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Contributors include participants in the ONC S&I Framework esMD Initiative, the HL7 Attachments Work Group and the HL7 Structured Documents Work Group
Acknowledgments

This guide was developed and produced through the joint efforts of Health Level Seven (HL7), and the Office of the National Coordinator (ONC) Standards and Interoperability (S&I) Framework—electronic submission of Medical Documentation (esMD) Initiative.

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2 INTRODUCTION

2.1 Note to Readers

This guide contains material by inclusion from the HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm) Draft Standard for Trial Use Release 2, Volume 1 and Volume 2 specification [referred to as C-CDA R2 V1 for Volume 1 and C-CDA R2 V2 for Volume 2 or collectively as C-CDA R2 through-out this guide]; additional constraints on templates defined in that guide are within the scope of review and balloting, however referenced content or citations are not. Reviewers are encouraged to provide feedback on the C-CDA R2.

2.2 Purpose

This guide is the result of a joint effort of the HL7 Attachments Work Group, the HL7 Structured Documents Work Group, the Centers for Medicare & Medicaid Services (CMS), and the Office of the National Coordinator (ONC) Standards and Interoperability (S&I) Framework Electronic Submission of Medical Documentation (esMD) Initiative.

The purpose of this implementation guide (IG) is to provide guidance on a standardized, implementable, interoperable electronic solution to reduce the time and expense related to the exchange of clinical and administrative information between and among providers and payers. This guide describes structured documentation templates that meet requirements for documentation of medical necessity and appropriateness of services to be delivered or that have been delivered in the course of patient care.

These document templates are designed for use when the provider needs to exchange more clinical information than is required by the C-CDA R2 document-level templates and/or must indicate why information for specific section-level or entry-level templates is not included. For example, payer policy may allow providers to submit any information they feel substantiates that a services is medically necessary and appropriate under the applicable coverage determination rules. The ability to submit any supporting documentation is a provider’s right under these rules as is the ability to declare that specific information is not available or not applicable which allows payers to avoid requesting additional documentation from the provider when such a request cannot be fulfilled.

While the goal of the templates defined in this guide is to enable providers to submit structured medical documentation when required for prior-authorization, pre-payment review or post payment audit, providers and payers may use these templates for any administrative or clinical purpose.

Notes:

Use of these document templates may be inappropriate for clinical or administrative purposes where the provider’s intent is to exchange only limited information about the patient encounter.

The new and additionally constrained templates defined in this guide are not intended to replace any of the current templates in the C-CDA R2 or its predecessor implementation guides.
2.3 Audience

The audience for this implementation guide include business analysts, policy managers, and the architects and developers of healthcare information technology (HIT) systems in the US Realm that exchange electronic medical data (documentation) between and among providers and payers.

2.4 Prerequisite Information

The reader of this IG must have an understanding of the following standards and related materials. While some background information may be provided, this guide is not intended to be a tutorial on these topics. At a minimum, access to the C-CDA R2 is required to properly understand and apply the templates in this guide.

3) HL7 Implementation Guide for CDA® Release 2: Digital Signatures and Delegation of Rights, Draft Standard for Trial Use, Release 1
6) LOINC (http://loinc.org)
7) UCUM (http://unitsofmeasure.org)
8) OIDS (http://www.hl7.org/oid)
9) ANSI/HL7 EHR-System Records Management and Evidentiary Support (RM-ES) Functional Profile, Release 1
10) ANSI/HL7 EHR-System Functional Model Release 1.1

2.5 Organization of the Guide

This guide loosely follows the basic structure and flow of the C-CDA R2 but does combine the type of information found in Volumes 1 and 2 into this single guide. Note that the flow of topics will largely remain the same, but section numbering is not congruent between the IGs.

2.6 Contents of the Publication

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3 CDA R2 BACKGROUND

3.1 Templatized CDA

This guide adheres to the principles and concepts expressed in the C-CDA R2 V1, Section 2.1 Templatized CDA.

This guide focuses on the following types of templates:

- **Document-level templates:** These templates constrain fields in the CDA header, and define highly constrained relationships to CDA sections. For example, an Enhanced Encounter Document document-level template might require that the patient’s name be present, and that the document contain a Physical Exam section.

- **Section-level templates:** These templates constrain fields in the CDA section, and define specific containment relationships to CDA entries. For example, a Physical-exam section-level template might require that the section/code be fixed to a particular LOINC code, and that the section contain a Systolic Blood Pressure observation. Where possible, this guide incorporates by reference section-level templates from the C-CDA R2 without change.

- **Entry-level templates:** These templates constrain the CDA clinical statement model in accordance with real world observations and acts. For example, a Systolic-blood-pressure entry-level template defines how the CDA Observation class is constrained (how to populate observation/code, how to populate observation/value, etc.) to represent the notion of a systolic blood pressure. C-CDA R2 section-level templates that are included in this guide by reference also include the entry-level templates that they contain as defined in the C-CDA R2. New sections and additionally constrained C-CDA R2 sections in this guide include by reference C-CDA R2 entry level templates as well as those defined in this guide.

- **Participation and other templates:** These templates group a common set of constraints for reuse in CDA documents. For example, the US Realm Date and Time (DTM.US.FIELDED) includes a set of common constraints for recording time. This template is referenced several times throughout the IG in place of repeating constraints.

A CDA implementation guide (such as this one) includes references to those templates that are applicable. On the implementation side, a CDA instance populates the template identifier [templateId] field where it wants to assert conformance to a given template. On the receiving side, the recipient can then not only test the instance for conformance against the CDA Extensible Markup Language (XML) schema, but also test the instance for conformance against asserted templates.
4 DESIGN CONSIDERATIONS

This guide adheres to the principles and concepts expressed in the C-CDA R2, Section 3 Design Considerations.

Design considerations describe overarching principles that have been developed and applied across the CDA templates in this guide. Material in this section can be thought of as “heuristics”, as opposed to the formal and testable constraints found in Volume 2 of this guide.

4.1 C-CDA Participations

This guide makes no changes to the C-CDA participations as defined in the C-CDA R2 V1, Section 3.1 C-CDA Participations.

4.2 Determining a Clinical Statement’s Status

This guide adheres to the concepts as expressed in the C-CDA R2 V1, Section 3.2 Determining a Clinical Statements Status.

4.3 Rendering Header Information for Human Presentation

This guide adheres to the concepts as expressed in the C-CDA R2 V1, Section 3.3 Rendering Header Information for Human Presentation.

4.4 Unknown and No Known Information

This guide adheres to the concepts as expressed in the C-CDA R2 V1, Section 3.4 Unknown and No Known Information.

Information technology solutions store and manage data, but sometimes data are not available. An item may be unknown, not relevant, or not computable or measureable, such as where a patient arrives at an Emergency Department unconscious and with no identification.

In many cases, the Consolidated CDA standard will stipulate that a piece of information is required (e.g., via a SHALL conformance verb). However, in most of these cases, the standard provides an “out”, allowing the sender to indicate that the information isn’t known.
4.4.1 Use of nullFlavors for Section and Entry Templates Conformance Statements

This guide makes liberal use of the SHALL conformance verb. In general, all new document-level templates and new or additionally constrained section-level templates constrain the use of their respective section and entry level templates to SHALL. The purpose is to ensure support for these subsidiary templates in conformant implementations.

The developers of this guide suggest that implementers automatically provide the appropriate nullFlavor for any condition where the respective information is not available (e.g. not supported by the EHR record, not asked, not answered, not applicable for the current implementation) except where the provider must individually elect to exclude existing encounter documentation because it is not applicable (nullFlavor=NA) or withheld due to security and privacy concerns (nullFlavor=MSK).

The use of these templates enables the resulting document to contain all of the relevant clinical record information associated with the patient encounter.

Notes:

1) Providers do not need to have information available for each of the “required” section and entry level templates defined or constrained in this guide. In the event information is not available, an appropriate nullFlavor is used to attest to the reason the information is not provided.

2) Some encounters may require the use of multiple document-level templates, including those defined in the C-CDA R2 to completely describe all relevant clinical activities (see Appendix D).

3) Providers should only include information in the templates that they deem appropriate to meet the clinical or administrative use for which the resulting document is intended.
4.4.2 Example use of nullFlavors for Section and Entry Templates

The following nullFlavors (from the PHVS_NullFlavor_HL7_V3, "2.16.840.1.114222.4.11.875") are specified as a minimum required value set for use at the section and entry level in this guide.

**Table 2: Section and Entry nullFlavor Minimum Value Set**

<table>
<thead>
<tr>
<th>Concept Code</th>
<th>Concept name</th>
<th>Usage in this guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI</td>
<td>No Information</td>
<td>This is the most general and default null flavor. (e.g. information is not available in the medical record and other Concept Codes do not apply)</td>
</tr>
<tr>
<td>NA</td>
<td>Not applicable</td>
<td>Known to have no proper value (e.g., last menstrual period for a male).</td>
</tr>
</tbody>
</table>

The following nullFlavors (from the PHVS_NullFlavor_HL7_V3, "2.16.840.1.114222.4.11.875") are specified as optional value set for use at the section and entry level in this guide. These nullFlavors may be used in addition to those defined in Table 2:

**Table 3: Section and Entry nullFlavor Optional Value Set**

<table>
<thead>
<tr>
<th>Concept Code</th>
<th>Concept name</th>
<th>Usage in this guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>NASK</td>
<td>Not asked</td>
<td>The patient was not asked.</td>
</tr>
<tr>
<td>ASKU</td>
<td>Asked but unknown</td>
<td>Information was sought but not found (e.g., patient was asked but didn’t know)</td>
</tr>
<tr>
<td>MSK</td>
<td>Masked</td>
<td>There is information on this item available but it has not been provided by the sender due to security, privacy or other reasons.</td>
</tr>
</tbody>
</table>
Figure 1: Example use of Section-Level nullFlavor

<table>
<thead>
<tr>
<th>Example Document-Level conformance statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. This structuredBody <strong>SHALL</strong> contain exactly one [1..1] <strong>component</strong> (CONF:XXXX) such that it</td>
</tr>
<tr>
<td>ii. <strong>SHALL</strong> contain exactly one [1..1] <strong>General Status Section</strong> (templateId:2.16.840.1.113883.10.20.2.5) (CONF:XXXX).</td>
</tr>
<tr>
<td>Provider has declared that the General Status section is not applicable for this document or for this patient</td>
</tr>
</tbody>
</table>

Example XML

```xml
<section nullFlavor="NA">
  <templateId root="2.16.840.1.113883.10.20.22.2.9.2"/>
  <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" Code="51847-2" displayName="General Status"/>
  <title>General Status</title>
  <text>Not Applicable</text>
</section>
```

Figure 2: Example use of Entry-Level nullFlavor

<table>
<thead>
<tr>
<th>Example Section-Level conformance statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>SHALL</strong> contain one or more [1..*] <strong>entry</strong> (CONF:CDP13310) such that it</td>
</tr>
<tr>
<td>a. <strong>SHALL</strong> contain exactly one [1..1] <strong>Planned Encounter (V2)</strong> (templateId:2.16.840.1.113883.10.20.22.4.40.2) (CONF:CDP13311).</td>
</tr>
<tr>
<td>No planned encounter information is available in the medical record</td>
</tr>
</tbody>
</table>

Example XML

```xml
<entry nullFlavor="NI">
  <templateId root="2.16.840.1.113883.10.20.22.4.40.2"/>
  <encounter moodCode="INT" classCode="ENC"/>
  <title>Planned Encounter</title>
  <text>No information</text>
</entry>
```
5 USING THIS IMPLEMENTATION GUIDE

This guide follows the conventions and practices as defined in the C-CDA R2 V2, Section 4 Using this Implementation Guide.

------------- begin citation -------------

This chapter describes the rules and formalisms used to constrain the CDA R2 standard. It describes the formal representation of CDA templates, the mechanism by which templates are bound to vocabulary, and additional information necessary to understand and correctly implement the normative content found in Volume 2 of this guide.

------------- end citation -------------

5.1 Levels of Constraint

The CDA standard describes conformance requirements in terms of three general levels corresponding to three different, incremental types of conformance statements see the C-CDA R2 V1, Section 4.1. This guide is considered to be a level-3 (coded/constrained entries) Implementation Guide.

5.2 Conformance Conventions Used in This Guide

This guide follows the conventions and practices as defined in the C-CDA R2 V1, Section 4.2 Conformance Conventions Used in This Guide. Additional considerations are noted by section.

5.2.1 Templates and Conformance Statements

Conformance statements within this implementation guide are consistent with the format and syntax of conformance statements declared in the C-CDA R2. Each constraint is uniquely identified by an identifier at or near the end of the constraint (e.g., CONF:CDP1-3101). These identifiers are persistent but not sequential. Where templates are adopted by reference to the C-CDA R2, conformance statements in the C-CDA R2 will apply. Were templates are indicated as conformant to templates in the C-CDA R2 or other implementation guides, new conformance statements are included in this guide.

5.2.2 Template Versioning

This guide follows the conventions and practices defined in the C-CDA R2 V1, Section 4.2.2 Template Versioning.

5.2.3 Open and Closed Templates

This guide follows the conventions and practices defined in the C-CDA R2 V1, Section 4.2.3 Open and Closed Templates.
5.2.4 Conformance Verbs (Keywords)

The keywords SHALL, SHOULD, MAY, NEED NOT, SHOULD NOT, and SHALL NOT in this document are to be interpreted as described in the HL7 Version 3 Publishing Facilitator's Guide.¹

- **SHALL**: an absolute requirement
- **SHALL NOT**: an absolute prohibition against inclusion
- **SHOULD/SHOULD NOT**: best practice or recommendation. There may be valid reasons to ignore an item, but the full implications must be understood and carefully weighed before choosing a different course
- **MAY/NEED NOT**: truly optional; can be included or omitted as the author decides with no implications

The keyword "SHALL" allows the use of nullFlavor unless the requirement is on an attribute or the use of nullFlavor is explicitly precluded. For specific use of nullFlavor with document, section and entry level templates defined or constrained in this guide see 3.4.1.

5.2.5 Cardinality

This guide follows the conventions and practices defined in the C-CDA R2 V1, Section 4.2.5 Cardinality.

5.2.6 Optional and Required with Cardinality

This guide follows the conventions and practices defined in the C-CDA R2 V1, Section 4.2.6 Optional and Required Cardinality.

5.2.7 Vocabulary Conformance

This guide follows the conventions and practices defined in the C-CDA R2 V1, Section 4.2.7 Vocabulary Conformance.

5.2.8 Containment Relationships

This guide follows the conventions and practices defined in the C-CDA R2 V1, Section 4.2.8 Containment Relationships.

5.2.9 Document-Level Templates ‘Properties’ Heading

This guide follows the conventions and practices defined in the C-CDA R2 V1, Section 4.2.9 Document-Level Templates ‘Properties’ Heading.

---

5.3 **XML Conventions Used in This Guide**

This guide follows the conventions set forth in C-CDA R2 V1, Section 4.3 XML Conventions Used in This Guide.
6 DOCUMENT-LEVEL TEMPLATES

Document-level templates describe the purpose and rules for constructing a conforming CDA document. Document templates include constraints on the CDA header and indicate contained section-level templates.

Each document-level template contains the following information:

• Scope and intended use of the document type
• Description and explanatory narrative
• Template metadata (e.g., templateId, etc.)
• Header constraints (e.g., document type, template id, participants)
• Required and optional section-level templates

Table 4: Document-Level Templates

<table>
<thead>
<tr>
<th>Document Template</th>
<th>OID</th>
<th>LOINC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Encounter Document (CDP1)</td>
<td>2.16.840.1.113883.10.20.35.1.1</td>
<td>TBD</td>
</tr>
<tr>
<td>Complete Hospitalization Document (CDP1)</td>
<td>2.16.840.1.113883.10.20.35.1.2</td>
<td>TBD</td>
</tr>
<tr>
<td>Complete Operative Note Document (CDP1)</td>
<td>2.16.840.1.113883.10.20.35.1.3</td>
<td>TBD</td>
</tr>
<tr>
<td>Complete Procedure Note Document (CDP1)</td>
<td>2.16.840.1.113883.10.20.35.1.4</td>
<td>TBD</td>
</tr>
<tr>
<td>Time Boxed Document (CDP1)</td>
<td>2.16.840.1.113883.10.20.35.1.5</td>
<td>TBD</td>
</tr>
</tbody>
</table>

Note: The Document Template names are proposed. The authors are soliciting feedback during the ballot process to suggest final names for the five document types.
## 6.1 Complete Encounter Document (CDP1)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.35.1.1 (open)]

### Table 5: Complete Encounter (CDP1) Document Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Documentation Section (CDP1)</td>
<td></td>
</tr>
<tr>
<td>Advance Directives Section (entries required) (V2)</td>
<td></td>
</tr>
<tr>
<td>Allergies Section (entries required) (V2)</td>
<td></td>
</tr>
<tr>
<td>Assessment and Plan Section (V2)</td>
<td></td>
</tr>
<tr>
<td>Assessment Section</td>
<td></td>
</tr>
<tr>
<td>Chief Complaint and Reason for Visit Section</td>
<td></td>
</tr>
<tr>
<td>Chief Complaint Section</td>
<td></td>
</tr>
<tr>
<td>Encounters Section (entries required) (V2)</td>
<td></td>
</tr>
<tr>
<td>Externally Defined CDE Section (CDP1)</td>
<td></td>
</tr>
<tr>
<td>Family History Section</td>
<td></td>
</tr>
<tr>
<td>Functional Status Section (V2-CDP1)</td>
<td></td>
</tr>
<tr>
<td>General Status Section</td>
<td></td>
</tr>
<tr>
<td>Goals Section (New)</td>
<td></td>
</tr>
<tr>
<td>Health Concerns Section (New)</td>
<td></td>
</tr>
<tr>
<td>Health Status Evaluation/Outcomes Section (New)</td>
<td></td>
</tr>
<tr>
<td>History of Past Illness Section (V2)</td>
<td></td>
</tr>
<tr>
<td>History of Present Illness Section</td>
<td></td>
</tr>
<tr>
<td>Immunizations Section (entries required) (V2)</td>
<td></td>
</tr>
<tr>
<td>Implants Section (NEW)</td>
<td></td>
</tr>
<tr>
<td>Instructions Section (V2)</td>
<td></td>
</tr>
<tr>
<td>Interventions Section (V2)</td>
<td></td>
</tr>
<tr>
<td>Medical Equipment Section (V2)</td>
<td></td>
</tr>
<tr>
<td>Medications Section (entries required) (V2)</td>
<td></td>
</tr>
<tr>
<td>Mental Status Section (New-CDP1)</td>
<td></td>
</tr>
<tr>
<td>Nutrition Section (NEW)</td>
<td></td>
</tr>
<tr>
<td>Objective Section</td>
<td></td>
</tr>
<tr>
<td>Orders Placed Section (CDP1)</td>
<td></td>
</tr>
<tr>
<td>Payers Section (V2)</td>
<td></td>
</tr>
<tr>
<td>Physical Exam Section (V2)</td>
<td></td>
</tr>
<tr>
<td>Physical Findings of Skin Section (New)</td>
<td></td>
</tr>
<tr>
<td>Plan of Treatment Section (V2-CDP1)</td>
<td></td>
</tr>
<tr>
<td>Problem Section (V2)</td>
<td></td>
</tr>
<tr>
<td>Procedures Section (entries required) (V2)</td>
<td></td>
</tr>
<tr>
<td>Reason for Referral Section (V2)</td>
<td></td>
</tr>
<tr>
<td>Reason for Visit Section</td>
<td></td>
</tr>
<tr>
<td>Results Section (entries required) (V2)</td>
<td></td>
</tr>
<tr>
<td>Review of Systems Section</td>
<td></td>
</tr>
<tr>
<td>Social History Section (V2-CDP1)</td>
<td></td>
</tr>
<tr>
<td>Subjective Section</td>
<td></td>
</tr>
<tr>
<td>Transportation Section (CDP1)</td>
<td></td>
</tr>
<tr>
<td>Vital Signs Section (entries required) (V2)</td>
<td></td>
</tr>
</tbody>
</table>
The Complete Encounter Document is generated by a provider at the end of an Office Visit, Consult, or Home Health encounter with a patient. Complete Encounters may involve face-to-face time with the patient or may fall under the auspices of telemedicine visits.

A Complete Encounter Document includes all sections relevant to the specific visit, except for details concerning procedures, operations or imaging performed during the encounter, which are included in different document types. Any section for which data is not available (not collected, not relevant, not supported by the EHR technology, etc.), SHALL have the appropriate nullFlavor specified as affirmative attestation that the information was not available (see section 3.4 regarding the use of nullFlavors).

The Complete Encounter Document is intended to support the entire contents of the medical record related to a specific encounter with a patient for the administrative or clinical exchange with a third party.

6.1.1 Properties

6.1.1.1 Header

1. Conforms to **US Realm Header (V2)** template (2.16.840.1.113883.10.20.22.1.1.2).

2. **SHALL** contain exactly one [1..1] templateId (CONF:CDP1-1201) such that it
   a. **SHALL** contain exactly one [1..1] 
      @root="2.16.840.1.113883.10.20.35.1.1" (CONF:CDP1-1202).

The Complete Encounter Document recommends use of one of the following document types from the C-CDA R2 depending on the purpose of the Visit:

1) ConsultDocumentType 2.16.840.1.113883.11.20.9.31,
2) HPDocumentType 2.16.840.1.113883.11.20.9.22 or
3) ProgressNoteDocumentTypeCode 2.16.840.1.113883.11.20.8.1

with further specification provided by author or performer, setting, or specialty. When pre-coordinated codes are used, any coded values describing the author or performer of the service act

3. **SHALL** contain exactly one [1..1] code, (CONF:CDP1-1203)
   a. which **SHALL** be selected from ValueSet CompleteEncounterDocumentType 2.16.840.1.113883.10.20.35.6.1 or HPDocumentType 2.16.840.1.113883.11.20.9.22 or ProgressNoteDocumentTypeCode 2.16.840.1.113883.11.20.8.1 **DYNAMIC** (CONF:CDP1-1204).

4. **SHALL** contain exactly one [1..1] title (CONF:CDP1-1205).
5. **SHOULD** contain zero or one [0..1] documentationOf (CONF:CDP1-1206).

6.1.1.2 serviceEvent

A documentationOf can contain a serviceEvent to further specialize the act inherent in the ClinicalDocument/code.

The serviceEvent/effectiveTime is the time period the note documents.
a. The documentationOf, if present, **SHALL** contain exactly one [1..1] `serviceEvent` (CONF:CDP1-1207).
   i. This serviceEvent **SHALL** contain exactly one [1..1] `templateId` (CONF:CDP1-1209) such that it
      1. **SHALL** contain exactly one [1..1] `@root`="2.16.840.1.113883.10.20.21.3.1" (CONF:CDP1-1210).
   ii. This serviceEvent **SHOULD** contain zero or one [0..1] `effectiveTime` (CONF:CDP1-1211).
      1. The serviceEvent/effectiveTime element **SHOULD** be present with effectiveTime/low element (CONF:CDP1-1211).
      2. If a width element is not present, the serviceEvent **SHALL** include effectiveTime/high (CONF:CDP1-1212).
      3. The content of effectiveTime **SHALL** be a conformant US Realm Date and Time (DTM.US.FIELDED) (CONF:CDP1-1213).

   ![Figure 3: Complete Encounter serviceEvent Example](image)

   6. **SHALL** contain exactly one [1..1] `componentOf` (CONF:CDP1-1214).

6.1.1.3 participant

This participant represents the clinician to contact for questions about the Complete Encounter. This call back contact individual may be a different person than the individual(s) identified in the author or legalAuthenticator participant.

7. **SHOULD** contain zero or more [0..*] `participant` (CONF:CDP1-1212) such that it
   a. **SHALL** contain exactly one [1..1] `@typeCode`="CALLBACK" call back contact (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 DYNAMIC) (CONF:CDP1-1213).
   b. **SHALL** contain exactly one [1..1] `associatedEntity` (CONF:CDP1-1214).
      i. This associatedEntity **SHALL** contain exactly one [1..1] `@classCode`="ASSIGNED" assigned entity (CodeSystem: RoleClass 2.16.840.1.113883.5.110 DYNAMIC) (CONF:CDP1-1215).
      ii. This associatedEntity **SHALL** contain at least one [1..*] `id` (CONF:CDP1-1216).
      iii. This associatedEntity **SHOULD** contain zero or more [0..*] `addr` (CONF:CDP1-1217).
iv. This associatedEntity **SHALL** contain at least one [1..*] **telecom** (CONF:CDP1-1218).

v. This associatedEntity **SHALL** contain exactly one [1..1] **associatedPerson** (CONF:CDP1-1219).

   1. This associatedPerson **SHALL** contain at least one [1..*] **name** (CONF:CDP1-1220).

vi. This associatedEntity **MAY** contain zero or one [0..1] **scopingOrganization** (CONF:CDP1-1221).

---

**Figure 4: Callback Participant Example**

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

---

**6.1.1.4 inFulfillmentOf**

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

8. **MAY** contain at least one [1..*] **inFulfillmentOf** (CONF:CDP1-1222).

   a. Such inFulfillmentOfs **SHALL** contain exactly one [1..1] **order** (CONF:CDP1-1223).

      i. This order **SHALL** contain at least one [1..*] **id** (CONF:CDP1-1224).
6.1.1.5 encompassingEncounter

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

a. This componentOf SHALL contain exactly one [1..1] encompassingEncounter (CONF:CDP1-1226).
   i. This encompassingEncounter SHALL contain exactly one [1..1] id (CONF:CDP1-1227).
   ii. This encompassingEncounter SHALL contain exactly one [1..1] effectiveTime (CONF:CDP1-1228).
      1. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:CDP1-1229).
   iii. This encompassingEncounter SHALL contain exactly one [1..1] responsibleParty (CONF:CDP1-1230).
      1. The responsibleParty element records only the party responsible for the encounter, not necessarily the entire episode of care (CONF:CDP1-1231).
      2. The responsibleParty element, SHALL contain an assignedEntity element which SHALL contain an assignedPerson element, a representedOrganization element, or both (CONF:CDP1-1232).

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

iv. This encompassingEncounter MAY contain zero or more [0..*] encounterParticipant (CONF:CDP1-1233).
   1. The encounterParticipant element, if present, records only participants in the encounter, not necessarily in the entire episode of care (CONF:CDP1-1234).
   2. An encounterParticipant element, if present, SHALL contain an assignedEntity element which SHALL contain an assignedPerson element, a representedOrganization element, or both (CONF:CDP1-1235).

