OntarioMD

OntarioMD Inc.

Electronic Medical Records

SPECIFICATION

Appendix B – Data Portability Requirements

FINAL

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Ontario
eHealth Ontario

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1. INTRODUCTION

1.1 SCOPE / PURPOSE OF THE DOCUMENT

The following Appendix defines Data Portability Requirements to be implemented into EMR Offering in order to facilitate the transfer of patients' electronic medical data from one EMR to another and includes:

i. Date Export Requirements
ii. Data Import Requirements
iii. EMR – CDS Schema

1.2 DEFINITIONS, ACRONYMS AND ABBREVIATIONS

TERM	MEANING
CPSO	**C**ollege of **P**hysicians and **S**urgeons of Ontario
DIN	**D**rug **I**dentification **N**umber
HRM	**H**ospital **R**eport **M**anager
ICD	**I**nternational **S**tatistical **C**lassification of **D**iseases and **R**elated **H**ealth **P**roblems ICD standards: ICD-9, ICD9-CM, ICD10, ICD10-CM, ICD10-PCS, ICD10-CA / CCI
ICD10-CA & CCI	ICD10-CA - **I**nternational **C**lassification of **D**iseases, 10th with Canadian Enhancements **CCI** - Canadian Classification of Health Interventions ▪ is the new national standard for classifying health care procedures. CCI is the companion classification system to ICD-10-CA. ▪ replaces the Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures (CCP) and the intervention portion of ICD-9-CM in Canada
ISO 3166-2	ISO 3166-2 Codes for the representation of names of countries and their subdivisions -- Part 1: Country codes http://www.iso.org/iso/en/ISOOnline.frontpage
ISO 639-2	ISO 639-2 Codes for the representation of names of languages — Part 2: Alpha-3 code
OHIP	**O**ntario **H**ealth **I**nsurance **P**lan
OHN	**O**ntario **H**ealth **N**umber
MOHLC	**M**inistry of **H**ealth and **L**ong-**T**erm **C**are
MRP	**M**ost **R**esponsible **P**hysician - the attending physician who is primarily responsible for the day-to-day care of patient. In absence, the covering physician will fulfill the MRP role.
Provider	A person who provides healthcare services to patients or an organization that facilitates such services
Standard Coding System	A code that identifies the coding scheme used in the source system to classify diseases, procedures and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. Recognized Standard Coding Systems: ICD, CPT, SNOWMED-CT, ICPC-2, ENCODE-FM
W3C Standard	**W**orld **W**ide Web **C**onsortium **S**tandard
WHO	**W**orld **H**ealth **O**rganization

1.3 RELATED DOCUMENTS AND REFERENCES

The following table lists all documents related to, or referenced by, the Software Requirements Specification:

DOCUMENT NAME	VERSION	DATE
EMR Document Mapping	1.0	17-Jan-2011
Appendix A – EMR Baseline Requirements	Final / v4.0	17-Jan-2011
Appendix C –Chronic Management Disease Requirements	Final / v4.0	17-Jan-2011
Appendix F – Hospital Report Management Requirements	Final / v4.0	17-Jan-2011

2. DATA PORTABILITY REQUIREMENTS

TERMINOLOGY:

For the purposes of the Data Export Requirements (2.1) and Data Import Requirements (2.2), the following terms and abbreviations are defined and is applicable to all tables in this section.

Core Data Set ("CDS") is comprised of the following three groups to provide a longitudinal representation of a patient medical record:

(i) Practice Management ("PM"),

(ii) Cumulative Patient Profile ("CPP"),

(iii) Extended Patient Information.

Practice Management ("PM") Categories consists of one of the three CDS Categories:

- appointments and
- patient demographics

Cumulative Patient Profile ("CPP") consists of one of the following CDS Categories:

- Family History
- Past Health
- Problem List
- Risk Factor
- Allergies and Adverse Reaction
- Medication
- Immunization
- Care Elements
- Alerts and Special Needs

Extended Patient Information Categories consists of one of the three CDS Categories:

- laboratory results
- physician's "my clinical notes"
- reports received
  - images (may be scanned reports left in image form and other images)
  - scanned or transcribed documents (e.g. converted to text or codes)
  - received electronically

CDS Schema is:

- a data structure that is used to export data to a CDS for a single instance of a EMR that is used by one or more physicians in a primary care medical practice
- comprised of CDS categories
- a single instance of a EMR has its own patient registration application. Example: If two different EMR products co-exist on the same system that would represent two separate EMR instances. In this case each EMR would export data to a separate CDS.

Data Portability ("DP") - is the import-export process by which the CDS is being transferred between two Electronic Medical Record Systems.

Structured Field - is a data element described in Section 2.3 - CDS Schema and behaves according to the definitions contained in the EMR - CDS Schema in Tables 1 to 14

Category Summary Line is:

- A text string, summarizing the content of the structured data elements within a category
- The format and content of each Category Summary Line is recommended per category

Residual Data is:

- The data in a category that is not defined by structured fields and is important information for patient care
- The information in the Residual Data will be structured as per the CDS XML Schema - Definition and CDS XML Schema - Data Type. See Section 3.2 for more information on the Residual Data.

Scoring Key: **M** = Mandatory criteria for certification
W = Weighted criteria

Status Key: **N** = New requirement for EMR Specification 4.0
P = Previous requirement from CMS Specification 3.0
U = Updated from a previous CMS Specification 3.0
R = Retired from previous CMS Specification 3.0

2.1 DATA EXPORT REQUIREMENTS

Requirement	Guidelines	W/M	Status	Discussion/Comments
a) Supports export of all provisioned CDS data for a physician.	In order for this requirement to be met a user administrator should be able to undertake the work without an EMR Vendor attending the process. At a minimum the export processes must function in a batch mode.	M	P	
b) Provides the ability to export records for selected patients within the EMR.	User must be able to identify the patient(s) to be included in the data export.	M	P	
c) Enables physician to select specific CDS Data Categories to be exported.	Requirement applies to export of data for all patients, or only for selected patient(s). CDS Data Categories are defined as per section 2.3, below. Example: Enable export of only patient demographics and medication and care elements.	M	U	Updated Guidelines Changed status from W to M
d) Generates files that contain available data elements as described in Section 2.3/ CDS Schema.	In order for this requirement to be met one file per patient must be generated.	M	P	
e) Generates files in XML format that comply with the schema as described in the CDS XML Schema - Definition and CDS XML Schema - Data Types.	See http://www.ontariomd.ca/emr for supporting documentation.	M	P	
f) Creates a ReadMe.txt file as described in Section 3.3 - ReadMe.txt.	In order for this requirement to be met ReadMe.txt must be output to a text file.	M	P	
g) Creates an Export Event Log file as described in 3.4 - Export Event Log.	In order for this requirement to be met Export Event Log must be output to a text file.	M	P	
h) Compresses and encrypts export files (i.e. CDS data, ReadMe.txt and the Export Event Log) using a standard software utility. Supports the ability to move the files to the media device.	In order for this requirement to be met, PGP utility must be supported. Please refer to http://www.pgpi.org/ and http://www.pgp.com for additional information.	M	U	Updated Requirement

Requirement	Guidelines	W/M	Status	Discussion/Comments
i) Documents the steps to move export files (i.e. CDS Data, ReadMe.txt and the Export Event Log) to the standard media devices and provides a password to secure and access the media. Documents the user steps for decryption and un-compression of export files.		M	P	
j) The standard format for xml exported file must be: PatientFN_PatientLN_PatientUniqueID_DOB	PatientFN – Patient First Name PatientLN – Patient Last Name PatientUniqueID - Unique Vendor ID Sequence DOB- date of birth DOB - format: ddmmyyyy	M	N	

2.2 DATA IMPORT REQUIREMENTS

Requirement	Guidelines	M/W	Status	Discussion/Comments
a) Document user instructions to move export files (i.e. CDS Data, ReadMe.txt and the Export Event Log) from media type to importing system.		M	P	
b) Supports import of all provisioned CDS data for a physician. Data from import file(s) must be imported to the EMR discrete data fields where applicable (as defined in Section 2.3). However, data fields that do not map must be grouped together and presented within patient record under the appropriate category.	In order for this requirement to be valid, a user administrator should be able to undertake the process without an EMR Vendor attending. At a minimum the import processes must function in a batch mode.	M	U	Updated Requirement.
c) Vendor must provide documents describing processes and/or tools for import support.	In order for this requirement to be met EMR vendor must provide documentation of the support services and their associated costs. E.g.: ▪ telephone support ▪ on-site detailed application support ▪ application tools to aid in the CDS import	W	P	As a part of the certification process, vendors will be required to provide documentation to provide technical substantiation for this requirement.

Requirement	Guidelines	M/W	Status	Discussion/Comments
d) Creates an Import Event Log file as described in 3.5 - Import Event Log.	In order for this requirement to be met Import Event Log must be output to a text file and printed.	M	P	
e) Generates Import Error Log file which includes each record that failed to upload for each patient.	Error log file must be output to a text file.	M	P	

2.3 EMR - CDS SCHEMA

This section identifies CDS Data Categories using the following headings:

1. Patient Demographic
2. Family History
3. Past Health
4. Problem List
5. Risk Factors
6. Allergies & Adverse Reactions
7. Medications & Treatments
8. Immunizations
9. Laboratory Results
10. Appointments
11. Physician's My Clinical Notes
12. Reports Received
13. Care Elements
14. Alerts and Special Needs

For the purposes of this section, the following terms and abbreviations are defined and shall be applied to all tables in this section:

CDS ID # -represent a unique identifier by which any data element in Appendix B will be identified. New data elements added to the CDS Schema are identified by '**N'**

Data Element means:

- a unit of data as set out in the CDS schema. "Data Element" means that data in column 1 of all tables in the CDS Schema.
- **" * "** this symbol means that CDS Data Category, or a subsection within a CDS Data Category or a data element may be repeated.
  - An example of a category that may be repeated is a patient that is on more than one medication or immunization.
  - An example of a subsection that repeats as a group is a patient demographic that contains a group of related fields (such as related contact person information for more than one contact) that will repeat together.

Required Fields:

- Y - the data element is a minimum requirement for the construction of a valid CDS record. A data element that is required (i.e. marked as Y) must have a value in the XML file in order for the file to be valid. If there are no records for a given heading (e.g. for risk factors), then this information would not be required.
- Y* - yes if 'Residual Data Element Name(*)' is provided. This is applicable just for Residual Data.
- Y** - yes if Diagnosis Code System Name is provided.

Definition means a detailed description of the Data Element**.**

Code Source means the source of the coding system or specific codes that are valid for a given data element.

Data Type means the characteristic of the data listed.

- **DATE**: YYYY-MM-DD **–**
  - YYYY = four-digit year , MM = two-digit month DD = two-digit day of month (01 through 31)
- **DATE/ TIME**: YYYY-MM-DDThh:mm:ss.sTZD
  - YYYY = four-digit year, MM = two-digit month, DD = two-digit day of month (01 through 31)
  - hh = two digits of hour (00 through 23), mm = two digits of minute (00 through 59)
  - ss = two digits of second (00 through 59), s = one or more digits representing a decimal fraction of a second
  - TZD = time zone designator (Z or +hh:mm or -hh:mm)
- **TIME:** hh:mm:ss.sTZD
- **NUM** (numeric)
- **AN** (alphanumeric) - means the data that does not have restrictions on special characters (e.g. * ‘ -).
- **AB (**alphabetic)

Form means a predefined data format designed to further define the Data Element in CDS Schema

- **Code:** means the source of the coding system or specific codes that are valid for a given data element.
- **Text**
- YYYY-MM-DD
- YYYY-MM-DDThh:mm:ss.sTZD

Length means the maximum number of characters that is represented in a particular Data Element in CDS Schema

- **NL -** No Limit
- **BOT** – Based On Type
- **TBD** – To Be Defined

Report Level means any reports received by a medical practice and stored within an EMR in accordance to the four levels described in Table 13.

Business Rules – as relates to Core Data Set elements

1. *PATIENT DEMOGRAPHICS*

Export of Patient Demographics information represents a snapshot of the patient data within the medical record at the time of export.

