

**Basic:** the section **must** be present in the document

**Extended:** the section can be completely omitted

**Mandatory:** when the section is provided, the data element must be provided

**Required:** when the section is provided, the data element must be provided, although exceptional justifications can be provided

N°	CONCEPTUAL GROUPING(Level 1)	SECTION*(LEVEL 2)*basic section	BASIC/E DATA ELEMENTS (LEVEL 3)	DESCRIPTION(Business and Functional meaning)	OPTIONAL/ Mandatory	Comments	Fit of Gap	B Zib 2017	BgZ 2017 sectie	Data element BgZ 2017	Kardinaliteit	Toelichting	
<b>1. PATIENT DATA/PATIENT IDENTIFICATION</b>													
	Identification	National Healthcare Patient Identifier	BASIC National Healthcare Patient Identifier (Country of Affiliation)	Unique identifier of the patient in his/her national health system	Required	Data set that enable identification	Fit	Patient v3.1	1.1 PatientGegevens	IdentificatieNummer	0.*		
	Insurance Information	Insurance Number	EXTEND Insurance Number	Example: ID for United Kingdom patient. Unique identifier of the insurance of the patient in his/her country of residence	Optional	In some countries, the insurance number is used for identification	Fit	Betaler v3.1	2.1 VerzekeringsGegevens	Verzekeraar.VerzekerdeNummer			
	Personal Information	Full Name	BASIC Given Name	Example: QQ 12 34 56 A. The first name of the patient. This field can contain the subject's identifying name(s) within the family name	Mandatory		Fit	NaamGegeven	1.1 PatientGegevens	Voornamen	0..1		
			BASIC Family Name/ Surname	Example: John, Marta. The surname/s of the patient. This field can contain the part of a name a person usually has in common	Mandatory		Fit	NaamGegeven	1.1 PatientGegevens	Geslachtsnaam.Voorvoegsels + Geslachtsnaam.Achternaam		1	
		Date of Birth	BASIC Date of Birth	Example: Español Smith. The date of birth of the patient. Since age affects drug dosages, this field may contain only the year, if day and month are not provided	Mandatory		Fit	Patient v3.1	1.1 PatientGegevens	Geboortedatum		1	
		Gender	BASIC Gender Code	Example: 01/01/2009. The gender of the patient. Gender is the biological sex of the patient. It must contain a recognized valid value for this field	Required	In some countries, the gender code is used for identification	Fit	Patient v3.1	1.1 PatientGegevens	Geslacht		1	
	Contact Information	Address	EXTEND Street	Example: Male, Female. The street where the patient has his/her domicile	Optional		Fit	Adresgegeven:	1.1 PatientGegevens	Straat			
			EXTEND Number of Street	Example: Oxford. The number of the street where the patient has his/her domicile	Optional		Fit	Adresgegeven:	1.1 PatientGegevens	Huisnummer + Huisnummerletter + Huisnummertoevoeging + AanduidingBijnummer			
			EXTEND City	The city where the patient has his/her domicile	Optional		Fit	Adresgegeven:	1.1 PatientGegevens	Woonplaats			
			EXTEND Postal Code	Example: London. The postal code where the patient has his/her domicile	Optional		Fit	Adresgegeven:	1.1 PatientGegevens	Postcode			
		EXTEND State or Province	Example: W1W 8LG. The state or province where the patient has his/her domicile	Optional		Gap							
		EXTEND Country	Example: London. The country where the patient has his/her domicile	Optional		Fit	Adresgegeven:	1.1 PatientGegevens	Land				
		Telephone No	EXTEND Telephone No	Example: UK. Phone number of the patient.	Optional	It is recommended to use the international dialing code	Fit	Contactgegeven:	1.1 PatientGegevens	Telefoonnummers.Telefoonnummer			
	E-mail	EXTEND E-mail	Example: +45 20 7025 6161. <u>The e-mail address of the patient.</u>	Optional		Fit	Contactgegeven:	1.1 PatientGegevens	EmailAdressen.EmailAdres				
