballot this content for comment was made to help share the detailed design work currently
- ongoing, and to solicit input from the HL7 community.
- 79 The 1997 DEEDS r1.0 data elements were reviewed over the course of several years with
- 80 EHRS/EDIS vendors, government agencies, professional societies<sup>8</sup> Section 5.14 of DEEDS r1.0
- 81 contained a set of codes for use with data elements specified under section 5.15, and these
- 82 have been mapped to, or used to identify areas where additional content was needed, in
- 83 conjunction with the LOINC committee<sup>9</sup>.
- 84 In those cases where there were LOINC identifiers for the same data element as both a
- 85 narrative (NAR) and coded (NOM) data-types, the NAR option was chosen, as it was felt to be
- the least constraining. It is expected that implementations of DEEDS would be explicit in
- 87 models and instances which format was being transmitted. This also helped align the codes
- used by DEEDS with those used in CDA r2 implementation guides.
- 89 In addition, several refinements have been added reflecting work by other relevant efforts, such
- 90 as a national consensus conference on defining the requirements for representation of chief
- 91 complaint data in clinical information systems<sup>10</sup> where the need to distinguish between what the
- 92 patient says (the "chief complaint"), what a healthcare professional interprets this (and other
- 93 information to mean), i.e. the presenting problem(s), and other (typically process or procedure
- 94 related) "reason(s) for visit".
- 95 It is not the intent of the DEEDS Update and Revision Work Group to publish a specification, in
- 96 competition with HL7--as that is contrary to the needs of the US emergency care community
- 97 who initiated this effort.
- 98 It is, however, the intent to publish future DEEDS specifications in a format which allows for
- 99 multiple implementation and adoption independent of any given interoperability paradigm. As

<sup>8</sup> The American College of Emergency Physicians (ACEP), American Academy of Emergency Medicine (AAEM), and Emergency Nurses Association (ENA) have representatives over the last few years. In addition DEEDS Update and Revision has been presented and discussed with the ACEP Informatics SIG at several annual meetings.

The patience and help from Clem McDonald, Stan Huff, Kathy Mercer and Dan Vreeman is gratefully acknowledged!

<sup>10</sup> Hass SW, Travers D, Tintinalli JE, Pollock D, Waller A, Barthell E, Burt Catharine, Chapman W, Coonan KM, Kamens D, McClay, Toward Vocabulary Control for Chief Complaint. *Academic Emergency Medicine* 2008; 15:476-482.

- such, the final DEEDS specification will closely resemble (as it is informed by) HL7 standards,
- but it will remain in the public domain. It will be the responsibility of the HL7 EC WG to create
- those interoperability standards based on DEEDS needed to accommodate the ONC S&I
- 103 Process and the needs of other HL7 participants.
- Each data element is identified by an OID, with mapping to related LOINC and SNOMED-CT
- 105 concepts. This mapping is incomplete, and further LOINC code requests are indicated with
- alphabetic placeholders. While this update and revision has resulted in a considerable number
- of new LOINC content specifiers, a similar effort collaborating with IHTSDO is needed. In spite
- of using these standards controlled clinical terminology, the definition of the data element is as
- defined by the DEEDS specification, with as close alignment with controlled terminologies as
- 110 possible. Any conflict between DEEDS definitions and definitions within LOINC or SNOMED-
- 111 CT reflect areas of future improvement.

#### **Ballot Intent**

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- 113 This is a "comment only" ballot. It is intended to share the five years of efforts by the DEEDS
- 114 Update and Revision WG and the HL7 Emergency Care WG with a broader community, to
- foster interoperability and information exchange. It is also a request for other groups working
- with the same clinical and administrative content to collaborate with the DEEDS Update and
- 117 Revision WG, HL7 Patient Care WG, and HL7 Emergency Care WG to create universal data
- element specifications which can be used uniformly in electronic healthcare infrastructure. This
- is also a request for broader participation in the ongoing data element specification. In
- 120 particular, those reviewing the ballot are asked to:
- **121** ❖ Respond with additional content specifications.
  - Review the LOINC and SNOMED assignments to the DEEDS 1.0 data elements for accuracy.
- Comment if the correct list of data elements is included in DEEDS 1.1? If not, what should be added or removed.
  - Comment if the list of data elements are organized correctly?
    - What aggregation / collection of data elements are useful? Several aggregations are identified (e.g. the history and physical is effectively an aggregation of various data elements—others are clearly needed).
    - ❖ The authors recognize that these are at varying levels of granularity, and in many cases are at a very high level. Details regarding the additional components/properties of the data elements are needed and welcome. Reviewers are asked to comment on the components of the current list of data elements and what is necessary to fully define the data elements so they can be used in clinical and public health information systems.
    - Contribute recommended and/or currently used value sets for those components using coded values.

137 138	Recommend changes that may be needed to make DEEDS more useful in non-US realms?
139 140	This effort was decided to be out of scope for this release, but is a recognized requirement.
141	Recommend other related efforts that should be engaged?
142	Ballot Documents
143 144 145	There is are several tables included in this ballot package. A brief description of the main table and two appendices including supportive tables follows.
146 147 148 149 150 151	❖ Table 1. DEEDS 1.1 Ballot Master – This is a comprehensive listing of all original DEEDS 1.0 data elements plus newly proposed data elements. They are currently organized top to bottom according to the original categories described in DEEDS 1.0. The columns included are intended to adequately describe each of the data elements, extend DEEDS to accommodate implementation and to bring DEEDS into conformance with modern data modeling. Columns included are:
152 153 154	<ul> <li>Project ID Number: A unique identifier assigned during this project period for use by the work team and commenters to refer to the item under development and evolution.</li> </ul>
155 156	<ul> <li>OID (Object Identifier): The unique identifying number assigned to that data element.</li> </ul>
157 158 159 160	DEEDS 1.0 Section ID: The number identifying the DEEDS 1.0 Section number the data element was either assigned to in DEEDS 1.0, or in the case of proposed new data elements is suggested to be assigned to in DEEDS 1.1. The Sections are labeled as they were in DEEDS 1.0 as:
161	Section 1. Patient Identification Data
162	Section 2. Facility and Practitioner Identification Data
163	Section 3. ED Payment Data
164	Section 4. ED Arrival and First Assessment Data
165	Section 5. ED History and Physical Examination Data
166	Section 6. ED Procedure and Result Data
167	Section 7. ED Medication Data
168	Section 8. ED Disposition and Diagnosis Data

- Section 9. Laboratory Results
- DEEDS 1.0 Reference #: Reference number from DEEDS 1.0 Specification for the History, Review of Systems and Physical Exam data elements.
  - ➤ Element History: Each element is identified as originating in DEEDS 1.0, or as a newly proposed data element for consideration for inclusion in DEEDS 1.1 using 1.0 and 1.1 respectively.
  - Rec (Recommendation): Several of the original DEEDS 1.0 data elements do not fit current data modeling methodologies. These generally fall into 2 categories. The first category contains items that are recommended to be replaced by an HL7 approved data item that meets the intent of the original DEEDS item. For example, current data modeling techniques consider items such as the ED practitioner ID and the ED practitioner type to be attributes of other data elements describing the care provider. The recommendation for these data items would be to identify and include the appropriate "parent" data item that would include these attributes and include that more up to date data model and to discontinue use of the older DEEDS 1.0 data element. These items are identified by "R" (Replace). The second category of recommendations to the original DEEDS 1.0 data elements contains items that are identified as not meeting current data modeling methods for data storage and management in one system, but that may be needed to support secondary uses of the data. An example of this data element is "Date/Time of first ED responsiveness assessment". This item would ordinarily be determined from the data contained within the clinical database at the time of reporting and may not be stored discretely. In the case of interoperability however, it may be important to exchange this specific information. DEEDS may need to accommodate the storage of this data element once it is received from a "sending" facility. These items are identified by "FE" (Future Evaluation needed).
  - > Item Name: This is the human readable name identifying the data element
- 195 > Definition/Uses: This is a short description of the data element
  - ➤ Data Type: This item further describes the data element by stating how the data are expected to be collected and stored. Data type is in alignment with and follows the definitions of data types as defined in the foundation chapter of the ballot document for HL7 Version 3 Standard.
  - ➤ LOINC Map: This items identifies the LOINC code that would be associated with the data element
  - SNOMED Map: This item identifies the SNOMED code that would be associated with the data element.

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- Two additional documents are included in this ballot submission for reference and review.

  These are:
- Appendix A. DEEDS 1.0 Data Elements with OID, and LOINC and SNOMED mapping:
  This table contains the data elements included in DEEDS 1.0. The column definitions are
  the same as described in Table 1. It is not the full DEEDS 1.0 Specification. To see the full
  DEEDS 1.0 Specification please refer to <a href="www.cdc.gov/ncipc/pub-res/deedspage.htm">www.cdc.gov/ncipc/pub-res/deedspage.htm</a>.
  Appendix A includes a listing of the data elements included in DEEDS 1.0 processed to
  include associated LOINC and SNOMED codes. In general, these codes were not included
  in DEEDS 1.0 and are an extension of that previous body of work.
- Appendix B. Proposed Laboratory Tests: This appendix includes the listing of proposed laboratory data elements to be included with DEEDS 1.1 with more detail. This table is limited to the listing of reportable labs most commonly used by emergency departments. It is recognized the most common orderable lab panels should also be articulated for a more comprehensive DEEDS. This work is planned for a future release and is not included here. Columns included with the lab data in Appendix B are:
  - Common Name: the generic name for the lab test.
  - Common Abbreviation: the generic abbreviation for the lab test.
  - LOINC Wiki Description: The description (if available) from the Regenstrief LOINC Mapping Assistant (RELMA®) database.
  - LOINC: The LOINC code number associated with the data element in the RELMA® database
  - Long Name: Fully specified name created in a standard way to enable linking to the universal test identifier using semi-automated methods.
  - Short Name: Mixed case name for the LOINC concept ≤ 30 characters in length.
  - Component: The component is the analyte being measured. It consists of three main subparts: The principal name (e.g., the name of the analyte or the measurement); challenge of provocation, if relevant, including time delay, substance of challenge, amount administered, and route of administration; and any standardization or adjustment.
  - Property: The kind of property distinguishes between different kinds of quantities of the same substance. Analytes are often measured using different types of units. Kinds of properties include: Mass, Substance, Catalytic Activity, Arbitrary, and Number. Pharmaceutical industry terms for tests include properties, such as Mass Substance Concentration (MSCnc) or Mass Substance Rate (MSRat). Definitions for the main property categories may be found in LOINC Users' Guide.