Table 1: Patient Demographics

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
1	Name Prefix		An honorific title used when addressing a person by name.	AN	Code	6	See Table 1.1 - Name Prefix.	Name prefix must be valid code.
2	(*) Name Part	Y	A part of a name. Typical name parts for person names are given names and family names. A name part may have a type signifying the role of the part in the whole name, and a qualifier for more detail about the name part type.	AN	Text	50		At a minimum Family Name and Given Name must be provided. See Section: Working with Name Part Elements
3	(*) Name Part Type	Y	Indicates whether the name part is a first/given name, middle name, initial or family name.	AN	Code	4	See Table 1.2 – Name Part	Name Part Type must be valid code: See Section: Working with Name Part Elements
4	(*) Name Part Qualifier		For any corresponding name a qualifier is required to distinguish the person's name.	AN	Code	2	See Table 1.3 – Name Part Qualifier	Name Part Qualifier must be valid code. See Section: Working with Name Part Elements
5	(*) Name Purpose	Y	If more than one name is recorded, a Name may have a code advising a system or user which name in a set of names to select for a given purpose.	AN	Code	2	See Table 1.4 – Name Purpose	Name Purpose must be valid code See Section: Working with Name Part Elements
6	Last Name Suffix		An additional term placed after a person's name.	AN	Code	3	See Table 1.5 – Name Suffix	Last Name Suffix must be valid code.
7	Date of Birth	Y	The date on which the patient was born.	DATE	YYYY-MM-DD	10	W3C Date Standard	
8	Health Card		Health Card identifier for the patient's primary healthcare insurance (e.g. OHN)	AN	Text	20		
9	Health Card Version		Currently OHN version code associated with Health Card	AB	Text	2		
10	Health Card Expiry Date	Y	Currently OHN Health Card Expiry Date	DATE	YYYY-MM-DD	10	W3C Date Standard	
11	Health Card Province		Province pertaining to Health Card.	AB	Code	5	See Table 1.6 –	Health Card Province must be valid code.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
							Province/State/Territory	
12	Chart Number		Number used by the medical practice to identify the associated hardcopy chart.	AN	Text	15		
13	Gender	Y	The reported sexual identity of a person for administrative purposes.	AN	Code	1	See Table 1.7 – Gender	Gender must be valid code.
14	Unique Vendor ID Sequence	Y	System-specific internal unique key (has no contextual meaning) to uniquely identify the patient within the exporting system.	AN	Text	20		The purpose of this field is to allow for tracking an imported patient record back to the ID within the exporting system. When imported, the value must be stored within the patient record.
15	Mailing Street Address line 1		A line of text that may include unit and street address information or postal delivery information within a municipality.	AN	Text	50		If only one of Mailing or Residential address is provided by the export, assume these addresses are identical, on import.
16	Mailing Street Address line 2		A line of text that may include unit and street address information or postal delivery information within a municipality.	AN	Text	50		If only one of Mailing or Residential address is provided, assume these addresses are identical, on import.
17	Mailing City		A line of text that includes the city for postal delivery purposes	AN	Text	80		If only one of Mailing or Residential address is provided, assume these addresses are identical, on import.
18	Mailing Country & Province/State		A code associating a country subdivision to an address	AN	Code	7	ISO 3166-2	If only one of Mailing or Residential address is provided, assume these addresses are identical, on import.
19	Mailing Postal/Zip Code		A code that is assigned by a country's postal service to a postal delivery area.	AN	Text	10		Postal/Zip code must not contain spaces. If only one of Mailing or Residential address is provided, assume these addresses are identical, on import.
20	Residence Street Address line 1		A line of text that may include unit and street address information or postal delivery information within a municipality.	AN	Text	50		If only one of Mailing or Residential address is provided, assume these addresses are identical, on import.
21	Residence Street Address line 2		A line of text that may include unit and street address information or postal delivery information within a municipality.	AN	Text	50		If only one of Mailing or Residential address is provided, assume these addresses are identical, on import.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
22	Residence City		City where the person lives	AN	Text	80		If only one of Mailing or Residential address is provided, assume these addresses are identical, on import.
23	Residence Country & Province/State		A code associating a country subdivision to an address.	AB	Code	7	ISO 3166-2	If only one of Mailing or Residential address is provided, assume these addresses are identical, on import.
24	Residence Postal/Zip Code		A code that is assigned by a country's postal service to a postal delivery area.	AN	Code	10		Postal/Zip code must not contain spaces. If only one of Mailing or Residential address is provided, assume these addresses are identical, on import.
25	Residence Phone		Phone number where person lives	NUM	Text	25		
26	Cell Phone		Preferred cell phone number for person contact.	NUM	Text	25		
27	Work Phone Extension		A number used after dialling the telephone number in order to access a person's personal telephone within an organization.	NUM	Text	5		
28	Work Phone		A patient's work telephone or organization phone number patient works.	NUM	Text	25		
29	Preferred Official Language		English or French language	AN	Code	3	See Table 1.9 – Official Language One of: ENG - English FRE - French	Preferred Official Language must be valid code. May repeat Preferred Spoken Language if it also represents Preferred Official Language
30	Preferred Spoken Language		Indicates in which language a person prefers to communicate.	AN	Text	25	ISO 639-2	May repeat Preferred Official Language if it also represents Preferred Spoken Language
31	(*) Contact Purpose		The type of a contact person	AN	Code & Free Text	2 & 50	Available options in CDS Schema: a) Coded values (see Table 1.10 – Contact Purpose) : ▪ EC -Emergency Contact, ▪ NK –Next of Kin, ▪ AS- Administrative Staff, ▪ CG - Care Giver, ▪ PA - Power of Attorney, ▪ IN - Insurance, ▪ GT - Guarantor, ▪ SDM -Substitute Decision Maker b) Non-coded values: free-text	Contact Purpose can be valid code *or* free text. EMR Offering must support multiple 'Contact Purpose' per each individual contact. <u>Export:</u> If the exporting system is not able to map to the coded value then export the Contact Purpose as free-text. <u>Import:</u> The importing system must be able to map the coded values and import the non-

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
								coded value (free text) in the NML section of the contact. CDS Schema: - New Data Element option: Substitute Decision Maker (SDM) - Removed Data Element option- Other (O) Note: SDM and EC are mandatory contact types in both, exporting and importing EMR system.
32	(*) Contact Last Name		Contact Last Name	AN	Text	50		EMR Offering must allow for multiple contacts.
33	(*) Contact First Name		Contact First Name	AN	Text	50		
34	(*) Contact Middle Name		Contact Middle Name	AN	Text	50		When imported, the value must be stored within the contact's record.
35	(*)Contact Residence Phone		The telephone of the contact person.	AN	Text	25		
36	(*) Contact Cell Phone		The telephone of the contact person.	AN	Text	25		
37	(*) Contact Work Phone		The telephone of the contact person.	AN	Text	25		
38	(*) Contact Work Phone Extension		A number used after dialling the telephone number in order to access a Contact's telephone within an organization.	NUM	Text	5		
39	(*) Contact Email Address		The email address preferred by the contact person	AN	Text	50		One primary email address per contact. Validate the email has an "@" sign and a valid extension after the period (e.g. .ca, .com, .net)
40	(*) Note about Contact Person		General Note about the contact person if available.	AN	Text	200		
41	Patient Note		Additional notes about the patient.	AN	Text	64k		
42	(*) Enrolment Status		Indicator for the enrolment status of a rostered patient.	NUM	Code	1	See Table 1.11 – Enrolment Status One of: 1 – Patient is rostered to the primary physician;	Enrolment Status must be valid code. The exporting/importing EMR Offering must support multiple values for Enrolment to capture enrolment history.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
							0- Patient is not rostered to the primary physician	Note: Updated CDS Schema to support historic enrolment.
43	(*) Enrolment Date		Date the rostered patient was enrolled.	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if enrolment status is set to '1'
44	(*) Enrolment Termination Date		Date the patient was terminated from the roster.	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if the enrolment status is '0-not rostered' and termination reason exists.
45	(*) Termination Reason		Reason the patient was removed from the roster.	NUM	Code	2	See Table 1.12 – Enrolment Termination Codes	Termination Reason must be valid code. Mandatory if the enrolment status is '0-not rostered' And previously was rostered.
46	Primary Physician ID	Y	Physician's OHIP Billing Number	NUM	Text	6		
47	Primary Physician First Name	Y	First Name of Primary Physician	AN	Text	50		
48	Primary Physician Last Name	Y	Last Name of Primary Physician	AN	Text	50		
49	Patient email		The email address preferred by the patient.	AN	Text	50		Validate the email has an @ sign and extension after the period.
50	Person Status	Y	Refers to whether the patient is active, inactive, deceased or other values as supported by the practice.	AN	Code & Free Text	1 & 50	Available options in CDS Schema: a) Coded Values (see Table 1.13 – Person Status): • Active (A), • Inactive (I) • Deceased (D) b) Non-coded value: free text	Person Status can be a coded value or non-coded value (free text). <u>Export:</u> If the exporting system is not able to map to the coded value (A / I / D) then export the Person Status as free-text. <u>Import:</u> The importing system must be able to map the coded values (A / I / D) and /or import the non-coded value (free text) in the patient demographic area. CDS Schema changes: Removed Data Element option- Other (O) Note: A / I / D are mandatory options in both, exporting and importing EMR system.
51	Person Status Date		Date associated with Person Status.	DATE	YYYY-MM-DD	10	W3C Date Standard	Associated with Person Status. Mandatory regardless the Patient Status value.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
52	SIN		Social Insurance Number	NUM	Text	9		
53 N	Primary Physician CPSO		Primary Physician CPSO number	AN	Text	5		

2. *FAMILY HISTORY*

May contain multiple records to represent family history item.

Table 2: Family History

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
54	Category Summary Line	Y	A text string, summarizing the content of the following more structured fields and information contained about Family History	AN	Text	64k		Export: Each exported Family History item must have its own Category Summary Line. At minimum the Category Summary Line must include following data elements: ▪ Diagnosis Problem Description ▪ Start Date Category Summary Line must comply with standard format (refer to Working with Category Summary Line) Import: Category Summary Line can be imported at vendor discretion.
55	Residual Data Element Name(*)		Name of the data field.	AN	Text	NL		The descriptive or reference name of the data item within the source EMR.
56	Residual Data Element Type(*)	Y*	Name of the data type The primitive XML data type of the data field.	AN	Text	NL	Primitive XML data type: http://www.w3.org/TR/xmlschema-2/) See Table 2.1 – XML Primitive Data Types	Residual Data Element Type must be valid code The data type by which the 'Residual Content' is to be interpreted.
57	Residual Content(*)	Y*	The content of the residual data element.	BOT	Text	NL		
58	Start Date		Known date or partial date related to the Family History issue/concern.	DATE	YYYY-MM-DD	10	W3C Date Standard	Date may be a partial date if known.
59	Age at Onset			NUM	Text	3		
60 N	Life Stage		The stage of life the patient is in at the Onset of the condition.	AN	Code	1	One of: ▪ N - Newborn ▪ I – Infant ▪ C - Child ▪ T- Adolescent ▪ A - Adult	
61	Diagnosis / Problem /		A description that identifies the	AN	Text	250		Data element to be populated even if the

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
	Procedure Description		family history (problem / diagnosis / procedure).					exporting system does not support a *Standard Coding System*. <u>Export:</u> ▪ If the exporting system does not support a Standard Coding System then xml data element must be populated with the value typed in by the provider. ▪ If the exporting system supports a Standard Coding System then the xml data element must be populated with the concatenated descriptor starting with base description plus sub-qualifying descriptors (Format : aaa^bbb^ccc). <u>Import:</u> ▪ If the importing system does not support the Standard Coding System then just the Diagnosis/Problem Description is mandatory to be imported discreetly. ▪ If the importing system supports the Standard Coding System then: ➢ If the importing system is able to map Diagnosis Code System / Diagnosis Code / Diagnosis Description then all 3 data elements are expected to be discreetly imported. The diagnoses / problem displayed in GUI must be appropriate. ➢ If the importing system is not able to map Diagnosis Code System / Diagnosis Code / Diagnosis then the Diagnoses/Problem Description is sufficient to be imported discreetly. The diagnoses / problem displayed in GUI must be appropriate.
62	Diagnosis/ Procedure Code System Name		The name of the Standard Coding System used to code a health condition or procedure.	AN	Text	250	Example: ENCODE-FM, SNOMED-CT, ICD9, ICD10-CA, ICPC-2, etc	Vendor's proprietary diagnosis code is not required to be exported. For business rules, see above (#60).
63	Diagnosis Code	Y**	The code associated with Diagnosis/Procedure as relates	AN	Text	20		Mandatory if the Diagnosis Code System Name is provided.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
			to a particular Standard Coding System (item#62).					Vendor's proprietary diagnosis code is not required to be exported. For business rules, see above (#60).
64 N	Diagnosis Description	Y**	The Description of a Diagnosis/Procedure as relates to a particular Diagnosis/Procedure Code (item #63)	AN	Text	250		Mandatory if the Diagnosis Code System Name is provided. For business rules, see above (#60).
65	Treatment		Type or nature of the treatment delivered	AN	Text	250		
66	Relationship		Relationship to patient.	AN	Text	50		Only refer to blood relationship that would not include step-father, or step-sister, etc.
67	Notes		General notes about the specific Family member health issue/concern.	AN	Text	32k		

3. *PAST HEALTH*

May contain multiple records to represent each past health situation.

