eHealth Network

Guideline on
the electronic exchange of health data
under Cross-Border Directive 2011/24/EU

Hospital Discharge Report

Draft Release 1.0, June 2023

The eHealth Network is a voluntary network, set up under article 14 of Directive 2011/24/EU.
It provides a platform of Member States' competent authorities dealing with eHealth.

To be submitted for eHealth Network adoption, June 2023

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1. USE CASE DESCRIPTION

1.1. Hospital Discharge Report for Cross Border Care

This Use Case represents a high level of consensus on what constitutes European eHealth services, as this Use Case was described by Directive 2011/24/EU of 9 March 2011 on the application of patients' rights in cross-border healthcare.

Use Case description:

Title	**Hospital Discharge Report sharing on a cross-border scale**
Purpose	Support continuity of care by improving efficiency and consistency of the hospital discharge process. ▪ In particular, support information sharing from healthcare professional in the country of treatment (Country B) to the patient country of affiliation (Country A). The sharing of information from country of affiliation (Country A) to country of treatment (Country B) should also be included. Additionally, the electronic exchange of hospital discharge reports can be used to inform the patient or representatives, reimbursement processes, secondary use of data (statistics, research, policy making). As information sharing should not be limited to the cross-border level, implementers, including Member States, could also use these guidelines for National and regional level interoperability to ensure consistency as well as avoid fragmentation and duplication of efforts.
Relevance	Hospital **Discharge** Reports (HDR) are in general the most comprehensive clinical documents, always generated after a hospitalisation. They are specific on what happened and was performed during the staying at hospital, including diagnoses, treatments, procedures, test results, but they frequently **contain the detailed** anamnesis and the indications (including, but not limited to) therapies, and care plan. For those **reasons**, Hospital Discharge Reports are key for the continuity of care, retrospectively and prospectively. The Hospital Discharge Report is a very useful summary of the patient clinical history for planned and **unplanned** care and as reference for searching for additional information. The HDRs are a relevant source of such retrospective information. In **particular**, in case of a new hospitalisation, it is always required

	to provide documents about the previous hospitalisations, **especially** for surgery. After the discharge from the hospital, the newly generated HDR should be **transferred** and added to the patient's EHR.
Domain	Hospital Discharge Report
Situation	Cross-border, (potential inter-regional or national)
Context	Different countries operate different health care systems, support their own culture for healthcare provision, and may use different (or several different) language(s) and possibly different clinical vocabularies and legal basis for the data processing. This raises challenges (e.g. in semantic interoperability) for the support of cross-border exchange of health data and may result in limitations in the use of patients' medical information during patient treatment and care process in different European countries. The political drive for cross border care within the European Union (EU) and an increasing focus on integrated care both have implications for Electronic Health Records (EHRs). The hospital discharge summary is a critical component to ensure quality and continuity of care and an electronic, interoperable record is of particular benefit in a cross-border setting. A Hospital Discharge Report plays a crucial role in keeping patients safe and ensure their well-being after leaving a hospital. The Hospital Discharge Report (HDR) consists of primary clinical information communicating a patient's encounter during a hospital stay to the patient in question and their health care professionals. They typically include a patient's medical history, a summary of the hospital stay, the health status of the patient at the time of discharge, and the care plan for the post-hospital care treatment. As such, the hospital discharge summary of a hospital encounter is compiled at the end of an inpatient stay for the patient. With a growing number of European citizens working and living in other Member States, it is increasingly important to achieve a way of exchanging hospital discharge information across the EU in a way that keeps the confidentiality, integrity, and availability of patient information, thereby providing continuity of care. Other benefits include reduced costs of treatment, ease of access to patient data for the patient in question and their healthcare professionals, reduction of unnecessary laboratory tests, etc. Two use cases are possible with regards to the HDR. Firstly, the HDR is sent from country A to country B in order to ensure continuity of care. Secondly, the HDR is retrieved by country B from country A. To ensure continuity of care during the transition between cross-border types of care, effective communication between healthcare professionals is required.

	Timely access to complete documentation regarding an inpatient stay can lead to improved quality of care after discharge. The hospital discharge report (HDR) generated at the end of an inpatient stay in Country B provides the basis for information: ▪ 1) sent from healthcare professionals in Country B to health care professionals in Country A; ▪ 2) retrieved by healthcare professionals in Country B from healthcare professionals in Country A. Depending on the member state legislation and practice, the HDR is provided to either the patient upon discharge and/or sent to the relevant healthcare professionals. The process flow includes following steps: 1. HDR author creates discharge report and stores it in their EHR system 2. Responsible physician validates the HDR 3. HDR sender electronically sends HDR to identified HDR receivers/ authenticated and authorised HDR retriever electronically retrieves the HDR. The following preconditions are met: standard structure of the HDR used, code systems used are interoperable (technically and semantically), for areas where coding has not yet been generally accepted the free text will have to be allowed. Narrative parts should have a pre-defined structure and content (e.g., parts of the medical history) as well as a list of obligatory data under each section. Security is ensured in the information exchange and treatment process. It is ensured that the healthcare professional is legally allowed to perform the functionalities described in this document. Creation-modification of information by unauthorised personnel is prevented. Any information disclosure to unauthorised persons or parties is prevented. The univocal and unmistakable identification of the patient is ensured.
Information	Hospital Discharge Report
Participants	Citizen/Patient Health professional in country of treatment and care (country B) Health professional in patient's country of origin/affiliation (country A)
Functional process steps	**+++ Scenario 1 - Send HDR to home country +++**

	After treating a *Patient* (from a different country of affiliation), the *Health Professional* prepares a *hospital discharge report*. **The Health Professional collects the patient's consent to return the HDR to the Country of Affiliation.** **The patient can identify specific recipients for the HDR.** **The Health Professional identifies the patient using identity traits from the Country of Affiliation.** The *hospital discharge report* is electronically transferred in a secure way, from the the "country of treatment" to the patient country of affiliation**, in an understandable way, namely regarding language, structure and vocabularies**. The *hospital discharge report* should **be** made available for *health professionals* (country A) involved with the continuity of care of the Patient. **+++ Scenario 2 - Retrieve HDR from home country +++** The *Patient* consults a *Health Professional* in country B. The *Health Professional* is identified, authenticated and authorised. The *Patient* is identified (identity confirmed by country A). The *Health Professional* provides information to the patient on how personal health data in the *hospital discharge report* will be collected and processed. The *Health Professional* requests the available *hospital discharge reports* from the patient's Country of Affiliation. The *Health Professional* selects and requests the relevant *hospital discharge report.* The *hospital discharge reports* is electronically transferred in a secure way, from the patient's country of affiliation to the country that s/he is receiving health treatment (the "country of treatment"). The *hospital discharge reports* is presented to the *health professional* in an understandable way, namely regarding language, structure and vocabularies. The *health professional* uses the *hospital discharge reports* to provide health care service.

Table 1: Hospital Discharge Report Use Case description

2. GUIDELINES FOR HOSPITAL DISCHARGE REPORT

The Member States in the eHealth Network have adopted these supplementary clauses to the general guidelines for the electronic exchange of health data under Cross-Border Directive 2011/24/EU to support the exchange of Hospital Discharge Report for for continuity of care in a cross-border setting. The Hospital Discharge Guideline builds on the foundations laid out by the Patient Summary and the ePrescription Guidelines (including datasets and code systems).

Chapter I - General Considerations

Article 1: Objectives, scope and maintenance

1. These guidelines, as adopted by the eHealth Network, are addressed to the Member States of the European Union and apply to the implementation of a patient dataset for cross-border exchange.
2. These guidelines could serve as a guiding principle for the national development and implementation of Hospital Discharge Reports.
3. The Hospital Discharge Report facilitates the free movement of patients across borders, as well as national interoperability, avoiding repeated costs, enabling savings for patients and healthcare systems. It also allows for the portability of data, which is one of the rights embedded in several legislative acts, such as the General Data Protection Regulation (GDPR). GDPR.

Article 2: Definitions

For the purpose of these guidelines, the definitions of Directive 2014/24/EU, of the eHealth Network General Guidelines *(link to be added as footnote in the word document),* supplemented by the following definitions shall apply:

Term	**Definition**
Episode of Care	identifiable grouping of healthcare-related activities characterized by the entity relationship between the subject of care and a healthcare provider, such grouping determined by the healthcare provider *SOURCE: ISO/TS 18308:2004, definition 3.23*
Hospital encounter	an interaction between a patient and healthcare provider(s) for the purpose of providing healthcare service(s) or assessing the health status of a patient.

	▪ *Encounter* is primarily used to record information about the actual activities that occurred, where *Appointment* is used to record planned activities. *Source: Encounter - FHIR v5.0.0-cibuild*
Inpatient care	is a medical treatment administered to a patient whose condition requires treatment in a hospital or other health care facility, and the patient is formally admitted to the facility by a doctor. Source:https://www.medicareresources.org/glossary/inpatient-care/
Health Care facility	dedicated setting where health care professionals deliver services for care of patients. For example, hospitals, free standing ambulatory surgical centres, nursing homes, extended care facilities, medical, dental and physician offices or clinics and other specialised treatment facilities. *Source: ISO 22441:2022(en), 3.17*
Hospital discharge report (HDR)	a hospital discharge report serves as the primary document communicating a patient's planned care to the post-hospital care team. Often, the discharge summary is the only form of communication that accompanies the patient to the next setting of care. is a report which encompasses a summary of events occurred during a hospital encounter usually manifesting as a hospital admission, stay and discharge, and including communication of planned care. The report could include but is not limited to: 1. Reason for hospitalization. 2. Significant findings. 3. Procedures and treatment provided. 4. Patient's discharge condition. 5. Patient and family, and health professional instructions (as appropriate). *Source: https://www.ncbi.nlm.nih.gov/books/NBK43715/*
Clinical finding	nny state observed directly or indirectly concerning a subject of care and their relationship with the environment. *Source: ISO 18104:2014(en), 3.2.2*

Article 3: Concept and intended use

1. The provisions in the "*eHealth Network GUIDELINE on the electronic exchange of health data under Cross-Border Directive 2011/24/EU - General guidelines*" apply.
2. The aim of the Use Case is to help support safe, high-quality cross-border care for emergency, unplanned and planned care events. This does not preclude the Hospital Discharge Report being used for any other medical purposes.

