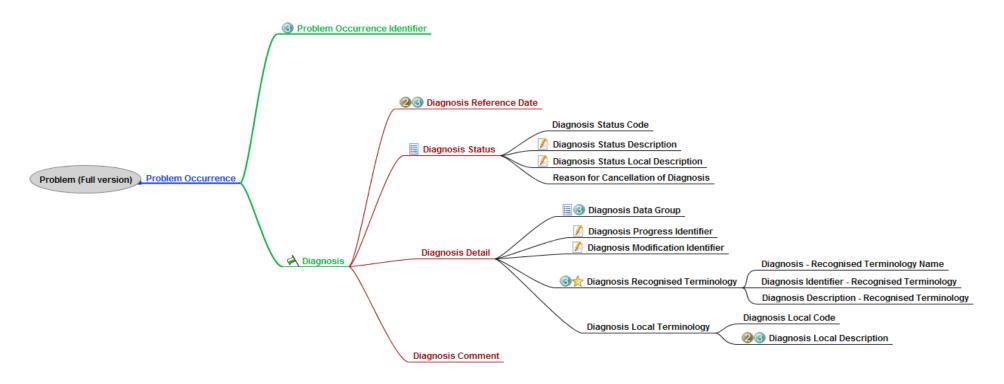


Form	Category 1	Category 2	Category 3	Entity Name	Entity ID	Definition	Data Type (code)	Data Type (description)	Validation Rule	Repeated Data	Code Table	Data requirement (Certified Level 1)	Data requirement (Certified Level 2)	Data requirement (Certified Level 3)	Example (Certified Level 1)	Example (Certified Level 2)	Example (Certified Level 3)
Problem (Simplified version)	Diagnosis			Diagnosis reference date		Date when the diagnosis was created. For eHR, if this date is not available, the last update date of the diagnosis should be used when submitting data to the eHR	TS	Time Stamp		R		NA	М	М		06/12/2010	06/12/2010
Problem (Simplified version)	Diagnosis	Diagnosis Status		Diagnosis status code	1003579	[eHR value] of the "Diagnosis status" code table which is used to identify the status of a reported diagnosis	CE	Coded Element		R	Diagnosis status	NA	NA	0			С
Problem (Simplified version)	Diagnosis	Diagnosis Status		Diagnosis status description	1003580	[eHR description] of the "Diagnosis status" code table which is used to identify the status of a reported diagnosis. The [Diagnosis status description] should be the corresponding description of the selected [Diagnosis status code]		String		R	Diagnosis status	NA .	NA	M if [Diagnosis status code] is given; NA if [Diagnosis status code] is blank			Cancelled
Problem (Simplified version)	Diagnosis	Diagnosis Status		Diagnosis status local description	1003581	Local description of the diagnosis status	ST	String		R		NA	0	M if [Diagnosis status code] is given; NA if [Diagnosis status code] is blank		not active	Wrong
Problem (Simplified version)	Diagnosis	Diagnosis Status		Reason for cancellation of diagnosis	1003582	The stated reason for cancelling the diagnosis	ST	String		R		NA	NA	O if [Diagnosis Status Code] is "C"; NA if [Diagnosis Status Code] is not "C"			Wrong diagnosis as no evidence supported that patient has this condition
Problem (Simplified version)	Diagnosis	Diagnosis Detail	Diagnosis Recognised Terminology	Diagnosis - recognised terminology name	1003583	Name of the recognised terminology / classification from which the diagnosis is referenced to	CE	Coded Element	If eHR value=1)HKCTT, Nature must be Diagnosis; 2)SNOMED CT, Clinical Finding or Situation with Explicit Context are allowed; 3)ICD10 & ICD10 MBD, all items are allowed; 4)ICPC2, all codes except those ended in range 30-69 are allowed	R	Recognised terminology name - problem	NA	NA	М			нкстт
Problem (Simplified version)	Diagnosis	Diagnosis Detail	Diagnosis Recognised Terminology	Diagnosis identifier - recognised terminology	1003584	Unique identifier of the reported diagnosis in the recognised terminology	CE	Coded Element	it should be included in the selected terminology of the "Recognised terminology name - Problem" code table: 1)HKCTT should be TermID; 2)SNOMEC CT should be ConceptID; 3)ICPC2, ICD10 & ICD10 MBD should be code	R		NA	NA	М			1234
Problem (Simplified version)	Diagnosis	Diagnosis Detail	Diagnosis Recognised Terminology	Diagnosis description - recognised terminology	1003585	The description of the reported diagnosis in the recognised reminology. It should be the corresponding description of the selected [Diagnosis identifier - recognised terminology].	CE	Coded Element	The description of the selected [Diagnosis identifier - recognised terminology] should be matched as: 1)HKCTT should be eHR description; 2SNOMED CT should be Preferred term; 3)(CD10 & ICD10 MBD should be Full name; 4)ICPC2 should be Full description	R		NA NA	NA	М			Transient ischaemic attack
Problem (Simplified version)	Diagnosis	Diagnosis Detail	Diagnosis Local Terminology	Diagnosis local code	1003586	Local code created by the healthcare provider for the reported diagnosis	ST	String		R		NA	0	0		332	332
Problem (Simplified version)	Diagnosis	Diagnosis Detail	Diagnosis Local Terminology	Diagnosis local description	1003587	Local description created by the healthcare provider for the reported diagnosis	ST	String		R		NA	М	М		Transient ischaemic attack - TIA	Transient ischaemic attack - TIA
Problem (Simplified version)	Diagnosis			Diagnosis comment	1003588	Comment made on the reported diagnosis	ST	String		R		NA	0	0		affect left side of body	affect left side of body

