Health & Care Information Model:

nl.zorg.Diagnosis-v2.0

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Better health through
better information

Content

1. nl.zorg.Diagnosis-v2.0

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DCM::ContactInformation.Address	*
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DCM::ContactInformation.Telecom	*
DCM::ContentAuthorList	*
DCM::CreationDate	15-5-2023
DCM::DeprecatedDate	
DCM::DescriptionLanguage	nl
DCM::EndorsingAuthority.Address	
DCM::EndorsingAuthority.Name	*
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1.1 Revision History

Publicatieversie 1.0 (15-04-2024)
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1.2 Concept

The diagnosis is the interpretation of the condition by the care provider. This is based on known combinations of conditions and the symptoms with which these present themselves. It may involve a single diagnosis or a differential diagnosis with conditions that are under consideration.

1.3 Mindmap

1.4 Purpose

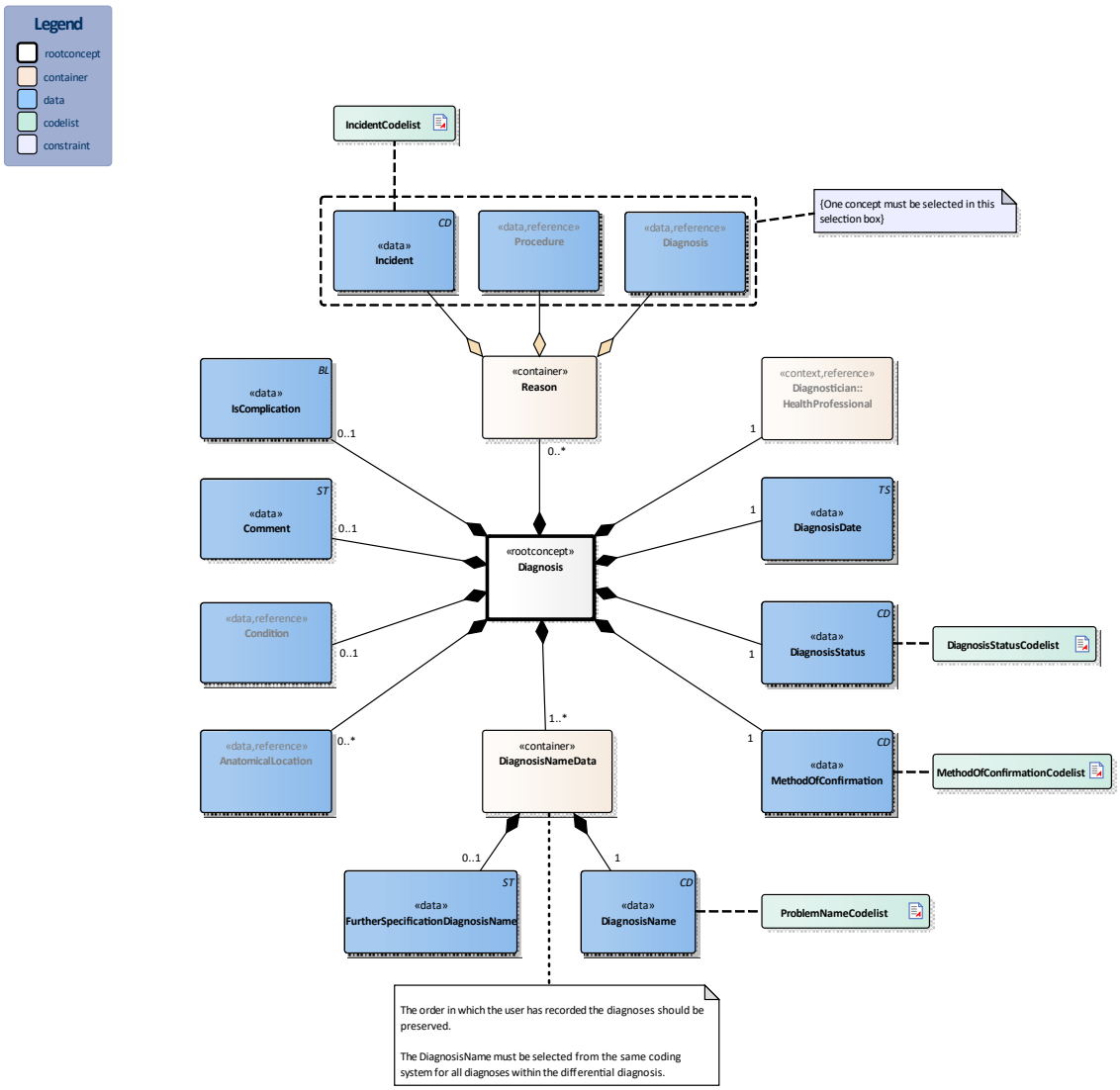
The diagnosis is the basis for the care plan and the activities of the health care providers that are involved in the patient's care. The diagnosis is important for evidence-based care and the evaluation of care provided, also in the form of comparative research on the basis of patients with similar conditions.

