UHIN STANDARDS COMMITTEE
Version 2.0
Discharge Summary Standard
Effective 03/04/2009

UHIN *Discharge Summary Standard* is compatible with all HL7 version 2.3 message standards.

Purpose
This Standard is an implementation guide providing the message framework of Discharge Summary messages based on the HL7 version 2.3 Standard for Discharge Summary messages exchanged in the State of Utah.

The details of the Discharge Summary message can be found in Appendices A, B and C.

Applicability
This standard is applicable to Health Care providers, Laboratories and Third Party Payers as defined by Utah Code Annotated R380-70.

Basic Concepts
- A sender will create an HL7 version 2.3 Discharge Summary message.
- The sender will send the HL7 version 2.3 Discharge Summary message to the identified receiver.
- The receiver will follow the HL7 Acknowledgement and Error Status Standard to send the applicable acknowledgment and/or error status response back to the sender who submitted the HL7 version 2.3 Discharge Summary message.

Detail
This structure provides an overview of the HL7 segment usage (e.g. repetitions, optional) used in this Standard.

Braces { } = Indicate one or more repetitions of the enclosed group of segments
Brackets [ ] = Show that the enclosed group of segments is optional.

MDM (See MSH-9.2 trigger event)	Medical Document Management	HL7 Standard Chapter
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
PV1	Patient Visit	3
TXA	Document Notification	9
{		
OBX	Observation/Result (one or more required)	7
}		

Discharge Summaries are currently exchanged using a variety of methods (e.g. fax, mail, proprietary specific systems, etc) and formats. This document standardizes HL7 version 2.x formatted discharge summaries for use in electronic exchanges of discharge summaries between entities in the State of Utah.

Implementation Issues

- **General:**
  - UHIN trading partners will follow the UHIN standard connection documents (SOAP over HTTPS when exchanging laboratory results via the UHIN gateway. Trading partners not exchanging through UHIN will need to negotiate the connectivity requirements.
  - Senders/Receivers must have an HL7 translator or use a third-party software tool (e.g. UHINt) to create and/or receive HL7 version 2.3 Discharge Summary messages.

- **Senders:**
  - A sender will communicate their desire to exchange an intended HL7 version 2.3 Discharge Summary message to the receiver, prior to the first exchange of data.
- **Receivers:**
  - A receiver is able to receive the intended HL7 version 2.3 Discharge Summary message from the sender.

Implementation Date

- The implementation date of this standard will be September 2009.

History: (MM/DD/YY)

	Original	A* 1	A 2	A3	A 4	A 5	A 6
ORIGINATION DATE	07/11/2006		08/14/2008				
APPROVAL DATE	02/07/2007		02/04/2009				
EFFECTIVE DATE	03/07/2007		03/04/2009				

* A = Amendment

Discharge Summary Standard Contents

Appendix A – Basic Definitions

Basic Definitions

- **Data Type (DT)** – The basic building block used to construct or restrict the contents of a data field.
  - CE – Coded element.
  - CK – Composite ID with check digit.
  - CM – Composite
  - CN – Composite ID number and name.
  - DT – Date, Date/time YYYYMMDD
  - FN – Family name
  - FT – Formatted text
  - ID – Coded values for HL7 tables, all components are a ST data type
  - IS – Coded value for user-defined table.
  - PN – person name
  - SI – Sequence ID. A positive integer in the form of an NM field.
  - ST – String, alphanumeric.
  - TQ – Timing/quantity
  - TS – Times stamp, date/time. Exact time if the event, including date/time.
  - TX – Text data
- **Element/Field** – A string of characters, see SEQ.
- **Health Level 7 (HL7[1]) –** HL7 is a Standards Development Organization (SDO) and focuses on the interface requirements between healthcare information systems.
- **Maximum Length (LEN**) – Maximum number of characters that one occurrence of the data field may occupy.
- **Optionality (OPT)** – Whether the field is required, optional, or conditional in a segment.
  - **R** – Required
  - **O** – Optional
  - **C** – Conditional
- **Position (Sequence within the segment, SEQ)** – See SEQ.
- **Repetition (RP#) –** Whether the field may repeat.
  - **N or blank –** No repetition
  - **Y –** The field may repeat an indefinite or site-determined number of times.
  - **(integer) –** The field may repeat up to the number of times specified by the integer.
- **Segment –** A logical grouping of fields (e.g. MSH, PID, PV1, OBX).
- **SEQ**– Ordinal position of the data field within the segment. This number is used to refer to the data field in the text comments that follow the segment definition table.
- **Table (TBL#) –** The table attribute of the data field definition specifies the HL7 identifier for a set of coded values.
- **Delimiter values**