10. SHALL contain exactly one [1..1] component (CONF:CDP1-1236).
6.1.2 structuredBody

a. This component **SHALL** contain exactly one [1..1] `structuredBody` (CONF:CDP1-1301).
   
i. This `structuredBody` **SHALL** contain exactly one [1..1] `component` (CONF:CDP1-1302) such that it
   
   1. **SHALL** contain exactly one [1..1] `Additional Documentation Section (CDP1)` (templateId:2.16.840.1.113883.10.20.35.2.1) (CONF:CDP1-1303).

ii. This `structuredBody` **MAY** contain zero or one [0..1] `component` (CONF:CDP1-1304) such that it
   
   1. **SHALL** contain exactly one [1..1] `Advance Directives Section (entries required) (V2)` (templateId:2.16.840.1.113883.10.20.2.21.1.2) (CONF:CDP1-1305).

iii. This `structuredBody` **SHALL** contain exactly one [1..1] `component` (CONF:CDP1-1306) such that it
   
   1. **SHALL** contain exactly one [1..1] `Allergies Section (entries required) (V2)` (templateId:2.16.840.1.113883.10.20.22.2.6.1.2) (CONF:CDP1-1307).

iv. This `structuredBody` **SHALL** contain exactly one [1..1] `component` (CONF:CDP1-1310) such that it
   
   1. **SHALL** contain exactly one [1..1] `Assessment and Plan Section (V2)` (templateId:2.16.840.1.113883.10.20.22.2.9.2) (CONF:CDP1-1311).

v. This `structuredBody` **SHALL** contain exactly one [1..1] `component` (CONF:CDP1-1312) such that it
   
   1. **SHALL** contain exactly one [1..1] `Assessment Section` (templateId:2.16.840.1.113883.10.20.22.2.8) (CONF:CDP1-1313).

vi. This `structuredBody` **SHALL** contain exactly one [1..1] `component` (CONF:CDP1-1314) such that it
   
   1. **SHALL** contain exactly one [1..1] `Chief Complaint and Reason for Visit Section` (templateId:2.16.840.1.113883.10.20.22.2.13) (CONF:CDP1-1315).

vii. This `structuredBody` **SHALL** contain exactly one [1..1] `component` (CONF:CDP1-1316) such that it
   
   1. **SHALL** contain exactly one [1..1] `Chief Complaint Section` (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) (CONF:CDP1-1317).

viii. This `structuredBody` **SHALL** contain exactly one [1..1] `component` (CONF:CDP1-1320) such that it
1. **SHALL** contain exactly one [1..1] Encounters Section (entries required) (V2)  
(templateId:2.16.840.1.113883.10.20.22.2.22.1.2)  
(CONF:CDP1-1321).

ix. This structuredBody **SHALL** contain exactly one [1..1] component  
(CONF:CDP1-1322) such that it

1. **SHALL** contain exactly one [1..1] Externally Defined CDE Section (CDP1)  
(templateId:2.16.840.1.113883.10.20.35.2.2)  
(CONF:CDP1-1323).

x. This structuredBody **SHALL** contain exactly one [1..1] component  
(CONF:CDP1-1324) such that it

1. **SHALL** contain exactly one [1..1] Family History Section  
(templateId:2.16.840.1.113883.10.20.22.1.15)  
(CONF:CDP1-1325).

xi. This structuredBody **SHALL** contain exactly one [1..1] component  
(CONF:CDP1-1326) such that it

1. **SHALL** contain exactly one [1..1] Functional Status Section (V2-CDP1)  
(templateId:2.16.840.1.113883.10.20.22.1.14.2.1)  
(CONF:CDP1-1327).

xii. This structuredBody **SHALL** contain exactly one [1..1] component  
(CONF:CDP1-1328) such that it

1. **SHALL** contain exactly one [1..1] General Status Section  
(templateId:2.16.840.1.113883.10.20.2.5)  
(CONF:CDP1-1329).

xiii. This structuredBody **SHALL** contain exactly one [1..1] component  
(CONF:CDP1-1330) such that it

1. **SHALL** contain exactly one [1..1] Goals Section (New)  
(templateId:2.16.840.1.113883.10.20.22.2.60)  
(CONF:CDP1-1331).

xiv. This structuredBody **SHALL** contain exactly one [1..1] component  
(CONF:CDP1-1332) such that it

1. **SHALL** contain exactly one [1..1] Health Concerns Section (New)  
(templateId:2.16.840.1.113883.10.20.22.2.58)  
(CONF:CDP1-1333).

xv. This structuredBody **SHALL** contain exactly one [1..1] component  
(CONF:CDP1-1334) such that it

1. **SHALL** contain exactly one [1..1] Health Status Evaluations/Outcomes Section (New)  
(templateId:2.16.840.1.113883.10.20.22.2.61)  
(CONF:CDP1-1335).

xvi. This structuredBody **SHALL** contain exactly one [1..1] component  
(CONF:CDP1-1336) such that it
1. **SHALL** contain exactly one [1..1] **History of Past Illness Section (V2)**
   (templateId:2.16.840.1.113883.10.20.22.2.20.2)
   (CONF:CDP1-1337).

xvii. This structuredBody **SHALL** contain exactly one [1..1] **component**
     (CONF:CDP1-1338) such that it

   1. **SHALL** contain exactly one [1..1] **History of Present Illness Section**
      (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4)
      (CONF:CDP1-1339).

xviii. This structuredBody **SHALL** contain exactly one [1..1] **component**
       (CONF:CDP1-1358) such that it

   1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries required) (V2)**
      (templateId:2.16.840.1.113883.10.20.22.2.2.1.2)
      (CONF:CDP1-1359).

xix. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-1360) such that it

   1. **SHALL** contain exactly one [1..1] **Implants Section (NEW)**
      (templateId:2.16.840.1.113883.10.20.22.2.33)
      (CONF:CDP1-1361).

xx. This structuredBody **SHALL** contain exactly one [1..1] **component**
   (CONF:CDP1-1362) such that it

   1. **SHALL** contain exactly one [1..1] **Instructions Section (V2)**
      (templateId:2.16.840.1.113883.10.20.22.2.45.2)
      (CONF:CDP1-1363).

xxi. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-1364) such that it

   1. **SHALL** contain exactly one [1..1] **Interventions Section (V2)**
      (templateId:2.16.840.1.113883.10.20.21.2.3.2)
      (CONF:CDP1-1365).

xxii. This structuredBody **SHALL** contain exactly one [1..1] **component**
     (CONF:CDP1-1366) such that it

   1. **SHALL** contain exactly one [1..1] **Medical Equipment Section (V2)**
      (templateId:2.16.840.1.113883.10.20.22.2.23.2)
      (CONF:CDP1-1367).

xxiii. This structuredBody **SHALL** contain exactly one [1..1] **component**
      (CONF:CDP1-1372) such that it

   1. **SHALL** contain exactly one [1..1] **Medications Section (entries required) (V2)**
      (templateId:2.16.840.1.113883.10.20.22.2.1.1.2)
      (CONF:CDP1-1373).
xxiv. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1374) such that it

1. **SHALL** contain exactly one [1..1] `Mental Status Section (NEW-CDP1)`
   (templateId:2.16.840.1.113883.10.20.22.2.56.1.1)
   (CONF:CDP1-1375).

xxv. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1376) such that it

1. **SHALL** contain exactly one [1..1] `Nutrition Section (NEW)`
   (templateId:2.16.840.1.113883.10.20.22.2.57)
   (CONF:CDP1-1377).

xxvi. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1378) such that it

1. **SHALL** contain exactly one [1..1] `Objective Section`
   (templateId:2.16.840.1.113883.10.20.21.2.1)
   (CONF:CDP1-1379).

xxvii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1384) such that it

1. **SHALL** contain exactly one [1..1] `Orders Placed Section (CDP1)`
   (templateId:2.16.840.1.113883.10.20.35.2.3)
   (CONF:CDP1-1385).

xxviii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1386) such that it

1. **SHALL** contain exactly one [1..1] `Payers Section (V2)`
   (templateId:2.16.840.1.113883.10.20.22.2.18.2)
   (CONF:CDP1-1387).

xxix. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1388) such that it

1. **SHALL** contain exactly one [1..1] `Physical Exam Section (V2)`
   (templateId:2.16.840.1.113883.10.20.2.10.2)
   (CONF:CDP1-1389).

xxx. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1390) such that it

1. **SHALL** contain exactly one [1..1] `Physical Findings of Skin Section (New)`
   (templateId:2.16.840.1.113883.10.20.22.2.62)
   (CONF:CDP1-1391).

xxxi. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1392) such that it

1. **SHALL** contain exactly one [1..1] `Plan of Treatment Section (V2-CDP1)`
   (templateId:2.16.840.1.113883.10.20.22.2.10.2.1)
   (CONF:CDP1-1393).
xxxii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1402) such that it
   1. **SHALL** contain exactly one [1..1] Problem Section (entries_required) (V2)
      (templateId:2.16.840.1.113883.10.20.22.2.5.1.2)
      (CONF:CDP1-1403).

xxxiii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1418) such that it
   1. **SHALL** contain exactly one [1..1] Procedures Section (entries_required) (V2)
      (templateId:2.16.840.1.113883.10.20.22.2.7.1.2)
      (CONF:CDP1-1419).

xxxiv. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1420) such that it
   1. **SHALL** contain exactly one [1..1] Reason for Referral Section (V2)
      (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.1.2)
      (CONF:CDP1-1421).

xxxv. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1422) such that it
   1. **SHALL** contain exactly one [1..1] Reason for Visit Section
      (templateId:2.16.840.1.113883.10.20.22.2.12)
      (CONF:CDP1-1423).

xxxvi. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1424) such that it
   1. **SHALL** contain exactly one [1..1] Results Section (entries_required) (V2)
      (templateId:2.16.840.1.113883.10.20.22.2.3.1.2)
      (CONF:CDP1-1425).

xxxvii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1426) such that it
   1. **SHALL** contain exactly one [1..1] Review of Systems Section
      (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18)
      (CONF:CDP1-1427).

xxxviii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1428) such that it
   1. **SHALL** contain exactly one [1..1] Social History Section (V2-CDP1)
      (templateId:2.16.840.1.113883.10.20.22.2.17.2.1)
      (CONF:CDP1-1429).

xxxix. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1430) such that it
   1. **SHALL** contain exactly one [1..1] Subjective Section
      (templateId:2.16.840.1.113883.10.20.22.2.2)
      (CONF:CDP1-1431).
xli. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-1436) such that it

1. **SHALL** contain exactly one [1..1] **Transportation Section** (CDP1)  
   (templateId:2.16.840.1.113883.10.20.35.2.4)  
   (CONF:CDP1-1435)

xlii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-1438) such that it

1. **SHALL** contain exactly one [1..1] **Vital Signs Section**  
   (entries required) (V2)  
   (templateId:2.16.840.1.113883.10.20.22.4.1.2)  
   (CONF:CDP1-1437).

xlii. **SHALL NOT** include an **Assessment and Plan Section**  
(V2) (templateId:2.16.840.1.113883.10.20.22.9.2) when  
an **Assessment Section**  
(templateId:2.16.840.1.113883.10.20.22.2.8) and a **Plan of Treatment Section** (V2-CDP1)  
(templateId:2.16.840.1.113883.10.20.22.2.10.2.1) are present (CONF:CDP1-1439).

xliii. **SHALL NOT** include a **Chief Complaint and Reason for Visit Section**  
(templateId:2.16.840.1.113883.10.20.22.2.13) when a **Chief Complaint Section**  
(templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) and a **Reason for Visit Section**  
(templateId:2.16.840.1.113883.10.20.22.2.12) are present (CONF:CDP1-1440).
Figure 6: Complete Encounter StructuredBody Sample

```
<component>
  <structuredBody>
    <component>
      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.6.1.2"/>
        <!-- Allergies section template -->
        <code code="48765-2" codeSystem="2.16.840.1.113883.6.1"
          displayName="Allergies, adverse reactions, alerts" codeSystemName="LOINC"/>
        <title>Allergies, Adverse Reactions, Alerts</title>
      </section>
    </component>
    <component>
      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.8"/>
        <!-- Assessment -->
        <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="51848-0"
          displayName="ASSESSMENT"/>
        <title>ASSESSMENT</title>
      </section>
    </component>
    <component>
      <section>
        <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.4"/>
        <!-- History of Present Illness -->
        <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="10164-2"
          displayName="HISTORY OF PRESENT ILLNESS"/>
        <title>HISTORY OF PRESENT ILLNESS</title>
      </section>
    </component>
    <component>
      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.1.1.2"/>
        <!-- MEDICATION SECTION (V2) (coded entries required) -->
        <code code="10160-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
          displayName="HISTORY OF MEDICATION USE"/>
        <title>MEDICATIONS</title>
      </section>
    </component>
    <component>
      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.10.2"/>
        <!-- Physical Exam (V2) -->
        <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="29545-1"
          displayName="PHYSICAL FINDINGS"/>
        <title>PHYSICAL EXAMINATION</title>
      </section>
    </component>
    <component>
      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.10.2"/>
        <!-- Plan of Treatment Section (V2) template -->
        <code code="18776-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
```
<component>
  <section>
    <!-- Problem Section (entries required) (V2) -->
    <templateId root="2.16.840.1.113883.10.20.22.2.5.1.2"/>
    <code code="11450-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
      displayName="PROBLEM LIST"/>
    <title>PROBLEMS</title>
    ...
  </section>
</component>

<component>
  <section>
    <!-- Procedures Section (entries optional) (V2) -->
    <templateId root="2.16.840.1.113883.10.20.22.2.7.2"/>
    <code code="47519-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
      displayName="HISTORY OF PROCEDURES"/>
    <title>PROCEDURES</title>
    ...
  </section>
</component>

<component>
  <section>
    <!-- Reason for Referral Section V2 -->
    <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.1.2"/>
    <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="42349-1"
      displayName="REASON FOR REFERRAL"/>
    <title>REASON FOR REFERRAL</title>
    ...
  </section>
</component>

<component>
  <section>
    <!-- Results Section (entries required) (V2) -->
    <templateId root="2.16.840.1.113883.10.20.22.2.3.1.2"/>
    <code code="30954-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
      displayName="RESULTS"/>
    <title>RESULTS</title>
    ...
  </section>
</component>

<component>
  <section>
    <!-- Social history section(V2) -->
    <templateId root="2.16.840.1.113883.10.20.22.2.17.2"/>
    <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" display="Social History"/>
    <title>SOCIAL HISTORY</title>
    ...
  </section>
</component>

<component>
  <section>
    <!-- Vital Signs-->
    <templateId root="2.16.840.1.113883.10.20.22.2.4.1.2"/>
    <!-- Vital Signs-->
  </section>
</component>
<code code="8716-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
    displayName="VITAL SIGNS"/>
<title>VITAL SIGNS</title>
...
</section>
</component>
</structuredBody>
</component>
</ClinicalDocument>
### 6.2 Complete Hospitalization Document (CDP1)

**Table 6: Complete Hospitalization (CDP1) Document Contexts**

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Documentation Section (CDP1)</td>
<td>Allergies Section (entries required) (V2)</td>
</tr>
<tr>
<td></td>
<td>Assessment and Plan Section (V2)</td>
</tr>
<tr>
<td></td>
<td>Assessment Section</td>
</tr>
<tr>
<td></td>
<td>Chief Complaint and Reason for Visit Section</td>
</tr>
<tr>
<td></td>
<td>Chief Complaint Section</td>
</tr>
<tr>
<td></td>
<td>Externally Defined CDE Section (CDP1)</td>
</tr>
<tr>
<td></td>
<td>Family History Section</td>
</tr>
<tr>
<td></td>
<td>Functional Status Section (V2-CDP1)</td>
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<tr>
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<td>General Status Section</td>
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<tr>
<td></td>
<td>Goals Section (New)</td>
</tr>
<tr>
<td></td>
<td>Health Concerns Section (New)</td>
</tr>
<tr>
<td></td>
<td>Health Status Evaluation/Outcomes Section (New)</td>
</tr>
<tr>
<td></td>
<td>History of Past Illness Section (V2)</td>
</tr>
<tr>
<td></td>
<td>History of Present Illness Section</td>
</tr>
<tr>
<td></td>
<td>Hospital Admission Diagnosis Section (V2)</td>
</tr>
<tr>
<td></td>
<td>Hospital Admission Medications Section (entries required) (V2)</td>
</tr>
<tr>
<td></td>
<td>Hospital Consultations Section</td>
</tr>
<tr>
<td></td>
<td>Hospital Course Section</td>
</tr>
<tr>
<td></td>
<td>Hospital Discharge Diagnosis Section (V2)</td>
</tr>
<tr>
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<td>Hospital Discharge Instructions Section</td>
</tr>
<tr>
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<td>Hospital Discharge Medications Section (entries required) (V2)</td>
</tr>
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<td>Hospital Discharge Physical Section</td>
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<td>Hospital Discharge Studies Summary Section</td>
</tr>
<tr>
<td></td>
<td>Immunizations Section (entries required) (V2)</td>
</tr>
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<td></td>
<td>Implants Section (NEW)</td>
</tr>
<tr>
<td></td>
<td>Instructions Section (V2)</td>
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<td>Medical Equipment Section (V2)</td>
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<tr>
<td></td>
<td>Medical (General) History Section</td>
</tr>
<tr>
<td></td>
<td>Medications Section (entries required) (V2)</td>
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<td>Mental Status Section (New-CDP1)</td>
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<td></td>
<td>Nutrition Section (NEW)</td>
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<td></td>
<td>Orders Placed Section (CDP1)</td>
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<td></td>
<td>Payers Section (V2)</td>
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<td></td>
<td>Physical Exam Section (V2)</td>
</tr>
<tr>
<td></td>
<td>Physical Findings of Skin Section (New)</td>
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<td></td>
<td>Plan of Treatment Section (V2-CDP1)</td>
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<td></td>
<td>Problem Section (V2)</td>
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<td>Procedures Section (entries required) (V2)</td>
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<td>Results Section (entries required) (V2)</td>
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<td>Review of Systems Section</td>
</tr>
<tr>
<td></td>
<td>Social History Section (V2-CDP1)</td>
</tr>
<tr>
<td></td>
<td>Transportation Section (CDP1)</td>
</tr>
</tbody>
</table>
The Complete Hospitalization is a document which synopsizes a patient's admission to a hospital; it provides pertinent information for the continuation of care following discharge. The Joint Commission requires the following information to be included in the Discharge Summary:

- The reason for hospitalization
- The procedures performed
- The care, treatment, and services provided
- The patient’s condition and disposition at discharge
- Information provided to the patient and family
- Provisions for follow-up care

A Complete Hospitalization Document includes all sections relevant to the admission, discharge and course of stay, except for information related to operations, procedures, imaging and shift or day records which are included in their respective document types. Any section for which data is not available (not collected, not relevant, not supported by the EHR technology, etc.) SHALL have the appropriate nullFlavor specified as affirmative attestation that the information was not available (see section 3.4 regarding the use of nullFlavors).

A complete record of the patient’s hospitalization may be contained in the combination of the Complete Hospitalization Document, Complete Operative Notes Document(s), Complete Procedures Document(s), and Time Boxed Documents. (see Appendix D)

The Complete Hospitalization Document is intended to support a complete synopsis of the admission and discharge portion of the medical record related to a specific admission of a patient for the administrative or clinical exchange with a third party.

6.2.1 Properties

6.2.1.1 Header

1. Conforms to [US Realm Header (V2)] template (2.16.840.1.113883.10.20.22.1.1.2).

2. Conforms to [Discharge Summary (V2)] template (2.16.840.1.113883.10.20.22.1.8.2).

3. SHALL contain exactly one [1..1] templateId (CONF:CDP1-1501) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.35.1.2" (CONF:CDP1-1502).

The Complete Hospitalization Document recommends use of a single document type code, TBD, with further specification provided by author or performer, setting, or specialty. When pre-coordinated codes are used, any coded values describing the author or performer of the service act or the practice setting must be consistent with the LOINC document type.
4. **SHALL** contain exactly one [1..1] **code** (CONF:CDP1-1503).
   a. This code **SHALL** contain exactly one [1..1] **code**, which **SHALL** be selected from ValueSet *DischargeSummaryDocumentTypeCode* 
   2.16.840.1.113883.11.20.4.1 DYNAMIC (CONF:AAA1504).

6.2.1.2 participant

   The participant element in the Complete Hospitalization Document header follows the General Header Constraints for participants. Complete Hospitalization Document does not specify any use for functionCode for participants. Local policies will determine how this element should be used in implementations.

5. **MAY** contain zero or more [0..*] **participant** (CONF:CDP1-1505).
   a. If present, the participant/associatedEntity element **SHALL** have an associatedPerson or scopingOrganization element (CONF:CDP1-1506).
   b. When participant/@typeCode is IND, associatedEntity/@classCode **SHALL** be selected from ValueSet 2.16.840.1.113883.11.20.9.33 INDRoleclassCodes STATIC 2011-09-30 (CONF:CDP1-1507).

6. **SHALL** contain exactly one [1..1] **componentOf** (CONF:CDP1-1508).

6.2.1.3 encompassingEncounter

   The Complete Hospitalization is always associated with a Hospital Admission using the encompassingEncounter element in the header.

   a. This **componentOf** **SHALL** contain exactly one [1..1] **encompassingEncounter** (CONF:CDP1-1509).

   The admission date is recorded in the **componentOf/encompassingEncounter/effectiveTime/low**.

   i. This **encompassingEncounter** **SHALL** contain exactly one [1..1] **effectiveTime/low** (CONF:CDP1-1510).

   ii. This **encompassingEncounter** **SHALL** contain exactly one [1..1] **effectiveTime/high** (CONF:CDP1-1511).

   The dischargeDispositionCode records the disposition of the patient at time of discharge. Access to the National Uniform Billing Committee (NUBC) code system requires a membership. The following conformance statement aligns with HITSP C80 requirements.

   iii. The dischargeDispositionCode **SHALL** be present where the value of code **SHOULD** be selected from ValueSet 
   2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status (code system 2.16.840.1.113883.6.301.5) DYNAMIC (www.nubc.org) (CONF:CDP1-1512).

   1. The dischargeDispositionCode, @displayName, or NUBC UB-04 Print Name, **SHALL** be displayed when the document is rendered (CONF:CDP1-1513).
The encounterParticipant elements represent only those participants in the encounter, not necessarily the entire episode of care.

iv. The encounterParticipant elements **MAY** be present. If present, the encounterParticipant/assignedEntity element **SHALL** have at least one assignedPerson or representedOrganization element present (CONF:CDP1-1514).

The responsibleParty element represents only the party responsible for the encounter, not necessarily the entire episode of care.

v. The responsibleParty element **MAY** be present. If present, the responsibleParty/assignedEntity element **SHALL** have at least one assignedPerson or representedOrganization element present (CONF:CDP1-1515).

**Figure 7: Complete Hospitalization Document Encompassing Encounter Example**

```xml
<componentOf>
  <encompassingEncounter>
    <id extension="9937012" root="2.16.840.1.113883.19" />
    <code codeSystem="2.16.840.1.113883.6.12" codeSystemName="CPT-4" code="99213" display="Evaluation and Management" />
    <effectiveTime>
      <low value="20090227130000+0500" />
      <high value="20090227130000+0500" />
    </effectiveTime>
    <dischargeDispositionCode code="01" codeSystem="2.16.840.1.113883.12.112" display="Routine Discharge" codeSystemName="HL7 Discharge Disposition" />
    <location>
      <healthCareFacility>
        <id root="2.16.540.1.113883.19.2" />
      </healthCareFacility>
    </location>
  </encompassingEncounter>
</componentOf>
```

7. **SHALL** contain exactly one [1..1] component (CONF:CDP1-1516).

6.2.2 structuredBody

a. This component **SHALL** contain exactly one [1..1] structuredBody (CONF:CDP1-1601).

i. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1602) such that it

1. **SHALL** contain exactly one [1..1] Additional Documentation Section (CDP1) (CONF:CDP1-1603).

ii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1606) such that it

1. **SHALL** contain exactly one [1..1] Allergies Section (entries required) (V2) (CONF:CDP1-1607).
iii. This structuredBody **SHALL** contain exactly one [1..1] **component**
(CONF:CDP1-1610) such that it
  1. **SHALL** contain exactly one [1..1] *Assessment and Plan Section (V2)*
     (templateId:2.16.840.1.113883.10.20.22.2.9.2)
     (CONF:CDP1-1611).

iv. This structuredBody **SHALL** contain exactly one [1..1] **component**
(CONF:CDP1-1612) such that it
  1. **SHALL** contain exactly one [1..1] *Assessment Section*
     (templateId:2.16.840.1.113883.10.20.22.2.8)
     (CONF:CDP1-1613).

v. This structuredBody **SHALL** contain exactly one [1..1] **component**
(CONF:CDP1-1614) such that it
  1. **SHALL** contain exactly one [1..1] *Chief Complaint and Reason for Visit Section*
     (templateId:2.16.840.1.113883.10.20.22.2.13)
     (CONF:CDP1-1615).

vi. This structuredBody **SHALL** contain exactly one [1..1] **component**
(CONF:CDP1-1616) such that it
  1. **SHALL** contain exactly one [1..1] *Chief Complaint Section*
     (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1)
     (CONF:CDP1-1617).

vii. This structuredBody **SHALL** contain exactly one [1..1] **component**
(CONF:CDP1-1622) such that it
  1. **SHALL** contain exactly one [1..1] *Externally Defined CDE Section (CDP1)*
     (templateId:2.16.840.1.113883.10.20.35.2.2)
     (CONF:CDP1-1623).

viii. This structuredBody **SHALL** contain exactly one [1..1] **component**
(CONF:CDP1-1624) such that it
  1. **SHALL** contain exactly one [1..1] *Family History Section*
     (templateId:2.16.840.1.113883.10.20.22.2.15)
     (CONF:CDP1-1625).

ix. This structuredBody **SHALL** contain exactly one [1..1] **component**
(CONF:CDP1-1626) such that it
  1. **SHALL** contain exactly one [1..1] *Functional Status Section (V2-CDP1)*
     (templateId:2.16.840.1.113883.10.20.22.2.14.2.1)
     (CONF:CDP1-1627).

x. This structuredBody **SHALL** contain exactly one [1..1] **component**
(CONF:CDP1-1628) such that it
  1. **SHALL** contain exactly one [1..1] *General Status Section*
     (templateId:2.16.840.1.113883.10.20.2.5)
     (CONF:CDP1-1629).
xi. This structuredBody **SHALL** contain exactly one [1..1] `component` (CONF:CDP1-1630) such that it
   1. **SHALL** contain exactly one [1..1] Goals Section (New)
      (templateId:2.16.840.1.113883.10.20.22.2.60)
      (CONF:CDP1-1631).

xii. This structuredBody **SHALL** contain exactly one [1..1] `component`
     (CONF:CDP1-1632) such that it
    1. **SHALL** contain exactly one [1..1] Health Concerns Section (New)
       (templateId:2.16.840.1.113883.10.20.22.2.58)
       (CONF:CDP1-1633).

xiii. This structuredBody **SHALL** contain exactly one [1..1] `component`
      (CONF:CDP1-1634) such that it
   1. **SHALL** contain exactly one [1..1] Health Status Evaluations/Outcomes Section (New)
      (templateId:2.16.840.1.113883.10.20.22.2.61)
      (CONF:CDP1-1635).

xiv. This structuredBody **SHALL** contain exactly one [1..1] `component`
     (CONF:CDP1-1636) such that it
    1. **SHALL** contain exactly one [1..1] History of Past Illness Section (V2)
       (templateId:2.16.840.1.113883.10.20.22.2.20.2)
       (CONF:CDP1-1637).

xv. This structuredBody **SHALL** contain exactly one [1..1] `component`
    (CONF:CDP1-1638) such that it
   1. **SHALL** contain exactly one [1..1] History of Present Illness Section
      (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4)
      (CONF:CDP1-1639).

xvi. This structuredBody **SHALL** contain exactly one [1..1] `component`
     (CONF:CDP1-1640) such that it
    1. **SHALL** contain exactly one [1..1] Hospital Admission Diagnosis Section (V2)
       (templateId:2.16.840.1.113883.10.20.22.2.43.2)
       (CONF:CDP1-1641).

xvii. This structuredBody **SHALL** contain exactly one [1..1] `component`
      (CONF:CDP1-1642) such that it
   1. **SHALL** contain exactly one [1..1] Hospital Admission Medications Section (entries required) (V2)
      (templateId:2.16.840.1.113883.10.20.22.2.44.1.2)
      (CONF:CDP1-1643).

xviii. This structuredBody **SHALL** contain exactly one [1..1] `component`
       (CONF:CDP1-1644) such that it
   1. **SHALL** contain exactly one [1..1] Hospital Consultations Section
xix. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-1646) such that it
   1. SHALL contain exactly one [1..1] Hospital Course Section (CONF:CDP1-1647).

xx. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-1648) such that it
   1. SHALL contain exactly one [1..1] Hospital Discharge Diagnosis Section (V2) (CONF:CDP1-1649).

xxi. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-1650) such that it
   1. SHALL contain exactly one [1..1] Hospital Discharge Instructions Section (CONF:CDP1-1651).

xxii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-1652) such that it
   1. SHALL contain exactly one [1..1] Hospital Discharge Medications Section (entries required) (V2) (CONF:CDP1-1653).

xxiii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-1654) such that it
   1. SHALL contain exactly one [1..1] Hospital Discharge Physical Section (CONF:CDP1-1655).

xxiv. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-1656) such that it
   1. SHALL contain exactly one [1..1] Hospital Discharge Studies Summary Section (CONF:CDP1-1657).

xxv. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-1658) such that it
   1. SHALL contain exactly one [1..1] Immunizations Section (entries required) (V2) (CONF:CDP1-1659).

xxvi. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-1660) such that it
1. **SHALL** contain exactly one [1..1] *Implants Section (NEW)*
   (templateId:2.16.840.1.113883.10.20.22.2.33)
   (CONF:CDP1-1661).

xxvii. This structuredBody **SHALL** contain exactly one [1..1] *component*
      (CONF:CDP1-1662) such that it
     
     1. **SHALL** contain exactly one [1..1] *Instructions Section (V2)*
        (templateId:2.16.840.1.113883.10.20.22.2.45.2)
        (CONF:CDP1-1663).

xxviii. This structuredBody **SHALL** contain exactly one [1..1] *component*
       (CONF:CDP1-1666) such that it
      
      1. **SHALL** contain exactly one [1..1] *Medical Equipment Section (V2)*
         (templateId:2.16.840.1.113883.10.20.22.2.23.2)
         (CONF:CDP1-1667).

xxix. This structuredBody **SHALL** contain exactly one [1..1] *component*
       (CONF:CDP1-1668) such that it
      
      1. **SHALL** contain exactly one [1..1] *Medical (General) History Section*
         (templateId:2.16.840.1.113883.10.20.22.2.39)
         (CONF:CDP1-1669).

xxx. This structuredBody **SHALL** contain exactly one [1..1] *component*
    (CONF:CDP1-1670) such that it
   
   1. **SHALL** contain exactly one [1..1] *Medications Administered Section (V2)*
      (templateId:2.16.840.1.113883.10.20.22.2.38.2)
      (CONF:CDP1-1671).

xxx. This structuredBody **SHALL** contain exactly one [1..1] *component*
    (CONF:CDP1-1672) such that it
   
   1. **SHALL** contain exactly one [1..1] *Medications Section (entries required) (V2)*
      (templateId:2.16.840.1.113883.10.20.22.2.1.1.2)
      (CONF:CDP1-1673).

xxxii. This structuredBody **SHALL** contain exactly one [1..1] *component*
      (CONF:CDP1-1674) such that it
     
     1. **SHALL** contain exactly one [1..1] *Mental Status Section (NEW-CDP1)*
        (templateId:2.16.840.1.113883.10.20.22.2.56.1.1)
        (CONF:CDP1-1675).

xxxiii. This structuredBody **SHALL** contain exactly one [1..1] *component*
       (CONF:CDP1-1676) such that it
      
      1. **SHALL** contain exactly one [1..1] *Nutrition Section (NEW)*
         (templateId:2.16.840.1.113883.10.20.22.2.57)
         (CONF:CDP1-1677).
xxxiv. This structuredBody **SHALL** contain exactly one [1..1] `component` (CONF:CDP1-1684) such that it
   1. **SHALL** contain exactly one [1..1] `Orders Placed Section (CDP1)`
      (templateId:2.16.840.1.113883.10.20.35.2.3)
      (CONF:CDP1-1685).

xxxv. This structuredBody **SHALL** contain exactly one [1..1] `component`
     (CONF:CDP1-1686) such that it
   1. **SHALL** contain exactly one [1..1] `Payers Section (V2)`
      (templateId:2.16.840.1.113883.10.20.22.18.2)
      (CONF:CDP1-1687).

xxxvi. This structuredBody **SHALL** contain exactly one [1..1] `component`
    (CONF:CDP1-1688) such that it
   1. **SHALL** contain exactly one [1..1] `Physical Exam Section (V2)`
      (templateId:2.16.840.1.113883.10.20.2.10.2)
      (CONF:CDP1-1689).

xxxvii. This structuredBody **SHALL** contain exactly one [1..1] `component`
     (CONF:CDP1-1690) such that it
   1. **SHALL** contain exactly one [1..1] `Physical Findings of Skin Section (New)`
      (templateId:2.16.840.1.113883.10.20.22.2.62)
      (CONF:CDP1-1691).

xxxviii. This structuredBody **SHALL** contain exactly one [1..1] `component`
     (CONF:CDP1-1692) such that it
   1. **SHALL** contain exactly one [1..1] `Plan of Treatment Section (V2-CDP1)`
      (templateId:2.16.840.1.113883.10.20.22.2.10.1)
      (CONF:CDP1-1693).

xxxix. This structuredBody **SHALL** contain exactly one [1..1] `component`
     (CONF:CDP1-1702) such that it
   1. **SHALL** contain exactly one [1..1] `Problem Section (entries required) (V2)`
      (templateId:2.16.840.1.113883.10.20.22.2.5.1.2)
      (CONF:CDP1-1703).

x.  This structuredBody **SHALL** contain exactly one [1..1] `component`
    (CONF:CDP1-1718) such that it
   1. **SHALL** contain exactly one [1..1] `Procedures Section (entries required) (V2)`
      (templateId:2.16.840.1.113883.10.20.22.2.7.1.2)
      (CONF:CDP1-1719).

xi.  This structuredBody **SHALL** contain exactly one [1..1] `component`
     (CONF:CDP1-1722) such that it
   1. **SHALL** contain exactly one [1..1] `Reason for Visit Section`
      (templateId:2.16.840.1.113883.10.20.22.2.12)
      (CONF:CDP1-1723).
xlii. This structuredBody **shall** contain exactly one [1..1] component (CONF:CDP1-1724) such that it

1. **shall** contain exactly one [1..1] Results Section (entries required) (V2)
   (templateId:2.16.840.1.113883.10.20.22.2.3.1.2)
   (CONF:CDP1-1725).

xliii. This structuredBody **shall** contain exactly one [1..1] component (CONF:CDP1-1726) such that it

1. **shall** contain exactly one [1..1] Review of Systems Section
   (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.18)
   (CONF:CDP1-1727).

xliv. This structuredBody **shall** contain exactly one [1..1] component (CONF:CDP1-1728) such that it

1. **shall** contain exactly one [1..1] Social History Section (V2-CDP1)
   (templateId:2.16.840.1.113883.10.20.22.2.17.2.1)
   (CONF:CDP1-1729).

xlv. This structuredBody **shall** contain exactly one [1..1] component (CONF:CDP1-1736) such that it

1. **shall** contain exactly one [1..1] Transportation Section (CDP1)
   (templateId:2.16.840.1.113883.10.20.35.2.4)
   (CONF:CDP1-1735)

xlvi. This structuredBody **shall** contain exactly one [1..1] component (CONF:CDP1-1738) such that it

1. **shall** contain exactly one [1..1] Vital Signs Section (entries required) (V2)
   (templateId:2.16.840.1.113883.10.20.22.2.4.1.2)
   (CONF:CDP1-1737).

xlvii. **shall not** include an Assessment and Plan Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId:2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2-CDP1) (templateId:2.16.840.1.113883.10.20.22.2.10.2.1) are present (CONF:CDP1-1739).

xlviii. **shall not** include a Chief Complaint and Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.13) when a Chief Complaint Section (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1) and a Reason for Visit Section (templateId:2.16.840.1.113883.10.20.22.2.12) are present (CONF:CDP1-1740).
Table 7: DischargeSummaryDocumentTypeCode

Value Set: DischargeSummaryDocumentTypeCode 2.16.840.1.113883.11.20.4.1
A value set of LOINC document codes for discharge summaries.

