Integrating the Healthcare Enterprise

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IHE Patient Care Coordination
Technical Framework Supplement

Labor and Delivery Profiles
(LDHP, LDS and MDS)

10

Trial Implementation

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Foreword

This is a supplement to the IHE Patient Care Coordination Technical Framework V9.0. Each supplement undergoes a process of public comment and trial implementation before being incorporated into the volumes of the Technical Frameworks.

This supplement is published on October 4, 2013 for Trial Implementation and may be available for testing at subsequent IHE Connectathons. The supplement may be amended based on the results of testing. Following successful testing it will be incorporated into the Patient Care Coordination Technical Framework. Comments are invited and may be submitted at http://www.ihe.net/PCC_Public_Comments.

This supplement describes changes to the existing technical framework documents.

"Boxed" instructions like the sample below indicate to the Volume Editor how to integrate the relevant section(s) into the relevant Technical Framework volume.

Amend section X.X by the following:

Where the amendment adds text, make the added text **bold underline**. Where the amendment removes text, make the removed text **~~bold strikethrough~~**. When entire new sections are added, introduce with editor's instructions to "add new text" or similar, which for readability are not bolded or underlined.

General information about IHE can be found at: www.ihe.net.

Information about the IHE Patient Care Coordination domain can be found at: http://www.ihe.net/IHE_Domains.

Information about the organization of IHE Technical Frameworks and Supplements and the process used to create them can be found at: http://www.ihe.net/IHE_Process and http://www.ihe.net/Profiles.

The current version of the IHE Patient Care Coordination Technical Framework can be found at: http://www.ihe.net/Technical_Frameworks.

IHE Patient Care Coordination Technical Framework Supplement – Labor and Delivery Profiles (includes Labor and Delivery History and Physical [LDHP], Labor and Delivery Summary [(LDS], and Maternal Discharge Summary [MDS])

CONTENTS

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Introduction

This supplement is written for Trial Implementation. It is written as changes to the latest revision of the documents listed below. The reader should have already read and understood these documents:

1. PCC Technical Framework Volume 1
2. PCC Technical Framework Volume 2

This supplement also references other documents[1]. The reader should have already read and understood these documents:

1. IT Infrastructure Technical Framework Volume 1
2. IT Infrastructure Technical Framework Volume 2
3. IT Infrastructure Technical Framework Volume 3
4. The Patient Identifier Cross-Reference (PIX) and Patient Demographic Query (PDQ) HL7 v3 Supplement to the IT Infrastructure Technical Framework.
5. HL7 and other standards documents referenced in Volume 1 and Volume 2

How to read the Labor and Delivery Profiles supplement

This supplement contains 3 content profiles – Labor and Delivery History and Physical (LDHP), Labor and Delivery Summary (LDS), and Maternal Discharge Summary (MDS). Labor and Delivery Record (LDR) is no longer a profile as it has been subsumed by Perinatal Workflow (PW) profile.

Please see the below documents that will need to be referenced to fully understand the profiles in this supplement. Each document has a short description describing what is contained.

1. **Perinatal Workflow (PW):** makes use of the antepartum, labor and delivery, postpartum, and newborn delivery profiles (some are in this supplement and many are in other supplements).
2. **Content Modules Supplement:** This document contains all PCC Section Templates, Entry Templates, and Value Sets that are NOT in Final Text (that is, they are not in the Technical Framework Volume 2).

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[1] The first four documents can be located on the IHE Website at http://www.ihe.net/Technical_Framework/index.cfm#IT. The remaining documents can be obtained from their respective publishers.

3. **PCC Technical Framework Volume 2:** This contains all PCC Section Templates, Entry
Templates and Value Sets (among other things) that ARE in Final Text.

How to Access the Reference Material

To access the latest version of the Perinatal Workflow, CDA Content Modules supplement or the
PCC Technical Framework, navigate to http://www.ihe.net/Technical_Frameworks/#pcc

Open Issues and Questions

1. How should grouping be handled for sections that are reused from other profiles? For
example several APHP sections are reused in LDHP and this should be called out
somewhere, probably in the grouping section, but existing profiles use of the groupings
section is not clear or consistent so a new table format should be explored. This could
also be put in an appendix since it applies to several related profiles.

2. In sections X.7, Y.7, Z.7 (mappings to PCC Templates) the origin of the groups of data
elements needs to be called out to show that these data did in fact originate from some
sort of standard or at the very least clinical consensus within PCC committee.

3. In the Newborn Discharge Summary (NDS) and Postpartum Visit Summary (PPVS)
profiles, the Labor and Delivery Events section is described much more inclusively than
the description in this profile. Specific data elements are now distributed between various
sections rather than all grouped in the Labor and Delivery Events section. For example,
medications administered is now a separate section, as is maternal complications which
are now included in the active problems section. Episiotomies, C-sections, etc., are now
in the procedures and interventions subsection of Labor and Delivery Events. The content
of these sections will need to be reconciled between the two profiles.

Closed Issues

1. ~~MCH is dependent on LDS to provide a disposition of the newborn upon transfer from the
birthing suite. Possible value sets may include: transfer to Newborn ICU; transfer to well
newborn nursery; transfer to tertiary facility. This has been captured in MDS as newborn
disposition at maternal discharge; however MCH needs this data at the time of transfer from
the birthing suite. This still needs to be addressed.~~ Resolved with the addition of a Patient
Transfer entry added to Coded Event Outcomes.
2. ~~In the labor and delivery summary there needs to be a way to capture coded results and
intake and output for both the mother and the newborn (same sections but for two separate
patients). Based on structural limitations at this time, only the newborn results are referenced
in Volume 2. This needs to be addressed before profile implementation.~~ Resolved by
including these sections for the Mother as main-line sections inheriting the context of the

recordTarget for the document and then also including these sections under the context of the Newborn Delivery Information section which now uses an alternate subject for the Newborn.