	Preferred HP/Legal organization	Given Name	BASIC	Example: jens@hotmail.com. Name of the health professional (HP) or the legal organization	Required		Fit	NaamGegeven	18.1 (Huisarts)	Voornamen	0.1		
			BASIC Family Name/ Surname	If the "Preferred HP" is used, the structure of the name is as follows: Family Name/ Surname	Required		Fit	NaamGegeven	18.1 (Huisarts)	Geslachtsnaam.Voorvoegsels + Geslachtsnaam.Achternaam		1	
		BASIC OR Name of the Legal organization	Required		Fit	Zorgaanbieder	18.1 (Huisarts)	OrganisatieNaam	0.1				
		BASIC Address	BASIC	Address of the health professional (HP) or the legal organization	Required	At minimum, the contact information must be provided	Fit	Adresgegeven:	18.1 (Huisarts)	Straat + Huisnummer + Huisnummerletter + Huisnummertoevoeging + AanduidingBijnummer + Woonplaats + Postcode + Land	0.*		
	Telephone No	BASIC	Telephone No	The phone number of the HP or the legal organization	Required		Fit	Contactgegeven:	18.1 (Huisarts)	Telefoonnummers.Telefoonnummer	0.*		

			BASIC	E-mail	The e-mail address of the health professional (HP) or Required	Fit	Contactgegevens 18.1 (Huisarts)	EmailAdressen.Email Adres	0.*	
			BASIC	Network Affiliation (*)	The European Network to which the HP organization is Optional	Gap				
	Contact Person/ Legal Guardian		EXTEND	Given Name	The first name of the contact person or legal guardian. Required This field can contain more than one element.	Fit	NaamGegeve 4.1 Contactpersoon	Voornamen	0.1	
			EXTEND	Family Name/ Surname	Example: Peter. The surname of the contact person or legal guardian. Required This field can contain more than one element.	Fit	NaamGegeve 4.1 Contactpersoon	Geslachtsnaam.Voornaam + Geslachtsnaam.Achternaam	0.1	
			EXTEND	Telephone No	Example: Español Smith. The phone number of the contact person or legal guardian. Optional	Fit	Contactgegevens 4.1 Contactpersoon	Telefoonnummers.Telefoonnummer		
			EXTEND	E-mail	The e-mail address of the contact person or legal guardian. Optional	Fit	Contactgegevens 4.1 Contactpersoon	EmailAdressen.Email Adres		
			EXTEND	Role of person (*)	Role of the contact person: legal guardian, next of kin. Optional	Gap (op wa. Contactpersoon)	Contactpersoon 4.1 Contactpersoon	Rol		Waardenlijst komt niet of niet geheel overeen
			EXTEND	Relationship level (*)	Relationship type with the patient (e.g. father, wife, etc.). Optional	Gap (op wa. Contactpersoon)	Contactpersoon 4.1 Contactpersoon	Relatie		Waardenlijst komt niet of niet geheel overeen
<b>2. PATIENT CLINICAL DATA</b>										
	ALERTS	Allergies and intolerances	BASIC	Allergy/Intolerance description	Textual description of the allergy or intolerance. Required	Gap (samer AllergieIntoler.)	AllergieIntoler. 9.1 (Allergie-intoleranties)	VeroorzakendeStof+All	1	Specifieke data-element bestaat niet in de zib2017. Mogelijk kan deze worden samengesteld uit andere velden.
					Intolerance/Medical alert information (other alerts not included in allergies): any other clinical information that is imperative to know so that the life or health of the patient does not come under threat.  Example 1: intolerance to aspirin due to gastrointestinal bleeding.  Example 2: intolerance to captopril because of cough (the patient is not allergic but can't tolerate it because of persistent cough)					
			BASIC	Type of propensity (*)	This element describes whether this condition refers to a medical alert or an allergy. Optional	Fit	AllergieIntoler. 9.1 (Allergie-intoleranties)	AllergieCategorie		Zelfde codestelsel SNOMED
			BASIC	Allergy manifestation (*)	Description of the clinical manifestation of the allergy. Optional	Gap (samer AllergieIntoler.)	AllergieIntoler. 9.1 (Allergie-intoleranties)	Reactie.Symptoom		In NL worden hier de individuele reacties weergegeven. In de EU lijkt hier een samenvatting van de reacties bedoeld te worden.
