Technical Interface Specification
For
eHR Allergy Record

Version 1.4.0

Sep 2016

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DOCUMENT SUMMARY

Document Item	Current Value
Document Title	Technical Interface Specification for eHR Allergy Record
Creation Date	28 Jun 2012
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Current Document Issue	Version 1.4.0
Document Description	The paper explains the technical interface for implementing Health Level Seven (HL7) version 2.5 standards messaging and Clinical Document Architecture (CDA) for transferring Allergy record from healthcare providers (HCP) to eHR system for Hong Kong Special Administrative Region eHR. The document should be read in conjunction with other related documents suggested by the eHR Information Standards Office.
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AMENDMENT HISTORY

Version No.	Summary of Changes	Date
1.0.0	Original version	28 Jun 2012
1.1.0	Enhanced according to the -dataset as of Feb 2013 defined by eHR Information Standards Office	13 Mar 2013
1.2.0	• Updated the definition of data fields: 'Record creation institution name' and 'Record update institution name' • Removed SNOMED CT from recognised terminology sets • Updated the code table name from 'Recognised terminology name - pharmaceutical product' to 'Recognised terminology name - pharmaceutical product or substance' • Updated the column ‘Notes’ of the following fields: o Allergen - recognised terminology name o Allergen identifier - recognised terminology o Allergen description - recognised terminology o Transaction type • Added section 8.3 XML Predefined Entities, update section reference in section 8 from 8.3.3 to 8.4.3 • Updated checking rules in section 10.2: <u>Delete allergen reason</u> o Insert and Update: N/A o Delete: O <u>Last Update Datetime</u> o Changed from ‘Optional’ to ‘Mandatory’ • Added remarks at the end of section 10.2 to specify that the prefix of namespace in XML in HL7 message is not expected • Aligned the terms used in eHR Sharing System (eHRSS) Bill: o Participant -> Healthcare recipient o Enroll -> Register o Rejoin -> Re-register • Updated the examples with ‘Delete allergen reason’ in section 13 'EXAMPLE OF HL7-HK MESSAGE STANDARDS'	15 Jun 2014

Version No.	Summary of Changes	Date
	• Updated the template of cover page and descriptions in footer • Updated the contents in section 'Intellectual Property Rights Notice'	
1.3.0	• Fix on MSH.8 • Section 7 Data Upload Requirement is added to state the 3 message upload mode • Section 14.4 Re-materialisation message is added to provide the re-materialisation message example • Updated Section 9.4.3 OBX - Observation/Result Segment OBX.4's remarks • Updated Section 14 Sample of Record Creation Date Time and Record Update Date Time from 2010-01-01 16:00:00 to 2010-01-01 16:00:00.000 • Added <last_update_dtm> in all CDA samples in section 14.3 • Moved <text/> after <clinicalDoc> in all CDA samples in section 14 • For update and delete scenario HL7 samples in Section 14, OBX.4 data upload format should be "NBL"	30 Jun 2015
1.4.0	• Updated checking rules in Section 10.4.2 <u>Type of allergen code</u> o Changed from 'Mandatory' to 'Optional' <u>Type of allergen description</u> o Changed from 'Mandatory' to 'Mandatory if [Type of allergen code] is given' 'NA if [Type of allergen code] is blank' <u>Type of allergen local description</u> o Changed from 'Mandatory' to 'Mandatory if [Type of allergen code] is given' 'Optional if [Type of allergen code] is blank' <u>Allergen – recognised terminology name</u>	15 Sep 2016

Version No.	Summary of Changes	Date
	○ Changed from 'Conditional Mandatory' to 'Mandatory' <u>Allergen identifier – recognised terminology</u> ○ Changed from 'Conditional Mandatory' to 'Mandatory' <u>Allergen description – recognised terminology</u> ○ Changed from 'Conditional Mandatory' to 'Mandatory'	

1 PURPOSE

1.1 OBJECTIVE

This document describes the technical interface for implementing Health Level Seven (HL7) version 2.5 standards messaging and Clinical Document Architecture (CDA) for transferring Allergy record from healthcare providers (HCP) to eHR system.

There are TWO data exchange standards for uploading clinical records to eHR system:

- HL7-HK Message Standards
- HL7-HK Localised Bulk Load Standards

HL7-HK Message Standards will be described in detail in this document. For the HL7-HK Localised Bulk Load Standards, please refer to 'Bulk Load Standards Specification for eHR Record'.

1.2 INTENDED READERS

This document is intended for all parties involving the interface development of EMR and eHR in Hong Kong.

2 SCOPE

This reference defines the implementation of HL7 version 2.5 messaging and CDA for the communication of HL7-HK Message Standards between EMR applications and eHR system. The structure of a HL7 message and CDA document, data mapping specification of eHR healthcare recipient (HCR) identity data, healthcare provider data, clinical data and functional data and the mechanism of creating a HL7 message for transferring Allergy record data will be covered in this document.

The recognised terminology sets applied in Allergy Sharable Dataset include:

- Hong Kong Clinical Terminology Table (HKCTT)
- Registered of Pharmaceutical Products (RPP)

Remarks: Please refer the latest eHR supported version of the above recognized terminology sets.

This document is referring to the health data defined in the eHR sharable dataset domain "Allergy" mentioned in **eHR Content Standards Guidebook** in eHR Office website. It provides interpretation and guidance to which HL7 trigger event and data elements are required for interfacing to eHR system.

3 REFERENCES

- Data Interface Requirement Document
  - Data Requirement Specification for eHR Allergy Record
  - Communication Protocol Specification

- eHR Information Standards Document
  - eHR Content Standards Guidebook
  - eHR Data Interoperability Standards
  - eHR Contents
  - eHR Codex

4 DEFINITIONS AND CONVENTIONS

4.1 HL7 MESSAGE STANDARDS

Health Level Seven (HL7) version 2.5 message standards will be implemented for healthcare records exchange under eHR programme. HL7 provides a framework and related standards for the exchange, integration, sharing, and retrieval of electronic health-related information. Each HL7 message contains information about a particular event such as patient admission, laboratory records, etc. CDA, which contains structured clinical data, can be embedded in the HL7 message for transmission.

To learn more about the HL7 organization and standards, please refer to the official HL7 website.

4.2 ABBREVIATIONS

Term	Description
CDA	Clinical Document Architecture
CDR	Clinical Data Repository
eHR	Electronic Health Record
eHR ISO	Electronic Health Record – Information Standards Office
EMR	Electronic Medical Record
HCP	Healthcare Provider
HL7	Health Level Seven
ORU	HL7 message type of "Unsolicited Observation Message"
HCR	eHR Healthcare Recipient

4.3 NOTATIONS

Value	Description
"quoted"	Fixed Value
#	HL7 Mandatory Field
✓	Required HL7 Segment
0..1	Zero to One occurrence
1..1	Exact One occurrence
0..*	Zero to Many occurrence
1..*	One to Many occurrence
N/A	Not Applicable
S0 - S99	Scenario numbering
RP/#	Repeatable Indicator [Y:Yes N: No] of HL7 element
TBL#	HL7 Table Reference Number
[ ]	Optional
{ }	Repeatable
YYYY	Year
MM	Month
DD	Day
hh	Hour (24-Hour)
mm	Minute
ss	Second
.sss	Millisecond

5 ASSUMPTIONS

- HCP is responsible for ensuring the integrity, accuracy and completeness of structured data when sending data to eHR.
- It is recommended that HCP should send the updated clinical record to eHR as soon as possible when there are any changes or new records of the eHR healthcare recipient (HCR).
- To ensure the integrity of the Allergy record, the complete set of structured data should be sent for any amendment.
- If the HCR does not have any allergy record, HCP is not expected to upload any allergy data of the HCR to eHR.

6 DELIVERY REQUIREMENTS

- HL7 version 2.5 message standards in XML format will be implemented for delivering Allergy event messages defined by eHR.
- The sharable dataset domain 'Allergy' supports eHR Data Compliance Level 2 and 3 only. Before sending clinical record to eHR, Healthcare Provider (HCP) has to register which data compliance levels she can comply to.
- A complete set of updated 'Allergy' data with an unique record key of the record is expected to be uploaded to eHR. eHR will use the HCP unique record key for subsequence data amendments in eHR repository.
- HCP must make sure the data submitted to eHR is complied with the compliance levels she declared in the message. The detail definition of the Data Compliance Level is stated in eHR Content Standards Guidebook posted in eHR Office website.

7 DATA UPLOAD REQUIREMENTS

7.1 TYPES OF FILE UPLOAD MODE

There are three types of file upload mode:

1. **Incremental mode** is the format for HCP to upload sharable data in ONE batch.
2. **Materialisation mode** is the format for HCP to upload a HCR's specific sharable dataset that exists in EMR, e.g. new registered HCR and re-registered HCR.
3. **Re-materialisation mode** is the format for HCP to clear the clinical data uploaded in eHR. It is required to upload the re-materialisation message before HCP next materialisation message for same HCR.

The following table shows the files required for different upload mode and its schedule:

	HCR information	**Clinical Data**	**Schedule**
Incremental Mode	Required	Required	Within agreed period
Materialisation Mode	Required	Required	Within agreed period
Re-materialisation Mode	Required	Not required	

Remarks:
For Materialisation Mode, 'Update' and 'Delete' transaction types are not accepted. If 'Update' or 'Delete' transaction type is uploaded using materialisation mode, the record will be rejected by eHR.

8 MESSAGE FORMAT OVERVIEW

8.1 DATA COMPONENTS FOR HL7-HK MESSAGE STANDARDS

According to HL7-HK Message Standards, there are three major components used to carry the clinical information related to the Allergy record when transferring data from healthcare providers to eHR. The three components are:

- HL7 version 2.5 ORU – Unsolicited Observation Message (Event R01):
  ORU^R01 event includes 3 mandatory segments
  - MSH – Message Header Segment
  - OBR – Observation Request Segment
  - OBX – Observation related to OBRs

- Clinical Document Architecture (CDA) Document

- XML digital signature:
  In order to ensure the integrity, reputation and authenticity of the message exchange, a XML digital signature is required to digitally sign the whole HL7 document. The eHR system will not accept messages that are not digitally signed.

HL7 version 2.5 ORU will be described in detail in *Section 8 HL7 v2.5 Unsolicited Observation Message* and Clinical Document Architecture will be described in *Section 9 CDA Document*.

8.2 OVERVIEW OF HL7 ORU - UNSOLICITED OBSERVATION MESSAGE

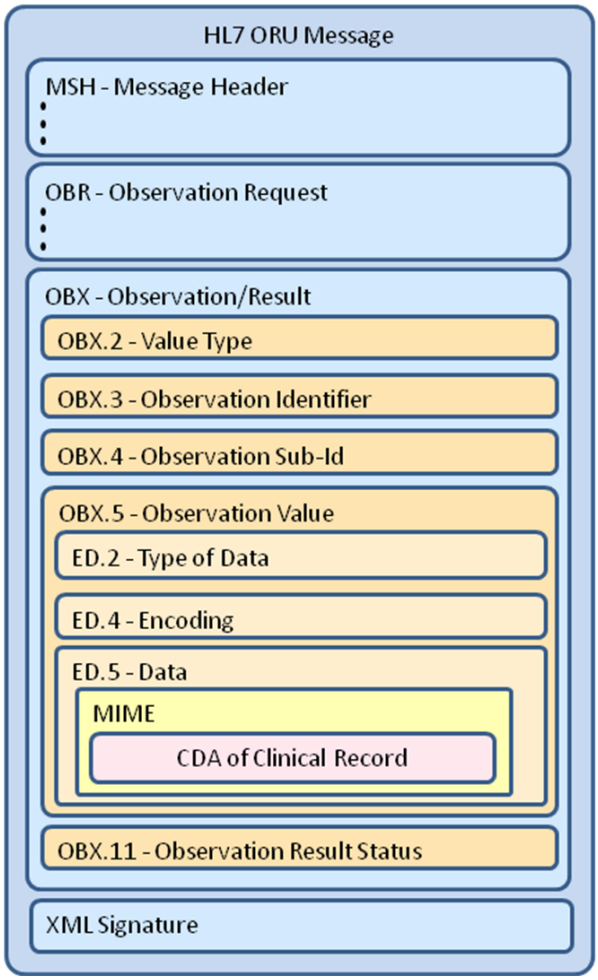

Figure 1- *HL7 v2.5 Unsolicited Observation Message for Allergy Record Transfer*

Figure 1 describes the overview structure of the an Allergy Record HL7 v2.5 ORU Message. In order to exchange an Allergy record, data mapping in the HL7 v2.5 Unsolicited Observation Message has to be complied.

And for the clinical information, the CDA and document reports (e.g. PDF), if any, are first Base64-encoded and embedded in MIME format, and then mapped to OBX.5 - ED.5 of ORU Message. In the following section, CDA will be explained in detail.

XML digital signature must be applied in eHR message communication.Since XML digital signature is not the element in the schema of HL7 v2.5 ORU Message, it should be applied and located in the last section of the message. The components and example of XML digital signature are explained in *Section 8.5 - XML Digital Signature on HL7*.

(Please refer to 'eHR Data Interoperability Standards' in eHealth Record Office website for further elaboration.)