Chapter II - Legal and Regulatory Considerations

Article 4: Data protection

1. Data contained in ~~patient summariesare~~ HDR are special category of personal data within the meaning of Art. 9 of the General Data Protection Regulation and therefore Member States will need to ensure processing and storage are in line with applicable data protection requirements.
2. Regarding patient rights, national regulation may allow patient to disclose certain elements of Hospital Discharge Report records. Nevertheless, the sensitive information in the HDR must be used confidentially and in the best interests of the patient.

Article 5: Identification authentication and authorisation

Implementation of the Hospital Discharge Report implies that each Member State has addressed enabling activities such as:

1. Providing an official ID number for each citizen for healthcare purposes. For cross-border purposes, an unambiguous patient identifier is a necessary requirement for each individual patient to be linked to the patient record in the country of affiliation.
2. Reference is made to the provisions defined in the eHealth Network General Guidelines in Article 5.

Article 6: Patient safety

Regarding patient safety, there are no specific additional requirements, reference is made to the provisions defined in the eHealth Network General Guidelines.

Chapter III - Organisational and Policy Considerations

Article 7: Enablers for implementation

The Hospital Discharge Report could complement the essential information provided within the Patient Summary making it highly valuable for unscheduled care where the healthcare professionals have no previous knowledge about the patient. Even so, it can also provide a complementary source of information in planned care by supporting health professionals to connect to the stream of information generated along the patient continuity of care.

1. Taking in consideration the nature of the information contained in the Hospital Discharge Report, it is up to each Member State, healthcare provider or initiative to identify the clinical processes that can benefit from its availability and possible updates.
2. The ability to populate the Hospital Discharge Report relies on the accessibility of patients' electronic health information. It is up to each Member State, healthcare provider or initiative to establish the necessary policies to ensure that the Hospital Discharge Report is available, and it is used in the aimed clinical processes.
3. The implementation of a Hospital Discharge Report might facilitate the possibility to indicate additional healthcare professionals/healthcare institutions, due to specific patient requirements such as an expert center for rare diseases and cancers.

Article 8: Quality standards and validation

There being no specific additional requirements, reference is made to the provisions defined in the eHealth Network General Guidelines.

Article 9: Education, training and awareness

1. The added value of the Hospital Discharge Report relies on its use under the right conditions. One essential condition is the education and instruction of health professionals to streamline the access to the Hospital Discharge Report without adding additional burden when compared to the access of other health information.
2. Healthcare professionals should be aware that the main purpose of the Hospital Discharge Report is continuity of care. The main focus will be on the information supporting this purpose. Other redundant information should be minimized. The structure of the Hospital Discharge Report should be standardized and information should be presented in a logical order for ease of the reader of the Hospital Discharge Report.
3. Taking in consideration the essential nature of the information present in a Hospital Discharge Report, it is important to instruct health professionals in the use of key pieces of information available.
4. Along the Citizen/Patient Continuity of Care, several health professionals will interact with the Patient. Each of these health professionals should be trained about the key information that should be included into the Hospital Discharge Report.

Chapter IV - Semantic Considerations

Article 10: Data

1. The content of the ~~Patient Summary~~ HDR Dataset is shown in chapter 4. The HDR Dataset comprises *HDR Header* and *HDR Body*.
2. Clinical information in the HDR will comprise narrative text along with coded data, the latter will allow an unambiguously way of communicating the same information between the country of affiliation and the country of treatment.
3. All clinically relevant information in coded elements must also be included and visible in a narrative part of the HDR .
4. It is the responsibility of the Member State to provide data in compliance with these guidelines. Member States are encouraged to align their future considerations on a national HDR according to the dataset structure given in chapter 4.
5. For a given patient, some of the elements might be empty as no data would be applicable or available; such situations should be communicated differently. Cardinality (i.e., repetition and optionality) of individual fields or groups of fields are not part of this document and can be defined in detailed implementation guides.
6. The structured and coded content of the HDR is received by the health professional in two languages, Country A language and a translation to Country B language. If Country B language is unavailable for a dataset, English can be used.
7. The structured and coded content of the HDR is received by the health professional in two languages. Depending on the country where the health professional is located, Country A or Country B language is available. If the Country A or Country B language is unavailable for a dataset, English can be used.
8. When the available coded information in one Member State cannot be transcoded into the selected preferred code system currently, the information should, as an interim solution, be transferred encoded, preferably displayed in English, and/or in narrative form.

Article 11: Terminology

1. The Use Cases require the ability to convey both meaning and context in the Hospital Discharge Report to enable safe, high-quality care. For that purpose, along with the dataset structure, preferred code systems provide concepts that will be understood by both the provider and the receiver of the Hospital Discharge Report.
2. Different code systems are used by Member States. The strategic long-term goal is to gradually reduce fragmentation and converge on the use of international code systems across Europe also considering, in the future, the expected wider use of new and emerging international standards such as the International Classification for Diseases 11th Revision (ICD-11), SNOMED CT or the International Classification of Health Interventions (ICHI). Likewise, the ISO Identification of Medicinal Products (IDMP) suite of standards should be used for medicinal products identification, as soon as made available

by the EMA and National Competent Authorities joint SPOR (Substances, Products, Organisations, Referentials) Project.

3. Member States wishing to engage in cross-border communication are encouraged to use for that communication, the preferred code systems as described in the Hospital Discharge Report Dataset in chapter 4.

Article 12: Controlled Lists (Value set Catalogues)

There being no specific additional requirements, reference is made to the provisions defined in the eHealth Network General Guidelines.

Chapter V - Technical Considerations

Article 13: Technical requirements

Member States are free to choose the technical implementation of their Hospital Discharge Report (HDR). Nonetheless, for cross-border exchange the format of the document for exchange shall be based on standards and profiles as agreed by the eHealth Network for the particular technical infrastructure. The cross-border specifications are described in section 5.3, which also refers to supporting requirements and other relevant documentation.

Article 14: Security

There being no specific additional requirements, reference is made to the provisions defined in the eHealth Network General Guidelines.

Article 15: Testing and audit

There being no specific additional requirements, reference is made to the provisions defined in the eHealth Network General Guidelines.

3. SUPPORTING INFORMATION

This chapter provides supporting information and explanatory text to aid understanding the guidelines, and the rationale underlying the recommendations. This chapter follows the same structure as the eHealth Network General Guidelines.

The main goal of this chapter is to disseminate common practices for initiatives implementing the exchange of hospital discharge reports and it is highly inspired by the lessons learnt in the MyHealth@EU implementation of these guidelines.

The material in this chapter is based on work of previous projects such as epSOS, EXPAND, OpenMedicine, eStandards, VALUeHEALTH, the joint EU/US Trillium Bridge and Trillium II, UNICOM and X-eHealth. Additional insights, for future evolutions, are expected from projects as UNICOM and X-eHealth.

Chapter I - General Considerations

Article 1: Objectives and scope

The objective of the Hospital Discharge Report (HDR) Guidelines is to retain the concept of a controlled HDR. The dataset is non-exhaustive, providing a robust, well-defined core set of data items.

Article 2: Definitions

There is no specific support information.

Article 3: Concept and intended use

These guidelines are non-binding and Member States are considered to have the right to choose freely their way of implementing national Hospital Discharge Report datasets. The Hospital Discharge Report guidelines focus on the content issues and the description of possible ways to produce this content for cross-border exchange, taking existing national implementations into consideration.

The selection of data elements comprising the Hospital Discharge Report may be extended to hold additional and necessary information in standardised modules as clinically relevant.

Chapter II - Legal and Regulatory Considerations

Article 4: Data protection

There being no specific additional requirements, reference is made to the provisions defined in the eHealth Network General Guidelines.

Article 5: Identification, authentication and authorisation

To be able to link patients with their patient records related to the HDR episode, the existence of a patient identifier is necessary. For cross-border purposes, an unambiguous patient identifier (which is not necessarily specific to healthcare) is also a necessary requirement for each individual patient to be linked to the patient record in the country of origin. Analysis of data shows that most Member States already have a national patient identifier available. In some cases, Member States have a regional patient identifier.

If a patient identifier is unavailable, other official documents could be used for patient identification, other official documents could be used for patient identification, such as a passport, ID card or driver's license.

Article 6: Patient safety

The Hospital Discharge Report is a clinical document to support the continuity of care. For the patient safety, it is important that the Health Professional is aware of the fact that the Hospital Discharge Report cannot be exhaustive. The provided data must be reliable, coherent both when it is declared the presence or the noted absence of specific clinical conditions.

Chapter III - Organisational and Policy Considerations

Article 7: Enablers for implementation

The primary goal of the HDR is to support cross-border care, so that any Member State must follow these guidelines for reference for HDR national implementation. The eHealth Network has agreed that the guidelines could serve as a common baseline for HDR at national level. The agreement on the HDR Dataset in Europe and its widespread implementation will assist Member States in the implementation of interoperable solutions for health care. Using the HDR guideline as the guiding principle for all types of EU-projects and implementations (such as registries and research projects) can foster the use of HDR data within the European Health Data Space.

Article 8: Quality standards and validation

Member States should work together to build a convergent use of code systems. Mappings should be done as shared activities when more Member States are affected. Also licensing activities with Standard Developing Organisations (SDO) partners should be done together. This will reduce the burden of the workload, support capacity building and also foster the EU pathway towards a harmonised way forward. This may be facilitated by the European Commission.

