Seminar on eHR Content

20 July 2012

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Domains

- Birth record
- Allergy / Adverse drug reaction
- Clinical note / summary
- Radiology examination
- Investigation report
- Referral



BIRTH RECORD



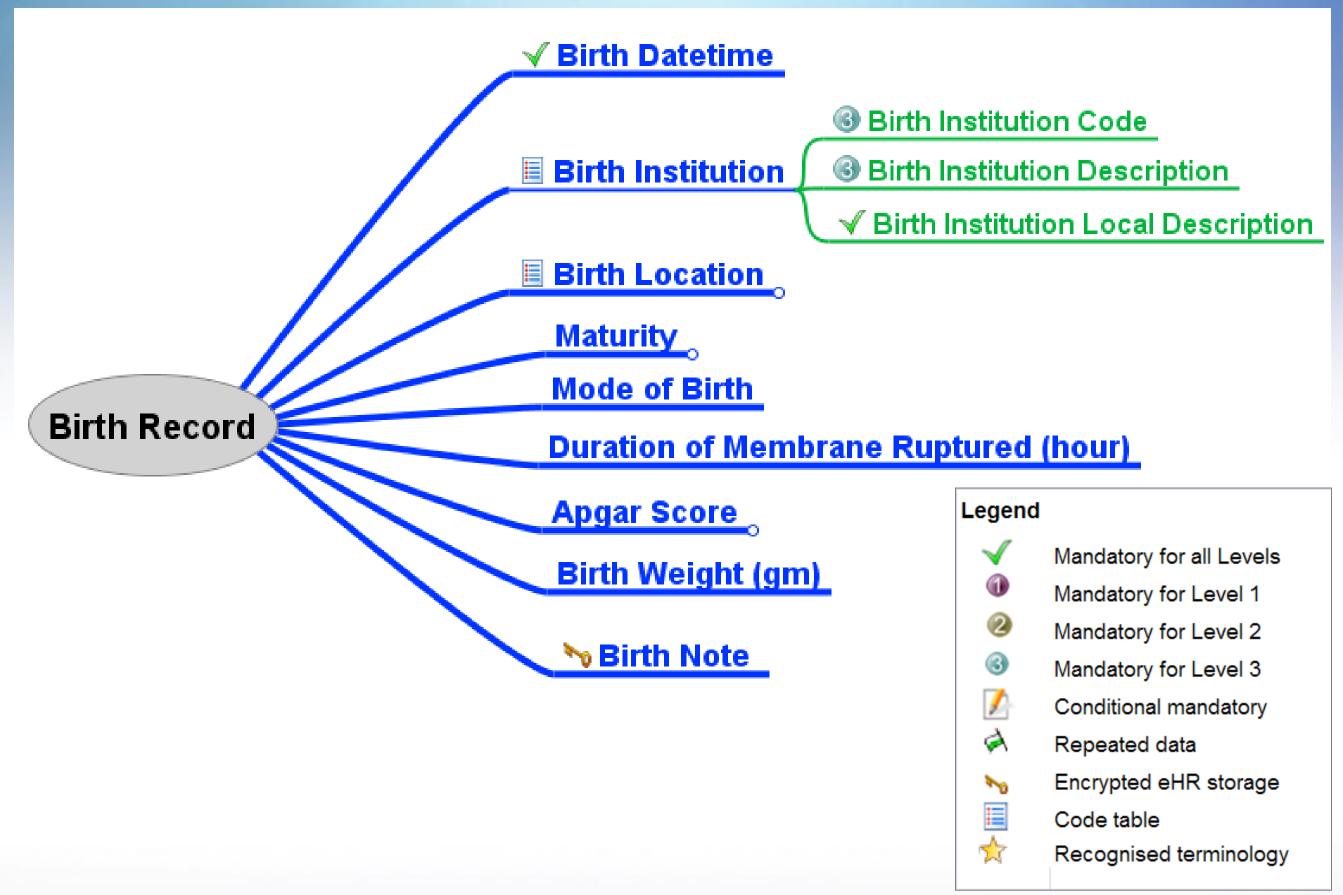
Birth record

 Basic information about the eHR Participant's birth, e.g. birth date time, birth institution, birth weight, maturity, APGAR scores...

 Part of the information relating to birth would be fall under the other sharable scope, e.g. diagnosis, procedure, assessment



Mind map: Birth record



Example – Level 1 (Birth record)

Entity Name	Data requirement	Example (Certified
	(Certified Level 1)	Level 1)
Birth datetime	Μ	11/02/2012
Birth institution local description	М	St. Paul Hospital
Birth note	Ο	abc



Example – Level 2 (Birth record)

Entity Name	Validation Rule	Data requirement	Example
		(Certified Level 2)	(Certified Level 2)
Birth datetime		M	20/12/2011 21:22
Birth institution local description		М	St. Paul Hospital
Birth location local description		0	Born on arrival
Maturity at birth (week)	Value between 20 to 44	Ο	36
Maturity at birth (day)	Value between 1 and 6	O if [Maturity at birth (week)] is given NA if [Maturity at birth (week)] is blank	1
Mode of birth		0	NSD
Duration of membrane ruptured (hour)		0	3
Apgar score (1 min)	Value within 0 to 10	0	8
Apgar score (5 min)	Value within 0 to 10	0	9
Apgar score (10 min)	Value within 0 to 10	0	10
Birth weight (gm)	Value between 400 to 5000	0	2810
Birth note		Ο	abc

Example – Level 3 (Birth record)

	Entity Name	Validation Rule	Code Table	Data requirement	Example (Certified
	•	▼	•	(Certified Level 3)	Level 3) 🕞
	Birth datetime			М	09/12/2001 23:59
(Birth institution code		Birth institution	М	РМН
	Birth institution description		Birth institution	М	Princess Margaret Hospital
	Birth institution local description			М	Princess Margaret Hospital
	Birth location code		Birth location	0	BBA
	Birth location description		Birth location	M if [Birth location code] is given NA if [Birth location code] is blank	Born before arrival
	Birth location local description			M if [Birth location code] is given NA if [Birth location code] is blank	Born in taxi
\bigcap	Maturity at birth (week)	Value between 20 to 44		0	38
	Maturity at birth (day)	Value between 1 and 6		O if [Maturity at birth (week)] is given NA if [Maturity at birth (week)] is blank	5
	Mode of birth			0	LSCS
	Duration of membrane ruptured (hour)			0	2
	Apgar score (1 min)	Value within 0 to 10		0	6
	Apgar score (5 min)	Value within 0 to 10		0	10
	Apgar score (10 min)	Value within 0 to 10		0	10
	Birth weight (gm)	Value between 400 to 5000		0	3150
	Birth note			0	abc

eHR viewer: Birth record

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計算計算 Viewer PPP Programmes	Administration Information		KA MAN WONG 🔛 Log out
OTTO, VON HABSBURG			Close Record X
HKIC : Z2389909 DOB : 04-f	Feb-2007 Age : 5 years Se	ex : M Details ►	Select Participant ►
All Local Non-Local	Birth Records		Legend >
	Place of birth	Hospital	*
🚹 📝 🗟 🖾 🖧 📗 🗡	Birth institution	HKSH	
Clinical Notes & Summary	Date and time of birth	04-Feb-2007 18:00	
Clinical Notes & Summary	Maturity	39 weeks	
Birth Records	Mode of delivery	Emergency LSCS	
Encounters	Duration of membranes ruptured (hour)	1	
Problem & Procedure	Birth weight (gm)	3039	
Problem / Diagnosis	Apgar score - 1 min.	10	
Procedure	Apgar score - 5 min.	10	
Other Investigation	Apgar score - 10 min.		
Medication	Birth Note		
Prescribing History			
Dispensing History			
 Laboratory Record Biochemistry 			
Haematology			
Microbiology			
 Radiology Record 			
Ultrasonography			
Magnetic Resonance Imaging			
Immunisation Record			