Delimiter	Suggested Value	Encoding Character Position	Usage
Segment Terminator	<CR>	-	Terminates a segment record. This value cannot be changed by implementers
Field Separator	|	-	Separates two adjacent data fields within a segment. It also separates the segment ID from the first data field in each segment
Component Separator	^	1	Separates adjacent components of data fields where allowed
Subcomponent Separator	&	4	Separates adjacent subcomponents of data fields where allowed. If there are no subcomponents, this

[1] HL7 refers to the application level of the ISO/OSI model http://www.hl7.org/

Delimiter	Suggested Value	Encoding Character Position	Usage
			character may be omitted.
Repetition Separator	~	2	Separates multiple occurrences of a field where allowed
Escape Character	\	3	Escape character for use with any field represented by an ST, TX or FT data type, or for use with the data (fourth) component of the ED data type. If no escape characters are used in a message, this character may be omitted. However, it must be present if subcomponents are used in the message.

Appendix B – Attribute Table

These tables list and describe the data fields in the segment and characteristics of their usage.

Table 1 - HL7– MSH – Message Header

(Please reference HL7 Header and Trailer Specification
for those fields not addressed below)

For column table heading definitions, see Appendix A – Basic Definitions

Example:
MSH| ^~\&| |9999| |1111|20060126130405| |**MDM^T02**|20060126130405|P|**2.3**| | |ER

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element	Comments
9	13	CM	R			00009	Message Type	Composite
9.1		ID	R				Message Type	Use “MDM”
9.2		ID	R				Trigger Event	Use one of the following trigger events- “T02” Original document notification and content. **OR** “T06” Document addendum notification and content. **OR** “T10 Document replacement notification and content
12	8	CM	R			00012	Version ID	Composite
12.1		ID	R				Version ID	Use “2.3”

Table 2 - HL7 – EVN – Event Type

For column table heading definitions, see Appendix A – Basic Definitions

Example:
EVN| |20060126130405 | | | | |

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element	Comments
1	3	ID	B			00099	Event Type Code	This field is for backward compatibility only. See MSH-9.2 allowable “trigger event(s)”
2	26	TS	R			00100	Recorded Date/Time	
3	26	TS	O			00101	Date/Time Planned Event	
4	3	IS	O		0062	00102	Event Reason Code	Table 12
5	60	XCN	O			00103	Operator ID	
6	26	TS	O			01278	Event Occurred	

Table 3 - HL7 – PID – Patient Identification Segment

For column table heading definitions, see Appendix A – Basic Definitions

Example:
PID|1| |123456| |SMITH^JOHN^^JR| |19650201|M| | | | | | | | | | | | | | | | | | | | |

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
1	4	SI	O	[0..1]		00104	Set ID – PID	This states the number of PID records
2			N/A			00105	Patient ID (external ID)	Not used at this time for HL7 Discharge Summary Message(s)
3	20	CM	R	[1..*]		00106	Patient ID (Internal ID)	Composite This includes the provider patient identification number and/or the attachment control number (see 3.5).
3.1		ST	R				ID Number	The ID number for the 3.5 qualifier.
3.2			N/A					
3.3			N/A					
3.4			R				Assigning Authority	Refers to the source organization or enterprise
3.4.1			R				Namespace ID	Identifier to be defined by trading partner
3.4.2			O				Universal ID	
3.4.3			O				Universal ID Type	