Article 9: Education, training and awareness

There is no specific support information.

Chapter IV - Semantic Considerations -

Article 10: Data

The Hospital Discharge Report can be created and signed by a health professional or be automatically generated by a system. In both cases, of manually and automatically generated HDR, information may be derived from multiple sources using different semantic standards and datasets, which complicates the exchange of cross-border HDR information. Therefore, a

selection of data elements (*see chapter 4. Hospital Discharge Dataset*) for Cross border care was compiled to serve as exchange format throughout the EU and Europe. This dataset can provide countries with a guideline to orient future evolutions of their Hospital Discharge Report. The content of the dataset is version controlled, subject to change through a change control process.

International standards shall be adopted to convey the contents of Hospital Discharge Report in a structured and coded way, unequivocally understandable by Health Professionals at national and cross-border level.

The identification of medicinal products, in particular, is posing important challenges for the exchange of information in the Hospital Discharge Report. It is expected that the coding schemes currently included within the data set will be complemented by data sets and identifiers developed during the implementation of the ISO IDMP set of standards. The European Medicines Agency is leading the work on this implementation in Europe in coordination with the National Competent Authorities in Member States.

In respect to the results section, it should be used to communicate the observed results for a patient that are relevant for the continuity of care.

In the instance where the Patient provides health information such as travel history relevant for the HDR to the healthcare professional (for example, a recent travel in a region of high prevalence of a specific infectious disease like Malaria), the section is not intended for data injected directly by the patient. Future revisions of the HDR Guideline might capture the need of such reported data.

Article 11: Terminology

Successful sharing of information requires the effective use of standards to support accurate and complete clinical documentation to ensure consistency.

The use of standardised and recognised code systems allows the unambiguous exchange of clinical information in the HDR. Both the Member State providing the information and the Member State receiving it need to understand the clinical concepts, therefore it is recommended to use preferred code systems as presented in chapter 4. Member States using different international standard code systems, should make use of mappings to the preferred code systems.

It is up to the eHealth Network to oversee the process by which code systems are kept under review and facilitate licensing arrangements.

Article 12: Controlled Lists (Value set Catalogue)

Since some code systems such as SNOMED CT, LOINC, and ICD (to name but three) contain a large number of concepts, it might not always be practical to use them in their entirety within the

European context where some Member States might use internally different code systems that they will have to cross-reference and/or translate. A clear set of criteria should be used to select the most significant concepts and arrive at a reasonable manageable content.

Some code systems, such as SNOMED CT, are restricted in use. In these cases, available unrestricted subsets should be considered, for example, the content of the SNOMED CT Global Patient Set (GPS).

Chapter V - Technical Considerations

Article 13: Technical requirements

There is no specific support information.

Article 14: Security

There is no specific support information.

Article 15: Testing and audit

There is no specific support information.

4. HOSPITAL DISCHARGE REPORT DATASET

The datasets indicated in the following tables are considered relevant for patient safety and the provision of adequate level of care both at cross-border and national level.
It is up to each implementation project to decide on the conformance and cardinality (i.e. data elements required or optional and number of repetitions).

The indicated "Preferred Code Systems" are inspired by the eHealth Digital Service Infrastructure implementation and the HL7 IPS implementations.

4.1 HOSPITAL DISCHARGE REPORT HEADER

#	Data element	Description	Preferred Code System/Valueset
A.1	**Report header data element**		
A.1.1	**Identification of the patient/subject**		
A.1.1.1	Given name	The given name/first name of the patient (also known as forename or first name). This field can contain more than one element.	
A.1.1.2	Family name/surname	The family name/surname/last name of the patient. This field can contain more than one element or multiple fields could be present.	
A.1.1.3	Date of birth	The date of birth of the patient [ISO TS 22220]. As age of the patient might be important for correct interpretation of the test result values, complete date of birth should be provided.	
A.1.1.4	Personal identifier	An identifier of the patient that is unique within a defined scope. Example: National ID (birth number) for Czech patient. Multiple identifiers could be provided.	
A.1.1.5	Nationality	Nationality of the patient.	eHDSICountry (ISO 3166)
A.1.1.6	Gender	This field must contain a recognised valid value for "administrative gender". If different, "physiological gender" should be communicated elsewhere.	HL7 Administrative Gender
A.1.1.7	Language communication	Patient communication language. Multiple communication languages might be provided.	BCP 47

A.1.2	**Patient/subject related contact information**		
A.1.2.1	**Patient address**		
A.1.2.1.1	Address	Mailing and home or office addresses. The addresses are always sequences of address parts (e.g. street address line, country, ZIP code, city) even if postal address formats may vary depending on the country. An address may or may not include a specific use code; if this attribute is not present it is assumed to be the default address useful for any purpose.	eHDSICountry (ISO 3166)
A.1.2.1.2	Telecom	Telecommunication contact information (addresses) associated to a person. Multiple telecommunication addresses might be provided.	
A.1.2.2	**Preferred healthcare professional (HP)** - This section can be repeated and linked to any specific information in the document, for example a link between a rare disease problem and the rare disease specialist responsible for the care of the individual patient (this section).		
A.1.2.2.1	Identifier	An identifier of the healthcare professional that is unique within a defined scope. Example: National healthcare professional ID. Multiple identifiers could be provided.	
A.1.2.2.2	Name of the HP	Name of the Health Professional that has been treating or taking responsibility for the patient. [the structure of the name will be the same as for the patient (given name, family name / surname)]	
A.1.2.2.3	Role of the HP	Healthcare professional role. Multiple roles could be provided.	ISCO or SNOMED CT specialty - to be discussed
A.1.2.2.4	HP Organisation	Healthcare Professional Organisation	

A.1.2.2.5	Address	Mailing and home or office addresses. The addresses are always sequences of address parts (e.g. street address line, country, ZIP code, city) even if postal address formats may vary depending on the country. An address may or may not include a specific use code; if this attribute is not present it is assumed to be the default address useful for any purpose.	eHDSICountry (ISO 3166)
A.1.2.2.6	Telecom	Telecommunication contact information (addresses) associated to a person. Multiple telecommunication addresses might be provided.	
A.1.2.3	**Contact person/ legal guardian** (multiple contacts could be provided)		
A.1.2.3.1	Role of that person	Role of the contact person: legal guardian, next of kin, other person to contact.	http://terminology.hl7.org/CodeSystem/v3-RoleClass
A.1.2.3.2	Relationship level	Relationship type with the patient (e.g. father, wife, daughter)	eHDSIPersonalRelationship
A.1.2.3.3	Identifier	An identifier of the healthcare professional that is unique within a defined scope. Example: National personal ID, passport number etc. Multiple identifiers could be provided.	
A.1.2.3.4	Given name	The first name of the contact person/guardian (example: Peter). This field can contain more than one element.	
A.1.2.3.5	Family name/surname	This field can contain more than one element. Example: Español Smith	

A.1.2.3.6	Address	Mailing, home or office addresses. The addresses are always sequences of address parts (e.g. street address line, country, ZIP code, city) even if postal address formats may vary depending on the country. An address may or may not include a specific use code; if this attribute is not present it is assumed to be the default address useful for any purpose.	eHDSICountry (ISO 3166)
A.1.2.3.7	Telecom	Telecommunication contact information (addresses) associated to a person. Multiple telecommunication addresses might be provided.	
A.1.3	**Health insurance and payment information** - Health insurance information is not always required, however, in some jurisdictions, the insurance number is also used as the patient identifier. It is necessary not just for identification but also forms access to funding for care.		
A.1.3.1	Health insurance code	Unique health insurance company identification code.	
A.1.3.2	Health insurance name	Full, official name of the healthcare insurance provider.	
A.1.3.3	Health insurance number	Number or code under which the insured person is registered at the insurance provider.	
A.1.4	**Information recipient -** (intended recipient or recipients of the report, additional recipients might be identified by the ordering party, e.g. GP, other specialist)		
A.1.4.1	Recipient identifier	The health professional identification number. Either an internal identifier assigned by a healthcare provider institution or (preferably) a national health professional ID such as the license or registration number. In case when recipient is not a health professional, e.g. patient, appropriate personal identifier should be used.	

A.1.4.2	Recipient name	Person name.	
A.1.4.3	Recipient organization ID	The healthcare provider organization identifier if known. Identifier that is unique within a defined scope. Example: National healthcare provider ID. Multiple identifiers could be provided.	
A.1.4.4	Recipient organization	The healthcare provider organization information.	
A.1.4.5	Address	Mailing and home or office addresses. The addresses are always sequences of address parts (e.g. street address line, country, ZIP code, city) even if postal address formats may vary depending on the country. An address may or may not include a specific use code; if this attribute is not present it is assumed to be the default address useful for any purpose.	eHDSICountry (ISO 3166)
A.1.4.6	Country	Country of the intended recipient.	eHDSICountry (ISO 3166)
A.1.4.7	Telecom	Telecommunication contact information (addresses) associated to a person. Multiple telecommunication addresses might be provided.	
A.1.5	**Author (by whom the Hospital discharge report was authored)**		
A.1.5.1	Author identifier	The health professional identification number. Either an internal identifier assigned by a healthcare provider institution or (preferably) a national health professional ID such as the license or registration number.	
A.1.5.2	Author name	Person name.	

