

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/ Comments	Fit of Gap	Zib 2020	BgZ 2020 sectie	Data element BgZ 2020	Kardinaliteit 2020	Toelichting	
1. PATIENT DATA/PATIENT IDENTIFICATION												
	Identification	National Healthcare Patient Identifier	BASIC National Healthcare Patient Identifier (Country of Affiliation)	Unique identifier of the patient in his/her national health system. Example: ID for United Kingdom patient.	Required Data set that enable	Fit	Patient v3.2	1.1 PatientGegevens	PatientIdentificatieNummer	0.*		
	Insurance Information	Insurance Number	EXTEND Insurance Number	Unique identifier of the insurance of the patient in his/her country of residence. Example: QQ 12 34 56 A	Optional In some countries, the insurance number is not used.	Fit	Betaler v3.1.1	2.1 VerzekeringsGegevens	Verzekeraar.VerzekerdeNummer			
	Personal Information	Full Name	BASIC Given Name	The first name of the patient. This field can contain the subject's identifying name(s) within the family name. Example: John, Marta.	Mandatory	Fit	NaamGegevens v1.1	1.1 PatientGegevens	Voornamen	0..1		
			BASIC Family Name/ Surname	The surname/s of the patient. This field can contain the part of a name a person usually has in common. Example: Español Smith.	Mandatory	Fit	NaamGegevens v1.1	1.1 PatientGegevens	Geslachtsnaam.Voorvoegsels + Geslachtsnaam.Achtern naam		1	
		Date of Birth	BASIC Date of Birth	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. Example: 01/01/2009.	Mandatory	Fit	Patient v3.2	1.1 PatientGegevens	Geboortedatum	0.1	ISO21090	
		Gender	BASIC Gender Code	The gender of the patient. Gender is the biological sex of the patient. It must contain a recognized valid value for this field. Example: Male, Female.	Required In some countries, the gender is not used.	Fit	Patient v3.2	1.1 PatientGegevens	Geslacht	0.1		
	Contact Information	Address	EXTEND Street	The street where the patient has his/her domicile. Example: Oxford	Optional	Fit	Adresgegevens v1.1	1.1 PatientGegevens	Straat			
			EXTEND Number of Street	The number of the street where the patient has his/her domicile. Example: 221	Optional	Fit	Adresgegevens v1.1	1.1 PatientGegevens	Huisnummer + Huisnummerletter + Huisnummertoevoeging + AanduidingBijNummer			
			EXTEND City	The city where the patient has his/her domicile. Example: London	Optional	Fit	Adresgegevens v1.1	1.1 PatientGegevens	Woonplaats			
			EXTEND Postal Code	The postal code where the patient has his/her domicile. Example: W1W 8LG	Optional	Fit	Adresgegevens v1.1	1.1 PatientGegevens	Postcode			
			EXTEND State or Province	The state or province where the patient has his/her domicile. Example: London	Optional	Gap						
			EXTEND Country	The country where the patient has his/her domicile. Example: UK	Optional	Fit	Adresgegevens v1.1	1.1 PatientGegevens	Land			
		Telephone No	EXTEND Telephone No	Phone number of the patient. Example: +45 20 7025 6161	Optional It is recommended if the patient has a telephone number.	Fit	Contactgegevens v1.2	1.1 PatientGegevens	Telefoonnummers.Telefoonnummer			
		E-mail	EXTEND E-mail	The e-mail address of the patient. Example: jens@hotmail.com	Optional	Fit	Contactgegevens v1.2	1.1 PatientGegevens	EmailAdressen.EmailAdres			
	Preferred HP/Legal organization	Given Name	BASIC Given Name	Name of the health professional (HP) or the legal organization. Example: jens@hotmail.com	Required	Fit	NaamGegevens v1.1	18.1 (Huisarts)	Voornamen	0.1		
			BASIC Family Name/ Surname	If the "Preferred HP" is used, the structure of the name is the same as for the patient. Example: John, Marta.	Required	Fit	NaamGegevens v1.1	18.1 (Huisarts)	Geslachtsnaam.Voorvoegsels + Geslachtsnaam.Achtern naam	0.1		
			BASIC OR Name of the Legal organization	Required	Fit	Zorgaanbieder v3.4	18.1 (Huisarts)	OrganisatieNaam	0.1			