Related files: Birth record

- Data schema
 - Birth record

- Codex
 - -Birth institution
 - -Birth location



Data schema: Birth record

Form	Entity Name	Entity ID	Definition	Data	Data Type	Validation	Repeated	Code Table	Data requirement	Data requirement	Data requirement	Example	Example	Example
	· ·			Туре			Data		(Certified Level 1)	(Certified Level 2)	(Certified Level 3)	(Certified Level	(Certified Level	
					(neeculation)	INAL 9	Data		(common nover i)	(contined cover z)	(common cover a)		1 C	•
				(code)								1)	2)	3)
Birth	Birth datetime	100310	The birth date or birth datetime of the	TS	Time stamp				M	M	M	11/02/2012	20/12/2011 21:22	09/12/2001 23:59
Record			eHR Participant											
Birth	Birth Institution code		eHR value of the "Birth Institution" code	CE	Coded			Birth	NA	NA	М			PMH
Record			table, to define the healthcare		element			Institution						
a the other pair			Institution where the eHR Participant		Sector 1 Sector									
The second se	Plate to shi dana		was born					- Alexandre						Defense and Management
Birth	Birth Institution	1003107	eHR description of the "Birth Institution"	31	String			Birth	NA	NA	M			Princess Margaret
Record	description		code table, to define the healthcare					Institution						Hospital
			Institution where the eHR Participant											
			was born. The (Birth Institution											
			description] should match with [Birth											
			Institution code).											
Birth	Birth Institution local	1003108	The local description of the healthcare	ΩT.	String				м	М	М	St. Doui Hocoltal	St. Doui Hospital	Princess Margaret
		1000100	Institution where the eHR Participant	0 1	oung							or, i dai noopitai	or, i dei ricopitali	Hospital
Record	description		•											nospital
			was born											
Birth	Birth location code			CE	Coded			Birth location	NA	NA	0			BBA
Record			table, to define the location where the		element									
			eHR Participant was born											
Birth	Birth location	1003103	eHR description of the "Birth location"	ST	String			Birth location	NA	NA	M If [Birth location			Born before
Record	description		code table, to define the location where		-						code) is given			arrival
			the eHR Participant was born. The								NA If [Birth location			
											code] is blank			
			[Birth location description] should								codej is biank			
			match with [Birth location code].											
Colorian.	Disk Isseites Isseit	4002404	I and dependent on other languages where		Older					~	to the second		Barrier and and	Dame in faul
Birth	Birth location local	1003104	Local description of the location where	SI.	String				NA	0	M If [Birth location		Born on arrival	Born in taxi
Record	description		the eHR Participant was born								code] is given			
											NA If Birth location			
											code) is blank			
Birth	Maturity at birth (week)	100308	The maturity period at birth presents in	NM	Numeric	Value			NA	0	0		36	38
Record			week			between 20								
						to 44								
Birth	Maturity at birth (day)	1003105	The maturity at birth (day) is the	NM	Numeric	Value			NA	O If [Maturity at birth	O if Maturity at Nirth		1	5
	matanty at orar (aay)	1000100			PROFESSION				nn -					
Record			remaining day of a week of the maturity			between 1				(week)] is given	(week)] is given			
			period at birth. This should be read			and 6					NA If [Maturity at birth			
			together with [Maturity at birth (week)].							(week)] is blank	(week)] is blank			
Birth	Mode of birth	100318	The method by which the eHR	ST	String				NA	0	0		NSD	LSCS
Record			Participant was delivered											
Birth	Duration of membrane	100309		NM	Numeric				NA	0	0		3	2
Record	ruptured (hour)		of the membrane and labour							-	-		-	-
	indemices (incer)													
Birth	Anapar coore (1 min)	100311	The Apgar score taken at 1 minute	NM	Numeric	Value			NA	0	0		8	6
Record	Apgar score (1 min)	1005TT	after birth	NN	Numenc	within 0 to			Dirt.	0	•		0	0
Record			alter biltin											
						10								
Birth	Apgar score (5 min)	100312	The Apgar score taken at 5 minutes	NM	Numeric	Value			NA	0	0		9	10
Record			after birth			within 0 to								
						10								
Birth	Apgar score (10 min)	100313	The Apgar score taken at 10 minutes	NM	Numeric	Value			NA	0	0		10	10
Record	12 1 1		after birth			within 0 to								
I The state of						10								
Birth	Birth wolabt (ars)	100314	The birth weight in gram of the eHR	NM	Numeric	Value			NA	0	0		2810	3150
	Birth weight (gm)			(10)	PROTICTICS				DAV	0	v		2010	3130
Record			Participant	1		between								
						400 to								
-					_	5000								
Birth	Birth note		The additional information about the	тх	Text				0	0	0	abc	abc	abc
Record			birth of the eHR Participant											
		•	•											

Codex: Birth institution

Birth Institution Purpose : To indicate the institution where the eHR participant is born Source:

Term ID	eHR Value	eHR Description	eHR Provider Registration Identifier
	KWH	Kwong Wah Hospital	
	PMH	Princess Margaret Hospital	
	PWH	Prince of Wales Hospital	
	PYN	Pamela Youde Nethersole Eastern Hospital	
	QEH	Queen Elizabeth Hospital	
	QMH	Queen Mary Hospital	
	ТМН	Tuen Mun Hospital	
	UCH	United Christian Hospital	
	CH	Canossa Hospital (Caritas)	
	EH	Evangel Hospital	
	HKA	Hong Kong Adventist Hospital	
	HKBH	Hong Kong Baptist Hospital	
	HKC	Hong Kong Central Hospital	
	HKS	Hong Kong Sanatorium & Hospital Limited	
	MWM	Matilda & War Memorial Hospital	
	PBH	Precious Blood Hospital (Caritas)	
	UH	Shatin International Medical Centre Union Hospital	
	SPH	St. Paul's Hospital	
	STH	St. Teresa's Hospital	
	TWA	Tsuen Wan Adventist Hospital	

Codex: Birth location

Birth Location

Purpose : to indicate the location where the birth was taken place Source : HA

Term ID eHR Value	eHR Description	Definition
BBA	Born before arrival	Born before arriving the hospital
BOA	Born on arrival	Born on arriving the Accident & Emergency Department
BIH	Born in hospital	Born in hospital





ALLERGY / ADVERSE DRUG REACTION (ADR)

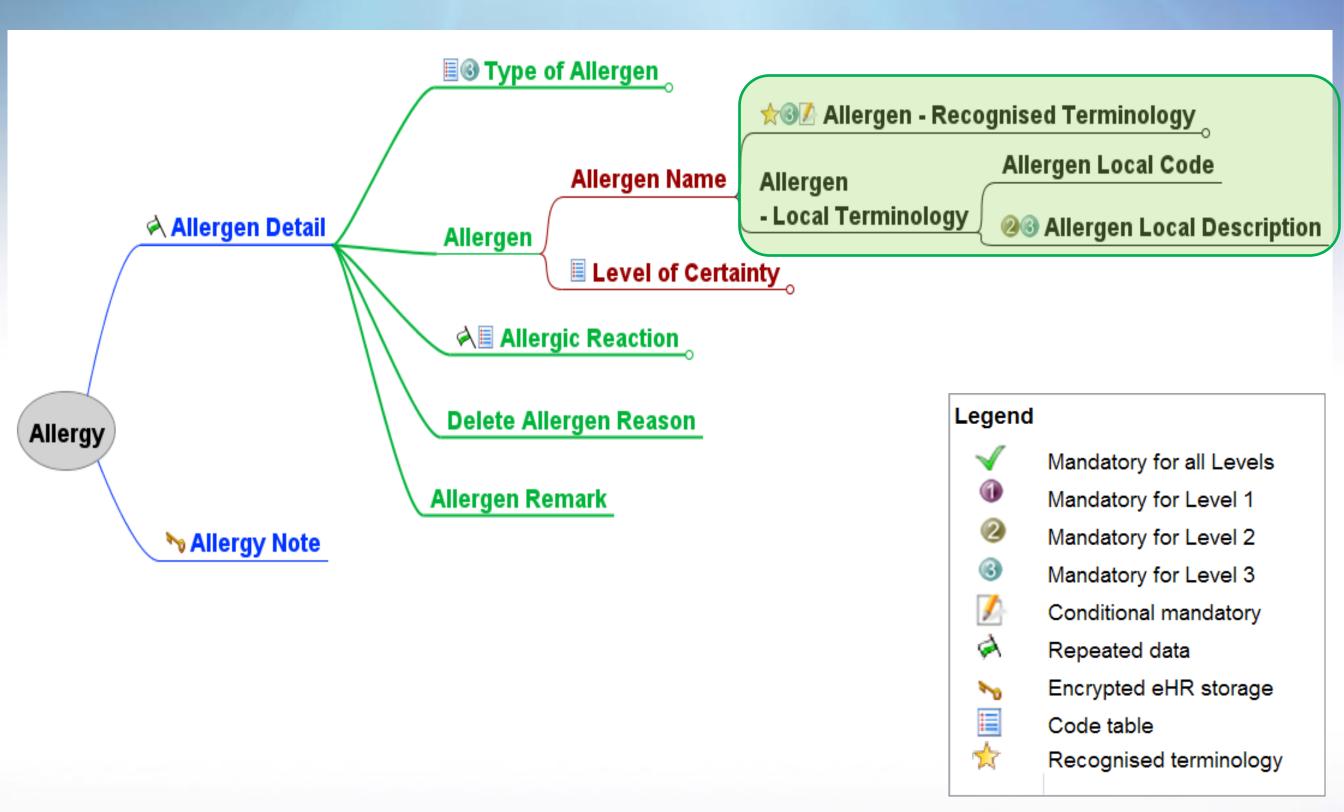
Allergy / ADR

- Include information on type of biological, physical or chemical agents that would result in / is proven to give rise to adverse health effects
- Details of the adverse reactions, if occurred, should also be included
- Absence of the information does not imply the absence of the condition
- Exclude "No known drug allergy" (NKDA) data

