

NoemaLife HL7 Integration Policy

HL7 2.5 Segments Definition

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NoemaLife HL7 Integration Policy: HL7 2.5 Segments Definition

by Davide Musiani and Francesco Masotti

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Chapter 1. Preface

1. Purpose of this document

The aim of this document is to specify the structure of the HL7 v2.5 segments used by the HL7 messages described in the integration use cases.

Just like any software artifact, this document will be fixed, updated and tested as needed. Any feedback is welcome.

2. How to read this document

Aside the first sections, this document leans to a double purpose of giving all the informations that are needed at the first time and, subsequently, be accessed as a reference manual. To this sake, we will follow a bottom-up approach, which also allows to jump back and forth in the document, examining specific subjects once at a time.

The document *NoemaLife HL7 Integration Policy - Use Cases and Integration Scenarios* [NL-HL7-IP-UC] is meant to add to this one all of the functional informations and specifications related to use cases definition, and must be considered an integral part of the NoemaLife HL7 Integration Policy.

Note: For more informations concerning localizations for CRS-SISS regional project, refer to CRS-SISS technical documentation [CRS-SISS-HL7]

3. Intended audience

This document should be read by anyone having some role within:

- the software production and maintenance process (analysts and developers), in order to have a common basis between all NoemaLife products for "internal" legacy integrations amongst products
- the cutomers' projects deployment of internal legacy integrations, to understand their logics and features.

4. Compliance against this document

As of this writing a wide variety of projects is in progress within the NoemaLife group. This document is binding for all the projects started from the final release of this document; projects that are already active are expected to tend to this specification and possibly schedule converging activities.

5. Future directions

No specific issues, at present.

6. Conventions

The key words “MUST”, “MUST NOT”, “REQUIRED”, “SHALL”, “SHALL NOT”, “SHOULD”, “SHOULD NOT”, “RECOMMENDED”, and “MAY” in this document are to be interpreted as described in *RFC 2119* [RFC-2119].

7. Changes log

Revision History

Revision **HEAD (0.6 RC)** (under development) Davide Musiani

- Segment IAM added for advanced allergies support
- Segment RXO added for Pharmacy/Treatment order details
- Segment RXR added for Pharmacy/Treatment management, administration route definition

- Added new specific version of NTE segment for Pharmacy/Treatment management
- Extended TQ1 segment definition to fit Pharmacy/Treatment management needs
- ORC segment changes:
 - Added new specialization of ORC segment for Pharmacy/Treatment management
 - Introduced in ORC-12 field the use of XCN.4 (Second and Further Given Names or Initials), when available

Revision **0.5.1**

14 May 2013

Davide Musiani

- BLG segment changes:
 - The use of segment BLG is now recommended in all messages where is has been included (OMG^O19, OML^O21 and OML^O33).
- OBR segment changes:
 - OBR for Laboratory Testing Management, OBR-4: better specified the use of alternate identifier (required only for Order Result Management scenario)
- ORC segment changes:
 - Introduced in ORC for Document Management the use of ORC-4 (Placer Group Number), when available
- TQ1 segment changes:
 - Segment format has been unified (no more dedicated formats for Document Management, Order Management and Laboratory Testing Management)
- TXA segment changes:
 - TXA-14 may include the Placer Order Number or the Placer Group Number, according to circumstances.

Revision **0.5.0**

14 March 2013

Davide Musiani Francesco Masotti

- PID segment changes:
 - PID-3, repetition "HC": better specified that the repetition is used only for Card Identification Number (CIN) of the EHS Card [IT: TEAM Card].
 - PID-3, CX.4, repetition "HC": generalized the use of HD.1 and HD.2 subfields for non-italian institutions.
 - PID-3, CX.6, repetition "HC": the Nation Code is now ISO 3166 alpha-2 (formerly alpha-3), for better compliance with EHS Card data [IT:TEAM Card].

Note that in all other cases where ISO 3166 nation codes are adopted, the alpha-3 version is used. PID-3 CX.6 is the only exception.
 - PID-3: added picture of EHS Card [IT: TEAM Card] with explanation of fields transmitted in HL7 messages.
 - PID-3: added management of repetition "PN" to manage the Person Identification Number (PIN) of the EHS Card [IT: TEAM Card].
 - PID-3, usage clarification of CX.7 (Effective Date) and CX.8 (Expiration Date)
 - PID-5, XPN.14 (Professional Suffix) changed from Loc CRS-SISS to Loc IT (CRS-SISS codings have been adopted as standard)
 - PID-26: Citizenship coding requirements have been relaxed; now it is not necessary to transmit both ISO 3166 alpha-3 and ISTAT code but is enough one of the two.
 - PID-32, changed from Loc CRS-SISS to Loc IT (CRS-SISS specifications have been adopted as standard)

- PID-34: separation in two distinct subfields of concepts: 'Last update application' and 'Source of demographic data'
- PD1 segment changes:
 - PD1-4 field , removed (previously used as Loc CRS-SISS for 'Data Decorrenza/Scadenza iscrizione AUSL')
- PV1 segment changes:
 - PV1-3, PL.10 changed from Loc CRS-SISS to Loc IT (CRS-SISS specifications have been adopted as standard)
 - PV1-7, PV1-8, PV1-17: more repetitions of doctor are allowed, but only to transmit different identifiers of the same doctor
- PV2 segment changes:
 - Introduced the use of PV2.31 (Recurring Service Code) instead of EVN-4 to transmit information related to the type of event in Short-stay encounters.
- EVN segment changes:
 - Changed the usage of EVN-4, now containing the HL7 event type of the message to be modified by an ADT^A08 message. Information previously transported in EVN-4 has been moved to PV2.31 (Recurring Service Code).
- NK1 segment changes:
 - NK1-11: enhanced codings for job type and job sector
 - NK1-34: enhanced codings for job status
- OBR segment changes:
 - OBR for Document and Order Management: OBR-18 changed to standard 'Physician Prescription Identifier'
 - OBR for Laboratory Testing Management, OBR-16: more repetitions of doctor are allowed, but only to transmit different identifiers of the same doctor
- ORC segment changes:
 - ORC for Document Management: ORC-8 changed from Loc CRS SISS to standard 'Order Booking Identifier'
 - ORC for Document and Order Management:
 - ORC-25 changed from Loc CRS-SISS to Loc IT (CRS-SISS specifications have been adopted as standard)
 - ORC-25, separation in two distinct subfields of concepts: 'Stato erogazione della prestazione' and 'Notifica evento a sistema esterno'
 - ORC for Order and Laboratory Testing Management, ORC-12: more repetitions of doctor are allowed, but only to transmit different identifiers of the same doctor
- TQ1 segment changes:
 - TQ1 for Document Management: TQ1-2 changed from Loc CRS-SISS to standard 'Quantity of supplied observation'
- TXA segment changes:

- TXA-2, standard value list merged with localized value lists. New document types added: 'Evaluation Notes', 'Medical Sickness Certificate' and 'Pathology Information Collection Report'
- TXA-9: more repetitions of doctor are allowed, but only to transmit different identifiers of the same doctor
- TXA-12, TXA-13: removed CRS-SISS localization for the identifier of the structured document.
- TXA-20, extended possible values to easily satisfy CRS-SISS requirements
- TXA-21 is now a required field
- TXA-22, more repetitions are introduced to allow different authenticators for the clinical document and the privacy document (DAO document in CRS-SISS projects). Also the date-time of the legal timestamp (Marca Temporale) is supported.
- DG1 segment changes:
 - DG1-17: more repetitions of doctor are allowed, but only to transmit different identifiers of the same doctor
- OBX segment changes:
 - OBX for Laboratory Testing Management, OBX-16: more repetitions of doctor are allowed, but only to transmit different identifiers of the same doctor
 - OBX for Document Management: OBX-3, removed CRS-SISS localization for physical document type in CE.6 (mapped to MIME subtypes in OBX-5.3)
 - OBX for Document Management: OBX-11, added 'LA' value for Legally Authenticated document
- MSA segment changes:
 - MSA-3 usage has been redefined in order to guarantee backward compatibility

Revision **0.4.0**

11 January 2013

Davide Musiani , Francesco Masotti

- MSH segment changes:
 - MSH-21 references the revision number of the *NoemaLife Integration Policy specifications*; the field is now Required
- PID segment changes:
 - PID-11 field: extended XAD.4 length to 3 chars for "ISTAT Regione" (Loc IT).
- PV1 segment changes:
 - PV1-3 field, changes for Loc CRS-SISS: 'Azienda Ospedaliera' in PL-10 and 'Struttura Conservazione Documento' in PL.11
 - PV1-19 field, CX.6 and CX.10 used for Loc SOLE requirements.
- PV2 segment changes:
 - Added new field PV2-8, "Expected Admission Date/Time"
 - Added new field PV2-9, "Expected Discharge Date/Time"
 - Added new field PV2-12, "Visit Description"
- ORC segment changes:
 - ORC for Document Management: ORC-3 has been declared as "required", ORC-2 as "required conditional"

- OBR segment changes:
 - New repetition has been introduced in OBR-46 to allow transmission, in Placer Order Management scenarios, of patients call-order identifier (queue processing order and patient anonymity during calls)
 - Modified the format of OBR-24 for Laboratory testing Management for an easier implementation in DNLab
 - Informed Consent moved from OBR-39 to OBR-46
 - Extended use of OBR-46 to specify the Agenda Code where a required service has been booked
 - In Laboratory Testing Management, field OBR-6 Requested Date/Time (containing *dtmdataaccettazione* for DNLab) has been moved to, TQ1-7
 - Suspected diagnosis has been moved from OBR-13 to OBR-31, and diagnosis code can be specified (e.g. ICD9 code)
 - OBR for Document Management: OBR-3 has been declared as "required", OBR-2 as "required conditional"
- TXA segment changes:
 - Extended possible values in TXA-21 for a better and easier compliance with CRS-SISS project
- OBX segment changes:
 - Table 0291, used during documents transmission for values in OBX-5 ED-3 (the document structure and format), has been extended to include custom MIME subtypes used in Noemalife projects (e.g. SISS and SOLE XML CDA enveloped formats, etc.)
 - OBX-7 for Laboratory Testing Management: extended the use to unformatted strings for representing reference values for non-numeric results
 - OBX-7 for Laboratory Testing Management: extended the use for representing EUCAST's MicS, MicR and Wild Type cut-off values
 - OBX-8 for Laboratory Testing Management: introduced management of repetitions to allow management of EUCAST's "Wild Type alert" flag.
 - OBX-11 for Laboratory Testing Management: added the result status "P" (Preliminary result)
 - Extended the use of OBX-17 for transmitting comments related to an identified microorganism or an antibiotic
 - Clarifications on usage of OBX-5 and OBX-8 in case of antibiotics testing (Laboratory Testing Management scenario).

Revision **0.3.0**

28 September 2012

Davide Musiani , Francesco Masotti

- Improved management of LIS result (DNLab "risultato corto") and LIS result comment (DNLab "risultato lungo") by better specifying the usage of OBX-2, OBX-5 and OBX-17
- Introduced the usage of OBX.10 in Laboratory Observation Result Management to easily identify the OBX segment carrying Antibiotic testing results
- Fixed TXA-20 and EVN-4 values for document messages in SISS environment
- Fixed OBX-5 description for Laboratory Results Management (wrong pointer to field structure in case data type = CE)

Revision **0.2.0**

28 June 2012

Davide Musiani , Francesco Masotti

FIRST OFFICIAL RELEASE

Revision **0.1.0**

21 May 2012

Davide Musiani , Francesco Masotti

RequestForComment version (RFC)

Chapter 2. HL7 Messages definition conventions

This chapter explains the rules and conventions adopted in tables describing the HL7 2.5 segments' structure.

1. Segments and Fields description conventions

Column "#"	Represents the standard HL7 2.5 SEQ (sequence) number (ordinal position of field in segment).
Column "Name"	Standard HL7 2.5 field's name
Column "Set"	This column merges two information that usually are separated in HL7 segments definitions: field optionality and field repeatability.

Table 2.1. Optionality types

SET	Meaning	Description
R	mandatory	
RE	mandatory if available/recommended	The element may be missing from the message, but it is recommended that the sending application transmit the information if available
RC	conditional mandatory	field item <i>mandatory</i> if condition laid out in Description column is true, else <i>optional</i>
O	optional	
OC	conditional optional	field item <i>optional</i> if condition laid out in Description column is true, else <i>ignored</i>
n/a	ignored	the field is ignored

Information related to repeatability of fields is added as a suffix to optionality codes using the following syntax:

No suffix	field is not repeatable
..N	field is repeatable to a maximum of N times
..*	field is repeatable an unlimited number of times

Example 2.1. Examples of optionality and repeatability syntax

R	Required field, not repeatable
O..2	Optional field, repeatable to a maximum of 2 times
RC..*	Field required under specific conditions (exposed in column "Description"), repeatable an unlimited number of times

Column "Description"	This column explains the usage and content of the field in details. Whenever needed, the field is structured in specific sections whose meaning is explained hereafter. If information related to the field is complex, a link to external specific sections/paragraphs MAY be given.
----------------------	---

Section "Format"	<p>Includes specific representation formats and structures the data MUST adhere and comply (e.g. date format "YYYYMMDD").</p> <p>Simple format is expanded inline inside the table, otherwise a link is provided to the field structure inside the Field definition section</p>
Section "Conditions"	<p>Explains conditions of usage or optionality of the field (e.g. PV1.2 = I)</p>
Section "Values"	<p>Specifies directives on values to set in the field, like values of sub-components, possible coded values, references to external sources defining the possible values (e.g. laws, standards, etc.).</p> <p>In case of composite fields, the value is intended to be assigned to the first component, if not stated differently.</p> <p>When value lists are applicable, they are expanded inline when having a short length, otherwise a link is provided to the table content inside the Table definition section</p>
Section "Loc"	<p>Explains values or usages that must be used in specific localizations (usually national or regional). Where possible, the nation code is expressed as ISO-3166 Alpha-3 format. For example, <i>Loc ITA</i> stands for Italian localization; <i>Loc CRS-SISS</i> stands for localization for Regione Lombardia regional project; <i>Loc SOLE</i> stands for localization for Regione Emilia-Romagna regional project.</p> <p>National or Regional localizations may be described in the national language for better comprehension.</p>

2. Exclusions and exceptions

- In segments definition tables included in the next chapters, **fields that are not explicitly mentioned MUST be considered as not supported.**
- Where not explicitly defined, the length of fields is intended to adhere to HL7 standard specifications (column "LEN" of standard HL7 tables). Nonetheless, upon specific needs and approved local agreement, different values MAY be adopted

Chapter 3. AL1 - Allergy

The AL1 segment contains patient allergy information of various types. Each AL1 segment describes a single patient allergy

1. Segment definition

#	Name	Set	Description																
01	Set ID - AL1	R	Identifier of each occurrence of the segment																
02	Allergen Type Code	O	<p>This field indicates a general allergy category (drug, food, pollen, etc.).</p> <p>Values: CE.1=Allergen type code. <i>ValueList</i> <see below>. Req</p> <p>CE.2=Allergen type description</p> <p>CE.3=<i>Constant</i>: HL70127 Req.</p> <p>Table 3.1. User Table 0127 - Allergen Type</p> <table border="1"> <tbody> <tr> <td>DA</td> <td>Drug Allergy</td> </tr> <tr> <td>FA</td> <td>Food Allergy</td> </tr> <tr> <td>MA</td> <td>Miscellaneous allergy</td> </tr> <tr> <td>MC</td> <td>Miscellaneous contraindication</td> </tr> <tr> <td>EA</td> <td>Environmental Allergy</td> </tr> <tr> <td>AA</td> <td>Animal Allergy</td> </tr> <tr> <td>PA</td> <td>Plant Allergy</td> </tr> <tr> <td>LA</td> <td>Pollen Allergy</td> </tr> </tbody> </table>	DA	Drug Allergy	FA	Food Allergy	MA	Miscellaneous allergy	MC	Miscellaneous contraindication	EA	Environmental Allergy	AA	Animal Allergy	PA	Plant Allergy	LA	Pollen Allergy
DA	Drug Allergy																		
FA	Food Allergy																		
MA	Miscellaneous allergy																		
MC	Miscellaneous contraindication																		
EA	Environmental Allergy																		
AA	Animal Allergy																		
PA	Plant Allergy																		
LA	Pollen Allergy																		
03	Allergen Code/Mnemonic/Description	R	<p>This field uniquely identifies a particular allergen. This element may conform to some external, standard coding system (that must be identified), or it may conform to local, largely textual or mnemonic descriptions</p> <p>Values: CE.1=Allergen code.</p> <p>CE.2=Allergen description</p> <p>CE.3=Name of coding system. <i>ValueList</i>: User Table 0396 - Coding System Req if CE.1 <> null</p>																
04	Allergy Severity Code	O	<p>This field indicates the general severity of the allergy</p> <p>Values: CE.1=Severity code. <i>ValueList</i> <see below>. Req</p> <p>CE.2=Severity description</p> <p>CE.3=<i>Constant</i>: HL70128 . Req</p> <p>Table 3.2. User Table 0128 - Allergy Severity</p> <table border="1"> <tbody> <tr> <td>SV</td> <td>Severe</td> </tr> <tr> <td>MO</td> <td>Moderate</td> </tr> <tr> <td>MI</td> <td>Mild</td> </tr> <tr> <td>U</td> <td>Unknown</td> </tr> </tbody> </table>	SV	Severe	MO	Moderate	MI	Mild	U	Unknown								
SV	Severe																		
MO	Moderate																		
MI	Mild																		
U	Unknown																		

AL1 - Allergy

#	Name	Set	Description						
			<table border="1"> <tr> <td colspan="2">Loc ITA</td> </tr> <tr> <td>DL</td> <td>Pericolo di vita</td> </tr> <tr> <td>DE</td> <td>Morte</td> </tr> </table>	Loc ITA		DL	Pericolo di vita	DE	Morte
Loc ITA									
DL	Pericolo di vita								
DE	Morte								
05	Allergy Reaction Code	O	Description of the specific allergic reaction that was documented						

Chapter 4. BLG - Billing segment

The BLG segment is used to provide billing information, on the ordered service, to the filling application.

1. Segment definition

1.1. BLG for Order Management and Laboratory Testing Management

Note

At present, BLG segment is **not actually used for the purpose of transmitting billing information**, as it is ment to, but rather to resolve a well-known HL7 messages' ambiguity.

In particular, the definition of messages OMG^O19, OML^O21 and OML^O33¹ includes the "ORDER_PRIOR" group of segments, used for the transmission of previous results. Several HL7 gateways may experience problems in parsing the above-mentioned messages, confusing the normal "ORDER" groups of segments with "ORDER_PRIOR" groups. To workaround this problem, a **"dummy" segment** may be added at the end of "ORDER" groups, to force the correct segments parsing and segments groups recognition; in NoemaLife HL7 Integration Policy it has been decided to use a "fake" BLG segment to this sake.

Despite the segment is optional in use cases' messages definitions, its use is RECOMMENDED.

#	Name	Set	Description						
02	Charge Type	RC	<table border="1"><tr><td>Values:</td><td>ZZ</td><td>States that the BLG is just a "dummy" segment to allow correct message parsing, and any data in it MUST NOT be used for any other purpose.</td></tr><tr><td>Conditions:</td><td colspan="2">Required when orders' messages parsing issues arise, due to ORDER_PRIOR group misunderstanding and wrong parsing</td></tr></table>	Values:	ZZ	States that the BLG is just a "dummy" segment to allow correct message parsing, and any data in it MUST NOT be used for any other purpose.	Conditions:	Required when orders' messages parsing issues arise, due to ORDER_PRIOR group misunderstanding and wrong parsing	
Values:	ZZ	States that the BLG is just a "dummy" segment to allow correct message parsing, and any data in it MUST NOT be used for any other purpose.							
Conditions:	Required when orders' messages parsing issues arise, due to ORDER_PRIOR group misunderstanding and wrong parsing								

¹In OML^O35 too, not currently used in NoemaLife integration policy

Chapter 5. DG1 - Diagnosis

The DG1 segment contains patient diagnosis information of various types, for example, admitting, primary, etc.

1. Segment definition

#	Name	Set	Description										
01	Set ID - DG1	R	Identifier of each occurrence of the segment										
02	Diagnosis Coding Method	n/a	Deprecated. Use DG1-3.										
03	Diagnosis Code - DG1	R	<p>Code assigned to the diagnosis</p> <p>Format: CE.1=Diagnosis Code. CE.2=Diagnosis Description CE.3=Name of Coding system. <i>ValueList:</i> <see below> Req if CE.1 <> null</p> <table border="1"> <tr> <td>I10</td> <td>ICD-10</td> </tr> <tr> <td>I10P</td> <td>ICD-10 Procedure Codes</td> </tr> <tr> <td>I9</td> <td>ICD-9</td> </tr> <tr> <td>I9C</td> <td>ICD-9CM</td> </tr> <tr> <td>99zzz or L</td> <td>Local general code</td> </tr> </table> <p>(Ref. User Table 0396 - Coding System)</p>	I10	ICD-10	I10P	ICD-10 Procedure Codes	I9	ICD-9	I9C	ICD-9CM	99zzz or L	Local general code
I10	ICD-10												
I10P	ICD-10 Procedure Codes												
I9	ICD-9												
I9C	ICD-9CM												
99zzz or L	Local general code												
04	Diagnosis Description	n/a	Deprecated. Use DG1-3.										
05	Diagnosis Date/Time	O	<p>This field contains the date/time that the diagnosis was determined.</p> <p>Format: YYYYMMDD[HH[MM[SS]]]</p>										
06	Diagnosis Type	O	<p>This field contains a code that identifies the type of diagnosis being sent</p> <p>Values: Table 5.1. User Table 0052 - Diagnosis Type</p> <table border="1"> <tr> <td>A</td> <td>Admitting [IT: Diagnosi di ammissione]</td> </tr> <tr> <td>W</td> <td>Working [IT: Non definitiva]</td> </tr> <tr> <td>F</td> <td>Final [IT: Diagnosi di dimissione]</td> </tr> <tr> <td>C</td> <td>Chronic [IT: In caso di patologia conclamata]</td> </tr> </table>	A	Admitting [IT: Diagnosi di ammissione]	W	Working [IT: Non definitiva]	F	Final [IT: Diagnosi di dimissione]	C	Chronic [IT: In caso di patologia conclamata]		
A	Admitting [IT: Diagnosi di ammissione]												
W	Working [IT: Non definitiva]												
F	Final [IT: Diagnosi di dimissione]												
C	Chronic [IT: In caso di patologia conclamata]												
15	Diagnosis Priority	OC	<p>Number that identifies the significance or priority of the diagnosis code</p> <p>Values: Table 5.2. HL7 Table 0359 - Diagnosis Priority</p> <table border="1"> <tr> <td>0</td> <td>Not included in diagnosis ranking [IT: diagnosi di ammissione]</td> </tr> <tr> <td>1</td> <td>Primary diagnosis</td> </tr> <tr> <td>2,..</td> <td>For ranked secondary diagnosis</td> </tr> </table> <p>Conditions: DG1-6=F</p>	0	Not included in diagnosis ranking [IT: diagnosi di ammissione]	1	Primary diagnosis	2,..	For ranked secondary diagnosis				
0	Not included in diagnosis ranking [IT: diagnosi di ammissione]												
1	Primary diagnosis												
2,..	For ranked secondary diagnosis												

#	Name	Set	Description										
16	Diagnosis Clinician	O..*	<p>Contains the doctor responsible for generating the diagnosis information.</p> <p>Note</p> <p>It is possible to use more than one repetition of the field, but information in each repetition MUST be related to the same doctor. Multiple repetitions MUST be used only to transmit <u>different identifiers</u> (ex. national identifier, regional identifier, local identifier, ecc.) of the <u>same doctor</u>; each repetition and its identifier MUST be clearly qualified according to the rules exposed below.</p> <p>Format: XCN.1=Doctor identifier. Req.</p> <p>XCN.2=Doctor Surname Recomm.</p> <p>XCN.3=Doctor Forename Recomm.</p> <p>XCN.13=Doctor identifier Type. Req.</p> <p>Values:</p> <table border="1"> <tr> <td>NN</td> <td>National Personal Identifier</td> </tr> <tr> <td>RRI</td> <td>Regional Registry ID</td> </tr> <tr> <td>LR</td> <td>Local Registry ID (<i>Not Compliant CRS-SISS</i>)</td> </tr> <tr> <td colspan="2">Loc ITA</td> </tr> <tr> <td>NNITA</td> <td>Tax Code</td> </tr> </table> <p>(Ref. HL7 Table 0203 - Identifier Type: IT)</p>	NN	National Personal Identifier	RRI	Regional Registry ID	LR	Local Registry ID (<i>Not Compliant CRS-SISS</i>)	Loc ITA		NNITA	Tax Code
NN	National Personal Identifier												
RRI	Regional Registry ID												
LR	Local Registry ID (<i>Not Compliant CRS-SISS</i>)												
Loc ITA													
NNITA	Tax Code												
20	Diagnosis Identifier	RC	<p>This field contains a value that uniquely identifies a single diagnosis for an encounter</p> <p>Format: EI.1=Unique Diagnosis identifier for an encounter. Req.</p> <p>EI.3=Identifier of event/movement to which the Diagnosis belongs</p> <p>Conditions: <i>Event=Update Diagnosis/Procedures</i></p>										
21	Diagnosis Action Code	RC	<p>This field defines the action to be taken for this diagnosis</p> <p>Values: Table 5.3. HL7 Table 0206 - Segment Action Code</p> <table border="1"> <tr> <td>A</td> <td>Add</td> </tr> <tr> <td>U</td> <td>Update</td> </tr> <tr> <td>D</td> <td>Delete</td> </tr> </table> <p>Conditions: <i>Event=Update Diagnosis/Procedures</i></p>	A	Add	U	Update	D	Delete				
A	Add												
U	Update												
D	Delete												

Example 5.1. Sample DG1 segment

- *Diagnosis Type*: Final diagnosis, Primary
- *Diagnosis Code* : 155.0
- *Diagnosis description*: Malignant neoplasm of liver primary,
- *Diagnosis coding system*: ICD-9-CM

DG1|001||155.0^Malignant neoplasm of liver primary^I9C||19880501103005|F|||||||1

Chapter 6. ERR - Error

The ERR segment is used to add error comments to acknowledgment messages.

1. Segment definition

#	Name	Set	Description						
03	HL7 Error Code	R	Identifies the HL7 (communications) error code Format: CWE.1=HL7 error code. <i>ValueList:</i> <u>HL7 Table 0357 - Message Error Condition Codes</u> . Req. CWE.2=HL7 error description CWE.3=Coding System. <i>Constant:</i> HL70357. Req.						
04	Severity	R	Identifies the severity of an application error Values: Table 6.1. HL7 Table 0516 – Error severity <table border="1" data-bbox="667 875 1399 1010"> <tr> <td>W</td> <td>Warning</td> </tr> <tr> <td>E</td> <td>Error</td> </tr> <tr> <td>I</td> <td>Information</td> </tr> </table>	W	Warning	E	Error	I	Information
W	Warning								
E	Error								
I	Information								
05	Application Error Code	O	Application specific code identifying the specific error that occurred. Format: CWE.1=Error code. CWE.2=Error description CWE.3=Application that generated the error, must be equal to MSH-04 (sending application). <i>ValueList:</i> <u>User Table 0361 - Application</u> Req.						
08	User Message	O	The text message to be displayed to the application user						

Example 6.1. Sample ERR segment

```
ERR|||100^Segment sequence error^HL70357|E|||^Missing required OBR segment^PICASSO|
```

2. Tables

Table 6.2. HL7 Table 0357 - Message Error Condition Codes

Value	Description	Comment
0	Message accepted	Success. Optional, as the AA conveys success. Used for systems that must always return a status code.
100	Segment sequence error	Error: The message segments were not in the proper order, or required segments are missing.

Value	Description	Comment
101	Required field missing	Error: A required field is missing from a segment
102	Data type error	Error: The field contained data of the wrong data type, e.g. an NM field contained "FOO"
103	Table value not found	Error: A field of data type ID or IS was compared against the corresponding table, and no match was found
200	Unsupported message type	Rejection: The Message Type is not supported
201	Unsupported event code	Rejection: The Event Code is not supported.
202	Unsupported processing id	Rejection: The Processing ID is not supported.
203	Unsupported version id	Rejection: The Version ID is not supported
204	Unknown key identifier	Rejection: The ID of the patient, order, etc., was not found. Used for transactions other than additions, e.g. transfer of a non-existent patient
205	Duplicate key identifier	Rejection: The ID of the patient, order, etc., already exists. Used in response to addition transactions (Admit, New Order, etc.).
206	Application record locked	Rejection: The transaction could not be performed at the application storage level, e.g., database locked.
207	Application internal error	Rejection: A catchall for internal errors not explicitly covered by other codes.

Chapter 7. EVN - Event Type

The EVN segment is used to communicate necessary trigger event information to receiving applications.

1. Segment definition

#	Name	Set	Description
01	Event Type Code	n/a	<i>Deprecated, use MSH-9 instead</i>
02	Recorded Date/Time	R	System date/time when the transaction was entered in the sending application. For example, on a transfer (A02), this field would contain the date/time the transfer was registered in the system, it might be before the patient was actually transferred Format: YYYYYMMDDHHMM[SS]
04	Event Reason Code	RC	In Patient Encounter scenario, for ADT^A08 messages only, this field is required to notify the type of HL7 event the A08 is ment to update (e.g. a previously sent A01, A02, etc.) In Document Management scenario, the field defines the notification type for Document Status Change Notification (T03) messages (e.g. "SISS_NOTIFY") Values: <u>User Table 0062 - Event Reason: IT</u> Conditions: (<i>Scenario=PatientEncounter and message = ADT^A08</i>) OR (<i>Scenario=DocumentManagement and Event= Document Status Change Notification</i>) Note <i>The use of this field to transmit the Day Hospital or Recurring Outpatient event subtype (e.g. notify if event is related to a DH access opening or closure) has been DEPRECATED. Use PV2-31 instead.</i>
06	Event Occurred	O	This field contains the date/time that the event actually occurred. For example, on a transfer (A02), this field would contain the date/time the patient was actually transferred. Format: YYYYYMMDDHHMM[SS]

Example 7.1. Sample EVN segment

```
//Inpatient, patient admission
EVN||20120305091158|||20120305091000
```

```
//Inpatient, patient admission update (ADT^A08 message)
EVN||20120305091210||A01||20120305091000
```

2. Tables

Table 7.1. User Table 0062 - Event Reason: IT

Value	Description	Comment
	Patient Encounter, ADT^A08 messages only	

EVN - Event Type

Value	Description	Comment
A01	States that the ADT^A08 message aims to update a previously sent ADT^A01 message	
A02	States that the ADT^A08 message aims to update a previously sent ADT^A02 message	
A03	States that the ADT^A08 message aims to update a previously sent ADT^A03 message	
A04	States that the ADT^A08 message aims to update a previously sent ADT^A04 message	
<i>Document Management</i>		
SISS_NOTIFY	The message is related to a notification to CRS-SISS	
	<i><Additional values to be agreed on local project agreements></i>	

Chapter 8. IAM - Patient Adverse Reaction Information Segment - Unique Identifier

The IAM segment contains person/patient adverse reaction information of various types. Each IAM segment describes a single person/patient adverse reaction.

