

# eDOCSNL

## ELECTRONIC MEDICAL RECORD

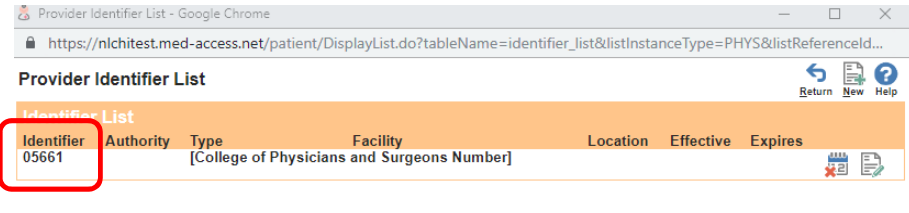
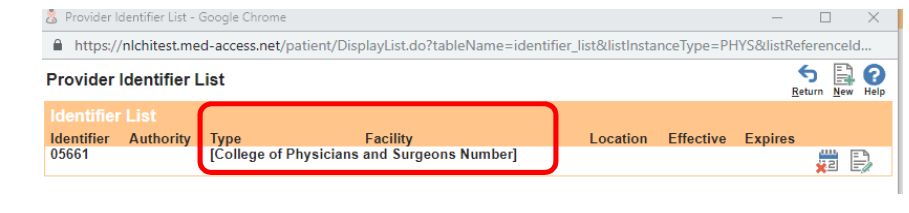
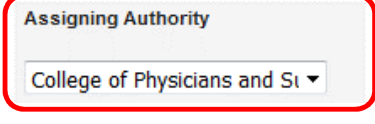


eDOCSNL/NLCHI Data Warehouse Approved Med Access Data Elements for Secondary Use

ID	Discrete Element	Med Access Source Location
PATIENT		
1	Primary Identifier	Fields: Primary Identifier Number <input type="text" value="129850451391"/> Primary Identifier Type 'Group' <input type="text" value="NL PHN"/>
2	Primary Identifier Type 'Group'	Fields: Primary Identifier Type 'Group' <input type="text" value="129850451391"/> Primary Identifier Type 'Group' <input type="text" value="NL PHN"/>
3	Patient Status	Fields: Status Patient Status <input type="text" value="Active"/> dd-MMM-yyyy
4	Client Street Address	Fields: Address Address & Phone <input type="text" value="247 PENNEY AVE"/> City: <input type="text" value="CLARENVILLE"/> Province: <input type="text" value="Newfoundland"/> Postal Code: <input type="text" value="A5A 4R1"/> Country: <input type="text" value="Canada"/> Designation, Addressee: <input type="text"/> Address Type 'Group': <input type="text" value="Home - Mailing"/>
5	Client City/Town	Fields: City Address & Phone <input type="text" value="247 PENNEY AVE"/> City: <input type="text" value="CLARENVILLE"/> Province: <input type="text" value="Newfoundland"/> Postal Code: <input type="text" value="A5A 4R1"/> Country: <input type="text" value="Canada"/> Designation, Addressee: <input type="text"/> Address Type 'Group': <input type="text" value="Home - Mailing"/>

6 Client Province	<p>Fields: Province</p> <p>Address &amp; Phone</p> <p>Address: 247 PENNEY AVE      City: CLARENVILLE      Province: Newfoundland      Postal Code: A5A 4R1</p> <p>Country: Canada      Designation, Addressee:      Address Type Group: Home - Mailing</p>
7 Client Postal Code	<p>Fields: Postal Code</p> <p>Address &amp; Phone</p> <p>Address: 247 PENNEY AVE      City: CLARENVILLE      Province: Newfoundland      Postal Code: A5A 4R1</p> <p>Country: Canada      Designation, Addressee:      Address Type Group: Home - Mailing</p>
8 Emergency Contact First Name	<p>Fields: First Name</p> <p>Emergency Contact and Other Information</p> <p>Primary Contact</p> <p>Prefix:      First Name:      Middle Name:      Last Name:</p>
9 Emergency Contact Last Name	<p>Fields: Last Name</p> <p>Emergency Contact and Other Information</p> <p>Primary Contact</p> <p>Prefix:      First Name:      Middle Name:      Last Name:</p>
10 Emergency Contact Telephone	<p>Fields: Either Home Phone, Cell Phone, or Work Phone.</p> <p>Home Phone:      Cell Phone:      Work Phone:      Ext.:</p>
11 Primary Provider	<p>Primary Provider:      Secondary Provider:</p>
12 Secondary Provider	<p>Referring Provider ✘      Family Provider ✘</p>