Volume 1 – Profiles

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Add the following to section 1.5

1.5 Copyright Permissions

Add the following to section 2.4

2.4 Dependencies of the PCC Integration Profiles

<Profile Name>	<?>	<?>	<->

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Add the following to section 2.5

2.5 History of Annual Changes

Add Section X

X Labor and Delivery History and Physical Content Profile (LDHP)

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Labor and Delivery History and Physical is a content profile that defines the structure of the data that is often collected during the initial admission to the birthing facility. It includes, but is not limited to demographics, histories, allergies, physical examinations, vital signs, and care plans.

X.1 Purpose and Scope

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The information collected during labor, delivery and the immediate postpartum period is very important to follow-up care for both mother and infant, whether the follow-up care is provided in an inpatient or outpatient facility. A physician's recommendation for a follow-up hematocrit test or evaluation of the incision in the office may be noted in the Labor and Delivery Summary or in the Maternal Discharge Summary. These documents must be available in both inpatient and

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outpatient settings.

Pertinent maternal information includes, but is not limited to, delivery type; labor type; anesthesia type; labor, delivery and postpartum complications; and specific maternal information such as medications, laboratory test results, allergies and plans for contraception. Pertinent neonatal information includes, but is not limited to, delivery method, gender, birth time, birth

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weight, gestational age at delivery, APGAR scores, and medications received in the delivery room including immunizations.

X.2 Process Flow

X.2.1 Use Cases

Change referenced section numbering when merged into technical framework

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For applicable use cases see Perinatal Workflow section X.2.1.

X.2.2 Diagrams

Change referenced section numbering when merged into technical framework

For applicable diagrams see Perinatal Workflow section X.2.2.

X.3 Actors/Transactions

220

There are two actors in this profile, the Content Creator and the Content Consumer. Content is created by a Content Creator and is to be consumed by a Content Consumer. The sharing or transmission of content from one actor to the other is addressed by the appropriate use of IHE profiles described below, and is out of scope of this profile. A Document Source or a Portable Media Creator may embody the Content Creator Actor. A Document Consumer, a Document

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Recipient, or a Portable Media Importer may embody the Content Consumer Actor. The sharing or transmission of content or updates from one actor to the other is addressed by the use of

appropriate IHE profiles described in the section on Content Bindings with XDS, XDM and
XDR in PCC TF-2:4.1.

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Figure X.3-1: Actor Diagram

X.3.1 Requirements of Actors

X.4 Options

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Table X.4-1: Labor and Delivery History and Physical Options

Actor	Option	Section
Content Consumer	View Option (See Note 1)	PCC TF-2:3.1.1
	Document Import Option (See Note 1) Section Import Option (See Note 1) Discrete Data Import Option (See Note 1)	PCC TF-2:3.1.2 PCC TF-2:3.1.3 PCC TF-2:3.1.4
Content Creator	No options defined	

Note 1: The Actor shall support at least one of these options.

X.5 Groupings

Groupings are needed to represent which templates are required from other content profiles and
240 will be added in future work.

X.6 Security Considerations

X.7 Content Modules

Table X.7-1: Labor and Delivery History and Physical Content Modules

Datum	PCC Template Name
Demographics	Header Modules (See Note 1)

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Datum	PCC Template Name
Chief Complaint	Chief Complaint (See Note 1)
Problem List	Active Problems
Admission Medication History	Admission Medication History
Pregnancy History	Pregnancy History (See Note 1)
HPI or Interim Medical History	History of Present Illness
Medical History	History of Past Illness (See Note 1)
Social History	Coded Social History (See Note 1)
Medical History – Relevant Family History	Coded Family Medical History (See Note 1)
Allergies	Allergies and Other Adverse Reactions (See Note 1)
Menstrual History/Symptoms Since LMP	Review of Systems (See Note 1)
Genetic Screening/Teratology Counseling	Coded Family History Medical History (See Note 1)
Infection History	Coded History of Infection (See Note 1)
Initial Physical Examination	Coded Physical Exam (See Note 1)
Vital Signs	Coded Vital Signs (See Note 1)
Pain Assessment	Pain Assessment Panel
Diagnostic Findings	Prenatal Events: Coded Results (See Note 1)
Antenatal Test Results	Coded Antenatal Testing and Surveillance
Surgical History	History of Surgical Procedures (See Note 1)
Prenatal Events	Prenatal Events
Estimated Delivery Date	Estimated Delivery Date
Care Plan	Care Plan

245   Note 1: This template is part of Antepartum History and Physical

X.8 References

This profile contains different summaries, based on data elements collected from different forms, originating from various organizations in the United States and Europe. The generic forms used to build this profile are:

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- Demographic information about the mother, the father and the child

- General information about the family

- Admission Assessment for Labor and Delivery

- Transport Summary during pregnancy (if any)

- Antepartum Summary

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- Labor & Delivery Summary (combined with the Newborn Birth Summary while in the birth room)

- Maternal Discharge Summary

- Patient Plan of Care Profile

These forms and data elements were collected with the assistance of the following organizations:

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ACOGAR	American College of Obstetricians and Gynecologists (ACOG), Antepartum Record
AUDIPOG	Association des Utilisateurs de Dossiers Informatisés en Périnatalogie, Obstétrique et Gynécologie
Dossier obstétrical	Fédération suisse des sages-femmes 2008
UHIN	Utah Health Information Network
IH	Intermountain Healthcare

Y Labor and Delivery Summary Content Profile (LDS)

Labor and Delivery Summary is a content profile that defines the structure of the data that is often collected during the labor and delivery period at the birthing facility. It includes, but is not limited to demographics, histories, allergies, physical examinations, vital signs, and newborn delivery information.

Y.1 Purpose and Scope

The information collected during labor, delivery, and the immediate postpartum period is very important to follow-up care for both mother and infant whether the follow-up care is provided in an inpatient or outpatient facility. A physician's recommendation for a follow-up hematocrit test or evaluation of the incision in the office may be noted in the Labor and Delivery Summary or in the Maternal Discharge Summary. These documents must be available in both inpatient and outpatient settings.