1.5 Patient Population

1.6 Evidence Base

The diagnosis is the interpretation of a condition by the health professional. The DiagnosisDate indicates the moment when the health professional made the diagnosis. In the case of a differential diagnosis, the health professional specifies ≥ 2 diagnosis names that he/she is currently considering. When a diagnose has ≥ 2 diagnosis names DiagnosticStatus has the value 'Differential diagnosis'.
At any given time, only one instance of Diagnosis applies to a Condition. The presentation of advancing diagnostic insight then consists of a series of instances of Diagnosis, all of which refer to the same Condition, and where the value of DiagnosisDate represents the chronology. An instance of Diagnosis with a more recent DiagnosisDate therefore replaces the previous diagnosis.
A health professional may wish to record a reason for a diagnosis. You can argue that in fact the condition has a cause, but the specification of the cause is based on the insight into what kind of condition it is. That is why we see the reason as part of the diagnosis.
The reason for a diagnosis can be an incident (e.g. a hip fracture due to a fall), a procedure (e.g. a bowel perforation due to a colonoscopy) or another diagnosis (e.g. neuropathy due to diabetes). There can be > 1 Reason: e.g. a fracture resulting from the combination of a fall and a condition that carries an increased risk of fractures.
Regardless of the diagnosis as specification of the nature of the condition, one may come to the conclusion that it is a complication. This can be represented separately using the IsComplication element. Whether there is a complication generally depends on the reason, but there are of course also reasons for which there is no complication in the sense of unintentional damage due to medical treatment or decisions.
The cardinality of the reference to Condition is 0..1, because when a diagnosis is denied there is no condition to which that diagnosis relates. To represent that a patient is not known to have, for example, diabetes type II or that diabetes type II has been excluded, one should use the Zib Exclusion with a reference to Diagnosis. In this case, the instance of Diagnosis does not refer to a Condition.

1.7 Information Model



«rootconcept»	Diagnosis	
Definitie	Root concept of the Diagnosis information model. This root concept contains all data elements of the Diagnosis information model.	
Datatype		
DCM::ConceptId	NL-CM:5.6.1	
DCM::DefinitionCode	SNOMED CT: 404684003 klinische bevinding	
Opties		

«context»	Diagnostician::HealthProfessional	
Definitie	The care professional who made the diagnosis. This can be a different individual than the person who recorded the diagnosis.	
Datatype		
DCM::ConceptId	NL-CM:5.6.2	
DCM::DefinitionCode	ParticipationType: PRF performer	
DCM::ReferencedConceptId	NL-CM:17.1.1	This is a reference to the rootconcept of information model HealthProfessional.
Opties		

«data»	DiagnosisDate	
Definitie	Date (and time) at which the care professional came to the diagnosis.	
Datatype	TS	
DCM::ConceptId	NL-CM:5.6.3	
DCM::DefinitionCode	SNOMED CT: 432213005 datum van diagnose	
Opties		

«data»	DiagnosisStatus	
Definitie	Indicates the status of the diagnostic process.	
Datatype	CD	
DCM::ConceptId	NL-CM:5.6.4	
DCM::ValueSet	DiagnosisStatusCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.5.6.3
Opties		

«data»	MethodOfConfirmation	
Definitie	The method that the care professional used to diagnose the condition, such as history taking only, history taking and physical examination or additional diagnostic examination.	
Datatype	CD	
DCM::ConceptId	NL-CM:5.6.5	
DCM::DefinitionCode	SNOMED CT: 418775008 methode van bevinding	
DCM::ValueSet	MethodOfConfirmationCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.5.6.2
Opties		

