

Table of Contents - Resources & Profiles	Standard
NHSN Protocol Subject Matter Expert (SME)	
dQM Lead	
Back-up dQM Analyst	
Measure Submission Frequency	
Initial Population - CQL Definition	
Initial Population - Protocol Definition	
Condition - US Core	US Core v3.1.1
Coverage	FHIR R4 v4.0.1
Device R-4	FHIR R4 v4.0.1
Diagnostic Report -R-4	FHIR R4 v.4.0.1
Diagnostic Report (Lab) - US Core	US Core v3.1.1
Diagnostic Report Profile for Report and Note Exchange	US Core v3.1.1
Encounter-US Core	US Core v3.1.1
Implantable Device - US Core	US Core v3.1.1
Laboratory Result Observation - US Core	US Core v3.1.1
Location-US Core	US Core v3.1.1
Medication-US Core	US Core v3.1.1
MedicationAdministration	FHIR R4 v4.0.1
MedicationRequest-US Core	US Core v3.1.1
Observation	FHIR R4 v4.0.1
Observation-Vital Signs	FHIR R4 v4.0.1
Patient - US Core	US Core v3.1.1
Procedure - US Core	US Core v3.1.1
Service Request	FHIR R4 v4.0.1
Specimen	FHIR R4 v4.0.1

Comment:

* 3.1.0 Version cited in 21 st Centuries Cures Act

<https://www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interopability-information-blocking-and-the-onc-health-it-certification>

FHIR R4:

<http://hl7.org/fhir/R4/downloads.html>

[Link to Change Log](#)

ACH dQM
All
Kim Figueroa Lynn Perrine & Mary-Margaret Richter
Monthly
Patients of all ages with Inpt, ED, OBS, SS encounter type or with Inpt, ED, OBS, SS encounter class or with an Inpt, ED, OBS, SS location during MP.
All encounters for patients of any age in an ED, observation, or inpatient location or all encounters for patients of any age with an ED, observation, inpatient, or short stay status during the measurement period.
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MS In the ACH dQM, the CQL logic for the Observation Supplemental Data Element (SDE) is constrained to the following categories: lab, social history, vital signs, survey, imaging, and procedure
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Date of Request	Data Element
4/4/2023	DiagnosticReport.id
4/4/2023	Observation.id
4/4/2023	Observation.subject
4/4/2023	Medication.ingredient.item[x]
4/4/2023	Encounter.identifier.system
4/13/2023	MedicationRequest.status
4/14/2023	NA
4/14/2023	Encounter.location
4/14/2023	Encounter.location.location
4/18/2023	{Resource}.language
4/18/2023	{Resource}.implicitRules
4/18/2023	{Resource}.Identifier.period
4/18/2023	{Resource}.Identifier.assigner
4/18/2023	Encounter.EpisodeOfCare
4/18/2023	Encounter.BasedOn
4/18/2023	Encounter.serviceProvider
4/18/2023	Encounter.appointment
4/18/2023	Condition.recorder
4/18/2023	Condition.asserter
4/18/2023	Coverage.type
4/18/2023	Coverage.dependent
4/18/2023	Coverage.costToBeneficiary
4/18/2023	Observation.category.extension
4/18/2023	Medication.ingredient.isActive
4/18/2023	MedicationRequest.statusReason
4/18/2023	MedicationRequest.supportingInformation
4/18/2023	MedicationRequest.performer
4/18/2023	MedicationRequest.performerType
4/18/2023	MedicationRequest.instantiatesCanonical
4/18/2023	MedicationRequest.instantiatesUri
4/18/2023	MedicationRequest.basedOn
4/18/2023	MedicationRequest.groupIdentifier
4/18/2023	MedicationRequest.insurance
4/18/2023	MedicationRequest.note
4/18/2023	MedicationRequest.dosageInstruction.sequence

4/18/2023	MedicationRequest.dosageInstruction.additionalInstruction
4/18/2023	MedicationRequest.dosageInstruction.site
4/18/2023	MedicationRequest.dosageInstruction.maxDosePerPeriod
4/18/2023	MedicationRequest.dosageInstruction.maxDosePerAdministration
4/18/2023	MedicationRequest.dosageInstruction.maxDosePerLifetime
4/18/2023	MedicationRequest.substitution
4/18/2023	MedicationRequest.dispenseRequest
4/18/2023	MedicationRequest.priorPrescription
4/18/2023	MedicationRequest.detectedIssue
4/18/2023	MedicationRequest.eventHistory
4/17/2023	Device.patient
4/18/2023	Observation.dateAbsentReason
5/1/2023	MedicationRequest.statusReason
5/1/2023	MedicationRequest.authoredOn
5/1/2023	MedicationRequest.instantiatesCanonical
5/1/2023	MedicationRequest.courseOfTherapyType
5/1/2023	MedicationRequest.dosageInstruction
5/1/2023	MedicationRequest.dosageInstruction.doseAndRate.id
5/1/2023	MedicationRequest.dosageInstruction.doseAndRate.extension
5/1/2023	MedicationRequest.dosageInstruction.doseAndRate.type
5/1/2023	Medication.status
5/1/2023	Medication.ingredient.itemCodeableConcept
5/1/2023	Medication.ingredient.itemReference
5/2/2023	MedicationRequest.requester

5/3/2023	Encounter.episodeOfCare
5/8/2023	MedicationRequest.dosageInstruction.dose AndRate.dose[x]
5/8/2023	MedicationRequest.priority
5/8/2023	MedicationRequest.reasonReference
5/8/2023	MedicationRequest.instantiatesCanonical
5/8/2023	MedicationRequest.instantiatesUri
5/15/2023	Medication.ingredient.itemCodeableConcept Medication.ingredient.itemReference
5/15/2023	NA
5/15/2023	Condition.onset.onsetDateTime Condition.onset.onsetAge Condition.onset.Period Condition.onset.Range Condition.onset.String
5/15/2023	Condition.abatement.onsetDateTime Condition.abatement.onsetAge Condition.abatement.Period Condition.abatement.Range Condition.abatement.String
5/15/2023	Observation.encounter NR to MS
5/15/2023	Observation.hasMember NR to MS
5/16/2023	DiagnosticReport.effective.effectiveDateTim e DiagnosticReport.effective.Period
5/22/2023	Observation.category
6/4/2023	Encounter.episodeOfCare
6/5/2023	Procedure.subject
6/5/2023	Procedure.encounter
6/5/2023	Procedure.location
6/5/2023	Procedure.reasonCode
6/6/2023	Observation.encounter
6/6/2023	Observation.dataAbsentReason
6/6/2023	Location
6/6/2023	MedicationRequest.dosageInstruction.dose/
6/6/2023	MedicationRequest.dosageInstruction.dose/

6/6/2023	Specimen.type (not required for Hypo, but if necessary for alignment)
6/6/2023	Medication.status
6/6/2023	Condition.encounter
6/6/2023	Condition.onset[x]
6/6/2023	Condition.abatement[x]
6/6/2023	Condition.recordedDate
6/21/2023	Location resource designation in TOC
6/28/2023	Medication.code
7/5/2023	TOC, dQM Measure Lead/Back-up Clinical Analyst Row
7/5/2023	Initial Population-CQL on TOC
7/10/2023	Specimen.subject
7/10/2023	Specimen.collection
7/10/2023	Specimen.collection.id
7/10/2023	Specimen.collection.extension
7/10/2023	Specimen.collection.modifierExtension
7/31/2023	MedicationAdministration.context
7/31/2023	MedicationAdministration.request
7/31/2023	Condition.clinicalStatus
7/31/2023	Condition.verificationStatus
8/1/2023	Patient.contact.modifierExtension
8/1/2023	Patient.communication.modifierExtension
8/1/2023	Patient.identifier.period
8/1/2023	Specimen.processing.modifierExtension
8/1/2023	Specimen.container.modifierExtension
8/1/2023	Specimen.container.identifier
8/1/2023	Specimen.text
8/1/2023	Specimen.contained
8/1/2023	Specimen.extension
8/1/2023	Specimen.processing.id
8/1/2023	Specimen.processing.extension
8/1/2023	Specimen.container.id
8/1/2023	Specimen.container.extension
8/1/2023	N/A

8/1/2023	Specimen.meta
8/1/2023	Specimen.modifierExtension
8/1/2023	Specimen.collection.id
8/1/2023	Specimen.collection.extension
8/1/2023	Specimen.collection.modifierExtension
8/1/2023	(Abbreviation Tab)
8/1/2023	Condition.meta
8/1/2023	Condition.text
8/1/2023	Condition.contained
8/1/2023	Condition.extension
8/1/2023	Condition.modifierExtension
8/1/2023	Condition.identifier
8/1/2023	Condition.stage.id
8/1/2023	Condition.stage.extension
8/1/2023	Condition.stage.modifierExtension
8/1/2023	Condition.evidence.id
8/1/2023	Condition.evidence.extension
8/1/2023	Condition.evidence.modifierExtension
8/1/2023	Coverage.meta
8/1/2023	Coverage.text
8/1/2023	Coverage.contained
8/1/2023	Coverage.extension
8/1/2023	Coverage.modifierExtension
8/1/2023	Coverage.identifier
8/1/2023	Coverage.class.id
8/1/2023	Coverage.class.extension
8/1/2023	Coverage.class.modifierExtension
8/1/2023	DiagnosticReport.meta
8/1/2023	DiagnosticReport.implicitRules
8/1/2023	DiagnosticReport.language
8/1/2023	DiagnosticReport.contained
8/1/2023	DiagnosticReport.extension
8/1/2023	DiagnosticReport.modifierExtension
8/1/2023	DiagnosticReport.identifier
8/1/2023	DiagnosticReport.category:LaboratorySlice.i d
8/1/2023	DiagnosticReport.category:LaboratorySlice.i d.extension
8/1/2023	DiagnosticReport.category:LaboratorySlice. coding.id
8/1/2023	DiagnosticReport.media.id

8/1/2023	DiagnosticReport.media.extension
8/1/2023	DiagnosticReport.media.modifierExtension
8/1/2023	DocumentReference.meta
8/1/2023	DocumentReference.text
8/1/2023	DocumentReference.contained
8/1/2023	DocumentReference.extension
8/1/2023	DocumentReference.modifierExtension
8/1/2023	DocumentReference.masterIdentifier
8/1/2023	DocumentReference.identifier
8/1/2023	DocumentReference.relatesTo.id
8/1/2023	DocumentReference.relatesTo.extension
8/1/2023	DocumentReference.relatesTo.modifierExtension
8/1/2023	DocumentReference.content.id
8/1/2023	DocumentReference.content.extension
8/1/2023	DocumentReference.content.modifierExtension
8/1/2023	DocumentReference.content.attachment.id
8/1/2023	DocumentReference.content.attachment.extension
8/1/2023	DocumentReference.content.attachment.language
8/1/2023	DocumentReference.context.id
8/1/2023	DocumentReference.context.extension
8/1/2023	DocumentReference.context.modifierExtension
8/1/2023	Encounter.meta
8/1/2023	Encounter.text
8/1/2023	Encounter.contained
8/1/2023	Encounter.extension
8/1/2023	Encounter.modifierExtension
8/1/2023	Encounter.identifier.id
8/1/2023	Encounter.identifier.extension
8/1/2023	Encounter.statusHistory.id
8/1/2023	Encounter.statusHistory.extension
8/1/2023	Encounter.statusHistory.modifierExtension
8/1/2023	Encounter.classHistory.id
8/1/2023	Encounter.classHistory.extension

8/1/2023	Encounter.classHistory.modifierExtension
8/1/2023	Encounter.participant.id
8/1/2023	Encounter.participant.extension
8/1/2023	Encounter.participant.modifierExtension
8/1/2023	Encounter.diagnosis.id
8/1/2023	Encounter.diagnosis.extension
8/1/2023	Encounter.diagnosis.modifierExtension
8/1/2023	Encounter.diagnosis.condition
8/1/2023	Encounter.hospitalization.id
8/1/2023	Encounter.hospitalization.extension
8/1/2023	Encounter.hospitalization.modifierExtension
8/1/2023	Encounter.location.id
8/1/2023	Encounter.location.extension
8/1/2023	Encounter.location.modifierExtension
8/1/2023	Immunization.meta
8/1/2023	Immunization.implicitRules
8/1/2023	Immunization.language
8/1/2023	Immunization.text
8/1/2023	Immunization.contained
8/1/2023	Immunization.extension
8/1/2023	Immunization.modifierExtension
8/1/2023	Immunization.performer.id
8/1/2023	Immunization.performer.extension
8/1/2023	Immunization.performer.modifierExtension
8/1/2023	Immunization.education.id
8/1/2023	Immunization.education.extension
8/1/2023	Immunization.education.modifierExtension
8/1/2023	Immunization.reaction.id
8/1/2023	Immunization.reaction.extension
8/1/2023	Immunization.reaction.modifierExtension
8/1/2023	Immunization.protocolApplied.id
8/1/2023	Immunization.protocolApplied.extension
8/1/2023	Immunization.protocolApplied.modifierExtension
8/1/2023	Device.meta
8/1/2023	Device.implicitRules
8/1/2023	Device.language

8/1/2023	Device.text
8/1/2023	Device.contained
8/1/2023	Device.extension
8/1/2023	Device.modifierExtension
8/1/2023	Device.identifier
8/1/2023	Device.deviceName.id
8/1/2023	Device.deviceName.extension
8/1/2023	Device.deviceName.modifierExtension
8/1/2023	Device.specialization.id
8/1/2023	Device.specialization.extension
8/1/2023	Device.specialization.modifierExtension
8/1/2023	Device.version.id
8/1/2023	Device.version.extension
8/1/2023	Device.version.modifierExtension
8/1/2023	Device.property.id
8/1/2023	Device.property.extension
8/1/2023	Device.property.modifierExtension
8/1/2023	Observation.meta
8/1/2023	Observation.text
8/1/2023	Observation.contained
8/1/2023	Observation.extension
8/1/2023	Observation.modifierExtension
8/1/2023	Observation.identifier
8/1/2023	Observation.category.id
8/1/2023	Observation.referenceRange.id
8/1/2023	Observation.referenceRange.extension
8/1/2023	Observation.referenceRange.modifierExtension
8/1/2023	Observation.component.id
8/1/2023	Observation.component.extension
8/1/2023	Observation.component.modifierExtension
8/1/2023	Location.meta
8/1/2023	Location.text
8/1/2023	Location.contained
8/1/2023	Location.extension
8/1/2023	Location.modifierExtension
8/1/2023	Location.address.id
8/1/2023	Location.address.extension
8/1/2023	Location.position.id
8/1/2023	Location.position.extension

8/1/2023	Location.position.modifierExtension
8/1/2023	Location.hoursOfOperation.id
8/1/2023	Location.hoursOfOperation.extension
8/1/2023	Location.hoursOfOperation.modifierExtension
8/1/2023	Medication.meta
8/1/2023	Medication.text
8/1/2023	Medication.contained
8/1/2023	Medication.extension
8/1/2023	Medication.modifierExtension
8/1/2023	Medication.identifier
8/1/2023	Medication.ingredient.id
8/1/2023	Medication.ingredient.extension
8/1/2023	Medication.ingredient.modifierExtension
8/1/2023	Medication.batch.id
8/1/2023	Medication.batch.extension
8/1/2023	Medication.batch.modifierExtension
8/1/2023	MedicationAdministration.meta
8/1/2023	MedicationAdministration.text
8/1/2023	MedicationAdministration.contained
8/1/2023	MedicationAdministration.extension
8/1/2023	MedicationAdministration.modifierExtension
8/1/2023	MedicationAdministration.identifier
8/1/2023	MedicationAdministration.performer.id
8/1/2023	MedicationAdministration.performer.extension
8/1/2023	MedicationAdministration.performer.modifierExtension
8/1/2023	MedicationAdministration.dosage.id
8/1/2023	MedicationAdministration.dosage.extension
8/1/2023	MedicationAdministration.dosage.modifierExtension
8/1/2023	MedicationRequest.meta
8/1/2023	MedicationRequest.text
8/1/2023	MedicationRequest.contained
8/1/2023	MedicationRequest.extension
8/1/2023	MedicationRequest.modifierExtension
8/1/2023	MedicationRequest.identifier
8/1/2023	MedicationRequest.dosageInstruction.id

8/1/2023	MedicationRequest.dosageInstruction.extension
8/1/2023	MedicationRequest.dosageInstruction.modifierExtension
8/1/2023	MedicationRequest.substitution.id
8/1/2023	MedicationRequest.substitution.extension
8/1/2023	MedicationRequest.substitution.modifierExtension
8/1/2023	Observation.meta
8/1/2023	Observation.implicitRules
8/1/2023	Observation.language
8/1/2023	Observation.text
8/1/2023	Observation.contained
8/1/2023	Observation.extension
8/1/2023	Observation.modifierExtension
8/1/2023	Observation.identifier
8/1/2023	Observation.referenceRange.id
8/1/2023	Observation.referenceRange.extension
8/1/2023	Observation.referenceRange.modifierExtension
8/1/2023	Observation.component.id
8/1/2023	Observation.component.extension
8/1/2023	Observation.component.modifierExtension
8/1/2023	Procedure.meta
8/1/2023	Procedure.implicitRules
8/1/2023	Procedure.language
8/1/2023	Procedure.text
8/1/2023	Procedure.contained
8/1/2023	Procedure.extension
8/1/2023	Procedure.modifierExtension
8/1/2023	Procedure.identifier
8/1/2023	Procedure.performer.id
8/1/2023	Procedure.performer.extension
8/1/2023	Procedure.performer.modifierExtension
8/1/2023	Procedure.focalDevice.id
8/1/2023	Procedure.focalDevice.extension
8/1/2023	Procedure.focalDevice.modifierExtension
8/1/2023	ServiceRequest.meta
8/1/2023	ServiceRequest.text
8/1/2023	ServiceRequest.contained

8/1/2023	ServiceRequest.extension
8/1/2023	ServiceRequest.modifierExtension
8/1/2023	ServiceRequest.identifier
8/2/2023	Patient.meta
8/2/2023	Patient.implicitRules
8/2/2023	Patient.language
8/2/2023	Patient.text
8/2/2023	Patient.contained
8/2/2023	Patient.modifierExtension
8/2/2023	Patient.telecom.id
8/2/2023	Patient.telecom.extension
8/4/2023	Observation.code
8/7/2023	MedicationRequest.dosageInstruction.site
8/7/2023	Encounter.diagnosis.condition
8/7/2023	Encounter.diagnosis.condition
8/8/2023	Device R4 Resource
8/9/2023	Diagnostic Report Profile for Report and Note Exchange
8/17/2023	MedicationRequest.dosageInstruction.text
8/18/2023	MedicationRequest.statusReason
9/6/2023	NA
10/2/2023	All data element alignment analysis
10/2/2023	All data element alignment analysis
10/3/2023	NHSN IG - Cross Measure, Monthly Column
10/4/2023`	Added an "ACH dQM" column with requirements
10/10/2023	Medication and Medication Request Resources in ACH dQM
10/18/2023	Medication.status
10/18/2023	Specimen.status

10/20/2023	Observation - Vital Signs Resource/Profile
10/25/2023	Observation.component.code
10/30/2023	Encounter.status

10/31/2023	Encounter.status
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11/1/2023	Observation.specimen (in Lab Result Observation -US Core)
11/7/2023	Patient.extension (gender identity)
11/8/2023	Observation-Vital Signs R4
11/8/2023	Observation.referenceRange Observation-Vital Signs R4
11/8/2023	Observation.component.referenceRange Observation-R4
11/8/2023	Observation.referenceRange Observation-R4
11/9/2023	Observation.component.referenceRange Observation-Vital Signs R4 Observation.referenceRange.age
11/9/2023	Observation-R4 Observation.referenceRange.age
11/9/2023	Observation-R4 Observation.referenceRange.low
11/9/2023	Observation-Vital Signs R4 Observation.referenceRange.low
11/9/2023	Observation-R4 Observation.referenceRange.high

11/9/2023	Observation-Vital Signs R4 Observation.referenceRange.high
11/9/2023	Observation-R4 Observation.component.referenceRange.lo w
11/9/2023	Observation-Vital Signs R4 Observation.component.referenceRange.lo w
11/9/2023	Observation-R4 Observation.component.referenceRange.hi gh
11/9/2023	Observation-Vital Signs R4 Observation.component.referenceRange.hi gh
11/13/2023	DiagnosticReport.imagingStudy DiagnosticReport.media DiagnosticReport.presentedForm
11/21/2023	Encounter.type
11/21/2023	Encounter.diagnosis.use
11/21/2023	Encounter.hospitalization.admitSource
11/21/2023	Encounter.location.status
11/21/2023	Device.status
11/21/2023	Device.deviceName.type
11/21/2023	Observation.category
11/21/2023	Observation.interpretation
11/21/2023	Observation.component.interpretation
11/30/2023	MedicationRequest-US Core
12/6/2023	DiagnosticReport.status
12/13/2023	Implantable Device (US Core) Device.owner
12/13/2023	Implantable Device (UsCore) Device.contact
12/13/2023	Implantable Device (UsCore) Device.location
12/13/2023	Implantable Device (UsCore) Device.url
12/13/2023	Implantable Device (UsCore) Device.note
12/13/2023	Implantable Device (UsCore) Device.safety
12/13/2023	Implantable Device (UsCore) Device.parent

12/13/2023	Observation Vital Signs (R4) Observation.component.referenceRange.lo w
12/13/2023	Observation Vital Signs (R4) Observation.component.referenceRange.hi gh
12/13/2023	Observation Vital Signs (R4) Observation.component.referenceRange.ty pe
12/13/2023	Observation Vital Signs (R4) Observation.component.referenceRange.a ppliesTo
12/13/2023	Observation Vital Signs (R4) Observation.component.referenceRange.a ge
12/13/2023	Observation Vital Signs (R4) Observation.component. referenceRange.text
1/2/2024	Observation.component.id
1/2/2024	Observation.component.extension
1/2/2024	Observation.component.modifierExtension
1/2/2024	Observation.component.dataAbsentReason
1/2/2024	Observation.value[x]
1/2/2024	Observation.note
1/2/2024	Condition.onset[x]
1/2/2024	Condition.abatement[x]
1/2/2024	Condition.recordedDate
1/2/2024	Location.alias
1/2/2024	Medication
1/2/2024	Medication.form
1/2/2024	Medication.amount
1/2/2024	Medication.ingredient
1/2/2024	Encounter.statusHistory
1/4/2024	Observation.encounter (Lab Result Observation)
1/4/2024	DiagnosticReport.specimen
1/4/2024	Location.partOf

1/4/2024	MedicationAdministration
1/4/2024	MedicationAdministration.statusReason
1/4/2024	MedicationAdministration.category
1/4/2024	MedicationAdministration.reasonCode
1/4/2024	MedicationAdministration.reasonReference
1/4/2024	MedicationRequest.dosageInstruction.method
1/4/2024	MedicationRequest.dosageInstruction.doseAndRate
1/4/2024	MedicationRequest.dosageInstruction.doseAndRate.type
1/4/2024	MedicationRequest.dosageInstruction.doseAndRate.dose[x]
1/4/2024	MedicationRequest.dosageInstruction.doseAndRate.rate[x]
1/4/2024	Procedure
1/4/2024	Procedure.encounter
1/4/2024	Procedure.location
1/4/2024	ServiceRequest
1/4/2024	ServiceRequest.category
1/4/2024	ServiceRequest.priority
1/4/2024	ServiceRequest.doNotPerform
1/4/2024	ServiceRequest.code
1/4/2024	ServiceRequest.encounter
1/4/2024	ServiceRequest.occurrence[x]
1/4/2024	ServiceRequest.asNeeded[x]
1/4/2024	ServiceRequest.reasonReference
1/4/2024	ServiceRequest.specimen
1/16/2024	DiagnosticReport.imagingStudy
1/16/2024	DiagnosticReport.media
1/16/2024	DiagnosticReport.presentedForm
1/24/2024	Diagnostic Report Report and Note
	DiagnosticReport.text
1/24/2024	Diagnostic Report- Lab
	DiagnosticReport.text
1/24/2024	Location.identifier
1/29/2024	location.managingOrg
1/29/2024	patient.managingOrganization

1/30/2024	DiagnosticReport.media.link
1/30/2024	DiagnosticReport.media.comment
1/30/2024	MedicationRequest.substitution.allowed[x]
1/30/2024	MedicationRequest.substitution.reason
2/9/2024	DiagnosticReport.presentedForm
2/15/2023	Implantable Device
	Device.deviceName
2/15/2024	Updates to binding strengths for ACH
3/1/2024	Encounter.participant
3/1/2024	Encounter.participant.id
3/1/2024	Encounter.participant.extension
3/1/2024	Encounter.participant.modifierExtension
3/1/2024	Encounter.participant.type
3/1/2024	Encounter.participant.period
3/1/2024	Encounter.participant.individual
3/7/2024	Service Request resource
4/2/2024	Diagnostic Report - R4 (Tab and TOC)
6/12/2024	MedicationRequest.requester

[illegible]

NR	NRT
MS[0..1] for Hypo and CDI/HOB	NRT only in Technical column
NR	NRT
NR	NRT
NR	NRT
NR	NRT
NR	NRT
NR	NRT
NR	NRT
NR	NRT
NR	R [1..1]
NR	MS [0..1]
NR	NRT
MS [0..*]	R [1..1]
MS [0..*]	NRT
MS [0..1]	NRT
R [1..1]	MS [0..*]
NR	NRT
NR	NRT
NR	MS [0..1]
R [1..1]	NR
NR	MS [0..1]
NR	MS [0..1]
Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-practitioner http://hl7.org/fhir/us/core/StructureDefinition/us-core-patient http://hl7.org/fhir/us/core/StructureDefinition/us-core-organization http://hl7.org/fhir/us/core/StructureDefinition/us-core-practitionerrole http://hl7.org/fhir/us/core/StructureDefinition/us-core-relatedperson Device)	Reference(US Core Practitioner Profile US Core Organization Profile US Core Patient Profile)

MS [0..1]	NRT
NR	MS [0..1]
NR	MS [0..1]
NR	MS [0..*]
NRT	MS [0..*]
NRT	MS [0..*]
MS [0..1]	Removed from table
NA	N/A
NR	Removed from table
N/A	Removed from table
NR	MS [0..1]
NR	MS [0..1]
NR	N/A
NR	R [1..*]
MS [0..1]	NRT
NR	R [1..1]
NR	MS [0..1]
NR	MS [0..1]
NR	MS [0..*]
NR	MS [0..1]
NR	MS [0..1]
MS [0..*]	R [1..*]
NR	MS [0..1]
NR	MS [0..1]

[illegible]

[illegible][illegible]

NRT
NRT

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[illegible][illegible]

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NR
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NR
NR
NR
NR
R [1..1]

NRT
NRT
NRT
NRT
NRT
NRT
NRT
NRT
NRT
NRT
NRT
R [1..1]

The following
constraint is written
into the CQL: "Blood
Glucose Laboratory and
Point of Care Tests"
<http://cts.nlm.nih.gov/fh/ir/ValueSet/2.16.840.1.113762.1.4.1190.38>

NRT

NRT
NRT
N/A
N/A

blank

R [1..1]
(left blank)
N/A
N/A

MS [0..1]

NRT
NA
NA
NA
NA

MS [0..1]

MS[0..1]
NA
NA
NA
NA

NR
NR

MS[0..*]
MS[0..1]

NA
MS [1..1]
R [1..1]

The following constraints are written into the CQL:
'in-progress', 'finished', 'triaged'

R [1..1]

The following constraints are written into the CQL:
'in-progress', 'finished', 'triaged', 'entered-in-error'

MS [0..*]

MS [0..1]
NR

NR

NR

NR

NR

NR

NR

NR

NR

NA
R [1..1]
R [1..1]

The following constraints are written into the CQL:
'in-progress', 'finished', 'triaged', 'onleave', 'entered-in-error'
R [1..1]

The following constraints are written into the CQL:
'in-progress', 'finished', 'triaged', 'onleave', 'entered-in-error'
MS [0..1]

MS [0..*]
MS [0..*]

MS[0..*]

MS [0..*]

MS [0..1]

MS [0..1]

MS [0..1]

MS [0..1]

MS [0..1]

MS [0..1]

N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A

R [1..1]	NRT
MS [0..1]	NRT
MS [0..*]	NRT
MS [0..*]	NR
MS [0..1]	MS [0..1]

(could have a null if lab result/status is not yet finalized)

MS [0..1]	NR
MS [0..1]	MS [0..1]
MS [0..1]	MS [0..1]
MS [0..1]	MS [0..1]
MS [0..*]	MS [0..*]
MS [0..*]	MS [0..*]
MS [0..1]	MS [0..1]
MS [0..1]	MS [0..1]
MS [0..*]	MS [0..*]
MS [0..1]	NR
MS [0..1]	MS [0..1]
MS [0..*]	MS [0..*]
MS [0..1]	MS [0..1]

MS [0..*]	MS [0..*]
MS [0..*]	MS [0..*]
MS [0..*]	MS [0..*]
MS [0..*]	MS [0..*]
MS [0..*]	MS [0..*]
MS [0..1]	MS [0..1]
MS [0..*]	MS [0..*]
MS [0..1]	MS [0..1]
MS [0..1]	MS [0..1]
MS [0..1]	MS [0..1]
MS [0..1]	MS [0..1]
MS [0..*]	MS [0..*]

MS[0..1]	MS [0..1]
MS [0..1]	MS [0..1]
MS [0..*]	MS [0..*]
MS [0..*]	MS [0..*]
MS [0..1]	MS [0...1]
MS [0..1]	MS [0..1]
MS [0..1]	MS [0..1]
MS [0..1]	MS [0..1]
MS [0..1]	MS [0..1]
MS [0..1]	MS [0..1]
MS [0..*]	MS [0..*]
MS [0..*]	MS [0..*]

NR	NRT
NR	NRT
NR	NRT
NR	NRT

NR	NRT
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NR	NRT
MS	NR
MS	NR

NR	NRT
NR	NRT
NR	NRT

NR	NRT
NR	NRT
MS [0..1*]	MS [0..*]

NA	NA
NR	NRT
NR	NRT
NR	NRT
NR	NRT
NR	NRT
NR	NRT
NR	NRT

N	MS
none	added
R[1..1]	NR

Details	Monthly FHIR Master Data Dictionary
Version of Document:	2.2
Date of Document	7/16/2024
Draft Purpose	This FHIR Master Data Dictionary docur
Authors	dQM Leads, FHIR Analysts, Protocol Lea
Scope	All monthly NHSN Measures
Abbreviation	Name
MS	Must Support
R	Required
NR	Not Required
NRT	Not Required by Technical Team
AI	Action Item
CQL	Clinical Quality Language

Key for use of colors, fonts, and tabs

Red Font	Cardinality differs from FHIR R4 or US C
Bold Font	In the FHIR Resource tabs, it indicates t
Teal Tab	FHIR R4 v.4.0.1 Profiles *Disclaimer: If l
Maroon Tab	US Core v.3.1.1 Profiles *Disclaimer: If l

NHSN Technical Guidance provided by Mamadou Bass Toure

Mark all **{Resource}.{dataElement}.identifiers** as NRT.

