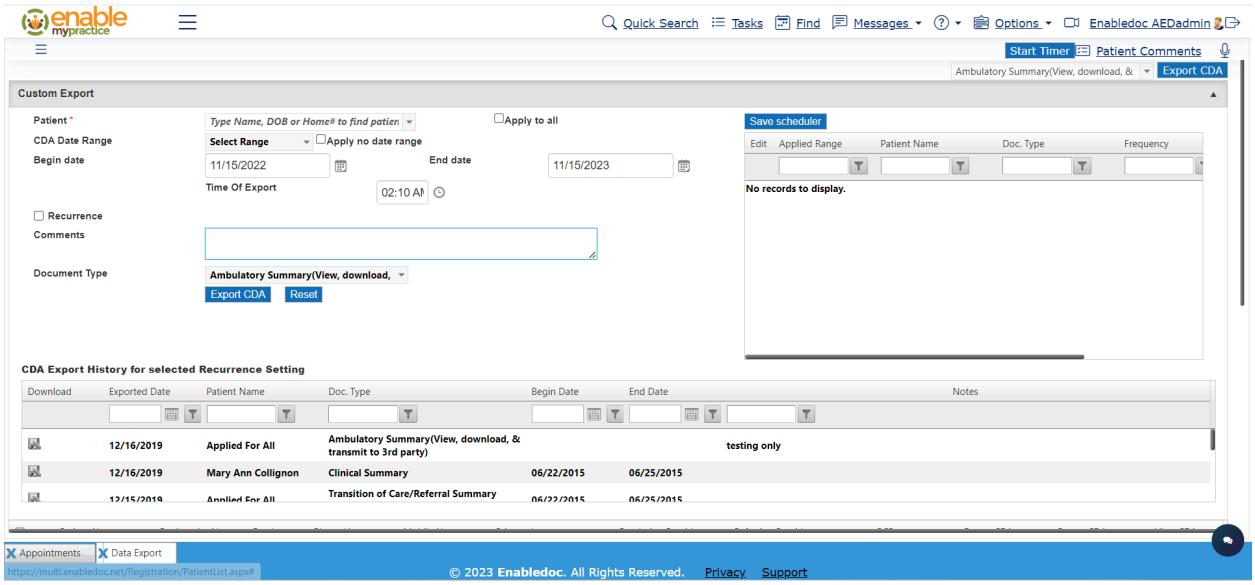
Enablemypractice™ Date Export Guide

Your Administrator must grant you access to the Data Export Screen to perform these functions. Please perform these steps to select export of system data to C-CDA and Excel and ability to download Patient Notes and file attachments.

- ➢ Click Registration.
- ➢ Click Data Export and this screen appears:



- ➢ Click Custom Export.
- ➢ Select a specific patient or check all.
- ➢ Select a begin and end date or select all.
- ➢ Set a time to run the data export.
- ➢ Click if you want the export to recur by day, days of the week, monthly or annually.
- ➢ Select the type of CDA file, Excel file to export, Notes, and Attachments.
- ➢ Type a Comment.
- ➢ Click Export.
- ➢ When the Export is complete, the file information appears in the table at the bottom.
- ➢ Click Download to download the file.

Export Options

C-CDA Files Structure

Data is exported using USCDI v3 AND HL7® CDA® R2.1 Implementation Guide: C-CDA Templates for Clinical Notes R2.1 Companion Guide, Release 2-US Realm, October 2019 standard.

Attachments

Attached files (images, excel, word, PDF) are grouped as a .zip file by patient and will download by patient name.

Clinical Notes:

Notes are grouped as a .zip file by patient and will download by patient name. Notes text can be exported from the PDF.

Patient Registration List:
This screen allows patient demographics and insurance data exported in an Excel file.

Excel File
This data is organized by Excel tab for the following data:
Condition: A clinical condition, problem, or diagnosis of concern.
Coverage: Insurance or medical plan or a payment agreement.
Encounter: An interaction between a patient and clinician for the purpose of providing care or assessing the health of a patient.