- No level 1 data



Mind map: Allergy



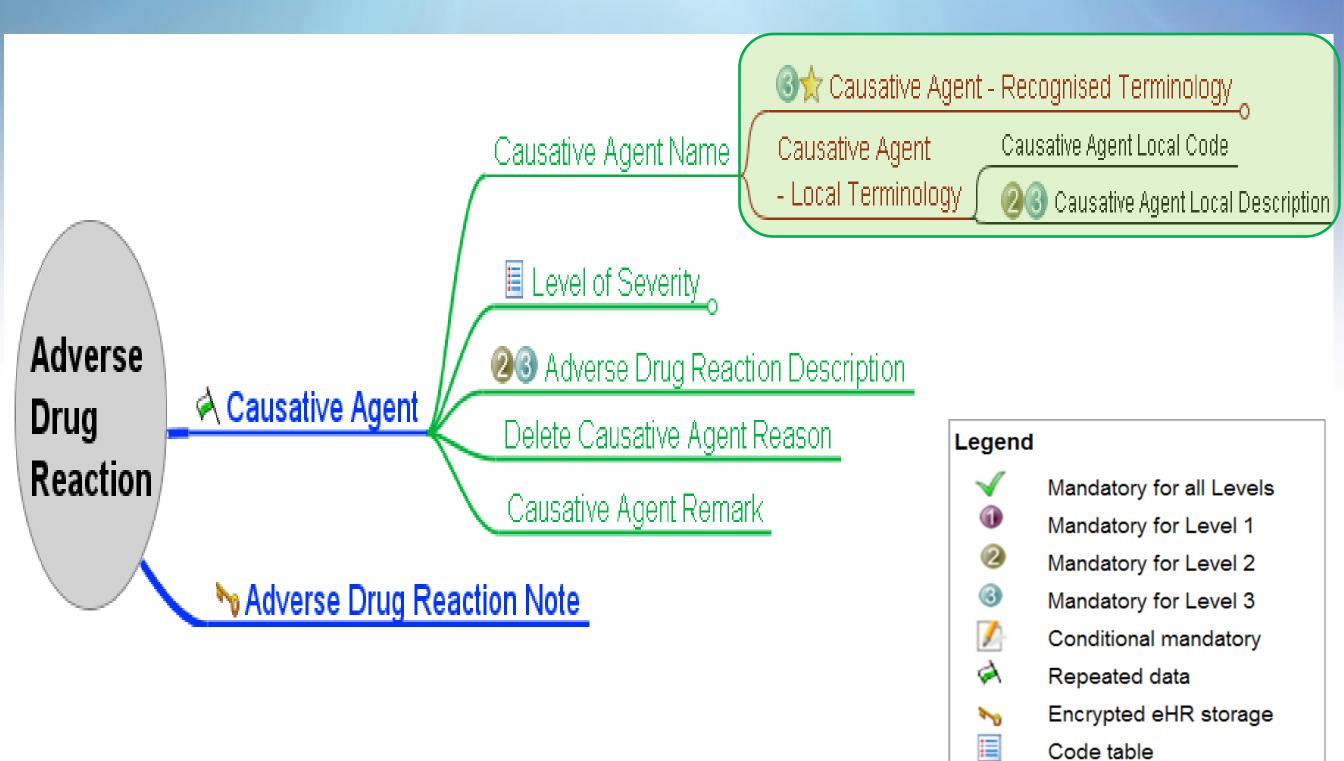
Example – Level 2 (Allergy)

Entity Name	Data requirement (Certified Level 2)	Example (Certified Level 2)
Type of allergen local description	0	Unknown
Allergen local code	0	abc
Allergen local description	М	Fish
Level of certainty local description	0	Not sure
Allergic reaction local description	0	Rash
Delete allergen reason	0	abc
Allergen remark	0	abc
Allergy note	0	abc

Example – Level 3 (Allergy)

	Determinant.	
Entity Name	Data requirement	Example (Certified Level 3)
	(Certified Level 3)	
Type of allergen code	M	Drug
Type of allergen description	М	Drug allergen
Type of allergen local description	M	Drug allergen
Allergen - recognised terminology name	M if [Type of allergen code] = "Drug" NA if [Type of allergen code] = "Non-drug" and "Unclassify"	SNOMED CT
Allergen identifier - recognised terminology	M if [Type of allergen code] = "Drug" NA if [Type of allergen code] = "Non-drug" and "Unclassify"	78507004
Allergen description - recognised terminology	M if [Type of allergen code] = "Drug" NA if [Type of allergen code] = "Non-drug" and "Unclassify"	Penicillin G
Allergen local code	Ο	a1234
Allergen local description	M	Peni G
Level of certainty code	0	S
Level of certainty description	M if [Level of certainty code] is given NA if [Level of certainty code] is blank	Suspected
Level of certainty local description	M if [Level of certainty code] is given NA if [Level of certainty code] is blank	Suspected
Allergic reaction code	0	2
Allergic reaction description	M if [Allergic reaction code] is given NA if [Allergic reaction code] is blank	Allergic rhinitis
Allergic reaction local description	M if [Allergic reaction code] is given NA if [Allergic reaction code] is blank	Allergic rhinitis
Delete allergen reason	0	abc
Allergen remark	0	abc
Allergy note	0	abc

Mind map: ADR



Code table

 $\frac{1}{2}$

Recognised terminology

Example – Level 2 (ADR)

Entity Name	Data requirement (Certified Level 2)	Example (Certified Level 2)	
Causative agent local code	0	258	
Causative agent local description	М	Peni	
Level of severity local description	0	mod	
Adverse drug reaction description	0	Skin rash	
Delete causative agent reason	0	error due to wrong patient	
Causative agent remark	0	abc	
Adverse drug reaction note	0	abc	



Example – Level 3 (ADR)

Entity Name	Code Table	Data requirement	Example (Certified
· · · · · · · · · · · · · · · · · · ·		(Certified Level 3)	Level 3) 🖵
Causative agent - recognised terminology name	Recognised terminology name - pharmaceutical product	М	НКСТТ
Causative agent identifier - recognised terminology		М	12345
Causative agent description - recognised terminology		М	Penicillin
Causative agent local code		0	258
Causative agent local description		M	Pen
Level of severity code	Adverse drug reaction severity level	0	М
Level of severity description	Adverse drug reaction severity level	M if [Level of severity code] is given NA if [Level of severity code] is blank	Mild
Level of severity local description		M if [Level of severity code] is given NA if [Level of severity code] is blank	Moderate
Adverse drug reaction description		0	Angioedema
Delete causative agent reason		0	mixing patient entry
Causative agent remark		0	abc
Adverse drug reaction note		0	abc



eHR viewer: Allergy & ADR

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<u>File Edit View Favorites Tools</u>						
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廣大妹 KWOK,TAI MUI				A	Close Record	×
HKIC : A987037A DOB : 19	16 Age : 96 years	Sex : F Details ►			ADR Select Particip	ant 🕨
All Local Non-Local	Allergy & Adverse Drug Read	ction			Lege	nd 🕨
	Allergen	Additional Information		Date	Institution	*
🚹 📝 🕫 🖾 👼 🕌 🖄	Paracetamol	Angiodema (Allergen Type: Drug	Ē	04-Apr-2012	QMH	
 Clinical Notes & Summary 		allergen: Allergen Note: rash over truck	<u>~</u>			
Clinical Notes & Summary		Allergen Type: to Drug Allergen in Allergen Remark: pinton given and rash subsided				
Referral	Dimenhydrinate	Rash		03-Apr-2012	QMH	
Problem & Procedure	Triloxane			-	Dr. Hui Wing Yan Clinic	
Problem / Diagnosis	Cefuroxime	Rash	ā		Dr. Ma Lok Kei Clinic	
Procedure	Perindopril Tertbutylamine			24-Mar-2011		
Other Investigation	Aspirin			24-Mar-2011	_	
 Medication 					_	
Prescribing History						
Dispensing History						
 Laboratory Record 	ADD Causative Agent	Additional Information		Date	Institution	-
Biochemistry	ADR Causative Agent	Additional Information		Date	Institution	
Haematology						
Blood Bank						
Microbiology						
Anatomical Pathology						
Radiology Record						
General Radiology		No Record				
Fluroscopy Magnetic Resonance Imaging						
Immunisation Record						

Related files: Allergy / ADR

- Data schema
 - Allergy
- Codex
 - 1. Recognised terminology name – pharmaceutical product
 - 2. <u>Allergy level of</u> <u>certainty</u>
 - 3. Allergic reaction

- Data schema
 - Adverse drug reaction
- Codex
 - 1. Recognised terminology name – pharmaceutical product
 - 2. ADR severity level