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
3.5			R				Identifier Type Code	Provider patient identification number(s) values are limited to at least one identifier are required. **"MR"** - Medical Record Number. **"NI"** - National unique individual identifier **"NNxxx"** – National person identifier **"PI"** – Patient internal identifier **"PN"** – Person number; **OR** **"PT"** - Patient external identifier". **If used as a "Unsolicited Claim Attachment"**, the Claim Attachment Identifier Type is also required. *The following value is also required if sending this message as a unsolicted attachment to a payer:* **"ACN"** – Attachment Control Number (The PWK06 in the X12 837 or 278 transaction).
3.6			R				Assigning facility	Refers to the facility within the organization or enterprise (only needed if ID is facility specific).
3.6.1			R				Namespace ID	Identifier to be defined by trading partner
3.6.2			O				Universal ID	
3.6.3			O				Universal ID Type	

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
4			C	[1..*]		00107	Alternative Patient ID – PID	Required if sending this message as an attachment to a payer. This includes the payer patient identification number and/or the payer transaction number (see 4.5).
4.1		ST	R				ID Number	The ID number for the 4.5 qualifier.
4.2			N/A					
4.3			N/A					
4.4			C				Assigning Authority	Payer Organization Name
4.4.1			C				Namespace ID	Identifier to be defined by trading partner Required if data is present in PID-4.1
4.4.2			O				Universal ID	
4.4.3			O				Universal ID Type	

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
4.5			C				Identifier Type Code	***Claim Attachment Patient Identifier Type:*** *The following value is required in this field if sending this message as an attachment to a payer.* *At least one of the following payer patient identifier values are required:* **"SN"** (Subscriber number); **"MA"** (Patient Medicaid number) or **"MC"** (Patient Medicare number) ***Solicited Attachment Identifier Type:*** *The following value is* also *required in this field, if sending this message as a solicited attachment to a payer based on a request from the payer (e.g. for* ***solicited claims*** *OR* ***solicited prior authorizations)***: **"ICN"** – Payer Control Number (The TRN02 in the X12 277 or 278 transaction). Required if data is present in PID-4.1
5	48	PN	R	[0..1]		00108	Patient Name	Composite It is recommended that the patient name follow UHIN Individual Name Standard
5.1		FN	R				Family Name	Required that something is placed in this field even with anonymous patients
5.2		ST	O				Given Name	Recommend use, if available

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
5.3		ST	O				Second and further given names or initials thereof	Recommend use, if available
5.4		ST	O				Suffix	Recommend use, if available
5.5		ST	O				Prefix	
5.6		ST	O				Degree	
5.7		ID	O				Name Type Code	
6			N/A				Mothers Maiden Name	Not used at this time for HL7 Discharge Summary Message(s)
7	26	CM	O	[0..1]		00110	Date/Time of Birth	Composite.
7.1		TS	O				Date only format “CCYYMMDD”	Recommend use, if available
8	1	ID	R	[0..1]	0001	000111	Sex	See table 10
9 thru 17			N/A					Not used at this time for HL7 Discharge Summary Message(s)
18		CK	O				Patient Account Number	
19 thru 30			N/A					Not used at this time for HL7 Discharge Summary Message(s)

Table 4 - HL7 - PV1 - Patient Visit Segment

For column table heading definitions, see Appendix A – Basic Definitions

Example:
PV1|||||||||||||||||||123456|||||||||||||||||01|||||||200602041820|200602060510|||||||

Position (Sequence within the segment)- Ordinal position of the data field within the segment. This number is used to refer to the data field in the text comments that follow the segment definition table. In the segment attribute tables this information is provided in the column labeled SEQ.

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
1	4	SI	O			00131	Set ID – PV1	
2	1	ID	O		0004	00132	Patient Class	See table 11
3			N/A					Not used at this time for HL7 Discharge Summary Message(s)
4	2	IS	O		0007	00134	Admission Type	Recommend use, if available
5 thru 6			N/A					Not used at this time for HL7 Discharge Summary Message(s)
7	60	CN	C			00137	Attending Doctor	Required if there is an attending doctor
7.1			R				ID Number	The ID number for the 7.13 qualifier. **Note:** The ID number is the NPI
7.2		FN	R				Family Name	
7.3		ST	R				Given Name	
7.4		ST	O				Second and further given names or initials thereof	Recommend use, if available
7.5		ST	O				Suffix	Recommend use, if available
7.6		ST	O				Prefix	
7.8 thru 7.12			N/A					
7.13		ID	R				Identifier Type Code	Value is limited to: **"NPI"** (National Provider Identifier)
8			N/A				Referring	Not used at this time for