«container»	DiagnosisNameData
Definitie	Container of the DiagnosisNameData concept. This container contains all data elements of the DiagnosisNameData concept. Represents a disease or physiological condition as part of the diagnosis.
Datatype	
DCM::ConceptId	NL-CM:5.6.6
Opties	

«data»	DiagnosisName	
Definitie	The term with associated code that the care professional selects from the used code system with conditions.	
Datatype	CD	
DCM::ConceptId	NL-CM:5.6.7	
DCM::DefinitionCode	SNOMED CT: 439401001 diagnose	
DCM::ValueSet	ProblemNameCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.5.6.4
Opties		

«data»	FurtherSpecificationDiagnosisName	
Definitie	A more detailed description of the DiagnosisName in free text, when this detail is not available in the used code list.	
Datatype	ST	
DCM::ConceptId	NL-CM:5.6.8	
Opties		

«data»	AnatomicalLocation	
Definitie	The location(s) on and/or in the body that is/are affected by the condition, conform the diagnostics.	
Datatype		
DCM::ConceptId	NL-CM:5.6.9	
DCM::DefinitionCode	SNOMED CT: 123037004 lichaamsstructuur	
DCM::ReferencedConceptId	NL-CM:20.7.1	This is a reference to the rootconcept of information model AnatomicalLocation.
Opties		

«data»	Condition	
Definitie	The Condition to which the Diagnosis applies.	
Datatype		
DCM::ConceptId	NL-CM:5.6.10	
DCM::ReferencedConceptId	NL-CM:5.4.1	This is a reference to the rootconcept of information model Condition.
Opties		

«data»	Comment	
Definitie	A comment in free text with respect to the diagnosis, that is not represented by the other data elements in the information model.	
Datatype	ST	
DCM::ConceptId	NL-CM:5.6.11	
DCM::DefinitionCode	LOINC: 48767-8 Annotation comment	
Opties		

«data»	IsComplication	
Definitie	Indicates whether or not the diagnosis involves a complication.	
Datatype	BL	
DCM::ConceptId	NL-CM:5.6.12	
Opties		

«container»	Reason	
Definitie	Container of the Reason concept.This container contains all data elements of the Reason concept.	
Datatype		
DCM::ConceptId	NL-CM:5.6.13	
Opties		

«data»	Incident	
Definitie	The unintended event during the care process that has led, could have led or could (still) lead to harm to the patient.	
Datatype	CD	
DCM::ConceptId	NL-CM:5.6.14	
DCM::DefinitionCode	SNOMED CT: 418019003 onopzettelijke gebeurtenis	
DCM::ValueSet	IncidentCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.5.6.1
Opties		

«data»	Procedure
Definitie	The procedure that gave rise to the condition to which the diagnosis

	relates.	
Datatype		
DCM::ConceptId	NL-CM:5.6.15	
DCM::DefinitionCode	SNOMED CT: 71388002 verrichting	
DCM::ReferencedConceptId	NL-CM:14.1.1	This is a reference to the rootconcept of information model Procedure.
Opties		

«data»	Diagnosis	
Definitie	The diagnosis with regard to another condition that is seen as a reason for the condition with the current diagnosis.	
Datatype		
DCM::ConceptId	NL-CM:5.6.16	
DCM::ReferencedConceptId	NL-CM:5.6.1	This is a reference to the rootconcept of information model Diagnosis.
Opties		

«document»	IncidentCodelist	
Definitie		
Datatype		
DCM::ValueSetBinding	Extensible	
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.5.6.1	
DCM::ValueSetIncludeOTH	True	
DCM::ValueSetStatus	Active	
HCIM::ValueSetLanguage	--	
Opties		

IncidentCodelijst	**OID: 2.16.840.1.113883.2.4.3.11.60.40.2.5.6.1**	
Codes	**Coding Syst. Name**	**Coding System OID**
SNOMED CT: <269691005 |medisch ongeval bij patiënt tijdens operatieve en medische zorg (gebeurtenis)|	SNOMED CT	2.16.840.1.113883.6.96

«document»	MethodOfConfirmationCodelist	
Definitie		
Datatype		
DCM::ValueSetBinding	Extensible	
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.5.6.2	
DCM::ValueSetIncludeOTH	True	
DCM::ValueSetStatus	Active	
HCIM::ValueSetLanguage	--	
Opties		

