U.S. Department of Health and Human Services

Office of the National Coordinator for Health Information Technology

Clinical Note Details

AHIC Extension/Gap

December 31, 2008

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1.0 Preface and Introduction

1.1 Background

In April and June of 2008, the American Health Information Community (AHIC) approved a recommendation to develop documents that address extensions/gaps from the use cases published between 2006 and 2008. One of the extensions/gaps prioritized for subsequent processing in the national health agenda activities in 2009 was Clinical Note Details. AHIC specifically requested that the 2009 Clinical Note Details Extension/Gap address the development, completion, and exchange of interoperable clinical notes. A clinical note can be structured and/or unstructured information exchanged between Electronic Health Records (EHRs) and other systems.

This extension/gap document is being developed by the Office of the National Coordinator for Health Information Technology (ONC) to represent AHIC priorities and provide context for the national health agenda activities, beginning with the selection of harmonized standards by the Healthcare Information Technology Standards Panel (HITSP). Components that need to be considered during the standards identification and harmonization activities include standardized vocabulary, data elements, datasets, and technical standards that support the information needs and processes for exchange of clinical notes between providers and other stakeholders. This document is the Final AHIC Extension/Gap. Feedback received on the AHIC Extension/Gap has been considered and incorporated into this document where applicable. HITSP has the opportunity to reuse standards, where applicable, from those previously recognized by the Secretary of Health and Human Services, to specify and constrain how they are to be used to advance interoperability and to work with standards development organizations to see that gaps in standards are filled.

1.2 Progress to Date

To date, the national health agenda, including activities of AHIC and HITSP, has not formally addressed all of the interoperability considerations for the communication of exchanging clinical notes between clinicians and across care settings.

Previously published AHIC use cases incorporate several concepts that have been evaluated by HITSP and could be leveraged during standards harmonization for this extension/gap.

- The 2008 Consultations and Transfers of Care Use Case includes the need for communicating information to request and fulfill a consultation and support transfers of care; and
- The 2008 Public Health Case Reporting Use Case includes the needs for communicating and reporting laboratory test results to public health when specific reporting criteria are met. This use case also describes the communication of public

health case reporting criteria for incorporation into EHR systems and utilization by clinicians.

2.0 Overview and Scope

2.1 Document/Request Overview

This extension/gap document is focused on information needs to facilitate the electronic exchange of Clinical Notes. The 2009 Clinical Note Details Extension/Gap document is divided into the following sections:

- Section 1.0, Preface and Introduction, describes the progress to date, the additional priorities identified by the AHIC, the resulting extensions/gaps, and their purpose;
- Section 2.0, Overview and Scope, describes the sections of an extension/gap document, the request being made to HITSP, and the scope of that request;
- Section 3.0, Functional Needs, describes the combination of end-user needs and system behaviors which support interoperability and information exchange;
- Section 4.0, Stakeholder Communities, describes individuals and organizations that participate in activities described in this extension/gap;
- Section 5.0, Issues and Obstacles, describes issues and obstacles which may need to be planned for, addressed, or resolved to achieve the capabilities described in the extension/gap;
- Section 6.0, References to Use Case Scenarios, describes various scenarios and information exchanges which assist in the communication of information. Scenarios may be re-used from previously published 2006 – 2008 Use Cases and/or new scenarios may be described;
- Section 7.0, Information Exchange, describes information exchange capabilities which are needed to support the scenarios and the high-level role of information exchange;
- Section 8.0, Dataset Considerations, identifies specific information opportunities relevant to this extension/gap document that may support future identification, development, and harmonization of standards;
- Appendix A, Glossary, provides contextual descriptions of key concepts and terms introduced in this extension/gap document; and
- Appendix B, Analysis and Examples, identifies specific data types, data sets, data elements, vocabularies, naming conventions, capabilities, and technical standards which may support future industry efforts in the identification, development, and harmonization of standards.

2.2 Scope

Clinical Notes are the means by which clinicians document a patient encounter, visit, or service. Clinicians treating patients as part of a consultation, in receipt of a transfer of care, care management, or providing continuity of care may access a patient's relevant clinical notes to gain a more comprehensive understanding of the patient's history.

Documents that are not authored and generated by a clinician (e.g., patient forms, consents, administrative documents) and do not constitute a clinician's documentation of a patient encounter or service are not in scope for this request. In addition, items which may accompany or support clinical notes, such as images and waveforms, are not in scope for this request.

Therefore, the requirements for the 2009 Clinical Note Details Extension/Gap can be summarized as:

- The authoring clinician's ability to view, select, document, and communicate clinical notes; and
- The consulting clinician or receiving clinician's ability to access available clinical note information and/or sections thereof.

The identification, development, and harmonization of standards to support the interoperability associated with the development, completion, and exchange of interoperable clinical notes has been preliminarily addressed. However, additional work with standards and professional organizations, care delivery organizations, and organizations providing information technology services and products to the healthcare industry is needed to support the interoperability needs associated with Clinical Note Details. As mentioned in Section 1.0, the needs expressed here have not yet been fully addressed by the national health agenda's standardization efforts. Examples of gaps in industry standards are outlined in the upcoming sections of this extension/gap document.

3.0 Functional Needs

This section describes a combination of end-user needs and system behaviors to support users during the exchange of clinical notes between EHRs and other systems. Support for this exchange includes the development of interoperability standards for vocabularies, data elements, datasets, and other technical components that are implicit in these functional needs. Rather than an all-inclusive list of functional interoperability requirements, key capabilities are outlined below. The descriptions in this section are not intended to prescribe policy nor propose architectures required to implement capabilities.