		BASIC Address	BASIC Address	Address of the health professional (HP) or the legal organization. Example: 123 Main St, London	Required At minimum, the contact information must be provided.	Fit	Adresgegevens v1.1	18.1 (Huisarts)	Straat + Huisnummer + Huisnummerletter + Huisnummertoevoeging + AanduidingBijNummer + Woonplaats + Postcode + Land	0.1		

			BASIC	Telephone No	The phone number of the HP or the legal organization. Required		Fit	Contactgegevens v1.2	18.1 (Huisarts)	Telefoonnummers.Telefoonnummer	0.*	
			BASIC	E-mail	The e-mail address of the health professional (HP) or organization. Required		Fit	Contactgegevens v1.2	18.1 (Huisarts)	EmailAdressen.EmailAdres	0.*	
	Contact Person/ Legal Guardian		BASIC	Network Affiliation (*)	The European Network to which the HP organization is affiliated. Optional	Name or web address	Gap					
			EXTEND	Given Name	The first name of the contact person or legal guardian. This field can contain more than one element. Required		Fit	NaamGegevens v1.1	4.1 (Contactpersoon)	Voornamen	0.1	
			EXTEND	Family Name/ Surname	Example: Peter. The surname of the contact person or legal guardian. This field can contain more than one element. Required		Fit	NaamGegevens v1.1	4.1 (Contactpersoon)	Geslachtsnaam.Voornamen + Geslachtsnaam.Achternaam	0.1	
			EXTEND	Telephone No	Example: Español Smith. The phone number of the contact person or legal guardian. Optional	It is recommended if	Fit	Contactgegevens v1.2	4.1 (Contactpersoon)	Telefoonnummers.Telefoonnummer		
			EXTEND	E-mail	The e-mail address of the contact person or legal guardian. Optional		Fit	Contactgegevens v1.2	4.1 (Contactpersoon)	EmailAdressen.EmailAdres		
			EXTEND	Role of person (*)	Role of the contact person: legal guardian, next of kin, etc. Optional		Gap (op waarde)	Contactpersoon v3.4	4.1 (Contactpersoon)	Rol		
			EXTEND	Relationship level (*)	Relationship type with the patient (e.g. father, wife, etc.). Optional		Gap (op waarde)	Contactpersoon v3.4	4.1 (Contactpersoon)	Relatie		
2. PATIENT CLINICAL DATA												
	ALERTS	Allergies and intolerances	BASIC	Allergy/Intolerance description	Textual description of the allergy or intolerance. Required		Gap (samenhangend)	AllergieIntolerantie v3.3	9.1 (Allergie-intoleranties)	VeroorzakendeStof + AllergieCategorie		1 Specifieke data-element bestaat niet in de BgZ 2020. 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 an allergy or intolerance. Optional	If the code is not available	Fit	AllergieIntolerantie v3.3	9.1 (Allergie-intoleranties)	AllergieCategorie		Zelfde codestelsel SNOMED
			BASIC	Allergy manifestation (*)	Description of the clinical manifestation of the allergy or intolerance. Optional		Gap (samenhangend)	AllergieIntolerantie v3.3	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.
			BASIC	Onset date	Date of the observation of the reaction. Optional		Fit	AllergieIntolerantie v3.3	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 v3.3				
			BASIC	Severity (*)	Severity of the clinical manifestation of the allergic reaction. Optional		Gap (op waarde)	AllergieIntolerantie v3.3	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 waarde)	AllergieIntolerantie v3.3	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, etc. Optional		Gap (op waarde)	AllergieIntolerantie v3.3	9.1 (Allergie-intoleranties)	AllergieStatus		Waardenlijst komt niet of niet geheel overeen..
			BASIC	Certainty (*)	Assertion about the certainty associated with a proposed diagnosis. Optional		Gap					
			BASIC	Allergen description	Description of the substance capable of triggering an allergic reaction. Required		Fit	AllergieIntolerantie v3.3	9.1 (Allergie-intoleranties)	VeroorzakendeStof		1
			BASIC	Allergen code	Standardized code corresponding to the allergen. Required	When the allergen code is not available	Gap (op waarde)	AllergieIntolerantie v3.3	9.1 (Allergie-intoleranties)	VeroorzakendeStof		1 Waardenlijst komt niet of niet geheel overeen.