WijzeVanVaststellenCodelijst			**OID: 2.16.840.1.113883.2.4.3.11.60.40.2.5.6.2**	
Concept Name	**Concept Code**	**Coding Syst. Name**	**Coding System OID**	**Description**
Afnemen van anamnese	84100007	SNOMED CT	2.16.840.1.113883.6.96	Vastgesteld op basis van de anamnese
Anamnese en lichamelijk onderzoek	63332003	SNOMED CT	2.16.840.1.113883.6.96	Vastgesteld op basis van het klinisch beeld

Anamnese en lichamelijk onderzoek met evaluatie en management van patiënt	14736009	SNOMED CT	2.16.840.1.113883.6.96	Vastgesteld op basis van het klinisch beeld en aanvullend onderzoek
Bevinding door verrichting	118240005	SNOMED CT	2.16.840.1.113883.6.96	Vastgesteld alléén op basis van een verrichting (toevalsbevinding)
Verwerven van gezondheidsinformatie van eerdere behandelaar voor klinische afstemming	117131000146104	SNOMED CT	2.16.840.1.113883.6.96	Overgenomen uit betrouwbare rapportage [DEPRECATED]

«document»	DiagnosisStatusCodelist	
Definitie		
Datatype		
DCM::ValueSetBinding	Required	
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.5.6.3	
DCM::ValueSetIncludeOTH	False	
DCM::ValueSetStatus	Active	
HCIM::ValueSetLanguage	--	
Opties		

DiagnoseStatusCodelijst			**OID: 2.16.840.1.113883.2.4.3.11.60.40.2.5.6.3**	
Concept Name	**Concept Code**	**Coding Syst. Name**	**Coding System OID**	**Description**
Preliminary diagnosis	148006	SNOMED CT	2.16.840.1.113883.6.96	Voorlopige diagnose
Established diagnosis	14657009	SNOMED CT	2.16.840.1.113883.6.96	Bevestigde diagnose
Differential diagnosis	47965005	SNOMED CT	2.16.840.1.113883.6.96	Differentiaaldiagnose

«document»	ProblemNameCodelist	
Definitie		
Datatype		
DCM::ValueSetBinding	Required	
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.5.6.4	
DCM::ValueSetIncludeOTH	True	
DCM::ValueSetStatus	Active	
HCIM::ValueSetLanguage	--	
Opties		

DiagnoseNaamCodelijst		**OID: 2.16.840.1.113883.2.4.3.11.60.40.2.5.6.4**
Codes	**Coding Syst. Name**	**Coding System OID**
Alle waarden	DHD Diagnosethesaurus	2.16.840.1.113883.2.4.3.120.5.1
Alle waarden	ICD-10, dutch translation	2.16.840.1.113883.6.3.2
SNOMED CT: ^11721000146100 | Nationale kernset patiëntproblemen | [DEPRECATED]	SNOMED CT	2.16.840.1.113883.6.96
Alle waarden	ICF	2.16.840.1.113883.6.254
Alle waarden	ICPC-1 NL	2.16.840.1.113883.2.4.4.31.1

Alle waarden	DSM-IV	2.16.840.1.113883.6.126
Alle waarden	DSM-5	2.16.840.1.113883.6.344
Alle waarden [DEPRECATED]	GGZ Diagnoselijst	2.16.840.1.113883.3.3210.14.2.2.35
SNOMED CT: ^350401000146101 | Referentieset met diagnosen betreffende geestelijke gezondheidszorg |	SNOMED CT	2.16.840.1.113883.6.96
SNOMED CT: <404684003 | Clinical finding |	SNOMED CT	2.16.840.1.113883.6.96

	Legend
Definitie	
Datatype	
Opties	

	Constraint
Definitie	One concept must be selected in this selection box
Datatype	
Opties	

1.8 Example Instances

Diagnose		
DiagnoseDatum	01-03-2023	05-03-2023
DiagnoseStatus	Voorlopige diagnose	Bevestigde diagnose
WijzeVanVaststellen	Vastgesteld op basis van het klinisch beeld	Vastgesteld op basis van het klinisch beeld en aanvullend onderzoek
IsComplicatie	Nee	Nee
Toelichting		
DiagnoseNaamGegevens		
DiagnoseNaam	Bronchitis	Longontsteking
Diagnosesteller::Zorgverlener		
Naam	Drs. L.J. Verhagen	Drs. L.J. Verhagen
Specialisme	Huisarts	Huisarts
AnatomischeLocatie		
Locatie		Long
Lateraliteit		Links
AandoeningOfGesteldheid		
PeriodeAanwezig		
StartDatumTijd	22-02-2023	22-02-2023
StatusDatum	01-03-2023	05-03-2023
Beloop		Verslechterd
Ernst	Mild	Matig