This segment is typically used in lieu of the AL1 - Patient Allergy Information Segment to support action code/unique identifier mode update definition of repeating segments, while the AL1 segment should be used to support Snapshot mode update definition.

IAM segment may be also used in a combined "Snapshot plus Unique Identifier" mode, in order to guarantee that all allergies data available is sent in each message including allergies info, even the deleted allergies. This to ensure that no data mismatch occurs in case some of the allergies messages are lost or fail to process, for any reason.

1. Segment definition

#	Name	Set	Description																		
01	Set ID - AL1	R	Identifier of each occurrence of the segment within the message. MUST NOT be used as unique allergy identifier, since the same allergy may have different values in this field if transmitted on different messages																		
02	Allergen Type Code	O	This field indicates a general allergy category (drug, food, pollen, etc.). Values: CE.1=Allergen type code. <i>ValueList</i> <see below>. Req CE.2=Allergen type description CE.3= <i>Constant</i> : HL70127 Req . Table 8.1. User Table 0127 - Allergen Type <table border="1" data-bbox="667 1393 1394 1789"> <tbody> <tr> <td>DA</td> <td>Drug Allergy</td> </tr> <tr> <td>FA</td> <td>Food Allergy</td> </tr> <tr> <td>MA</td> <td>Miscellaneous allergy / Other allergy</td> </tr> <tr> <td>NA</td> <td>NO KNOWN ALLERGIES</td> </tr> <tr> <td>MC</td> <td>Miscellaneous contraindication (<i>currently not supported</i>)</td> </tr> <tr> <td>EA</td> <td>Environmental Allergy (<i>currently not supported</i>)</td> </tr> <tr> <td>AA</td> <td>Animal Allergy (<i>currently not supported</i>)</td> </tr> <tr> <td>PA</td> <td>Plant Allergy (<i>currently not supported</i>)</td> </tr> <tr> <td>LA</td> <td>Pollen Allergy (<i>currently not supported</i>)</td> </tr> </tbody> </table>	DA	Drug Allergy	FA	Food Allergy	MA	Miscellaneous allergy / Other allergy	NA	NO KNOWN ALLERGIES	MC	Miscellaneous contraindication (<i>currently not supported</i>)	EA	Environmental Allergy (<i>currently not supported</i>)	AA	Animal Allergy (<i>currently not supported</i>)	PA	Plant Allergy (<i>currently not supported</i>)	LA	Pollen Allergy (<i>currently not supported</i>)
DA	Drug Allergy																				
FA	Food Allergy																				
MA	Miscellaneous allergy / Other allergy																				
NA	NO KNOWN ALLERGIES																				
MC	Miscellaneous contraindication (<i>currently not supported</i>)																				
EA	Environmental Allergy (<i>currently not supported</i>)																				
AA	Animal Allergy (<i>currently not supported</i>)																				
PA	Plant Allergy (<i>currently not supported</i>)																				
LA	Pollen Allergy (<i>currently not supported</i>)																				
03	Allergen Code/Mnemonic/Description	R	This field uniquely identifies a specific allergen. This element may conform to some external, standard coding system (that must be identified), or it may conform to local, largely textual or mnemonic descriptions Values: CE.1=Allergen code <i>ValueList</i> : "NA" as a dummy allergen code if no allergies are known; otherwise, values according to coding system. CE.2=Allergen description																		

IAM - Patient Adverse
Reaction Information
Segment - Unique Identifier

#	Name	Set	Description														
			CE.3=Name of coding system. <i>ValueList</i> : User Table 0396 - Coding System Req if CE.1 <> null														
04	Allergy Severity Code	O	<p>This field indicates the general severity of the allergy</p> <p>Values: CE.1=Severity code. <i>ValueList</i> <see below>. Req</p> <p>CE.2=Severity description</p> <p>CE.3=<i>Constant</i>: HL70128 . Req</p> <p>Table 8.2. User Table 0128 - Allergy Severity</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>SV</td> <td>Severe</td> </tr> <tr> <td>MO</td> <td>Moderate</td> </tr> <tr> <td>MI</td> <td>Mild</td> </tr> <tr> <td>U</td> <td>Unknown</td> </tr> <tr> <td colspan="2">Loc ITA</td> </tr> <tr> <td>DL</td> <td>Life danger (Pericolo di vita)</td> </tr> <tr> <td>DE</td> <td>Death (Morte)</td> </tr> </table>	SV	Severe	MO	Moderate	MI	Mild	U	Unknown	Loc ITA		DL	Life danger (Pericolo di vita)	DE	Death (Morte)
SV	Severe																
MO	Moderate																
MI	Mild																
U	Unknown																
Loc ITA																	
DL	Life danger (Pericolo di vita)																
DE	Death (Morte)																
05	Allergy Reaction Code	O..*	<p>Includes information on the reaction code.</p> <p>Format: Since HL7 does not allow for transmission of reaction code and reaction description in separate fields, then the following format will be used:</p> <p style="text-align: center;"><i>reaction-code@reaction-description</i></p> <p>Values: Standard coding systems are RECOMMENDED if existing; otherwise locally-agreed coding systems may be used.</p> <p>If coded values are used, then the reaction description is REQUIRED.</p> <p>If reaction is recorded just as free text, then the reaction code subfield is optional.</p> <p>E.g. CON@Convulsions</p>														
06	Allergy Action Code	R	<p>Defines the action that occurred at the sending system while recording allergy information.</p> <p>Values: Table 8.3. HL7 Table 0323 - Action Code</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>U</td> <td>Update (also means Add/Insert, or Update, or No Change; it's up to the receiving system to manage data properly)</td> </tr> <tr> <td>D</td> <td>Delete (also used when an allergy is date-ended)</td> </tr> <tr> <td>A</td> <td>Add/insert (<i>currently not supported</i>)</td> </tr> <tr> <td>X</td> <td>No Changes (<i>currently not supported</i>)</td> </tr> </table>	U	Update (also means Add/Insert, or Update, or No Change; it's up to the receiving system to manage data properly)	D	Delete (also used when an allergy is date-ended)	A	Add/insert (<i>currently not supported</i>)	X	No Changes (<i>currently not supported</i>)						
U	Update (also means Add/Insert, or Update, or No Change; it's up to the receiving system to manage data properly)																
D	Delete (also used when an allergy is date-ended)																
A	Add/insert (<i>currently not supported</i>)																
X	No Changes (<i>currently not supported</i>)																
07	Allergy Unique Identifier	R	<p>Unique identifier of an allergy recording.</p> <p>At the receiver, it is REQUIRED to use this field (not IAM-3) to uniquely identify a specific allergy.</p>														

IAM - Patient Adverse
Reaction Information
Segment - Unique Identifier

#	Name	Set	Description								
			<p>An allergy recording revision number may also be included, in order to allow the receiver to check if modifications occurred.</p> <p>Format: EI.1 = Allergy identifier; unique across Patient data Req</p> <p>EI.3 = Allergy revision number</p>								
08	Action reason	O	<p>Reason for the allergy deletion or date-ending.</p> <p>Conditions: Managed only when IAM-6 = D (allergy deleted or date-ended)</p>								
09	Sensitivity to Causative Agent Code	O	<p>This field contains the reason why the patient should not be exposed to a substance.</p> <p>Values: CE.1=Sensitivity code. <i>ValueList</i> <see below>. Req</p> <p>CE.2=Sensitivity description</p> <p>CE.3=<i>Constant</i>: HL70436 . Req</p> <p>Table 8.4. User-defined Table 0436 - Sensitivity to Causative Agent Code</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>AD</td> <td>Adverse Reaction</td> </tr> <tr> <td>AL</td> <td>Allergy</td> </tr> <tr> <td>IN</td> <td>Intolerance</td> </tr> <tr> <td>CT</td> <td>Contraindication (<i>currently not supported</i>)</td> </tr> </table>	AD	Adverse Reaction	AL	Allergy	IN	Intolerance	CT	Contraindication (<i>currently not supported</i>)
AD	Adverse Reaction										
AL	Allergy										
IN	Intolerance										
CT	Contraindication (<i>currently not supported</i>)										
11	Onset Date	O	<p>Start date of allergy; is the actual start date of the first known reaction</p> <p>Format: YYYYMMDD</p>								
12	Onset Date Text	O	<p>End date of allergy</p> <p><i>NOTE: this field is used in conscious violation of HL7 standard</i></p> <p>Format: YYYYMMDD</p>								
13	Reported Date/Time	O	<p>Timestamp of the registration of allergy at the source system</p> <p>Format: YYYYMMDDHHMMSS</p>								
14	Reported by	O	<p>Source of allergy information (e.g. the patient itself, a parent, etc.)</p> <p>Format: XPN.1 FN.1 = Family name</p> <p>XPN.2 = Given name</p> <p>XPN.3 = Second and Further Given Names or Initials Thereof</p> <p>In case the information is not structured in separate fields for name components, but rather given as a plain string, it MUST be set in the first subfield (XPN.1 FN.1)</p>								
17	Allergy Clinical Status code	O	<p>Status of recorded allergy.</p> <p>Format: CE.1 = Status code</p> <p>CE.2 = Status description</p> <p>CE.3=<i>Constant</i>: HL70438 . Req</p>								

IAM - Patient Adverse
Reaction Information
Segment - Unique Identifier

#	Name	Set	Description																		
			<p>Values: Table 8.5. User-defined Table 0438 - Allergy Clinical Status</p> <table border="1"> <tr><td>U</td><td>Unconfirmed</td></tr> <tr><td>P</td><td>Pending</td></tr> <tr><td>S</td><td>Suspect</td></tr> <tr><td>C</td><td>Confirmed or Verified</td></tr> <tr><td>V</td><td>Validated</td></tr> <tr><td>I</td><td>Confirmed but inactive</td></tr> <tr><td>E</td><td>Erroneous</td></tr> <tr><td>D</td><td>Doubt raised</td></tr> <tr><td>T</td><td>Terminated</td></tr> </table>	U	Unconfirmed	P	Pending	S	Suspect	C	Confirmed or Verified	V	Validated	I	Confirmed but inactive	E	Erroneous	D	Doubt raised	T	Terminated
U	Unconfirmed																				
P	Pending																				
S	Suspect																				
C	Confirmed or Verified																				
V	Validated																				
I	Confirmed but inactive																				
E	Erroneous																				
D	Doubt raised																				
T	Terminated																				
18	Stated by Person	O	<p>Last User who recorded/amended the allergy.</p> <p>Format: XCN.1 = Identifier Req</p> <p> XCN.2 FN.1 = Family name</p> <p> XCN.3 = Given Name</p> <p> XCN.4 = Second and Further Given Names or Initials Thereof</p>																		
20	Stated at Date/Time	O	<p>Last Date and time when the allergy was recorded/amended.</p> <p>Format: YYYYMMDDHHMMSS</p>																		

Chapter 9. MRG - Merge patient

The MRG segment provides receiving applications with information necessary to the merging of patient data (event A40) or the moving of visit data to a different patient (A45).

1. Segment definition

#	Name	Set	Description
01	Prior Patient Identifier List	R	This field contains the old patient identifier list that must be merged to the patient identified by the PID segment in the message. Format: Same format of PID-3: see Patient Identifier List for details
05	Prior Visit Number	RC	This field contains the prior visit number that must be moved to the patient identified by the PID segment in the message. Format: CX.1=prior visit/episode number. Req. CX.4=application that assigned the visit/episode number. <i>ValueList:</i> User Table 0363 - Assigning Authority: IT . Req. CX.5= <i>Constant</i> : VN Req. Conditions: <i>Event</i> =Move Visit

Example 9.1. Sample MRG segment

Merge Patient:

```
MRG|0000000009400547^^^PK^PI
```


MSA - Message Acknowledgment

Value	Description	Comment
CR	Enhanced mode: Accept acknowledgment: Commit Reject	

Chapter 11. MSH - Message Header

The MSH segment defines the intent, source, destination, and some specifics of the syntax of a message.

1. Segment definition

#	Name	Set	Description
01	Field Separator	R	Field separator character Values:
02	Encoding Characters	R	This field contains the four characters in the following order: the component separator, repetition separator, escape character, and subcomponent separator. Values: ^~\&
03	Sending Application	R	This field uniquely identifies the sending application among all other applications within the network enterprise. Values: <u>User Table 0361 - Application</u>
04	Sending Facility	O	Name of the owner company of the sending application. <i>(Def. HL7: This field identifies the sending application among multiple identical instances of the application running on behalf of different organizations).</i> Values: Company Name (e.g. NoemaLife)
05	Receiving Application	O	This field uniquely identifies the receiving application among all other applications within the network enterprise. Values: <i>Original message:</i> HD.1= <u>User Table 0361 - Application</u> <i>Acknowledge message:</i> HD.1=MSH-03 from original message
06	Receiving Facility	O	Name of the owner company of the receiving application. <i>(Def. HL7: This field identifies the receiving application among multiple identical instances of the application running on behalf of different organizations).</i> Values: <i>Original message</i> Company Name (e.g. NoemaLife) <i>Acknowledge message:</i> HD.1=MSH-04 from original message
07	Date/Time Of Message	R	Message creation date Format: YYYYMMDDHHMMSS
09	Message Type	R	This field contains the message type and trigger event for the message. Format: MSG.1=Message type code. <i>ValueList:</i> <u>HL7 Table 0076 - Message type. Req.</u> MSG.2=Trigger Event. <i>ValueList:</i> <u>HL7 Table 0003 - Event. Req.</u>

#	Name	Set	Description						
10	Message control ID	R	This field contains a number or other identifier that uniquely identifies the message. The receiving system echoes this ID back to the sending system in the Message acknowledgment segment (MSA). Values: <i>Original message:</i> Message identifier <i>Acknowledge message:</i> MSH-10 from original message						
11	Processing ID	R	Defines the intent for processing the message. Values: <i>Original message:</i> <table border="1" data-bbox="667 584 1398 779"> <tr> <td>P</td> <td>Production message. Mandatory value for integrations running in a production environment.</td> </tr> <tr> <td>T</td> <td>Training message. <i>Not used.</i></td> </tr> <tr> <td>D</td> <td>Debug message. <i>Reserved for future monitoring messages.</i></td> </tr> </table> <i>Acknowledge message:</i> MSH-11 from original message	P	Production message. Mandatory value for integrations running in a production environment.	T	Training message. <i>Not used.</i>	D	Debug message. <i>Reserved for future monitoring messages.</i>
P	Production message. Mandatory value for integrations running in a production environment.								
T	Training message. <i>Not used.</i>								
D	Debug message. <i>Reserved for future monitoring messages.</i>								
12	Version ID	R	HL7 version used Values: 2.5						
18	Character Set	O	This field contains the character set for the entire message Values: <table border="1" data-bbox="667 1070 1398 1115"> <tr> <td>8859/15</td> <td>ISO 8859-15 (Latin 9). (<i>Compliance: IHE</i>)</td> </tr> </table>	8859/15	ISO 8859-15 (Latin 9). (<i>Compliance: IHE</i>)				
8859/15	ISO 8859-15 (Latin 9). (<i>Compliance: IHE</i>)								
21	Message Profile Identifier	R..*	Definition of the revision number of the <i>NoemaLife Integration Policy specifications</i> the message is adherent to. Format: EI.1= Revision number <i>Format: nlip-x.y.z</i> Req. EI.2=NoemaLife. Req.						

Example 11.1. Sample MSH segment

```
MSH|^~\&|DNLAB|NOEMALIFE|PEOPLE|NOEMALIFE|20120227053539|
|ADT^A31|HL7Gtw0135BD17AA9100|P|2.5|||8859/1||nlip-0.3.0^NoemaLife|
```

2. Tables

Table 11.1. User Table 0361 - Application

Value	Description	Comment
HELIOS	ADT	
SOLDANELLA	CUP	
GALILEO	EEMR	
ATHENA	Anatomic Pathology	
DNLAB	LIS	
POWERLAB	LIS	

Value	Description	Comment
PEOPLE	MPI	
ELEKTRA	RIS	
PICASSO	Middleware	
JCAPS	Middleware	

The table contains an entry for each NoemaLife application in the integration domain. In case of multiple instances of the same application running in the integration domain, add the suffix -1,2.... to the application name listed in the table (e.g. DNLAB-1, DNLAB-2 in case of two instances of DNLAB).

Table 11.2. HL7 Table 0076 - Message type

Value	Description	Comment
ACK	General acknowledgment message	
ADT	Patient Administration message	
MDM	Medical document management message	
ORM	General Order Request message	
ORR	General Order Response message	
OML	Laboratory Order message	
ORL	Laboratory Order Response message	
OMG	General Clinical Order message	
ORG	General Clinical Order Acknowledge message	
OUL	Unsolicited laboratory observation message	
ORL	Laboratory acknowledgment message (unsolicited)	
ORU	Order Result Unsolicited message	

Table 11.3. HL7 Table 0003 - Event

Value	Description	Comment
A28	Add person information	
A31	Update person information	
A40	Merge patient	
A01	Admit/visit notification	
A11	Cancel admit/visit notification	
A02	Transfer a patient	
A12	Cancel transfer	
A03	Discharge/end visit	
A13	Cancel discharge/end visit	
A04	Register a patient	
A05	Pre-admit a patient	
A38	Cancel pre-admit	
A45	Move Visit	
O01	ORM - Order message	
O02	ORR - Order response	
O19	OMG – General clinical order	

MSH - Message Header

Value	Description	Comment
O20	ORG/ORL – General clinical order response	
O21	OML - Laboratory order	
O22	ORL - General laboratory order response message to any OML	
O33	OML – Laboratory order for multiple orders related to a single specimen	
O34	ORL – Laboratory order response message to a multiple order related to single specimen OML	
O35	OML – Laboratory order for multiple orders related to a single container of a specimen	
O36	ORL - Laboratory order response message to a single container of a specimen OML	
R01	ORU/ACK - Unsolicited transmission of an observation message	
R22	OUL – Unsolicited Specimen Oriented Observation Message	
R24	OUL – Unsolicited Order Oriented Observation Message	
T01	MDM/ACK - Original document notification	
T02	MDM/ACK - Original document notification and content	
T05	MDM/ACK - Document addendum notification	
T06	MDM/ACK - Document addendum notification and content	
T09	MDM/ACK - Document replacement notification	
T10	MDM/ACK - Document replacement notification and content	
T11	MDM/ACK - Document cancel notification	

Chapter 12. NK1 - Next Of Kin/ Associated Parties

The NK1 segment contains information about the patient's other related parties. Any associated parties may be identified.

When NK1-3=SEL, the segment is used to extend patient data in segments PID and PD1, to provide informations about his job.

1. Segment definition

#	Name	Set	Description										
01	Set ID	R	Identifier of the occurrence of the segment inside the message										
02	Name	OC	This field contains the name of the next of kin or associated party, whose relationship with the patient is defined in NK1-3 Format: Same format of PID-5: see <u>Patient Name</u> for details Conditions: NK1-3<>SEL										
03	Relationship	R	Actual personal relationship that the next of kin/associated party has to the patient. Values: <u>User Table 0063 - Relationship</u>										
04	Address	OC.4	This field contains the address of the next of kin/associated party Format: Same format of PID-11: see <u>Patient Address</u> for details Conditions: NK1-3<>SEL										
05	Phone Number	OC.*	This field contains the phone number of the next of kin/associated party Format: Same format of PID-13: see <u>Phone Number - Home</u> for details Conditions: NK1-3<>SEL										
11	Next of Kin / Associated Parties Job Code/ Class	OC	Patient's Job code/classification. This field is used together with NK1.34 to give a detailed description of patient's job type and status. Format: JCC.1=Patient's job code. <i>ValueList:</i> <u>User Table 0327 - Job Code</u> . JCC.2=Patient's job sector. <i>ValueList:</i> <table border="1" data-bbox="922 1603 1398 1854"> <tbody> <tr> <td>A</td> <td>Agriculture, phishing, hunting</td> </tr> <tr> <td>I</td> <td>Industry</td> </tr> <tr> <td>C</td> <td>Commerce, service, tourism</td> </tr> <tr> <td>G</td> <td>Government, public administration</td> </tr> <tr> <td>O</td> <td>Other</td> </tr> </tbody> </table> JCC.3=Patient's job free textual description Conditions: NK1-3=SEL	A	Agriculture, phishing, hunting	I	Industry	C	Commerce, service, tourism	G	Government, public administration	O	Other
A	Agriculture, phishing, hunting												
I	Industry												
C	Commerce, service, tourism												
G	Government, public administration												
O	Other												
13	Organization name	OC	This field may be used to communicate the name of the organization at which the patient works.										

NK1 - Next Of Kin/
Associated Parties

#	Name	Set	Description																														
			Conditions: NK1-3=SEL																														
33	Associated Party's Identifiers	OC	<p>This field contains the identifiers for the next of kin/associated party.</p> <p>Format: Same format of PID-3: see Patient Identifier List for details</p> <p>Conditions: NK1-3<>SEL</p>																														
34	Job Status	OC	<p>Patient's job status. This field is used together with NK1.11 to give a detailed description of patient's job type and status.</p> <p>Values: Table 12.1. User Table 0311 - Job Status</p> <table border="1" style="margin-left: 40px;"> <tbody> <tr> <td>P</td> <td>Permanent [IT:Occupato, a tempo indeterminato]</td> <td>Ref. HL7</td> </tr> <tr> <td>T</td> <td>Temporary [IT: Occupato, a tempo determinato]</td> <td>"</td> </tr> <tr> <td>O</td> <td>Other</td> <td>"</td> </tr> <tr> <td>U</td> <td>Unknown</td> <td>"</td> </tr> <tr> <td>I</td> <td>Unemployed, never worked/looking for first job [IT: In cerca di prima occupazione]</td> <td>Ref. HL7 Italia</td> </tr> <tr> <td>D</td> <td>Unemployed at present [IT: Attualmente disoccupato]</td> <td>"</td> </tr> <tr> <td>S</td> <td>Student [IT: Studente/minore]</td> <td>"</td> </tr> <tr> <td>R</td> <td>Retired [IT: Pensionato]</td> <td>Def. NoemaLife</td> </tr> <tr> <td>PEN</td> <td>Pensionato</td> <td>"</td> </tr> <tr> <td>CAS</td> <td>Casalinga</td> <td>"</td> </tr> </tbody> </table> <p>Conditions: NK1-3=SEL</p>	P	Permanent [IT:Occupato, a tempo indeterminato]	Ref. HL7	T	Temporary [IT: Occupato, a tempo determinato]	"	O	Other	"	U	Unknown	"	I	Unemployed, never worked/looking for first job [IT: In cerca di prima occupazione]	Ref. HL7 Italia	D	Unemployed at present [IT: Attualmente disoccupato]	"	S	Student [IT: Studente/minore]	"	R	Retired [IT: Pensionato]	Def. NoemaLife	PEN	Pensionato	"	CAS	Casalinga	"
P	Permanent [IT:Occupato, a tempo indeterminato]	Ref. HL7																															
T	Temporary [IT: Occupato, a tempo determinato]	"																															
O	Other	"																															
U	Unknown	"																															
I	Unemployed, never worked/looking for first job [IT: In cerca di prima occupazione]	Ref. HL7 Italia																															
D	Unemployed at present [IT: Attualmente disoccupato]	"																															
S	Student [IT: Studente/minore]	"																															
R	Retired [IT: Pensionato]	Def. NoemaLife																															
PEN	Pensionato	"																															
CAS	Casalinga	"																															

Example 12.1. Sample NK1 segment

- *Name:* Bianchi Maria
- *Relationship:* Mother
- *Phones:*

Working: +39 064855344

Home: +39 34822334455

```
NK1 | 2 | BIANCHI^MARIA | MTH | | ^WPN^^^+39^^^^^^^064855344~
^PRN^CP^^+39^^^^^^^34822334455 | |
```

2. Tables

Table 12.2. User Table 0063 - Relationship

Value	Description	Comment (from HL7 Italia)
SEL	Self	Il paziente stesso

NK1 - Next Of Kin/
Associated Parties

Value	Description	Comment (from HL7 Italia)
SPO	Spouse	Coniuge
DOM	Life partner	Convivente
CHD	Child	Figlio
GCH	Grandchild	Nipote
NCH	Natural child	Figlio naturale
SCH	Stepchild	Figlio naturale del coniuge nato in un precedente matrimonio
FCH	Foster child	Figlio adottivo
DEP	Handicapped dependent	Il paziente è diversamente abile e dipende quindi da questa persona.
WRD	Ward of court	Tutore legale (per minorenni o persone incapaci di intenedere o di volere)
PAR	Parent	Genitore
MTH	Mother	Madre
FTH	Father	Padre
CGV	Care giver	Persona che si prende cura del paziente (non solo infermiere professionale)
GRD	Guardian	Tutore
GRP	Grandparent	Nonno o nonna
EXF	Extended family	Famiglia allargata
SIB	Sibling	Fratello o sorella
BRO	Brother	Fratello
SIS	Sister	Sorella
FND	Friend	Amico
OAD	Other adult	Altro adulto
EME	Employee	Dipendente
EMR	Employer	Datore di lavoro
ASC	Associate	Associato (Socio nella stessa società)
EMC	Emergency contact	Contatto in caso di emergenza
OWN	Owner	Proprietario (in caso di pazienti animali)
TRA	Trainer	Allenatore
MGR	Manager	Manager
NON	None	Nessuno
UNK	Unknown	Sconosciuto
OTH	Other	Altro

Table 12.3. User Table 0327 - Job Code

Value	Description	Comment
AP	Apprentice, trainee	[IT: Apprendista]
BM	Businessman	[IT: Imprenditore]

NK1 - Next Of Kin/
Associated Parties

Value	Description	Comment
CL	Clerk, teacher	[IT: Impiegato, Insegnante]
CP	Cooperative Partner	[IT: Socio di cooperativa]
CW	Co-worker	[IT: Coadiuvante]
EX	Executive	[IT: Dirigente]
FL	Freelance	[IT: Libero professionista]
HC	Handicapped	[IT: Disabile]
HW	Home worker	[IT: Lavoratore domiciliare]
MG	Manager	[IT: Direttivo, Quadro]
MI	Military	[IT: Forze Armate]
OT	Other	[IT: Altro]
SC	Special categories workers	[IT: Categorie speciali]
SE	Self-employed	[IT: Lavoratore in proprio]
WK	Worker, workman	[IT: Operaio]

Chapter 13. NTE - Notes and Comments

The Note segment is used to communicate additional informations about Documents.

1. Segment definition

1.1. NTE for Document Management

Current use is about authorization to publication of clinical documents to external systems (e.g. Portal application). Can be extended to include additional uses.

#	Name	Set	Description				
01	Set ID - NTE	R	Identifier of each occurrence of the segment.				
02	Source of comment	O	Values: O = Other System is source of comment				
03	Comment	R	Variable content depending on the value of NTE-4.2				
04	Comment Type	R	<p>This field identifies the type of information included in NTE-3</p> <p>Values:</p> <p>CE.1=GI</p> <p>CE.2=</p> <table border="1" style="width: 100%;"> <thead> <tr> <th colspan="2">Publication to external systems</th> </tr> </thead> <tbody> <tr> <td style="width: 30%;">PORTAL</td> <td> <p>Authorization to publication in the "Document Portal" application.</p> <p><i>Note 1:</i> user credentials for access to the Portal can be specified in OBR-46</p> <p><i>Note 2:</i> When scenario < > Document Management, consent to publication can be defined in PV2-45</p> <p>ValueList in NTE-3:</p> <p>Y = Yes, Authorization given</p> <p>N = No, Authorization NOT given</p> </td> </tr> </tbody> </table>	Publication to external systems		PORTAL	<p>Authorization to publication in the "Document Portal" application.</p> <p><i>Note 1:</i> user credentials for access to the Portal can be specified in OBR-46</p> <p><i>Note 2:</i> When scenario < > Document Management, consent to publication can be defined in PV2-45</p> <p>ValueList in NTE-3:</p> <p>Y = Yes, Authorization given</p> <p>N = No, Authorization NOT given</p>
Publication to external systems							
PORTAL	<p>Authorization to publication in the "Document Portal" application.</p> <p><i>Note 1:</i> user credentials for access to the Portal can be specified in OBR-46</p> <p><i>Note 2:</i> When scenario < > Document Management, consent to publication can be defined in PV2-45</p> <p>ValueList in NTE-3:</p> <p>Y = Yes, Authorization given</p> <p>N = No, Authorization NOT given</p>						

Example 13.1. Sample NTE segment

```
//Authorization to publication in Document Portal
NTE|1|O|Y|GI^PORTAL|
```

1.2. NTE for Loc=CRS-SISS and Document Management

As required by CRS-SISS project, NTE segment is used to convey attributes about the main clinical document (DCE) and the associated privacy document (DAO) in MDM messages (refer to CRS-SISS technical documentation [CRS-SISS-HL7]).