Mark all **{Resource}.contained** as NRT.

Mark all **{Resource}.meta** as NRT.

Mark all **{Resource}.text** as NRT.

y

nents the NHSN specific measure requirements to inform the development of t
ads

Details

If available, it will be queried by NHSNLink for measure calculation or risk adjustment.

Required to be queried by NHSNLink for the NHSN Application to determine initial population.

Queried by NHSNLink but not required to calculate the measures.

Not queried by NHSNLink and determined by the technical team as not needed.

In the change log tab, the dQM leads will indicate if an update requires an action item.

CQL is machine-readable and structured on the FHIR data model.

The NHSN dQM CQL defines the following items:

- The initial population eligible for the measure
- Line-level data required to calculate measure metrics
- Additional line-level data for stratification, risk adjustment, social determinants of health, and patient matching

Core standards or conformance is more constrained against FHIR R4 or US Core the parent data elements.

JRL links are directed to a different version of this standard, please email the dC
JRL links are directed to a different version of this standard, please email the dC

he CDC NHSN dQM IG for monthly measures.

Comments

Must be designated as MS or R if wanted in the Silver table.

Must be designated as MS or R if wanted in the Silver table.

Elements designated as NR will go into the Bronze table but will not progress to Silver.

NRT elements will not be included in the bundle.

If an AI is identified, a Jira ticket is typically assigned to a responsible party.

FHIR bundle validation will occur against the CDC NHSN dQM IG, version 3.1.1 of US Core Profiles, and version 4.0.1 of FHIR R4.

profiles.

QM project manager to correct the hyperlink.

QM project manager to correct the hyperlink.

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FHIR Path	Min	Max	Must Support?
Condition	0	*	
Condition.id	0	1	
Condition.meta	0	1	
Condition.implicitRules	0	1	
Condition.language	0	1	
Condition.text	0	1	
Condition.contained	0	*	
Condition.extension	0	*	

Condition.modifierExtension	0	*	
Condition.identifier	0	*	
Condition.clinicalStatus	0	1	Y
Condition.verificationStatus	0	1	Y
Condition.category	1	*	Y
Condition.severity	0	1	
Condition.code	1	1	Y
Condition.bodySite	0	*	

Condition.subject	1	1	Y
Condition.encounter	0	1	
Condition.onset[x]	0	1	
Condition.abatement[x]	0	1	
Condition.recordedDate	0	1	
Condition.recorder	0	1	
Condition.asserter	0	1	
Condition.stage	0	*	
Condition.stage.id	0	1	

Condition.stage.extension	0	*	
Condition.stage.modifierExtension	0	*	
Condition.stage.summary	0	1	
Condition.stage.assessment	0	*	
Condition.stage.type	0	1	
Condition.evidence	0	*	
Condition.evidence.id	0	1	
Condition.evidence.extension	0	*	

Condition.evidence.modifierExtension	0	*	
Condition.evidence.code	0	*	
Condition.evidence.detail	0	*	
Condition.note	0	*	

Data Type(s)	FHIR Short Description
Condition	Detailed information about conditions, problems or diagnoses us-core-1: A code in Condition.category SHOULD be from US Core Condition Category Codes value set.
string	Logical id of this artifact
Meta	Metadata about the resource
uri	A set of rules under which this content was created
code	Language of the resource content
Narrative	Text summary of the resource, for human interpretation
Resource	Contained, inline Resources
Extension	Additional content defined by implementations

Extension	Extensions that cannot be ignored
Identifier	External Ids for this condition
CodeableConcept	active recurrence relapse inactive remission resolved
CodeableConcept	unconfirmed provisional differential confirmed refuted entered-in-error
CodeableConcept	problem-list-item encounter-diagnosis health-concern
CodeableConcept	Subjective severity of condition
CodeableConcept	Identification of the condition, problem or diagnosis
CodeableConcept	Anatomical location, if relevant

Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-patient)	Who has the condition?
Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-encounter)	Encounter created as part of
dateTime Age Period Range String	Estimated or actual date, date-time, or age
dateTime Age Period Range String	When in resolution/remission
dateTime	Date record was first recorded
Reference(Practitioner PractitionerRole Patient RelatedPerson)	Who recorded the condition
Reference(Practitioner PractitionerRole Patient RelatedPerson)	Person who asserts this condition
BackboneElement	Stage/grade, usually assessed formally
string	Unique id for inter-element referencing

Extension	Additional content defined by implementations
Extension	Extensions that cannot be ignored even if unrecognized
CodeableConcept	Simple summary (disease specific)
Reference(ClinicalImpression DiagnosticReport Observation)	Formal record of assessment
CodeableConcept	Kind of staging
BackboneElement	Supporting evidence
string	Unique id for inter-element referencing
Extension	Additional content defined by implementations

Extension	Extensions that cannot be ignored even if unrecognized
CodeableConcept	Manifestation/symptom
Reference(Resource)	Supporting information found elsewhere
Annotation	Additional information about the Condition

FHIR Definition	Binding Strength
The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	
The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.	
A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	
The base language in which the resource is written.	preferred
A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.	
These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.	
An Extension	

May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Business identifiers assigned to this condition by the performer or other systems which remain constant as the resource is updated and propagates from server to server.	
The clinical status of the condition. NOTE (7/31/2023): This is an invariant. When clinicalStatus is not present (empty), then a verificationStatus of "entered in error " is required. This will not be captured in FHIR validation.	required
The verification status to support the clinical status of the condition. NOTE (7/31/2023): This is an invariant. When clinicalStatus is not present (empty), then a verificationStatus of "entered in error " is required. This will not be captured in FHIR validation.	required
A category assigned to the condition.	extensible
A subjective assessment of the severity of the condition as evaluated by the clinician.	preferred
Identification of the condition, problem or diagnosis.	extensible
The anatomical location where this condition manifests itself.	example

Indicates the patient or group who the condition record is associated with.	
The Encounter during which this Condition was created or to which the creation of this record is tightly associated.	
Estimated or actual date or date-time the condition began, in the opinion of the clinician.	
The date or estimated date that the condition resolved or went into remission. This is called "abatement" because of the many overloaded connotations associated with "remission" or "resolution" - Conditions are never really resolved, but they can abate.	
The recordedDate represents when this particular Condition record was created in the system, which is often a system-generated date.	
Individual who recorded the record and takes responsibility for its content.	
Individual who is making the condition statement.	
Clinical stage or grade of a condition. May include formal severity assessments.	
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	

May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
A simple summary of the stage such as "Stage 3". The determination of the stage is disease-specific.	example
Reference to a formal record of the evidence on which the staging assessment is based.	
The kind of staging, such as pathological or clinical staging.	example
Supporting evidence / manifestations that are the basis of the Condition's verification status, such as evidence that confirmed or refuted the condition.	
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
A manifestation or symptom that led to the recording of this condition.	example
Links to other relevant information, including pathology reports.	
Additional information about the Condition. This is a general notes/comments entry for description of the Condition, its diagnosis and prognosis.	

Binding Description	FHIR Binding Value Set	ACH dQM
		MS [0.*]
		R [1..1]
		NRT
		NRT
Common Languages.	http://hl7.org/fhir/R4/valueset-la	NRT
		NRT
		NRT
		NRT

		NRT
		NRT
ConditionClinicalStatusCodes	http://hl7.org/fhir/R4/ValueSet/c	MS [0..1]
ConditionVerificationStatus	http://hl7.org/fhir/R4/ValueSet/c	MS [0..1]
US Core Condition Category Codes	http://hl7.org/fhir/us/core/STU3	R [1..*]
Condition/DagnosisSeverity	http://hl7.org/fhir/R4/ValueSet/c	NR
US Core Condition Code	https://hl7.org/fhir/us/core/STU3	R [1..1]
SNOMEDCTBodyStructures	https://hl7.org/fhir/R4/valueset-l	NR

		R [1..1]
		MS [0.1]
		MS [0..1]
		MS [0..1]
		MS [0..1]
		NRT
		NRT
		NR
		NRT

		NRT
		NRT
ConditionStage	https://hl7.org/fhir/R4/valueset-c	NR
		NR
ConditionStageType	https://hl7.org/fhir/R4/valueset-c	NR
		NR
		NRT
		NRT

		NRT
Manifestation AndSymptom Codes	https://hl7.org/fhir/R4/valueset-1	NR
		NR
		NR

[Back to TOC](#)

FHIR Path	Min	Max	Type(s)	FHIR Short Description
Coverage			DomainResource	Insurance or medical plan or a payment agreement Elements defined in Ancestors: id, meta, implicitRules, language, text, contained, extension, modifierExtension
Coverage.id	0	1	id	Logical id of this artifact
Coverage.meta	0	1	Meta	Metadata about the resource
Coverage.implicitRules	0	1	uri	A set of rules under which this content was created

Coverage.language	0	1	code	Language of the resource content
Coverage.text	0	1	Narrative	Text summary of the resource, for human interpretation
Coverage.contained	0	*	Resource	Contained, inline Resources

Coverage.extension	0	*	Extension	Additional content defined by implementations
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Coverage.modifierExtension	0	*	Extension	Extensions that cannot be ignored

Coverage.identifier	0	*	Identifier	Business Identifier for the coverage
Coverage.status	1	1	code	active cancelled draft entered-in-error
Coverage.type	0	1	CodeableConcept	Coverage category such as medical or accident
Coverage.policyHolder	0	1	Reference(Patient RelatedPerson Organization)	Owner of the policy
Coverage.subscriber	0	1	Reference(Patient RelatedPerson)	Subscriber to the policy
Coverage.subscriberId	0	1	string	ID assigned to the subscriber
Coverage.beneficiary	1	1	Reference(Patient)	Plan beneficiary

Coverage.dependent	0	1	string	Dependent number
Coverage.relationship	0	1	CodeableConcept	Beneficiary relationship to the subscriber
Coverage.period	0	1	Period	Coverage start and end dates
Coverage.payor	1	*	Reference(Organization Patient RelatedPerson)	Issuer of the policy
Coverage.class	0	*	BackboneElement	Additional coverage classifications
Coverage.class.id	0	1	string	Unique id for inter-element referencing

Coverage.class.extension	0	*	Extension	Additional content defined by implementations
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Coverage.class.modifierExtension	0	*	Extension	Extensions that cannot be ignored even if unrecognized

Coverage.class.type	1	1	CodeableConcept	Type of class such as 'group' or 'plan'
Coverage.class.value	1	1	string	Value associated with the type
Coverage.class.name	0	1	string	Human readable description of the type and value
Coverage.order	0	1	positiveInt	Relative order of the coverage
Coverage.network	0	1	string	Insurer network

Coverage.costToBeneficiary	0	*	BackboneElement	Patient payments for services/products
Coverage.costToBeneficiary.id	0	1	string	Unique id for inter-element referencing
Coverage.costToBeneficiary.extension	0	*	Extension	Additional content defined by implementations

Coverage.costToBeneficiary.modifierExtension	0	*	Extension	Extensions that cannot be ignored even if unrecognized
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Coverage.costToBeneficiary.type	0	1	CodeableConcept	Cost category
Coverage.costToBeneficiary.value[x] valueQuantity valueMoney	1	1	SimpleQuantity Money	The amount or percentage due from the beneficiary
Coverage.costToBeneficiary.exception	0	*	BackboneElement	Exceptions for patient payments
Coverage.costToBeneficiary.exception.id	0	1	string	Unique id for inter-element referencing
Coverage.costToBeneficiary.exception.extension	0	*	Extension	Additional content defined by implementations

Coverage.costToBeneficiary.exception.modifierExtension	0	*	Extension	Extensions that cannot be ignored even if unrecognized
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Coverage.costToBeneficiary.exception.type	1	1	CodeableConcept	Exception category
Coverage.costToBeneficiary.exception.period	0	1	Period	The effective period of the exception
Coverage.subrogation	0	1	boolean	Reimbursement to insurer
Coverage.contract	0	*	Reference(Contract)	Contract details

FHIR Definition	Binding Strength	Binding Description	Binding Value Set
Financial instrument which may be used to reimburse or pay for health care products and services. Includes both insurance and self-payment.			
The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.			
The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.			
A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.			

The base language in which the resource is written.	preferred	IETF language tag	https://hl7.org/fhir/val
A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.			
These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.			

May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.			
--	--	--	--

May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).			
--	--	--	--

A unique identifier assigned to this coverage.			
The status of the resource instance.	required	FinancialResourceStatusCodes	https://hl7.org/fhir/R4/
The type of coverage: social program, medical plan, accident coverage (workers compensation, auto), group health or payment by an individual or organization.	extensible	CoverageTypeAndSelf-PayCodes	https://vsac.nlm.nih.gov/
The party who 'owns' the insurance policy.			
The party who has signed-up for or 'owns' the contractual relationship to the policy or to whom the benefit of the policy for services rendered to them or their family is due.			
The insurer assigned ID for the Subscriber.			
The party who benefits from the insurance coverage; the patient when products and/or services are provided.			

A unique identifier for a dependent under the coverage.			
The relationship of beneficiary (patient) to the subscriber.	extensible	SubscriberRelationshipCodes	https://hl7.org/fhir/R4/
Time period during which the coverage is in force. A missing start date indicates the start date isn't known, a missing end date means the coverage is continuing to be in force.			
The program or plan underwriter or payor including both insurance and non-insurance agreements, such as patient-pay agreements.			
A suite of underwriter specific classifiers.			
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.			

May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.			
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The type of classification for which an insurer-specific class label or number and optional name is provided, for example may be used to identify a class of coverage or employer group, Policy, Plan.	extensible	CoverageClassCodes	https://hl7.org/fhir/R4/
The alphanumeric string value associated with the insurer issued label.			
A short description for the class.			
The order of applicability of this coverage relative to other coverages which are currently in force. Note, there may be gaps in the numbering and this does not imply primary, secondary etc. as the specific positioning of coverages depends upon the episode of care.			
The insurer-specific identifier for the insurer-defined network of providers to which the beneficiary may seek treatment which will be covered at the 'in-network' rate, otherwise 'out of network' terms and conditions apply.			

A suite of codes indicating the cost category and associated amount which have been detailed in the policy and may have been included on the health card.			
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.			
May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.			

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The category of patient centric costs associated with treatment.	extensible	CoverageCopolyTypeCodes	https://hl7.org/fhir/R4/
The amount due from the patient for the cost category.			
A suite of codes indicating exceptions or reductions to patient costs and their effective periods.			
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.			
May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.			

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The code for the specific exception.	example	ExampleCoverageFinancialExceptionCodes	https://hl7.org/fhir/R4/
The timeframe during when the exception is in force.			
When 'subrogation=true' this insurance instance has been included not for adjudication but to provide insurers with the details to recover costs.			
The policy(s) which constitute this insurance coverage.			

ACH dQM
MS [0..*]
R[1..1]
NRT
NRT

NRT

NRT

NRT

NRT

NRT

NRT
R[1..1]
MS [0..1]
MS [0..1]
MS [0..1]
MS [0..1]
R[1..1]

MS [0..1]
MS [0..1]
MS [0..1]
R[1..*]
NR
NRT

NRT

NRT

NRT
NR
NR
NR
NR

NRT

NRT

NRT

NRT

NRT
NRT
NRT
NRT
NRT

NRT

NRT
NRT
NR
NR

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Path	Min	Max	Data Type(s)
Device	0	*	
Device.id	0	1	id
Device.meta	0	1	Meta

Device.implicitRules	0	1	uri
Device.language	0	1	code
Device.text	0	1	Narrative
Device.contained	0	*	Resource

Device.extension	0	*	Extension
Device.modifierExtension	0	*	Extension
Device.identifier	0	*	Identifier
Device.definition	0	1	CodeableReference(D eviceDefinition)

Device.udiCarrier	0	*	BackboneElement
Device.udiCarrier.id	0	1	string
Device.udiCarrier.extension	0	*	Extension
Device.udiCarrier.modifierExtension	0	*	Extension
Device.udiCarrier.deviceIdentifier	0	1	string

Device.udiCarrier.issuer	0	1	uri
Device.udiCarrier.jurisdiction	0	1	uri
Device.udiCarrier.carrierAIDC	0	1	base64Binary

Device.udiCarrier.carrierHRF	0	1	string
Device.udiCarrier.entryType	0	1	code
Device.status	0	1	code
Device.statusReason	0	*	Extensible/Codeable Concept
Device.distinctIdentifier	0	1	string
Device.manufacturer	0	1	string

Device.manufactureDate	0	1	dateTime
Device.expirationDate	0	1	dateTime
Device.lotNumber	0	1	string

Device.serialNumber	0	1	string
Device.deviceName	0	*	BackboneElement
Device.deviceName.id	0	1	string

Device.deviceName.extension	0	*	Extension
Device.deviceName.modifierExtension	0	*	Extension
Device.deviceName.name	1	1	string
Device.deviceName.type	1	1	code
Device.modelNumber	0	1	string
Device.partNumber	0	1	string

Device.type	0	1	CodeableConcept
Device.specialization	0	*	Backbone Element
Device.specialization.systemType	1	1	Codeable Concept
Device.specialization.version	0	1	string
Device.version	0	*	BackboneElement
Device.version.type	0	1	CodeableConcept
Device.version.component	0	1	Identifier
Device.version.value	1	1	string

Device.property	0	*	BackboneElement
Device.property.id	0	1	string
Device.property.extension	0	*	Extension
Device.property.modifierExtension	0	*	Extension
Device.property.type	1	1	CodeableConcept
Device.property.valueQuantity	0	*	Quantity

Device.property.valueCode	0	*	Codeable Concept
Device.patient	0	1	Reference (Patient)
Device.owner	0	1	Reference(Organization)
Device.contact	0	*	ContactPoint
Device.location	0	1	Reference(Location)
Device.url	0	1	uri
Device.note	0	*	Annotation
Device.safety	0	*	CodeableConcept
Device.parent	0	1	Reference(Device)

FHIR Short Description
Item used in healthcare
Logical id of this artifact
Metadata about the resource

A set of rules under which this content was created

Language of the resource content

Text summary of the resource, for human interpretation

Contained, inline Resources

Additional content defined by implementations

Extensions that cannot be ignored

Instance identifier

The reference to the definition for the device

Unique Device Identifier (UDI) Barcode string
Unique id for inter-element referencing
Additional content defined by implementations
Extensions that cannot be ignored even if unrecognized
Mandatory fixed portion of UDI

UDI Issuing Organization

Regional UDI authority

UDI Machine Readable Barcode String

UDI Human Readable Barcode String
barcode rfid manual card self-reported electronic-transmission unknown
Name of device manufacturer

Date when the device was made

Date and time of expiry of this device (if applicable)

Lot number of manufacture

Serial number assigned by the manufacturer

The name or names of the device as known to the manufacturer and/or patient

Unique id for inter-element referencing

Additional content defined by implementations
Extensions that cannot be ignored even if unrecognized
The name of the device.
The manufacturer's model number for the device
The part number or catalog number of the device

The kind or type of device
The actual design of the device or software version running on the device
The type of the device version, e.g. manufacturer, approved, internal
The version text

Unique id for inter-element referencing
Additional content defined by implementations
Extensions that cannot be ignored even if unrecognized
Value of the property

Organization responsible for device
Details for human/organization for support
Where the device is found
Network address to contact device
Device notes and comments
Safety Characteristics of Device

FHIR Definition	Comments
A type of a manufactured item that is used in the provision of healthcare without being substantially changed through that activity. The device may be a medical or non-medical device.	
The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	Within the context of the FHIR RESTful interactions, the resource has an id except for cases like the create and conditional update. Otherwise, the use of the resource id depends on the given use case.
The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.	

A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	Asserting this rule set restricts the content to be only understood by a limited set of trading partners. This inherently limits the usefulness of the data in the long term. However, the existing health eco-system is highly fractured, and not yet ready to define, collect, and exchange data in a generally computable sense. Wherever possible, implementers and/or
The base language in which the resource is written.	Language is provided to support indexing and accessibility (typically, services such as text to speech use the language tag). The html language tag in the narrative applies to the narrative. The language tag on the resource may be used to specify the language of other
A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical	Contained resources do not have a narrative. Resources that are not contained SHOULD have a narrative. In some cases, a resource may only have text with little or no additional discrete data (as long as all
These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, nor can they have their own independent transaction scope. This is allowed to be a Parameters resource if and only if it is referenced by a resource that provides context/meaning.	This should never be done when the content can be identified properly, as once identification is lost, it is extremely difficult (and context dependent) to restore it again. Contained resources may have profiles and tags in their meta elements, but SHALL

May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of
May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is ~~allowed to define an extension, there is a set of~~	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to
Unique instance identifiers assigned to a device by manufacturers other organizations or owners.	Certain attributes, like serial number and UDI Carrier (the HRF or AIDC barcode string) are not device instance identifiers as they are not consistently able to uniquely identify the instance of a device, thus are not appropriate to be used to value
The reference to the definition for the device.	

Unique device identifier (UDI) assigned to device label or package. Note that the Device may include multiple udiCarriers as it either may include just the udiCarrier for the jurisdiction it is sold, or for multiple jurisdictions it could have been sold.	UDI may identify an unique instance of a device, or it may only identify the type of the device. See [UDI mappings](device-mappings.html#udi) for a complete mapping of UDI parts to Device.
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and managable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.
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The device identifier (DI) is a mandatory, fixed portion of a UDI that identifies the labeler and the specific version or model of a device.	

Organization that is charged with issuing UDIs for devices. For example, the US FDA issuers include:

- 1) GS1: <http://hl7.org/fhir/NamingSystem/gs1-di>,
- 2) HIBCC: <http://hl7.org/fhir/NamingSystem/hibcc-di>,
- 3) ICCBBA for blood containers:
<http://hl7.org/fhir/NamingSystem/iccbba-blood-di>,
- 4) ICCBA for other devices:
<http://hl7.org/fhir/NamingSystem/iccbba-other-di> #
Informationsstelle für Arzneispezialitäten (IFA GmbH)
(EU only): <http://hl7.org/fhir/NamingSystem/ifa-gmbh-di>.

The identity of the authoritative source for UDI generation within a jurisdiction. All UDIs are globally unique within a single namespace with the appropriate repository uri as the system. For example, UDIs of devices managed in the U.S. by the FDA, the value is <http://hl7.org/fhir/NamingSystem/us-fda-udi> or in the European Union by the European Commission <http://hl7.org/fhir/NamingSystem/eu-ec-udi>.

The full UDI carrier of the Automatic Identification and Data Capture (AIDC) technology representation of the barcode string as printed on the packaging of the device - e.g., a barcode or RFID. Because of limitations on character sets in XML and the need to round-trip JSON data through XML, AIDC Formats *SHALL* be base64 encoded.

The AIDC form of UDIs should be scanned or otherwise used for the identification of the device whenever possible to minimize errors in records resulting from manual transcriptions. If separate barcodes for DI and PI are present, concatenate the string with DI first and in order of human readable expression on label.

The full UDI carrier as the human readable form (HRF) representation of the barcode string as printed on the packaging of the device.	If separate barcodes for DI and PI are present, concatenate the string with DI first and in order of human readable expression on label.
A coded entry to indicate how the data was entered.	
Status of the Device availability.	
Reason for the status of the Device availability.	
The distinct identification string as required by regulation for a human cell, tissue, or cellular and tissue-based product.	For example, this applies to devices in the United States regulated under Code of Federal Regulation 21CFR§1271.290(c).
A name of the manufacturer or entity legally responsible for the device.	

The date and time when the device was manufactured.	
The date and time beyond which this device is no longer valid or should not be used (if applicable).	
Lot number assigned by the manufacturer.	

The serial number assigned by the organization when the device was manufactured.	Alphanumeric Maximum 20. While a serial number is a type of identifier, in the context of devices for which a UDI is required, thus a serial number may be part of the production identifier, it is more informative to have the serial number as a dedicated attribute together with the other UDI production identifier. When the device is not subject to including the UDI (e.g., its presence and exchange is not mandated by local regulatory requirements or specific use case at hand), thus the concept of production identifiers is not relevant as a set, it remains helpful for consistency to still use Device.serialNumber rather than using Device.identifier with an appropriate type. Systems that do not realize an identifier is a serial number may place it in Device.identifier or if the identifier.system is known for the serial number, it may also be populated in the Device.identifier as a globally unique id_.
This represents the manufacturer's name of the device as provided by the device, from a UDI label, or by a person describing the Device. This typically would be used when a person provides the name(s) or when the device represents one of the names available from DeviceDefinition.	
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	

May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.
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Name of the device	
udi-label-name user-friendly-name patient-reported-name manufacturer-name model-name other	
The manufacturer's model number for the device.	
The part number or catalog number of the device.	Alphanumeric Maximum 20.

The kind or type of device. A device instance may have more than one type - in which case those are the types that apply to the specific instance of the device.	Multiple device types are use when a device is categorized in more than one context – for example, hybrid devices in which the device is both of type gateway and sensor.
The capabilities supported on a device, the standards to which the device conforms for a particular purpose, and used for the communication.	
The standard that is used to operate and communicate.	
The version of the standard that is used to operate and communicate	This is a business versionId, not a resource version id
The actual design of the device or software version running on the device.	
The type of the device version, e.g. manufacturer, approved, internal.	
A single component of the device version	
The version text.	

The actual configuration settings of a device as it actually operates, e.g., regulation status, time properties.	
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.
May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.
Updated definition -Code that specifies the property DeviceDefinitionPropetyCode (Extensible)	
Property value as a quantity.	

Property value as a code, e.g., NTP4 (syncd to NTP).	
Patient information, If the device is affixed to a person.	If the device is implanted in a patient, then need to associate the device to the patient.
An organization that is responsible for the provision and ongoing maintenance of the device.	
Contact details for an organization or a particular human that is responsible for the device.	used for troubleshooting etc.
The place where the device can be found.	
A network address on which the device may be contacted directly.	If the device is running a FHIR server, the network address should be the Base URL from which a conformance statement may be retrieved.
Descriptive information, usage information or implantation information that is not captured in an existing element.	
Provides additional safety characteristics about a medical device. For example devices containing latex.	
The parent device.	For example a vital signs monitor (parent) where three separate modules can be plugged into such as interchangeable blood pressure, oximeter, temperature modules. These modules are represented as devices with the .parent valued to the vital signs monitor when plugged in.

Binding Strength	Binding Description	FHIR Binding Value Set	ACH dQM
			MS[0..*]
			R[1..1]
			NRT

			NRT
required	IETF language tag for a human language	https://hl7.org/fhir/val	NRT
			NRT
			NRT

			NRT
			NRT
			NRT
			NR

			MS[0..*]
			NRT
			NRT
			NRT
			MS[0..1]

			NR
			NR
			MS[0..1]

			MS[0..1]
required	Codes to identify how UDI data was entered.	http://hl7.org/fhir/R4/v	MS[0..1]
required	The record status of the device.	http://hl7.org/fhir/R4/v	MS[0..1]
			NR
			MS[0..1]
			NR

			NR
			NR
			NR

			NR
			MS [0..*]
			NRT

			NRT
			NRT
			R[1..1]
required	Device Name Type	https://hl7.org/fhir/R4/	R[1..1]
			NR
			NR

Extensible	Codes to identify medical devices.	https://hl7.org/fhir/R4/	R[1..1]
			NR
			NR
			NR
			NR
example	The type of version indicated for the device.	http://hl7.org/fhir/ValueSet	NR
Note: This element does not have an example value set in v4.0.1 so we have listed Version 5 value set			
			NR
			NR

			NR
			NR
			NRT
			NRT
example	Device property type.	http://hl7.org/fhir/ValueSet	NR
Note: This element does not have an example value set in v4.0.1 so we have listed Version 5 value set			
			NR

			NR
			R[1..1]
			NR
			NR
			NR
			NR
			NR
example		http://hl7.org/fhir/ValueSet	NR
Note: This element does not have an example value set in v4.0.1 so we have listed Version 5 value set			
			NR

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Path	Min	Max
DiagnosticReport	0	*
DiagnosticReport.id	0	1
DiagnosticReport.basedOn	0	*
DiagnosticReport.status	1	1
DiagnosticReport.category	0	*

DiagnosticReport.code	1	1
DiagnosticReport.subject	0	1
DiagnosticReport.encounter	0	1
DiagnosticReport.effective[x]	0	1

DiagnosticReport.issued	0	1
DiagnosticReport.conclusionCode	0	*
DiagnosticReport.meta	0	1

DiagnosticReport.implicitRules	0	1

DiagnosticReport.language	0	1

DiagnosticReport.text	0	1
DiagnosticReport.contained	0	*

DiagnosticReport.extension	0	*
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DiagnosticReport.modifierExtension	0	*
DiagnosticReport.identifier	0	*

DiagnosticReport.performer	0	*
DiagnosticReport.resultsInterpreter	0	*
DiagnosticReport.specimen	0	*
DiagnosticReport.result	0	*
DiagnosticReport.imagingStudy	0	*

DiagnosticReport.media	0	*
DiagnosticReport.media.link	0	1
DiagnosticReport.conclusion	0	1
DiagnosticReport.presentedForm	0	*

Data Type(s)	FHIR Short Description	FHIR Definition
	US Core Diagnostic Report Profile for Report and Note exchange	Clinical Testing and Imaging tests performed on a patient that results in structured or unstructured (narrative) findings specific to the patient.
string	Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.
Reference(CarePlan ImmunizationRecommendation MedicationRequest NutritionOrder ServiceRequest)	What was requested	Details concerning a service requested.
code	registered partial preliminary final +	The status of the diagnostic report.
CodeableConcept	Service category	A code that classifies the clinical discipline, department or diagnostic service that created the report (e.g. cardiology, biochemistry, hematology, MRI). This is used for searching, sorting and display purposes.

CodeableConcept	US Core Report Code	The test, panel, report, or note that was ordered.
Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-patient)	The subject of the report - usually, but not always, the patient	The subject of the report. Usually, but not always, this is a patient. However, diagnostic services also perform analyses on specimens collected from a variety of other sources.
Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-encounter)	Health care event when test ordered	The healthcare event (e.g. a patient and healthcare provider interaction) which this DiagnosticReport is about.
dateTime Period	Clinically relevant time/time-period for report	The time or time-period the observed values are related to. When the subject of the report is a patient, this is usually either the time of the procedure or of specimen collection(s), but very often the source of the date/time is not known, only the date/time itself.

instant	DateTime this version was made	The date and time that this version of the report was made available to providers, typically after the report was reviewed and verified.
CodeableConcept	Codes for the clinical conclusion of test results	One or more codes that represent the summary conclusion (interpretation/impression) of the diagnostic report.
Meta	Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.

uri	A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.
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code	Language of the resource content	The base language in which the resource is written.

Narrative	Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.
Resource	Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.

Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.
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Extension	Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).
Identifier	Business identifier for report	Identifiers assigned to this report by the performer or other systems.