- **Organization**: A grouping of people or organizations with a common purpose.
- **Patient**: Demographics and other administrative information about an individual receiving health related services.
- **Practitioner**: A person who is directly or indirectly involved in the provisioning of healthcare.
- **Encounter**: An interaction between a patient and clinician for the purpose of providing care or assessing the health of a patient.
- **Procedure**: An action that is or was performed on or for a patient. This can be a physical intervention like an operation, or less invasive like long term services, counseling, or hypnotherapy.
- **ServiceRequest**: A record of a request for service such as diagnostic investigations, treatments, or operations to be performed.
- **FamilyMemberHistory**: Information about patient's relatives
- **Immunization**: A record of the administration of a vaccine to a patient, or a record of an immunization as reported by a patient, a clinician or another party.
- **Location**: Details and position information for a physical place.
- **MedicationAdministration**: A record of a patient consuming or otherwise being administered a medication.
- **MedicationRequest**: An order or request for both supply of medication and instructions for administration to a patient.
- **MedicationStatement**: A record of a medication that is or was being consumed by a patient.
- **Observation**: A measurement or simple assertion made about a patient, device or other subject.

Organization

- source: A value representing the source of the data captured within this record Required code
- identifier: A unique organization identifier Required string
- name: Name used for the organization Required string
- address-line-1: The house number, apartment number, street name, and similar address information. Required string
- address-line-2: The house number, apartment number, street name, and similar address information. Optional string address-
- city: A city specified in an address Required string
- addresscountry: A country specified in an address Required string
- address postal code: A postal code specified in an address Required string

- address-state: A state specified in an address Required string
- type: Kind of organization Preferred code
- type-system: The code system for which the type code belongs Preferred uri
- alias: A list of alternate names that the organization is known as, or was known as in the past Preferred string
- phone: A phone number for the organization Preferred string
- email: An email address for the organization Preferred string
- part-of: The organization of which this organization
- forms a part Preferred See section: Organization

Encounter Data

- source: A value representing the source of the data captured within this record - Required code
- identifier: A unique encounter identifier Required string
- status: The current state of the encounter Required code See Values: Encounter Status
- subject: The patient present at the encounter Required See Section: Patient
- start-date: The start date or date-time of the encounter Required dateTime
- class: The classification of the patient encounter (e.g. inpatient, emergency, etc.) Required code - See Values: V3 Value SetActEncounterCode
- participant: An identifier for an individual involved in the encounter other than the patient Required See Section Practitioner
- end-date: The end date or date-time of the encounter Preferred dateTime
- type: The specific type of encounter Preferred code

Patient

- source: A value representing the source of the data captured within this record. Required code
- identifier: A unique patient identifier Required string
- organization: The organization that is the custodian of the patient record See Section: Organization
- gender: The administrative gender of the patient Required code See values: AdministrativeGender
- birthdate: The patient's date of birth Required date
- addresspostalcode: A postalCode specified in an address Required string
- address-state: A state specified in an address Required string
- race: The race of the patient Required See values: OMB Race Categories
- race-text: A free-text representation of the patient's race Required string
- ethnicity: The ethnicity of the patient Required See values: OMB Ethnicity Categories
- ethnicity-text: A free-text representation of the patient's ethnicity Required string
- first: The first name of the patient Preferred string
- middle: The middle name of the patient Preferred string
- family: The family name of the patient Preferred string
- email: An email address for the patient Preferred string

- phone: A phone number for the patient Preferred string
- deceased: This patient has been marked as deceased, or has a death date entered Preferred boolean
- death-date: The date of death of the patient Preferred dateTime
- address-line-1: The house number, apartment number, street name, and similar address information. Preferred String
- address-line-2: The house number, apartment number, street name, and similar address information. Optional string
- marital-status: The marital (civil) status of the patient Preferred code
- marital-statustext: A free-text representation of the patient's marital status Preferred string
- mrn: The medical record number used for the patient at this organization Preferred string
- language: A language which may be used to communicate with the patient about his or her health Preferred See values: Common Languages
- languagepreferred: Indicates whether or not the patient prefers this language Preferred boolean See value: common languages
- languageproficiencylevel: The level of proficiency for this mode of communication and language Preferred See values: v3 Code System LanguageAbilityProficiency
- languageproficiencytype: The mode of communication (spoken, written, etc.) for the proficiency Preferred See values: v3 Code System LanguageAbilityMode
- language-text: A free-text representation of the communication language Preferred string
- birth-sex: The sex assigned to the patient at birth Preferred see values: Birth Sex
- primarycaregiver: The relationship of the patient's primary caregiver to the patient Preferred
- text: A free-text representation of the patient's relationship to their primary caregiver Preferred string
- gender-identity: The gender with which the patient identifies Preferred See values: genderidentity
- sexual orientation: A person's identification of their emotional, romantic, sexual, or affectional attraction to another person
- text: A free-text representation of the patient's gender identity Preferred string
- religious affiliation: Coded religious affiliation of the patient Preferred
- religiousaffiliation-text: A free-text representation of the religious affiliation of the patient Preferred string
- note: Any other notes and comments made about the patient Preferred string

