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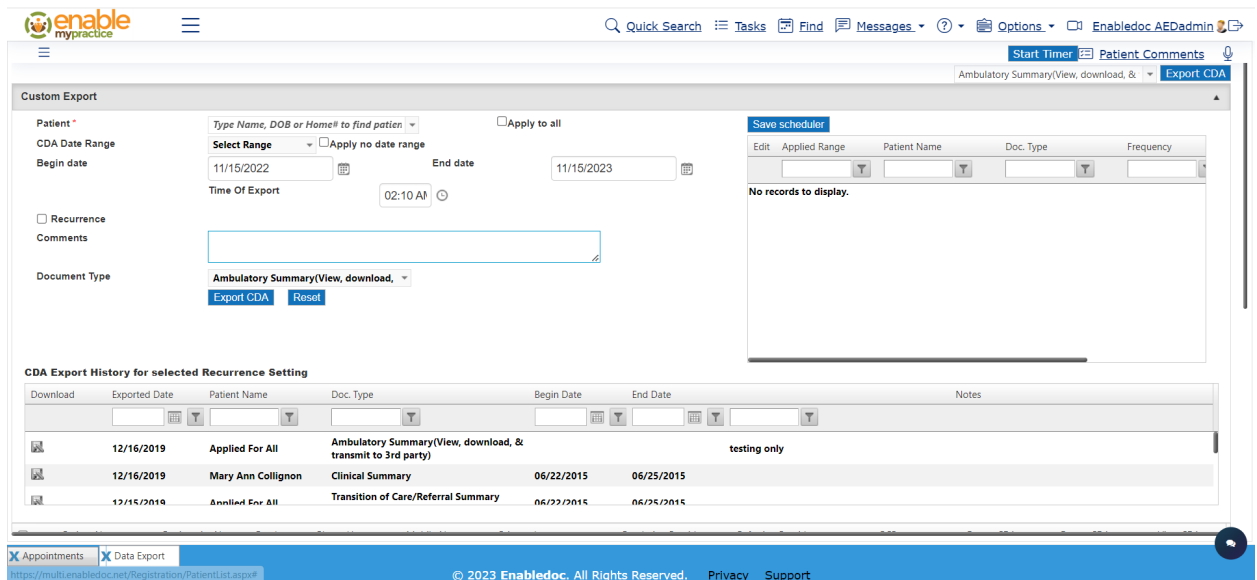
Your Administrator must grant you access to the Data Export Screen to perform these functions. Please perform these steps to select export of system data to C-CDA and Excel and ability to download Patient Notes and file attachments.

1. Click Registration.
2. Click Data Export and this screen appears:

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

Export Options
C-CDA Files Structure
Data is exported using USCDI v1 AND HL7® CDA® R2 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.

Notes:

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

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
- ➢ text: A free-text representation of the patient's gender identity Preferred string
- ➢ religiousaffiliation: 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

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

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