#	Name	Set	Description																								
01	Set ID - NTE	R	Identifier of each occurrence of the segment.																								
02	Source of comment	O	Values: O = Other System is source of comment																								
03	Comment	R	Variable content depending on the value of NTE-4.2																								
04	Comment Type	R	<p>This field identifies the type of information included in NTE-3</p> <p>Values:</p> <p>CE.1=GI</p> <p>CE.2=</p> <table border="1"> <thead> <tr> <th colspan="2">Attributi DCE: negli NTE relativi all'OBX del DCE</th> </tr> </thead> <tbody> <tr> <td>hashReferto / hashCDA</td> <td>Contiene l'output ottenuto applicando la funzione hash al referto testuale/strutturato e permette di identificare il documento attraverso una stringa. Req</td> </tr> <tr> <td>algoritmoHashReferto / algoritmoHashCDA</td> <td>Contiene l'algoritmo utilizzato per il calcolo dell'hash del documento testuale/strutturato. Req</td> </tr> <tr> <td>validazioneSchema</td> <td>Contiene la versione dello schema del documento strutturato. Req</td> </tr> <tr> <td>sizeDocumentoReferto / sizeDocumentoCDA</td> <td>Contiene la dimensione del documento testuale/strutturato. Req</td> </tr> <tr> <td>linguaggioDocumentoReferto / linguaggioDocumentoCDA</td> <td>Contiene il codice del linguaggio del documento testuale/strutturato. Req</td> </tr> <tr> <td>notaReperibilità</td> <td>testo della nota di reperibilità</td> </tr> <tr> <th colspan="2">Attributi DAO: negli NTE relativi all'OBX del DAO</th> </tr> <tr> <td>versioneXSLT</td> <td>Contiene la versione del file di transform utilizzata per la generazione del documento di autorizzazione</td> </tr> <tr> <th colspan="2">Attributi Amministrativi: in coda agli NTE dell'ultimo OBX</th> </tr> <tr> <td>consultazioneElettronica</td> <td>Il dipartimentale indica se il DCE verrà consultato dal cittadino attraverso i servizi SISS oppure se richiederà la stampa del referto all'azienda (Opzionale) ValueList in NTE-3: SI/NO</td> </tr> <tr> <td>sezioneFascicolo</td> <td>indica a quale/i sezione/i del Fascicolo Sanitario Elettronico del SISS viene registrato il link del documento. ValueList in NTE-3:</td> </tr> </tbody> </table>	Attributi DCE: negli NTE relativi all'OBX del DCE		hashReferto / hashCDA	Contiene l'output ottenuto applicando la funzione hash al referto testuale/strutturato e permette di identificare il documento attraverso una stringa. Req	algoritmoHashReferto / algoritmoHashCDA	Contiene l'algoritmo utilizzato per il calcolo dell'hash del documento testuale/strutturato. Req	validazioneSchema	Contiene la versione dello schema del documento strutturato. Req	sizeDocumentoReferto / sizeDocumentoCDA	Contiene la dimensione del documento testuale/strutturato. Req	linguaggioDocumentoReferto / linguaggioDocumentoCDA	Contiene il codice del linguaggio del documento testuale/strutturato. Req	notaReperibilità	testo della nota di reperibilità	Attributi DAO: negli NTE relativi all'OBX del DAO		versioneXSLT	Contiene la versione del file di transform utilizzata per la generazione del documento di autorizzazione	Attributi Amministrativi: in coda agli NTE dell'ultimo OBX		consultazioneElettronica	Il dipartimentale indica se il DCE verrà consultato dal cittadino attraverso i servizi SISS oppure se richiederà la stampa del referto all'azienda (Opzionale) ValueList in NTE-3: SI/NO	sezioneFascicolo	indica a quale/i sezione/i del Fascicolo Sanitario Elettronico del SISS viene registrato il link del documento. ValueList in NTE-3:
Attributi DCE: negli NTE relativi all'OBX del DCE																											
hashReferto / hashCDA	Contiene l'output ottenuto applicando la funzione hash al referto testuale/strutturato e permette di identificare il documento attraverso una stringa. Req																										
algoritmoHashReferto / algoritmoHashCDA	Contiene l'algoritmo utilizzato per il calcolo dell'hash del documento testuale/strutturato. Req																										
validazioneSchema	Contiene la versione dello schema del documento strutturato. Req																										
sizeDocumentoReferto / sizeDocumentoCDA	Contiene la dimensione del documento testuale/strutturato. Req																										
linguaggioDocumentoReferto / linguaggioDocumentoCDA	Contiene il codice del linguaggio del documento testuale/strutturato. Req																										
notaReperibilità	testo della nota di reperibilità																										
Attributi DAO: negli NTE relativi all'OBX del DAO																											
versioneXSLT	Contiene la versione del file di transform utilizzata per la generazione del documento di autorizzazione																										
Attributi Amministrativi: in coda agli NTE dell'ultimo OBX																											
consultazioneElettronica	Il dipartimentale indica se il DCE verrà consultato dal cittadino attraverso i servizi SISS oppure se richiederà la stampa del referto all'azienda (Opzionale) ValueList in NTE-3: SI/NO																										
sezioneFascicolo	indica a quale/i sezione/i del Fascicolo Sanitario Elettronico del SISS viene registrato il link del documento. ValueList in NTE-3:																										

#	Name	Set	Description
			01=Generalista 02=Rete patologia 03=Generalista e Rete patologia
			flagInviareAISiss Il dipartimentale indica se il DCE dovrà essere notificato o meno al SISS . Req ValueList in NTE-3: 01 = da inviare 02 = invio in carico al dipartimentale 03 = da non inviare
			retePatologia Codice della rete di patologia di appartenenza del referto ValueList in NTE-3: 01 = Rete Oncologica 02 = Rete di Epilessia 03 = Rete di Ematologia 04 = Rete di Nefrologia e Dialisi 05 = Rete IMA
			marcaTemporale Indica se il documento DCE è marcato o da marcare- obbligatorio ValueList in NTE-3: 01=Marcato 02=Da marcare (sul Repository) 03=Da non marcare
			notaReperibilità testo della nota di reperibilità. Req al DCE è associato un DAO <i>and</i> autorizzazioneConsultazione=SI
			<i>Autorizzazione e Oscuramento: (vedi elenco attributi sotto)</i> Obbligatorio se al DCE è associato un DAO, e in tal caso vanno specificati <i>tutti</i> gli attributi in ripetizioni NTE distinte. ValueList in NTE-3: SI/NO
			10 tossicodipendenza
			20 HIV
			30 violenze subite
			40 interruzione volontaria gravidanza
			50 oscuramento volontario richiesto dal cittadino
			autorizzazioneConsultazione indicazione dell'autorizzazione alla consultazione in autonomia

Example 13.2. Sample NTE segment

```
// per hashReferto
NTE|1|O|PkikvIAZST9SosxxWmQJ218GXWQ=|GI^hashReferto|

// per Oscuramento e autorizzazione
NTE|1|O|SI|GI^10|
NTE|2|O|SI|GI^20|
NTE|3|O|NO|GI^30|
NTE|4|O|NO|GI^40|
NTE|5|O|NO|GI^50|
NTE|6|O|SI|GI^autorizzazioneConsultazione|
```

1.3. NTE for Pharmacy/Treatment management

Current use is about various types of notes related to Pharmacy/Treatment management.

#	Name	Set	Description										
01	Set ID - NTE	R	Identifier of each occurrence of the segment.										
02	Source of comment	O	Used to identify the source of comment. Values: <table border="1" style="margin-left: 20px;"> <tr> <td colspan="2">Scenario = Medicine on Discharge</td> </tr> <tr> <td>P</td> <td>Prescribing system (placer) is source of comment</td> </tr> </table>	Scenario = Medicine on Discharge		P	Prescribing system (placer) is source of comment						
Scenario = Medicine on Discharge													
P	Prescribing system (placer) is source of comment												
03	Comment	R	Free text containing the comment/note itself; its meaning and use is defined in NTE-4 CE.1										
04	Comment Type	R	This field identifies the type of information included in NTE-3 Format: CE.1 = Comment/Note type or category. <i>ValueList: Req</i> <table border="1" style="margin-left: 20px;"> <tr> <td colspan="2">Scenario = Medicine on Discharge</td> </tr> <tr> <td>GR</td> <td>Reason for changing or stopping the prescription</td> </tr> <tr> <td>MD</td> <td>Medicines notes</td> </tr> <tr> <td>GP</td> <td>Notes to General Practitioner</td> </tr> <tr> <td>PH</td> <td>Pharmacy note</td> </tr> </table>	Scenario = Medicine on Discharge		GR	Reason for changing or stopping the prescription	MD	Medicines notes	GP	Notes to General Practitioner	PH	Pharmacy note
Scenario = Medicine on Discharge													
GR	Reason for changing or stopping the prescription												
MD	Medicines notes												
GP	Notes to General Practitioner												
PH	Pharmacy note												

Example 13.3. Sample NTE segment

```
// Comment for General practitioner
NTE|1|P|Administer only in case of sharp pain|GP|
```

Chapter 14. OBR - Observation Request

The Observation Request segment defines the attributes of a particular request for diagnostic services (e.g., laboratory, EKG) or clinical observations (e.g., vital signs or physical exam). When a placer requests a given set of observations, always include an order segment.

1. Segment definition

1.1. OBR for Document Management

#	Name	Set	Description
02	Placer Order Number	RC	Placer application's order number. It identifies an order uniquely among all orders from a particular ordering application. If available, MUST be set and equal to ORC-2. Format: EI.1=order identifier EI.2=placer application. <i>ValueList:</i> <u>User Table 0361 - Application</u> Condition: <i>Scenario</i> =Document Management and Placer Order Number available
03	Filler Order Number	R	Order number associated with the filling application. It must uniquely identify the order from other orders in a particular filling application. Must be equal to ORC-3 Format: EI.1=order identifier EI.2=filler application. <i>ValueList:</i> <u>User Table 0361 - Application</u>
04	Universal Service Identifier	R	This field contains the identifier code for the requested observation Format: CE.1=observation identifier assigned by filler application . Req. CE.2=description of observation identifier CE.3=name of coding system. <i>ValueList:</i> <u>User Table 0396 - Coding System</u> Req. CE.4=alternate observation identifier CE.5=description of alternate observation identifier CE.6=name of alternate coding system. <i>ValueList:</i> <u>User Table 0396 - Coding System</u>
18	Placer Field 1	O	Physician prescription identifier [ITA: Codice RUR della prescrizione]
27	Quantity/timing	n/a	<i>Deprecated, use TQ1 segment</i>
32	Principal Result Interpreter	R	NoemaLife usage of the field is intended to specification of the facility that produced the document. Format NDL.7=Facility Loc ITA Struttura in cui viene prodotto il referto ^a

#	Name	Set	Description
			<p><i>Format</i> NDL.7.1=Codice Azienda Ospedaliera</p> <p>NDL.7.2=Codice del Presidio (8 cifre)</p> <p>NDL.7.3=Codice Reparto/Ambulatorio</p>
46	Placer Supplemental Service Information	OC..*	<p>This field contains supplemental service information sent from the placer system to the filler system.</p> <p>Current usages include:</p> <ul style="list-style-type: none"> User credentials for access to Document Distribution applications <p>Authorization and consent to document publishing is given in NTE segment for Document Management, else in PV2-45</p> <p>Format: see <u>Placer Supplemental Service Information</u></p> <p>Conditions: <i>Scenario</i>= Document Management</p>

^aLe specifiche CRS-SISS prevedono l'utilizzo di PV1-3 per specificare la struttura in cui viene prodotto il referto; noi preferiamo preservare PV1-3 al significato di 'Assigned Patient Location' e utilizzare invece OBR-32.

1.2. OBR for Order Management

Important

Following specifications for OBR segment do *NOT* apply to the Laboratory system, that must refer instead to OBR for Laboratory Testing Management

#	Name	Set	Description
01	Set ID – OBR	O	Identifier of each occurrence of the segment.
02	Placer Order Number	RC	<p>Placer application's order number. It identifies an order uniquely among all orders from a particular ordering application. Must be equal to ORC-2</p> <p>Format: EI.1=order identifier</p> <p>EI.2=placer application. <i>ValueList:</i> <u>User Table 0361 - Application</u></p> <p>Condition: <i>Scenario</i>=Placer Order Management</p>
03	Filler Order Number	RC	<p>Order number associated with the filling application. It must uniquely identify the order from other orders in a particular filling application. Must be equal to ORC-3</p> <p>Format: EI.1=order identifier</p> <p>EI.2=filler application. <i>ValueList:</i> <u>User Table 0361 - Application</u></p> <p>Condition: <i>Scenario</i>=Filler Order Management</p>
04	Universal Service Identifier	R	<p>This field contains the identifier code for the requested observation</p> <p>Format: CE.1=observation identifier assigned by filler application . Req.</p> <p>CE.2=description of observation identifier</p> <p>CE.3=name of coding system. <i>ValueList:</i> <u>User Table 0396 - Coding System</u> Req.</p>

#	Name	Set	Description										
			<p>CE.4=alternate observation identifier</p> <p>CE.5=description of alternate observation identifier</p> <p>CE.6=name of alternate coding system. <i>ValueList</i>: <u>User Table 0396 - Coding System</u></p>										
13	Relevant Clinical Information	O	<p>This field is used to report additional clinical information about the patient in textual and unstructured format (ex. textual anamnesis)</p> <p><i>Notes</i>:</p> <ul style="list-style-type: none"> clinical informations MAY be sent in a structured form using OBX segments. suspected diagnosis MUST be specified in OBR-31 										
15	Specimen Source	OC	<p>This field identifies the site where the specimen should be obtained or where the service should be performed.</p> <p>Note: for Laboratory Order Management, SPM (Specimen) segment MUST be used instead of OBR-15</p> <p>Format: SPS.5=Site Modifier. <i>ValueList</i>: see below</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>R</td> <td>Right</td> </tr> <tr> <td>L</td> <td>Left</td> </tr> <tr> <td colspan="2">Loc ITA</td> </tr> <tr> <td>DX</td> <td>Destra</td> </tr> <tr> <td>SX</td> <td>Sinistra</td> </tr> </table> <p>(Ref. HL7 Table 0495 - Body Site Modifier)</p> <p>Condition: <i>Scenario</i> <> Laboratory Order Management</p>	R	Right	L	Left	Loc ITA		DX	Destra	SX	Sinistra
R	Right												
L	Left												
Loc ITA													
DX	Destra												
SX	Sinistra												
18	Placer Field 1	O	Physician prescription identifier [ITA: Codice RUR della prescrizione]										
19	Placer Field 2	O	Generic notes about the Order										
20	Filler Field 1	OC	<p>StudyUID</p> <p>Conditions: Scenario=Radiology Filler Order Management</p>										
21	Filler Field 2	OC	<p>AccessionNumber</p> <p>Conditions: Scenario=Radiology Filler Order Management</p>										
24	Diagnostic Serv Sect ID	O	<p>Diagnostic service where the observation was performed.</p> <p>Values: Ref. <u>HL7 Table 0074 - Diagnostic Service Section</u></p>										
25	Result Status	RC	<p>This field contains the status of results for this order</p> <p>Values:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>I</td> <td>Working (no results available; specimen received, procedure incomplete)</td> </tr> <tr> <td>P</td> <td>Preliminary: A verified early result is available, final results not yet obtained</td> </tr> <tr> <td>F</td> <td>Final Results (results stored and verified. Can only be changed with a corrected result)</td> </tr> </table>	I	Working (no results available; specimen received, procedure incomplete)	P	Preliminary: A verified early result is available, final results not yet obtained	F	Final Results (results stored and verified. Can only be changed with a corrected result)				
I	Working (no results available; specimen received, procedure incomplete)												
P	Preliminary: A verified early result is available, final results not yet obtained												
F	Final Results (results stored and verified. Can only be changed with a corrected result)												

#	Name	Set	Description								
			<table border="1"> <tr> <td>X</td> <td>Order Deleted (no results available; Order canceled)</td> </tr> </table> <p>(Ref. HL7 Table 0123 - Result Status)</p> <p>Conditions: <i>Scenario</i> in (Filler Order Management; Observation Reporting)</p>	X	Order Deleted (no results available; Order canceled)						
X	Order Deleted (no results available; Order canceled)										
27	Quantity/timing	RC	<p>This field determines the priority, quantity, frequency, and timing of an atomic service.</p> <p>This field MUST have the same value of ORC-7.</p> <p>Note: although this field is deprecated in HL7 2.5 and usage of TQ1 segment is recommended, we keep this field for usage with ORM messages in Radiology scenario, where TQ1 segment is not available.</p> <p>Format: TQ.1=quantity of required service (default=1)</p> <p>TQ.4=it indicates the earliest date/time at which the services should be started. Req.</p> <p>TQ.6=priority <i>ValueList</i>: <see below></p> <p>Table 14.1. User Table 0485 – Extended Priority Codes</p> <table border="1"> <tr> <td>S</td> <td>Emergency (highest priority)</td> </tr> <tr> <td>A</td> <td>Urgent (highest priority after S)</td> </tr> <tr> <td>R</td> <td>Routine</td> </tr> </table> <p>Conditions: <i>Scenario</i> = Placer Order Management</p>	S	Emergency (highest priority)	A	Urgent (highest priority after S)	R	Routine		
S	Emergency (highest priority)										
A	Urgent (highest priority after S)										
R	Routine										
30	Transportation Mode	O	<p>This field identifies how (or whether) to transport a patient, when applicable.</p> <p>Table 14.2. HL7 Table 0124 - Transportation Mode</p> <table border="1"> <tr> <td>CART</td> <td>Cart - patient travels on cart or gurney</td> </tr> <tr> <td>PORT</td> <td>The examining device goes to patient's location</td> </tr> <tr> <td>WALK</td> <td>Patient walks to diagnostic service</td> </tr> <tr> <td>WHLC</td> <td>Wheelchair</td> </tr> </table>	CART	Cart - patient travels on cart or gurney	PORT	The examining device goes to patient's location	WALK	Patient walks to diagnostic service	WHLC	Wheelchair
CART	Cart - patient travels on cart or gurney										
PORT	The examining device goes to patient's location										
WALK	Patient walks to diagnostic service										
WHLC	Wheelchair										
31	Reason for Study	O..*	<p>Defines the reason why the study is required. If the suspected diagnosis/pathology is available, it MUST be specified in this field; if available, specify the diagnosis code with associated coding system.</p> <p>Format: CE.1=Code</p> <p>CE.2=Description</p> <p>CE.3=Coding System Req if CE.1 <> null</p> <p>Loc CRS-SISS: Nel caso CRS-SISS è possibile utilizzare una ripetizione aggiuntiva del campo per definire la "Modalità di erogazione", secondo le specifiche del progetto SISS.</p>								

#	Name	Set	Description
			In tal caso qualificare la ripetizione con CE.3='99SISS'.
39	Collector's comment	n/a	<i>Note: Informed Consent has moved to OBR-46</i>
46	Placer Supplemental Service Information	OC..*	<p>This field contains supplemental service information sent from the placer system to the filler system.</p> <p>Current usages include:</p> <ul style="list-style-type: none"> • <i>User credentials</i> for access to Document Distribution applications. <p>Authorization and consent to document publishing is given in NTE segment for Document Management, else in PV2-45.</p> <ul style="list-style-type: none"> • <i>Patient call order identifier</i>, defined upon outpatient order confirmation on patient arrival, used by Order Filler to ensure the correct patients call (and patient queue processing) order and anonymity of calls. • <i>Informed Consent</i>, for services that require patient's consent. • <i>Agenda code</i>, for identification of the filler's agenda where services have been booked. <p>Format: see <u>Placer Supplemental Service Information</u></p> <p>Conditions: <i>Scenario= Placer Order Management</i></p>

1.3. OBR for Laboratory Testing Management

Important

Following specifications for OBR segment are for the Laboratory system *ONLY*, and apply to the Placer Order Management and Order Result Management scenarios.

#	Name	Set	Description
01	Set ID – OBR	O	Identifier of each occurrence of the segment.
02	Placer Order Number	RC	<p>Placer application's order number. It identifies an order uniquely among all orders from a particular ordering application. MUST be equal to ORC-2.</p> <p>Format: EI.1=order identifier</p> <p>EI.2=placer application. <i>ValueList: <u>User Table 0361 - Application</u></i></p> <p>Condition: <i>Scenario=Placer Order Management</i></p>
03	Filler Order Number	RC	<p>Order number associated with the filling application. It must uniquely identify the order from other orders in a particular filling application. MUST be equal to ORC-3</p> <p>Format: EI.1=filler local order identifier</p> <p>EI.2=filler application. <i>ValueList: <u>User Table 0361 - Application</u></i></p>

#	Name	Set	Description
			<p>EI.3=enterprise-wide, unique, filler-generated identifier of the order</p> <p>Loc DNLAB</p> <p>format <bytidlab>-<stridrichiesta>-<dtmdataaccettazione, YYYYMMDDHHMM> is REQUIRED for EI.3</p> <p>Condition: Scenario in (Filler Order Management; Order Result Management)</p>
04	Universal Service Identifier	R	<p>This field contains the identifier code for the requested observation</p> <p>Format: CE.1=observation identifier assigned by filler application . Req.</p> <p>Loc DNLAB: Values:</p> <ul style="list-style-type: none"> • "LIS_MIC" if the OBR is related to a Microorganism identification • "LIS_ATB" if the OBR is related to an Antibiotic testing • the <i>requested</i> observation identifier in all other cases (may be a <i>complex test</i> as well as a <i>elementary test</i>, accordingly to what the placer required) <p>CE.2=description of observation identifier</p> <p>CE.3=name of coding system. <i>ValueList: User Table 0396 - Coding System</i> Req.</p> <p>CE.4=alternate observation identifier</p> <p>Loc DNLAB: if the OBR is not related to Microorganisms nor Antibiotics, MUST include the <i>requested</i> observation identifier including observation <i>version</i>, in format <id_observation>@<version> Req. if Scenario = Order Result Management</p> <p>CE.5=description of alternate observation identifier</p> <p>CE.6=name of alternate coding system. <i>ValueList: User Table 0396 - Coding System</i> Req. if Scenario = Order Result Management</p>
16	Ordering provider	O	Identity of the person who is responsible for creating the request (i.e., ordering physician).

#	Name	Set	Description								
			<p>Note</p> <p>It is possible to use more than one repetition of the field, but information in each repetition MUST be related to the same doctor. Multiple repetitions MUST be used only to transmit <u>different identifiers</u> (ex. national identifier, regional identifier, local identifier, ecc.) of the <u>same doctor</u>; each repetition and its identifier MUST be clearly qualified according to the rules exposed below.</p> <p>Format: see <u>Ordering Provider</u></p>								
18	Placer Field 1	OC	<p>Loc DNLAB Zona di lavorazione del campione</p> <p>Condition: <i>Scenario</i> in (Placer Order Management, Filler Order Management)</p>								
19	Placer Field 2	OC	<p>Loc: DNLAB Sede di lavorazione del campione</p> <p>Condition: <i>Scenario</i> in (Placer Order Management, Filler Order Management)</p>								
24	Diagnostic Serv Sect ID	O	<p>Diagnostic service where the observation was performed.</p> <p>Values: Ref. <u>HL7 Table 0074 - Diagnostic Service Section</u></p> <p>In case more Diagnostic Services of the same type exists, the code from HL7 table 0074 SHOULD be completed and specified using a numeric "instance identifier" for each, using format <ID from table 0074>-<Diagnostic Service Instance/ID Number>.</p>								
25	Result Status	RC	<p>This field contains the status of results for this order. MUST match OBX.11 in the same results group</p> <p>Values:</p> <table border="1"> <tr> <td>I</td> <td>Working (no results available; specimen received, procedure incomplete)</td> </tr> <tr> <td>R</td> <td>Results entered (not verified yet)</td> </tr> <tr> <td>F</td> <td>Final Results (results stored and verified. Can only be changed with a corrected result)</td> </tr> <tr> <td>C</td> <td>Record coming over is a correction and thus replaces a final result</td> </tr> </table> <p>Conditions: <i>Scenario</i>= Order Result management</p>	I	Working (no results available; specimen received, procedure incomplete)	R	Results entered (not verified yet)	F	Final Results (results stored and verified. Can only be changed with a corrected result)	C	Record coming over is a correction and thus replaces a final result
I	Working (no results available; specimen received, procedure incomplete)										
R	Results entered (not verified yet)										
F	Final Results (results stored and verified. Can only be changed with a corrected result)										
C	Record coming over is a correction and thus replaces a final result										
26	Parent Result	RC	<p>This field contains the link to the <i>parent results</i> when results need to be represented accordingly to a multi-level structure (e.g. microbiology).</p> <p>Format: CE.1= contains the <i>elementary test</i>³identifier of the parent result (e.g. the Microorganism identification for an Antibiotic testing) Req.</p> <p>MUST match the parent observation identifier in OBX.3 CE.1 of parent segments group</p> <p>Conditions: <i>Scenario</i>= Order Result management and result is related to a Microorganism Identification or an Antibiotic testing</p> <p>See also details in paragraph <i>Microbiology results representation</i> inside document <i>NoemaLife HL7 Integration Policy - Use Cases and Integration Scenarios</i> [NL-HL7-IP-UC]</p>								

#	Name	Set	Description
29	Parent	RC	<p>This field contains the link to the <i>parent results group</i> when results need to be represented accordingly to a multi-level structure (e.g. microbiology).</p> <p>Format: EIP.2 EI.1= contains the <i>complex test</i>^b identifier of the parent result (e.g. for a Microorganism identification, should be the complex test required) Req.</p> <p>MUST match the parent observation identifier in OBR.4 CE.1 of parent segments group</p> <p>Conditions: <i>Scenario</i>= Order Result management and result is related to a Microorganism Identification or an Antibiotic testing</p> <p>See also details in paragraph <i>Microbiology results representation</i> inside document <i>NoemaLife HL7 Integration Policy - Use Cases and Integration Scenarios</i> [NL-HL7-IP-UC]</p>
46	Placer Supplemental Service Information	OC.*	<p>This field contains supplemental service information sent from the placer system to the filler system.</p> <p>Current usages include:</p> <ul style="list-style-type: none"> "Tests Profile" identifier <p>If the test whose result is being transmitted was originally requested using a "<i>Test Profile</i>" code (a single code allowing to order many different tests together), then this repetition MAY be used to transmit the original Test Profile code</p> <p>Format: see <u>Placer Supplemental Service Information</u></p> <p>Conditions: <i>Scenario</i>= Order Result Management</p>

^aIn DNLAB, relates to "analisi elementare"

^bIn DNLAB, relates to "analisi multipla"

2. Fields definition

2.1. OBR-16

Ordering physician

#	Name	Set	Description						
XCN.1	ID Number	R	<p>Doctor's identifier</p> <p>Values Depends on XCN.13</p>						
XCN.2 FN.1	family name	O	Surname						
XCN.3	given name	O	First name						
XCN.13	identifier type code	R	<p>It defines the type of identifier specified in XCN.1</p> <p>Values:</p> <table border="1"> <tr> <td>NN</td> <td>National Personal Identifier</td> </tr> <tr> <td>RRI</td> <td>Regional Registry ID</td> </tr> <tr> <td>LR</td> <td>Local Registry ID (<i>Not Compliant CRS-SISS</i>)</td> </tr> </table>	NN	National Personal Identifier	RRI	Regional Registry ID	LR	Local Registry ID (<i>Not Compliant CRS-SISS</i>)
NN	National Personal Identifier								
RRI	Regional Registry ID								
LR	Local Registry ID (<i>Not Compliant CRS-SISS</i>)								

#	Name	Set	Description						
			<table border="1"> <tr> <td></td> <td>It is RECOMMENDED to use standard, enterprise-wide adopted identifiers.</td> </tr> <tr> <td colspan="2">Loc ITA</td> </tr> <tr> <td>NNITA</td> <td>Tax Code (<i>Note:</i> for CRS-SISS use: NN)</td> </tr> </table> <p>(Ref. HL7 Table 0203 - Identifier Type: IT)</p>		It is RECOMMENDED to use standard, enterprise-wide adopted identifiers.	Loc ITA		NNITA	Tax Code (<i>Note:</i> for CRS-SISS use: NN)
	It is RECOMMENDED to use standard, enterprise-wide adopted identifiers.								
Loc ITA									
NNITA	Tax Code (<i>Note:</i> for CRS-SISS use: NN)								

2.2. OBR-46

Placer Supplemental Service Information

#	Name	Set	Description										
CE.1	Identifier	R	<p>Value assigned to the information identified by CE.3.</p> <p>Important</p> <p>When CE.1 contains <i>sensitive data</i> (e.g. credentials, accounts, etc.), some form of data obfuscation is REQUIRED during transmission. The following guidelines are given:</p> <ul style="list-style-type: none"> since the encryption capabilities may depend on the technological stack used to implement the HL7 gateways, the specific encryption algorithm SHOULD be defined on local agreement, to guarantee a reliable and effective implementation at the sender and receiver applications. The use of standard, widely-adopted and secure algorithms is RECOMMENDED (e.g. AES128, AES256, 3DES, etc.) encryption password SHOULD be agreed locally, and may be a static password or a dynamic password calculated from data contained in the message itself (e.g. concatenation of some of the <i>required</i> fields in the message, like name, surname, etc.) since encryption algorithms results are likely to produce strings containing HL7-forbidden characters, it is REQUIRED to encode CE.1 using Base64. 										
CE.3	Name of Coding System	R	<p>Identifier of information. <i>ValueList:</i> <see below>.</p> <p>Table 14.3. User Table 0411 - Supplemental service information values</p> <table border="1"> <tr> <td>PortalUser</td> <td>Credentials for accessing Portal/Document Distribution application - Username</td> </tr> <tr> <td>PortalPassword</td> <td>Credentials for accessing Portal/Document Distribution application - Password</td> </tr> <tr> <td>PortalControlkey</td> <td>Credentials for accessing Portal/Document Distribution application - Control Key</td> </tr> <tr> <td>TestProfile</td> <td>The Tests Profile code, if used for requesting many single tests together in a single operation</td> </tr> <tr> <td>PatientCallOrderID</td> <td>Patient call order identifier, used to call patients (outpatients especially) in the correct processing sequence (defined by check-in/order confirmation operation on patient arrival)</td> </tr> </table>	PortalUser	Credentials for accessing Portal/Document Distribution application - Username	PortalPassword	Credentials for accessing Portal/Document Distribution application - Password	PortalControlkey	Credentials for accessing Portal/Document Distribution application - Control Key	TestProfile	The Tests Profile code, if used for requesting many single tests together in a single operation	PatientCallOrderID	Patient call order identifier, used to call patients (outpatients especially) in the correct processing sequence (defined by check-in/order confirmation operation on patient arrival)
PortalUser	Credentials for accessing Portal/Document Distribution application - Username												
PortalPassword	Credentials for accessing Portal/Document Distribution application - Password												
PortalControlkey	Credentials for accessing Portal/Document Distribution application - Control Key												
TestProfile	The Tests Profile code, if used for requesting many single tests together in a single operation												
PatientCallOrderID	Patient call order identifier, used to call patients (outpatients especially) in the correct processing sequence (defined by check-in/order confirmation operation on patient arrival)												

#	Name	Set	Description
			InformedConsent Patient's consent, for observations that require it. ValueList in CE.1: 1 = consent given 0 = consent NOT given
			AgendaCode Identifier of filler's agenda where services have been booked.