Location

- source: A value representing the source of the data captured within this record Required code
- identifier: A unique location identifier Required string
- name: Name of the location as used by humans Required string
- alias: A list of alternate names that the location is known as, or was known as, in the past Preferred string

- description: Additional details about the location that could be displayed as further information to identify the location beyond its name Preferred string
- type: Indicates the type of function performed at the location Preferred code
- address-text: A free-text representation of an address of the location Preferred string
- address-line-1: The house number, apartment number, street name, and similar address information. Preferred string
- address-line-2: The house number, apartment number, street name, and similar address information. Optional string
- address-city: A city specified in an address Preferred string
- address-country: A country specified in an address Preferred string
- addresspostalcode: A postal code specified in an address Preferred string
- address-state: A state specified in an address Preferred string
- organization: The organization responsible for provisioning and upkeep See section: Organization
- part-of: Another location this one is physically a part of See this section: Location

Practitioner

- source: A value representing the source of the data captured within this record Required code
- identifier: A unique practitioner identifier Required string
- active: Whether the practitioner record is active Required boolean
- npi:The National Provider Identifier of the practitioner Preferred integer
- first: The first given name of the practitioner Preferred string
- family: The family name of the practitioner Preferred string
- email: An email address for the practitioner Preferred string
- phone: A phone number for the practitioner Preferred string
- discipline-1: The professional discipline of the practitioner Preferred code
- discipline-2: The professional discipline of the practitioner Optional code
- discipline-3: The professional discipline of the practitioner Optional code
- discipline-4: The professional discipline of the practitioner Optional code
- discipline-5: The professional discipline of the practitioner Optional code
- qualificationcode: Coded representation of the practitioner's qualification. Preferred see values: hl7VSdegreeLicenseCertificate

Procedure

- source: A value representing the source of the data captured within this record Required code
- code: A code that identifies the specific procedure that was performed Required code
- identifier: A unique identifier for the procedure record Required string
- encounter: An identifier for the encounter during which this procedure was performed or to which this record is tightly associated Required See section: Encounter
- date: The date or date-time when the procedure was performed Required dateTime
- status: A code specifying the state of the procedure Required code EventStatus

- subject: An identifier for the patient on which the procedure was performed Required Seec Section: Patient
- code-system: The code system to which the procedure code belongs Preferred uri
- based-on: An identifier for the service request that initiated this procedure Preferred See Section: ServiceRequest

Service Request

- source: A value representing the source of the data captured within this record Required code
- identifier: A unique identifier for the service request record Required string
- encounter The encounter during which this service request is made or to which this
- record is tightly associated Required See Section: Encounter
- authored: The date or date-time when the service request was signed Required dateTime
- intent: A code specifying the kind of service request (proposal, plan, order, etc.) Required code See Values: RequestIntent
- requester: The individual that initiated the request and has responsibility for its activation Required See Section: Practitioner
- status: A code specifying the current state of the order or referral Required see values: RequestStatus
- subject: The patient on whom the service is to be performed Required See Section: Patient
- code: A code that identifies a particular service that has been requested Preferred code
- code-system: The code system to which the service request code belongs Preferred uri