		Medical alert information (other than allergies and intolerances)	EXTEND	Healthcare alert description (*)	Description of medical alerts in textual format: any condition, diagnosis, or procedure. Required		Fit	Alert v4.1	8.1 Alert	AlertNaam+AlertType+BeginDatumTijd	0.1 (alerttype is wel verplicht, maar is op zichzelf geen beschrijving van het alert)	Concatinatie van verschillende velden in BgZ dataset. In 2020 is Einddatum beschikbaar. Voorstel om alleen actieve alerts (dus zonder einddatum) te versturen in PS
	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 or agent. Optional		Gap					
			EXTEND	Vaccine/prophylaxis description	Generic description of the vaccine/prophylaxis or its purpose. Required		Gap	Vaccinatie v4.0	12.1 (Vaccinaties)	ProductCode	0.1	
			EXTEND	Vaccination code	Standardized code corresponding to the vaccination. Optional		Gap	Vaccinatie v4.0	12.1 (Vaccinaties)	ProductCode		NL is op G standaard, EU is Snomed lijst
			EXTEND	Vaccine medicinal product	Medicinal product name. Required		Fit	Vaccinatie v4.0	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 v4.0	12.1 (Vaccinaties)	VaccinatieDatum		1

		EXTEND Number in a series of vaccination	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	The data element is not available	Fit	Zorgaanbieder v3.4	12.1 (Vaccinaties)	OrganisatieNaam				
		EXTEND Health Professional identifier	Name or identifier of the health professional responsible for the vaccination	Optional	The data element is not available	Fit	Zorgverlener v3.5	12.1 (Vaccinaties)	ZorgverlenerIdentificatieNummer				Samenvoegen bestaande velden mogelijk nodig
		EXTEND Country of vaccination (*)	The country in which the individual has been vaccinated	Optional		Fit	Adresgegevens v1.1	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 v4.4	6.1 (Problemen)	ProbleemNaam				1 Alleen die problemen ophalen waar ProbleemStatus 'inactief' is
			Example: Hepatic cyst (the patient has been treated)										
		EXTEND Problem code	Standardized code corresponding to the medical problem	Required	If the code is not available	Fit	Probleem v4.4	6.1 (Problemen)	ProbleemNaam				1
		EXTEND Onset date	Date when the patient first experienced the condition	Required		Fit	Probleem v4.4	6.1 (Problemen)	ProbleemBeginDatum	0.1			
		EXTEND End Date	Problem resolution date; the date when the medical problem was resolved	Required		Fit	Probleem v4.4	6.1 (Problemen)	ProbleemEindDatum	0.1			
		EXTEND Resolution Circumstances	Describes the reason by which the problem changed	Optional		Gap							
			Example: It can happen that this field is already included										
		EXTEND Problem Status code	Standardized code corresponding to the problem status	Optional		Gap (op waarde lijst)							Waardenlijst komt niet of niet geheel overeen.
		EXTEND Health Professional related with	Identify the Health Professional who may be specifically related to the problem	Optional		Gap		6.1 (Problemen)					
		EXTEND External Resource related with	Identify the External Resource which may be specifically related to the problem	Optional		Gap							
		EXTEND Text (*)	This section may provide both synthetic anamnesis and additional information	Required	Please refer to eHNA	Gap							
MEDICAL PROBLEMS	Medical History (*)	List of current problems/diagnoses	Problem/Diagnosis description	Required	Problems/diagnosis that fit under these conditions:	Fit	Probleem v4.4	6.1 (Problemen)	ProbleemNaam				1 Alleen die problemen ophalen waar ProbleemStatus 'actief' is
		BASIC Problem code	Standardized code corresponding to the medical problem	Required	If the code is not available	Fit	Probleem v4.4	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 v4.4	6.1 (Problemen)	ProbleemBeginDatum	0.1			
		BASIC Diagnosis ascertainment status (*)	Assertion about the certainty associated with a diagnosis	Optional		Gap (op waarde lijst)	Probleem v4.4	6.1 (Problemen)	VerificatieStatus				Waardenlijst komt niet of niet geheel overeen.
