

# **Health & Care Information Model:**

## **nl.zorg.EncounterReport-v1.0**

Status: Final

Release status: Prepublished

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# 1. nl.zorg.EncounterReport-v1.0

DCM::CoderList	Projectgroep VIPP GGZ
DCM::ContactInformation.Address	*
DCM::ContactInformation.Name	*
DCM::ContactInformation.Telecom	*
DCM::ContentAuthorList	Projectgroep VIPP GGZ
DCM::CreationDate	30-3-2022
DCM::DeprecatedDate	
DCM::DescriptionLanguage	nl
DCM::EndorsingAuthority.Address	
DCM::EndorsingAuthority.Name	*
DCM::EndorsingAuthority.Telecom	
DCM::Id	2.16.840.1.113883.2.4.3.11.60.40.3.15.3
DCM::KeywordList	
DCM::LifecycleStatus	Final
DCM::ModelerList	Projectgroep VIPP GGZ
DCM::Name	nl.zorg.ContactVerslag
DCM::PublicationDate	15-10-2023
DCM::PublicationStatus	Prepublished
DCM::ReviewerList	
DCM::RevisionDate	
DCM::Supersedes	*
DCM::Version	1.0
HCIM::PublicationLanguage	EN

## 1.1 Revision History

Publicatieversie 1.0 (10-06-2022)

## 1.2 Concept

The contact report is a textual report of a (partial) consult between the care provider and the patient.

## 1.3 Mindmap

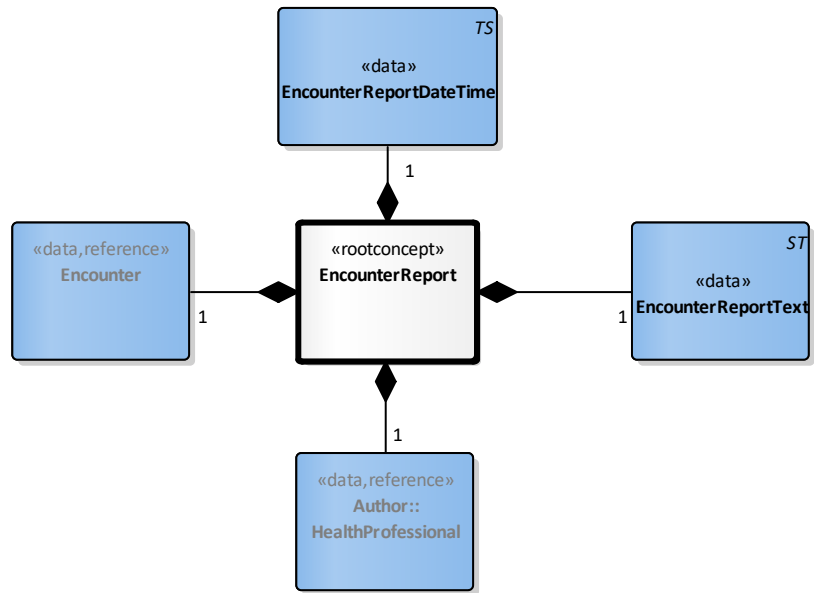
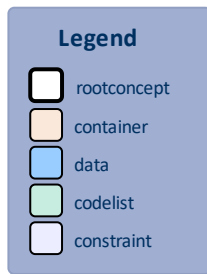
## 1.4 Purpose

A contact report offers a care provider the possibility to record information in a structured manner in free text about a contact with a patient.

## 1.5 Patient Population

## 1.6 Evidence Base

## 1.7 Information Model



«rootconcept»	EncounterReport	
<b>Definitie</b>	Root concept of the EncounterReport information model. This root concept contains all data elements of the EncounterReport information model.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:15.3.1	
<b>DCM::DefinitionCode</b>	SNOMED CT: 11591000146107 Patient encounter report	
<b>Opties</b>		

«data»	Author::HealthProfessional	
<b>Definitie</b>	The healthcare provider who prepared the report and who is responsible for its content.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:15.3.2	
<b>DCM::ReferencedConceptId</b>	NL-CM:17.1.1	This is a reference to the rootconcept of information model HealthProfessional.
<b>Opties</b>		

«data»	Encounter	
<b>Definitie</b>	The encounter the report is about.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:15.3.3	
<b>DCM::DefinitionCode</b>	SNOMED CT: 308335008 Patient encounter procedure	
<b>DCM::ReferencedConceptId</b>	NL-CM:15.1.1	This is a reference to the rootconcept of information model Encounter.
<b>Opties</b>		

«data»	EncounterReportDateTime	
<b>Definitie</b>	Date and, if applicable, the time the report was made.	
<b>Datatype</b>	TS	
<b>DCM::ConceptId</b>	NL-CM:15.3.4	
<b>Opties</b>		

«data»	EncounterReportText	
<b>Definitie</b>	The actual content of the contact as free text.	

<b>Datatype</b>	ST	
<b>DCM::ConceptId</b>	NL-CM:15.3.5	
<b>DCM::DefinitionCode</b>	SNOMED CT: 422813005	
	Document section	
<b>Opties</b>		

Legend	
<b>Definitie</b>	
<b>Datatype</b>	
<b>Opties</b>	

## 1.8 Example Instances

ContactVerslag	
ContactVerslagDatum Tijd	21-11-2020
<b>Auteur</b>	
Medewerkerscode	01299
AGBCode	01999999
Initialen	G.L.
Geslachtsnaam	Klaassen
ZorgverlenersRol	Psychiater
ContactVerslagTekst	Goed verzorgde man, normaal contact, wanhopige klachtenpresentatie, onrustige motoriek (grimassen, oor vastgrijpen). Bewustzijn helder, oriëntatie intact, geheugen en zelfwaarneming ongestoord, bovengemiddeld intelligent, geen psychotische kenmerken, denken normaal van tempo en vorm, inhoudelijk preoccupatie met oorsuizen, stemming somber (er kan een lachje af), rationaliseren, isoleren van het affect, niet actief suïcidaal.

## 1.9 Instructions

## 1.10 Interpretation

## 1.11 Care Process

## 1.12 Example of the Instrument

## 1.13 Constraints

## 1.14 Issues

## 1.15 References

## 1.16 Functional Model

## 1.17 Traceability to other Standards

## 1.18 Disclaimer

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