13 Family Provider																									
14 Referring provider																									
PRESCRIBED MEDICATIONS																									
15 Medication Prescribed Name	<p>Fields: Drug Name and Generic Drug Name</p> <div style="border: 1px solid #ccc; padding: 5px;"> <p><b>Prescription Id: 87596</b> <span style="float: right;"><b>Status: Approved</b> </span></p> <p>Prescription Type <input type="radio"/> Simple <input checked="" type="radio"/> Continuous <input type="radio"/> Short Term</p> <div style="border: 2px solid red; padding: 2px;"> <p>Drug Name* AUBAGIO 14 MG TABLET</p> <p>Generic Drug Name TERIFLUNOMIDE</p> </div> </div>																								
16 Medication Dosage	<p>Fields: Dose</p> <div style="border: 1px solid #ccc; padding: 5px;"> <p>Dose </p> <div style="border: 2px solid red; padding: 2px;"> <input type="text" value="1"/> <input type="text" value="Tablet(s)"/> </div> </div>																								
17 Medication Dosage Unit of Measure	<p>Fields: Dose</p> <div style="border: 1px solid #ccc; padding: 5px;"> <p>Dose </p> <div style="border: 2px solid red; padding: 2px;"> <input type="text" value="1"/> <input type="text" value="Tablet(s)"/> </div> </div>																								
18 Medication Form	<p>Fields: Form</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #e0e0e0;"> <th>Fav</th> <th>Id</th> <th>Code</th> <th>Sys Name</th> <th>Route</th> <th>Form</th> <th>Strength</th> <th></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td>2416328</td> <td>DIN</td> <td>AUBAGIO 14 MG TABLET (SANOFI GENZYME,)</td> <td>Oral</td> <td><div style="border: 2px solid red; padding: 2px;">TABLET</div></td> <td>4 MG</td> <td> </td> </tr> <tr> <td></td> <td>69980</td> <td>GF</td> <td>TERIFLUNOMIDE 14 mg TABLET</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Fav	Id	Code	Sys Name	Route	Form	Strength		<input type="checkbox"/>	2416328	DIN	AUBAGIO 14 MG TABLET (SANOFI GENZYME,)	Oral	<div style="border: 2px solid red; padding: 2px;">TABLET</div>	4 MG			69980	GF	TERIFLUNOMIDE 14 mg TABLET				
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19 Medication Frequency	<p>Fields: Frequency and PRN (when necessary)</p> <div style="border: 1px solid #ccc; padding: 5px;"> <p>Frequency <input type="text" value="QD - Once"/> <input type="checkbox"/> PRN <input type="checkbox"/></p> </div>																								

20 Medication Route	<p>Fields: Route</p> <p>Refills: 3    Route*: Oral</p> <p>Start Date*: 22-Jan-2018    End Date*: 22-May-2018</p>
21 Medication Prescription Date	<p>Fields: Start Date(?)</p> <p>Refills: 3    Route*: Oral</p> <p>Start Date*: 22-Jan-2018    End Date*: 22-May-2018</p>
PROVIDER	
22 Provider Role	<p><b>User Settings: gharrison</b></p> <p>Role: MD</p> <p>Username: gharrison</p>
23 Provider First Name	<p>Identification</p> <p>Linked to user: Harrison, George</p> <p>Last Name: Harrison    First Name: George</p>
24 Provider Middle Name	<p>First Name: George    Initials:</p>
25 Provider Last Name	<p>Identification</p> <p>Linked to user: Harrison, George</p> <p>Last Name: Harrison    First Name: George</p>