Specific URL Pending
Valueset Source: [http://www.loinc.org/](http://www.loinc.org/)

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Print Name</th>
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<tr>
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<td>Discharge summarization note</td>
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<td>11490-0</td>
<td>LOINC</td>
<td>Physician</td>
</tr>
<tr>
<td>28655-9</td>
<td>LOINC</td>
<td>Attending physician</td>
</tr>
<tr>
<td>29761-4</td>
<td>LOINC</td>
<td>Dentistry</td>
</tr>
<tr>
<td>34745-0</td>
<td>LOINC</td>
<td>Nursing</td>
</tr>
<tr>
<td>34105-7</td>
<td>LOINC</td>
<td>Hospital Discharge summary</td>
</tr>
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<td>LOINC</td>
<td>Physician</td>
</tr>
<tr>
<td>...</td>
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<td></td>
</tr>
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</table>
6.3 **Complete Operative Note Document (CDP1)**

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.35.1.3 (open)]

**Table 8: Complete Operative (CDP1) Note Document Contexts**

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<th>Contained By:</th>
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<tbody>
<tr>
<td></td>
<td>Additional Documentation Section (CDP1)</td>
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<tr>
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<td>Anesthesia Section (V2)</td>
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<tr>
<td></td>
<td>Complications (V2)</td>
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<tr>
<td></td>
<td>Externally Defined CDE Section (CDP1)</td>
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<td>Implants Section (NEW)</td>
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<td>Operative Note Fluid Section</td>
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<td>Operative Note Surgical Procedure Section</td>
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<td>Orders Placed Section (CDP1)</td>
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<td>Physical Findings of Skin Section (New)</td>
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<td>Plan of Treatment Section (V2-CDP1)</td>
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<td>Planned Procedure Section (V2)</td>
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<td>Postoperative Diagnosis Section</td>
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<td>Preoperative Diagnosis Section (V2)</td>
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<td>Procedure Description Section</td>
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<td>Procedure Estimated Blood Loss Section</td>
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<td>Procedure Specimens Taken Section</td>
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<td>Surgery Description Section (New)</td>
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<td></td>
<td>Surgical Drains Section</td>
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</tbody>
</table>

The Complete Operative Note is a frequently used type of procedure note with specific requirements set forth by regulatory agencies.

The Complete Operative Note is created immediately following a surgical or other high-risk procedure. It records the pre and post-surgical diagnosis, pertinent events of the procedure, as well as the condition of the patient following the procedure. The report should be sufficiently detailed to support the diagnoses, justify the treatment, document the course of the procedure, and provide continuity of care.

A Complete Operative Note includes all sections relevant to the Operative Procedure. Any section for which data is not available (not collected, not relevant, not supported by the EHR technology, etc.) SHALL have the appropriate nullFlavor specified as affirmative attestation that the information was not available (see section 3.4 regarding the use of nullFlavors).
The Complete Operative Note Document is intended to support the entire contents of the medical record related to a specific operative procedure performed on a patient for the administrative or clinical exchange with a third party.

6.3.1 Properties

6.3.1.1 Header

1. Conforms to US Realm Header (V2) template (2.16.840.1.113883.10.20.22.1.1.2).
2. Conforms to Operative Note (V2) template (2.16.840.1.113883.10.20.22.1.7.2).
3. SHALL contain exactly one [1..1] templateId (CONF:CDP1-1801) such that it a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.1.2" (CONF:CDP1-1802).

The Complete Operative Note recommends use of a single document type code, TBD, with further specification provided by author or performer, setting, or specialty. When pre-coordinated codes are used, any coded values describing the author or performer of the service act or the practice setting must be consistent with the LOINC document type.

4. SHALL contain exactly one [1..1] code (CONF:CDP1-1803).
   a. This code SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet SurgicalOperationNoteDocumentTypeCode 2.16.840.1.113883.11.20.1. Dynamic (CONF:CDP1-1803).

5. SHALL contain at least one [1..*] documentationOf (CONF:CDP1-1804).

6.3.1.2 serviceEvent

A serviceEvent represents the main act, such as a colonoscopy or an appendectomy, being documented. A serviceEvent can further specialize the act inherent in the ClinicalDocument/code, such as where the ClinicalDocument/code is simply "Surgical Operation Note" and the procedure is "Appendectomy." serviceEvent is required in the Operative Note and it must be equivalent to or further specialize the value inherent in the ClinicalDocument/code; it shall not conflict with the value inherent in the ClinicalDocument/code, as such a conflict would create ambiguity. serviceEvent/effectiveTime can be used to indicate the time the actual event (as opposed to the encounter surrounding the event) took place.

If the date and the duration of the procedure is known, serviceEvent/effectiveTime/low is used with a width element that describes the duration; no high element is used. However, if only the date is known, the date is placed in both the low and high elements.

   a. Such documentationOfs SHALL contain exactly one [1..1] serviceEvent (CONF:CDP1-1805).
      i. This serviceEvent SHALL contain exactly one [1..1] effectiveTime (CONF:CDP1-1806).
         1. The serviceEvent/effectiveTime SHALL be present with effectiveTime/low (CONF:CDP1-1807).
2. If a width is not present, the serviceEvent/effectiveTime SHALL include effectiveTime/high (CONF:CDP1-1808).

3. When only the date and the length of the procedure are known a width element SHALL be present and the serviceEvent/effectiveTime/high SHALL NOT be present (CONF:CDP1-1809).

4. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:CDP1-1810).

6.3.1.3 performer

The performer represents clinicians who actually and principally carry out the serviceEvent. Typically, these are clinicians who have surgical privileges in their institutions such as Surgeons, Obstetrician/Gynecologists, and Family Practice Physicians. The performer may also be Nonphysician Providers (NPP) who have surgical privileges. There may be more than one primary performer in the case of complicated surgeries. There are occasionally co-surgeons. Usually they will be billing separately and will each dictate their own notes. An example may be spinal surgery, where a general surgeon and an orthopedic surgeon both are present and billing off the same Current Procedural Terminology (CPT) codes. Typically two Operative Notes are generated; however, each will list the other as a co-surgeon.

ii. This serviceEvent SHALL contain exactly one [1..1] performer (CONF:CDP1-1811) such that it

1. SHALL contain exactly one [1..1] @typeCode="PPRF" Primary performer (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) (CONF:CDP1-1812).

2. SHALL contain exactly one [1..1] assignedEntity (CONF:CDP1-1813).

   a. This assignedEntity SHALL contain exactly one [1..1] code (CONF:CDP1-1814).

      i. This code SHOULD contain zero or one [0..1] @code, which SHOULD be selected from ValueSet Provider Role Value Set 2.16.840.1.113883.3.88.12.3221.4 DYNAMIC (CONF:CDP1-1815).
iii. The value of serviceEvent/code SHALL be from ICD9 CM Procedures (CodeSystem 2.16.840.1.113883.6.104), CPT-4 (CodeSystem 2.16.840.1.113883.6.12), or values descending from 71388002 (Procedure) from the SNOMED CT (CodeSystem 2.16.840.1.113883.6.96) ValueSet Procedure 2.16.840.1.113883.3.88.12.80.28 DYNAMIC (CONF:CDP1-1816).

b. Any assistants SHALL be identified and SHALL be identified as secondary performers (SPRF) (CONF:CDP1-1817).

6. SHALL contain exactly one [1..1] component (CONF:CDP1-1818).

6.3.2 structuredBody

a. This component SHALL contain exactly one [1..1] structuredBody (CONF:CDP1-1301).

i. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-1902) such that it
1. **SHALL** contain exactly one [1..1] Additional Documentation Section (CDP1) (templateId:2.16.840.1.113883.10.20.35.2.1) (CONF:CDP1-1903).

ii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1908) such that it

1. **SHALL** contain exactly one [1..1] Anesthesia Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.25.2) (CONF:CDP1-1909).

iii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1918) such that it

1. **SHALL** contain exactly one [1..1] Complications Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.37.2) (CONF:CDP1-1919).

iv. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1922) such that it

1. **SHALL** contain exactly one [1..1] Externally Defined CDE Section (CDP1) (templateId:2.16.840.1.113883.10.20.35.2.2) (CONF:CDP1-1923).

v. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1960) such that it

1. **SHALL** contain exactly one [1..1] Implants Section (NEW) (templateId:2.16.840.1.113883.10.20.22.2.33) (CONF:CDP1-1961).

vi. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1966) such that it

1. **SHALL** contain exactly one [1..1] Medical Equipment Section (V2) (templateId:2.16.840.1.113883.10.20.22.2.23.2) (CONF:CDP1-1967).

vii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1980) such that it

1. **SHALL** contain exactly one [1..1] Operative Note Fluids Section (templateId:2.16.840.1.113883.10.20.7.12) (CONF:CDP1-1981).

viii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1982) such that it

1. **SHALL** contain exactly one [1..1] Operative Note Surgical Procedure Section (templateId:2.16.840.1.113883.10.20.7.14) (CONF:CDP1-1983).
ix. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1984) such that it

1. **SHALL** contain exactly one [1..1] *Orders Placed Section (CDP1)*
   (templateId:2.16.840.1.113883.10.20.35.2.3)
   (CONF:CDP1-1985).

x. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1986) such that it

1. **SHALL** contain exactly one [1..1] *Payers Section (V2)*
   (templateId:2.16.840.1.113883.10.20.22.2.18.2)
   (CONF:CDP1-1987).

xi. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1990) such that it

1. **SHALL** contain exactly one [1..1] *Physical Findings of Skin Section (New)*
   (templateId:2.16.840.1.113883.10.20.22.2.62)

xii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1992) such that it

1. **SHALL** contain exactly one [1..1] *Plan of Treatment Section (V2-CDP1)*
   (templateId:2.16.840.1.113883.10.20.22.2.10.2.1)
   (CONF:CDP1-1993).

xiii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1994) such that it

1. **SHALL** contain exactly one [1..1] *Planned Procedure Section (V2)*
   (templateId:2.16.840.1.113883.10.20.22.2.30.2)
   (CONF:CDP1-1995).

xiv. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-1996) such that it

1. **SHALL** contain exactly one [1..1] *Postoperative Diagnosis Section*
   (templateId:2.16.840.1.113883.10.20.22.2.35)
   (CONF:CDP1-1997).

xv. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-2000) such that it

1. **SHALL** contain exactly one [1..1] *Preoperative Diagnosis Section (V2)*
   (templateId:2.16.840.1.113883.10.20.22.2.34.2)

xvi. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-2004) such that it

1. **SHALL** contain exactly one [1..1] *Procedure Description Section*
   (templateId:2.16.840.1.113883.10.20.22.2.27)
   (CONF:CDP1-2005).
xvii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2006) such that it
   1. SHALL contain exactly one [1..1] Procedure Disposition Section
      (templateId:2.16.840.1.113883.10.20.18.2.12)
      (CONF:CDP1-2007).

xviii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2008) such that it
   1. SHALL contain exactly one [1..1] Procedure Estimated Blood Loss Section
      (templateId:2.16.840.1.113883.10.20.18.2.9)
      (CONF:CDP1-2009).

xix. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2010) such that it
   1. SHALL contain exactly one [1..1] Procedure Findings Section (V2)
      (templateId:2.16.840.1.113883.10.20.22.2.28.2)
      (CONF:CDP1-2011).

xx. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2012) such that it
   1. SHALL contain exactly one [1..1] Procedure Implants Section
      (templateId:2.16.840.1.113883.10.20.22.2.40)
      (CONF:CDP1-2013).

xxi. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2014) such that it
   1. SHALL contain exactly one [1..1] Procedure Indications Section (V2)
      (templateId:2.16.840.1.113883.10.20.22.2.29.2)
      (CONF:CDP1-2015).

xxii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2016) such that it
   1. SHALL contain exactly one [1..1] Procedure Specimens Taken Section
      (templateId:2.16.840.1.113883.10.20.22.2.31)

xxiii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2032) such that it
   1. SHALL contain exactly one [1..1] Surgery Description Section (New)
      (templateId:2.16.840.1.113883.10.20.22.2.26)
      (CONF:CDP1-2033).

xxiv. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2034) such that it
   1. SHALL contain exactly one [1..1] Surgical Drains Section
      (templateId:2.16.840.1.113883.10.20.7.13)
      (CONF:CDP1-2035).
7. A consent, if present, **SHALL** be represented as ClinicalDocument/authorization/consent (CONF:CDP1-2036).

**Table 9: SurgicalOperationNoteDocumentTypeCode**

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>11504-8</td>
<td>LOINC</td>
<td>{Provider}</td>
</tr>
<tr>
<td>34137-0</td>
<td>LOINC</td>
<td>{Provider}</td>
</tr>
<tr>
<td>28583-3</td>
<td>LOINC</td>
<td>Dentistry</td>
</tr>
<tr>
<td>28624-5</td>
<td>LOINC</td>
<td>Podiatry</td>
</tr>
<tr>
<td>28573-4</td>
<td>LOINC</td>
<td>Physician</td>
</tr>
<tr>
<td>34877-1</td>
<td>LOINC</td>
<td>Urology</td>
</tr>
<tr>
<td>34874-8</td>
<td>LOINC</td>
<td>Surgery</td>
</tr>
<tr>
<td>34870-6</td>
<td>LOINC</td>
<td>Plastic surgery</td>
</tr>
<tr>
<td>34868-0</td>
<td>LOINC</td>
<td>Orthopedics</td>
</tr>
<tr>
<td>34818-5</td>
<td>LOINC</td>
<td>Otorhinolaryngology</td>
</tr>
</tbody>
</table>

**Table 10: Provider Role Value Set**

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP</td>
<td>Provider Role (HL7)</td>
<td>Consulting Provider</td>
</tr>
<tr>
<td>PP</td>
<td>Provider Role (HL7)</td>
<td>Primary Care Provider</td>
</tr>
<tr>
<td>RP</td>
<td>Provider Role (HL7)</td>
<td>Referring Provider</td>
</tr>
</tbody>
</table>
### 6.4 Complete Procedure Document (CDP1)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.35.1.4 (open)]

#### Table 11: Complete Procedure (CDP1) Document Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Additional Documentation Section (CDP1)</td>
</tr>
<tr>
<td></td>
<td>Allergies Section (entries required) (V2)</td>
</tr>
<tr>
<td></td>
<td>Anesthesia Section (V2)</td>
</tr>
<tr>
<td></td>
<td>Assessment and Plan Section (V2)</td>
</tr>
<tr>
<td></td>
<td>Assessment Section</td>
</tr>
<tr>
<td></td>
<td>Chief Complaint and Reason for Visit Section</td>
</tr>
<tr>
<td></td>
<td>Chief Complaint Section</td>
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<tr>
<td></td>
<td>Complications (V2)</td>
</tr>
<tr>
<td></td>
<td>Externally Defined CDE Section (CDP1)</td>
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<td></td>
<td>Family History Section</td>
</tr>
<tr>
<td></td>
<td>History of Past Illness Section (V2)</td>
</tr>
<tr>
<td></td>
<td>History of Present Illness Section</td>
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<tr>
<td></td>
<td>Implants Section (NEW)</td>
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<tr>
<td></td>
<td>Medical Equipment Section (V2)</td>
</tr>
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<td></td>
<td>Medical (General) History Section</td>
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<td>Medications Section (entries required) (V2)</td>
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<td></td>
<td>Orders Placed Section (CDP1)</td>
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<td></td>
<td>Payers Section (V2)</td>
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<td>Physical Exam Section (V2)</td>
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<td>Physical Findings of Skin Section (New)</td>
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<td>Plan of Treatment Section (V2-CDP1)</td>
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<td></td>
<td>Planned Procedure Section (V2)</td>
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<td></td>
<td>Postprocedure Diagnosis Section (V2)</td>
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<td>Procedure Description Section</td>
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<tr>
<td></td>
<td>Procedure Disposition Section</td>
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<tr>
<td></td>
<td>Procedure Estimated Blood Loss Section</td>
</tr>
<tr>
<td></td>
<td>Procedure Findings Section (V2)</td>
</tr>
<tr>
<td></td>
<td>Procedure Implants Section</td>
</tr>
<tr>
<td></td>
<td>Procedure Indications Section (V2)</td>
</tr>
<tr>
<td></td>
<td>Procedure Specimens Taken Section</td>
</tr>
<tr>
<td></td>
<td>Procedures Section (entries required) (V2)</td>
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<td></td>
<td>Reason for Visit Section</td>
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<td>Review of Systems Section</td>
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<tr>
<td></td>
<td>Social History Section (V2-CDP1)</td>
</tr>
<tr>
<td></td>
<td>Surgery Description Section (New)</td>
</tr>
</tbody>
</table>

Complete Procedure Document encompasses many types of non-operative procedures including interventional cardiology, gastrointestinal endoscopy, osteopathic manipulation, and many other specialty fields. Complete Procedure Documents are differentiated from Complete Operative Note Documents because they do not involve incision or excision as the primary act.
The Complete Procedure Note is created immediately following a non-operative procedure. It records the indications for the procedure and, when applicable, post-procedure diagnosis, pertinent events of the procedure, and the patient’s tolerance for the procedure. It should be detailed enough to justify the procedure, describe the course of the procedure, and provide continuity of care.

A Complete Procedure Document includes all sections relevant to the specific procedure. Any section for which data is not available (not collected, not relevant, not supported by the EHR technology, etc.) SHALL have the appropriate nullFlavor specified as affirmative attestation that the information was not available (see section 3.4 regarding the use of nullFlavors).

The Complete Procedure Document is intended to support the entire contents of the medical record related to a specific procedure performed on a patient for the administrative or clinical exchange with a third party.

6.4.1 Properties

6.4.1.1 Header

1. Conforms to **US Realm Header (V2)** template (2.16.840.1.113883.10.20.22.1.1.2).

2. Conforms to **Procedure Note (V2)** template (2.16.840.1.113883.10.20.22.1.6.2).

3. **SHALL** contain exactly one [1..1] `templateId` (CONF:CDP1-2101) such that it
   a. **SHALL** contain exactly one [1..1] `@root` = "2.16.840.1.113883.10.20.35.1.4" (CONF:CDP1-2102).

The Complete Procedure Document recommends use of a single document type code, TBD, with further specification provided by author or performer, setting, or specialty. When pre-coordinated codes are used, any coded values describing the author or performer of the service act or the practice setting must be consistent with the LOINC document type.

4. **SHALL** contain exactly one [1..1] `code` (CONF:CDP1-2103).
   a. This code **SHALL** contain exactly one [1..1] `@code`, which **SHALL** be selected from ValueSet **ProcedureNoteDocumentTypeCodes** 2.16.840.1.113883.11.20.6.1 **DYNAMIC** (CONF:CDP1-2104).

6.4.1.2 participant

The participant element in the Complete Procedure Document header follows the General Header Constraints for participants.

5. **MAY** contain zero or more [0..*] `participant` (CONF:CDP1-2105) such that it
   a. **SHALL** contain exactly one [1..1] `@typeCode` = "IND" Individual (CodeSystem: participationFunction 2.16.840.1.113883.5.88 **STATIC** (CONF:8505).

   b. **SHALL** contain exactly one [1..1] `functionCode` = "PCP" Primary Care Physician (CodeSystem: participationFunction 2.16.840.1.113883.5.88 **STATIC** (CONF:CDP1-2106).
   i. This `associatedEntity/@classCode` **SHALL** contain exactly one [1..1] `associatedPerson` (CONF:CDP1-2018).

   6. **SHALL** contain at least one [1..*] `documentationOf` (CONF:CDP1-2109) such that it

### 6.4.1.3 serviceEvent

A `serviceEvent` is required in the Complete Procedure Document to represent the main act, such as a colonoscopy or a cardiac stress study, being documented. It must be equivalent to or further specialize the value inherent in the `ClinicalDocument/@code` (such as where the `ClinicalDocument/@code` is simply "Procedure Note" and the procedure is "colonoscopy"), and it shall not conflict with the value inherent in the `ClinicalDocument/@code`, as such a conflict would create ambiguity. A `serviceEvent/effectiveTime` element indicates the time the actual event (as opposed to the encounter surrounding the event) took place.

`serviceEvent/effectiveTime` may be represented two different ways in the Complete Procedure Document. For accuracy to the second, the best method is `effectiveTime/low` together with `effectiveTime/high`. If a more general time, such as minutes or hours, is acceptable OR if the duration is unknown, an `effectiveTime/low` with a width element may be used. If the duration is unknown, the appropriate HL7 null value such as "NI" or "NA" must be used for the width element.

a. **SHALL** contain exactly one [1..1] `serviceEvent` (CONF:CDP1-2110).
   i. This `serviceEvent` **SHALL** contain exactly one [1..1] `effectiveTime` (CONF:CDP1-2111).
      1. This `effectiveTime` **SHALL** contain exactly one [1..1] `low` (CONF:CDP1-2112).
      2. The `serviceEvent/effectiveTime` **SHALL** be present with `effectiveTime/low` (CONF:CDP1-2113).
      3. If a width is not present, the `serviceEvent/effectiveTime` **SHALL** include `effectiveTime/high` (CONF:CDP1-2114).
      4. When only the date and the length of the procedure are known a width element **SHALL** be present and the `serviceEvent/effectiveTime/high` **SHALL NOT** be present (CONF:CDP1-2115).
      5. The content of `effectiveTime` **SHALL** be a conformant US Realm Date and Time (DTM_US_FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:CDP1-2116).

### 6.4.1.4 performer

The `performer participant` represents clinicians who actually and principally carry out the `serviceEvent`. Typically, these are clinicians who have the appropriate privileges in their institutions such as gastroenterologists, interventional radiologists, and family practice physicians. Performers may also be non-physician providers (NPPs) who have
other significant roles in the procedure such as a radiology technician, dental assistant, or nurse.

ii. This serviceEvent SHALL contain exactly one [1..1] performer (CONF:CDP1-2117).
   1. This performer SHALL contain exactly one [1..1] 
      @typeCode="PPRF" Primary Performer (CodeSystem: 
      HL7ParticipationType 2.16.840.1.113883.5.90 STATIC) 
      (CONF:CDP1-2118).
   2. This performer SHALL contain exactly one [1..1] 
      assignedEntity (CONF:CDP1-2118).
      a. This assignedEntity SHOULD contain zero or one [0..1] 
         code (CONF:CDP1-2119).
         i. The code, if present, SHOULD contain zero or 
            one [0..1] @code, which SHALL be selected 
            from ValueSet Healthcare Provider 
            Taxonomy (HIPAA) 
            2.16.840.1.114222.4.11.1066 DYNAMIC 
            (CONF:ACDP12120).

Figure 10: Complete Procedure Note Performer Example

```xml
<performer typeCode="PPRF">
  <assignedEntity>
    <id extension="IO00017" root="2.16.840.1.113883.19.5" />
    <code code="207RG0100X" codeSystem="2.16.840.1.113883.6.96" codeSystemName="NUCC" displayName="Gastroenterologist" />
    <addr>
      <streetAddressLine>1001 Hospital Lane</streetAddressLine>
      <city>Ann Arbor</city>
      <state>MI</state>
      <postalCode>99999</postalCode>
      <country>US</country>
    </addr>
    <telecom value="tel:(999)555-1212" />
    <assignedPerson>
      <name>
        <prefix>Dr.</prefix>
        <given>Tony</given>
        <family>Tum</family>
      </name>
    </assignedEntity>
  </performer>
```

iii. The value of Clinical Document 
/documentationOf/serviceEvent/code SHALL be from ICD9 CM 
Procedures (codeSystem 2.16.840.1.113883.6.104), CPT-4 
(codeSystem 2.16.840.1.113883.6.12), or values descending from 
71388002 (Procedure) from the SNOMED CT (codeSystem 
2.16.840.1.113883.6.96) ValueSet 
2.16.840.1.113883.3.88.12.80.28 Procedure DYNAMIC 
(CONF:CDP1-2121).
b. Any assistants \textbf{SHALL} be identified and \textbf{SHALL} be identified as secondary performers (SPRF) (CONF:CDP1-2122).

7. \textbf{SHOULD} contain zero or one [0..1] \texttt{componentOf} (CONF:CDP1-2123).

6.4.1.5 encompassingEncounter

a. The \texttt{componentOf}, if present, \textbf{SHALL} contain exactly one [1..1] \texttt{encompassingEncounter} (CONF:CDP1-2124).
   i. This encompassingEncounter \textbf{SHALL} contain exactly one [1..1] \texttt{code} (CONF:CDP1-2125).
   ii. This encompassingEncounter \textbf{MAY} contain zero or one [0..1] \texttt{encounterParticipant} (CONF:30874) such that it
      1. \textbf{SHALL} contain exactly one [1..1] @\texttt{typeCode}="REF" Referrer (CONF:CDP1-2126).
   iii. This encompassingEncounter \textbf{SHALL} contain at least one [1..*] \texttt{location} (CONF:CDP1-2127).
      1. Such locations \textbf{SHALL} contain exactly one [1..1] \texttt{healthCareFacility} (CONF:CDP1-2128).
         a. This healthCareFacility \textbf{SHALL} contain at least one [1..*] \texttt{id} (CONF:CDP1-2128).

8. \textbf{SHALL} contain exactly one [1..1] \texttt{component} (CONF:CDP1-2200).