3. Tables

Table 14.4. HL7 Table 0074 - Diagnostic Service Section

Value	Description	Comment
BG	Blood Gases	
BLB	Blood Bank	
CH	Chemistry	
CP	Cytopathology	
CT	CAT Scan	
CTH	Cardiac Catheterization	
CUS	Cardiac Ultrasound	
EC	Electrocardiac (e.g., EKG, EEC, Holter)	
EN	Electroneuro (EEG, EMG,EP,PSG)	
HM	Hematology	
ICU	Bedside ICU Monitoring	
IMM	Immunology	
LAB	Laboratory	
MB	Microbiology	
MCB	Mycobacteriology	
MYC	Mycology	
NMR	Nuclear Magnetic Resonance	
NMS	Nuclear Medicine Scan	
NRS	Nursing Service Measures	
OSL	Outside Lab	
OT	Occupational Therapy	
OTH	Other	
OUS	OB Ultrasound	
PF	Pulmonary Function	
PHR	Pharmacy	
PHY	Physician (Hx. Dx, admission note, etc.)	
PT	Physical Therapy	
RAD	Radiology	
RC	Respiratory Care (therapy)	

OBR - Observation Request

Value	Description	Comment
RT	Radiation Therapy	
RUS	Radiology Ultrasound	
RX	Radiograph	
SP	Surgical Pathology	
SR	Serology	
TX	Toxicology	
VR	Virology	
VUS	Vascular Ultrasound	
XRC	Cineradiograph	
<i><The table can be extended with additional codes to be agreed></i>		

Chapter 15. OBX - Observation/Result

The OBX segment is used in several scenarios and with different purposes; the basic role, anyway, is to transmit a single observation or observation fragment. In the following will be explained the usage of OBX for:

- transmitting encapsulated data (e.g., a PDF document, a CDA document, a DICOM image, etc.)
- transmitting relevant clinical information upon order requests
- transmitting structured results of observations

1. Segment definition

1.1. OBX for Document Management

#	Name	Set	Description						
01	Set ID - OBX	R	Identifier of each occurrence of the segment.						
02	Value Type	R	<p>This field defines the format of OBX-5</p> <p>Values:</p> <table border="1"> <tr> <td>ED</td> <td>Encapsulated Data (if document encapsulated inside the message)</td> </tr> <tr> <td>RP</td> <td>Reference Pointer (if external document referenced by link)</td> </tr> </table> <p>(Ref. HL7 Table 0125 - Value Type)</p>	ED	Encapsulated Data (if document encapsulated inside the message)	RP	Reference Pointer (if external document referenced by link)		
ED	Encapsulated Data (if document encapsulated inside the message)								
RP	Reference Pointer (if external document referenced by link)								
03	Observation Identifier	R	<p>Document identifier.</p> <p>Format: CE.1=Unique document identifier; in case a single OBX, it is equal to TXA-12.1 Req</p> <p>CE.2=Document type; in case of a single OBX in the message, it is equal to TXA-2. <i>ValueList:</i> User Table 0270 - Document Type. Req</p> <p>Loc CRS-SISS:</p> <p>CE.3=Tipologia contenuto. <i>ValueList:</i> <vedi sotto>. Req</p> <table border="1"> <tr> <td>REF</td> <td>Referto</td> </tr> <tr> <td>DAO</td> <td>Documento di autorizzazione</td> </tr> <tr> <td>CDA2</td> <td>Documento strutturato CDA2 per referto specialistico generico</td> </tr> </table> <p>CE.5= Tipologia interna del documento. <i>ValueList:</i> Vedi specifiche HL7-SISS [CRS-SISS-HL7] Req. if CE.3 <> DAO</p>	REF	Referto	DAO	Documento di autorizzazione	CDA2	Documento strutturato CDA2 per referto specialistico generico
REF	Referto								
DAO	Documento di autorizzazione								
CDA2	Documento strutturato CDA2 per referto specialistico generico								
05	Observation Value	R	<p>This field contains the document content. The data type for this field depends on the value specified in OBX.2</p> <p>Format: see OBX-5 for Data Type = ED for details</p>						
11	Observation result status	R	<p>Defines the state of the document contained in OBX.5.</p> <p>Value:</p> <table border="1"> <tr> <td>F</td> <td>Final results (i.e. Validated document)</td> </tr> <tr> <td>R</td> <td>Results entered - not verified (i.e. Draft document)</td> </tr> <tr> <td>LA</td> <td>Legally Authenticated document</td> </tr> </table>	F	Final results (i.e. Validated document)	R	Results entered - not verified (i.e. Draft document)	LA	Legally Authenticated document
F	Final results (i.e. Validated document)								
R	Results entered - not verified (i.e. Draft document)								
LA	Legally Authenticated document								

#	Name	Set	Description
			Ref. HL7 Table 0085 - Observation result status codes interpretation

1.2. OBX for Order Management and Patient Encounter

#	Name	Set	Description								
01	Set ID - OBX	R	Identifier of each occurrence of the segment.								
02	Value Type	R	This field contains the format of the observation value in OBX-5 Values: <table border="1" style="margin-left: 20px;"> <tr> <td>ST</td> <td>For Short Textual results (e.g "Positive", etc.)</td> </tr> <tr> <td>NM</td> <td>For Numeric results(e.g. "210")</td> </tr> <tr> <td>SN</td> <td>For Structured Numeric results (e.g. ">300")</td> </tr> <tr> <td>CE</td> <td>Coded Entry (e.g. "NEG^Negative^LN")</td> </tr> </table>	ST	For Short Textual results (e.g "Positive", etc.)	NM	For Numeric results(e.g. "210")	SN	For Structured Numeric results (e.g. ">300")	CE	Coded Entry (e.g. "NEG^Negative^LN")
ST	For Short Textual results (e.g "Positive", etc.)										
NM	For Numeric results(e.g. "210")										
SN	For Structured Numeric results (e.g. ">300")										
CE	Coded Entry (e.g. "NEG^Negative^LN")										
03	Observation Identifier	R	This field contains a unique identifier for the observation. The format is that of the Coded Element (CE). Format: CE.1=identifier Req. CE.2=description Req. CE.3=name of coding system (eg. LOINC). <i>ValueList:</i> <u>User Table 0396 - Coding System</u> Req. CE.4=alternate identifier CE.5=alternative description CE.6=name of alternate coding system (eg. LOINC). <i>ValueList:</i> <u>User Table 0396 - Coding System</u> Example: 29463^Body Weight^LN								
05	Observation Value	R	This field contains the value observed by the observation producer. The data type for this field depends on the value specified in OBX.2 Format: see OBX-5 for <u>Data Type = ED</u> for details								
06	Units	RC	Unit of measure. Common ISO Derived Units & ISO+ Extensions Conditions: Required if an observation's value is measured on a continuous scale								
11	Observation result status	R	Defines the state of the observation contained in OBX.5 Value: <table border="1" style="margin-left: 20px;"> <tr> <td>F</td> <td>Final results. Can only be changed with a corrected result.</td> </tr> </table> Ref. HL7 Table 0085 - Observation result status codes interpretation	F	Final results. Can only be changed with a corrected result.						
F	Final results. Can only be changed with a corrected result.										

Example 15.1. Sample OBX segment

Numeric Results:

OBX|1|NM|2164-2^CREATININECLEARANCE^LN||52.7|ml/min|88-174|L|||F|||200510060830

1.3. OBX for Laboratory Testing Management

#	Name	Set	Description										
01	Set ID - OBX	R	Identifier of each occurrence of the segment.										
02	Value Type	R	<p>This field contains the format of the observation value in OBX-5</p> <p>Values:</p> <table border="1"> <tr> <td>ST</td> <td>For Short Textual results (e.g "Positive", etc.).</td> </tr> <tr> <td>NM</td> <td>For Numeric results (also suitable for antibiotics susceptibility measure) (e.g. "210")</td> </tr> <tr> <td>SN</td> <td>For Structured Numeric results (also suitable for antibiotics susceptibility measure) (e.g. ">300")</td> </tr> <tr> <td>CE</td> <td>Coded Entry (e.g. "NEG^Negative^LN"; also used for identified microorganisms, e.g. "412643004^Beta hemolytic Streptococcus A^SCT")</td> </tr> <tr> <td>TX</td> <td>For Long Textual results (e.g. a long descriptive report or result). (Loc DNLAB: see notes in <u>OBX-5</u>)</td> </tr> </table>	ST	For Short Textual results (e.g "Positive", etc.).	NM	For Numeric results (also suitable for antibiotics susceptibility measure) (e.g. "210")	SN	For Structured Numeric results (also suitable for antibiotics susceptibility measure) (e.g. ">300")	CE	Coded Entry (e.g. "NEG^Negative^LN"; also used for identified microorganisms, e.g. "412643004^Beta hemolytic Streptococcus A^SCT")	TX	For Long Textual results (e.g. a long descriptive report or result). (Loc DNLAB : see notes in <u>OBX-5</u>)
ST	For Short Textual results (e.g "Positive", etc.).												
NM	For Numeric results (also suitable for antibiotics susceptibility measure) (e.g. "210")												
SN	For Structured Numeric results (also suitable for antibiotics susceptibility measure) (e.g. ">300")												
CE	Coded Entry (e.g. "NEG^Negative^LN"; also used for identified microorganisms, e.g. "412643004^Beta hemolytic Streptococcus A^SCT")												
TX	For Long Textual results (e.g. a long descriptive report or result). (Loc DNLAB : see notes in <u>OBX-5</u>)												
03	Observation Identifier	R	<p>This field contains a unique identifier for the observation</p> <p>Format: CE.1=identifier Req. (Loc DNLAB: per i risultati di laboratorio, <i>analisi singola</i>)</p> <p>CE.2=description Req.</p> <p>CE.3=name of coding system (e.g. LOINC). <i>ValueList</i>: <u>User Table 0396 - Coding System</u></p> <p>CE.4=alternate identifier Req. (Loc DNLAB: in lab results not related to microorganisms and antibiotics, set to <i>analisi singola@versione</i>)</p> <p>CE.5=alternative description</p> <p>CE.6=name of alternate coding system (eg. LOINC). <i>ValueList</i>: <u>User Table 0396 - Coding System</u></p>										
04	Observation subID	RC	<p>This field is used to distinguish between multiple microorganisms identified in microbiology results representation</p> <p>Conditions: Required if OBX is related to a microorganism identification or an antibiotic testing</p> <p>See also details in paragraph <i>Microbiology results representation</i> inside document <i>NoemaLife HL7 Integration Policy - Use Cases and Integration Scenarios</i> [NL-HL7-IP-UC]</p>										
05	Observation Value	R	<p>This field contains the value observed by the observation producer. The result may be a number, a structured number, a coded value, a short text (e.g. "Positive") or a long text (descriptive comment).</p> <p>The data structure for this field depends on the value specified in OBX-2.</p> <p>In case of antibiotic testing results, this field is dedicated to the MIC result.</p> <p>Format:</p> <ul style="list-style-type: none"> If OBX-2 in (ST, SN, NM, TX) then OBX-5 MUST contain a plain, simple string representing a number, a structured number or an alphanumeric text; HL7 sub-fields (separated by HL7 character ^) MUST NOT be used 										

#	Name	Set	Description
			<ul style="list-style-type: none"> • if OBX-2 = "CE", see <u>OBX-5 for Data Type = CE</u> for details <p>Loc DNLAB: Usage according to values in "risultato corto" and "risultato lungo":</p> <ul style="list-style-type: none"> • If "risultato corto" is not empty, then OBX-5 MUST be used for "risultato corto" and OBX-2 set accordingly (ST, NM, SN, CE). If "risultato lungo" is not empty too, OBX-17 MUST be used for it. • If "risultato corto" is empty and "risultato lungo" is not, then OBX-5 MUST be used to transmit "risultato lungo", and OBX-2 MUST be set to TX; OBX.17 will be empty.
06	Units	RE	Unit of measure. Common ISO Derived Units & ISO+ Extensions
07	References Range	RE	<p>Reference ranges for observations. Only the reference range that actually apply to patient condition (e.g. according to sex, age, etc.) should be notified.</p> <p>Format:</p> <ul style="list-style-type: none"> • In case of <u>numeric results</u>, allowed formats are as per HL7 standard: <ul style="list-style-type: none"> • LowerLimit-UpperLimit • >LowerLimit • <UpperLimit • In case of <u>non-numeric results</u>, an unformatted string can also be used to transmit reference ranges. This may include reference values stating the "normal" value (e.g. "Negative"), or more complex textual reference indications • In case of <u>antibiotics testing</u>, the EUCAST's susceptibility, resistance and Wild Type reference values (cut-offs) SHOULD be transmitted as a string composed using the following format: <p style="margin-left: 40px;"><i>S<=MicS;R>MicR;WT=WildType</i></p> <p style="margin-left: 40px;">where <i>MicS</i> is MIC Susceptibility cut-off value, <i>MicR</i> is MIC Resistance cut-off value, <i>WildType</i> is WildType cut-off value.</p>
08	Abnormal flags	RE..2	<p>Normalcy status of the observations.</p> <p>In case of antibiotic testing results, this field is used to transmit the Interpreted Susceptibility result (R-S-I) and the "Wild Type alert" flag.</p> <p>Format: Since Normalcy status, Interpreted Susceptibility and "Wild Type alert" flag may be present at the same time, two repetitions of this fields are used. Field repetitions does not have a qualifying subfield, thus the following <u>positional assignment of repetitions</u> MUST be respected to allow a proper data interpretation at the receiver:</p> <ul style="list-style-type: none"> • First repetition: MUST be used <u>only</u> for general ab-normalcy flags and Interpreted Susceptibility flags, if available • Second repetition: MUST be used <u>only</u> for "Wild Type alert" flag, if available <p><i>Examples:</i></p>

#	Name	Set	Description																														
			<ul style="list-style-type: none"> • Only Interpreted Susceptibility "S" is present: ... S ... • Both Interpreted Susceptibility "S" and "Wild Type alert" flags are present: ... S~WT ... • Only "Wild Type alert" flag is present: ... ~WT ... <p>Values: Table 15.1. User Table 0078 - Abnormal flags</p> <table border="1"> <tr> <td colspan="2"><i>Common results values:</i></td> </tr> <tr> <td>L</td> <td>Below low normal</td> </tr> <tr> <td>H</td> <td>Above high normal</td> </tr> <tr> <td>LL</td> <td>Below lower panic limits</td> </tr> <tr> <td>HH</td> <td>Above upper panic limits</td> </tr> <tr> <td>N</td> <td>Normal (for non numeric results)</td> </tr> <tr> <td>A</td> <td>Abnormal (for non numeric results)</td> </tr> <tr> <td>AA</td> <td>Very abnormal (for non numeric results)</td> </tr> <tr> <td colspan="2"><i>Microbiology results values (antibiotics testing):</i></td> </tr> <tr> <td>S</td> <td>Susceptible</td> </tr> <tr> <td>R</td> <td>Resistant</td> </tr> <tr> <td>I</td> <td>Intermediate</td> </tr> <tr> <td>MS</td> <td>Moderately susceptible</td> </tr> <tr> <td>VS</td> <td>Very susceptible</td> </tr> <tr> <td>WT</td> <td>Used to notify the "Wild Type alert" flag has been raised</td> </tr> </table>	<i>Common results values:</i>		L	Below low normal	H	Above high normal	LL	Below lower panic limits	HH	Above upper panic limits	N	Normal (for non numeric results)	A	Abnormal (for non numeric results)	AA	Very abnormal (for non numeric results)	<i>Microbiology results values (antibiotics testing):</i>		S	Susceptible	R	Resistant	I	Intermediate	MS	Moderately susceptible	VS	Very susceptible	WT	Used to notify the "Wild Type alert" flag has been raised
<i>Common results values:</i>																																	
L	Below low normal																																
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<i>Microbiology results values (antibiotics testing):</i>																																	
S	Susceptible																																
R	Resistant																																
I	Intermediate																																
MS	Moderately susceptible																																
VS	Very susceptible																																
WT	Used to notify the "Wild Type alert" flag has been raised																																
10	Nature of Abnormal Test	RC	<p>This field is used to define the nature of abnormality of test or the type of result</p> <p>Conditions: Required if OBX is related to an <i>antibiotic testing</i>.</p> <p>Values:</p> <table border="1"> <tr> <td>AB</td> <td>MUST be used if OBX is carrying results of Antibiotic testing</td> </tr> </table> <p>See also details in paragraph <i>Microbiology results representation</i> inside document <i>NoemaLife HL7 Integration Policy - Use Cases and Integration Scenarios</i> [NL-HL7-IP-UC]</p>	AB	MUST be used if OBX is carrying results of Antibiotic testing																												
AB	MUST be used if OBX is carrying results of Antibiotic testing																																
11	Observation result status	R	<p>Defines the state of the observation contained in OBX.5</p> <p>Value: Table 15.2. HL7 Table 0085 - Observation result status codes interpretation</p> <table border="1"> <tr> <td>R</td> <td>Results entered - not verified (Loc DNLAB: risultati validati tecnicamenti)</td> </tr> <tr> <td>F</td> <td>Final results. Can only be changed with a corrected result. (Loc DNLAB: risultati validati clinicamente e ufficialmente pubblicati)</td> </tr> <tr> <td>D</td> <td>Deletes the OBX record</td> </tr> <tr> <td>C</td> <td>Record coming over is a correction and thus replaces a final result</td> </tr> <tr> <td>X</td> <td>Results cannot be obtained for this observation</td> </tr> </table>	R	Results entered - not verified (Loc DNLAB: risultati validati tecnicamenti)	F	Final results. Can only be changed with a corrected result. (Loc DNLAB: risultati validati clinicamente e ufficialmente pubblicati)	D	Deletes the OBX record	C	Record coming over is a correction and thus replaces a final result	X	Results cannot be obtained for this observation																				
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D	Deletes the OBX record																																
C	Record coming over is a correction and thus replaces a final result																																
X	Results cannot be obtained for this observation																																

#	Name	Set	Description
			P Preliminary results. (Loc DNLAB: sigle di tipo "esame in corso")
13	User Defined Access Checks	RC	Number of microorganisms identified. Condition: Applies only to microbiology result groups including the top-level microbiology observation (e.g. "Positive", "Negative", etc.).
14	Date/Time of the Observation	R	Date and time when the result included in OBX-5 was clinically validated. Format: YYYYMMDDHHMM[SS]
16	Responsible Observer	RE	It should contain the identity of the observer responsible of correctness and clinical validity of published result. Note It is possible to use more than one repetition of the field, but information in each repetition MUST be related to the same doctor. Multiple repetitions MUST be used only to transmit <u>different identifiers</u> (ex. national identifier, regional identifier, local identifier, ecc.) of the <u>same doctor</u> ; each repetition and its identifier MUST be clearly qualified according to the rules exposed below. Format: see OBX-16 for details
17	Observation Method	RE	This field is used to transmit a comment related to the result in OBX-5; this apply both to numerical/textual results, as well as results representing an identified microorganism or an antibiotic. Note This usage is a conscious violation of HL7 standard. Format: CE.2 = comment to the result (free, long text) Req. (Loc DNLAB: see notes in OBX-5) CE.3 = name of coding system. Req. Value: "COM"

2. Fields definition

2.1. OBX-5 for Data Type = ED

#	Name	Set	Description				
ED.2	type of data	R	MIME Type <i>Note:</i> Here we follow HL7 2.7.1 specifications, and use HL7 table 0834 (containing MIME Types) instead of 0191. Values: In case of a single OBX, same value of TXA-3. <i>ValueList:</i> HL7 Table 0834 - Type Of Data (MIME Types) ^a				
ED.3	data subtype	R	MIME Subtype Values: See HL7 Table 0291 - Subtype of referenced data ^b				
ED.4	encoding	R	Values: <table border="1"> <tr> <td>A</td> <td>no encoding - data are displayable ASCII characters.</td> </tr> <tr> <td>Hex</td> <td>hexadecimal encoding</td> </tr> </table>	A	no encoding - data are displayable ASCII characters.	Hex	hexadecimal encoding
A	no encoding - data are displayable ASCII characters.						
Hex	hexadecimal encoding						

#	Name	Set	Description
			Base64 ^a encoding as defined by MIME (Multipurpose Internet Mail Extensions) standard RFC 1521. ^a CRS-SISS preferred value
ED.5	data	R	Document content, encoded as specified in ED.4

^a CRS-SISS preferred value: "multipart"

^b CRS-SISS preferred value: "octet-stream"

^a CRS-SISS preferred value

2.2. OBX-5 for Data Type = RP

#	Name	Set	Description
RP.1	pointer	R	Pointer, assigned by the system that stores the data, used to identify and access the data.
RP.2	application ID	O	A unique designator of the system that stores the data.
RP.3	type of data	O	MIME Type Format: HL7 Table 0834 - Type Of Data (MIME Types)
RP.4	data subtype	O	MIME Subtype Format: HL7 Table 0291 - Subtype of referenced data

2.3. OBX-5 for Data Type = CE

#	Name	Set	Description
CE.1	identifier	R	The unique identifier representing the coded result (e.g. "POS", "esccol")
CE.2	description	O	The textual description of the result (e.g. "Positive", "Escherichia Coli")
CE.3	type of data	O	Format: User Table 0396 - Coding System

2.4. OBX-16

#	Name	Set	Description										
XCN.1	ID Number	R	Doctor's identifier Values Depends on XCN.13										
XCN.2 FN.1	family name	RE	Surname										
XCN.3	given name	RE	First name										
XCN.13	identifier type code	R	It defines the type of identifier specified in XCN.1 Values: <table border="1" style="width: 100%;"> <tbody> <tr> <td>NN</td> <td>National Personal Identifier</td> </tr> <tr> <td>RRI</td> <td>Regional Registry ID</td> </tr> <tr> <td>LR</td> <td>Local Registry ID (<i>Not Compliant</i> CRS-SISS) It is RECOMMENDED to use standard, enterprise-wide adopted identifiers.</td> </tr> <tr> <td colspan="2">Loc ITA</td> </tr> <tr> <td>NNITA</td> <td>Tax Code (<i>Note:</i> for CRS-SISS use: NN)</td> </tr> </tbody> </table>	NN	National Personal Identifier	RRI	Regional Registry ID	LR	Local Registry ID (<i>Not Compliant</i> CRS-SISS) It is RECOMMENDED to use standard, enterprise-wide adopted identifiers.	Loc ITA		NNITA	Tax Code (<i>Note:</i> for CRS-SISS use: NN)
NN	National Personal Identifier												
RRI	Regional Registry ID												
LR	Local Registry ID (<i>Not Compliant</i> CRS-SISS) It is RECOMMENDED to use standard, enterprise-wide adopted identifiers.												
Loc ITA													
NNITA	Tax Code (<i>Note:</i> for CRS-SISS use: NN)												

#	Name	Set	Description
			(Ref. HL7 Table 0203 - Identifier Type: IT)

3. Tables

Table 15.3. HL7 Table 0291 - Subtype of referenced data

Value	Description	Full MIMEtype name	Superseded values (old NoemaLife values)
octet-stream	Binary Data	application/octet-stream	
pdf	Adobe Portable Document Format	application/pdf	ZPDF
mword	Microsoft Word	application/mword	ZDOC
zip	Zip Archive	application/zip	
xml	XML - Extensible Markup Language	application/xml	
mpeg	Mpeg Audio or Video	video/mpeg audio/mpeg	
mp4	MPEG-4 Video	video/mp4	
bmp	Bitmap Image File	image/bmp	
gif	Graphics Interchange Format	image/gif	
jpeg	JPEG Image	image/jpeg	
tiff	Tagged Image File Format	image/tiff	
html	HyperText Markup Language (HTML)	text/html	
plain	Text File	text/plain	
x-hl7-cda-level-one	HL7 Clinical Document Architecture Level One document	application/x-hl7-cda-level-one	
x-p7m_pdf	PDF digitally signed (using PKCS standard)	application/x-p7m_pdf	ZP7M, ZP7M_PDF
x-p7m_txt	Text document, digitally signed (using PKCS standard)	application/x-p7m_txt	ZP7M_TXT
x-m7m_pdf	PDF digitally signed (using PKCS standard). Includes authenticated timestamp	application/x-m7m_pdf	ZM7M, ZM7M_PDF
vnd.ita-er.sole.cda22_mime_pdf	An XML-CDA (ballot 2.2) defined by SOLE Italian project (Emilia Romagna)	application/vnd.ita-er.sole.cda22_mime_pdf	ZCDASOLE2.2(MIME(PDF)) (short form: zCdaSoleMimePdf)
vnd.nl.dnlab.medir.cdaml0+sig	An XML-CDA defined by MEDIR Italian project specifications,	application/vnd.nl.dnlab.medir.cdaml0+sig	ZDNLABMEDIR_CDAML0-SIG (short form: zdnlabmedir_cdaml0Sig)

Value	Description	Full MIMEtype name	Superseded values (old NoemaLife values)
	enveloped in a DNLAB structure, with a signed element (enveloped XML-signature). NOTE: to be compliant with NoemaLife specification, it shouldn't have "_SIG" suffix, because "_" implicates the necessity to apply a transformation to extract and view data content. Next versions may have a "-" instead of "_" (e.g. ZDNLAB_CDAM1.1-SIG). It substitutes ZDNLAB_CDAM1.0_SIG already used in real Sardegna installations		
vnd.nl.dnlab.medir.cdam10	An XML-CDA defined by MEDIR Italian project specifications, enveloped in a DNLAB structure, without any signed element.	application/ vnd.nl.dnlab.medir.cdam10	ZDNLABMEDIR_CDAM1.0 (short form: zdnlabmedir_cdam10). Also supersedes ZDNLAB_CDAM1.0 already used in running Sardegna installations.
vnd.nl.dnlab.themis.cda20+sig	Used in Italian LAURO installation where CDA are signed with THEMIS system. This is signed CDA version	application/ vnd.nl.dnlab.themis.cda20+sig	ZDNLABTHEMIS_CDA2.0-SIG (short form: zdnlabthemis_cda20Sig)
vnd.nl.dnlab.themis.cda20	Used in Italian LAURO installation where CDA are signed with THEMIS system	application/ vnd.nl.dnlab.themis.cda20	ZDNLABTHEMIS_CDA2.0 (short form: zdnlabthemis_cda20)
vnd.ita-lomb.rel.zip_cda2+xsl-html	A CDA version 2 for Lombardia Haematology Network (REL), zipped together with a style-sheet for rendering it to HTML format.	application/vnd.ita-lomb.rel.zip_cda2+xsl-html	ZZIP(CDAREL2) (short form: zzipcdarel2)
vnd.ita-lomb.rol.zip_cda2+xsl-html	A CDA version 2 for Lombardia Oncology Network (ROL), zipped together with a style-sheet for	application/vnd.ita-lomb.rol.zip_cda2+xsl-html	ZZIP(CDAROL2) (short form: zzipcdarol2)

Value	Description	Full MIMEtype name	Superseded values (old NoemaLife values)
	rendering it to HTML format.		
vnd.nl.zip_cda2	A zipped CDA version 2	application/vnd.nl.zip_cda2	ZZIP(CDA) (short form: zzipcda)
vnd.nl.mime_cda2+xsl-pdf	A multipart MIME object including Xml Cda 2 and the XSL needed to fop it into a PDF	application/vnd.nl.mime_cda2+xsl-pdf	ZMIME(CDA2.0+XSL) (short form: zmimeCdaXsl)
vnd.nl.pem_mime_cda2+xsl-pdf	A multipart MIME object including Xml Cda 2 and the XSL needed to fop it into a PDF. The MIME object containing the two files is encapsulated into a Base64 envelope	application/vnd.nl.pem_mime_cda2+xsl-pdf	ZPEM_MIME(CDA2.0+XSL) (short form: zpem_mimeCdaXsl)
vnd.nl.p7m_mime_cda2+xsl-pdf	A multipart MIME object including Xml Cda 2 and the XSL needed to fop it into a PDF. The MIME object containing the two files is digitally signed using PKCS standard	application/vnd.nl.p7m_mime_cda2+xsl-pdf	ZP7M_MIME(CDA2.0+XSL) (short form: zp7m_mimeCdaXsl)

The content of this table is pre-adopted from HL7 Version 2.7.1, using MIME media subtypes established in accordance with RFC 2046 (<http://ietf.org/rfc/rfc2046.txt>).

Standard MIME subtypes are registered with the "Internet Assigned Numbers Authority" (IANA); non standard (custom, locally agreed) MIME Types MUST use the "x-" or "vnd." prefixes.

Superseded values MUST NOT be used, and their value is given just for reference to previous installations and uses.

Chapter 16. ORC - Common Order

The Common Order segment (ORC) is used to transmit fields that are common to all orders (all types of services that are requested).

ORC is an optional segment in Document messages (MDM) to convey informations about the order associated to the document.