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
							Doctor	HL7 Discharge Summary Message(s)
9	60	CN	C	Y	0010	00139	Consulting Doctor	Required if there is a consulting doctor See table 12
9.1			R				ID Number	If PV1-9 is populated, this element is required The ID number for the 9.13 qualifier. **NOTE:** The ID number is the NPI.
9.2		FN	R				Family Name	
9.3		ST	R				Given Name	
9.4		ST	O				Second and further given names or initials thereof	Recommend use, if available
9.5		ST	O				Suffix	Recommend use, if available
9.6		ST	O				Prefix	
9.8 thru 9.12			N/A					
9.13		ID	C				Identifier Type Code	If PV1-9.1 is populated, this element is required Value is limited to: **"NPI"** (National Provider Identifier)
10 thru 18			N/A					Not used at this time for HL7 Discharge Summary Message(s)
19	15	NM	R			00149	Visit Number	This can also be the encounter #
20 thru 35			N/A					Not used at this time for HL7 Discharge Summary Message(s)
36	3	ID	R		0112	00166	Discharge Disposition	See table 14
37 thru 43			N/A					Not used at this time for HL7 Discharge Summary Message(s)

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
44	26	TS	R			00174	Admit Date/Time	Use "CCYYMMDDHHMM"
45	26	TS	R			00174	Discharge Date/Time	Use "CCYYMMDDHHMM"
46 thru 52			N/A					Not used at this time for HL7 Discharge Summary Message(s)

Table 5 - HL7 – TXA – Transcription Document Header Segment

For column table heading definitions, see Appendix A – Basic Definitions

Example:
TXA|1|DS|TX|200602060510|Smith M.D., John|20060206| | | | |1234568| | | | |AU| | | |Smith M.D., John^200605100430| |

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
1	4	SI	R			00914	Set ID – Document	
2	30	IS	R		0270	00915	Document Type	Allowed document type value: **"DS"** = Discharge Summary Table 17
3	2	ID	C		0191	00916	Document content Presentation	Allowable document referenced data include: "TX" = text data **OR** "FT" = formatted text. See table 16
4	26	TS	R			00917	Activity Date/Time	This is the date of the activity/encounter.
5	60	XCN	R			00918	Primary Activity Provider Code/Name	This is the person identified in the document as being responsible for performing the activity (See TXA-4).
5.1			C				ID Number	The ID number for the 5.13 qualifier. **NOTE:** The ID number is the NPI.
5.2		FN	R				Family Name	
5.3		ST	R				Given Name	
5.4		ST	O				Second and further given names or initials thereof	Recommend use, if available
5.5		ST	O				Suffix	Recommend use, if available

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
5.6		ST	O				Prefix	
5.8 thru 5.12			N/A					
5.13		ID	C				Identifier Type Code	Values are limited: **"NPI"** **NOTE:** Value is limited to: **"NPI"** (National Provider Identifier)
6	26	TS	R			00919	Origination Date/Time	CCYYMMDD Time (HHMM) is optional
7	26	TS	O			00920	Transcription Date/Time	
8	26	TS	O			00921	Edit Date/Time	
9	60	XCN	O			00922	Originator Code/Name	
10	60	XCN	O	Y		00923	Assigned Document Authenticator	
11	48	XCN	C			00924	Transcriptionist Code/Name	
12	30	EI	R			00925	Unique Document Number	
13	30	ST	C			00926	Parent Document Number	Required if trigger event "T06 " **OR** "T10" are used. This is the original "Unique Document Number" (TXA-12) when trigger event "T02" was sent.
14	22	EI	O	Y		00216	Placer Order Number	
15	22	EI	O			00217	Filler Order Number	
16	30	ST	O			00927	Unique Document File Name	
17	2	ID	R		0271	00928	Document Completion Status	Table 18
18	2	ID	O		0272	00929	Document Confidentiality Status	Table 19
19	2	ID	O		0273	00930	Document Availability	Table 20