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- System: The system indicates the type of sample (e.g. urine, serum). It may consist of up to two parts. The first part names the system, and the second part names a subpart origin of the sample that is not the patients (e.g., fetus, donor, blood product unit, etc.).
  - Time as PCT: i.e., whether the measurement is an observation at a moment of time, or an observation integrated over an extended duration of time e.g., 24-hour urine.
  - Scale Type: the type of scale e.g., whether the measurement is quantitative (a true measurement) ordinal (a ranked set of options), nominal (e.g., E. coli;
     Staphylococcus aureus), or narrative (e.g., dictation results from x-rays).
  - Method Type: indicated the technique used to obtain the type of sample e.g., tape measure, derived, measured.
  - Class: An arbitrary classification of the terms for grouping related observations together.
  - Expected Units of Measure: The expected unit of measure the item will be reported
  - Curated Range and Units: A curated list of normal ranges and associated units (expressed as near UCUM codes) for physical quantities and survey scores.
  - SNOMED CT Code: The Systemized Nomenclature of Medicine- Clinical Terms (SNOMED CT) code associated with the data element
  - SNOMED CT Term: The Systemized Nomenclature of Medicine- Clinical Terms (SNOMED CT) preferred term associated with the data element
  - SNOMED CT Type: The Systemized Nomenclature of Medicine- Clinical Terms (SNOMED CT) data type associated with the data element

#### **Future Plans**

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This is a first step in an effort to modernize the DEEDS specification with a goal of making it a worthwhile specification for general use. At least two other releases are anticipated as part of this effort, each following an informative ballot cycle. Those interested in becoming early adopters should wait until DEEDS 1.3, as details needed for a DEEDS-compliant implementation will not be defined until that cycle of revision.

- DEEDS 1.2 is expected to provide additional details needed for the data elements in this releases, as well as adding several hundred additional data elements. More formal information models (typically UML class diagrams) which are closely related to the existing HL7 v3 standards will be used to define each data element, making more technical review possible.
- In addition, efforts to harmonize data element specifications with NEMSIS, the American College of Surgeons National Trauma Registry, the National Emergency Airway Registry, American Associations of Poison Control Centers National Poison Data System, and other similar efforts

- 276 (e.g. surviving sepsis, acute cardiac care, pediatric emergency medicine) will be established. It is expected that there will be a significant convergence of these data specifications.
- 278 It is also hoped that international standards development interests will become part of this effort,
- as similar efforts have been identified in other countries. While emergency care systems vary in
- other realms, the clinical practice of emergency care should be comparable and the potential for
- international collaborations<sup>11</sup> can be facilitated by these efforts.
- 282 DEEDS 1.3 will include value set and other logical constraints needed to fully define the data
- 283 elements.
- Subsequent to addressing the comments of the DEEDS 1.3 ballot (anticipated for 2013) HL7 v3
- templates will be created from the specification will be made available, resources allowing,
- 286 following the guidelines being developed by HL7 Patient Care and Template WG for Detailed
- 287 Clinical Models (DCMs).
- 288 It is the intent of the HL7 Emergency Care WG to collaborate with the HL7 Structured Document
- 289 WG to create an implementation guide for the Emergency Department Encounter Record for
- 290 CDA r3. It is also expected that the same models will be used to generate templates for use in
- any US ONC S&I related work.

Arnold, JL, Corte, FD; International Emergency Medicine: Recent Trends and Future Challenges; European Journal of Emergency Medicine. 2003:10(3); 180-188

# **DEEDS 1.1 BALLOT MASTER TABLE**

This specification is abbreviated to show the format but not the entire content. Please check the Page numbers The final ballot document will be available through normal HL7 channels.

# HL7 Version 3 Specification: Data Elements for Emergency Department Systems (DEEDS) V1

Project ID#	OID	DEEDS 1.0 Section Id.	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.1	SECTION 1: PATIE DEMOGRAPHICS	NT								
1.1.2	1.3.6.1.4.1.32130.1.1.1	1.01		1.0	R	Internal ID	Primary identifier used by facility to identify patient at admission (e.g., medical record number).	II	56794-1	398225001
1.1.3	1.3.6.1.4.1.32130.1.1.2	1.02		1.0		Name	Legal name of patient of identifier when the patient presents.	PN	45965-1	371484003
1.1.4	1.3.6.1.4.1.32130.1.1.3	1.03		1.0	R	Alias	Any names patient has been known by other than current legal name.	PN	56798-2	429086007
1.1.5	1.3.6.1.4.1.32130.1.1.4	1.04		1.0		Date of birth	Patient's date of birth.	GTS	21112-8	184099003
1.1.6	1.3.6.1.4.1.32130.1.1.22	1.1		1.1		Age	Patient's age at the time of registration.	PQ	30525-0	424144002
1.1.7	1.3.6.1.4.1.32130.1.1.22.1	1.1		1.1		Age group	Categorization of age within specified ranges used for statistical analysis, treatment planning, differential diagnosis, and provider accreditation.	СО	46251-5	
1.1.8	1.3.6.1.4.1.32130.1.1.5	1.05		1.0		Sex	A value representing the gender (sex) of a Living subject.	CS	21840-4	184100006
1.1.9	1.3.6.1.4.1.32130.1.1.6	1.06		1.0		Race	Race of patient, entered as American Indian or Alaskan Native, Asian or Pacific Islander, Black, White, or unknown.	CE	32624-9	103579009
1.1.10	1.3.6.1.4.1.32130.1.1.7	1.07		1.0		Ethnicity	Ethnicity of patient, entered as Hispanic, not of Hispanic origin, or unknown.	CE	21838-8	186034007
1.1.11	1.3.6.1.4.1.32130.1.1.8	1.08		1.0		Address	Address of patient	AD	56799-0	397635003
1.1.12	1.3.6.1.4.1.32130.1.1.23	1.1		1.1		Nationality	Nationality as specified by the National Census Bureau (e.g. what is on your passport).	CD	CITZN-X	
1.1.13	1.3.6.1.4.1.32130.1.1.24	1.1		1.1		Country of origin	The country identified by the patient or representative (e.g. what is on your birth certificate).	CD	ORIGIN-X	

Project ID#	OID	DEEDS 1.0 Section Id.	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.14	1.3.6.1.4.1.32130.1.1.9	1.09		1.0		Telephone number	Telephone number at which patient can be contacted.	TEL	42077-8	184103008
1.1.15	1.3.6.1.4.1.32130.1.1.10	1.1		1.0	R	Account number	Identifier assigned by facility billing or accounting office for all charges and payments for this ED visit.	II	56795-8	
1.1.16	1.3.6.1.4.1.32130.1.1.19	1.1		1.1		Encounter unique identifier	A unique identifier for each encounter.	II	52463-7	
1.1.17	1.3.6.1.4.1.32130.1.1.20	1.1		1.1		Episode unique identifier	An identifier code in the source system that distinguishes the current episode of the sequence of encounters relating to a single health problem.	II	56797-4	
1.1.18	1.3.6.1.4.1.32130.1.1.11	1.11		1.0	R	Social Security number	Personal identification number assigned by US Social Security Administration.	II	45396-9	398093005
1.1.19	1.3.6.1.4.1.32130.1.1.12	1.12		1.0		Occupation	Patient's current work, entered as code with associated text description or as text description alone.	CE	21847-9	
1.1.20	1.3.6.1.4.1.32130.1.1.13	1.13		1.0		Industry	Industry or business in which patient currently works, entered as code with associated text description or as text description alone.	CE	21844-6	
1.1.21	1.3.6.1.4.1.32130.1.5.15.0.5150	5.15	HX05150	1.1		Current employment	A description of the manner in which the patient gathers the resources required to provide nutritional sustenance, shelter, and other important resources necessary to live.	CD	11294-6	184104002
1.1.22	1.3.6.1.4.1.32130.1.1.14	1.14		1.0	R	Emergency contact name	Name of person whom the patient designates to be primary contact if notification is necessary.	EN	56861-8	
1.1.23	1.3.6.1.4.1.32130.1.1.15	1.15		1.0	R	Emergency contact address	Address of emergency contact.	AD	56862-6	
1.1.24	1.3.6.1.4.1.32130.1.1.16	1.16		1.0	R	Emergency contact telephone number	Telephone number of emergency contact.	TEL	56863-4	
1.1.25	1.3.6.1.4.1.32130.1.1.17	1.17		1.0	R	Emergency contact relationship	Relationship of emergency contact to patient, entered as locally assigned code or as text descriptor.	CE	56864-2	
1.1.26	1.3.6.1.4.1.32130.1.1.18	1.1		1.1		Emergency contact information	Emergency contact name, address, phone number and a relationship to the patient.		56864-2	406548001

Project ID#	OID	1.0	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.27	1.3.6.1.4.1.32130.1.4.33	1.4		1.1		Individuals accompanying patient to ED	Individual(s) who accompanied the patient upon first entering the ED.		56813-9	
1.1.28	1.3.6.1.4.1.32130.1.1.21	1.1		1.1		Special Accomodation	A code identifying a person's disability such as vision, hearing, speech, mentally, and mobility impaired or requires a crib, crutches, gurney, wheelchair or walker.	CD	DISAB-X	
1.1.29	1.3.6.1.4.1.32130.1.5.15.2.1	5.15		1.1		Advance Directives	Advance care directives are specific instructions, prepared in advance, that are intended to direct a person's medical care if he or she becomes unable to do so in the future.		42348-3	310301000
1.1.30	Section 2: FACILITY	AND PRA	ACTITIONE	<u>R</u>						
1.1.31	1.3.6.1.4.1.32130.1.2.1	2.01		1.0		ED Facility ID (NPIN)	National Provider Identifier for facility where patient seeks or receives outpatient emergency care.	II	45399-3	
1.1.32	1.3.6.1.4.1.32130.1.2.23	1.2		1.1		Transferring facility (from outside facility to ED, i.e. in bound)	The healthcare facility from which a transfer is initiated and effected.		TXFAC-X	
1.1.33	1.3.6.1.4.1.32130.1.2.24	1.2		1.1		Accepting/admitting facility (Inbound)	The hospital or other healthcare facility to which a patient is accepted and transported for subsequent care.		ACPTFAC-X	
1.1.34	1.3.6.1.4.1.32130.1.2.22	1.2		1.1		Transferring provider (from outside facility to ED, i.e. in bound)	Physician responsible for transferring a patient from an outside facility.		TXMD-X	
1.1.35	1.3.6.1.4.1.32130.1.2.21	1.2		1.1		Admitting provider (Inbound)	Provider who accepts an incoming patient.		ACCPTMD-X	
1.1.36	1.3.6.1.4.1.32130.1.2.16	1.2		1.1		Attending ED physician	The Emergency Department attending physician with primary responsible for the overall care of a patient while in the Emergency Department.		EDATTEND-X	