Data schema: Allergy

Form	Entity Name	Entity ID	Definition	Data	Data Type	Validation Rule	Repeated	Code Table	Data requirement	Data requirement	Example (Certified	Example (Certified
	Linely Hand	children in the second s		Type (code)	(description)		Data		(Certified Level 2)	(Certified Level 3)	Level 2)	Level 3)
Allergy	Type of allergen code	1003138	eHR value of the "Type of allergen" code table	CE	Coded element		R	Type of allergen	NA	м		Drug
	Type of allergen description		eHR description of the "Type of allergen" code table, should match with [Type of allergen code]	ST	String		R	Type of allergen	NA	м		Drug allergen
Allergy	Type of allergen local description	1003140	Local description of the type of allergen	ST	String		R		0	м	Unknown	Drug allergen
	Allergen - recognised terminology name		Recognised terminology / classification set for the allergen	CE	Coded element	If eHR value = HKCTT, allowable nature is "Pharmaceutical product"; if eHR value = SNOMED CT, allowable hierarchy is "Pharmaceutical / biologic product"		Recognised terminology name - pharmaceutic al product	NA	M if [Type of allergen code] = "Drug" NA if [Type of allergen code] = "Non-drug" and "Unclassify"		SNOMED CT
	Allergen Identifier - recognised terminology	1003134	Unique identifier of the allergen in the recognised terminology	CE	Coded element	[Allergen identifier - recognised terminology] should be included in the selected recognised terminology of the "Recognised terminology name - pharmaceutical product" code table.	R		NA	M if [Type of allergen code] = "Drug" NA if [Type of allergen code] = "Non-drug" and "Unclassify"		78507004
-	Allergen description - recognised terminology		terminology		Coded element	[Allergen description - recognised terminology] should be matched with the corresponding description of the selected [Allergen identifier - recognised terminology]	R		NA	M if [Type of allergen code] - "Drug" NA if [Type of allergen code] - "Non-drug" and "Unclassify"		Penidilin G
Allergy	Allergen local code	1003136	Local code of the allergen developed by the healthcare organisation	ST	String		R		0	0	abc	a1234
Allergy	Allergen local description		Local description of the allergen developed by the healthcare organisation	ST	String		R		м	м	Fish	Peni G
Allergy	Level of certainty code		eHR value of the "Allergy level of certainty" code table, to define the level of certainty of the allergen causing an allergic reaction	CE	Coded element		R	Allergy level of certainty	NA	0		0
	Level of certainty description		eHR description of the "Allergy level of certainty" code table, to define the level of certainty of the allergen causing an allergic reaction. The [Level of certainty description] should match with [Level of certainty code].	ST	String		R	Allergy level of certainty	NA	M If [Level of certainty code] is given NA If [Level of certainty code] is blank		Suspected
	Level of certainty local description		Local description of the level of certainty of the allergen causing an allergic reaction	ST	String		R		0	M If [Level of certainty code] is given NA If [Level of certainty code] is blank	Not sure	Suspected
Allergy	Allergic reaction code		eHR value of the "Allergic reaction" code table	CE	Coded element		R	Allergic reaction	NA	0		2
	Allergic reaction description		eHR description of the "Allergic reaction" code table, should match with [Allergic reaction code]	ST	String		R	Allergic reaction	NA	M If [Allergic reaction code] is given NA If [Allergic reaction code] is blank		Allergic minitis
	Allergic reaction local description		Local description of the allergic reaction	ST	String		R		0	M If [Allergic reaction code] is given NA If [Allergic reaction code] is blank	Rash	Allergic minitis
Allergy	Delete allergen reason		Reason of deletion of the allergen	ST	String		R		0	0	abc	abc
Allergy	Allergen remark			ST	String		R		0	0	abc	abc
Allergy	Allergy note	1003147	The additional information about the allergy	ST	String				0	0	abc	abc

Data schema: ADR

eHR Sharable Data - Adverse Drug Reaction

Correc	Estitu Nama	Catile ID	Definition	Data	Data Treas	Validation Rule	Dencated	Code Table	Data analizzation	Data manine set	Example (Cartificat	Example /Cartificat
Form	Entity Name	Entity ID	Definition	Data Type (code)	Data Type (description)		Repeated Data	Code Table	Data requirement (Certified Level 2)	Data requirement (Certified Level 3)	Example (Certified Level 2)	Example (Certified Level 3)
Adverse	Causative agent -	1003149	Recognised terminology /	CE	Coded	If eHR value = HKCTT,	R	Recognised	NA	M		HKCTT
Drug	recognised terminology		classification set for the causative		element	allowable nature is		terminology				
Reaction	name		agent			"Pharmaceutical product"; if		name -				
			-9			eHR value = SNOMED CT,		pharmaceutical				
						allowable hierarchy is		product				
						"Pharmaceutical / biologic		product				
Adverse	Causative agent identifier -	1003150	Unique identifier of the causative	CE	Coded	product" [Causative agent identifier -	D		NA	м		12345
		1003130		UE	element		R.		100	m		12040
Drug	recognised terminology		agent in the recognised terminology		element	recognised terminology]						
Reaction						should be included in the						
						selected recognised						
						terminology of the						
						"Recognised terminology						
						name - pharmaceutical						
						product" code table						
Adverse	Causative agent	1003151	Description of the causative agent in	CE	Coded	[Causative agent description -	R		NA	M		Penicillin
Drug	description - recognised		the recognised terminology		element	recognised terminology]						
Reaction	terminology					should be matched with the						
						corresponding description of						
						the selected [Causative agent						
						identifier - recognised						
						terminology]						
Adverse	Causative agent local code	1003152	Local code of the causative agent	ST	String	(certain lotogy)	R		0	0	258	258
Drug			developed by the healthcare						-	-		
Reaction			organisation									
Adverse	Causative agent local	1003153	Local description of the causative	ST	String		R		м	м	Peni	Pen
Drug	description		agent developed by the healthcare	· ·								
Reaction	description		organisation									
Adverse	Level of severity code	1003158	eHR value of the "Adverse drug	CE	Coded		R	Adverse drug	NA	0		М
Drug	Level of Seveniy code		reaction severity level" code table	~~	element			reaction severity		Ŭ		
Reaction			reaction sevency level code table		element			level				
Adverse	Level of severity	1003159	eHR description of the "Adverse drug	CT.	String		R	Adverse drug	NA	M if [Level of severity		Mild
Drug	description	1003138	reaction severity level" code, should	51	Sung		R.	reaction severity	100	code] is given		INTINA .
	description											
Reaction			match with [Level of severity code]					level		NA if [Level of severity		
										code] is blank		
Adverse	Level of severity local	1003160	I and dependenties of the advance days	CT	Chien		R		0	M (fill and of an arbitra	and d	Moderate
Adverse		1003100	Local description of the adverse drug	51	String		R		0	M if [Level of severity	mod	Moderate
Drug	description		reaction severity level							code] is given		
Reaction										NA if [Level of severity		
										code] is blank		
							_					
Adverse	Adverse drug reaction		Description of the adverse drug	ST	String		R		0	0	Skin rash	Angioedema
Drug	description		reaction									
Reaction	-											
Adverse	Delete causative agent	1003165		ST	String		R		0	0	error due to wrong	mixing patient entry
Drug	reason		agent								patient	
Reaction												
Adverse	Causative agent remark	1003166	The additional information about the	ST	String		R		0	0	abc	abc
Drug			causative agent									
Reaction												
Adverse	Adverse drug reaction note	1003167	The additional information about the	ST	String				0	0	abc	abc
Drug			adverse drug reaction to a causative		-							
Reaction			agent									
2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -			Lever the second s									

Codex:



RT name – pharmaceutical product (only 3 allowable RT)

Recognised Terminology Name - Pharmaceutical Product Purpose: to define the names of the recognised terminology for pharmaceutical product

Term ID	eHR Value	eHR Description	Allowable Values		
	HKCTT	Hong Kong Clinical Terminology Table	Nature = Pharmaceutical Products		
	CPP	Compendium of Pharmaceutical Products	All values		
	SNOMED CT	Systematized Nomenclature of Medicine - Clinical Terms	Hierarchy = Pharmaceutical / biologic product		



Codex: Allergy level of certainty

Allergy level of certainty Purpose: to define the certainty of the allergy Souce: e-HR

Term ID	eHR Value	eHR Description
	S	Suspected
	С	Certain



Codex: Allergic reaction

Allergic Reaction Purpose: to define the allergic reaction Souce: HA

Term ID	eHR Value	eHR Description
	1	Allergic contact dermatitis
	2	Allergic rhinitis
	3	Anaphylaxis
	4	Angioedema
	5	Aplastic anaemia
	6	Asthma
	7	Atopic dermatitis
	8	Cholestasis
	9	Eczema
	10	Erythema multiforme
	11	Erythema nodosum
	12	Erythroderma
	13	Exfoliative dermatitis
	14	Fever
	15	Fibrosing alveolitis
	16	Fixed eruptions
	17	Generalised liver damage
	18	Haemolytic anaemia
	19	Photosensitivity
	20	Pruritis
	21	Rash
	22	Serum sickness
	23	Stevens-Johnson Syndrome
	24	Toxic erythema
	25	Urticaria
	26	Others
	27	Manifestation uncertain