A.1.5.3	Author organization ID	The healthcare provider organization identifier if known. Identifier that is unique within a defined scope. Example: National healthcare provider ID. Multiple identifiers could be provided.	
A.1.5.4	Author organization	The healthcare provider organization identifier if known. Identifier that is unique within a defined scope. Example: National healthcare provider ID. Multiple identifiers could be provided.	
A.1.5.5	DateTime	Date and time of the last modification of the document by its Author.	
A.1.6	**Attester** (multiple attesters could be provided)		
A.1.6.1	Attester identifier	The health professional identification number. Either an internal identifier assigned by a healthcare provider institution or (preferably) a national health professional ID such as the license or registration number.	
A.1.6.2	Attester name	Person name.	
A.1.6.3	Attester organization ID	The healthcare provider organization identifier if known. Identifier that is unique within a defined scope. Example: National healthcare provider ID. Multiple identifiers could be provided.	
A.1.6.4	Attester organization	The healthcare provider organization information.	
A.1.6.5	Approval date and time	Date and time of the approval of the document by Attester.	
A.1.7	**Legal authenticator** (The person taking responsibility for the medical content of the document)		

A.1.7.1	Legal authenticator identifier	The health professional identification number. Either an internal identifier assigned by a healthcare provider institution or (preferably) a national health professional ID such as the license or registration number. Multiple identifier could be provided.	
A.1.7.2	Legal authenticator name	Person name.	
A.1.7.3	Legal authenticator organization ID	The healthcare provider organization identifier if known. Identifier that is unique within a defined scope. Example: National healthcare provider ID. Multiple identifiers could be provided.	
A.1.7.4	Legal authenticator organization	The healthcare provider organization information.	
A.1.7.5	Authentication date and time	Date and time when the document was authorized.	
A.1.8	**Document metadata**		
A.1.8.1	Document ID	Unique identifier of the document	
A.1.8.2	Document type	A coded type of the document. Fixed value "Hospital dicharge summary"	LOINC
A.1.8.3	Document status	The status of the Hospital discharge report. E.g., preliminary, final.	hl7:CompositionStatus
A.1.8.4	Report date and time	Date and time of the result report creation.	

A.1.8.5	Document title	Document title, e.g. "Hospital discharge report"	
A.1.8.6	Report custodian	Organisation that is in charge of maintaining the report	
A.1.8.7	Confidentiality	Level of confidentiality of the document. Implicit value is normal.	hl7:confidentiality
A.1.8.8	Language	Language in which the document is written. Language is expressed by the ISO language code.	BCP 47
A.1.8.9	Version	Version of the document	
A.1.9	**Digital signatures**		
A.1.9.1	Digital signature	Digital signature of the document	
A.1.9.2	Time stamp	An electronic time stamp	

Table 2: Hospital discharge report dataset for administrative data

4.2. HOSPITAL DISCHARGE REPORT BODY

#	Data Element	Description	Preferred Code System/Valueset
A.2.1	**Advance directives**		
A.2.1.1	**Living will**	Only directives being expressed only during current inpatient stay. Multiple records of living wills could be provided.	
A.2.1.1.1	Date and time	The date and time on which the living will was recorded.	
A.2.1.1.2	Type	Type of a living will, e.g. Do not resuscitate, donorship statement, power of attorney etc.	SNOMED CT, value set

A.2.1.1.3	Comment	Comment on the living will.	
A.2.1.1.4	Related conditions	The problem or disorder to which the living will applies. Multiple fields could be provided.	ICD-10* SNOMED CT GPS Orphacode if rare disease is diagnosed
A.2.1.1.5	Living will document	Scanned source document with the living will and the patient's signature, such as a PDF.	
A.2.2	**Emergency information**		
A.2.2.1	**Allergy and Intolerance**	A record of allergies and intolerances is mandatory. For patients without allergies or intolerances, this fact must be explicitly expressed with the appropriate code.	
A.2.2.1.1	Allergy description	Textual description of the allergy or intolerance	
A.2.2.1.2	Agent or Allergen	A specific allergen or other agent/substance (drug, food, chemical agent, etc.) to which the patient has an adverse reaction propensity.	SNOMED CT ATC DLP
A.2.2.1.3	Type of propensity	This element describes whether this condition refers to an allergy, non-allergy intolerance, or unknown class of intolerance (not known to be allergy or intolerance)	SNOMED CT

A.2.2.1.4	Allergy manifestation	Description of the clinical manifestation of the allergic reaction including date of manifestation and severity. Example: anaphylactic shock, angioedema (the clinical manifestation also gives information about the severity of the observed reaction). Multiple manifestations could be provided.	SNOMED CT
A.2.2.1.5	Criticality	Potential risk for future life-threatening adverse reactions when exposed to a substance known to cause an adverse reaction.	SNOMED CT
A.2.2.1.6	Onset date	Date of onset of allergy, e.g., date of the first observation of the reaction. Could be also expressed using a life period (childhood, adolescency)	SNOMED CT (Age group)
A.2.2.1.7	End date	Date of resolution of the allergy (e.g. when the clinician deemed there is no longer any need to track the underlying condition)	
A.2.2.1.8	Status	Current status of the allergy or intolerance, for example, whether it is active, in remission, resolved, and so on …	Active, resolved, …
A.2.2.1.9	Certainty	Assertion about the certainty associated with a propensity, or potential risk, of a reaction to the identified substance. Diagnostic and/or clinical evidence of condition.	SNOMED CT
A.2.2.1.10	Last Manifestation	Daten (and time) of last known manifestation.	
A.2.2.2	**Medical alerts**		

A.2.2.2.1	Alert name	A warning, other than a condition or problem. The warning can be entered in code (there are codes for frequently used alerts), but seeing the dynamic nature of the warnings cf. SARS and Ebola, these alerts will often be entered as free text.	SNOMED CT LOINC
A.2.2.2.3	Condition	The patient's health problem or condition that is the subject of the alert. This could involve a patient's problem, condition or diagnosis that is seen as a contraindication in prescribing medication or which has to be taken into account when shaping diagnostic and therapeutic policy. This can be in the patient's own interest, or it can involve a problem or disorder that can make the patient a risk to their surroundings, such as an infection hazard. These are references to conditions included on the patient's problem list.	MKN-10* SNOMED CT Orphacode
A.2.2.2.4	Specialist contact	A reference to the specialist treating the condition, esp. if it is a rare disease. Multiple references could be provided.	
A.2.2.2.5	Comment	Explanatory comments to the alert that cannot be expressed in any of the other elements.	
A.2.2.2.6	Level	Level of the alert or risk.	SNOMED CT
A.2.2.2.7	Period	Period of time when the alert was effective. Only start date will be recorded most of the time.	

A.2.3	**Encounter**		
A.2.3.1	Encounter type	The type of the encounter whether inpatient or short stay encounter.	Selection from hl7v3:ActEncounterCode
A.2.3.2	Encounter note	A narrative description of the encounter course.	
A.2.3.3	**Admission**		
A.2.3.3.1	Admission urgency	Admission type, either emergency or planned	http://terminology.hl7.org/ValueSet/v3-xEncounterAdmissionUrgency
A.2.3.3.2	Admission date	Admission date and time.	
A.2.3.3.3	Admitting professional Id	The health professional identification number. Either an internal identifier assigned by a healthcare provider institution or (preferably) a national health professional ID such as the license or registration number.	
A.2.3.3.4	Admitting professional name	Person name.	
A.2.3.3.5	Admit Source	From where patient was admitted (e.g. physician referral, transfer).	http://terminology.hl7.org/CodeSystem/admit-source
A.2.3.3.6	Referring professional Id	The health professional identification number. Either an internal identifier assigned by a healthcare provider institution or (preferably) a national health professional ID such as the license or registration number.	
A.2.3.3.7	Referring professional name	Person name.	

A.2.3.3.8	Referring organization	The healthcare provider organization information.	
A.2.3.4	**Admission reason**		
A.2.3.4.1	Admission reason	Reason or reasons for admission, e.g. Problem, procedure or finding.	ICD-10* SNOMED CT Orphacode
A.2.3.4.2	Admission reason comment	Explanation of the reason for the encounter.	
A.2.3.4.3	Admission legal status	Legal status/situation at admission. The legal status indicates the basis on which the patient is staying in a healthcare organization. This can be either voluntary or involuntary, however the legal status is always determined by a court. A patient can also receive healthcare based on a forensic status. (voluntary, involuntary, admission by legal authority).	SNOMED CT
A.2.3.5	**Discharge**		
A.2.3.5.1	Discharge date	Discharge date and time	
A.2.3.5.2	Discharge destination type	Type of location to which the patient will go after the encounter. E.g. home, hospital, nursing home, left against medical advice etc.	http://terminology.hl7.org/CodeSystem/discharge-disposition
A.2.3.5.3	Destination location	The location/organization to which the patient will go after the encounter. Name, address and telecommunication contact.	
A.2.3.6	**Location -** All locations/departments where the patient stayed within the hospital.		