Pertinent maternal information includes, but is not limited to, delivery type; labor type; anesthesia type; labor, delivery and postpartum complications; and specific maternal information such as medications, laboratory test results, allergies, and plans for contraception. Pertinent neonatal information includes, but is not limited to, delivery method, gender, birth time, birth weight, gestational age at delivery, APGAR scores, and medications received in the delivery room including immunizations.

Y.2 Process Flow

Y.2.1 Use Cases

Change referenced section numbering when merged into technical framework

For applicable use cases see Perinatal Workflow section X.2.1.

Y.2.2 Diagrams

Change referenced section numbering when merged into technical framework

For applicable diagrams see Perinatal Workflow section X.2.2.

Y.3 Actors/Transactions

There are two actors in this profile, the Content Creator and the Content Consumer. Content is created by a Content Creator and is to be consumed by a Content Consumer. The sharing or transmission of content from one actor to the other is addressed by the appropriate use of IHE profiles described below, and is out of scope of this profile. A Document Source or a Portable Media Creator may embody the Content Creator Actor. A Document Consumer, a Document Recipient, or a Portable Media Importer may embody the Content Consumer Actor. The sharing

or transmission of content or updates from one actor to the other is addressed by the use of appropriate IHE profiles described in the section on Content Bindings with XDS, XDM and XDR in PCC TF-2:4.1.

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Figure Y.3-1: Actor Diagram

300 ### Y.3.1 Requirements of Actors

Y.4 Options

Table Y.4-1: Labor and Delivery Summary Options

Actor	Option	Section
Content Consumer	View Option (See Note 1)	PCC TF-2:3.1.1
	Document Import Option (See Note 1)	PCC TF-2:3.1.2
	Section Import Option (See Note 1)	PCC TF-2:3.1.3
	Discrete Data Import Option (See Note 1)	PCC TF-2:3.1.4
Content Creator	No options defined	

Note 1: The Actor shall support at least one of these options.

305 ## Y.5 Groupings

Groupings are needed to represent which templates are required from other content profiles and will be added in future work.

Y.6 Security Considerations

Y.7 Content Modules

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Table Y.7-1: Labor and Delivery Summary Content Modules

Data Element Name	PCC Template Name
Problem List	Active Problems
Admission Medication History	Admission Medication History

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Data Element Name	PCC Template Name
Allergies	Allergies and Other Adverse Reactions
Admission Assessment and Plan	Assessment and Plan
Patient's Birth Plan	Birth Plan
Chief Complaint	Chief Complaint
Advanced Directives	Coded Advance Directives
Antenatal Test Results	Coded Antenatal Testing and Surveillance
Initial Physical Examination and Maternal Physical Exam	Coded Detailed Physical Examination
Diagnostic Findings; Maternal and Fetal Labs	Coded Results
	Estimated Blood Loss
Estimated Date of Delivery Determined at Admission	Estimated Delivery Date
Blood Transfusions Received in Labor and Delivery	History of Blood Transfusion
Date of first prenatal care visit Date of last prenatal care visit Total number of prenatal care visits for this pregnancy Date last normal menses began Number of previous live births now living Number of previous live births now dead Date of last live birth Total number of other pregnancy outcomes Date of last other pregnancy outcome Risk factors in this pregnancy	Pregnancy History
Infections present and/or treated during this pregnancy	Coded History of Infection
Past Medical History	History of Past Illness
Interim Medical History	History of Present Illness
Surgical Procedures	History of Surgical Procedures
Admitting Diagnosis	Hospital Admission Diagnosis
Intake and Output (excludes estimated blood loss)	Intake and Output
Intravenous Fluids	Intravenous Fluids Administered
Detailed Information on Labor and Delivery	Labor and Delivery Events
	Coded Event Outcomes
Procedures During Labor and Delivery	Procedures and Interventions
Medications Administered	Medications Administered
	Pain Assessment Panel
Arrival Mode	Transport Mode
Newborn Delivery Information	Newborn Delivery Information (LDS)
Problem List	Active Problems

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Data Element Name	PCC Template Name
	Event Outcomes
	Coded Event Outcomes
Medications Administered	Medications Administered
Newborn Physical Exam	Coded Detailed Physical Examination
Coded Results	Coded Results
Intake and Output	Intake and Output
Procedures and Interventions	Procedures and Interventions

Note 1: The record Target in an LDS document is the Mother. The Newborn Delivery Information section establishes a context where the newborn is the subject.

Y.8 References

315 This profile contains different summaries based on data elements collected from different forms originating from various organizations in the United States and Europe. The generic forms used to build this profile are:

- Demographic information about the mother, the father and the child

- General information about the family

320 - Admission Assessment for Labor and Delivery

- Transport Summary during pregnancy (if any)

- Antepartum Summary

- Labor & Delivery Summary (combined with the Newborn Birth Summary while in the birth room)

325 - Maternal Discharge Summary

- Patient Plan of Care Profile

These forms and data elements were collected with the assistance of the following organizations:

ACOGAR	American College of Obstetricians and Gynecologists (ACOG), Antepartum Record
AUDIPOG	Association des Utilisateurs de Dossiers Informatisés en Périnatalogie, Obstétrique et Gynécologie
Dossier obstétrical	Fédération suisse des sages-femmes 2008
UHIN	Utah Health Information Network
IH	Intermountain Healthcare

330 # Z Maternal Discharge Summary Content Profile (MDS)

Maternal Discharge Summary is a content profile that defines the structure of the data that is often collected t-delivery until discharge from the birthing facility. It includes, but is not limited to demographics, medications, laboratory results, newborn delivery information, patient education, and outcomes.

335 ## Z.1 Purpose and Scope

The information collected during labor, delivery, and the immediate postpartum period is very important to follow-up care for both mother and infant whether the follow-up care is provided in an inpatient or outpatient facility. A physician's recommendation for a follow-up hematocrit test or evaluation of the incision in the office may be noted in the Labor and Delivery Summary or in
340 the Maternal Discharge Summary. These documents must be available in both inpatient and outpatient settings.