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1.1.48	1.3.6.1.4.1.32130.1.2.13	2.13		1.0	R	Date/time ED consult request initiated	Date/ time when emergency physician or other appropriate requester first attempts to contact specified ED consultant or consulting service.	TS		
1.1.49	1.3.6.1.4.1.32130.1.2.14	2.14		1.0	R	Date/time ED consult starts	Date/ time when ED consultant's services begin.	TS		
1.1.50	1.3.6.1.4.1.32130.1.8.41			1.1		Provider assuming ultimate responsibility for care for patient upon ED disposition	At the point of leaving the ED the care of the patient is transferred to the next provider from whom the patient is expected to receive care. Such as a hospital admitting physician, referred specialty physician or primary care provider.		56855-0	
1.1.51	1.3.6.1.4.1.32130.1.8.41.1			1.1		Provider assuming care for patient upon ED disposition (e.g. resident accepting patient)	The individual (identified) who is going to be responsible for the immediate and direct care of the patient once they have left the emergency department.		56856-8	
1.1.52	1.3.6.1.4.1.32130.1.2.28			1.1		Accepting physician Outbound	Provider who has accepted a patient in transfer from another facility.		ACPTMD-X	
1.1.53	1.3.6.1.4.1.32130.1.2.20			1.1		Follow up provider	Follow up provider is a physician or other healthcare provider to whom a patient is sent for continuing care after discharge.		FUPROV-X	
1.1.54	1.3.6.1.4.1.32130.1.2.27			1.1		Primary care clinic/system	The location from which the patient receives overall longitudinal medical care.		PRIMCLIN-X	
1.1.55	1.3.6.1.4.1.32130.1.2.15			1.1		Primary care provider	The provider from which the patient receives overall longitudinal medical care.		PCP-X	
1.1.56	1.3.6.1.4.1.32130.1.2.2	2.02		1.0	R	Primary practitioner name	Name of physician or other practitioner who provides patient's overall longitudinal care.	PN		
1.1.57	1.3.6.1.4.1.32130.1.2.3	2.03		1.0	R	Primary practitioner Id	National Provider Identifier or locally assigned identifier for primary practitioner.	II		
1.1.58	1.3.6.1.4.1.32130.1.2.4	2.04		1.0	R	Primary practitioner type	Primary practitioner's profession or occupation and specialty or subspecialty.	CE		

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1.1.59	1.3.6.1.4.1.32130.1.2.5	2.05		1.0	R	Primary practitioner address	Address of primary practitioner.	AD		
1.1.60	1.3.6.1.4.1.32130.1.2.6	2.06		1.0	R	Primary practitioner telephone number	Telephone number of primary practitioner.	TEL		
1.1.61	1.3.6.1.4.1.32130.1.2.7	2.07		1.0	R	Primary practitioner organization	Name of the health care organization that provides patient's overall longitudinal care.	ORG		
1.1.62	Section 3: ED PAYM	IENT DAT	<u>A</u>							
1.1.63	1.3.6.1.4.1.32130.1.3.1	3.01		1.0		Insurance coverage or other expected source of payment	Entity or person expected to be responsible for patient's bill, entered as insurance company, Medicare, Medicaid, workers' compensation, other government payments, self-pay, no charge, other, or unknown.	0	48768-6	
1.1.64	1.3.6.1.4.1.32130.1.3.2	3.02		1.0	R	Insurance company	Identifier for patient's insurance company or carrier.	EN		
1.1.65	1.3.6.1.4.1.32130.1.3.3	3.03		1.0	R	Insurance company address	Address of patient's insurance company.	AD		
1.1.66	1.3.6.1.4.1.32130.1.3.4	3.04		1.0	R	Insurance plan type	Insurance plan in which patient is enrolled.	CE		
1.1.67	1.3.6.1.4.1.32130.1.3.5	3.05		1.0	R	Insurance policy ID	Identifier for patient's insurance policy; the identifier that uniquely denotes the insurance policy participant.	II		
1.1.68	1.3.6.1.4.1.32130.1.3.6	3.06		1.0		ED payment authorization requirement	Indicator of whether payment authorization for ED services is required by third-party payer, entered as required, not required, not applicable, or unknown.	CE	?	
1.1.69	1.3.6.1.4.1.32130.1.3.7	3.07		1.0		Status of ED payment authorization attempt	Indicator of whether contact with thud-party payer is attempted and whether contact is established, entered as contact not attempted, contact attempted but not established, contact attempted and established, or unknown whether contact attempted or established.	CE	?	

Project ID#	OID	1.0	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.70	1.3.6.1.4.1.32130.1.3.8	3.08		1.0	R	Date/time of ED payment authorization attempt	Date and time when payment authorization is sought from third-party payer.	GTS	?	
1.1.71	1.3.6.1.4.1.32130.1.3.9	3.09		1.0		ED payment authorization decision	Date and time when third-party payer provides decision regarding payment authorization.	CE	?	
1.1.72	1.3.6.1.4.1.32130.1.3.9	3.10		1.0	R	Date/time of ED payment authorization decision	Date and time when third-party payer provides decision regarding payment authorization.	GTS	?	
1.1.73	1.3.6.1.4.1.32130.1.3.11	3.11		1.0		Entity contacted to authorize ED payment	Name of insurance company or other entity contacted to authorize payment for ED services.	EN	?	
1.1.74	1.3.6.1.4.1.32130.1.3.12	3.12		1.0		ED payment authorization code	Identifier assigned by third-party payer to track payment authorization for ED services.	CE	?	
1.1.75	1.3.6.1.4.1.32130.1.3.13	3.13		1.0		Person contacted to authorize ED payment	Person employed by or associated with a specific third-party payer who is contacted for payment authorization.	PN	?	
1.1.76	1.3.6.1.4.1.32130.1.3.14	3.14		1.0		Telephone number of entity or person contacted to authorize ED payment	Telephone number of entity or person contacted to authorize payment for ED services.	TEL	?	
1.1.77	1.3.6.1.4.1.32130.1.3.15	3.15		1.0		Total ED facility charges	Name of insurance company or other entity contacted to authorize payment for ED services.	МО	?	
1.1.78	1.3.6.1.4.1.32130.1.3.16	3.16		1.0		Total ED professional fees	Total professional fees billed for this ED visit.	0	?	

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1.1.80	1.3.6.1.4.1.32130.1.4.3	4.03		1.0		EMS unit that transported ED patient	Identifier for EMS unit that transported patient to ED.	licensedEntity	11319-1	
1.1.81	1.3.6.1.4.1.32130.1.4.4	4.04		1.0		EMS agency that transported ED patient	Identifier for EMS agency that transported patient to ED.	licensedEntity	11318-3	
1.1.82	1.3.6.1.4.1.32130.1.4.3.1			1.1		EMS dispatch time	Time/Date stamp when the EMS unit is dispatched.	IVL_TS		
1.1.83	1.3.6.1.4.1.32130.1.4.3.2			1.1		EMS arrival time	Time/Date stamp when the EMS unit arrives on scene.	IVL_TS		
1.1.84	1.3.6.1.4.1.32130.1.4.3.3			1.1		EMS scene departure time	Time/Date stamp when the EMS unit leaves the scene.	IVL_TS		
1.1.85	1.3.6.1.4.1.32130.1.4.2	4.02		1.0		Mode of transport to ED	Patient's mode of transport to ED.	CE	11459-5	424483007
1.1.86	1.3.6.1.4.1.32130.1.4.13			1.1		Prehospital care	Any initial medical care given an ill or injured patient by a paramedic or other person before the patient reaches the hospital emergency department.		56814-7	
1.1.87	1.3.6.1.4.1.32130.1.8.5.1			1.1		Time ED patient accepted for admission/transfer	Time/Date stamp when the ED patient is accepted by the next care provider for either admission to the facility or transferred to another care facility		ACPTTIM-X	
1.1.88	1.3.6.1.4.1.32130.1.8.5.2			1.1		Time patient received by accepting facility/unit	Time/Date stamp how long patient spent at an accepting facility or unit.		RECDTIM-X	
1.1.89	1.3.6.1.4.1.32130.1.4.1	4.01		1.0		Date/time first documented in ED	First date and time documented in patient's record for this ED visit.	TS	11288-8	405799000
1.1.90	1.3.6.1.4.1.32130.1.4.5	4.05		1.0		Source of referral to ED	Individual or group who decided patient should seek care at this ED.	Entity (PSN, ORG, PUB)	11293-8	
1.1.91	1.3.6.1.4.1.32130.1.4.35	1.4		1.1		Signs of life upon arrival	Presence of any indication of life at time of arrival to the ED (e.g. pulse, heart beat, blood pressure,	CD	LIFES-X	

Project ID #	OID	DEEDS 1.0 Section Id.	1.0	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.101	1.3.6.1.4.1.32130.1.4.32	4.32		1.0	R	Medication allergy reported in ED	Medication to which patient is allergic, as reported by patient or responsible informant, entered as code with associated text description or as text description alone.	CD		
1.1.102	1.3.6.1.4.1.32130.1.5.15.0.1510			1.1		Reason for visit	The basis, or purpose, for an encounter in an ED setting (this may be a process or procedure).	CD	29299-5	
1.1.103	1.3.6.1.4.1.32130.1.5.15.0.1520			1.1		Presenting problem	A clinically relevant concept describing the healthcare professional's interpretation of the cause creating the health issues promoting the patient to seek care.	CD	56817-0	406524005
1.1.104	1.3.6.1.4.1.32130.1.4.14	4.14		1.0	FE	First ED Glasgow eye-opening component assessment	First date and time documented in patient's record for this ED visit.	СО	11324-1	
1.1.105	1.3.6.1.4.1.32130.1.4.15	4.15		1.0	FE	First ED Glasgow verbal component assessment	Location of a patient.	СО	11326-6	
1.1.106	1.3.6.1.4.1.32130.1.4.16	4.16		1.0	FE	First ED Glasgow motor component assessment	First ED assessment of Glasgow Coma Scale motor component for injured patient.	СО	11325-8	
1.1.107	1.3.6.1.4.1.32130.1.4.17	4.17		1.0	FE	Date/time of first ED Glasgow Coma Scale assessment	Date and time when Glasgow Coma Scale is first assessed in ED for injured patient.	TS		
1.1.108	1.3.6.1.4.1.32130.1.4.18	4.18		1.0	FE	First ED systolic blood pressure	The first reading taken in the Emergency Department for systolic (contraction of ventricles) blood pressure. Normal readings are between 100 to 120 mm Hg.	PQ	11378-7	
1.1.109	1.3.6.1.4.1.32130.1.4.19	4.19		1.0	R/FE	Date/time of first ED systolic blood pressure	The first Date and time documented in patient's record for systolic (contraction of ventricles) blood pressure taken in the Emergency Department.	TS		

Project ID#	OID	1.0	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.121	1.3.6.1.4.1.32130.1.4.31	4.31		1.0		Date of last tetanus immunization	Date when patient was last immunized for tetanus, as reported by patient or responsible informant.	TS	55257-0	
1.1.122	Section 5: HISTORY	AND PHY	SICAL EX	AMINATIO	ON D	ATA				
1.1.123	1.3.6.1.4.1.32130.1.5.1	5.01		1.0		Date/time of first ED practitioner evaluation	Time of first ED practitioner evaluation following triage and acuity assessment. This corresponds to provider seen time. (This is one of some key times captured during an ED encounter including: arrival time, triage time, time seen by provider, and discharge	GTS	MDSEEN-T	
1.1.124	1.3.6.1.4.1.32130.1.5.16	5.16		1.0	R	Date/time ED clinical finding obtained	Date and time when history or physical examination finding is obtained.	GTS		
1.1.125	1.3.6.1.4.1.32130.1.5.17	5.17		1.0	R	ED clinical finding practitioner ID	National Provider Identifier or locally assigned identifier for practitioner who obtains clinical finding.	II		
1.1.126	1.3.6.1.4.1.32130.1.5.18	5.18		1.0	R	ED clinical finding practitioner type	Profession or occupation and specialty or subspecialty of practitioner who obtains clinical finding.	CE		
1.1.127	1.3.6.1.4.1.32130.1.5.19	5.19		1.0	R	ED clinical finding data source	Source of history or physical examination finding, entered as patient, paramedic emergency medical technician, parent, spouse, partner, other family member, caretaker, nurse, physician, other practitioner, acquaintance, bystander, law enforcement personnel, existing medical records, other, or unknown.	INF		
1.1.128	1.3.6.1.4.1.32130.1.5.14	5.14		1.0	R	ED clinical finding type	Type of clinical finding reported (e.g., history of present illness, physical examination).	CE		
1.1.129	1.3.6.1.4.1.32130.1.5.15	5.15		1.0		ED clinical finding	History or physical examination finding, entered in accordance with finding type (e.g., text description for history of present illness, number for apical heart rate).			