1. Segment definition

1.1. ORC for Document Management

#	Name	Set	Description		
01	Order Control	R	Determines the function of the order segment Values: NW		
02	Placer Order Number	RC	Placer application's order number. It identifies an order uniquely among all orders from a particular ordering application. If available, MUST be set and equal to OBR-2. Format: EI.1=order identifier EI.2=placer application. <i>ValueList:</i> <u>User Table 0361 - Application</u> Condition: <i>Scenario</i> =Document Management and Placer Order Number available		
03	Filler Order Number	R	Order number associated with the filling application. It must uniquely identify the order from other orders in a particular filling application. Must be equal to OBR-3. Format: EI.1=order identifier assigned by filler application <i>Loc: DNLAB:</i> format <bytidlab>-<stridrichiesta>-<dtmdataaccettazione, YYYYMMDDHHMM> is REQUIRED EI.2=filler application. <i>ValueList:</i> <u>User Table 0361 - Application</u>		
04	Placer Group Number	RC	This field allows an order placing application to group sets of orders together and subsequently identify them. Format: EI.1=order group identifier EI.2=placer application. <i>ValueList:</i> <u>User Table 0361 - Application</u> Condition: <i>Scenario</i> =Document Management and Placer Group Number available		
08	Parent	O	Order booking identifier from the order booking facility [IT: codice prenotazione CUP] ^a		
25	Order Status Modifier	O	Loc ITA: Indica se la prestazione è stata erogata e se è aggiuntiva rispetto alla prescrizione originaria. <i>ValueList:</i> <vedi sotto>		
			<table border="1"> <tr> <td>PE</td> <td>Prestazione erogata</td> </tr> </table>	PE	Prestazione erogata
PE	Prestazione erogata				

#	Name	Set	Description
			PA Prestazione aggiuntiva erogata

^aCRS-SISS valorizza il campo con il codice IUP della prescrizione associata al documento

1.2. ORC for Order Management

#	Name	Set	Description																												
01	Order Control	R	<p>Determines the function of the order segment</p> <p>Values:</p> <table border="1"> <tr> <td colspan="2">Scenario = Placer Order Management</td> </tr> <tr> <td>NW</td> <td>New Order</td> </tr> <tr> <td>CA</td> <td>Cancel Order</td> </tr> <tr> <td>SC</td> <td>Status changed.</td> </tr> <tr> <td colspan="2">Scenario = Placer Order Management and Message=application acknowledge</td> </tr> <tr> <td>OK</td> <td>Order accepted</td> </tr> <tr> <td>UA</td> <td>Unable to accept order</td> </tr> <tr> <td>CR</td> <td>Order cancelled as required</td> </tr> <tr> <td>UC</td> <td>Unable to cancel order</td> </tr> <tr> <td colspan="2">Scenario = Filler Order Management</td> </tr> <tr> <td>SN</td> <td>Send order number</td> </tr> <tr> <td>NA</td> <td>Number Assigned</td> </tr> <tr> <td>OC</td> <td>Order Cancelled</td> </tr> <tr> <td>SC</td> <td>Status changed</td> </tr> </table> <p>Ref. HL7 Table 0119 - Order control codes</p>	Scenario = Placer Order Management		NW	New Order	CA	Cancel Order	SC	Status changed.	Scenario = Placer Order Management and Message=application acknowledge		OK	Order accepted	UA	Unable to accept order	CR	Order cancelled as required	UC	Unable to cancel order	Scenario = Filler Order Management		SN	Send order number	NA	Number Assigned	OC	Order Cancelled	SC	Status changed
Scenario = Placer Order Management																															
NW	New Order																														
CA	Cancel Order																														
SC	Status changed.																														
Scenario = Placer Order Management and Message=application acknowledge																															
OK	Order accepted																														
UA	Unable to accept order																														
CR	Order cancelled as required																														
UC	Unable to cancel order																														
Scenario = Filler Order Management																															
SN	Send order number																														
NA	Number Assigned																														
OC	Order Cancelled																														
SC	Status changed																														
02	Placer Order Number	RC	<p>Placer application's order number. It identifies an order uniquely among all orders from a particular ordering application. Must be equal to OBR-2</p> <p>Format: EI.1=order identifier EI.2=placer application. <i>ValueList:</i> User Table 0361 - Application</p> <p>Condition: <i>Scenario</i>=Placer Order Management</p>																												
03	Filler Order Number	RC	<p>Order number associated with the filling application. It must uniquely identify the order from other orders in a particular filling application. Must be equal to OBR-3</p> <p>Format: EI.1=order identifier EI.2=filler application. <i>ValueList:</i> User Table 0361 - Application</p> <p>Condition: <i>Scenario</i>=Filler Order Management</p>																												
04	Placer Group Number	OC	<p>This field allows an order placing application to group sets of orders together and subsequently identify them.</p> <p>Format: EI.1=order group identifier EI.2=placer application. <i>ValueList:</i> User Table 0361 - Application</p>																												

#	Name	Set	Description												
			Condition: <i>Scenario=Placer Order Management</i>												
05	Order Status	OC	<p>The purpose of this field is to report the status of an order.</p> <table border="1"> <tr> <td>CM</td> <td>Order is completed</td> </tr> <tr> <td>IP</td> <td>In process, unspecified</td> </tr> <tr> <td>CA</td> <td>Order was canceled</td> </tr> <tr> <td>DC</td> <td>Order was discontinued (i.e. canceled after it was in IP state)</td> </tr> <tr> <td>SC</td> <td>Order scheduled</td> </tr> <tr> <td>A</td> <td>Some, but not all, results available</td> </tr> </table> <p>Ref. HL7 Table 0038 - Order status</p> <p>Condition: <i>Scenario=Filler Order Management</i></p>	CM	Order is completed	IP	In process, unspecified	CA	Order was canceled	DC	Order was discontinued (i.e. canceled after it was in IP state)	SC	Order scheduled	A	Some, but not all, results available
CM	Order is completed														
IP	In process, unspecified														
CA	Order was canceled														
DC	Order was discontinued (i.e. canceled after it was in IP state)														
SC	Order scheduled														
A	Some, but not all, results available														
07	Quantity/Timing	RC	<p>This field determines the priority, quantity, frequency, and timing of an atomic service.</p> <p>It MUST have the same value of OBR-27</p> <p>Note: although this field is deprecated in HL7 2.5 and usage of TQ1 segment is recommended, we keep this field for usage with ORM messages for Radiology, where TQ1 segment is not available.</p> <p>Format: TQ.1=quantity of required service (default=1)</p> <p>TQ.4=earliest date/time at which the services should be started. Req.</p> <p>TQ.6=priority <i>ValueList</i>: see below</p> <p>Table 16.1. User Table 0485 – Extended Priority Codes</p> <table border="1"> <tr> <td>S</td> <td>Emergency (highest priority)</td> </tr> <tr> <td>A</td> <td>Urgent (highest priority after S)</td> </tr> <tr> <td>R</td> <td>Routine</td> </tr> </table> <p>Condition: <i>Scenario=Placer Order Management</i></p>	S	Emergency (highest priority)	A	Urgent (highest priority after S)	R	Routine						
S	Emergency (highest priority)														
A	Urgent (highest priority after S)														
R	Routine														
08	Parent	O	Order booking identifier from the order booking facility [IT: codice prenotazione CUP] ^a												
09	Date/Time of Transaction	O	<p>Date/time when order was entered in the placer application [IT: data di richiesta dell'ordine]</p> <p>Format: YYYYMMDD[HH[MM[SS]]]</p>												
12	Ordering Provider	RC..*	<p>Identity of the person who is responsible for creating the request (i.e., ordering physician).</p> <p>Note</p> <p>It is possible to use more than one repetition of the field, but information in each repetition MUST be related to the same doctor. Multiple repetitions MUST be used only to transmit <u>different identifiers</u> (ex. national identifier, regional identifier, local identifier, ecc.) of the <u>same</u></p>												

#	Name	Set	Description				
			<p><u>doctor</u>; each repetition and its identifier MUST be clearly qualified according to the rules exposed below.</p> <p>Format: see <u>Ordering Provider</u></p> <p>Conditions: <i>Scenario=Placer Order Management</i></p>				
13	Enterer's location	RC	<p>Point of care requesting the order</p> <p><i>Note:</i> duplicates ORC-17 for compatibility with existing NoemaLife specifications.</p> <p>Format: PL.1=Code of Ward/Ambulatory Req. PL.9=Ward/Ambulatory description</p> <p>Conditions: <i>Scenario=Placer Order Management</i></p>				
16	Order Control Code Reason	OC	<p>Reason for order cancelation</p> <p><i>Note:</i> the diagnostic hypothesis [IT: quesito diagnostico] must not be set here but in OBR-13</p> <p>Format: XCN.2=description</p> <p>Conditions: <i>Scenario=Filler Order Management and ORC-1=CA</i></p>				
17	Entering Organization	RC	<p>Point of care requesting the order.</p> <p><i>Note:</i> duplicates ORC-13 for compatibility with existing NoemaLife specifications.</p> <p>Format: CE.1=Code of Ward/Ambulatory Req. CE.2=Ward/Ambulatory description</p> <p>Conditions: <i>Scenario=Placer Order Management</i></p>				
25	Order Status Modifier	OC	<p>Loc ITA: Indica lo stato di erogazione di una prestazione, e l'eventuale notifica dell'evento ad un sistema esterno</p> <p>Format: CW.1=Stato di erogazione della prestazione <i>ValueList:</i> <vedi sotto></p> <table border="1" data-bbox="940 1509 1394 1599"> <tr> <td>PE</td> <td>Prestazione erogata</td> </tr> <tr> <td>PA</td> <td>Prestazione aggiuntiva erogata</td> </tr> </table> <p>CW.4=Flag evento notificato. <i>ValueList:</i> Y=Yes; N=No.</p> <p>CW.6=Identificativo del sistema esterno destinatario della notifica (es. 'SISS')</p> <p>Condition: <i>Scenario=Filler Order Management</i></p>	PE	Prestazione erogata	PA	Prestazione aggiuntiva erogata
PE	Prestazione erogata						
PA	Prestazione aggiuntiva erogata						

^aCRS-SISS valorizza il campo con il codice IUP della prescrizione associata all'ordine

1.3. ORC for Laboratory Testing Management

#	Name	Set	Description																																
01	Order Control	R	<p>Determines the function of the order segment</p> <p>Values:</p> <table border="1"> <tr> <td colspan="2">Scenario = Placer Order Management</td> </tr> <tr> <td>NW</td> <td>New Order</td> </tr> <tr> <td>CA</td> <td>Cancel Order</td> </tr> <tr> <td>SC</td> <td>Status changed.</td> </tr> <tr> <td colspan="2">Scenario = Filler Order Management</td> </tr> <tr> <td>SN</td> <td>Send order number</td> </tr> <tr> <td>OC</td> <td>Order Cancelled</td> </tr> <tr> <td>SC</td> <td>Status changed</td> </tr> <tr> <td colspan="2">Scenario = Order Result Management</td> </tr> <tr> <td>SC</td> <td>Status changed</td> </tr> <tr> <td colspan="2">Message=ACK</td> </tr> <tr> <td>OK</td> <td>Order accepted</td> </tr> <tr> <td>UA</td> <td>Unable to accept order</td> </tr> <tr> <td>CR</td> <td>Order cancelled as required</td> </tr> <tr> <td>UC</td> <td>Unable to cancel order</td> </tr> <tr> <td>NA</td> <td>Number Assigned</td> </tr> </table> <p>Ref. HL7 Table 0119 - Order control codes</p>	Scenario = Placer Order Management		NW	New Order	CA	Cancel Order	SC	Status changed.	Scenario = Filler Order Management		SN	Send order number	OC	Order Cancelled	SC	Status changed	Scenario = Order Result Management		SC	Status changed	Message= ACK		OK	Order accepted	UA	Unable to accept order	CR	Order cancelled as required	UC	Unable to cancel order	NA	Number Assigned
Scenario = Placer Order Management																																			
NW	New Order																																		
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Scenario = Order Result Management																																			
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OK	Order accepted																																		
UA	Unable to accept order																																		
CR	Order cancelled as required																																		
UC	Unable to cancel order																																		
NA	Number Assigned																																		
02	Placer Order Number	RC	<p>Placer application's order number. It identifies an order uniquely among all orders from a particular ordering application. Must be equal to OBR.2</p> <p>Format: EI.1=order identifier EI.2=placer application. <i>ValueList:</i> <u>User Table 0361 - Application</u></p> <p>Condition: <i>Scenario</i>=Placer Order Management</p>																																
03	Filler Order Number	RC	<p>Order number associated with the filling application. It must uniquely identify the order from other orders in a particular filling application. Must be equal to OBR.3</p> <p>Format: EI.1=filler local order identifier EI.2=filler application. <i>ValueList:</i> <u>User Table 0361 - Application</u> EI.3=enterprise-wide, unique, filler-generated identifier of the order</p> <p>Loc DNLAB</p> <p>format <bytidlab>-<stridrichiesta>-<dtmdataaccettazione, YYYYMMDDHHMM> is REQUIRED for EI.3</p> <p>Condition: <i>Scenario</i> in (Filler Order Management, Order Result management)</p>																																

#	Name	Set	Description												
04	Placer Group Number	OC	<p>This field allows an order placing application to group sets of orders together and subsequently identify them.</p> <p>Format: EI.1=order group identifier EI.2=placer application. <i>ValueList:</i> <u>User Table 0361 - Application</u></p> <p>Condition: <i>Scenario</i> in (Placer Order Management, Order Result Management)</p>												
05	Order Status	OC	<p>The purpose of this field is to report the status of an order.</p> <table border="1"> <tr> <td>CM</td> <td>Order is completed</td> </tr> <tr> <td>IP</td> <td>In process, unspecified</td> </tr> <tr> <td>CA</td> <td>Order was canceled</td> </tr> <tr> <td>DC</td> <td>Order was discontinued (i.e. canceled after it was in IP state)</td> </tr> <tr> <td>SC</td> <td>Order scheduled</td> </tr> <tr> <td>A</td> <td>Some, but not all, results available</td> </tr> </table> <p>Ref. HL7 Table 0038 - Order status</p> <p>Condition: <i>Scenario</i> in (Filler Order Management, Order Result Management)</p>	CM	Order is completed	IP	In process, unspecified	CA	Order was canceled	DC	Order was discontinued (i.e. canceled after it was in IP state)	SC	Order scheduled	A	Some, but not all, results available
CM	Order is completed														
IP	In process, unspecified														
CA	Order was canceled														
DC	Order was discontinued (i.e. canceled after it was in IP state)														
SC	Order scheduled														
A	Some, but not all, results available														
07	Quantity/Timing	RC	<p>This field determines the priority, quantity, frequency, and timing of an atomic service.</p> <p>It MUST have the same value of OBR.27</p> <p>Note: although this field is deprecated in HL7 2.5 and usage of TQ1 segment is recommended, we keep this field for usage with ORM messages for Radiology, where TQ1 segment is not available.</p> <p>Format: TQ.1=quantity. Default=1 TQ.4=earliest date/time at which the services should be started. Req. for Radiology. TQ.6=priority <i>ValueList:</i> see below</p> <p>Table 16.2. User Table 0485 – Extended Priority Codes</p> <table border="1"> <tr> <td>S</td> <td>Emergency (highest priority)</td> </tr> <tr> <td>A</td> <td>Urgent (highest priority after S)</td> </tr> <tr> <td>R</td> <td>Routine</td> </tr> </table> <p>Condition: <i>Scenario</i>= Radiology Placer Order Management</p>	S	Emergency (highest priority)	A	Urgent (highest priority after S)	R	Routine						
S	Emergency (highest priority)														
A	Urgent (highest priority after S)														
R	Routine														
09	Date/Time of Transaction	O	<p>Date/time when order was entered in the placer application [IT: data di richiesta dell'ordine]</p> <p>Format: YYYYMMDD[HH[MM[SS]]]</p>												

#	Name	Set	Description
12	Ordering Provider	RC.*	<p>Identity of the person who is responsible for creating the request (i.e., ordering physician).</p> <p>Note</p> <p>It is possible to use more than one repetition of the field, but information in each repetition MUST be related to the same doctor. Multiple repetitions MUST be used only to transmit <u>different identifiers</u> (ex. national identifier, regional identifier, local identifier, ecc.) of the <u>same doctor</u>; each repetition and its identifier MUST be clearly qualified according to the rules exposed below.</p> <p>Format: see <u>Ordering Provider</u></p> <p>Conditions: <i>Scenario=Placer Order Management</i></p>
21	Ordering Facility Name	RC	<p>Point of care requesting the order</p> <p>Format: XON.1=Description of Ward/Ambulatory. XON.7=type of code in XON.9. <i>Constant:</i> FI (Ref. <u>HL7 Table 0203 - Identifier Type: IT</u>) Req. XON.9=Code of Ward/Ambulatory Req.</p> <p>Conditions: <i>Scenario=Placer Order Management</i></p>

1.4. ORC for Pharmacy/Treatment management

#	Name	Set	Description										
01	Order Control	R	<p>Determines the function of the order segment</p> <p>Values:</p> <table border="1"> <tr> <td colspan="2">Scenario = Medicines on Discharge</td> </tr> <tr> <td>NW</td> <td>New prescription line</td> </tr> <tr> <td>CA</td> <td>Cancel prescription line</td> </tr> <tr> <td>XO</td> <td>Change prescription line</td> </tr> <tr> <td>OP</td> <td>Prescription line unchanged^a</td> </tr> </table> <p>^aThis usage of OP value is a conscious violation of HL7 standard</p> <p>Ref. HL7 Table 0119 - Order control codes</p>	Scenario = Medicines on Discharge		NW	New prescription line	CA	Cancel prescription line	XO	Change prescription line	OP	Prescription line unchanged ^a
Scenario = Medicines on Discharge													
NW	New prescription line												
CA	Cancel prescription line												
XO	Change prescription line												
OP	Prescription line unchanged ^a												
02	Placer Order Number	RC	<p>Placer application's order number. It uniquely identifies a prescription line.</p> <p>Format: EI.1 = prescription line identifier EI.2 = placer application. <i>ValueList:</i> <u>User Table 0361 - Application</u></p> <p>Condition: <i>Scenario=Medicines on Discharge</i></p>										
05	Order Status	RC	<p>The purpose of this field is to report the status of a prescription.</p> <table border="1"> <tr> <td colspan="2">Scenario = Medicines on Discharge^a</td> </tr> <tr> <td>SC</td> <td>Medicine was started during the current episode (indication mandatory)</td> </tr> </table>	Scenario = Medicines on Discharge ^a		SC	Medicine was started during the current episode (indication mandatory)						
Scenario = Medicines on Discharge ^a													
SC	Medicine was started during the current episode (indication mandatory)												

#	Name	Set	Description								
			<table border="1"> <tr> <td>DC</td> <td>Patient medicine discontinued (reason mandatory)</td> </tr> <tr> <td>RP</td> <td>Patient medicine changed (reason mandatory)</td> </tr> <tr> <td>IP</td> <td>Patient medicine continued</td> </tr> <tr> <td>HD</td> <td>General Practitioner to start</td> </tr> </table> <p>^aThe usage of listed values is a conscious violation of HL7 standard and HL7 Table 0038</p> <p>Condition: <i>Scenario=Medicines on Discharge</i></p>	DC	Patient medicine discontinued (reason mandatory)	RP	Patient medicine changed (reason mandatory)	IP	Patient medicine continued	HD	General Practitioner to start
DC	Patient medicine discontinued (reason mandatory)										
RP	Patient medicine changed (reason mandatory)										
IP	Patient medicine continued										
HD	General Practitioner to start										
09	Date/Time of Transaction	O	<p>This field contains the date and time of the event that initiated the current transaction.</p> <p>Format: YYYYMMDDHHMM[SS]</p>								
12	Ordering Provider	R..*	<p>Identity of the person who is responsible for creating the request (i.e. prescriber).</p> <p>Note</p> <p>It is possible to use more than one repetition of the field, but information in each repetition MUST be related to the same doctor. Multiple repetitions MUST be used only to transmit <u>different identifiers</u> (ex. national identifier, regional identifier, local identifier, ecc.) of the <u>same doctor</u>; each repetition and its identifier MUST be clearly qualified according to the rules exposed below.</p> <p>Format: see <u>Ordering Provider</u></p>								
25	Order Status Modifier	RC	<p>This field is used to report the stage of the authorization process.</p> <p>Code is actually composed by two parts: prescriber authorization status (prefix P) and validator/pharmacist authorization status (prefix V). A number following the prefix states the authorization status; codes are separated by a semi-colon. Refer to IHE for greater details.</p> <table border="1"> <tr> <td colspan="2"><i>Scenario = Medicines on Discharge^a</i></td> </tr> <tr> <td>P3;V1</td> <td> Prescription line completed by the prescriber. Prescription line to be validated by the pharmacist </td> </tr> <tr> <td>P3;V3</td> <td> Prescription line completed by the prescriber. Prescription line validated by the pharmacist </td> </tr> </table> <p>^aThe usage of listed values is a conscious violation of HL7 standard and HL7 Table 0038</p> <p>Condition: <i>Scenario = Medicines on Discharge</i></p>	<i>Scenario = Medicines on Discharge^a</i>		P3;V1	Prescription line completed by the prescriber. Prescription line to be validated by the pharmacist	P3;V3	Prescription line completed by the prescriber. Prescription line validated by the pharmacist		
<i>Scenario = Medicines on Discharge^a</i>											
P3;V1	Prescription line completed by the prescriber. Prescription line to be validated by the pharmacist										
P3;V3	Prescription line completed by the prescriber. Prescription line validated by the pharmacist										

^aThis usage of OP value is a conscious violation of HL7 standard

^aThe usage of listed values is a conscious violation of HL7 standard and HL7 Table 0038

^aThe usage of listed values is a conscious violation of HL7 standard and HL7 Table 0038

2. Fields definition

2.1. ORC-12

Ordering physician

#	Name	Set	Description
XCN.1	ID Number	R	Doctor's identifier

#	Name	Set	Description										
			Values Depends on XCN.13										
XCN.2 FN.1	family name	RE	Surname										
XCN.3	given name	RE	First name										
XCN.4	second and further given names or initials thereof	RE	Further given names or initials										
XCN.13	identifier type code	R	<p>It defines the type of identifier specified in XCN.1</p> <p>Values:</p> <table border="1"> <tr> <td>NN</td> <td>National Personal Identifier</td> </tr> <tr> <td>RRI</td> <td>Regional Registry ID</td> </tr> <tr> <td>LR</td> <td>Local Registry ID (<i>Not Compliant</i> CRS-SISS)</td> </tr> <tr> <td colspan="2">Loc ITA</td> </tr> <tr> <td>NNITA</td> <td>Tax Code (<i>Note:</i> for CRS-SISS use: NN)</td> </tr> </table> <p>(Ref. HL7 Table 0203 - Identifier Type: IT)</p>	NN	National Personal Identifier	RRI	Regional Registry ID	LR	Local Registry ID (<i>Not Compliant</i> CRS-SISS)	Loc ITA		NNITA	Tax Code (<i>Note:</i> for CRS-SISS use: NN)
NN	National Personal Identifier												
RRI	Regional Registry ID												
LR	Local Registry ID (<i>Not Compliant</i> CRS-SISS)												
Loc ITA													
NNITA	Tax Code (<i>Note:</i> for CRS-SISS use: NN)												

Chapter 17. PD1 - Patient Additional Demographic

The patient additional demographic segment contains demographic information that is likely to change about the patient.

1. Segment definition

#	Name	Set	Description								
03	Patient Primary Facility	R..2	<p>This field contains the name and identifier that specifies the “primary care” healthcare facility selected by the patient</p> <p>Loc ITA: Ripetizione contenente informazioni sulle AUSL/Distretti di Assistenza e/o Residenza</p> <p>Values:</p> <p>XON.1=Descrizione AUSL</p> <p>XON.7= <i>ValueList</i>: <vedi sotto>. Req.</p> <table border="1"> <tr> <td>ASLR</td> <td>ASL di Residenza</td> </tr> <tr> <td>ASLA</td> <td>ASL di Assistenza</td> </tr> <tr> <td>DASLR</td> <td>Distretto ASL di Residenza</td> </tr> <tr> <td>DASLA</td> <td>Distretto ASL di Assistenza</td> </tr> </table> <p>XON.10=codice identificativo dell’AUSL di 6 cifre (3 cifre del codice della Regione + 3 cifre del Codice regionale dell’ Azienda Sanitaria). Req.</p>	ASLR	ASL di Residenza	ASLA	ASL di Assistenza	DASLR	Distretto ASL di Residenza	DASLA	Distretto ASL di Assistenza
ASLR	ASL di Residenza										
ASLA	ASL di Assistenza										
DASLR	Distretto ASL di Residenza										
DASLA	Distretto ASL di Assistenza										
12	Protection Indicator	O	<p>This field determines whether access to information about this person should be kept from users who do not have adequate authority for the patient. [ITA: Campo che indica se le informazioni anagrafiche della persona sono riservate per richiesta di <i>anonimato</i>]</p> <p>Values:</p> <table border="1"> <tr> <td>Y</td> <td>Protect access to information [ITA: Accesso ai dati anagrafici protetto]</td> </tr> <tr> <td>N</td> <td>Normal access [ITA: Accesso normale]</td> </tr> </table>	Y	Protect access to information [ITA: Accesso ai dati anagrafici protetto]	N	Normal access [ITA: Accesso normale]				
Y	Protect access to information [ITA: Accesso ai dati anagrafici protetto]										
N	Normal access [ITA: Accesso normale]										

Example 17.1. Sample PD1 segment

```
PD1|||ASL Bologna^^^^^^ASLA^^^080105~
ASL Bergamo^^^^^^ASLR^^^030301
```

Chapter 18. PID - Patient Identification

The PID segment is used by all applications as the primary means of communicating patient identification information. This segment contains permanent patient identifying and demographic information that, for the most part, is not likely to change frequently.

1. Segment definition

#	Name	Set	Description								
03	Patient Identifier List	R..*	<p>This field contains the list of identifiers (one or more) used by the healthcare facility to uniquely identify a patient. Below is the list of identifier types that must be handled in NoemaLife integrations:</p> <ul style="list-style-type: none"> • Patient Internal Identifier (PI) • National Person Identifier (NNxxx, where xxx is the ISO table 3166 3-character (alphabetic) country code) • Social Security Number (SS) <p>Loc ITA National Personal Identifier for Italy is NNITA, and will contain the Tax Code (IIT: Codice Fiscale)</p> <p>Additional identifier types that must be handled :</p> <ul style="list-style-type: none"> • PNT: codice STP • HC: tessera TEAM <p>Format: see <u>Patient Identifier List</u> for details</p>								
04	Alternate Patient ID	n/a	<i>Deprecated</i> ⁰¹								
05	Patient Name	R	<p>Patient Name and Surname. Only one occurrence of this field is handled for integrations between NoemaLife applications</p> <p>Format: see <u>Patient Name</u> for details</p>								
06	Mother's Maiden Name	O	<p>Mother's name, for newborn babies</p> <p>Format: XPN.1=Mother's name XPN.2=Mother's surname</p>								
07	Date/Time of Birth	RE	Format: YYYYMMDD[HH[MM[SS]]]								
08	Administrative Sex	R	<p>Values:</p> <table border="1"> <tbody> <tr> <td>M</td> <td>Male</td> </tr> <tr> <td>F</td> <td>Female</td> </tr> <tr> <td>O</td> <td>Other</td> </tr> <tr> <td>U</td> <td>Unknown</td> </tr> </tbody> </table>	M	Male	F	Female	O	Other	U	Unknown
M	Male										
F	Female										
O	Other										
U	Unknown										
11	Patient Address	RE..4	<p>Repetition used to specify following patient informations:</p> <ul style="list-style-type: none"> • Birthplace • Residence address • Domicile address • Temporary address • Mailing address <p>Format: see <u>Patient Address</u> for details</p>								

#	Name	Set	Description												
13	Phone Number - Home	O..*	<p>Patient's personal phone numbers</p> <p>Format: see <u>Phone Number - Home</u> for details</p>												
16	Marital Status	O	<p>Patient's marital (civil) status</p> <p>Values: Table 18.1. User Table 0002 - Marital Status</p> <table border="1"> <tr> <td>A</td> <td>Separated</td> </tr> <tr> <td>D</td> <td>Divorced</td> </tr> <tr> <td>M</td> <td>Married</td> </tr> <tr> <td>S</td> <td>Single</td> </tr> <tr> <td>W</td> <td>Widowed</td> </tr> <tr> <td>U</td> <td>Unknown</td> </tr> </table>	A	Separated	D	Divorced	M	Married	S	Single	W	Widowed	U	Unknown
A	Separated														
D	Divorced														
M	Married														
S	Single														
W	Widowed														
U	Unknown														
18	Patient Account Number	RC	<p>Loc ITA: Per indicazione di IHE Italia, il campo è valorizzato con il codice fiscale, già inserito in PID-3 con tipo NNITA</p> <p>CX.1=Codice fiscale. Req.</p> <p>CX.4, HD.1=CF. Req.</p> <p>CX.5=NNITA. Req.</p> <p>Conditions: <i>Loc=IT</i></p>												
21	Mother's Identifier	O	<p>Mother's identifier for newborn.</p> <p>Format: see <u>Patient Identifier List</u> for details</p>												
26	Citizenship	O..*	<p>Patient's citizenship. This field repeats since persons can be citizens of more than one country</p> <p>Values: CE.1= Nation. <i>CodedValue:</i> ISO table 3166 alpha-3. Req. if CE.4 and CE.6 are empty</p> <p>CE.2= Nation ISO description</p> <p>CE.3=ISO3166 Req if CE.4 and CE.6 are empty.</p> <p><i>Loc ITA:</i> CE.4= Nation.<i>CodedValue:</i> ISTAT Nazioni. (3 chars). Valore 100 se nazionalità italiana, oppure codice ISTAT dello stato estero se nazionalità estera. Req. if CE.1 and CE.3 are empty</p> <p>CE.5= Nation ISTAT description</p> <p>CE.6=99ISTAT Req if CE.1 and CE.3 are empty.</p> <p>Even if it is not required to set both codes, it is RECOMMENDED.</p>												
29	Patient Death Date and Time	O	<p>Date and time at which the patient death occurred</p> <p>Format: YYYYMMDD[HH[MM[SS]]]</p>												
30	Patient death indicator	O	<p>This field indicates whether the patient is deceased.</p> <p>Values:</p> <table border="1"> <tr> <td>Y</td> <td>the patient is deceased</td> </tr> <tr> <td>N</td> <td>the patient is not deceased</td> </tr> </table>	Y	the patient is deceased	N	the patient is not deceased								
Y	the patient is deceased														
N	the patient is not deceased														

#	Name	Set	Description										
31	Identity unknown indicator	O	<p>This field indicates whether or not the patient's/person's identity is known.</p> <p>Values:</p> <table border="1"> <tr> <td>Y</td> <td>the patient identity is unknown</td> </tr> <tr> <td>N</td> <td>the patient identity is known</td> </tr> </table>	Y	the patient identity is unknown	N	the patient identity is known						
Y	the patient identity is unknown												
N	the patient identity is known												
32	Identity Reliability Code	O..*	<p>This field contains a coded value used to communicate information regarding the reliability of patient/ person identifying data</p> <p>Loc ITA Viene utilizzata la ripetibilità del campo per elencare le certificazioni associate alla posizione anagrafica, in termini di ente certificatore e data di certificazione.⁰²</p> <p>Format: <Certificazione>@YYYYMMDD</p> <p>Values: <Certificazione> può assumere i seguenti valori::</p> <table border="1"> <tr> <td>MEF</td> <td>Ministero Economia e Finanze (dati afferenti alla composizione del Codice Fiscale)</td> </tr> <tr> <td>ASL</td> <td>Anagrafe Sanitaria (dati domicilio sanitario)</td> </tr> <tr> <td>NAR</td> <td>Anagrafe Regionale (dati domicilio sanitario)</td> </tr> <tr> <td>COM</td> <td>Anagrafe Comunale (dati di residenza)</td> </tr> <tr> <td>AZI</td> <td>Anagrafe Aziendale</td> </tr> </table>	MEF	Ministero Economia e Finanze (dati afferenti alla composizione del Codice Fiscale)	ASL	Anagrafe Sanitaria (dati domicilio sanitario)	NAR	Anagrafe Regionale (dati domicilio sanitario)	COM	Anagrafe Comunale (dati di residenza)	AZI	Anagrafe Aziendale
MEF	Ministero Economia e Finanze (dati afferenti alla composizione del Codice Fiscale)												
ASL	Anagrafe Sanitaria (dati domicilio sanitario)												
NAR	Anagrafe Regionale (dati domicilio sanitario)												
COM	Anagrafe Comunale (dati di residenza)												
AZI	Anagrafe Aziendale												
33	Last Update Date/Time	O	<p>This field contains the last update date and time for the patient's/person's identifying and demographic data.</p> <p>Format: YYYYMMDD[HH[MM[SS]]]</p>										
34	Last Update Facility	O	<p>Name of the Application of the last update to a patient's/person's identifying and demographic data.</p> <p>Values: HD.1=Name of the Application of last update. <i>ValueList:</i> User Table 0361 - Application</p> <p>Loc CRS-SISS: HD.2=Anagrafe di provenienza dei dati dell#assistito</p> <table border="1"> <tr> <td>CRS</td> <td>Smartcard</td> </tr> <tr> <td>NAR</td> <td>Archivio assistiti</td> </tr> <tr> <td>SISS</td> <td>Archivio ex-assistiti e contatti</td> </tr> </table>	CRS	Smartcard	NAR	Archivio assistiti	SISS	Archivio ex-assistiti e contatti				
CRS	Smartcard												
NAR	Archivio assistiti												
SISS	Archivio ex-assistiti e contatti												

⁰¹Nelle specifiche CRS-SISS per i messaggi A28 (Create Person), l'Anagrafica centralizzata (BDA) valorizza il campo con l'id paziente del dipartimentale che ha creato la posizione anagrafica. Nelle specifiche NoemaLife tutti gli identificativi paziente sono gestiti in PID-3

⁰²Ci si scosta da HL7 Italia per aderire alle specifiche del progetto Regionale CRS-SISS in quanto introducono il concetto di certificazione del dato anagrafico.

Example 18.1. Sample PID segment

- *Patient Name:* Ing. Mario Rossi
- *Identifier generated by MPI:* 000000009400547
- *Tax code (CF):* RSMRA54A12A944M
- *Social security number (SSN):* 999AV098
- *Birthdate:* 01-DEC-1954
- *Birthplace:* Bologna
- *Sex:* Male
- *Marital status:* Single
- *Residence:* Piazza Marconi 9, 20123, Milano
- *Phone Number:* +39 026463789
- *eMail:* rossimario@gmail.com
- *Citizenship:* Italiana
- *Certificazione:* MEF

```
PID|||000000009400547^^^PK^PI~RSMRA54A12A944M^^^CF^NNITA~999AV098^^^CS^SS|
|ROSSI^MARIO^^^Ing.^L||19541201|M||
|^BOLOGNA^^^ITA^BDL^^037006~Piazza Marconi, 9^^MILANO^^20123^ITA^L^^015146|
|^PRN^^^+39^^^^^^026463789~^NET^^rossimario@gmail.com^^^^^^^||S|
|RSMRA54A12A944M^^^CF^NNITA|||IT^ITALIA^^~|||MEF@20060724
```

2. Fields definition

2.1. PID-3

This field contains the list of identifiers (one or more) used by the healthcare facility to uniquely identify a patient.