A.2.3.6.1	Period	Time period during which the patient was present at the location	
A.2.3.6.2	Organization Id	The organization's part identifier.	
A.2.3.6.3	Organization Part Name	Full name of the organization part, e.g. Name of the department	
A.2.3.6.4	Organization Part Details	Address, contact names and contact details, specialty of the organization part.	
A.2.4	**Admission evaluation -** Admission status should be reported exceptionally only if it is relevant to ensure continuity of care.		
A.2.4.1	***Objective findings***		
A.2.4.1.1	Date and time	Date and time of the examination	
A.2.4.1.2	Performer	Identifies the originator/author and provides provenance information about the source of the results data that may have not originated with the source of the whole document.	
A.2.4.1.3	**Anthropometric obsevations**	Observation of Body weight and height of the patient, BMI, circumference of head, waist, hip, limbs and skin fold thickness. Result of the observation includes text, numeric and coded results of the measurement including measurement units. Multiple observations could be provided.	
A.2.4.1.3.1	Observation category	Fixed value "vital-signs"	

A.2.4.1.3.2	Observation description	Observation details including code that identifies observation, specification of the observed body structure or specimen, date and time of the specimen collection.	SNOMED CT << 1153637007 | Body height (observable entity) | OR << 27113001 | Body weight (observable entity) | OR 60621009 | Body mass index (observable entity) | OR 363812007 | Head circumference (observable entity) | OR 248366000 | Chest circumference (observable entity) | OR 276361009 | Waist circumference (observable entity) |
A.2.4.1.3.3	Observation result	Result of the observation including numeric and coded results of the measurement, details about how the tests were done to get the result values, information about referential ranges and result interpretation. Content of the observation result will vary according to the type of the observation.	SNOMED CT UCUM (for units of measurement)
A.2.4.1.3.4	Performer	Identifies the originator/author and provides provenance information about the source of the results data that may have not originated with the source of the whole document or section.	
A.2.4.1.4	**Vital signs**	Vital signs observation: • Required: Pulse rate, respiratory rate, systolic and diastolic blood pressure with site information • Optional: 02 saturation	
A.2.4.1.4.1	Observation category	Fixed value "vital-signs"	http://hl7.org/fhir/ValueSet/observation-category fixed value "vital-signs"

A.2.4.1.4.2	Observation description	Observation details including code that identifies observation, specification of the observed body structure or specimen, date and time of the specimen collection.	SNOMED CT 364075005 | Heart rate (observable entity) | OR 86290005 | Respiratory rate (observable entity) | OR 271649006 | Systolic blood pressure (observable entity) | OR 271650006 | Diastolic blood pressure (observable entity) | OR 386725007 | Body temperature (observable entity) | OR 103228002 | Hemoglobin saturation with oxygen (observable entity) |
A.2.4.1.4.3	Observation result	Result of the observation including numeric and coded results of the measurement, details about how the tests were done to get the result values, information about referential ranges and result interpretation. Content of the observation result will vary according to the type of the observation.	UCUM (measurement units)
A.2.4.1.4.4	Performer	Identifies the originator/author and provides provenance information about the source of the results data that may have not originated with the source of the whole document or section.	

A.2.4.1.5	**Physical examination**	Physical examination is the process of evaluating objective anatomical findings. It is typically the first diagnostic measure performed after taking the patient's history, which allows an initial assessment of symptoms and is useful for determining the differential diagnoses and further steps. Physical examination can be performed through observation, palpation, percussion, and auscultation.	
A.2.4.1.5.1	Observation Note	A narrative description of the observation.	
A.2.4.1.5.2	Performer	Identifies the originator/author and provides provenance information about the source of the results data that may have not originated with the source of the whole document or section.	
A.2.4.2	**Functional status** Functional status can be assessed in several different ways, usually with a focus on the person's abilities to perform basic activities of daily living (ADL), which include basic self-care such as bathing, feeding, and toileting and instrumental activities of daily living (IADL), which includes activities such as cooking, shopping, and managing one's own affairs. For details see: https://paciowg.github.io/functional-status-ig/		
A.2.4.2.1	Date and time	Date and time of the examination	
A.2.4.2.2	Performer	Identifies the originator/author and provides provenance information about the source of the results data that may have not originated with the source of the whole document. Multiple performers could be provided.	

A.2.4.2.3	Description	Need for the patient to be continuously assessed by third parties; functional status may influence decisions about how to plan and administer treatments	
A.2.4.2.4	Functional status assessment	Formalized assessment of the patient's functional status according to the individual assessment categories of the selected assessment system (e.g. WHO-ICF)	
A.2.4.1.4.1	Observation category	Fixed value "functioning"	https://paciowg.github.io/functional-status-ig/CodeSystem-pacio-cat-cs.html
A.2.4.1.4.2	Onset Date	Onset date of a condition	
A.2.4.1.4.3	Result description	Narrative representation of the observation result and findings.	
A.2.4.1.4.4	Observation details	Observation details including code that identifies observation, specification of the observed body structure or specimen, date and time of the specimen collection.	ICF WHO
A.2.4.1.4.5	Observation result	Result of the observation including numeric and coded results of the measurement, details about how the tests were done to get the result values, information about referential ranges and result interpretation. Content of the observation result will vary according to the type of the observation.	ICF WHO
A.2.6	**Patient history**		
A.2.6.1	**Medical history**		

A.2.6.1.1	***Past problems***	A list of conditions of a patient that patient suffered in the past or still suffers. Unlike diagnostic summary, medical history is not only a list but could contain broader description of the condition and its progress, details about treatment including medication and patient response to treatment. Past problem section (unlike the same section of the patient summary) should include only conditions that are important for continuity of care. This section, if provided, complements diagnostic summary section of the discharge report.	
A.2.6.1.1.1	Problem description	Problem specification	
A.2.6.1.1.2	Code	Problem code	ICD-10* Orphacode IPS Absent or Unknown Problems ICD-O-3
A.2.6.1.1.3	Onset date	Onset date of the problem/condition	
A.2.6.1.1.4	Abetement date	The date or estimated date that the condition resolved or went into remission.	
A.2.6.1.1.5	Clinical status	Status of the problem (active, resolved, inactive, ...)	hl7:condition-clinical
A.2.6.1.1.6	Resolution circumstances	Describes the reason for which the status of the problem changed from current to inactive (e.g. surgical procedure, medical treatment, etc.). This field includes "free text" if the resolution circumstances are not already included in other fields such as surgical procedure, medical device, etc., e.g. hepatic cystectomy (this will be the resolution circumstances for the problem "hepatic cyst" and will be included in surgical procedures).	

A.2.6.1.1.7	Severity	A subjective assessment of the severity of the condition as evaluated by the clinician.	-
A.2.6.1.1.8	Stage	Stage/grade, usually assessed formally using a specific staging/grading system.	TNM
A.2.6.1.2	***Devices and Implants***	Devices and Implants	
A.2.6.1.2.1	Device and implant description	Describes the patient's implanted and external medical devices and equipment upon which their health status depends. Includes devices such as cardiac pacemakers, implantable fibrillator, prosthesis, ferromagnetic bone implants, etc. of which the HP needs to be aware.	SNOMED CT < 63653004 | Biomedical device (physical object) | OR eHDSIDevice OR IPS Absent or Unknown Devices
A.2.6.1.2.2	Device ID	Normalised identifier of the device instance such as UDI according to REGULATION (EU) 2017/745	
A.2.6.1.2.3	Implant date	The date and time the device was implanted or when its use began.	
A.2.6.1.2.4	End date	Date and time when the device was explanted from the patient or the external device was no longer in use; likewise when the device is planned to be explanted	
A.2.6.1.2.5	Reason	The medical reason for use of the medical device.	ICD-10 SNOMED CT Orphacode

A.2.6.1.3	***History of procedures***	Historical procedures performed on or for a patient, relevant for the current encounter. Examples include surgical procedures, diagnostic procedures, endoscopic procedures, biopsies, counseling, physiotherapy, personal support services, adult day care services, etc.	
A.2.6.1.3.1	Procedure code	Procedure code	SNOMED CT < 71388002 | Procedure (procedure) |
A.2.6.1.3.2	Procedure description	Narrative description of the procedure	
A.2.6.1.3.3	Body site	Procedure target body site and laterality	SNOMED CT < 442083009 | Anatomical or acquired body structure (body structure) |
A.2.6.1.3.4	Procedure date	Date and time when procedure was performed	
A.2.6.1.3.5	Procedure reason	The coded reason why the procedure was performed. This may be a coded entity or may simply be present as text.	ICD-10* SNOMED CT Orphacode
A.2.6.1.3.6	Outcome	The outcome of the procedure - did it resolve the reasons for the procedure being performed? Applicable mainly on surgical procedures.	SNOMED CT 385669000| Successful 385671000| Unsuccessful 385670004| Partially successful
A.2.6.1.3.7	Focal device	A device that is implanted, removed or otherwise manipulated (calibration, battery replacement, fitting a prosthesis, attaching a wound-vac, etc.) as a focal portion of the Procedure. Multiple focal devices could be provided.	

A.2.6.1.4	***Vaccination***	Vaccination history of the patient.	
A.2.6.1.4.1	Disease or agent targeted	Disease or agent that the vaccination provides protection against	ICD-10* SNOMED CT
A.2.6.1.4.2	Vaccine/prophylaxis	Generic description of the vaccine/prophylaxis or its component(s)	SNOMED CT ATC (IDMP)
A.2.6.1.4.4	Vaccine medicinal product	Medicinal product name	
A.2.6.1.4.5	Marketing Autorisation Holder	Marketing Authorisation Holder or manufacturer (Identifier and name)	EMA's Organisations System data (SPOR)
A.2.6.1.4.6	Number in a series of vaccinations / doses	Order in the vaccination course.	
A.2.6.1.4.7	Date of vaccination	The date and time when the vaccination was administered	
A.2.6.1.4.8	Next vaccination date	The date when the vaccination is planned to be given/repeated (e.g. next dose)	
A.2.6.1.5	***Epidemiological history***	Travel history and infectious contacts	
A.2.6.1.5.1	*Infectious contacts*	Infectious contacts of the patient	
A.2.6.1.5.1.1	Time period	A date and duration or date time interval of contact. Partial dates are allowed.	
A.2.6.1.5.1.2	Infectious agent	Information about suspected infectious agent or agents the person was exposed to.	ICD-10* chapter 1