9 HL7 V2.5 UNSOLICITED OBSERVATION MESSAGE

9.1 HL7 MESSAGE

In eHR environment, HL7 v2.5 message in XML format and CDA release 2.0 will be used for message interchange. An HL7 message is composed of 'Message Type', 'Message Event' and 'Message Structure'. Message Type identifies the business purpose of a message. 'Message Event' is a unique identifier to the context in which message is generated. And, 'Message Structure' is a data structure used to express an association of a message type with an event for a class of messages.

For eHR Allergy Record exchange, the following message event will be applied:

Message Type	ORU (Unsolicited Observation Message)
Message Event	R01
Message Structure	ORU_R01
Usage	To carry structured HCR-oriented clinical data from local EMR system to eHR.

CDA is used to contain most of the data elements required in 'Allergy' domain. Then, the CDA containing structured data can be attached in the HL7 V2.5 messages for data exchange.

9.2 ORU - UNSOLICITED OBSERVATION MESSAGE (EVENT R01)

The ORU message is for transmitting Allergy record from healthcare provider to eHR. Under HL7-HK Message Standards, clinical data and transaction data are embedded in the three segments of the ORU Message. They are: Message Header (MSH), Observation Request (OBR) and Observation/Result (OBX). In the following sections, the message structure of ORU Message and the data mapping of ORU message among clinical and functional information will be shown.

9.3 MESSAGE STRUCTURE OF UNSOLICITED OBSERVATION MESSAGE

Required eHR Segment	ORU^R01^ORU_R01	ORU Message	Chapter in HL7 Specification
✓	**MSH**	Message Header	2
	[{ SFT }]	Software Segment	2
	{	--- PATIENT_RESULT begin	
	[	--- PATIENT begin	
	PID	Patient Identification	3
	[PD1]	Additional Demographics	3
	[{NTE}]	Notes and Comments	2

	[{NK1}]	Next of Kin/Associated Parties	3
	[	--- VISIT begin	
	PV1	Patient Visit	3
	[PV2]	Patient Visit – Additional Info	3
	]	--- VISIT end	
	]	--- PATIENT end	
	{	--- ORDER_OBSERVATION begin	
	[ORC]	Order common	4
✓	**OBR**	Observations Request	7
	{[NTE]}	Notes and comments	2
	[{	--- TIMING_QTY begin	
	TQ1	Timing/Quantity	4
	[{TQ2}]	Timing/Quantity Order Sequence	4
	}]	--- TIMING_QTY end	
	[CTD]	Contact Data	11
	[{	--- OBSERVATION begin	
	OBX	Observation related to OBR	7
	{[NTE]}	Notes and comments	2
	}]	--- OBSERVATION end	
	[{FT1}]	Financial Transaction	6
	{[CTI]}	Clinical Trial Identification	7
	[{	--- SPECIMEN begin	
	SPM	Specimen	
✓	[{**OBX**}]	Observation related to Specimen	
	}]	--- SPECIMEN end	
	}	--- ORDER_OBSERVATION end	
	}	--- PATIENT_RESULT end	
	[DSC]	Continuation Pointer	2
✓	[Signature]	XML Digital Signature	

9.4 DATA MAPPING IN UNSOLICITED OBSERVATION MESSAGE

In order to exchange Allergy record, data mapping in the HL7 v2.5 Unsolicited Observation Message has to be complied.

9.4.1 MSH - MESSAGE HEADER

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
#<MSH.1>	1	ST			Field Separator	"|"	• Fixed value
#<MSH.2>	4	ST			Encoding Characters	"^~\&"	• Fixed value
<MSH.3> <HD.1>	227	HD		0361	Sending Application Namespace ID	System Version	HCP's system name and version for data exchange
<MSH.4> <HD.1>	227	HD		0362	Sending Facility Namespace ID	Healthcare Provider Identifier	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution for participation in eHR Sharing System
<MSH.5> <HD.1>	227	HD		0361	Receiving Application Namespace ID	"EIF"	• Fixed value
<MSH.6> <HD.1>	227	HD		0362	Receiving Facility Namespace ID	"eHR"	• Fixed value
#<MSH.7> <TS.1>	26	TS DTM			Date/Time Of Message Time	Message generation datetime	In format: YYYYMMDDhhmmss

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<MSH.8>	40	ST			Security	Data Compliance Level e.g. 2	Possible value: **2**: Level 2 **3**: Level 3
#<MSH.9> <MSG.1> <MSG.2> <MSG.3>	15	MSG			Message Type Message Type Code Trigger Event Message Structure	 "ORU" "R01" "ORU_R01"	 • Fixed value • Fixed value • Fixed value
#<MSH.10>	20	ST			Message Control ID	Unique message identifier in sending application	Values can be in any combination of alphanumeric characters i.e. [A-Z][0-9][-_]
#<MSH. 11> <PT.1>	3	PT			Processing ID Processing ID	 "P"	 • Fixed value: • **P**: Production
#<MSH.12> <VID.1>	60	VID			Version ID Version ID	 "2.5"	 • Fixed value
<MSH.13>	15	NM			Sequence Number	NOT USE	
<MSH.14>	180	ST			Continuation Pointer	NOT USE	
<MSH.15>	2	ID		0155	Accept Acknowledgment Type	"NE"	• Fixed value • **NE**: Never
<MSH.16>	2	ID		0155	Application Acknowledgment Type	NOT USE	
<MSH.17>	3	ID		0399	Country Code	NOT USE	

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<MSH.18>	16	ID	Y	0211	Character Set	NOT USE	
<MSH.19>	250	CE			Principal Language Of Message	NOT USE	
<MSH.20>	20	ID		0356	Alternate Character Set Handling Scheme	NOT USE	
<MSH.21>	427	EI	Y		Message Profile Identity	NOT USE	

9.4.2 OBR - OBSERVATION REQUEST SEGMENT

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBR.1>	4	SI			Set ID – OBR	NOT USE	
<OBR.2>	22	EI			Placer Order Number	NOT USE	
<OBR.3>	22	EI			Filler Order Number	NOT USE	
#<OBR.4> <CE.1>	250	CE			Universal Service Identifier Identifier	"AL1"	• Fixed value • Sharable Dataset Code (eHR Record Type)
<OBR.5>	2	ID			Priority – OBR	NOT USE	
<OBR.6>	26	TS			Requested Date/Time	NOT USE	
<OBR.7>	26	TS			Observation Date/Time #	NOT USE	
<OBR.8>	26	TS			Observation End Date/Time #	NOT USE	
<OBR.9>	20	CQ			Collection Volume *	NOT USE	
<OBR.10>	250	XCN	Y		Collector Identifier *	NOT USE	
<OBR.11>	1	ID		0065	Specimen Action Code *	NOT USE	
<OBR.12>	250	CE			Danger Code	NOT USE	

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBR.13>	300	ST			Relevant Clinical Information	NOT USE	
<OBR.14>	26	TS			Specimen Received Date/Time *	NOT USE	
<OBR.15>	300	SPS			Specimen Source	NOT USE	
<OBR.16>	250	XCN	Y		Ordering Provider	NOT USE	
<OBR.17>	250	XTN	Y/2		Order Callback Phone	NOT USE	
<OBR.18>	60	ST			Placer Field 1	NOT USE	
<OBR.19>	60	ST			Placer Field 2	NOT USE	
<OBR.20>	60	ST			Filler Field 1 +	NOT USE	
<OBR.21>	60	ST			Filler Field 2 +	NOT USE	
<OBR.22>	26	TS			Results Rpt/Status Chng –	NOT USE	
<OBR.23>	40	MOC			Charge to Practice +	NOT USE	
<OBR.24>	10	ID		0074	Diagnostic Serv Sect ID	NOT USE	
<OBR.25>	1	ID		0123	Result Status +	NOT USE	
<OBR.26>	400	PRL			Parent Result +	NOT USE	
<OBR.27>	200	TQ	Y		Quantity/Timing	NOT USE	

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBR.28>	250	XCN	Y		Result Copies To	NOT USE	
<OBR.29>	200	EIP			Parent	NOT USE	
<OBR.30>	20	ID		0124	Transportation Mode	NOT USE	
<OBR.31>	250	CE	Y		Reason for Study	NOT USE	
<OBR.32>	200	NDL			Principal Result Interpreter +	NOT USE	
<OBR.33>	200	NDL	Y		Assistant Result Interpreter +	NOT USE	
<OBR.34>	200	NDL	Y		Technician +	NOT USE	
<OBR.35>	200	NDL	Y		Transcriptionist +	NOT USE	
<OBR.36>	26	TS			Scheduled Date/Time +	NOT USE	
<OBR.37>	4	NM			Number of Sample Containers *	NOT USE	
<OBR.38>	250	CE	Y		Transport Logistics of Collected Sample *	NOT USE	
<OBR.39>	250	CE	Y		Collector's Comment *	NOT USE	
<OBR.40>	250	CE			Transport Arrangement Responsibility	NOT USE	

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBR.41>	30	ID		0224	Transport Arranged	NOT USE	
<OBR.42>	1	ID		0225	Escort Required	NOT USE	
<OBR.43>	250	CE	Y		Planned Patient Transport Comment	NOT USE	
<OBR.44>	250	CE		0088	Procedure Code	NOT USE	
<OBR.45>	250	CE	Y	0340	Procedure Code Modifier	NOT USE	
<OBR.46>	250	CE	Y	0411	Placer Supplemental Service Information	NOT USE	
<OBR.47>	250	CE	Y	0411	Filler Supplemental Service Information	NOT USE	
<OBR.48>	250	CWE		0476	Medically Necessary Duplicate Procedure Reason	NOT USE	
<OBR.49>	2	IS		0507	Result Handling	NOT USE	

9.4.3 OBX - OBSERVATION/RESULT SEGMENT

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBX.1>	4	SI			Set ID – OBX	NOT USE	
<OBX.2>	2	ID		0125	Value Type	"ED"	• Fixed value • This field defines the datatype of OBX.5 **ED**: Encapsulated Data
#<OBX.3> <CE.1>	250	CE			Observation Identifier Identifier	"AL1"	• Fixed value • Sharable Dataset Code (eHR Record Type)
<OBX.4>	20	ST			Observation Sub-Id	e.g. NBL	Possible value of data upload format: **NBL**: Non-Bulk load; **NBL-M**: Non-Bulk load for materialisation; **NBL-R:** Non-Bulk load for re-materialisation *Remarks:* ***Materialisation*** **-** HCP upload a HCR's specific sharable dataset that exists in EMR.

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBX.5> <ED.2> <ED.4> <ED.5>	99999	Varies	Y		Observation Value Type of Data Encoding Data	 “multipart” “A” MIME package	 • Fixed value • Fixed value **A**: ASCII text • Encapsulated data values of embedded CDA
<OBX.6>	250	CE			Units	NOT USE	
<OBX.7>	60	ST			References Range	NOT USE	
<OBX.8>	5	IS	Y	0078	Abnormal Flags	NOT USE	
<OBX.9>	5	NM			Probability	NOT USE	
<OBX.10>	2	ID	Y	0080	Nature of Abnormal Test	NOT USE	
#<OBX.11>	1	ID		0085	Observation Result Status	“F”	Fixed value: **F**: Final result
<OBX.12>	26	TS			Effective Date of Reference Range	NOT USE	
<OBX.13>	20	ST			User Defined Access Checks	NOT USE	
<OBX.14>	26	TS			Date/Time of the Observation	NOT USE	

Tag	Len	HL7 Data Type	RP/#	TBL#	Element Name	Fields	Remarks
<OBX.15>	250	CE			Producer's ID	NOT USE	
<OBX.16>	250	XCN	Y		Responsible Observer	NOT USE	
<OBX.17>	250	CE	Y		Observation Method	NOT USE	
<OBX.18>	22	EI	Y		Equipment Instance Identifier	NOT USE	
<OBX.19>	26	TS			Date/Time of the Analysis	NOT USE	

9.5 XML DIGITAL SIGNATURE ON HL7

The components of XML digital signature are listed below:

No.	XML Tag	XPath	Attribute	Element Name	Mandatory (M) / Optional(O)	Remarks
1	Signature	Signature		Signature	M	Sign the HL7 message *(Please refer to "XML Signature Syntax and Processing (Second Edition)" provided by W3C Recommendation 10 June 2008)*
			@xmlns		M	Fixed Value: "http://www.w3.org/2000/09/xmldsig#"
2	SignedInfo	Signature/SignedInfo		Signed Information	M	
2.1	CanonicalizationMethod	Signature/SignedInfo/ CanonicalizationMethod		Canonicalization Method	M	
			@Algorithm	Algorithm	M	Fixed Value: "http://www.w3.org/TR/2001/REC-xml-c14n-20010315"
2.2	SignatureMethod	Signature/SignedInfo/ SignatureMethod		Signature Method	M	
			@Algorithm	Algorithm	M	Fixed Value: "http://www.w3.org/2001/04/xmldsig-more#rsa-sha256"