26 <b>Provider Identifier</b>	 <p>Provider Identifier List - Google Chrome  <a href="https://nlchitest.med-access.net/patient/DisplayList.do?tableName=identifier_list&amp;listInstanceType=PHYS&amp;listReferenceld...">https://nlchitest.med-access.net/patient/DisplayList.do?tableName=identifier_list&amp;listInstanceType=PHYS&amp;listReferenceld...</a>  <b>Provider Identifier List</b>  <b>Identifier List</b>  <table border="1"> <thead> <tr> <th>Identifier</th> <th>Authority</th> <th>Type</th> <th>Facility</th> <th>Location</th> <th>Effective</th> <th>Expires</th> </tr> </thead> <tbody> <tr> <td>05661</td> <td></td> <td>[College of Physicians and Surgeons Number]</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table></p>	Identifier	Authority	Type	Facility	Location	Effective	Expires	05661		[College of Physicians and Surgeons Number]				
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27 <b>Provider Identifier Type</b>	 <p>Provider Identifier List - Google Chrome  <a href="https://nlchitest.med-access.net/patient/DisplayList.do?tableName=identifier_list&amp;listInstanceType=PHYS&amp;listReferenceld...">https://nlchitest.med-access.net/patient/DisplayList.do?tableName=identifier_list&amp;listInstanceType=PHYS&amp;listReferenceld...</a>  <b>Provider Identifier List</b>  <b>Identifier List</b>  <table border="1"> <thead> <tr> <th>Identifier</th> <th>Authority</th> <th>Type</th> <th>Facility</th> <th>Location</th> <th>Effective</th> <th>Expires</th> </tr> </thead> <tbody> <tr> <td>05661</td> <td></td> <td>[College of Physicians and Surgeons Number]</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table></p>	Identifier	Authority	Type	Facility	Location	Effective	Expires	05661		[College of Physicians and Surgeons Number]				
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05661		[College of Physicians and Surgeons Number]													
28 <b>Provider Identifier Assigning Authority</b>	 <p><b>Assigning Authority</b>  College of Physicians and Surgeons</p>														
29 <b>Submitting Site Identifier</b>	Back end data only														
30 <b>Submitting Site Name</b>	Back end data only														
<b>POSSIBLE ALLERGIES AND INTOLERANCES</b>															
31 <b>Drug Allergy</b>	 <p><b>Drug Allergy</b>  Allergen: amoxicillin  Date of Reaction: 23-Jan-2018</p>														
32 <b>Drug Intolerance</b>	 <p><b>Drug Intolerance</b>  Allergen: tinnitus after aspirin  Date of Reaction: 23-Jan-2018</p>														

33 Non-Drug Allergen	<div data-bbox="730 168 1299 293"> <h3>Non-Drug Allergy</h3> <table border="1"> <tr> <td>Allergen</td> <td>Date of Reaction</td> </tr> <tr> <td>mushrooms</td> <td>23-Jan-2018</td> </tr> </table> </div>	Allergen	Date of Reaction	mushrooms	23-Jan-2018							
Allergen	Date of Reaction											
mushrooms	23-Jan-2018											
34 Non-Drug Intolerance	<div data-bbox="730 350 1299 475"> <h3>Non-Drug Intolerance</h3> <table border="1"> <tr> <td>Allergen</td> <td>Date of Reaction</td> </tr> <tr> <td>dairy</td> <td>23-Jan-2018</td> </tr> </table> </div>	Allergen	Date of Reaction	dairy	23-Jan-2018							
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dairy	23-Jan-2018											
35 Severity	<div data-bbox="730 565 1692 911"> <p>Chicken Ball 33 years (709) 384-1114</p> <h3>Non-Drug Intolerance</h3> <table border="1"> <tr> <td>Allergen</td> <td>Date of Reaction</td> <td rowspan="5">           Secondary Reaction  <input type="checkbox"/> Anaphylaxis  <input type="checkbox"/> Conjunctivitis  <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Fever  <input type="checkbox"/> Liver Toxicity  <input type="checkbox"/> Nausea/Vomiting  <input type="checkbox"/> Nephrotoxicity  <input type="checkbox"/> Ototoxicity  <input type="checkbox"/> Rash  <input type="checkbox"/> Respiratory Distress  <input type="checkbox"/> Rhinorrhea         </td> </tr> <tr> <td>Drug Allergen Group</td> <td>Date Reported*</td> </tr> <tr> <td>Reaction*</td> <td>Severity*</td> </tr> <tr> <td>Other Reaction</td> <td>Confirmation Status</td> </tr> <tr> <td></td> <td>Suspect</td> </tr> </table> <p>Reported by: Physician</p> <p>Comments*</p> <p>Save</p> </div>	Allergen	Date of Reaction	Secondary Reaction <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Liver Toxicity <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Nephrotoxicity <input type="checkbox"/> Ototoxicity <input type="checkbox"/> Rash <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Rhinorrhea	Drug Allergen Group	Date Reported*	Reaction*	Severity*	Other Reaction	Confirmation Status		Suspect
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Drug Allergen Group	Date Reported*											
Reaction*	Severity*											
Other Reaction	Confirmation Status											
	Suspect											
36 Date of Reaction												
37 Date Reported												
38 Confirmation Status												
SERVICE DELIVERY LOCATION												
39 Service Delivery Location Identifier	<div data-bbox="730 1242 1207 1414"> <h3>Location Settings</h3> <p>Group Working Hours:  </p> <p>Facility: <input type="text"/></p> <p>Location Code: 123</p> </div>											