Diagnose	
DiagnoseDatum	15-01-2023
DiagnoseStatus	Bevestigde diagnose
WijzeVanVaststellen	Vastgesteld op basis van het klinisch beeld en aanvullend onderzoek
IsComplicatie	Nee
Toelichting	Val van fiets na aanrijding
DiagnoseNaamGegevens	
DiagnoseNaam	Radiusfractuur
NadereSpecificatieDiagnoseNaam	Distale radiusfractuur
Diagnosesteller::Zorgverlener	
Naam	C.A. van der Kamp
Specialisme	Algemene heelkunde
AnatomischeLocatie	
Locatie	Radius
Lateraliteit	Links
Aanleiding	
Incident	Val
AandoeningOfGesteldheid	
PeriodeAanwezig	
StartDatumTijd	15-01-2023
StatusDatum	15-01-2023
Beloop	

Diagnose			
DiagnoseDatum	03-04-2023	03-04-2023	20-04-2023
DiagnoseStatus	Voorlopige diagnose	Voorlopige diagnose	Bevestigde diagnose
WijzeVanVaststellen	Vastgesteld op basis van anamnese en klinisch beeld	Vastgesteld op basis van het klinisch beeld en aanvullend onderzoek	Vastgesteld op basis van het klinisch beeld en aanvullend onderzoek
IsComplicatie	Nee		
Toelichting			
DiagnoseNaamGegevens			
DiagnoseNaamGegevens 1			
DiagnoseNaam	Angina pectoris	Angina pectoris	Slokdarmspasme
DiagnoseNaamGegevens 2			
DiagnoseNaam	Longembolie	Slokdarmspasme	
DiagnoseNaamGegevens 3			
DiagnoseNaam	Slokdarmspasme		
Diagnosesteller::Zorgverlener			
Naam	Drs. L.J. Verhagen	H. verhoeven	G.A. de Jong
Specialisme	Huisarts	Inwendige geneeskunde	Inwendige geneeskunde
AnatomischeLocatie			
Locatie	Thorax	Thorax	Slokdarm
Lateraliteit			
AandoeningOfGesteldheid			
PeriodeAanwezig			
StartDatumTijd	03-04-2023	03-04-2023	03-04-2023
StatusDatum	03-04-2023	03-04-2023	20-04-2023
Beloop		Onveranderd	Verbeterd
Ernst	Matig		

Diagnose		
DiagnoseDatum	08-09-2023	09-09-2023
DiagnoseStatus	Voorlopige diagnose	Bevestigde diagnose
WijzeVanVaststellen	Vastgesteld op basis van anamnese en klinisch beeld	Vastgesteld op basis van het klinisch beeld en aanvullend onderzoek
IsComplicatie	Nee	Ja
Toelichting		
DiagnoseNaamGegevens		
DiagnoseNaam	Pneumothorax	Longembolie
Diagnosesteller::Zorgverlener		
Naam	Drs. L.J. Verhagen	G.A. de Jong
Specialisme	Huisarts	Inwendige geneeskunde
AnatomischeLocatie		
Locatie	Thorax	Long
Lateraliteit	links	links
AandoeningOfGesteldheid		
PeriodeAanwezig		
StartDatumTijd	08-09-2023	08-09-2023
StatusDatum	08-09-2023	09-09-2023
Beloop		Onveranderd
Ernst	Ernstig	

1.9 Instructions

A diagnosis always refers to the condition of which it is the interpretation. If > 1 instance of Diagnosis refers to the same condition, then the instantiation with the most recent diagnosis date represents the current diagnosis.
Valuesets from this zib may be deprecated when the SNOMED decision comes into force in the Netherlands. More information on the SNOMED decision and what its implementation means for zibs can be found at https://zibs.nl/wiki/SNOMEDbesluit. (Dutch)

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

written version will be leading in case of textual differences. This will apply if both have the same version number and date. A definitive version has priority over a draft version. A revised version has priority over previous versions.

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