Table 3: Past Health

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
68	Category Summary Line	Y	A text string, summarizing the content of the following more structured fields and information contained about past health	AN	Text	64k		Export: Each exported Past Health item must have its own Category Summary Line. At minimum the Category Summary Line must include following data elements and format: ▪ Past Health Problem Description or Procedures ▪ Start Date Category Summary Line must comply with standard format (refer to Working with Category Summary Line) Import: Category Summary Line can be imported at vendor discretion.
69	Residual Data Element Name(*)		Name of the data field	AN	Text	NL		The descriptive or reference name of the data item within the source EMR.
70	Residual Data Element Type(*)	Y**	Name of the data type The primitive XML data type of the data field.	AN	Text	NL	Primitive XML data type: http://www.w3.org/TR/xmlschema-2/) See Table 2.1 – XML Primitive Data Types	Residual Data Element Type must be valid code The data type by which the 'Residual Content' is to be interpreted.
71	Residual Content(*)	Y**	Name of the data value	BOT	Text	NL		
72	Past Health Problem/Diagnosis or Procedure Description.		Description of Health Condition.	AN	Text	250		Data element to be populated regardless if the exporting system does or does not support a *Standard Coding System.* *Same business rules as for #60*
73	Diagnosis / Procedure Coding System Name		The name of the Standard Coding System used to code a health condition or procedure.	AN	Text	250	Example: ENCODE-FM, SNOMED-CT, ICD9, ICD10-CA, ICPC-2, etc	Required if diagnosis code &/or description provided. For additional business rules, see above (#72)
74	Diagnosis/Procedure Code	Y**	The code associated with Diagnosis/Procedure as relates to a particular Standard Coding System (item#73).	AN	Text	20		Mandatory if the Diagnosis Code System Name is provided. Vendor's proprietary diagnosis/procedure code is

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
								not required to be exported. For additional business rules, see above (#72).
75	Diagnosis/Procedure Description	Y**	The Description of a diagnosis/procedure as relates to a particular Standard Coding System (item #74)	AN	Text	250		Mandatory if the Diagnosis Code System Name is provided. May be the same or different than 'Past Health Problems or Procedures' data element. For additional business rules, see above (#72).
76	Onset or Event Date		Date or period of Onset of the condition	DATE	YYYY-MM-DD	10	W3C Date Standard	May contain exact date or approximate date.
77 N	Life Stage at Onset		The stage of life the patient is in at the Onset of the condition	AN	Code	1	One of: ▪ N - Newborn ▪ I – Infant ▪ C - Child ▪ T- Adolescent ▪ A - Adult	Life Stage must be valid code.
78	Resolved Date		Date or approx. time of resolution of condition	DATE	YYYY-MM-DD	10	W3C Date Standard	May contain exact date if known or approximate date of resolution.
79 N	Procedure Date		Date of the Procedure	DATE	YYYY-MM-DD	10		
80	Notes		General notes about the specific Past Health situation	AN	Text	64k		

4. *PROBLEM LIST*

May contain multiple records to represent each health problem, sign or symptom.

Table 4: Problem List

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
81	Category Summary Line	Y	A text string, summarizing the content of the following structured fields and information contained about the current relevant problem(s), signs and symptoms	AN	Text	64k		Export: Each exported Problem Health item must have its own Category Summary Line. At minimum the Category Summary Line must include following data elements and format: ▪ Diagnosis Problem Description ▪ Start Date Category Summary Line must comply with standard format (refer to Working with Category Summary Line) Import: Category Summary Line can be imported at vendor discretion
82	Residual Data Element Name(*)		Name of the data field	AN	Text	NL		The descriptive or reference name of the data item within the source EMR.
83	Residual Data Element Type(*)	Y*	Name of the data type The primitive XML data type of the data field.	AN	Text	NL	Primitive XML data type: http://www.w3.org/TR/xmlschema-2/) See Table 2.1 – XML Primitive Data Types	Residual Data Element Type must be valid code The data type by which the 'Residual Content' is to be interpreted.
84	Residual Content(*)	Y*	Name of the data value	BOT	Text	NL		
85	Problem / Diagnosis Description		A description that identifies the diagnosis/ problem .	AN	Text	250		Data element to be populated regardless the fact the exporting system does or does not support a *Standard Coding System.* *Same business rules as #60*
86	Diagnosis Code System Name		The name of the Standard Coding System used to code a health condition or procedure.	AN	Text	250	Example: ENCODE-FM, SNOMED-CT, ICD9, ICD10-CA, ICPC-2, etc	Required if diagnosis code &/or description provided. For additional business rules, see above (#85)
87	Diagnosis Code	Y**	The code associated with Diagnosis as relates to a particular Standard Coding System (item#86).	AN	Text	20		Problem code as entered by the healthcare provider

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
88	Diagnosis Code Description	Y**	The Description of a diagnosis as relates to a particular Standard Coding System (item #87)	AN	Text	250		Mandatory if the Diagnosis Code System Name is provided. May be the same or different than 'Diagnosis / Problem Description'. For additional business rules, see above (#85).
89	Problem Description		A description of the problem reported.	AN	Text	250		May be blank if no problem description was reported
90	Problem Status		The activity of the problem	AN	Text	50		Status as defined by the sending EMR
91	Onset Date	Y	Date of onset	DATE	YYYY-MM-DD	10	W3C Date Standard	May contain exact or partial date if known.
92 N	Life Stage at Onset		The stage of life the patient is in at the Onset of the condition	AN	Code	1	One of: ▪ N - Newborn ▪ I – Infant ▪ C - Child ▪ T- Adolescent ▪ A - Adult	Life Stage must be valid code.
93	Resolution Date		Date problem resolved	DATE	YYYY-MM-DD	10	W3C Date Standard	May contain exact or partial date if known.
94	Notes		Any information the source system has recorded as medically relevant and stored in the source system as a note.	AN	Text	64k		

5. *RISK FACTORS*

May contain multiple records to represent each risk factor.

Table 5: Risk Factors

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
95	Category Summary Line	Y	A text string, summarizing the content of the following structured fields and information contained about the Risk Factors.	AN	Text	64k		Export: Each exported Risk Factor item must have its own Category Summary Line. At minimum the Category Summary Line must include following data elements: ▪ Risk Factor ▪ Start Date Category Summary Line must comply with standard format (refer to Working with Category Summary Line) Import: Category Summary Line can be imported at vendor discretion.
96	(*) Residual Data Element Name		Name of the data field	AN	Text	NL		The descriptive or reference name of the data item within the source EMR.
97	(*) Residual Data Element Type	Y*	Name of the data type. The primitive XML data type of the data field.	AN	Text	NL	Can be any primitive XML data type (http://www.w3.org/TR/xmlschema-2/) See Table 2.1 – XML Primitive Data Types	Residual Data Element Type must be valid code The data type by which the 'Residual Content' is to be interpreted.
98	(*) Residual Content	Y*	The content of the residual data element.	BOT	Text	NL		
99	Risk Factor		Factors placing patient at health risk.	AN	Text	120		
100	Exposure Details		Specific agent details of the exposure.	AN	Text	1k		
101	Age of Onset			NUM	Text	3		
102	Start Date		Date the patient was first exposed to the risk factor	DATE	YYYY-MM-DD	10	W3C Date Standard	Date may be a partial date if known.
103	End Date		Date the patient was last exposed to the risk factor	DATE	YYYY-MM-DD	10	W3C Date Standard	Date may be a partial date if known.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
104 N	Life Stage		The stage of life the patient is in at the Start Date of the condition.	AN	Code	1	One of: ▪ N - Newborn ▪ I – Infant ▪ C - Child ▪ T- Adolescent ▪ A - Adult	
105	Notes		Captures additional notes about a risk factor.	AN	Text	64k		

6. *ALLERGIES & ADVERSE REACTIONS*

May contain multiple records to represent each allergy & adverse reaction.

Table 6: Allergies and Adverse Reactions

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
106	Category Summary Line	Y	A text string, summarizing the content of the following structured fields and information contained about the Allergy& Adverse Reaction	AN	Text	64k		Export: Each exported Allergy & Adverse Reaction item must have its own Category Summary Line. At minimum the Category Summary Line must include following data elements and format: ▪ Property of Offending Agent ▪ Start Date Category Summary Line must comply with standard format (refer to Working with Category Summary Line) Import: Category Summary Line can be imported at vendor discretion.
107	(*) Residual Data Element Name		Name of the data field	AN	Text	NL		The descriptive or reference name of the data item within the source EMR.
108	(*) Residual Data Element Type	Y*	Name of the data type. The primitive XML data type of the data field.	AN	Text	NL	Primitive XML data type (http://www.w3.org/TR/xmlschema-2/) See Table 2.1 – XML Primitive Data Types	Residual Data Element Type must be valid code The data type by which the 'Residual Content' is to be interpreted.
109	(*) Residual Content	Y*	The content of the residual data element.	BOT	Text	NL		
110	Offending Agent Description		Text description of agent, whether drug or non-drug.	AN	Text	120		
111	Property of Offending Agent		Agent that caused the related allergy or adverse reaction	AN	Code	2	One of: ▪ Drug (DR); ▪ Non-drug (ND) and ▪ Unknown (UK)	Property of Offending Agent must be valid code. See Table 6.1 – Property of Allergy/Adverse Reaction Offending Agent
112	Code Type		DIN is the only code type supported currently.	AN	Text	3		Required where code value provided is a drug related DIN.
113	Code Value		The values of the representative DIN.	AN	Text	20		Mandatory if Code Type data element is populated. If the allergy or adverse reaction is related to a drug, then a representative DIN code needs to be

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
								included. If the allergy or adverse reaction is due to a non-drug then data element will not be populated.
114	Reaction Type		Identifies the type of reaction as allergy or adverse reaction	AB	Code	2	One of: ▪ Allergy (AL) or ▪ Adverse Reaction (AR)	Reaction Type must be valid code. See Table 6.2 – Allergy/Adverse Reaction Type
115	Start Date		Start Date of Allergy or Adverse Reaction	DATE	YYYY-MM-DD	10	W3C Date Standard	May contain partial date.
116 N	Life Stage at Onset		The stage of life the patient is in at the Start Date of the condition	AN	Code	1	One of: ▪ N - Newborn ▪ I – Infant ▪ C - Child ▪ T- Adolescent ▪ A - Adult	
117	Severity		The severity is coded to determine its significance	AN	Code	2	One of: ▪ Mild (MI), ▪ Moderate (MO) ▪ Severe Life Threatening (LT) ▪ No Reaction (NO)	Severity must be valid code. Vendor should map the severity levels in their system to the provided levels. See Table 6.3 – Allergy/Adverse Reaction Severity
118	Reaction		A short text field to note reaction, e.g. Rash, Lip swelling, etc	AN	Text	120		
119	Recorded Date		Date corresponding to Known Allergies Date the allergy/adverse reaction is recorded in the EMR.	DATE	YYYY-MM-DD	10	W3C Date Standard	Partial Date is acceptable.
120	Notes		Additional Notes about Allergies or Adverse Reactions	AN	Text	32k		

7. *MEDICATIONS and TREATMENTS*

All medications and treatments current and past that are recorded need to be exported and imported.
May contain multiple records to represent each medication.
In the case of the same medication being prescribed multiple times then there will be one such record for each prescription.