40 Service Delivery Location Name	<p><b>Update Facility</b></p> <p><b>Identification</b></p> <p>Name: Health Sciences Centre, ; Type: Hospital; Sending Facility: ; Specialty: No Known Specialties; Billable: <input checked="" type="checkbox"/></p>
41 Service Delivery Location Type of Service	<p><b>Update Facility</b></p> <p><b>Identification</b></p> <p>Name: Health Sciences Centre, ; Type: Hospital; Sending Facility: ; Specialty: No Known Specialties; Billable: <input checked="" type="checkbox"/></p>
42 Service Delivery Street Address	<p><b>Address &amp; Phone</b></p> <p>Address: ; City: ; Province: Newfoundland; Postal Code: ; Country: Canada; Phone #: ; Fax #: ; Address Type: Office</p>
43 Service Delivery City/Town	<p><b>Address &amp; Phone</b></p> <p>Address: ; City: ; Province: Newfoundland; Postal Code: ; Country: Canada; Phone #: ; Fax #: ; Address Type: Office</p>
44 Service Delivery Province	<p><b>Address &amp; Phone</b></p> <p>Address: ; City: ; Province: Newfoundland; Postal Code: ; Country: Canada; Phone #: ; Fax #: ; Address Type: Office</p>
45 Service Delivery Postal Code	<p><b>Address &amp; Phone</b></p> <p>Address: ; City: ; Province: Newfoundland; Postal Code: ; Country: Canada; Phone #: ; Fax #: ; Address Type: Office</p>

46 Service Delivery Phone Number	<p><b>Address &amp; Phone</b></p> <p>Address <input type="text"/>  <input type="text"/>  <input type="text"/></p> <p>City <input type="text"/> </p> <p>Country <input type="text"/> Canada</p> <p>Province <input type="text"/> Newfoundland</p> <p>Postal Code <input type="text"/></p> <p>Phone # <input type="text"/></p> <p>Fax # <input type="text"/></p> <p>Address Type <input type="text"/> Office</p>
47 Service Delivery Fax Number	<p><b>Address &amp; Phone</b></p> <p>Address <input type="text"/>  <input type="text"/>  <input type="text"/></p> <p>City <input type="text"/> </p> <p>Country <input type="text"/> Canada</p> <p>Province <input type="text"/> Newfoundland</p> <p>Postal Code <input type="text"/></p> <p>Phone # <input type="text"/></p> <p>Fax # <input type="text"/></p> <p>Address Type <input type="text"/> Office</p>
. ENCOUNTER	
48 Encounter Start Date	<p>Type <input type="text"/> CDM</p> <p>Date <input type="text"/> 02-Feb-2018  Friday</p>
49 Encounter Appt Creation Date	Back end data only
50 Encounter Billing Code	<p>Facility <input type="text"/> </p> <p>Bill <input type="text"/> 145 Test </p>
51 Appointment Status	<p><b>Patient</b></p> <p>Last Name <input type="text"/> First Name <input type="text"/></p> <p>Chart Number <input type="text"/> Insurer # <input type="text"/></p> <p><b>Appointment</b></p> <p>Type <input type="text"/></p> <p>Concern <input type="text"/></p> <p>Date <input type="text"/> 23-Jan-2019  Wednesday</p> <p>Notes <input type="text"/></p> <p>Time <input type="text"/> 10:30 AM - hh:mm aa minutes</p> <p>Provider <input type="text"/> Fudge, Mitchell</p> <p>Status <input type="text"/> Booked</p> <p>Save <input type="button"/></p>