#	Name	Set	Description	
CX.1	ID Number	R	Values:	
			<i>If CX.5=</i>	<i>Value</i>
			<i>PI</i>	Patient identifier
			<i>NNITA</i>	Tax Code [IT: Codice Fiscale]
			<i>SS</i>	Social Security Number [IT: Codice Tessera Sanitaria]
			<i>PNT</i>	Patient Temporary code [IT: Codice STP]
			<i>HC</i>	Health Card Identification Number. Used to transmit the <u>card</u> identifier (CIN) of the European Health Insurance Card (EHIC, [IT: TEAM])
	<i>PN</i>	Person number Used to transmit the <u>person</u> identifier (PIN) of the European Health Insurance Card (EHIC, [IT: TEAM])		
CX.4	Assigning Authority	R	Code of Authority that created CX.1 code	
			Loc ITA:	
			<i>If CX.5=</i>	<i>Value</i>
			<i>PI</i>	<i>if CX.1 assigned by MPI:</i>

#	Name	Set	Description														
			<table border="1"> <tr> <td></td> <td>PK <i>else:</i> Application that assigned the identifier. User Table 0361 - Application</td> </tr> <tr> <td>NNITA</td> <td>CF</td> </tr> <tr> <td>SS</td> <td>CS</td> </tr> <tr> <td>PNT</td> <td>STP</td> </tr> <tr> <td>HC, PN</td> <td> HD.1=Code of Authority/Institution who released the EHIS Card [<i>Loc IT:</i> TEAM card, <i>Value:</i> 500001] HD.2= Name of Authority/Institution who released the EHIS Card [<i>Loc ITA:</i> TEAM card, <i>Value:</i> SSN-MIN SALUTE] </td> </tr> </table>		PK <i>else:</i> Application that assigned the identifier. User Table 0361 - Application	NNITA	CF	SS	CS	PNT	STP	HC, PN	HD.1=Code of Authority/Institution who released the EHIS Card [<i>Loc IT:</i> TEAM card, <i>Value:</i> 500001] HD.2= Name of Authority/Institution who released the EHIS Card [<i>Loc ITA:</i> TEAM card, <i>Value:</i> SSN-MIN SALUTE]				
	PK <i>else:</i> Application that assigned the identifier. User Table 0361 - Application																
NNITA	CF																
SS	CS																
PNT	STP																
HC, PN	HD.1=Code of Authority/Institution who released the EHIS Card [<i>Loc IT:</i> TEAM card, <i>Value:</i> 500001] HD.2= Name of Authority/Institution who released the EHIS Card [<i>Loc ITA:</i> TEAM card, <i>Value:</i> SSN-MIN SALUTE]																
CX.5	Identifier Type Code	R	Qualifier of CX.1 code. Values: <table border="1"> <tr> <td>PI</td> <td>Patient Internal Identifier</td> </tr> <tr> <td>SS</td> <td>Social Security Number (SSN)</td> </tr> <tr> <td>PNT</td> <td>Temporary Living Subject Number</td> </tr> <tr> <td>HC</td> <td>Health Card Number (<i>Loc ITA, HL7 Italia::</i> identifies the TEAM Card Number, CIN)</td> </tr> <tr> <td>PN</td> <td>Person Number. Identifies the TEAM Card Person Identifier (PIN) (<i>Loc ITA::</i> equivalente al Codice Fiscale)</td> </tr> <tr> <td colspan="2">Loc ITA</td> </tr> <tr> <td>NNITA</td> <td>National Person Identifier for Italy (<i>Compliant HL7 Italia</i>).</td> </tr> </table> <p>(Ref. HL7 Table 0203 - Identifier Type)</p>	PI	Patient Internal Identifier	SS	Social Security Number (SSN)	PNT	Temporary Living Subject Number	HC	Health Card Number (<i>Loc ITA, HL7 Italia::</i> identifies the TEAM Card Number, CIN)	PN	Person Number. Identifies the TEAM Card Person Identifier (PIN) (<i>Loc ITA::</i> equivalente al Codice Fiscale)	Loc ITA		NNITA	National Person Identifier for Italy (<i>Compliant HL7 Italia</i>).
PI	Patient Internal Identifier																
SS	Social Security Number (SSN)																
PNT	Temporary Living Subject Number																
HC	Health Card Number (<i>Loc ITA, HL7 Italia::</i> identifies the TEAM Card Number, CIN)																
PN	Person Number. Identifies the TEAM Card Person Identifier (PIN) (<i>Loc ITA::</i> equivalente al Codice Fiscale)																
Loc ITA																	
NNITA	National Person Identifier for Italy (<i>Compliant HL7 Italia</i>).																
CX.6	Assigning Facility	RE	Values: <table border="1"> <tr> <td><i>If CX.5=</i></td> <td><i>Value</i></td> </tr> <tr> <td>PI</td> <td>n/a⁰¹</td> </tr> <tr> <td>NNITA</td> <td>n/a</td> </tr> <tr> <td>SS</td> <td>Loc IT: ISTAT code of emitting Region</td> </tr> <tr> <td>PNT</td> <td>n/a</td> </tr> <tr> <td>HC</td> <td>Nation code: ISO 3166 alpha-2 (e.g.: "IT" for ITALY)</td> </tr> <tr> <td>PN</td> <td>n/a</td> </tr> </table> <p>⁰¹CRS-SISS richiede il codice dell'applicazione che ha generato l'id paziente, che noi invece specifichiamo in CX.4</p>	<i>If CX.5=</i>	<i>Value</i>	PI	n/a ⁰¹	NNITA	n/a	SS	Loc IT: ISTAT code of emitting Region	PNT	n/a	HC	Nation code: ISO 3166 alpha-2 (e.g.: "IT" for ITALY)	PN	n/a
<i>If CX.5=</i>	<i>Value</i>																
PI	n/a ⁰¹																
NNITA	n/a																
SS	Loc IT: ISTAT code of emitting Region																
PNT	n/a																
HC	Nation code: ISO 3166 alpha-2 (e.g.: "IT" for ITALY)																
PN	n/a																
CX.7	Effective Date	O	Release date of identifier Format: YYYYMMDD[HH[MM[SS]]] Values: <table border="1"> <tr> <td><i>If CX.5=</i></td> <td><i>Value</i></td> </tr> </table>	<i>If CX.5=</i>	<i>Value</i>												
<i>If CX.5=</i>	<i>Value</i>																

#	Name	Set	Description						
			<table border="1"> <tr> <td>SS</td> <td>Loc IT: data di decorrenza dell'assistenza sanitaria.⁰²</td> </tr> </table> <p>⁰²CRS-SISS prevede l'utilizzo di PD1-4</p>	SS	Loc IT: data di decorrenza dell'assistenza sanitaria. ⁰²				
SS	Loc IT: data di decorrenza dell'assistenza sanitaria. ⁰²								
CX.8	Expiration Date	O	Expiration date of identifier Format: YYYYMMDD[HH[MM[SS]]] Values: <table border="1"> <thead> <tr> <th>If CX.5=</th> <th>Value</th> </tr> </thead> <tbody> <tr> <td>SS</td> <td>Loc IT: data di scadenza dell'assistenza sanitaria.⁰³</td> </tr> <tr> <td>HC, PN</td> <td>Expiration date of European Health Insurance Card (EHIC, [IT: TEAM])</td> </tr> </tbody> </table> <p>⁰³CRS-SISS prevede l'utilizzo di PD1-4</p>	If CX.5=	Value	SS	Loc IT: data di scadenza dell'assistenza sanitaria. ⁰³	HC, PN	Expiration date of European Health Insurance Card (EHIC, [IT: TEAM])
If CX.5=	Value								
SS	Loc IT: data di scadenza dell'assistenza sanitaria. ⁰³								
HC, PN	Expiration date of European Health Insurance Card (EHIC, [IT: TEAM])								
CX.9	Assigning Jurisdiction	O	n/a						

⁰¹CRS-SISS richiede il codice dell'applicazione che ha generato l'id paziente, che noi invece specifichiamo in CX.4

⁰²CRS-SISS prevede l'utilizzo di PD1-4

⁰³CRS-SISS prevede l'utilizzo di PD1-4

Example 18.2. Sample PID-3 field

- Identifier generated by MPI: 000000009400547
- Tax code (CF): RSSMRA54A12A944M
- Social security number (SSN): 999AV098

000000009400547^^^PK^PI~RSSMRA54A12A944M^^^CF^NNITA~999AV098^^^CS^SS

2.1.1. Fields for European Health Insurance Card (EHIC, [IT: TEAM])

The following picture gives a deeper description of European Health Insurance Card (EHIC, [IT: TEAM]) and information it carries.



2.2. PID-5

This field contains Patient Name and Surname

#	Name	Set	Description												
XPN.1	Family Name	R	Person Surname												
XPN.2	Given Name	R	Person Name												
XPN.5	Prefix	O	Name prefix (e.g. Mr,..)												
XPN.6	Degree	O	Name Title (e.g. Dr,..)												
XPN.7	Name Type Code	R	Name Type. Values: <table border="1" style="margin-left: 20px;"> <tr> <td>L</td> <td>Legal Name</td> </tr> <tr> <td>S</td> <td>Coded Pseudo-Name to ensure anonymity</td> </tr> </table> (Ref. HL7 Table 0200 - Name Type)	L	Legal Name	S	Coded Pseudo-Name to ensure anonymity								
L	Legal Name														
S	Coded Pseudo-Name to ensure anonymity														
XPN.14	Professional Suffix	O	Used to specify an abbreviation, or a string of abbreviations denoting qualifications that support the person's profession, (e.g., licenses, certificates, degrees, affiliations with professional societies, etc.). Loc ITA: Titolo di studio. ^a <table border="1" style="margin-left: 20px;"> <tr> <td>1</td> <td>Nessuno</td> </tr> <tr> <td>2</td> <td>Elementare</td> </tr> <tr> <td>3</td> <td>Media inferiore</td> </tr> <tr> <td>4</td> <td>Media superiore</td> </tr> <tr> <td>5</td> <td>Laurea</td> </tr> <tr> <td>6</td> <td>Laurea breve</td> </tr> </table>	1	Nessuno	2	Elementare	3	Media inferiore	4	Media superiore	5	Laurea	6	Laurea breve
1	Nessuno														
2	Elementare														
3	Media inferiore														
4	Media superiore														
5	Laurea														
6	Laurea breve														

^aCRS-SISS compliant

2.3. PID-11

This field contains a list of Patient Addresses; the type of address is defined by XAD.7:

#	Name	Set	Description
XAD.1	Street Address	OC	Street and dwelling number. Format: SAD.1= Street name and dwelling number [IT: Via e numero civico] <i>OR</i> SAD.2= Street name [IT: Via] SAD.3= Dwelling number [IT: numero civico] Conditions: XAD.7 <> BDL
XAD.2	Other Designation	OC	Second line of address [IT: Descrizione frazione/località] Conditions: XAD.7 <> BDL
XAD.3	City	R	City description [IT: descrizione comune]

#	Name	Set	Description										
XAD.4	State or Province	O	State or province where the addressee is located. Loc ITA: Regione dell'indirizzo. <i>CodedValue:</i> ISTAT Regioni (3 cifre)										
XAD.5	Zip or Postal Code	OC	Address ZIP or postal code [IT: CAP del comune di residenza/domicilio/recapito temporaneo] Conditions: XAD.7 <> BDL										
XAD.6	Country	O	Country where the address is located. <i>CodedValue:</i> ISO 3166 alpha-3 Nation code										
XAD.7	Address Type	O	Kind or type of address. Value: Table 18.2. HL7 Table 0190 - Address Type <table border="1" style="margin-left: 40px;"> <tr> <td>BDL</td> <td>Birth Place</td> </tr> <tr> <td>L</td> <td>Residence address (Legal address)</td> </tr> <tr> <td>H</td> <td>Domicile address (Home address)</td> </tr> <tr> <td>C</td> <td>Temporary living address</td> </tr> <tr> <td>M</td> <td>Mailing address</td> </tr> </table>	BDL	Birth Place	L	Residence address (Legal address)	H	Domicile address (Home address)	C	Temporary living address	M	Mailing address
BDL	Birth Place												
L	Residence address (Legal address)												
H	Domicile address (Home address)												
C	Temporary living address												
M	Mailing address												
XAD.8	Other geographic designation	O	This component specifies any other geographic designation Loc ITA: Provincia. <i>CodedValue:</i> Sigla automobilistica (2 caratteri)										
XAD.9	County/Parish Code	O	Parish Code of address Loc ITA: Comune. <i>CodedValue:</i> ISTAT comuni. Nel caso di pazienti nati/residenti all'estero, utilizzare il prefisso 999 seguito dal codice ISTAT dello stato estero.										
XAD.13	Effective Date	OC	Starting validity date of address Format: YYYYMMDD[HH[MM[SS]]] Conditions: XAD.7 <> BDL										
XAD.14	Expiration Date	OC	Ending validity date of address Format: YYYYMMDD[HH[MM[SS]]] Conditions: XAD.7 <> BDL										

Example 18.3. Sample PID-11 field

- *Birthplace:* Bologna, Italia
- *Residence:* Piazza Marconi 9, 20123, Milano, Italia

^^BOLOGNA^^^ITA^BDL^^037006~Piazza Marconi,9^^MILANO^^20123^ITA^L^^015146

2.4. PID-13

This field contains a list of Patient's phone numbers and email address.

#	Name	Set	Description										
XTN.2	Telecommunication Use Code	RC	Value: Table 18.3. HL7 Table 0201 - Telecommunication use code <table border="1" style="margin-left: 20px;"> <tr> <td>PRN</td> <td>Primary residence phone number</td> </tr> <tr> <td>ORN</td> <td>Other residence phone number</td> </tr> <tr> <td>WPN</td> <td>Work phone number</td> </tr> <tr> <td>NET</td> <td>Email address</td> </tr> <tr> <td>EMR</td> <td>Emergency number</td> </tr> </table>	PRN	Primary residence phone number	ORN	Other residence phone number	WPN	Work phone number	NET	Email address	EMR	Emergency number
PRN	Primary residence phone number												
ORN	Other residence phone number												
WPN	Work phone number												
NET	Email address												
EMR	Emergency number												
XTN.3	Telecommunication Equipment Type	OC	Value: Table 18.4. HL7 Table 0202 - Telecommunication equipment type <table border="1" style="margin-left: 20px;"> <tr> <td>CP</td> <td>Cellular Phone</td> </tr> <tr> <td>PH</td> <td>Telephone</td> </tr> <tr> <td>FX</td> <td>Fax</td> </tr> </table> Conditions: XTN.2 <> NET	CP	Cellular Phone	PH	Telephone	FX	Fax				
CP	Cellular Phone												
PH	Telephone												
FX	Fax												
XTN.4	Email Address	RC	Email address Conditions: XTN.2 = NET										
XTN.5	Country Code	OC	International prefix, without heading '+' (e.g. 39 for Italy) Conditions: XTN.2 <> NET										
XTN.12	Unformatted Telephone number	RC	Fax or Phone number, including national prefix (e.g. 026463789) Conditions: XTN.2 <> NET										

Example 18.4. Sample PID-13 field

- *Phone Number (primary):* +39 026463789
- *eMail:* rossimario@gmail.com

^PRN^^^39^^^^^^^026463789~^NET^^rossimario@gmail.com^^^^^^^

3. Tables

Table 18.5. User Table 0363 - Assigning Authority: IT

Value	Description	Comment
<i>Authorities for Patient ID generation: use application names (see User Table 0361 - Application)</i>		
PK	Master patient Index	
DNLAB		
ATHENA		
...		
<i>Authorities for Visit ID generation:</i>		
ADT	Inpatient registration application	
ED	Emergency department application	

Value	Description	Comment
AMB	Ambulatory patients application	

Table 18.6. User Table 0396 - Coding System

Value	Description	Comment
99zzz or L	Local general code	
LN	Logical Observation Identifier Names and Codes (LOINC®)	
AS4	ASTM E1238/ E1467 Universal	
I9C	ICD-9CM	
ISO+	ISO 2955.83 (units of measure) with HL7 extensions	
ISOnnnn	ISO Defined Codes where nnnn is the ISO table number	
SNT	SNOMED topology codes (anatomic sites)	
I10P	ICD-10 Procedure Codes	
...	<Additional values to be added based on local needs>	
99SISS	Codifiche SISS	
99ISTAT	Codifiche ISTAT	
99<application name>	Local codes defined by <application name> (see User Table 0361 - Application)	Example: 99DNLAB, 99ATHENA,...

Chapter 19. PR1 - Procedures

The PR1 segment contains information relative to various types of procedures that can be performed on a patient.

1. Segment definition

#	Name	Set	Description								
01	Set ID - PR1	R	Identifier of each occurrence of the segment								
02	<i>Procedure Coding Method</i>	n/a	<i>Deprecated. Use PR1-3.</i>								
03	Procedure Code	R	<p>Code assigned to the procedure</p> <p>Format: CE.1=Procedure Code.</p> <p>CE.2=Procedure Description</p> <p>CE.3=Name of Coding system. <i>ValueList:</i> <see below>. Req if CE.1 <> null</p> <table border="1"> <tr> <td>I10P</td> <td>ICD-10 Procedure Codes</td> </tr> <tr> <td>I9C</td> <td>ICD-9CM</td> </tr> <tr> <td>99zzz or L</td> <td>Local general code</td> </tr> </table> <p>(Ref. User Table 0396 - Coding System)</p>	I10P	ICD-10 Procedure Codes	I9C	ICD-9CM	99zzz or L	Local general code		
I10P	ICD-10 Procedure Codes										
I9C	ICD-9CM										
99zzz or L	Local general code										
04	<i>Procedure Description</i>	n/a	<i>Deprecated. Use PR1-3.</i>								
05	Procedure Date/Time	O	<p>This field contains the date/time that the procedure was performed.</p> <p>Format: YYYYMMDD[HH[MM[SS]]]</p>								
06	Procedure Functional Type	O	<p>This field contains the optional code that further defines the type of procedure.</p> <p>Values: Table 19.1. User Table 0230 - Procedure Functional Type</p> <table border="1"> <tr> <td>A</td> <td>Anesthesia</td> </tr> <tr> <td>P</td> <td>Procedure for treatment (therapeutic, including operations)</td> </tr> <tr> <td>I</td> <td>Invasive procedure not classified elsewhere [IT: Procedura invasiva (intervento chirurgico)]</td> </tr> <tr> <td>D</td> <td>Diagnostic procedure</td> </tr> </table>	A	Anesthesia	P	Procedure for treatment (therapeutic, including operations)	I	Invasive procedure not classified elsewhere [IT: Procedura invasiva (intervento chirurgico)]	D	Diagnostic procedure
A	Anesthesia										
P	Procedure for treatment (therapeutic, including operations)										
I	Invasive procedure not classified elsewhere [IT: Procedura invasiva (intervento chirurgico)]										
D	Diagnostic procedure										
14	Procedure Priority	O	<p>Number that identifies the significance or priority of the procedure code</p> <p>Values: Table 19.2. HL7 Table 0418 - Procedure Priority</p> <table border="1"> <tr> <td>0</td> <td>the admitting procedure [IT: procedura da non inserire nella SDO]</td> </tr> <tr> <td>1</td> <td>primary procedure [IT: procedura da inserire nella SDO come principale]</td> </tr> <tr> <td>2,...</td> <td>for ranked secondary procedures [IT: procedura da inserire nella SDO come secondaria]</td> </tr> </table>	0	the admitting procedure [IT: procedura da non inserire nella SDO]	1	primary procedure [IT: procedura da inserire nella SDO come principale]	2,...	for ranked secondary procedures [IT: procedura da inserire nella SDO come secondaria]		
0	the admitting procedure [IT: procedura da non inserire nella SDO]										
1	primary procedure [IT: procedura da inserire nella SDO come principale]										
2,...	for ranked secondary procedures [IT: procedura da inserire nella SDO come secondaria]										

#	Name	Set	Description						
19	Procedure Identifier	RC	<p>This field contains a value that uniquely identifies a single procedure for an encounter</p> <p>Format: EI.1=Unique Procedure identifier for an encounter. Req. EI.3=Identifier of event/movement to which the Procedure belongs</p> <p>Conditions: <i>Event</i>=Update Diagnosis/Procedures</p>						
20	Procedure Action Code	RC	<p>This field defines the action to be taken for this procedure</p> <p>Values: Table 19.3. HL7 Table 0206 - Segment Action Code</p> <table border="1" data-bbox="730 678 1396 810"> <tbody> <tr> <td>A</td> <td>Add</td> </tr> <tr> <td>U</td> <td>Update</td> </tr> <tr> <td>D</td> <td>Delete</td> </tr> </tbody> </table> <p>Conditions: <i>Event</i>=Update Diagnosis/Procedures</p>	A	Add	U	Update	D	Delete
A	Add								
U	Update								
D	Delete								

Example 19.1. Sample PR1 segment

- *Procedure Priority:* Primary
- *Procedure Code :* 12.22
- *Procedure description:* Biopsia dell'iride
- *Procedure coding system:* ICD-9-CM

```
PR1|1||12.22^Biopsia dell'iride^I9C|||P|||||||1
```

Chapter 20. PV1 - Patient Visit

1. Segment definition

The PV1 segment is used by Registration/Patient Administration applications to communicate information on an account or visit-specific basis.

In *Person Management scenario* the segment is not used to convey visit informations, and, according to IHE, PV1-2 will be given the 'N' value

#	Name	Set	Description																											
02	Patient Class	R	<p>Classification of patient encounter</p> <p>Values: Table 20.1. User Table 0004 - Patient Class</p> <table border="1"> <thead> <tr> <th>Value</th> <th>Description</th> <th>Context</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>Not Applicable</td> <td>Patient Identity Management</td> </tr> <tr> <td>O</td> <td>Ambulatory (Outpatients)</td> <td>Outpatients scenario</td> </tr> <tr> <td>I</td> <td>Inpatients</td> <td>Inpatient scenario</td> </tr> <tr> <td>E</td> <td>Emergency</td> <td>Emergency scenario</td> </tr> <tr> <td>P</td> <td>Preadmit</td> <td>Pre-admission scenario</td> </tr> <tr> <td>C</td> <td>Follow-Up [IT: Post Ricovero]</td> <td>Follow-up/Post admission scenario</td> </tr> <tr> <td colspan="3">Loc ITA (compliant HL7 Italia)</td> </tr> <tr> <td>D</td> <td>Day Hospital</td> <td>Short-stay scenario</td> </tr> </tbody> </table>	Value	Description	Context	N	Not Applicable	Patient Identity Management	O	Ambulatory (Outpatients)	Outpatients scenario	I	Inpatients	Inpatient scenario	E	Emergency	Emergency scenario	P	Preadmit	Pre-admission scenario	C	Follow-Up [IT: Post Ricovero]	Follow-up/Post admission scenario	Loc ITA (compliant HL7 Italia)			D	Day Hospital	Short-stay scenario
Value	Description	Context																												
N	Not Applicable	Patient Identity Management																												
O	Ambulatory (Outpatients)	Outpatients scenario																												
I	Inpatients	Inpatient scenario																												
E	Emergency	Emergency scenario																												
P	Preadmit	Pre-admission scenario																												
C	Follow-Up [IT: Post Ricovero]	Follow-up/Post admission scenario																												
Loc ITA (compliant HL7 Italia)																														
D	Day Hospital	Short-stay scenario																												
03	Assigned Patient Location	RC	<p>Current patient's location, typically a ward for Inpatients or an ambulatory for Outpatients.</p> <p>In case of Cancel Transfer or Cancel Discharge events, it contains the prior patient's location.</p> <p>Format: see <u>Assigned Patient Location</u> for details</p> <p>Loc ITA: Per gli Inpatients, si intende il reparto giuridico di ricovero .</p> <p>Conditions: <i>Scenario</i>=Patient Encounter Management</p>																											
04	Admission Type	OC	<p>Circumstances under which the patient was or will be admitted</p> <p>Loc ITA:</p> <table border="1"> <thead> <tr> <th>Significato (compliant HL7 Italia)</th> <th>Contesto</th> </tr> </thead> <tbody> <tr> <td>Tipo Ricovero</td> <td><i>Scenario</i>=Inpatient</td> </tr> <tr> <td>Modalità con la quale il paziente viene ammesso</td> <td><i>Scenario</i>=Outpatient</td> </tr> </tbody> </table> <p>Format: IS.1=Admission Type: <i>ValueList</i>: <u>User Table 0007 - Admission types: IT (Compliant HL7 Italia)</u></p> <p>Conditions: (PV1-2 <> N)</p>	Significato (compliant HL7 Italia)	Contesto	Tipo Ricovero	<i>Scenario</i> =Inpatient	Modalità con la quale il paziente viene ammesso	<i>Scenario</i> =Outpatient																					
Significato (compliant HL7 Italia)	Contesto																													
Tipo Ricovero	<i>Scenario</i> =Inpatient																													
Modalità con la quale il paziente viene ammesso	<i>Scenario</i> =Outpatient																													
05	Preadmit number	O	<p>Used in Admit Inpatient event to communicate the number of previous Preadmit or Emergency encounter (PV1.19).</p>																											

#	Name	Set	Description								
			<p>Values: CX.1=Visit number (PV1-19) of previous encounter. Req.</p> <p>CX.4=Application that opened the previous encounter. <i>ValueList:</i> User Table 0363 - Assigning Authority: IT. Req.</p> <p>CX.5=<i>Constant:</i> VN</p>								
06	Prior Patient Location	RC	<p>This field contains the prior patient location if the patient is being transferred</p> <p>Format: Same format of PV1-3: see <u>Assigned Patient Location</u> for details</p> <p>Conditions: <i>Event</i> = Transfer Inpatient</p>								
07	Attending Doctor	OC..*	<p>Attending physician information.</p> <p>Note</p> <p>It is possible to use more than one repetition of the field, but information in each repetition MUST be related to the same doctor. Multiple repetitions MUST be used only to transmit <u>different identifiers</u> (ex. national identifier, regional identifier, local identifier, ecc.) of the <u>same doctor</u>; each repetition and its identifier MUST be clearly qualified according to the rules exposed below.</p> <p>Loc ITA: Medico responsabile della cura del paziente.</p> <table border="1"> <thead> <tr> <th>Meaning</th> <th>Context</th> </tr> </thead> <tbody> <tr> <td>Medico di base</td> <td>Scenario=PatientIdentity or Scenario<> Inpatients</td> </tr> <tr> <td>Medico ospedaliero che ha in cura il paziente</td> <td>Scenario=Inpatients</td> </tr> <tr> <td>Medico che effettua la dimissione</td> <td>Scenario=Inpatients and Event=Discharge Patient</td> </tr> </tbody> </table> <p>Format:</p> <p>see <u>Attending Doctor</u> for details</p> <p>Conditions:</p> <p><i>Scenario</i>=PatientIdentity OR <i>Scenario</i>=PatientEncounter</p>	Meaning	Context	Medico di base	Scenario=PatientIdentity or Scenario<> Inpatients	Medico ospedaliero che ha in cura il paziente	Scenario=Inpatients	Medico che effettua la dimissione	Scenario=Inpatients and Event=Discharge Patient
Meaning	Context										
Medico di base	Scenario=PatientIdentity or Scenario<> Inpatients										
Medico ospedaliero che ha in cura il paziente	Scenario=Inpatients										
Medico che effettua la dimissione	Scenario=Inpatients and Event=Discharge Patient										
08	Referring Doctor	OC..*	<p>Referring physician information; doctor who required the visit/consultation/health services</p> <p>Note</p> <p>It is possible to use more than one repetition of the field, but information in each repetition MUST be related to the same doctor. Multiple repetitions MUST be used only to transmit <u>different identifiers</u> (ex. national identifier, regional identifier, local identifier, ecc.) of the <u>same doctor</u>; each repetition and its identifier MUST be clearly qualified according to the rules exposed below.</p> <p>Format: Same format of PV1-7: see <u>Attending Doctor</u> for details</p> <p>Conditions: (PV1-2 <> N)</p>								

#	Name	Set	Description								
10	Hospital Service	OC	<p>Loc ITA: Tipo di Trattamento o di Intervento che il paziente deve ricevere. In caso di pazienti degenti in regime diurno (day hospital), indica il Motivo del Ricovero</p> <p>Values:</p> <p>Table 20.2. User Table 0069 - HospitalService</p> <table border="1"> <tr> <td>1</td> <td>Ricovero diurno diagnostico (ivi compreso il follow up)</td> </tr> <tr> <td>2</td> <td>Ricovero diurno chirurgico (day surgery)</td> </tr> <tr> <td>3</td> <td>Ricovero diurno terapeutico</td> </tr> <tr> <td>4</td> <td>Ricovero diurno riabilitativo</td> </tr> </table> <p>Conditions:</p> <p><i>Scenario=PatientEncounter and PV1-2=D</i></p>	1	Ricovero diurno diagnostico (ivi compreso il follow up)	2	Ricovero diurno chirurgico (day surgery)	3	Ricovero diurno terapeutico	4	Ricovero diurno riabilitativo
1	Ricovero diurno diagnostico (ivi compreso il follow up)										
2	Ricovero diurno chirurgico (day surgery)										
3	Ricovero diurno terapeutico										
4	Ricovero diurno riabilitativo										
11	Temporary location	OC	<p>Temporary patient location.</p> <p>Format: Same format of PV1-3: see <u>Assigned Patient Location</u> for details</p> <p>Loc ITA: Reparto temporaneo o assistenziale (eventuale locazione alternativa assistenziale in caso in cui il paziente non possa essere collocato al letto descritto in PV1-3)</p> <p>Conditions:</p> <p><i>Scenario=PatientEncounter</i></p>								
14	Admit Source	OC	<p>Source of admission (IT: Provenienza del paziente)</p> <p>Values: <u>User Table 0023 - Admit Source: IT (Compliant HL7 Italia)</u></p> <p>Conditions: <i>Scenario=PatientEncounter AND Event in (Admit, Register, Preadmit)</i></p>								
17	Admitting doctor	OC..*	<p>Admitting physician information</p> <p>Note</p> <p>It is possible to use more than one repetition of the field, but information in each repetition MUST be related to the same doctor. Multiple repetitions MUST be used only to transmit <u>different identifiers</u> (ex. national identifier, regional identifier, local identifier, ecc.) of the <u>same doctor</u>; each repetition and its identifier MUST be clearly qualified according to the rules exposed below.</p> <p>Same format of PV1-7: see <u>Attending Doctor</u> for details</p> <p>Conditions: <i>Scenario=PatientEncounter</i></p>								
19	Visit Number	RC	<p>This field contains the unique number assigned to each patient visit. ⁰¹</p> <p>Format: CX.1 = Visit number. Req.</p> <p>CX.4 = Application that is registering the visit. <i>ValueList:</i> User Table 0363 - Assigning Authority: IT. Req.</p> <p>CX.5 =</p>								

#	Name	Set	Description						
			<table border="1"> <tr> <td>VN</td> <td>Inpatients</td> </tr> <tr> <td>MR</td> <td>Outpatients</td> </tr> </table> <p>CX.6 = Facility assigning the Visit number. Loc ITA: Codice presidio ospedaliero / substruttura (2 caratteri)</p> <p>CX.10 = Agency responsible for definition and assignment of Visit number. Loc ITA: Codice ministeriale Azienda Ospedaliera (6 caratteri)</p> <p>Conditions: PV1-2<>N</p>	VN	Inpatients	MR	Outpatients		
VN	Inpatients								
MR	Outpatients								
20	Financial Class	OC..*	<p>Financial class(es) assigned to the patient for the purpose of identifying sources of reimbursement.⁰²</p> <p>Loc ITA: Condizione dell'assistito in relazione alle eventuali esenzioni. (<i>Compliant HL7 Italia</i>)</p> <p>Format::</p> <p>FC.1= Codice di esenzione. Rif. codici di esenzione ministeriali</p> <p>FC.2= Data scadenza dell'esenzione. <i>Format:YYYYMMDD</i></p> <p>Conditions:</p> <p><i>Scenario=Outpatients OR Scenario=PatientIdentity</i></p>						
21	Charge Price Indicator	OC	<p>This field contains the code used to determine which price schedule is to be used</p> <p>Loc ITA: (<i>Compliant HL7 Italia</i>)</p> <table border="1"> <thead> <tr> <th>Meaning</th> <th>Context</th> </tr> </thead> <tbody> <tr> <td>Onere della Degenza</td> <td><i>Inpatients.</i></td> </tr> <tr> <td>Regime erogazione di</td> <td><i>Outpatients.</i></td> </tr> </tbody> </table> <p>Values: FC.1=User Table 0032 - ChargePriceIndicator: IT (<i>Compliant HL7 Italia</i>)</p> <p>Conditions:</p> <p><i>Scenario=PatientEncounter</i></p>	Meaning	Context	Onere della Degenza	<i>Inpatients.</i>	Regime erogazione di	<i>Outpatients.</i>
Meaning	Context								
Onere della Degenza	<i>Inpatients.</i>								
Regime erogazione di	<i>Outpatients.</i>								
24	Contract code	OC	<p>This field identifies the type of contract entered into by the healthcare facility and the guarantor for the purpose of settling outstanding account balances.</p> <p>Loc ITA: Tipo di convenzione contrattuale che la struttura sanitaria ha stipulato con il soggetto che deve farsi carico del pagamento della prestazioni effettuate. (<i>Compliant HL7 Italia</i>)</p> <p>Values: User Table 0044 - ContractCode: IT</p> <p>Conditions:</p> <p><i>Scenario=PatientEncounter</i></p>						
36	Discharge Disposition	OC	<p>This field contains the disposition of the patient at time of discharge (i.e., discharged to home, expired, etc.).</p>						

#	Name	Set	Description
			Values: <u>User Table 0112 - DischargeDisposition: IT (Compliant HL7 Italia)</u> Conditions: <i>Scenario=PatientEncounter</i>
43	Prior Temporary Location	OC	This field contains the prior patient temporary location if the patient is being transferred Format: Same format of PV1-3: see <u>Assigned Patient Location</u> for details Conditions: <i>Event = Transfer Inpatient</i>
44	Admit date/time	RC	Actual admission timestamp Format: YYYYMMDDHHMM[SS] Conditions: <i>Scenario=PatientEncounter AND Event in (A01, A04, A05)</i>
45	Discharge date/time	RC	Actual discharge timestamp Format: YYYYMMDDHHMM[SS] Conditions: <i>Scenario=PatientEncounter AND Event =A03</i>
50	Alternate Visit ID	OC	This field contains the alternative, temporary, or pending visit ID number Format: CX.1=Alternate Visit number. Req CX.4=Application that is registering the identifier in CX.1. <i>ValueList: Ref. User Table 0363 - Assigning Authority: IT.</i> Req Conditions: <i>Scenario=PatientEncounter</i>
51	Visit Indicator	OC	Values: <i>Constant: V</i> Conditions: <i>PV1-2 <> N</i>

⁰¹CRS-SISS nel caso di messaggi Preadmit patient (A05) richiede l'utilizzo di PV1-5

⁰²Nel caso di Inpatients il CRS-SISS assegna al campo il significato di "Onere della degenza", che noi invece specifichiamo in PV1-21

2. Fields definition

2.1. PV1-3

Assigned Patient Location.¹ This field contains the patient's initial assigned location or the location to which the patient is being moved. For canceling a transaction or discharging a patient, the current location (after the cancellation event or before the discharge event) should be in this field.