Table7: Medications

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
121	Category Summary Line	Y	A text string, summarizing the content of the following structured fields and information contained about Medications.	AN	Text	64k		Export: Each exported Medication item must have its own Category Summary Line. At minimum the Category Summary Line must include following data elements: ▪ Medication Name or Drug Description (for compound) ▪ Start Date Category Summary Line must comply with standard format (refer to Working with Category Summary Line) Import: Category Summary Line can be imported at vendor discretion.
122	(*) Residual Data Element Name		Name of the data field	AN	Text	NL		The descriptive or reference name of the data item within the source EMR.
123	(*) Residual Data Element Type	Y*	Name of the data type. The primitive XML data type of the data field.	AN	Text	NL	Can be any primitive XML data type (http://www.w3.org/TR/xmlschema-2/) See Table 2.1 – XML Primitive Data Types	Residual Data Element Type must be valid code The data type by which the 'Residual Content' is to be interpreted.
124	(*) Residual Content	Y*	The content of the residual data element.	BOT	Text	NL		
125	Prescription Written Date		The written date of the current prescription	DATE	YYYY-MM-DD	10	W3C Date Standard	Full date or partial date is acceptable.
126	Start Date		The start date of the current prescription.	DATE	YYYY-MM-DD	10	W3C Date Standard	Must be on or after the written date.
127	Drug Identification Number		Representative Drug Identification Number (DIN).	AN	Text	20		Required if the medication is coded within the exporting EMR's Drug Database.
128	Medication Name		The name assigned to a drug.	AN	Text	120		

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
	(previously Name)							
129	Drug Strength (previous Strength)		The quantity of the ingredient in a drug.	AN	Text	10	Example : IngredientX 250mg/5ml: DrugQuantity250mg, DrugVolume=5ml IngredientY: 250mg/ml: DrugStrength=250mg, DrugStrengthUnitOfMeasure=1ml IngredientZ 250mg/tablet DrugStrength=250mg, DrugStrengthUnitOfMeasure=tablet	The drug strength from the drug database when DIN is provided **else** the strength as entered by the provider. Upon export, just the strength of the first ingredient is expected to be exported for the case the drug has a representative DIN else the strength as entered by provider. New: Sample export format for drug strength: IngredientX: 250/5 IngredientY: 250/1 IngredientZ: 250/1
130	Drug Strength Unit of Measure (previously Strength Unit Of Measure)		Drug's strength unit of measure, as prescribed in the source system.	AN	Text	20	See above	New: Sample export format IngredientX: mg/ml IngredientY: mg/ml IngredientZ: mg/tablet
131	Number of Refills/Repeats		Subsequent fills that follow the initial prescription.	NUM	Text	100		
132	Dosage		Dose *amount* of medication intended to be consumed during a single administration as prescribed in the source system.	AN	Text	120		Dosage unit of measure must be mapped to HL7 standard. Example 'Dosage & Dosage Unit of Measure' : 2 tsp , 2 puffs, 2%, 5 ml, 250 mg
133 N	Dosage Unit of Measure		Unit of measure of a drug dosage taken at any one time.	AN	Text	50		
134	Drug Form (previously Form)		Form of administration, as prescribed in the source system.	AN	Text	120		Form must be mapped to HL7 standard.
135	Route		Route of administration, as prescribed in the source system	AN	Text	120		Route must be mapped to HL7 standard.
136	Frequency		Frequency of prescribed use, as prescribed in the source system	AN	Text	120		Exporting source system should map medication frequency to the values catalogued.
137	Duration		*Number of days* of medication to be dispensed for the first administration of the	NUM	Text	1k		If the source system supports durations that are other than day (ie weeks, mth, year) then upon export the duration must be calculated in 'days'.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
			prescription.					
138 N	Refill Duration		Number of days of medication to be dispensed for the refills of the prescription.	NUM	Text	1k		If the source system supports durations that are other than day (ie weeks, mths, year) then upon export the duration must be calculated in 'days'. The 'Refill Duration' applies just to one refill.
139	Quantity		The quantity of medication to be dispensed for the first administration of the prescription	NUM	Text	1k		It is assumed that the unit of measure is the same as the Dosage Unit of Measure.
140 N	Refill Quantity		The quantity of medication to be dispensed for the refills of the prescription	NUM	Text	1k		It is assumed that the unit of measure is the same as the Dosage Unit of Measure.
141	Long Term Medication		Indicator for Long-Term Medication	AN	Code	1	Yes (Y) or No (N)	
142	Past Medication		Indicator for discontinuation of medication treatment plan.	AN	Code	1	Yes (Y) – discontinued medication No (N) - current medication	
143	Prescribed By Last Name		Last name of prescriber	AN	Text	50		
144	Prescribed By First Name		First name of prescriber	AN	Text	50		
145	Prescribed By Identifier		OHIP Physician number of prescriber	NUM	Text	6		
146	Notes		Notes the provider may attach to the prescription record to communicate with the pharmacist	AN	Text	32k		**Implementation Note:** The field length issues (CMS3.02 length of 32k/32000 versus MR2009 field length of 2000) will be resolved in a subsequent release of the EMR specification.
147	Prescription Instructions		Refers to directions for use.	AN	Text	32k		
148	Patient compliance		Typically used to indicate that the patient is compliant with the medication as prescribed	AN	Text	1		The values for this data element must be "Y", "N", or blank. If blank the patient's compliance with their medication has not been documented in the EMR.
149 N	Treatment Type		Describes the categorization of the treatment type required by the MR2009 message.	AN	Text	50	Valid values are: ▪ CHRON – Continuous/chronic ▪ ACU – Acute ▪ ONET – One Time ▪ PRN Long-term – As needed ▪ PRN Short-term – As needed	
150	Prescription Status		Describes the lifecycle of the	AN	Code	10	Valid statuses are: ▪ New,	

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
N			prescription as required by the MR2009 message.				▪ Active, ▪ Suspended, ▪ Aborted, ▪ Completed, ▪ Obsolete ▪ Nullified	
151 N	Non-Authoritative Indicator	Y	Indicates that the electronically stored (and retrieved) prescription is non-authoritative (i.e. A paper copy must be viewed before the prescription can be dispensed).	AN	Text	1	Yes (Y) – paper copy required before dispense No (N) – no paper copy required before dispense	
152 N	Prescription Identifier		Unique ID to identify a prescription.	AN	Text	50		
153 N	Prior Prescription Reference Identifier		A reference to a previous prescription which the current prescription replaces.	AN	Text	20		
154 N	Dispense Interval		Indicates a minimum amount of time that must occur between dispenses.	AN	Text	10		
155 N	Drug Description		A free form textual description of a drug. This usually is only populated for custom compounds, providing instructions on the composition and creation of the compound.	AN	Text	2000		Can be used to define a compound. **Rationale:** Allows description of compound ingredients and/or recipe in free text form.
156 N	Substitution Not Allowed		A prescriber's instruction that a specific prescribed product be dispensed as is, or not.	AN	Text	1	Yes (Y) – substitution not allowed No (N) – substitution allowed	
157 N	Problem Code		A coded form of the problem that is the reason for the current prescription required by the MR2009 message	AN	Code	10		
158 N	Protocol Identifier		A unique identifier for a specific protocol or guideline which the prescription has been written in accordance with.	AN	Text	20		

8. *IMMUNIZATIONS*

May contain multiple records to represent each immunization.
In the case of the same immunization, vaccine and or booster administered multiple times then there will be one such record for each occurrence.

Table 8: Immunizations

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
159	Category Summary Line	Y	A text string, summarizing the content of the following structured fields and information contained about the Immunization record.	AN	Text	64k		Export: Each exported Immunization item must have its own Category Summary Line. At minimum the Category Summary Line must include following data elements and format: ▪ Immunization Name or Immunization Type ▪ Date Category Summary Line must comply with standard format (refer to Working with Category Summary Line) Import: Category Summary Line can be imported at vendor discretion.
160	Residual Data Element Name(*)		Name of the data field.	AN	Text	NL		The descriptive or reference name of the data item within the source EMR.
161	Residual Data Element Type(*)	Y*	Name of the data type. The primitive XML data type of the data field.	AN	Text	NL	Can be any primitive XML data type (http://www.w3.org/TR/xmlschema-2/) See Table 2.1 – XML Primitive Data Types	Residual Data Element Type must be valid code The data type by which the 'Residual Content' is to be interpreted.
162	Residual Content(*)	Y*	The content of the residual data element.	BOT	Text	NL		
163	Immunization Name	Y	Immunization Name is based on the brand name and can be associated with a DIN as provided by EMR's Drug Database.	AN	Text	120		Export historical data: ▪ If DIN number is extractable then export the Brand Name ▪ If DIN number is not extractable then export the available name/type Export starting with EMR v4.0: ▪ If DIN number is extractable then export the Immunization's Brand Name (#163) **and** the associated Immunization Type (#164) ▪ If DIN number is not extractable then export the

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
								available Immunization Name With different data extracts (ie Diabetes Registry), EMR Offering must be able to identify the Immunization Name / DIN as belonging to an Immunization Type as defined in '***Canadian Immunization Guide'***.
164 N	Immunization Type		Immunization Type is the Immunogen component of the Vaccine Type as prescribed in the 'Canadian Immunization Guide'.	AN	Code	20	See Table 8.1 – Immunization Type (Abbreviation). http://www.phac-aspc.gc.ca/publicat/cig-gci/app-ann-eng.php	Export historical data: ▪ If DIN number is extractable then export the type if available ▪ If DIN number is not extractable then this field should be empty Export starting with EMR v4.0 Spec. ▪ If DIN number is extractable then export the predefined Immunization Type ▪ If DIN number is not extractable then export the selected predefined Immunization Type.
165	Manufacturer		Manufacturer of the administered immunization	AN	Text	120		
166	Lot #		The product lot number corresponding to the administered immunization.	AN	Text	120		
167	Route		Route or method of immunization used.	AN	Text	120		
168	Site		Site location corresponding to the administered immunization.	AN	Text	120		
169	Dose		Dose amount and unit of measure corresponding to the administered immunization.	AN	Text	120		
170	Immunization Code		A coded identifier for the immunization.	AN	Text	20		Use DIN where the immunization has a representative DIN
171	Coding Vocabulary		Vocabulary to denote the immunization code (currently "DIN")	AN	Text	3		Valid value: 'DIN'
172	Date		Date that the immunization was administered or refused.	DATE	YYYY-MM-DD	10	W3C Date Standard	

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
173	Refused Flag	Y	A flag to indicate that the immunization was not given but refused.	AB	Text	1	Yes (Y) – refused immunization No (N) – administered immunization	
174	Instructions			AN	Text	250		
175	Notes		Field to allow provider to enter additional information about patient immunization.	AN	Text	32k		

9. *LABORATORY RESULTS*

May contain multiple records to represent each of the electronically received or manually entered Laboratory Results.
It is mandatory to export all available Laboratory Results electronically received or manually entered into the EMR