6.4.2 structuredBody

a. This component \textbf{SHALL} contain exactly one [1..1] \texttt{structuredBody} (CONF:CDP1-1301).
   i. This structuredBody \textbf{SHALL} contain exactly one [1..1] \texttt{component} (CONF:CDP1-2202) such that it
1. **SHALL** contain exactly one [1..1] Additional Documentation Section (CDP1)
   (templateId:2.16.840.1.113883.10.20.20.35.2.1)
   (CONF:CDP1-2203).

   ii. This structuredBody **SHALL** contain exactly one [1..1] component
       (CONF:CDP1-1306) such that it
          1. **SHALL** contain exactly one [1..1] Allergies Section
             (entries required) (V2)
             (templateId:2.16.840.1.113883.10.20.22.2.6.1.2)
             (CONF:CDP1-2207).

   iii. This structuredBody **SHALL** contain exactly one [1..1] component
       (CONF:CDP1-2208) such that it
          1. **SHALL** contain exactly one [1..1] Anesthesia Section
             (V2)
             (templateId:2.16.840.1.113883.10.20.22.2.25.2)
             (CONF:CDP1-2209).

   iv. This structuredBody **SHALL** contain exactly one [1..1] component
       (CONF:CDP1-2210) such that it
          1. **SHALL** contain exactly one [1..1] Assessment and Plan
             Section (V2)
             (templateId:2.16.840.1.113883.10.20.22.2.9.2)
             (CONF:CDP1-2211).

   v. This structuredBody **SHALL** contain exactly one [1..1] component
       (CONF:CDP1-2212) such that it
          1. **SHALL** contain exactly one [1..1] Assessment Section
             (templateId:2.16.840.1.113883.10.20.22.2.8)
             (CONF:CDP1-2213).

   vi. This structuredBody **SHALL** contain exactly one [1..1] component
       (CONF:CDP1-2214) such that it
          1. **SHALL** contain exactly one [1..1] Chief Complaint and
             Reason for Visit Section
             (templateId:2.16.840.1.113883.10.20.22.2.13)
             (CONF:CDP1-2215).

   vii. This structuredBody **SHALL** contain exactly one [1..1] component
       (CONF:CDP1-2216) such that it
          1. **SHALL** contain exactly one [1..1] Chief Complaint
             Section
             (templateId:1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1)
             (CONF:CDP1-2217).

   viii. This structuredBody **SHALL** contain exactly one [1..1] component
       (CONF:CDP1-2218) such that it
       1. **SHALL** contain exactly one [1..1] Complications
          Section (V2)
             (templateId:2.16.840.1.113883.10.20.22.2.37.2)
             (CONF:CDP1-2219).

   ix. This structuredBody **SHALL** contain exactly one [1..1] component
       (CONF:CDP1-2222) such that it
1. **SHALL** contain exactly one [1..1] *Externally Defined CDE Section (CDP1)*
   (templateId:2.16.840.1.113883.10.20.35.2.2)
   (CONF:CDP1-2223).

x. This structuredBody **SHALL** contain exactly one [1..1] **component**
   (CONF:CDP1-2224) such that it
   1. **SHALL** contain exactly one [1..1] *Family History Section*
      (templateId:2.16.840.1.113883.10.20.22.1.15)
      (CONF:CDP1-2225).

xi. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-2236) such that it
    1. **SHALL** contain exactly one [1..1] *History of Past Illness Section (V2)*
       (templateId:2.16.840.1.113883.10.20.22.2.20.2)
       (CONF:CDP1-2237).

xii. This structuredBody **SHALL** contain exactly one [1..1] **component**
     (CONF:CDP1-2238) such that it
     1. **SHALL** contain exactly one [1..1] *History of Present Illness Section*
        (templateId:1.3.6.1.4.1.19376.1.5.3.1.3.4)
        (CONF:CDP1-2239).

xiii. This structuredBody **SHALL** contain exactly one [1..1] **component**
     (CONF:CDP1-2260) such that it
     1. **SHALL** contain exactly one [1..1] *Implants Section (NEW)*
        (templateId:2.16.840.1.113883.10.20.22.2.33)
        (CONF:CDP1-2261).

xiv. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-2266) such that it
    1. **SHALL** contain exactly one [1..1] *Medical Equipment Section (V2)*
       (templateId:2.16.840.1.113883.10.20.22.2.23.2)
       (CONF:CDP1-2267).

xv. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-2268) such that it
    1. **SHALL** contain exactly one [1..1] *Medical (General) History Section*
       (templateId:2.16.840.1.113883.10.20.22.2.39)
       (CONF:CDP1-2269).

xvi. This structuredBody **SHALL** contain exactly one [1..1] **component**
     (CONF:CDP1-2270) such that it
     1. **SHALL** contain exactly one [1..1] *Medications Administered Section (V2)*
        (templateId:2.16.840.1.113883.10.20.22.2.38.2)
        (CONF:CDP1-2271).
xvii. This structuredBody **SHALL** contain exactly one [1..1] **component**

   (CONF:CDP1-2272) such that it

   1. **SHALL** contain exactly one [1..1] Medications Section

      (entries required) (V2)

      (templateId:2.16.840.1.113883.10.20.22.2.1.1.2)

      (CONF:CDP1-2273).

xviii. This structuredBody **SHALL** contain exactly one [1..1] **component**

   (CONF:CDP1-2284) such that it

   1. **SHALL** contain exactly one [1..1] Orders Placed

      Section (CDP1)

      (templateId:2.16.840.1.113883.10.20.35.2.3)

      (CONF:CDP1-2285).

xix. This structuredBody **SHALL** contain exactly one [1..1] **component**

   (CONF:CDP1-2286) such that it

   1. **SHALL** contain exactly one [1..1] Payers Section

      (V2)

      (templateId:2.16.840.1.113883.10.20.22.2.18.2)

      (CONF:CDP1-2287).

xx. This structuredBody **SHALL** contain exactly one [1..1] **component**

   (CONF:CDP1-2288) such that it

   1. **SHALL** contain exactly one [1..1] Physical Exam

      Section (V2)

      (templateId:2.16.840.1.113883.10.20.2.10.2)

      (CONF:CDP1-2289).

xxi. This structuredBody **SHALL** contain exactly one [1..1] **component**

   (CONF:CDP1-2290) such that it

   1. **SHALL** contain exactly one [1..1] Physical Findings of

      Skin Section (New)

      (templateId:2.16.840.1.113883.10.20.22.2.62)

      (CONF:CDP1-2291).

xxii. This structuredBody **SHALL** contain exactly one [1..1] **component**

   (CONF:CDP1-2292) such that it

   1. **SHALL** contain exactly one [1..1] Plan of Treatment

      Section (V2-CDP1)

      (templateId:2.16.840.1.113883.10.20.22.2.10.2.1)

      (CONF:CDP1-2293).

xxiii. This structuredBody **SHALL** contain exactly one [1..1] **component**

   (CONF:CDP1-2294) such that it

   1. **SHALL** contain exactly one [1..1] Planned Procedure

      Section (V2)

      (templateId:2.16.840.1.113883.10.20.22.2.30.2)

      (CONF:CDP1-2295).

xxiv. This structuredBody **SHALL** contain exactly one [1..1] **component**

   (CONF:CDP1-2298) such that it

   1. **SHALL** contain exactly one [1..1] Postprocedure

      Diagnosis Section (V2)

      (templateId:2.16.840.1.113883.10.20.22.2.36.2)

      (CONF:CDP1-2299).
xxv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-2304) such that it
   1. **SHALL** contain exactly one [1..1] Procedure Description Section  
      (templateId:2.16.840.1.113883.10.20.22.2.27)  
      (CONF:CDP1-2305).

xxvi. This structuredBody **SHALL** contain exactly one [1..1] **component**  
      (CONF:CDP1-2306) such that it
   1. **SHALL** contain exactly one [1..1] Procedure Disposition Section  
      (templateId:2.16.840.1.113883.10.20.18.2.12)  
      (CONF:CDP1-2307).

xxvii. This structuredBody **SHALL** contain exactly one [1..1] **component**  
      (CONF:CDP1-2308) such that it
   1. **SHALL** contain exactly one [1..1] Procedure Estimated Blood Loss Section  
      (templateId:2.16.840.1.113883.10.20.18.2.9)  
      (CONF:CDP1-2309).

xxviii. This structuredBody **SHALL** contain exactly one [1..1] **component**  
      (CONF:CDP1-2310) such that it
   1. **SHALL** contain exactly one [1..1] Procedure Findings Section (V2)  
      (templateId:2.16.840.1.113883.10.20.22.2.28.2)  
      (CONF:CDP1-2311).

xxix. This structuredBody **SHALL** contain exactly one [1..1] **component**  
      (CONF:CDP1-2312) such that it
   1. **SHALL** contain exactly one [1..1] Procedure Implants Section  
      (templateId:2.16.840.1.113883.10.20.22.2.40)  
      (CONF:CDP1-2313).

xxx. This structuredBody **SHALL** contain exactly one [1..1] **component**  
      (CONF:CDP1-2314) such that it
   1. **SHALL** contain exactly one [1..1] Procedure Indications Section (V2)  
      (templateId:2.16.840.1.113883.10.20.22.2.29.2)  
      (CONF:CDP1-2315).

xxxii. This structuredBody **SHALL** contain exactly one [1..1] **component**  
      (CONF:CDP1-2316) such that it
   1. **SHALL** contain exactly one [1..1] Procedure Specimens Taken Section  
      (templateId:2.16.840.1.113883.10.20.22.2.31)  
      (CONF:CDP1-2317).

xxxii. This structuredBody **SHALL** contain exactly one [1..1] **component**  
      (CONF:CDP1-2318) such that it
   1. **SHALL** contain exactly one [1..1] Procedures Section  
      (entries required) (V2)
xxxiii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2322) such that it

1. SHALL contain exactly one [1..1] Reason for Visit Section (CONF:CDP1-2323).

xxxiv. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2326) such that it

1. SHALL contain exactly one [1..1] Review of Systems Section (CONF:CDP1-2327).

xxxv. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2328) such that it

1. SHALL contain exactly one [1..1] Social History Section (V2-CDP1) (CONF:CDP1-2329).

xxxvi. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2332) such that it

1. SHALL contain exactly one [1..1] Surgery Description Section (New) (CONF:CDP1-2333).

xxxvii. SHALL NOT include an Assessment and Plan Section (V2) (CONF:CDP1-2339) when an Assessment Section (CONF:CDP1-2339) and a Plan of Treatment Section (V2-CDP1) (CONF:CDP1-2339) are present.

xxxviii. SHALL NOT include a Chief Complaint Section (CONF:CDP1-2340) with a Chief Complaint and Reason for Visit Section (CONF:CDP1-2340).

9. A consent, if present, SHALL be represented as ClinicalDocument/authorization/consent (CONF:CDP1-2342).

<table>
<thead>
<tr>
<th>Table 12: ProcedureNoteDocumentTypeCodes</th>
</tr>
</thead>
</table>

Value Set: ProcedureNoteDocumentTypeCodes 2.16.840.1.113883.11.10.20.6.1
A value set of LOINC document codes for Procedure Notes.

Specific URL Pending
Valueset Source: [http://search.loinc.org](http://search.loinc.org)
<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>28570-0</td>
<td>LOINC</td>
<td>Provider-unspecified Procedure note</td>
</tr>
<tr>
<td>11505-5</td>
<td>LOINC</td>
<td>Physician procedure note</td>
</tr>
<tr>
<td>18744-3</td>
<td>LOINC</td>
<td>Bronchoscopy study</td>
</tr>
<tr>
<td>18745-0</td>
<td>LOINC</td>
<td>Cardiac catheterization study</td>
</tr>
<tr>
<td>18746-8</td>
<td>LOINC</td>
<td>Colonoscopy study</td>
</tr>
<tr>
<td>18751-8</td>
<td>LOINC</td>
<td>Endoscopy study</td>
</tr>
<tr>
<td>18753-4</td>
<td>LOINC</td>
<td>Flexible sigmoidoscopy study</td>
</tr>
<tr>
<td>18836-7</td>
<td>LOINC</td>
<td>Cardiac stress study Procedure</td>
</tr>
<tr>
<td>28577-5</td>
<td>LOINC</td>
<td>Dentist procedure note</td>
</tr>
<tr>
<td>28625-2</td>
<td>LOINC</td>
<td>Podiatry procedure note</td>
</tr>
<tr>
<td>...</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 6.5 Time Boxed Document (CDP1)

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.35.1.5 (open)]

#### Table 13: Time Boxed (CDP1) Document Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Additional Documentation Section (CDP1)</td>
</tr>
<tr>
<td></td>
<td>Allergies Section (entries required) (V2)</td>
</tr>
<tr>
<td></td>
<td>Assessment and Plan Section (V2)</td>
</tr>
<tr>
<td></td>
<td>Assessment Section</td>
</tr>
<tr>
<td></td>
<td>Externally Defined CDE Section (CDP1)</td>
</tr>
<tr>
<td></td>
<td>Functional Status Section (V2-CDP1)</td>
</tr>
<tr>
<td></td>
<td>General Status Section</td>
</tr>
<tr>
<td></td>
<td>Goals Section (New)</td>
</tr>
<tr>
<td></td>
<td>Health Concerns Section (New)</td>
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<tr>
<td></td>
<td>Health Status Evaluation/Outcomes Section (New)</td>
</tr>
<tr>
<td></td>
<td>Hospital Consultations Section</td>
</tr>
<tr>
<td></td>
<td>Hospital Course Section</td>
</tr>
<tr>
<td></td>
<td>Immunizations Section (entries required) (V2)</td>
</tr>
<tr>
<td></td>
<td>Implants Section (NEW)</td>
</tr>
<tr>
<td></td>
<td>Instructions Section (V2)</td>
</tr>
<tr>
<td></td>
<td>Interventions Section (V2)</td>
</tr>
<tr>
<td></td>
<td>Medical Equipment Section (V2)</td>
</tr>
<tr>
<td></td>
<td>Medications Section (entries required) (V2)</td>
</tr>
<tr>
<td></td>
<td>Mental Status Section (New-CDP1)</td>
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<tr>
<td></td>
<td>Nutrition Section (NEW)</td>
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<td></td>
<td>Objective Section</td>
</tr>
<tr>
<td></td>
<td>Orders Placed Section (CDP1)</td>
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<tr>
<td></td>
<td>Payers Section (V2)</td>
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<td>Physical Exam Section (V2)</td>
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<td>Physical Findings of Skin Section (New)</td>
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<td></td>
<td>Plan of Treatment Section (V2-CDP1)</td>
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<tr>
<td></td>
<td>Problem Section (V2)</td>
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<tr>
<td></td>
<td>Procedures Section (entries required) (V2)</td>
</tr>
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<td></td>
<td>Results Section (entries required) (V2)</td>
</tr>
<tr>
<td></td>
<td>Review of Systems Section</td>
</tr>
<tr>
<td></td>
<td>Subjective Section</td>
</tr>
<tr>
<td></td>
<td>Vital Signs Section (entries required) (V2)</td>
</tr>
</tbody>
</table>

The Time Boxed Document is generated by a provider at the end of a fixed period of time (shift, day, etc) within the context of a larger encounter (e.g. Hospitalization) with a patient.

A complete record of the patient’s Hospital stay should be contained in the combination of the Complete Hospitalization Document, Complete Operative Notes Document(s), Complete Procedures Document(s), and Time Boxed Documents. (see Appendix D)

The Time Boxed Document is intended to capture the complete activity for the period covered. It may exclude anything that is covered in one of the other Complete Document Templates (e.g. Complete Procedure Document).
A Time Boxed Document includes all sections relevant to the interval covered. Any section for which data is not available (not collected, not relevant, not supported by the EHR technology, etc.) SHALL have the appropriate nullFlavor specified as affirmative attestation that the information was not available (see section 3.4 regarding the use of nullFlavors).

6.5.1 Properties

6.5.1.1 Header

1. Conforms to **US Realm Header (V2)** template
   
   (2.16.840.1.113883.10.20.22.1.1.2).

2. **SHALL** contain exactly one [1..1] templateId (CONF:CDP1-2401) such that it
   
   a. **SHALL** contain exactly one [1..1] 
      
      @root="2.16.840.1.113883.10.20.35.1.5" (CONF:CDP1-2402).

   The Time Boxed Document recommends use of the document type code **TBD**, with further specification provided by author or performer, setting, or specialty. When pre-coordinated codes are used, any coded values describing the author or performer of the service act

3. **SHALL** contain exactly one [1..1] code, (CONF:CDP1-2403)
   
   a. which **SHALL** be selected from ValueSet **TimeBoxedDocumentType**
      
      2.16.840.1.113883.10.20.35 DYNAMIC (CONF:CDP1-2404).

4. **SHALL** contain exactly one [1..1] title (CONF:CDP1-2405).

5. **SHOULD** contain zero or one [0..1] documentationOf (CONF:CDP1-2406).

6.5.1.2 serviceEvent

A documentationOf can contain a serviceEvent to further specialize the act inherent in the TimeBoxedDocumentType.

The serviceEvent/effectiveTime is the time period the note documents.

a. The documentationOf, if present, **SHALL** contain exactly one [1..1]
   
   serviceEvent (CONF:CDP1-2407).
   
   i. This serviceEvent **SHALL** contain exactly one [1..1]
      
      @classCode="PCPR" Care Provision (CodeSystem: HL7ActClass
      
      2.16.840.1.113883.5.6 STATIC) (CONF:CDP1-2408).

   ii. This serviceEvent **SHALL** contain exactly one [1..1] templateId
      
      (CONF:CDP1-1209) such that it
      
      1. **SHALL** contain exactly one [1..1]
         
         @root="2.16.840.1.113883.10.20.21.3.1" (CONF:CDP1-2410).

   iii. This serviceEvent **SHOULD** contain zero or one [0..1] effectiveTime
      
      (CONF:CDP1-2411).
      
      1. The serviceEvent/effectiveTime element **SHOULD** be present
         
         with effectiveTime/low element (CONF:CDP1-2412).

      2. If a width element is not present, the serviceEvent **SHALL**
         
         include effectiveTime/high (CONF:CDP1-2413).
3. The content of effectiveTime SHALL be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:CDP1-2414).

Figure 13: Time Boxed serviceEvent Example

```xml
<documentationOf>
  <serviceEvent classCode="PCPR">
    <templateId root="2.16.840.1.113883.10.20.21.3.1" />
    <effectiveTime>
      <low value="200503291200" />
      <high value="200503291400" />
    </effectiveTime>
  ...  
  </serviceEvent>
</documentationOf>
```

6. SHALL contain exactly one [1..1] componentOf (CONF:CDP1-2415).

6.5.1.3 participant

This participant represents the clinician to contact for questions about the Time Boxed Document. This call back contact individual may be a different person than the individual(s) identified in the author or legalAuthenticator participant.

7. SHOULD contain zero or more [0..*] participant (CONF:CDP1-2416) such that it
   a. SHALL contain exactly one [1..1] @typeCode="CALLBACK" call back contact (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90 DYNAMIC) (CONF:CDP1-2417).
   b. SHALL contain exactly one [1..1] associatedEntity (CONF:CDP1-2418).
      i. This associatedEntity SHALL contain exactly one [1..1] @classCode="ASSIGNED" assigned entity (CodeSystem: RoleClass 2.16.840.1.113883.5.110 DYNAMIC) (CONF:CDP1-2419).
      ii. This associatedEntity SHALL contain at least one [1..*] id (CONF:CDP1-2420).
      iii. This associatedEntity SHOULD contain zero or more [0..*] addr (CONF:CDP1-2421).
      iv. This associatedEntity SHALL contain at least one [1..*] telecom (CONF:CDP1-2422).
      v. This associatedEntity SHALL contain exactly one [1..1] associatedPerson (CONF:CDP1-2423).
         1. This associatedPerson SHALL contain at least one [1..*] name (CONF:CDP1-2424).
      vi. This associatedEntity MAY contain zero or one [0..1] scopingOrganization (CONF:CDP1-2425).
**Figure 14: Callback Participant Example**

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

6.5.1.4 *encompassingEncounter*

A Time Boxed Document is always associated with an encounter; the id element of the *encompassingEncounter* is required to be present and represents the identifier for the encounter. When the Time Boxed Document spans more than one encounter, it should be associated with the first relevant encounter.

c. This componentOf **SHALL** contain exactly one [1..1] *encompassingEncounter* (CONF:CDP1-2426).

   i. This *encompassingEncounter* **SHALL** contain exactly one [1..1] *id* (CONF:CDP1-2427).

   ii. This *encompassingEncounter* **SHALL** contain exactly one [1..1] *effectiveTime* (CONF:CDP1-2428).
      1. The content of *effectiveTime* **SHALL** be a conformant US Realm Date and Time (DTM.US.FIELDED) (2.16.840.1.113883.10.20.22.5.4) (CONF:CDP1-2429).

   iii. This *encompassingEncounter* **SHALL** contain exactly one [1..1] *responsibleParty* (CONF:CDP1-2430).
      1. The *responsibleParty* element records only the party responsible for the encounter, not necessarily the entire episode of care (CONF:CDP1-24231).

      2. The *responsibleParty* element, **SHALL** contain an *assignedEntity* element which **SHALL** contain an *assignedPerson* element, a *representedOrganization* element, or both (CONF:CDP1-2432).
The encounterParticipant element represents persons who participated in the encounter and not necessarily the entire episode of care.

iv. This encompassing Encounter MAY contain zero or more [0..*] encounterParticipant (CONF:CDP1-2433).
   1. The encounterParticipant element, if present, records only participants in the encounter, not necessarily in the entire episode of care (CONF:CDP1-2434).
   2. An encounterParticipant element, if present, SHALL contain an assignedEntity element which SHALL contain an assignedPerson element, a representedOrganization element, or both (CONF:CDP1-2435).

8. SHALL contain exactly one [1..1] component (CONF:CDP1-2500).

6.5.2 structuredBody
   a. This component SHALL contain exactly one [1..1] structuredBody (CONF:CDP1-2501).
      i. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2502) such that it
         1. SHALL contain exactly one [1..1] Additional Documentation Section (CDP1) (CONF:CDP1-2503).
      ii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2506) such that it
          1. SHALL contain exactly one [1..1] Allergies Section (entries required) (V2) (CONF:CDP1-2507).
      iii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2510) such that it
          1. SHALL contain exactly one [1..1] Assessment and Plan Section (V2) (CONF:CDP1-2511).
      iv. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2512) such that it
          1. SHALL contain exactly one [1..1] Assessment Section (CONF:CDP1-2513).
      v. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2522) such that it
         1. SHALL contain exactly one [1..1] Externally Defined CDE Section (CDP1) (CONF:CDP1-2523).
vi. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-2526) such that it

1. **SHALL** contain exactly one [1..1] **Functional Status Section** (V2-CDP1) (CONF:CDP1-2527).

vii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-2528) such that it

1. **SHALL** contain exactly one [1..1] **General Status Section** (CONF:CDP1-2529).

viii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-2530) such that it

1. **SHALL** contain exactly one [1..1] **Goals Section (New)** (CONF:CDP1-2531).

ix. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-2532) such that it

1. **SHALL** contain exactly one [1..1] **Health Concerns Section (New)** (CONF:CDP1-2533).

x. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-2534) such that it

1. **SHALL** contain exactly one [1..1] **Health Status Evaluations/Outcomes Section (New)** (CONF:CDP1-2535).

xi. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-2536) such that it

1. **SHALL** contain exactly one [1..1] **Hospital Consultations Section** (CONF:CDP1-2537).

xii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-2538) such that it

1. **SHALL** contain exactly one [1..1] **Hospital Course Section** (CONF:CDP1-2547).

xiii. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-2558) such that it

1. **SHALL** contain exactly one [1..1] **Immunizations Section (entries required) (V2)** (CONF:CDP1-2559).
xiv. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CDP1-2560) such that it
   1. **SHALL** contain exactly one [1..1] **Implants Section (NEW)**
      (templateId:2.16.840.1.113883.10.20.22.2.33)
      (CONF:CDP1-2561).

xv. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-2562) such that it
    1. **SHALL** contain exactly one [1..1] **Instructions Section (V2)**
       (templateId:2.16.840.1.113883.10.20.22.2.45.2)
       (CONF:CDP1-2563).

xvi. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-2564) such that it
    1. **SHALL** contain exactly one [1..1] **Interventions Section (V2)**
       (templateId:2.16.840.1.113883.10.20.21.2.3.2)
       (CONF:CDP1-2565).

xvii. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-2566) such that it
    1. **SHALL** contain exactly one [1..1] **Medical Equipment Section (V2)**
       (templateId:2.16.840.1.113883.10.20.22.2.23.2)
       (CONF:CDP1-2567).

xviii. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-2572) such that it
    1. **SHALL** contain exactly one [1..1] **Medications Section (entries required) (V2)**
       (templateId:2.16.840.1.113883.10.20.22.2.1.2)
       (CONF:CDP1-2573).

xix. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-2574) such that it
    1. **SHALL** contain exactly one [1..1] **Mental Status Section (NEW-CDP1)**
       (templateId:2.16.840.1.113883.10.20.22.2.56.1.1)
       (CONF:CDP1-2575).

xx. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-2576) such that it
    1. **SHALL** contain exactly one [1..1] **Nutrition Section (NEW)**
       (templateId:2.16.840.1.113883.10.20.22.2.57)
       (CONF:CDP1-2577).

xxi. This structuredBody **SHALL** contain exactly one [1..1] **component**
    (CONF:CDP1-2578) such that it
    1. **SHALL** contain exactly one [1..1] **Objective Section**
       (templateId:2.16.840.1.113883.10.20.21.2.1)
       (CONF:CDP1-2579).
xxii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2584) such that it

1. SHALL contain exactly one [1..1] Orders Placed Section (CDP1)
   (templateId:2.16.840.1.113883.10.20.35.2.3)
   (CONF:CDP1-2585).

xxiii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2586) such that it

1. SHALL contain exactly one [1..1] Payers Section (V2)
   (templateId:2.16.840.1.113883.10.20.22.18.2)
   (CONF:CDP1-2587).

xxiv. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2588) such that it

1. SHALL contain exactly one [1..1] Physical Exam Section (V2)
   (templateId:2.16.840.1.113883.10.20.2.10.2)
   (CONF:CDP1-2589).

xxv. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2590) such that it

1. SHALL contain exactly one [1..1] Physical Findings of Skin Section (New)
   (templateId:2.16.840.1.113883.10.20.22.2.62)
   (CONF:CDP1-2591).

xxvi. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2592) such that it

1. SHALL contain exactly one [1..1] Plan of Treatment Section (V2-CDP1)
   (templateId:2.16.840.1.113883.10.20.22.2.10.1)
   (CONF:CDP1-2593).

xxvii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2602) such that it

1. SHALL contain exactly one [1..1] Problem Section (entries_required) (V2)
   (templateId:2.16.840.1.113883.10.20.22.2.5.1.2)
   (CONF:CDP1-2603).

xxviii. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2618) such that it

1. SHALL contain exactly one [1..1] Procedures Section (entries_required) (V2)
   (templateId:2.16.840.1.113883.10.20.22.2.7.1.2)
   (CONF:CDP1-2619).

xxix. This structuredBody SHALL contain exactly one [1..1] component (CONF:CDP1-2624) such that it

1. SHALL contain exactly one [1..1] Results Section (entries_required) (V2)
   (templateId:2.16.840.1.113883.10.20.22.2.3.1.2)
   (CONF:CDP1-2625).
xxx. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-2630) such that it
   1. **SHALL** contain exactly one [1..1] **Subjective Section** (templateId:2.16.840.1.113883.10.20.22.2.2) (CONF:CDP1-2631).

xxxi. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-2634) such that it
   1. **SHALL** contain exactly one [1..1] **Surgical Drains Section** (templateId:2.16.840.1.113883.10.20.7.13) (CONF:CDP1-2635).

xxxii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CDP1-2638) such that it
   1. **SHALL** contain exactly one [1..1] **Vital Signs Section (entries required) (V2)** (templateId:2.16.840.1.113883.10.20.22.2.4.1.2) (CONF:CDP1-2637).

xxxiii. **SHALL NOT** include an Assessment and Plan Section (V2) (templateId: 2.16.840.1.113883.10.20.22.2.9.2) when an Assessment Section (templateId: 2.16.840.1.113883.10.20.22.2.8) and a Plan of Treatment Section (V2-CDP1) (templateId: 2.16.840.1.113883.10.20.22.2.10.2.1) are present (CONF:CDP1-2639).
Figure 15: Time Boxed StructuredBody Sample