Reference(US Core Practitioner Profile US Core Organization Profile)	Responsible Diagnostic Service	The diagnostic service that is responsible for issuing the report.
Reference(Practitioner PractitionerRole Organization CareTeam)	Primary result interpreter	The practitioner or organization that is responsible for the report's conclusions and interpretations.
Reference(Specimen)	Specimens this report is based on	Details about the specimens on which this diagnostic report is based.
Reference(US Core Laboratory Result Observation Profile)	Observations	[Observations](http://hl7.org/fhir/R4/observation.html) that are part of this diagnostic report.
Reference(ImagingStudy)	Reference to full details of imaging associated with the diagnostic report	One or more links to full details of any imaging performed during the diagnostic investigation. Typically, this is imaging performed by DICOM enabled modalities, but this is not required. A fully enabled PACS viewer can use this information to provide views of the source images.

BackboneElement	Key images associated with this report	A list of key images associated with this report. The images are generally created during the diagnostic process, and may be directly of the patient, or of treated specimens (i.e. slides of interest).
Reference(Media)	Reference to the image source	Reference to the image source.
string	Clinical conclusion (interpretation) of test results	Concise and clinically contextualized summary conclusion (interpretation/impression) of the diagnostic report.
Attachment	Entire report as issued	Rich text representation of the entire result as issued by the diagnostic service. Multiple formats are allowed but they

Comments	Binding Strength	Binding Description	FHIR Binding Value Set
This is intended to capture a single report and is not suitable for use in displaying summary information that covers multiple reports. For example, this resource has not been designed for laboratory cumulative reporting formats nor detailed structured reports for sequencing.			
The only time that a resource does not have an id is when it is being submitted to the server using a create operation.			
Note: Usually there is one test request for each result, however in some circumstances multiple test requests may be represented using a single test result resource. Note that there are also cases where one request leads to multiple reports.			
	required	DiagnosticReportStatus	https://hl7.org/fhir/
Multiple categories are allowed using various categorization schemes. The level of granularity is defined by the category concepts in the value set. More fine-grained filtering can be performed using the metadata and/or terminology hierarchy in DiagnosticReport.code.	extensible	DiagnosticServiceSectionCodes	http://hl7.org/fhir/

The typical patterns for codes are: 1) a LOINC code either as a translation from a "local" code or as a primary code, or 2) a local code only if no suitable LOINC exists, or 3) both the local and the LOINC translation. Systems SHALL be capable of sending the local code if one exists.	extensible	LOINCDiagnosticReportCodes	https://hl7.org/fhir/R4/valueset-report-codes.html
			http://hl7.org/fhir/ValueSet/report-codes
This will typically be the encounter the event occurred within, but some events may be initiated prior to or after the official completion of an encounter but still be tied to the context of the encounter (e.g. pre-admission laboratory tests).			
If the diagnostic procedure was performed on the patient, this is the time it was performed. If there are specimens, the diagnostically relevant time can be derived from the specimen collection times, but the specimen information is not always available, and the exact relationship between the specimens and the diagnostically relevant time is not always automatic.			

May be different from the update time of the resource itself, because that is the status of the record (potentially a secondary copy), not the actual release time of the report.			
	example	Diagnosis codes provided as adjuncts to the report.	http://hl7.org/fhir

Asserting this rule set restricts the content to be only understood by a limited set of trading partners. This inherently limits the usefulness of the data in the long term. However, the existing health eco-system is highly fractured, and not yet ready to define, collect, and exchange data in a generally computable sense. Wherever possible, implementers and/or specification writers should avoid using this element. Often, when used, the URL is a reference to an implementation guide that defines these special rules as part of it's narrative along with other profiles, value sets, etc.			
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Language is provided to support indexing and accessibility (typically, services such as text to speech use the language tag). The html language tag in the narrative applies to the narrative. The language tag on the resource may be used to specify the language of other presentations generated from the data in the resource. Not all the content has to be in the base language. The Resource.language should not be assumed to apply to the narrative automatically. If a language is specified, it should it also be specified on the div element in the html (see rules in HTML5 for information about the relationship between xml:lang and the html lang attribute).	preferred	A human language.	http://hl7.org/fhir
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Contained resources do not have narrative. Resources that are not contained SHOULD have a narrative. In some cases, a resource may only have text with little or no additional discrete data (as long as all minOccurs=1 elements are satisfied). This may be necessary for data from legacy systems where information is captured as a "text blob" or where text is additionally entered raw or narrated and encoded information is added later.			
This should never be done when the content can be identified properly, as once identification is lost, it is extremely difficult (and context dependent) to restore it again. Contained resources may have profiles and tags in their meta elements, but SHALL NOT have security labels.			

There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.			
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There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.			
Usually assigned by the Information System of the diagnostic service provider (filler id).			

This is not necessarily the source of the atomic data items or the entity that interpreted the results. It is the entity that takes responsibility for the clinical report.			
Might not be the same entity that takes responsibility for the clinical report.			
If the specimen is sufficiently specified with a code in the test result name, then this additional data may be redundant. If there are multiple specimens, these may be represented per observation or group.			
Observations can contain observations.			
ImagingStudy and the image element are somewhat overlapping - typically, the list of image references in the image element will also be found in one of the imaging study resources. However, each caters to different types of displays for different types of purposes. Neither, either, or both may be provided.			

"application/pdf" is recommended as the most reliable and interoperable in this context.			

ACH dQM
MS [0..*]
R[1..1]
MS [0..*]
R[1..1]
R[1..*]

R[1..1]

R[1..1]

MS [0..1]

R[1..1]

MS[0..1]
MS[0..*]
NRT

NRT

NRT

NRT

NRT

NRT

NRT
NRT

NR
NR
NR
NR
NRT

NRT
NRT
NR
NRT

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FHIR Path	Min	Max	Must Support?
DiagnosticReport	0	*	
DiagnosticReport.id	0	1	
DiagnosticReport.meta	0	1	

DiagnosticReport.implicitRules	0	1	

DiagnosticReport.language	0	1	

DiagnosticReport.text	0	1	
DiagnosticReport.contained	0	*	
DiagnosticReport.extension	0	*	

DiagnosticReport.modifierExtension	0	*	
DiagnosticReport.identifier	0	*	
DiagnosticReport.basedOn	0	*	
DiagnosticReport.status	1	1	Y
DiagnosticReport.category	1	*	Y
DiagnosticReport.category:LaboratorySlice	1	1	Y
DiagnosticReport.category:LaboratorySlice.id	0	1	
DiagnosticReport.category:LaboratorySlice.id.extension	0	*	

DiagnosticReport.category:LaboratorySlice.coding	1	*	
DiagnosticReport.category:LaboratorySlice.coding.id	0	1	
DiagnosticReport.category:LaboratorySlice.coding.system	1	1	
DiagnosticReport.category:LaboratorySlice.coding.version	0	1	
DiagnosticReport.category:LaboratorySlice.coding.code	0	2	
DiagnosticReport.category:LaboratorySlice.coding.display	0	1	
DiagnosticReport.category:LaboratorySlice.coding.userSelected	0	1	
DiagnosticReport.code	1	1	Y
DiagnosticReport.subject	1	1	Y

DiagnosticReport.encounter	0	1	
DiagnosticReport.effective[x]	1	1	Y
DiagnosticReport.issued	1	1	Y
DiagnosticReport.performer	0	*	Y

DiagnosticReport.resultsInterpreter	0	*	
DiagnosticReport.specimen	0	*	
DiagnosticReport.result	0	*	Y
DiagnosticReport.imagingStudy	0	*	
DiagnosticReport.media	0	*	
DiagnosticReport.media.id	0	1	

DiagnosticReport.media.extension	0	*	
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DiagnosticReport.media.modifierExtension	0	*	
DiagnosticReport.media.comment	0	1	
DiagnosticReport.media.link	1	1	

DiagnosticReport.conclusion	0	1	
DiagnosticReport.conclusionCode	0	*	
DiagnosticReport.presentedForm	0	*	

Data Type(s)	FHIR Short Description	FHIR Definition
	A Diagnostic report - a combination of request information, atomic results, images, interpretation, as well as formatted reports	The US Core Diagnostic Report Profile is based upon the core FHIR DiagnosticReport Resource and created to meet the 2015 Edition Common Clinical Data Set 'Laboratory test(s) and Laboratory value(s)/result(s)' requirements.
string	Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.
Meta	Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.

uri	A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.
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code	Language of the resource content	The base language in which the resource is written.

Narrative	Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.
Resource	Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.
Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.

Extension	Extensions that cannot be ignored	May be used to represent additional information that is ~~not part of the basic definition of~~
Identifier	Business identifier for report	Identifiers assigned to this report by the performer or other
Reference(CarePlan ImmunizationRecommendation MedicationRequest NutritionOrder ServiceRequest)	What was requested	Details concerning a service requested.
code	registered partial preliminary final +	The status of the diagnostic report.
CodeableConcept	Service category	A code that classifies the clinical discipline, department or diagnostic service that created the report (e.g. cardiology, biochemistry, hematology, MRI). This is used for searching, sorting and display purposes.
CodeableConcept	Service category	A code that classifies the clinical discipline, department or diagnostic service that created the report (e.g. cardiology, biochemistry, hematology, MRI). This is used for searching, sorting and display purposes.
string	Unique id for inter-element referencing	
Extension	Additional content defined by implementations	

Coding	Code defined by a terminology system	
string	Unique id for inter-element referencing	
url	identity of the terminology system	
string	Version of the system - if relevant	
code	Symbol in syntax defined by the system	
string	Representation defined by the system	
boolean	If this coding was chosen directly by the user	
CodeableConcept	US Core Laboratory Report Order Code	The test, panel or battery that was ordered.
Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-patient)	The subject of the report - usually, but not always, the patient	The subject of the report. Usually, but not always, this is a patient. However, diagnostic services also perform analyses on specimens collected from a variety of other sources.

Reference(Encounter)	Health care event when test ordered	The healthcare event (e.g. a patient and healthcare provider interaction) which this DiagnosticReport is about.
dateTimePeriod	Specimen Collection Datetime or Period	The time or time-period the observed values are related to. When the subject of the report is a patient, this is usually either the time of the procedure or of specimen collection(s), but very often the source of the date/time is not known, only the date/time itself.
instant	DateTime this version was made	The date and time that this version of the report was made available to providers, typically after the report was reviewed and verified.
Reference(US Core Practitioner Profile US Core Organization Profile)	Responsible Diagnostic Service	The diagnostic service that is responsible for issuing the report.

Reference(Practitioner PractitionerRole Organization CareTeam)	Primary result interpreter	The practitioner or organization that is responsible for the report's conclusions and interpretations.
Reference(Specimen)	Specimens this report is based on	Details about the specimens on which this diagnostic report is based.
Reference(US Core Laboratory Result Observation Profile)	Observations	[Observations](http://hl7.org/fhir/R4/observation.html) that are part of this diagnostic report.
Reference(ImagingStudy)	Reference to full details of imaging associated with the diagnostic report	One or more links to full details of any imaging performed during the diagnostic investigation. Typically, this is imaging performed by DICOM enabled modalities, but this is not required. A fully enabled PACS viewer can use this information to provide views of the source images.
BackboneElement	Key images associated with this report	A list of key images associated with this report. The images are generally created during the diagnostic process, and may be directly of the patient, or of treated specimens (i.e. slides of interest).
string	Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.

Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.
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Extension	Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).
string	Comment about the image (e.g. explanation)	A comment about the image. Typically, this is used to provide an explanation for why the image is included, or to draw the viewer's attention to important features.
Reference(Media)	Reference to the image source	Reference to the image source.

string	Clinical conclusion (interpretation) of test results	Concise and clinically contextualized summary conclusion (interpretation/impression) of the diagnostic report.
CodeableConcept	Codes for the clinical conclusion of test results	One or more codes that represent the summary conclusion (interpretation/impression) of the diagnostic report.
Attachment	Entire report as issued	Rich text representation of the entire result as issued by the diagnostic service. Multiple formats are allowed but they SHALL be semantically equivalent.

Comments	Binding Strength	Binding Description
This is intended to capture a single report and is not suitable for use in displaying summary information that covers multiple reports. For example, this resource has not been designed for laboratory cumulative reporting formats nor detailed structured reports for sequencing.		
The only time that a resource does not have an id is when it is being submitted to the server using a create operation.		

Asserting this rule set restricts the content to be only understood by a limited set of trading partners. This inherently limits the usefulness of the data in the long term. However, the existing health eco-system is highly fractured, and not yet ready to define, collect, and exchange data in a generally computable sense. Wherever possible, implementers and/or specification writers should avoid using this element. Often, when used, the URL is a reference to an implementation guide that defines these special rules as part of it's narrative along with other profiles, value sets, etc.		
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Language is provided to support indexing and accessibility (typically, services such as text to speech use the language tag). The html language tag in the narrative applies to the narrative. The language tag on the resource may be used to specify the language of other presentations generated from the data in the resource. Not all the content has to be in the base language. The Resource.language should not be assumed to apply to the narrative automatically. If a language is specified, it should it also be specified on the div element in the html (see rules in HTML5 for information about the relationship between xml:lang and the html lang attribute).	preferred	CommonLanguages Max Binding: All Languages
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Contained resources do not have narrative. Resources that are not contained SHOULD have a narrative. In some cases, a resource may only have text with little or no additional discrete data (as long as all minOccurs=1 elements are satisfied). This may be necessary for data from legacy systems where information is captured as a "text blob" or where text is additionally entered raw or narrated and encoded information is added later.		
This should never be done when the content can be identified properly, as once identification is lost, it is extremely difficult (and context dependent) to restore it again. Contained resources may have profiles and tags in their meta elements, but SHALL NOT have security labels.		
There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.		

There can be no stigma associated with the use of extensions by any		
Usually assigned by the Information System of the		
Note: Usually there is one test request for each result, however in some circumstances multiple test requests may be represented using a single test result resource. Note that there are also cases where one request leads to multiple reports.		
	required	
Multiple categories are allowed using various categorization schemes. The level of granularity is defined by the category concepts in the value set. More fine-grained filtering can be performed using the metadata and/or terminology hierarchy in DiagnosticReport.code.	example	Codes for diagnostic service sections.
Multiple categories are allowed using various categorization schemes. The level of granularity is defined by the category concepts in the value set. More fine-grained filtering can be performed using the metadata and/or terminology hierarchy in DiagnosticReport.code.	example	Required Pattern: At least the following

	Complex	Fixed Value: (complex)
	Fixed Value	diagnostiServiceSectionID
	Fixed Value	
UsageNote= The typical patterns for codes are: 1) a LOINC code either as a translation from a "local" code or as a primary code, or 2) a local code only if no suitable LOINC exists, or 3) both the local and the LOINC translation. Systems SHALL be capable of sending the local code if one exists.	extensible	US Core Diagnostic Report Laboratory Codes (LOINC codes)

This will typically be the encounter the event occurred within, but some events may be initiated prior to or after the official completion of an encounter but still be tied to the context of the encounter (e.g. pre-admission laboratory tests).		
If the diagnostic procedure was performed on the patient, this is the time it was performed. If there are specimens, the diagnostically relevant time can be derived from the specimen collection times, but the specimen information is not always available, and the exact relationship between the specimens and the diagnostically relevant time is not always automatic.		
May be different from the update time of the resource itself, because that is the status of the record (potentially a secondary copy), not the actual release time of the report.		
This is not necessarily the source of the atomic data items or the entity that interpreted the results. It is the entity that takes responsibility for the clinical report.		

Might not be the same entity that takes responsibility for the clinical report.		
If the specimen is sufficiently specified with a code in the test result name, then this additional data may be redundant. If there are multiple specimens, these may be represented per observation or group.		
Observations can contain observations.		
ImagingStudy and the image element are somewhat overlapping - typically, the list of image references in the image element will also be found in one of the imaging study resources. However, each caters to different types of displays for different types of purposes. Neither, either, or both may be provided.		

There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.		
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There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.		
The comment should be displayed with the image. It would be common for the report to include additional discussion of the image contents in other sections such as the conclusion.		

	example	SNOMEDCTClinicalFindings
"application/pdf" is recommended as the most reliable and interoperable in this context.		

FHIR Binding Value Set	ACH dQM
	MS [0..*]
	R [1..1]
	NRT

	NRT
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http://hl7.org/fhir/ValueSet	NRT
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	NRT
	NRT
	NRT

	NRT
	NRT
	NR
http://hl7.org/fhir/R4/	R [1..1]
http://hl7.org/fhir/R4/	R [1..*]
	R [1..1]
	NRT
	NRT

	NR
	NRT
https://terminology.hl7.org/5.2.0/CodeSystem-v2-0074.html	NR
	NR
	NR
	NR
	NR
https://www.hl7.org/fh/	R [1..1]
	R [1..1]

	NR
	R [1..1]
	R [1..1]
	NR

	NR
	MS [0..*]
	MS [0..*]
	NRT
	NRT
	NRT

	NRT
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	NRT
	NRT
	NRT

	NR
https://hl7.org/fhir/R4/	NR
	NRT

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Path	Min	Max	Must Support?
DiagnosticReport	0	*	
DiagnosticReport.id	0	1	
DiagnosticReport.meta	0	1	

DiagnosticReport.implicitRules	0	1	

DiagnosticReport.language	0	1	

DiagnosticReport.text	0	1	
DiagnosticReport.contained	0	*	

DiagnosticReport.extension	0	*	
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DiagnosticReport.modifierExtension	0	*	
DiagnosticReport.identifier	0	*	

DiagnosticReport.basedOn	0	*	
DiagnosticReport.status	1	1	Y
DiagnosticReport.category	0	*	Y
DiagnosticReport.code	1	1	Y
DiagnosticReport.subject	1	1	Y

DiagnosticReport.encounter	0	1	Y
DiagnosticReport.effective[x]	1	1	Y
DiagnosticReport.issued	0	1	Y
DiagnosticReport.performer	0	*	Y
DiagnosticReport.resultsInterpreter	0	*	

DiagnosticReport.specimen	0	*	
DiagnosticReport.result	0	*	Y
DiagnosticReport.imagingStudy	0	*	Y
DiagnosticReport.media	0	*	Y
DiagnosticReport.media.id	0	1	

DiagnosticReport.media.extension	0	*	
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DiagnosticReport.media.modifierExtension	0	*	
--	---	---	--

DiagnosticReport.media.comment	0	1	
DiagnosticReport.media.link	1	1	Y
DiagnosticReport.conclusion	0	1	
DiagnosticReport.conclusionCode	0	*	
DiagnosticReport.presentedForm	0	*	Y

Data Type(s)	FHIR Short Description	FHIR Definition
	US Core Diagnostic Report Profile for Report and Note exchange	Clinical Testing and Imaging tests performed on a patient that results in structured or unstructured (narrative) findings specific to the patient.
string	Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.
Meta	Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.

uri	A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.
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code	Language of the resource content	The base language in which the resource is written.

Narrative	Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.
Resource	Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.

Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.
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Extension	Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).
Identifier	Business identifier for report	Identifiers assigned to this report by the performer or other systems.

Reference(CarePlan ImmunizationRecommendation MedicationRequest NutritionOrder ServiceRequest)	What was requested	Details concerning a service requested.
code	registered partial preliminary final +	The status of the diagnostic report.
CodeableConcept	Service category	A code that classifies the clinical discipline, department or diagnostic service that created the report (e.g. cardiology, biochemistry, hematology, MRI). This is used for searching, sorting and display purposes.
CodeableConcept	US Core Report Code	The test, panel, report, or note that was ordered.
Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-patient)	The subject of the report - usually, but not always, the patient	The subject of the report. Usually, but not always, this is a patient. However, diagnostic services also perform analyses on specimens collected from a variety of other sources.

Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-encounter)	Health care event when test ordered	The healthcare event (e.g. a patient and healthcare provider interaction) which this DiagnosticReport is about.
dateTime Period	Clinically relevant time/time-period for report	The time or time-period the observed values are related to. When the subject of the report is a patient, this is usually either the time of the procedure or of specimen collection(s), but very often the source of the date/time is not known, only the date/time itself.
instant	DateTime this version was made	The date and time that this version of the report was made available to providers, typically after the report was reviewed and verified.
Reference(US Core Practitioner Profile US Core Organization Profile)	Responsible Diagnostic Service	The diagnostic service that is responsible for issuing the report.
Reference(Practitioner PractitionerRole Organization CareTeam)	Primary result interpreter	The practitioner or organization that is responsible for the report's conclusions and interpretations.

Reference(Specimen)	Specimens this report is based on	Details about the specimens on which this diagnostic report is based.
Reference(US Core Laboratory Result Observation Profile)	Observations	[Observations](http://hl7.org/fhir/R4/observation.html) that are part of this diagnostic report.
Reference(ImagingStudy)	Reference to full details of imaging associated with the diagnostic report	One or more links to full details of any imaging performed during the diagnostic investigation. Typically, this is imaging performed by DICOM enabled modalities, but this is not required. A fully enabled PACS viewer can use this information to provide views of the source images.
BackboneElement	Key images associated with this report	A list of key images associated with this report. The images are generally created during the diagnostic process, and may be directly of the patient, or of treated specimens (i.e. slides of interest).
string	Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.

Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.
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Extension	Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).
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string	Comment about the image (e.g. explanation)	A comment about the image. Typically, this is used to provide an explanation for why the image is included, or to draw the viewer's attention to important features.
Reference(Media)	Reference to the image source	Reference to the image source.
string	Clinical conclusion (interpretation) of test results	Concise and clinically contextualized summary conclusion (interpretation/impression) of the diagnostic report.
CodeableConcept	Codes for the clinical conclusion of test results	One or more codes that represent the summary conclusion (interpretation/impression) of the diagnostic report.
Attachment	Entire report as issued	Rich text representation of the entire result as issued by the diagnostic service. Multiple formats are allowed but they

Comments	Binding Strength	Binding Description	FHIR Binding Value Set
This is intended to capture a single report and is not suitable for use in displaying summary information that covers multiple reports. For example, this resource has not been designed for laboratory cumulative reporting formats nor detailed structured reports for sequencing.			
The only time that a resource does not have an id is when it is being submitted to the server using a create operation.			

Asserting this rule set restricts the content to be only understood by a limited set of trading partners. This inherently limits the usefulness of the data in the long term. However, the existing health eco-system is highly fractured, and not yet ready to define, collect, and exchange data in a generally computable sense. Wherever possible, implementers and/or specification writers should avoid using this element. Often, when used, the URL is a reference to an implementation guide that defines these special rules as part of it's narrative along with other profiles, value sets, etc.			
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Language is provided to support indexing and accessibility (typically, services such as text to speech use the language tag). The html language tag in the narrative applies to the narrative. The language tag on the resource may be used to specify the language of other presentations generated from the data in the resource. Not all the content has to be in the base language. The Resource.language should not be assumed to apply to the narrative automatically. If a language is specified, it should it also be specified on the div element in the html (see rules in HTML5 for information about the relationship between xml:lang and the html lang attribute).	preferred	A human language.	http://hl7.org/fhir
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Contained resources do not have narrative. Resources that are not contained SHOULD have a narrative. In some cases, a resource may only have text with little or no additional discrete data (as long as all minOccurs=1 elements are satisfied). This may be necessary for data from legacy systems where information is captured as a "text blob" or where text is additionally entered raw or narrated and encoded information is added later.			
This should never be done when the content can be identified properly, as once identification is lost, it is extremely difficult (and context dependent) to restore it again. Contained resources may have profiles and tags in their meta elements, but SHALL NOT have security labels.			

There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.			
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Usually assigned by the Information System of the diagnostic service provider (filler id).			

Note: Usually there is one test request for each result, however in some circumstances multiple test requests may be represented using a single test result resource. Note that there are also cases where one request leads to multiple reports.			
	required		https://hl7.org/fhi
Multiple categories are allowed using various categorization schemes. The level of granularity is defined by the category concepts in the value set. More fine-grained filtering can be performed using the metadata and/or terminology hierarchy in DiagnosticReport.code.	required		https://hl7.org/fhi
The typical patterns for codes are: 1) a LOINC code either as a translation from a "local" code or as a primary code, or 2) a local code only if no suitable LOINC exists, or 3) both the local and the LOINC translation. Systems SHALL be capable of sending the local code if one exists.	extensible	LOINC codes	https://hl7.org/fhi

This will typically be the encounter the event occurred within, but some events may be initiated prior to or after the official completion of an encounter but still be tied to the context of the encounter (e.g. pre-admission laboratory tests).			
If the diagnostic procedure was performed on the patient, this is the time it was performed. If there are specimens, the diagnostically relevant time can be derived from the specimen collection times, but the specimen information is not always available, and the exact relationship between the specimens and the diagnostically relevant time is not always automatic.			
May be different from the update time of the resource itself, because that is the status of the record (potentially a secondary copy), not the actual release time of the report.			
This is not necessarily the source of the atomic data items or the entity that interpreted the results. It is the entity that takes responsibility for the clinical report.			
Might not be the same entity that takes responsibility for the clinical report.			

If the specimen is sufficiently specified with a code in the test result name, then this additional data may be redundant. If there are multiple specimens, these may be represented per observation or group.			
Observations can contain observations.			
ImagingStudy and the image element are somewhat overlapping - typically, the list of image references in the image element will also be found in one of the imaging study resources. However, each caters to different types of displays for different types of purposes. Neither, either, or both may be provided.			

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The comment should be displayed with the image. It would be common for the report to include additional discussion of the image contents in other sections such as the conclusion.			
	example	Diagnosis codes provided as adjuncts to the report.	https://hl7.org/fhi
"application/pdf" is recommended as the most reliable and interoperable in this context.			

ACH dQM
MS [0..*]
R[1..1]
NRT

NRT

NRT

NRT

NRT

NRT

NRT
NRT

MS [0..*]
R[1..1]
R[1..*]
R[1..1]
R[1..1]

MS [0..1]
R[1..1]
MS[0..1]
NR
NR

NR
NR
NRT
NRT
NRT

NRT

NRT

NRT
NRT
NR
MS[0..*]
NRT

[Back to TOC](#)

FHIR Path	Min	Max	Must Support?	Data Type(s)
Encounter	0	*		Encounter
Encounter.id	0	1		string
Encounter.meta	0	1		Meta
Encounter.implicitRules	0	1		uri
Encounter.language	0	1		code
Encounter.text	0	1		Narrative

Encounter.contained	0	*		Resource
Encounter.extension	0	*		Extension
Encounter.modifierExtension	0	*		Extension
Encounter.identifier	0	*	Y	Identifier

Encounter.identifier.id	0	1		string
Encounter.identifier.extension	0	*		Extension
Encounter.identifier.use	0	1		code
Encounter.identifier.type	0	1		CodeableCo ncept
Encounter.identifier.system	1	1	Y	uri
Encounter.identifier.value	1	1	Y	string

Encounter.identifier.period	0	1		Period
Encounter.identifier.assigner	0	1		Reference(O rganization)
Encounter.status	1	1	Y	code
Encounter.statusHistory	0	*		BackboneEl ement
Encounter.statusHistory.id	0	1		string

Encounter.statusHistory.extension	0	*		Extension
Encounter.statusHistory.modifierExtension	0	*		Extension
Encounter.statusHistory.status	1	1		code
Encounter.statusHistory.period	1	1		Period

Encounter.class	1	1	Y	Coding
Encounter.classHistory	0	*		BackboneElement
Encounter.classHistory.id	0	1		string
Encounter.classHistory.extension	0	*		Extension

Encounter.classHistory.modifierExtension	0	*		Extension
Encounter.classHistory.class	1	1		Coding
Encounter.classHistory.period	1	1		Period

Encounter.type	1	*	Y	CodeableCo ncept
Encounter.serviceType	0	1		CodeableCo ncept
Encounter.priority	0	1		CodeableCo ncept
Encounter.subject	1	1	Y	Reference(U S Core Patient Profile)

Encounter.episodeOfCare	0	*		Reference(E pisodeOfCa re)
Encounter.basedOn	0	*		Reference(S erviceReque st)
Encounter.participant	0	*	Y	BackboneEl ement
Encounter.participant.id	0	1		string
Encounter.participant.extension	0	*		Extension

Encounter.participant.modifierExtension	0	*		Extension
Encounter.participant.type	0	*	Y	CodeableConcept
Encounter.participant.period	0	1	Y	Period

Encounter.participant.individual	0	1	Y	Reference(U S Core Practitioner Profile)
Encounter.appointment	0	*		Reference(A ppointment)
Encounter.period	0	1	Y	Period
Encounter.length	0	1		Duration
Encounter.reasonCode	0	*	Y	CodeableCo ncept

Encounter.reasonReference	0	*	Y	Reference(C ondition Procedure Observation Immunizati onRecomm endation)
Encounter.diagnosis	0	*		BackboneEl ement
Encounter.diagnosis.id	0	1		string
Encounter.diagnosis.extension	0	*		Extension

Encounter.diagnosis.modifierExtension	0	*		Extension
Encounter.diagnosis.condition	1	1		Reference(Condition Procedure)
Encounter.diagnosis.use	0	1		CodeableConcept
Encounter.diagnosis.rank	0	1		positiveInt

Encounter.account	0	*		Reference(Account)
Encounter.hospitalization	0	1	Y	BackboneElement
Encounter.hospitalization.id	0	1		string
Encounter.hospitalization.extension	0	*		Extension

Encounter.hospitalization.modifierExtension	0	*		Extension
Encounter.hospitalization.preAdmissionIdentifier	0	1		Identifier
Encounter.hospitalization.origin	0	1		Reference(Location Organization)
Encounter.hospitalization.admitSource	0	1		CodeableConcept

Encounter.hospitalization.reAdmission	0	1		CodeableConcept
Encounter.hospitalization.dietPreference	0	*		CodeableConcept
Encounter.hospitalization.specialCourtesy	0	*		CodeableConcept
Encounter.hospitalization.specialArrangement	0	*		CodeableConcept
Encounter.hospitalization.destination	0	1		Reference(Location Organization)
Encounter.hospitalization.dischargeDisposition	0	1	Y	CodeableConcept

Encounter.location	0	*	Y	BackboneElement
Encounter.location.id	0	1		string
Encounter.location.extension	0	*		Extension

Encounter.location.modifierExtension	0	*		Extension
Encounter.location.location	1	1	Y	Reference(Location)
Encounter.location.status	0	1		code
Encounter.location.physicalType	0	1		CodeableConcept

Encounter.location.period	0	1		Period
Encounter.serviceProvider	0	1	Y	Reference(O rganization)
Encounter.partOf	0	1		Reference(E ncounter)

FHIR Short Description	FHIR Definition	Binding Strength
An interaction during which services are provided to the patient	This is basic constraint on Encounter for use in US Core resources.	
Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	
Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.	
A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	
Language of the resource content	The base language in which the resource is written.	Preferred Max Binding
Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.	

Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Identifier(s) by which this	Identifier(s) by which this encounter is known.	

Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
usual official temp secondary old (If known)	The purpose of this identifier.	required
Description of identifier	A coded type for the identifier that can be used to determine which identifier to use for a specific purpose.	extensible
The namespace for the identifier value	Establishes the namespace for the value - that is, a URL that describes a set values that are unique.	
The value that is unique	The portion of the identifier typically relevant to the user and which is unique within the context of the system.	