Table 9: Laboratory Results

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
176	Laboratory Name	Y	Name of the Lab delivering the Test Results	AN	Text	120		Lab responsible for issuing the test result (not necessarily the lab performing the test)
177	Test Name Reported by Laboratory		Test name reported by Laboratory	AN	Text	120		
178	Test Code		Test Code Reported by the Laboratory	AN	Text	50		
179	Test Result Name		Exporting system or physician description of the name used to identify the lab test result	AN	Text	120		E.g. Hemoglobin
180	Accession Number		Accession number issued by lab for the test result(s) report	AN	Text	120		Required if Lab provides this information
181	Result Value		The numeric result value	AN	Text	120		Required where there is a numeric test result. Include decimal places
182	Result Unit of Measure		Unit of Measure as supplied by the Lab associated with the Result Value	AN	Text	120		Includes unit quantity and unit of measure numeric and alpha numeric. Required where a test result value is provided
183	Reference Range Low Limit		A numeric value where it exists	NUM	Text	1k		Required where there is a numeric test result. Include decimal places
184	Reference Range High Limit		A numeric value where it exists	NUM	Text	1k		Required where there is a numeric test result. Include decimal places
185	Reference Range Text		Where lab sends high and/or low data that can't be parsed as high or low reference range	AN	Text	1k		
186	Lab Requisition Date/Time		Date & Time that the lab test was ordered	DATE/ TIME		30	W3C Date Standard	Format: YYYY-MM-DDThh:mm:ss.sTZD
187	Collection Date/Time	Y	The date and time that the specimen was collected	DATE/ TIME		30	W3C Date Standard	Date followed by Time as recorded by the Testing Lab.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
								Format: YYYY-MM-DDThh:mm:ss.sTZD
188	(*) Date/Time Result Reviewed		The date the lab result is reviewed.	DATE		30	W3C Date Standard	Format: YYYY-MM-DDThh:mm:ss.sTZD
189	(*)Result Reviewer First Name		The First Name of the authorized person that reviewed result.	AN	Text	50		
190	(*) Result Reviewer Last Name		The Last Name of the authorized person that reviewed result.	AN	Text	50		
191	(*) Result Reviewer OHIP Physician Number		The OHIP Physician Number of the authorized person that reviewed result.	AN	Text	6		
192	Result Normal / Abnormal Flag		A flag set by the lab to indicate a test result is deemed normal, abnormal or unknown.	AN	Code	1	Abnormal (Y), Normal (N) or Unknown (U)	If there is no CDS Data available in this data field the EMR must translate the value of this data field to Unknown (U)
193	Text – Test Results Information reported by the Laboratory		Results Information reported by the Laboratory that must be left unstructured (e.g. microbiology results, cytology, etc.)	AN	Text	32k		
194	Notes from Lab		Notes Associated from Results reported by Lab.	AN	Text	32k		
195	Physician’s notes		Physicians Notes Associated with Results reported.	AN	Text	32k		
196 N	OLIS Test Result Status		The status of the Test Result as provided by OLIS.	AN	Code	1		

10. *APPOINTMENTS*

May contain multiple records each of which describes a past or future appointment for a patient.
Export Appointments: (1) do not export future appointments and (2) all appointments belonging to a patient, regardless the practitioner must be exported
Import Appointments: All appointments related to a patient must be imported, whether the practitioner is or is not part of the new EMR implementation.

Table 10: Appointments

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
197	Appointment Time	Y	Appointment Time as scheduled in the source system	TIME		20	W3C Date Standard	Format: hh:mm:ss.sTZD
198	Duration		Length of appt. in minutes as scheduled in the source system	NUM	Text	1k		
199	Appointment Status		Status of the appointment	AN	Text	250		Example: Confirmed, Cancelled, No-Show, No-Cancellation Allowed and other descriptors possible.
200	Appointment Date	Y	Date of appointment	DATE	YYYY-MM-DD	10	W3C Date Standard	
201	Provider Last Name		Last name of Provider that patient is expected to visit	AN	Text	50		
202	Provider First Name		First name of Provider that patient is expected to visit	AN	Text	50		
203	Provider OHIP Physician Number		Provider ID Currently, Provider's OHIP Billing Number where it exists	AN	Text	6		
204	Appointment Purpose		Appointment Purpose / Reason for Visit	AN	Text	250		May contain procedure(s) and other details about the appointment.
205	Appointment Notes		Summary detailing the patient appointment	AN	Text	32k		Notes to include everything but the patient's name. Note: changed to non-mandatory in schema

11. *PHYSICIAN'S MY CLINICAL NOTES*

This section may contain one or more types of clinical notes that the physician and staff record and the physician signs-off.

Table 11: Physician's My Clinical Notes

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
206	Note Type		Heading to identify the type of note as per Business Rules	AN	Text	50		Physician Progress Note, Referral Note and other.
207	My Clinical Notes Content		Text content of the Clinical Note	AN	Text	NL		Format the note according to the order that the information was entered. Any SOAP note must be a single text note. Each Subjective, Objective, Assessment and Plan component of a note needs to be concatenated into one(1) note if it is stored/processed separately.
208	Event Occurred Date/Time		Date and Time of the appointment.	DATE/ TIME		20	W3C Date Standard	This is the appointment date/time when patient presents. Format: YYYY-MM-DDThh:mm:ss.sTZD
209	Note Date and Time Entered		Date and time note was entered in the EMR	DATE/ TIME		30	W3C Date Standard	This is the date when the Progress Note /SOAP was first created. Format: YYYY-MM-DDThh:mm:ss.sTZD
210	(*) Note Date and Time Signed		Date and time note was signed	DATE/ TIME		30	W3C Date Standard	Format: YYYY-MM-DDThh:mm:ss.sTZD
211 N	(*) Note Provider First Name		First Name of the authorized person that signed the Note.	AN	Text	50		
212 N	(*) Note Provider Last Name		Last Name of the authorized person that signed the Note.	AN	Text	50		
213	(*) Note Signatory OHIP ID		OHIP number to identify the physician that signed the Note.	NUM	Text	6		Provide OHIP id number of the person who signed the note, if available.

12. *REPORTS RECEIVED*

This section may contain one or more Reports Received as text, audio and image files.

Table 12: Reports Received

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
214	Report Media		The media used for the report.	AN	Code	20	Email Download Portable Media Hardcopy	
215	Report Format	Y	The format used for the report.	AN	Code	50	Text Binary	If Report format equals: **Text:** Report Content Data Element contains the embedded text of the report **Binary:** Report Content Data Element contains a base64 encoded binary file, defined by the Report File Extension
216	Report Type File Extension	Y***	File Extension of the report defined in the Report Content Data Element.	AN	Text	50		Vendor to consistently specify the format and extension of the file. Required if Report Format Data Element = Binary Example: .doc, .txt, .wav, mp3, .jpg, etc. Note: Y*** - mandatory if 'Report Format' = binary else not mandatory.
217	Report Content		Content of the Report.	AN	Text	NL		May be text or an encoded binary file. Report content to be organized according to the way it was entered by the user or received electronically. If report content is a binary file, this should be encoded into base64 and placed in this field.
218	Report Class	Y	These are subcategories for Reports	AN	Code	50	One of: ▪ Diagnostic Imaging Report ▪ Diagnostic Test Report ▪ Cardio Respiratory Therapy Report ▪ Medical Record Report ▪ Consultant Report ▪ Lab Report	Vendor should map the report classes in their system to the provided report class. Note: additional options added to support scanned Lab Results and HRM reports.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
							▪ Other Letter	
219	Report Sub-class		These are the subcategories for a the Report Class	AN	Text	50		See Report Sub-Cass suggested entries in Table 12.1 corresponding to Report Sub-Class.
220	Event Occurred Date/Time		Date and Time the report was created.	DATE/ TIME		30	W3C Date Standard	Date Format: YYYY-MM-DDThh:mm:ss.sTZD
221	Report Date and Time Received		Date and time the report was received in the medical practice.	DATE/ TIME		30	W3C Date Standard	Date Format YYYY-MM-DDThh:mm:ss.sTZD
222	Source Physician		Report Principal Author First Name *and* Report Principal Author Last Name	AN	Text			Replaces: Report Principal Author First Name and Report Principal Author Last Name. The name of the author that originated the report. Note: Schema updated to support export of the physician's FirstName and Last Name discretely or concatenated.
223 N	Source Facility		Source / origin of report See Appendix A	AN	Text	120		The name of the external facility that originated the report. Examples: Hosp ital, Clinic. Note: Sending facility name from HRM to be mapped to this field.
224	(*) Reviewed by First Name		First Name of the authorized person that reviewed the Report	AN	Text	50		
225	(*) Reviewed by Last Name		Last Name of the authorized person that reviewed the Report.	AN	Text	50		
226	(*) Report Reviewed By		OHIP number to identify the physician that signed the Note.	AN	NUM	6		
227	(*) Report Date and Time Reviewed		Date and time report was reviewed.	DATE/ TIME		30	W3C Date Standard	If the report is not reviewed then this data element is left blank. Date Format: YYYY-MM-DDThh:mm:ss. sTZD
228	Sending Facility ID		Unique ID for a sending	AN	NUM	4		Ref Hospital Report Manager.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
N			facility.					EMPI number
229 N	Sending Facility Report Number		Unique ID for a report at the sending facility.	AN	Text	75		Ref. Hospital Report Manager The same Report Identifier is expected to address subsequent instances of the report resulting from changes or updates, additions, cancellation or reports that are resent.
230 N	(*) Accompanying Sub-Class		Mnemonic or description of the Sub-Class	AN	Text	60		Ref Hospital Report Manager
231 N	(*) Accompanying Mnemonic		Mnemonic for procedure in DI and CRT reports.	AN	Text	200		Ref. Hospital Report Manager.
232 N	(*) Accompanying Description		Description for procedure in DI and CRT reports.	AN	Text	200		Ref. Hospital Report Manager
233 N	(*) Observation Date Time		Date and Time that the observation/service was performed for each DI and CRT reports.	DATE/ TIME		30	W3C Date Standard	Ref. Hospital Report Manager Date Format: YYYY-MM-DDThh:mm:ss.sTZD
234 N	HRM Result Status		Status of message from Hospital Report Manager	AN	Text	1		Ref. Hospital Report Manager. Provided by Report Manager: ▪ S – Signed ▪ C – Cancelled
235 N	Message Unique ID		Unique identifier for each message	AN	Text	50		Ref. Hospital Report Manager This field is used when a transactional import of Report information from the OntarioMD Report Manager based on a Core Data Set file.

Table 12.1 – Report Sub-Class

Report Class	Report Sub-class Examples	
Diagnostic Imaging Report	Misc. X-Ray, Mammogram, Chest X-Ray, Abdomen X-Ray, Lumbar Spine X-Ray, Cervical Spine X-Ray, Upper GI Series, ERCP X-Ray, UGI with Small Bowel, Barium Enema, Myelogram, IVP, Hysterosalpingogram, Coronary Angiography, Carotid Angiography, Other Angiography, Misc. CT Scan, CT Scan Head, CT Scan Body, Misc. MRI Scan, MRI Scan Head, MRI Scan Body, Misc. Ultrasound, Ultrasound Abdomen, Ultrasound Pelvis, Ultrasound Obstetrical, Ultrasound Breast, Ultrasound Thyroid, Venous Doppler Ultrasound, Carotid Doppler Ultrasound, Sonohistogram, Echocardiogram, Misc. Nuclear Scan, Bone Scan, Stress Heart Scan (Thallium, Sestamibi, Myoview), Brain Scan, Lung Scan, Liver-Spleen Scan, Bone Densitometry, Retinal Tomograph, Retinal Angiography	
Diagnostic Test Reports	Misc. Diagnostic Test, Pap Test Report, Mantoux Test, ECG, Stress Test (Exercise, Persantine, Dobutamine), Holter Monitor, Loop Recorder, Ambulatory BP Monitoring, Arterial Segmental Pressures (ABI), Pulmonary Function Testing, Bronchoscopy, EEG, EMG, Sleep Study, EGD-oscopy, Sigmoidoscopy, Colonoscopy, Cystoscopy, Urodynamic Testing, Colposcopy, Audiogram	
Cardio Respiratory Report	Echocardiography Bubble Study, Pericardiocentesis, Echocardiography Esophageal	
Other Letters	Letter from Patient, Living Will, Power of Attorney for Health Care, Consent from Patient, Authorization from Patient, Letter from Lawyer, Letter from WSIB, Letter from Insurance Company, Disability Report, Miscellaneous Letter	
Report Sub-class for Consult *Consult Report Sub-class value = Value A + Value B* E.g. On-Call Physician Progress Report	*Consult Report Values A* On-Call Physician, On-Call Nurse, Emergency Physician, Urgent Care/Walk-In Clinic Physician, Hospitalis, Anaesthesiology, Allergy & Immunology, Audiology, Cardiology, Cardiovascular Surgery, Chiropody / Podiatry, Chiropractic, Clinical Biochemistry, Dentistry, Dermatology, Dietitian, Emergency Medicine, Endocrinology, Family Practice, Gastroenterology, General Surgery, Genetics, Geriatrics, Hematology, Infectious Disease, Internal Medicine, Kinesiology, Microbiology, Midwifery, Naturopathy, Neonatology, Nephrology, Neurology, Neurosurgery, Nuclear Medicine, Nursing, Nurse Practitioner, Obstetrics & Gynecology, Occupational Therapy, Oncology / Chemotherapy, Ophthalmology, Optometry, Oral Surgery, Orthopedic Surgery, Osteopathy, Other Therapy, Otolaryngology (ENT), Palliative Care, Pathology, Paediatrics, Pharmacology, Physical Medicine, Physiotherapy, Plastic Surgery, Psychiatry, Psychology, Diagnostic Radiology, Respiratory Technology, Respirology, Rheumatology, Social Work, Speech Therapy, Sports Medicine, Therapeutic Radiology, Thoracic Surgery, Urology, Uro-Gynecology, Vascular Surgery, Other Consultant	*Consult Report Values B* Consultation, Admission History, Operative Report, Discharge Summary, Progress Report, Encounter Report