Family Member History

- source: A value representing the source of the data captured within this record Required code
- identifier: A unique identifier for this record Required string
- status: A code specifying the status of the record of the family history of a specific family member Required code See Values: FamilyHistoryStatus
- patient: The patient for whom this family member history is recorded Required See Section: Patient
- relationship: The type of relationship this person has to the patient (father, mother, brother, etc.) Required code
- date: The date or date-time when the history was recorded or last updatedPreferred dateTime
- birth-sex: The birth sex of the family member Preferred See value: AdministrativeGender
- born: An exact or approximate date of birth of the relative Preferred date
- age: An exact or approximate age of the relative (in years) Preferred integer
- estimated-age: If true, indicates that the age value specified is an estimated value Preferred boolean
- deceased: The relative has been marked as deceased, or has a death date entered Preferred boolean
- note A general note about the relative Preferred string

- condition: A code that identifies the condition that the relative Preferred code
- conditionsystem: The code system to which the condition code belongs Preferred uri
- conditionoutcome: Indicates what happened following the condition Preferred code
- conditiononset: When the condition first manifested Preferred dateTime
- condition-note: Additional information about the condition Preferred string

Immunization

- source: A value representing the source of the data captured within this record Required code
- identifier: A unique identifier for the immunization record Required string
- date: The date or date-time that the vaccine was/was to be administeredRequired dateTime
- patient: The patient who received the immunization Required See Section: Patient
- status: The current state of the immunization event Required See value: Immunization Status Codes
- vaccine-code: A code representing the vaccine that was/was to be administered Required See values: Vaccine Administered Value Set
- location: The service delivery location or facility where the vaccine administration occurred
- Preferred See section: Location
- performer: The individual or organization who was involved in the immunization event Preferred see section: Practitioner
- reaction: The observation of a reaction that followed the immunization event Preferred see section: Condition

AllergyIntolerance

- source: A value representing the source of the data captured within this record Required code
- category: The category of the identified substance Required See values: AllergyIntoleranceCategory
- identifier: A unique identifier for the allergy/intolerance record Required string
- patient: The patient who has the allergy/intolerance Required see section: Patient
- reactionmanifestation: Clinical symptoms and signs associated with the event Required see values: SNOMED CT Clinical Findings
- asserter: The individual who is the source of the information about the recorded allergy/intolerance Preferred see section: Practitioner
- clinical-status: The clinical status of the allergy/intolerance Preferred see values: AllergyIntolerance Clinical Status Codes
- code: A code that identifies the allergy/intolerance Preferred code

V3 Health Status/Assessments

1. Functional Status: Ability to perform activities of daily living (ADLs)

Mobility, self-care, independence level: Common in PT/OT workflows (e.g., shoulder ROM, gait, dressing ability)

2. Disability Status: Presence and type of disability

May include:

- Physical disability
- Cognitive disability
- Sensory impairment

3. Mental / Cognitive Status: Cognitive function (memory, orientation, executive function) and Mental status observations: Often derived from: Cognitive assessments (e.g., Mini-Cog, MoCA) Clinical observations

4. Pregnancy Status: Identifies a patient is pregnant and Pregnancy state (e.g., trimester, postpartum)

Care Plan

- source: A value representing the source of the data captured within this record Required code
- identifier: A unique identifier for the care plan record Required string
- status: Status of the care plan: active, on hold, revoked, completed, etc. Required see vales: RequestStatus
- intent: Intent: proposal, plan, order, or option Required see values: Care Plan Intent
- subject: The patient for whom this care plan is designed Required see section: Patient
- encounter: The encounter created as part of this care plan Required see section: Encounter
- start: The starting date of the care plan Required dateTime
- end: The ending date of the care plan Required dateTime
- created: When the care plan was first recorded Required dateTime
- based-on: A care plan on which this one is based Preferred see section CarePlan

Medication Administration

- source: A value representing the source of the data captured within this record Required code
- identifier: A unique identifier for the medication administration record Required string
- dosagequantity: The quantity associated with the administered medication dosage Required decimal
- dosage-unit: The units associated with the administered medication dosage Required string
- dosage-route: The route or path of administration of a therapeutic agent into or onto the patient Required code SNOMED CT Route Codes
- effective-start: The start date or date-time of the medication administration Required dateTime
- medication: A code for the medication being administered Required code
- status: A code specifying the current state of the administration Required see values: Medication administration status codes