A.2.6.1.5.1.3	Proximity	Proximity to the source/carrier of the infectious agent during exposure. Proximity could be expressed by text, code or value specifying distance from the InfectiousAgentCarrier.	SNOMED CT 255589003| Direct 255541007| Indirect
A.2.6.1.5.1.4	Country	Country in which the person was potentially exposed to infectious agent.	ISO 3166
A.2.6.1.5.1.5	Additional information	A textual note with additional information about infectious contact.	
A.2.6.1.5.2	*Travel history*	Travel history reported by the patient. Multiple records could be provided.	
A.2.6.1.5.2.1	Time period	Start and end date or end date and duration of stay in a country. Partial dates are allowed.	
A.2.6.1.5.2.2	Country visited	A country visited by the patient.	ISO 3166
A.2.6.1.5.2.3	Comment	Relevant notes on the travel stay.	
A.2.6.2	***Family history***	Information about serious illnesses in close blood relatives with known or suspected genetic potential or with possible impact on patient care.	
A.2.6.2.1	Patient relationship	The family relation between the related person and the patient.	hl7:v3-RoleCode where concept is-a PersonalRelationshipRoleType
A.2.6.2.2	Date of birth	Full or partial date of birth	
A.2.6.2.3	Age or date of death	Age or date of the death of the family member.	
A.2.6.2.4	Education	Level of education of the parents or guardians that treat the child patient.	hl7: v3.EducationLevel

A.2.6.2.5	Condition	Medical problems this person suffers or suffered.	ICD-10* SNOMED CT Orphacode
A.2.6.2.6	Cause of death	Information about disease or condition that was the main cause of death.	ICD-10* SNOMED CT Orphacode
A.2.6.3	***Social history***		
A.2.6.3.1	Participation in society	Participation in society details.	
A.2.6.3.1.1	Work situation	Work Situation describes the extent to which and in what way the patient participates in the workforce. Work is meant in the broadest sense of the word: activities that contribute to the person themselves, their environment or society. This includes both paid and unpaid work.	
A.2.6.3.1.2	Hobby	An activity the patient enjoys doing in their free time.	
A.2.6.3.1.3	Social network	A description of the patient's social network, such as family, neighbors and friends.	
A.2.6.3.2	Education		
A.2.6.3.2.1	Education level	Indication of the highest level of education achieved.	hl7:v3.EducationLevel
A.2.6.3.2.2	Comment	If deemed relevant, a specification of the degree program can be provided by means of an explanation (e.g.: patient is in medical school).	

A.2.6.3.3	Living situation	Household type and other related living situation information.	
A.2.6.3.3.1	House type	Type of home the patient lives in.	SNOMED CT < 365508006 | Finding of residence and accommodation circumstances (finding) |
A.2.6.3.3.2	Home adaption	Adaptions present in the home that have been made in the context of the illness or disability to make the functioning of the patient safer and more comfortable and to enable independent living. Multiple data elements could be provided.	SNOMED CT 467158009| Bath/shower chair 465153004| Stairlift, chair 465302005| Assistive toilet 705401004| Assistive bed 705390009| Home and premises assistive furnishing/adaptation 360303004| Hand rail
A.2.6.3.3.3	Living conditions	Conditions that affect the accessibility of the home or the stay in the home. Multiple data elements could be provided.	SNOMED CT 160708008| Stairs in house 609241003| Lives in apartment with elevator access 715758005| Access to residence by stairs 424948003| Obstructed means of residential entrance 423155007| Housing contains structural barriers to movement 424661000| Cluttered living space 424415008| Dirty living conditions 224152001| Keeps pets 423527000| Unsafe floor covering
A.2.6.3.4	Family situation	Family situation details.	
A.2.6.3.4.1	Comment	A comment on the family situation.	

A.2.6.3.4.2	Family composition	The family composition describes the patient's home situation and the form of cohabitation. A family can consist of one or more people.	SNOMED CT < 365481000 | Finding of household composition (finding) |
A.2.6.3.4.3	Marital status	A person's marital status according to the terms and definition in the national civil code.	hl7: v3-MaritalStatus
A.2.6.3.4.4	Number of children	The number of children the patient has. Children in the context of this information model include step children, foster children, biological and adopted children.	
A.2.6.3.4.5	Number of children at home	The number of children living at home with the patient.	
A.2.6.3.4.6	Child details	Child age, co-living status and comment. Multiple child details could be provided.	
A.2.6.3.4.7	Care responsibility	The activities the patient carries out to care for a dependent family member.	
A.2.6.4	***Abuse***		
A.2.6.4.1	*Alcohol use*	Alcohol consumption by the patient. Multiple records on alcohol use could be provided.	
A.2.6.4.1.1	Status	The status of the patient's alcohol use.	SNOMED CT 219006| Current drinker of alcohol 105542008| Current non-drinker of alcohol 82581004| Ex-drinker 783261004| Lifetime non-drinker of alcohol
A.2.6.4.1.2	Period and quantity	Period of use and amount (The extent of the patient's alcohol use in units of alcohol per time period.)	

A.2.6.4.1.3	Comment	Textual comment.	
A.2.6.4.2	*Tobacco use*	Represent smoking or tobacco habits. Multiple records on tabacco use could be provided.	
A.2.6.4.2.1	Status	The status of the patient's tobacco use.	SNOMED CT 449868002| Smokes every day 230059006 | Occasional cigarette smoker (finding) | 43381005 | Passive smoker (finding) | 8517006 | Ex-smoker (finding) | 405746006 | Current non smoker but past smoking history unknown (finding) |266919005 | Never smoked tobacco (finding) |
A.2.6.4.2.2	Period and quantity	Period of use and amount (The extent of the patient's tobacco use in units of alcohol per time period.)	
A.2.6.4.2.3	Comment	Textual comment.	
A.2.6.4.3	*Drug abuse*	Abuse of drugs and other substances.	
A.2.6.4.3.1	Status	The status of the patient's drug use.	SNOMED CT 417284009 | Current drug user (finding) | 228367002 | Does not misuse drugs (situation) | 228368007 | Has never misused drugs (situation) | 44870007 | Misused drugs in past (finding) |
A.2.6.4.3.2	Period and quantity	Period of use and amount.	

A.2.6.4.3.3	Drug or medication type	Type of the drug abuse	SNOMED CT Heroin (substance)| 387341002 Benzodiazepine (substance) |372664007 Methadone (substance) |387286002 Hydroxybutyric acid (substance) |62821004 Cocaine (substance) |387085005 Cocaine freebase (substance) |229003004 Methylenedioxymethamphetamine (substance) |288459003 Amphetamine (substance) |703842006 Cannabis (substance) |398705004 Hallucinogenic mushrooms (substance)| 229006007 Lysergic acid diethylamide (substance)| 15698006 Ketamine (substance)| 373464007 Phencyclidine (substance) |9721008 Methamphetamine (substance) |387499002 Anabolic steroid (substance)|111151007 Laxative (substance)|372800002 Buprenorphine (substance)|387173000 Fentanyl (substance)|373492002 Barbiturate (substance)|372798009
A.2.6.4.3.4	Route of administration	Route or routes of administration	EDQM Standard Terms
A.2.6.4.3.5	Comment	Textual comment	
A.2.6.4.4	*Addiction*	Type of addiction. Multiple additions can be reported.	ICD-10* SNOMED CT
A.2.7	**Hospital stay**		

A.2.7.1	**Diagnostic summary**	All problems/diagnoses that affected care during the inpatient case or are important to be recorded to ensure continuity of care. The diagnostic summary differentiates, in accordance with the international recommendation, between problems treated during hospital stay and other (untreated) problems. Treated problems are problems that were the subject of diagnostics, therapy, nursing, or (continuous) monitoring during the hospitalisation. Furthermore problems could by divided into three categories: problems present on admission (POA), conditions acquired during hospital stay (HAC) and problems that cannot be classified as being of any of the two (N/A). The diagnostic summary contains all conditions as they were recognised at the end of hospitalisation, after all examinations. This section contains concise, well specified, codeable, summary of problems. Problems are ordered by importance (main problems first) during hospital stay. Description of the problem might be completed with additional details in the medical history section and/or in the Synthesis section.	
A.2.7.1.1	Problem description	Problem specification in narrative form	
A.2.7.1.2	Code	Problem code	ICD-10* SNOMED CT ICD-O Orphacode
A.2.7.1.3	Onset date	Onset date of a problem/condition	
A.2.7.1.4	Abatement date	The date or estimated date that the condition resolved or went into remission.	
A.2.7.1.5	Category	Category of the problem allows to flag for conditions acquired during hospital stay.	- Present on admission [POA]) - Hospital acquired condition [HAC] - Not applicable or unknown [N/A]

A.2.7.1.6	Treatment class	Class of the problem (treated, other) in relation to the hospital encounter. Treated problems were treated or affected provisioning of care (diagnostics, therapy, nursing, monitoring) during hospital encounter. At least one problem should be marked as Treated. Other problems are recorded only if they are important for continuity of care (after discharge).	Treated, Other
A.2.7.1.7	Resolution circumstances	Describes the reason for which the status of the problem changed from current to inactive (e.g. surgical procedure, medical treatment, etc.). This field includes "free text" if the resolution circumstances are not already included in other fields such as surgical procedure, medical device, etc., e.g. hepatic cystectomy (this will be the resolution circumstances for the problem "hepatic cyst" and will be included in surgical procedures).	
A.2.7.1.8	Severity	A subjective assessment of the severity of the condition as evaluated by the clinician.	hl7:condition-severity
A.2.7.1.9	Stage	Stage/grade, usually assessed formally using a specific stagin/grading system. Multiple assessment systems could be used.	TNM ICD-O
A.2.7.2	**Major procedures**	Surgeries and other "instrumental" interventions (endoscopic, intravascular) performed during hospitalisation and significant for continuity of care. This section does not include purely diagnostic procedures (MRI, CT, etc.). If no significant performance has been performed, this fact must be explicitly stated using the IPS code Absent and Unknown Data.	