13. *CARE ELEMENTS*

Care elements refer to clinical data captured as a part of the clinical encounter (as described in Appendix C – Chronic Disease Management Requirements).
May contain multiple records, each of which represents a patient health-related characteristic documented within the EMR.

Table 13.1: Smoking Status

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
236	Smoking Status	Y	Patient Status as a smoker.	AN	Text	1	Must Be one of: Y – Yes N – No	
237	Date Smoking Status Recorded	Y	Date smoking status recorded.	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if smoking status recorded.

Table 13.2: Smoking Packs/Day

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
238	Smoking Packs/Day	Y	Reported number of Packs/Day smoked.	NUM	Text	2	WHIC CDM Data Standards Appendix C, Item 3.6	
239	Date Smoking Packs/Day Recorded	Y	Date Smoking Packs/Day Recorded	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if smoking packs/day recorded.

Table 13.3: Weight

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
240	Weight	Y	Measured patient weight.	NUM	Text	1k		
241	Weight Unit of Measure	Y	Unit of measure	AN	Text	10		
242	Date Weight Recorded	Y	Date weight recorded	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if weight reported.

Table 15.4: Height

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
243	Height	Y	Measured patient height in cm	NUM	Text	1k		
244	Height Unit of Measure	Y	Unit of measure	AN	Text	10		
245	Date Height Recorded	Y	Date height recorded	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if height reported.

Table 13.5: Waist Circumference

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
246	Waist Circumference	Y	Measured patient waist circumference in cm	NUM	Text	1k		
247	Waist Circumference Unit of Measure	Y	Unit of measure	AN	Text	10		
248	Date Waist Circumference Recorded	Y	Date waist circumference recorded	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if waist circumference reported.

Table 13.6: Blood Pressure

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
249	Systolic Blood Pressure	Y	Measured systolic blood pressure in mmHg	NUM	Text	1k		
250	Diastolic Blood Pressure	Y	Measured diastolic blood pressure in mmHg	NUM	Text	1k		
251	BP Unit of Measure	Y	Unit of measure	AN	Text	10		
252	Date Blood Pressure Recorded	Y	Date blood pressure recorded	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if blood pressure reported.

Table 13.7: Screening for Further Complications - Diabetes

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
253	Exam Performed Code	Y	Code for the screening performed.	AN	Text	1k	32468-1 (Retinal Exam) 11397-7 (Foot Exam) Neurological Exam (No Code)	
254	Date Exam Performed	Y	Date exam was performed.	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if exam reported.

Table 13.8: Motivational Counseling - Diabetes

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
255	Counselling Performed	Y	Diabetes-related motivational counselling.	AN	Text	1k	Nutrition Exercise Smoking Cessation Other	Each instance of counselling documented must have its own record.
256	Date Item Addressed	Y	Date counselling was conducted.	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if counselling reported.

Table 13.9: Self-Management/Collaborative Goal Setting - Diabetes

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
257	Code Value		Code representing self-management or collaborative goal setting	AN	Text	1k		
258	Documented Goals Text	Y	Text of the documented diabetes-related self-management or collaborative goals.	AN	Text	NL		The descriptive text of the documented goals.
259	Documentation Date	Y	Date goals documented.	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if goals reported.

Table 13.10: Self-Management Challenges/Barriers to Self-Management - Diabetes

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
260	Code Value	Y	Code representing barriers to self-management	AN	Text	7	LOINC	This value will always be 44941-3 for this report.
261	Challenges Identified (Y/N)	Y	Reports whether the patient has identified any challenges or barriers to self-management of diabetes.	AN	Text	1		Either Yes (Y) or No (N).
262	Documentation Date	Y	Date challenges identified	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if challenges identified.

Table 13.11: Education/Self-Management Training - Diabetes

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
263	Education/Training performed (Y/N)	Y	Reports whether the patient has had any diabetes-related education, or self-management training	AN	Text	1	Either Yes (Y) or No (N).	
264	Documentation Date	Y	Date education/training documented.	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if education/training reported.

Table 13.12: Hypoglycemic Episodes

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
265	Number of Reported Episodes	Y	Patient self-reported frequency of episodes since last appointment.	NUM	Text	8		
266	Documentation Date	Y	Date frequency of hypoglycemic episodes reported.	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if frequency of hypoglycaemic episodes reported.

Table 34.13: Self-Monitoring of Blood Glucose

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
267	Self-Monitoring Y/N	Y	Patient report of whether they perform self-monitoring of blood glucose.	AN	Text	1	Either Yes (Y) or No (N).	
268	Documentation Date	Y	Date status of self-monitoring of blood glucose reported.	DATE	YYYY-MM-DD	10	W3C Date Standard	Mandatory if self-monitoring of blood glucose reported.

14. *ALERTS & SPECIAL NEEDS*

This section may contain Medical Alerts and Special. May contain multiple records, each of which represents a Medical Alert or Special Needs information documented within the EMR

Table 13: Reports Received

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
269 N	Category Summary Line		A text string, summarizing the content of the following structured fields and information contained about the Alerts & Special Needs.	AN	Text	NL		Export: Each exported Alerts & Special Needs item must have its own Category Summary Line. At minimum the Category Summary Line must include following data elements and format: ▪ Alert Description ▪ Date Active Category Summary Line must comply with standard format (refer to Working with Category Summary Line) Import: Category Summary Line can be imported at vendor discretion.
270 N	(*) Residual Data Element Name		Name of the data field	AN	Text	NL		
271 N	(*) Residual Data Element Type	Y*	Name of the data type. The primitive XML data type of the data field.	AN	Text	NL	Can be any primitive XML data type (http://www.w3.org/TR/xmlschema-2/) See Table 2.1 – XML Primitive Data Types	Residual Data Element Type must be valid code The data type by which the 'Residual Content' is to be interpreted.
272 N	(*) Residual Content	Y*	The content of the residual data element.	BOT	Text	NL		
273 N	Alert Description	Y	Description of the Alert or Special Need.	AN	Text	1k		
274 N	Notes		Field to capture additional notes about an alert or special need.	AN	Text	1k		
275 N	Date Active		Date the Alert or Special Need was first active.	DATE	YYYY-MM-DD	10	W3C Date Standard	
276 N	End Date		Date the Alert or Special Need was no longer active.	DATE	YYYY-MM-DD	10	W3C Date Standard	

3. SUPPORTING INFORMATION

3.1 CODE TABLES

This Section contains code tables referenced within the EMR Core Data Set.

Table 1.1: Name Prefix

Reference: HISCA - Stakeholder Client Data Set v1.2

http://www.health.alberta.ca/documents/HISCA-Stakeholder-Provider-Data.pdf

Code	Value
Bro	Brother
Capt	Captain
Chief	Chief
Cst	Constable
Corp	Corporal
Dr	Doctor
Fr	Father
Hon	Honourable
Lt	Lieutenant
Madam	Madam
Mme	Madame
Mlle	Mademoiselle
Major	Major
Mayor	Mayor
Miss	Miss
Mr	Mister
Mssr	Monsieur
Mrs	Mrs
Ms	Ms
Prof	Professor
Reeve	Reeve
Rev	Reverend
Rthon	Right Honourable
Sen	Senator
Sgt	Sergeant
Sr	Sister

Table 1.2: Name Part Type

Reference: CC e-Health Standards Code Tables to Support the Request and Clinical Care Data Set v1.0

Code	Value	Description
FAMC	Family	Family name, this is the name that links to the genealogy.
GIV	Given	Individual's given name not the common name shared by the family.

Table 1.3: Name Part Qualifier
Reference: CC e-Health Standards Code Tables to Support the Request and Clinical Care Data Set v1.0

Code	Value	Description
BR	Birth	A name that a person had shortly after being born. Usually for family names but may be used to mark given names at birth that may have changed later.
SP	Spouse	The name assumed from the partner in a marital relationship. Usually the spouse's family name. Note that no inference about gender can be made from the existence of spouse names.
CL	Callme	A callme name is (usually a given name) that is preferred when a person is directly addressed.
IN	Initial	Indicates that a name part is just an initial.

Table 1.4: Name Purpose
Reference: CC e-Health Standards Code Tables to Support the Request and Clinical Care Data Set v1.0

Code	*Value*	*Description*
HC	Health Card Name	As recorded on the health care card.
L	Legal Name	Known as/conventional/the one you use.
AL	Alias Name	Represents any self-asserted name the person is using or has used and/or any other name that a person is currently and/or was formerly known by, but which is different from all other type codes. An individual may have multiple alias names.
C	License Name	As recorded on a license, record, certificate, etc. (only if different from legal name).

Table 1.5: Name Suffix
Reference: HISCA - Stakeholder Client Data Set v1.2
http://www.health.alberta.ca/documents/HISCA-Stakeholder-Provider-Data.pdf

Code	Value
Jr	Junior
Sr	Senior
II	The Second
III	The Third
IV	The Fourth

Table 1.6: Province/State/Territory

Reference: CC e-Health Standards Code Tables to Support the Request and Clinical Care Data Set v1.0

Code	Value						
CA-AB	Alberta		US-GA	Georgia		US-NV	Nevada
CA-BC	British Columbia		US-GU	Guam		US-NY	New York
CA-MB	Manitoba		US-HI	Hawaii		US-OH	Ohio
CA-NB	New Brunswick		US-IA	Iowa		US-OK	Oklahoma
CA-NL	Newfoundland		US-ID	Idaho		US-OR	Oregon
CA-NS	Nova Scotia		US-IL	Illinois		US-PA	Pennsylvania
CA-NT	Northwest Territories		US-IN	Indiana		US-PR	Puerto Rico
CA-NU	Nunavut		US-KS	Kansas		US-RI	Rhode Island
CA-ON	Ontario		US-KY	Kentucky		US-SC	South Carolina
CA-PE	Prince Edward Island		US-LA	Louisiana		US-SD	South Dakota
CA-QC	Quebec		US-MA	Massachusetts		US-TN	Tennessee
CA-SK	Saskatchewan		US-MD	Maryland		US-TX	Texas
CA-YT	Yukon Territory		US-ME	Maine		US-UT	Utah
US-AK	Alaska		US-MI	Michigan		US-VA	Virginia
US-AL	Alabama		US-MN	Minnesota		US-VI	Virgin Islands
US-AR	Arkansas		US-MO	Missouri		US-VT	Vermont
US-AZ	Arizona		US-MS	Mississippi		US-WA	Washington
US-CA	California		US-MT	Montana		US-WI	Wisconsin
US-CO	Colorado		US-NC	North Carolina		US-WV	West Virginia
US-CT	Connecticut		US-ND	North Dakota		US-WY	Wyoming
US-CZ	Canal Zone		US-NE	Nebraska		-50	Not Available, Temporarily
US-DC	District of Columbia		US-NH	New Hampshire		-70	Asked, Unknown
US-DE	Delaware		US-NJ	New Jersey		-90	Not Applicable
US-FL	Florida		US-NM	New Mexico			