- subject: The patient receiving the medication Required see section: patient
- category: The type of medication administration Preferred code Medication administration category codes
- context: The encounter or episode of care during which the medication administration was performed Preferred see section: Encounter
- effective-end: The end date or date-time of the medication administration Preferred dateTime
- medicationsystem: The code system to which the medication code belongs Preferred uri
- performer: The individual who administered the medication see Section: Practitioner
- reason-given: A code indicating why the medication was given Preferred code
- request: The original request or order to administer the medication Preferred see section: MedicationRequest

MedicationRequest

- source: A value representing the source of the data captured within this record Required code
- identifier: A unique identifier for the medication request record Required string
- status: A code specifying the current state of the order or prescription Required see values: Medicationrequest status
- authored: The date or date-time when the order or prescription was initially written or authored Required dateTime
- dosagequantity: The quantity associated with the requested medication dosage Required decimal
- dosage-unit: The units associated with the requested medication dosage Required string
- intent: A code specifying the kind of medication request (proposal, plan, order, etc.) Required see values: Medication request intent
- medication: A code for the medication being requested Required code
- requester: The individual or organization that initiated the request and has responsibility for its activation Required see section: Practitioner

Observation

- source: A value representing the source of the data captured within this record Required code
- identifierL A unique identifier for the observation record Required string
- encounter: The encounter during which this observation is made Required see section: Encounter
- code: A code that describes what was observed Required code
- date: The clinically relevant date or datetime for the observation Required dateTime
- status: The status of the observation result value Required see value: ObservationStatus
- subject: The patient that the observation is about Required see section: Patient
- category: A code that classifies the general type of observation being made Preferred see values: Observation Category Codes

- code-system: The code system to which the observation code belongs Preferred uri
- code-text: A free-text representation of the observation code Preferred string
- value-code: The coded value determined as a result of making the observation Preferred code
- value-codesystem: The code system to which the observation value code belongs Preferred uri
- value-codetext: A free-text representation of the observation value code Preferred string
- value-date: The date-time value determined as a result of making the observation Preferred dateTime
- value-datestart: The starting date-time value determined as a result of making the observation Preferred dateTime
- value-dateend: The ending date-time determined as a result of making the observation Preferred dateTime
- valuequantity: The quantity determined as a result of making the observation Preferred decimal
- value-unit: The units of the quantity determined as a result of making the observation Preferred string
- value-string: The information determined as a result of making the observation Preferred string
- start-date: The start of the clinically relevant time period for the observation Preferred dateTime
- end-date: The end of the clinically relevant time period for the observation Preferred dateTime
- device: An identifier for the device used to generate the observation data Preferred string
- devicesystem: The namespace of the device identifier Preferred uri
- performer: The individual responsible for the observation Preferred see section: Practitioner
- note-text: Comments about the observation Preferred string

Medication Statement

source: A value representing the source of the data captured within this record Required code

identifier: A unique identifier for the medication statement record Required string

status: A code representing the state of this medication's use Required see values: Medication status codes

subject: The patient who was/is taking the medication Required see section: Patient

medication: A code for the medication which the statement is about Required code

dosage-quantity: The quantity associated with the medication statement dosage Required decimal

dosage-unit: The units associated with the medication statement dosage Required string

effective-start: The date or date-time when the patient began taking the medication Required dateTime

medicationsystem: The code system to which the medication code belongs Preferred uri

category: The type of medication usage Preferred code

context: The encounter or episode of care that establishes the context for this medication statement

VALUES

Encounter status

- planned
- arrived
- triaged
- in-progress
- onleave
- finished
- cancelled
- entered-in-error
- unknown

Encounter status

- planned
- arrived
- triaged
- in-progress
- onleave
- finished
- cancelled
- entered-in-error
- unknown

administrativegender

- male - Male
- female - Female
- other - Other
- unknown

V3 Code System LanguageAbilityProficiency

- E - Excellent
- F - Fair
- G - Good
- P - Poor

v3 Code System LanguageAbilityMode

- ESGN Expressed signed
- ESP Expressed spoken
- EWR Expressed written
- RSGN Received signed
- RSP Received spoken
- RWR Received written

