Form	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 reference date		This refers to the date when the diagnosis is last updated.	TS	Time Stamp		R		NA	M	M		6/12/2010	6/12/2010
Problem (Simplified version)	Diagnosis status code		eHR value of the "Diagnosis status" code table.	CE	Coded Element		R	Diagnosis status	NA	NA	O			C
Problem (Simplified version)	Diagnosis status description		eHR description of the "Diagnosis status" code table. The [Diagnosis status description] should match with the corresponding description of the selected [Diagnosis status code]	ST	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 status local description		Local description of the diagnosis status	ST	String		R		NA	O	M if [Diagnosis status code] is given; NA if [Diagnosis status code] is blank		Wrong	Wrong
Problem (Simplified version)	Reason for cancellation of diagnosis		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 -recognised terminology name		Recognised terminology / classfication set for the diagnosis	CE	Coded Element	If eHR value = HKCTT, allowable nature is "Diagnosis"; if eHR value = SNOMED CT, allowable hierarchy is "Clinical findings" or "Situation with explicit context"; if eHR value is "ICPC2", allowable items would be all codes except those ended in the range 30-69; if eHR value is "ICD10", all items in the code table is allowed	R	Recognised terminology name - problem	NA	NA	M			HKCTT
Problem (Simplified version)	Diagnosis identifier - recognised terminology		Unique identifier of individual diagnosis in the recognised terminology	CE	Coded Element	[Diagnosis Recognised Terminology Identifier] should be included in the selected terminology of the "Recognised terminology name - Problem" code table	R		NA	NA	M			1234
Problem (Simplified version)	Diagnosis description - recognised terminology		Description of individual diagnosis in the recognised terminology	CE	Coded Element	[Diagnosis description - recognised terminology] should be matched with the corresponding description of the selected [Diagnosis identifier - recognised terminology]	R		NA	NA	M			Transient ischaemic attack
Problem (Simplified version)	Diagnosis local code		Local code of the diagnosis developed by the healthcare organization	ST	String		R		NA	O	O		332	332
Problem (Simplified version)	Diagnosis local description		Local description of the diagnosis developed by the healthcare organization	ST	String		R		NA	M	M		Transient ischaemic attack - TIA	Transient ischaemic attack - TIA
Problem (Simplified version)	Diagnosis comment		Comment of the diagnosis made by the healthcare staff	ST	String		R		NA	O	O		affect left side of body	affect left side of body

Form	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 (Full version)	Problem occurrence identifier		Identifier of the individual problem occurrence	ST	String				NA	NA	M			7896
Problem (Full version)	Diagnosis reference date		This refers to the progress create date of this diagnosis. If this date is not available, the last update date should be submitted.	TS	Time Stamp		R		NA	M	M		6/12/2010	6/12/2010
Problem (Full version)	Diagnosis status code		eHR value of the "Diagnosis status" code table	CE	Coded Element		R	Diagnosis status	NA	NA	O			C
Problem (Full version)	Diagnosis status description		eHR description of the "Diagnosis status" code table. The [Diagnosis status description] should match with the corresponding description of the selected [Diagnosis status code]	ST	String		R	Diagnosis status	NA	NA	M if [Diagnosis status code] is given; NA if [Diagnosis status code] is blank			Cancelled
Problem (Full version)	Diagnosis status local description		Local description of the diagnosis status	ST	String		R		NA	O	M if [Diagnosis status code] is given; NA if [Diagnosis status code] is blank		Wrong	Wrong
Problem (Full version)	Reason for cancellation of diagnosis		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 (Full version)	Diagnosis data group		eHR value of "Data group" code table to define the group of data submitted for the diagnosis	CE	Coded Element	Only if "Data Group" = C or D or E, allow multiple	R	Data group	NA	NA	M			D
Problem (Full version)	Diagnosis progress identifier		Identifier of individual non-CDF progress	ST	String	Mandatory for data with "Data Group" = C or D or E ; Optional for data with "Data Group" = H	R		NA	NA	M if "Data Group" = C or D or E ; O if "Data Group" = H			35885
Problem (Full version)	Diagnosis modification identifier		Identifier of individual CDF progress	ST	String	Mandatory for data with "Data Group" = C or E or H ; Optional for data with "Data Group" = D	R		NA	NA	M if "Data Group" = C or E or H ; O if "Data Group" = D			20005
Problem (Full version)	Diagnosis -recognised terminology name		Recognised terminology / classfication set for the diagnosis	CE	Coded Element	If eHR value = HKCTT, allowable nature is "Diagnosis"; if eHR value = SNOMED CT, allowable hierarchy is "Clinical findings" or "Situation with explicit context"; if eHR value is "ICPC2", allowable items would be all codes except those ended in the range 30-69; if eHR value is "ICD10", all items in the code table is allowed	R	Recognised terminology name - problem	NA	NA	M			HKCTT
Problem (Full version)	Diagnosis identifier - recognised terminology		Unique identifier of individual diagnosis in the recognised terminology	CE	Coded Element	[Diagnosis identifier - recognised terminology identifier] should be included in the selected terminology of the "Recognised terminology name - Problem" code table	R		NA	NA	M			1234
Problem (Full version)	Diagnosis description - recognised terminology		Description of individual diagnosis in the recognised terminology	CE	Coded Element	[Diagnosis description - recognised terminology] should be matched with the corresponding description of the selected [Diagnosis identifier - recognised terminology] ; If [Diagnosis - recognised terminology name] = HKCTT and [Diagnosis data group] = H, eHR description should be provided as [Diagnosis description - recognised terminology]	R		NA	NA	M			Transient ischaemic attack
Problem (Full version)	Diagnosis local code		Local code of the diagnosis developed by the healthcare organization	ST	String		R		NA	O	O		332	332
Problem (Full version)	Diagnosis local description		Local description of the diagnosis developed by the healthcare organization	ST	String		R		NA	M	M		Transient ischaemic attack - TIA	Transient ischaemic attack - TIA
Problem (Full version)	Diagnosis comment		Comment of the diagnosis made by the healthcare staff	ST	String		R		NA	O	O		affect left side of body	affect left side of body

Diagnosis Status
Purpose : to indicate the status of the diagnosis
Source : HA

Term ID	eHR Value	eHR Description
	P	Provisional
	A	Active
	I	Inactive
	R	Resolved
	C	Cancelled

Data Group Table

Purpose : To identify the group of data in problem and procedure domains

Reference: eHR & HA

Term ID	eHR Value	eHR Description
	H	Clinical Data Framework name
	C	Clinical Data Framework intrinsic data
	E	Clinical Data Framework extrinsic data
	D	Recognized terminology

Recognised terminology name - problem

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

Reference: eHR

Term ID	eHR Value	eHR Description
	HKCTT	Hong Kong Clinical Terminology Table
	SNOMED CT	Systematized Nomenclature of Medicine - Clinical Terms
	ICD10-2001	International Statistical Classification of Diseases and Related Health Problems Tenth Revision (2001)
	ICD10-2010	International Statistical Classification of Diseases and Related Health Problems Tenth Revision (2010)
	ICPC2	International Classification for Primary Care, Second edition