Table 1.7: Gender

Reference: CC e-Health Standards Code Tables to Support the Request and Clinical Care Data Set v1.0

Code	Value
M	Male
F	Female
O	Other
U	Unknown

Table 1.8: Preferred Phone

Code	Value
R	Residence
C	Cellular/Mobile
W	Work

Table 1.9: Official Language

Code	Value
ENG	English
FRE	French

Table 1.10: Contact Purpose

Code	Value
EC	Emergency Contact
NK	Next of kin
AS	Administrative Staff
CG	Care Giver
PA	Power of Attorney
IN	Insurance
GT	Guarantor
O	Other

Table 1.11: Enrollment Status

Code	Value
1	Patient is rostered to the primary physician
0	Patient is not rostered to the primary physician

Table 1.12: Enrollment Termination Codes

Reference: MOHLTC Fact Sheet: Fall 2005 – Enrolment Report Patient Details Termination Reasons

Code	Value	Description
12	ENDED BY MOH	Health Number error
14	ENDED BY MOH	Patient identified as deceased on ministry database
24	ADDED IN ERROR	Patient added to roster in error
30	ENDED BY MOH	Pre-member/ Assigned member ended; now enrolled or registered with red and white health card
32	ENDED BY MOH	Pre-member/ Assigned member ended; now enrolled or registered with photo health card
33	ENDED BY MOH	Termination reason cannot be released (due to patient confidentiality)
35	ROSTER TRANSFER	Patient transferred from roster per physician request
36	RE-ENROLLED	Original enrolment ended; patient now re-enroled
37	ENTERED LTC	Original enrolment ended; patient now enrolled as Long Term Care
38	LEFT LTC	Long Term Care enrolment ended; patient has left Long Term Care
39	ASSIGNED MEMBER ENDED	Assigned member status ended; roster transferred per physician request
40	MEMBER DECEASED	Physician reported member as deceased
41	ENDED BY MOH	Patient no longer meets selection criteria for your roster – assigned to another physician
42	ENTERED LTC	Physician ended enrolment; patient entered Long Term Care facility
44	ENDED BY PHYS	Physician ended patient enrolment
51	ENDED BY MOH	Patient no longer meets selection criteria for your roster
53	PATIENT MOVED	Physician ended enrolment; patient moved out of geographic area
54	PATIENT LEFT PROV	Physician ended enrolment; patient left province
56	ENDED BY PHYS	Physician ended enrolment; per patient request
57	ENDED BY MOH	Enrolment terminated by patient
59	MOH OUT OF GEO	Enrolment ended; patient out of geographic area
60	ENDED BY MOH	No current eligibility
61	GEO ACTIVATED	Patient out of geographic area; address over-ride applied
62	GEO DEACTIVATED	Patient out of geographic area; address over-ride removed
73	ENDED BY MOH	No current eligibility
74	ENDED BY MOH	No current eligibility
82	NO CONFIRMATION	Ministry has not received enrolment/ Consent form
84	ENDED BY MOH	Termination reason cannot be released (due to patient confidentiality)
90	ENDED BY MOH	Termination reason cannot be released (due to patient confidentiality)
91	ENDED BY MOH	Termination reason cannot be released (due to patient confidentiality)

Table 1.13: Person Status

Code	Value	Description
A	Active	Patient is a part of the practice
I	Inactive	Patient is not a part of the practice
D	Deceased	Patient is deceased

Table 1.14: Healthcare Practitioner Type

Reference: CC e-Health Standards Code Tables to Support the Request and Clinical Care Data Set v1.0

Code	Value
3111	Specialist Physicians
3112	General Practitioners and Family Physicians
3113	Dentists
3121	Optometrists
3122	Chiropractors
3123	Other Professional Occupations in Health Diagnosing and Treating
3131	Pharmacists
3132	Dieticians and Nutritionists
3141	Audiologists and Speech-Language Pathologists
3142	Physiotherapists
3143	Occupational Therapists
3144	Other Professional Occupations in Therapy and Assessment
3152	Registered Nurses
3214	Respiratory Therapists, Clinical Perfusionists and Cardio-Pulmonary Technologists
3221	Denturists
3222	Dental Hygienists and Dental Therapists
3231	Opticians
3232	Midwives and Practitioners of Natural Healing
3233	Licensed Practical Nurses
3235	Other Technical Occupations in Therapy and Assessment
4151	Psychologists
4152	Social Workers
4153	Family, Marriage and Other Related Counselors
4154	Ministers of Religion
4167	Recreation, Sports and Fitness Program Supervisors and Consultants
4212	Community and Social Service Workers
4213	Employment Counsellors
4215	Instructors and Teachers of Persons with Disabilities
4217	Other Religious Occupations

Table 2.1: XML Primitive Data Types

Reference: WC3 XML Schema Part 2: Datatypes, Section 3.2 – 28 October 2004)

Datatype	Description
string	The string datatype represents character strings in XML.
boolean	boolean has the ·value space· required to support the mathematical concept of binary-valued logic: {true, false}.
decimal	decimal represents a subset of the real numbers, which can be represented by decimal numerals.
float	float is patterned after the IEEE single-precision 32-bit floating point type [IEEE 754-1985].
double	The double datatype is patterned after the IEEE double-precision 64-bit floating point type [IEEE 754-1985].
duration	duration represents a duration of time. The ·value space· of duration is a six-dimensional space where the coordinates designate the Gregorian year, month, day, hour, minute, and second components defined in § 5.5.3.2 of [ISO 8601], respectively.
dateTime	dateTime values may be viewed as objects with integer-valued year, month, day, hour and minute properties, a decimal-valued second property, and a boolean timezoned property.
time	time represents an instant of time that recurs every day.
date	The ·value space· of date consists of top-open intervals of exactly one day in length on the timelines of dateTime, beginning on the beginning moment of each day (in each timezone), i.e. '00:00:00', up to but not including '24:00:00' (which is identical with '00:00:00' of the next day).
gYearMonth	gYearMonth represents a specific gregorian month in a specific gregorian year. The ·value space· of gYearMonth is the set of Gregorian calendar months as defined in § 5.2.1 of [ISO 8601].
gYear	gYear represents a gregorian calendar year.
gMonthDay	gMonthDay is a gregorian date that recurs, specifically a day of the year such as the third of May.
gDay	gDay is a gregorian day that recurs, specifically a day of the month such as the 5th of the month.
gMonth	gMonth is a gregorian month that recurs every year.
hexBinary	hexBinary represents arbitrary hex-encoded binary data.
base64Binary	base64Binary represents Base64-encoded arbitrary binary data.
anyURI	anyURI represents a Uniform Resource Identifier Reference (URI).

Table 6.1: Property of Allergy/Adverse Reaction Offending Agent

Code	Value	Description
DR	Drug	Offending agent is a drug/medication
ND	Non-drug	Offending agent is not a drug/medication
UK	Unknown	Offending agent is unknown

Table 6.2: Allergy/Adverse Reaction Type

Code	Value
AL	Allergy
AR	Adverse Reaction

Table 6.3: Allergy/Adverse Reaction Severity

Code	Value
NO	No Reaction
MI	Mild
MO	Moderate
LT	Severe Life Threatening

Table 7.1: Medication Frequency

Code	Value
QD	Once a day
BID	Two times a day
TID	3 times a day
QID	Four times a day
QAM	Every morning
QNOON	Once a day, at noon
QPM	Once a day, in the evening
QHS	Once a day, at night
Q1H	Every Hour
Q1-2H	Every 1-2 hours
Q2H	Every 2 hours
Q2-3H	Every 2-3 hours
Q3H	Every 3 hours
Q3-4H	Every 3-4 hours
Q4H	Every 4 hours
Q4-6H	Every 4 to 6 hours
Q6H	Every 6 hours
Q6-8H	Every 6 to 8 hours
Q8H	Every 8 hours
Q8-12H	Every 8 to 12 hours
Q12H	Every 12 hours
Q2D	Every 2 days
1/week	Once a week
2/week	Twice a week
1/5day	Once every 5 days
1/6day	Once every 6 days
21/28D	21 out of 28 days
1/month	Once a month
ONCE	A single dose
OTH	Other
PRN	as needed

Table 8.1 – Canadian Immunization Guide: Immunization Name – Abbreviations for Products Available in Canada

Immunization Type	Abbreviation
Active Immunizing Agents	
Bacillus Calmette-Guérin	BCG
Cholera - Oral	Chol-O
Cholera - E.coli - Oral	Chol-Ecol-O
Diphtheria, Tetanus, Acellular Pertussis - pediatric	DTaP
Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio - pediatric	DTaP-IPV
Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio, Haemophilus influenzae type b - pediatric	DTaP-IPV-Hib
Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio, Haemophilus influenzae type b, Hepatitis B - pediatric	DTaP-IPV-Hib-HB
Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio, Hepatitis B - pediatric	DTaP-IPV-HB
Diphtheria, Tetanus, Acellular Pertussis, Haemophilus influenzae type b - pediatric	DTaP-Hib
Diphtheria, Tetanus, Polio - pediatric	DT-IPV
Hepatitis A	HA
Hepatitis A and B	HAHB
Hepatitis A and Typhoid - Injection	HA-Typh-I
Hepatitis B	HB
Hepatitis B - Thimerosal free	HBTmf
Haemophilus influenzae type b	Hib
Influenza	Inf
Inactivated Polio	IPV
Japanese Encephalitis	JE
Meningococcal - Conjugate	Men-C
Meningococcal - Polysaccharide	Men-P-AC Men-P-ACWY
Measles, Mumps, Rubella	MMR
Measles, Rubella	MR
Pneumococcal-Conjugate - valent	Pneu-C-7
Pneumococcal-Polysaccharide - valent	Pneu-P-23
Rabies	Rab
Tetanus	T
Tetanus, Diphtheria - adult	Td
Tetanus, Diphtheria, Acellular Pertussis - adult	Tdap
Tetanus, Diphtheria, Inactivated Polio - adult	Td-IPV
Tickborne Encephalitis	TBE
Typhoid - Injection	Typh-I
Typhoid - Oral	Typh-O
Varicella	Var
Yellow Fever	YF
Passive Immunizing Agents	
Botulism Antitoxin	BAtx
Diphtheria Antitoxin	DAtx
Immune Globulin	Ig
Hepatitis B Immunoglobulin	HBIg
Rabies Immunoglobulin	RabIg
Respiratory Syncytial Virus Immunoglobulin	RSVIg
Tetanus Immunoglobulin	TIg
Varicella Immunoglobulin	VarIg

3.2 RESIDUAL DATA

Within each respective section of the Core Data Set, residual data will be captured within three fields.
This structure will allow exporting EMR vendors a flexible method to represent existing data that does not fit into any other defined field and allow importing EMR vendors to quickly identify what the residual data represents and its corresponding data type.
All three fields must be grouped in a set and can be repeated multiple times, as a group, within each section as required.