Time period when id is/was valid for use	Time period during which identifier is/was valid for use.	
Organization that issued id (may be just text)	Organization that issued/manages the identifier.	
planned arrived triaged in-progress onleave finished cancelled +	planned arrived triaged in-progress onleave finished cancelled +.	required
List of past encounter statuses	The status history permits the encounter resource to contain the status history without needing to read through the historical versions of the resource, or even have the server store them.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	

Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
planned arrived triaged in-progress onleave finished cancelled +	planned arrived triaged in-progress onleave finished cancelled +.	required
The time that the episode was in the specified status	The time that the episode was in the specified status.	

Classification of patient encounter	Concepts representing classification of patient encounter such as ambulatory (outpatient), inpatient, emergency, home health or others due to local variations.	extensible
List of past encounter classes	The class history permits the tracking of the encounters transitions without needing to go through the resource history. This would be used for a case where an admission starts of as an emergency encounter, then transitions into an inpatient scenario. Doing this and not restarting a new encounter ensures that any lab/diagnostic results can more easily follow the patient and not require re-processing and not get lost or cancelled during a kind of discharge from emergency to inpatient.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

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inpatient outpatient ambulatory emergency +	inpatient outpatient ambulatory emergency +.	extensible
The time that the episode was in the specified class	The time that the episode was in the specified class.	

Specific type of encounter	Specific type of encounter (e.g. e-mail consultation, surgical day-care, skilled nursing, rehabilitation).	extensible
Specific type of service	Broad categorization of the service that is to be provided (e.g. cardiology).	example
Indicates the urgency of the encounter	Indicates the urgency of the encounter.	example
The patient or group present at the encounter	The patient or group present at the encounter.	

Episode(s) of care that this encounter should be recorded against	Where a specific encounter should be classified as a part of a specific episode(s) of care this field should be used. This association can facilitate grouping of related encounters together for a specific purpose, such as government reporting, issue tracking, association via a common problem. The association is recorded on the encounter as these are typically created after the episode of care and grouped on entry rather than editing the episode of care to append another encounter to it (the episode of care could span years).	
The ServiceRequest that initiated this encounter	The request this encounter satisfies (e.g. incoming referral or procedure request).	
List of participants involved in the encounter	The list of people responsible for providing the service.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

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Role of participant in encounter	Role of participant in encounter.	extensible
Period of time during the encounter that the participant participated	The period of time that the specified participant participated in the encounter. These can overlap or be subsets of the overall encounter's period.	

Persons involved in the encounter other than the patient	Persons involved in the encounter other than the patient.	
The appointment that scheduled this encounter	The appointment that scheduled this encounter.	
The start and end time of the encounter	The start and end time of the encounter.	
Quantity of time the encounter lasted (less time absent)	Quantity of time the encounter lasted. This excludes the time during leaves of absence.	
Coded reason the encounter takes place	Reason the encounter takes place, expressed as a code. For admissions, this can be used for a coded admission diagnosis.	preferred

Reason the encounter takes place (reference)	Reason the encounter takes place, expressed as a code. For admissions, this can be used for a coded admission diagnosis.	
The list of diagnosis relevant to this encounter	The list of diagnosis relevant to this encounter.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

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The diagnosis or procedure relevant to the encounter	Reason the encounter takes place, as specified using information from another resource. For admissions, this is the admission diagnosis. The indication will typically be a Condition (with other resources referenced in the evidence.detail), or a Procedure.	
Role that this diagnosis has within the encounter (e.g. admission, billing, discharge ...)	Role that this diagnosis has within the encounter (e.g. admission, billing, discharge ...).	preferred
Ranking of the diagnosis (for each role type)	Ranking of the diagnosis (for each role type).	

The set of accounts that may be used for billing for this Encounter	The set of accounts that may be used for billing for this Encounter.	
Details about the admission to a healthcare service	Details about the admission to a healthcare service.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

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Pre-admission identifier	Pre-admission identifier.	
The location/organization from which the patient came before admission	The location/organization from which the patient came before admission.	
From where patient was admitted (physician referral, transfer)	From where patient was admitted (physician referral, transfer).	preferred

The type of hospital re-admission that has occurred (if any). If the value is absent, then this is not identified as a readmission	Whether this hospitalization is a readmission and why if known.	preferred
Diet preferences reported by the patient	Diet preferences reported by the patient.	preferred
Special courtesies (VIP, board member)	Special courtesies (VIP, board member).	preferred
Wheelchair, translator, stretcher, etc.	Any special requests that have been made for this hospitalization encounter, such as the provision of specific equipment or other things.	preferred
Location/organization to which the patient is discharged	Location/organization to which the patient is discharged.	
Category or kind of location after discharge	Category or kind of location after discharge.	preferred

List of locations where the patient has been	List of locations where the patient has been during this encounter.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

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Location the encounter takes place	The location where the encounter takes place.	
planned active reserved completed	The status of the participants' presence at the specified location during the period specified. If the participant is no longer at the location, then the period will have an end date/time.	required
The physical type of the location (usually the level in the location hierachy - bed room ward etc.)	This will be used to specify the required levels (bed/ward/room/etc.) desired to be recorded to simplify either messaging or query.	extensible

Time period during which the patient was present at the location	Time period during which the patient was present at the location.	
The organization (facility) responsible for this encounter	The organization that is primarily responsible for this Encounter's services. This MAY be the same as the organization on the Patient record,	
Another Encounter this encounter is part of	Another Encounter of which this encounter is a part of (administratively or in time).	

Binding Description	FHIR Binding Value Set	ACH dQM
		R [1..*]
		R [1..1]
		NRT
		NRT
CommonLanguages AllLanguages	https://hl7.org/fhir/R4/	NRT
		NRT

		NRT
		NRT
		NRT
		R [1..*]

		NRT
		NRT
IdentifierUse	http://hl7.org/fhir/R4/	MS [0..1]
IdentifierType	http://hl7.org/fhir/R4/	MS[0..1]
		R[1..1]
		R [1..1]

		MS [0..1]
		NRT
EncounterStatus	https://hl7.org/fhir/R4/	R [1..1] The following constraints are written into the CQL: 'in-progress', 'finished', 'triaged', 'onleave', 'entered-in-error'
		NR
		NRT

		NRT
		NRT
EncounterStatus	http://hl7.org/fhir/R4/	NR
		NR

ActEncounterCode	http://hl7.org/fhir/R4/	R [1..1] The following constraints are written into the CQL: 'inpatient acute', 'inpatient encounter', 'inpatient non-acute' 'observation encounter', short stay', 'emergency'
		MS [0..*]
		NRT
		NRT

		NRT
ActEncounterCode	https://terminology.hl7.org/	R [1..1]
		R [1..1]

USCoreEncounterType	https://hl7.org/fhir/us/	R [1..*] The following constraints are written into the CQL: "Emergency Department Visit": 'http://cts.nlm.nih.gov/fhir/ValueSet/2.16.840.1.113883.3.117.1.7.1.292' "Observation Services": 'http://cts.nlm.nih.gov/fhir/ValueSet/2.16.840.1.113762.1.4.1111.143' "Encounter Inpatient": 'http://cts.nlm.nih.gov/fhir/ValueSet/2.16.840.1.113883.3.666.5.307'
ServiceType	http://hl7.org/fhir/R4/	NR
ActPriority	https://terminology.hl7.org/	NR
		R [1..1]

		NRT
		NRT
		NRT
		NRT
		NRT

		NRT
ParticipantType	http://hl7.org/fhir/R4/	NRT
		NRT

		NRT
		NRT
		R[1..1]
		NR
EncounterReasonCodes	http://hl7.org/fhir/R4/	MS [0..*]

		NR
		MS [0..*]
		NRT
		NRT

		NRT
		R [1..1]
DiagnosisRole	https://hl7.org/fhir/R4/	MS [0..1]
		MS [0..1]

		NR
		MS [0..1]
		NRT
		NRT

		NRT
		NR
		MS [0..1]
AdmitSource	https://hl7.org/fhir/R4/	R [1..1]

HL7VSReAdmissionIndicator	https://terminology.hl7.org/terminology.html	MS [0..1]
Diet	http://hl7.org/fhir/R4/	MS [0..1]
SpecialCourtesy	http://hl7.org/fhir/R4/	NR
SpecialArrangements	http://hl7.org/fhir/R4/	NR
		NR
DischargeDisposition	http://hl7.org/fhir/R4/	MS [0..1]

		R [1..*] The following constraints are written into the CQL: Inpatient, Emergency, and Observation Locations 2.16.840.1.113762.1.4.1046.265
		NRT
		NRT

		NRT
		R [1..1]
EncounterLocationStatus	http://hl7.org/fhir/R4/	MS [0..1]
LocationType	http://hl7.org/fhir/R4/	MS [0..1]

		R [1..1]
		NRT
		NR

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FHIR Path	Min	Max	Must Support?	Data Type(s)
Device	0	*		
Device.id	0	1		string
Device.meta	0	1		Meta
Device.implicitRules	0	1		uri

Device.language	0	1		code
Device.text	0	1		Narrative
Device.contained	0	*		Resource
Device.extension	0	*		Extension

Device.modifierExtension	0	*		Extension
Device.identifier	0	*		Identifier
Device.definition	0	1		Reference(DeviceDefinition)
Device.udiCarrier	0	1	Y	BackboneElement

Device.udiCarrier.carrierAIDC	0	1	Y	base64Binary
Device.udiCarrier.carrierHRF	0	1	Y	string
Device.udiCarrier.deviceIdentifier	1	1	Y	string
Device.udiCarrier.entryType	0	1		code
Device.udiCarrier.issuer	0	1		uri

Device.udiCarrier.jurisdiction	0	1		uri
Device.status	0	1		code
Device.statusReason	0	*		CodeableConcept
Device.distinctIdentifier	0	1		string
Device.manufacturer	0	1		string
Device.manufactureDate	0	1	Y	dateTime
Device.expirationDate	0	1	Y	dateTime
Device.lotNumber	0	1	Y	string
Device.serialNumber	0	1	Y	string
Device.deviceName	0	*		BackboneElement

Device.deviceName.extension	0	*		Extension
Device.deviceName.id	0	1		string
Device.deviceName.modifierExtension	0	*		Extension
Device.deviceName.name	1	1		string

Device.deviceName.type	1	1		code
Device.modelNumber	0	1		string
Device.partNumber	0	1		string
Device.type	1	1	Y	CodeableConcept
Device.specialization	0	*		BackboneElement
Device.specialization.id	0	1		string
Device.specialization.extension	0	*		Extension

Device.specialization.modifierExtension	0	*		Extension
Device.specialization.systemType	1	1		CodeableConcept
Device.specialization.version	0	1		string
Device.version	0	*		BackboneElement
Device.version.id	0	1		string

Device.version.extension	0	*		Extension
Device.version.modifierExtension	0	*		Extension
Device.version.type	0	1		CodeableConcept
Device.version.component	0	1		Identifier
Device.version.value	1	1		string

Device.property	0	*		BackboneElement
Device.property.id	0	1		string
Device.property.extension	0	*		Extension
Device.property.modifierExtension	0	*		Extension

Device.property.type	1	1		CodeableConcept
Device.property.valueQuantity	0	*		Quantity
Device.property.valueCode	0	*		CodeableConcept
Device.patient	1	1	Y	Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-patient)
Device.owner	0	1		Reference(http://hl7.org/fhir/R4/organization.html)
Device.contact	0	*		contactPoint
Device.location	0	1		Reference(http://hl7.org/fhir/R4/location.html)
Device.url	0	1		uri
Device.note	0	*		Annotation
Device.safety	0	*		CodeableConcept
Device.parent	0	1		Reference(http://hl7.org/fhir/R4/device.html)

FHIR Short Description	FHIR Definition
Item used in healthcare	The US Core Implantable Device Profile is based upon the core FHIR Device Resource and created to meet the 2015 Edition Common Clinical Data Set 'Unique device identifier(s) for a patient's implantable device(s)' requirements.
Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.
Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.
A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.

Language of the resource content	The base language in which the resource is written.
Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.
Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.

Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).
Instance identifier	Unique instance identifiers assigned to a device by manufacturers other organizations or owners.
The reference to the definition for the device	The reference to the definition for the device.
Unique Device Identifier (UDI) Barcode string	Unique device identifier (UDI) assigned to device label or package. Note that the Device may include multiple udiCarriers as it either may include just the udiCarrier for the jurisdiction it is sold, or for multiple jurisdictions it could have been sold.

UDI Machine Readable Barcode String	The full UDI carrier of the Automatic Identification and Data Capture (AIDC) technology representation of the barcode string as printed on the packaging of the device - e.g., a barcode or RFID. Because of limitations on character sets in XML and the need to round-trip JSON data through XML, AIDC Formats *SHALL* be base64 encoded.
UDI Human Readable Barcode String	The full UDI carrier as the human readable form (HRF) representation of the barcode string as printed on the packaging of the device.
Mandatory fixed portion of UDI	The device identifier (DI) is a mandatory, fixed portion of a UDI that identifies the labeler and the specific version or model of a device.
barcode rfid manual +	A coded entry to indicate how the data was entered.
UDI Issuing Organization	Organization that is charged with issuing UDIs for devices. For example, the US FDA issuers include : 1) GS1: http://hl7.org/fhir/NamingSystem/gs1-di , 2) HIBCC: http://hl7.org/fhir/NamingSystem/hibcc-di , 3) ICCBBA for blood containers: http://hl7.org/fhir/NamingSystem/iccbba-blood-di , 4) ICCBA for other devices: http://hl7.org/fhir/NamingSystem/iccbba-other-di .

Regional UDI authority	The identity of the authoritative source for UDI generation within a jurisdiction. All UDIs are globally unique within a single namespace with the appropriate repository uri as the system. For example, UDIs of devices managed in the U.S. by the FDA, the value is http://hl7.org/fhir/NamingSystem/fda-udi .
active inactive entered-in-error unknown	Status of the Device availability.
online paused standby offline not-ready transduc-discon hw-discon off	Reason for the status of the Device availability.

The distinct identification string	The distinct identification string as required by regulation for a human cell, tissue, or cellular and tissue-based product.
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Name of device manufacturer	A name of the manufacturer.
Date when the device was made	The date and time when the device was manufactured.
Date and time of expiry of this device (if applicable)	The date and time beyond which this device is no longer valid or should not be used (if applicable).
Lot number of manufacture	Lot number assigned by the manufacturer.
Serial number assigned by the manufacturer	The serial number assigned by the organization when the device was manufactured.
The name of the device as given by the manufacturer	This represents the manufacturer's name of the device as provided by the device, from a UDI label, or by a person describing the Device. This typically would be used when a person provides the name(s) or when the device represents one of the names available from DeviceDefinition.

Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.
Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).
The name of the device	The name of the device.

udi-label-name user-friendly-name patient-reported-name manufacturer-name model-name other	The type of deviceName. UDILabelName UserFriendlyName PatientReportedName ManufactureDeviceName ModelName.
The model number for the device	The model number for the device.
The part number of the device	The part number of the device.
The kind or type of device	The kind or type of device.
The capabilities supported on a device, the standards to which the device conforms for a particular purpose, and used for the communication	The capabilities supported on a device, the standards to which the device conforms for a particular purpose, and used for the communication.
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.

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The standard that is used to operate and communicate	The standard that is used to operate and communicate.
The version of the standard that is used to operate and communicate	The version of the standard that is used to operate and communicate.
The actual design of the device or software version running on the device	The actual design of the device or software version running on the device.
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.

Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.
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The type of the device version	The type of the device version.
A single component of the device version	A single component of the device version.
The version text	The version text.

The actual configuration settings of a device as it actually operates, e.g., regulation status, time properties	The actual configuration settings of a device as it actually operates, e.g., regulation status, time properties.
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.
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Code that specifies the property DeviceDefinitionPropertyCode (Extensible)	Code that specifies the property DeviceDefinitionPropertyCode (Extensible).
Property value as a quantity	Property value as a quantity.
Property value as a code, e.g., NTP4 (syncd to NTP)	Property value as a code, e.g., NTP4 (syncd to NTP).
Patient to whom Device is affixed	Patient information, If the device is affixed to a person.
Organization responsible for device	An organization that is responsible for the provision and ongoing maintenance of the device.
Details for human/organization for support	Contact details for an organization or a particular human that is responsible for the device.
Where the device is found	The place where the device can be found.
Network address to contact device	A network address on which the device may be contacted directly.
Device notes and comments	Descriptive information, usage information or implantation information that is not captured in an existing element.
Safety Characteristics of Device	Provides additional safety characteristics about a medical device. For example devices containing latex.
The parent device	The parent device.

Comments	Binding Strength	Binding Description
The only time that a resource does not have an id is when it is being submitted to the server using a create operation.		
Asserting this rule set restricts the content to be only understood by a limited set of trading partners. This inherently limits the usefulness of the data in the long term. However, the existing health eco-system is highly fractured, and not yet ready to define, collect, and exchange data in a generally computable sense. Wherever possible, implementers and/or specification writers should avoid using this element. Often, when used, the URL is a reference to an implementation guide that defines these special rules as part of it's narrative along with other profiles, value sets, etc.		

Language is provided to support indexing and accessibility (typically, services such as text to speech use the language tag). The html language tag in the narrative applies to the narrative. The language tag on the resource may be used to specify the language of other presentations generated from the data in the resource. Not all the content has to be in the base language. The Resource.language should not be assumed to apply to the narrative automatically. If a language is specified, it should also be specified on the div element in the html (see rules in HTML5 for information about the relationship between xml:lang and the html lang attribute).	preferred	A human language.
Contained resources do not have narrative. Resources that are not contained SHOULD have a narrative. In some cases, a resource may only have text with little or no additional discrete data (as long as all minOccurs=1 elements are satisfied). This may be necessary for data from legacy systems where information is captured as a "text blob" or where text is additionally entered raw or narrated and encoded information is added later.		
This should never be done when the content can be identified properly, as once identification is lost, it is extremely difficult (and context dependent) to restore it again. Contained resources may have profiles and tags in their meta elements, but SHALL NOT have security labels.		
There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.		

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The barcode string from a barcode present on a device label or package may identify the instance, include names given to the device in local usage, or may identify the type of device. If the identifier identifies the type of device, Device.type element should be used.		
Some devices may not have UDI information (for example. historical data or patient reported data).		

The AIDC form of UDIs should be scanned or otherwise used for the identification of the device whenever possible to minimize errors in records resulting from manual transcriptions. If separate barcodes for DI and PI are present, concatenate the string with DI first and in order of human readable expression on label.		
If separate barcodes for DI and PI are present, concatenate the string with DI first and in order of human readable expression on label.		
	required	Codes to identify how UDI data was entered.

This element is labeled as a modifier because the status contains the codes inactive and entered-in-error that mark the device (record) as not currently valid.	required	The availability status of the device.
	extensible	The availability status reason of the device.
For example, this applies to devices in the United States regulated under <i>Code of Federal Regulation 21CFR§1271.290(c)</i> .		
Alphanumeric Maximum 20.		

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	required	The type of name the device is referred by.
Alphanumeric Maximum 20.		
	extensible	Codes to identify medical devices
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used for troubleshooting etc.		
If the device is running a FHIR server, the network address should be the Base URL from which a conformance statement may be retrieved.		
	Example	

Binding Value Set	ACH dQM
<i>Note: if the</i>	
	MS [0..*]
	R [1..1]
	NRT
	NRT

https://hl7.org/fhir/	NRT
	NRT
	NRT
	NRT

	NRT
	NRT
	NR
	MS [0..1]

	MS [0..1]
	MS [0..1]
	R [1..1]
http://hl7.org/fhir/ValueSet/udi-entry-type 4.0.1	NR
	NR

	NR
https://hl7.org/fhir/	MS [0..1]
http://hl7.org/fhir/R	NR
	MS[0..1]
	NR
	MS [0..1]
	MS [0..1]
	MS [0..1]
	MS [0..1]
	MS [0..*]

	NRT
	NRT
	NRT
	R [1..1]

https://hl7.org/fhir/	R [1..1]
	NR
	NR
http://hl7.org/fhir/R	R [1..1]
	NR
	NRT
	NRT

	NRT
	NR
	NR
	NR
	NRT

	NRT
	NRT
	NR
	NR
	NR

	NR
	NRT
	NRT
	NRT

	NR
	NR
	NR
	R [1..1]
	NR
	NR
	NR
	NR
	NR
https://hl7.org/fhir/	NR
	NR

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FHIR Path	Min	Max	Must Support?
Observation	0	*	
Observation.id	0	1	
Observation.meta	0	1	
Observation.implicitRules	0	1	
Observation.language	0	1	
Observation.text	0	1	

Observation.contained	0	*	
Observation.extension	0	*	

Observation.modifierExtension	0	*	
Observation.identifier	0	*	
Observation.basedOn	0	*	
Observation.partOf	0	*	

Observation.status	1	1	Y
Observation.category	1	*	Y
Observation.category:Laboratory	1	1	Y
Observation.category:Laboratory.id	0	1	
Observation.category:Laboratory.extension	0	*	
Observation.category:Laboratory.coding	1	*	Y
Observation.category:Laboratory.coding.id	0	1	
Observation.category:Laboratory.coding.extension	0	*	

Observation.category:Laboratory.coding.system	1	1	Y
Observation.category:Laboratory.coding.version	0	1	
Observation.category:Laboratory.coding.code	1	1	Y
Observation.category:Laboratory.coding.display	0	1	
Observation.category:Laboratory.coding.userSelected	0	1	
Observation.category:Laboratory.text	0	1	
Observation.code	1	1	Y

Observation.subject	1	1	Y
Observation.focus	0	*	
Observation.encounter	0	1	
Observation.effective[x]	0	1	Y
Observation.issued	0	1	

Observation.performer	0	*	
Observation.value[x]	0	1	Y
Observation.dataAbsentReason	0	1	Y
Observation.interpretation	0	*	
Observation.note	0	*	
Observation.bodySite	0	1	
Observation.method	0	1	
Observation.specimen	0	1	
Observation.device	0	1	

Observation.referenceRange	0	*	
Observation.referenceRange.id	0	1	
Observation.referenceRange.extension	0	*	

Observation.referenceRange.modifierExtension	0	*	
Observation.referenceRange.low	0	1	
Observation.referenceRange.high	0	1	

Observation.referenceRange.type	0	1	
Observation.referenceRange.appliesTo	0	*	
Observation.referenceRange.age	0	1	
Observation.referenceRange.text	0	1	
Observation.hasMember	0	*	
Observation.derivedFrom	0	*	

Observation.component	0	*	
Observation.component.id	0	1	
Observation.component.extension	0	*	

Observation.component.modifierExtension	0	*	
Observation.component.code	1	1	
Observation.component.value[x]	0	1	
Observation.component.dataAbsentReason	0	1	

Observation.component.interpretation	0	*	
Observation.component.referenceRange	0	*	

Data Type(s)	FHIR Short Description	FHIR Definition
Observation	Measurements and simple assertions	This profile is created to meet the 2015 Edition Common Clinical Data Set 'Laboratory test(s) and Laboratory value(s)/result(s)' requirements.
string	Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.
Meta	Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.
uri	A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.
code	Language of the resource content	The base language in which the resource is written.
Narrative	Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.

Resource	Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.
Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.

Extension	Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).
Identifier	Business Identifier for observation	A unique identifier assigned to this observation.
Reference(CarePlan DeviceRequest ImmunizationRecommendation MedicationRequest NutritionOrder ServiceRequest)	Fulfills plan, proposal or order	A plan, proposal or order that is fulfilled in whole or in part by this event. For example, a MedicationRequest may require a patient to have laboratory test performed before it is dispensed.
Reference(MedicationAdministration MedicationDispense MedicationStatement Procedure Immunization ImagingStudy)	Part of referenced event	A larger event of which this particular Observation is a component or step. For example, an observation as part of a procedure.

code	registered preliminary final amended +	The status of the result value.
Slice Definition	Classification of type of observation Slice: Unordered, Open by pattern:\$this	A code that classifies the general type of observation being made.
CodeableConcept	Classification of type of observation	A code that classifies the general type of observation being made.
string	Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.
Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.
Coding	Code defined by a terminology system	A reference to a code defined by a terminology system.
string	Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.
Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.

uri	Identity of the terminology system Fixed Value: http://terminology.hl7.org/CodeSystem/observation-category	The identification of the code system that defines the meaning of the symbol in the code.
string	Version of the system - if relevant	The version of the code system which was used when choosing this code. Note that a well-maintained code system does not need the version reported, because the meaning of codes is consistent across versions. However this cannot consistently be assured, and when the meaning is not guaranteed to be consistent, the version SHOULD be exchanged.
code	Symbol in syntax defined by the system Fixed Value: laboratory	A symbol in syntax defined by the system. The symbol may be a predefined code or an expression in a syntax defined by the coding system (e.g. post-coordination).
string	Representation defined by the system	A representation of the meaning of the code in the system, following the rules of the system.
boolean	If this coding was chosen directly by the user	Indicates that this coding was chosen by a user directly - e.g. off a pick list of available items (codes or displays).
string	Plain text representation of the concept	A human language representation of the concept as seen/selected/uttered by the user who entered the data and/or which represents the intended meaning of the user.
CodeableConcept	Laboratory Test Name	The test that was performed. A LOINC **SHALL** be used if the concept is present in LOINC.

Reference(US Core Patient Profile)	Who and/or what the observation is about	The patient, or group of patients, location, or device this observation is about and into whose record the observation is placed. If the actual focus of the observation is different from the subject (or a sample of, part, or region of the subject), the `focus` element or the `code` itself specifies the actual focus of the observation.
Reference(Resource)	What the observation is about, when it is not about the subject of record	The actual focus of an observation when it is not the patient of record representing something or someone associated with the patient such as a spouse, parent, fetus, or donor. For example, fetus observations in a mother's record. The focus of an observation could also be an existing condition, an intervention, the subject's diet, another observation of the subject, or a body structure such as tumor or implanted device. An example use case would be using the Observation resource to capture whether the mother is trained to change her child's tracheostomy tube. In this example, the child is the patient of record and the mother is the focus.
Reference(Encounter)	Healthcare event during which this observation is made	The healthcare event (e.g. a patient and healthcare provider interaction) during which this observation is made.
dateTime Period	Clinically relevant time/time-period for observation us-core-1: Datetime must be at least to day.	For lab tests this is the specimen collection date. For Ask at Order Entry Questions (AOE)'s this is the date the question was asked.
instant	Date/Time this version was made available	The date and time this version of the observation was made available to providers, typically after the results have been reviewed and verified.

Reference(Practitioner PractitionerRole Organization CareTeam Patient RelatedPerson)	Who is responsible for the observation	Who was responsible for asserting the observed value as "true".
Quantity CodeableConcept string boolean integer Range Ratio SampledData time dateTime Period	Result Value	The Laboratory result value. If a coded value, the valueCodeableConcept.code **SHOULD** be selected from [SNOMED CT](http://hl7.org/fhir/ValueSet/uslab-obs-codedresults) if the concept exists. If a numeric value, valueQuantity.code **SHALL** be selected from [UCUM](http://unitsofmeasure.org). A FHIR [UCUM Codes value set](http://hl7.org/fhir/STU3/valueset-ucum-units.html) that defines all UCUM codes is in the FHIR specification.
CodeableConcept	Why the result is missing	Provides a reason why the expected value in the element Observation.value[x] is missing.
CodeableConcept	High, low, normal, etc.	A categorical assessment of an observation value. For example, high, low, normal.
Annotation	Comments about the observation	Comments about the observation or the results.
CodeableConcept	Observed body part	Indicates the site on the subject's body where the observation was made (i.e. the target site).
CodeableConcept	How it was done	Indicates the mechanism used to perform the observation.
Reference(Specimen)	Specimen used for this observation	The specimen that was used when this observation was made.
Reference(Device DeviceMetric)	(Measurement) Device	The device used to generate the observation data.

BackboneElement	Provides guide for interpretation	Guidance on how to interpret the value by comparison to a normal or recommended range. Multiple reference ranges are interpreted as an "OR". In other words, to represent two distinct target populations, two `referenceRange` elements would be used.
string	Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.
Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.

Extension	Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).
SimpleQuantity	Low Range, if relevant	The value of the low bound of the reference range. The low bound of the reference range endpoint is inclusive of the value (e.g. reference range is ≥ 5 - ≤ 9). If the low bound is omitted, it is assumed to be meaningless (e.g. reference range is ≤ 2.3).
SimpleQuantity	High Range, if relevant	The value of the high bound of the reference range. The high bound of the reference range endpoint is inclusive of the value (e.g. reference range is ≥ 5 - ≤ 9). If the high bound is omitted, it is assumed to be meaningless (e.g. reference range is ≥ 2.3).

CodeableConcept	Reference range qualifier	Codes to indicate the what part of the targeted reference population it applies to. For example, the normal or therapeutic range.
CodeableConcept	Reference range population	Codes to indicate the target population this reference range applies to. For example, a reference range may be based on the normal population or a particular sex or race. Multiple `appliesTo` are interpreted as an "AND" of the target populations. For example, to represent a target population of African American females, both a code of female and a code for African American would be used.
Range	Applicable age range, if relevant	The age at which this reference range is applicable. This is a neonatal age (e.g. number of weeks at term) if the meaning says so.
string	Text based reference range in an observation	Text based reference range in an observation which may be used when a quantitative range is not appropriate for an observation. An example would be a reference value of "Negative" or a list or table of "normals".
Reference(Observation QuestionnaireResponse MolecularSequence)	Related resource that belongs to the Observation group	This observation is a group observation (e.g. a battery, a panel of tests, a set of vital sign measurements) that includes the target as a member of the group.
Reference(DocumentReference ImagingStudy Media QuestionnaireResponse Observation MolecularSequence)	Related measurements the observation is made from	The target resource that represents a measurement from which this observation value is derived. For example, a calculated anion gap or a fetal measurement based on an ultrasound image.

BackboneElement	Component results	Some observations have multiple component observations. These component observations are expressed as separate code value pairs that share the same attributes. Examples include systolic and diastolic component observations for blood pressure measurement and multiple component observations for genetics observations.
string	Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.
Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.

Extension	Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).
CodeableConcept	Type of component observation (code / type)	Describes what was observed. Sometimes this is called the observation "code".
Quantity CodeableConcept string boolean integer Range Ratio SampledData time dateTime Period	Actual component result	The information determined as a result of making the observation, if the information has a simple value.
CodeableConcept	Why the component result is missing	Provides a reason why the expected value in the element Observation.component.value[x] is missing.

CodeableConcept	High, low, normal, etc.	A categorical assessment of an observation value. For example, high, low, normal.
	Provides guide for interpretation of component result	Guidance on how to interpret the value by comparison to a normal or recommended range.