Codex: ADR severity level



Adverse Drug Reaction Severity Level

Purpose: to define the severity level of the adverse drug reaction Reference: HA

Term ID	eHR Value	eHR Description
	Μ	Mild
	S	Severe



CLINICAL NOTE / SUMMARY

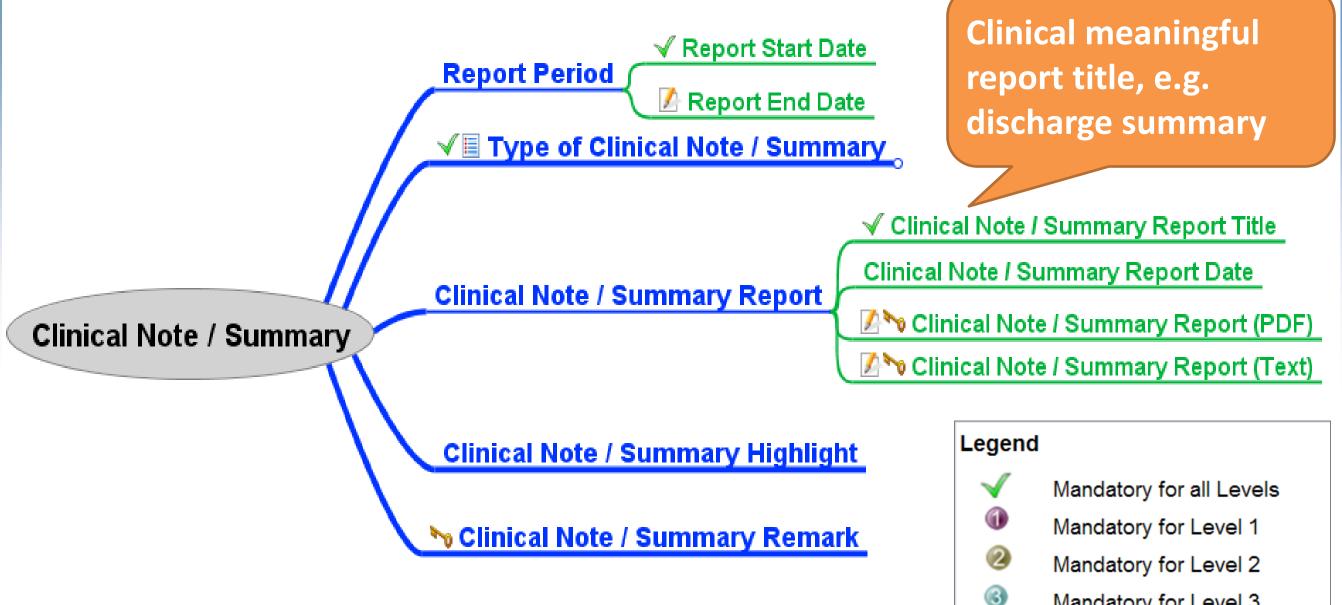


Clinical note / summary

- Contains information that record/summarize the followings of a particular clinical encounter/episode:
 - Reason originates the episode & eHR participant condition during initial encounter
 - ADR, allergies and clinical alert found during the encounter/episode
 - these info should also be separately sent to the eHR as the appropriate section
 - Major diagnostic findings during the course of the episode
 - Problems identified
 - Significant procedures performed & other related therapeutic treatment, e.g. medication
 - eHR participant's condition, therapeutic orders or treatment plan for that encounter or while preparing a periodic episode summary or upon termination of an episode
 - FU arrangement
 - Education to the eHR participant / family, if applicable
- Level 1 data only



Mind map: Clinical note / summary



- Mandatory for Level 3
 - Conditional mandatory
- Repeated data
- Encrypted eHR storage
- Code table

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Recognised terminology

Example – Level 1 (Clinical note / summary)

Entity Name	Code Table	Data requirement (Certified Level 1)	Example (Certified Level 1)
Report start date		M	12/9/2010
Report end date		M if [Type of clinical note / summary] eHR value = "IP" & "A&E"	16/09/2010
Type of clinical note / summary code	Type of clinical note /	М	IP
Type of clinical note / summary description	Type of clinical note /	М	In-patient record
Type of clinical note / summary local description		М	Hospitalisation record
Clinical note / summary report title		М	Discharge summary
Clinical note / summary report date		0	2/1/2012
Clinical note / summary report (PDF)		M if [Clinical note / summary report (Text)] is blank	
Clinical note / summary report (Text)		M if [Clinical note / summary report (PDF)] is blank	
Clinical note / summary highlight		0	Fever for lx
Clinical note / summary remark		0	abc

eHR viewer: Clinical note / summary

間 健 通 health	Viewer PPP Programmes	Administra	tion Information	KA MAN WONG	Log out
	c妹 KWOK,TALMUI C:A987037A DOB:1916	Age :	96 years Sex : F Details ►	Allergy & Close Rec ADR Select Par	
~~	Clinical NotesLegend >Type: All Last 1 year Discharge SummaryInpatient record06-Apr-2012 to 09-Apr-2012QMHDischarge SummaryInpatient record03-Apr-2012 to 05-Apr-2012QMHConsultation NoteOutpatient record05-Feb-2012Dr. Hui Wing Yan ClinicConsultation NoteOutpatient record26-Jul-2011PYHConsultation NoteOutpatient record21-Dec-2012DH	Report	Hospital Authority Queen Mary Hospital Discharge Summary <u>Discharge Information</u> Date of Admission: 06-04-2012 Plann Drug Allergy: Patient Information Household information: F Physical condition: BP - upper / lower: 147 mmHg /	Case No: HN12345678(9) HKID: A987037(A) Name: KWOK, TAI MUI MRN: DOB: 1916 Sex: F Age: 96y Ward: E2 Spec: ORT [HKID] Med Date of Discharge: 09-04-2012	
		Remarks:	The additional information about the ep	isode	

Related Files: Clinical note / summary

- Data schema
 - -Clinical note / summary

- Codex
 - -Type of clinical note / summary



Data schema: Clinical note / summary

Form	Entity Name	Entity ID	Definition	Data	Data Type	Validation	Repeated	Code Table	Data requirement	Example
	amay name	charge 10			(description)		Data		(Certified Level 1)	
				(code)	(accomption)	a na siat trian	100 Sel 254	۱ ۱	(sectories Level I)	service Level IJ
				(soue)				۱ ۱		
				1				۱		
				1				۱ ۱		
				1				۱ ۱		
Clinical Note /	Report start date	<u> </u>	The start date of the report of the healthcare	TS	Time stamp	<u> </u>	<u> </u>	ļi	M	9/12/2010
Summary	e energe en des actuals la Salad Mar		service:		a since seeming			۱ ۱		The second of the
,			1) For In-patient: Use Admission Date	1				۱		
			2) For out-patient: Use Attendance Date	1				۱		
L		L	3) For A&E: Use A&E Admission Date	L	L	L		! i		·
Clinical Note /	Report end date		The end date of the report of the healthcare	TS	Time stamp	Not earlier			M if [Type of	16/09/2010
Summary	l	.	service:		•	than the		۱ ۱	clinical note /	
	Į	.	1) For In-patient: Use Discharge Date			[Report start		۱ ۱	summary] eHR	
	l	.	2) For out-patient: Optional			date]		۱ ۱	value = "IP" &	
		L	3) For A&E: Use A&E Discharge Date					l i	"A&E"	
	Type of clinical note /		eHR value of the "Type of clinical note /	CE	Coded			Type of clinical	М	IP
Summary	summary code	,	summary" code table		element	.		note / summary		
		ļ				ļ		L		
	Type of clinical note /			ST	String			Type of clinical	м	In-patient record
Summary	summary description	,	summary" code table, [Type of clinical note /			.		note / summary		
			summary description] should match with [Type	1				۱ ۱		
	and the second	 	of clinical note / summary code]			ļ		۱		
	Type of clinical note /			ST	String			۱ ۱	М	Hospitalisation
	summary local description	 	summary			 	<u> </u>	۹		record
	Clinical note / summary		Report title of the clinical note / summary	ST	String			۱ ۱	м	Discharge
	report title Clinical note / summary	 	The documentation date of the clinical note /	TS	Time stamp	 	łi	μ	0	summary 1/2/2012
				10	nine stamp			۱ ۱	0	11212012
Summary	report date		summary report, If this documentation date is not available, use the report creation date.	1				۱ ۱		
			not available, use the report creation date.	1				۱ ۱		
Clinical Note /	Clinical note / summary	t	Clinical note / summary report in Portable	ED	Encapsulated	t	†`	ŀi	M if [Clinical note /	
	report (PDF)		Document Format (PDF)		data	.		۱ ۱	summary report	
,				1				۱	(Text)] is blank	~
		ļ		L	<u> </u>	ļ		۱		
	Clinical note / summary		Clinical note / summary report in text format	тх	Text			۱	M if [Clinical note /	
Summary	report (Text)			1				۱	summary report	
				1				۱ ۱	(PDF)] is blank	
Clinical Note /	Clinical note / summary	<u> </u>	Summary of important notes for the clinical	ST	String	<u> </u>		ŀ	0	Fever for Ix
	highlight		note / summary, e.g. important findings	1				۱		
,	· · · · ·			1				۱ ۱		
		ļ				ļ	i	۱		
	Clinical note / summary			ТΧ	Text			۱	0	abc
Summary	remark		note / summary	1				۱ ۱		
1				1				۱ ۱		
L	1	<u> </u>	L	L	<u> </u>	L	L	L		',

Codex: Type of clinical note / summary

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
		Accident and emergency record	care in Accident and Emergency
	OP	Outpatient record	Record generated during out-patient
	U F	Outpatient record	attendance
	IP	Inpatient record	Record generated during inpatient
	11-	Inpatient lecolu	care
	отн	Other record	Record generated with unidentified
	UIII		healthcare service type is received