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<component>
  <structuredBody>
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      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.6.1.2"/>
        <!-- Alergies section template -->
        <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="48765-2"/>
        <title>Allergies, adverse reactions, alerts</title>
      </section>
    </component>
    <component>
      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.8"/>
        <!-- Assessment -->
        <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="51848-0"/>
        <title>ASSESSMENT</title>
      </section>
    </component>
    <component>
      <section>
        <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.5"/>
        <!-- History of Present Illness -->
        <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="10164-2"/>
        <title>HISTORY OF PRESENT ILLNESS</title>
      </section>
    </component>
    <component>
      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.1.1.2"/>
        <!-- MEDICATION SECTION (V2) (coded entries required) -->
        <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="10160-0"/>
        <title>MEDICATIONS</title>
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      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.1.1.1.2"/>
        <!-- Physical Exam (V2) -->
        <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="29545-1"/>
        <title>PHYSICAL EXAMINATION</title>
      </section>
    </component>
    <component>
      <section>
        <templateId root="2.16.840.1.113883.10.20.22.2.10.2"/>
        <!-- Plan of Treatment Section (V2) template -->
        <code codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" code="18776-5"/>
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</component>
```
displayName="Treatment plan"/>
<title>PLAN OF CARE</title>
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<!-- Problem Section (entries required) (V2) -->
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<!-- Procedures Section (entries optional) (V2) -->
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displayName="HISTORY OF PROCEDURES"/>
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<!-- Reason for Referral Section V2 -->
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displayName="Social History"/>
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<!-- Vital Signs -->
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<!-- Vital Signs-->
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7 SECTION-LEVEL TEMPLATES

This chapter contains the section-level templates referenced by one or more of the document types of this Complete Document Templates guide. These templates describe the purpose of each section and the section-level constraints.

Section-level templates are always included in a document. One and only one of each section type is allowed in a given document instance. Please see the document context tables to determine the sections that are contained in a given document type. Please see the conformance verb in the conformance statements to determine if it is required (SHALL), strongly recommended (SHOULD) or optional (MAY).

All section-level templates referenced by this guide are listed in Table 1. This table includes the Template Name, Source (see below), Template OID, LOINC code, and a reference to each document-level template in this guide that references the section-level template. Most section-level templates are adopted “as is” from the HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm) Draft Standard for Trial Use Release 2 (C-CDA R2) as indicated by the value in the Source column.

Source is defined as:
- CDP1 – section-level template is new and defined in this guide
- New – section-level template is new in the C-CDA R2
- V2 – section-level template from C-CDA R1.1 with a new version in C-CDA R2
- V1.1 – section-level template is in C-CDA R2 and unchanged from C-CDA R1.1
- New-CDP1 - New with additional constraints in this guide
- V2-CDP1 - V2 with additional constraints in this guide

All section-level templates that have a Source of New, V2, V1.1 are explicitly referenced to their definitions in the C-CDA R2 and are not further defined in this guide

Each section-level template contains the following:
- Template metadata (e.g., templateId, etc.)
- Description and explanatory narrative
- LOINC section code
- Section title
- Requirements for a text element
- Entry-level template names and Ids for referenced templates (required and optional)
- Narrative Text

The text element within the section stores the narrative to be rendered, as described in the CDA R2 specification, and is referred to as the CDA narrative block.

The content model of the CDA narrative block schema is hand crafted to meet requirements of human readability and rendering. The schema is registered as a MIME type (text/x-hl7-text+xml), which is the fixed media type for the text element.

As noted in the CDA R2 specification, the document originator is responsible for ensuring that the narrative block contains the complete, human readable, attested content of the section. Structured entries support computer processing and computation and are not a replacement for the attestable, human-readable content of
the CDA narrative block. The special case of structured entries with an entry relationship of "DRIV" (is derived from) indicates to the receiving application that the source of the narrative block is the structured entries, and that the contents of the two are clinically equivalent.

As for all CDA documents—even when a report consisting entirely of structured entries is transformed into CDA—the encoding application must ensure that the authenticated content (narrative plus multimedia) is a faithful and complete rendering of the clinical content of the structured source data. **As a general guideline, a generated narrative block should include the same content in human readable form that would be available to users viewing that content in the originating system.** Although content formatting in the narrative block need not be identical to that in the originating system, the narrative block should use elements from the CDA narrative block schema to provide sufficient formatting to support human readability when rendered according to the rules defined in Section Narrative Block (§ 4.3.5) of the CDA R2 specification.

By definition, a receiving application cannot assume that all clinical content in a section (i.e., in the narrative block and multimedia) is contained in the structured entries unless the entries in the section have an entry relationship of "DRIV".

Additional specification information for the CDA narrative block can be found in the CDA R2 specification in sections 1.2.1, 1.2.3, 1.3, 1.3.1, 1.3.2, 4.3.4.2, and 6.

### Table 14: Section-Level Templates

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<thead>
<tr>
<th>Section</th>
<th>Section-Level Templates</th>
<th>Source</th>
<th>Template OID</th>
<th>LOINC Code</th>
<th>Complete Encounter</th>
<th>Complete Hospitalization</th>
<th>Complete OP Note</th>
<th>Complete Procedure</th>
<th>Time Based</th>
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<td>6.1</td>
<td>Additional Documentation Section (CDP1)</td>
<td>CDP1</td>
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**New section level templates in this guide**

**Additionally constrained section level templates from C-CDA R2**

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**Unchanged sections from C-CDA R2**

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</tr>
<tr>
<td>Hospital Consultations Section</td>
<td>V1.1</td>
<td>2.16.840.1.113883.10.20.22.2.4.2</td>
<td>18841-7</td>
<td>[1..1]</td>
<td></td>
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</tr>
<tr>
<td>Hospital Course Section</td>
<td>V1.1</td>
<td>1.3.6.1.4.1.19376.1.5.3.1.1.1.1.1</td>
<td>8648-8</td>
<td>[1..1]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Discharge Diagnosis Section (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.22.2</td>
<td>11535-2</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Hospital Discharge Instructions Section</td>
<td>V1.1</td>
<td>2.16.840.1.113883.10.20.22.2.2.22.2</td>
<td>8653-8</td>
<td>[1..1]</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Discharge Medications Section (entries required) (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.22.2</td>
<td>10183-2</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Hospital Discharge Physical Section</td>
<td>V1.1</td>
<td>1.3.6.1.4.1.19376.1.5.3.1.1.1.1.1</td>
<td>10184-0</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Hospital Discharge Studies Summary Section</td>
<td>V1.1</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2</td>
<td>11493-4</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Immunizations Section (entries required) (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>11369-6</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Implants Section (New)</td>
<td>New</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>55122-6</td>
<td>[1..1]</td>
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<tr>
<td>Instructions Section (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>69730-0</td>
<td>[1..1]</td>
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<td></td>
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</tr>
<tr>
<td>Interventions Section (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>62387-6</td>
<td>[1..1]</td>
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<td></td>
</tr>
<tr>
<td>Medical (General) History Section</td>
<td>V1.1</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>11329-0</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Medical Equipment Section (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>46264-8</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Medications Administered Section (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>29549-3</td>
<td>[1..1]</td>
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<td></td>
</tr>
<tr>
<td>Medications Section (entries required) (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.2.3</td>
<td>10160-0</td>
<td>[1..1]</td>
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<td></td>
</tr>
<tr>
<td>Nutrition Section (New)</td>
<td>New</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>61144-2</td>
<td>[1..1]</td>
<td></td>
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</tr>
<tr>
<td>Objective Section</td>
<td>V1.1</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>61149-1</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Operative Note Fluid Section</td>
<td>V1.1</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>10216-0</td>
<td>[1..1]</td>
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<td></td>
</tr>
<tr>
<td>Operative Note Surgical Procedure Section</td>
<td>V1.1</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>10223-6</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Payers Section (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>48768-6</td>
<td>[1..1]</td>
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<td></td>
</tr>
<tr>
<td>Physical Exam Section (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>29545-1</td>
<td>[1..1]</td>
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<td></td>
</tr>
<tr>
<td>Physical Findings of Skin Section (New)</td>
<td>New</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>10206-1</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Planned Procedure Section (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>59772-4</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Postoperative Diagnosis Section (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>10218-6</td>
<td>[1..1]</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Postprocedure Diagnosis Section</td>
<td>V1.1</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>59769-0</td>
<td>[1..1]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preoperative Diagnosis Section (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>10219-4</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Problem Section (entries required) (V2)</td>
<td>V2</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>11450-4</td>
<td>[1..1]</td>
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</tr>
<tr>
<td>Procedure Description Section</td>
<td>V1.1</td>
<td>2.16.840.1.113883.10.20.22.2.2.2.2.3</td>
<td>29554-3</td>
<td>[1..1]</td>
<td></td>
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</tr>
</tbody>
</table>

HL7 CDA R2 IG: Additional CDA R2 Templates – Clinical Documents for Payers Set 1 Release 1

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HL7 DSTU ballot January 2015
### 7.1 Additional Documentation Section (CDP1)

[section: templateId 2.16.840.1.113883.10.20.35.2.1 (open)]

#### Table 15: Additional Documentation Section (CDP1) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Encounter Documentation (CDP1)</td>
<td>Comment Activity</td>
</tr>
<tr>
<td>Complete Hospitalization Document (CDP1)</td>
<td></td>
</tr>
<tr>
<td>Complete Operative Note Document (CDP1)</td>
<td></td>
</tr>
<tr>
<td>Complete Procedure Document (CDP1)</td>
<td></td>
</tr>
<tr>
<td>Time Boxed Document (CDP1)</td>
<td></td>
</tr>
</tbody>
</table>

This section contains additional documentation captured by the provider related to care provided or planned for the patient that is not supported in any other section of the document. (example – physicians rationale for decision – verify not included in any other section)

1. **SHALL** contain exactly one [1..1] `templateId` (CONF:CDP1-2701) such that it
   a. **SHALL** contain exactly one [1..1] 
      `@root="2.16.840.1.113883.10.20.35.2.1"` (CONF:CDP1-2702).
2. **SHALL** contain exactly one [1..1] `code` (CONF:CDP1-2703).
   a. This code **SHALL** contain exactly one [1..1] `@code="TBD"` Additional Documentation (CONF:CDP1-2704).
   b. This code **SHALL** contain exactly one [1..1] 
      `@codeSystem="2.16.840.1.113883.6.1"` (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:CDP1-2705).
3. **SHALL** contain exactly one [1..1] `title` (CONF:CDP1-2706).
4. SHALL contain exactly one [1..1] text (CONF:CDP1-2707).
5. SHALL contain one or more [1..*] entry (CONF:CDP1-2708) such that it
   a. SHALL contain exactly one [1..1] Comment Activity
      (templateId:2.16.840.1.113883.10.20.22.4.75.2) (CONF:CDP1-2709).

**Figure 16: Additional Documentation Section (CDP1) Example**

```
<component>
  <section>
    <templateId root=""/>
    <!-**** Additional Documentation Section CDP1 template **** -->
    <code code="" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
           displayName=""/>
    <title>Additional Documentation</title>
    <text>
      ...
    </text>
    <entry>
      ...
    </entry>
    <entry>
      ...
    </entry>
    <entry>
      ...
    </entry>
  </section>
</component>
```

7.2 Externally Defined Clinical Data Elements Section (CDP1)
[section: templateId 2.16.840.1.113883.10.20.35.2.2 (open)]

**Table 16: Externally Defined Clinical Data Elements Section (CDP1) Contexts**

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Encounter Documentation (CDP1)</td>
<td>Externally Defined CDE Organizer (CDP1)</td>
</tr>
<tr>
<td>Complete Hospitalization Document (CDP1)</td>
<td></td>
</tr>
<tr>
<td>Complete Operative Note Document (CDP1)</td>
<td></td>
</tr>
<tr>
<td>Complete Procedure Document (CDP1)</td>
<td></td>
</tr>
<tr>
<td>Time Boxed Document (CDP1)</td>
<td></td>
</tr>
</tbody>
</table>

This section contains externally defined Clinical Data Elements that may be created through the interaction of the provider with templates (internal to the EHR or externally defined) that store XML tagged name-value pairs or more complex XML tagged information/content models and a reference to the externally defined...
information/content model, value set or clinical vocabulary. The referenced content model, value set or clinical vocabulary shall be pointed to by a URI in the Externally Defined CDA organizer and the specific XML tagged data shall be included in the Externally Defined CDE template.

1. **SHALL** contain exactly one [1..1] `templateId` (CONF:CDP1-2801) such that it
   a. **SHALL** contain exactly one [1..1] @root="2.16.840.1.113883.10.20.35.2.2" (CONF:CDP1-2802).

2. **SHALL** contain exactly one [1..1] `code` (CONF:CDP1-2803).
   a. This code **SHALL** contain exactly one [1..1] @code="TBD" (CONF:CDP1-2804).
   b. This code **SHALL** contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:CDP1-2805).

3. **SHALL** contain exactly one [1..1] `title` (CONF:CDP1-2806).

4. **SHALL** contain exactly one [1..1] `text` (CONF:CDP1-2807).

5. **SHALL** contain one or more [1..*] `entry` (CONF:CDP1-2808).
   a. The entry **SHALL** contain exactly one [1..1] Externally Defined CDE Organizer (CDP1) templateId:2.16.840.1.113883.10.20.35.4.1) (CONF:CDP1-2809).

*Figure 17: Externally Defined Clinical Data Elements Section Example*

```xml
<section>
  <templateId root="2.16.840.1.113883.10.20.22.35.2.2"/>
  <code code="TBD" codeSystem="2.16.840.1.113883.6.1"
         codeSystemName="LOINC"
         displayName="------------------------"/>
  <title>Externally Defined Clinical Data Elements</title>
  <text>External CDEs</text>
  <entry>
    <act classCode="ACT" moodCode="EVN">
      <!-- Externally Defined CDE Organizer Template -->
      ...
    </act>
  </entry>
</section>
```
7.3 Orders Placed Section (CDP1)

Table 17: Orders Placed Section (CDP1) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Encounter Documentation (CDP1)</td>
<td>Act Order (CDP1)</td>
</tr>
<tr>
<td>Complete Hospitalization Document (CDP1)</td>
<td>Encounter Order (CDP1)</td>
</tr>
<tr>
<td>Complete Operative Note Document (CDP1)</td>
<td>Medication Activity Order (CDP1)</td>
</tr>
<tr>
<td>Complete Procedure Document (CDP1)</td>
<td>Observation Order (CDP1)</td>
</tr>
<tr>
<td>Time Boxed Document (CDP1)</td>
<td>Procedure Order (CDP1)</td>
</tr>
<tr>
<td></td>
<td>Supply Order (CDP1)</td>
</tr>
</tbody>
</table>

This section contains data that defines orders for observations, interventions, encounters, services, and procedures for the patient. It includes orders that have been entered into an EHR. These are indicated by the @moodCode RQO and statusCode completed or active for the entries within this section. The entries in this section represent the details of the orders and not the acts involved in the processing and fulfillment of the order. The process of and fulfillment of the order is represented by other entries.

Any entry-level template for which data is not available (not collected, not relevant, not supported by the EHR technology, etc.) SHALL have the appropriate nullFlavor specified as affirmative attestation that the information was not available (see section 3.4 regarding the use of nullFlavors).

1. SHALL contain exactly one [1..1] templateId (CONF:CDP1-2901) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.35.2.3" (CONF:CDP1-2902).
2. SHALL contain exactly one [1..1] code (CONF:CDP1-2903).
   a. This code SHALL contain exactly one [1..1] @code="TBD" Orders Placed (CONF:CDP1-2904).
   b. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:CDP1-2905).
3. SHALL contain exactly one [1..1] title (CONF:CDP1-2906).
4. SHALL contain exactly one [1..1] text (CONF:CDP1-2907).
5. SHALL contain one or more [1..*] entry (CONF:CDP1-208) such that it
   a. SHALL contain exactly one [1..1] Act Order (CDP1)
      (templateId:2.16.840.1.113883.10.20.35.4.1) (CONF:CDP1-2909).
6. SHALL contain one or more [1..*] entry (CONF:CDP1-2910) such that it
   a. SHALL contain exactly one [1..1] Encounter Order (CDP1)
      (templateId:2.16.840.1.113883.10.20.35.4.2) (CONF:CDP1-2911).
7. SHALL contain one or more [1..*] entry (CONF:CDP1-2912) such that it
   a. SHALL contain exactly one [1..1] Medication Activity Order (CDP1)
      (templateId: 2.16.840.1.113883.10.20.35.4.5) (CONF:CDP1-2913).
8. SHALL contain one or more [1..*] entry (CONF:CDP1-2914) such that it
   a. SHALL contain exactly one [1..1] Observation Order (CDP1)
      (templateId:2.16.840.1.113883.10.20.35.4.6) (CONF:CDP1-2915).
9. SHALL contain one or more [1..*] entry (CONF:CDP1-2916) such that it
a. **SHALL** contain exactly one [1..1] **Procedure Order (CDP1)**
   (templateId:2.16.840.1.113883.10.20.35.4.7) (CONF:CDP1-2917).

10. **SHALL** contain one or more [1..*] entry (CONF:CDP1-2918) such that it
    a. **SHALL** contain exactly one [1..1] **Supply Order (CDP1)**
       (templateId:2.16.840.1.113883.10.20.35.4.8) (CONF:CDP1-2919).

**Figure 18: Placed Orders Section (CDP1) Example**

```xml
<component>
  <section>
    <templateId root="2.16.840.1.113883.10.20.35.2.3"/>
    <!-- ***** Placed Orders Section CDP1 template ***** -->
    <code code="TBD" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
          displayName="Placed Orders"/>
    <title>PLACED ORDERS</title>
    <text>
      ...
    </text>
    <entry>
      <act classCode="ACT" moodCode="RQO">
        ...
      </act>
    </entry>
    <entry>
      <encounter moodCode="INT" classCode="ENC">
        <templateId root="/">
        <!-- Encounter Order V2 template -->
        ...
      </encounter>
    </entry>
  </section>
</component>
```

### 7.4 Transportation Section (CDP1)
[section: templateId 2.16.840.1.113883.10.20.35.2.4 (open)]

**Table 18: Transportation Section Contexts**

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Encounter Documentation (CDP1)</td>
<td></td>
</tr>
<tr>
<td>Complete Hospitalization Document (CDP1)</td>
<td></td>
</tr>
</tbody>
</table>

The Transportation Section describes in a narrative format the transportation method (such as emergency transport), other than the patient’s or caregiver’s personal transportation, that was used to bring the patient to the location for the current encounter. This information is normally provided as a summary by the entity that provides the transportation service.
1. **SHALL** contain exactly one [1..1] **templateId** (CONF:CDP1-:3001) such that it
   a. **SHALL** contain exactly one [1..1] 
      @root="2.16.840.1.113883.10.20.35.2.4" (CONF:CDP1-3002).
2. **SHALL** contain exactly one [1..1] **code** (CONF:CDP1-3003).
   a. This code **SHALL** contain exactly one [1..1] @code="TBD" Transportation (CONF:CDP1-3004).
   b. This code **SHALL** contain exactly one [1..1] 
      @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:CDP1-3005).
3. **SHALL** contain exactly one [1..1] **title** (CONF:CDP1-3006).
4. **SHALL** contain exactly one [1..1] **text** (CONF:CDP1-3007).

**Figure 19: Transportation Section (CDP1) Example**

```xml
<section>
  <templateId root="2.16.840.1.113883.10.20.35.2.4" />
  <code code="TBD" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Transportation" />
  <title>Transportation Information</title>
  <text>
    <paragraph>
      The patient was transported by Emergency Medical Services from home which was 12.5 miles from the Emergency Department ...
    </paragraph>
  </text>
</section>
```

7.5 *Functional Status Section (V2-CDP1)*

[section: templateId 2.16.840.1.113883.10.20.22.2.14.2.1 (open)]

**Table 19: Functional Status Section (V2-CDP1) Contexts**

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Encounter Documentation (CDP1)</td>
<td>Assessment Scale Observation</td>
</tr>
<tr>
<td>Complete Hospitalization Document (CDP1)</td>
<td>Caregiver Characteristics</td>
</tr>
<tr>
<td>Time Boxed Document (CDP1)</td>
<td>Functional Status Observation (V2)</td>
</tr>
<tr>
<td></td>
<td>Functional Status Organizer (V2)</td>
</tr>
<tr>
<td></td>
<td>Non-Medicinal Supply Activity (V2)</td>
</tr>
<tr>
<td></td>
<td>Self-Care Activities (ADL and IADL) (NEW)</td>
</tr>
<tr>
<td></td>
<td>Sensory and Speech Status (NEW)</td>
</tr>
</tbody>
</table>

The Functional Status Section contains observations and assessments of a patient’s physical abilities. A patient’s functional status may include information regarding the patient’s general function such as ambulation, ability to perform Activities of Daily Living (ADLs) (e.g., bathing, dressing, feeding, grooming) or Instrumental Activities of Daily Living (IADLs) (e.g., shopping, using a telephone, balancing a check book). Problems that impact function (e.g., dyspnea, dysphagia) can be contained in the section.

This Functional Status Section variant has additional constraints with regard to the entry level templates. If information for an entry level template does not exist, the
appropriate nullFlavor may be supplied as an attestation that the information does not exist or cannot be shared (see section 3.4 regarding the use of nullFlavors).

1. **SHALL** contain exactly one [1..1] `templateId` (CONF:CDP1-3101) such that it
   a. **SHALL** contain exactly one [1..1] `@root="2.16.840.1.113883.10.20.22.2.14.2.1"` (CONF:CDP1-3102).

2. **SHALL** contain exactly one [1..1] `code` (CONF:CDP1-3103).
   a. This code **SHALL** contain exactly one [1..1] `@code="47420-5"` Functional Status (CONF:CDP1-3104).
   b. This code **SHALL** contain exactly one [1..1] `@codeSystem="2.16.840.1.113883.6.1"` (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:CDP1-3105).

3. **SHALL** contain exactly one [1..1] `title` (CONF:CDP1-3106).

4. **SHALL** contain exactly one [1..1] `text` (CONF:CDP1-3107).

5. **SHALL** contain one or more [1..*] `entry` (CONF:CDP1-3108) such that it
   a. **SHALL** contain exactly one [1..1] **Functional Status Organizer (V2)** (templateId:2.16.840.1.113883.10.20.22.4.66.2) (CONF:CDP1-3109).

6. **SHALL** contain one or more [1..*] `entry` (CONF:CDP1-3110) such that it
   a. **SHALL** contain exactly one [1..1] **Functional Status Observation (V2)** (templateId:2.16.840.1.113883.10.20.22.4.67.2) (CONF:CDP1-3111).

7. **SHALL** contain one or more [1..*] `entry` (CONF:CDP1-3112) such that it
   a. **SHALL** contain exactly one [1..1] **Caregiver Characteristics** (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:CDP1-3113).

8. **SHALL** contain one or more [1..*] `entry` (CONF:CDP1-3114) such that it
   a. **SHALL** contain exactly one [1..1] **Assessment Scale Observation** (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:CDP1-3115).

9. **SHALL** contain one or more [1..*] `entry` (CONF:CDP1-3116) such that it
   a. **SHALL** contain exactly one [1..1] **Non-Medicinal Supply Activity (V2)** (templateId:2.16.840.1.113883.10.20.22.4.50.2) (CONF:CDP1-3117).

10. **SHALL** contain one or more [1..*] `entry` (CONF:CDP1-3118) such that it
    a. **SHALL** contain exactly one [1..1] **Self-Care Activities (ADL and IADL) (NEW)** (templateId:2.16.840.1.113883.10.20.22.4.128) (CONF:CDP1-3119).

11. **SHALL** contain one or more [1..*] `entry` (CONF:CDP1-3120) such that it
    a. **SHALL** contain exactly one [1..1] **Sensory and Speech Status (NEW)** (templateId:2.16.840.1.113883.10.20.22.4.127) (CONF:CDP1-3121).
Figure 20: Functional Status Section (V2-CDP1) Example

```xml
<section>
  <templateId root="2.16.840.1.113883.10.20.22.2.14.2.1" />
  <!-- Functional Status Section (V2-CDP1) template -->
  <code code="47420-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" display="Functional Status" />
  <title>FUNCTIONAL STATUS</title>
  <text>
  ...
  </text>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Self Care Activities (NEW) -->
      <templateId root="2.16.840.1.113883.10.20.22.4.128" />
      ...
    </observation>
  </entry>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Assessment Scale Observation -->
      <templateId root="2.16.840.1.113883.10.20.22.4.69" />
      ...
    </observation>
  </entry>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Non-Medicinal Supply Activity (V2) -->
      <templateId root="2.16.840.1.113883.10.20.22.4.50.2" />
      ...
    </observation>
  </entry>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Sensory and Speech Status(NEW) -->
      <templateId root="2.16.840.1.113883.10.20.22.4.127" />
      ...
    </observation>
  </entry>
  <entry>
    <organizer classCode="CLUSTER" moodCode="EVN">
      <!-- Functional Status Organizer (V2) -->
      <templateId root="2.16.840.1.113883.10.20.22.4.66.2" />
      ...
    </organizer>
  </entry>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Functional Status Observation (V2) -->
      <templateId root="2.16.840.1.113883.10.20.22.4.67.2" />
      ...
    </observation>
  </entry>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Caregiver characteristics -->
      <templateId root="2.16.840.1.113883.10.20.22.4.72" />
      ...
    </observation>
  </entry>
</section>
```
7.6 Mental Status Section (NEW-CDP1)

Table 20: Mental Status Section (NEW-CDP1) Contexts

<table>
<thead>
<tr>
<th>-contained By</th>
<th>Contains:</th>
</tr>
</thead>
</table>

The Mental Status Section contains observation and evaluations related to patient’s psychological and mental competency and deficits including cognitive functioning (e.g., mood, anxiety, perceptual disturbances) and cognitive ability (e.g., concentration, intellect, visual-spatial perception).

This Mental Status Section variant has additional constraints with regard to the entry level templates. If information for an entry level template does not exist, the appropriate nullFlavor may be supplied as an attestation that the information does not exist or cannot be shared (see section 3.4 regarding the use of nullFlavors).

1. SHALL contain exactly one [1..1] templateId (CONF:CDP1-3201) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.56.1.1" (CONF:CDP1-3202).
2. SHALL contain exactly one [1..1] code (CONF:CDP1-3203).
   a. This code SHALL contain exactly one [1..1] @code="10190-7" Mental Status (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:CDP1-3204).
   b. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CONF:CDP1-3205).
3. SHALL contain exactly one [1..1] title (CONF:CDP1-3206).
4. SHALL contain exactly one [1..1] text (CONF:CDP1-3207).
5. SHALL contain one or more [1..*] entry (CONF:CDP1-3208) such that it
   a. SHALL contain exactly one [1..1] Cognitive Status Organizer (V2) (templateId:2.16.840.1.113883.10.20.22.4.75.2) (CONF:CDP1-3209).
6. SHALL contain one or more [1..*] entry (CONF CDP13210) such that it
   a. SHALL contain exactly one [1..1] Cognitive Status Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.74.2) (CONF:CDP1-3211).
7. SHALL contain one or more [1..*] entry (CONF:CDP1-3212) such that it
   a. SHALL contain exactly one [1..1] Caregiver Characteristics (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:CDP1-3213).
8. SHALL contain one or more [1..*] entry (CONF:CDP1-3214) such that it
a. **SHALL** contain exactly one [1..1] *Assessment Scale Observation*
   (templateId:2.16.840.1.113883.10.20.22.4.69) (CONF:CDP1-3215).

9. **SHALL** contain one or more [1..*] **entry** (CONF:CDP1-3216) such that it
   a. **SHALL** contain exactly one [1..1] *Non-Medicinal Supply Activity (V2)*
      (templateId:2.16.840.1.113883.10.20.22.4.50.2) (CONF:CDP1-3217).

10. **SHALL** contain one or more [1..*] **entry** (CONF:CDP1-3218) such that it
    a. **SHALL** contain exactly one [1..1] *Cognitive Abilities Observation (NEW)*
       (templateId:2.16.840.1.113883.10.20.22.4.126) (CONF:CDP1-3219).

11. **SHALL** contain one or more [1..*] **entry** (CONF:CDP1-3220) such that it
    a. **SHALL** contain exactly one [1..1] *Mental Status Observation (NEW)*
       (templateId:2.16.840.1.113883.10.20.22.4.125) (CONF:CDP1-3221).
Figure 21: Mental Status Section (New-CDP1) Example