					Example: anaphylactic shock, angioedema (the clinical manifestation)					
			BASIC	Onset date	Date of the observation of the reaction. Optional	Fit	AllergieIntoler. 9.1 (Allergie-intoleranties)	BeginDatumTijd		
			BASIC	End Date (*)	Date of resolution of the allergy (e.g. when the clinical manifestation has resolved). Optional	Gap	AllergieIntolerantie v3.2			
			BASIC	Severity (*)	Severity of the clinical manifestation of the allergy. Optional	Gap (op wa. AllergieIntoler.)	AllergieIntoler. 9.1 (Allergie-intoleranties)	Reactie.Ernst		Waardenlijst komt niet of niet geheel overeen. Zelfde codestelsel SNOMED.
			BASIC	Criticality (*)	Potential risk for future life-threatening adverse reaction. Optional	Gap (op wa. AllergieIntoler.)	AllergieIntoler. 9.1 (Allergie-intoleranties)	MateVanKritiekZijn		Waardenlijst komt niet of niet geheel overeen..
			BASIC	Status (*)	Current status of the allergy or intolerance, for example active, resolved, or resolved with caution. Optional	Gap (op wa. AllergieIntoler.)	AllergieIntoler. 9.1 (Allergie-intoleranties)	AllergieStatus		Waardenlijst komt niet of niet geheel overeen..
			BASIC	Certainty (*)	Assertion about the certainty associated with a propensity. Optional	Gap				
			BASIC	Allergen description	Description of the substance capable of triggering an allergic reaction. Required	Fit	AllergieIntoler. 9.1 (Allergie-intoleranties)	VeroorzakendeStof	1	
			BASIC	Allergen code	Standardized code corresponding to the allergen. Required	Gap (op wa. AllergieIntoler.)	AllergieIntoler. 9.1 (Allergie-intoleranties)	VeroorzakendeStof	1	
		Medical alert information (other than allergies)	EXTEND	Healthcare alert description (*)	Description of medical alerts in textual format: any information that is imperative to know so that the life or health of the patient does not come under threat. Required	Fit	Alert v3.2 8.1 Alert	AlertNaam+AlertType+ 0.1		
					Example 1: intolerance to aspirin due to gastrointestinal bleeding. Example 2: intolerance to captopril because of cough Example 3: the patient has a rare disease that requires special attention Example 4: Airway Alert / Difficult Intubation Example 5: Diagnoses such as malignant hyperthermia Example 6: transplanted organs illustrate other information Example 7: participation in a clinical trial that has to be reported					
	MEDICAL HISTORY	Vaccinations	EXTEND	Disease or agent targeted description	Disease or agent that the vaccination provides protection against. Optional	Gap				
			EXTEND	Disease or agent targeted code	Standardized code corresponding to the disease. Optional	Gap				
			EXTEND	Vaccine/prophylaxis description	Generic description of the vaccine/prophylaxis or its indication. Required	Fit	Vaccinatie v3.1 12.1 (Vaccinaties)	ProductCode	0.1	
			EXTEND	Vaccination code	Standardized code corresponding to the vaccination. Optional	Gap	Vaccinatie v3.1 12.1 (Vaccinaties)	ProductCode		NL is op G standaard, EU is Snomed lijst
			EXTEND	Vaccine medicinal product	Medicinal product name. Required	Fit	Vaccinatie v3.1 12.1 (Vaccinaties)	ProductCode	0.1	Code + Description uit de G standaard
			EXTEND	Marketing Authorisation Holder	Marketing Authorisation Holder. Optional	Gap				
			EXTEND	Vaccination date	The date when the immunization was received. Required	Fit	Vaccinatie v3.1 12.1 (Vaccinaties)	VaccinatieDatum	1	