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
							Status	
20	2	ID	O		0275	00932	Document Storage Status	Table 21
21	30	ST	C			00933	Document Change Reason	Required if changes are made to the document
22	60	CM	C	Y		00934	Authentication Person, Time Stamp	Required when TXA-17 is equal to "AU" or "LA " Required if there is an Authentication Person
22.1			C				ID Number	The ID number for the 22.13 qualifier. **NOTE:** The ID number is the NPI.
22.2		FN	R				Family Name	
22.3		ST	R				Given Name	
22.4		ST	O				Second and further given names or initials thereof	Recommend use, if available
22.5		ST	O				Suffix	Recommend use, if available
22.6		ST	O				Prefix	
22.8 thru 22.12			N/A					
22.13		ID	C				Identifier Type Code	Values are limited: **"NPI"** **NOTE:** Value is limited to: **"NPI"** (National Provider Identifier)
23	60	XCN	O	Y		00935	Distributed Copies (Code and name of Recipients)	

Table 6 - HL7 – OBX – Observation/Result Segment

For column table heading definitions, see Appendix A – Basic Definitions

Example:
OBX|1|TX|^Disch Report^L^11535-2^ Hospital Discharge DX (Narrative)^LN| | Major depressive disorder| | | | | |F| | |200602040510| | |

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
1	4	SI	R	[0..1]		00569	Set ID –	OBX sequence number
2	2	ID	R	[0..1]	0125	00570	Value Type	Allowable document referenced data include: “TX” = text data **OR** “FT” = formatted text. See table 15
3	80	CM	R	[1..1]		00571	Observation Identifier	Composite
3.1		ST	O				Identifier	Recommend use, if available
3.2		ST	R				Text	Agreed upon by trading partners
3.3		ID	R		0396		Name of Coding System	Recommend use, if available. See table 22. Use L= local for local field
3.4		ST	C				Alternate Identifier	If you have content, the label must be identified using LOINC Code as specified by the appropriate Document Type: -Discharge Summary (Appendix C) Example: “11535-2”

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element Name	Comments and Examples
3.5		ST	C				Alternate Text	If you have content, the label must be identified using LOINC Data Element as specified by the appropriate Document Type: -Discharge Summary (Appendix C) Example: “Hospital Discharge DX (Narrative)”
3.6		IS	C		0396		Name of Alternate Coding System	If you have Discharge Summary content (see Appendix C) in field(s) OBX-3.4 and OBX-3.5, this field (OBX-3.6) must be identified as “LN” See table 22.
4	20	ST	O	[0..1]		00572	Observation Sub-ID	
5	65536	*	C	[0..*]		00573	Observation Value	Each observation value OBX-5 is the reported value as identified in each corresponding OBX-3 observation identifier “category label”
6 thru 10			N/A					Not used at this time for HL7 Discharge Summary Message(s)
11	2	ID	R	[1..1]	0085	00579	Observation Result Status	See table 13
12 thru 13			N/A					Not used at this time for HL7 Discharge Summary Message(s)
14	26	TS	O			00582	Date/Time of the Observation	Use “CCYYMMDDHHMM”
15 thru 16			N/A					Not used at this time for HL7 Discharge Summary Message(s)

Table 7 - HL7 – MSH/ACK –Acknowledgement Header

(Please reference Clinical Acknowledgment and Error Status Standard
for those fields not addressed below)

For column table heading definitions, see Appendix A – Basic Definitions

Example MSH Segment-
MSH| ^~\&| |9999^HT000346-001^UHIN| |1111^HT000346-002^UHIN|20060126130405| |**ACK^T02**
|20060126130405|P|**2.3**| | |ER

SEQ	LEN	DT	OPT	RP#	TBL#	ITEM#	Element	Comments
9	13	CM	R	[1..1]		00009	Message Type	Composite
9.1		ID	R				Message Type	Use “ACK”
9.2		ID	R				Trigger Event	Use the same trigger event which was contained in the MSH-9.2 field (event type) in table 1.
12	8	CM	R R	[1..1]		00012	Version ID	Composite
12.1		ID	R				Version ID	Use “2.3”