Pertinent maternal information includes, but is not limited to, delivery type; labor type; anesthesia type; labor, delivery and postpartum complications; and specific maternal information such as medications, laboratory test results, allergies, and plans for contraception. Pertinent
345 neonatal information includes, but is not limited to, delivery method, gender, birth time, birth weight, gestational age at delivery, APGAR scores, and medications received in the delivery room including immunizations.

Z.2 Process Flow

Z.2.1 Use Cases

350 | *Change referenced section numbering when merged into technical framework* |
|---|

For applicable use cases see Perinatal Workflow section X.2.1.

Z.2.2 Diagrams

Change referenced section numbering when merged into technical framework

For applicable diagrams see Perinatal Workflow section X.2.2.

355 ## Z.3 Actors/Transactions

There are two actors in this profile, the Content Creator and the Content Consumer. Content is created by a Content Creator and is to be consumed by a Content Consumer. The sharing or transmission of content from one actor to the other is addressed by the appropriate use of IHE profiles described below, and is out of scope of this profile. A Document Source or a Portable
360 Media Creator may embody the Content Creator Actor. A Document Consumer, a Document Recipient, or a Portable Media Importer may embody the Content Consumer Actor. The sharing

or transmission of content or updates from one actor to the other is addressed by the use of appropriate IHE profiles described in the section on Content Bindings with XDS, XDM and XDR in PCC TF-2:4.1.

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Figure Z.3-1: Actor Diagram

Z.3.1 Requirements of Actors

370 ## Z.4 Options

Table Z.4-1: Maternal Discharge Summary Options

Actor	Option	Section
Content Consumer	View Option (See Note 1)	PCC TF-2:3.1.1
	Document Import Option (See Note 1)	PCC TF-2:3.1.2
	Section Import Option (See Note 1)	PCC TF-2:3.1.3
	Discrete Data Import Option (See Note 1)	PCC TF-2:3.1.4
Content Creator	No options defined	

Note 1: The Actor shall support at least one of these options.

Z.5 Groupings

375 Groupings are needed to represent which templates are required from other content profiles and will be added in future work.

Z.6 Security Considerations

Z.7 Content Modules

380 **Table Z.7-1: Maternal Discharge Summary Content Modules**

Data Element	PCC Template Name
Demographics	Header Modules (See Note 1)

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Data Element	PCC Template Name
Discharge Date/Time	Header Module
Admission Diagnosis	Hospital Admission Diagnosis
Problem List	Active Problems
Discharge Diagnosis	Discharge Diagnosis
Discharge Disposition	Discharge Disposition
Discharge Method	Transport Mode
Condition on Discharge	Discharge Status
Allergies	Allergies and Other Adverse Reactions
Events during the hospitalization	Hospital Course
Advance Directive	Coded Advance Directives (See Note 1)
Medications prescribed at discharge	Hospital Discharge Medications
Imaging Reports	Coded Hospital Studies Summary
Pain Assessment	Pain Assessment Panel
Skin Assessment	Braden Score
Postpartum Complications	Active Problems
Discharge Diet	Postpartum Hospitalization Treatment: Discharge Diet
Medications Administered	Postpartum Hospitalization Treatment: Medications Administered
Hgb/Hct	Postpartum Hospitalization Treatment: Coded Results
Postpartum Procedures	Postpartum Hospitalization Treatment: Procedures and Interventions
Postpartum Plan of Care	Postpartum Hospitalization Treatment: Care Plan
Immunizations Recommendations	Immunization Recommendations
Immunizations Given	Postpartum Hospitalization Treatment: Immunizations
Type of IV Fluids Received	Intravenous Fluids Administered
Blood loss after the immediate delivery time-frame	Estimated Blood Loss
Number of blood transfusions (units) patient received	Transfusion History
Teaching/Instructions Given and Patient Verbalizes Understanding	Patient Education
Delivery Type (e.g., vaginal, cesarean section, vaginal birth after cesarean section and type of incision if C-section	Labor and Delivery Events: Procedures and Interventions
Risk Screening	Coded Social History
Discharge Activity	Provider Orders
Lactation Consultation	Consultations
First and Last Name of Baby at Birth	NDS: Header Module
First and Last Name of Baby at Discharge	NDS: Header Module
Baby's Unique IDENTIFIER	NDS: Header Module

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Data Element	PCC Template Name
Baby's Sex/Gender	LDS: Newborn Delivery Information
Circumcision (if Male)	NDS: Procedures and Interventions
Birth Weight	LDS: Newborn Delivery Information
Pediatrician's Name	NDS: Care Plan
Discharge Disposition(baby)	Newborn Status at Maternal Discharge

Note 1: This template is part of Labor and Delivery Summary

Z.8 References

This profile contains different summaries based on data elements collected from different forms originating from various organizations in the United States and Europe. The generic forms used to build this profile are:

- Demographic information about the mother, the father and the child

- General information about the family

- Admission Assessment for Labor and Delivery

- Transport Summary during pregnancy (if any)

- Antepartum Summary

- Labor & Delivery Summary (combined with the Newborn Birth Summary while in the birth room)

- Maternal Discharge Summary

- Patient Plan of Care Profile

These forms and data elements were collected with the assistance of the following organizations:

ACOGAR	American College of Obstetricians and Gynecologists (ACOG), Antepartum Record
AUDIPOG	Association des Utilisateurs de Dossiers Informatisés en Périnatalogie, Obstétrique et Gynécologie
Dossier obstétrical	Fédération suisse des sages-femmes 2008
UHIN	Utah Health Information Network
IH	Intermountain Healthcare

Volume 2 – Transactions and Content Modules

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5.0 Namespaces and Vocabularies

codeSystem	codeSystemName	Description

5.1 IHE Format Codes

Profile	Format Code	Media Type	Template ID
Labor and Delivery History and Physical (LDHP)	urn:ihe:pcc:ldhp:2009	text/xml	1.3.6.1.4.1.19376.1.5.3.1.1.21.1.1
Labor and Delivery Summary (LDS)	urn:ihe:pcc:lds:2009	text/xml	1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2
Maternal Discharge Summary (MDS)	urn:ihe:pcc:mds:2009	text/xml	1.3.6.1.4.1.19376.1.5.3.1.1.21.1.3

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6 PCC Content Modules

6.2 Folder Content Modules

See Perinatal Workflow section 6.2.L.