A.2.7.2.1	Procedure code	Procedure code from supported code system	SNOMED CT
A.2.7.2.2	Procedure description	Narrative description of the procedure	
A.2.7.2.3	Body site	Procedure target body site and laterality	SNOMED CT < 442083009 | Anatomical or acquired body structure (body structure) |
A.2.7.2.4	Procedure date	Date and time when procedure was performed	
A.2.7.2.5	Procedure reason	The coded reason why the procedure was performed. This may be a coded entity or may simply be present as text.	ICD-10* SNOMED CT Orphacode
A.2.7.2.6	Outcome	The outcome of the procedure - did it resolve the reasons for the procedure being performed?	SNOMED CT 385669000| Successful 385671000| Unsuccessful 385670004| Partially successful
A.2.7.2.7	Complication	Any complications that occurred during the procedure, or in the immediate post-performance period. These are generally tracked separately from the procedure description, which will typically describe the procedure itself rather than any 'post procedure' issues.	ICD-10* SNOMED CT Orphacode
A.2.7.2.8	Focal device	A reference to the device or devices that is/are implanted, removed or otherwise manipulated (calibration, battery replacement, fitting a prosthesis, attaching a wound-vac, etc.) as a focal portion of the Procedure.	

A.2.7.3	**Medical devices and implants**	Implants and used medical devices that affect or may affect the provision of health services (diagnosis and treatment). Also medical devices explanted or its use was stopped during hospitalization. If the section is blank, the reason must be explicitly stated using the IPS Absent and Unknown Data coding system	
A.2.7.3.1	Device and implant description	Describes the patient's implanted and external medical devices and equipment upon which their health status depends. Includes devices such as cardiac pacemakers, implantable fibrillator, prosthesis, ferromagnetic bone implants, etc. of which the HP needs to be aware.	SNOMED CT IPS Absent or Unknown Devices
A.2.7.3.2	Device ID	Normalised identifier of the device instance such as UDI according to REGULATION (EU) 2017/745	
A.2.7.3.3	Implant date	The date and time the device was implanted or when its use began.	
A.2.7.3.4	End date	Date and time when the device was explanted from the patient or the external device was no longer in use; likewise when the device is planned to be explanted	
A.2.7.3.5	Reason	The medical reason for use of the medical device.	ICD-10* SNOMED CT Orphacode

A.2.7.4	**Another significant treatment**	Treatment provided, which cannot be unequivocally characterized as the major procedure (in the sense of the previous definition), but is significant - typically chemotherapy, radiotherapy, purification methods (dialysis, hemoperfusion), circulation support methods (counterpulsation, etc.), administration of blood derivatives or others.	
A.2.7.4.1	Procedure code	Procedure code from supported code system	SNOMED CT
A.2.7.4.2	Procedure description	Narrative description of the procedure	
A.2.7.4.3	Body site	Procedure target body site and laterality	SNOMED CT < 442083009 | Anatomical or acquired body structure (body structure) |
A.2.7.4.4	Procedure date	Date and time when procedure was performed	
A.2.7.4.5	Procedure reason	The coded reason why the procedure was performed. This may be a coded entity or may simply be present as text.	ICD-10* SNOMED CT Orphacode
A.2.7.5	**Pharmacotherapy**	Selected drug treatment during hospitalization. Medicinal products that were administered during hospitalization and whose administration has already been discontinued before discharge or continues only for a short time after discharge, while knowledge of their administration is important for continuity of care (antibiotics other than completely routine, corticosteroids in high doses, etc.) will be listed. Medicinal products, the administration of which was started during hospitalization, but is also recommended after discharge, will be listed in the summary table in the recommendation section.	
A.2.7.5.1	Medication reason	The reason why the medication is or was prescribed, or used. It provides a link to the Past or current health conditions or problems that the patient has had or has.	ICD-10* SNOMED CT Orphacode

A.2.7.5.2	Intended use	Indication intended use as: prevention or treatment Example: prophylaxis, treatment, diagnostic, anaesthesia.	
A.2.7.5.3	Brand name	Brand name if biological medicinal product or when justified by the health professional (ref. Commission Directive 2012/52/EU)	
A.2.7.5.4	Active ingredient list	Substance that alone or in combination with one or more other ingredients produces the intended activity of a medicinal product. Example: "paracetamol"	ATC (IDMP)
A.2.7.5.5	Strength	The content of the active ingredient expressed quantifiably per dosage unit, per unit of volume or per unit of weight, according to the pharmaceutical dose form. Example: 500 mg per tablet	UCUM EDQM Standard terms
A.2.7.5.6	Pharmaceutical dose form	The form in which a pharmaceutical product is presented in the medicinal product package (e.g. tablet, syrup)	EDQM Standard Terms
A.2.7.5.7	Dosage Regimen	Number of units per intake and frequency of intake over a specified duration of time. Example: 1 tablet every 24h, for 10 days	
A.2.7.5.8	Route of administration	Path by which the pharmaceutical product is taken into or makes contact with the body.	EDQM Standard Terms
A.2.7.5.9	Period of treatment	The time interval when the patient was, or was not, given the medication.	

A.2.7.6	**Significant Observation Results**	Results of significant functional, diagnostic and imaging examinations to ensure continuity of care, performed during hospitalization. Results of examinations ordered but not yet delivered (status = "registered") should be presented separately from results already delivered.	
A.2.7.6.1	Date	Date and time of the observation	
A.2.7.6.2	Observation status	Status of the observation (e.g. registered, preliminary, final)	hl7:observation-status
A.2.7.6.3	Result description	Narrative representation of the observation result and findings.	
A.2.7.6.4	Observation details	Observation details including code that identifies observation, specification of the observed body structure or specimen, date and time of the specimen collection.	LOINC NPU SNOMED CT RADLEX
A.2.7.6.5	Observation result	Result of the observation including numeric and coded results of the measurement, details about how the tests were done to get the result values, information about referential ranges and result interpretation. Content of the observation result will vary according to the type of the observation.	SNOMED CT UCUM
A.2.7.6.6	Performer	Identifies the originator/author and provides provenance information about the source of the results data that may have not originated with the source of the whole PS document.	
A.2.7.6.7	Reporter	With certain observation results, e.g. there may also be an interpreter or a person responsible for validation.	

A.2.7.7	**Synthesis**	This section provides clinical synthesis (e.g. description of reasons and course of hospital stay) clustered by managed conditions, Clinical synthesis may include clinical reasoning (differential diagnostics, explanaition of clinical context) in clinically complex conditions.	
A.2.7.7.1	Problem synthesis	Summary description of the reason and course of hospitalization for a specific problem.	
A.2.7.7.1.1	Problem description	Problem specification in narrative form and/or a link to the problem managed during hospital stay.	
A.2.7.7.1.2	Reason and course of hospitalization	Detailed description of the reason and course of hospitalization (for the entire hospitalization).	
A.2.7.7.2	Clinical reasoning	The clinical summary can be concluded with a clinical consideration (diff. diagnosis, explanation of context, etc.) for clinically complex conditions.	
A.2.8	**Discharge details** (structured information should be provided, however if not available, at least a summary note should be present).		
A.2.8.1	**Objective findings**		
A.2.8.1.1	Date	Date and time of the examination at or before discharge	
A.2.8.1.2	Performer	Identifies the originator/author and provides provenance information about the source of the results data that may have not originated with the source of the whole document.	

A.2.8.1.3	**Anthropometric obsevations**	Results of anthropometric observations: • Required: body weight and height, BMI • Optional: circumference of head, waist, hip, limbs and skin fold thickness...	
A.2.8.1.3.1	Result description	Narrative representation of the observation result and findings.	
A.2.8.1.3.2	Observation details	Observation details including code that identifies observation, specification of the observed body structure or specimen, date and time of the specimen collection.	SNOMED CT
A.2.8.1.3.3	Observation result	Result of the observation including numeric and coded results of the measurement, details about how the tests were done to get the result values, information about referential ranges and result interpretation. Content of the observation result will vary according to the type of the observation.	SNOMED CT UCUM
A.2.8.1.3.4	Performer	Identifies the originator/author and provides provenance information about the source of the results data that may have not originated with the source of the whole PS document.	
A.2.8.1.4	**Vital signs**	Observation of Vital signs: • Required: systolic and diastolic blood pressure including site of measurement, pulse rate, respiratory rate • Optional: 02 saturation, temperature, pain (scale), ...	
A.2.8.1.4.1	Result description	Narrative representation of the observation result and findings.	

A.2.8.1.4.2	Observation details	Observation details including code that identifies observation, specification of the observed body structure or specimen, date and time of the specimen collection.	SNOMED CT
A.2.8.1.4.3	Observation result	Result of the observation including numeric and coded results of the measurement, details about how the tests were done to get the result values, information about referential ranges and result interpretation. Content of the observation result will vary according to the type of the observation.	SNOMED CT UCUM (measurement units)
A.2.8.1.4.4	Performer	Identifies the originator/author and provides provenance information about the source of the results data that may have not originated with the source of the whole PS document.	
A.2.8.1.5	**Physical examination**	Physical examination is the process of evaluating objective anatomical findings. It is typically the first diagnostic measure performed after taking the patient's history, which allows an initial assessment of symptoms and is useful for determining the differential diagnoses and further steps. Physical examination can be performed through observation, palpation, percussion, and auscultation.	
A.2.8.1.5.1	Observation Note	A narrative description of the observation. It should be structured by organ system (e.g. Head, neck, body, arms,...)	
A.2.8.1.5.2	Performer	Identifies the originator/author and provides provenance information about the source of the results data that may have not originated with the source of the whole document.	