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1.1.130	HISTORY									
1.1.131	1.3.6.1.4.1.32130.1.5.15.0		HX00000	1.1		Patient history	The comprehensive history of the patient. May include medical history, surgical history, social history, occupational history, facility history etc.		PATHX-X	271905007
1.1.132	1.3.6.1.4.1.32130.1.5.15.0.1000		HX01000	1.1		Source of history	The person who provided the patient's medical history to the care provider collecting it. Usually the patient, but could be a family member or other care giver.		8674-4	
1.1.133	1.3.6.1.4.1.32130.1.5.15.0.2090			1.1		Limitations in obtaining history	Specific conditions which preclude obtaining a fully reliable history. E.g. patient unconscious, intoxicated, etc.	CD	56830-3	
1.1.134	1.3.6.1.4.1.32130.1.4.6	4.06	HX01500	1.0		Chief complaint	Patient's reason for seeking care or attention, expressed in words as close as possible to those used by patient or responsible informant, entered as code with associated text description or as text description alone.		46239-0	422843007
1.1.135	1.3.6.1.4.1.32130.1.4.7	4.07		1.0		Initial encounter for current instance of chief complaint	Indicator that this is patient's first encounter at any health care facility or with any practitioner for current instance of chief complaint.	0	11371-2	
1.1.136	1.3.6.1.4.1.32130.1.5.15.0.2000		HX02000	1.1		History of present illness	Specific information about the onset, duration, and character of the present illness, as well as of any acts or factors that aggravate or ameliorate the symptoms. The HPI may be expressed as a narrative account along with associated quantitative related facts.		10164-2	422625006
1.1.137	1.3.6.1.4.1.32130.1.5.15.0.2079			1.1		Time last ate (solid food)	Date/Time patient last ate solid food	TS	55259-6	
1.1.138	1.3.6.1.4.1.32130.1.5.15.0.2080			1.1		Time last drank (liquid)	Date/Time patient last consumed liquids	TS	55260-4	
1.1.139	PROBLEM LIST		HX03000			Problem List				

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1.1.140	1.3.6.1.4.1.32130.1.5.15.0.2001			1.1		Problem description	Problem description: adjectival qualifiers of the problem. e.g. "sharp", "dull", "non-migratory", "upper quadrant", "chronic".		56818-8	
1.1.141	1.3.6.1.4.1.32130.1.5.15.0.2003			1.1		Problem diagnostic considerations	Current list of diagnostic possibilities, known as the Differential Diagnosis.		56865-9	
1.1.142	1.3.6.1.4.1.32130.1.5.15.0.2100			1.1		Problem associated signs and symptoms	Symptoms experienced by the patient in addition to the chief complaint.	CD	56831-1	
1.1.143	1.3.6.1.4.1.32130.1.5.15.0.2071			1.1		Problem frequency	How frequently the problem occurs.	CD	56826-1	
1.1.144	1.3.6.1.4.1.32130.1.5.15.0.2060			1.1		Problem location	Anatomical location of the problem.	CD	56824-6	
1.1.145	1.3.6.1.4.1.32130.1.5.15.0.2030			1.1		Problem relieving factors	An agent that alleviates a symptom (a problem).		55258-8	
1.1.146	1.3.6.1.4.1.32130.1.5.15.0.2074			1.1		Episode symptom duration	Length of time symptoms/pain last during an episode.	URG_TS	56827-9	
1.1.147	INJURY									
1.1.148	1.1.125	5.02		1.0		Date/time of illness or injury onset	Onset date and time of acute illness or injury most responsible for precipitating patient's ED visit.	GTS	11368-8	263501003
1.1.149	1.3.6.1.4.1.32130.1.5.3	5.03		1.0		Injury incident description	Brief description of injury incident that precipitated patient's ED visit.	CD	11374-6	
1.1.150	1.3.6.1.4.1.32130.1.5.5.1			1.1		Injury incident location coordinates	The geographic location that the patient suffered their injury.			
1.1.151	1.3.6.1.4.1.32130.1.5.4	5.04		1.0		Coded cause of injury	Encoded description of injury event that precipitated patient's ED visit (e.g., International Classification of Diseases. 9th Revision, Clinical Modification' external cause-of-injury code).	CE	11373-8	
1.1.152	1.3.6.1.4.1.32130.1.5.5	5.05		1.0		Injury incident location type	Type of place where patient's injury occurred	CD	11376-1	

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1.1.153	1.3.6.1.4.1.32130.1.5.6	5.06		1.0		Injury activity	Type of activity patient was involved in at time of injury, entered as sports, leisure, paid work, unpaid work, educational activity, vital activity (e.g., resting, eating), other, or unknown.	CD	11372-0	
1.1.154	1.3.6.1.4.1.32130.1.5.8.1			1.1		Airbag deployment in MVC	Whether or not airbags were deployed in a motor vehicle collision (MVC).	CD		
1.1.155	1.3.6.1.4.1.32130.1.5.7	5.07		1.0		Injury intent	Indicator of whether injury resulted from unintentional or intentional act or one of unknown intent, entered as unintentional. intentionally self-inflicted (confirmed), intentionally self-inflicted (suspected), assault (confirmed), assault (suspected), legal intervention (inflicted by police or other authorities during law enforcement), or undetermined.	CD	11375-3	
1.1.156	1.3.6.1.4.1.32130.1.5.8	5.08		1.0		Safety equipment use	Use or nonuse of equipment designed to prevent injury during vehicle crash or other injury-producing event that precipitated patient's ED visit, entered for shoulder belt, lap belt, seat belt not otherwise specified. driver's front air bag, passenger's front air bag, front air bag not otherwise specified, side air bag, air bag not otherwise specified, child safety seat, helmet, eye protection, protective clothing, protective flotation device, or other protective gear.	CD	11457-9	
1.1.157	PAIN									
1.1.158	1.3.6.1.4.1.32130.1.5.15.0.2051			1.1		Pain quality	Description of the specific sensory quality of pain (e.g. sharp, dull, burning, etc.).	CD	32419-4	
1.1.159	1.3.6.1.4.1.32130.1.5.15.0.2062			1.1		Pain radiation	Pain spreading to, or along, a distance from a focus or point of origin.	CD	38205-1	
1.1.160	1.3.6.1.4.1.32130.1.5.15.0.2072			1.1		Pain time course	Temporal course of pain, e.g. progressive, waxing and waning.	CD	38206-9	
1.1.161	1.3.6.1.4.1.32130.1.5.15.0.2073			1.1		Pain onset	Character of onset of symptoms/pain, especially rapidity of onset, gradual vs. rapid, and degree of intensity thereupon.	CD	38203-6	

Project ID#	OID	DEEDS 1.0 Section Id.	1.0	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.162	1.3.6.1.4.1.32130.1.5.15.0.2075			1.1		Pain duration	Length of time symptoms/pain have been present since onset. May be constant, varying, episodic, decreasing, or increasing.	URG_TS	38207-7	
1.1.163	1.3.6.1.4.1.32130.1.5.15.0.2031			1.1		Pain relieving factors	Activities or medications which alleviate pain.		38210-1	
1.1.164	PAST HISTORY		HX04000	1.1		Past history				
1.1.165			HX04050	1.1		General Health	Narrative description from the patient typically be described in general terms, along a scale of excellent, good, fair, and poor of the historical health status.			
1.1.166	1.3.6.1.4.1.32130.1.5.15.0.4100		HX04100	1.1		Prior major illnesses and injuries	Prior major illnesses and injuries in the patient's past medical history.		11338-1	
1.1.167	1.3.6.1.4.1.32130.1.5.15.0.4000			1.1		Past Medical History (PMH)	Narrative history of all relevant medical events and problems a person has experienced over his/her life course, including psychiatric illness.		11348-0	
1.1.168	1.3.6.1.4.1.32130.1.5.15.0.4301			1.1		Medical Device Use	List of the medical devices employed in the current medical care of the patient, (e.g. cochlear implants, pace makers, AICDs, PICC lines, BiPAP, intramedullary rods, insulin pump, etc.)		46264-8	364697006
1.1.169	1.3.6.1.4.1.32130.1.5.15.0.4210			1.1		Childhood illnesses	History of routine and exceptional childhood illnesses.	CD	10156-8	
1.1.170	1.3.6.1.4.1.32130.1.5.15.0.4001			1.1		Health Concern	Any issue persisting over time related to an individual's health. Examples include Problems, Medication Allergies and Intolerance, Past Medical History.		CONCERN-X	
1.1.171	1.3.6.1.4.1.32130.1.5.15.0.4150		HX04150	1.1		Prior operations	A history of the surgical procedures/operations and complications, if any—that a particular patient had. See past surgical history.	CD	10167-5	
1.1.172	1.3.6.1.4.1.32130.1.5.15.0.4155			1.1		History of Hospitalizations and History of Outpatient Visits	History of recent care for problems related to the current encounter.		46239-0	