No.	XML Tag	XPath	Attribute	Element Name	Mandatory (M) / Optional(O)	Remarks
2.3	Reference	Signature/SignedInfo/ Reference		Reference element for the whole HL7 document	M	
			@ URI	URI	M	Fixed Value: “” *(Empty String).* Apply the signature to the whole HL7 document
2.3.1	Transforms	Signature/SignedInfo/ Reference/Transforms		Transforms	M	
2.3.1.1	Transform	Signature/SignedInfo/ Reference/Transforms/ Transform		Transform	M	
			@Algorithm	Algorithm	M	Fixed Value: “http://www.w3.org/2000/09/xmldsig#enveloped-signature”
2.3.2	DigestMethod	Signature/SignedInfo/ Reference/DigestMethod			M	
			@Algorithm	Algorithm	M	Fixed Value: “http://www.w3.org/2001/04/xmlenc#sha256”
2.3.3	DigestValue	Signature/SignedInfo/ Reference/DigestValue		Digest Value	M	Message’s Digest Value

No.	XML Tag	XPath	Attribute	Element Name	Mandatory (M) / Optional(O)	Remarks
3	SignatureValue	Signature/SignatureValue		Signature value	M	Canonicalize and then calculate the SignatureValue over SignedInfo based on algorithms specified in SignedInfo as specified in XML Signature [XMLDSIG]
4	KeyInfo	Signature/KeyInfo		Key Info	M	
4.1	X509Data	Signature/KeyInfo/ X509Data		X509 Data	M	
4.1.1	X509SubjectName	Signature/KeyInfo/ X509Data/ X509SubjectName		X509 Subject Name	M	Distinguished name (DN) that contains the information for both the owner or requestor of the certificate (called the Subject DN) and the CA that issues the certificate (called the Issuer DN)
4.1.2	X509Certificate	Signature/KeyInfo/ X509Data/ X509Certificate		Certificate	M	base64-encoded [X509v3] certificate *(Please refer to the content of X509Data in "XML Signature Syntax and Processing (Second Edition)" provided by W3C Recommendation 10 June 2008)*

Example

```
<?xml version="1.0" encoding="UTF-8"?>
<ORU_R01 xmlns="..." xmlns:xsi="..." xsi:schemaLocation="...">
  <MSH>...</MSH>
  <ORU_R01.PATIENT_RESULT>
    <ORU_R01.ORDER_OBSERVATION>
      <OBR>...</OBR>
      <ORU_R01.OBSERVATION>
        <OBX>...</OBX>
      </ORU_R01.OBSERVATION>
    </ORU_R01.ORDER_OBSERVATION>
  </ORU_R01.PATIENT_RESULT>
  <Signature xmlns="http://www.w3.org/2000/09/xmldsig#">
    <SignedInfo>
      <CanonicalizationMethod Algorithm="http://www.w3.org/TR/2001/REC-xml-c14n-20010315"/>
      <SignatureMethod Algorithm="http://www.w3.org/2001/04/xmldsig-more#rsa-sha256"/>
      <Reference URI="">
        <Transforms>
          <Transform Algorithm="http://www.w3.org/2000/09/xmldsig#enveloped-signature"/>
        </Transforms>
        <DigestMethod Algorithm="http://www.w3.org/2001/04/xmlenc#sha256"/>
        <DigestValue>xxxxx</DigestValue>
      </Reference>
    </SignedInfo>
    <SignatureValue>xxxxxxxxxx</SignatureValue>
    <KeyInfo>
      <X509Data>
        <X509SubjectName>xxxxx</X509SubjectName>
        <X509Certificate>xxxxxxxxxx</X509Certificate>
      </X509Data>
    </KeyInfo>
  </Signature>
</ORU_R01>
```

XML Digital Signature

10 CDA DOCUMENT

The HL7 Clinical Document Architecture (CDA) is a document mark-up standard that specifies the structure and semantics of "clinical documents" for the purpose of exchanging clinical information. It can be exchanged as a Multipurpose Internet Mail Extensions (MIME, RFC 2046) package, encoded as an encapsulated data type (ED). For the preparation of encoded MIME, please refer to *Section 11 – Preparation of Message for Data Transfer*.

10.1 CDA DOCUMENT STRUCTURE OVERVIEW

Under HL7-HK Message Standards, two types of information will be included in CDA document, which are:

- CDA General Information
- Clinical Information related to HCR Identity Information, Healthcare Provider Information and Allergy Record Data

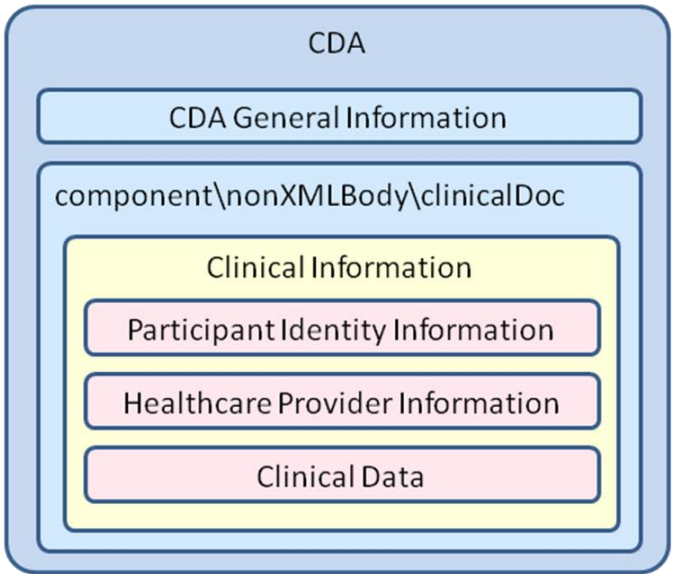

Figure 2 – *Overview of CDA for Allergy Record*

Clinical data of subject domain will be wrapped by the <nonXMLBody> element within the <component> element. In the *Section 9.3 - CDA Document Skeleton* will introduce the structure and contents required in eHR Allergy Record.

10.2 ALLERGY RECORD DATASET OVERVIEW

Allergy record may be constituted of allergy detail with the allergen data, type of allergen and the delete reason. Each Allergy record will have a unique record number.

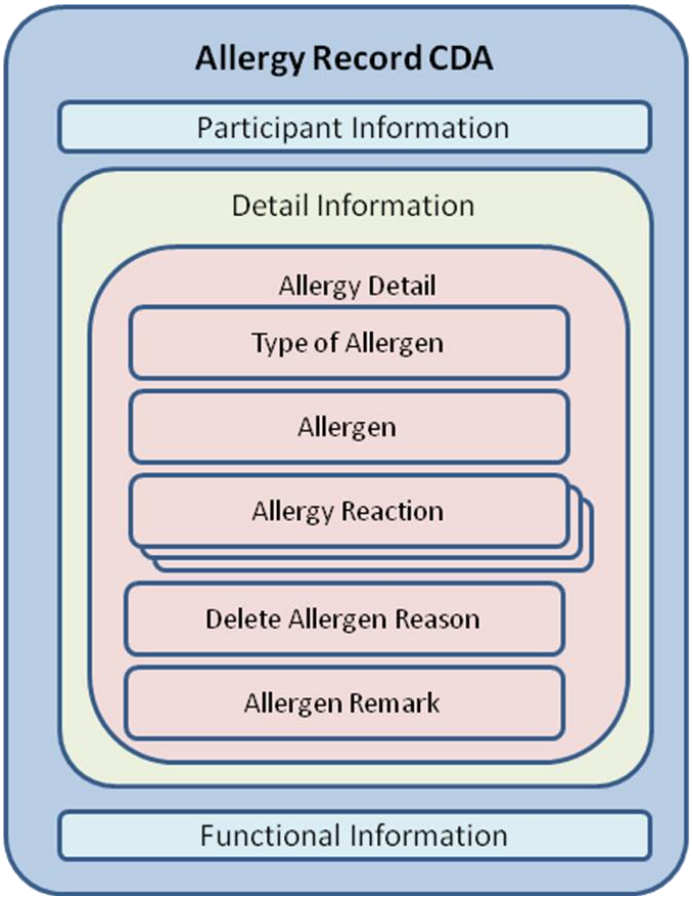

Figure 3 – *Overview of an Allergy Record CDA*

Final Allergy record will be accepted by eHR for data exchange and uploaded to eHR within a single ORU HL7 Message in the OBX.5 segments. Please refer to Figure 1 - *HL7 v2.5 Unsolicited Observation Message for Allergy Record Transfer* for the message structure.

10.3 CDA DOCUMENT SKELETON

```
<ClinicalDocument xmlns="…" xmlns:xsi="…" xsi:schemaLocation="…">

  … Start of CDA Header …
 <typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
 <id/>
 <code code="AL1"/>
 <title>Allergy</title>
 <effectiveTime/>
 <confidentialityCode/>
 <recordTarget>
   <patientRole>
     <id/>
   </patientRole>
 </recordTarget>
 <author>
   <time/>
   <assignedAuthor>
     <id/>
   </assignedAuthor>
 </author>
 <custodian>
   <assignedCustodian>
     <representedCustodianOrganization>
       <id/>
     </representedCustodianOrganization>
   </assignedCustodian>
 </custodian>

  … Start of CDA Body …
 <component>
   <nonXMLBody>
     <clinicalDoc>
       <participant>
         <ehr_no/>
         <hkid/>
         <doc_type/>
         <doc_no/>
         <person_eng_surname/>
         <person_eng_given_name/>
         <person_eng_full_name/>
         <sex/>
         <birth_date/>
       </participant>
       <detail>
         <allergy_detail>
           <record_key/>
           <transaction_dtm/>
           <transaction_type/>
           <last_update_dtm/>
           <episode_no/>
           <attendance_inst_id/>
           <type_of_allergen>
             <type_of_allergen_code/>
             <type_of_allergen_desc/>
             <type_of_allergen_lt_desc/>
           </type_of_allergen>
           <allergen>
```

CDA General Information

HCR Identity

Allergy Details


```
              <allergen_rt_name/>
              <allergen_rt_id/>
              <allergen_rt_desc/>
              <allergen_lt_code/>
              <allergen_lt_desc/>
              <level_of_certainty_code/>
              <level_of_certainty_desc/>
              <level_of_certainty_lt_desc/>
            </allergen>
            <allergic_reaction>
              <allergic_reaction_code/>
              <allergic_reaction_desc/>
              <allergic_reaction_lt_desc/>
            </allergic_reaction>
            <delete_allergen_reason/>
            <allergen_remark/>
            <allergy_note/>
            <record_creation_dtm/>
            <record_creation_inst_id/>
            <record_creation_inst_name/>
            <record_update_dtm/>
            <record_update_inst_id/>
            <record_update_inst_name/>
          </allergy_detail>
      </detail>
     </clinicalDoc>
    </nonXMLBody>
    <text/>
  </component>
</ClinicalDocument>
```

Allergy Details

10.4 DATA MAPPING IN CD FOR HL7-HK MESSAGE STANDARDS

The CDA document is divided into two sections: 'CDA General Information' and 'Clinical Information'. The data mapping of each CDA component will be described in following sections:

10.4.1CDA GENERAL INFORMATION

A CDA document is wrapped by the <ClinicalDocument> element. Under HL7-HK Message Standards, same set of 'CDA General Information' of CDA is required for ALL Subject Domains. The following table shows the data requirements of CDA document requested by eHR. All the following tag elements and information are necessary to be present in the CDA.

No.	XML Tag	XPath	Attribute	Definition	Maximum Length	Cardinality	Remarks
1	ClinicalDocument	ClinicalDocument		A CDA document is wrapped by the <ClinicalDocument> element		1..1	
1.1			@xmlns	Message namespace	string(500)	1..1	Fixed value: xmlns="urn:hl7-org:v3"
1.2			@xmlns:xsi	XML schema instance namespace	string(500)	1..1	Fixed value: xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
1.3			@xsi:schemaLocation	Physical location of schema documents	string(500)	1..1	Fixed value: xsi:schemaLocation="urn:hl7-org:v3 CDA.xsd"

No.	XML Tag	XPath	Attribute	Definition	Maximum Length	Cardinality	Remarks
2	typeId	ClinicalDocument/ typeId		A technology-neutral explicit reference to the CDA, Release 2 specification		1..1	
2.1			@root	The OID for HL7 Registered models	string(500)	1..1	Fixed value: “2.16.840.1.113883.1.3”
2.2			@extension	The unique identifier for the CDA, Release 2 Hierarchical description	string(255)	1..1	Fixed value: “POCD_HD000040”
3	id	ClinicalDocument/id		It represents the unique instance identifier (UID) of a clinical document		1..1	Leave the tag blank, i.e. <id/>. Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards.*
4	code	ClinicalDocument/ code		The code specifying the particular kind of document		1..1	
4.1			@code	The code specifying the particular kind of document	string(20)	1..1	Fixed value: “AL1”
5	title	ClinicalDocument/ title			string(100)	1..1	Fixed value: “Allergy”

No.	XML Tag	XPath	Attribute	Definition	Maximum Length	Cardinality	Remarks
6	effectiveTime	ClinicalDocument/ effectiveTime		Document creation datetime		1..1	Leave the tag blank, i.e. <effectiveTime />. Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.
7	confidentialityCode	ClinicalDocument/ confidentialityCode		Confidentiality of the clinical document		1..1	Leave the tag blank, i.e. <confidentialityCode/>. Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.
8	recordTarget	ClinicalDocument/ recordTarget		The recordTarget represents the medical record that this document belongs to		1..1	Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.
9	patientRole	ClinicalDocument/ recordTarget/ patientRole		A recordTarget is represented as a relationship between a person and an organization, where the person is in a patient role		1..1	Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.
10	id	ClinicalDocument/ recordTarget/ patientRole/id		Unique identifier of the patient role		1..1	Leave the tag blank, i.e. <id/>. Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.