6.3 HL7 Version 3.0 Content Modules

410 ### 6.3.1 CDA Document Content Modules

Add section 6.3.1.A

6.3.1.A Labor and Delivery History and Physical 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.1

The Labor and Delivery History and Physical (LDHP) content profile represents the patient's history and physical performed during admission to the birthing facility. The LDHP is a Medical
415 Summary and inherits all header constraints from Medical Summary. It also uses parts of the Antepartum History and Physical where needed.

6.3.1.A.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:pcc:ldhp:2009**

6.3.1.A.2 LOINC Code

420 The LOINC code for this document is **57056-4** Labor and Delivery admission history and physical

6.3.1.A.3 Standards

CCD	ASTM/HL7 Continuity of Care Document
CDAR2	HL7 CDA Release 2.0
ACOGAR	American College of Obstetricians and Gynecologists (ACOG), Antepartum Record
LOINC	Logical Observation Identifiers, Names and Codes
SNOMED	Systemized Nomenclature for Medicine
CDTHP	CDA for Common Document Types History and Physical Notes (DSTU)

6.3.1.A.4 Specification

425 This section references content modules using Template ID as the key identifier. Definitions of the modules are found in either:

- IHE Patient Care Coordination Volume 2: Final Text

- IHE PCC Content Modules supplement

430 **Table 6.3.1.A.4-1: Labor and Delivery History and Physical Specification**

Template Name	Opt	Section Template Id	Value Set Template Id
Chief Complaint (See Note 1)	R	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1	N/A
History of Present Illness (See Note 1)	R	1.3.6.1.4.1.19376.1.5.3.1.3.4	N/A
History of Past Illness (See Note 1)	R	1.3.6.1.4.1.19376.1.5.3.1.3.8	1.3.6.1.4.1.19376.1.5.3.1.1.16.5.1
Coded History of Infection (See Note 1)	R	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	1.3.6.1.4.1.19376.1.5.3.1.1.16.5.6
Active Problems	R	1.3.6.1.4.1.19376.1.5.3.1.3.6	N/A
Pregnancy History (See Note 1)	R	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	N/A
Coded Social History (See Note 1) This section shall include the patient's social history including tobacco, alcohol and drug use (current or prior) as well as other environmental exposures.	R	1.3.6.1.4.1.19376.1.5.3.1.3.16.1	1.3.6.1.4.1.19376.1.5.3.1.4.13.4
Coded Family Medical History (See Note 1)	R	1.3.6.1.4.1.19376.1.5.3.1.3.15	1.3.6.1.4.1.19376.1.5.3.1.1.16.5.4
Admission Medication History	R	1.3.6.1.4.1.19376.1.5.3.1.3.20	N/A
Allergies and Other Adverse Reactions (See Note 1)	R	1.3.6.1.4.1.19376.1.5.3.1.3.13	N/A
Review of Systems (See Note 1)	R	1.3.6.1.4.1.19376.1.5.3.1.3.18	1.3.6.1.4.1.19376.1.5.3.1.1.16.5.5
Coded Physical Exam (See Note 1)	R	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	N/A
Vital Signs (See Note 1)	C	1.3.6.1.4.1.19376.1.5.3.1.3.25	N/A
History of Surgical Procedures (See Note 1)	R2	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2	N/A
Prenatal Events	R	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.2	N/A
Prenatal Events: Coded Results (See Note 1)	R	1.3.6.1.4.1.19376.1.5.3.1.3.28	N/A
Estimated Delivery Date	R	1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1	N/A

Template Name	Opt	Section Template Id	Value Set Template Id
Care Plan	R2	1.3.6.1.4.1.19376.1.5.3.1.3.31	N/A
Coded Antenatal Testing and Surveillance	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1	N/A
Pain Assessment Panel	R2	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4	N/A

Note 1: This template is part of Antepartum History and Physical and should be pulled from there when available.

6.3.1.A.5 Conformance

435 CDA Release 2.0 documents that conform to the requirements of this content module shall indicate their conformance by the inclusion of the appropriate <templateId> elements in the header of the document. This is shown in the sample document below. A CDA Document may conform to more than one template. This content module inherits from the History and Physical content module, and so must conform to the requirements of that template as well, thus all <templateId> elements shown in the example below shall be included.

```
440   <ClinicalDocument xmlns='urn:hl7-org:v3'>
        <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3"/>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.2'/><!--Medical Summary-->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.1.4'/><!--History and Physical-->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.1.1'/><!--Antepartum History and Physical-->
       <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.1.1'/><!--Labor and Delivery History and
445   Physical-->
        <id root=' ' extension=' '/>
        <code code='57056-4' displayName='Labor and delivery admission history and physical'
          codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
        <title>Labor and Delivery Record History and Physical</title>
450     <effectiveTime value='20080601012005'/>
        <confidentialityCode code='N' displayName='Normal'
          codeSystem='2.16.840.1.113883.5.25' codeSystemName='Confidentiality' />
        <languageCode code='en-US'/>
            :
455   <component><structuredBody>
        <component>
          <section>
            <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1'/>
            <!-- Required Chief Complaint Section content -->
460       </section>
        </component>
        <component>
          <section>
            <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.4'/>
465         <!-- Required History of Present Illness Section content -->
          </section>
        </component>
        <component>
          <section>
470         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.8'/>
            <!-- Required History of Past Illness Section content -->
          </section>
        </component>
        <component>
475       <section>
            <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1'/>
            <!-- Required Coded History of Infection Section content -->
          </section>
        </component>
480     <component>
          <section>
            <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.6'/>
            <!-- Required Active Problems Section content -->
          </section>
485     </component>
        <component>
          <section>
            <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4'/>
            <!-- Required Pregnancy History Section content -->
490       </section>
        </component>
        <component>
          <section>
            <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.16.1'/>
495         <!-- Required Coded Social History Section content -->
          </section>
        </component>
        <component>
          <section>
500         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.15'/>
            <!-- Required Coded Family Medical History Section content -->
          </section>
```