```xml
<section>
  <templateId root="2.16.840.1.113883.10.20.22.2.56.1.1"/>
  <!-- Mental Status Section (New-CDP1) template -->
  <code code="10190-7" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="MENTAL STATUS"/>
  <title>MENTAL STATUS</title>
  <text>
    ...
  </text>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Assessment Scale Observation -->
      <templateId root="2.16.840.1.113883.10.20.22.4.69"/>
      ...
    </observation>
  </entry>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Caregiver characteristics -->
      <templateId root="2.16.840.1.113883.10.20.22.4.72"/>
      ...
    </observation>
  </entry>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Non-Medicinal Supply Activity (V2) template -->
      <templateId root="2.16.840.1.113883.10.20.22.4.50.2"/>
      ...
    </observation>
  </entry>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Mental Status Observation (NEW) -->
      <templateId root="2.16.840.1.113883.10.20.22.4.125"/>
      ...
    </observation>
  </entry>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Cognitive Abilities Observation (NEW) -->
      <templateId root="2.16.840.1.113883.10.20.22.4.126"/>
      ...
    </observation>
  </entry>
  <entry>
    <observation classCode="OBS" moodCode="EVN">
      <!-- Cognitive Status Observation V2 -->
      <templateId root="2.16.840.1.113883.10.20.22.4.74.2"/>
      ...
    </observation>
  </entry>
  <entry>
    <organizer classCode="CLUSTER" moodCode="EVN">
      <!-- Cognitive Status Organizer V2 -->
      <templateId root="2.16.840.1.113883.10.20.22.4.75.2"/>
      ...
    </organizer>
  </entry>
</section>
```
7.7 Plan of Treatment Section (V2-CDP1)

Table 21: Plan of Treatment Section (V2-CDP1) Contexts:

<table>
<thead>
<tr>
<th>Contained By</th>
<th>Contains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Encounter Documentation (CDP1)</td>
<td>Handoff Communication (NEW)</td>
</tr>
<tr>
<td>Complete Hospitalization Document (CDP1)</td>
<td>Instruction [V2]</td>
</tr>
<tr>
<td>Complete Operative Note Document (CDP1)</td>
<td>Nutrition Recommendations (NEW)</td>
</tr>
<tr>
<td>Complete Procedure Document (CDP1)</td>
<td>Planned Act [V2]</td>
</tr>
<tr>
<td>Time Boxed Document (CDP1)</td>
<td>Planned Encounter [V2]</td>
</tr>
<tr>
<td></td>
<td>Planned Medication Activity [V2]</td>
</tr>
<tr>
<td></td>
<td>Planned Observation [V2]</td>
</tr>
<tr>
<td></td>
<td>Planned Procedure [V2]</td>
</tr>
<tr>
<td></td>
<td>Planned Supply [V2]</td>
</tr>
</tbody>
</table>

This section contains data that defines pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only. These are indicated by the @moodCode of the entries within this section. All active, incomplete, or pending orders, appointments, referrals, procedures, services, or any other pending event of clinical significance to the current care of the patient should be listed.

This section may also contain information about ongoing care of the patient, clinical reminders, patient’s values, beliefs, preferences, care expectations, and overarching care goals.

Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and health-care quality improvements, including widely accepted performance measures.

Values may include the importance of quality of life over longevity. These values are taken into account when prioritizing all problems and their treatments.

Beliefs may include comfort with dying or the refusal of blood transfusions because of the patient’s religious convictions.

Preferences may include liquid medicines over tablets, or treatment via secure email instead of in person.

Care expectations may range from being treated only by female clinicians, to expecting all calls to be returned within 24 hours.

Overarching goals described in this section are not tied to a specific condition, problem, health concern, or intervention. Examples of overarching goals could be to minimize pain or dependence on others, or to walk a daughter down the aisle for her marriage.

The plan may also indicate that patient education will be provided.

This Plan of Treatment Section variant has additional constraints with regard to the entry level templates. If information for an entry level template does not exist, the appropriate nullFlavor may be supplied as an attestation that the information does not exist or cannot be shared (see section 3.4 regarding the use of nullFlavors).
1. SHALL contain exactly one [1..1] templateId (CONF:CDP1-3301) such that it
   a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.10.2.1" (CONF:CDP1-3302).
2. SHALL contain exactly one [1..1] code (CONF:CDP1-3303).
   a. This code SHALL contain exactly one [1..1] @code="18776-5" Plan of Treatment (CodeSystem: LOINC 2.16.840.1.113883.6.1 STATIC) (CONF:CDP1-3304).
   b. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CONF:CDP1-3305).
3. SHALL contain exactly one [1..1] title (CONF:CDP1-3306).
4. SHALL contain exactly one [1..1] text (CONF:CDP1-3307).
5. SHALL contain one or more [1..*] entry (CONF:CDP1-3308) such that it
   a. SHALL contain exactly one [1..1] Planned Observation (V2)
      (templateId:2.16.840.1.113883.10.20.22.4.44.2) (CONF:CDP1-3309).
6. SHALL contain one or more [1..*] entry (CONF:CDP1-3310) such that it
   a. SHALL contain exactly one [1..1] Planned Encounter (V2)
      (templateId:2.16.840.1.113883.10.20.22.4.40.2) (CONF:CDP1-3311).
7. SHALL contain one or more [1..*] entry (CONF:CDP1-3312) such that it
   a. SHALL contain exactly one [1..1] Planned Act (V2)
      (templateId:2.16.840.1.113883.10.20.22.4.39.2) (CONF:CDP1-3313).
8. SHALL contain one or more [1..*] entry (CONF:CDP1-3314) such that it
   a. SHALL contain exactly one [1..1] Planned Procedure (V2)
      (templateId:2.16.840.1.113883.10.20.22.4.41.2) (CONF:CDP1-3315).
9. SHALL contain one or more [1..*] entry (CONF:CDP1-3316) such that it
   a. SHALL contain exactly one [1..1] Planned Medication Activity (V2)
      (templateId:2.16.840.1.113883.10.20.22.4.42.2) (CONF:CDP1-3317).
10. SHALL contain one or more [1..*] entry (CONF:CDP1-3318) such that it
    a. SHALL contain exactly one [1..1] Planned Supply (V2)
       (templateId:2.16.840.1.113883.10.20.22.4.43.2) (CONF:CDP1-3319).
11. SHALL contain one or more [1..*] entry (CONF:CDP1-3320) such that it
    a. SHALL contain exactly one [1..1] Instruction (V2)
       (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:CDP1-3321).
12. SHALL contain one or more [1..*] entry (CONF:CDP1-3322) such that it
    a. SHALL contain exactly one [1..1] Handoff Communication (NEW)
       (templateId:2.16.840.1.113883.10.20.22.4.141) (CONF:CDP1-3323).
13. SHALL contain one or more [1..*] entry (CONF:CDP1-3324) such that it
    a. SHALL contain exactly one [1..1] Nutrition Recommendations (NEW)
       (templateId:2.16.840.1.113883.10.20.22.4.130) (CONF:CDP1-3325).
7.8 Social History Section (V2-CDP1)

Table 22: Social History Section (V2-CDP1) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Encounter Documentation (CDP1)</td>
<td>Caregiver Characteristics</td>
</tr>
<tr>
<td>Complete Hospitalization Document (CDP1)</td>
<td>Characteristics of Home Environment (NEW)</td>
</tr>
<tr>
<td>Complete Procedure Document (CDP1)</td>
<td>Cultural and Religious Observation (NEW)</td>
</tr>
<tr>
<td></td>
<td>Current Smoking Status (V2)</td>
</tr>
<tr>
<td></td>
<td>Pregnancy Observation</td>
</tr>
<tr>
<td></td>
<td>Social History Observation (V2)</td>
</tr>
<tr>
<td></td>
<td>Tobacco Use (V2)</td>
</tr>
</tbody>
</table>

This section contains social history data that influences a patient’s physical, psychological or emotional health (e.g. smoking status, pregnancy). Demographic data, such as marital status, race, ethnicity, and religious affiliation, is captured in the header.

This Social History Section variant has additional constraints with regard to the entry level templates. If information for an entry level template does not exist, the appropriate nullFlavor may be supplied as an attestation that the information does not exist or cannot be shared (see section 3.4 regarding the use of nullFlavors).
1. SHALL contain exactly one [1..1] templateId (CONF:7936) such that it
   a. SHALL contain exactly one [1..1]
      @root="2.16.840.1.113883.10.20.22.2.17.2" (CONF:CDP1-3401).

2. SHALL contain exactly one [1..1] code (CONF:CDP1-3402).
   a. This code SHALL contain exactly one [1..1] @code="29762-2" Social History
      (CONF:CDP1-3403).
   b. This code SHALL contain exactly one [1..1]
      @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:CDP1-3404).

3. SHALL contain exactly one [1..1] title (CONF:CDP1-3405).
4. SHALL contain exactly one [1..1] text (CONF:CDP1-3406).
5. SHALL contain one or more [1..*] entry (CONF:CDP1-3407) such that it
   a. SHALL contain exactly one [1..1] Social History Observation (V2) (templateId:2.16.840.1.113883.10.20.22.4.38.2) (CONF:CDP1-3408).
6. SHALL contain one or more [1..*] entry (CONF:CDP1-3409) such that it
   a. SHALL contain exactly one [1..1] Pregnancy Observation (templateId:2.16.840.1.113883.10.20.15.3.8) (CONF:CDP1-3410).
7. SHALL contain one or more [1..*] entry (CONF:CDP1-3411) such that it
   a. SHALL contain exactly one [1..1] Current Smoking Status (V2) (templateId:2.16.840.1.113883.10.20.22.4.78.2) (CONF:CDP1-3412).
8. SHALL contain one or more [1..*] entry (CONF:CDP1-3413) such that it
   a. SHALL contain exactly one [1..1] Tobacco Use (V2) (templateId:2.16.840.1.113883.10.20.22.4.85.2) (CONF:CDP1-3414).
9. SHALL contain one or more [1..*] entry (CONF:CDP1-3415) such that it
   a. SHALL contain exactly one [1..1] Caregiver Characteristics (templateId:2.16.840.1.113883.10.20.22.4.72) (CONF:CDP1-3416).
10. SHALL contain one or more [1..*] entry (CONF:CDP1-3417) such that it
    a. SHALL contain exactly one [1..1] Cultural and Religious Observation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.111) (CONF:CDP1-3418).
11. SHALL contain one or more [1..*] entry (CONF:CDP1-3419) such that it
    a. SHALL contain exactly one [1..1] Characteristics of Home Environment (NEW) (templateId:2.16.840.1.113883.10.20.22.4.109) (CONF:CDP1-3420).
Figure 23: Social History Section (V2-CDP1) Example

```xml
<component>
  <section>
    <templateId root="2.16.840.1.113883.10.20.22.2.17.2.1"/>
    <!-- *** Social History Section V2-CDP1 template *** -->
    <code code="29762-2" codeSystem="2.16.840.1.113883.6.1" displayName="Social History"/>
    <title>SOCIAL HISTORY</title>
    <text>
      ...
    </text>
    <entry>
      <observation classCode="OBS" moodCode="EVN">
        <!-- Social history observation V2-->
        <templateId root="2.16.840.1.113883.10.20.22.4.38.2"/>
        ...
      </observation>
    </entry>
    <entry>
      <observation classCode="OBS" moodCode="EVN">
        <!-- ** Current smoking status observation ** -->
        <templateId root="2.16.840.1.113883.10.20.22.4.78.2"/>
        ...
      </observation>
    </entry>
    <entry>
      <observation classCode="OBS" moodCode="EVN">
        <!-- Caregiver Characteristics -->
        <templateId root="2.16.840.1.113883.10.20.22.4.72"/>
        ...
      </observation>
    </entry>
    <entry>
      <observation classCode="OBS" moodCode="EVN">
        <!-- **Cultural and Religious Observations(NEW)** -->
        <templateId root="2.16.840.1.113883.10.20.22.4.111"/>
        ...
      </observation>
    </entry>
    <entry>
      <observation classCode="OBS" moodCode="EVN">
        <!-- ** Characteristics of Care Environment** -->
        <templateId root="2.16.840.1.113883.10.20.22.4.109"/>
        ...
      </observation>
    </entry>
  </section>
</component>
```
This chapter describes the clinical statement entry templates used within the sections of the additional attachment template documents. Entry templates contain constraints that are required for conformance.

Entry-level templates are always in sections.

Each entry-level template description contains the following information:

- Key template metadata (e.g., templateId, etc.)
- Description and explanatory narrative.
- Required CDA acts, participants and vocabularies.
- Optional CDA acts, participants and vocabularies.

Several entry-level templates require an effectiveTime:

The effectiveTime of an observation is the time interval over which the observation is known to be true. The low and high values should be as precise as possible, but no more precise than known. While CDA has multiple mechanisms to record this time interval (e.g., by low and high values, low and width, high and width, or center point and width), we constrain most to use only the low/high form. The low value is the earliest point for which the condition is known to have existed. The high value, when present, indicates the time at which the observation was no longer known to be true. The full description of effectiveTime and time intervals is contained in the CDA R2 normative edition.

Provenance in entry templates:

As in Release 2 of the Consolidated CDA, there is a “SHOULD” Author constraint on several entry-level templates. Authorship and Author timestamps must be explicitly asserted in these cases, unless the values propagated from the document header hold true.

ID in entry templates:

Entry-level templates may also describe an ID element, which is an identifier for that entry. This ID may be referenced within the document, or by the system receiving the document. The ID assigned must be globally unique.

For this guide, any entry level templates that are explicitly referenced C-CDA R2 section-level templates (New, V2, V1.1) and additionally constrained C-CDA R2 section-level templates (New-CDP1, V2-CDP1) are defined only in the C-CDA R2. The only entry-level templates defined in this guide are those referenced by the section-level templates defined in this guide (CDP1).

All entry-level templates referenced directly by this guide (not by reference to sections contained in the C-CDA R2) are listed in Table 23. This table give the Template Name, Source (see below), and Template OID. Most entry-level templates are adopted “as is” from the HL7 Implementation Guide for CDA® Release 2:Consolidated CDA Templates for Clinical Notes (US Realm) Draft Standard for Trial Use Release 2 (C-CDA R2) as indicated by the value in the Source column.

Source is defined as:
- CDP1 - entry-level template is new and defined in this guide
- New - entry-level template is new in the C-CDA R2
- V2 - entry-level template from C-CDA R1.1 with new version in C-CDA R2
- V1.1 - entry-level template is in C-CDA R2 and unchanged from C-CDA R1.1

All entry-level templates that have a Source of New, V2, V1.1 are explicitly referenced to their definitions in the C-CDA R2 and are not further defined in this guide

<table>
<thead>
<tr>
<th>Table 23: Entry-Level Templates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section</strong></td>
</tr>
<tr>
<td>7.1</td>
</tr>
<tr>
<td>7.2</td>
</tr>
<tr>
<td>7.3</td>
</tr>
<tr>
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<td>7.6</td>
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<td>7.7</td>
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<td>7.8</td>
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<td>7.35</td>
</tr>
<tr>
<td>7.36</td>
</tr>
</tbody>
</table>

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### 8.1 Act Order (CDP1)

![Image](https://via.placeholder.com/150)

[act: templateID 2.16.840.1.113883.10.20.35.4.1 (open)]

<table>
<thead>
<tr>
<th>Table 24: Act Order (CDP1) Contexts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contained By</td>
</tr>
<tr>
<td>Orders Placed Section (CDP1)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

This template represents ordering acts that are not classified as an observation or a procedure according to the HL7 RIM. Examples of these acts are a dressing change, the teaching or feeding of a patient or the providing of comfort measures.

The priority of the activity to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference. The effectiveTime indicates the time when the order took place.

Note: the Act Order (CDP1) template is a copy of the C-CDA R2 Planned Act (V2) template (2.16.840.1.113883.10.20.22.4.39.2) with additional constraints on moodCode and statusCode to select only placed orders (moodCode = RQO and statusCode = completed or active). A new OID was assigned along with new conformance statements because of the change in name to reflect the use of the entry level template and the additional constraints.
### Table 25: Act Order (CDP1) Constraints Overview

<table>
<thead>
<tr>
<th>XPath</th>
<th>Card.</th>
<th>Verb</th>
<th>Data Type</th>
<th>CONF#</th>
<th>Fixed Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>act[templateId/@root = '2.16.840.1.113883.10.20.22.4.39.2']</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>@classCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1350</td>
<td>2.16.840.1.113883.5.6 (HL7ActClass) = ACT</td>
</tr>
<tr>
<td>@moodCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1350</td>
<td>2.16.840.1.113883.11.20.9.2 moodCode = RQO</td>
</tr>
<tr>
<td>templateId</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1350</td>
<td></td>
</tr>
<tr>
<td>@root</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1350</td>
<td>2.16.840.1.113883.10.20.35.4.1</td>
</tr>
<tr>
<td>id</td>
<td>1..*</td>
<td>SHALL</td>
<td></td>
<td>CDP1350</td>
<td></td>
</tr>
<tr>
<td>code</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1350</td>
<td></td>
</tr>
<tr>
<td>statusCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1350</td>
<td>2.16.840.1.113883.10.20.35.6.1 (ActStatus2)</td>
</tr>
<tr>
<td>effectiveTime</td>
<td>0..1</td>
<td>SHOULD</td>
<td></td>
<td>CDP1350</td>
<td></td>
</tr>
<tr>
<td>performer</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP1351</td>
<td></td>
</tr>
<tr>
<td>author</td>
<td>0..1</td>
<td>SHOULD</td>
<td></td>
<td>CDP1351</td>
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</tr>
<tr>
<td>entryRelationship</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP1351</td>
<td></td>
</tr>
<tr>
<td>@typeCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1351</td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR</td>
</tr>
<tr>
<td>observation</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1351</td>
<td></td>
</tr>
<tr>
<td>entryRelationship</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP1351</td>
<td></td>
</tr>
<tr>
<td>@typeCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1351</td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR</td>
</tr>
<tr>
<td>observation</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1351</td>
<td></td>
</tr>
<tr>
<td>entryRelationship</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP1351</td>
<td></td>
</tr>
<tr>
<td>@typeCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1351</td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON</td>
</tr>
<tr>
<td>observation</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1352</td>
<td></td>
</tr>
<tr>
<td>entryRelationship</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP1352</td>
<td></td>
</tr>
<tr>
<td>@typeCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1352</td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ</td>
</tr>
<tr>
<td>act</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1352</td>
<td></td>
</tr>
</tbody>
</table>
1. **SHALL** contain exactly one [1..1] `@classCode`="ACT" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:CDP1-3501).

2. **SHALL** contain exactly one [1..1] `@moodCode`, which **SHALL** be "RQO" taken from the ValueSet **Planned moodCode** (Act/Encounter/Procedure) 2.16.840.1.113883.11.20.9.23 STATIC 2011-09-30 (CONF:CDP1-3502).

3. **SHALL** contain exactly one [1..1] `templateId` (CONF:CDP1-3503) such that it
   a. **SHALL** contain exactly one [1..1] `@root`="2.16.840.1.113883.10.20.35.4.1" (CONF:CDP1-3504).

4. **SHALL** contain at least one [1..*] `id` (CONF:CDP1-3505).

5. **SHALL** contain exactly one [1..1] `code` (CONF:CDP1-3506).
   a. This code in a Planned Act **SHOULD** be selected from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96) (CONF:CDP1-3524).

6. **SHALL** contain exactly one [1..1] `statusCode` which **SHALL** be selected from ValueSet ActStatus2 2.16.840.1.113883.10.20.35.6.1 (CONF:CDP1-3525).

   The effectiveTime in an ordered act represents the time that the act should occur.

7. **SHOULD** contain zero or one [0..1] `effectiveTime` (CONF:CDP1-3509).

   The clinician who did or is expected to carry out the act could be identified using act/performer.

8. **MAY** contain zero or more [0..*] `performer` (CONF:CDP1-3510).

   The author in an ordered act represents the clinician who requested the act.

9. **SHOULD** contain zero or one [0..1] `Author Participation` (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:CDP1-3511).

   This entryRelationship represents the priority that a patient places on the activity.

10. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:CDP1-3512) such that it
    a. **SHALL** contain exactly one [1..1] `@typeCode`="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-3513).
    
    b. **SHALL** contain exactly one [1..1] `Patient Priority Preference` (NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:CDP1-3514).

   This entryRelationship represents the priority that a provider places on the activity.

11. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:CDP1-3515) such that it
    a. **SHALL** contain exactly one [1..1] `@typeCode`="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-3516).
    
    b. **SHALL** contain exactly one [1..1] `Provider Priority Preference` (NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:CDP1-3517).

   This entryRelationship represents the indication for the act.
12. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:CDP1-3518) such that it
   a. **SHALL** contain exactly one [1..1] [@typeCode="RSON"] Has Reason
      (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002)
      (CONF:CDP1-3519).
   b. **SHALL** contain exactly one [1..1] `Indication (V2)`
      (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:CDP1-3520).

This entryRelationship captures any instructions associated with the act.

13. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:CDP1-3521) such that it
   a. **SHALL** contain exactly one [1..1] [@typeCode="SUBJ"] Has subject
      (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002)
      (CONF:CDP1-3522).
   b. **SHALL** contain exactly one [1..1] `Instruction (V2)`
      (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:CDP1-3523).

**Figure 24: Act Order (CDP1) Example**

```
<act classCode="ACT" moodCode="RQO">
  <templateId root="2.16.840.1.113883.10.20.35.4.1" />
  <!-- Act Order CDP1 template -->
  <id root="7658963e-54da-496f-bf18-dea1dadaa3b0" />
  <code code="423171007" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Elevate head of bed" />
  <statusCode code="completed" />
  <effectiveTime value="20130902" />
  <author typeCode="AUT">
    <!-- Author Participation -->
  </author>
  <entryRelationship typeCode="RSON">
    <!-- Patient Priority Preference -->
    ...
  </entryRelationship>
  <entryRelationship typeCode="RSON">
    <!-- Provider Priority Preference -->
    ...
  </entryRelationship>
  <entryRelationship typeCode="RSON">
    <!-- Indication (V2) -->
    ...
  </entryRelationship>
  <entryRelationship typeCode="SUBJ">
    <!-- Instruction (V2) -->
    ...
  </entryRelationship>
</act>
```
8.2 Encounter Order (CDP1)

This template represents an encounter order. The type of encounter (e.g. comprehensive outpatient visit) is represented. Clinicians participating in the encounter and the location of the ordered encounter may be captured. The priority that the patient and providers place on the encounter may be represented.

Note: the Encounter Order (CDP1) template is a copy of the C-CDA R2 Planned Encounter (V2) template (2.16.840.1.113883.10.20.22.4.40.2) with additional constraints on moodCode and statusCode to select only placed orders (moodCode = RQO and statusCode = completed or active). A new OID was assigned along with new conformance statements because of the change in name to reflect the use of the entry level template and the additional constraints.
Table 27: Encounter Order (CDP1) Constraints Overview

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<thead>
<tr>
<th>XPath</th>
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<th>Verb</th>
<th>Data Type</th>
<th>CONF#</th>
<th>Fixed Value</th>
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<tr>
<td>encounter[templateId/@root = '2.16.840.1.113883.10.20.35.4.2']</td>
<td></td>
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<td></td>
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<tr>
<td>@classCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13601</td>
<td>2.16.840.1.113883.5.6 (HL7ActClass) = ENC</td>
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<tr>
<td>@moodCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13602</td>
<td>2.16.840.1.113883.11.20.9.23 moodCode = RQO</td>
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<tr>
<td>templateId</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13603</td>
<td></td>
</tr>
<tr>
<td>@root</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13604</td>
<td>2.16.840.1.113883.10.20.35.4.2</td>
</tr>
<tr>
<td>id</td>
<td>1..*</td>
<td>SHALL</td>
<td></td>
<td>CDP13605</td>
<td></td>
</tr>
<tr>
<td>code</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13606</td>
<td>2.16.840.1.113883.11.20.9.52 (Encounter Planned or Requested)</td>
</tr>
<tr>
<td>statusCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13607</td>
<td>2.16.840.1.113883.10.20.35.6.1 (ActStatus2)</td>
</tr>
<tr>
<td>effectiveTime</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13609</td>
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<td>performer</td>
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<td>@typeCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13614</td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = LOC</td>
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<tr>
<td>participantRole</td>
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<td>SHALL</td>
<td></td>
<td>CDP13615</td>
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<td></td>
<td>CDP13617</td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR</td>
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<td>observation</td>
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<td>CDP13618</td>
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<td>SHALL</td>
<td></td>
<td>CDP13620</td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR</td>
</tr>
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<td>observation</td>
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<td>SHALL</td>
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<td>CDP13622</td>
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<td>SHALL</td>
<td></td>
<td>CDP13623</td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON</td>
</tr>
<tr>
<td>observation</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13624</td>
<td></td>
</tr>
</tbody>
</table>

1. **SHALL** contain exactly one [1..1] @classCode="ENC" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:CDP1-3601).
2. **SHALL** contain exactly one [1..1] @moodCode, which **SHALL** be “RQO” taken from the ValueSet Planned moodCode (Act/Encounter/Procedure) 2.16.840.1.113883.11.20.9.23 STATIC 2011-09-30 (CONF:CDP1-3602).
3. **SHALL** contain exactly one [1..1] templateId (CONF:CDP1-3603) such that it 
a. **SHALL** contain exactly one [1..1] @root="2.16.840.1.113883.10.20.35.4.2" (CONF:CDP1-3604).
4. **SHALL** contain at least one [1..*] id (CONF:CDP1-3605).

Records the type of encounter ordered.

5. **SHALL** contain exactly one [1..1] code, which **SHOULD** be selected from ValueSet **Encounter Planned or Requested** 2.16.840.1.113883.11.20.9.52 (CONF:CDP1-3606).

6. **SHALL** contain exactly one [1..1] statusCode which **SHALL** be selected from ValueSet ActStatus2 2.16.840.1.113883.10.20.35.6.1 (CONF:CDP1-3607).

7. **SHALL** contain exactly one [1..1] effectiveTime (CONF:CDP1-3609).

Performers represent clinicians who are responsible for assessing and treating the patient.

8. **MAY** contain zero or more [0..*] performer (CONF:CDP1-3610) such that it
   a. **SHALL** contain exactly one [1..1] assignedEntity (CONF:CDP1-3611).

   The author in an ordered encounter represents the clinician who requested the encounter.

9. **SHOULD** contain zero or one [0..1] author (CONF:CDP1-3612).

   This location participation captures where the ordered encounter may take place.

10. **MAY** contain zero or more [0..*] participant (CONF:CDP1-3613) such that it
    a. **SHALL** contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-3614).
    b. **SHALL** contain exactly one [1..1] Service Delivery Location (templateId:2.16.840.1.113883.10.20.22.4.32) (CONF:CDP1-3615).

   This entryRelationship represents the priority that a patient places on the encounter.

11. **MAY** contain zero or one [0..1] entryRelationship (CONF:CDP1-3616) such that it
    a. **SHALL** contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-3617).
    b. **SHALL** contain exactly one [1..1] Patient Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:CDP1-3618).

   This entryRelationship represents the priority that a provider places on the encounter.

12. **MAY** contain zero or more [0..*] entryRelationship (CONF:CDP1-3619) such that it
    a. **SHALL** contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-3620).
    b. **SHALL** contain exactly one [1..1] Provider Priority Preference (NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:CDP1-3621).

   This entryRelationship captures the reason for the ordered encounter.

13. **MAY** contain zero or more [0..*] entryRelationship (CONF:CDP1-3622) such that it
a. **SHALL** contain exactly one [1..1] `@typeCode="RSON"` Has Reason
(CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002)
(CONF:CDP1-3623).

b. **SHALL** contain exactly one [1..1] **Indication (V2)**
(templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:CDP1-3624).

### Table 28: Encounter Requested

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>185349003</td>
<td>SNOMED CT</td>
<td>encounter for &quot;check-up&quot; (procedure)</td>
</tr>
<tr>
<td>439740005</td>
<td>SNOMED CT</td>
<td>postoperative follow-up visit (procedure)</td>
</tr>
<tr>
<td>439708006</td>
<td>SNOMED CT</td>
<td>home visit (procedure)</td>
</tr>
<tr>
<td>438515009</td>
<td>SNOMED CT</td>
<td>E-mail encounter from carer (procedure)</td>
</tr>
<tr>
<td>...</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Figure 25: Encounter Order (CDP1) Example**

```xml
<entry>
  <encounter moodCode="RQO" classCode="ENC">
    <templateId root="2.16.840.1.113883.10.20.35.4.2"/>
    <!-- Encounter Order CDP1 template -->
    <id root="9a6dbac-17d3-4195-89a4-1121bc809b4d"/>
    <code code="185349003" displayName="encounter for check-up (procedure)"
      codeSystemName="SNOMED CT" codeSystem="2.16.840.1.113883.6.96"/>
    <statusCode code="completed"/>
    <effectiveTime value="20130615"/>
    <performer>
      <assignedEntity>
        ...
      </assignedEntity>
      ...
    </performer>
    <entryRelationship typeCode="REFR">
      <observation classCode="OBS" moodCode="EVN">
        <![CDATA[Patient Priority Preference--]]>
        <templateId root="2.16.840.1.113883.10.20.22.4.142"/>
      </observation>
    </entryRelationship>
    <entryRelationship typeCode="REFR">
      <observation classCode="OBS" moodCode="EVN">
        <![CDATA[Provider Priority Preference--]]>
      </observation>
    </entryRelationship>
  </encounter>
</entry>
```

### 8.3 Externally Defined CDE (CDP1)

[organizer: templateId 2.16.840.1.113883.10.20.35.4.3 (open)]

**Table 29: Externally Defined CDE (CDP1) Contexts**

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Externally Defined CDE Organizer (CDP1)</td>
<td></td>
</tr>
</tbody>
</table>

This template includes the name–value pairs for externally defined clinical data elements or the information required by an externally defined information/content model to represent name-value pairs in context. The organizer includes all information to identify the specific external template that was used to capture the CDEs. Name-Value pairs or information/content model information must be identified by externally defined XML tags.
### Table 30: Externally Defined CDE (CDP1) Constraints Overview

<table>
<thead>
<tr>
<th>XPath</th>
<th>Card.</th>
<th>Verb</th>
<th>Data Type</th>
<th>CONF#</th>
<th>Fixed Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>observation[templateId/@root = '2.16.840.1.113883.10.20.35.4.3']</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>@classCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1370 1</td>
<td>2.16.840.1.113883.5.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(HL7ActClass)</td>
<td>OBS</td>
</tr>
<tr>
<td>@moodCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1370 2</td>
<td>2.16.840.1.113883.5.1001</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(ActMood)</td>
<td>EVN</td>
</tr>
<tr>
<td>templateId</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1370 3</td>
<td></td>
</tr>
<tr>
<td>@root</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1370 4</td>
<td>2.16.840.1.113883.10.20.35.4.3</td>
</tr>
<tr>
<td>id</td>
<td>1..*</td>
<td>SHALL</td>
<td></td>
<td>CDP1370 5</td>
<td></td>
</tr>
<tr>
<td>code</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1370 6</td>
<td></td>
</tr>
<tr>
<td>name</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1370 7</td>
<td></td>
</tr>
<tr>
<td>@value</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1370 8</td>
<td></td>
</tr>
<tr>
<td>value</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1370 9</td>
<td></td>
</tr>
<tr>
<td>@value</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1371 0</td>
<td></td>
</tr>
<tr>
<td>model</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1371 1</td>
<td></td>
</tr>
<tr>
<td>@value</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP1371 2</td>
<td></td>
</tr>
</tbody>
</table>

1. **SHALL** contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC** (CONF:CDP1-3701)).
2. **SHALL** contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC** (CONF:CDP1-3702)).
3. **SHALL** contain exactly one [1..1] templateId (CONF:CDP1-3703) such that it
   a. **SHALL** contain exactly one [1..1] @root="2.16.840.1.113883.10.20.35.4.3" (CONF:CDP1-3701).
4. **SHALL** contain at least one [1..*] id (CONF:CDP1-3704).
5. **SHALL** contain exactly one [1..1] code (CONF:CDP1-3705).
   a. **SHOULD** be from an externally defined source (see Externally Defined CDE Organizer) or other terminology named by the US Department of Health and Human Services Office of National Coordinator or other federal agency (CONF:CDP1-3706).
6. **SHALL** contain exactly one [1..1] name (CONF:CDP1-3707).
   a. The text **SHALL** be an XML tagged string that is a name taken from the externally defined source (CONF:CDP1-3708).
7. **SHALL** contain exactly one [1..1] value (CONF:CDP1-3709).
a. The value **SHALL** be an XML tagged string that is value associated with the externally defined name (CONF:CDP1-3710).

8. **SHALL** contain exactly one [1..1] **model** (CONF:CDP1-3711).
   a. The value **SHALL** be an XML tagged string that includes elements for name/value pairs and their context based on an externally defined information/content model (CONF:CDP1-3712).

9. **SHALL NOT** include **name** and **value** if **model** is present (CONF:CDP1-3713).

**Figure 26: Externally Defined CDE (CDP1) Example**