			EXTEND	Number in a series of vaccinations	Order in the vaccination course. Optional	Gap				
			EXTEND	Batch/lot number (*)	A distinctive combination of numbers and/or letters. Optional	Gap				
			EXTEND	Administering centre (*)	Name or identifier of administering centre or a health professional. Optional	Fit	Zorgaanbieder 21.1 Vaccinaties	OrganisatieNaam		
					name of the administering centre or unique identifier of address of the health professional					
			EXTEND	Health Professional identifier	Name or identifier of the health professional responsible for administering the vaccine. Optional	Fit	Zorgverlener v 12.1 Vaccinaties	ZorgverlenerIdentificatieNummer		Samenvoegen bestaande velden mogelijk nodig
					name of the Health Professional or unique identifier of address of the Health Professional					

		EXTEND Country of vaccination (*)	The country in which the individual has been vaccinated	Optional	Fit	Adresgegevens: 12.1 Vaccinaties	Land (vanuit zorgaanbieder)		
		EXTEND Next vaccination date (**)	The date when the vaccination is planned to be given	Optional	Gap				
	List of Resolved, Closed or Inactive	EXTEND Problem description	Problems or diagnosis not included under the definition	Required	Fit	Probleem v4.1 6.1 (Problemen)	ProbleemNaam	1	Alleen die problemen ophalen waar ProblemStatus 'inactief' is
		EXTEND Problem code	Example: Hepatic cyst (the patient has been treated)	Standardized code corresponding to the medical problem	Required	If the code is not available: Fit	Probleem v4.1 6.1 (Problemen)	ProbleemNaam	1
		EXTEND Onset date	Date when the patient first experienced the condition	Required	Fit	Probleem v4.1 6.1 (Problemen)	ProbleemBeginDatum	0.1	
		EXTEND End Date	Problem resolution date; the date when the medication was stopped	Required	Fit	Probleem v4.1 6.1 (Problemen)	ProbleemEindDatum	0.1	
		EXTEND Resolution Circumstances	Describes the reason by which the problem changed	Optional	Gap				
		EXTEND Problem Status code	Standardized code corresponding to the problem status	Optional	Gap (op waardelijst)				Waardenlijst komt niet of niet geheel overeen.
		EXTEND Health Professional related with	Identify the Health Professional who may be specified	Optional	Fit	BasisElemente 6.1 Problemen	Auteur		
	Medical History (*)	EXTEND External Resource related with	Identify the External Resource which may be specified	Optional	Gap				
		EXTEND Text (*)	This section may provide both synthetic anamnesis	Required	Gap	Please refer to eHN			
MEDICAL PROBLEMS	List of current problems/diagnoses	BASIC Problem/Diagnosis description	Problems/diagnosis that fit under these conditions:	Required	Fit	Probleem v4.1 6.1 (Problemen)	ProbleemNaam	1	Alleen die problemen ophalen waar ProblemStatus 'actief' is
		BASIC Problem code	Standardized code corresponding to the medical problem	Required	If the code is not available: Fit	Probleem v4.1 6.1 (Problemen)	ProbleemNaam	1	
		BASIC Onset date	Date of the medical problem onset; the date when the patient first experienced the condition	Required	Fit	Probleem v4.1 6.1 (Problemen)	ProbleemBeginDatum	0.1	
		BASIC Diagnosis ascertainment status (*)	Assertion about the certainty associated with a diagnosis	Optional	Gap (op waardelijst)	Probleem v4.1 6.1 (Problemen)	VerificatieStatus		Waardenlijst komt niet of niet geheel overeen.