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1.1.173	1.3.6.1.4.1.32130.1.5.15.0.4200		HX04200	1.1		Prior Hospitalizations	History of prior hospitalizations, often limited to those relevant to the current encounter.		11336-5	
1.1.174	1.3.6.1.4.1.32130.1.5.15.0.4250		HX04250	1.1		Prior outpatient visits	History of recent outpatient encounters as relates to the presenting problem and/or reason for visit.		11346-4	
1.1.175	MEDICATIONS									
1.1.176	1.3.6.1.4.1.32130.1.5.15.0.4300		HX04300	1.1		Current medications	This is the list of medications (prescription, OTC, herbal, etc.) that the patient is currently taking. These may impact the patient's care during the visit and may require modification at the time of disposition based on changes in the patient's condition		10160-0	
1.1.177	1.3.6.1.4.1.32130.1.5.15.0.4120			1.1		Allergies, adverse reactions and alerts	Contains a list and description of any allergies or adverse reactions pertinent to current or past medical history. At a minimum this section should contain currently active and any relevant historical allergies and adverse reactions.		48765-2	
1.1.178	1.3.6.1.4.1.32130.1.5.15.0.4130			1.1		History of adverse drug reaction	The history of specific reactions to medications.		44939-7	
1.1.179	1.3.6.1.4.1.32130.1.5.15.0.4140			1.1		Reported Medication Allergy	Drug/medication allergy reported by the patient. These can include events which might be otherwise characterized as adverse reactions by medical professionals.		11382-9	
1.1.180	1.3.6.1.4.1.32130.1.5.10.1			1.1		Quantity of medication most recently taken	Amount of last dose of medication	PQ	65818-7	
1.1.181	1.3.6.1.4.1.32130.1.5.10.3			1.1		Time medication due for next dose	When the next dose of medication is scheduled	IVL_PQ	43742-6	
1.1.182	1.3.6.1.4.1.32130.1.5.10.4			1.1		Time medication most recently taken	When the last dose of medication was taken.	TS	45285-4	
1.1.183	1.3.6.1.4.1.32130.1.5.9	5.09		1.0		Current therapeutic medication	Current therapeutic medication used by patient, entered as code with associated text description or as text description alone.	CD	18605-6	

Project ID#	OID	DEEDS 1.0 Section Id.	1.0	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.184	1.3.6.1.4.1.32130.1.5.10	5.1		1.0		Current therapeutic medication dose	Dose of current therapeutic medication at each administration.	IVL <pq></pq>	18607-2	
1.1.185	1.3.6.1.4.1.32130.1.5.11	5.11		1.0		Current therapeutic medication dose units	Units for dose of current therapeutic medication.	CS		
1.1.186	1.3.6.1.4.1.32130.1.5.12	5.12		1.0		Current therapeutic medication schedule	Frequency and duration of administration of current therapeutic medication.	PIVL	18608-0	
1.1.187	1.3.6.1.4.1.32130.1.5.13	5.13		1.0		Current therapeutic medication route	Route by which current therapeutic medication is administered.	CD	18609-8	
1.1.188	1.3.6.1.4.1.32130.1.5.15.0.4350		HX04350	1.1		Allergies	Narrative list provided by the patient of substances causing allergic or adverse reactions.		10155-0	
1.1.189	1.3.6.1.4.1.32130.1.5.15.0.4400		HX04400	1.1		Growth and developmental history	Narrative description provided by patient regarding growth and maturation		11334-0	
1.1.190	IMMUNIZATION									
1.1.191	1.3.6.1.4.1.32130.1.5.15.0.4450		HX04450	1.1		Immunization status	Patients report of currency of immunizations captured as yes/no to specific immunizations	CD	11370-4	408864009
1.1.192	1.3.6.1.4.1.32130.1.5.15.0.4451			1.1		Immunization history	Narrative report provided by patient regarding Immunization/Vaccination history including a list of all vaccines a patient has been given.		11369-6	
1.1.193	1.3.6.1.4.1.32130.1.5.15.0.4452			1.1		Tetanus immunization status	Tetanus immunization status: Current tetanus toxoid immunization status, including elapsed time since last booster	CD	11458-7	
1.1.194	1.3.6.1.4.1.32130.1.5.15.0.4453			1.1		Rabies immunization status	History of prior rabies immunization or results of testing.	CD	55261-2	
1.1.195	1.3.6.1.4.1.32130.1.5.15.0.4454			1.1		Influenza immunization status	Influenza immunization status: Current (Y/N/unknown)	CD	55262-0	
1.1.196	1.3.6.1.4.1.32130.1.5.15.0.4455			1.1		Pertussis immunization status	History of pertussis vaccination	CD	55263-8	

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1.1.219	1.3.6.1.4.1.32130.1.5.15.0.4478			1.1		Dengue status	History or serology of prior infection with Dengue Virus, including serotype (if known, or if type of outbreak was known)	CD	DENGUE-X	
1.1.220	1.3.6.1.4.1.32130.1.5.15.0.4479			1.1		Clinical trial / investigational product study status	Indicator that the patient is currently enrolled in a research protocol of an investigational agent or product.	CD	TRIAL-X	
1.1.221	1.3.6.1.4.1.32130.1.5.15.0.4499			1.1		Reason for non- vaccination	The reason why the vaccination was not administered.	CD	NONVA-X	429684009
1.1.222	1.3.6.1.4.1.32130.1.7.32			1.1		Hepatitis B immune globulin given [Volume]	Amount of HbIG given.		10397-8	
1.1.223	1.3.6.1.4.1.32130.1.7.33			1.1		Immune serum globulin given [Volume]	Amount of Immune serum globulin given		10402-6	
1.1.224	1.3.6.1.4.1.32130.1.7.37			1.1		Varicella zoster virus immune globulin given [Volume]	Amount of VZIG given.		10428-1	
1.1.225	1.3.6.1.4.1.32130.1.5.15.0.4500		HX04500	1.1		Feeding and dietary status	Ability of patient to feed themselves and nutritional history.	CD	11320-9	
1.1.226	1.3.6.1.4.1.32130.1.5.15.0.4550		HX04550	1.1		Physical functioning	Baseline ability to perform ADLs and other aspects of physical ability.	CD	47420-5	
1.1.227	1.3.6.1.4.1.32130.1.5.15.0.4600		HX04600	1.1		Mental and emotional well-being	Information collected regarding the patient's emotional state and stability, symptoms of mental illness, response to usual stressors, as well as coping mechanisms and emotion support.	CD	10165-9	
1.1.228	1.3.6.1.4.1.32130.1.5.15.0.4650		HX04650	1.1		Cognitive functioning	Information about the patient's current level of thinking capacity, including symbolic operations, perception, memory, creation of imagery, and capacity for judgment.	CD	11332-4	
1.1.229	SOCIAL AND FAMILY	HISTOR	RY							
1.1.230	1.3.6.1.4.1.32130.1.5.15.0.5000		HX05000	1.1		Social history	Narrative history of patient's social habits such as marriage status, alcohol, tobacco and drug use.	CD	29762-2	160476009

Project ID #	OID	DEEDS 1.0 Section Id.	1.0	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.242	1.3.6.1.4.1.32130.1.5.15.0.5256		HX05256	1.1		Binge drinking episodes per month	Quantitative number reported by patient of times per month of consumption of five or more drinks in a row by men — or four or more drinks in a row by women.	URG_PQ	11286-2	
1.1.243	1.3.6.1.4.1.32130.1.5.15.0.5258			1.1		Alcoholic drinks per week	Average number of alcoholic drinks per week the patient consumes.	URG_PQ	44940-5	
1.1.244	1.3.6.1.4.1.32130.1.5.15.0.5300		HX05300	1.1		Tobacco use	Use of tobacco products currently or in the past.	CD	11366-2	229819007
1.1.245	1.3.6.1.4.1.32130.1.5.15.0.5307			1.1		Current smoker	This is a status which may be explicitly captured or derived from the last tobacco use based upon rules, e.g. if the patient smoked within the past week they are a current smoker.	CD	64234-8	
1.1.246				1.1		Amount of Tobacco Use	Amount of tobacco products that the patient uses, e.g. 1 pack, 1 tin, etc. This combines with frequency to give you 1 pack per day, etc.			
1.1.247				1.1		Frequency of Tobacco Use	Frequency of tobacco products use by the patient, e.g. per day, per week, etc. This combines with amount to give you 1 pack per day, etc.			
1.1.248				1.1		Last Tobacco Use	The date and time that the patient last used tobacco products			
1.1.249				1.1		Type of Tobacco	Assessment of what type(s) of tobacco the patient uses, e.g. cigarettes, cigars, chew, etc.			
1.1.250	1.3.6.1.4.1.32130.1.5.15.0.5301		HX05301	1.1		Cigarette packs smoked per day	The number of cigarette packs smoked per day by the patient.	URG_PQ	8663-7	
1.1.251	1.3.6.1.4.1.32130.1.5.15.0.5306		HX05306	1.1		Cigarette pack- years	The number of cigarette packs smoked per day by the patient.	URG_PQ	8664-5	
1.1.252				1.1		Length of tobacco use	This is an assessment of the length of time (frequently years) that the patient used tobacco products. It is combined with amount and frequency to calculate the total life tobacco use burden.			
1.1.253				1.1		Lifetime tobacco use	This is an assessment of the total lifetime tobacco use burden for the patient, e.g. 40 pack year history.			

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1.1.254				1.1		Tobacco Cessation Education Provided	Assessment of whether the patient was given education regarding tobacco use cessation.			
1.1.255	1.3.6.1.4.1.32130.1.5.15.0.5350		HX05350	1.1		Other nonmedical drug use	Narrative history of non- therapeutic/recreational/abuse of prescription or OTC drugs reported	CD	11342-3	363908000
1.1.256	1.3.6.1.4.1.32130.1.5.15.0.5360			1.1		Last use of substance of abuse	Date/Time of the last used abused substance.	URG_TS	56832-9	
1.1.257	1.3.6.1.4.1.32130.1.5.15.0.5365			1.1		Substance abused	Substances/drugs abused by the patient.	CD	56832-9	
1.1.258	1.3.6.1.4.1.32130.1.5.15.0.5400		HX05400	1.1		Level of education	Quantitative number reported by patients pertaining to level of education. Most often reported in years.	СО	11379-5	224285004
1.1.259	1.3.6.1.4.1.32130.1.5.15.0.5450		HX05450	1.1		Sexual History	Narrative description of a patient's sexual practices, sexual orientation and behavior, use of barrier methods to prevent disease transmission/pregnancy.	CD	11350-6	363901006
1.1.260	1.3.6.1.4.1.32130.1.5.15.0.5455			1.1		Number of life-time sexual partners	Quantitative number of sexual partners a patient has reported	URG_PQ	55215-8	228462007
1.1.261	1.3.6.1.4.1.32130.1.5.15.0.5500		HX05500	1.1		Travel History	Narrative description of dates and places where patient has traveled to.	CD	10182-4	161085007
1.1.262	1.3.6.1.4.1.32130.1.5.15.0.5550		HX05550	1.1		Other relevant social factors	Narrative description of other relevant social, economic, home life or other circumstances.	CD	11344-9	
1.1.263	1.3.6.1.4.1.32130.1.5.15.0.6000		HX06000	1.1		Family history	History of specific disorders in family members. Includes both positive findings, descriptions of disease in identified family members, and negative finding (e.g. no history of VTE)	CD	10157-6	422432008
1.1.264	REVIEW OF SYSTEM	S								
1.1.265	1.3.6.1.4.1.32130.1.5.15.0.7000		HX07000	1.1		Review of Systems	A systematic review of symptoms and complaints across the entire spectrum of body systems.		10187-3	423374008