52 Appointment Provider

**Appointment**

**Not Validated**  
 **This Patient is Unassigned**

Type: Urgent/Fit-In  
Date: 15-Jun-2020 Monday  
Time: 11:30 AM - 11:45 AM 15 minutes  
Status: Booked

Concern:   
Notes:   
Provider: Test, EOrder ET  
Bill:

Save

53 Appointment Date Time

Time: 12:15 PM - 01:15 PM 60 minutes  
Status: Booked



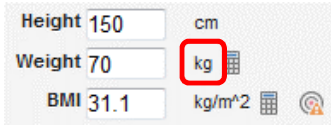
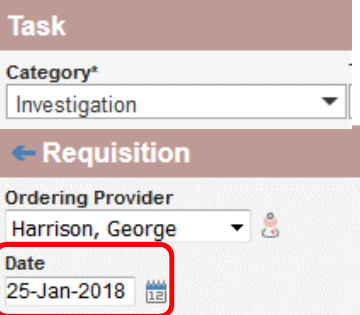
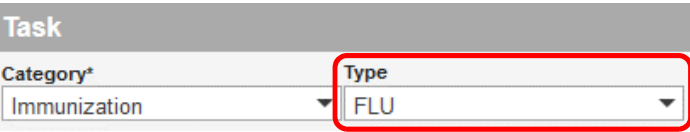
54 Encounter/Visit Health Concern (Diagnosis)

**Assessment**

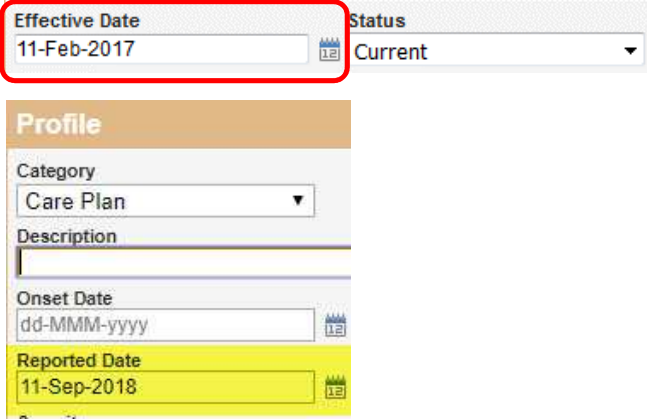
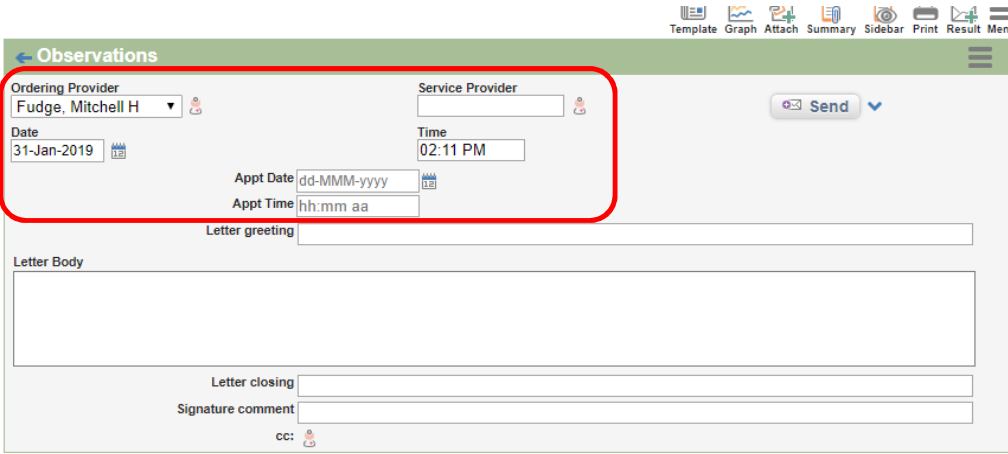
Diagnosis: asthma\* 493  
Billing Item:

CONDITIONS

55 Medical Profile Diagnosis	<div data-bbox="737 152 1381 542"> <h3>Profile</h3> <p>Category: Medical   Type: <input type="text"/></p> <p>Diagnosis: chronic bronchitis*   Code: 491</p> <p>Onset Date: 13-Mar-2018   Status: Current</p> <p>Reported Date: 19-Mar-2018   Confirmation Status: Confirmed</p> <p>Severity: <input type="text"/>   Persistence: <input type="text"/></p> <p>Risk Factor <input checked="" type="checkbox"/>   Confidential <input type="checkbox"/></p> </div>
56 Medical Profile Diagnosis Date of Onset	<div data-bbox="737 594 1381 987"> <h3>Profile</h3> <p>Category: Medical   Type: <input type="text"/></p> <p>Diagnosis: chronic bronchitis*   Code: 491</p> <p>Onset Date: 13-Mar-2018   Status: Current</p> <p>Reported Date: 19-Mar-2018   Confirmation Status: Confirmed</p> <p>Severity: <input type="text"/>   Persistence: <input type="text"/></p> <p>Risk Factor <input checked="" type="checkbox"/>   Confidential <input type="checkbox"/></p> </div>
<b>OBSERVATIONS</b>	
57 Systolic Blood Pressure	<div data-bbox="737 1044 1087 1214"> <h3>Visit</h3> <p>← Observations</p> <p>BP 120/59 mm Hg</p> </div>
58 Diastolic Blood Pressure	<div data-bbox="737 1235 1087 1308"> <p>BP 120/59 mm Hg</p> </div>
59 Height	<div data-bbox="737 1333 1071 1455"> <p>Height 150 cm</p> <p>Weight 70 kg</p> <p>BMI 31.1 kg/m<sup>2</sup></p> </div>

60 Height Unit Of Measure	
61 Weight	
62 Weight Unit Of Measure	
DIAGNOSTIC ORDERS	
63 Investigation Ordered Date	
64 Investigation Category, Type, Description, Reason and Date	The decision here was to pull the title of the requisition sent and date
IMMUNIZATIONS	
65 Vaccine Administered Name	

66 Vaccine Administered Recorded Date	<p>Ordering Provider Harrison, George</p> <p>Date 25-Jan-2018</p> <p>Service Provider [ ]</p> <p>Time 03:26 PM</p>
67 Vaccine Administered Lot Number	<p>Lot # 62584</p> <p>Injection site: [ ]</p> <p>Dose: 10 mL</p>
SURGICAL HISTORY	
68 Surgical Procedure	<p><b>Profile</b></p> <p>Category: Surgical Hx      Type: Abdominal</p> <p>Procedure: appendectomy      Code: [ ]</p>
ADVANCE DIRECTIVES	
69 Advance Directive Type	<p><b>Profile</b></p> <p>Category: Preferences      Type: Do Not Resuscitate</p> <p><b>Profile</b></p> <p>Category: Care Plan      Type: Advance Care Directive</p>

<p>70 Advance Directive Type Last Modified</p>	 <p>Effective Date: 11-Feb-2017</p> <p>Status: Current</p> <p><b>Profile</b></p> <p>Category: Care Plan</p> <p>Description:</p> <p>Onset Date: dd-MMM-yyyy</p> <p>Reported Date: 11-Sep-2018</p>
<p>Consults</p>	
<p>71 Consult Category, Type, Description, Reason and Date</p>	<p>The decision here was to pull the title of the requisition sent and date</p>
<p>72 Consult Ordering Provider, Service Provider, Appt Date, App Time, Date, Time.</p>	 <p>← Observations</p> <p>Ordering Provider: Fudge, Mitchell H</p> <p>Service Provider:</p> <p>Date: 31-Jan-2019</p> <p>Time: 02:11 PM</p> <p>Appt Date: dd-MMM-yyyy</p> <p>Appt Time: hh:mm aa</p> <p>Letter greeting:</p> <p>Letter Body:</p> <p>Letter closing:</p> <p>Signature comment:</p> <p>cc:</p>