No.	XML Tag	XPath	Attribute	Definition	Maximum Length	Cardinality	Remarks
11	author	ClinicalDocument/ author		It represents the humans and/or machines that authored the document		1..1	Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.
12	time	ClinicalDocument/ author/time		It represents the day and time of the authoring of the original content		1..1	Leave the tag blank, i.e. <time/>. Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.
13	assignedAuthor	ClinicalDocument/ author/assignedAuthor		An author is a person in the role of an assigned author		1..1	Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.
14	id	ClinicalDocument/ author/assignedAuthor /id		Unique identifier of the assigned author		1..1	Leave the tag blank, i.e. <id/>. Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.
15	custodian	ClinicalDocument/ custodian		The custodian is the steward that is entrusted with the care of the document		1..1	Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.
16	assignedCustodian	ClinicalDocument/ custodian/ assignedCustodian		A custodian is a scoping organization in the role of an assigned custodian. The steward organization is an entity scoping the role of AssignedCustodian.		1..1	Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.

No.	XML Tag	XPath	Attribute	Definition	Maximum Length	Cardinality	Remarks
17	representedCustodian Organization	ClinicalDocument/ custodian/ assignedCustodian/ representedCustodian Organization		It is the represented custodian organization that is entrusted with the care of the document.		1..1	Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.
18	id	ClinicalDocument/ custodian/ assignedCustodian/ representedCustodian Organization/id		Unique identifier of represented custodian organization		1..1	Leave the tag blank, i.e. <id/>. Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.
19	text	ClinicalDocument/ component/ nonXMLBody/text		It is used to reference data that is stored externally to the CDA document or to encode the data directly inline		1..1	Leave the tag blank, i.e. <text/>. Please refer to *Section 9.5 Additional Mandatory Elements in CDA for HL7-HK Message Standards*.

10.4.2 CLINICAL INFORMATION

In general, the clinical information can be divided into two sections: 'HCR' and 'Detail'.

In the 'HCR section, information includes:

- HCR Identity Data

In the 'Detail' section, clinical information of the subject domain will be included:

- Allergy Details
  - Transaction Data
  - Type of Allergen Data
  - Allergen Data
  - Allergy Reaction Data
  - Delete Allergen Reason Data
  - Allergen Remark Data
  - Allergy Note Data
  - Allergy Record Creation Data
  - Allergy Record Update Data

It is assumed that only three scenarios will trigger the transfer of Allergy data. They are:

- Uploading New Allergy Record (S1)
- Overriding Existing Allergy Record (S2)
- Deletion of Existing Allergy Record (S3)

For details of scenarios, please refer to Data Requirement Specification for eHR Allergy Record.

The data mappings of elements in 'HCR' and 'Detail' sections will be described as below:

<HCR> Section

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/component/nonXMLBody/clinicalDoc/)	Maximum Length	Cardinality			Remarks
					S1 (New)	S2 (Override)	S3 (Delete)	
1.1	eHR number	ehr_no	participant/ehr_no	string(12)	1..1			Fixed length
1.2	HKIC number	hkid	participant/hkid	string(12)	0..1 if [Identity document number] is given 1..1 if [Identity document number] is blank			
1.3	Type of identity document	doc_type	participant/doc_type	string(6)	0..1 if [Identity document number] is blank 1..1 if [Identity document number] is given			Refer to the code set of "Type of identity document" in eHR Office website
1.4	Identity document number	doc_no	participant/doc_no	string(30)	0..1 if [HKIC number] is given 1..1 if [HKIC number] is blank			
1.5	English surname	person_eng_surname	participant/ person_eng_surname	string(40)	0..1 if [English full name] is not blank 1..1 if [English full name] is blank			Surname should be in uppercase letters.
1.6	English given name	person_eng_given_name	participant/ person_eng_given_name	string(40)	0..1 if [English full name] is not blank 1..1 if [English full name] is blank			Given name should be in uppercase letters.

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/component/nonXMLBody/clinicalDoc/)	Maximum Length	Cardinality			Remarks
					S1 (New)	S2 (Override)	S3 (Delete)	
1.7	English full name	person_eng_full_name	participant/ person_eng_full_name	string(100)	0..1 if [English surname] and [English given name] are not blank 1..1 if [English surname] and [English given name] are blank ** If patient has either English surname or given name stored in local EMR system, full name should be filled.*			Full name should be in uppercase letters. In format: [Surname]+[,]+ 1 white space +[Given Name] e.g CHAN, TAI MAN
1.8	Sex	sex	participant/sex	string(1)	1..1			Refer to the code set of "Sex" in eHR Office website

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/component/nonXMLBody/clinicalDoc/)	Maximum Length	Cardinality			Remarks
					S1 (New)	S2 (Override)	S3 (Delete)	
1.9	Date of birth	birth_date	participant/birth_date	string(23)	1..1			In format: YYYY-MM-DD hh:mm:ss.sss If birth time cannot be provided, the time should be in fixed value “00:00:00.000”. E.g. 2010-01-31 00:00:00.000 Remarks: • If date is exact to ‘Year’ (e.g.2010), the unknown month and day is suggested to be set as ’01-01’ E.g. 2010-**01-01** 00:00:00.000 • If date is exact to ‘Month’(e.g. 2010-12), the unknown day is suggested to be set as ‘01’ E.g. 2010-12-**01** 00:00:00.000

<Detail> Section

The table below shows the data mapping of clinical information for Allergy Record shown in *Section 9.3 CDA Document Skeleton*. In general, there are three data compliance levels (Level 1, 2 and 3). Please note that only Data Compliance Level 2 and 3 is applicable for Allergy Record.

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/ component/nonXMLBody /clinicalDoc/)	Maximum Length	Cardinality Not Applicable (N/A – Data field should not be submitted)						Remarks
					Level 2			Level 3			
					S1 (New)	S2 (Override)	S3 (Delete)	S1 (New)	S2 (Override)	S3 (Delete)	
1	Allergy detail	allergy_detail	detail/allergy_detail		1..*		N/A	1..*		N/A	Parent Tag
2	Record key	record_key	detail/allergy_detail/ record_key	string(50)	1..1			1..1			
3	Transaction datetime	transaction_dtm	detail/allergy_detail/ transaction_dtm	string(23)	1..1			1..1			In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005
4	Transaction type	transaction_type	detail/allergy_detail/ transaction_type	string(1)	1..1			1..1			Possible value: **I** : Insert operation **U** : Update operation **D** : Delete operation *Remarks:* *U' and 'D' are not accepted in materialisation mode.*

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/ component/nonXMLBody /clinicalDoc/)	Maximum Length	Cardinality Not Applicable (N/A – Data field should not be submitted)						Remarks
					Level 2			Level 3			
					S1 (New)	S2 (Override)	S3 (Delete)	S1 (New)	S2 (Override)	S3 (Delete)	
5	Last update datetime	last_update_dtm	detail/allergy_detail/ last_update_dtm	string(23)	1..1			1..1			In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 16:30:05.005
6	Episode number	episode_no	detail/allergy_detail/ episode_no	string(20)	0..1			0..1			
7	Attendance institution identifier	attendance_inst_id	detail/allergy_detail/ attendance_inst_id	string(10)	0..1			0..1			
8	Type of allergen	type_of_allergen	detail/allergy_detail/ type_of_allergen		0..1		N/A	0..1		N/A	Parent Tag
8.1	Type of allergen code	type_of_allergen_code	detail/allergy_detail/ type_of_allergen/ type_of_allergen_code	string(20)	N/A			0..1		N/A	Refer to the code set of “Type of allergen” in eHR Office website
8.2	Type of allergen description	type_of_allergen_desc	detail/allergy_detail/ type_of_allergen/ type_of_allergen_desc	string(255)	N/A			1..1 if [Type of allergen code] is given NA if [Type of allergen code] is blank		N/A	Refer to the code set description of “Type of allergen” in eHR Office website

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/ component/nonXMLBody /clinicalDoc/)	Maximum Length	Cardinality Not Applicable (N/A – Data field should not be submitted)						Remarks
					Level 2			Level 3			
					S1 (New)	S2 (Override)	S3 (Delete)	S1 (New)	S2 (Override)	S3 (Delete)	
8.3	Type of allergen local description	type_of_allergen_lt_desc	detail/allergy_detail/ type_of_allergen/ type_of_allergen_lt_desc	string(255)	0..1		N/A	1..1 if [Type of allergen code] is given 0..1 if [Type of allergen code] is blank		N/A	
9	Allergen	allergen	detail/allergy_detail/ allergen		1..1		N/A	1..1		N/A	Parent Tag
9.1	Allergen - recognised terminology name	allergen_rt_name	detail/allergy_detail/ allergen/allergen_rt_name	string(20)	N/A			1..1		N/A	• Refer to the code set name of "Recognised terminology name - pharmaceutical product or substance" in eHR Office website • If eHR value = HKCTT, allowable nature is "Pharmaceutical product" or "Substanec"

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/ component/nonXMLBody /clinicalDoc/)	Maximum Length	Cardinality Not Applicable (N/A – Data field should not be submitted)						Remarks
					Level 2			Level 3			
					S1 (New)	S2 (Override)	S3 (Delete)	S1 (New)	S2 (Override)	S3 (Delete)	
9.2	Allergen identifier - recognised terminology	allergen_rt_id	detail/allergy_detail/ allergen/allergen_rt_id	string(20)	N/A			1..1		N/A	• Refer to the code set of "Recognised terminology name - pharmaceutical product or substance" in eHR Office website • [Allergen identifier - recognised terminology] should be included in the selected recognised terminology of the "Recognised terminology name - pharmaceutical product or substance" code table.
9.3	Allergen description - recognised terminology	allergen_rt_desc	detail/allergy_detail/ allergen/allergen_rt_desc	string(2000)	N/A			1..1		N/A	• Refer to the code set description of "Recognised terminology name - pharmaceutical product or substance" in eHR Office website

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/ component/nonXMLBody /clinicalDoc/)	Maximum Length	Cardinality Not Applicable (N/A – Data field should not be submitted)						Remarks
					Level 2			Level 3			
					S1 (New)	S2 (Override)	S3 (Delete)	S1 (New)	S2 (Override)	S3 (Delete)	
											• [Allergen description - recognised terminology] should be matched with the corresponding description of the selected [Allergen identifier - recognised terminology] • For HKCTT, use "eHR Description" or "Concept Full Description" • For RPP, use "Product Name"
9.4	Allergen local code	allergen_lt_code	detail/allergy_detail/ allergen/allergen_lt_code	string(20)	0..1		N/A	0..1		N/A	
9.5	Allergen local description	allergen_lt_desc	detail/allergy_detail/ allergen/allergen_lt_desc	string(2000)	1..1		N/A	1..1		N/A	

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/ component/nonXMLBody /clinicalDoc/)	Maximum Length	Cardinality Not Applicable (N/A – Data field should not be submitted)						Remarks
					Level 2			Level 3			
					S1 (New)	S2 (Override)	S3 (Delete)	S1 (New)	S2 (Override)	S3 (Delete)	
9.6	Level of certainty code	level_of_certainty_code	detail/allergy_detail/ allergen/ level_of_certainty_code	string(2)	N/A			0..1		N/A	Refer to the code set of "Allergy level of certainty" in eHR Office website
9.7	Level of certainty description	level_of_certainty_desc	detail/allergy_detail/ allergen/ level_of_certainty_desc	string(255)	N/A			1..1 if [Level of certainty code] is given NA if [Level of certainty code] is blank		N/A	Refer to the code set description of "Allergy level of certainty" in eHR Office website
9.8	Level of certainty local description	level_of_certainty_lt_desc	detail/allergy_detail/ allergen/ level_of_certainty_lt_desc	string(255)	0..1		N/A	1..1 if [Level of certainty code] is given 0..1 if [Level of certainty code] is blank		N/A	
10	Allergic reaction	allergic_reaction	detail/allergy_detail/ allergic_reaction		0..*		N/A	0..*		N/A	Parent Tag
10.1	Allergic reaction code	allergic_reaction_code	detail/allergy_detail/ allergic_reaction/ allergic_reaction_code	string(2)	N/A			0..1		N/A	Refer to the code set of "Allergic reaction" in eHR Office website