V3 Value SetActEncounterCode

- AMB ambulatory
- EMER emergency
- FLD field
- HH home health
- IMP inpatient encounter
- ACUTE inpatient acute
- NONAC inpatient non-acute
- OBSENC observation encounter
- PRENC pre-admission
- SS short stay
- VR virtual
- Vaccine Administered

OMB Race Categories

- 1002-5 American Indian or Alaska Native
- 2028-9 Asian
- 2054-5 Black or African American
- 2076-8 Native Hawaiian or Other Pacific Islander
- 2106-3 White
- 2131-1 Other Race
- ASKU asked but unknown
- UNK unknown

V3 Sexual Orientation

- Lesbian, gay or homosexual. 38628009
- Straight or heterosexual. 20430005
- Bisexual. 42035005
- Something else, please describe. nullFlavor OTH
- Don't know. nullFlavor UNK
- Choose not to disclose. nullFlavor ASKU

OMB Ethnicity Categories

- 2135-2 Hispanic or Latino
- 2186-5 Not Hispanic or Latino
- ASKU asked but unknown
- UNK unknown

common languages

- ar Arabisk
- bn Bengali
- cs Czech
- da Danish
- de German
- de-AT German (Austria)
- de-CH German (Switzerland)
- de-DE German (Germany)
- el Greek
- en English
- en-AU English (Australia)
- en-CA English (Canada)
- en-GB English (Great Britain)
- en-IN English (India)
- en-NZ English (New Zeland)
- en-SG English (Singapore)
- en-US English (United States)
- es Spanish
- es-AR Spanish (Argentina)
- es-ES Spanish (Spain)
- es-UY Spanish (Uruguay)
- fi Finnish

- fr French
- fr-BE French (Belgium)
- fr-CH French (Switzerland)

hl7VSdegreeLicenseCertificate

- PN Advanced Practice Nurse
- AAS Associate of Applied Science
- AA Associate of Arts
- ABA Associate of Business Administration
- AE Associate of Engineering
- AS Associate of Science
- BA Bachelor of Arts
- BBA Bachelor of Business Administration
- BE Bachelor or Engineering
- BFA Bachelor of Fine Arts
- BN Bachelor of Nursing
- BS Bachelor of Science
- BSL Bachelor of Science - Law
- BSN Bachelor on Science - Nursing
- BT Bachelor of Theology
- CER Certificate
- CANP Certified Adult Nurse Practitioner
- CMA Certified Medical Assistant
- CNP Certified Nurse Practitioner
- CNM Certified Nurse Midwife
- CRN Certified Registered Nurse
- CNS Certified Nurse Specialist
- CPNP Certified Pediatric Nurse Practitioner
- CTR Certified Tumor Registrar
- DIP Diploma

EventStatus

- preparation Preparation
- in-progress In Progress
- not-done Not Done
- on-hold On Hold
- stopped Stopped
- completed Completed
- entered-in-error Entered in Error

RequestIntent

- proposal Proposal
- plan Plan
- directive Directive
- order Order
- original-order Original Order
- reflex-order Reflex Order
- filler-order Filler Order
- instance-order Instance Order
- option Option

Requeststatus

- draft Draft
- active Active
- on-hold On Hold
- revoked Revoked
- completed Completed
- entered-in-error Entered in Error
- unknown Unknown

FamilyHistoryStatus

- partial Partial
- completed Completed
- entered-in-error Entered in Error
- health-unknown Health Unknown

Immunization Status Codes

- completed Completed
- entered-in-error Entered in Error
- not-done Not Done

Medication Status Codes

- active Active
- completed Completed
- entered-in-error Entered in Error

- intended Intended
- Code Display
- stopped Stopped
- on-hold On Hold
- unknown Unknown
- not-taken Not Taken

Medication administration category codes

- inpatient Inpatient
- outpatient Outpatient
- community Community

Medication administration status codes

- in-progress In Progress
- not-done Not Done
- on-hold On Hold
- completed Completed
- entered-in-error Entered in Error
- stopped Stopped
- unknown Unknown