Binding Strength	Binding Description (Value Set Name)	Binding Value Set	ACH dQM
			MS [0..*]
			R [1..1]
			NRT
			NRT
preferred	CommonLanguages	https://hl7.org/fhir/R4/valueset-languages.html	NRT
			NRT

			NRT
			NRT

			NRT
			NRT
			NR
			NR

required	ObservationStatus	http://hl7.org/fhir/R4/ValueSet/obs	R [1..1]
preferred	ObservationCategoryCode s	https://hl7.org/fhir/R4/valueset-obs	R [1..*]
preferred	ObservationCategoryCode s	http://hl7.org/fhir/ValueSet/observation-category	R [1..1]
			NRT
			NRT
			NR
			NR
			NR

			NR
			NR
			NR
			NR
			NR
			NR
extensible	LOINCCodes	https://hl7.org/fhir/R4/valueset-0	R [1..1]

			R [1..1]
			NR
			MS [0..1]
			R [1..1]
			MS [0..1]

			NR
			MS [0..1]
extensible	DataAbsentReason	http://hl7.org/fhir/R4/ValueSet/data-absent-reason-codes	MS [0..1]
extensible	ObservationInterpretationCodes	https://hl7.org/fhir/R4/valueset-observation-interpretation-codes	MS [0..*]
			NR
example	SNOMEDCTBodyStructures	https://hl7.org/fhir/R4/valueset-body-structures	MS [0..1]
extensible	ObservationMethods	https://hl7.org/fhir/R4/valueset-observation-methods	MS [0..1]
			MS [0..1]
			NR

			NR
			NRT
			NRT

			NRT
			NR
			NR

preferred	ObservationReferenceRangeMeaningCodes	https://hl7.org/fhir/R4/valueset-re	NR
example	ObservationReferenceRangeAppliesToCodes	https://hl7.org/fhir/R4/valueset-re	NR
			NR
			NR
			NR
			NR

			MS [0..*]
			NRT
			NRT

			NRT
extensible	LOINCCodes	http://hl7.org/fhir/R4/valueset-ob	R [1..1]
			MS [0..1]
extensible	DataAbsentReason	http://hl7.org/fhir/R4/ValueSet/da	NR

extensible	ObservationInterpretation Codes	https://hl7.org/fhir/R4/valueset-observation-interpretation-codes	MS [0..*]
			NR

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FHIR Path	Min	Max	Must Support
Location	0	*	
Location.id	0	1	Y
Location.meta	0	1	
Location.implicitRules	0	1	
Location.language	0	1	
Location.text	0	1	
Location.contained	0	*	
Location.extension	0	*	

Location.modifierExtension	0	*	
Location.identifier	0	*	
Location.status	0	1	Y
Location.operationalStatus	0	1	
Location.name	1	1	Y
Location.alias	0	*	

Location.description	0	1	
Location.mode	0	1	
Location.type	0	*	
Location.telecom	0	*	Y
Location.address	0	1	Y
Location.address.id	0	1	

Location.address.extension	0	*	
Location.address.use	0	1	
Location.address.type	0	1	
Location.address.text	0	1	
Location.address.line	0	*	Y
Location.address.city	0	1	Y
Location.address.district	0	1	
Location.address.state	0	1	Y
Location.address.postalCode	0	1	Y
Location.address.country	0	1	
Location.address.period	0	1	
Location.physicalType	0	1	

Location.position	0	1	
Location.position.id	0	1	
Location.position.extension	0	*	
Location.position.modifierExtension	0	*	
Location.position.longitude	1	1	
Location.position.latitude	1	1	
Location.position.altitude	0	1	
Location.managingOrganization	0	1	Y

Location.partOf	0	1	
Location.hoursOfOperation	0	*	
Location.hoursOfOperation.id	0	1	
Location.hoursOfOperation.extension	0	*	
Location.hoursOfOperation.modifierExtension	0	*	
Location.hoursOfOperation.daysOfWeek	0	*	
Location.hoursOfOperation.allDay	0	1	
Location.hoursOfOperation.openingTime	0	1	
Location.hoursOfOperation.closingTime	0	1	

Location.availabilityExceptions	0	1	
Location.endpoint	0	*	

Data Type(s)	FHIR Short Description
	Details and position information for a physical place
string	Logical id of this artifact
Meta	Metadata about the resource
uri	A set of rules under which this content was created
code	Language of the resource content
Narrative	Text summary of the resource, for human interpretation
Resource	Contained, inline Resources
Extension	Additional content defined by implementations

Extension	Extensions that cannot be ignored
Identifier	Unique code or number identifying the location to its users
code	active suspended inactive
Coding	The operational status of the location (typically only for a bed/room)
string	Name of the location as used by humans
string	A list of alternate names that the location is known as, or was known as, in the past

string	Additional details about the location that could be displayed as further information to identify the location beyond its name
code	instance kind
CodeableConcept	Type of function performed
ContactPoint	Contact details of the location
Address	Physical location
string	Unique id for inter-element referencing

Extension	Additional content defined by implementations
code	home work temp old billing - purpose of this address
code	postal physical both
string	Text representation of the address
string	Street name, number, direction & P.O. Box etc.
string	Name of city, town etc.
string	District name (aka county)
string	Sub-unit of country (abbreviations ok)
string	US Zip Codes
string	Country (e.g. can be ISO 3166 2 or 3 letter code)
Period	Time period when address was/is in use
CodeableConcept	Physical form of the location

BackboneElement	The absolute geographic location
string	Unique id for inter-element referencing
Extension	Additional content defined by implementations
Extension	Extensions that cannot be ignored even if unrecognized
decimal	Longitude with WGS84 datum
decimal	Latitude with WGS84 datum
decimal	Altitude with WGS84 datum
Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-organization)	Organization responsible for provisioning and upkeep

Reference(Location)	Another Location this one is physically a part of
BackboneElement	What days/times during a week is this location usually open
string	Unique id for inter-element referencing
Extension	Additional content defined by implementations
Extension	Extensions that cannot be ignored even if unrecognized
code	mon tue wed thu fri sat sun
boolean	The Location is open all day
time	Time that the Location opens
time	Time that the Location closes

string	Description of availability exceptions
Reference(Endpoint)	Technical endpoints providing access to services operated for the location

FHIR Definition	Binding Strength
Details and position information for a physical place where services are provided and resources and participants may be stored, found, contained, or accommodated.	
The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	
The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.	
A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	
The base language in which the resource is written.	preferred
A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.	
These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.	
May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Unique code or number identifying the location to its users.	
The status property covers the general availability of the resource, not the current value which may be covered by the operationStatus, or by a schedule/slots if they are configured for the location.	required
The operational status covers operation values most relevant to beds (but can also apply to rooms/units/chairs/etc. such as an isolation unit/dialysis chair). This typically covers concepts such as contamination, housekeeping, and other activities like maintenance.	preferred
Name of the location as used by humans. Does not need to be unique.	
A list of alternate names that the location is known as, or was known as, in the past.	

Description of the Location, which helps in finding or referencing the place.	
Indicates whether a resource instance represents a specific location or a class of locations.	required
Indicates the type of function performed at the location.	extensible
The contact details of communication devices available at the location. This can include phone numbers, fax numbers, mobile numbers, email addresses and web sites.	
Physical location.	
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	

May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
The purpose of this address.	required
Distinguishes between physical addresses (those you can visit) and mailing addresses (e.g. PO Boxes and care-of addresses). Most addresses are both.	required
Specifies the entire address as it should be displayed e.g. on a postal label. This may be provided instead of or as well as the specific parts.	
This component contains the house number, apartment number, street name, street direction, P.O. Box number, delivery hints, and similar address information.	
The name of the city, town, suburb, village or other community or delivery center.	
The name of the administrative area (county).	
Sub-unit of a country with limited sovereignty in a federally organized country. A code may be used if codes are in common use (e.g. US 2 letter state codes).	extensible
A postal code designating a region defined by the postal service.	
Country - a nation as commonly understood or generally accepted.	
Time period when address was/is in use.	
Physical form of the location, e.g. building, room, vehicle, road.	extensible

The absolute geographic location of the Location, expressed using the WGS84 datum (This is the same co-ordinate system used in KML).	
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Longitude. The value domain and the interpretation are the same as for the text of the longitude element in KML (see notes below).	
Latitude. The value domain and the interpretation are the same as for the text of the latitude element in KML (see notes below).	
Altitude. The value domain and the interpretation are the same as for the text of the altitude element in KML (see notes below).	
The organization responsible for the provisioning and upkeep of the location.	

Another Location of which this Location is physically a part of.	
What days/times during a week is this location usually open.	
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Indicates which days of the week are available between the start and end Times.	required
The Location is open all day.	
Time that the Location opens.	
Time that the Location closes.	

A description of when the locations opening ours are different to normal, e.g. public holiday availability. Succinctly describing all possible exceptions to normal site availability as detailed in the opening hours Times.	
Technical endpoints providing access to services operated for the location.	

Binding Description	Binding Value Set	ACH dQM
		R [1..*]
		R [1..1]
		NRT
		NRT
CommonLanguages	https://hl7.org/fhir/R4/valuesets	NRT
		NRT
		NRT
		NRT

		NRT
		NRT
LocationStatus	https://hl7.org/fhir/R4/valueset-location-status.html	MS [0..1]
hl7VS-bedStatus	http://terminology.hl7.org/ValueSet/vs-bed-status	NR
		R [1..1]
		MS [0..*]

		NR
LocationMode	https://hl7.org/fhir/R4/valueset-location-mode	NR
ServiceDeliveryLocationRoleType	http://terminology.hl7.org/ValueSet/v2-16840-1.113762.1.4.1046.265	R [1..*] The following constraint is written into the CQL: valueset "Inpatient, Emergency, and Observation Locations": 'http://cts.nlm.nih.gov/fhir/ValueSet/2.16.840.1.113762.1.4.1046.265'
		MS [0..*]
		MS [0..1]
		NRT

		NRT
AddressUse	https://hl7.org/fhir/R4/valuation.html	MS [0..1]
AddressType	https://hl7.org/fhir/R4/valuation.html	NR
		NR
		NR
		NR
		NR
USPS Two Letter Alphabetic Codes	https://hl7.org/fhir/us/core/elements.html#USPS2LetterAlphabeticCodes	NR
		NR
		NR
		NR
Physical form of the location.	https://hl7.org/fhir/R4/valuation.html	MS [0..1]

		NR
		NRT
		NRT
		NRT
		NR
		NR
		NR
		NR

		MS [0..1]
		NR
		NRT
		NRT
		NRT
The days of the week.	https://hl7.org/fhir/R4/va	NR
		NR
		NR
		NR

		NR
		NR

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FHIR Path	Min	Max	Must Support?
Medication	0	*	
Medication.id	0	1	
Medication.meta	0	1	
Medication.implicitRules	0	1	
Medication.language	0	1	

Medication.text	0	1	
Medication.contained	0	*	
Medication.extension	0	*	

Medication.modifierExtension	0	*	
Medication.identifier	0	*	

Medication.code	1	1	Y
Medication.status	0	1	
Medication.manufacturer	0	1	
Medication.form	0	1	
Medication.amount	0	1	
Medication.ingredient	0	*	
Medication.ingredient.id	0	1	

Medication.ingredient.extension	0	*	
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Medication.ingredient.modifierExtension	0	*	
Medication.ingredient.item[x]	1	1	
Medication.ingredient.isActive	0	1	

Medication.ingredient.strength	0	1	
Medication.batch	0	1	
Medication.batch.id	0	1	
Medication.batch.extension	0	*	
Medication.batch.modifierExtension	0	*	
Medication.batch.lotNumber	0	1	
Medication.batch.expirationDate	0	1	

Data Type(s)	FHIR Short Description	FHIR Definition	Binding Strength
Medication	Definition of a Medication	The US Core Medication Profile is based upon the core FHIR Medication Resource and created to meet the 2015 Edition Common Clinical Data Set 'Medications' requirements.	
string	Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	
Meta	Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.	
uri	A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	
code	Language of the resource content	The base language in which the resource is written. (ex English)	preferred

Narrative	Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.	
Resource	Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.	
Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

Extension	Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Identifier	Business identifier for this medication	Business identifier for this medication.	

CodeableConcept	Codes that identify this medication	A code (or set of codes) that specify this medication, or a textual description if no code is available. Usage note: This could be a standard medication code such as a code from RxNorm, SNOMED CT, IDMP etc. It could also be a national or local formulary code, optionally with translations to other code systems.	extensible
code	active inactive entered-in-error	A code to indicate if the medication is in active use.	required
Reference(Organization)	Manufacturer of the item	Describes the details of the manufacturer of the medication product. This is not intended to represent the distributor of a medication product.	
CodeableConcept	powder tablets capsule +	Describes the form of the item. Powder; tablets; capsule.	extensible
Ratio	Amount of drug in package	Specific amount of the drug in the packaged product. For example, when specifying a product that has the same strength (For example, Insulin glargine 100 unit per mL solution for injection), this attribute provides additional clarification of the package amount (For example, 3 mL, 10mL, etc.).	
BackboneElement	Active or inactive ingredient	Identifies a particular constituent of interest in the product.	
string	Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	

Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
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Extension	Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
CodeableConcept Reference(Substance Medication)	The actual ingredient or content	The actual ingredient - either a substance (simple ingredient) or another medication of a medication.	
boolean	Active ingredient indicator	Indication of whether this ingredient affects the therapeutic action of the drug.	

Ratio	Quantity of ingredient present	Specifies how many (or how much) of the items there are in this Medication. For example, 250 mg per tablet. This is expressed as a ratio where the numerator is 250mg and the denominator is 1 tablet.	
BackboneElement	Details about packaged medications	Information that only applies to packages (not products).	
string	Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Extension	Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
Extension	Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that <u>modifies the understanding of</u>	
string	Identifier assigned to batch	The assigned lot number of a batch of the specified product.	
dateTime	When batch will expire	When this specific batch of product will expire.	

Binding Description	Binding Value Set	ACH dQM
		MS [0..*]
		R [1..1]
		NRT
		NRT
CommonLanguages	https://hl7.org/fhir/R4/valuesets	NRT

		NRT
		NRT
		NRT

		NRT
		NRT

USCoreMedicationCodes	http://hl7.org/fhir/us/core/STU	R [1..1]
Medication Status Codes	https://hl7.org/fhir/R4/valueset	MS [0..*]
		NR
4.0.1 SNOMEDCTForm Codes	https://hl7.org/fhir/R4/valueset	MS [0..1]
		MS [0..1]
		MS [0..*]
		NRT

		NRT
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		NRT
		R [1..1]
		NRT

		NR
		NR
		NRT
		NRT
		NRT
		NR
		NR

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FHIRPath	Min	Max	Data Type(s)
MedicationAdministration	0	*	
MedicationAdministration.id	0	1	id
MedicationAdministration.meta	0	1	Meta
MedicationAdministration.implicitRules	0	1	uri
MedicationAdministration.language	0	1	code

MedicationAdministration.text	0	1	Narrative
MedicationAdministration.contained	0	*	Resource
MedicationAdministration.extension	0	*	Extension

MedicationAdministration.modifierExtension	0	*	Extension
MedicationAdministration.identifier	0	*	Identifier

MedicationAdministration.instantiates	0	*	uri
MedicationAdministration.partOf	0	*	Reference(MedicationAdministration Procedure)
MedicationAdministration.status	1	1	code
MedicationAdministration.statusReason	0	*	CodeableConcept
MedicationAdministration.category	0	1	CodeableConcept
MedicationAdministration.medication[x]	1	1	CodeableConcept Reference(Medication)
MedicationAdministration.subject	1	1	Reference(Patient Group)

MedicationAdministration.context	0	1	Reference(Encounter EpisodeOfCare)
MedicationAdministration.supportingInformation	0	*	Reference(Any)
MedicationAdministration.effective[x]	1	1	dateTime Period
MedicationAdministration.performer	0	*	BackboneElement
MedicationAdministration.performer.id	0	1	string

MedicationAdministration.performer.extension	0	*	Extension
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MedicationAdministration.performer.modifierExtension	0	*	Extension
MedicationAdministration.performer.function	0	1	CodeableConcept
MedicationAdministration.performer.actor	1	1	Reference(Practitioner PractitionerRole Patient RelatedPerson Device)
MedicationAdministration.reasonCode	0	*	CodeableConcept
MedicationAdministration.reasonReference	0	*	Reference(Condition Observation DiagnosticReport)

MedicationAdministration.request	0	1	Reference(MedicationRequest)
MedicationAdministration.device	0	*	Reference(Device)
MedicationAdministration.note	0	*	Annotation
MedicationAdministration.dosage	0	1	BackboneElement
MedicationAdministration.dosage.id	0	1	string
MedicationAdministration.dosage.extension	0	*	Extension

MedicationAdministration.dosage.modifierExtension	0	*	Extension
MedicationAdministration.dosage.text	0	1	string

MedicationAdministration.dosage.site	0	1	CodeableConcept
MedicationAdministration.dosage.route	0	1	CodeableConcept
MedicationAdministration.dosage.method	0	1	CodeableConcept
MedicationAdministration.dosage.dose	0	1	SimpleQuantity
MedicationAdministration.dosage.rate[x]	0	1	Ratio SimpleQuantity
MedicationAdministration.eventHistory	0	*	Reference(Provenance)

FHIR Short Description	FHIR Definition	Binding Strength
Administration of medication to a patient	Describes the event of a patient consuming or otherwise being administered a medication. This may be as simple as swallowing a tablet or it may be a long running infusion. Related resources tie this event to the authorizing prescription, and the specific encounter between patient and health care practitioner.	
Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	
Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.	
A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	
Language of the resource content	The base language in which the resource is written.	preferred but limited to AllLanguages

Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.	
Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
External identifier	Identifiers associated with this Medication Administration that are defined by business processes and/or used to refer to it when a direct URL reference to the resource itself is not appropriate. They are business identifiers assigned to this resource by the performer or other systems and remain constant as the resource is updated and propagates from server to server.	

Instantiates protocol or definition	A protocol, guideline, orderset, or other definition that was adhered to in whole or in part by this event.	
Part of referenced event	A larger event of which this particular event is a component or step.	
in-progress not-done on-hold completed entered-in-error stopped unknown	Will generally be set to show that the administration has been completed. For some long running administrations such as infusions, it is possible for an administration to be started but not completed or it may be paused while some other process is under way.	required
Reason administration not performed	A code indicating why the administration was not performed.	extensible
Type of medication usage	Indicates where the medication is expected to be consumed or administered.	extensible
What was administered	Identifies the medication that was administered. This is either a link to a resource representing the details of the medication or a simple attribute carrying a code that identifies the medication from a known list of medications.	extensible
Who received medication	The person or animal or group receiving the medication.	

Encounter or Episode of Care administered as part of	The visit, admission, or other contact between patient and health care provider during which the medication administration was performed.	
Additional information to support administration	Additional information (for example, patient height and weight) that supports the administration of the medication.	
Start and end time of administration	A specific date/time or interval of time during which the administration took place (or did not take place, when the 'notGiven' attribute is true). For many administrations, such as swallowing a tablet the use of dateTime is more appropriate.	
Who performed the medication administration and what they did	Indicates who or what performed the medication administration and how they were involved.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	

Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
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Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Type of performance	Distinguishes the type of involvement of the performer in the medication administration.	example
Who performed the medication administration	Indicates who or what performed the medication administration.	
Reason administration performed	A code indicating why the medication was given.	example
Condition or observation that supports why the medication was administered	Condition or observation that supports why the medication was administered.	

Request administration performed against	The original request, instruction or authority to perform the administration.	
Device used to administer	The device used in administering the medication to the patient. For example, a particular infusion pump.	
Information about the administration	Extra information about the medication administration that is not conveyed by the other attributes.	
Details of how medication was taken + Rule: SHALL have at least one of dosage.dose or dosage.rate[x]	Describes the medication dosage information details e.g. dose, rate, site, route, etc.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Free text dosage instructions e.g. SIG	Free text dosage can be used for cases where the dosage administered is too complex to code. When coded dosage is present, the free text dosage may still be present for display to humans. The dosage instructions should reflect the dosage of the medication that was administered.	

Body site administered to	A coded specification of the anatomic site where the medication first entered the body. For example, "left arm".	example
Path of substance into body	A code specifying the route or physiological path of administration of a therapeutic agent into or onto the patient. For example, topical, intravenous, etc.	extensible
How drug was administered	A coded value indicating the method by which the medication is intended to be or was introduced into or on the body. This attribute will most often NOT be populated. It is most commonly used for injections. For example, Slow Push, Deep IV.	example
Amount of medication per dose	The amount of the medication given at one administration event. Use this value when the administration is essentially an instantaneous event such as a swallowing a tablet or giving an injection.	
Dose quantity per unit of time	Identifies the speed with which the medication was or will be introduced into the patient. Typically, the rate for an infusion e.g. 100 ml per 1 hour or 100 ml/hr. May also be expressed as a rate per unit of time, e.g. 500 ml per 2 hours. Other examples: 200 mcg/min or 200 mcg/1 minute; 1 liter/8 hours.	
A list of events of interest in the lifecycle	A summary of the events of interest that have occurred, such as when the administration was verified.	

Binding Description (Value Set Name)	Binding Value Set	ACH dQM
		MS [0..*]
		R [1..1]
		NRT
		NRT
CommonLanguages	https://hl7.org/fhir/R4/value	NRT

		NRT
		NRT
		NRT

		NRT
		NRT

		NR
		NR
MedicationAdministration Status Codes	https://hl7.org/fhir/R4/valueset.html	R [1..1]
SNOMEDCTReasonMedicationNotGiven Codes	https://hl7.org/fhir/R4/valueset.html	MS [0..*]
MedicationAdministration Category Codes	https://hl7.org/fhir/R4/valueset.html	MS [0..*]
MedicationClinicalDrug (RxNorm code system)	https://vsac.nlm.nih.gov/val	R [1..1]
		R [1..1]

		MS [0..1]
		NR
		R [1..1]
		NR
		NRT

		NRT
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		NRT
MedicationAdministration Performer Function Codes	https://hl7.org/fhir/R4/value	NR
		NR
ReasonMedicationGiven Codes	https://hl7.org/fhir/R4/value	MS [0..*]
		MS [0..*]

		MS [0..1]
		NR
		NR
		R [1..1]
		NRT
		NRT

		NRT
		NR

SNOMEDCTAnatomicalStructureForAdministrationSiteCodes	https://hl7.org/fhir/R4/value	NR
SNOMEDCTRouteCodes	https://hl7.org/fhir/R4/value	R [1..1]
SNOMEDCTAdministrationMethodCodes	https://hl7.org/fhir/R4/value	MS [0..1]
		R [1..1]
		NR
		NR

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FHIR Path	Min	Max	Must Support?
MedicationRequest	0	*	
MedicationRequest.id	0	1	
MedicationRequest.meta	0	1	
MedicationRequest.implicitRules	0	1	

MedicationRequest.language	0	1	
MedicationRequest.text	0	1	

MedicationRequest.contained	0	*	
MedicationRequest.extension	0	*	

MedicationRequest.modifierExtension	0	*	
MedicationRequest.identifier	0	*	

MedicationRequest.status	1	1	Y
MedicationRequest.statusReason	0	1	
MedicationRequest.intent	1	1	Y
MedicationRequest.category	0	*	

MedicationRequest.priority	0	1	
MedicationRequest.doNotPerform	0	1	
MedicationRequest.reported[x]	0	1	Y
MedicationRequest.medication[x]	1	1	Y
MedicationRequest.subject	1	1	Y

MedicationRequest.encounter	0	1	Y
MedicationRequest.supportingInformation	0	*	
MedicationRequest.authoredOn	1	1	Y
MedicationRequest.requester	1	1	Y
MedicationRequest.performer	0	1	
MedicationRequest.performerType	0	1	
MedicationRequest.recorder	0	1	
MedicationRequest.reasonCode	0	*	

MedicationRequest.reasonReference	0	*	
MedicationRequest.instantiatesCanonical	0	*	
MedicationRequest.instantiatesUri	0	*	
MedicationRequest.basedOn	0	*	
MedicationRequest.groupIdentifier	0	1	
MedicationRequest.courseOfTherapyType	0	1	
MedicationRequest.insurance	0	*	
MedicationRequest.note	0	*	

MedicationRequest.dosageInstruction	0	*	Y
MedicationRequest.dosageInstruction.id	0	1	
MedicationRequest.dosageInstruction.extension	0	*	

MedicationRequest.dosageInstruction.modifierExtension	0	*	
MedicationRequest.dosageInstruction.sequence	0	1	
MedicationRequest.dosageInstruction.text	0	1	Y

MedicationRequest.dosageInstruction.additionalInstruction	0	*	
MedicationRequest.dosageInstruction.patientInstruction	0	1	
MedicationRequest.dosageInstruction.timing	0	1	
MedicationRequest.dosageInstruction.asNeeded[x]	0	1	
MedicationRequest.dosageInstruction.site	0	1	

MedicationRequest.dosageInstruction.route	0	1	
MedicationRequest.dosageInstruction.method	0	1	
MedicationRequest.dosageInstruction.doseAndRate	0	*	
MedicationRequest.dosageInstruction.doseAndRate.id	0	1	
MedicationRequest.dosageInstruction.doseAndRate.extension	0	*	
MedicationRequest.dosageInstruction.doseAndRate.type	0	1	

MedicationRequest.dosageInstruction.doseAndRate.dose[x]	0	1	
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MedicationRequest.dosageInstruction.doseAndRate.rate[x]	0	1	
MedicationRequest.dosageInstruction.maxDosePerPeriod	0	1	

MedicationRequest.dosageInstruction.maxDosePerAdministration	0	1	
MedicationRequest.dosageInstruction.maxDosePerLifetime	0	1	
MedicationRequest.dispenseRequest	0	1	
MedicationRequest.dispenseRequest.id	0	1	

MedicationRequest.dispenseRequest.extension	0	*	
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MedicationRequest.dispenseRequest.modifierExtension	0	*	
MedicationRequest.dispenseRequest.initialFill	0	1	
MedicationRequest.dispenseRequest.initialFill.id	0	1	

MedicationRequest.dispenseRequest.initialFill.extension	0	*	
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MedicationRequest.dispenseRequest.initialFill.modifierExtension	0	*	
MedicationRequest.dispenseRequest.initialFill.quantity	0	1	
MedicationRequest.dispenseRequest.initialFill.duration	0	1	
MedicationRequest.dispenseRequest.dispenseInterval	0	1	

MedicationRequest.dispenseRequest.validityPeriod	0	1	
MedicationRequest.dispenseRequest.numberOfRepeatsAllowed	0	1	
MedicationRequest.dispenseRequest.quantity	0	1	

MedicationRequest.dispenseRequest.expectedSupplyDuration	0	1	
MedicationRequest.dispenseRequest.former	0	1	
MedicationRequest.substitution	0	1	
MedicationRequest.substitution.id	0	1	
MedicationRequest.substitution.extension	0	*	

MedicationRequest.substitution.modifier Extension	0	*	
MedicationRequest.substitution.allowed[x]	1	1	
MedicationRequest.substitution.reason	0	1	
MedicationRequest.priorPrescription	0	1	

MedicationRequest.detectedIssue	0	*	
MedicationRequest.eventHistory	0	*	

Data Type(s)	FHIR Short Description
	Ordering of medication for patient or group
string	Logical id of this artifact
Meta	Metadata about the resource
uri	A set of rules under which this content was created

code	Language of the resource content
Narrative	Text summary of the resource, for human interpretation

Resource	Contained, inline Resources
Extension	Additional content defined by implementations

Extension	Extensions that cannot be ignored
Identifier	External ids for this request

code	active on-hold cancelled completed entered-in-error stopped draft unknown
CodeableConcept	Reason for current status+F14
code	proposal plan order original-order reflex-order filler-order instance-order option
CodeableConcept	Type of medication usage

code	routine urgent asap stat
boolean	True if request is prohibiting action
boolean Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-practitioner http://hl7.org/fhir/us/core/StructureDefinition/us-core-organization http://hl7.org/fhir/us/core/StructureDefinition/us-core-patient http://hl7.org/fhir/us/core/StructureDefinition/us-core-practitionerrole http://hl7.org/fhir/us/core/StructureDefinition/us-core-relatedperson)	Reported rather than primary record
CodeableConcept Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-medication)	Medication to be taken
Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-patient)	Who or group medication request is for

Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-encounter)	Encounter created as part of encounter/admission/stay
Reference(Resource)	Information to support ordering of the medication
dateTime	When request was initially authored
Reference(US Core Practitioner Profile US Core Organization Profile US Core Patient Profile)	Who/What requested the Request
Reference(Practitioner PractitionerRole Organization Patient Device RelatedPerson CareTeam)	Intended performer of administration
CodeableConcept	Desired kind of performer of the medication administration
Reference(Practitioner PractitionerRole)	Person who entered the request
CodeableConcept	Reason or indication for ordering or not ordering the medication

Reference(Condition Observation)	Condition or observation that supports why the prescription is being written
canonical	Instantiates FHIR protocol or definition
uri	Instantiates external protocol or definition
Reference(CarePlan MedicationRequest ServiceRequest ImmunizationRecommendation)	What request fulfills
Identifier	Composite request this is part of
CodeableConcept	Overall pattern of medication administration
Reference(Coverage ClaimResponse)	Associated insurance coverage
Annotation	Information about the prescription

Dosage	How the medication should be taken
string	Unique id for inter-element referencing
Extension	Additional content defined by implementations

Extension	Extensions that cannot be ignored even if unrecognized
integer	The order of the dosage instructions
string	Free text dosage instructions e.g. SIG

CodeableConcept	Supplemental instruction or warnings to the patient - e.g. "with meals", "may cause drowsiness"
string	Patient or consumer oriented instructions
Timing	When medication should be administered
boolean CodeableConcept	Take "as needed" (for x)
CodeableConcept	Body site to administer to

CodeableConcept	How drug should enter body
CodeableConcept	Technique for administering medication
Element	Amount of medication administered
string	Unique id for inter-element referencing
Extension	Additional content defined by implementations
CodeableConcept	The kind of dose or rate specified

Range Quantity {SimpleQuantity}	Amount of medication per dose

Ratio RangeQuantity {SimpleQuantity}	Amount of medication per unit of time
Ratio	Upper limit on medication per unit of time

Quantity {SimpleQuantity}	Upper limit on medication per administration
Quantity {SimpleQuantity}	Upper limit on medication per lifetime of the patient
BackboneElement	Medication supply authorization
string	Unique id for inter-element referencing

Extension	Additional content defined by implementations
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Extension	Extensions that cannot be ignored even if unrecognized
BackboneElement	First fill details
string	Unique id for inter-element referencing

Extension	Additional content defined by implementations
-----------	---

Extension	Extensions that cannot be ignored even if unrecognized
Quantity {SimpleQuantity}	First fill quantity
Duration	First fill duration
Duration	Minimum period of time between dispenses

Period	Time period supply is authorized for
unsignedInt	Number of refills authorized
Quantity {SimpleQuantity}	Amount of medication to supply per dispense

Duration	Number of days supply per dispense
Reference(Organization)	Intended dispenser
BackboneElement	Any restrictions on medication substitution
string	Unique id for inter-element referencing
Extension	Additional content defined by implementations

Extension	Extensions that cannot be ignored even if unrecognized
boolean CodeableConcept	Whether substitution is allowed or not
CodeableConcept	Why should (not) substitution be made
Reference(MedicationRequest)	An order/prescription that is being replaced

Reference(DetectedIssue)	Clinical Issue with action
Reference(Provenance)	A list of events of interest in the lifecycle

FHIR Definition	Comments	Binding Strength
The US Core Medication Request (Order) Profile is based upon the core FHIR MedicationRequest Resource and created to meet the 2015 Edition Common Clinical Data Set 'Medications' requirements.		
The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	The only time that a resource does not have an id is when it is being submitted to the server using a create operation.	
The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.		
A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	Asserting this rule set restricts the content to be only understood by a limited set of trading partners. This inherently limits the usefulness of the data in the long term. However, the existing health ecosystem is highly fractured, and not yet ready to define, collect, and exchange data in a generally computable sense. Wherever possible, implementers and/or specification writers should avoid using this element. Often, when used, the URL is a reference to an implementation guide that defines these special rules as part of it's narrative along with other profiles, value sets, etc.	