The data type Patient Location (PL) contains several location identifiers that should be thought of in the following order from the most general to the most specific: facility , building, floor, point of care, room , bed.

#	Name	Set	Description
<i>PL.1</i>	point of care	R	Code of Ward/Ambulatory
<i>PL.2</i>	room	O	Room assigned to the patient
<i>PL.3</i>	bed	O	Bed assigned to the patient

¹Nei messaggi documentali il CRS-SISS prevede l'uso del campo per specificare la "Struttura in cui viene prodotto il referto", che noi invece valorizziamo in OBR-32

#	Name	Set	Description
PL.4	facility	O	Facility owning the point of care in PL.1. Generally describes the highest level physical designation of an institution, medical center or enterprise. Loc ITA: Presidio. <i>CodedValue:</i> Codifica ministeriale presidi (6 cifre). (<i>Compliant HL7 Italia</i>)
PL.7	building	O	Building of the facility where the point of care in PL.1 is located. Loc ITA: Stabilimento (subcodice da codice presidio). <i>CodedValue:</i> Codifica ministeriale stabilimenti (2 cifre). (<i>Compliant HL7 Italia</i>)
PL.8	floor	O	Floor where the room is located
PL.9	location description	R	Ward/Ambulatory description
PL.10	Comprehensive Location Identifier	O	Loc ITA: Codice Azienda Ospedaliera ^a
PL.11	Assigning Authority for Location	n/a	n/a ^b

^aCRS-SISS prevede l'uso di PL.4

^bCRS-SISS prevede l'uso del campo per specificare la Struttura di Conservazione del documento, che noi definiamo in TXA.23

Example 20.1. Sample PV1-3 field

Example for Italian Localization

- *Ward:* 008.01 - CARDIOLOGIA
- *Room:* A
- *Bed:* 7
- *Facility:* Ospedale di Imola del Presidio di Imola-Castel San Pietro Terme (Presidio: 080044; Subcodice: 01)

008.01^A^7^080044^^^01^^CARDIOLOGIA^^

2.2. PV1-7

Attending Doctor.

#	Name	Set	Description
XCN.1	ID Number	R	Doctor's identifier ^a Values: Depends on XCN.13
XCN.2	family name	RE	Surname
XCN.3	given name	RE	Forename
XCN.9	assigning authority	OC	Loc ITA: HD.1= ASL di appartenenza del medico. <i>CodedValue:</i> Codice Regione (3 cifre) + Codice regionale dell'Azienda Sanitaria (3 cifre). Req. HD.3= <i>Constant:</i> ASLA (Ref. HL7 Table 0203 - Identifier Type: IT)

#	Name	Set	Description										
			<p>Conditions:</p> <p><i>Scenario=PatientIdentity</i></p>										
XCN.13	identifier type code	R	<p>It defines the type of identifier specified in XCN.1.</p> <p>Values:</p> <table border="1"> <tr> <td>NN</td> <td>National Personal Identifier</td> </tr> <tr> <td>RRI</td> <td>Regional Registry ID</td> </tr> <tr> <td>LR</td> <td>Local Registry ID (<i>Not Compliant CRS-SISS</i>)</td> </tr> <tr> <td colspan="2">Loc ITA</td> </tr> <tr> <td>NNITA</td> <td>Tax Code</td> </tr> </table> <p>(Ref. HL7 Table 0203 - Identifier Type: IT)</p>	NN	National Personal Identifier	RRI	Regional Registry ID	LR	Local Registry ID (<i>Not Compliant CRS-SISS</i>)	Loc ITA		NNITA	Tax Code
NN	National Personal Identifier												
RRI	Regional Registry ID												
LR	Local Registry ID (<i>Not Compliant CRS-SISS</i>)												
Loc ITA													
NNITA	Tax Code												
XCN.19	Effective date	OC	<p>Loc ITA: Data scelta medico di base. <i>Format:</i> YYYYMMDD[HH[MM[SS]]]</p> <p>Conditions:</p> <p><i>Scenario=PatientIdentity</i></p>										
XCN.20	Expiration date	OC	<p>Loc ITA: Data revoca medico di base. <i>Format:</i> YYYYMMDD[HH[MM[SS]]]</p> <p>Conditions:</p> <p><i>Scenario=PatientIdentity</i></p>										

³CRS-SISS, nel caso di messaggi documentali, richiede di specificare il Codice Fiscale del medico.

3. Tables

Table 20.3. User Table 0023 - Admit Source: IT (Compliant HL7 Italia)

Value	Description	Comment
1	paziente che acceda all'istituto di cura senza proposta di ricovero formulata da un medico	Per degenti. Rif. DM 27/10/2000, n. 380
2	paziente che acceda all'istituto di cura con proposta del medico di base	"
3	ricovero precedentemente programmato dallo stesso istituto di cura;	"
4	paziente trasferito da un istituto di cura pubblico;	"
5	paziente trasferito da un istituto di cura privato accreditato;	"
6	paziente trasferito da istituto di cura privato non accreditato;	"
7	paziente trasferito da altro tipo di attività di ricovero (acuti, riabilitazione, lungodegenza) o da altro regime di ricovero (ricovero diurno o ordinario) nello stesso istituto;	"
9	altro.	"
10	Medico specialista ospedaliero	Per specialistica ambulatoriale. Rif HL7 Italia
11	Medico specialista territoriale	"

Value	Description	Comment
12	Richiesta INPS, INAIL	"
20	Segnalazione del medico di base	Per ADI. Rif HL7 Italia
21	Segnalazione dell'ospedale	"
22	Segnalazione di parenti/familiari	"
23	Segnalazione di servizi sociali	"
24	Segnalazione di volontariato	"

Table 20.4. User Table 0007 - Admission types: IT (Compliant HL7 Italia)

Value	Description	Comment
1	Ricovero programmato non urgente	Per degenti. Rif. DM 27/10/2000, n. 380
2	Ricovero Urgente	"
3	Ricovero per trattamento sanitario obbligatorio (TSO)	"
4	Ricovero programmato con pre-ospedalizzazione	"
5	Ricovero d'urgenza in OBI	Per degenti. Rif. HL7 Italia
6	Ordinario (programmabile)	Per specialistica ambulatoriale. Rif. HL7 Italia
7	Urgente	"
	<i><eventuali valori aggiuntivi in base a flussi regionali o per esigenze locali></i>	

Table 20.5. User Table 0032 - ChargePriceIndicator: IT (Compliant HL7 Italia)

Value	Description	Comment
1	A totale carico SSN	Per Degenti e Ambulatoriali
2	Ricovero a prevalente carico SSN, con parte delle spese a carico del paziente(differenza alberghiera)	Per Degenti
3	Ricovero con successivo rimborso (totale o parziale) a carico del SSN	Per Degenti
4	Senza oneri per il SSN (solvente);	Per Degenti e Ambulatoriali
5	A prevalente carico del SSN, con parte delle spese a carico del paziente (libera professione);	Per Degenti e Ambulatoriali
6	ricovero a prevalente carico del SSN, con parte delle spese a carico del paziente (libera professione e differenza alberghiera);	Per Degenti
7	A carico del SSN di pazienti stranieri provenienti da Paesi convenzionati con SSN;	Per Degenti e Ambulatoriali
8	A carico del SSN di pazienti stranieri con dichiarazione di indigenza;	Per Degenti e Ambulatoriali
9	altro	Per Degenti e Ambulatoriali
A	ricovero a carico del Ministero dell'interno di pazienti stranieri con dichiarazione di indigenza;	Per Degenti
N	Naviganti	Per Ambulatoriali
C	Prestazioni rese a detenuti	Per Ambulatoriali

La tabella contiene i codici utilizzabili per esprimere l'Onere della degenza per pazienti degenti (Rif. DM 27/10/2000, n. 380) e il Regime di erogazione per pazienti ambulatoriali (Rif 28/SAN). Da completare eventualmente con altri valori presi dai flussi regionali, o inseriti a completamento delle esigenze locali.

Table 20.6. User Table 0044 - ContractCode: IT

Value	Description	Comment
SSN	Domiciliato in ASL, Cittadino italiano	Rif. People - progetto Empoli
EMI	Cittadino italiano emigrato, residente estero	"
UE	Cittadinanza europea, regolarmente soggiornante	"
TEAM	Cittadinanza europea, soggiorno temporaneo	"
STP	Extra UE, non regolarmente soggiornante	"
E109	Lavoratore UE distaccato, figli iscritti in Italia	"
E121	Titolare di pensione, Attestato E121	"
E120	In attesa di pensione, Attestato E120	"
E106	Studente o lavoratore distaccato, attestato E106	"
E112	Maternità o cure mediche programmate, E112	"
E123	Malattia e/o infortuni sul lavoro, Attestato E123	"
E000	Altro attestato UE	"
XUEO	Cittadino extraUE regolarmente soggiornante, iscrizione obbligatoria	"
XUEF	Cittadino extraUE regolarmente soggiornante, iscrizione facoltativa	"
CNV1	Cittadino extraUE di paese convenzionato, titolare di attestato, regolarmente soggiornante	"
CNV2	Cittadino extraUE di paese convenzionato, soggiorno temporaneo	"
SASN	Servizio Assistenza Sanitaria Naviganti	"

La tabella definisce l'elenco delle convenzioni di assistenza riconosciute dall'ASL. Attualmente i valori in tabella sono quelli del progetto di Empoli, e vanno adattati in base alle esigenze locali.

Table 20.7. User Table 0112 - DischargeDisposition: IT (Compliant HL7 Italia)

Value	Description	Comment
1	Deceduto	Per degenti. Rif. DM 27/10/2000, n. 380
2	Dimissione ordinaria al domicilio del paziente	"
3	Dimissione ordinaria presso una residenza sanitaria assistenziale (RSA)	"
4	dimissione al domicilio del paziente con attivazione di ospedalizzazione domiciliare	"
5	dimissione volontaria (da utilizzare anche nei casi in cui il paziente in ciclo di trattamento diurno non si sia ripresentato durante il ciclo programmato)	"
6	trasferimento ad un altro istituto di ricovero e cura, pubblico o privato, per acuti;	"
7	trasferimento ad altro regime di ricovero o ad altro tipo di attività di ricovero nell'ambito dello stesso istituto;	"

Value	Description	Comment
8	trasferimento ad un istituto pubblico o privato di riabilitazione;	"
9	dimissione ordinaria con attivazione di assistenza domiciliare integrata	"
10	Ricoverato	Per pazienti in uscita da Pronto Soccorso. Rif. HL7 Italia
11	Rifiuta ricovero	"
12	Giunto cadavere	"
13	Completamento del programma assistenziale	Per assistenza domiciliare o altra tipologia di assistenza erogata. Rif. HL7 Italia

Table 20.8. HL7 Table 0203 - Identifier Type: IT

Value	Description	Comment
ANT	Temporary Account Number	Identificativo del dipartimentale (temporaneo). Rif. HL7 Italia
DN	Doctor Number	Codice ricetta del medico. Rif. HL7 Italia
FI	Facility Id	
HC	Health Card Number	per tessera TEAM. Rif. HL7 Italia
LR	Local Registry ID	Identificativo locale.
MD	Medical License number	Codice matricola del medico. Rif. HL7 Italia
NNxxx	National Person Identifier where the xxx is the ISO table 3166 3-character (alphabetic) country code	NNITA – Per codice fiscale. Rif. HL7 Italia
PI	Patient internal identifier	Identificativo paziente aziendale. Rif. HL7 Italia
PNT	Temporary Living Subject Number	Per STP. Rif. HL7 Italia
RRI	Regional registry ID	Chiave regionale. Rif. HL7 Italia
SS	Social Security number	Codice della tessera sanitaria. Rif. HL7 Italia
VN	Visit number	Numero nosologico o numero di contatto. Rif. HL7 Italia
ASLA	AUSL di assistenza	AUSL di assistenza. Rif. HL7 Italia
ASLR	AUSL di appartenenza	AUSL di appartenenza. Rif. HL7 Italia
MR	Medical Record	Numero di cartella. Rif. CRS-SISS

The table contains a subset of HL7 table 0203, with main identifiers relevant for Italian localization as proposed by HL7 Italia and, partly, by CRS-SISS

Chapter 21. PV2 - Patient Visit - Additional Information

The PV2 segment is a continuation of informations contained in the PV1 segment.

1. Segment definition

#	Name	Set	Description
03	Admit Reason	OC	Reason for patient admission, coded or free-text. In case the Admit Reason equals the ICD9 / ICD10 Admission Diagnosis, then it SHOULD be transmitted using a <u>DG1 - Diagnosis</u> segment. Format: CE.1=Admit reason code CE.2=Admit reason description Req. CE.3=Coding system. <i>ValueList:</i> <u>User Table 0396 - Coding System</u> Req. if CE.1 <> null Conditions: <i>Event</i> =Admit Inpatient
04	Transfer Reason	OC	Reason for a patient location change, coded or free-text. Format: CE.1=Transfer reason code CE.2=Transfer reason description Rea. CE.3=Coding system. <i>ValueList:</i> <u>User Table 0396 - Coding System</u> Rea if CE.1 <> null Conditions: <i>Event</i> =Transfer Inpatient
07	Visit User Code	RC	Internal event key: it is a unique key, inside each visit, identifying the event (e.g.: Admit, Transfer,..) in the sending application. For example, it might be assigned the timestamp when the event was registered (same value as EVN-2). It allows for event cancelling or update between the sending and the receiving application. Format: Free format, do no exceed 64 chars. Condition: <i>Scenario</i> =Patient Encounter
08	Expected Admit Date/Time	O	May contain the date and time that the patient is expected to be admitted. Format: YYYYMMDDHHMM[SS] Conditions: <i>Scenario</i> =Patient Encounter Management (Outpatient and Pre-Admission)
09	Expected discharge Date/Time	O	May contain the date and time that the patient is expected to be discharged. Format: YYYYMMDDHHMM[SS] Conditions: <i>Scenario</i> =Patient Encounter Management (Inpatient and Short-Stay)
12	Visit Description	O	May contain a description of the encounter, or a reason for it, in a free-text format. Conditions: <i>Scenario</i> =Patient Encounter Management
21	Visit Publicity Code	O	User-defined code indicating what level of publicity is allowed for a specific visit

PV2 - Patient Visit -
Additional Information

#	Name	Set	Description										
			<p>Loc ITA Livello di riservatezza dei dati della visita o dell'accesso (<i>Compliant HL7 Italia</i>).</p> <p><i>Nota:</i> In ambito <i>CRS-SISS</i> si usa il campo PV2-45 per l'oscuramento dei dati clinici del paziente.</p> <p>Values:</p> <table border="1"> <tr> <td>F</td> <td>Family Only [ITA: Solo Familiari]</td> </tr> <tr> <td>N</td> <td>No Publicity [ITA: Consenso negato]</td> </tr> <tr> <td>Y</td> <td>Publicity [ITA: Consenso accordato]</td> </tr> <tr> <td>U</td> <td>Unknown</td> </tr> <tr> <td>O</td> <td>Other</td> </tr> </table> <p>(Ref. User Table 0215 - Publicity Code)</p>	F	Family Only [ITA: Solo Familiari]	N	No Publicity [ITA: Consenso negato]	Y	Publicity [ITA: Consenso accordato]	U	Unknown	O	Other
F	Family Only [ITA: Solo Familiari]												
N	No Publicity [ITA: Consenso negato]												
Y	Publicity [ITA: Consenso accordato]												
U	Unknown												
O	Other												
25	Visit Code	Priority O	<p>This field contains the priority of the visit</p> <p>Loc ITA (<i>Compliant HL7 Italia</i>) La distinzione del ricovero in programmato ed urgente viene già determinata tramite i campi PV1- 2, PV1-4. Un possibile utilizzo di questo campo può essere quello di inviare:</p> <ul style="list-style-type: none"> • Priorità di accesso, legata alle prestazioni di specialistica ambulatoriale • Gravità dell'episodio (triage, per episodi di Pronto Soccorso) • Classificazione delle priorità basata sui tempi massimi di attesa <p>Values:</p> <p>User Table 0217 - Visit Priority Code: IT</p>										
31	Recurring Service Code	RC	<p>In Patient Encounter scenario for Day Hospital it is required to differentiate between first patient access and following ones.</p> <p>In Patient Encounter scenario for Outpatients it is required in case of recurring ambulatory encounters.</p> <p>Values: User Table 0219 - Recurring Service Code: IT</p> <p>Conditions: Scenario=PatientEncounter and PV1-2 in (D, O)</p>										
36	Newborn Baby Indicator	O	<p>Indicates whether the patient is a baby.</p> <p>Values:</p> <table border="1"> <tr> <td>Y</td> <td>The patient is a baby</td> </tr> <tr> <td>N</td> <td>The patient is NOT a baby</td> </tr> </table>	Y	The patient is a baby	N	The patient is NOT a baby						
Y	The patient is a baby												
N	The patient is NOT a baby												
38	Mode of arrival	O	<p>Identifies how the patient was brought to the healthcare facility.</p> <p>Format: CE.1=Mode of arrival code. <i>ValueList:</i> <see below></p> <p>Table 21.1. User Table 0430 - Mode of Arrival</p> <table border="1"> <tr> <td>A</td> <td>Ambulance</td> </tr> <tr> <td>C</td> <td>Car</td> </tr> <tr> <td>F</td> <td>On Foot [IT: A piedi]</td> </tr> <tr> <td>U</td> <td>Unknown</td> </tr> <tr> <td>H</td> <td>Helicopter [ITA: Eliambulanza]</td> </tr> </table>	A	Ambulance	C	Car	F	On Foot [IT: A piedi]	U	Unknown	H	Helicopter [ITA: Eliambulanza]
A	Ambulance												
C	Car												
F	On Foot [IT: A piedi]												
U	Unknown												
H	Helicopter [ITA: Eliambulanza]												

PV2 - Patient Visit -
Additional Information

#	Name	Set	Description																		
			<table border="1"> <tr> <td>P</td> <td>Public transport</td> </tr> <tr> <td>O</td> <td>Other</td> </tr> </table> <p>CE.2=Mode of arrival description CE.3=HL70430. Req.if CE.1 <> null</p>	P	Public transport	O	Other														
P	Public transport																				
O	Other																				
45	Advance Directive Code	OC..*	<p>Indicates the patient's instructions to the healthcare facility.</p> <p>Current usage include patient consent to publication of clinical data. May be extended for additional needs</p> <p>Format: CE.1=Value assigned to directive. <i>ValueList:</i> Y=Yes; N=No Req CE.2=Directive identifier. <i>ValueList:</i><see below> Req.</p> <table border="1"> <tr> <td>Publish_Order_Con</td> <td>Consent to publication of Order related clinical data to Portal application</td> </tr> <tr> <td>Publish_Visit_P</td> <td>Consent to publication of Visit related clinical data to Portal application</td> </tr> <tr> <td></td> <td></td> </tr> </table> <p>CE.3=99GALILEO. Req</p> <p>Loc=CRS-SISS</p> <p>CE.1=Valore Oscuramento. <i>ValueList:</i> SI/NO Req CE.2=Tipologia Oscuramento. <i>ValueList:</i><see below> Req.</p> <table border="1"> <tr> <td colspan="2">Tipologia di oscuramento volontario dei referti prodotti nell'ambito dell'evento sanitario.</td> </tr> <tr> <td>10</td> <td>Oscuramento per tossicodipendenza</td> </tr> <tr> <td>20</td> <td>Oscuramento per HIV</td> </tr> <tr> <td>30</td> <td>Oscuramento per Violenze Subite</td> </tr> <tr> <td>40</td> <td>Oscuramento per interruzione volontaria gravidanza</td> </tr> <tr> <td>50</td> <td>Oscuramento volontario cittadino</td> </tr> </table> <p>CE.3=99SISS Req.</p> <p>Conditions: <i>Scenario</i> in (Patient Encounter, Order Management)</p>	Publish_Order_Con	Consent to publication of Order related clinical data to Portal application	Publish_Visit_P	Consent to publication of Visit related clinical data to Portal application			Tipologia di oscuramento volontario dei referti prodotti nell'ambito dell'evento sanitario.		10	Oscuramento per tossicodipendenza	20	Oscuramento per HIV	30	Oscuramento per Violenze Subite	40	Oscuramento per interruzione volontaria gravidanza	50	Oscuramento volontario cittadino
Publish_Order_Con	Consent to publication of Order related clinical data to Portal application																				
Publish_Visit_P	Consent to publication of Visit related clinical data to Portal application																				
Tipologia di oscuramento volontario dei referti prodotti nell'ambito dell'evento sanitario.																					
10	Oscuramento per tossicodipendenza																				
20	Oscuramento per HIV																				
30	Oscuramento per Violenze Subite																				
40	Oscuramento per interruzione volontaria gravidanza																				
50	Oscuramento volontario cittadino																				

Example 21.1. Sample PV2 segment

```
// an Inpatient Admission
PV2|||2298006^Myocardial infraction^SNT|||876500982347||201212051800|||
  Suspect of myocardial infraction, admission recommended|||F|||A||
  |||N||A|||Y^Publish_Visit_Portal^99GALILEO

// an Inpatient Transfer
PV2|||05^Transferred due to better conditions^L|||334765412239|||
  Suspect of myocardial infraction, admission recommended|||F|||
  A|||N||A|||Y^Publish_Visit_Portal^99GALILEO

// a Short-Stay administrative opening
PV2|||323542345343|||This is the visit reason|||F|||C|||DHO
  |||Y||U|||Y^Publish_Visit_Portal^99GALILEO~SI^50^99SISS

// Short-Stay accesses begins and ends
PV2|||554222345522|||This is te access reason|||F|||C|||DHAB
  |||Y||U|||Y^Publish_Visit_Portal^99GALILEO~SI^50^99SISS

PV2|||554235554455|||F|||C|||DHAE|||Y||U|||
  |Y^Publish_Visit_Portal^99GALILEO~SI^50^99SISS

// a Short-Stay administrative closure
PV2|||124466739874|||F|||C|||DHC|||
  ||Y||U|||Y^Publish_Visit_Portal^99GALILEO~SI^50^99SISS
```

2. Tables

Table 21.2. User Table 0217 - Visit Priority Code: IT

Value	Description	Comment
R	Triage - Red	For Emergency Department
Y	Triage - Yellow	"
G	Triage - Green	"
W	Triage - White	"
...	<Additional values to be added on local needs>	

Table 21.3. User Table 0219 - Recurring Service Code: IT

Value	Description	Comment
<i>Patient Encounter</i>		
DHO	Day Hospital Open	Day Hospital encounter administrative opening
DHAB	Day Hospital Access Begin	Day Hospital access - begin
DHAE	Day Hospital Access End	Day Hospital access - end
DHC	Day Hospital Close	Day Hospital encounter administrative closure
RO	Recurring Ambulatory Open	First Recurring Ambulatory access

PV2 - Patient Visit -
Additional Information

Value	Description	Comment
RE	Recurring Ambulatory Encounter	Following Recurring Ambulatory accesses
RC	Recurring Ambulatory Close	Last Recurring Ambulatory access

Chapter 22. RXO - Pharmacy/ Treatment Order Segment

The PR1 segment contains information relative to various types of procedures that can be performed on a patient.

1. Segment definition

#	Name	Give	Set	Description
01	Requested Code	Give	RC	Identifies the treatment product or treatment ordered to be given to the patient. Format: CE.1 = treatment code Req CE.2 = treatment text CE. 3 = name of coding system Req. Loc UK: "dm+d" Condition: Required if RXO-6 = null
02	Requested Amount Minimum	Give -	RC	This field is the ordered amount. In a variable dose order, this is the minimum ordered amount. In a non-varying dose order, this is the exact amount of the order. Condition: Required if RXO-6 = null
03	Requested Amount Maximum	Give -	O	In a variable dose order, this is the maximum ordered amount. In a non-varying dose order, this field is not used.
04	Requested Units	Give	RC	This field indicates the units for the give amount. Condition: Required if RXO-6 = null
06	Provider's Pharmacy/ Treatment Instructions		RC	Contains a free text version of the prescription line Format: CE.2 = Treatment free text Condition: mandatory if RXO-1, RXO-2 and RXO-4 are all null.
20	Indication		RC	It identifies the condition or problem for which the drug/treatment was prescribed. It is provided in a free text format. Format: CE.2 = Indication free text Condition: <i>Scenario</i> =Medicines on discharge. Mandatory if the treatment was started during the patient current episode (ORC-5 = SC)

Chapter 23. RXR - Pharmacy/ Treatment Route Segment

The Pharmacy/Treatment Route segment contains the alternative combination of route, site, administration device, and administration method that are prescribed.

1. Segment definition

#	Name	Set	Description
01	Route	R	This field contains the route of administration. It is provided in a free text format. Format: CE.2 = Route free text description Req
02	Administration Site	O	This field contains the site of the administration route. It is provided in a free text format. Format: CWE.2 = Administration site free text description Req
04	Administration Method	O	This field identifies the specific method requested for the administration of the drug or treatment to the patient. It is provided in a free text format. Format: CWE.2 = Administration method free text description Req
05	Routing instruction	O	This field provides instruction on administration routing. It is provided in a free text format. Format: CE.2 = Routing instruction free text description Req

Chapter 24. SPM - Specimen

The intent of this segment is to describe the characteristics of a specimen; a specimen as a physical entity that is the target of an observation.

1. Segment definition

#	Name	Set	Description
01	Set ID – SPM	O	Identifier of each occurrence of the segment.
02	Specimen ID	O	<p>Specimen identifier assigned by placer or filler application</p> <p>Format: EIP.1.1=Placer Assigned Identifier</p> <p>EIP.1.2=Placer Application. <i>ValueList:</i> <u>User Table 0361 - Application</u></p> <p>EIP.2.1=Filler Assigned Identifier</p> <p>EIP.2.2=Filler Application. <i>ValueList:</i> <u>User Table 0361 - Application</u></p>
04	Specimen Type	R	<p>Describes the precise nature of the entity that will be the source material for the observation.</p> <p>Format: CWE.1=Source Code Req.if Scenario = Laboratory Testing Management</p> <p>CWE.2=Source Description</p> <p>CWE.3=Coding system. <i>ValueList:</i><u>User Table 0396 - Coding System</u> Req.if CWE.1 is not empty</p>
07	Specimen Collection Method	O	<p>Describes the procedure or process by which the specimen was collected.</p> <p>Format: CWE.1=Code</p> <p>CWE.2=Description</p> <p>CWE.3=Coding system. <i>ValueList:</i><u>User Table 0396 - Coding System</u> Req.if CWE.1 is not empty</p>
08	Specimen Source Site	O	<p>Specifies the source from which the specimen was obtained. For example, in the case where a liver biopsy is obtained via a percutaneous needle, the source would be 'liver.'</p> <p>Format: CWE.1=Code</p> <p>CWE.2=Description</p> <p>CWE.3=Coding system. <i>ValueList:</i><u>User Table 0396 - Coding System</u> Req.if CWE.1 is not empty</p>
10	Specimen Collection Site	O	<p>This field differs from 'SPM-8-Specimen Source Site' in those cases where the source site must be approached via a particular site (e.g., anatomic location). For example, in the case where a liver biopsy is obtained via a percutaneous needle, the collection site would be the point of entry of the needle. For venous blood collected from the left radial vein, the collection site could be "antecubital fossa".</p> <p>Format: CWE.1=Code</p>

#	Name	Set	Description
			CWE.2=Description CWE.3=Coding system. <i>ValueList:User Table 0396 - Coding System Req.if CWE.1 is not empty</i>
17	Specimen Collection Date/Time	O	The date and time when the specimen was acquired from the source Format: YYYYMMDDHHMM[SS]
26	Number of Specimen Containers	O	This field identifies the number of containers for a given sample.