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/ component/nonXMLBody /clinicalDoc/)	Maximum Length	Cardinality Not Applicable (N/A – Data field should not be submitted)						Remarks
					Level 2			Level 3			
					S1 (New)	S2 (Override)	S3 (Delete)	S1 (New)	S2 (Override)	S3 (Delete)	
10.2	Allergic reaction description	allergic_reaction_desc	detail/allergy_detail/ allergic_reaction/ allergic_reaction_desc	string(255)	N/A			1..1 if [Allergic reaction code] is given NA if [Allergic reaction code] is blank		N/A	Refer to the code set description of "Allergic reaction" in eHR Office website
10.3	Allergic reaction local description	allergic_reaction_lt_desc	detail/allergy_detail/ allergic_reaction/ allergic_reaction_lt_desc	string(255)	0..1		N/A	1..1 if [Allergic reaction code] is given 0..1 if [Allergic reaction code] is blank		N/A	
11	Delete allergen reason	delete_allergen_reason	detail/allergy_detail/ delete_allergen_reason	string(255)	N/A *Remarks: if 'Delete allergen reason' is uploaded in 'Insert' or 'Override' scenario, the whole record will be rejected.*		0..1	N/A *Remarks: if 'Delete allergen reason' is uploaded in 'Insert' or 'Override' scenario, the whole record will be rejected.*		0..1	

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/ component/nonXMLBody /clinicalDoc/)	Maximum Length	Cardinality Not Applicable (N/A – Data field should not be submitted)						Remarks
					Level 2			Level 3			
					S1 (New)	S2 (Override)	S3 (Delete)	S1 (New)	S2 (Override)	S3 (Delete)	
12	Allergen remark	allergen_remark	detail/allergy_detail/ allergen_remark	string(255)	0..1		N/A	0..1		N/A	
13	Allergy note	allergy_note	detail/allergy_detail/ allergy_note	string(4000)	0..1		N/A	0..1		N/A	
14	Record creation datetime	record_creation_dtm	detail/allergy_detail/ record_creation_dtm	string(23)	0..1		N/A	0..1		N/A	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 15:20:30.005
15	Record creation institution identifier	record_creation_inst_id	detail/allergy_detail/ record_creation_inst_id	string(10)	0..1		N/A	0..1		N/A	Fixed length
16	Record creation institution name	record_creation_inst_name	detail/allergy_detail/ record_creation_inst_name	string(255)	0..1		N/A	0..1		N/A	
17	Record last update datetime	record_update_dtm	detail/allergy_detail/ record_update_dtm	string(23)	1..1		N/A	1..1		N/A	In format: YYYY-MM-DD hh:mm:ss.sss e.g. 2010-01-31 15:20:30.005

No.	Data Field	XML Tag	XPath (prefix:ClinicalDocument/ component/nonXMLBody /clinicalDoc/)	Maximum Length	Cardinality Not Applicable (N/A – Data field should not be submitted)						Remarks
					Level 2			Level 3			
					S1 (New)	S2 (Override)	S3 (Delete)	S1 (New)	S2 (Override)	S3 (Delete)	
18	Record update institution identifier	record_update_inst_id	detail/allergy_detail/ record_update_inst_id	string(10)	0..1		N/A	0..1		N/A	Fixed length
19	Record update institution name	record_update_inst_name	detail/allergy_detail/ record_update_inst_name	string(255)	0..1		N/A	0..1		N/A	

10.5 ADDITIONAL MANDATORY ELEMENTS IN CDA FOR HL7-HK MESSAGE STANDARDS

A CDA document is wrapped by the <ClinicalDocument> element. From *Section 9.3 CDA Document Skeleton*, tag elements which are mandatory under CDA schema but NOT REQUIRED by eHR are highlighted. Required tag elements of CDA under HL7-HK Message Standards will be introduced in *Section 9.4 Data Mapping in CDA under HL7-HK Message Standards*.

For the tag elements which are mandatory under CDA schema but it required by eHR, the value of this tag is allowed to be "Blank". For example, tag element "code" is allowed to be "Blank" in HL7-HK Message Standards, the tag element should be presented as "<code/>" in the CDA.

The table below shows the tag elements which is mandatory under CDA schema but NOT REQUIRED by eHR.

XML Tag	XPath	Definition	Cardinality	Remarks
id	ClinicalDocument/id	It represents the unique instance identifier (UID) of a clinical document	1..1	
effectiveTime	ClinicalDocument/ effectiveTime	Document creation datetime	1..1	
confidentialityCode	ClinicalDocument/ confidentialityCode	Confidentiality of the clinical document	1..1	
recordTarget	ClinicalDocument/ recordTarget	The recordTarget represents the medical record that this document belongs to	1..1	
patientRole	ClinicalDocument/ recordTarget/patientRole	A recordTarget is represented as a relationship between a person and an organization, where the person is in a patient role	1..1	
id	ClinicalDocument/ recordTarget/patientRole/id	Unique identifier of the patient role	1..1	
author	ClinicalDocument/author	It represents the humans and/or machines that authored the document	1..1	

XML Tag	XPath	Definition	Cardinality	Remarks
time	ClinicalDocument/author/ time	It represents the day and time of the authoring of the original content	1..1	
assignedAuthor	ClinicalDocument/author/ assignedAuthor	An author is a person in the role of an assigned author	1..1	
id	ClinicalDocument/author/ assignedAuthor/id	Unique identifier of the assigned author	1..1	
custodian	ClinicalDocument/ custodian	The custodian is the steward that is entrusted with the care of the document	1..1	
assignedCustodian	ClinicalDocument/ custodian/ assignedCustodian	A custodian is a scoping organization in the role of an assigned custodian. The steward organization is an entity scoping the role of AssignedCustodian.	1..1	
representedCustodianOrganization	ClinicalDocument/ custodian/ assignedCustodian / representedCustodianOrganization	It is the represented custodian organization that is entrusted with the care of the document.	1..1	
id	ClinicalDocument/ custodian/ assignedCustodian/ representedCustodianOrganization/id	Unique identifier of represented custodian organization	1..1	
text	ClinicalDocument/ component/nonXMLBody/ text	It is used to reference data that is stored externally to the CDA document or to encode the data directly inline	1..1	

11 OTHER REQUIREMENTS

11.1 CHARACTER SET AND ENCODING

Unicode Transformation Format – 8 bit (UTF-8) will be used in eHR Clinical Data Sharing data exchange. HCP is required to ensure the file that sent to eHR should use UTF-8 encoding as below:

Data File Type	Character and Encoding	Version
HL7 message (e.g. ORU^R01)	UTF-8	XML 1.0
CDA in MIME package	UTF-8 base64	MIME 1.0

11.2 XML PREDEFINED ENTITIES

Extensible Markup Language (XML) is adopted in eHR Clinical Data Sharing data exchange using HL7 messages. The XML specification defines five "predefined entities" representing special characters, and requires that all XML processors honor them. To render the character, the format `&name;` must be used. For example, `&` renders as the character `&` . The table below lists the 5 predefined entities in XML:

Name	Character	Entity Reference	Description
gt	>	>	Greater than
lt	<	<	Less than
amp	&	&	Ampersand
apos	‘	'	Apostrophe
quot	“	"	Quotation mark

The prefix of namespace in XML in HL7 message is not expected.

12 PREPARATION OF MESSAGE FOR DATA TRANSFER

12.1 BASIC REQUIREMENTS

- CDA XSD
- CDA document
- MIME encoder or base64 encoder
- HL7 version 2.5 ORU Message

12.2 HL7 MESSAGE STRUCTURE APPLIED

- Event Type: ORU
- Event Code: R01
- Event Name: Unsolicited Observation Message
- Usage: It provides structured HCR-oriented clinical data between systems.

12.3 PREPARE A HL7 ORU MESSAGE WITH CDA DOCUMENTS

1. Prepare CDA document with clinical data according to the message structure and data mapping in this Technical Interface Specification for eHR Allergy Record and Data Requirement for Allergy Record.

2. Prepare HL7 ORU Message complying with HL7 message structure and data mapping specified in this specification.

3. Use MIME encoder or base64 encoder to encode the CDA document in Base64.

4. Embed the encoded CDA document in MIME format into OBX.5.5 – ED.5 of the ORU Message. *(Refer to Section 11.4 - Data Mapping for MIME Package for the details of MIME standards)*

5. Save the file of HL7 message and CDA document complying with the file naming convention defined in *Section 12 - File Naming Convention*.

6. Send out the HL7 ORU Message via ebMS to the eHR system.

12.4 DATA MAPPING FOR MIME PACKAGE (CDA)

Below shows the eHR standard structure of a MIME Package. And explanation of the elements inside the MIME package will be shown in the following table.

```
MIME-Version: 1.0
Content-Type: multipart/mixed; boundary=<boundary_value>

--<boundary_value>
Content-Type: text/xml; charset=UTF-8;
name="8088450656.BRANCHA.AL1.CDA.20110702084530"
Content-Disposition: attachment;
filename="8088450656.BRANCHA.AL1.CDA.20110702084530"
Content-Transfer-Encoding: base64

<base64 encoded string of CDA>

--<boundary_value>--
```

CDA Part

Header		Attribute	Mandatory (M) / Optional(O)	Default Value	Remarks
MIME-Version			M	1.0	
Content-Type			M	multipart/mixed	
		boundary	M	*<boundary string>*	*<boundary string>*: typically a long random string that doesn't clash with the body text
<blank line>					
CDA Document	--*<boundary_value>*				
	Content-Type		M	text/xml	
		charset	M	UTF-8	
		name	O	*<file name>*	*<file name>:* The file's original name Format of the file name should be complied with the naming convention specified in *Section 12.2 CDA Document Name*
	Content-Disposition		M	attachment	
		filename	M	*<file name>*	*<file name>:* The file's original name Format of the file name should be complied with the naming convention specified in *Section 12.2 CDA Document Name*
	Content-Transfer-Encoding		M	base64	
	<blank line>				
	<BASE64 Content String>				
--*<boundary_value>*--					

Remarks:

1. There will be only one CDA Document which must be the first attachment of the MIME.

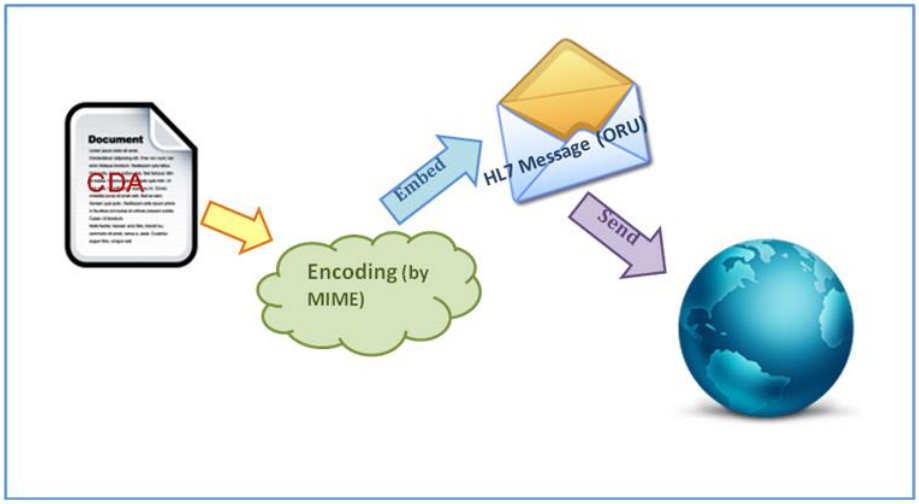

Figure 4 - *CDA Document Exchange in HL7 Message*

13 FILE NAMING CONVENTION

This section describes the file naming standards of the files included in HL7 message under HL7-HK Message Standards. The file components include:

- HL7 Message File
- CDA Document

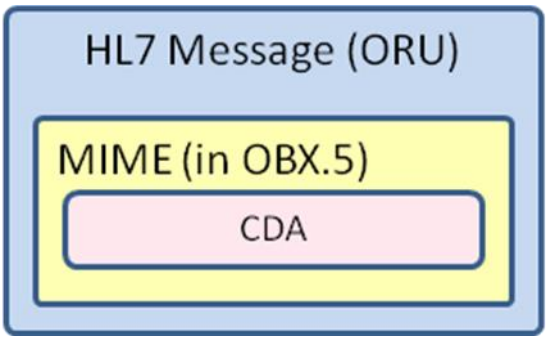

Figure 5- *File Components in HL7 Message*

13.1 HL7 MESSAGE FILE NAME

The naming convention of the file which is carrying the HL7 message is specified as below:

Format

With Sending Location Code,

<HCP ID>.<Sending Location Code>.<Record Type>.HL7.<Message Control ID>

Example

e.g. 8088450656.BRANCHA.AL1.HL7.20110701230000

Naming Convention

1. The file name should be in capital letters.
2. The value of each file name component should not contain dot "."
3. Message Control ID refers to the value in MSH.10
4. If the **<*Sending Location code*>** cannot be provided, its value can be set as same as **<*HCP ID*>**.
5. The value of the <***Sending Location code***> can be in any combination of alphanumeric characters i.e. [A-Z][0-9][-_]

The following table shows the components of file name and the respective definitions:

Sequence	Component	Definition	Maximum Length	Remarks
1	HCP ID	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution for participation in eHR Sharing System	string(10)	Fixed length
2	Sending Location Code	A code to indicate the location where the data is sent from. The format should be agreed before the interface is on production.	string(20)	
3	Record Type	A standardised short term to distinguish the sharable dataset	string(20)	Fixed value: AL1
4	HL7	HL7 File	string(3)	Fixed value: HL7
5	Message Control ID	Message Control ID refers to the value in MSH.10 of HL7 file	string(14)	Values can be in any combination of alphanumeric characters i.e. [A-Z][0-9][-_]

