Form	Entity Name	Entity ID	Definition	Data Type (code)	Data Type (description)	Validation Rule	Repeated Data	Code Table	Data Type in IAMS	Data requirement (Certified Level 1)	Data requirement (Certified Level 2)	Data requirement (Certified Level 3)	Example (Certified Level 1)	Example (Certified Level 2)	Example (Certified Level 3)
Problem (Simplified version)	Diagnosis reference date	1003578	Date when the diagnosis was created. For eHR, if this date is not available, the last update date of the diagnosis should be used when submitting data to the eHR	TS	Time Stamp		R		Date/Time	NA	M	M		6/12/2010	6/12/2010
Problem (Simplified version)	Diagnosis status code	1003579	[eHR value] of the "Diagnosis status" code table which is used to identify the status of a reported diagnosis	CE	Coded Element		R	Diagnosis status	CE	NA	NA	O			C
Problem (Simplified version)	Diagnosis status description	1003580	[eHR description] of the "Diagnosis status" code table which is used to identify the status of a reported diagnosis. The [Diagnosis status description] should be the corresponding description of the selected [Diagnosis status code]	ST	String		R	Diagnosis status	ST	NA	NA	M if [Diagnosis status code] is given; NA if [Diagnosis status code] is blank			Cancelled
Problem (Simplified version)	Diagnosis status local description	1003581	Local description of the diagnosis status	ST	String		R		ST	NA	NA	M if [Diagnosis status code] is given; NA if [Diagnosis status code] is blank			Wrong
Problem (Simplified version)	Reason for cancellation of diagnosis	1003582	The stated reason for cancelling the diagnosis	ST	String		R		ST	NA	NA	O if [Diagnosis Status Code] is "C" ; NA if [Diagnosis Status Code] is not "C"			Wrong diagnosis as no evidence supported that patient has this condition
Problem (Simplified version)	Diagnosis - recognised terminology name	1003583	Name of the recognised terminology / classification from which the diagnosis is referenced to	CE	Coded Element	If eHR value=1)HKCTT, Nature must be Diagnosis; 2)SNOMED CT, Clinical Finding or Situation with Explicit Context are allowed; 3)ICD10 & ICD10 MBD, all items are allowed; 4)ICPC2, all codes except those ended in range 30-69 are allowed	R	Recognised terminology name - problem	CE	NA	NA	M			HKCTT
Problem (Simplified version)	Diagnosis identifier - recognised terminology	1003584	Unique identifier of the reported diagnosis in the recognised terminology	CE	Coded Element	it should be included in the selected terminology of the "Recognised terminology name - Problem" code table: 1)HKCTT should be TermID; 2)SNOMED CT should be ConceptID; 3)ICPC2, ICD10 & ICD10 MBD should be code	R		DE	NA	NA	M			1234
Problem (Simplified version)	Diagnosis description - recognised terminology	1003585	The description of the reported diagnosis in the recognised terminology. It should be the corresponding description of the selected [Diagnosis identifier - recognised terminology].	CE	Coded Element	The description of the selected [Diagnosis identifier - recognised terminology] should be matched as: 1)HKCTT should be eHR description; 2)SNOMED CT should be Preferred term; 3)ICD10 & ICD10 MBD should be Full name; 4)ICPC2 should be Full description	R		DE	NA	NA	M			Transient ischaemic attack
Problem (Simplified version)	Diagnosis local code	1003586	Local code created by the healthcare provider for the reported diagnosis	ST	String		R		ST	NA	O	O		332	332
Problem (Simplified version)	Diagnosis local description	1003587	Local description created by the healthcare provider for the reported diagnosis	ST	String		R		ST	NA	M	M		Transient ischaemic attack - TIA	Transient ischaemic attack - TIA
Problem (Simplified version)	Diagnosis comment	1003588	Comment made on the reported diagnosis	ST	String		R		ST	NA	O	O		affect left side of body	affect left side of body

Recognised terminology name - problem

Purpose: To define the names of the recognised terminology for problem

Reference eHR

Term ID	eHR Value	eHR Description	Allowable Values
	HKCTT	Hong Kong Clinical Terminology Table	Nature= Diagnosis
	SNOMED CT	Systematized Nomenclature of Medicine - Clinical Terms	Hierarchy = Clinical finding, Situation
	ICD10-2001	International Statistical Classification of Diseases and Related Health Problems Tenth Revision (2001)	Valid ICD 10 codes
	ICD10-2010	International Statistical Classification of Diseases and Related Health Problems Tenth Revision (2010)	Valid ICD 10 codes
	ICD10-MBD	ICD-10 Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines	Valid ICD 10 MBD codes
	ICPC2	International Classification for Primary Care, Second edition	Valid ICPC2 codes - excluding those with last 2 digits in the range of 30-69

Diagnosis Status

Purpose : to indicate the status of the diagnosis

Source : HA

Term ID	eHR Value	eHR Description	Definition
	P	Provisional	Diagnosis not confirmed
	A	Active	Under management
	I	Inactive	No active treatment required
	R	Resolved	Cured
	C	Cancelled	Cancel

Data Group Table

Purpose : To identify the group of data in diagnosis and procedure

Reference: eHR & HA

Term ID	eHR Value	eHR Description
	H	Clinical Data Framework name
	C	Clinical Data Framework intrinsic data
	E	Clinical Data Framework extrinsic data
	D	Recognised terminology