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```
          </component>
          <component>
505         <section>
              <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.20'/>
              <!-- Required Admission Medication History Section content -->
            </section>
          </component>
510       <component>
            <section>
              <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.13'/>
              <!-- Required Allergies and Other Adverse Reactions Section content -->
            </section>
515       </component>
          <component>
            <section>
              <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.18'/>
              <!-- Required Review of Systems Section content -->
520         </section>
          </component>
          <component>
            <section>
              <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1'/>
525           <!-- Required Coded Physical Exam Section content -->
            </section>
          </component>
          <component>
            <section>
530           <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.25'/>
              <!-- Conditional Vital Signs Section content -->
            </section>
          </component>
          <component>
535         <section>
              <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2'/>
              <!-- Required if known History of Surgical Procedures Section content -->
            </section>
          </component>
540       <component>
            <section>
              <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.2'/>
              <!-- Required Prenatal Events Section content -->
            </section>
545       </component>
          <component>
            <section>
              <templateId root='1.3.6.1.4.1.19376.1.5.3.1.11.2.2.1'/>
              <!-- Required Estimated Delivery Date Section content -->
550         </section>
          </component>
          <component>
            <section>
              <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.31'/>
555           <!-- Required if known Care Plan Section content -->
            </section>
          </component>
          <component>
            <section>
560           <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1'/>
              <!-- Required if known Coded Antenatal Testing and Surveillance Section content -->
            </section>
          </component>
          <component>
565         <section>
              <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4'/>
```

```
            <!-- Required if known Pain Assessment Panel Section content -->
          </section>
       </component>
570   </structuredBody></component>
</ClinicalDocument>
```

Figure 6.3.1.A.5-1: Sample Labor and Delivery History and Physical Document

Add section 6.3.1.B

575 6.3.1.B Labor and Delivery Summary 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2

The Labor and Delivery Summary (LDS) content profile represents a summary of the most critical information concerning the labor and delivery care in a birthing facility. The LDS is a Medical Summary and inherits all header constraints from Medical Summary. It also uses parts of the Labor and Delivery History and Physical profile where needed.

580 6.3.1.B.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:pcc:lds:2009**

6.3.1.B.2 LOINC Code

The LOINC code for this document is **57057-2** Labor and delivery summary

6.3.1.B.3 Standards

CCD	ASTM/HL7 Continuity of Care Document
CDAR2	HL7 CDA Release 2.0
ACOGAR	American College of Obstetricians and Gynecologists (ACOG), Antepartum Record
LOINC	Logical Observation Identifiers, Names and Codes
SNOMED	Systemized Nomenclature for Medicine
CDTHP	CDA for Common Document Types History and Physical Notes (DSTU)

585 6.3.1.B.4 Specification

This section references content modules using Template ID as the key identifier. Definitions of the modules are found in either:

- IHE Patient Care Coordination Volume 2: Final Text
- IHE PCC Content Modules supplement

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Table 6.3.1.B.4-1: Labor and Delivery Summary Specification (Mother)

Template Name	Opt	Section Template Id	Value Set Template Id
Hospital Admission Diagnosis This section shall indicate the reasons for admitting the mother to the birthing facility (e.g., premature labor, ruptured membrane).	R	1.3.6.1.4.1.19376.1.5.3.1.3.3	N/A
Admission Medication History	R2	1.3.6.1.4.1.19376.1.5.3.1.3.20	N/A
Chief Complaint	R	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1	N/A
Transport Mode	R	1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2	N/A
Assessment and Plan This section should contain assessment of the mother's pregnancy status and expectations for care including proposals, goals, and order requests for her condition and the birthing process.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5	N/A
Pain Assessment Panel	R	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4	N/A
Coded Results This section shall contain any lab draws during the delivery time interval including: Cord Blood Gas(es); Cord Blood for Type/Cross, Rh and Coomb's Test. The Antepartum Laboratory Value Set may be used to represent the results.	R	1.3.6.1.4.1.19376.1.5.3.1.3.28	1.3.6.1.4.1.19376.1.5.3.1.1.16.5.7
Coded Antenatal Testing and Surveillance	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1	1.3.6.1.4.1.19376.1.5.3.1.1.21.3.10
Coded History of Infection	O	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	1.3.6.1.4.1.19376.1.5.3.1.1.16.5.6
Pregnancy History	O	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	N/A
History of Present Illness	R	1.3.6.1.4.1.19376.1.5.3.1.3.4	N/A
History of Past Illness This section shall include clinically relevant information to the labor and delivery. This section should use the codes as specified in the Antepartum History and Physical History of Past Illness Value Set.	R	1.3.6.1.4.1.19376.1.5.3.1.3.8	1.3.6.1.4.1.19376.1.5.3.1.1.16.5.1
Active Problems This section shall include the patient's current active problem list as well as any labor, delivery and/or operative complications the patient may have including significant fever > 100.4 .	R	1.3.6.1.4.1.19376.1.5.3.1.3.6	N/A

_____

Template Name	Opt	Section Template Id	Value Set Template Id
Coded Advance Directives	R2	1.3.6.1.4.1.19376.1.5.3.1.3.35	N/A
Birth Plan	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.1	N/A
Allergies and Other Adverse Reactions This section shall include one observation of Latex Allergy which may be negated through the negationInd attribute. Latex Allergy is particularly relevant for Obstetrics because of the frequency of vaginal exams that might involve the use of latex gloves. The observation value code for Latex Allergy is '300916003'. The codeSystem is '2.16.840.1.113883.6.96'. The codeSystemName is 'SNOMED CT'	R	1.3.6.1.4.1.19376.1.5.3.1.3.13	N/A
Coded Detailed Physical Examination This section shall also include mother's weight at delivery.	R	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	N/A
Estimated Delivery Date	R	1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1	N/A
Medications Administered This section shall include the following data elements including route, timing and indication: Anesthesia, Sedatives, Tocolytics, Oxytocin, Antihypertensives, Anticonvulsants/Antispasmodics, Opiates (IM or IV), Antibiotics, Other Medications	R	1.3.6.1.4.1.19376.1.5.3.1.3.21	N/A
Intravenous Fluids Administered This section shall include the types of IV fluids the mother received.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6	N/A
Intake and Output This section shall include any intake and output during labor and delivery.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3	N/A
Estimated Blood Loss	R2	1.3.6.1.4.1.19376.1.5.3.1.1.9.2	N/A
History of Blood Transfusion	R	1.3.6.1.4.1.19376.1.5.3.1.1.9.12	N/A
History of Surgical Procedures This section shall contain any procedure that occurred during the interval between the Labor & Delivery History and Physical and the Labor & Delivery summary time frames.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2	N/A

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Template Name	Opt	Section Template Id	Value Set Template Id
Labor and Delivery Events The Labor and Delivery Events Section SHALL include a narrative text containing relevant information collected during the labor and delivery process. In an LDS document, this section shall contain information pertinent to the labor and delivery process including: date/time of labor onset, type of labor, duration of active phase of labor, spontaneous rupture of membranes (date/time), description of amniotic fluid (color, character, odor, amount/quantity), presence of particulate meconium, delivery obstetric provider, delivery date/time, placenta delivery date/time, weeks gestation at time of delivery, presentation of fetus at delivery and fetal monitoring findings.	R	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3	N/A
Newborn Delivery Information	R	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4	

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6.3.1.B.5 Conformance

CDA Release 2.0 documents that conform to the requirements of this content module shall indicate their conformance by the inclusion of the appropriate <templateId> elements in the header of the document. This is shown in the sample document below. A CDA Document may
600 conform to more than one template. This content module inherits from the Medical Summary content module, and so must conform to the requirements of that template as well, thus all <templateId> elements shown in the example below shall be included.