RADIOLOGY EXAMINATION



Radiology examination

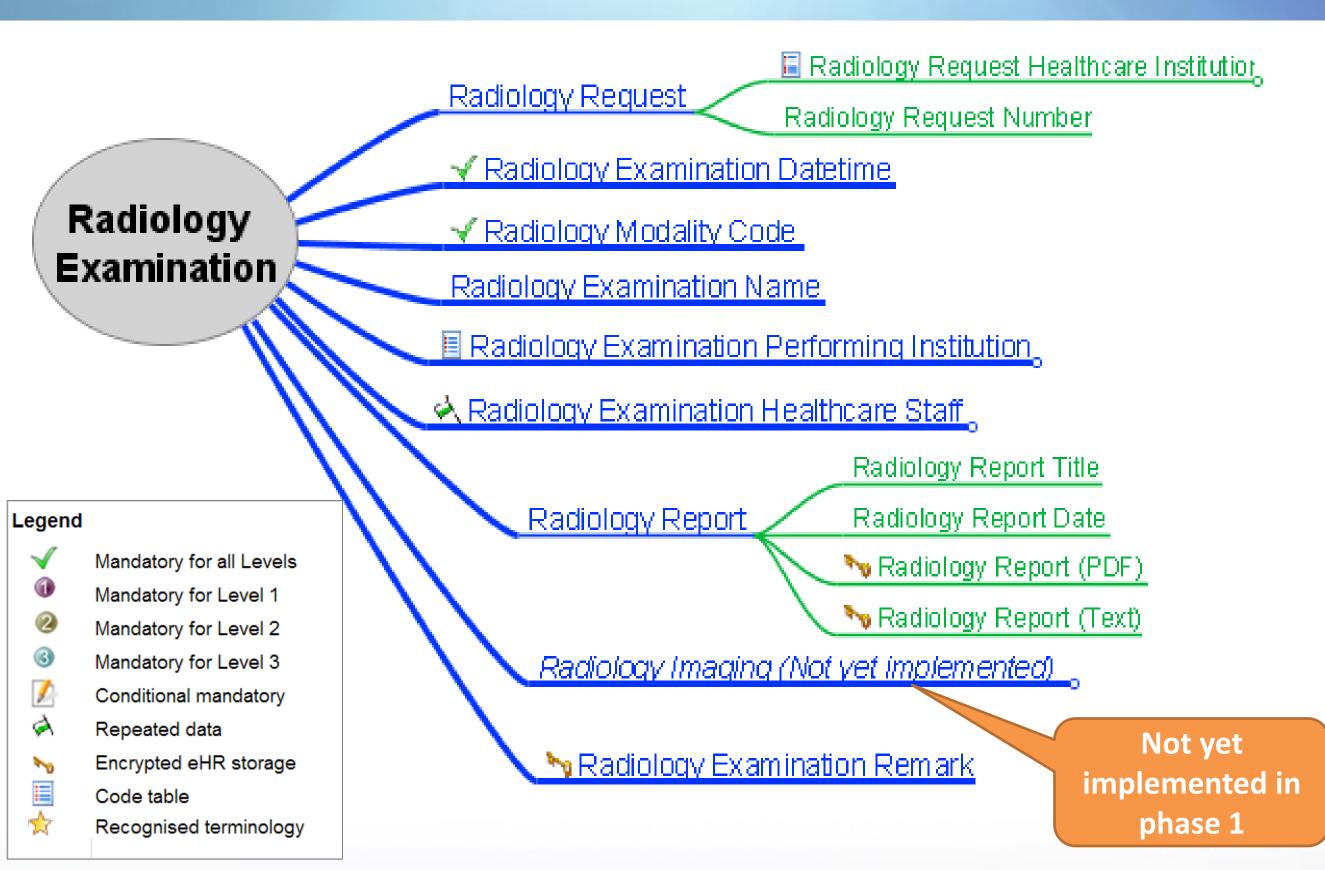
 Radiology result would include radiology report and images

- Images: to be implemented in later phases

- Sub-classified according to radiology modality, e.g.
 - plain x-ray, fluoroscopy, ultrasound, CT, MRI, NM, angiography and vascular IR, non-vascular IR, PET & others



Mind map: Radiology examination



Example – Level 1 (Radiology examination)

Entity Name	Data requirement (Certified Level 1)	Example (Certified Level 1)
Radiology request number	0	53215
Radiology examination datetime	М	12/6/2010
Radiology modality code	М	СТ
Radiology examination name	0	brain
Radiology report title	0	CT brain report
Radiology report date	0	12/6/2010
Radiology report (PDF)	0	
Radiology report (Text)	Ο	
Radiology examination remark	0	abc

Example – Level 2 (Radiology examination)

	Entity Name	Data requirement	Example (Certified Level 2)
		(Certified Level 2) 🛒	
	Radiology request healthcare institution local description	0	Dr. Chan Clinic
	Radiology request number	0	53256
	Radiology examination datetime	М	12/6/2010
	Radiology modality code	М	MRI
	Radiology examination name	0	Head and neck
	Radiology examination performing institution local description	0	Dr. Chan Clinic
	Radiology examination healthcare staff English surname	0	Chan
	Radiology examination healthcare staff English given name	0	Tai Man
	Radiology examination healthcare staff Chinese name	0	陳大文
	Radiology examination healthcare staff type local description	0	Supervisor
7	Radiology report title	0	MRI on Head and Neck report
	Radiology report date	0	12/6/2010
	Radiology report (PDF)	0	
	Radiology report (Text)	0	
	Radiology examination remark	0	abc

Example – Level 3 (Radiology examination) (1)

Entity Name	Code Table	Data requirement (Certified Level 3)	Example (Certified Level 3)
Radiology request healthcare institution identifier		0	КН
Radiology request healthcare institution description		M if [Radiology request institution identifier] is given NA if [Radiology request institution identifier] is blank	Kowloon Hospital
Radiology request healthcare institution local description		M if [Radiology request institution identifier] is given NA if [Radiology request institution identifier] is blank	Kowloon Hospital
Radiology request number		0	123546
Radiology examination datetime		М	12/6/2010
Radiology modality code	Radiology modality	М	СТ
Radiology examination name		0	Abdomen and pelvic
Radiology examination performing institution identifier		0	KH
Radiology examination performing institution description		M if [Radiology performing institution identifier] is given NA if [Radiology performing institution identifier] is blank	Kowloon Hospital
Radiology examination performing institution local description		M if [Radiology performing institution identifier] is given NA if [Radiology performing institution identifier] is blank	Kowloon Hospital

Example – Level 3 (Radiology examination) (2)

Entity Name	Code Table	Data requirement (Certified Level 3)	Example (Certified Level 3)
Radiology examination healthcare staff identifier		0	CHSML01
Radiology examination healthcare staff English name prefix	Healthcare staff English name prefix	0	P - Prof
Radiology examination healthcare staff English surname		0	Chan
Radiology examination healthcare staff English given name		0	Tai Man
Radiology examination healthcare staff Chinese name		0	陳大文
Radiology examination healthcare staff Chinese name suffix	Healthcare staff Chinese name suffix	0	P - 教授
Radiology examination healthcare staff type code	Procedure healthcare staff type	0	С
Radiology examination healthcare staff type description		M if [radiology examination healthcare staff type code] is given NA if [radiology examination healthcare staff type code] is blank	Chief procedure healthcare staff
Radiology examination healthcare staff type local description		M if [radiology examination healthcare staff type code] is given NA if [radiology examination healthcare staff type code] is blank	Chief in-charge
Radiology report title		0	CT scan of abdomen report
Radiology report date		0	12/6/2010
Radiology report (PDF)		0	2
Radiology report (Text)		0	
Radiology examination remark		0	abc

eHR viewer: Radiology examination

	16 Ag	e : 96 years	Se	x∶F Details ►	Allergy & Close Record > Allergy & Close Record > C
All Local Non-Local	Radiology F	Record			Legend >
🚮 📝 聴 📼 🖧 📗 🧪	Date View	Document View	Modalit	ty: ALL 💽 Last 1 year	
Clinical Notes & Summary	Exam Date	 Modality 	÷	Examination	Performed At
Clinical Notes & Summary	20-Jun-2012	MRI	1	Image: MR-BRAIN (PLAIN-CONTRAST)	SPH
Referral	08-Apr-2012	FL	1	Videofluorographic swallowing study	QMH
Encounters	06-Apr-2012	XR	740	Chest (Plain)	QMH
Problem & Procedure	04-Apr-2012	XR	1	Chest (Plain)	QMH
Problem / Diagnosis	23-Feb-2012	XR	1	Chest (Plain)	HKS
Procedure	14-Feb-2012	XR	1	Chest (Plain)	HKS
Other Investigation					
Medication					
Prescribing History					
Dispensing History					
 Laboratory Record 	[· · · · · · · · · · · · · · · · · · ·
Biochemistry	Text Report				*
Haematology	Text Report	•			
Blood Bank	History:				
Microbiology	Admitted for c	hest infection. Inc	identally 1	found to have RUL opacity, LZ rounded op	pacity. Right shoulder pain.
Anatomical Pathology	Chest X-ray (AP sitting, apico-lo	ordotic an	d lateral views):	
Radiology Record				-	nt interval change since March 2001. A slow growing
General Radiology		-	-	T assessment suggested.	
Fluroscopy Magnetic Reconance Imaging					
Magnetic Resonance Imaging Immunisation Record		oulder (AP & latera	-		
minumsauon Record	_		_	ater tuberosity of the left proximal humerus nent appear unremarkable. The LLZ opaci	s, suggestive of degenerative change. No other bony lesion ty noted on the chest film is also visible.