13.2 CDA DOCUMENT NAME

The naming convention of the file which is carrying the CDA document is specified as below:

Format

With Sending Location Code,

<HCP ID>.<Sending Location Code>.<Record Type>.CDA.<Generation Date>

Example

e.g. 8088450656.BRANCHA.AL1.CDA.20110702084530

Naming Convention

1. The file name should be in capital letters.
2. Generation date provided in the file name should be in YYYYMMDDhhmmss format (YYYY:year; MM:month; DD:day; hh:hour; mm:minute; ss:second).
3. The value of each file name component should not contain dot "."
4. If the <Sending Location code> cannot be provided, its value can be set as same as <HCP ID>.
5. The value of the <Sending Location code> can be in any combination of alphanumeric characters i.e. [A-Z][0-9][-_]

The following table shows the components of file name and the respective definitions:

Sequence	Component	Definition	Maximum Length	Remarks
1	HCP ID	A unique identifier assigned by eHR Healthcare Provider Index to each healthcare institution for participation in eHR Sharing System	string(10)	Fixed length
2	Sending Location Code	A code to indicate the location where the data is sent from. The format should be agreed before the interface is on production.	string(20)	
3	Record Type	A standardised short term to distinguish the sharable dataset	string(20)	Fixed value: AL1
4	CDA	CDA File	string(3)	Fixed value: CDA
5	Generation Date	File generation date	string(14)	In format: YYYYMMDDhhmmss

14 EXAMPLE OF HL7-HK MESSAGE STANDARDS

14.1 CDA AND MESSAGE EXAMPLE OF SCENARIO S1 (NEW)

Example: Uploading New Allergy Record (S1)

Example Data

Data Field	Sample Value
eHR number	201000000001
HKIC number	A1234563
Type of document	ID *(Refer the Document Type published in eHealth Record Office website)*
Identity document number	A1234563
English surname	CHAN
English given name	TAI MAN
English full name	CHAN, TAI MAN
Sex	M
Date of birth	2009-01-01 00:00:00.000
Record key	AL1001
Transaction datetime	2012-05-01 00:00:00.000
Transaction type	I
Last update datetime	2012-05-01 00:00:00.000
Episode number	EP-12345
Attendance institution identifier	1735455950
Type of allergen code	Drug
Type of allergen description	Drug allergen
Type of allergen local description	Penicillin allergen
Allergen - recognised terminology name	HKCTT
Allergen identifier - recognised terminology	78507004
Allergen description - recognised terminology	Penicillin G
Allergen local code	A1234
Allergen local description	Peni G
Level of certainty code	S
Level of certainty description	Suspected
Level of certainty local description	Suspected
Allergy reaction code	2
Allergy reaction description	Allergic rhinitis
Allergy reaction local description	Allergic rhinitis
Delete allergen reason	*N/A*
Allergen remark	Just known for 1 month
Allergy note	Suspected allergy known for 1 month
Record creation datetime	2010-01-01 16:00:00

Record creation institution identifier	1735455950
Record creation institution name	Princess Margaret Hospital
Record last update datetime	*N/A*
Record update institution identifier	*N/A*
Record update institution name	*N/A*

CDA Example

```
<?xml version="1.0" encoding="UTF-8"?>
<ClinicalDocument xmlns="urn:hl7-org:v3"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xsi:schemaLocation="urn:hl7-org:v3 CDA.xsd">
<!--
************************************
Participant Information
************************************
-->
  <typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
  <id/>
  <code code="AL1"/>
  <title>Allergy</title>
  <effectiveTime/>
  <confidentialityCode/>
  <recordTarget>
    <patientRole>
      <id/>
    </patientRole>
  </recordTarget>
  <author>
    <time/>
    <assignedAuthor>
      <id/>
    </assignedAuthor>
  </author>
  <custodian>
    <assignedCustodian>
      <representedCustodianOrganization>
        <id/>
      </representedCustodianOrganization>
    </assignedCustodian>
  </custodian>
<!--
************************************
Detail Information
************************************
-->
  <component>
    <nonXMLBody>
      <clinicalDoc>
        <participant>
          <ehr_no>201000000001</ehr_no>
          <hkid>A1234563</hkid>
          <doc_type>ID</doc_type>
          <doc_no>A1234563</doc_no>
          <person_eng_surname>CHAN</person_eng_surname>
          <person_eng_given_name>TAI MAN</person_eng_given_name>
          <person_eng_full_name>CHAN, TAI MAN</person_eng_full_name>
          <sex>M</sex>
          <birth_date>2009-01-01 00:00:00.000</birth_date>
```



```xml
        </participant>
        <detail>
          <allergy_detail>
            <record_key>AL1001</record_key>
            <transaction_dtm>2012-05-01 00:00:00.000</transaction_dtm>
            <transaction_type>I</transaction_type>
            <last_update_dtm>2012-05-01 00:00:00.000</last_update_dtm>
            <episode_no>EP-12345</episode_no>
            <attendance_inst_id>1735455950</attendance_inst_id>
            <type_of_allergen>
              <type_of_allergen_code>Drug</type_of_allergen_code>
              <type_of_allergen_desc>Drug allergen</type_of_allergen_desc>
              <type_of_allergen_lt_desc>
                Penicillin allergen
              </type_of_allergen_lt_desc>
            </type_of_allergen>
            <allergen>
              <allergen_rt_name>HKCTT</allergen_rt_name>
              <allergen_rt_id>78507004</allergen_rt_id>
              <allergen_rt_desc>Penicillin G </allergen_rt_desc>
              <allergen_lt_code>A1234</allergen_lt_code>
              <allergen_lt_desc> Peni G</allergen_lt_desc>
              <level_of_certainty_code>S</level_of_certainty_code>
              <level_of_certainty_desc>
                Suspected
              </level_of_certainty_desc>
              <level_of_certainty_lt_desc>
                Suspected
              </level_of_certainty_lt_desc>
            </allergen>
            <allergic_reaction>
              <allergic_reaction_code>2</allergic_reaction_code>
              <allergic_reaction_desc>
                Allergic rhinitis
              </allergic_reaction_desc>
              <allergic_reaction_lt_desc>
                Allergic rhinitis
              </allergic_reaction_lt_desc>
            </allergic_reaction>
            <delete_allergen_reason/>
            <allergen_remark>Just known for 1 month</allergen_remark>
            <allergy_note>
              Suspected alllergy known for 1 month
            </allergy_note>
            <record_creation_dtm>
              2010-01-01 16:00:00.000
            </record_creation_dtm>
            <record_creation_inst_id>
              1735455950
            </record_creation_inst_id>
            <record_creation_inst_name>
              Princess Margaret Hospital
            </record_creation_inst_name>
            <record_update_dtm/>
            <record_update_inst_id/>
            <record_update_inst_name/>
          </allergy_detail>
        </detail>
      </clinicalDoc>
      <text/>
    </nonXMLBody>
```



```
  </component>
</ClinicalDocument>
```

Message Example (with CDA)

```
<?xml version="1.0" encoding="utf-8"?>
<ORU_R01 xmlns="urn:hl7-org:v2xml"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xsi:schemaLocation="urn:hl7-org:v2xml ORU_R01.xsd">
  <MSH>
  <MSH.1>|</MSH.1>
  <MSH.2>^~\&amp;</MSH.2>
  <MSH.3>
    <HD.1>CMS 3.0</HD.1>
  </MSH.3>
  <MSH.4>
    <HD.1>8088450656</HD.1>
  </MSH.4>
  <MSH.5>
    <HD.1>EIF</HD.1>
  </MSH.5>
  <MSH.6>
    <HD.1>eHR</HD.1>
  </MSH.6>
  <MSH.7>
    <TS.1>20110427181041</TS.1>
  </MSH.7>
  <MSH.8>3</MSH.8>
  <MSH.9>
    <MSG.1>ORU</MSG.1>
    <MSG.2>R01</MSG.2>
    <MSG.3>ORU_R01</MSG.3>
  </MSH.9>
  <MSH.10>20110427181041</MSH.10>
  <MSH.11>
    <PT.1>P</PT.1>
  </MSH.11>
  <MSH.12>
    <VID.1>2.5</VID.1>
  </MSH.12>
  <MSH.15>NE</MSH.15>
  </MSH>
  <ORU_R01.PATIENT_RESULT>
   <ORU_R01.ORDER_OBSERVATION>
    <OBR>
    <OBR.4>
      <CE.1>AL1</CE.1>
    </OBR.4>
    </OBR>
    <ORU_R01.OBSERVATION>
    <OBX>
      <OBX.2>ED</OBX.2>
      <OBX.3>
        <CE.1>AL1</CE.1>
      </OBX.3>
      <OBX.4>NBL-M</OBX.4>
      <OBX.5>
        <ED.2>multipart</ED.2>
        <ED.4>A</ED.4>
        <ED.5>
MIME-Version: 1.0
```



```
Content-Type: multipart/mixed; boundary=00163630f5f354355b046be66f6d

--00163630f5f354355b046be66f6d
Content-Type: text/xml; charset=UTF-8;
name="8088450656.BRANCHA.AL1.CDA.20110702084530"
Content-Disposition: attachment;
filename="8088450656.BRANCHA.AL1.CDA.20110702084530"
Content-Transfer-Encoding: base64

PD94bWwgdmVyc2lvbj0iMS4wIiBlbmNvZGluZz0iVVRGLTgiPz4NCjwhLS0gQ0RBIFNhbXBs
ZSBmb3IgSEtlSFIgSW50ZXJvcGVyYWJpbGl0eSAtLT4NCg0KPCEtLSBDb3B5cmlnaHQ6IFRo
ZSBvd25lcnNoaXAgb2YgdGhpcyBkb2N1bWVudCBzaG91bGQgYmUgUHJlcGFyYXRvcnkgR3Jv
dXAgb24gZUhSIENvbnRlbnQgJiBTdGFuZGFyZHMgdW5kZXIgZUhSIENvbnRlbnQgYW5kIElu
Zm9ybWF0aW9uIFN0YW5kYXJkcyBXb3JraW5nIEdyb3VwIGFuZCBmdXR1cmUgZUhSIG9mZmlj
ZS4gQWxsIFJpZ2h0cyBSZXNlcnZlZC4gLS0+DQo8IS0tIERpc2NsYWltZXI6IFRoZSBJbmZv
IGZvciBFcGlzb2RlIFN1bW1hcnkgd2hpY2ggYXR0YWNoZWQgdGhlIFBERiAgLS0+DQoNCjxDF0
aW9uPSJ1cm46aGw3LW9yZzp2MyBDREEueHNkIiBjbGFzc0NvZGU9IkRPQ0NMSU4iIG1vb2RD
b2RlPSJFVk4iPg0KDQo8IS0tIA0KKioqKioqKioqKioqKioqKioqKioqKioqKioqKioqKioq
KioqKg0KSGVhZGVyIEluZm9ybWF0aW9uDQoqKioqKioqKioqKioqKioqKioqKioqKioqKioq
KioqKioqDQotLT4JDQoNCgk8dHlwZUlkIHJvb3Q9IjIuMTYuODQwLjEuMTEzODgzLjEu
MyIgZXh0ZW5zaW9uPSJQT0NEX0hEMDAwMDQwIi8+DQoJPCEtLSB0ZW1wbGF0ZUlkIHJvb3Q9
IjIuMTYuODQwLjEuMTEzODgzLjEwLjIwLjEiLyAtLT4NCgkNCgk8IS0tIERvY3VtZW50IElE
OyB1bmlxdWUsIGFzc2lnbmVkIGJ5IFByb3ZpZGVyL0N1c3RvZGlhbiwgcm9vdCBjb2RlIG9m
ICBQcm92aWRlci9DdXN0b2RpYW4gdG8gYmUgZGVmaW5lZC0tPg0KCTxpZCByb290PSIyLjE2
Ljg0MC4xLjExMzg4My42LjEiIGV4dGVuc2lvbj0iMTIzNDU2NzgiLz4NCgkNCgk8Y29kZSBj
b2RlPSIzNDEzMy05IiBjb2RlU3lzdGVtPSIyLjE2Ljg0MC4xLjExMzg4My42LjEiIGRpc3Bs
dW1lbnQ+DQo=
        </ED.5>
      </OBX.5>
      <OBX.11>F</OBX.11>
    </OBX>
    </ORU_R01.OBSERVATION>
   </ORU_R01.ORDER_OBSERVATION>
  </ORU_R01.PATIENT_RESULT>
</ORU_R01>
```


14.2 CDA AND MESSAGE EXAMPLE OF SCENARIO S2 (OVERRIDE)

Example: Overriding Existing Allergy Record (S2)