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1.1.266	1.3.6.1.4.1.32130.1.5.15.0.7050		HX07050	1.1		Constitutional symptoms	Symptoms pertinent that affects the general well- being or general status of a patient. Examples include weight loss, fatigue, malaise, shaking, chills, fever, and vomiting.		56872-5	
1.1.267	1.3.6.1.4.1.32130.1.5.15.0.7100		HX07100	1.1		Eye/vision symptoms	Symptoms relating to the organ of vision.		10171-7	
1.1.268	1.3.6.1.4.1.32130.1.5.15.0.7150		HX07150	1.1		Ears, nose and sinuses, mouth and throat symptoms	Grouping of symptoms pertinent to the upper aerodigestive tract and organs of special senses.		11354-8	
1.1.269	1.3.6.1.4.1.32130.1.5.15.0.7151			1.1		Ear symptoms	Symptoms pertinent to the ear or hearing such as earache, ear infection, hearing loss, tinnitus, vertigo, discharge. If hearing is decreased, use or non-use of hearing aids.		10169-1	
1.1.270	1.3.6.1.4.1.32130.1.5.15.0.7152			1.1		Nose symptoms	Symptoms pertinent to the nose such as but not limited to colds, stuffiness, hay fever, nosebleed, sinus or anosmia.		10174-1	
1.1.271	1.3.6.1.4.1.32130.1.5.15.0.7153			1.1		Mouth and teeth symptoms	Symptoms relating to the teeth, bleeding gums, sore throat, hoarseness, dysphagia, includes recent dental cleaning/procedures.		10175-8	
1.1.272	1.3.6.1.4.1.32130.1.5.15.0.7200		HX07200	1.1		Cardiovascular symptoms	Symptoms pertinent to the heart and blood vessels.		CVROS-X	
1.1.273	1.3.6.1.4.1.32130.1.5.15.0.7300		HX07300	1.1		Respiratory symptoms	Symptoms pertinent to respiration. Includes positive/negative history of specific disorders (e.g. COPD, Asthma)		RESPROS-X	
1.1.274	1.3.6.1.4.1.32130.1.5.15.0.7400		HX07400	1.1		Gastrointestinal symptoms	Symptoms pertinent to the entire digestive tract, from the mouth to the anus (e.g. nausea, vomiting, diarrhea, constipation, anorexia)		11355-5	
1.1.275	1.3.6.1.4.1.32130.1.5.15.0.7500		HX07500	1.1		Genitourinary symptoms	Symptoms pertinent to the genitals and urinary organs and gender specific reproductive tract.		11356-3	
1.1.276	1.3.6.1.4.1.32130.1.5.15.0.7560		HX07560	1.1		Reproductive symptoms	Gender specific symptoms pertinent to or employed in reproduction.		10176-6	

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1.1.301	1.3.6.1.4.1.32130.1.5.15.0.8053			1.1		History of hereditary disorders	Information about, including absence of, and screening for specific diseases, E.g. VTE, bleeding disorders, inborn errors, CF, SCA		32435-0	
1.1.302	1.3.6.1.4.1.32130.1.5.15.0.8056			1.1		History of nervous system disorders	Information about, including absence of, specific diseases. E.g. CVA, seizures.		8681-9	
1.1.303	1.3.6.1.4.1.32130.1.5.15.0.8057			1.1		History of psychiatric disorders	Information about, including absence of, specific diseases. E.g. depression, bipolar		11358-9	
1.1.304	1.3.6.1.4.1.32130.1.5.15.0.8058			1.1		History of respiratory system disorders	Information about, including absence of, specific diseases. E.g. COPD, asthma, CF		10177-4	
1.1.305	1.3.6.1.4.1.32130.1.5.15.0.8060			1.1		Frequency of seizures	Quantitative measurement of the number of seizures experienced per month.		55414-7	
1.1.306	PREGNANCY									
1.1.307	1.3.6.1.4.1.32130.1.5.15.0.2076			1.1		Onset of painful contractions	Date/time of the onset of painful contractions with pregnancy/labor	URG_TS	56866-7	
1.1.308	1.3.6.1.4.1.32130.1.5.15.0.2077			1.1		Time contractions became regular	Date/Time labor contractions became regular in frequency.	URG_TS	56828-7	
1.1.309	1.3.6.1.4.1.32130.1.5.15.0.2078			1.1		Time membranes ruptured	Date/Time amniotic sac ruptured during labor	TS	56829-5	
1.1.310	1.3.6.1.4.1.32130.1.5.15.0.4110			1.1		Pregnancy history	Narrative description of previous pregnancies, issues encountered and outcome.	CD	10162-6	248983002
1.1.311	1.3.6.1.4.1.32130.1.5.15.0.4111			1.1		Pregnancy status	Current pregnancy status (y/n/unknown)	CD	PREGER-X	
1.1.312	1.3.6.1.4.1.32130.1.5.15.0.7566			1.1		Current pregnancy history	Narrative description of current pregnancy, issues encountered etc.		56833-7	
1.1.313	1.3.6.1.4.1.32130.1.5.15.0.7567			1.1		Due date/EDD	Estimated due date and method used to calculate. Historically this has been called the Estimated Date of Confinement.	URG_TS	11778-8	161714006
1.1.314	1.3.6.1.4.1.32130.1.5.15.0.7568			1.1		Gravida	Number of times previously pregnant	СО	11996-6	161732006
1.1.315	1.3.6.1.4.1.32130.1.5.15.0.7569			1.1		Parity	Number of children the patient has previously delivered past the 20 <sup>th</sup> week.	СО	11977-6	364325004

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1.1.316	1.3.6.1.4.1.32130.1.5.15.0.7571			1.1		Number of fetuses this pregnancy	The number of fetuses a pregnant woman is carrying in current pregnancy	СО	55281-0	246435002
1.1.317	1.3.6.1.4.1.32130.1.5.15.0.7572			1.1		Fetal movement	Narrative description of fetal movement felt.		56834-5	364617005
1.1.318	1.3.6.1.4.1.32130.1.5.15.0.7573			1.1		Viability of current pregnancy	Narrative Indicator regarding the potential for the current pregnancy to result in a live born child.	PPD_PQ	56835-2	364327007
1.1.319	1.3.6.1.4.1.32130.1.5.15.0.7574			1.1		Symptoms and circumstances of pregnancy	Current pregnancy status of patient as reported by patient or responsible informant, entered as yes, no, not applicable, or unknown.		11449-6	406199001
1.1.320	1.3.6.1.4.1.32130.1.5.15.0.7575			1.1		Date symptoms of pregnancy first noted	Date/Time the symptoms of pregnancy were first noted.		55282-8	248987001
1.1.321	1.3.6.1.4.1.32130.1.5.15.0.7577			1.1		Date next OB clinic visit	The date of the next scheduled obstetrical visit.	TS	57070-5	
1.1.322	1.3.6.1.4.1.32130.1.5.15.0.7578			1.1		Obstetric delivery method	Intended or prior method of delivery.	CD	57071-3	
1.1.323	1.3.6.1.4.1.32130.1.5.15.0.7579			1.1		Obstetric trimester	Current trimester of their pregnancy; i.e. first, second, or third. Translates to roughly less than 13 weeks (first trimester), between 13 and 27 weeks (second trimester), and more than 37 weeks (third trimester).	СО	32418-6	
1.1.324	1.3.6.1.4.1.32130.1.5.15.0.7580			1.1		Multiple pregnancy	History of multiple gestation pregnancies.	СО	45371-2	
1.1.325	PHYSICAL EXAMINA	TION								
1.1.326	1.3.6.1.4.1.32130.1.5.15.1		PE01000	1.1		Physical Examination	Narrative description of observed physical findings.		29545-1	425044008

Project ID#	OID	DEEDS 1.0 Section Id.	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.379	1.3.6.1.4.1.32130.1.5.15.1.3200		PE03200	1.1		Cardiovascular system exam	Narrative description of the observed findings of the cardiovascular system.		11390-2	271910006
1.1.380			PE03210			Cardiac	Narrative description of the observed findings of the heart			
1.1.381	1.3.6.1.4.1.32130.1.5.15.1.3250		PE03250	1.1		Peripheral vascular exam	Narrative description of the observed findings of the peripheral vascular system.		10208-7	
1.1.382	1.3.6.1.4.1.32130.1.5.15.1.3300		PE03300	1.1		Respiratory system exam	Narrative description of the observed findings of the respiratory system. May include appearance of the patients breathing, rate of respiration, color of mucous membranes and nail beds.		11412-4	271908009
1.1.383	1.3.6.1.4.1.32130.1.5.15.1.3400		PE03400	1.1		Gastrointestinal system exam	Narrative description of the observed findings of the gastrointestinal system.		11399-3	
1.1.384	1.3.6.1.4.1.32130.1.5.15.1.3500		PE03500	1.1		Genitourinary exam	Narrative description of the observed findings of the genitourinary system.		10198-0	271912003
1.1.385	1.3.6.1.4.1.32130.1.5.15.1.3600		PE03600	1.1		Musculoskeletal exam	Narrative description of the observed findings of the musculoskeletal exam		11410-8	271916000
1.1.386			PE03700			Integumentary/skin	Narrative description of the observed findings of the integumentary system. May include appearance of skin, hair, and nails.			
1.1.387	1.3.6.1.4.1.32130.1.5.15.1.3800		PE03800	1.1		Neurological exam	Narrative description of the observed findings of the brain and nervous system		10202-0	271909001
1.1.388	1.3.6.1.4.1.32130.1.5.15.1.3810		PE03810	1.1		Mental status exam	Narrative description of the observed findings of the patient's mental state. May include appearance, attitude, behavior, mood, affect, speech, thought process, thought content, perception, cognition, insight, and judgment.		10190-7	
1.1.389	1.3.6.1.4.1.32130.1.5.15.1.3830		PE03830	1.1		Sensory exam	Narrative description of patients report of sensations of fine touch, pain and temperature after stimulus.		32473-1	
1.1.390	1.3.6.1.4.1.32130.1.5.15.1.3850		PE03850	1.1		Strength	Narrative description of the observed findings of patient's strength.		10212-9	
1.1.391	1.3.6.1.4.1.32130.1.5.15.1.3870		PE03870	1.1		Balance and coordination	Narrative description of the observed findings of the patient's balance and coordination.		10209-5	