Table 8 - HL7 – MSA – Message Acknowledgement Segment

(Please reference Clinical Acknowledgment and Error Status Standard)

Table 9 - HL7 – ERR – Error Segment

(Please reference Clinical Acknowledgment and Error Status Standard)

Table 10 - HL7 User-Defined Table 0001 – Sex

Value	Description	Comments
F	Female	
M	Male	
O	Other	
U	Unknown	

Table 11 - HL7 User-Defined Table 0004 – Patient Class

Value	Description
E	Emergency
I	Inpatient
O	Outpatient
P	Preadmit
R	Recurring Patient
B	Obstetrics

Table 12 - HL7 Table 0007 – Admission Type

Value	Description
A	Accident
E	Emergency
L	Labor and Delivery
R	Routine

Table 13 - HL7 Table 0062 – Event Reason

Value	Description	Comments
01	Patient Request	
02	Physician Order	
03	Census Management	

Table 14 - HL7 User-Defined Table 0085 – Observation Result Status Code Interpretation

Value	Description
C	Record coming over is a correction and thus replaces a final result
D	Deletes the OBX record
F	Final result; Can only be changed with corrected result
I	Specimen in lab; results pending
P	Preliminary results
R	Results entered – not verified
S	Partial results
X	Results cannot be obtained for this observation
U	Results status change to Final without retransmitting results already sent as "preliminary" E.g. radiology changes status from preliminary to final.
W	Post original as wrong, e.g. transmitted for wrong patient.

Table 15 – User-Defined Table 0112 – Discharge Disposition

Value	Description	Comments
01	Discharged to home or self care (routine discharge)	
02	Discharged/transferred to another short term general hospital for inpatient care	
03	Discharged/transferred to skilled nursing facility (SNF)	
04	Discharged/transferred to an intermediate care facility (ICF)	
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution	
06	Discharged/transferred to home under care of organized home health service organization	
07	Left against medical advice or discontinued care	
08	Discharged/transferred to home under care of Home IV provider	
09	Admitted as an inpatient to this hospital	
10..19	Discharge to be defined at state level, if necessary	Not used in the HL7 Discharge Summary message
20	Expired (i.e. dead)	
21..29	Expired to be defined at state level, if necessary	Not used in the HL7 Discharge Summary message
30	Still patient or expected to return for outpatient services (i.e. still a patient)	
31..39	Still patient to be defined at state level, if necessary (i.e. still a patient)	Not used in the HL7 Discharge Summary message
40	Expired (i.e. died) at home	
41	Expired (i.e. died) in a medical facility; e.g., hospital, SNF, ICF, or free standing hospice	
42	Expired (i.e. died) - place unknown	

Table 16 - HL7 Table 0125 – Value Type

Value	Description	Comments
AD	Address	
CE	Coded Entry	Bolded
CF	Coded Element with Formatted Values	
CK	Composite ID With Check Digit	
CN	Composite ID and Name	
CP	Composite Price	
CX	Extended Composite ID with Check Digit	
DT	Date	
ED	Encapsulated Data	
FT	Formatted Text	Display, bolded
MO	Money	
NM	Numeric	Bolded
PN	Person Name	
RP	Reference Pointer	
SN	Structured Numeric	Bolded
ST	String Data	Bolded
TM	Time	
TN	Telephone Number	
TS	Time Stamp (Date & Time)	
TX	Text Data	Display, bolded
XAD	Extended Address	
XCN	Extended Composite Name and Number For Person	
XON	Extended Composite Name and Number For Organizations	
XPN	Extended Person Name	
XTN	Extended Telecommunication Number	

Table 17 - HL7 Table 0191 – Value Type

Value	Description	Comments
SI	Scanned image	Not used in the HL7 Discharge Summary message
NS	Non-scanned image	Not used in the HL7 Discharge Summary message
SD	Scanned document	Not used in the HL7 Discharge Summary message
TX	**Machine readable text document**	
FT	**Formatted text**	
IM	Image data (new with HL7 v2.3)	Not used in the HL7 Discharge Summary message
AU	Audio data (new with HL7 v2.3)	Not used in the HL7 Discharge Summary message
AP	Other application data, typically uninterrupted binary data (new with HL7 v2.3)	Not used in the HL7 Discharge Summary message