Example Data

Data Field	Sample Value
eHR number	201000000001
HKIC number	A1234563
Type of document	ID *(Refer the Document Type published in eHealth Record Office website)*
Identity document number	A1234563
English surname	CHAN
English given name	TAI MAN
English full name	CHAN, TAI MAN
Sex	M
Date of birth	2009-01-01 00:00:00.000
Record key	AL1001
Transaction datetime	2012-05-01 00:00:00.000
Transaction type	U
Last update datetime	2012-05-01 00:00:00.000
Episode number	EP-12345
Attendance institution identifier	1735455950
Type of allergen code	Drug
Type of allergen description	Drug allergen
Type of allergen local description	Penicillin allergen
Allergen - recognised terminology name	CPP
Allergen identifier - recognised terminology	56432
Allergen description - recognised terminology	Penicillin
Allergen local code	A1234
Allergen local description	Peni
Level of certainty code	S
Level of certainty description	Suspected
Level of certainty local description	Suspected
Allergy reaction code	2
Allergy reaction description	Allergic rhinitis
Allergy reaction local description	Allergic rhinitis
Delete allergen reason	*N/A*
Allergen remark	Just known for 2 months
Allergy note	Suspected allergy known for 2 months
Record creation datetime	*N/A*
Record creation institution identifier	*N/A*

Record creation institution name	*N/A*
Record last update datetime	2010-01-10 10:30:00
Record update institution identifier	1735455950
Record update institution name	Princess Margaret Hospital

CDA Example

```
<?xml version="1.0" encoding="UTF-8"?>
<ClinicalDocument xmlns="urn:hl7-org:v3"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xsi:schemaLocation="urn:hl7-org:v3 CDA.xsd">
<!--
************************************
Participant Information
************************************
-->
  <typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
  <id/>
  <code code="AL1"/>
  <title>Allergy</title>
  <effectiveTime/>
  <confidentialityCode/>
  <recordTarget>
    <patientRole>
      <id/>
    </patientRole>
  </recordTarget>
  <author>
    <time/>
    <assignedAuthor>
      <id/>
    </assignedAuthor>
  </author>
  <custodian>
    <assignedCustodian>
      <representedCustodianOrganization>
        <id/>
      </representedCustodianOrganization>
    </assignedCustodian>
  </custodian>
<!--
************************************
Detail Information
************************************
-->
  <component>
    <nonXMLBody>
      <clinicalDoc>
        <participant >
          <ehr_no>201000000001</ehr_no>
          <hkid>A1234563</hkid>
          <doc_type>ID</doc_type>
          <doc_no>A1234563</doc_no>
          <person_eng_surname>CHAN</person_eng_surname>
          <person_eng_given_name>TAI MAN</person_eng_given_name>
          <person_eng_full_name>CHAN, TAI MAN</person_eng_full_name>
          <sex>M</sex>
          <birth_date>2009-01-01 00:00:00.000</birth_date>
        </participant >
```



```xml
        <detail>
          <allergy_detail>
            <record_key>AL1001</record_key>
            <transaction_dtm>2012-05-01 00:00:00.000</transaction_dtm>
            <transaction_type>U</transaction_type>
            <last_update_dtm>2012-05-01 00:00:00.000</last_update_dtm>
            <episode_no>EP-12345</episode_no>
            <attendance_inst_id>1735455950</attendance_inst_id>
            <type_of_allergen>
              <type_of_allergen_code>Drug</type_of_allergen_code>
              <type_of_allergen_desc>Drug allergen</type_of_allergen_desc>
              <type_of_allergen_lt_desc>
                Penicillin allergen
              </type_of_allergen_lt_desc>
            </type_of_allergen>
            <allergen>
              <allergen_rt_name>CPP</allergen_rt_name>
              <allergen_rt_id>56432</allergen_rt_id>
              <allergen_rt_desc>Penicillin</allergen_rt_desc>
              <allergen_lt_code>A1234</allergen_lt_code>
              <allergen_lt_desc> Peni</allergen_lt_desc>
              <level_of_certainty_code>S</level_of_certainty_code>
              <level_of_certainty_desc>
                Suspected
              </level_of_certainty_desc>
              <level_of_certainty_lt_desc>
                Suspected
              </level_of_certainty_lt_desc>
            </allergen>
            <allergic_reaction>
              <allergic_reaction_code>2</allergic_reaction_code>
              <allergic_reaction_desc>
                Allergic rhinitis
              </allergic_reaction_desc>
              <allergic_reaction_lt_desc>
                Allergic rhinitis
              </allergic_reaction_lt_desc>
            </allergic_reaction>
            <delete_allergen_reason/>
            <allergen_remark>Just known for 2 months</allergen_remark>
            <allergy_note>
              Suspected alllergy known for 2 months
            </allergy_note>
            <record_creation_dtm/>
            <record_creation_inst_id/>
            <record_creation_inst_name/>
            <record_update_dtm>
              2010-01-10 10:30:00.000
            </record_update_dtm>
            <record_update_inst_id>
              1735455950
            </record_update_inst_id>
            <record_update_inst_name>
              Princess Margaret Hospital
            </record_update_inst_name>
          </allergy_detail>
        </detail>
      </clinicalDoc>
      <text/>
    </nonXMLBody>
  </component>
```



```
</ClinicalDocument>
```

Message Example (with CDA)

```
<?xml version="1.0" encoding="utf-8"?>
<ORU_R01 xmlns="urn:hl7-org:v2xml"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xsi:schemaLocation="urn:hl7-org:v2xml ORU_R01.xsd">
  <MSH>
  <MSH.1>|</MSH.1>
  <MSH.2>^~\&amp;</MSH.2>
  <MSH.3>
    <HD.1>CMS 3.0</HD.1>
  </MSH.3>
  <MSH.4>
    <HD.1>8088450656</HD.1>
  </MSH.4>
  <MSH.5>
    <HD.1>EIF</HD.1>
  </MSH.5>
  <MSH.6>
    <HD.1>eHR</HD.1>
  </MSH.6>
  <MSH.7>
    <TS.1>20110427181041</TS.1>
  </MSH.7>
  <MSH.8>3</MSH.8>
  <MSH.9>
    <MSG.1>ORU</MSG.1>
    <MSG.2>R01</MSG.2>
    <MSG.3>ORU_R01</MSG.3>
  </MSH.9>
  <MSH.10>20110427181041</MSH.10>
  <MSH.11>
    <PT.1>P</PT.1>
  </MSH.11>
  <MSH.12>
    <VID.1>2.5</VID.1>
  </MSH.12>
  <MSH.15>NE</MSH.15>
  </MSH>
  <ORU_R01.PATIENT_RESULT>
   <ORU_R01.ORDER_OBSERVATION>
    <OBR>
    <OBR.4>
      <CE.1>AL1</CE.1>
    </OBR.4>
    </OBR>
    <ORU_R01.OBSERVATION>
    <OBX>
      <OBX.2>ED</OBX.2>
      <OBX.3>
        <CE.1>AL1</CE.1>
      </OBX.3>
      <OBX.4>NBL</OBX.4>
      <OBX.5>
        <ED.2>multipart</ED.2>
        <ED.4>A</ED.4>
        <ED.5>
      MIME-Version: 1.0
Content-Type: multipart/mixed; boundary=00163630f5f354355b046be66f6d
```



```
--00163630f5f354355b046be66f6d
Content-Type: text/xml; charset=UTF-8;
name="8088450656.BRANCHA.AL1.CDA.20110702084530"
Content-Disposition: attachment;
filename="8088450656.BRANCHA.AL1.CDA.20110702084530"
Content-Transfer-Encoding: base64

PD94bWwgdmVyc2lvbj0iMS4wIiBlbmNvZGluZz0iVVRGLTgiPz4NCjwhLS0gQ0RBIFNhbXBs
ZSBmb3IgSEtlSFIgSW50ZXJvcGVyYWJpbGl0eSAtLT4NCg0KPCEtLSBDb3B5cmlnaHQ6IFRo
ZSBvd25lcnNoaXAgb2YgdGhpcyBkb2N1bWVudCBzaG91bGQgYmUgUHJlcGFyYXRvcnkgR3Jv
dXAgb24gZUhSIENvbnRlbnQgJiBTdGFuZGFyZHMgdW5kZXIgZUhSIENvbnRlbnQgYW5kIElu
Zm9ybWF0aW9uIFN0YW5kYXJkcyBXb3JraW5nIEdyb3VwIGFuZCBmdXR1cmUgZUhSIG9mZmlj
ZS4gQWxsIFJpZ2h0cyBSZXNlcnZlZC4gLS0+DQo8IS0tIERpc2NsYWltZXI6IFRoZSBJbmZv
IGZvciBFcGlzb2RlIFN1bW1hcnkgd2hpY2ggYXR0YWNoZWQgdGhlIFBERiAgLS0+DQoNCjxDF0
aW9uPSJ1cm46aGw3LW9yZzp2MyBDREEueHNkIiBjbGFzc0NvZGU9IkRPQ0NMSU4iIG1vb2RD
b2RlPSJFVk4iPg0KDQo8IS0tIA0KKioqKioqKioqKioqKioqKioqKioqKioqKioqKioqKioq
KioqKg0KSGVhZGVyIEluZm9ybWF0aW9uDQoqKioqKioqKioqKioqKioqKioqKioqKioqKioq
KioqKioqDQotLT4JDQoNCgk8dHlwZUlkIHJvb3Q9IjIuMTYuODQwLjEuMTEzODgzLjEu
MyIgZXh0ZW5zaW9uPSJQT0NEX0hEMDAwMDQwIi8+DQoJPCEtLSB0ZW1wbGF0ZUlkIHJvb3Q9
IjIuMTYuODQwLjEuMTEzODgzLjEwLjIwLjEiLyAtLT4NCgkNCgk8IS0tIERvY3VtZW50IElE
OyB1bmlxdWUsIGFzc2lnbmVkIGJ5IFByb3ZpZGVyL0N1c3RvZGlhbiwgcm9vdCBjb2RlIG9m
ICBQcm92aWRlci9DdXN0b2RpYW4gdG8gYmUgZGVmaW5lZC0tPg0KCTxpZCByb290PSIyLjE2
Ljg0MC4xLjExMzg4My42LjEiIGV4dGVuc2lvbj0iMTIzNDU2NzgiLz4NCgkNCgk8Y29kZSBj
b2RlPSIzNDEzMy05IiBjb2RlU3lzdGVtPSIyLjE2Ljg0MC4xLjExMzg4My42LjEiIGRpc3Bs
dW1lbnQ+DQo=
        </ED.5>
      </OBX.5>
      <OBX.11>F</OBX.11>
    </OBX>
    </ORU_R01.OBSERVATION>
   </ORU_R01.ORDER_OBSERVATION>
  </ORU_R01.PATIENT_RESULT>
</ORU_R01>
```


14.3 CDA AND MESSAGE EXAMPLE OF SCENARIO S3 (DELETE)

Example: Deletion Of Existing Allergy Record (S3)

Example Data

Data Field	Sample Value
eHR number	201000000001
HKIC number	A1234563
Type of document	ID *(Refer the Document Type published in eHealth Record Office website)*
Identity document number	A1234563
English surname	Chan
English given name	Tai Man
English full name	Chan, TAI Man
Sex	M
Date of birth	2009-01-01 00:00:00.000
Record key	AL1001
Transaction datetime	2012-05-01 00:00:00.000
Transaction type	D
Last update datetime	2012-05-01 00:00:00.000
Delete allergen reason	This entry is not for this patient

CDA Example

```
<?xml version="1.0" encoding="UTF-8"?>
<ClinicalDocument xmlns="urn:hl7-org:v3"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xsi:schemaLocation="urn:hl7-org:v3 CDA.xsd">
<!--
************************************
Participant Information
************************************
-->
  <typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
  <id/>
  <code code="AL1"/>
  <title>Allergy</title>
  <effectiveTime/>
  <confidentialityCode/>
    <recordTarget>
    <patientRole>
      <id/>
    </patientRole>
  </recordTarget>
  <author>
    <time/>
    <assignedAuthor>
      <id/>
    </assignedAuthor>
  </author>
  <custodian>
    <assignedCustodian>
```



```
      <representedCustodianOrganization>
        <id/>
      </representedCustodianOrganization>
    </assignedCustodian>
  </custodian>
<!--
************************************
Detail Information
************************************
-->
  <component>
    <nonXMLBody>
      <clinicalDoc>
        <participant>
          <ehr_no>201000000001</ehr_no>
          <hkid>A1234563</hkid>
          <doc_type>ID</doc_type>
          <doc_no>A1234563</doc_no>
          <person_eng_surname>CHAN</person_eng_surname>
          <person_eng_given_name>TAI MAN</person_eng_given_name>
          <person_eng_full_name>CHAN, TAI MAN</person_eng_full_name>
          <sex>M</sex>
          <birth_date>2009-01-01 00:00:00.000</birth_date>
        </participant>
        <detail>
          <allergy_detail>
            <record_key>AL1001</record_key>
            <transaction_dtm>2012-05-01 00:00:00.000</transaction_dtm>
            <transaction_type>D</transaction_type>
            <last_update_dtm>2012-05-01 00:00:00.000</last_update_dtm>
            <delete_allergen_reason>
              This entry is not for this patient
            </delete_allergen_reason>
          </allergy_detail>
        </detail>
      </clinicalDoc>
      <text/>
    </nonXMLBody>
  </component>
</ClinicalDocument>
```