Related files: Radiology examination

- Data schema
 - Radiology examination
- Codex
 - Radiology modality
 - Healthcare staff English name prefix
 - Healthcare staff Chinese name suffix
 - Procedure healthcare staff type



Data schema: Radiology examination (1)

					-									
Form	Entity Name	Entity ID	Definition	Data Type (oode)	Data Type (decoription)	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)
Radiology Examination	Radiology request healthcare institution identifier		A unique identifier assigned by eHR Healthcare Provider Index to each healthcare Institution who created the radiology request	Œ	Coded element				NA	NA	0			KH
Radiology	Radiology request		Description of the healthcare institution who created the radiology	ST	String				NA	NA	M If (Radiology request			Kowloon Hospital
Examination	healthcare institution description		request								Institution identifier) is given NA if (Radiology request institution identifier) is blank			
Radiology Examination	Radiology request healthcare institution local description		Local description of the healthcare institution who created the radiology request	ST	Sting				NA	o	M If [Radiology request institution identifier] is given NA If [Radiology request institution identifier] is blank		Dr. Chan Clinic	Kowioon Hospitai
Radiology Examination	Radiology request number		A unique identifier issued by the healthcare institution who requests the radiology examination	ST	String				0	0	o	53215	53256	123546
Radiology	Radiology examination		Date / time when the radiology examination was performed. If the	TS	Time stamp				M	M	M	6/12/2010	6/12/2010	6/12/2010
Examination	datetme		radiology procedure examination date / time is not available, can use the report creation date; if report creation date is not available, can use the submission date to eHR.											
Radiology Examination	Radiology modality code		eHR value of the "Radiology modality" code table, to define modality of the radiology examination	CE	Coded element			Radiology modality	м	м	м	ст	MRI	MRI
Radiology Examination	Radiology examination name		The name of the radiology examination such as the examination region(s) or site(s)	ST	String				0	0	0	brain	Head and neck	Abdomen and pelvic
Radiology	Radiology examination		A unique identifier assigned by eHR Healthcare Provider Index to	CE	Coded				NA	NA	0			KH
Examination	performing institution identifier		each healthcare institution who performed the radiology examination		element									
Radiology Examination	Radiology examination performing institution description		Description of the healthcare institution who performed the radiology examination	ST	String				NA	NA	M If (Radiology performing institution identifier) is given NA if (Radiology performing institution identifier) is blank			Kowloon Hospital
Radiology Examination	Radiology examination performing institution local description		Local description of the healthcare institution who performed the radiology examination	ST	Sting				NA	o	M If [Radiology performing institution identifier] is given NA If [Radiology performing institution identifier] is blank		Dr. Chan Clinic	Kowioon Hospital
Radiology Examination	Radiology examination healthcare staff identifier		A unique identifier of the healthcare staff who performed the radiology examination	Œ	Coded element		R		NA	NA	Ô			CHSML01
Radiology Examination	Radiology examination healthcare staff English name prefix		eHR value of the "Healthcare staff English name prefix" code table, to define the prefix of the English name of the healthcare staff who performed the radiology examination	Œ	Coded element		R	Healthcare staff English name prefix	NA	NA	0			P - Prof
Radiology	Radiology examination		Sumame name in English of the healthcare staff who performed	ST	String		R	prena	NA	0	0		Chan	Chan
Examination	healthcare starr English sumame		the radiology examination											
Radiology Examination	Radiology examination healthcare staff English given name		Given name in English of the healthcare staff who performed the radiology examination	ST	String		R		NA	0	0		Tal Man	Tai Man
Radiology	Radiology examination healthcare staff Chinese name		Full name in Chinese of the healthcare staff who performed the radiology examination. Encoding method: unicode	ат	String		R		NA	0	0		陳大文	陳大文
Radiology Examination	Radiology examination healthcare staff Chinese name suffix		eHR value of the "Healthcare staff Chinese name suffix" code table, to define the suffix of the Chinese name of the healthcare staff who performed the radiology examination	CE	Coded element		R	Healthcare staff Chinese name suffix	NA	NA	0			P-数授
Radiology	Radiology examination		eHR value of the "Procedure healthcare staff type" code table, to	CE	Coded		R	Procedure	NA	NA	0			C
Examination	healthcare staff type code		define the healthcare staff type who performed the radiology examination		element			healthcare staff type						
Radiology Examination	Radiology examination healthcare staff type description		eHR description of the "Procedure healthcare staff type" code table, to define the healthcare staff type who performed the radiology examination	ST	Sting		R		NA	NA	M ff (radiology examination healthcare staff type code) is given NA ff (radiology examination healthcare staff type code) is blank			Chief procedure healthcare staff
Radiology Examination	Radiology examination healthcare staff type local description		Local description of the healthcare staff type who performed the radiology examination	вт	String		R		NA	o	M f (radiology examination healthcare staff type code) is given NA f (radiology examination healthcare staff type code) is blank		Supervisor	Chief in-charge
Radiology	Radiology report title		The title of the radiology report	ST	String				0	0	O	CT brain report		MRI on abdomen and
Examination													report	pelvic report

Data schema: Radiology examination (2)

eHR Sharable Data - Radiology Examination

Radiology	Radiology report date	The documentation date of the radiology report, first use the last	T8	Time stamp	0	0	0	6/12/2010	6/12/2010	6/12/2010
Examination		endorsed date; if not available, use first endorsed date; if not								
		available, use radiology examination date.								
Radiology	Radiology report (PDF)	Report of the radiology examination that is formatted in Portable	ED	Encapsulated	0	0	0	1	-	
Examination		Document Format (PDF)		data				1	1	*
Radiology	Radiology report (Text)	Report of the radiology examination that is performed in text	TX	Text	0	0	0			
Examination		format								
Radiology	Radiology Image accession	The reference number of the radiology image(s)	ST	Sting	0	0	0	A12234	A12235	A12235
Examination	number									
Radiology	Radiology Image	The images of the radiology examination								
Examination										
Radiology	Radiology examination	The additional information about the radiology examination	TX	Text	0	0	0	abc	abc	abc
Examination	remark	record								



Codex: Radiology modality

Radiology Modality Table

- Purpose : To identify the Modality of the Radiology examination, the type of radiology examination so that the report can be filed in the e-HR automatically
- Reference : HA

Term ID	eHR Value	eHR Description
	XR	General radiology
	FL	Fluroscopy
	US	Ultrasonography
	СТ	Computed tomography
	BI	Breast imaging
	AEVIR	Angiographic examination / Vascular interventional radiology
	NVIR	Non-vascular interventional radiology
	MRI	Magnetic resonance imaging
	NM	Nuclear medicine
	PET/CT	Positron emission tomography / computed tomograhy fusion imaging
	PET/MR	Positron emission tomography / magnetic resonance fusion imaging
	OTH	Other radiology modality



Codex:

HC staff English name prefix HC staff Chinese name suffix

Healthcare Staff English Name Prefix Purpose : Title to address the healthcare staff in English Reference : OGCIO

Term ID	eHR Value	eHR Description
	Prof	Professor
	Dr	Doctor

Healthcare staff Chinese Name Suffix Purpose : title to address the healthcare staff in Chinese Reference : OGCIO

Term ID	eHR Value	eHR Description
	教授	教授
	醫生	醫生
	醫師	略苛

Codex: HC staff type

Procedure Healthcare Staff Type Table

Purpose : To indicate the healthcare staff who chiefly responsible for performing the procedure **Source :** HA

Term ID eHR Value	eHR Description
С	Chief procedure healthcare staff
Α	Assistant procedure healthcare staff



INVESTIGATION REPORT



Investigation report

- Other than laboratory and radiology diagnostics tests, other various types of diagnostic reports would be fall into this domain, for examples:
 - Audiogram, Ambulatory BP monitoring,
 Echocardiogram, Treadmill, Holter, PFT, EEG, EMG,
 ESWL, ETT ...





Mind map: Investigation report



- Mandatory for all Levels
- Mandatory for Level 1
- Mandatory for Level 2
- Mandatory for Level 3
- Conditional mandatory
- Repeated data
- ▶ Encrypted eHR storage
 - Code table

E

Recognised terminology

Investigation Report Highlight

by Investigation Report Remark



Example – Level 1 (Investigation report)

Entity Name	Data requirement (Certified Level 1)	Example (Certified Level 1)	
Investigation report reference date	М	2/1/2012	
Investigation report title	М	Echocardiogram Report	
Investigation report (PDF)	M if [Investigation report (Text)] is blank		
Investigation report report (Text)	M if [Investigation report (PDF)] is blank		
Investigation report highlight	0	Cardiac	
Investigation report remark	0	abc	



eHR viewer: Investigation report

	大妹 KWOK,TAI MUI IC:A987037A DC	DB : 1916	Age : 9	06 years Sex : F Details 🕨		Allergy & ADR	Close F Select	Record × Participant ►		
	Other Investigation	Legend	Report C	ontent						
	Pulmonary Function Test 12-Jan-2012 PWH	-		NO NO NO	🖹 闭 🛝 🗥 Page 🕇 of 1	J	₽ Ø	115% 💌		
	Echocardiogram 04-Jan-2012 QEH Spec. Pulmonary	ħ	N.S.A.	Hospital Authority Prince of Wales Hospital	Case No: HN12345678(9) Name: KWOK, TAI MUI	HKID: A987037				
	11-Nov-2011 PWH	12	40NC	Pulmonary Function Lab	Sex: F Age: 96y	DOB:191	6	E		
	Pulmonary Function Test 22-Oct-2010 PWH	74	14	1) Urgency: Routine	Ward: 3C Spec: SUR	TARK.	7.4	9. I		
>>	Pulmonary Function Test 23-May-2008 PWH	12	"ONCA	2) Active TB: No If Active TB, Start treatment since: 3) Current use of bronchodilator: No 4) NPA result: not indicated 5) Fever: No						
	Pulmonary Function Test 21-May-2007 PWH	12		6) Simple Spirometry (FEV1, FVC): Yes 7) Simple Spirometry pre & post bronchodil Full Lung Function:	ator: No		1	48. E		
			Investigation Remarks:	8) Lung Volumes: No 9) Flow Volumes Loop: pre 10) Diffusion Capacity (DLCO): No 11) Body Box (please consult Resp. Team): 12) PI/PE Max: No 13) Remarks: Highlight: Cardiac This is remark	No No Cta Marka	Kawkowc.ta	Ganan Ang	6.		