		BASIC Health Professional Related with	Identify the Health Professional who may be specified	Optional	Fit	Zorgverlener v 6.1 Problemen			
		BASIC External Resource related with	Identify the External Resource which may be specified	Optional	Gap				
	Medical devices	BASIC Device and Implant description	Describes the patient's implanted and external medical devices	Required	The medical devices: Fit	MedischHulpn 11.1 (Medische Hulpmiddelen)	ProductOmschrijving	0.1	
		BASIC Device unique identifier	Normalised identifier of the device instance such as the device name	Required	Fit	MedischHulpn 11.1 (Medische Hulpmiddelen)	Product.ProductID	0.1	
		BASIC Implant date	Date when the procedure to implant the medical device was performed	Required	Fit	MedischHulpn 11.1 (Medische Hulpmiddelen)	BeginDatum	0.1	
		BASIC End date (*)	Date when the device was explanted from the patient	Optional	Gap	MedischHulpn 11.1 (Medische Hulpmiddelen)	EindDatum		
	Procedures	BASIC Procedure description	Describes the type of the surgical procedure.	Required	Fit	Verrichting v4. 15.1 Verrichtingen	VerrichtingType	1	
		BASIC Procedure code	Standardized code corresponding to the surgical procedure	Required	If the code is not available: Gap (op waardelijst)	Verrichting v4. 15.1 Verrichtingen	VerrichtingType	1	Waardenlijst komt niet of niet geheel overeen.
		BASIC Body site (*)	Procedure target body site	Optional	Fit	Verrichting v4. 15.1 Verrichtingen	VerrichtingAnatomischeLocatie + VerrichtingType		Zowel EU als NL hebben Snomed lijst, maar waardelijst EU niet bekend op tijdstip van analyse
		BASIC Procedure date	Date when the surgical procedure was performed.	Required	Fit	Verrichting v4.1		0.1	
	Functional status (*)	EXTEND Description (*)	Need for the patient to be continuously assessed by the clinician	Required	Fit	Functioneeloef 5.1 Functionele/Mentale Status	StatusNaam + StatusW	1	
		EXTEND Onset Date (*)	Onset date of a condition	Optional	Gap				
		EXTEND Functional assessment description	Description of the functional assessment	Optional	Fit	Functioneeloef 5.1 Functionele/mentale status	StatusNaam		mogelijke gap op codestelsel EU waarschijnlijk alleen ICF, in NL ook andere codestelsels mogelijk.
		EXTEND Functional assessment code (*)	Standardized code corresponding to the functional assessment	Optional	If the code is not available: Fit	Functioneeloef 5.1 Functionele/mentale status	StatusNaam		mogelijke gap op codestelsel EU waarschijnlijk alleen ICF, in NL ook andere codestelsels mogelijk.
		EXTEND Functional assessment date (*)	Date of the functional assessment	Optional	Fit	Functioneeloef 5.1 Functionele/mentale status	StatusDatum		Voor de losse functionele statussen (horen, zien, mobiliteit) is geen startdatum bekend, dus daar is een gap.
		EXTEND Functional assessment result (*)	Functional assessment result value	Optional	The result can be coded as a textual descriptor or a standardized code or a value corresponding to the descriptor	Functioneeloef 5.1 Functionele/mentale status	StatusWaarde		
MEDICATION SUMMARY	Current and relevant past medication (Relevant prescribed medicines)	BASIC Medication reason (*)	The reason why the medication is or was prescribed, or used	Optional	Gap (op waardelijst)	Probleem v4.1 10.1 Medicatieafspraken	ProbleemNaam		G standaard, DHD diagnosesaurus, ICD, ICF, OMAHA Snomed, ICPC, NANDA, DSM IV, 5, GGZdiagnoselijst. NL staat meer waardelijsten toe dan EU
		BASIC Intended use (**)	Indication intended use as: prevention or treatment	Optional	Gap (op waardelijst)	Probleem v4.1 10.1 Medicatieafspraken	AanvullendeAfspraak		Waardenlijst komt niet of niet geheel overeen.