Field Name	Field Description	XML	Notes
Residual Data Element Name	The name of the data field	<name> … </name>	
Residual Data Element Type	The primitive XML datatype of the data field	<datatype> … </datatype>	Mandatory if a Residual Data Element Name is provided
Residual Data Element Content	The content of the data element	<content> … </content>	Mandatory if a Residual Data Element Name is provided

To illustrate an example of how the residual data fields are to be used, assume that a patient has the following Personal History information that needs to be exported (NOTE: This is only an example and not the expected format for validation):

Dislocated Shoulder, May 3, 2000
Using the residual data fields, this data can be represented:

```
<ResidualInfo>
        <cdsd:DataElement>
                <cdsd:Name>Incident</ cdsd:Name >
                <cdsd:DataType>text</cdsd:DataType>
                <cdsd:Content>Dislocated Shoulder</cdsd:Content>
        </cdsd:DataElement>
        <cdsd:DataElement>
                <cdsd:Name >Incident Date</cdsd:Name>
                <cdsd:DataType>date</cdsd:DataType>
                <cdsd:Content>20000503</cdsd:Content>
        </cdsd:DataElement>
</ResidualInfo>
```

3.3 README.TXT

ReadMe.txt will, at a minimum, include the following information:

- Contact information of the Physician Group the data is being exported from
- Name of EMR vendor, Offering and version number (if used) the data is being exported from
- Date and Time stamp at time of export
- Total patients files exported

Example: ReadMe.txt:

Physician Group	“Fairlaine FHN”
EMR Vendor, Product & Version	“Sparrow”, “Sparrow Hawk, version 1.3.4”
Date and Time stamp	“January 1, 2007, 12:00am
Total patients files extracted	“5,238”

3.4 EXPORT EVENT LOG

The Export Event Log will at a minimum include the following information:

- Patient ID
- CDS Categories and their respective number of occurrences within the category

Example A: "Export Event Log" file:

Patient ID	Family History	Past Health	Problem List	Risk Factor	Allergy & Adverse Reaction	Medication	Immunization	Labs	App	My Clinical Notes	Reports:		Care Elements	Alerts & Special Needs
											Text	Binary		
ID0000001	2	7	8	2	1	1253	7	7	7	7	123	234	289	25
ID0000002	5	9	9	3	0	167	8	8	8	8	23	34	0	10
ID0000003	1	3	11	2	1	237	9	9	9	9	0	0	0	15

3.5 IMPORT EVENT LOG

The Import Event Log will at a minimum include the following information:

- Patient ID
- CDS Categories and their respective number of occurrences within the category that were imported

Example: "Import Event Log" file:

Patient ID	Family History	Past Health	Problem List	Risk Factor	Allergy & Adverse Reaction	Medication	Immunization	Labs	Appointment	My Clinical Notes	Reports:		Care Elements	Alerts & Special Needs
											Text	Binary		
ID0000001	2	7	8	2	1	1253	7	7	7	7	123	234	289	25
ID0000002	5	9	9	3	0	167	8	8	8	8	23	34	0	10
ID0000003	1	3	11	2	1	237	9	9	9	9	0	0	0	15

3.6 WORKING WITH NAME PART ELEMENTS

As a guide for using the Name Part the following applies: when sharing clients' given name parts, the distinction between first, second, and third given name parts is inferred from the natural order in which they would be displayed and exported [in Canada, that means first given name part first, second given name part second third given name part third, (followed by family name part).]. Canadians may have numerous middle names, which need to be represented in the CDS export. As a result, it is important to consider the 2nd, 3rd and 4th names as 'given names'.

Example:
Name (text): Jane Smith Doe, Brown will be translated into following and provided by export in this order:

Name Part: ***Jane***
Name Part Type: 'Given'
Name Part Qualifier: 'Birth'
Name Purpose: 'Legal'

Name Part: ***Smith*** this is how the *middle name* is communicated / represented
Name Part Type: 'Given'
Name Part Qualifier: 'Birth'
Name Purpose: 'Legal'

Name Part: ***Doe***
Name Part Type: 'Family'
Name Part Qualifier: 'Spouse'
Name Purpose: 'Legal'

Name Part: ***Brown***
Name Part Type: 'Family'
Name Part Qualifier: 'Birth'
Name Purpose: Legal

3.7 WORKING WITH CATEGORY SUMMARY LINE

Following standard format applies to Category Summary Line:

<CategorySummaryLine>[DataElementName**1**]:DataElementValue**1**,[DataElementName**2**]:DataElementValue**2**,…….

…….,[DataElementName**N**]:DataElementValue**N**</CategorySummaryLine>

3.8 WORKING WITH RESIDUAL DATA

Residual data will be captured within three fields. This structure will allow exporting CMS vendors a flexible method to represent existing data that does not fit into any other defined field for the correspondent CDS Category and allow importing CMS vendors to quickly identify what the residual data represents and its corresponding datatype.

Residual Data Element	Field Description	Notes
Name	The name of the data field	
Data Type	The primitive XML datatype of the data field	Mandatory if a Residual Data Element Name is provided Note: if DataType = Date then date format must follow W3C Date Standard
Content	The content of the data element	Mandatory if a Residual Data Element Name is provided

All three fields must be grouped in a set and can be repeated multiple times, as a group, within each section as required.

To illustrate an example of how the residual data fields are to be used, assume that a patient has the following Personal History information that needs to be exported (NOTE: This is only an example and not the expected format for validation):

Dislocated Shoulder, May 3, 2000
Using the residual data fields, this data can be represented:

```
<ResidualInfo>
        <cdsd:DataElement>
                <cdsd:Name>Incident</ cdsd:Name >
                 <cdsd:DataType>text</cdsd:DataType>
                <cdsd:Content>Dislocated Shoulder</cdsd:Content>
```



```
        </cdsd:DataElement>
        <cdsd:DataElement>
                <cdsd:Name >Incident Date</cdsd:Name>
                <cdsd:DataType>date</cdsd:DataType>
                <cdsd:Content>20000503</cdsd:Content>
        </cdsd:DataElement>
</ResidualInfo>
```


4. RETIRED REQUIREMENTS / CDS CATEGORIES / DATA ELEMENTS

4.1 RETIRED REQUIREMENTS

Following requirements have been retired from Appendix B v4.0.

#	Requirement	Guidelines	W/M	Status	Discussion/Comments
Date Export Requirements					
R1	Exports patient audit information as described in requirement	Audit information may be a text representation of a patient's audit history, or a file export of the same information. Exported audit trail cannot contain system references that are meaningless outside of the exporting system context.	M	R	Replaced by 1.2.2 Data Management (a) / Appendix A (see Appendix B v3.02)
Date Import Requirements					
R2	Imports patient audit information as exported in requirement 1.3.1	Imported audit information must become a part of the patient record, and accessible from the patient's chart. Requiring a user to search through import logs to access audit information will not satisfy this requirement.	M	R	See above

4.2 RETIRED CDS CATEGORIES

Following CDS Categories have been retired from Appendix B v4.0

#	Retired FROM	CDS CATEGORY	Comments
R1	Export	Personal History	Retired from Appendix B Retired from CDS Schema
R2	Export	Audit Information	Retired from Appendix B Retired from CDS Schema
R3	Import	Personal History	Retired from Appendix B Retired from CDS Schema
R4	Import	Audit Information	Retired from Appendix B Retired from CDS Schema

4.3 RETIRED DATA ELEMENTS

Following Data Elements have been retired from Appendix B v4.0.
Refer to Appendix B v3.02 for complete information about the following retired data elements.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
Demographics								
R1	Patient Warning Flags		If alerts on file about the person this flag is set to 1 otherwise default is 0	NUM	Code	1	1 = alert, 0 = no alert Default is blank	Reason for removal: Created new CDS Category for Alerts and Special Needs
R2	Family Member Link		System-specific internal unique key (has no contextual meaning) to uniquely identify the person. Link to one or more family members Each member of one "family" will share the same key.	AN	Text	20		
R3	Preferred Phone		Identify the preferred phone for person contact.	AB	Code	1	One of: Residence (R), Cell (C) or Work (W)	Preferred Phone must be valid code. See Table 1.8 – Preferred Phone.
Past Health								
R4	Resolved Indicator		Indicates whether the condition is ongoing or resolved	AN	Text	250		May contain a note
R5	Medical/Surgical Flag		Categorizes the past health item	AN	Code	1	One of: Medical (M) Surgical (S), Obstetrical (O) Psychiatric (P) Trauma (T),or Unknown (U)	Person Status must be valid code. See Table 4.1 – Medical/Surgical Flag
Allergies & Adverse Reaction								
R6	Known Allergies		Captures whether the patient has reported whether they have any allergies	AN	Code	1	One of: 0 – Patient has reported that they do not have any allergies 1 - Question not asked.	"0" indicates that the patient has been asked by the physician if they're allergic to anything and they replied No "1" indicates there are no current allergies listed. "Blank" is the default value
R7	Healthcare Practitioner Type		Role of the healthcare professional that created the information about allergies or adverse reactions	AN	Code	10	Continuing Care eHealth Standards Code Tables: Care Practitioner Type http://www.ontariomd.ca/emr	Role only e.g. nurse, physician, etc. Healthcare Practitioner Type must be valid code. See Table 7.5 – Healthcare Practitioner Type
Medication								

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
R8	End Date		The end date of the current prescription	DATE	YYYY-MM-DD	10	W3C Date Standard	Must be on or after the start date. This date may also be used as the discontinued date.
R9	Last Refill Date		The date of the last refill, as reported.	DATE	YYYY-MM-DD	10	W3C Date Standard	
Laboratory Results								
R10	Result Reviewer		Person authorized that reviewed result	AN	Text	50		OHIP number representing physician that reviewed the result. Otherwise First & Last Name of reviewer
R11	Date/Time Result received by EMR		The date the lab result is received on the EMR	DATE		30	W3C Date Standard	Date followed by Time as recorded by the Testing Lab.
Appointments								
R12	Sequence Index		Identifying different patients in the same time slot.	NUM	Text	2		Always start at 1
Physician's My Clinical Notes								
R13	Note Principal Author Function		Function of the principal author	AN	Text	50		Consistency required by Vendor to identify the principal author function (e.g. Nurse Practitioner; Physician; etc.)
R14	Note Principal Author Last Name		Identity of principal author of the note –Last Name	AN	Text	50		If a note has multiple authors, this data element should contain the name of the person who created the note.
R15	Note Principal Author First Name		Identity of principal author of the note – First Name	AN	Text	50		If a note has multiple authors, this data element should contain the name of the person who created the note.
R16	Note Provider First Name		OHIP Number to Identity the principal author of the note (where it is a physician or OHIP billing provider)	NUM	Text	6		Corresponds with the identity of the principal author in the "Note Principle Author" data element
Reports Received								
R17	Report Principal Author First Name		Identity of principal author of the report - First Name	AN	Text	60		
R18	Report Principal Author Last Name		Identity of principal author of the report - Last Name	AN	Text	60		

5. AMENDED REQUIREMENTS / CDS CATEGORIES / DATA ELEMENTS

5.1 DATE AMENDED: APRIL 6, 2011

Following CDS Categories have been added /updated.

PERSONAL HISTORY: new category added.

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
N	Category Summary Line	Y	A text string, summarizing the content of the following more structured fields and information contained about Family History	AN	Text	64k		Export: Each exported Family History item must have its own Category Summary Line. At minimum the Category Summary Line must include following data elements: ▪ Diagnosis Problem Description ▪ Start Date Category Summary Line must comply with standard format (refer to Working with Category Summary Line) Import: Category Summary Line can be imported at vendor discretion.
N	Residual Data Element Name(*)		Name of the data field.	AN	Text	NL		The descriptive or reference name of the data item within the source EMR.
N	Residual Data Element Type(*)	Y*	Name of the data type The primitive XML data type of the data field.	AN	Text	NL	Primitive XML data type: http://www.w3.org/TR/xmlschema-2/) See Table 2.1 – XML Primitive Data Types	Residual Data Element Type must be valid code The data type by which the 'Residual Content' is to be interpreted.
N	Residual Content(*)	Y*	The content of the residual data element.	BOT	Text	NL		

PHYSICIAN'S MY CLINICAL NOTES: new data elements added

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
N	(*) Participating Provider First Name		First Name of the participating provider.	AN	Text	50		
N	(*) Participating Provider Last Name		Last Name of the participating provider.	AN	Text	50		
N	(*)Participating Provider OHIP ID		OHIP number to identify the participating provider.	NUM	Text	6		Provide OHIP id number of the participating provider, if available.

REPORTS RECEIVED: new data element added

CDS #	DATA ELEMENT	REQ FIELD	DEFINITION	DATA TYPE	FORM	LEN	CODE SOURCE	BUSINESS RULES
N	Note	Y	Notes about a report.	AN	Text	32k		Export: Each exported Family History item must have its own Category Summary Line.