eHR Sharable Data - Problem



Form	Category 1	Category 2	Category	Category	Entity Name	Entity ID	Definition	Data	Data Type	Validation Rule		Code Table	Data requirement	Data requirement				Example (Certified
			3	4				Type (code)	(description)		Data		(Certified Level 1)	(Certified Level 2)	(Certified Level 3)	Level 1)	Level 2)	Level 3)
Problem (Full	Problem				Problem occurrence	1003596	Identifier of individual problem occurrence which	ST	String				NA	NA	M			7896
version)	Occurrence				identifier		represents incidents of the reported diagnosis							M				
Problem (Full version)	Problem Occurrence	Diagnosis			Diagnosis reference date	1003578	Date when the diagnosis was created. For eHR, if this date is not available, the last update date of the	TS	Time Stamp		ĸ		NA	M	M		06/12/2010	06/12/2010
version)	Occurrence						diagnosis should be used when submitting data to the											
							eHR											
Problem (Full	Problem	Diagnosis	Diagnosis		Diagnosis status code	1003579	[eHR value] of the "Diagnosis status" code table which	CE	Coded Element		R	Diagnosis status	NA	NA	0			С
version)	Occurrence		Status				is used to identify the status of a reported diagnosis											
Problem (Full	Problem	Diagnosis	Diagnosis		Diagnosis status	1002500	[eHR description] of the "Diagnosis status" code table	ет	String		D	Diagnosis status	NA	NA NA	M if [Diagnosis status code]			Cancelled
version)	Occurrence	Diagnosis	Status		description	1000000	which is used to identify the status of a reported	31	Sung		1	Diagnosis status	ING	ING	is given;			Caricelled
,							diagnosis. The [Diagnosis status description] should be								NA if [Diagnosis status code]			
							the corresponding description of the selected [Diagnosis								is blank			
Doubless (Full	Deckless	Diament's	Diament's		Diameter status level	4000504	status code]	ST	Otelere				NA NA	0	M // /Diamonia status as dal			14/
Problem (Full version)	Problem Occurrence	Diagnosis	Diagnosis Status		Diagnosis status local description	1003581	Local description of the diagnosis status	51	String		K		NA	U	M if [Diagnosis status code] is given;		not active	Wrong
vortioni	Cocarronce		Olaldo		Goodipion										NA if [Diagnosis status code]			
															is blank			
Problem (Full	Problem	Diagnosis	Diagnosis			1003582	The stated reason for cancelling the diagnosis	ST	String		R		NA	NA	O if [Diagnosis Status Code]			Wrong diagnosis as no
version)	Occurrence		Status		diagnosis										is "C" ; NA if [Diagnosis			evidence supported
															Status Code] is not "C"			that patient has this condition
																		Condition
Problem (Full	Problem	Diagnosis	Diagnosis		Diagnosis data group	1003597	[eHR value] of "Data group" code table which is used to	CE	Coded Element	Only if "Data Group" = C or D or E, allow multiple	R	Data group	NA	NA	M			D
version)	Occurrence		Detail				define the group of data submitted for the diagnosis											
Problem (Full	Problem	Discounts	Diament's	-	Diameter	4000500	I de altre est de la ficial de la companya de la co	OT	Otelere	Management of the state of the ID-10 Court of Court of the ID-10 Court			NA	NA NA	M if "Data Group" = C or D			35885
version)	Occurrence	Diagnosis	Diagnosis Detail		Diagnosis progress identifier	1003598	Identifier of individual progress issued by the healthcare insitution for diagnosis not created in "Clinical Data	51	String	Mandatory for data with "Data Group" = C or D or E	K		NA	NA NA	or E :			35885
vortion)	Cocarronce		Dottan		i dell'allo		Framework"			Optional for data with "Data Group" = H					O if "Data Group" = H			
										·								
Problem (Full	Problem	Diagnosis	Diagnosis		Diagnosis modification	1003599	Identifier of individual progress issued by the healthcare	ST	String	Mandatory for data with "Data Group" = C or E or H	R		NA	NA	M if "Data Group" = C or E			20005
version)	Occurrence		Detail		identifier		insitution for diagnosis data created in "Clinical Data Framework"			;					or H; O if "Data Group" = D			
							Framework			Optional for data with "Data Group" = D					O ir "Data Group" = D			
Problem (Full	Problem	Diagnosis	Diagnosis	Diagnosis	Diagnosis - recognised	1003583	Name of the recognised terminology / classification	CE	Coded Element	If eHR value=1)HKCTT, Nature must be Diagnosis;	R	Recognised	NA	NA	M			HKCTT
version)	Occurrence	_	Detail		terminology name		from which the diagnosis is referenced to			2)SNOMED CT, Clinical Finding or Situation with		terminology name						
				Terminology						Explicit Context are allowed; 3)ICD10 & ICD10 MBD, all items are allowed; 4)ICPC2, all codes		- problem						
										except those ended in range 30-69 are allowed								
										CADOPI WICHO CHICAGO IN TUNIGO CO CO CITO CHICAGO								
Problem (Full	Problem	Diagnosis	Diagnosis	Diagnosis	Diagnosis identifier -	1003584	Unique identifier of the reported diagnosis in the	CE	Coded Element	It should be included in the selected terminology of	R		NA	NA	M			1234
version)	Occurrence		Detail		recognised terminology		recognised terminology			the "Recognised terminology name - Problem" code								
				Terminology						table: 1)HKCTT should be TermID; 2)SNOMED CT should be ConceptID; 3)ICPC2, ICD10 & ICD10								
										MBD should be code								
Problem (Full	Problem	Diagnosis	Diagnosis	Diagnosis	Diagnosis description -	1003585	The description of the reported diagnosis in the	CE	Coded Element	The description of the selected [Diagnosis identifier	R		NA	NA	M			Transient ischaemic
version)	Occurrence		Detail	Recognised			recognised terminology. It should be the corresponding			recognised terminology] should be matched as:								attack
				Terminology			description of the selected [Diagnosis identifier - recognised terminology].			1)HKCTT should be eHR description; 2)SNOMED CT should be Preferred term; 3)ICD10 & ICD10								
							recognised terminologyj.			MBD should be Full name; 4)ICPC2 should be Full								
										description								
																		1
Problem (Full	Problem	Diagnosis	Diagnosis	Diagnosis	Diagnosis local code	1003586	Local code created by the healthcare provider for the	ST	String		R		NA	0	0		332	332
version)	Occurrence	D.a.g. 10313	Detail	Local	Diagnosis isodi code		reported diagnosis	J .	Cumg		l'`		140	3			50 <u>2</u>	332
,			1	Terminology														
			1													_		
Problem (Full	Problem	Diagnosis	Diagnosis Detail	Diagnosis	Diagnosis local description	1003587	Local description created by the healthcare provider for	ST	String		R		NA	М	M	Ti	ransient ischaemic attack - TIA	Transient ischaemic attack - TIA
version)	Occurrence		Detail	Local Terminology			the reported diagnosis										auack - HA	attack - IIA
	1		1	. similology														
Problem (Full	Problem	Diagnosis			Diagnosis comment	1003588	Comment made on the reported diagnosis	ST	String		R		NA	0	0	aff	ect left side of body	affect left side of body
version)	Occurrence	1				1												