Message Example (with CDA)

```
<?xml version="1.0" encoding="utf-8"?>
<ORU_R01 xmlns="urn:hl7-org:v2xml"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xsi:schemaLocation="urn:hl7-org:v2xml ORU_R01.xsd">
  <MSH>
  <MSH.1>|</MSH.1>
  <MSH.2>^~\&amp;</MSH.2>
  <MSH.3>
    <HD.1>CMS 3.0</HD.1>
  </MSH.3>
  <MSH.4>
    <HD.1>8088450656</HD.1>
  </MSH.4>
  <MSH.5>
    <HD.1>EIF</HD.1>
  </MSH.5>
  <MSH.6>
    <HD.1>eHR</HD.1>
```



```
  </MSH.6>
  <MSH.7>
    <TS.1>20110427181041</TS.1>
  </MSH.7>
  <MSH.8>3</MSH.8>
  <MSH.9>
    <MSG.1>ORU</MSG.1>
    <MSG.2>R01</MSG.2>
    <MSG.3>ORU_R01</MSG.3>
  </MSH.9>
  <MSH.10>20110427181041</MSH.10>
  <MSH.11>
    <PT.1>P</PT.1>
  </MSH.11>
  <MSH.12>
    <VID.1>2.5</VID.1>
  </MSH.12>
  <MSH.15>NE</MSH.15>
  </MSH>
  <ORU_R01.PATIENT_RESULT>
   <ORU_R01.ORDER_OBSERVATION>
    <OBR>
    <OBR.4>
      <CE.1>AL1</CE.1>
    </OBR.4>
    </OBR>
    <ORU_R01.OBSERVATION>
    <OBX>
      <OBX.2>ED</OBX.2>
      <OBX.3>
        <CE.1>AL1</CE.1>
      </OBX.3>
      <OBX.4>NBL</OBX.4>
      <OBX.5>
        <ED.2>multipart</ED.2>
        <ED.4>A</ED.4>
        <ED.5>
      MIME-Version: 1.0
Content-Type: multipart/mixed; boundary=00163630f5f354355b046be66f6d

--00163630f5f354355b046be66f6d
Content-Type: text/xml; charset=UTF-8;
name="8088450656.BRANCHA.AL1.CDA.20110702084530"
Content-Disposition: attachment;
filename="8088450656.BRANCHA.AL1.CDA.20110702084530"
Content-Transfer-Encoding: base64

PD94bWwgdmVyc2lvbj0iMS4wIiBlbmNvZGluZz0iVVRGLTgiPz4NCjwhLS0gQ0RBIFNhbXBs
ZSBmb3IgSEtlSFIgSW50ZXJvcGVyYWJpbGl0eSAtLT4NCg0KPCEtLSBDb3B5cmlnaHQ6IFRo
ZSBvd25lcnNoaXAgb2YgdGhpcyBkb2N1bWVudCBzaG91bGQgYmUgUHJlcGFyYXRvcnkgR3Jv
dXAgb24gZUhSIENvbnRlbnQgJiBTdGFuZGFyZHMgdW5kZXIgZUhSIENvbnRlbnQgYW5kIElu
Zm9ybWF0aW9uIFN0YW5kYXJkcyBXb3JraW5nIEdyb3VwIGFuZCBmdXR1cmUgZUhSIG9mZmlj
ZS4gQWxsIFJpZ2h0cyBSZXNlcnZlZC4gLS0+DQo8IS0tIERpc2NsYWltZXI6IFRoZSBJbmZv
IGZvciBFcGlzb2RlIFN1bW1hcnkgd2hpY2ggYXR0YWNoZWQgdGhlIFBERiAgLS0+DQoNCjxDF0
aW9uPSJ1cm46aGw3LW9yZzp2MyBDREEueHNkIiBjbGFzc0NvZGU9IkRPQ0NMSU4iIG1vb2RD
b2RlPSJFVk4iPg0KDQo8IS0tIA0KKioqKioqKioqKioqKioqKioqKioqKioqKioqKioqKioq
KioqKg0KSGVhZGVyIEluZm9ybWF0aW9uDQoqKioqKioqKioqKioqKioqKioqKioqKioqKioq
KioqKioqDQotLT4JDQoNCgk8dHlwZUlkIHJvb3Q9IjIuMTYuODQwLjEuMTEzODgzLjEu
MyIgZXh0ZW5zaW9uPSJQT0NEX0hEMDAwMDQwIi8+DQoJPCEtLSB0ZW1wbGF0ZUlkIHJvb3Q9
IjIuMTYuODQwLjEuMTEzODgzLjEwLjIwLjEiLyAtLT4NCgkNCgk8IS0tIERvY3VtZW50IElE
OyB1bmlxdWUsIGFzc2lnbmVkIGJ5IFByb3ZpZGVyL0N1c3RvZGlhbiwgcm9vdCBjb2RlIG9m
```

```
ICBQcm92aWRlci9DdXN0b2RpYW4gdG8gYmUgZGVmaW5lZC0tPg0KCTxpZCByb290PSIyLjE2
Ljg0MC4xLjExMzg4My42LjEiIGV4dGVuc2lvbj0iMTIzNDU2NzgiLz4NCgkNCgk8Y29kZSBj
b2RlPSIzNDEzMy05IiBjb2RlU3lzdGVtPSIyLjE2Ljg0MC4xLjExMzg4My42LjEiIGRpc3Bs
dW1lbnQ+DQo=
        </ED.5>
      </OBX.5>
      <OBX.11>F</OBX.11>
    </OBX>
    </ORU_R01.OBSERVATION>
   </ORU_R01.ORDER_OBSERVATION>
  </ORU_R01.PATIENT_RESULT>
</ORU_R01>
```


14.4 RE-MATERIALISATION MESSAGE

Example Data

Data Field	Sample Value
eHR number	201000000001
HKIC number	A1234563
Type of document	ID *(Refer the "Document Type" published in eHealth Record Office website)*
Identity document number	A1234563
English surname	CHAN
English given name	TAI MAN
English full name	CHAN, TAI MAN
Sex	M
Date of birth	2009-01-01 00:00:00.000

CDA Example

```
<?xml version="1.0" encoding="UTF-8"?>
<ClinicalDocument xsi:schemaLocation="urn:hl7-org:v3 CDA.xsd"
xmlns="urn:hl7-org:v3" xmlns:xsi="http://www.w3.org/2001/XMLSchema-
instance">
  <!--
  ************************************
  CDA General Information
  ************************************
  -->
  <typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
  <id/>
  <code code="AL1"/>
  <title>Allergy</title>
  <effectiveTime/>
  <confidentialityCode/>
  <recordTarget>
    <patientRole>
      <id/>
    </patientRole>
  </recordTarget>
  <author>
    <time/>
    <assignedAuthor>
      <id/>
```



```
    </assignedAuthor>
  </author>
  <custodian>
    <assignedCustodian>
      <representedCustodianOrganization>
        <id/>
      </representedCustodianOrganization>
    </assignedCustodian>
  </custodian>
  <!--
  ************************************
  Clinical Information
  ************************************
  -->
  <component>
    <nonXMLBody>
      <clinicalDoc>
        <participant>
          <ehr_no>201000000001</ehr_no>
          <hkid>A1234563</hkid>
          <doc_type>ID</doc_type>
          <doc_no>A1234563</doc_no>
          <person_eng_surname>CHAN</person_eng_surname>
          <person_eng_given_name>TAI MAN</person_eng_given_name>
          <person_eng_full_name>CHAN, TAI MAN</person_eng_full_name>
          <sex>M</sex>
          <birth_date>2009-01-01 00:00:00.000</birth_date>
        </participant>
      </clinicalDoc>
      <text/>
    </nonXMLBody>
  </component>
</ClinicalDocument>
```

Message Example (with CDA)

```
<?xml version="1.0" encoding="utf-8"?>
<ORU_R01 xmlns="urn:hl7-org:v2xml"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xsi:schemaLocation="urn:hl7-org:v2xml ORU_R01.xsd">
  <MSH>
  <MSH.1>|</MSH.1>
  <MSH.2>^~\&amp;</MSH.2>
  <MSH.3>
    <HD.1>CMS 3.0</HD.1>
  </MSH.3>
  <MSH.4>
    <HD.1>8088450656</HD.1>
  </MSH.4>
  <MSH.5>
    <HD.1>EIF</HD.1>
  </MSH.5>
  <MSH.6>
    <HD.1>eHR</HD.1>
  </MSH.6>
  <MSH.7>
    <TS.1>20110427181041</TS.1>
  </MSH.7>
  <MSH.8>3</MSH.8>
  <MSH.9>
```

```
    <MSG.1>ORU</MSG.1>
    <MSG.2>R01</MSG.2>
    <MSG.3>ORU_R01</MSG.3>
  </MSH.9>
  <MSH.10>20110427181041</MSH.10>
  <MSH.11>
    <PT.1>P</PT.1>
  </MSH.11>
  <MSH.12>
    <VID.1>2.5</VID.1>
  </MSH.12>
  <MSH.15>NE</MSH.15>
  </MSH>
  <ORU_R01.PATIENT_RESULT>
   <ORU_R01.ORDER_OBSERVATION>
    <OBR>
    <OBR.4>
      <CE.1>AL1</CE.1>
    </OBR.4>
    </OBR>
    <ORU_R01.OBSERVATION>
    <OBX>
      <OBX.2>ED</OBX.2>
      <OBX.3>
        <CE.1>AL1</CE.1>
      </OBX.3>
      <OBX.4>NBL-R</OBX.4>
      <OBX.5>
        <ED.2>multipart</ED.2>
        <ED.4>A</ED.4>
        <ED.5>
      MIME-Version: 1.0
Content-Type: multipart/mixed; boundary=00163630f5f354355b046be66f6d

--00163630f5f354355b046be66f6d
Content-Type: text/xml; charset=UTF-8;
name="8088450656.BRANCHA.AL1.CDA.20110702084530"
Content-Disposition: attachment;
filename="8088450656.BRANCHA.AL1.CDA.20110702084530"
Content-Transfer-Encoding: base64

PD94bWwgdmVyc2lvbj0iMS4wIiBlbmNvZGluZz0iVVRGLTgiPz4NCjwhLS0gQ0RBIFNhbXBs
ZSBmb3IgSEtlSFIgSW50ZXJvcGVyYWJpbGl0eSAtLT4NCg0KPCEtLSBDb3B5cmlnaHQ6IFRo
ZSBvd25lcnNoaXAgb2YgdGhpcyBkb2N1bWVudCBzaG91bGQgYmUgUHJlcGFyYXRvcnkgR3Jv
dXAgb24gZUhSIENvbnRlbnQgJiBTdGFuZGFyZHMgdW5kZXIgZUhSIENvbnRlbnQgYW5kIElu
Zm9ybWF0aW9uIFN0YW5kYXJkcyBXb3JraW5nIEdyb3VwIGFuZCBmdXR1cmUgZUhSIG9mZmlj
ZS4gQWxsIFJpZ2h0cyBSZXNlcnZlZC4gLS0+DQo8IS0tIERpc2NsYWltZXI6IFRoZSBJbmZv
IGZvciBFcGlzb2RlIFN1bW1hcnkgd2hpY2ggYXR0YWNoZWQgdGhlIFBERiAgLS0+DQoNCjxDF0
aW9uPSJ1cm46aGw3LW9yZzp2MyBDREEueHNkIiBjbGFzc0NvZGU9IkRPQ0NMSU4iIG1vb2RD
b2RlPSJFVk4iPg0KDQo8IS0tIA0KKioqKioqKioqKioqKioqKioqKioqKioqKioqKioqKioq
KioqKg0KSGVhZGVyIEluZm9ybWF0aW9uDQoqKioqKioqKioqKioqKioqKioqKioqKioqKioq
KioqKioqDQotLT4JDQoNCgk8dHlwZUlkIHJvb3Q9IjIuMTYuODQwLjEuMTEzODgzLjEu
MyIgZXh0ZW5zaW9uPSJQT0NEX0hEMDAwMDQwIi8+DQoJPCEtLSB0ZW1wbGF0ZUlkIHJvb3Q9
IjIuMTYuODQwLjEuMTEzODgzLjEwLjIwLjEiLyAtLT4NCgkNCgk8IS0tIERvY3VtZW50IElE
OyB1bmlxdWUsIGFzc2lnbmVkIGJ5IFByb3ZpZGVyL0N1c3RvZGlhbiwgcm9vdCBjb2RlIG9m
ICBQcm92aWRlci9DdXN0b2RpYW4gdG8gYmUgZGVmaW5lZC0tPg0KCTxpZCByb290PSIyLjE2
Ljg0MC4xLjExMzg4My42LjEiIGV4dGVuc2lvbj0iMTIzNDU2NzgiLz4NCgkNCgk8Y29kZSBj
b2RlPSIzNDEzMy05IiBjb2RlU3lzdGVtPSIyLjE2Ljg0MC4xLjExMzg4My42LjEiIGRpc3Bs
dW1lbnQ+DQo=
        </ED.5>
      </OBX.5>
```

```
      <OBX.11>F</OBX.11>
    </OBX>
    </ORU_R01.OBSERVATION>
   </ORU_R01.ORDER_OBSERVATION>
  </ORU_R01.PATIENT_RESULT>
</ORU_R01>
```