The base language in which the resource is written.	Language is provided to support indexing and accessibility (typically, services such as text to speech use the language tag). The html language tag in the narrative applies to the narrative. The language tag on the resource may be used to specify the language of other presentations generated from the data in the resource. Not all the content has to be in the base language. The Resource.language should not be assumed to apply to the narrative automatically. If a language is specified, it should it also be specified on the div element in the html (see rules in HTML5 for information about the relationship between xml:lang and the html lang attribute).	preferred
A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.	Contained resources do not have narrative. Resources that are not contained SHOULD have a narrative. In some cases, a resource may only have text with little or no additional discrete data (as long as all minOccurs=1 elements are satisfied). This may be necessary for data from legacy systems where information is captured as a "text blob" or where text is additionally entered raw or narrated and encoded information is added later.	

These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.	This should never be done when the content can be identified properly, as once identification is lost, it is extremely difficult (and context dependent) to restore it again. Contained resources may have profiles and tags In their meta elements, but SHALL NOT have security labels.	
May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.	

May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.	
Identifiers associated with this medication request that are defined by business processes and/or used to refer to it when a direct URL reference to the resource itself is not appropriate. They are business identifiers assigned to this resource by the performer or other systems and remain constant as the resource is updated and propagates from server to server.	This is a business identifier, not a resource identifier.	

A code specifying the current state of the order. Generally, this will be active or completed state.	This element is labeled as a modifier because the status contains codes that mark the resource as not currently valid.	required
Captures the reason for the current state of the MedicationRequest.	This is generally only used for "exception" statuses such as "suspended" or "cancelled". The reason why the MedicationRequest was created at all is captured in reasonCode, not here.	extensible
Whether the request is a proposal, plan, or an original order.	It is expected that the type of requester will be restricted for different stages of a MedicationRequest. For example, Proposals can be created by a patient, relatedPerson, Practitioner or Device. Plans can be created by Practitioners, Patients, RelatedPersons and Devices. Original orders can be created by a Practitioner only. An instance-order is an instantiation of a request or order and may be used to populate Medication Administration Record. This element is labeled as a modifier because the intent alters when and how the resource is actually applicable.	required
Indicates the type of medication request (for example, where the medication is expected to be consumed or administered (i.e. inpatient or outpatient)).	The category can be used to include where the medication is expected to be consumed or other types of requests.	extensible

Indicates how quickly the Medication Request should be addressed with respect to other requests.		required
If true indicates that the provider is asking for the medication request not to occur.	If do not perform is not specified, the request is a positive request e.g. "do perform".	
Indicates if this record was captured as a secondary 'reported' record rather than as an original primary source-of-truth record. It may also indicate the source of the report.		
Identifies the medication being requested. This is a link to a resource that represents the medication which may be the details of the medication or simply an attribute carrying a code that identifies the medication from a known list of medications.	If only a code is specified, then it needs to be a code for a specific product. If more information is required, then the use of the Medication resource is recommended. For example, if you require form or lot number or if the medication is compounded or extemporaneously prepared, then you must reference the Medication resource.	extensible
A link to a resource representing the person or set of individuals to whom the medication will be given.	The subject on a medication request is mandatory. For the secondary use case where the actual subject is not provided, there still must be an anonymized subject specified.	

The Encounter during which this [x] was created or to which the creation of this record is tightly associated.	This will typically be the encounter the event occurred within, but some activities may be initiated prior to or after the official completion of an encounter but still be tied to the context of the encounter." If there is a need to link to episodes of care they will be handled with an extension.	
Include additional information (for example, patient height and weight) that supports the ordering of the medication.		
The date (and perhaps time) when the prescription was initially written or authored on.		
The individual, organization, or device that initiated the request and has responsibility for its activation.		
The specified desired performer of the medication treatment (e.g. the performer of the medication administration).		
Indicates the type of performer of the administration of the medication.	If specified without indicating a performer, this indicates that the performer must be of the specified type. If specified with a performer then it indicates the requirements of the performer if the designated performer is not available.	example
The person who entered the order on behalf of another individual for example in the case of a verbal or a telephone order.		
The reason or the indication for ordering or not ordering the medication.	This could be a diagnosis code. If a full condition record exists or additional detail is needed, use reasonReference.	example

Condition or observation that supports why the medication was ordered.	This is a reference to a condition or observation that is the reason for the medication order. If only a code exists, use reasonCode.	
The URL pointing to a protocol, guideline, orderset, or other definition that is adhered to in whole or in part by this MedicationRequest.	can include a version number (FHIR based)	
The URL pointing to an externally maintained protocol, guideline, orderset or other definition that is adhered to in whole or in part by this MedicationRequest.		
A plan or request that is fulfilled in whole or in part by this medication request.		
A shared identifier common to all requests that were authorized more or less simultaneously by a single author, representing the identifier of the requisition or prescription.		
The description of the overall pattern of the administration of the medication to the patient.	This attribute should not be confused with the protocol of the medication.	example
Insurance plans, coverage extensions, pre-authorizations and/or pre-determinations that may be required for delivering the requested service.		
Extra information about the prescription that could not be conveyed by the other attributes.		

Indicates how the medication is to be used by the patient.	There are examples where a medication request may include the option of an oral dose or an Intravenous or Intramuscular dose. For example, "Ondansetron 8mg orally or IV twice a day as needed for nausea" or "Compazine® (prochlorperazine) 5-10mg PO or 25mg PR bid prn nausea or vomiting". In these cases, two medication requests would be created that could be grouped together. The decision on which dose and route of administration to use is based on the patient's condition at the time the dose is needed.	
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.		
May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.	

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Indicates the order in which the dosage instructions should be applied or interpreted.		
Free text dosage instructions e.g. SIG.		

Supplemental instructions to the patient on how to take the medication (e.g. "with meals" or "take half to one hour before food") or warnings for the patient about the medication (e.g. "may cause drowsiness" or "avoid exposure of skin to direct sunlight or sunlamps").	Information about administration or preparation of the medication (e.g. "infuse as rapidly as possibly via intraperitoneal port" or "immediately following drug x") should be populated in dosage.text.	example
Instructions in terms that are understood by the patient or consumer.		
When medication should be administered.	This attribute might not always be populated while the Dosage.text is expected to be populated. If both are populated, then the Dosage.text should reflect the content of the Dosage.timing.	
Indicates whether the Medication is only taken when needed within a specific dosing schedule (Boolean option), or it indicates the precondition for taking the Medication (CodeableConcept).	Can express "as needed" without a reason by setting the Boolean = True. In this case the CodeableConcept is not populated. Or you can express "as needed" with a reason by including the CodeableConcept. In this case the Boolean is assumed to be True. If you set the Boolean to False, then the dose is given according to the schedule and is not "prn" or "as needed".	example
Body site to administer to.	If the use case requires attributes from the BodySite resource (e.g. to identify and track separately) then use the standard extension [bodySite](http://hl7.org/fhir/R4/extension-body-site.html). May be a summary code, or a reference to a very precise definition of the location, or both.	example

How drug should enter body.		extensible
Technique for administering medication.	Terminologies used often pre-coordinate this term with the route and or form of administration.	example
The amount of medication administered.		
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.		
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The kind of dose or rate specified, for example, ordered or calculated.		example

Amount of medication per dose.	Note that this specifies the quantity of the specified medication, not the quantity for each active ingredient(s). Each ingredient amount can be communicated in the Medication resource. For example, if one wants to communicate that a tablet was 375 mg, where the dose was one tablet, you can use the Medication resource to document that the tablet was comprised of 375 mg of drug XYZ. Alternatively if the dose was 375 mg, then you may only need to use the Medication resource to indicate this was a tablet. If the example were an IV such as dopamine and you wanted to communicate that 400mg of dopamine was mixed in 500 ml of some IV solution, then this would all be communicated in the Medication resource. If the administration is not intended to be instantaneous (rate is present or timing has a duration), this can be specified to convey the total amount to be administered over the period of time as indicated by the schedule e.g. 500 ml in dose, with timing used to convey that this should be done over 4 hours.	
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Amount of medication per unit of time.	It is possible to supply both a rate and a doseQuantity to provide full details about how the medication is to be administered and supplied. If the rate is intended to change over time, depending on local rules/regulations, each change should be captured as a new version of the MedicationRequest with an updated rate, or captured with a new MedicationRequest with the new rate. It is possible to specify a rate over time (for example, 100 ml/hour) using either the rateRatio and rateQuantity. The rateQuantity approach requires systems to have the capability to parse UCUM grammar where ml/hour is included rather than a specific ratio where the time is specified as the denominator. Where a rate such as 500ml over 2 hours is specified, the use of rateRatio may be more semantically correct than specifying using a rateQuantity of 250 mg/hour.	
Upper limit on medication per unit of time.	This is intended for use as an adjunct to the dosage when there is an upper cap. For example "2 tablets every 4 hours to a maximum of 8/day".	

Upper limit on medication per administration.	This is intended for use as an adjunct to the dosage when there is an upper cap. For example, a body surface area related dose with a maximum amount, such as 1.5 mg/m ² (maximum 2 mg) IV over 5 – 10 minutes would have doseQuantity of 1.5 mg/m ² and maxDosePerAdministration of 2 mg.	
Upper limit on medication per lifetime of the patient.		
Indicates the specific details for the dispense or medication supply part of a medication request (also known as a Medication Prescription or Medication Order). Note that this information is not always sent with the order. There may be in some settings (e.g. hospitals) institutional or system support for completing the dispense details in the pharmacy department.		
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.		

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Indicates the quantity or duration for the first dispense of the medication.	If populating this element, either the quantity or the duration must be included.	
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.		

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The amount or quantity to provide as part of the first dispense.		
The length of time that the first dispense is expected to last.		
The minimum period of time that must occur between dispenses of the medication.		

This indicates the validity period of a prescription (stale dating the Prescription).	It reflects the prescribers' perspective for the validity of the prescription. Dispenses must not be made against the prescription outside of this period. The lower-bound of the Dispensing Window signifies the earliest date that the prescription can be filled for the first time. If an upper-bound is not specified then the Prescription is open-ended or will default to a stale-date based on regulations.	
An integer indicating the number of times, in addition to the original dispense, (aka refills or repeats) that the patient can receive the prescribed medication. Usage Notes: This integer does not include the original order dispense. This means that if an order indicates dispense 30 tablets plus "3 repeats", then the order can be dispensed a total of 4 times and the patient can receive a total of 120 tablets. A prescriber may explicitly say that zero refills are permitted after the initial dispense.	If displaying "number of authorized fills", add 1 to this number.	
The amount that is to be dispensed for one fill.		

Identifies the period time over which the supplied product is expected to be used, or the length of time the dispense is expected to last.	In some situations, this attribute may be used instead of quantity to identify the amount supplied by how long it is expected to last, rather than the physical quantity issued, e.g. 90 days supply of medication (based on an ordered dosage). When possible, it is always better to specify quantity, as this tends to be more precise. expectedSupplyDuration will always be an estimate that can be influenced by external factors.	
Indicates the intended dispensing Organization specified by the prescriber.		
Indicates whether or not substitution can or should be part of the dispense. In some cases, substitution must happen, in other cases substitution must not happen. This block explains the prescriber's intent. If nothing is specified substitution may be done.		
Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.		
May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.	

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True if the prescriber allows a different drug to be dispensed from what was prescribed.	This element is labeled as a modifier because whether substitution is allow or not, it cannot be ignored.	example
Indicates the reason for the substitution, or why substitution must or must not be performed.		example
A link to a resource representing an earlier order related order or prescription.		Y

Indicates an actual or potential clinical issue with or between one or more active or proposed clinical actions for a patient; e.g. Drug-drug interaction, duplicate therapy, dosage alert etc.	This element can include a detected issue that has been identified either by a decision support system or by a clinician and may include information on the steps that were taken to address the issue.	Y
Links to Provenance records for past versions of this resource or fulfilling request or event resources that identify key state transitions or updates that are likely to be relevant to a user looking at the current version of the resource.	This might not include provenances for all versions of the request – only those deemed “relevant” or important. This SHALL NOT include the provenance associated with this current version of the resource. (If that provenance is deemed to be a “relevant” change, it will need to be added as part of a later update. Until then, it can be queried directly as the provenance that points to this version using _revinclude All Provenances should have some historical version of this Request as their subject.).	Y

Binding Description	Binding Value Set	ACH dQM
		MS [0..*]
		R [1..1]
		NRT
		NRT

CommonLanguages	https://hl7.org/fhir	NRT
		NRT

		NRT
		NRT

		NRT
		NRT

medicationrequest Status	https://hl7.org/fhir/	R [1..1]
medicationRequest Status Reason Codes	https://hl7.org/fhir/	MS[0..1]
medicationRequest Intent	https://hl7.org/fhir/	R [1..1]
medicationRequest Category Codes	https://hl7.org/fhir/	MS [0..*]

RequestPriority	https://hl7.org/fhir/	MS [0..1]
		MS [0..1]
		MS [0..1]
US Core Medication Codes (RxNorm)	http://cts.nlm.nih.gov/	R [1..1]
		R [1..1]

		MS [0..1]
		NRT
		R [1..1]
		NR
		NRT
Procedure Performer Role Codes	https://hl7.org/fhir	NRT
		NR
Condition/ Problem/Diagnosis Codes	https://hl7.org/fhir	MS [0..*]

		MS [0..*]
		MS [0..*]
		MS [0..*]
		NRT
		NRT
Medication request course of therapy codes	http://hl7.org/fhir/	MS[0..1]
		NRT
		NRT

		MS [0..*]
		NRT
		NRT

		NRT
		NRT
		MS [0..1]

A coded concept identifying additional instructions such as "take with water" or "avoid operating heavy machinery".	http://hl7.org/fhir/	NRT
		NR
		MS [0..1]
A coded concept identifying the precondition that should be met or evaluated prior to consuming or administering a medication dose. For example "pain", "30 minutes prior to sexual intercourse", "on flare-up" etc.	https://hl7.org/fhir/	MS [0..1]
A coded concept describing the site location the medicine enters into or onto the body.	https://hl7.org/fhir/	MS [0..1]

A coded concept describing the route or physiological path of administration of a therapeutic agent into or onto the body of a subject.	http://hl7.org/fhir/	R [1..1]
A coded concept describing the technique by which the medicine is administered.	http://hl7.org/fhir/	MS [0..1]
		MS [0..*]
		NRT
		NRT
The kind of dose or rate specified.	http://hl7.org/fhir/	MS [0..1]

		MS [0..1]
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ActSubstanceAdmin SubstitutionCode	https://terminology	NRT
SubstanceAdminSub stitutionReason	http://terminology	NRT
		NRT

		NRT
		NRT

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FHIR Path	Min	Max	Data Type(s)
Observation	0	*	DomainResource
Observation.id	0	1	id
Observation.meta	0	1	Meta
Observation.implicitRules	0	1	uri
Observation.language	0	1	code
Observation.text	0	1	Narrative

Observation.contained	0	*	Resource
Observation.extension	0	*	Extension

Observation.modifierExtension	0	*	Extension
Observation.identifier	0	*	Identifier
Observation.basedOn	0	*	Reference(CarePlan DeviceRequest ImmunizationRecommendation MedicationRequest NutritionOrder ServiceRequest)

Observation.partOf	0	*	Reference(MedicationAdministration MedicationDispense MedicationStatement Procedure Immunization ImagingStudy)
Observation.status	1	1	code
Observation.category	0	*	CodeableConcept
Observation.code	1	1	CodeableConcept
Observation.subject	0	1	Reference(Patient Group Device Location)

Observation.focus	0	*	Reference(Any)
Observation.encounter	0	1	Reference(Encounter)
Observation.effective[x]	0	1	dateTime Period Timing Instant

Observation.issued	0	1	instant
Observation.performer	0	*	Reference(Practitioner PractitionerRole Organization CareTeam Patient RelatedPerson)
Observation.value[x]	0	1	Quantity CodeableConcept string boolean integer Range Ratio SampledData time dateTime Period
Observation.dataAbsentReason	0	1	CodeableConcept
Observation.interpretation	0	*	CodeableConcept
Observation.note	0	*	Annotation
Observation.bodySite	0	1	CodeableConcept
Observation.method	0	1	CodeableConcept
Observation.specimen	0	1	Reference(Specimen)

Observation.device	0	1	Reference(Device DeviceMetric)
Observation.referenceRange	0	*	BackboneElement
Observation.referenceRange.id	0	1	string
Observation.referenceRange.extension	0	*	Extension

Observation.referenceRange. modifierExtension	0	*	Extension
Observation.referenceRange. low	0	1	SimpleQuantity

Observation.referenceRange. high	0	1	SimpleQuantity
Observation.referenceRange. type	0	1	CodeableConcept
Observation.referenceRange. appliesTo	0	*	CodeableConcept
Observation.referenceRange. age	0	1	Range
Observation.referenceRange. text	0	1	string

Observation.hasMember	0	*	Reference(Observation QuestionnaireResponse MolecularSequence)
Observation.derivedFrom	0	*	Reference(DocumentReference ImagingStudy Media QuestionnaireResponse Observation MolecularSequence)
Observation.component	0	*	BackboneElement
Observation.component.id	0	1	string

Observation.component.extension	0	*	Extension
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Observation.component.modifierExtension	0	*	Extension
Observation.component.code	1	1	CodeableConcept

Observation.component.value[x]	0	1	Quantity CodeableConcept string boolean integer Range Ratio SampledData time dateTime Period
Observation.component.dataAbsentReason	0	1	CodeableConcept
Observation.component.interpretation	0	*	CodeableConcept
Observation.component.referenceRange	0	*	

FHIR Short Description	FHIR Definition	Binding Strength
Measurements and simple assertions	Measurements and simple assertions made about a patient, device or other subject.	
Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	
Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.	
A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	
Language of the resource content	The base language in which the resource is written.	preferred but limited to AllLanguages
Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.	

Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Business Identifier for observation	A unique identifier assigned to this observation.	
Fulfills plan, proposal or order	A plan, proposal or order that is fulfilled in whole or in part by this event. For example, a MedicationRequest may require a patient to have laboratory test performed before it is dispensed.	

Part of referenced event	A larger event of which this particular Observation is a component or step. For example, an observation as part of a procedure.	
registered preliminary final amended +	The status of the result value.	required
Classification of type of observation	A code that classifies the general type of observation being made.	preferred
Type of observation (code / type)	Describes what was observed. Sometimes this is called the observation "name".	extensible
Who and/or what the observation is about	The patient, or group of patients, location, or device this observation is about and into whose record the observation is placed. If the actual focus of the observation is different from the subject (or a sample of, part, or region of the subject), the `focus` element or the `code` itself specifies the actual focus of the observation.	

What the observation is about, when it is not about the subject of record	The actual focus of an observation when it is not the patient of record representing something or someone associated with the patient such as a spouse, parent, fetus, or donor. For example, fetus observations in a mother's record. The focus of an observation could also be an existing condition, an intervention, the subject's diet, another observation of the subject, or a body structure such as tumor or implanted device. An example use case would be using the Observation resource to capture whether the mother is trained to change her child's tracheostomy tube. In this example, the child is the patient of record and the mother is the focus.	
Healthcare event during which this observation is made	The healthcare event (e.g. a patient and healthcare provider interaction) during which this observation is made.	
Clinically relevant time/time-period for observation	The time or time-period the observed value is asserted as being true. For biological subjects - e.g. human patients - this is usually called the "physiologically relevant time". This is usually either the time of the procedure or of specimen collection, but very often the source of the date/time is not known, only the date/time itself.	

Date/Time this version was made available	The date and time this version of the observation was made available to providers, typically after the results have been reviewed and verified.	
Who is responsible for the observation	Who was responsible for asserting the observed value as "true".	
Actual result	The information determined as a result of making the observation, if the information has a simple value.	
Why the result is missing	Provides a reason why the expected value in the element Observation.value[x] is missing.	extensible
High, low, normal, etc.	A categorical assessment of an observation value. For example, high, low, normal.	extensible
Comments about the observation	Comments about the observation or the results.	
Observed body part	Indicates the site on the subject's body where the observation was made (i.e. the target site).	extensible
How it was done	Indicates the mechanism used to perform the observation.	extensible
Specimen used for this observation	The specimen that was used when this observation was made.	

(Measurement) Device	The device used to generate the observation data.	
Provides guide for interpretation + <i>Rule: Must have at least a low or a high or text</i>	Guidance on how to interpret the value by comparison to a normal or recommended range. Multiple reference ranges are interpreted as an "OR". In other words, to represent two distinct target populations, two `referenceRange` elements would be used.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Low Range, if relevant	The value of the low bound of the reference range. The low bound of the reference range endpoint is inclusive of the value (e.g. reference range is ≥ 5 - ≤ 9). If the low bound is omitted, it is assumed to be meaningless (e.g. reference range is ≤ 2.3).	

High Range, if relevant	The value of the high bound of the reference range. The high bound of the reference range endpoint is inclusive of the value (e.g. reference range is ≥ 5 - ≤ 9). If the high bound is omitted, it is assumed to be meaningless (e.g. reference range is ≥ 2.3).	
Reference range qualifier	Codes to indicate the what part of the targeted reference population it applies to. For example, the normal or therapeutic range.	preferred
Reference range population	Codes to indicate the target population this reference range applies to. For example, a reference range may be based on the normal population or a particular sex or race. Multiple `appliesTo` are interpreted as an "AND" of the target populations. For example, to represent a target population of African American females, both a code of female and a code for African American would be used.	example
Applicable age range, if relevant	The age at which this reference range is applicable. This is a neonatal age (e.g. number of weeks at term) if the meaning says so.	
Text based reference range in an observation	Text based reference range in an observation which may be used when a quantitative range is not appropriate for an observation. An example would be a reference value of "Negative" or a list or table of "normals".	

Related resource that belongs to the Observation group	This observation is a group observation (e.g. a battery, a panel of tests, a set of vital sign measurements) that includes the target as a member of the group.	
Related measurements the observation is made from	The target resource that represents a measurement from which this observation value is derived. For example, a calculated anion gap or a fetal measurement based on an ultrasound image.	
Component results	Some observations have multiple component observations. These component observations are expressed as separate code value pairs that share the same attributes. Examples include systolic and diastolic component observations for blood pressure measurement and multiple component observations for genetics observations.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	

Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
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Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Type of component observation (code / type)	Describes what was observed. Sometimes this is called the observation "code".	extensible

Actual component result	The information determined as a result of making the observation, if the information has a simple value.	
Why the component result is missing	Provides a reason why the expected value in the element Observation.component.value[x] is missing.	extensible
High, low, normal, etc.	A categorical assessment of an observation value. For example, high, low, normal.	extensible
Provides guide for interpretation of component result	Guidance on how to interpret the value by comparison to a normal or recommended range.	

Binding Description (Value Set Name)	Binding Value Set	ACH dQM
		MS [0..*]
		R[1..1]
		NRT
		NRT
CommonLanguages	https://hl7.org/fhir/R4/valueset-	NRT
		NRT

		NRT
		NRT

		NRT
		NRT
		NRT

		MS[0..*]
ObservationStatus	https://hl7.org/fhir/R4/valueset-	R [1..1]
ObservationCategoryCodes	https://hl7.org/fhir/R4/valueset-	R [1..*] CQL constrains to these Categories: Social-history, vital-signs, imaging, laboratory, procedure, survey
LOINCCodes	https://hl7.org/fhir/R4/valueset-	R [1..1]
		R [1..1]

		NR
		MS [0..1]
		R [1..1]

		MS [0..1]
		NR
		MS [0..1]
DataAbsentReason	https://hl7.org/fhir/R4/valueset-	NR
ObservationInterpretationCodes	https://hl7.org/fhir/R4/valueset-	MS [0..*]
		NR
SNOMEDCTBodyStructures	https://hl7.org/fhir/R4/valueset-	MS [0..1]
ObservationMethods	https://hl7.org/fhir/R4/valueset-	MS [0..1]
		NR

		NR
		MS[0..*]
		NRT
		NRT

		NRT
		MS [0..1]

		MS [0..1]
ObservationReferenceRangeMeaningCodes	https://hl7.org/fhir/R4/valueset-	NR
ObservationReferenceRangeAppliesToCodes	https://hl7.org/fhir/R4/valueset-	NR
		MS [0..1]
		NR

		MS [0..*]
		NR
		MS [0..*]
		NRT

		NRT
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		NRT
LOINCCodes	https://hl7.org/fhir/R4/valueset-	R [1..1]

		MS [0..1]
DataAbsentReason	https://hl7.org/fhir/R4/valueset-	NR
ObservationInterpretationCodes	https://hl7.org/fhir/R4/valueset-	MS [0..*]
		MS [0..*]

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FHIR Path	Min	Max	Must Support?	Data Type(s)
Observation	0	*		DomainResource
Observation.id	0	1		id
Observation.meta	0	1		Meta
Observation.implicitRules	0	1		uri
Observation.language	0	1		code

Observation.text	0	1		Narrative
Observation.contained	0	*		Resource
Observation.extension	0	*		Extension

Observation.modifierExtension	0	*		Extension
Observation.identifier	0	*		Identifier
Observation.basedOn	0	*		Reference(CarePlan DeviceRequest ImmunizationRecommendation MedicationRequest NutritionOrder ServiceRequest)

Observation.partOf	0	*		Reference(MedicationAdministration MedicationDispense MedicationStatement Procedure Immunization ImagingStudy)
Observation.status	1	1	Y	code
Observation.category	1	*	Y	CodeableConcept
Observation.category(VSCat)	1	1	Y	CodeableConcept
Observation.category.id	0	1		string

Observation.category.extension	0	*		extension
Observation.category.coding	1	*	Y	coding
Observation.category.coding.id	0	1	Y	string
Observation.category.coding.extension	0	*		extension
Observation.category.coding.system	1	1	Y	uri

Observation.category.coding.version	0	1		string
Observation.category.coding.code	1	1	Y	code
Observation.category.coding.display	0	1		string
Observation.category.coding.userSelected	0	1		boolean
Observation.category.text	0	1		string

Observation.code	1	1	Y	CodeableConcept
Observation.subject	1	1	Y	Reference(Patient Group Device Location)
Observation.focus	0	*		Reference(Any)

Observation.encounter	0	1		Reference(Encounter)
Observation.effective[x]	1	1	Y	dateTime Period Timing Instant
Observation.issued	0	1		instant
Observation.performer	0	*		Reference(Practitioner PractitionerRole Organization CareTeam Patient RelatedPerson)
Observation.value[x]	0	1	Y	Quantity CodeableConcept string boolean integer Range Ratio SampledData time dateTime Period

Observation.dataAbsentReason	0	1	Y	CodeableConcept
Observation.interpretation	0	*		CodeableConcept
Observation.note	0	*		Annotation
Observation.bodySite	0	1		CodeableConcept
Observation.method	0	1		CodeableConcept
Observation.specimen	0	1		Reference(Specimen)
Observation.device	0	1		Reference(Device DeviceMetric)
Observation.referenceRange	0	*		BackboneElement
Observation.referenceRange.id	0	1		string

Observation.referenceRange.extension	0	*		Extension
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Observation.referenceRange.modifier Extension	0	*		Extension
Observation.referenceRange.low	0	1		SimpleQuantity

Observation.referenceRange.high	0	1		SimpleQuantity
Observation.referenceRange.type	0	1		CodeableConcept
Observation.referenceRange.appliesTo	0	*		CodeableConcept
Observation.referenceRange.age	0	1		Range
Observation.referenceRange.text	0	1		string

Observation.hasMember	0	*		Reference(Observation QuestionnaireResponse MolecularSequence)
Observation.derivedFrom	0	*		Reference(DocumentReference ImagingStudy Media QuestionnaireResponse Observation MolecularSequence)
Observation.component	0	*	Y	BackboneElement
Observation.component.id	0	1		string

Observation.component.extension	0	*		Extension
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Observation.component.modifierExtension	0	*		Extension
Observation.component.code	1	1	Y	CodeableConcept

Observation.component.value[x]	0	1	Y	Quantity CodeableConcept string boolean integer Range Ratio SampledData time dateTime Period
Observation.component.dataAbsentReason	0	1	Y	CodeableConcept
Observation.component.interpretation	0	*		CodeableConcept
Observation.component.referenceRange	0	*		
Observation.component.referenceRange.low	0	1		SimpleQuantity
Observation.component.referenceRange.high	0	1		SimpleQuantity

Observation.component.referenceRange.type	0	1		CodeableConcept
Observation.component.referenceRange.appliesTo	0	*		CodeableConcept
Observation.component.referenceRange.age	0	1		Range
Observation.component.referenceRange.text	0	1		String

FHIR Short Description	FHIR Definition	Binding Strength	Binding Description (Value Set Name)
Measurements and simple assertions	Measurements and simple assertions made about a patient, device or other subject.		
Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.		
Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.		
A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.		
Language of the resource content	The base language in which the resource is written.	preferred but limited to AllLanguages	CommonLanguages

Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.		
Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.		
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.		

Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).		
Business Identifier for observation	A unique identifier assigned to this observation.		
Fulfills plan, proposal or order	A plan, proposal or order that is fulfilled in whole or in part by this event. For example, a MedicationRequest may require a patient to have laboratory test performed before it is dispensed.		

Part of referenced event	A larger event of which this particular Observation is a component or step. For example, an observation as part of a procedure.		
registered preliminary final amended +	The status of the result value.	required	ObservationStatus
Classification of type of observation	A code that classifies the general type of observation being made.	preferred	ObservationCategoryCodes
	A code that classifies the general type of observation being made	preferred	
	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.		

	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set		
	A reference to a code defined by a terminology system.		
	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.		
	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of		
	The identification of the code system that defines the meaning of the symbol in the code.		

	The version of the code system which was used when choosing this code. Note that a well-maintained code system does not need the version reported, because the meaning of codes is consistent across versions. However this cannot consistently be assured, and when the meaning is not guaranteed to be consistent, the version SHOULD be exchanged.		
	A symbol in syntax defined by the system. The symbol may be a predefined code or an expression in a syntax defined by the coding system (e.g. post-coordination).		
	A representation of the meaning of the code in the system, following the rules of the system.		
	Indicates that this coding was chosen by a user directly - e.g. off a pick list of available items (codes or displays).		
	A human language representation of the concept as seen/selected/uttered by the user who entered the data and/or which represents the intended meaning of the user.		