		BASIC Brand name (*)	Brand name if biological medicinal product or when the active ingredient is not known	Optional	Fit	Farmaceutisch 10.1 Medicatieafspraken	ProductCode		Er moet waar mogelijk worden afgeleid uit GPK, ATC, GTIN, HPK
		BASIC Active ingredient(s)	Substance that alone or in combination with one or more other substances is responsible for the pharmacological effect	Required	Fit	Farmaceutisch 10.1 Medicatieafspraken	Ingredient.IngredientC	0.1	ATC, GPK, PRK, ZI, SSK, GTIN, HPK, SNK, Gstandaard artikelen, KNMP nummer, AT code
		BASIC Strength(s)	The content of the active ingredient expressed quantitatively	Required	From technical point of view: Gap	FarmaceutischProduct v2.0		0.1	
			Strength has the following sub-elements:  Value (100, 200 etc.) Unit (mg, gr etc.)  Example: 500 mg per tablet.		For each active ingredient: Fit				
		BASIC Pharmaceutical dose form	The form in which a pharmaceutical product is presented	Optional	Gap (op waardelijst)	Farmaceutisch 10.1 Medicatieafspraken	FarmaceutischeVorm		Waardenlijst komt niet of niet geheel overeen.
		BASIC Dosage Regimen	Number of units per intake and frequency of intake	Required	Posology is currently not supported: Fit	Gebruiksaanwijzing 10.1 Medicatieafspraken	KeerDosis	0.1	
			Example: 1 tablet every 24h, for 10 days.		Example: 1 unit/intake: Fit				
			A specific posology is not supported: Gap		This attribute is part of the posology: Fit				

		BASIC	Frequency of intakes	Frequency of the intakes that the patient should take (per hour/day/month/ week).	Required	This attribute is part of	Fit	Gebruiksaanstru 10.1 Medicatieafspraken	Toedieningsschema.F 0.1 requentie	
		BASIC	Timing of intakes	Example: Each month. Moment of the day when the intakes should be taken	Optional		Fit	Gebruiksaanstru 10.1 Medicatieafspraken	Toedieningsschema.D agDeel	
		BASIC	Duration of treatment	Example: During the early evening The duration for which the patient should take the medicine	Required	This attribute is part of	Fit	Gebruiksaanstru 10.1 Medicatieafspraken	Toedieningsschema.Int 0.1	
		BASIC	Date of onset of treatment	Example: During 14 days. Date when the patient needs to start taking the medicine	Required	It is constituted of 3	Fit	Gebruiksaanstru 10.1 Medicatieafspraken	Medicatieafspraken.Get 0.1	
		BASIC	Medicine status (**)	Current status of the medicine.	Mandatory	Possible values are 'Fit	Fit	Medicatieafspraken 10.1 Medicatieafspraken	Medicatieafspraken.Sto 0.1 pType	Alle niet gestopte medicaties zijn nog actief --> waarschijnlijk geen gap. Afhankelijk van uiteindelijke implementatie.
		BASIC	Route of administration	Route of administration of the medicine.	Optional		Fit	10.1 Medicatieafspraken	Toedieningsweg	
SOCIAL HISTORY	Social History Observations	EXTEND	Social History Observation description	Textual description of the social history	Mandatory	Health related "lifestyle" related Example: Cigarette smoking	Gap (same as)	AlcoholGebruik v3.1 7.2 DrugsGebruik v3.2 7.4 TabaksGebruik v3.1 7.5 Voedingsadvies v3.1	Concatinatie van rootconcept+toelichting+gebruik+status+hoeveelheid	1 Mogelijk door samenvoeging bestaande velden te verkrijgen.
		EXTEND	Social History Observation code	Standardized code corresponding to the social history	Mandatory		Gap (same as)	AlcoholGebruik v3.1 7.2 DrugsGebruik v3.2 7.4 TabaksGebruik v3.1 7.5 Voedingsadvies v3.1	Rootconcept	1 Waardenlijst komt niet of niet geheel overeen.