```
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```

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<ClinicalDocument xmlns='urn:hl7-org:v3'>
  <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3"/>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.2'/><!--Medical Summary-->
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2'/><!--Labor and Delivery Summary-->
  <id root=' ' extension=' '/>
  <code code='57057-2' displayName='Labor and delivery summary'
    codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
  <title>Labor and Delivery Summary</title>
  <effectiveTime value='20080601012005'/>
  <confidentialityCode code='N' displayName='Normal'
    codeSystem='2.16.840.1.113883.5.25' codeSystemName='Confidentiality' />
  <languageCode code='en-US'/>
      :
  <component><structuredBody>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.3'/>
        <!-- Required Hospital Admission Diagnosis Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.20'/>
        <!-- Required if known Admission Medication History Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1'/>
        <!-- Required Chief Complaint Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2'/>
        <!-- Required Transport Mode Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5'/>
        <!-- Required if known Assessment and Plan Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4'/>
        <!-- Required Pain Assessment Panel Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.28'/>
        <!-- Required Coded Results Section content -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1''/>
        <!-- Required if known Coded Antenatal Testing and Surveillance Section content -->
      </section>
    </component>
    <component>
      <section>
```

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                <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.4'/>
                <!-- Required History of Present Illness Section content -->
             </section>
670     </component>
        <component>
          <section>
                <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.8'/>
                <!-- Required History of Past Illness Section content -->
675          </section>
        </component>
        <component>
          <section>
                <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.6 '/>
680          <!-- Required Active Problems Section content -->
             </section>
        </component>
        <component>
          <section>
685          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.35'/>
                <!-- Required if known Coded Advance Directives Section content -->
             </section>
        </component>
        <component>
690       <section>
                <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.1'/>
                <!-- Required if known Birth Plan Section content -->
             </section>
        </component>
695     <component>
          <section>
                <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.13'/>
                <!-- Required Allergies and Other Adverse Reactions Section content -->
             </section>
700     </component>
        <component>
          <section>
                <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1'/>
                <!-- Required Coded Detailed Physical Examination Section content -->
705          </section>
        </component>
        <component>
          <section>
                <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1'/>
710          <!-- Required Estimated Delivery Date Section content -->
             </section>
        </component>
        <component>
          <section>
715          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.21'/>
                <!-- Required Medications Administered Section content -->
             </section>
        </component>
        <component>
720       <section>
                <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6'/>
                <!-- Required if known Intravenous Fluids Administered Section content -->
             </section>
        </component>
725     <component>
          <section>
                <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2'/>
                <!-- Required if known History of Surgical Procedures Section content -->
             </section>
730     </component>
```

```
      <component>
       <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3'/>
        <!-- Required if known Intake and Output Section content -->
       </section>
      </component>
      <component>
       <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.2'/>
        <!-- Required if known Estimated Blood Loss Section content -->
       </section>
      </component>
      <component>
       <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.12'/>
        <!-- Required History of Blood Transfusion Section content -->
       </section>
      </component>
      <component>
       <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2'/>
        <!-- Required if known History of Surgical Procedures Section content -->
       </section>
      </component>
      <component>
       <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3'/>
        <!-- Required Labor and Delivery Events Section content -->
       </section>
      </component>
      <component>
       <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4'/>
        <!-- Required Newborn Delivery Information Section content -->
       </section>
      </component>
     </structuredBody></component>
</ClinicalDocument>
```

Figure 6.3.1.B.5-1: Sample Labor and Delivery Summary Document

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Add section 6.3.1.C

6.3.1.C Maternal Discharge Summary 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.3

The Maternal Discharge Summary (MDS) content profile represents a snapshot of the patient's
postpartum stay until her discharge from the birthing facility. The MDS is a Medical Summary
and inherits all header constraints from Medical Summary.