Project ID#	OID	1.0	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.392	1.3.6.1.4.1.32130.1.5.15.1.3890		PE03890	1.1		Deep tendon reflexes	Narrative description of the observed findings of deep tendon reflexes.		10194-9	
1.1.393	1.3.6.1.4.1.32130.1.5.15.1.3900		PE03900	1.1		Psychiatric exam	Narrative description of the observed findings of the psyche		11451-2	
1.1.394	1.3.6.1.4.1.32130.1.5.15.1.3950		PE03950	1.1		Hematologic, lymphatic and immunologic	Narrative description of the observed findings of the blood, lymph and immunologic systems.		11447-0	
1.1.395	ASSESSMENT/SCRE	ENING T	OOLS							
1.1.396	1.3.6.1.4.1.32130.1.5.15.2.13			1.1		HAD scale: anxiety score	Hospital Anxiety & Depression scale (HADS)/HAD Scale - a questionnaire commonly used to assess levels of anxiety and depression.		HADANX-X	401319005
1.1.397	1.3.6.1.4.1.32130.1.5.15.2.14			1.1		HAD scale: depression score	Total HAD-D score and interpretation		HADDEP-X	401320004
1.1.398	1.3.6.1.4.1.32130.1.5.15.2.17			1.1		Home falls and accidents screening tool score	The Home Falls and Accidents Screening Tool (HOME FAST) is an established screening instrument for use in a community preventive care trial for older people. This item is the total score and interpretation of the 25-item survey / questionnaire.		HOMEFALL-X	446881008
1.1.399	1.3.6.1.4.1.32130.1.5.15.2.18			1.1		Mini-mental state examination score	Total score of the Mini-Mental State Examination (MMSE). Includes evaluation of level of consciousness and interpretation based on age and/or educational status (interpretation must state these explicitly)		MMSE-X	447316007
1.1.400	1.3.6.1.4.1.32130.1.5.15.2.23			1.1		Wells deep vein thrombosis clinical probability score	Total score and interpretation of the Wells DVT Clinical Prediction Rule for Deep Venous Thrombosis		WELLS-X	429053008
1.1.401	1.3.6.1.4.1.32130.1.5.15.2.24			1.1		Braden scale skin assessment panel	The Braden Scale is used to assess the patient's level of risk for development of pressure ulcers. The evaluation is based on six indicators: sensory perception, moisture, activity, mobility, nutrition, and friction or shear. This item describes the total score and interpretation of the patient's risk.		38228-3	413139004

Project ID #	OID	DEEDS 1.0 Section Id.	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.402	1.3.6.1.4.1.32130.1.5.15.2.25			1.1		Mangled extremity severity score (MESS)	Used to estimate the viability of an extremity after trauma, to determine need for salvage vs. empiric amputation. This item describes the total score and interpretation of the MESS.		MESS-X	
1.1.403	1.3.6.1.4.1.32130.1.5.15.2.3			1.1		Pneumonia severity index (PORT Score)	The pneumonia severity index [PSI] or PORT Score is a clinical prediction rule used to calculate the probability of morbidity and mortality among patients with community acquired pneumonia. This item describes the total score and interpretation of the PSI.		PORT-X	
1.1.404	1.3.6.1.4.1.32130.1.5.15.2.4			1.1		NINDS Stroke Severity Scale	The National Institutes of Health Stroke Scale (NIHSS) is a systematic assessment tool that provides a quantitative measure of stroke-related neurologic deficit. This item describes the total score and interpretation of Stroke Scale.		NINDS-X	
1.1.405	1.3.6.1.4.1.32130.1.5.15.2.8			1.1		PHQ-9 Score	The Patient Health Questionnaire (PHQ-9) is a self- administered 9-question version of the depression module of a diagnostic instrument for common mental disorders. This item describes the total score and the interpretation of the PHQ-9.		44261-6	
1.1.406	1.3.6.1.4.1.32130.1.5.15.2.9			1.1		Brief pain inventory score	The Brief Pain Inventory is a medical questionnaire used to measure pain, developed by the Pain Research Group of the WHO Collaborating Centre for Symptom Evaluation in Cancer Care. This item describes the total score and interpretation of the BPI.		BPI-X	443223005
1.1.407	Section 6: ED PROCE	DURE A	ND RESUL	T DATA						
1.1.408	PROCEDURE DATA									
1.1.409	1.3.6.1.4.1.32130.1.6.1	6.01		1.0		ED procedure indication	Explanation of why procedure was ordered, entered as code with associated text description or as text description alone.	CD	10217-8 10217-8	

Project ID#	OID	DEEDS 1.0 Section Id.	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.410	1.3.6.1.4.1.32130.1.6.2	6.02		1.0		ED procedure	Service or intervention, not part of routine history or physical examination, that is designed for diagnosis or therapy, entered as code with associated text description or as text description alone.	CE	29306-8	
1.1.411	1.3.6.1.4.1.32130.1.6.2.2			1.0		Procedure performed	Name of the procedure performed.		10223-6	
1.1.412	1.3.6.1.4.1.32130.1.6.3	6.03		1.0	R	Date/time ED procedure ordered	Date and time when procedure is ordered.	TS		
1.1.413	1.3.6.1.4.1.32130.1.6.4	6.04		1.0	R	Date/time ED procedure starts	Date and time when procedure begins.	TS		
1.1.414	1.3.6.1.4.1.32130.1.6.5	6.05		1.0	R	Date/time ED procedure ends	Date and time when procedure is completed or stopped.	TS		
1.1.415	1.3.6.1.4.1.32130.1.6.6	6.06		1.0	R	ED procedure practitioner ID	National Provider Identifier or locally assigned identifier for practitioner who performs procedure.	II		
1.1.416	1.3.6.1.4.1.32130.1.6.7	6.07		1.0	R	ED procedure practitioner type	Profession or occupation and specialty or subspecialty of practitioner who performs procedure.	CE		
1.1.417				1.1		Surgeon	Provider performing the procedure			
1.1.418				1.1		Procedure Assistant	Staff assisting in the procedure			
1.1.419				1.1		Procedure anesthesia used	Anesthetic used in the performance of the procedure, e.g. lidocaine, sedation, etc.		10213-7	
1.1.420				1.1		Procedure description	Narrative description of the procedure performed.		8724-7	
1.1.421				1.1		Procedure specimens obtained	Specimens obtained during the procedure.		8721-3	
1.1.422				1.1		Procedure Closure	Closure type used at the end of the procedure.			

Project ID#	OID	DEEDS 1.0 Section Id.	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.423				1.1		Procedure estimated blood loss	Estimate of the blood lost during the procedure.		8717-1	
1.1.424				1.1		Wound irrigation/Cleaning fluid	Amount and type of fluid used to irrigate and cleanse a wound. Example (1000 cc of sterile normal saline)		39128-4	
1.1.425	1.3.6.1.4.1.32130.1.6.2.1			1.1		Procedure complications	Complications that were encountered during the procedure.		10222-8	
1.1.426				1.1		Procedure findings	Findings made during the procedure.		10215-2	
1.1.427	1.3.6.1.4.1.32130.1.6.8	6.08		1.0	R	Date/time ED diagnostic procedure result reported	Date and time when procedure result is reported.	TS		
1.1.428	1.3.6.1.4.1.32130.1.6.9	6.09		1.0	R	ED procedure result type	Type of procedure result reported (e.g., complete blood count, chest x-ray interpretation).	CE	11314-2	
1.1.429	1.3.6.1.4.1.32130.1.6.10	6.10		1.0		ED procedure result	Result of procedure, entered in accordance with result type (e.g., number for a complete blood count, text description for chest x-ray interpretation).	CD	11313-4	
1.1.430	RESULTS AND FINE	DINGS								
1.1.431	1.3.6.1.4.1.32130.1.6.11	6.11		1.1		ECG Interpretation	Emergency physician interpretation of ECG.		8601-7 or 18844-1	271921002
1.1.432	1.3.6.1.4.1.32130.1.6.12	6.12		1.1		Diagnostic Imaging Interpretation	Emergency physician interpretation of diagnostic imagining results.		18726-0	282290005
1.1.433	1.3.6.1.4.1.32130.1.6.13	6.13		1.1		Diagnostic test results	Diagnostic test results		30954-2	
1.1.434	1.3.6.1.4.1.32130.1.6.13.2			1.1		Pulmonary function results	Results of pulmonary function testing.		27896-0	
1.1.435	1.3.6.1.4.1.32130.1.6.13.3			1.1		Cardiac monitoring findings	Results related to cardiac monitoring; specifically relates to rhythm assessments.		26441-6	

Project ID#	OID	DEEDS 1.0 Section Id.	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.456	1.3.6.1.4.1.32130.1.6.13.1.8			1.1		Urinalysis results	Results related to urinalysis testing.		18729-4	n/a use individual test IDs
1.1.457	1.3.6.1.4.1.32130.1.6.13.1.9			1.1		Calculated and derived values (FeNa, Anion gap, etc.)	Results related to calculated and derived values		56847-7	n/a use individual test IDs
1.1.458	1.3.6.1.4.1.32130.1.6.14			1.1		Interpretation and review of laboratory results	Emergency physician interpretation of laboratory results.		56850-1	
1.1.459	1.3.6.1.4.1.32130.1.6.15.4			1.1		Volume of urine in bladder when catheter placed	The volume of urine collected and measured at the time that a urinary catheter was placed.		19153-6	
1.1.460	1.3.6.1.4.1.32130.1.6.16.1			1.1		Fluid output chest tube [Volume]	Volume of fluid collected from a chest tube.		9129-8	
1.1.461	1.3.6.1.4.1.32130.1.6.16.10			1.1		Fluid output total [Volume] Measured	Sum of all measured outputs from all sources. This reflects the output in the Intake/Output measurement.		9257-7	
1.1.462	1.3.6.1.4.1.32130.1.6.16.104			1.1		Rate of Urine output	This is the volume of urine collected and measured over a window of time.		9188-4	
1.1.463	1.3.6.1.4.1.32130.1.6.16.12			1.1		Intravascular catheter site	This captures the anatomic location where a catheter was placed.		8981-3	
1.1.464	1.3.6.1.4.1.32130.1.6.16.2			1.1		Fluid output emesis [Volume]	Total volume of emesis measured.		9137-1	
1.1.465	1.3.6.1.4.1.32130.1.6.16.3			1.1		Fluid output gastric tube [Volume]	Total volume collected via gastric fluid.		9149-6	
1.1.466	1.3.6.1.4.1.32130.1.6.16.30			1.1		Fluid intake oral Estimated	Estimated volume of oral intake during a specified time period (e.g. ml/shift).		8999-5	
1.1.467	1.3.6.1.4.1.32130.1.6.16.34			1.1		Fluid balance 1 hour	The net total between fluids taken in through all means (IV, by mouth, gastric tube) and output through all means (emesis, urine, stool) measured in hourly increments.		9093-6	