		EXTEND	Social History Observation value	Value of the corresponding observation.	Required		Fit	AlcoholGebruik v3.1 7.2 DrugsGebruik v3.2 7.4 TabaksGebruik v3.1	WaarnemingGebruik. Hoeveelheid WaarnemingGebruik. Hoeveelheid WaarnemingGebruik. Hoeveelheid (voorkeur) of WaarnemingGebruik. PackYears (indien hoeveelheid niet beschikbaar is)	1
		EXTEND	Reference date range	Period of time (start and/or end date) during which the observation is made Example: From 1974 to 2004.	Required		Fit	AlcoholGebruik v3.1 7.2 DrugsGebruik v3.2 7.4 TabaksGebruik v3.1	From + WaarnemingGebruik. StartDatum + to + WaarnemingGebruik. StopDatum From + WaarnemingGebruik. StartDatum + to + WaarnemingGebruik. StopDatum From + WaarnemingGebruik. StartDatum + to + WaarnemingGebruik. StopDatum	1
PREGNANCY HISTORY	Current pregnancy status	EXTEND	Expected date of delivery	Date in which the woman is due to give birth. Year, month, day Example: 01/01/2010.	Required		Gap			Zib zwangerschap bestaat wel, maar zit niet in BgZ
		EXTEND	Pregnancy observation code	Standardized code corresponding to the mode of delivery	Mandatory	Indicates if the delivery is	Gap			Zib zwangerschap bestaat wel, maar zit niet in BgZ
		EXTEND	Date of observation (*)	Date on which the observation of the pregnancy status was made	Optional		Gap			Zib zwangerschap bestaat wel, maar zit niet in BgZ
		EXTEND	Status (*)	Provides the woman's current state at the date of the observation	Optional		Gap			Zib zwangerschap bestaat wel, maar zit niet in BgZ
	History of previous pregnancies	EXTEND	Previous pregnancy status (*)	Information on the woman's previous pregnancies: Yes, previous pregnancies No previous pregnancies	Optional	If the status is unknown	Gap			Zib zwangerschap bestaat wel, maar zit niet in BgZ
		EXTEND	Previous pregnancy description (*)		Required		Gap			Zib zwangerschap bestaat wel, maar zit niet in BgZ
		EXTEND	Outcome date (*)	Date referred to the previous pregnancies outcome	Optional		Gap			Zib zwangerschap bestaat wel, maar zit niet in BgZ
		EXTEND	Outcome (*)	Outcome of the previous pregnancies	Optional		Gap			Zib zwangerschap bestaat wel, maar zit niet in BgZ
		EXTEND	Number of children (*)	Number of children/fetus in this specific pregnancy	Optional		Gap			Zib zwangerschap bestaat wel, maar zit niet in BgZ. Het aantal kinderen in deze zwangerschap zit niet in de zib
PATIENT PROVIDED DATA	Travel history (**)	EXTEND	Country (**)	Country(s) visited	Required		Gap			Zib zwangerschap bestaat wel, maar zit niet in BgZ. Het aantal kinderen in deze zwangerschap zit niet in de zib
		EXTEND	Period (**)	Date of entry and departure	Optional		Gap			Zib zwangerschap bestaat wel, maar zit niet in BgZ. Het aantal kinderen in deze zwangerschap zit niet in de zib

RESULTS	Advance Directive (*) Result observations (*)	EXTEND Documentation (*) EXTEND Date (*)	Existence of documentation on living will Date and time of the observation	Optional Optional	Fit Fit	Wilsverklaring 3.2 Wilsverklaring Laboratorium 14.1 LaboratoriumUitslagen Uitslag v4.1 13.1 Bloeddruk Bloeddruk 13.2 Lichaamsgewicht v3.1 13.3 Lichaamslengte Lichaamsgewicht v3.1 Lichaamslengte v3.1	WilsverklaringType LaboratoriumTest.Test DatumTijd BloeddrukDatumTijd GewichtDatumTijd LengteDatumTijd	In BgZ is dit alleen de laatste observatie en niet alles van vier maanden terug
		EXTEND Observation type (*)	Observation results types that may be measurements Examples: Diagnostic results (Blood group, Laboratory Observations) Physical findings (Vital signs observations)	Optional	Fit	Laboratorium 14.1 LaboratoriumUitslagen Uitslag v4.1 13.1 Bloeddruk Bloeddruk 13.2 Lichaamsgewicht v3.1 13.3 Lichaamslengte Lichaamsgewicht v3.1 Lichaamslengte v3.1	Rootconcept Rootconcept Rootconcept Rootconcept	Mapping rootconcept nodig naar EU waardelijst HL7 ObservationCategoryCodes