Table 18 - HL7 User-Defined Table 0270 – Document Type

Value	Description	Comments
AR	Autopsy report	Not used in the HL7 Discharge Summary message
CD	Cardio diagnostics	Not used in the HL7 Discharge Summary message
CN	Consultation	Not used in the HL7 Discharge Summary message
DI	Diagnostic imaging	Not used in the HL7 Discharge Summary message
DS	**Discharge Summary**	
ED	Emergency department report	Not used in the HL7 Discharge Summary message
HP	History and Physical Examination	Not used in the HL7 Discharge Summary message
OP	Operative Report	Not used in the HL7 Discharge Summary message
PC	Psychiatric consultation	Not used in the HL7 Discharge Summary message
PH	Psychiatric history and physical examination	Not used in the HL7 Discharge Summary message
PN	Procedure note	Not used in the HL7 Discharge Summary message
PR	Progress note	Not used in the HL7 Discharge Summary message
SP	Surgical Pathology	Not used in the HL7 Discharge Summary message
TS	Transfer Summary	Not used in the HL7 Discharge Summary message

Table 19 - HL7 Table 0271 – Document Completion Status

Value	Description	Comments
DI	Dictated	
DO	Documented	
IP	In Progress	
IN	Incomplete	
PA	Pre-authenticated	
AU	Authenticated	
LA	Legally authenticated	

Table 20 - HL7 Table 0272 – Document Confidentiality Status

Value	Description	Comments
VR	Very restricted	
RE	Restricted	
UC	Usual control	

Table 21 - HL7 Table 0273 – Document Availability Status

Value	Description	Comments
AV	Available for patient care	
DE	Deleted	
OB	Obsolete	
UN	Unavailable for patient care	

Table 22 - HL7 Table 0275 – Document Storage Status

Value	Description	Comments
AC	Active	
AA	Active and archived	
AR	Archived (not active)	
PU	Purged	

Table 23 - HL7 User-Defined Table 0396 – Coding System

Value	Description	Comments
99zzz	Local general code, where zzz is an alphanumeric character	Use L = local
C4	CPT-4	Not used in the HL7 Discharge Summary message
HPC	HCFA Procedure Code (HCPCS)	Not used in the HL7 Discharge Summary message
I10P	ICD-10 Procedure Code	Not used in the HL7 Discharge Summary message
I9C	ICD-9CM	Not used in the HL7 Discharge Summary message
LN	Logical Observation Identifier Names and Codes (LOINC®)	
SNM	Systemized Nomenclature of Medicine (SNOMED)	Not used in the HL7 Discharge Summary message
SNM2	SNOMED 2	Not used in the HL7 Discharge Summary message
SNM3	Snowmed International (SNOMED 3)	Not used in the HL7 Discharge Summary message
SCT	Snomed CT	Not used in the HL7 Discharge Summary message

Appendix C – Standardized Identifier Content for the Discharge Summary

Standardized Identifier Content for the Discharge Summary using LOINC codes in OBX-3.4 (LOINC Code) and OBX-3.5 (LOINC Data Element)

This list does not preclude sending additional LOINC codes, but provides basic data elements which are typically included in a discharge summary.

- **BOLD** items are main categories
- NON-BOLDED items are sub-categories of the main categories

LOINC Code (OBX-3.4)	LOINC Data Element (OBX-3.5)
8646-2	**Hospital Admission DX**
18842-5	**Hospital Discharge History**
10184-0	**Hospital Discharge Physical (Narrative)**
8648-8	**Hospital Course (Narrative)**
10185-7	Hospital Discharge Procedures
11493-4	Hospital Discharge Studies Summary
18841-7	Hospital Consultation (Narrative)
11535-2	**Hospital Discharge DX (Narrative)**
18776-5	**Treatment Plan (Narrative)**
8653-8	Hospital Discharge Instructions Text (Narrative)
10183-2	Hospital Discharge Medications (Narrative)
11544-4	Hospital Discharge Follow-up