Example 24.1. Sample SPM segment

```
SPM|1|^0300058301&DNLAB||90^Blood^L|||LNA^Line, Arterial^L|ARM^Arm^L||R^Right^L|||||
|20061128154000|||||||1
```

Chapter 25. TQ1 - Timing/Quantity

This segment determines the quantity, frequency, priority, and timing of a service.

1. Segment definition

#	Name	Set	Description
01	Set ID - TQ1	O	Identifier of each occurrence of the segment
02	Quantity	O	Quantity of required/supplied observation/treatment
03	Repeat pattern	OC..*	<p>The repeating frequency with which the treatment is to be administered.</p> <p>When the quantity timing specification must change to a different repeat pattern after some period of time, a new TQ1 segment must be used to show the new repeat pattern. Note that the end date of the current TQ1 will show when the current timing specification ends, and the start date of the next TQ1 shows when the new timing specification begins.</p> <p>Format: <i>Details to be defined</i></p> <p>Condition: <i>Scenario = Pharmacy/Treatment Management</i></p>
04	Explicit time	OC..*	<p>This field explicitly lists the actual times referenced by the code in TQ1-3.</p> <p>This field will be used to clarify the TQ1-3 in cases where the actual administration times vary within an institution. If the time of the service request spans more than a single day, this field is only practical if the same times of administration occur for each day of the service request. If the actual start time of the service request (as given by TQ1-7) is after the first explicit time, the first administration is taken to be the first explicit time after the start time. In the case where the patient moves to a location having a different set of explicit times, the existing service request may be updated with a new quantity/timing segment showing the changed explicit times.</p> <p>Format: <i>Details to be defined</i></p> <p>Condition: <i>Scenario = Pharmacy/Treatment Management</i></p>
05	Relative time and units	OC..*	<p>This field is used to define the interval between schedules for administrations.</p> <p>If this field contains a value, it overrides any value in the explicit time interval field. The units component of the CQ data type is constrained to units of time.</p> <p>Format: <i>Details to be defined</i></p> <p>Condition: <i>Scenario = Pharmacy/Treatment Management</i></p>
06	Service duration	OC	<p>It contains the duration for which the treatment is requested.</p> <p>Format: <i>Details to be defined</i></p> <p>Condition: <i>Scenario = Pharmacy/Treatment Management</i></p>
07	Start Date/Time	RC	<p>It indicates the earliest date/time at which the services/treatments should be started.^a</p> <p>Format: YYYYMMDD[HH[MM[SS]]]</p> <p>Condition: <i>Scenario <> Document Management</i></p>

#	Name	Set	Description						
08	End Date/Time	O	<p>This field contains the latest date/time that the service/treatment should be performed.^b</p> <p>Format: YYYYMMDD[HH[MM[SS]]]</p>						
09	Priority	OC	<p>This field describes the urgency of the request. If this field is blank, the default is R.</p> <p>Values: Table 25.1. User Table 0485 – Extended Priority Codes</p> <table border="1"> <tr> <td>S</td> <td>Emergency (highest priority)</td> </tr> <tr> <td>A</td> <td>Urgent (highest priority after S)</td> </tr> <tr> <td>R</td> <td>Routine</td> </tr> </table> <p>Condition: <i>Scenario</i> <> Pharmacy/Treatment Management</p>	S	Emergency (highest priority)	A	Urgent (highest priority after S)	R	Routine
S	Emergency (highest priority)								
A	Urgent (highest priority after S)								
R	Routine								
10	Condition Text	OC	<p>This is a free text field that describes the conditions under which the drug is to be given (e.g. "pain", or "to keep blood pressure below 110")</p> <p>Condition: <i>Scenario</i> = Pharmacy/Treatment Management</p>						
11	Text instruction	RC	<p>This field is a full text version of the instruction.</p> <p>Condition: If <i>Scenario</i> = Pharmacy/Treatment Management, and if none of the fields Repeat Pattern, Service Duration, Start Date/Time, End Date/Time are populated a free text instruction MUST be provided.</p>						
12	Conjunction	RC	<p>This field indicates that more TQ1 segment are to follow.</p> <p>Values: Table 25.2. HL7 Table 0472 - TQ Conjunction ID</p> <table border="1"> <tr> <td>S</td> <td> <p>Synchronous</p> <p>Do the next specification after this one (unless otherwise constrained by the following fields: <i>TQ1-7-start date/time</i> and <i>TQ1-8-end date/time</i>). An "S" specification implies that the second timing sequence follows the first</p> </td> </tr> <tr> <td>A</td> <td> <p>Asynchronous</p> <p>Do the next specification in parallel with this one (unless otherwise constrained by the following fields: <i>TQ1-7-start date/time</i> and <i>TQ1-8-end date/time</i>). The conjunction of "A" specifies two parallel instructions, as are sometimes used in medication, e.g., prednisone given at 1 tab on Monday, Wednesday, Friday, and at 1/2 tab on Tuesday, Thursday, Saturday, Sunday.</p> </td> </tr> <tr> <td>C</td> <td> <p>Actuation time</p> <p>It will be followed by a completion time for the service.</p> </td> </tr> </table> <p>Condition: If <i>Scenario</i> = Pharmacy/Treatment Management, and if the TQ1 segment is repeated in the message, this field MUST be populated with the appropriate Conjunction code indicating the sequencing of the following TQ1 segment.</p>	S	<p>Synchronous</p> <p>Do the next specification after this one (unless otherwise constrained by the following fields: <i>TQ1-7-start date/time</i> and <i>TQ1-8-end date/time</i>). An "S" specification implies that the second timing sequence follows the first</p>	A	<p>Asynchronous</p> <p>Do the next specification in parallel with this one (unless otherwise constrained by the following fields: <i>TQ1-7-start date/time</i> and <i>TQ1-8-end date/time</i>). The conjunction of "A" specifies two parallel instructions, as are sometimes used in medication, e.g., prednisone given at 1 tab on Monday, Wednesday, Friday, and at 1/2 tab on Tuesday, Thursday, Saturday, Sunday.</p>	C	<p>Actuation time</p> <p>It will be followed by a completion time for the service.</p>
S	<p>Synchronous</p> <p>Do the next specification after this one (unless otherwise constrained by the following fields: <i>TQ1-7-start date/time</i> and <i>TQ1-8-end date/time</i>). An "S" specification implies that the second timing sequence follows the first</p>								
A	<p>Asynchronous</p> <p>Do the next specification in parallel with this one (unless otherwise constrained by the following fields: <i>TQ1-7-start date/time</i> and <i>TQ1-8-end date/time</i>). The conjunction of "A" specifies two parallel instructions, as are sometimes used in medication, e.g., prednisone given at 1 tab on Monday, Wednesday, Friday, and at 1/2 tab on Tuesday, Thursday, Saturday, Sunday.</p>								
C	<p>Actuation time</p> <p>It will be followed by a completion time for the service.</p>								

^aIn DNLAB the field is filled with <dtmdataaccettazione>

^bRegardless of the value of the end date/time, the treatment should be stopped at the earliest of the date/times specified by either the duration or the end date/time.

Chapter 26. TXA - Transcription Document Header

The TXA segment contains information specific to the document but does not include the text of the document.

1. Segment definition

#	Name	Set	Description																														
01	Set ID - TXA	R	Identifier of each occurrence of the segment																														
02	Document Type	O	<p>This field identifies the type of document.</p> <p>Values: Values are driven by customer project specific needs; general values are listed in 0270 table below.</p> <p>Table 26.1. User Table 0270 - Document Type</p> <table border="1"> <thead> <tr> <th colspan="2"><i>Subset of HL7 values</i></th> </tr> </thead> <tbody> <tr> <td>DS</td> <td>Discharge Summary [IT: Lettera di dimissione]^a</td> </tr> <tr> <td>ED</td> <td>Emergency department report [IT: Verbale di Pronto Soccorso]^b</td> </tr> <tr> <td>OP</td> <td>Operative Report [IT: Verbale operatorio]</td> </tr> <tr> <td>TS</td> <td>Transfer Summary [IT: Lettera di trasferimento]</td> </tr> <tr> <td>CN</td> <td>Consultation</td> </tr> <tr> <th colspan="2"><i>NoemaLife custom values</i></th> </tr> <tr> <td>LAB</td> <td>Laboratory Department report^c</td> </tr> <tr> <td>MIC</td> <td>Microbiology report^d</td> </tr> <tr> <td>RAD</td> <td>Radiology Department report^e</td> </tr> <tr> <td>ANP</td> <td>Anatomic Pathology Department report^f</td> </tr> <tr> <td>AMB</td> <td>Ambulatory Referral^g</td> </tr> <tr> <td>EVN</td> <td>Evaluation Note^h</td> </tr> <tr> <td>MSC</td> <td>Medical Sickness Certificateⁱ</td> </tr> <tr> <td>PIC</td> <td>Pathology Information Collection Report^j (report used to collect specific clinical data for a pathology)</td> </tr> </tbody> </table> <p>^aCodice CRS-SISS: 05 ^bCodice CRS-SISS: 04 ^cCodice CRS-SISS: 02; Codice SOLE: LAB ^dCodice CRS-SISS: 02; Codice SOLE: MIC ^eCodice CRS-SISS: 03; Codice SOLE: RAD ^fCodice CRS-SISS: 02 ^gCodice CRS-SISS: 01; Codice SOLE: SPS ^hCodice CRS-SISS: 08 ⁱCodice CRS-SISS: 16 ^jCodice CRS-SISS: 14</p>	<i>Subset of HL7 values</i>		DS	Discharge Summary [IT: Lettera di dimissione] ^a	ED	Emergency department report [IT: Verbale di Pronto Soccorso] ^b	OP	Operative Report [IT: Verbale operatorio]	TS	Transfer Summary [IT: Lettera di trasferimento]	CN	Consultation	<i>NoemaLife custom values</i>		LAB	Laboratory Department report ^c	MIC	Microbiology report ^d	RAD	Radiology Department report ^e	ANP	Anatomic Pathology Department report ^f	AMB	Ambulatory Referral ^g	EVN	Evaluation Note ^h	MSC	Medical Sickness Certificate ⁱ	PIC	Pathology Information Collection Report ^j (report used to collect specific clinical data for a pathology)
<i>Subset of HL7 values</i>																																	
DS	Discharge Summary [IT: Lettera di dimissione] ^a																																
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MSC	Medical Sickness Certificate ⁱ																																
PIC	Pathology Information Collection Report ^j (report used to collect specific clinical data for a pathology)																																
03	Document Content Presentation	R	<p>Document content MIME Type.</p> <p><i>Note:</i> Here we follow HL7 2.7.1 specifications, and use HL7 table 0834 (containing MIME Types) instead of 0191.</p>																														

#	Name	Set	Description														
			<p>Values: Table 26.2. HL7 Table 0834 - Type Of Data (MIME Types)</p> <table border="1"> <tr> <td>application</td> <td>Application data</td> </tr> <tr> <td>audio</td> <td>Audio data</td> </tr> <tr> <td>image</td> <td>Image data</td> </tr> <tr> <td>multipart</td> <td>MIME multipart package ^a</td> </tr> <tr> <td>model</td> <td>Model data (RFC 2077)</td> </tr> <tr> <td>video</td> <td>Video data</td> </tr> <tr> <td>text</td> <td>Text data</td> </tr> </table> <p>^aPreferred value for CRS-SISS</p>	application	Application data	audio	Audio data	image	Image data	multipart	MIME multipart package ^a	model	Model data (RFC 2077)	video	Video data	text	Text data
application	Application data																
audio	Audio data																
image	Image data																
multipart	MIME multipart package ^a																
model	Model data (RFC 2077)																
video	Video data																
text	Text data																
06	Origination Date/Time	O	<p>This field contains the date and time when the document was created</p> <p>Format: YYYYMMDDHHMM[SS]</p>														
09	Originator Code/Name	R.*	<p>Person who created the document (author)</p> <p>Note</p> <p>It is possible to use more than one repetition of the field, but information in each repetition MUST be related to the same doctor. Multiple repetitions MUST be used only to transmit <u>different identifiers</u> (ex. national identifier, regional identifier, local identifier, ecc.) of the <u>same doctor</u>; each repetition and its identifier MUST be clearly qualified according to the rules exposed below.</p> <p>Format: XCN.1= Person identifier of document creator (author) Req.</p> <p>XCN.2=Surname. Req.</p> <p>XCN.3=Forename. Req.</p> <p>XCN.13=Type of identifier specified in XCN.1. Req.</p> <table border="1"> <tr> <td>PI</td> <td>Person identifier assigned by MPI (Master Patient Index)</td> </tr> <tr> <td colspan="2">Loc ITA</td> </tr> <tr> <td>NNITA</td> <td>Codice Fiscale</td> </tr> <tr> <td>RRI</td> <td>Regional identifier</td> </tr> <tr> <td>LR</td> <td>Local identifier</td> </tr> </table> <p>(Ref <u>HL7 Table 0203 - Identifier Type: IT</u>)</p> <p>Note</p> <p>This field MUST be used to transmit only the document creator (author). If existing, other actors involved in document life-cycle (e.g. legal authenticator) MUST be specified in TXA-22.</p>	PI	Person identifier assigned by MPI (Master Patient Index)	Loc ITA		NNITA	Codice Fiscale	RRI	Regional identifier	LR	Local identifier				
PI	Person identifier assigned by MPI (Master Patient Index)																
Loc ITA																	
NNITA	Codice Fiscale																
RRI	Regional identifier																
LR	Local identifier																
12	Unique Document Number	R	<p>This field contains the unique document identification numbers.</p> <p>In case that more than one document is transmitted in OBX segments, the field is used for the document identification numbers of the <i>main</i> document.</p>														

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#	Name	Set	Description						
			<p>Format: EI.1= document identifier assigned by the <i>system that generated the document Req</i></p> <p>EI.3= document identifier assigned by the <i>Document Repository actor</i></p>						
13	Parent Document Number	RC	<p>This field contains a document number that identifies the parent document to which this document applies.</p> <p>Format: EI.1= identifier of parent document assigned by the sending system Req</p> <p>EI.3= identifier of parent document assigned by the Document Repository actor</p> <p>Conditions: <i>Event</i> in (Replacement Document Notification, Cancel Document Notification)</p>						
14	Placer Order Number	OC	<p>Identifier of the Order that originated the document (Placer Order).</p> <p>Since under some circumstances there may be differences between Placer Order Number and Placer Group Number, in those cases it is REQUIRED to transmit the Placer Group Number (having higher relevance).</p> <p>Format: EI.1= Placer Order Number/Placer Group Number</p> <p>EI.2 = Code of Order Placer application. <i>ValueList: User Table 0361 - Application</i></p> <p>Conditions: The Document has been originated by an Order (e.g. Documents from Diagnostic systems)</p>						
15	Filler Order Number	RC	<p>Filler Order Number of the Order that originated the document</p> <p>Format: EI.1= Filler Order Number Loc DNLAB: format <bytidlab>-<stridrichiesta>-<dtmdataaccettazione, YYYYMMDDHHMM> is REQUIRED</p> <p>EI.2 = Code of Order Filler application. <i>ValueList: User Table 0361 - Application</i></p> <p>Conditions: The Document has been originated by an Order (e.g. Documents from Diagnostic systems)</p>						
16	Unique Document File Name	OC	<p>This field is used to communicate the Document URI if the document is stored at an external Registry/Repository (e.g. Document URI on CRS-SISS Regional Document Registry)</p> <p>Conditions: Event=Document Status Change Notification (T03)</p>						
17	Document Completion Status	R	<p>This field identifies the current completion status of the document</p> <p>Values: Table 26.3. User Table 0271 - Document Completion Status</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tbody> <tr> <td>IP</td> <td>In Progress [ITA: documento in bozza]</td> </tr> <tr> <td>AU</td> <td>Authenticated [ITA: documento validato ma non firmato digitalmente]</td> </tr> <tr> <td>LA</td> <td>Legally Authenticated [ITA: documento firmato digitalmente]</td> </tr> </tbody> </table>	IP	In Progress [ITA: documento in bozza]	AU	Authenticated [ITA: documento validato ma non firmato digitalmente]	LA	Legally Authenticated [ITA: documento firmato digitalmente]
IP	In Progress [ITA: documento in bozza]								
AU	Authenticated [ITA: documento validato ma non firmato digitalmente]								
LA	Legally Authenticated [ITA: documento firmato digitalmente]								

#	Name	Set	Description															
20	Document Storage Status	RC	<p>The field is used to carry the Document Storage Status, or the result/outcome of the notification/status change if there was an error. The type of notification is defined in the EVN.4</p> <p>Values: Table 26.4. HL7 Table 0275 - Document Storage Status</p> <table border="1" style="width: 100%;"> <tr> <td>AC</td> <td>Active</td> </tr> <tr> <td>AA</td> <td>Active and Archived</td> </tr> <tr> <td>AR</td> <td>Archived</td> </tr> <tr> <td>PU</td> <td>Purged</td> </tr> <tr> <td colspan="2"><i>NoemaLife custom values</i></td> </tr> <tr> <td><ExtSystem>-OK</td> <td>Notification to the External System (code <ExtSystem>) was successful. <i>Example: "SISS-OK" means "successful notification to SISS external system".</i></td> </tr> <tr> <td><ExtSystem>-<errorCode></td> <td>Notification to the External System (code <ExtSystem>) was unsuccessful with error code <errorCode></td> </tr> </table> <p>Conditions <i>Event = Document Status Change Notification (T03)</i></p>	AC	Active	AA	Active and Archived	AR	Archived	PU	Purged	<i>NoemaLife custom values</i>		<ExtSystem>-OK	Notification to the External System (code <ExtSystem>) was successful. <i>Example: "SISS-OK" means "successful notification to SISS external system".</i>	<ExtSystem>-<errorCode>	Notification to the External System (code <ExtSystem>) was unsuccessful with error code <errorCode>	
AC	Active																	
AA	Active and Archived																	
AR	Archived																	
PU	Purged																	
<i>NoemaLife custom values</i>																		
<ExtSystem>-OK	Notification to the External System (code <ExtSystem>) was successful. <i>Example: "SISS-OK" means "successful notification to SISS external system".</i>																	
<ExtSystem>-<errorCode>	Notification to the External System (code <ExtSystem>) was unsuccessful with error code <errorCode>																	
21	Document Change Reason	R	<p>This field contains the reason for document status change.</p> <p>If Event= Document Status Change Notification, it may contain an error description associated to a failed event notification (e.g. error description for a Legal Timestamp generation failure).</p> <p>Values:</p> <table border="1" style="width: 100%;"> <thead> <tr> <th><i>Value</i></th> <th><i>Condition</i></th> <th></th> </tr> </thead> <tbody> <tr> <td>OR</td> <td><i>Event = Original Document</i>⁰¹</td> <td></td> </tr> <tr> <td>RP</td> <td><i>Event = Replacement Document</i>⁰²</td> <td></td> </tr> <tr> <td>CA</td> <td><i>Event = Cancel Document</i>⁰³</td> <td></td> </tr> <tr> <td><error description></td> <td><i>Event = Document Status Change Notification</i></td> <td></td> </tr> </tbody> </table> <p>⁰¹Codice CRS-SISS: "01" (Standard) ⁰²Codice CRS-SISS: "03" (Sostitutivo) ⁰³Codice CRS-SISS: "04" (Annullativo)</p>	<i>Value</i>	<i>Condition</i>		OR	<i>Event = Original Document</i> ⁰¹		RP	<i>Event = Replacement Document</i> ⁰²		CA	<i>Event = Cancel Document</i> ⁰³		<error description>	<i>Event = Document Status Change Notification</i>	
<i>Value</i>	<i>Condition</i>																	
OR	<i>Event = Original Document</i> ⁰¹																	
RP	<i>Event = Replacement Document</i> ⁰²																	
CA	<i>Event = Cancel Document</i> ⁰³																	
<error description>	<i>Event = Document Status Change Notification</i>																	
22	Authentication Person, Time Stamp	RC.*	<p>This field contains a set of components describing by whom and when authentication was performed (either manually or electronically).</p> <p>This field is repeatable in order to specify different kinds of authentications, identified by component PPN.17.</p> <p>Format:</p> <p>PPN.1 = Identifier of Validator/Authenticator person Req. if (PPN-17 <> TIMESTAMP)</p> <p>PPN.2 = Surname. Req. if (PPN-17 <> TIMESTAMP)</p> <p>PPN.3 = Forename. Req. if (PPN-17 <> TIMESTAMP)</p> <p>PPN.13 = Type of identifier specified in PPN.1. <i>ValueList:</i> <see below> Req. if (PPN-17 <> TIMESTAMP)</p>															

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#	Name	Set	Description																				
			<table border="1"> <tr> <td>PI</td> <td>Person identifier assigned by MPI</td> </tr> <tr> <td colspan="2">Loc ITA</td> </tr> <tr> <td>NNITA</td> <td>Codice Fiscale ⁰⁴</td> </tr> <tr> <td>RRI</td> <td>Regional identifier</td> </tr> <tr> <td>LR</td> <td>Local identifier</td> </tr> </table> <p>⁰⁴Required value for CRS-SISS</p> <p>(Ref HL7 Table 0203 - Identifier Type: IT)</p> <p>PPN.15 = Date/Time Action Performed <i>Format</i>: YYYYMMDDHHMM[SS] Req.</p> <p>PPN.17 = Type of authentication <i>ValueList</i>: <see below>. Req.</p> <table border="1"> <thead> <tr> <th>Value</th> <th>Meaning</th> </tr> </thead> <tbody> <tr> <td>AU</td> <td>Identifies the repetition containing data related to Authentication of clinical document <i>Note</i>: may apply if TXA-17 in (AU, LA). <i>Note</i>: "AU" and "LA" repetitions may coexist, since theoretically the person clinically validating the document and legally authenticating it may differ.</td> </tr> <tr> <td>LA</td> <td>Identifies the repetition containing data related to Legal Authentication of clinical document <i>Note</i>: applies only if TXA-17=LA</td> </tr> <tr> <td>PRIVACY</td> <td>Identifies the repetition containing data related to Legal Authentication of Privacy Document attachment [ITA: documento DAO per CRS-SISS] <i>Note</i>: applies only if TXA-17=LA</td> </tr> <tr> <td>TIMESTAMP</td> <td>Identifies the repetition containing data related to document's Legal Timestamp [ITA: Marca temporale] <i>Note</i>: applies only if TXA-17=LA</td> </tr> </tbody> </table> <p>Conditions: TXA-17 in (AU, LA)</p>	PI	Person identifier assigned by MPI	Loc ITA		NNITA	Codice Fiscale ⁰⁴	RRI	Regional identifier	LR	Local identifier	Value	Meaning	AU	Identifies the repetition containing data related to Authentication of clinical document <i>Note</i> : may apply if TXA-17 in (AU, LA). <i>Note</i> : "AU" and "LA" repetitions may coexist, since theoretically the person clinically validating the document and legally authenticating it may differ.	LA	Identifies the repetition containing data related to Legal Authentication of clinical document <i>Note</i> : applies only if TXA-17=LA	PRIVACY	Identifies the repetition containing data related to Legal Authentication of Privacy Document attachment [ITA: documento DAO per CRS-SISS] <i>Note</i> : applies only if TXA-17=LA	TIMESTAMP	Identifies the repetition containing data related to document's Legal Timestamp [ITA: Marca temporale] <i>Note</i> : applies only if TXA-17=LA
PI	Person identifier assigned by MPI																						
Loc ITA																							
NNITA	Codice Fiscale ⁰⁴																						
RRI	Regional identifier																						
LR	Local identifier																						
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TIMESTAMP	Identifies the repetition containing data related to document's Legal Timestamp [ITA: Marca temporale] <i>Note</i> : applies only if TXA-17=LA																						
23	Distributed Copies	RC..*	<p>Loc ITA: L'utilizzo corrente del campo è limitato ad identificare la "struttura di conservazione del documento" (informazione richiesta dal progetto CRS-SISS)</p> <p>Format: XCN.1= Codice Azienda Ospedaliera. Req. XCN.2= Descrizione Azienda Ospedaliera XCN.13 = FI ⁰⁵Req.</p>																				

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#	Name	Set	Description
			Conditions: <i>Loc=CRS-SISS</i>

^aCodice CRS-SISS: 05

^bCodice CRS-SISS: 04

^cCodice CRS-SISS: 02; Codice SOLE: LAB

^dCodice CRS-SISS: 02; Codice SOLE: MIC

^eCodice CRS-SISS: 03; Codice SOLE: RAD

^fCodice CRS-SISS: 02

^gCodice CRS-SISS: 01; Codice SOLE: SPS

^hCodice CRS-SISS: 08

ⁱCodice CRS-SISS: 16

^jCodice CRS-SISS: 14

^aPreferred value for CRS-SISS

⁰¹Codice CRS-SISS: "01" (Standard)

⁰²Codice CRS-SISS: "03" (Sostitutivo)

⁰³Codice CRS-SISS: "04" (Annullativo)

⁰⁴Required value for CRS-SISS

⁰⁵FI=Facility Identifier.

Loc CRS-SISS

Differenze più significative nell'utilizzo di TXA rispetto alle specifiche del progetto CRS-SISS:

Campo	CRS-SISS	Specifiche NoemaLife
Creatore del documento	TXA-11; XCN-13 = COMPILATORE	TXA-9
Autenticatore (firmatario)	PV1-8; XCN-13 = REFERTANTE	TXA-22, PPN.17=LA
Autorizzante	PV1-8; XCN-13 = AUTORIZZANTE	TXA-22, PPN.17=PRIVACY

Chapter 27. ZET - Local Attribute Table

The intent of this segment is to convey custom informations.

Currently ZET segment is used in the Laboratory Placer Order Management, to convey labels informations from the Order Filler to the Order Placer. Each ZET segment contains informations for one label printout.

1. Segment definition

1.1. ZET for Lis Placer Order Management

#	Name	Set	Description
01	StrIdCampEtichetta	R	Specimen identifier (for barcode printing)
02	StrDescrEtichetta	R	Label description
03	StrIdContenitore	O	Identifier of container
04	StrSiglaContenitore	O	Code of container
05	StrNotePrelievo	O	Notes for specimen collection
06	BytIdLab	R	Laboratory Identifier
07	StrIdRichiesta	R	Filler order number
08	DtmDataAccettazione	R	Date of order
09	BytLivelloUrgenza	R	Order priority
10	StrIdPaziente	R	Patient identifier
11	StrCognome	R	Patient surname
12	StrNome	R	Patient name
13	StrSesso	R	Patient sex
14	DtmDataNascita	R	Patient Date of Birth
15	StrCodiceFiscale	O	Patient Tax Code
16	StrCodiceSanitario	O	Patient SSN
17	StrIdRepartoRich	R	Identifier of ordering facility (i.e.Ward, Ambulatory)
18	StrNomeReparto	R	Name of ordering facility
19	StrIdPuntoAccettazione	R	Identifier of ordering location
20	StrIdMateriale	R	Specimen Source code
21	StrIdProvenienza	O	Specimen Source Site
22	MemElencoAnalisi	R	List or required tests
23	StrIdSettore	R	Identifier of Laboratory sector in charge of the observation
24	StrNomeSettore	R	Name of Laboratory sector in charge of the observation
25	DtmDataOraPrelievo	R	Date/Time when the specimen is to be collected. Format: YYYYMMDDHHMM
26	DtmDataConsegnaReferto	R	Date/Time when the order is expected to be reported. Format: YYYYMMDDHHMM

External References

Corporate Documents

- [BPSDP] *Software Development Process*. Blueprints. Federico Lelli, Nicolò Dé Faveri Tron, Raffaella Tibaldi, Michele Carenini, Davide Distefano, Paolo Apparuti, and Tommaso Sansoni. <http://distro.noemalife.loc/projects/devspecs/1.0.0/docs/html/sdp.html> .
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- [NL-HL7-IP-UC] *NoemaLife HL7 Integration Policy*. Use Cases and Integration Scenarios. Davide Musiani and Francesco Masotti. <http://distro.noemalife.loc/projects/legacyproductsintegrations/HEAD/docs/html/nl-hl7-ip-usecases.html> .
- [NL-HL7-IP-MSG] *NoemaLife HL7 Integration Policy*. HL7 2.5 Segments Definition. Davide Musiani and Francesco Masotti. <http://distro.noemalife.loc/projects/legacyproductsintegrations/HEAD/docs/html/nl-hl7-ip-hl725msg.html> .
- [SDK] *NoemaLife Software Development Kit*. SDK Usage documentation. . <http://distro.noemalife.loc/projects/sdk/HEAD/docs/html/usage.html> .
- [LPI-CONFLUENCE] *Legacy Products Integrations project - Confluence home page*. . Davide Musiani. <http://confluence.noemalife.loc/display/ATI/Legacy+Products+Integrations> .

Internet Resources

- [RFC-2119] *Key words for use in RFCs to Indicate Requirement Levels*. RFC 2119. S. Bradner. Copyright © 1997. <http://www.ietf.org/rfc/rfc2119.txt> .

Standards

- [IHE-ITI-TF] *IHE Technical Framework*. IT Infrastructure (rev. 8.0). . Copyright © 2011. http://www.ihe.net/Technical_Framework/index.cfm#IT .
- [IHE-ITI-LTF] *IHE Technical Framework*. Laboratory Technical Framework (rev. 2.1). . Copyright © 2008. http://www.ihe.net/Technical_Framework/index.cfm#laboratory .
- [IHE-RAD-TF_v10] *IHE Technical Framework*. Radiology Technical Framework (rev. 10.0). . Copyright © 2011. http://www.ihe.net/Technical_Framework/index.cfm#radiology .
- [IHE-RAD-TF_v11] *IHE Technical Framework*. Radiology Technical Framework (rev. 11.0). . Copyright © 2012. http://www.ihe.net/Technical_Framework/index.cfm#radiology .
- [CRS-SISS-HL7] *Integrazioni interne tra sistemi dipartimentali delle Aziende Sanitarie tramite protocollo HL7*. Ver.9.1. . Copyright © 2012. <http://www.siss.regione.lombardia.it/EdmaSissPortaleSitoWeb/documentoDiProgetto.do?doc=15796627> .