		EXTEND Result description (*)	Narrative representation of the observation result a	Required	Fit	Laboratorium 14.1 LaboratoriumUitslagen Uitslag v4.1 13.1 Bloeddruk Bloeddruk 13.2 Lichaamsgewicht v3.1 13.3 Lichaamslengte Lichaamsgewicht v3.1 Lichaamslengte v3.1	LaboratoriumTest.Test Code+LaboratoriumTest.Uitslag DiastolischeBloeddruk+SystolischeBloeddruk+GemiddeldeBloeddruk GewichtWaarde LengteWaarde	1
		EXTEND Observation details (*) EXTEND Observation results (*)	Observation details including code that identifies observation Result of the observation including numeric and codes	Optional Optional	Fit Fit	Laboratorium 14.1 LaboratoriumUitslagen Laboratorium 14.1 LaboratoriumUitslagen	Monster.AnatomischeLocatie LaboratoriumTest.ReferenceBovengrens + LaboratoriumTest.ReferenceOndergrens+LaboratoriumTest.InterpretatieVlaggen+Toelichting	
		EXTEND Performer (*) EXTEND Reporter (*) EXTEND Text (*)	Identifies the originator/author and provides provenance With certain observation results, e.g. there may also be Narrative containing the plan including proposals, goals In the future it is expected that this Section could be	Optional Optional Required	Fit Gap Gap	Zorgaanbieder 14.1 LaboratoriumUitslagen	OrganisatieNaam	
PLAN OF CARE	Therapeutic recommendations							Wel in basiselementen, maar niet in BgZ MSZ 2017 Dit behoort tot zib ZorgAfspraak die zit niet in de BgZ

**3. PATIENT SUMMARY DATA (Information about the Patient Summary itself)**

Country	Country	BASIC	Country	Name of the patient's Country of affiliation.	Mandatory	
Patient Summary	Date Created	BASIC	Date Created	Date on which the Patient Summary was generated.	Required	
	Date of Last Update	BASIC	Date of Last Update	Date on which the Patient Summary was last updated	Mandatory	
Nature of the Patient Summary	Nature of the Patient Summary	BASIC	Nature of the Patient Summary	Defines the context in which the PS was generated.	Mandatory	The purpose of this element is to highlight if the data is collected manually by a HP or is collected automatically from different sources (e.g., hospital doctor repository, general practitioners etc.), through predetermined clinical rules.  direct human intervention by an HP automatically generated mixed approach (human intervention and automatic)  The Data Element Nature of the Patient Summary is automatically derived from the Data Element Author and Organisation
Author and Organisation	Author and Organisation (*)	BASIC	Author and Organisation	At least one Author and Organisation shall be listed. Mandatory event that there is no Author, at least one Organisation be listed	Mandatory	The Author should be able to provide further information on the provenance of the data present in the patient summary. Different authors contributing to individual sections and/or entries could be provided at the relevant level.
Legal authenticator	Legal authenticator	BASIC	Legal authenticator	Legal entity (Health Professional or Health Care Provider) authenticated the Patient Summary	Mandatory	When the data is collected from different sources and pre-existing documents that are part of a bigger system, the organization responsible of that collection should "sign" the PS as responsible.  The legal authenticator should refer to Country of affiliation (as accountable for the clinical data). It will be Country of affiliation decision to confirm if the "Legal Authenticator" is the NCPeH, a HP or a HCPO, depending on national provisions. This requirement is applicable to any clinical data exchanged, independently of the format (e.g., PDF or xml).
Documentation Of	Documentation Of	BASIC	Documentation Of	Representation of providers who are wholly or partially involved in the generation of the Patient Summary It indicates the performer, time/date and range of time	Required	
Related Document	Related Document	BASIC	Related Document	Used to indicate a parent document	Mandatory	
Additional Information/Knowledge Reference	Additional information/Knowledge Reference	EXTEND	External reference (*)	A reference leading to Clinical Practice Guidelines (Clinical Practice Guidelines)	Optional	