		BASIC Health Professional Related with	Identify the Health Professional who may be specifically related to the problem	Optional		Gap (samenvoegen)	Zorgverlener v3.5	6.1 (Problemen)					
		BASIC External Resource related with	Identify the External Resource which may be specifically related to the problem	Optional		Gap							
	Medical devices	BASIC Device and Implant description	Describes the patient's implanted and external medical devices	Required	The medical device is not available	Fit	MedischHulpmiddel v3.11.1 (Medische Hulpmiddelen)	ProductOmschrijving	0.1				
		BASIC Device unique identifier	Normalised identifier of the device instance such as device ID	Required		Fit	MedischHulpmiddel v3.11.1 (Medische Hulpmiddelen)	Product.ProductID	0.1				
		BASIC Implant date	Date when the procedure to implant the medical device was performed	Required		Fit	MedischHulpmiddel v3.11.1 (Medische Hulpmiddelen)	BeginDatum	0.1				
		BASIC End date (*)	Date when the device was explanted from the patient	Optional		Fit	MedischHulpmiddel v3.11.1 (Medische Hulpmiddelen)	EindDatum					
	Procedures	BASIC Procedure description	Describes the type of the surgical procedure.	Required		Fit	Verrichting v5.2	15.1 Verrichtingen	VerrichtingType				1
		BASIC Procedure code	Standardized code corresponding to the surgical procedure	Required	If the code is not available	Gap (op waarde lijst)	Verrichting v5.2	15.1 Verrichtingen	VerrichtingType				1 Waardenlijst komt niet of niet geheel overeen.
		BASIC Body site (*)	Procedure target body site	Optional		Gap (op waarde lijst)	AnatomischeLocatie v115.1 Verrichtingen	Locatie en Lateraliteit					Zowel EU als NL hebben Snomed lijst, maar waardelijst EU niet bekend
	Functional status (*)	BASIC Procedure date	Date when the surgical procedure was performed.	Required		Fit	Verrichting v5.2	15.1 Verrichtingen	VerrichtingStartDatum	0.1			
		EXTEND Description (*)	Need for the patient to be continuously assessed by the health professional	Required		Fit	FunctieHoren v3.2	5.2 Functie horen	Rootconcept + Hoofnctie				1
							FunctieZien v3.1	5.3 Functie zien	Rootconcept+VisueleFunctie				
							FunctioneleOfMentaleStatus v3.2	5.1 Functionele/Mentale Status	StatusNaam+StatusWaarde				
		EXTEND Onset Date (*)	Onset date of a condition	Optional		Gap							
		EXTEND Functional assessment description	Description of the functional assessment	Optional		Gap (op waarde lijst)	FunctioneleOfMentaleStatus v5.1 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	Gap (op waarde lijst)	FunctioneleOfMentaleStatus v5.1 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	FunctioneleOfMentale 5.1	Functionele/mentale st: 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 co	Gap (op waarc	FunctioneleOfMentale 5.1	Functionele/mentale st: StatusWaarde				
MEDICATION SUMMARY	Current and relevant past medic (Relevant prescribed medicines \	BASIC	Medication reason (*)	The reason why the medication is or was prescribed, or used	Optional		Gap (op waarc	Probleem v4.4	10.1	Medicatieafspraak	ProbleemNaam	G standaard, DHD diagnosethesaurus, ICD, ICF, OMAHA Snomed, ICPC, NANDA, DSM IV, 5, GGZdiagnoselijst. NL staat meer waardelijsten toe dan EU	
		BASIC	Intended use (**)	This is the reason why the medication is being prescribed or used. It provides a link to the Past or current health conditions or problems that the patient has had or has. Indication intended use as: prevention or treatment	Optional		Gap (op waarc	Probleem v4.4	10.1	Medicatieafspraak	AanvullendeAfspraak	Waardenlijst komt niet of niet geheel overeen.	
		BASIC	Brand name (*)	Example: prophylaxis, treatment, diagnostic, anaest Brand name if biological medicinal product or when	Optional	Fit	FarmaceutischProduct	10.1	Medicatieafspraak	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 Example: Paracetamol.	Required	In Art-Decor, the "A	Fit	FarmaceutischProduct	10.1	Medicatieafspraak	Ingredient.IngredientCo 0.1	de	ATC, GPK, PRK, ZI, SSK, GTIN, HPK, SNK, Gstandaard artikelen, KNMP nummer,AT code
		BASIC	Strength(s)	The content of the active ingredient expressed quar Strength has the following sub-elements: Value (100, 200 etc.) Unit (mg, gr etc.) Example: 500 mg per tablet.	Required	From technical poin	Gap		Ingredient.Sterkte.Ingre 0.1	dientHoeveelheid	Het gaat om Ingredient hoeveelheid, maar die is helaas niet of niet altijd gevuld als het een product betreft met een productcode en waarvoor geen bereiding nodig is in de apotheek. Vraag is of dat erg is omdat product ook al gedeeld heeft en dit in de naam ookde ingredient hoeveelheid heeft afhankelijk van de gekozen g-standaard		
		BASIC	Pharmaceutical dose form	The form in which a pharmaceutical product is presi	Optional	Gap (op waarc	FarmaceutischProduct	10.1	Medicatieafspraak	FarmaceutischeVorm	Waardenlijst komt niet of niet geheel overeen.		