Type of observation (code / type)	Describes what was observed. Sometimes this is called the observation "name".	extensible	LOINCCodes
Who and/or what the observation is about	The patient, or group of patients, location, or device this observation is about and into whose record the observation is placed. If the actual focus of the observation is different from the subject (or a sample of, part, or region of the subject), the `focus` element or the `code` itself specifies the actual focus of the observation.		
What the observation is about, when it is not about the subject of record	The actual focus of an observation when it is not the patient of record representing something or someone associated with the patient such as a spouse, parent, fetus, or donor. For example, fetus observations in a mother's record. The focus of an observation could also be an existing condition, an intervention, the subject's diet, another observation of the subject, or a body structure such as tumor or implanted device. An example use case would be using the Observation resource to capture whether the mother is trained to change her child's tracheostomy tube. In this example, the child is the patient of record and the mother is the focus.		

Healthcare event during which this observation is made	The healthcare event (e.g. a patient and healthcare provider interaction) during which this observation is made.		
Clinically relevant time/time-period for observation	The time or time-period the observed value is asserted as being true. For biological subjects - e.g. human patients - this is usually called the "physiologically relevant time". This is usually either the time of the procedure or of specimen collection, but very often the source of the date/time is not known, only the date/time itself.		
Date/Time this version was made available	The date and time this version of the observation was made available to providers, typically after the results have been reviewed and verified.		
Who is responsible for the observation	Who was responsible for asserting the observed value as "true".		
Actual result *Vital Signs value are recorded using the Quantity data type. For supporting observations such as Cuff size could use other datatypes such as CodeableConcept.	The information determined as a result of making the observation, if the information has a simple value.		

Why the result is missing	Provides a reason why the expected value in the element Observation.value[x] is missing.	extensible	DataAbsentReason
High, low, normal, etc.	A categorical assessment of an observation value. For example, high, low, normal.	extensible	ObservationInterpretationCodes
Comments about the observation	Comments about the observation or the results.		
Observed body part	Indicates the site on the subject's body where the observation was made (i.e. the target site).	extensible	SNOMEDCTBodyStructures
How it was done	Indicates the mechanism used to perform the observation.	extensible	ObservationMethods
Specimen used for this observation	The specimen that was used when this observation was made.		
(Measurement) Device	The device used to generate the observation data.		
Provides guide for interpretation + <i>Rule: Must have at least a low or a high or text</i>	Guidance on how to interpret the value by comparison to a normal or recommended range. Multiple reference ranges are interpreted as an "OR". In other words, to represent two distinct target populations, two `referenceRange` elements would be used.		
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.		

Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.		
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Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).		
Low Range, if relevant	The value of the low bound of the reference range. The low bound of the reference range endpoint is inclusive of the value (e.g. reference range is ≥ 5 - ≤ 9). If the low bound is omitted, it is assumed to be meaningless (e.g. reference range is ≤ 2.3).		

High Range, if relevant	The value of the high bound of the reference range. The high bound of the reference range endpoint is inclusive of the value (e.g. reference range is ≥ 5 - ≤ 9). If the high bound is omitted, it is assumed to be meaningless (e.g. reference range is ≥ 2.3).		
Reference range qualifier	Codes to indicate the what part of the targeted reference population it applies to. For example, the normal or therapeutic range.	preferred	ObservationReferenceRangeMeaningCodes
Reference range population	Codes to indicate the target population this reference range applies to. For example, a reference range may be based on the normal population or a particular sex or race. Multiple `appliesTo` are interpreted as an "AND" of the target populations. For example, to represent a target population of African American females, both a code of female and a code for African American would be used.	example	ObservationReferenceRangeAppliesToCodes
Applicable age range, if relevant	The age at which this reference range is applicable. This is a neonatal age (e.g. number of weeks at term) if the meaning says so.		
Text based reference range in an observation	Text based reference range in an observation which may be used when a quantitative range is not appropriate for an observation. An example would be a reference value of "Negative" or a list or table of "normals".		

Related resource that belongs to the Observation group	This observation is a group observation (e.g. a battery, a panel of tests, a set of vital sign measurements) that includes the target as a member of the group.		
Related measurements the observation is made from	The target resource that represents a measurement from which this observation value is derived. For example, a calculated anion gap or a fetal measurement based on an ultrasound image.		
Component results *Used when reporting systolic and diastolic blood pressure. vs-3: If there is no a value a data absent reason must be present	Some observations have multiple component observations. These component observations are expressed as separate code value pairs that share the same attributes. Examples include systolic and diastolic component observations for blood pressure measurement and multiple component observations for genetics observations.		
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.		

Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.		
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Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).		
Type of component observation (code / type)	Describes what was observed. Sometimes this is called the observation "code".	extensible	LOINCCodes

Actual component result	The information determined as a result of making the observation, if the information has a simple value.	required	
Why the component result is missing	Provides a reason why the expected value in the element Observation.component.value[x] is missing.	extensible	DataAbsentReason
High, low, normal, etc.	A categorical assessment of an observation value. For example, high, low, normal.	extensible	ObservationInterpretationCodes
Provides guide for interpretation of component result	Guidance on how to interpret the value by comparison to a normal or recommended range.		
Low Range, if relevant	The value of the low bound of the reference range. The low bound of the reference range endpoint is inclusive of the value (e.g. reference range is $\geq 5 - \leq 9$). If the low bound is omitted, it is assumed to be meaningless (e.g. reference range is ≤ 2.3).		
High Range, if relevant	The value of the high bound of the reference range. The high bound of the reference range endpoint is inclusive of the value (e.g. reference range is $\geq 5 - \leq 9$). If the high bound is omitted, it is assumed to be meaningless (e.g. reference range is ≥ 2.3).		

Reference range qualifier	Codes to indicate the what part of the targeted reference population it applies to. For example, the normal or therapeutic range.	Preferred	ObservationReferenceRangeMeaningCodes
Reference range population	Codes to indicate the what part of the targeted reference population it applies to. For example, the normal or therapeutic range.	Example	ObservationReferenceRangeAppliesToCodes
Applicable age range, if relevant	The age at which this reference range is applicable. This is a neonatal age (e.g. number of weeks at term) if the meaning says so.		
Text based reference range in an observation	Text based reference range in an observation which may be used when a quantitative range is not appropriate for an observation. An example would be a reference value of "Negative" or a list or table of "normals".		

Binding Value Set	ACH dQM
	MS [0..*]
	R[1..1]
	NRT
	NRT
https://hl7.org/fhir/R4/valueset-	NRT

	NRT
	NRT
	NRT

	NRT
	NRT
	NRT

	MS[0..*]
https://hl7.org/fhir/R4/valueset-	R [1..1]
	R [1..*]
	R [1..1]
	NRT

	NRT
	R[1..*]
	NRT
	NRT
https://hl7.org/fhir/R4/valueset-	R[1..1]

	NR
	R[1..1]
	NR
	NR
	NR

http://hl7.org/fhir/R4/valueset-o	R [1..1]
	R [1..1]
	NR

	MS [0..1]
	R [1..1]
	MS [0..1]
	NR
	MS [0..1]

https://hl7.org/fhir/R4/valueset-	NR
https://hl7.org/fhir/R4/valueset-	MS [0..*]
	NR
https://hl7.org/fhir/R4/valueset-	MS [0..1]
https://hl7.org/fhir/R4/valueset-	MS [0..1]
	NR
	NR
	MS[0..*]
	NRT

	NRT
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	NRT
	MS [0..1]

	MS [0..1]
hl7.org/fhir/R4/valueset-referen	NR
https://hl7.org/fhir/R4/valueset-	NR
	MS [0..1]
	NR

	MS [0..*]
	NR
	MS [0..*]
	NRT

	NRT
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	NRT
https://hl7.org/fhir/R4/valueset-	R [1..1]

https://hl7.org/fhir/R4/valueset-	MS [0..1]
https://hl7.org/fhir/R4/valueset-	NR
https://hl7.org/fhir/R4/valueset-	MS [0..*]
	MS [0..*]
	MS[0..1]
	MS[0..1]

https://hl7.org/fhir/R4/valueset-referencerange-meaning.html	NR
https://hl7.org/fhir/R4/valueset-	NR
	MS[0..1]
	NR

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FHIR Path	Min	Max	Must Support?	Data Type(s)
Patient	0	*		
Patient.id	0	1		string
Patient.meta	0	1		Meta
Patient.implicitRules	0	1		uri
Patient.language	0	1		code
Patient.text	0	1		Narrative

Patient.contained	0	*		Resource
Patient.extension	0	*		Extension

Patient.extension (race)	0	1	Y	(Complex) optional 'ombCategory', optional 'detailed' and a required 'text'. - 'ombCategory' component is optional, but allows for up to 5 races from ombCategory-race ValueSet (note this is denoted by the 0..5 cardinality on the 3.1.1 definition of us-core-race - o When present, the structure will always following a 'coding' datatype, as denoted by 'valueCoding' - 'detailed' component is also optional, but may be present an infinite number of times, each 'detailed' containing one of the 917 race codes - o When present, the structure will always following a 'coding' datatype, as denoted by 'valueCoding' - 'text' as required is required to be present, but there are no rules around this data beyond it'll be a string (ie it likely will be some combination of ombCategory and/or 'detailed', if
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Patient.extension (ethnicity)	0	1	Y	(Complex)
Patient.extension (sex at birth)	0	1	Y	code
Patient.extension (gender identity)	0	1		Extension {http://hl7.org/fhir/ us/core/StructureD efinition/us-core- genderIdentity}

Patient.modifierExtension	0	*		Extension
Patient.identifier	1	*	Y	Identifier
Patient.identifier.id	0	1		string
Patient.identifier.extension	0	*		Extension
Patient.identifier.use	0	1		code

Patient.identifier.type	0	1		CodeableConcept
Patient.identifier.system	1	1	Y	uri
Patient.identifier.value	1	1	Y	string
Patient.identifier.period	0	1		Period
Patient.identifier.assigner	0	1		Reference(Organization)
Patient.active	0	1		boolean
Patient.name	1	*	Y	HumanName
Patient.name.id	0	1		string

Patient.name.extension	0	*		Extension
Patient.name.use	0	1		code
Patient.name.text	0	1		string
Patient.name.family	0	1	Y	string
Patient.name.given	0	*	Y	string
Patient.name.prefix	0	*		string
Patient.name.suffix	0	*		string
Patient.name.period	0	1		Period

Patient.telecom	0	*	Y	ContactPoint
Patient.telecom.id	0	1		string
Patient.telecom.extension	0	*		Extension
Patient.telecom.system	1	1	Y	code
Patient.telecom.value	1	1	Y	string
Patient.telecom.use	0	1	Y	code
Patient.telecom.rank	0	1		positiveInt
Patient.telecom.period	0	1		Period
Patient.gender	1	1	Y	code
Patient.birthDate	0	1	Y	date
Patient.deceased[x]	0	1		boolean dateTime

Patient.address	0	*	Y	Address
Patient.address.id	0	1		string
Patient.address.extension	0	*		Extension
Patient.address.use	0	1		code
Patient.address.type	0	1		code
Patient.address.text	0	1		string
Patient.address.line	0	*	Y	string
Patient.address.city	0	1	Y	string
Patient.address.district	0	1		string

Patient.address.state	0	1	Y	string
Patient.address.postalCode	0	1	Y	string
Patient.address.country	0	1		string
Patient.address.period	0	1	Y	Period
Patient.maritalStatus	0	1		CodeableConcept
Patient.multipleBirth[x]	0	1		boolean integer
Patient.photo	0	*		Attachment
Patient.contact	0	*		BackboneElement
Patient.contact.id	0	1		string
Patient.contact.extension	0	*		Extension

Patient.contact.modifierExtension	0	*		Extension
Patient.contact.relationship	0	*		CodeableConcept
Patient.contact.name	0	1		HumanName
Patient.contact.telecom	0	*		ContactPoint
Patient.contact.address	0	1		Address
Patient.contact.gender	0	1		code
Patient.contact.organization	0	1		Reference(Organization)

Patient.contact.period	0	1		Period
Patient.communication	0	*	Y	BackboneElement
Patient.communication.id	0	1		string
Patient.communication.extension	0	*		Extension

Patient.communication.modifierExtension	0	*		Extension
Patient.communication.language	1	1	Y	CodeableConcept
Patient.communication.preferred	0	1		boolean
Patient.generalPractitioner	0	*		Reference(Organization Practitioner PractitionerRole)
Patient.managingOrganization	0	1		Reference(Organization)

Patient.link	0	*		BackboneElement
Patient.link.id	0	1		string
Patient.link.extension	0	*		Extension
Patient.link.modifierExtension	0	*		Extension

Patient.link.other	1	1		Reference(Patient RelatedPerson)
Patient.link.type	1	1		code

FHIR Short Description	FHIR Definition	Binding Strength
Information about an individual or animal receiving health care services	The US Core Patient Profile is based upon the core FHIR Patient Resource and designed to meet the applicable patient demographic data elements from the 2015 Edition Common Clinical Data Set.	
Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	
Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.	
A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	
Language of the resource content	The base language in which the resource is written.	preferred
Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.	

Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.	
Extension	An Extension	

US Core Race Extension	Concepts classifying the person into a named category of humans sharing common history, traits, geographical origin or nationality. The race codes used to represent these concepts are based upon the [CDC Race and Ethnicity Code Set Version 1.0](http://www.cdc.gov/phn/resources/vocabulary/index.html) which includes over 900 concepts for representing race and ethnicity of which 921 reference race. The race concepts are grouped by and pre-mapped to the 5 OMB race categories: - American Indian or Alaska Native - Asian - Black or African American - Native Hawaiian or Other Pacific Islander - White.	
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US Core ethnicity Extension	Concepts classifying the person into a named category of humans sharing common history, traits, geographical origin or nationality. The ethnicity codes used to represent these concepts are based upon the [CDC ethnicity and Ethnicity Code Set Version 1.0](http://www.cdc.gov/phn/resources/vocabulary/index.html) which includes over 900 concepts for representing race and ethnicity of which 43 reference ethnicity. The ethnicity concepts are grouped by and pre-mapped to the 2 OMB ethnicity categories: - Hispanic or Latino - Not Hispanic or Latino.	
Extension	A code classifying the person's sex assigned at birth as specified by the [Office of the National Coordinator for Health IT (ONC)](https://www.healthit.gov/newsroom/about-onc).	required
Extension	An Extension	

Extensions that cannot be ignored	May be used to <i>represent additional information that is not part of the basic definition of the resource</i> and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
An identifier for this patient	An identifier for this patient.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
usual official temp secondary old (If known)	The purpose of this identifier.	required

Description of identifier	A coded type for the identifier that can be used to determine which identifier to use for a specific purpose.	extensible
The namespace for the identifier value Example General: http://www.acme.com/identifiers/patient	Establishes the namespace for the value - that is, a URL that describes a set values that are unique.	
The value that is unique within the system.	The portion of the identifier typically relevant to the user and which is unique within the context of the system.	
Time period when id is/was valid for use	Time period during which identifier is/was valid for use.	
Organization that issued id (may be just text)	Organization that issued/manages the identifier.	
Whether this patient's record is in active use	Whether this patient record is in active use. Many systems use this property to mark as non-current patients, such as those that have not been seen for a period of time based on an organization's business rules. It is often used to filter patient lists to exclude inactive patients Deceased patients may also be marked as inactive for the same reasons, but may be active for some time after death.	
A name associated with the patient us-core-8: Either Patient.name.given and/or Patient.name.family SHALL be present or a Data Absent Reason Extension SHALL be present.	A name associated with the individual.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	

Additional content defined by implementations	May be <i>used to represent additional information that is not part of the basic definition of the element.</i> To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
usual official temp nickname anonymous old maiden	Identifies the purpose for this name.	required
Text representation of the full name	Specifies the entire name as it should be displayed e.g. on an application UI. This may be provided instead of or as well as the specific parts.	
Family name (often called 'Surname')	The part of a name that links to the genealogy. In some cultures (e.g. Eritrea) the family name of a son is the first name of his father.	
Given names (not always 'first'). Includes middle names This repeating element order: Given Names appear in the correct order for presenting the name	Given name.	
Parts that come before the name This repeating element order: Prefixes appear in the correct order for presenting the name	Part of the name that is acquired as a title due to academic, legal, employment or nobility status, etc. and that appears at the start of the name.	
Parts that come after the name This repeating element order: Suffixes appear in the correct order for presenting the name	Part of the name that is acquired as a title due to academic, legal, employment or nobility status, etc. and that appears at the end of the name.	
Time period when name was/is in use	Indicates the period of time when this name was valid for the named person.	

A contact detail for the individual	A contact detail (e.g. a telephone number or an email address) by which the individual may be contacted.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
phone fax email pager url sms other	Telecommunications form for contact point - what communications system is required to make use of the contact.	required
The actual contact point details	The actual contact point details, in a form that is meaningful to the designated communication system (i.e. phone number or email address).	
home work temp old mobile - purpose of this contact point	Identifies the purpose for the contact point.	required
Specify preferred order of use (1 = highest)	Specifies a preferred order in which to use a set of contacts. ContactPoints with lower rank values are more preferred than those with higher rank values.	
Time period when the contact point was/is in use	Time period when the contact point was/is in use.	
male female other unknown	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	required
The date of birth for the individual	The date of birth for the individual.	
Indicates if the individual is deceased or not	Indicates if the individual is deceased or not.	

An address for the individual	An address for the individual.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be <i>used to represent additional information that is not part of the basic definition of the element.</i> To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
home work temp old billing - purpose of this address	The purpose of this address.	required
home postal physical both	Distinguishes between physical addresses (those you can visit) and mailing addresses (e.g. PO Boxes and care-of addresses). Most addresses are both.	required
Text representation of the address	Specifies the entire address as it should be displayed e.g. on a postal label. This may be provided instead of or as well as the specific parts.	
Street name, number, direction & P.O. Box etc. This repeating element order: The order in which lines should appear in an address label	This component contains the house number, apartment number, street name, street direction, P.O. Box number, delivery hints, and similar address information.	
Name of city, town etc.	The name of the city, town, suburb, village or other community or delivery center.	
District name (aka county)	The name of the administrative area (county).	

Sub-unit of country (abbreviations ok)	Sub-unit of a country with limited sovereignty in a federally organized country. A code may be used if codes are in common use (e.g. US 2 letter state codes).	extensible
US Zip Codes	A postal code designating a region defined by the postal service.	
Country (e.g. can be ISO 3166 2 or 3 letter code)	Country - a nation as commonly understood or generally accepted.	
Time period when address was/is in use	Time period when address was/is in use.	
Marital (civil) status of a patient	This field contains a patient's most recent marital (civil) status.	extensible
Whether patient is part of a multiple birth	Indicates whether the patient is part of a multiple (boolean) or indicates the actual birth order (integer).	
Image of the patient	Image of the patient.	
A contact party (e.g. guardian, partner, friend) for the patient	A contact party (e.g. guardian, partner, friend) for the patient.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be <i>used to represent additional information that is not part of the basic definition of the element.</i> To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
The kind of relationship	The nature of the relationship between the patient and the contact person.	extensible
A name associated with the contact person	A name associated with the contact person.	
A contact detail for the person	A contact detail for the person, e.g. a telephone number or an email address.	
Address for the contact person	Address for the contact person.	
male female other unknown	Administrative Gender - the gender that the contact person is considered to have for administration and record keeping purposes.	required
Organization that is associated with the contact	Organization on behalf of which the contact is acting or for which the contact is working.	

The period during which this contact person or organization is valid to be contacted relating to this patient	The period during which this contact person or organization is valid to be contacted relating to this patient.	
A language which may be used to communicate with the patient about his or her health	A language which may be used to communicate with the patient about his or her health.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
The language which can be used to communicate with the patient about his or her health	The ISO-639-1 alpha 2 code in lower case for the language, optionally followed by a hyphen and the ISO-3166-1 alpha 2 code for the region in upper case; e.g. "en" for English, or "en-US" for American English versus "en-EN" for England English.	extensible
Language preference indicator	Indicates whether or not the patient prefers this language (over other languages he masters up a certain level).	
Patient's nominated primary care provider	Patient's nominated care provider.	
Organization that is the custodian of the patient record	Organization that is the custodian of the patient record.	

Link to another patient resource that concerns the same actual person	Link to another patient resource that concerns the same actual patient.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to <i>represent additional information that is not part of the basic definition of the element.</i> To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
Extensions that cannot be ignored even if unrecognized	May be used to <i>represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element</i> in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	

The other patient or related person resource that the link refers to	The other patient resource that the link refers to.	
replaced-by replaces refer seealso	The type of link between this patient resource and another patient resource.	required

Binding Description	Binding Value Set	ACH dQM (cross-setting for all measures)
		R [1..1]
		R [1..1]
		NRT
		NRT
A human language.	http://hl7.org/fhir/ValueSet/languages	NRT
		NRT

		NRT
		NR

US Core Race Extension	http://hl7.org/fhir/us/core/StructureDefinition/us-core-race	MS[0...*]
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US Core ethnicity Extension	http://hl7.org/fhir/us/core/StructureDefinition/us-core-ethnicity	MS[0..*]
Birth Sex	http://hl7.org/fhir/us/core/StructureDefinition/us-core-birthsex	MS [0..1]
		MS [0.. *]

		NRT
		R [1..*]
		NR
		NR
Identifier Use	https://hl7.org/fhir/R4/valueset	MS[0..1]

Identifier Type Codes	https://hl7.org/fhir/R4/valueset	MS[0..1]
		NR
		R [1..1]
		MS [0..1]
		NR
		NR
		R [1..*]
		NR

		NR
NameUse	https://hl7.org/fhir/R4/valueset	MS[0..1]
		MS[0..1]
		MS[0..1]
		MS[0..*]
		MS[0..*]
		MS[0..*]
		MS[0..1]

		MS[0..*]
		NRT
		NRT
ContactPointSystem	https://hl7.org/fhir/R4/valueset	R [1..1]
		R [1..1]
ContactPointUse	https://hl7.org/fhir/R4/valueset	MS[0..1]
		MS[0..1]
		MS[0..1]
AdministrativeGender	https://hl7.org/fhir/R4/valueset	R [1..1]
		R [1..1]
		MS[0..1]

		MS[0..*]
		NR
		NR
AddressUse	https://hl7.org/fhir/R4/valueset	MS[0..1]
AddressType	https://hl7.org/fhir/R4/valueset	MS[0..1]
		MS[0..1]
		MS[0..*]
		MS[0..1]
		MS[0..1]

USPS Two Letter Alphabetic Codes	https://hl7.org/fhir/us/core/STU	MS[0..1]
		MS[0..1]
		MS[0..1]
		MS[0..1]
Marital Status Codes	https://hl7.org/fhir/R4/valueset	NR
		NR
		NR
		MS[0..*]
		NR
		NR

		NRT
The nature of the relationship between a patient and a contact person for that patient.	https://hl7.org/fhir/R4/valueset	MS[0..*]
		MS[0..1]
		MS[0..*]
		MS[0..1]
The gender of a person used for administrative purposes.	https://hl7.org/fhir/R4/valueset	NR
		NR

		MS[0..1)
		MS[0..*]
		NR
		NR

		NRT
	https://hl7.org/fhir/us/core/STU	R [1..1]
		MS[0..1]
		NR
		NR

		MS[0..*]
		MS [0..*]
		MS [0..*]
		MS [0..*]

		R [1..1]
LinkType	https://hl7.org/fhir/R4/valueset	R [1..1]

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FHIR Path	Min	Max	Must Support?	Data Type(s)
Procedure	0	*		
Procedure.id	0	1		string
Procedure.meta	0	1		Meta

Procedure.implicitRules	0	1		uri
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Procedure.language	0	1		code
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Procedure.text	0	1		Narrative
Procedure.contained	0	*		Resource

Procedure.extension	0	*		Extension
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Procedure.modifierExtension	0	*		Extension
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Procedure.identifier	0	*		Identifier
Procedure.instantiatesCanonical	0	*		canonical(PlanDefinition ActivityDefinition Measure OperationDefinition Questionnaire)
Procedure.instantiatesUri	0	*		uri
Procedure.basedOn	0	*		Reference(CarePlan ServiceRequest)

Procedure.partOf	0	*		Reference(Procedure Observation MedicationAdministration)
Procedure.status	1	1	Y	code

Procedure.statusReason	0	1		CodeableConcept
Procedure.category	0	1		CodeableConcept
Procedure.code	1	1	Y	CodeableConcept
Procedure.subject	1	1	Y	Reference(http://hl7.org/fhir/us/core/StructureDefinition/us-core-patient)
Procedure.encounter	0	1		Reference(Encounter)

Procedure.performed[x]	1	1	Y	dateTime Period string Age Range
Procedure.recorder	0	1		Reference(Patient RelatedPerson Practitioner PractitionerRole)
Procedure.asserter	0	1		Reference(Patient RelatedPerson Practitioner PractitionerRole)
Procedure.performer	0	*		BackboneElement
Procedure.performer.id	0	1		string

Procedure.performer.extension	0	*		Extension
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Procedure.performer.modifierExtension	0	*		Extension
Procedure.performer.function	0	1		CodeableConcept
Procedure.performer.actor	1	1		Reference(Practitioner PractitionerRole Organization Patient RelatedPerson Device)

Procedure.performer.onBehalfOf	0	1		Reference(Organization)
Procedure.location	0	1		Reference(Location)

Procedure.reasonCode	0	*		CodeableConcept
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Procedure.reasonReference	0	*		Reference(Condition Observation Procedure DiagnosticReport DocumentReference)
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Procedure.bodySite	0	*		CodeableConcept
Procedure.outcome	0	1		CodeableConcept
Procedure.report	0	*		Reference(DiagnosticReport DocumentReference Composition)
Procedure.complication	0	*		CodeableConcept
Procedure.complicationDetail	0	*		Reference(Condition)

Procedure.followUp	0	*		CodeableConcept
Procedure.note	0	*		Annotation
Procedure.focalDevice	0	*		BackboneElement
Procedure.focalDevice.id	0	1		string
Procedure.focalDevice.extension	0	*		Extension

Procedure.focalDevice.modifierExtension	0	*		Extension
Procedure.focalDevice.action	0	1		CodeableConcept
Procedure.focalDevice.manipulated	1	1		Reference(Device)
Procedure.usedReference	0	*		Reference(Device Medication Substance)

Procedure.usedCode	0	*		CodeableConcept
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FHIR Short Description	FHIR Definition	Comments
An action that is being or was performed on a patient	The US Core Condition Profile is based upon the core FHIR Procedure Resource and created to meet the 2015 Edition Common Clinical Data Set 'Procedures' requirements.	
Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	The only time that a resource does not have an id is when it is being submitted to the server using a create operation.
Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.	

A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	Asserting this rule set restricts the content to be only understood by a limited set of trading partners. This inherently limits the usefulness of the data in the long term. However, the existing health ecosystem is highly fractured, and not yet ready to define, collect, and exchange data in a generally computable sense. Wherever possible, implementers and/or specification writers should avoid using this element. Often, when used, the URL is a reference to an implementation guide that defines these special rules as part of it's narrative along with other profiles, value sets, etc.
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Language of the resource content	The base language in which the resource is written.	Language is provided to support indexing and accessibility (typically, services such as text to speech use the language tag). The html language tag in the narrative applies to the narrative. The language tag on the resource may be used to specify the language of other presentations generated from the data in the resource. Not all the content has to be in the base language. The Resource.language should not be assumed to apply to the narrative automatically. If a language is specified, it should it also be specified on the div element in the html (see rules in HTML5 for information about the relationship between xml:lang and the html lang attribute).
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Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.	Contained resources do not have narrative. Resources that are not contained SHOULD have a narrative. In some cases, a resource may only have text with little or no additional discrete data (as long as all minOccurs=1 elements are satisfied). This may be necessary for data from legacy systems where information is captured as a "text blob" or where text is additionally entered raw or narrated and encoded information is added later.
Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.	This should never be done when the content can be identified properly, as once identification is lost, it is extremely difficult (and context dependent) to restore it again. Contained resources may have profiles and tags In their meta elements, but SHALL NOT have security labels.

Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.
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Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.
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External Identifiers for this procedure	Business identifiers assigned to this procedure by the performer or other systems which remain constant as the resource is updated and is propagated from server to server.	This is a business identifier, not a resource identifier (see [discussion](http://hl7.org/fhir/R4/resource.html#identifiers)). It is best practice for the identifier to only appear on a single resource instance, however business practices may occasionally dictate that multiple resource instances with the same identifier can exist - possibly even with different resource types. For example, multiple Patient and Person resource instances might share the same social insurance number.
Instantiates FHIR protocol or definition	The URL pointing to a FHIR-defined protocol, guideline, order set or other definition that is adhered to in whole or in part by this Procedure.	
Instantiates external protocol or definition	The URL pointing to an externally maintained protocol, guideline, order set or other definition that is adhered to in whole or in part by this Procedure.	This might be an HTML page, PDF, etc. or could just be a non-resolvable URI identifier.
A request for this procedure	A reference to a resource that contains details of the request for this procedure.	

Part of referenced event	A larger event of which this particular procedure is a component or step.	The MedicationAdministration resource has a partOf reference to Procedure, but this is not a circular reference. For example, the anesthesia MedicationAdministration is part of the surgical Procedure (MedicationAdministration.partOf = Procedure). For example, the procedure to insert the IV port for an IV medication administration is part of the medication administration (Procedure.partOf = MedicationAdministration).
preparation in-progress not-done on-hold stopped completed entered-in-error unknown	A code specifying the state of the procedure. Generally, this will be the in-progress or completed state.	The "unknown" code is not to be used to convey other statuses. The "unknown" code should be used when one of the statuses applies, but the authoring system doesn't know the current state of the procedure. This element is labeled as a modifier because the status contains codes that mark the resource as not currently valid.

Reason for current status	Captures the reason for the current state of the procedure.	This is generally only used for "exception" statuses such as "not-done", "suspended" or "aborted". The reason for performing the event at all is captured in reasonCode, not here.
Classification of the procedure	A code that classifies the procedure for searching, sorting and display purposes (e.g. "Surgical Procedure").	
Identification of the procedure	The specific procedure that is performed. Use text if the exact nature of the procedure cannot be coded (e.g. "Laparoscopic Appendectomy").	
Who the procedure was performed on	The person, animal or group on which the procedure was performed.	
Encounter created as part of	The Encounter during which this Procedure was created or performed or to which the creation of this record is tightly associated.	This will typically be the encounter the event occurred within, but some activities may be initiated prior to or after the official completion of an encounter but still be tied to the context of the encounter.