A.2.8.2	**Functional status at discharge**	Functional status can be assessed in several different ways, usually with a focus on the person's abilities to perform basic activities of daily living (ADL), which include basic self-care such as bathing, feeding, and toileting and instrumental activities of daily living (IADL), which includes activities such as cooking, shopping, and managing one's own affairs. For details see: https://paciowg.github.io/functional-status-ig/	
A.2.8.2.1	Date and time	Date and time of the examination	
A.2.8.2.2	Performer	Identifies the originator/author and provides provenance information about the source of the results data that may have not originated with the source of the whole document.	
A.2.8.2.3	Description	Need for the patient to be continuously assessed by third parties; functional status may influence decisions about how to plan and administer treatments	
A.2.8.2.4	Functional status assessment	Assessment of functional status of the patient	
A.2.8.2.4.1	Onset Date	Onset date of a condition	
A.2.8.2.4.2	Result description	Narrative representation of the observation result and findings.	
A.2.8.2.4.3	Observation details	Observation details including code that identifies observation, specification of the observed body structure or specimen, date and time of the specimen collection.	ICF WHO

A.2.8.2.4.4	Observation result	Result of the observation including numeric and coded results of the measurement, details about how the tests were done to get the result values, information about referential ranges and result interpretation. Content of the observation result will vary according to the type of the observation.	ICF WHO
A.2.8.3	Discharge note	Discharge summary note	
A.2.9	**Recommendations** **Care plan and other recommendations after discharge.**		
A.2.9.1	**Care plan**	Care plan after discharge. Multiple care plans could be provided.	
A.2.9.1.1	Title	Human-friendly name for the care plan (e.g. Hip replacement care plan)	
A.2.9.1.2	Addresses	Identifies the conditions/problems/concerns/diagnoses/etc. whose management and/or mitigation are handled by this plan.	ICD-10 SNOMED CT Orphacode
A.2.9.1.3	Description	A description of the scope and nature of the plan.	
A.2.9.1.4	PlanPeriod	Indicates when the plan did (or is intended to) come into effect and end.	
A.2.9.1.5	Other details	Other structured and coded details, care team, goals to be achieved.	
A.2.9.1.6	Activity	Actions to occur as part of plan.	

A.2.9.1.6.1	Kind	A description of the kind of care plan activity. For example, a MedicationRequest, a ServiceRequest, or a CommunicationRequest.	hl7:resource-types: Appointment CommunicationRequest DeviceRequest MedicationRequest NutritionOrder Task ServiceRequest VisionPrescription
A.2.9.1.6.2	Activity description	Detail description of the activity.	
A.2.9.1.6.3	Specific attributes	Specific structured attributes per each activity type, e.g. prescription request, appointment	
A.2.9.2	Medication summary	Summary information on the medication recommended for the period after discharge, indicating whether the medication is changed or newly started. Compared to previous practices, the overview is supplemented with medication that has been discontinued.	
A.2.9.2.1	Status	A code representing judgment about the state of the medication.	hl7:medication-statement-status
A.2.9.2.2	Medication reason	The reason why the medication is or was prescribed, or used	ICD-10* SNOMED CT Orphacode
A.2.9.2.3	Reason for change	Reason for change of medication	hl7:reason-medication-status-codes
A.2.9.2.4	Code	National code of the medication.	IDMP

A.2.9.2.5	Brand name	Brand name if biological medicinal product or when justified by the health professional (ref. Commission Directive 2012/52/EU)	
A.2.9.2.6	Active ingredient list	Substance that alone or in combination with one or more other ingredients produces the intended activity of a medicinal product. Example: "paracetamol"	ATC (IDMP)
A.2.9.2.7	Strength	The content of the active ingredient expressed quantifiably per dosage unit, per unit of volume or per unit of weight, according to the pharmaceutical dose form. Example: 500 mg per tablet	UCUM EDQM Standard terms
A.2.9.2.8	Pharmaceutical dose form	The form in which a pharmaceutical product is presented in the medicinal product package (e.g. tablet, syrup)	EDQM Standard terms
A.2.9.2.9	Dosage Regimen	Number of units per intake and frequency of intake over a specified duration of time. Example: 1 tablet every 24h, for 10 days	
A.2.9.2.10	Route of administration	Path by which the pharmaceutical product is taken into or makes contact with the body.	EDQM Standard terms
A.2.9.2.11	Period of treatment	The interval of time during which it is being asserted that the patient is/was/will be taking the medication (or was not taking).	

A.2.9.2.12	Days supplied	Number of days for which the patient was provided with the drug. By supply is meant either handing over the medicine or writing out a prescription. If the patient has not been provided with the drug (e.g. if the patient has a sufficient supply of the drug), O value is recorded.	

(*) In a foreseeable future, the suggested preferred vocabularies might be superseded or complemented, as mentioned in Guidelines Article 11(2).

(**) The Preferred code system(s) has been selected based on adequacy to convey the information using the methodology of the Subgroup on Semantics. When more alternative international code systems are available, all are listed when it is assumed to be unlikely that agreement can be reached short term. Mapping between code systems could be proposed for specific use cases.

Table 3: Hospital discharge report data set for patient clinical data

5. REFERENCES AND EXAMPLES

5.1. Common Semantic Strategy

The Release 1 of the eHealth Network guidelines on Hospital discharge report was prepared in full alignment with the goals, roadmap and governance proposed in the Common Semantic Strategy for health in EU, adopted by the eHealth Network in Nov 2019.

5.2. European Health Data Space & European Electronic Health Record exchange format

The Hospital Discharge Report concept originates from Recommendation on a European Electronic Health Record exchange format (EEHRxf) and is being taken forward by the European Health Data Space Regulation Proposal.

Link: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52022PC0197

5.3. Hospital Discharge Report Example

Hospital discharge report

Creation date: 18.3.2023 v 08:15 | Version: 1

Vzorná nemocnice

Expand menu Expand all

Patient: Ing. Jana Example, PhD. (Ž) ČP: 999999/9999 (VZP)

Gender	Female	**Address:**	
Maiden name	Dvořáková	Ulice 13a	
Date of birth	xx.xx.1935	150 00 Praha 5	
Place of birth	Žilina		
		Lega guardiens:	
Insurance nember	9999999999	**JUDr. Eliáš Example**	
Health insurance house	Všeobecná zdravotní pojišťovna (111)	Ulice 1234	
Marital status	maried	516 00 Město	
Citizenship	Czech Republic	Mobile +420 600 000 111	
Communication languages	Czech	Phone (home) +420 222 222 222	
	Slovak, preferred	Phone (work) +420 333 333 333	
Phone (home)	+420 216 200 100		
Mobile	+420 603 200 100		
Email	email@provider.cz		

Hospital encounter: Example hospital

In-patient encounter from 09.10.2022 to 17.10.2022

Example hospital
Rovná 345
550 00 Malá Obec, Středočeský kraj

Phone +420 613 111 222 0
Fax +420 201 201 201
info@nempriklad.cz
http://www.nempriklad.cz

Case number: Pn123456
Admission date and time: 09.05.2022, 10:46
Discharge date and time: 17.05.2022, 12:00

Contact person:
Prof. Jan Voštěp
Phone (work) +420 212 444 555

Allergies, Intolerances and Medical Allerts:

- Drug Allergy: Penicillin
- Permanent anticoagulant treatment in permanent atrial fibrillation, transient hemiparesis after discontinuation
- Repeated loss of blood in the stool

This is a sample discharge report containing fictitious information that does not represent any real case. The report illustrates the basic technical capabilities of the design.

Admission reason

Bleeding into the digestive system

Hospital stay

Diagnostic summary

Diagnosis / Problem description	Onset date	Resolution date	Category	Code
Treated conditions				
Angiectasia in ascending colon	10.05.2022	10.05.2022	POA	*K55.2*
Recurrent lossy hyposideremic anemia from angiectasia in the ascending colon	30.07.2016		POA	*D50.0*
Polyp of the sigmoid	10.05.2022		POA	
Transient ischemic attack (TIA) with transient left-sided hemiparesis	11.5.2022	11.5.2022	HAC	*G45.9*
Permanent atrial fibrillation	2011		POA	*I48.1*
Amiodarone hypothyroidism	2018		POA	*E03.2 Y52.2*
Other conditions (untreated)				
Stricture of the right ureter	2020			
Postmenopausal osteoporosis, stable finding	2018			*M81.0*
Varicose veins of the lower limbs	2014			*I83.9*
Isolated hypercholesterolemia				*E78.0*
Presbyacusis bilat.				*H91.1*

Surgeries and other "instrumental" interventions

Procedure Date	Description	Outcome	Complications
15.5.2022	Destruction of angiectasias in the ascending colon by argon plasmacoagulation via colonoscopy and polypectomy in the sigmoid colon	Successful	None

Medical devices and implants

No implants or medical devices

Other significant treatment

Fraxiparine 0.3 ml every 12 hours sc. (when discontinuing oral anticoagulation)

Results not yet delivered

Histology from a resected polyp in the colon.

Clinical synthesis

87-year-old patient treated with long-term (since 2016) parenteral iron replacement and repeated erythrocyte transfusions. However, at the

Coloscopic examination 10.5.2022:
In the sigmoid, a small polyp about 4 mm in size - a biopsy was taken, there are several angiectasias in the ascending colon, which bleed slightly when touched with the colonoscope. Other parts of the colon are without pathological findings. The ileocecal valve and terminal ileum could not be intubated.

Coloscopic examination 15.5.2022:
Total colonoscopy with destruction of four angiodysplasias in the ascending colon by argon plasma coagulation; the procedure was performed without complications
Total colonoscopy with treatment of angiodysplasia in the right colon with argon plasma coagulation: performed argon plasma coagulation of 4 small angiectasias in the transverse and 3 in the ascendens.

Konzilia

ENT consultation:
subjective pain 0/10 NRS, hearing impairment, obj. OM bilat ear canals quiet, eardrums intact, gray, no retraction, middle ear air audio bilat perc. hearing loss 40-40-40-50-55-60-70 dB, tympanum low A bilat. Dr. presbyacusis bilat

In case of any question please contact:	MUDr. Jan Pudr Phone (work) +420 613 345 344
Signature:	Prof. Jan Voštěp, 17. 9. 2022 11:25 MUDr. Jan Pudr, 17. 9. 2022 11:35
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