Vaccine Administered Value Set

- 54 adenovirus vaccine, type 4, live, oral
- 55 adenovirus vaccine, type 7, live, oral
- 82 adenovirus vaccine, unspecified formulation
- 24 anthrax vaccine
- 19 Bacillus Calmette-Guerin vaccine
- 27 botulinum antitoxin
- 26 cholera vaccine, unspecified formulation
- 29 cytomegalovirus immune globulin, intravenous
- 56 dengue fever vaccine
- 12 diphtheria antitoxin
- 28 diphtheria and tetanus toxoids, adsorbed for pediatric use
- 20 diphtheria, tetanus toxoids and acellular pertussis vaccine
- 106 diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis antigens
- 107 diphtheria, tetanus toxoids and acellular pertussis vaccine,
- unspecified formulation
- 110 DTaP-hepatitis B and poliovirus vaccine
- 50 DTaP-Haemophilus influenzae type b conjugate vaccine

- 120 diphtheria, tetanus toxoids and acellular pertussis vaccine,
- Haemophilus influenzae type b conjugate, and poliovirus vaccine,
- inactivated (DTaP-Hib-IPV)
- 130 Diphtheria, tetanus toxoids and acellular pertussis vaccine, and
- poliovirus vaccine, inactivated
- 01 diphtheria, tetanus toxoids and pertussis vaccine
- 22 DTP-Haemophilus influenzae type b conjugate vaccine
- 102 DTP- Haemophilus influenzae type b conjugate and hepatitis b vaccine
- 57 hantavirus vaccine
- 52 hepatitis A vaccine, adult dosage
- 83 hepatitis A vaccine, pediatric/ adolescent dosage, 2 dose schedule
- 84 hepatitis A vaccine, pediatric/ adolescent dosage, 3 dose schedule

AllergyIntoleranceCategory

- food Food
- medication Medication
- environment Environment
- biologic Biologic

AllergyIntoleranceCriticality

- low Low Risk
- high High Risk
- unable-to-assess Unable to Assess Risk

AllergyIntoleranceSeverity

- mild Mild
- moderate Moderate
- severe Severe

AllergyIntoleranceType

- allergy Allergy
- intolerance Intolerance

AllergyIntolerance Clinical Status Codes

- active Active
- inactive Inactive
- resolved Resolved

Birth Sex

- F Female
- M Male
- ASKU asked but unknown
- OTH other
- UNK unknown

SNOMED CT Clinical Findings

- 404684003 Clinical finding (finding)
- 109006 Anxiety disorder of childhood OR
- adolescence 122003 Choroidal hemorrhage
- 127009 Spontaneous abortion with laceration of cervix
- 129007 Homoiothermia
- 134006 Decreased hair growth
- 140004 Chronic pharyngitis
- 144008 Normal peripheral vision
- 150003 Abnormal bladder continence
- 151004 Gonococcal meningitis
- 162004 Severe manic bipolar I disorder without psychotic features
- 165002 Accident-prone
- 168000 Typhlolithiasis
- 171008 Injury of ascending right colon without open wound into abdominal cavity
- 172001 Endometritis following molar AND/OR ectopic pregnancy
- 175004 Supraorbital neuralgia
- 177007 Poisoning by sawfly larvae
- 179005 Apraxia of dressing
- 181007 Hemorrhagic bronchopneumonia
- 183005 Autoimmune pancytopenia
- 184004 Withdrawal arrhythmia
- 188001 Injury of intercostal artery
- 192008 Congenital syphilitic hepatomegaly
- 193003 Benign hypertensive renal disease
- 195005 Illegal abortion with endometritis

RequestStatus

- draft Draft
- active Active
- on-hold On Hold
- revoked Revoked

- completed Completed
- entered-in-error Entered in Error
- unknown Unknown

Care Plan Intent

- proposal Proposal
- plan Plan
- order Order
- option Option

Medicationrequest Status

- active Active
- on-hold On Hold
- cancelled Cancelled
- completed Completed
- entered-in-error Entered in Error
- stopped Stopped
- draft Draft
- unknown Unknown

Medication Request Intent

- proposal Proposal
- plan Plan
- order Order
- original-order Original Order
- reflex-order Reflex Order
- filler-order Filler Order
- instance-order Instance Order
- option Option