Related file: Investigation report

- Data schema
 - Investigation report



Data schema: Investigation report

eHR Sharable Data - Investigation Report

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)
Investigation Report	Investigation report reference date		The date when the investigation was performed. If the investigation date is not available, use the report creation date.	TS	Time stamp				М	1/2/2012
Investigation Report	Investigation report title		The title of the investigation report	ST	String				М	Echocardiogram Report
Investigation Report	Investigation report (PDF)		Investigation report in Portable Document Format (PDF)	ED	Encapsulated data				M if [Investigation report (Text)] is blank	
Investigation Report	Investigation report report (Text)		Investigation report in text format	ТХ	Text				M if [Investigation report (PDF)] is blank	
Investigation Report	Investigation report highlight		Summary of important notes for the investigation report, e.g. important findings	ST	String				0	Cardiac
Investigation Report	Investigation report remark		The additional information about the investigation report	ТХ	Text				0	abc



REFERRAL

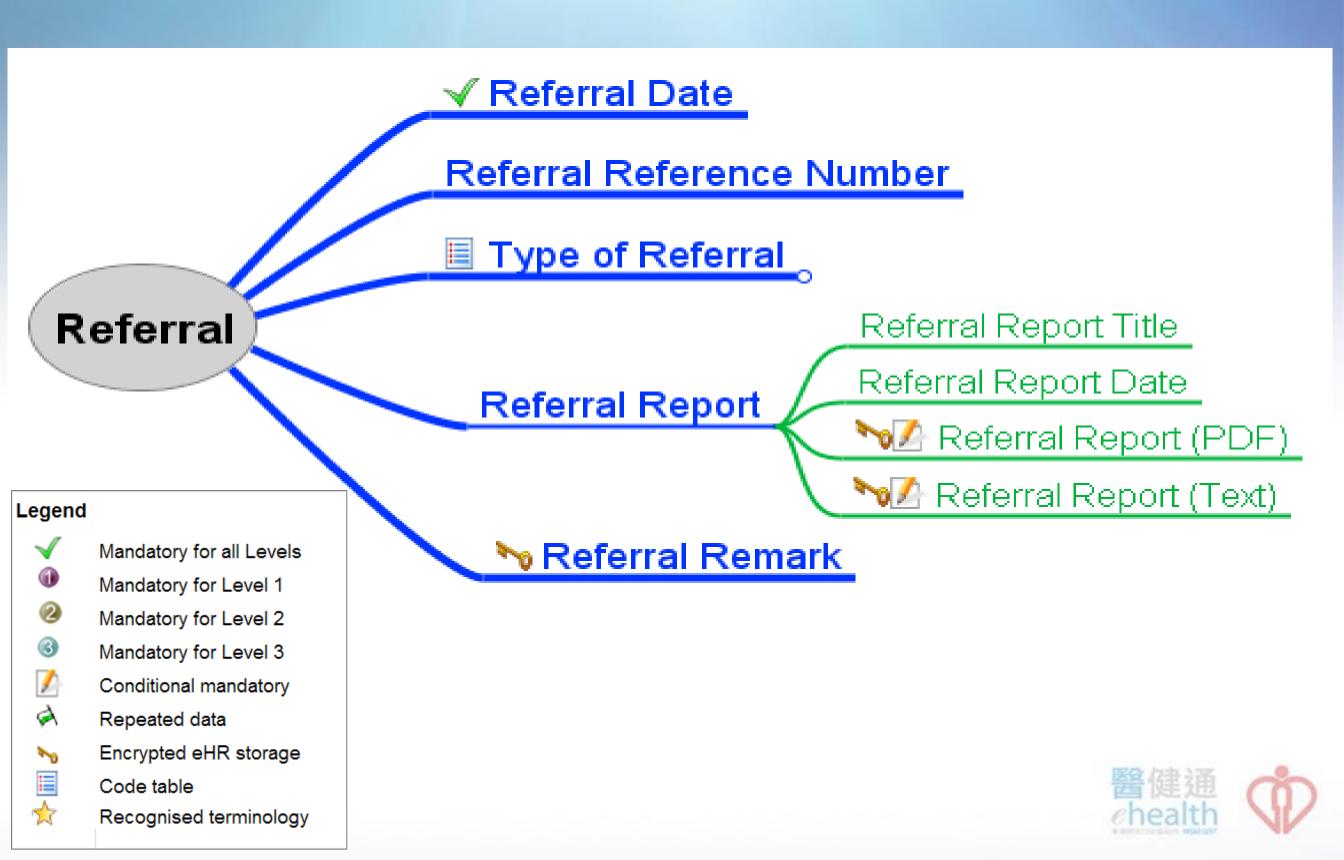


Referral

- Referral documents the information that is required when a healthcare provider refers all or a portion of an eHR participant's care to another healthcare provider, and the reply from the receiving healthcare provider to the referrer
- Level 1 data only



Mind map: Referral



Example – Level 1 (Referral)

Entity Name	Code Table	Data requirement (Certified Level 1)	Example (Certified Level 1)
Referral date	-	M	1/2/2011
Referral reference number		0	125600
Type of referral code	Type of referral	0	Request
Type of referral description	Type of referral	M if [Type of referral code] is given NA if [Type of referral code] is blank	Request referral
Type of referral local description		M if [Type of referral code] is given NA if [Type of referral code] is blank	Request referral
Referral report title		0	Referral to MCH
Referral report date		0	1/2/2011
Referral report (PDF)		M if [Referral report (Text)] is blank	POF
Referral report (Text)		M if [Referral report (PDF)] is blank	
Referral remark		0	abc

eHR viewer: Referral

器 (計)通 chealth	Viewer PPP	Programmes	Administration Informatio	n			KA M/	AN WONG	🔀 Log out
	大妹 KWOK,TAI MUI C:A987037A	DOB : 1916	Age : 96 years	Sex : F	Details ►		Allergy & ADR	Close Rec Select Pa	
~	Referral Last 1 year Referral to CARDIO 06-Apr-2012 QMH Referral to ENT 15-Sep-2010 DH Referral to MED 08-Jun-2009 Chai Tai Man Clinic	Legend >	E Report Content	Re: KOW or seeing the ab rmation: cant history and estigation Repo Results:	K TAI MUI [A987037(A) Reason for referral: Ap ove-named patient.	G/F, Ka Ka Ho C	1 Deferral Lette CA Duse, Wing Hon Esta Medici Tel: 2300-12 06/04/20 Case no: HN1234567	er R ate ine 234 012	
	-	-							

Related files: Referral

- Data schema
 - Referral

- Codex
 - Type of referral



Data schema: Referral

eHR Sharable Data - Referral

Form	Entity Name	Entity	Definition	Data	Data Type	Validation	Repeated	Code	Data requirement	Example (Certified
		D		Type (code)	(description)	Rule	Data	Table	(Certified Level 1)	Level 1)
Referral	Referral date		The datetime when the referral is created / documented.	TS	Time stamp				М	2/1/2011
Referral	Referral reference number		A reference number issued by the healthcare provider for the referral	ST	String				0	125600
Referral	Type of referral code		eHR value of the "Type of referral" code table	CE	Coded element			Type of referral	0	Request
Referral	Type of referral description		eHR description of the "Type of referral" code table, should match with [Type of referral code]	ST	String			Type of referral	M if [Type of referral code] is given NA if [Type of referral code] is blank	Request referral
Referral	Type of referral local description		Local description of type of referral	ST	String				M if [Type of referral code] is given NA if [Type of referral code] is blank	Request referral
Referral	Referral report title		The title of the referral report	ST	String				0	Referral to MCH
Referral	Referral report date	2	The documentation date of the referral report, If the documentation date is not available, use the report creation date.	TS	Time stamp				0	2/1/2011
Referral	Referral report (PDF)		Referral report in Portable Document Format (PDF)	ED	Encapsulated data				M if [Referral report (Text)] is blank	~
Referral	Referral report (Text)		Referral report in text format	ТΧ	Text				M if [Referral report (PDF)] is blank	
Referral	Referral remark		The additional information about the referral	ТΧ	Text				0	abc

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Codex: Type of referral

Type of referral Purpose : To define type of referral Source :

Term ID	eHR Value	eHR Description	Definition
	Request	-	The request referral is made by a healthcare provider (referring provider) to refer a patient to other healthcare providers such as specialists for ongoing care.
	Reply	Reply referral	The reply to a request referral is made by the referred healthcare provider.
	Unknown	Unknown type of referral	The type of referral is not known.



THANK YOU