		BASIC	Dosage Regimen	Number of units per intake and frequency of intake Example: 1 tablet every 24h, for 10 days.	Required	Posology is currentl	Fit	GebruiksInstructie v1.2	10.1	Medicatieafspraak	KeerDosis 0.1		
		BASIC	Frequency of intakes	Frequency of the intakes that the patient should take (per hour/day/month/ week). Example: Each month.	Required	This attribute is part	Fit	GebruiksInstructie v1.2	10.1	Medicatieafspraak	Toedieningsschema.Fre 0.1	quentie	
		BASIC	Timing of intakes	Moment of the day when the intakes should be take	Optional	Fit	GebruiksInstructie v1.2	10.1	Medicatieafspraak	Toedieningsschema.Dag Deel			
		BASIC	Duration of treatment	Example: During the early evening The duration for which the patient should take the r	Required	This attribute is part	Fit	GebruiksInstructie v1.2	10.1	Medicatieafspraak	Toedieningsschema.Toe 0.1	dieningsduur	
		BASIC	Date of onset of treatment	Example: During 14 days. Date when the patient needs to start taking the pre:	Required	It is constituted of 3	Fit	GebruiksInstructie v1.2	10.1	Medicatieafspraak	Medicatieafspraak.Gebr 0.1	uikperiode.Ingangsdatum	
		BASIC	Medicine status (**)	Current status of the medicine.	Mandatory	Possible values are '	Fit	Medicatieafspraak v.1.	10.1	Medicatieafspraak	MedicatieafspraakStop 0.1	Type	Alle niet gestopte medicaties zijn nog actief --> waarschijnlijk geen gap. Afhankelijk van uiteindelijke implementatie.
SOCIAL HISTORY	Social History Observations	EXTEND	Social History Observation desc	Textual description of the social history	Mandatory	Health related "lifes	Gap (samenvc	AlcoholGebruik v3.2	7.3	AlcoholGebruik	Concatinatie van	1	Mogelijk door samenvoeging bestaande velden te verkrijgen.
		EXTEND	Social History Observation code	Standardized code corresponding to the social histo	Mandatory		Gap (samenvc	AlcoholGebruik v3.2	7.3	AlcoholGebruik	Rootconcept	1	Waardenlijst komt niet of niet geheel overeen.

		EXTEND Social History Observation value	Value of the corresponding observation.	Required	Fit	AlcoholGebruik v3.2 DrugsGebruik v3.3 TabaksgGebruik v3.2	7.3 AlcoholGebruik 7.2 DrugsGebruik 7.4 TabaksGebruik	WaarnemingGebruik.H oeveelheid WaarnemingGebruik.H oeveelheid WaarnemingGebruik.H oeveelheid (voorkeur) of WaarnemingGebruik.Pa ckYears (indien hoeveelheid niet beschikbaar is)	1
		EXTEND Reference date range	Period of time (start and/or end date) during which Example: From 1974 to 2004.	Required	Fit	AlcoholGebruik v3.2 DrugsGebruik v3.3 TabaksgGebruik v3.2	7.3 AlcoholGebruik 7.2 DrugsGebruik 7.4 TabaksGebruik	From + WaarnemingGebruik.St artDatum + to + WaarnemingGebruik.St opDatum From + WaarnemingGebruik.St artDatum + to + WaarnemingGebruik.St opDatum From + WaarnemingGebruik.St artDatum + to + WaarnemingGebruik.St opDatum	1
PREGNANCY HISTORY	Current pregnancy status	EXTEND Expected date of delivery	Date in which the woman is due to give birth. Year, r 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 es	Mandatory	Gap				Zib zwangerschap bestaat wel, maar zit niet in BgZ
		EXTEND Date of observation (*)	Date on which the observation of the pregnancy sta	Optional	Gap				Zib zwangerschap bestaat wel, maar zit niet in BgZ
		EXTEND Status (*)	Provides the woman's current state at the date of tf	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	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 (**) EXTEND Period (**)	Country(s) visited Date of entry and departure	Required Optional	Gap Gap				