6.3.1.C.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:pcc:mds:2009**

6.3.1.C.2 LOINC Code

The LOINC code for this document is **57058-0** Maternal Discharge Summary

---

780 ## 6.3.1.C.3 Standards

CCD	ASTM/HL7 Continuity of Care Document
CDAR2	HL7 CDA Release 2.0
ACOGAR	American College of Obstetricians and Gynecologists (ACOG), Antepartum Record
LOINC	Logical Observation Identifiers, Names and Codes
SNOMED	Systemized Nomenclature for Medicine
CDTHP	CDA for Common Document Types History and Physical Notes (DSTU)

6.3.1.C.4 Specification

This section references content modules using Template ID as the key identifier. Definitions of the modules are found in either:

- IHE PCC TF-2 Final Text

785 - IHE PCC Content Modules supplement

Table 6.3.1.C.4-1: Maternal Discharge Summary Specification

Template Name	Opt	Section Template Id	Value Set Template Id
Hospital Admission Diagnosis	R	1.3.6.1.4.1.19376.1.5.3.1.3.3	N/A
Discharge Diagnosis	R	1.3.6.1.4.1.19376.1.5.3.1.3.7	N/A
Discharge Disposition This section shall include the discharge disposition such as discharge to home, transfer to another facility, expired (maternal death including date/time), etc.	R	1.3.6.1.4.1.19376.1.5.3.1.3.32	N/A
Transport Mode	R2	1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2	N/A
Discharge Status This section shall include the patient's status or condition at discharge such as stable, critical, etc.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.12	N/A
Allergies and Other Adverse Reactions	R	1.3.6.1.4.1.19376.1.5.3.1.3.13	N/A
Hospital Course	R	1.3.6.1.4.1.19376.1.5.3.1.3.5	N/A
Coded Advance Directives	R2	1.3.6.1.4.1.19376.1.5.3.1.3.35	N/A
Hospital Discharge Medications	R	1.3.6.1.4.1.19376.1.5.3.1.3.22	N/A
Coded Hospital Studies Summary	R	1.3.6.1.4.1.19376.1.5.3.1.3.30	N/A
Coded Social History This section shall also include: Intimate Partner Violence Screening and Postpartum Depression Screening	R	1.3.6.1.4.1.19376.1.5.3.1.3.16.1	1.3.6.1.4.1.19376.1.5.3.1.4.13.4

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Template Name	Opt	Section Template Id	Value Set Template Id
Pain Assessment Panel	R2	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4	N/A
Active Problems This section shall also include any postpartum complications the patient encountered.	R2	1.3.6.1.4.1.19376.1.5.3.1.3.6	N/A
Braden Score	R2	1.3.6.1.4.1.19376.1.5.3.1.1.12.2.3	N/A
Postpartum Hospitalization Treatment	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.7	N/A
Postpartum Hospitalization Treatment: Care Plan This section shall include Contraception Plan, Diagnostic Studies Pending, Feeding Method and type (baby), Follow-up Appointment date/time and follow-up provider.	R2	1.3.6.1.4.1.19376.1.5.3.1.3.31	N/A
Postpartum Hospitalization Treatment: Procedures and Interventions This section shall include all procedures occurring in the postpartum period including tubal ligation.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	N/A
Postpartum Hospitalization Treatment: Coded Results Relevant laboratory results shall be recorded and the Antepartum Laboratory Value Set should be used to represent the results including postpartum hemoglobin and hematocrit results.	R	1.3.6.1.4.1.19376.1.5.3.1.3.28	1.3.6.1.4.1.19376.1.5.3.1.1.16.5.7
Postpartum Hospitalization Treatment: Immunizations	R2	1.3.6.1.4.1.19376.1.5.3.1.4.12	N/A
Postpartum Hospitalization Treatment: Medications Administered	R2	1.3.6.1.4.1.19376.1.5.3.1.3.21	N/A
Postpartum Hospitalization Treatment: Discharge Diet	R2	1.3.6.1.4.1.19376.1.5.3.1.3.33	N/A
Intravenous Fluids Administered This section shall include the types of IV fluids administered.	R	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6	N/A
Immunization Recommendations	R2	1.3.6.1.4.1.19376.1.5.3.1.1.18.3.1	N/A
Estimated Blood Loss	R2	1.3.6.1.4.1.19376.1.5.3.1.1.9.2	N/A
Transfusion History	R	1.3.6.1.4.1.19376.1.5.3.1.1.9.12	N/A
Patient Education	R2	1.3.6.1.4.1.19376.1.5.3.1.1.9.38	N/A

Template Name	Opt	Section Template Id	Value Set Template Id
Labor and Delivery Events: Procedures and Interventions This section shall include information about the delivery type (e.g., vaginal, vaginal birth after cesarean section or cesarean section along with incision type.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	N/A
Provider Orders This section shall include information about the patient's discharge activity.	R	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.1	N/A
Consultations This section shall include consultations such as a lactation consultation.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.8	N/A
NDS Header Module This section shall include the first and last name of the baby at birth, at discharge and the baby's unique identifier.	R	?	
LDS: Newborn Delivery Information This section shall include information such as the birth date and time; birthweight; head circumference; sex/gender of newborn, etc.	R	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4	N/A
NDS Procedures and Interventions: This section shall include procedures such as a circumcision (if male).	R	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	N/A
NDS: Care Plan This section shall contain information regarding the plans for the newborn including feeding plan; pediatrician's name, etc.	R	1.3.6.1.4.1.19376.1.5.3.1.3.31	N/A
Newborn Status at Maternal Discharge	R	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.8	N/A
Event Outcomes This section shall include a narrative description of the outcomes following a procedure, an intervention or a problem during the postpartum period of the hospitalization. Furthermore, Event Outcomes section shall contain a simple Observation using LOINC Code 11636-8 that reports the number of births live or dead that occurred during the delivery event.	R	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9	N/A

6.3.1.C.5 Conformance

790   CDA Release 2.0 documents that conform to the requirements of this content module shall
indicate their conformance by the inclusion of the appropriate <templateId> elements in the
header of the document. This is shown in the sample document below. A CDA Document may
conform to more than one template. This content module inherits from the Medical Summary
content module, and so must conform to the requirements of that template as well, thus all
<templateId> elements shown in the example below shall be included.

795

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800     <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.2'/> <!--Medical Summary-->
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.1.3'/> <!--Maternal Discharge Summary-->
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              <!-- Required Event Outcomes Section content -->
            </section>
          </component>
      </structuredBody></component>
    </ClinicalDocument>
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Figure 6.3.1.C.5-1: Sample Maternal Discharge Summary Document