```
<observation classCode="OBS" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.35.4.3"/>
  <id root="7c0704bb-9c40-41b5-9c7d-26b2d59e234f"/>
  <code code="TBD"/>
  <name>
    <CMS="2.16.840.1.113883.10.20.35.5.111">This is the question</CMS="2.16.840.1.113883.10.20.35.5.111">
  </name>
  <value>
    <CMS="2.16.840.1.113883.10.20.35.5.111">This is the value that was entered by the provider</CMS="2.16.840.1.113883.10.20.35.5.111">
  </value>
</observation>
```

### 8.4 Externally Defined CDE Organizer (CDP1)

[act: templateId 2.16.840.1.113883.10.20.35.4.4 (open)]

**Table 31: Externally Defined CDE (CDP1) Contexts**

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Externally Defined Clinical Data Elements Section [CDP1]</td>
<td>Author Participation (NEW)</td>
</tr>
<tr>
<td></td>
<td>Externally Defined CDE (CDP1)</td>
</tr>
</tbody>
</table>

This template provides a mechanism for grouping externally defined CDEs based on the external template used to collect the name-value pairs or model. It contains information applicable to all externally defined CDEs. The Externally Defined CDE Organizer categorizes the contained CDEs based on their template library (e.g., “CMS Prior-Authorization”).
### Table 32: Externally Defined CDE Organizer Constraints Overview

<table>
<thead>
<tr>
<th>XPath</th>
<th>Card.</th>
<th>Verb</th>
<th>Data Type</th>
<th>CONF#</th>
<th>Fixed Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>organizer[templateId/@root = '2.16.840.1.113883.10.20.35.4.4']</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>@classCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13801</td>
<td>2.16.840.1.113883.5.6 (HL7ActClass)</td>
</tr>
<tr>
<td>@moodCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13802</td>
<td>2.16.840.1.113883.5.1001 (ActMood) = EVN</td>
</tr>
<tr>
<td>templateId</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13803</td>
<td></td>
</tr>
<tr>
<td>@root</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13804</td>
<td>2.16.840.1.113883.10.20.35.4.4</td>
</tr>
<tr>
<td>text</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13805</td>
<td></td>
</tr>
<tr>
<td>@mediaType</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13806</td>
<td>application/CDE</td>
</tr>
<tr>
<td>reference</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13807</td>
<td></td>
</tr>
<tr>
<td>URI</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13808</td>
<td>URI to template library</td>
</tr>
<tr>
<td>templateId</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13809</td>
<td></td>
</tr>
<tr>
<td>@root</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13810</td>
<td>OID for external template instance</td>
</tr>
<tr>
<td>component</td>
<td>1..*</td>
<td>SHALL</td>
<td></td>
<td>CDP13811</td>
<td></td>
</tr>
<tr>
<td>observation</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13812</td>
<td>External template owner description</td>
</tr>
<tr>
<td>component</td>
<td>1..*</td>
<td>SHALL</td>
<td></td>
<td>CDP13813</td>
<td></td>
</tr>
<tr>
<td>observation</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13814</td>
<td>External template name</td>
</tr>
<tr>
<td>effectiveTime</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13815</td>
<td></td>
</tr>
<tr>
<td>author</td>
<td>0..1</td>
<td>SHOULD</td>
<td></td>
<td>CDP13816</td>
<td></td>
</tr>
<tr>
<td>component</td>
<td>1..*</td>
<td>SHALL</td>
<td></td>
<td>CDP13817</td>
<td></td>
</tr>
<tr>
<td>observation</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13818</td>
<td></td>
</tr>
</tbody>
</table>

1. **SHALL** contain exactly one [1..1] @classCode (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 **STATIC** (CONF:CDP1-3801)).

2. **SHALL** contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001 **STATIC** (CONF:CDP1-3802)).

3. **SHALL** contain exactly one [1..1] templateId (CONF:CDP1-3803) such that it
   a. **SHALL** contain exactly one [1..1] @root="2.16.840.1.113883.10.20.35.4.4" (CONF:CDP1-3804).

4. **SHALL** contain exactly one [1..1] text (CONF:CDP1-3805).
   a. **SHALL** contain exactly one [1..1] @mediaType="application/CDE" (CONF:CDP1-3806).
   b. The text, if present, **SHALL** contain exactly one [1..1] reference (CONF:CDP1-3807).
      i. **SHALL** contain a @value that contains a URI to the external template definition library (CONF:CDP1-3808).

5. **SHALL** contain exactly one [1..1] templateId (CONF:CDP1-3809) such that it
a. **SHALL** contain exactly one [1..1]

b. The @root contains an OID representing the External Template Instance (CONF:CDP1-3810).

6. **SHALL** contain exactly one [1..1] text (CONF:CDP1-3811).
   c. **SHALL** contain exactly one [1..1] owner description (CONF:CDP1-3812).

7. **SHALL** contain exactly one [1..1] text (CONF:CDP1-3813).
   d. **SHALL** contain exactly one [1..1] template name (CONF:CDP1-3814).

8. **SHALL** contain exactly one [1..1] effectiveTime (CONF:CDP1-3815)

9. **SHOULD** contain zero or more [0..*] Author Participation (NEW) (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:CDP1-3816).

10. **SHALL** contain at least one [1..*] component (CONF:CDP1-3817) such that it
    a. **SHALL** contain exactly one [1..1] Externally Defined CDE (CDP1) (templateId:2.16.840.1.113883.10.20.35.4.3) (CONF:CDP1-3818).
Figure 27: Externally Defined CDE Organizer (CDP1) Example

```xml
<act classCode="ACT" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.35.4.4" />
  <id root="5a784260-6856-4f38-9638-80c751aff2fb" />
  <observation classCode="DGIMG" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.6.2.8" />
    <id root="1.2.840.113619.2.62.994044785528.20060823.200608232232322.3" />
    <code code="1.2.840.10008.5.1.4.1.1.1" codeSystem="1.2.840.10008.2.6.1" codeSystemName="DCMUID" displayName="Computed Radiography Image Storage"/>
  </observation>
  <code code="46241-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Hospital Admission Diagnosis"/>
  <statusCode code="active" />
  <effectiveTime>
    <low value="20090303" />
  </effectiveTime>
  <entryRelationship typeCode="SUBJ" inversionInd="false">
    <observation classCode="OBS" moodCode="EVN">
      <!-- Problem observation template -->
      <templateId root="2.16.840.1.113883.10.20.22.4.4" />
      ...
    </observation>
  </entryRelationship>
  <statusCode code="completed" />
  <effectiveTime>
    <low value="200803190830-0800" />
    <high value="200803190830-0800" />
  </effectiveTime>
  <author>...
  </author>
  <component>
    <observation classCode="OBS" moodCode="EVN">
      <!-- ** Result observation ** -->
      <templateId root="2.16.840.1.113883.10.20.22.4.2.2" />
      ...
    </observation>
  </component>
  </organizer>
</act>
```
8.5 Medication Activity Order (CDP1)

Table 33: Medication Activity Order (CDP1) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orders Placed Section (CDP1)</td>
<td>Author Participation (NEW)</td>
</tr>
<tr>
<td></td>
<td>Indication (V2)</td>
</tr>
<tr>
<td></td>
<td>Instruction (V2)</td>
</tr>
<tr>
<td></td>
<td>Medication Information (V2)</td>
</tr>
<tr>
<td></td>
<td>Patient Priority Preference (NEW)</td>
</tr>
<tr>
<td></td>
<td>Precondition for Substance Administration (V2)</td>
</tr>
<tr>
<td></td>
<td>Provider Priority Preference (NEW)</td>
</tr>
</tbody>
</table>

This template represents ordered medication activities. The priority of the medication activity to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference. The effectiveTime indicates the time when the medication activity is intended to take place. The authorTime indicates when the documentation of the order occurred.

Note: the Medication Activity Order (CDP1) template is a copy of the C-CDA R2 Planned Medication Activity (V2) template (2.16.840.1.113883.10.20.22.4.42.2) with additional constraints on moodCode and statusCode to select only placed orders (moodCode = RQO and statusCode = completed or active). A new OID was assigned along with new conformance statements because of the change in name to reflect the use of the entry level template and the additional constraints.
### Table 34: Medication Activity Order (CDP1) Constraints Overview

<table>
<thead>
<tr>
<th>XPath</th>
<th>Card.</th>
<th>Verb</th>
<th>Data Type</th>
<th>CONF#</th>
<th>Fixed Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>substanceAdministration[@root = '2.16.840.1.113883.10.20.35.4.5']</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>@classCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13901</td>
<td>2.16.840.1.113883.5.6 (HL7ActClass) = SBADM</td>
</tr>
<tr>
<td>@moodCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13902</td>
<td>2.16.840.1.113883.11.20.9.2 4 moodCode = RQO</td>
</tr>
<tr>
<td>templateId</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13903</td>
<td></td>
</tr>
<tr>
<td>@root</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13904</td>
<td>2.16.840.1.113883.10.20.35.4.5</td>
</tr>
<tr>
<td>id</td>
<td>1..*</td>
<td>SHALL</td>
<td></td>
<td>CDP13905</td>
<td></td>
</tr>
<tr>
<td>statusCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13906</td>
<td>2.16.840.1.113883.10.20.35.6.1 (ActStatus2)</td>
</tr>
<tr>
<td>effectiveTime</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP13908</td>
<td></td>
</tr>
<tr>
<td>repeatNumber</td>
<td>0..1</td>
<td>MAY</td>
<td></td>
<td>CDP13909</td>
<td></td>
</tr>
<tr>
<td>routeCode</td>
<td>0..1</td>
<td>MAY</td>
<td></td>
<td>CDP13910</td>
<td>2.16.840.1.113883.3.88.12.3 221.8.7 (Medication Route FDA Value Set)</td>
</tr>
<tr>
<td>approachSiteCode</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP13911</td>
<td>2.16.840.1.113883.3.88.12.3 221.8.9 (Body Site Value Set)</td>
</tr>
<tr>
<td>doseQuantity</td>
<td>0..1</td>
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<td>2.16.840.1.113883.11.1283 9 (UnitsOfMeasureCaseSensitive)</td>
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</tr>
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<td>SHALL</td>
<td></td>
<td>CDP13926</td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR</td>
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<td>SHALL</td>
<td></td>
<td>CDP13927</td>
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<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP13928</td>
<td></td>
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<td>SHALL</td>
<td></td>
<td>CDP13929</td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RSON</td>
</tr>
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</table>
observation 1..1 SHALL CDP13930
entryRelationship 0..* MAY CDP13931
@typeCode 1..1 SHALL CDP13932
  2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ
act 1..1 SHALL CDP13933
precondition 0..* MAY CDP13934
@typeCode 1..1 SHALL CDP13935
  2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = PRCN
criterion 1..1 SHALL CDP13936

1. **SHALL** contain exactly one [1..1] `@classCode`="SBADM" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:CDP1-3901).
2. **SHALL** contain exactly one [1..1] `@moodCode`, which **SHALL** be “RQO” taken from the ValueSet **Planned moodCode (SubstanceAdministration/Supply)** 2.16.840.1.113883.11.20.9.24 STATIC 2011-09-30 (CONF:CDP1-3902).
3. **SHALL** contain exactly one [1..1] `templateId` (CONF:CDP1-3903) such that it
   a. **SHALL** contain exactly one [1..1]
      @root="2.16.840.1.113883.10.20.35.4.5" (CONF:CDP1-3904).
4. **SHALL** contain at least one [1..*] `id` (CONF:CDP1-3905).
5. **SHALL** contain exactly one [1..1] `statusCode` which **SHALL** be selected from ValueSet ActStatus2 2.16.840.1.113883.10.20.35.6.1 (CONF:CDP1-3906).

The effectiveTime in an ordered medication activity represents the time that the medication activity should occur.

6. **SHALL** contain exactly one [1..1] `effectiveTime` (CONF:CDP1-3908).

In a Medication Activity Order, repeatNumber defines the number of allowed administrations. For example, a repeatNumber of "3" means that the substance can be administered up to 3 times.

7. **MAY** contain zero or one [0..1] `repeatNumber` (CONF:CDP1-3909).
8. **MAY** contain zero or one [0..1] `routeCode`, which **SHALL** be selected from ValueSet **Medication Route FDA Value Set** 2.16.840.1.113883.3.88.12.3221.8.7 DYNAMIC (CONF:CDP1-3910).
9. **MAY** contain zero or more [0..*] `approachSiteCode`, which **SHALL** be selected from ValueSet **Body Site Value Set** 2.16.840.1.113883.3.88.12.3221.8.9 DYNAMIC (CONF:CDP1-3911).
10. **MAY** contain zero or one [0..1] `doseQuantity` (CONF:CDP1-3912).
    a. The doseQuantity, if present, **SHOULD** contain zero or one [0..1] `@unit`, which
       **SHALL** be selected from ValueSet **UnitsOfMeasureCaseSensitive** 2.16.840.1.113883.1.11.12839 DYNAMIC (CONF:CDP1-3913).
11. **MAY** contain zero or one [0..1] `rateQuantity` (CONF:CDP1-3914).
    a. The rateQuantity, if present, **SHOULD** contain zero or one [0..1] `@unit`, which
       **SHALL** be selected from ValueSet **UnitsOfMeasureCaseSensitive** 2.16.840.1.113883.1.11.12839 DYNAMIC (CONF:CDP1-3915).
12. **MAY** contain zero or one [0..1] `maxDoseQuantity` (CONF:CDP1-3916).
13. **MAY** contain zero or one [0..1] `administrationUnitCode`, which **SHALL** be selected from ValueSet `AdministrableDrugForm` 2.16.840.1.113883.1.11.14570 DYNAMIC (CONF:CDP1-3917).

14. **SHALL** contain exactly one [1..1] `consumable` (CONF:CDP1-3918).
   a. This consumable **SHALL** contain exactly one [1..1] `Medication Information (V2)` (templateId:2.16.840.1.113883.10.20.22.4.23.2) (CONF:CDP1-3919).

The clinician who performed or is expected to perform the medication activity could be identified using `substanceAdministration/performer`.

15. **MAY** contain zero or more [0..*] `performer` (CONF:CDP1-3920).

The author in a medication activity order represents the clinician who requested the medication activity.

16. **SHOULD** contain zero or one [0..1] `Author Participation (NEW)` (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:CDP1-3921).

This entryRelationship represents the priority that a patient places on the medication activity order.

17. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:CDP1-3922) such that it
   a. **SHALL** contain exactly one [1..1] `typeCode`="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-3923).
   b. **SHALL** contain exactly one [1..1] `Patient Priority Preference (NEW)` (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:CDP1-3924).

This entryRelationship represents the priority that a provider places on the medication activity order.

18. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:CDP1-3925) such that it
   a. **SHALL** contain exactly one [1..1] `typeCode`="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-3926).
   b. **SHALL** contain exactly one [1..1] `Provider Priority Preference (NEW)` (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:CDP1-3927).

This entryRelationship represents the indication for the medication activity order.

19. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:CDP1-3928) such that it
   b. **SHALL** contain exactly one [1..1] `Indication (V2)` (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:CDP1-3930).

This entryRelationship captures any instructions associated with the medication activity order.

20. **MAY** contain zero or more [0..*] `entryRelationship` (CONF:CDP1-3931) such that it
a. **SHALL** contain exactly one [1..1] `@typeCode`="SUBJ" Has Subject
   (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002)
   (CONF:CDP1-3932).

b. **SHALL** contain exactly one [1..1] Instruction (V2)
   (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:CDP1-3933).

21. **MAY** contain zero or more [0..*] precondition (CONF:CDP1-3934).

   a. The precondition, if present, **SHALL** contain exactly one [1..1]
      `@typeCode`="PRCN" Precondition (CodeSystem: HL7ActRelationshipType
      2.16.840.1.113883.5.1002) (CONF:CDP1-3935).

   b. The precondition, if present, **SHALL** contain exactly one [1..1]
      Precondition for Substance Administration (V2)
      (templateId:2.16.840.1.113883.10.20.22.4.25.2) (CONF:CDP1-3936).

---

**Figure 28: Medication Action Order (CDP1) Example**

```xml
<substanceAdministration moodCode="RQO" classCode="SBADM">
  <templateId root="2.16.840.1.113883.10.20.35.4.5" />
  <!-- Medication Activity Order (CDP1) -->
  <id root="cdbd33f0-6cde-11db-9fe1-0800200c9a66" />
  <text>Heparin 0.25 ml Pre-filled Syringe</text>
  <statusCode code="completed" />
  <!-- The effectiveTime in a medication activity order
       represents the time that the medication should occur. -->
  <effectiveTime value="20130905" />
  <consumable>
    <manufacturedProduct classCode="MANU">
      <!-- Medication Information (V2) -->
      ...
    </manufacturedProduct>
  </consumable>
  <entryRelationship typeCode="REFR">
    <observation classCode="OBS" moodCode="EVC">
      <!-- Patient Priority Preference-->
      ...
    </observation>
  </entryRelationship>
  <entryRelationship typeCode="REFR">
    <observation classCode="OBS" moodCode="EVC">
      <!-- Provider Priority Preference-->
      ...
    </observation>
  </entryRelationship>
  <entryRelationship typeCode="RSON">
    <!-- Indication (V2) -->
    ...
  </entryRelationship>
  <entryRelationship typeCode="SUBJ">
    <!-- Instruction (V2) -->
    ...
  </entryRelationship>
</substanceAdministration>
```
8.6 Observation Order (CDP1)

[observation: templateId 2.16.840.1.113883.10.20.35.4.6 (open)]

Table 35: Observation Order (CDP1) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orders Placed Section (CDP1)</td>
<td>Author Participation (NEW)</td>
</tr>
<tr>
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<td>Indication (V2)</td>
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<td>Instruction (V2)</td>
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<td>Patient Priority Preference (NEW)</td>
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<tr>
<td></td>
<td>Planned Coverage (NEW)</td>
</tr>
<tr>
<td></td>
<td>Provider Priority Preference (NEW)</td>
</tr>
</tbody>
</table>

This template represents ordered observations that result in new information about the patient which cannot be classified as a procedure according to the HL7 RIM. Examples of these procedures are diagnostic imaging procedures, EEGs, and EKGs.

The importance of the ordered observation to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference. The effectiveTime indicates the time when the observation is ordered to take place and authorTime indicates when the documentation of the order occurred.

The Completed Observation template may also indicate the potential insurance coverage for the observation.

Note: the Observation Order (CDP1) template is a copy of the C-CDA R2 Planned Observation (V2) template (2.16.840.1.113883.10.20.22.4.44.2) with additional constraints on moodCode and statusCode to select only placed orders (moodCode = RQO and statusCode = completed or active). A new OID was assigned along with new conformance statements because of the change in name to reflect the use of the entry level template and the additional constraints.
### Table 36: Observation Order (CDP1) Constraints Overview

<table>
<thead>
<tr>
<th>XPath</th>
<th>Card.</th>
<th>Verb</th>
<th>Data Type</th>
<th>CONF#</th>
<th>Fixed Value</th>
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<tr>
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<td>2.16.840.1.113883.3.88.12.3 221.8.9 (Body Site Value Set)</td>
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<td>SHALL</td>
<td></td>
<td>CDP14029</td>
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</tr>
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</table>
1. **SHALL** contain exactly one [1..1] @classCode="OBS" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:CDP1-4001).

2. **SHALL** contain exactly one [1..1] @moodCode, which **SHALL** be “RQO” taken from the ValueSet **Planned moodCode (Observation)** 2.16.840.1.113883.11.20.9.25 STATIC 2011-09-30 (CONF:CDP1-4002).

3. **SHALL** contain exactly one [1..1] templateId (CONF:30451) such that it
   a. **SHALL** contain exactly one [1..1] @root = "2.16.840.1.113883.10.20.35.4.6" (CONF:CDP1-4003).

4. **SHALL** contain at least one [1..*] id (CONF:CDP1-4004).

5. **SHALL** contain exactly one [1..1] code (CONF:CDP1-4005).
   a. This @code **SHOULD** be selected from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96), and MAY be selected from CPT-4 (CodeSystem: 2.16.840.1.113883.6.12) or ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) (CONF:CDP1-4006).

6. **SHALL** contain exactly one [1..1] statusCode which **SHALL** be selected from ValueSet ActStatus2 2.16.840.1.113883.10.20.35.6.1 (CONF:CDP1-4007).

The effectiveTime in an ordered observation represents the time that the observation should occur.

7. **SHOULD** contain zero or one [0..1] effectiveTime (CONF:CDP1-4009).

8. **MAY** contain zero or one [0..1] value (CONF:CDP1-4010).

In an ordered observation the provider may suggest that an observation should be performed using a particular method.

9. **MAY** contain zero or one [0..1] methodCode (CONF:CDP1-4011).

The targetSiteCode is used to identify the part of the body of concern for the ordered observation.

10. **SHOULD** contain zero or more [0..*] targetSiteCode, which **SHALL** be selected from ValueSet **Body Site Value Set** 2.16.840.1.113883.3.88.12.3221.8.9 (CONF:CDP1-4012).

The clinician who did or is expected to perform the observation is/could be identified using procedure/performer.

11. **MAY** contain zero or more [0..*] performer (CONF:CDP1-4013).

The author in an ordered observation represents the clinician who is requesting the observation.

12. **SHOULD** contain zero or more [0..*] **Author Participation (NEW)**
    (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:CDP1-4014).

This entryRelationship represents the priority that the patient places on the observation.

13. **MAY** contain zero or more [0..*] entryRelationship (CONF:CDP1-4015) such that it
    a. **SHALL** contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-4016).
b. **SHALL** contain exactly one [1..1] **Patient Priority Preference (NEW)** (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:CDP1-4017).

This entryRelationship represents the priority that a provider places on the observation.

14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4018) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-4019).
   b. **SHALL** contain exactly one [1..1] **Provider Priority Preference (NEW)** (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:CDP1-4020).

This entryRelationship represents the indication for the observation.

15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4021) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-4022).
   b. **SHALL** contain exactly one [1..1] **Indication (V2)** (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:CDP1-4023).

This entryRelationship captures any instructions associated with the ordered observation.

16. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4024) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-4025).
   b. **SHALL** contain exactly one [1..1] **Instruction (V2)** (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:CDP1-4026).

This entryRelationship represents the insurance coverage the patient may have for the observation.

17. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4027) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="COMP" Has Component (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-4028).
   b. **SHALL** contain exactly one [1..1] **Planned Coverage (NEW)** (templateId:2.16.840.1.113883.10.20.22.4.129) (CONF:CDP1-4029).

**Table 37: Planned moodCode (Observation)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Code System</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>INT</td>
<td>ActMood</td>
<td>Intent</td>
</tr>
<tr>
<td>GOL</td>
<td>ActMood</td>
<td>Goal</td>
</tr>
<tr>
<td>PRMS</td>
<td>ActMood</td>
<td>Promise</td>
</tr>
<tr>
<td>PRP</td>
<td>ActMood</td>
<td>Proposal</td>
</tr>
<tr>
<td>RQO</td>
<td>ActMood</td>
<td>Request</td>
</tr>
</tbody>
</table>

The value set is used to restrict the moodCode only to future moods.
**Figure 29: Observation Order (CDP1) Example**

```xml
<observation classCode="OBS" moodCode="RQO">
  <templateId root="2.16.840.1.113883.10.20.35.4.6" />
  <!-- Observation Order CDP1 template -->
  <id root="b52bee94-c34b-4e2c-8c15-5ad9d6def205" />
  <code code="284034009" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="pulse oximetry monitoring" />
  <statusCode code="completed" />
  <effectiveTime value="20130903" />
  <author typeCode="AUT">
    <!-- Author Participation -->
  </author>
  <entryRelationship typeCode="REFR">
    <!-- Patient Priority Preference -->
    ...
  </entryRelationship>
  <entryRelationship typeCode="REFR">
    <!-- Provider Priority Preference -->
    ...
  </entryRelationship>
  <entryRelationship typeCode="RSON">
    <!-- Indication (V2) -->
    ...
  </entryRelationship>
  <entryRelationship typeCode="SUBJ">
    <!-- Instruction (V2) -->
    ...
  </entryRelationship>
  <entryRelationship typeCode="COMP">
    <!-- Planned Coverage -->
    ...
  </entryRelationship>
</observation>
```
8.7 Procedure Order (CDP1)

[procedure: templateId 2.16.840.1.113883.10.20.35.4.7 (open)]

Table 38: Procedure Order (CDP1) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orders Placed Section (CDP1)</td>
<td>Author Participation (NEW)</td>
</tr>
<tr>
<td></td>
<td>Indication [V2]</td>
</tr>
<tr>
<td></td>
<td>Instruction [V2]</td>
</tr>
<tr>
<td></td>
<td>Patient Priority Preference (NEW)</td>
</tr>
<tr>
<td></td>
<td>Planned Coverage (NEW)</td>
</tr>
<tr>
<td></td>
<td>Provider Priority Preference (NEW)</td>
</tr>
</tbody>
</table>

This template represents in process or completed alterations of the patient's physical condition. Examples of such procedures are tracheostomy, knee replacement, and craniectomy. The priority of the procedure to the patient and provider is communicated through Patient Priority Preference and Provider Priority Preference. The effectiveTime indicates the time when the procedure is intended to take place and authorTime indicates when the documentation occurred. The Procedure Order Template may also indicate the potential insurance coverage for the procedure.

Note: the Procedure Order (CDP1) template is a copy of the C-CDA R2 Planned Procedure (V2) template (2.16.840.1.113883.10.20.22.4.21.2) with additional constraints on moodCode and statusCode to select only placed orders (moodCode = RQO and statusCode = completed or active). A new OID was assigned along with new conformance statements because of the change in name to reflect the use of the entry level template and the additional constraints.
### Table 39: Procedure Order (CDP1) Constraints Overview

<table>
<thead>
<tr>
<th>XPath</th>
<th>Card.</th>
<th>Verb</th>
<th>Data Type</th>
<th>CONF#</th>
<th>Fixed Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>procedure[templateId/@root = '2.16.840.1.113883.10.20.35.4.7']</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>@classCode</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1410 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.16.840.1.113883.5.6 (HL7ActClass) = PROC</td>
<td></td>
</tr>
<tr>
<td>@moodCode</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1410 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.16.840.1.113883.11.20.9.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>moodCode = RQO</td>
<td></td>
</tr>
<tr>
<td>templateId</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1410 3</td>
<td></td>
</tr>
<tr>
<td>@root</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1410 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.16.840.1.113883.10.20.35.4.7</td>
<td></td>
</tr>
<tr>
<td>id</td>
<td>1..*</td>
<td>SHAL</td>
<td></td>
<td>CDP1410 5</td>
<td></td>
</tr>
<tr>
<td>code</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1410 6</td>
<td></td>
</tr>
<tr>
<td>statusCode</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1410 7</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.16.840.1.113883.10.20.35.6.1 (ActStatus2)</td>
<td></td>
</tr>
<tr>
<td>effectiveTime</td>
<td>0..1</td>
<td>SHOULD</td>
<td></td>
<td>CDP1410 9</td>
<td></td>
</tr>
<tr>
<td>methodCode</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP1411 0</td>
<td></td>
</tr>
<tr>
<td>targetSiteCode</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP1411 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.16.840.1.113883.3.88.12.3 221.8.9 (Body Site Value Set)</td>
<td></td>
</tr>
<tr>
<td>performer</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP1411 2</td>
<td></td>
</tr>
<tr>
<td>author</td>
<td>0..1</td>
<td>SHOULD</td>
<td></td>
<td>CDP1411 3</td>
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</tr>
<tr>
<td>entryRelationship</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP1411 4</td>
<td></td>
</tr>
<tr>
<td>@typeCode</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1411 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR</td>
<td></td>
</tr>
<tr>
<td>observation</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1411 6</td>
<td></td>
</tr>
<tr>
<td>entryRelationship</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP1411 7</td>
<td></td>
</tr>
<tr>
<td>@typeCode</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1411 8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR</td>
<td></td>
</tr>
<tr>
<td>observation</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1411 9</td>
<td></td>
</tr>
<tr>
<td>entryRelationship</td>
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<td>MAY</td>
<td></td>
<td>CDP1412 0</td>
<td></td>
</tr>
<tr>
<td>@typeCode</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1412 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>observation</td>
<td>1..1</td>
<td>SHAL</td>
<td></td>
<td>CDP1412 2</td>
<td></td>
</tr>
<tr>
<td>entryRelationship</td>
<td>0..*</td>
<td>MAY</td>
<td></td>
<td>CDP1412</td>
<td></td>
</tr>
<tr>
<td>@typeCode</td>
<td>1..1</td>
<td>SHALL</td>
<td>CDP1412 4</td>
<td>2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
<td>-------</td>
<td>-----------</td>
<td>------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>@inversionInd</td>
<td>1..1</td>
<td>SHALL</td>
<td>CDP1412 5</td>
<td>true</td>
<td></td>
</tr>
<tr>
<td>act</td>
<td>1..1</td>
<td>SHALL</td>
<td>CDP1412 6</td>
<td>CDP1412</td>
<td></td>
</tr>
<tr>
<td>entryRelationship</td>
<td>0..*</td>
<td>MAY</td>
<td>CDP1412 7</td>
<td>CDP1412</td>
<td></td>
</tr>
<tr>
<td>@typeCode</td>
<td>1..1</td>
<td>SHALL</td>
<td>CDP1412 8</td>
<td>COMP</td>
<td></td>
</tr>
<tr>
<td>act</td>
<td>1..1</td>
<td>SHALL</td>
<td>CDP1412 9</td>
<td>CDP1412</td>
<td></td>
</tr>
</tbody>
</table>

1. **SHALL** contain exactly one [1..1] `@classCode`="PROC" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:CDP1-4101).

2. **SHALL** contain exactly one [1..1] `@moodCode`, which **SHALL** be “RQO” taken from the ValueSet **Planned moodCode** (Act/Encounter/Procedure) 2.16.840.1.113883.11.20.9.23 STATIC 2011-09-30 (CONF:CDP1-4102).

3. **SHALL** contain exactly one [1..1] `templateId` (CONF:CDP1-4103) such that it
   a. **SHALL** contain exactly one [1..1] `@root`="2.16.840.1.113883.10.20.35.4.7" (CONF:CDP1-4104).
   
4. **SHALL** contain at least one [1..*] `id` (CONF:CDP1-4105).

5. **SHALL** contain exactly one [1..1] `code` (CONF:CDP1-4106).
   a. The procedure/code in a planned procedure **SHOULD** be selected from LOINC (codeSystem 2.16.840.1.113883.6.1) or SNOMED CT (CodeSystem: 2.16.840.1.113883.6.96), and **MAY** be selected from CPT-4 (CodeSystem: 2.16.840.1.113883.6.12) or ICD10 PCS (CodeSystem: 2.16.840.1.113883.6.4) (CONF:CDP1-4130).

6. **SHALL** contain exactly one [1..1] `statusCode` which **SHALL** be selected from ValueSet ActStatus2 2.16.840.1.113883.10.20.35.6.1 (CONF:CDP1-4131).

The **effectiveTime** in a procedure order represents the time that the procedure should occur.

7. **SHOULD** contain zero or one [0..1] `effectiveTime` (CONF:CDP1-4109).

In a procedure order, the provider may suggest that a procedure should be performed using a particular method.

8. **MAY** contain zero or more [0..*] `methodCode` (CONF:CDP1-4110).

The `targetSiteCode` is used to identify the part of the body of concern for the procedure order.

9. **MAY** contain zero or more [0..*] `targetSiteCode`, which **SHALL** be selected from ValueSet **Body Site Value Set** 2.16.840.1.113883.3.88.12.3221.8.9 (CONF:CDP1-4111).

The clinician who did or is expected to perform the procedure could be identified using procedure/performer.
10. **MAY** contain zero or more [0..*] **performer** (CONF:CDP1-4112).

The author in a procedure order represents the clinician who is requesting the procedure.

11. **SHOULD** contain zero or one [0..1] **Author Participation (NEW)**
    (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:CDP1-4113).

This entryRelationship represents the priority that a patient places on the procedure.

12. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4114) such that it
    a. **SHALL** contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-4115).
    b. **SHALL** contain exactly one [1..1] **Patient Priority Preference (NEW)** (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:CDP1-4116).

This entryRelationship represents the priority that a provider places on the procedure.

13. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4117) such that it
    a. **SHALL** contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-4118).
    b. **SHALL** contain exactly one [1..1] **Provider Priority Preference (NEW)** (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:CDP1-4119).

This entryRelationship represents the indication for the procedure.

14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4120) such that it
    a. **SHALL** contain exactly one [1..1] @typeCode="RSON" Has Reason (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-4121).
    b. **SHALL** contain exactly one [1..1] **Indication (V2)** (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:CDP1-4122).

This entryRelationship captures any instructions associated with the procedure order.

15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4123) such that it
    a. **SHALL** contain exactly one [1..1] @typeCode="SUBJ" Has Subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-4124).
    b. **SHALL** contain exactly one [1..1] @inversionInd="true" True (CONF:CDP1-4125).
    c. **SHALL** contain exactly one [1..1] **Instruction (V2)** (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:CDP1-4126).

This entryRelationship represents the insurance coverage the patient may have for the procedure.

16. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4127) such that it
    a. **SHALL** contain exactly one [1..1] @typeCode="COMP" Has component (CONF:CDP1-4128).
b. **SHALL** contain exactly one [1..1] Planned Coverage (NEW) (templateId:2.16.840.1.113883.10.20.22.4.129) (CONF:CDP1-4129).

---

**Figure 30: Procedure Order (CDP1) Example**