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 v3.1.1 LaboratoriumUitslag v4.6 Bloeddruk v3.2.1 Lichaamsgewicht v3.2 Lichaamslengte v3.1.1	3.2 Wilsverklaring 14.1 LaboratoriumUitslagen 13.1 Bloeddruk 13.2 Lichaamsgewicht 13.3 Lichaamslengte	WilsverklaringType LaboratoriumTest.TestD atumTijd 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 measuremen Examples: Diagnostic results (Blood group, Laboratory Observa Physical findings (Vital signs observations)	Optional	Fit	LaboratoriumUitslag v4.6 Bloeddruk v3.2.1 Lichaamsgewicht v3.2 Lichaamslengte v3.1.1	14.1 LaboratoriumUitslagen 13.1 Bloeddruk 13.2 Lichaamsgewicht 13.3 Lichaamslengte	Rootconcept Rootconcept Rootconcept Rootconcept	Mapping rootconcept naar EU waardelijst HL7 ObservationCategoryCod es

			EXTEND Result description (*)	Narrative representation of the observation result a Required	Fit	LaboratoriumUitslag v4.6 Bloeddruk v3.2.1 Lichaamsgewicht v3.1.2 Lichaamslengte v3.1.2	14.1 LaboratoriumUitslagen 13.1 Bloeddruk 13.2 Lichaamsgewicht 13.3 Lichaamslengte	LaboratoriumTest.TestCode+LaboratoriumTest.TestUitslag DiastolischeBloeddruk+SystolischeBloeddruk+GemiddeldeBloeddrukGewichtWaarde LengteWaarde	1
			EXTEND Observation details (*)	Observation details including code that identifies of Optional	Fit	LaboratoriumUitslag v4.6	14.1 LaboratoriumUitslagen	Monster.MonsterMateriaal+Monster.AnatomischeLocatie.Locatie+Monster.AnatomischeLocatie.Lateraliteit+Monster.AfnameDatumTijd	
			EXTEND Observation results (*)	Result of the observation including numeric and coc Optional	Fit	LaboratoriumUitslag v4.6	14.1 LaboratoriumUitslagen	LaboratoriumTest.ReferentieBovengrens + LaboratoriumTest.ReferentieOndergrens+LaboratoriumTest.InterpretatieVlaggen+Toelichting	
			EXTEND Performer (*)	Identifies the originator/author and provides prover Optional	Fit	Zorgaanbieder v3.4	14.1 LaboratoriumUitslagen	OrganisatieNaam	
	PLAN OF CARE	Therapeutic recommendations (EXTEND Reporter (*) EXTEND Text (*)	With certain observation results, e.g. there may also Narrative containing the plan including proposals, g Required	Optional Required	Gap Gap			Dit behoort tot zib ZorgAfspraak die zit niet in de BgZ
In the future it is expected that this Section could be									
3. PATIENT SUMMARY DATA (Information about the Patient Summary itself)									
	Country	Country	BASIC	Country	Name of the patient's Country of affiliation. Mandatory			NCPeH	
	Patient Summary	Date Created	BASIC	Date Created	Date on which the Patient Summary was generated. Required			NCPeH	
		Date of Last Update	BASIC	Date of Last Update	Date on which the Patient Summary was last update Mandatory			NCPeH	
	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		NCPeH	
					direct human intervention by an HP automatically generated mixed approach (human intervention and automatic)	The Data Element N			
	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 Organisat be listed	The Author should list the provenance of t Different authors co entries could be pro		NCPeH	
	Legal authenticator	Legal authenticator	BASIC	Legal authenticator	Legal entity (Health Professional or Health Care Provider) who authenticated the Patient Summary Mandatory	When the data is co		NCPeH	
						The legal authenticator			
	Documentation Of	Documentation Of	BASIC	Documentation Of	Representation of providers who are wholly or partially involved in the care of the patient. Required			NCPeH	
					It indicates the performer, time/date and range of time				
	Related Document	Related Document	BASIC	Related Document	Used to indicate a parent document Mandatory			NCPeH	
	Additional Information/Knowledge Reference	Additional information/Knowledge Reference	EXTEND	External reference (*)	A reference leading to Clinical Practice Guidelines (Clinical Practice Guideline) Optional			NCPeH	