Diagnosis Status

Purpose : to indicate the status of the diagnosis

Source : HA

Term ID	eHR Value	eHR Description	Definition
9050360	Р	Provisional	Diagnosis not confirmed
9050003	Α	Active	Under management
9050192	I	Inactive	No active treatment required
9050379	R	Resolved	Cured
9050058	С	Cancelled	Cancel

Data Group Table

Purpose: To identify the group of data in diagnosis and procedure

Reference: eHR & HA

Term ID	eHR Value	eHR Description
9050076	Η	Clinical Data Framework name
9050075	С	Clinical Data Framework intrinsic data
9050074	E	Clinical Data Framework extrinsic data
9050369	D	Recognised terminology

Recognised terminology name - problem

Purpose: To define the names of the recognised terminology for problem

Reference eHR

Term ID	eHR Value	eHR Description	Allowable Values
9050183	HKCTT	Hong Kong Clinical Terminology Table	Nature= Diagnosis
9050434	SNOMED CT	Systematized Nomenclature of Medicine - Clinical Terms	Hierarchy = Clinical finding, Situation
9050203	ICD10-2001	International Statistical Classification of Diseases and Related Health Problems Tenth Revision (2001)	Valid ICD 10 codes
9050204	ICD10-2010	International Statistical Classification of Diseases and Related Health Problems Tenth Revision (2010)	Valid ICD 10 codes
9050186	ICD10-MBD	ICD-10 Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines	Valid ICD 10 MBD codes
9050202	ICPC2	International Classification for Primary Care, Second	Valid ICPC2 codes - excluding those with last 2 digits in the range of 30-69