Form	Entity Name	Entity ID	Definition	Data Type (code)	Data Type (description)	Validation Rule	Repeated Data	Code Table	Data requirement (Certified Level 1)	Example (Certified Level 1)
Clinical Note / Summary	Report start date		The start date of the report of the healthcare service: 1) For In-patient: Use Admission Date 2) For out-patient: Use Attendance Date 3) For A&E: Use A&E Admission Date	TS	Time stamp				M	9/12/2010
Clinical Note / Summary	Report end date		The end date of the report of the healthcare service: 1) For In-patient: Use Discharge Date 2) For out-patient: Optional 3) For A&E: Use A&E Discharge Date	TS	Time stamp	Not earlier than the [Report start date]			M if [Type of clinical note / summary] eHR value = "IP" & "A&E"	16/09/2010
Clinical Note / Summary	Type of clinical note / summary code		eHR value of the "Type of clinical note / summary" code table	CE	Coded element			Type of clinical note / summary	M	IP
Clinical Note / Summary	Type of clinical note / summary description		eHR description of the "Type of clinical note / summary" code table, [Type of clinical note / summary description] should match with [Type of clinical note / summary code]	ST	String			Type of clinical note / summary	M	In-patient record
Clinical Note / Summary	Type of clinical note / summary local description		Local description of the type of clinical note / summary	ST	String				M	Hospitalisation record
Clinical Note / Summary	Clinical note / summary report title		Report title of the clinical note / summary	ST	String				M	Discharge summary
Clinical Note / Summary	Clinical note / summary report date		The documentation date of the clinical note / summary report, If this documentation date is not available, use the report creation date.	TS	Time stamp				O	1/2/2012
Clinical Note / Summary	Clinical note / summary report (PDF)		Clinical note / summary report in Portable Document Format (PDF)	ED	Encapsulated data				M if [Clinical note / summary report (Text)] is blank	
Clinical Note / Summary	Clinical note / summary report (Text)		Clinical note / summary report in text format	TX	Text				M if [Clinical note / summary report (PDF)] is blank	
Clinical Note / Summary	Clinical note / summary highlight		Summary of important notes for the clinical note / summary, e.g. important findings	ST	String				O	Fever for Ix
Clinical Note / Summary	Clinical note / summary remark		The additional information about the clinical note / summary	TX	Text				O	abc

Type of clinical note / summary
Purpose : To indicate type of clinical note / summary
Source : HA ePR

Term ID	eHR Value	eHR Description	Definition
	AE	Accident and emergency record	Record generated during receiving care in Accident and Emergency
	OP	Outpatient record	Record generated during out-patient attendance
	IP	Inpatient record	Record generated during inpatient care
	OTH	Other record	Record generated with unidentified healthcare service type is received