Project ID#	OID	1.0	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.489						Blood Product/Transfusion	Blood transfusion is the process of receiving blood products into one's circulation intravenously.  Transfusions are used in a variety of medical conditions to replace lost components of the blood.  Early transfusions used whole blood, but modern medical practice commonly uses only components of the blood, such as red blood cells, white blood cells, plasma, clotting factors, and platelets.			
1.1.490	Section 7: ED MEDIC	ATION D	<u>ATA</u>							
1.1.491	1.3.6.1.4.1.32130.1.7.1	7.01		1.0	R	Date/time ED medication ordered	Date and time when ED medication is ordered.	TS		
1.1.492	1.3.6.1.4.1.32130.1.7.2	7.02		1.0	R	ED medication ordering practitioner ID	National Provider Identifier or locally assigned identifier for practitioner who orders ED medication.	II	11306-8	
1.1.493	1.3.6.1.4.1.32130.1.7.3	7.03		1.0	R	ED medication ordering practitioner type	Profession or occupation and specialty or subspecialty of practitioner who orders ED medication.	CE	11307-6	
1.1.494	1.3.6.1.4.1.32130.1.7.4	7.04		1.0		ED medication	Medication administered during ED visit, entered as code with associated text description or as text description alone.	CE	29549-3	
1.1.495	1.3.6.1.4.1.32130.1.7.5	7.05		1.0		ED medication dose	Dose of ED medication at each administration.	PQ		
1.1.496	1.3.6.1.4.1.32130.1.7.6	7.06		1.0	R	ED medication dose units	Units for dose of ED medication.	CS		
1.1.497	1.3.6.1.4.1.32130.1.7.7	7.07		1.0	R	ED medication schedule	Frequency and duration of administration of ED medication.			
1.1.498	1.3.6.1.4.1.32130.1.7.8	7.08		1.0	R	ED medication route	Route by which ED medication is administered.	CE		
1.1.499	1.3.6.1.4.1.32130.1.7.9	7.09		1.0	R	Date/time ED medication starts	Date and time when administration of ED medication begins.	TS		
1.1.500	1.3.6.1.4.1.32130.1.7.10	7.10		1.0	R	Date/time ED medication stops	Date and time when administration of ED medication concludes.	TS		

Project ID#	OID	1.0	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.501	1.3.6.1.4.1.32130.1.7.11	7.11		1.0	R	ED medication administering practitioner ID	National Provider Identifier or locally assigned identifier for practitioner who administers ED medication.			
1.1.502	1.3.6.1.4.1.32130.1.7.12	7.12		1.0	R	ED medication administering practitioner type	Profession or occupation and specialty or subspecialty of practitioner who administers ED medication.	CE		
1.1.503	Section 8: ED DISPO	SITION A	ND DIAGN	OSTIC D	ATA					
1.1.504	1.3.6.1.4.1.32130.1.8.1	8.01		1.0		Date/time of recorded ED disposition	Date and time when ED practitioner's decision about patient's disposition is first recorded.		DISPO-X	
1.1.505	1.3.6.1.4.1.32130.1.8.2	8.02		1.0		ED disposition	Patient's anticipated location or status following ED visit.		11302-7	306563004
1.1.506	1.3.6.1.4.1.32130.1.8.3	8.03		1.0	R	Inpatient practitioner ID	National Provider Identifier or locally assigned identifier for practitioner whose inpatient service patient is admitted to.	II		
1.1.507	1.3.6.1.4.1.32130.1.8.4	8.04		1.0		Inpatient practitioner type	Profession or occupation and specialty or subspecialty of practitioner whose inpatient service Patient is admitted to.	CE	56854-3	
1.1.508	1.3.6.1.4.1.32130.1.8.5	8.05		1.0		Facility receiving ED patient	National Provider Identifier for facility to which patient is transformed or discharged at conclusion of ED visit.	0	RECFAC-X	
1.1.509	1.3.6.1.4.1.32130.1.8.6	8.06		1.0		Date/time patient departs ED	Date and time when patient leaves ED.	TS	LEAVEED-X	
1.1.510	1.3.6.1.4.1.32130.1.8.7	8.07		1.0		ED follow-up care assistance	Follow-up care needs of ED patient at discharge, entered as no follow-up care assistance necessary, follow-up care assistance available or arranged before ED discharge, follow-up care arrangements pending, other, or unknown.	0	FOLLOW-X	

Project ID#	OID	1.0	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.531	1.3.6.1.4.1.32130.1.5.15.0.4202			1.1		Discharge follow-up provider	Provider the patient is advised to see for follow up evaluation.		11544-4	
1.1.532	1.3.6.1.4.1.32130.1.5.15.0.4204			1.1		Discharge date	Date/Time the patient was discharged from the health care facility	IVL_TS	52525-3	
1.1.533	1.3.6.1.4.1.32130.1.8.27	8.27		1.0		ED Service Level	Extent of services provided by ED physician, nurse. or other practitioner during patient's ED visit (e.g., Physicians' Current Procedural Terminology' evaluation and management services code), entered as code with associated text description or as text description alone.	0	11315-9	
1.1.534	1.3.6.1.4.1.32130.1.8.28	8.28		1.0	R	ED Service Level Practitioner ID	ED Service Level Practitioner ID			
1.1.535	1.3.6.1.4.1.32130.1.8.29	8.29		1.0	R	ED Service Level Practitioner Type	ED Service Level Practitioner Type			
1.1.536	1.3.6.1.4.1.32130.1.8.30	8.30		1.0		Patient Problem Assessed in ED Outcome Observation	Patient's complaint or condition (e.g., headache) for which outcome is observed, entered as code with associated text description or as text description alone.	CD	11383-7	
1.1.537	1.3.6.1.4.1.32130.1.8.31	8.31		1.0		ED Outcome Observation	Change in patient's specified health problem (e.g immediate relief of headache pain with ED treatment), as assessed by practitioner during ED visit or at follow-up, entered as code with associated text description or as text description alone.	CD	56853-5	
1.1.538	1.3.6.1.4.1.32130.1.8.32	8.32		1.0	R	Date/Time of ED Outcome Observation	Date/Time of ED Outcome Observation	GTS		
1.1.539	1.3.6.1.4.1.32130.1.8.33	8.33		1.0	R	ED Outcome Observation Practitioner ID	ED Outcome Observation Practitioner ID	II		
1.1.540	1.3.6.1.4.1.32130.1.8.34	8.34		1.0	R	ED Outcome Observation Practitioner Type	ED Outcome Observation Practitioner Type	CE		

Project ID#	OID	DEEDS 1.0 Section Id.	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.541	1.3.6.1.4.1.32130.1.8.35	8.35		1.0	R	ED Patient Satisfaction Report Type	ED Patient Satisfaction Report Type	CE		
1.1.542	1.3.6.1.4.1.32130.1.8.36	8.36		1.0		ED Patient Satisfaction Report	Patient's reported satisfaction with specified aspect of ED care (e.g., long waiting time before seen by physician), entered as code with associated text description or as text description alone.	CD	11310-0	
1.1.543				1.1		Discharge follow up Date/Time	Date/Time when the patient is scheduled to receive additional evaluation after discharge.			
1.1.544	1.3.6.1.4.1.32130.1.8.37			1.1		Cause of death	Official cause of death as coded from the death certificate in valid ICD-7, ICD-8, ICD-9, and ICD-10 codes		21984-0	184305005
1.1.545	1.3.6.1.4.1.32130.1.8.39			1.1		Time of death	Date/Time of death		55287-7	398299004
1.1.546	Section 9: LAB TES	T DATA						1		
1.1.547				1.1		Complete Blood Count	A common blood test that is used to screen for a range of disorders and provides information on red and white blood cells and platelets		57021-8	
1.1.548				1.1		Complete Blood Count	This panel is the traditional hemogram plus platelet count which must now be reported with hemograms according to current US re-imbursement rule The panel includes 2 different RDWs to accommodate the two different ways of reporting them. (Most automated instruments report as a percent). The hemoglobin produced by the automatic counters does not use a counting method to generate the hemoglobin so we have used the methodless version of hemoglobin in this panel.		58410-2	

Project ID #	OID	DEEDS 1.0 Section Id.	DEEDS 1.0 Reference #	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.549				1.1		WBC COUNT BLD	A population of white blood cells, generated in the bone marrow, that include granular cells (basophils, eosinophils, neutrophils) as well as non-granular leukocytes (lymphocytes, monocytes). White blood cells are intrinsic components of the blood. They are produced in the bone marrow and help to defend against infectious agents and foreign materials. As part of the immune system, they also help fight against malignant and aberrant cells.		6690-2	
1.1.550				1.1		RBC COUNT BLD	Mature erythrocytes are non-nucleated red blood cells with biconcave disks containing hemoglobin. Hemoglobin transports oxygen.		789-8	
1.1.551				1.1		HEMOGLOBIN TOTAL BLD	Hemoglobin (Hb or Hgb) is the iron-containing oxygen-transport metalloprotein in the red blood cells of vertebrates, and the tissues of some invertebrates.		718-7	
1.1.552				1.1		HEMATOCRIT BLD	This is the test that referral labs will report when hematocrit alone is ordered.		20570-8	
1.1.553				1.1		HEMATOCRIT BLD	This is the test that referral labs will report when hematocrit alone is ordered. The volume of packed red blood cells in a blood sample. The volume is measured by centrifugation in a tube with graduated markings, or with automated blood cell counters. It is an indicator of erythrocyte status in disease. For example, in anemia the volume is low and in polycythemia it is high.		4544-3	
1.1.554				1.1		MCV BLD	The mean corpuscular volume, or MCV, is a measure of the average red blood cell volume. MCV measurements classify anemias as either microcytic (MCV below normal range) or macrocytic (MCV above normal range).		787-2	

Project ID #	OID	DEEDS 1.0 Section Id.	1.0	Element History	Rec.	Item Name	Definition/Uses	Data Type	LOINC Map	SNOMED Map
1.1.768				1.1		Wound Culture	One of the three domains of life (the others being Eukarya and Archaea), also called Eubacteria. They are unicellular prokaryotic microorganisms which generally possess rigid cell walls and multiply by cell division. They exhibit three principal forms: round or coccal, rodlike or bacillary, and spiral or spirochetal. Bacteria can be classified by their response to oxygen (aerobic, anaerobic, or facultatively anaerobic) and by how they obtain their energy (chemotrophic, i.e. via a chemical reaction or phototrophic, via a light reaction). In addition, chemotrophs obtain their energy from chemicals, lithotrophic from inorganic compounds and organotrophic from organic compounds. Bacteria are also classified by the source carbon that they utilize: heterotrophic, from organic sources or autotrophic, from carbon dioxide. They can also be classified by whether or not they stain (based on the structure of their cell walls) with crystal violet dye: gram-negative or gram-positive.		6462-6	
1.1.769				1.1		Herpes Viral Culture	The herpes simplex virus (HSV) manifests itself in two common viral infections, each marked by painful, watery blisters in the skin or mucous membranes (such as the mouth or lips) or on the genitals. The disease is contagious, particularly during an outbreak, and is incurable with present technology. An infection on the lips is commonly known as a cold sore or fever blister. These are sometimes confused with canker sores or aphthous ulcers, which have a similar appearance; these appear inside the mouth and are not caused by the herpes simplex virus. When not symptomatic HSV lies dormant in nerve cells, growing along the axons of the skin during an outbreak. When the outbreak has passed, the virus 'dies back' along the nerve until it is only present in the nerve body. The dormancy of the virus within the nerve bodies		5859-4	

## **APPENDICES**

- A. <u>DEEDS 1.0 Data Elements</u>
- **B.** Laboratory Data Elements

The appendices are available to HL7 Members