When the procedure was performed	Estimated or actual date, date-time, period, or age when the procedure was performed. Allows a period to support complex procedures that span more than one date, and also allows for the length of the procedure to be captured.	Age is generally used when the patient reports an age at which the procedure was performed. Range is generally used when the patient reports an age range when the procedure was performed, such as sometime between 20-25 years old. dateTime supports a range of precision due to some procedures being reported as past procedures that might not have millisecond precision while other procedures performed and documented during the encounter might have more precise UTC timestamps with timezone.
Who recorded the procedure	Individual who recorded the record and takes responsibility for its content.	
Person who asserts this procedure	Individual who is making the procedure statement.	
The people who performed the procedure	Limited to "real" people rather than equipment.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	

Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.
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Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.
Type of performance	Distinguishes the type of involvement of the performer in the procedure. For example, surgeon, anaesthetist, endoscopist.	
The reference to the practitioner	The practitioner who was involved in the procedure.	

Organization the device or practitioner was acting for	The organization the device or practitioner was acting on behalf of.	
Where the procedure happened	The location where the procedure actually happened. E.g. a newborn at home, a tracheostomy at a restaurant.	

Coded reason procedure performed	The coded reason why the procedure was performed. This may be a coded entity of some type, or may simply be present as text.	Use Procedure.reasonCode when a code sufficiently describes the reason. Use Procedure.reasonReference when referencing a resource, which allows more information to be conveyed, such as onset date. Procedure.reasonCode and Procedure.reasonReference are not meant to be duplicative. For a single reason, either Procedure.reasonCode or Procedure.reasonReference can be used. Procedure.reasonCode may be a summary code, or Procedure.reasonReference may be used to reference a very precise definition of the reason using Condition Observation Procedure DiagnosticReport DocumentReference. Both Procedure.reasonCode and Procedure.reasonReference can be used if they are describing different reasons for the procedure.
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The justification that the procedure was performed	The justification of why the procedure was performed.	It is possible for a procedure to be a reason (such as C-Section) for another procedure (such as an epidural). Other examples include endoscopy for dilatation and biopsy (a combination of diagnostic and therapeutic use). Use Procedure.reasonCode when a code sufficiently describes the reason. Use Procedure.reasonReference when referencing a resource, which allows more information to be conveyed, such as onset date. Procedure.reasonCode and Procedure.reasonReference are not meant to be duplicative. For a single reason, either Procedure.reasonCode or Procedure.reasonReference can be used. Procedure.reasonCode may be a summary code, or Procedure.reasonReference may be used to reference a very precise definition of the reason using Condition Observation Procedure DiagnosticReport DocumentReference. Both Procedure.reasonCode and Procedure.reasonReference can be used if they
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Target body sites	Detailed and structured anatomical location information. Multiple locations are allowed - e.g. multiple punch biopsies of a lesion.	If the use case requires attributes from the BodySite resource (e.g. to identify and track separately) then use the standard extension [procedure-targetbodystructure] (http://hl7.org/fhir/R4/extension-procedure-targetbodystructure.html).
The result of procedure	The outcome of the procedure - did it resolve the reasons for the procedure being performed?	If outcome contains narrative text only, it can be captured using the CodeableConcept.text.
Any report resulting from the procedure	This could be a histology result, pathology report, surgical report, etc.	There could potentially be multiple reports - e.g. if this was a procedure which took multiple biopsies resulting in a number of anatomical pathology reports.
Complication following the procedure	Any complications that occurred during the procedure, or in the immediate post-performance period. These are generally tracked separately from the notes, which will typically describe the procedure itself rather than any 'post procedure' issues.	If complications are only expressed by the narrative text, they can be captured using the CodeableConcept.text.
A condition that is a result of the procedure	Any complications that occurred during the procedure, or in the immediate post-performance period.	

Instructions for follow up	If the procedure required specific follow up - e.g. removal of sutures. The follow up may be represented as a simple note or could potentially be more complex, in which case the CarePlan resource can be used.	
Additional information about the procedure	Any other notes and comments about the procedure.	
Manipulated, implanted, or removed device	A device that is implanted, removed or otherwise manipulated (calibration, battery replacement, fitting a prosthesis, attaching a wound-vac, etc.) as a focal portion of the Procedure.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.

Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	There can be no stigma associated with the use of extensions by any application, project, or standard - regardless of the institution or jurisdiction that uses or defines the extensions. The use of extensions is what allows the FHIR specification to retain a core level of simplicity for everyone.
Kind of change to device	The kind of change that happened to the device during the procedure.	
Device that was changed	The device that was manipulated (changed) during the procedure.	
Items used during procedure	Identifies medications, devices and any other substance used as part of the procedure.	For devices actually implanted or removed, use Procedure.device.

Coded items used during the procedure	Identifies coded items that were used as part of the procedure.	For devices actually implanted or removed, use Procedure.device.
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Binding Strength	Binding Description	Binding Value Set	ACH dQM
			MS [0..*]
			R [1..1]
			NRT

			NRT
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preferred	A human language.	https://hl7.org/fhir	NRT
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			NRT
			NRT

			NRT
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			NRT
--	--	--	-----

			NRT
			NR
			NR
			NR

			NR
required		http://hl7.org/fhir/	R [1..1]

example	A code that identifies the reason a procedure was not performed.	https://hl7.org/fhir/	NR
example	A code that classifies a procedure for searching, sorting and display purposes.	https://hl7.org/fhir/	NR
extensible	Codes describing the type of Procedure	https://hl7.org/fhir/	R [1..1]
			R [1..1]
			MS[0..1]

			R [1..1] change to R [1..1] Restrict data type to DateTime and Period
			NR
			NR
			NR
			NRT

			NRT
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			NRT
example	A code that identifies the role of a performer of the procedure.	https://hl7.org/fhir/	NR
			NR

			NR
			MS [0..1]

extensible	A code that identifies the reason a procedure is required.	https://hl7.org/fhir	MS [0..*]
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			MS [0..*]
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extensible	Codes describing anatomical locations. May include laterality.	https://hl7.org/fhir/	MS [0..*]
example	An outcome of a procedure - whether it was resolved or otherwise.	https://hl7.org/fhir/	NR
			NR
example	Codes describing complications that resulted from a procedure.	https://hl7.org/fhir/	NR
			NR

example	Specific follow up required for a procedure e.g. removal of sutures.	https://hl7.org/fhir/	NR
			NR
			NR
			NRT
			NRT

			NRT
preferred	A kind of change that happened to the device during the procedure.	https://hl7.org/fhir/	NR
			NR
			NR

example	Codes describing items used during a procedure.	https://hl7.org/fhir/	NR
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FHIR Path	Min	Max	Data Type(s)
ServiceRequest	0	*	
ServiceRequest.id	0	1	id
ServiceRequest.meta	0	1	Meta
ServiceRequest.implicitRules	0	1	uri
ServiceRequest.language	0	1	code
ServiceRequest.text	0	1	Narrative
ServiceRequest.contained	0	*	Resource

ServiceRequest.extension	0	*	Extension
ServiceRequest.modifierExtension	0	*	Extension
ServiceRequest.identifier	0	*	Identifier
ServiceRequest.instantiatesCanonical	0	*	canonical(ActivityDefinition PlanDefinition)
ServiceRequest.instantiatesUri	0	*	uri

ServiceRequest.basedOn	0	*	Reference(CarePlan ServiceRequest MedicationRequest)
ServiceRequest.replaces	0	*	Reference(ServiceRequest)
ServiceRequest.requisition	0	1	Identifier
ServiceRequest.status	1	1	code
ServiceRequest.intent	1	1	code
ServiceRequest.category	0	*	CodeableConcept
ServiceRequest.priority	0	1	code
ServiceRequest.doNotPerform	0	1	boolean
ServiceRequest.code	0	1	CodeableConcept
ServiceRequest.orderDetail	0	*	CodeableConcept

ServiceRequest.quantity[x]	0	1	Quantity RatioRange
ServiceRequest.subject	1	1	Reference(Patient Group Location Device)
ServiceRequest.encounter	0	1	Reference(Encounter)
ServiceRequest.occurrence[x]	0	1	dateTime Period Timing
ServiceRequest.asNeeded[x]	0	1	boolean CodeableConcept
ServiceRequest.authoredOn	0	1	dateTime
ServiceRequest.requester	0	1	Reference(Practitioner PractitionerRole Organization Patient RelatedPerson Device)
ServiceRequest.performerType	0	1	CodeableConcept
ServiceRequest.performer	0	*	Reference(Practitioner PractitionerRole Organization CareTeam HealthcareService Patient Device RelatedPerson)
ServiceRequest.locationCode	0	*	CodeableConcept

ServiceRequest.locationReference	0	*	Reference(Location)
ServiceRequest.reasonCode	0	*	CodeableConcept
ServiceRequest.reasonReference	0	*	Reference(Condition Observation DiagnosticReport DocumentReference)
ServiceRequest.insurance	0	*	Reference(Coverage ClaimResponse)
ServiceRequest.supportingInfo	0	*	Reference(Resource)
ServiceRequest.specimen	0	*	Reference(Specimen)
ServiceRequest.bodySite	0	*	CodeableConcept
ServiceRequest.note	0	*	Annotation
ServiceRequest.patientInstruction	0	1	string
ServiceRequest.relevantHistory	0	*	Reference(Provenance)

FHIR Short Description	FHIR Definition	Binding Strength
A request for a service to be performed	A record of a request for service such as diagnostic investigations, treatments, or operations to be performed.	
Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	
Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.	
A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	
Language of the resource content	The base language in which the resource is written.	preferred
Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.	
Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.	

Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and that modifies the understanding of the element that contains it and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer is allowed to define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Identifiers assigned to this order	Identifiers assigned to this order instance by the orderer and/or the receiver and/or order fulfiller.	
Instantiates FHIR protocol or definition	The URL pointing to a FHIR-defined protocol, guideline, orderset or other definition that is adhered to in whole or in part by this ServiceRequest.	
Instantiates external protocol or definition	The URL pointing to an externally maintained protocol, guideline, orderset or other definition that is adhered to in whole or in part by this ServiceRequest.	

What request fulfills	Plan/proposal/order fulfilled by this request.	
What request replaces	The request takes the place of the referenced completed or terminated request(s).	
Composite Request ID	A shared identifier common to all service requests that were authorized more or less simultaneously by a single author, representing the composite or group identifier.	
draft active on-hold revoked completed entered-in-error unknown	The status of the order.	required
proposal plan directive order original-order reflex-order filler-order instance-order option	Whether the request is a proposal, plan, an original order or a reflex order.	required
Classification of service	A code that classifies the service for searching, sorting and display purposes (e.g. "Surgical Procedure").	extensible
routine urgent asap stat	Indicates how quickly the ServiceRequest should be addressed with respect to other requests.	required
True if service/procedure should not be performed	Set this to true if the record is saying that the service/procedure should NOT be performed.	
What is being requested/ordered	A code that identifies a particular service (i.e., procedure, diagnostic investigation, or panel of investigations) that have been requested.	extensible
Additional order information	Additional details and instructions about the how the services are to be delivered. For example, and order for a urinary catheter may have an order detail for an external or indwelling catheter, or an order for a bandage may require additional instructions specifying how the bandage should be applied.	example

Service amount	An amount of service being requested which can be a quantity (for example \$1,500 home modification), a ratio (for example, 20 half day visits per month), or a range (2.0 to 1.8 Gy per fraction).	
Individual or Entity the service is ordered for	On whom or what the service is to be performed. This is usually a human patient, but can also be requested on animals, groups of humans or animals, devices such as dialysis machines, or even locations (typically for environmental scans).	
Encounter in which the request was created	An encounter that provides additional information about the healthcare context in which this request is made.	
When service should occur	The date/time at which the requested service should occur.	
Preconditions for service	If a CodeableConcept is present, it indicates the pre-condition for performing the service. For example "pain", "on flare-up", etc.	example
Date request signed	When the request transitioned to being actionable.	
Who/what is requesting service	The individual who initiated the request and has responsibility for its activation.	
Performer role	Desired type of performer for doing the requested service.	example
Requested performer	The desired performer for doing the requested service. For example, the surgeon, dermatopathologist, endoscopist, etc.	
Requested location	The preferred location(s) where the procedure should actually happen in coded or free text form. E.g. at home or nursing day care center.	example

Requested location	A reference to the the preferred location(s) where the procedure should actually happen. E.g. at home or nursing day care center.	
Explanation/Justification for procedure or service	An explanation or justification for why this service is being requested in coded or textual form. This is often for billing purposes. May relate to the resources referred to in `supportingInfo`.	example
Explanation/Justification for service or service	Indicates another resource that provides a justification for why this service is being requested. May relate to the resources referred to in `supportingInfo`.	
Associated insurance coverage	Insurance plans, coverage extensions, pre-authorizations and/or pre-determinations that may be needed for delivering the requested service.	
Additional clinical information	Additional clinical information about the patient or specimen that may influence the services or their interpretations. This information includes diagnosis, clinical findings and other observations. In laboratory ordering these are typically referred to as "ask at order entry questions (AOEs)". This includes observations explicitly requested by the producer (filler) to provide context or supporting information needed to complete the order. For example, reporting the amount of inspired oxygen for blood gas measurements.	
Procedure Samples	One or more specimens that the laboratory procedure will use.	
Location on Body	Anatomic location where the procedure should be performed. This is the target site.	example
Comments	Any other notes and comments made about the service request. For example, internal billing notes.	
Patient or consumer-oriented instructions	Instructions in terms that are understood by the patient or consumer.	
Request provenance	Key events in the history of the request.	

Binding Description	Binding Value Set	ACH dQM
		MS [0..*]
		R [1..1]
		NRT
		NRT
Common Languages	https://hl7.org/fhir/R4/valueset-languages	NRT
		NRT
		NRT

		NRT
		NRT
		NRT
		NR
		NR

		NR
		NR
		NR
RequestStatus	https://hl7.org/fhir/R4/valueset-r	R [1..1]
RequestIntent	https://hl7.org/fhir/R4/valueset-r	R [1..1]
Service Request Category Codes	https://hl7.org/fhir/R4/valueset-s	MS [0..*]
Request priority	https://hl7.org/fhir/R4/valueset-r	MS [0..1]
		MS [0..1]
Procedure Codes (SNOMED CT)	https://hl7.org/fhir/R4/valueset-p	MS [0..1]
Service Request Order Details Codes	https://hl7.org/fhir/R4/valueset-s	NR

		NR
		R [1..1]
		MS [0..1]
		MS [0..1]
SNOMED CT Medication As Needed Reason Codes	https://hl7.org/fhir/R4/valueset-n	MS [0..1]
		R [1..1]
		NR
Participant Roles	https://hl7.org/fhir/R4/valueset-p	NR
		NR
V3 Value SetServiceDelivery LocationRoleType	https://hl7.org/fhir/R4/v3/Service	NR

		NR
Procedure Reason Codes	https://hl7.org/fhir/R4/valueset-p	NR
		MS [0..*]
		NR
		NR
		MS [0..*]
SNOMED CT Body Structures	https://hl7.org/fhir/R4/valueset-b	NR
		NR
		NR
		NR

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FHIR Path	Min	Max	Data Type(s)
Specimen	0	*	
Specimen.id	0	1	id
Specimen.meta	0	1	Meta
Specimen.implicitRules	0	1	uri
Specimen.language	0	1	code
Specimen.text	0	1	Narrative

Specimen.contained	0	*	Resource
Specimen.extension	0	*	Extension
Specimen.modifierExtension	0	*	Extension
Specimen.identifier	0	*	Identifier
Specimen.accessionIdentifier	0	1	Identifier

Specimen.status	0	1	code
Specimen.type	0	1	CodeableConcept
Specimen.subject	0	1	Reference(Patient Group Device Substance Location)
Specimen.receivedTime	0	1	dateTime
Specimen.parent	0	*	Reference(Specimen)
Specimen.request	0	*	Reference(ServiceRequest)
Specimen.collection	0	1	BackboneElement

Specimen.collection.id	0	1	string
Specimen.collection.extension	0	*	Extension
Specimen.collection.modifierExtension	0	*	Extension
Specimen.collection.collector	0	1	Reference(Practitioner PractitionerRole)
Specimen.collection.collected[x]	0	1	dateTimePeriod
Specimen.collection.duration	0	1	Duration
Specimen.collection.quantity	0	1	Quantity {SimpleQuantity}
Specimen.collection.method	0	1	CodeableConcept
Specimen.collection.bodySite	0	1	CodeableConcept

Specimen.collection.fastingStatus[x]	0	1	CodeableConcept Duration
Specimen.processing	0	*	BackboneElement
Specimen.processing.id	0	1	string
Specimen.processing.extension	0	*	Extension

Specimen.processing.modifierExtension	0	*	Extension
Specimen.processing.description	0	1	string
Specimen.processing.procedure	0	1	CodeableConcept
Specimen.processing.additive	0	*	Reference(Substance)
Specimen.processing.time[x]	0	1	dateTime Period
Specimen.container	0	*	BackboneElement

Specimen.container.id	0	1	string
Specimen.container.extension	0	*	Extension
Specimen.container.modifierExtension	0	*	Extension

Specimen.container.identifier	0	*	Identifier
Specimen.container.description	0	1	string
Specimen.container.type	0	1	CodeableConcept
Specimen.container.capacity	0	1	Quantity {SimpleQuantity}
Specimen.container.specimenQuantity	0	1	Quantity {SimpleQuantity}
Specimen.container.additive[x]	0	1	CodeableConcept Reference(Substance)
Specimen.condition	0	*	CodeableConcept
Specimen.note	0	*	Annotation

FHIR Short Description	FHIR Definition	Binding Strength
Sample for analysis	A sample to be used for analysis.	
Logical id of this artifact	The logical id of the resource, as used in the URL for the resource. Once assigned, this value never changes.	
Metadata about the resource	The metadata about the resource. This is content that is maintained by the infrastructure. Changes to the content might not always be associated with version changes to the resource.	
A set of rules under which this content was created	A reference to a set of rules that were followed when the resource was constructed, and which must be understood when processing the content. Often, this is a reference to an implementation guide that defines the special rules along with other profiles etc.	
Language of the resource content	The base language in which the resource is written.	preferred
Text summary of the resource, for human interpretation	A human-readable narrative that contains a summary of the resource and can be used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it "clinically safe" for a human to just read the narrative. Resource definitions may define what content should be represented in the narrative to ensure clinical safety.	

Contained, inline Resources	These resources do not have an independent existence apart from the resource that contains them - they cannot be identified independently, and nor can they have their own independent transaction scope.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the resource. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
Extensions that cannot be ignored	May be used to represent additional information that is not part of the basic definition of the resource and	
External Identifier	Id for specimen.	
Identifier assigned by the lab	The identifier assigned by the lab when accessioning specimen(s). This is not necessarily the same as the specimen identifier, depending on local lab procedures.	

available unavailable unsatisfactory entered-in-error	The availability of the specimen.	required
Kind of material that forms the specimen	The kind of material that forms the specimen.	required
Where the specimen came from. This may be from patient(s), from a location (e.g., the source of an environmental sample), or a sampling of a substance or a device	Where the specimen came from. This may be from patient(s), from a location (e.g., the source of an environmental sample), or a sampling of a substance or a device.	
The time when specimen was received for processing	Time when specimen was received for processing or testing.	
Specimen from which this specimen originated	Reference to the parent (source) specimen which is used when the specimen was either derived from or a component of another specimen.	
Why the specimen was collected	Details concerning a service request that required a specimen to be collected.	
Collection details	Details concerning the specimen collection.	

Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To	
Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of	
Who collected the specimen	Person who collected the specimen.	
Collection time	Time when specimen was collected from subject - the physiologically relevant time.	
How long it took to collect specimen	The span of time over which the collection of a specimen occurred.	
The quantity of specimen collected	The quantity of specimen collected; for instance the volume of a blood sample, or the physical measurement of an anatomic pathology sample.	
Technique used to perform collection	A coded value specifying the technique that is used to perform the procedure	example
Anatomical collection site	Anatomical location from which the specimen was collected (if subject is a patient). This is the target site. This element is not used for environmental specimens.	extensible

Whether or how long patient abstained from food and/or drink	Abstinence or reduction from some or all food, drink, or both, for a period of time prior to sample collection.	extensible
Processing and processing step details	Details concerning processing and processing steps for the specimen.	
Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	

Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	
Textual description of procedure	Textual description of procedure.	
Indicates the treatment step applied to the specimen	A coded value specifying the procedure used to process the specimen.	example
Material used in the processing step	Material used in the processing step.	
Date and time of specimen processing	A record of the time or period when the specimen processing occurred. For example the time of sample fixation or the period of time the sample was in formalin.	
Direct container of specimen (tube/slide, etc.)	The container holding the specimen. The recursive nature of containers; i.e. blood in tube in tray in rack is not addressed here.	

Unique id for inter-element referencing	Unique id for the element within a resource (for internal references). This may be any string value that does not contain spaces.	
Additional content defined by implementations	May be used to represent additional information that is not part of the basic definition of the element. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension.	
Extensions that cannot be ignored even if unrecognized	May be used to represent additional information that is not part of the basic definition of the element and that modifies the understanding of the element in which it is contained and/or the understanding of the containing element's descendants. Usually modifier elements provide negation or qualification. To make the use of extensions safe and manageable, there is a strict set of governance applied to the definition and use of extensions. Though any implementer can define an extension, there is a set of requirements that SHALL be met as part of the definition of the extension. Applications processing a resource are required to check for modifier extensions. Modifier extensions SHALL NOT change the meaning of any elements on Resource or DomainResource (including cannot change the meaning of modifierExtension itself).	

Id for the container	Id for container. There may be multiple; a manufacturer's bar code, lab assigned identifier, etc. The container ID may differ from the specimen id in some circumstances.	
Textual description of the container	Textual description of the container.	
Kind of container directly associated with specimen	The type of container associated with the specimen (e.g. slide, aliquot, etc.).	example
Container volume or size	The capacity (volume or other measure) the container may contain.	
Quantity of specimen within container	The quantity of specimen in the container; may be volume, dimensions, or other appropriate measurements, depending on the specimen type.	
Additive associated with container	Introduced substance to preserve, maintain or enhance the specimen. Examples: Formalin, Citrate, EDTA.	example
State of the specimen	A mode or state of being that describes the nature of the specimen.	extensible
Comments	To communicate any details or issues about the specimen or during the specimen collection. (for example: broken vial, sent with patient, frozen).	

Binding Description	Binding Value Set	ACH dQM
		MS [0..*]
		R [1..1]
		NRT
		NRT
Common Languages	https://hl7.org/fhir/R4/valuesets	NRT
		NRT

		NRT
		NRT
		NRT
		MS [0..*]
		MS [0..1]

SpecimenStatus	https://hl7.org/fhir/R4/valueset.html#specimen-status	MS[0..1]
V2 Specimen Type	https://hl7.org/fhir/R4/valueset.html#specimen-type	R [1..1]
		MS [0..1]
		NR
		NR
		NR
		R [1..1]

		NRT
		NRT
		NRT
		NR
		R [1..1]
		NR
		NR
FHIR Specimen Collection Method	https://hl7.org/fhir/R4/valueset-specimen-collection-method	NR
SNOMED CT Body Structures	http://hl7.org/fhir/R4/valueset-snomed-ct-body-structures	R [1..1]

v2 Relevant Clinical Information	https://hl7.org/fhir/R4/v2/	NR
		NR
		NRT
		NRT

		NRT
		NR
Specimen processing procedure	https://hl7.org/fhir/R4/valueset-specimen-processing-procedure.html	NR
		NR
		NR
		NR

		NRT
		NRT
		NRT

		NRT
		NR
Specimen container	https://hl7.org/fhir/R4/valueset-specimen-container.html	NR
		NR
		NR
v2 Additive	http://terminology.hl7.org/ValueSet/v2-Additive.html	NR
v2 Specimen Condition	http://terminology.hl7.org/ValueSet/v2-Specimen-Condition.html	NR
		NR

Property
URL
Version
Name
Title
Status
Experimental
Date
Publisher
Contact
Jurisdiction
Description
Purpose
Copyright
FHIR Version
Kind
Type
Base Definition
Abstract
Derivation

Property
URL
Version
Name
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Version
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Title
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Experimental
Date
Publisher
Contact
Contact
Description
Purpose
Copyright
FHIR Version
Kind
Type
Base Definition
Abstract
Derivation

Value
http://hl7.org/fhir/us/core/StructureDefinition/us-core-condition
4.1.0
USCoreCondition
US Core Condition Profile
active
false
2020-06-27
HL7 International - Cross-Group Projects
No display for ContactDetail
United States of America
Defines constraints and extensions on the Condition resource for the minimal set of data to query and return concerns information.
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4.0.1
resource
Condition
http://hl7.org/fhir/StructureDefinition/Condition
false
constraint

Value
http://hl7.org/fhir/us/core/StructureDefinition/us-core-condition
4.1.0
USCoreCondition
US Core Condition Profile
active
false
2020-06-27
HL7 International - Cross-Group Projects
No display for ContactDetail
United States of America
Defines constraints and extensions on the Condition resource for the minimal set of data to query and return concerns information.
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4.0.1
resource
Condition
http://hl7.org/fhir/StructureDefinition/Condition
false
constraint

Value

<http://hl7.org/fhir/us/core/StructureDefinition/us-core-documentreference>

4.1.0

USCoreDocumentReferenceProfile

US Core DocumentReference Profile

active

false

2020-07-02

HL7 International - Cross-Group Projects

No display for ContactDetail

United States of America

The document reference profile used in US Core.

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4.0.1

resource

DocumentReference

<http://hl7.org/fhir/StructureDefinition/DocumentReference>

false

constraint

Value

<http://hl7.org/fhir/us/core/StructureDefinition/us-core-encounter>

4.1.0

USCoreEncounterProfile

US Core Encounter Profile

active

false

2019-05-21

HL7 International - Cross-Group Projects

No display for ContactDetail

United States of America

The Encounter referenced in the US Core profiles.

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4.0.1

resource

Encounter

<http://hl7.org/fhir/StructureDefinition/Encounter>

false

constraint

Value

<http://hl7.org/fhir/us/core/StructureDefinition/us-core-immunization>

4.1.0

USCoreImmunizationProfile

US Core Immunization Profile
active
false
2019-08-26
HL7 International - Cross-Group Projects
No display for ContactDetail
United States of America
Defines constraints and extensions on the Immunization resource for the minimal set of data to query and immunization information.
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4.0.1
resource
Immunization
http://hl7.org/fhir/StructureDefinition/Immunization
false
constraint

Value

http://hl7.org/fhir/us/core/StructureDefinition/us-core-location
4.1.0
USCoreLocation
US Core Location Profile
active
false
2019-05-21
HL7 International - Cross-Group Projects
No display for ContactDetail
United States of America
Defines basic constraints and extensions on the Location resource for use with other US Core resources
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4.0.1
resource
Location
http://hl7.org/fhir/StructureDefinition/Location
false
constraint

Value

http://hl7.org/fhir/us/core/StructureDefinition/us-core-medication
4.1.0
USCoreMedicationProfile
US Core Medication Profile
active

false
2019-05-21
HL7 International - Cross-Group Projects
No display for ContactDetail
United States of America
Defines constraints and extensions on the Medication resource for the minimal set of data to query and retrieve patient's medication information.
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4.0.1
resource
Medication
http://hl7.org/fhir/StructureDefinition/Medication
false
constraint

Value

http://hl7.org/fhir/us/core/StructureDefinition/us-core-medicationrequest
4.1.0
USCoreMedicationRequestProfile
US Core MedicationRequest Profile
active
false
2020-06-26
HL7 International - Cross-Group Projects
No display for ContactDetail
United States of America
Defines constraints and extensions on the MedicationRequest resource for the minimal set of data to query and retrieve information.
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4.0.1
resource
MedicationRequest
http://hl7.org/fhir/StructureDefinition/MedicationRequest
false
constraint

Value

http://hl7.org/fhir/us/core/StructureDefinition/us-core-observation-lab
4.1.0
USCoreLaboratoryResultObservationProfile
US Core Laboratory Result Observation Profile
active
false

2020-06-27
HL7 International - Cross-Group Projects
No display for ContactDetail
United States of America
Defines constraints and extensions on the Observation resource for the minimal set of data to query and results
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4.0.1
resource
Observation
http://hl7.org/fhir/StructureDefinition/Observation
false
constraint

Value
http://hl7.org/fhir/us/core/StructureDefinition/us-core-procedure
4.1.0
USCoreProcedureProfile
US Core Procedure Profile
active
false
2020-06-29
HL7 International - Cross-Group Projects
No display for ContactDetail
United States of America
Defines constraints and extensions on the Procedure resource for the minimal set of data to query and re information. This profile can be used to record a service or intervention that is or was performed on or for
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4.0.1
resource
Procedure
http://hl7.org/fhir/StructureDefinition/Procedure
false
constraint

Value
http://hl7.org/fhir/us/core/StructureDefinition/us-core-servicerequest
4.1.0
USCoreServiceRequest
US Core Service Request
active

2018-08-22T00:00:00+00:00
HL7 International - Cross-Group Projects
No display for ContactDetail
United States of America
Defines constraints and extensions on the ServiceRequest resource for the minimal set of data to query and with diagnostic and clinical tests and clinical interventions for a patient
Used by permission of HL7 International, all rights reserved Creative Commons License
4.0.1
resource
ServiceRequest
http://hl7.org/fhir/StructureDefinition/ServiceRequest
false
constraint

Value
http://hl7.org/fhir/StructureDefinition/Coverage
4.3.0
Coverage
draft
false
2022-05-28T12:47:40+10:00
Health Level Seven International (Financial Management)
No display for ContactDetail
No display for ContactDetail
Financial instrument which may be used to reimburse or pay for health care products and services. Includes payment.
Coverage provides a link between covered parties (patients) and the payors of their healthcare costs (both
4.3.0
resource
Coverage
http://hl7.org/fhir/StructureDefinition/DomainResource
false
specialization

Value
http://hl7.org/fhir/StructureDefinition/MedicationAdministration
4.3.0
MedicationAdministration
draft

false
2022-05-28T12:47:40+10:00
Health Level Seven International (Pharmacy)
No display for ContactDetail
No display for ContactDetail
Describes the event of a patient consuming or otherwise being administered a medication. This may be a tablet or it may be a long running infusion. Related resources tie this event to the authorizing prescription between patient and health care practitioner.
4.3.0
resource
MedicationAdministration
http://hl7.org/fhir/StructureDefinition/DomainResource
false
specialization

Value

http://hl7.org/fhir/StructureDefinition/Observation
4.3.0
Observation
active
false
2022-05-28T12:47:40+10:00
Health Level Seven International (Orders and Observations)
No display for ContactDetail
No display for ContactDetail
Measurements and simple assertions made about a patient, device or other subject.
Observations are a key aspect of healthcare. This resource is used to capture those that do not require mechanisms.
4.3.0
resource
Observation
http://hl7.org/fhir/StructureDefinition/DomainResource
false
specialization

Value

http://hl7.org/fhir/StructureDefinition/Specimen
4.3.0
Specimen
draft

false
2022-05-28T12:47:40+10:00
Health Level Seven International (Orders and Observations)
No display for ContactDetail
No display for ContactDetail
A sample to be used for analysis.
4.3.0
resource
Specimen
http://hl7.org/fhir/StructureDefinition/DomainResource
false
specialization