```xml
<entry>
  <procedure moodCode="RQO" classCode="PROC">
    <templateId root="2.16.840.1.113883.10.20.35.4.7"/>
    <!-- **Procedure Order CDP1 template ** -->
    <id root="9a6d1bac-17d3-4195-89c4-1121bc809b5a"/>
    <code code="73761001" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" display="Colonoscopy"/>
    <statusCode code="completed"/>
    <effectiveTime value="20130613"/>
    <!-- Author Participation -->
    <author typeCode="AUT">
      ...
    </author>
    <entryRelationship typeCode="REFR">
      <observation classCode="OBS" moodCode="EVN">
        <!-- Patient Priority Preference -->
        <templateId root="2.16.840.1.113883.10.20.22.4.142"/>
        ...
      </observation>
    </entryRelationship>
    <entryRelationship typeCode="REFR">
      <observation classCode="OBS" moodCode="EVN">
        <!-- Provider Priority Preference -->
        <templateId root="2.16.840.1.113883.10.20.22.4.143"/>
        ...
      </observation>
    </entryRelationship>
    <entryRelationship typeCode="RSON">
      <observation classCode="OBS" moodCode="EVN">
        <!-- Indication -->
        <templateId root="2.16.840.1.113883.10.20.22.4.19.2"/>
        ...
      </observation>
    </entryRelationship>
    <entryRelationship typeCode="SUBJ">
      <act classCode="ACT" moodCode="INT">
        <!-- Instruction -->
        <templateId root="2.16.840.1.113883.10.20.22.4.20.2"/>
        ...
      </act>
    </entryRelationship>
    <entryRelationship typeCode="COMP">
      <observation classCode="ACT" moodCode="INT">
        <!-- Planned Coverage -->
        <templateId root="2.16.840.1.113883.10.20.22.4.129"/>
        ...
      </observation>
    </entryRelationship>
  </procedure>
</entry>
```
### 8.8 Supply Order (CDP1)

[supply: templateId 2.16.840.1.113883.10.20.35.4.8 (open)]

#### Table 40: Supply Order (CDP1) Contexts

<table>
<thead>
<tr>
<th>Contained By:</th>
<th>Contains:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orders Placed Section (CDP1)</td>
<td>Author Participation (NEW)</td>
</tr>
<tr>
<td></td>
<td>Immunization Medication Information (V2)</td>
</tr>
<tr>
<td></td>
<td>Indication (V2)</td>
</tr>
<tr>
<td></td>
<td>Instruction (V2)</td>
</tr>
<tr>
<td></td>
<td>Medication Information (V2)</td>
</tr>
<tr>
<td></td>
<td>Patient Priority Preference (NEW)</td>
</tr>
<tr>
<td></td>
<td>Planned Coverage (NEW)</td>
</tr>
<tr>
<td></td>
<td>Product Instance</td>
</tr>
<tr>
<td></td>
<td>Provider Priority Preference (NEW)</td>
</tr>
</tbody>
</table>

This template represents both medicinal and non-medicinal supplies for the patient (e.g. medication prescription, order for wheelchair). The importance of the supply order to the patient and provider may be indicated in the Patient Priority Preference and Provider Priority Preference.

The effective time indicates the time when the supply took place or is intended to take place and author time indicates when the documentation of the order occurred. The Supply Order template may also indicate the potential insurance coverage for the procedure.

Depending on the type of supply, the product or participant will be either a Medication Information product (medication), an Immunization Medication Information product (immunization), or a Product Instance participant (device/equipment).

All entries in the Supply Order Template must be placed orders (moodCode = RQO).

Note: the *Supply Order (CDP1)* template is a copy of the C-CDA R2 Planned Supply (V2) template (2.16.840.1.113883.10.20.22.4.43.2) with additional constraints on moodCode and statusCode to select only placed orders (moodCode = RQO and statusCode = completed or active). A new OID was assigned along with new conformance statements because of the change in name to reflect the use of the entry level template and the additional constraints.
Table 41: Supply Order (CDP1) Constraints Overview

<table>
<thead>
<tr>
<th>XPath</th>
<th>Card.</th>
<th>Verb</th>
<th>Data Type</th>
<th>CONF#</th>
<th>Fixed Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>supply[templateId/@root = '2.16.840.1.113883.10.20.35.4.8']</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>@classCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP14201</td>
<td>2.16.840.1.113883.5.6 (HL7ActClass) = SPLY</td>
</tr>
<tr>
<td>@moodCode</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP14202</td>
<td>2.16.840.1.113883.11.20.9.2 moodCode = RQO</td>
</tr>
<tr>
<td>templateId</td>
<td>1..1</td>
<td>SHALL</td>
<td></td>
<td>CDP14203</td>
<td></td>
</tr>
<tr>
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| @typeCode                    | 1..1  | SHALL|           | CDP14220                                       | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REF

|                             |       |      |           |                                                |                                                                             |
| observation                 | 1..1  | SHALL|           | CDP14221                                       |                                                                             |
| entryRelationship           | 0..*  | MAY  |           | CDP14222                                       |                                                                             |
| @typeCode                   | 1..1  | SHALL|           | CDP14223                                       | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REF

|                             |       |      |           |                                                |                                                                             |
| observation                 | 1..1  | SHALL|           | CDP14224                                       |                                                                             |
| entryRelationship           | 0..*  | MAY  |           | CDP14225                                       |                                                                             |
| @typeCode                   | 1..1  | SHALL|           | CDP14226                                       | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = RS

|                             |       |      |           |                                                |                                                                             |
| observation                 | 1..1  | SHALL|           | CDP14227                                       |                                                                             |
| entryRelationship           | 0..*  | MAY  |           | CDP14228                                       |                                                                             |
| @typeCode                   | 1..1  | SHALL|           | CDP14229                                       | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = SUBJ

|                             |       |      |           |                                                |                                                                             |
| act                         | 1..1  | SHALL|           | CDP14230                                       |                                                                             |
| entryRelationship           | 0..*  | MAY  |           | CDP14231                                       |                                                                             |
| @typeCode                   | 1..1  | SHALL|           | CDP14232                                       | 2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = Subj

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1. **SHALL** contain exactly one [1..1] \@classCode="SPLY" (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6 STATIC) (CONF:CDP1-4201).

2. **SHALL** contain exactly one [1..1] \@moodCode, which **SHALL** be “RQO” taken from the ValueSet **Planned moodCode (SubstanceAdministration/Supply)** 2.16.840.1.113883.11.20.9.24 STATIC 2011-09-30 (CONF:CDP1-4202).

3. **SHALL** contain exactly one [1..1] templateId (CONF:CDP1-4203) such that it
   a. **SHALL** contain exactly one [1..1] 
      \@root="2.16.840.1.113883.10.20.35.6.1" (CONF:CDP1-4204).

4. **SHALL** contain at least one [1..*] id (CONF:CDP1-4205).

5. **SHALL** contain exactly one [1..1] statusCode which **SHALL** be selected from ValueSet **ActStatus2 2.16.840.1.113883.10.20.35.6.1** (CONF:CDP1-4206).

The effectiveTime in an ordered supply represents the time that the supply was ordered.

6. **SHOULD** contain zero or one [0..1] effectiveTime (CONF:CDP1-4208).

In a Supply order, repeatNumber indicates the number of times the supply event can occur. For example, if a medication is filled at a pharmacy and the the prescription may be refilled 3 more times, the supply RepeatNumber equals 4.

7. **MAY** contain zero or one [0..1] repeatNumber (CONF:CDP1-4209).

8. **MAY** contain zero or one [0..1] quantity (CONF:CDP1-4210).

This product represents medication that is ordered for the patient.

9. **MAY** contain zero or one [0..1] product (CONF:CDP1-4211) such that it
   a. **SHALL** contain exactly one [1..1] **Medication Information** (V2) (templateId:2.16.840.1.113883.10.20.22.4.23.2) (CONF:CDP1-4212).
   b. If the product is Medication Information then the product **SHALL NOT** be Immunization Medication Information and the participant **SHALL NOT** be Product Instance (CONF:CDP1-4234).

This product represents immunization medication that is ordered for the patient.

10. **MAY** contain zero or one [0..1] product (CONF:CDP1-4213) such that it
    a. **SHALL** contain exactly one [1..1] **Immunization Medication Information** (V2) (templateId:2.16.840.1.113883.10.20.22.4.54.2) (CONF:CDP1-4214).
    b. If the product is Immunization Medication Information then the product **SHALL NOT** be Medication Information and the participant **SHALL NOT** be Product Instance (CONF:CDP1-4235).

The clinician who is expected to perform the supply could be identified using supply/performer.

11. **MAY** contain zero or more [0..*] performer (CONF:CDP1-4215).

The author in a supply represents the clinician who is requesting the supply.

12. **SHOULD** contain zero or one [0..1] **Author Participation (NEW)** (templateId:2.16.840.1.113883.10.20.22.4.119) (CONF:CDP1-4216).
This participant represents a device that is ordered for the patient.

13. **MAY** contain zero or one [0..1] **participant** (CONF:CDP1-4217) such that it
   a. **SHALL** contain exactly one [1..1] **Product Instance**
      (templateId:2.16.840.1.113883.10.20.22.4.37) (CONF:CDP1-4218).
   b. If the participant is Product Instance then the product **SHALL NOT** be Medication Information (V2) and the product **SHALL NOT** be Immunization Medication Information (V2) (CONF:CDP1-4236).

This entryRelationship represents the priority that a patient places on the supply.

14. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4219) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-4220).
   b. **SHALL** contain exactly one [1..1] **Patient Priority Preference** (NEW) (templateId:2.16.840.1.113883.10.20.22.4.142) (CONF:CDP1-4221).

This entryRelationship represents the priority that a provider places on the supply.

15. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4222) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:31123).
   b. **SHALL** contain exactly one [1..1] **Provider Priority Preference** (NEW) (templateId:2.16.840.1.113883.10.20.22.4.143) (CONF:CDP1-4224).

This entryRelationship represents the indication for the supply.

16. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4225) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="RSON" Has Reason
   b. **SHALL** contain exactly one [1..1] **Indication** (V2)
      (templateId:2.16.840.1.113883.10.20.22.4.19.2) (CONF:CDP1-4227).

This entryRelationship captures any instructions associated with the supply order.

17. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4228) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="SUBJ" Has Subject
      (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CDP1-4229).
   b. **SHALL** contain exactly one [1..1] **Instruction** (V2)
      (templateId:2.16.840.1.113883.10.20.22.4.20.2) (CONF:CDP1-4230).

This entryRelationship represents the insurance coverage the patient may have for the supply.

18. **MAY** contain zero or more [0..*] **entryRelationship** (CONF:CDP1-4231) such that it
   a. **SHALL** contain exactly one [1..1] @typeCode="COMP" Has Component
b. **SHALL** contain exactly one [1..1] Planned Coverage (NEW) (templateId:2.16.840.1.113883.10.20.22.4.129) (CONF:CDP1-4233).
Figure 31: Supply Order (CDP1) Example

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<supply moodCode="RQO" classCode="SPLY">
  <templateId root="2.16.840.1.113883.10.20.35.4.8" />
  <Supply Order (CDP1) -->
  <id root="9a6d1bac-17d3-4195-89c4-1121bc809b5d" />
  <statusCode code="completed" />
  <!-- The effectiveTime in a supply order represents the time that the order should occur. -->
  <effectiveTime value="20130615" />
  <repeatNumber value="1" />
  <quantity value="3" />
  <!-- This product represents medication that is ordered for the patient. -->
  <product>
    <manufacturedProduct classCode="MANU">
      <!-- Medication Information (V2) -->
      <templateId root="2.16.840.1.113883.10.20.22.4.23.2" />
      <id root="2a620155-9d11-439e-92b3-5d9815ff4ee8" />
      <manufacturedMaterial>
        <code code="573621" codeSystem="2.16.840.1.113883.6.88" displayName="Proventil 0.09 MG/ACTUAT inhalant solution">
          <originalText>
            <reference value="#MedSec_1" />
          </originalText>
          <originalText>
            <translation code="573621" displayName="Proventil 0.09 MG/ACTUAT inhalant solution" codeSystem="2.16.840.1.113883.6.88" codeSystemName="RxNorm" />
          </originalText>
        </code>
      </manufacturedMaterial>
      <manufacturerOrganization>
        <name>Medication Factory Inc.</name>
      </manufacturerOrganization>
      <manufacturedProduct>
      </product>
      <!-- The clinician who is expected to perform the supply could be identified using supply/performer. -->
      <performer>
        ...
      </performer>
      <!-- The author in a supply represents the clinician who is requesting the supply. -->
      <author typeCode="AUT">
        ...
      </author>
      <entryRelationship typeCode="REFR">
        <!-- Patient Priority Preference -->
        ...
      </entryRelationship>
      <entryRelationship typeCode="REFR">
        <!-- Provider Priority Preference -->
        ...
      </entryRelationship>
      <entryRelationship typeCode="RSON">
        <!-- Indication (V2) -->
        ...
      </entryRelationship>
    </manufacturedProduct>
  </product>
</supply>
```
<entryRelationship typeCode="SUBJ">
  <!-- Instruction (V2) -->
  ...
</entryRelationship>

<entryRelationship typeCode="COMP">
  <!-- Planned Coverage -->
  ...
</entryRelationship>
</supply>
9 REFERENCES

- Extensible Markup Language (XML) 1.0 (Fifth Edition), [http://www.w3c.org/TR/2008/REC-xml-20081126/](http://www.w3c.org/TR/2008/REC-xml-20081126/)
- HL7 Implementation Guide for CDA Release 2: Consultation Notes, (U.S. Realm), Draft Standard for Trial Use, Release 1, Levels 1, 2, and 3, DSTU Updated: January 2010
- HL7 Implementation Guide for CDA Release 2: History and Physical (H&P) Notes (U.S. Realm) Draft Standard for Trial Use, Release 1, Levels 1, 2, and 3 A CDA Implementation guide for History and Physical Notes, DSTU Updated: January 2010
- HL7 Implementation Guide for CDA Release 2: Procedure Note (Universal Realm), Draft Standard for Trial Use, Release 1, Levels 1, 2, and 3, July 2010
- HL7 Implementation Guide for CDA Release 2: Unstructured Documents, Release 1, Level 1 (Universal Realm), Draft Standard for Trial Use, September 2010
- Implementation Guide for CDA Release 2.0 Operative Note, (U.S. Realm), Draft Standard for Trial Use, Release 1, Levels 1, 2 and 3, Published, March 2009
- Implementation Guide for CDA Release 2.0, Care Record Summary Release 2 Discharge Summary, (U.S. Realm) Draft Standard for Trial Use, Levels 1, 2 and 3, December 2009
- Implementation Guide for CDA Release 2.0, Progress Note (U.S. Realm), Draft Standard for Trial Use, Levels 1, 2, and 3, January 2011

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HL7 DSTU ballot January 2015
A007-FE2C65F77075/0/CMS_New_Revised_HAP_FINAL_withScoring.pdf (page 26).

- XML Path Language (XPath), Version 1.0. [http://www.w3.org/TR/xpath/](http://www.w3.org/TR/xpath/)
- ASC X12 277 – Health Care Claim Request for Additional Information
- ASC X12 275 – Additional Information to Support a Health Care Claim or Encounter
- ASC X12 278 – Health Care Services Request for Review and Response
- ASC X12 275 – Additional Information to Support a Health Care Service Review
## 10 Template IDs

**CDP1** – template ID is in this guide only

**C-CDA R2** – template ID from C-CDA R2 is explicitly incorporated by reference in this guide

### Table 42: Template List

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# 11 Value Sets in this Guide

**Table 43: Valueset List**

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**Table 44: ActStatus2**

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Contains the names (codes) for states in the state-machine of the RIM Act class used in this guide.

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### 12 Code Systems in This Guide

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## APPENDIX A — ACRONYMS AND ABBREVIATIONS

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<th>Acronym</th>
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<td>Activities of Daily Living</td>
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<td>C-CDA R2 V2</td>
<td>Consolidated CDA Release 2 Volume 2</td>
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<tr>
<td>CCD</td>
<td>Continuity of Care Document</td>
</tr>
<tr>
<td>CDA</td>
<td>Clinical Document Architecture</td>
</tr>
<tr>
<td>CDA R2</td>
<td>Clinical Document Architecture Release 2</td>
</tr>
<tr>
<td>CDE</td>
<td>Clinical Data Element</td>
</tr>
<tr>
<td>CDP1</td>
<td>Clinical Documents for Payers – Set 1 (this document)</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>DSTU</td>
<td>Draft Standard for Trial Use</td>
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<tr>
<td>EHR</td>
<td>electronic health record</td>
</tr>
<tr>
<td>esMD</td>
<td>electronic submission of Medical Documentation</td>
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<td>H&amp;P</td>
<td>History and Physical</td>
</tr>
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<td>HIT</td>
<td>healthcare information technology</td>
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<td>HL7</td>
<td>Health Level Seven</td>
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<td>HTML</td>
<td>Hypertext Markup Language</td>
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<td>IADL</td>
<td>Instrumental Activities of Daily Living</td>
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<td>ICD</td>
<td>International Classification of Diseases</td>
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<td>IG</td>
<td>Implementation Guide</td>
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<td>IHE</td>
<td>Integrating the Healthcare Enterprise</td>
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<td>LOINC</td>
<td>Logical Observation Identifiers Names and Codes</td>
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<tr>
<td>MIME</td>
<td>Multipurpose Internet Mail Extensions</td>
</tr>
<tr>
<td>NUBC</td>
<td>National Uniform Billing Committee</td>
</tr>
<tr>
<td>ONC</td>
<td>Office of National Coordinator</td>
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<tr>
<td>PDF</td>
<td>portable document format</td>
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<td>RIM</td>
<td>Reference Information Model</td>
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<td>S&amp;I</td>
<td>Standards and Interoperability</td>
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<td>SDWG</td>
<td>Structured Documents Working Group</td>
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<td>SNOMED CT</td>
<td>Systemized Nomenclature for Medicine – Clinical Terms</td>
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<td>SWG</td>
<td>Sub Work Group</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------</td>
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<tr>
<td>UCUM</td>
<td>Unified Code for Units of Measure</td>
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<tr>
<td>UML</td>
<td>Unified Modeling Language</td>
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<tr>
<td>URL</td>
<td>Uniform Resource Locator</td>
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<td>VIS</td>
<td>Vaccine Information Statement</td>
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<td>XML</td>
<td>eXtensible Markup language</td>
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<td>XPath</td>
<td>XML Path Language</td>
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APPENDIX B — EXTENSIONS TO CDA R2

This implementation guide inherits all extensions from the C-CDA R2 – see C-CDA R2 V1 Appendix C (Extensions to CDA R2) for details.
APPENDIX C — MIME MULTIPART/RELATED MESSAGES

APPENDIX D — USAGE

D.1 Overview

The document-level templates defined in this implementation guide, in conjunction with document-level templates from the C-CDA R2, provide a positive attestation as to the presence or absence of all relevant clinical and administrative information from a single encounter between a provider and a patient. When these documents are created by a conformant EHR, the provider is able to communicate all information relative to the encounter with the patient and assert that information is not available or not applicable for each “required” section (see section 3.4 on use of null flavors). If the provider then applies a digital signature to the document, the result is a non-repudiation declaration of the relevant encounter information.

D.2 Purpose

See section 1.2 Purpose These document templates are designed for use when the provider needs to exchange a more comprehensive set of clinical information than is supported by the C-CDA R2 document-level templates and/or must declare why information for specific section-level or entry-level templates are not included. For example, payers may allow providers to submit any information they feel substantiates that a services is medically necessary and appropriate under the applicable coverage determination rules. The ability to submit any supporting documentation is a provider’s right under these rules and the ability to declare why specific information is not available which allows payers to avoid requesting additional documentation from the provider when such a request cannot be fulfilled.

Note: Use of these more comprehensive document templates may be inappropriate for clinical or administrative purposes where the provider’s intent is to exchange only limited information about the encounter with the patient.
D.3 Document Template Use

This table describes the use of one or more document templates to describe the relevant clinical information in a single encounter between a provider and patient.

Table 46: Document Template Use

<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>Structured Documents</th>
<th>Complete Documents Templates</th>
<th>C-CDA R2</th>
<th>C-CDA R2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>Base</td>
<td>n/a</td>
<td>n/a</td>
<td>As Needed</td>
</tr>
<tr>
<td>Consult</td>
<td>Base</td>
<td>n/a</td>
<td>n/a</td>
<td>As Needed</td>
</tr>
<tr>
<td>Home Health</td>
<td>Base</td>
<td>n/a</td>
<td>As Needed</td>
<td>As Needed</td>
</tr>
<tr>
<td>LTC</td>
<td>As Needed</td>
<td>Base</td>
<td>Per period</td>
<td>As Needed</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>As Needed</td>
<td>Base</td>
<td>Per period</td>
<td>As Needed</td>
</tr>
</tbody>
</table>

Legend:
1) Base – primary document for this type of encounter (e.g. Complete Encounter Document)
2) n/a – not applicable – not expected for this encounter type
3) As Needed – documents that may be necessary for the encounter type to describe the entire visit with the patient (e.g. if a colonoscopy is performed during a consult, the documentation should consist of both a Complete Encounter Document and a Complete Procedure document)
4) Per Period – used to represent documentation that is created on a periodic basis (e.g. a shift, a day) in addition to the Base.
5) Optional – may substitute for or be supplied in addition to the Base.

The other document types defined in the C-CDA R2 may be used for any of the original intended clinical or administrative purposes where the provider deems the information contained in the document type for the encounter necessary and sufficient for the intended purpose.

D.4 Contents of New Document Templates

Each new document-level template contains, all of the sections defined for the C-CDA R2 document level template(s) listed. Please note that all new document templates require the contents of each section or a null flavor to define why the information is not included (see Section 3.4 on use of null flavors). Each new document type includes additional section level templates that are defined or additionally constrained in this implementation guide.

1) Complete Encounter Document includes all:
   a. C-CDA R2 Progress Note Document sections
   b. C-CDA R2 Consult Document sections
   c. C-CDA R2 History and Physical Document sections
2) Complete Hospitalization Document includes all:
   a. C-CDA R2 Discharge Summary Document sections
   b. C-CDA R2 History and Physical Document sections
3) Complete Procedure Document includes all:
   a. C-CDA R2 Procedure Document sections
4) Complete Operative Note Document includes all:
   a. C-CDA R2 Operative Note Document sections
5) Time Boxed Document has no equivalent templates.

### D.5 Comparison Tables

The following tables provide a comparison of the new Document Level templates in this implementation guide versus the existing Document Level templates in the C-CDA R2.

Definitions:
- **Src** = source of section

<table>
<thead>
<tr>
<th>Src</th>
<th>V1.1</th>
<th>V2</th>
<th>New</th>
<th>V2-CDP1</th>
<th>CDP1</th>
<th>V2-CDP1</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>from C-CDA R1.1 and unchanged in C-CDA R2</td>
<td>from C-CDA R1.1 with new version in C-CDA R2</td>
<td>new in C-CDA R2</td>
<td>from C-CDA R2 with additional constraints</td>
<td>new in this guide</td>
<td>uses the V2-CDP1 section version</td>
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</tbody>
</table>

Cardinality
- **SHALL** = [1..1], or [1,*]
- **SHOULD** = [0..1], or [0,*]
- **May** = [0..1], or [0,*]
- **SHALL** = additional constraints are applied
- **May** = additional constraints are applied

<table>
<thead>
<tr>
<th>Table 47: Comparison of C-CDA R2 and CDP1 Operative Note and Procedure Note Templates</th>
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<tbody>
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<td><strong>Sections in CCDA</strong></td>
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<td>New Sections</td>
</tr>
<tr>
<td>Additional Documentation Section (CDP1)</td>
</tr>
<tr>
<td>Externally Defined CDE Section (CDP1)</td>
</tr>
<tr>
<td>Orders Placed Section (CDP1)</td>
</tr>
<tr>
<td>Additionally Constrained Sections</td>
</tr>
<tr>
<td>Plan of Treatment Section (CDP1)</td>
</tr>
<tr>
<td>Social History Section (CDP1)</td>
</tr>
<tr>
<td>Existing Sections (includes R2 of above)</td>
</tr>
<tr>
<td>Allergies Section (entries optional)</td>
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<td>Assessment and Plan Section</td>
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<td>Allergies Section (entries required)</td>
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<tr>
<td>Assessment and Plan Section</td>
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<td>MAY*</td>
<td>SHALL*</td>
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<td>SHALL*</td>
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<tr>
<td>Chief Complaint and Reason for Visit Section</td>
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<td>MAY*</td>
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Table 49: Comparison of C-CDA R2 Discharge Summary, History and Physical, and CDP1 Enhanced Hospitalization
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### Table 50: Comparison of CDP1 Document-Level Templates

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E.1 Relationship of standards and Implementation Guides

The HL7 Clinical Document Architecture Release 2 (CDA R2) is based on the HL7 Reference Information Model and the W3C XML standard. Release 1.1 and 2 of the Consolidated CDA are both based on CDA R2 and are designated C-CDA R1.1 and C-CDA R2 respectively. This document is the Complete Document Templates, references the C-CDA R2 and is designated CDP1. C-CDA R1.1 is DSTU. C-CDA R2 and CDP1 are balloted as DSTU. The Attachments Work Group created a Supplemental Implementation Guide to describe how a payer requests a C-CDA document by LOINC code from a provider using an ANS X12N 277 or 278 transaction and receives it using the ASN X12N 275 transaction. This supplemental guide is an Informative guide.
## E.2 Observations vs EHR vs MU2 vs certification

### Table 51: Comparison of MU2/EHR Certification vs C-CDA R2 and CDP1

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