A. The ability to review a listing of available clinical note types.

   i. When creating a clinical note for a patient, an authoring clinician may need the ability to review a listing of common clinical note types. These listings may be acquired through libraries of commonly used clinical note types and may also include and specify clinical documentation requirements for specific clinical note types. These listings may be grouped by encounter or service type. Examples of these clinical note types may include: History and Physical, Progress/Office Note, Consult Note, Operative Note, Procedure Note, Plan of Care, Triage Note, and Discharge Summary.

B. The ability to select a clinical note based upon standardized service, role, clinical condition, diagnosis, specialty, and/or location.

   i. Using the list of available clinical notes, an authoring clinician may select and complete clinical note documentation within an EHR.

C. The ability to incorporate listings of available clinical note templates provided by external sources into an EHR.

   i. Listings of available commonly used clinical note templates may be available through libraries. These libraries may also include and specify clinical documentation requirements for specific clinical note types in templates that are human readable or can be processed electronically. These libraries may be made available by clinical specialty organizations and societies, healthcare organizations, external knowledge suppliers, regulatory associations, standards development organizations, and others.

D. The ability to provide required and optional clinical note details by using templates to facilitate development of a clinical note.

   i. When creating a clinical note for a patient, an authoring clinician may select templates that provide guidance for structuring and completing the relevant note type. The template may provide required and optional sections or fields to

facilitate development of comprehensive and complete documentation that adheres to industry, organizational, and/or coding guidelines for the selected type of note or type of patient encounter.

ii. The use of templates may enable the automated population of patient demographic or clinical information available or documented in other areas of the medical record during the current encounter, or during previous encounters. The use and implementation of this capability may vary based upon organizational and provider policies and preferences.

E. The ability to select from a listing of relevant options for a section within a clinical note to reduce the amount of free text information input for the section.

i. The use of templates and standard reference terminologies may reduce the amount of free text information input by the clinician to complete a particular section of a clinical note. The template may provide guidance to enable consistency and completion of documentation that adheres to industry or recommended guidelines for the selected clinical note section.

F. The ability to communicate relevant clinical notes to the next provider of care to support a consultation or transfer of care.

i. In support of a request for consultation or patient transfer to another organization, an authorized care provider may provide access to relevant completed clinical notes to the next provider of care. Unique identification of provider organizations and/or individual providers is needed to exchange clinical notes.

ii. Available clinical notes for a patient may be accessed from a list of clinical documents that may be sorted by parameters including but not limited to: note type, date range, reason for encounter/visit, problem/diagnosis, clinician name, clinical specialty, and organization type. The clinician may provide access to clinical notes for the current patient encounter or previous patient encounters.

G. The ability to communicate replacement, amended, and annotated notes to the next provider of care.

i. An authoring clinician may replace or amend a clinical note that was previously communicated to the next provider of care in support of a request for consultation or patient transfer to another organization. The updated clinical note is communicated to the next provider of care.

H. The ability for a clinician to view a list of clinical notes completed for a patient.

i. In providing care for a patient, the clinician may require access to additional patient information. The clinician may review a list of available clinical notes for a patient.

ii. The clinician may wish to sort the list of available clinical notes by parameters including but not limited to: clinical note type, date range, reason for encounter/visit, problem/diagnosis, clinician name, clinical specialty, and organization type.

I. The ability to view a clinical note for a patient from another organization within the clinician's or facility's electronic health record.

i. The clinician is able to access and view prior clinical notes for a patient. The requesting clinician or clinician at the transferring facility has previously granted access to these clinical notes.

ii. The consulting clinician or receiving clinician may request access to clinical notes residing in another EHR based upon knowledge or access to a patient's encounter history.

iii. The clinical note accessed by the consulting clinician or receiving clinician includes sufficient context to support document management within the clinician's EHR.

J. The ability to compare or view a patient's progress over time for a specific type of clinical note or specific section within clinical notes.

i. A clinician may view a patient's progress or history over time for a specific type of patient encounter and access desired sections of a note to review progress.

K. The ability to reuse sections or data elements within an exchanged clinical note for use in a new note/record without loss of relevant originating information (e.g., author, universal date/time information was documented).

i. A clinician may access and incorporate clinical note information at the section or data element level into new clinical documentation in a manner that includes originating information about the section or data element.

4.0 Stakeholder Communities

Examples of stakeholders who may be directly or indirectly involved in the exchange of clinical notes have been listed below. Specific descriptions of each type of stakeholder can be found in the previous 2006 – 2008 AHIC Use Cases.

Stakeholders that may be directly involved in the exchange of general clinical notes may include: Authoring Clinicians, Consulting Clinicians, and Receiving Clinicians.

Stakeholders that may assist in clinical note communication may include: EHR System Suppliers.

Stakeholders that may be sources or recipients of clinical note information may include: Consumers, Clinicians, Provider Organizations, Patients, Knowledge Suppliers, Public Health, Government Agencies, and Healthcare Payors.

5.0 Issues and Obstacles

A number of issues in today's health information technology environment are obstacles to achieving the healthcare data standardization and interoperability to promote patient safety, reduce healthcare costs, and increase the value of electronic health information exchange. Some general issues were described within the 2006 – 2008 AHIC Use Cases. Examples of specific issues and obstacles related to Clinical Notes are outlined below.

A. Clinical Note Types:

i. In order for clinicians to effectively develop and exchange clinical notes, standard terminology and naming conventions for note type, note name, type of service, problem/diagnosis, and clinical specialty, and roles may be needed.

   a. Without the ability to map current standards and/or select a specific interoperable standard to ensure communication it may be difficult to efficiently select and communicate clinical notes.

   b. Without the identification and adoption of standard naming or coding conventions, it may be difficult to effectively select and communicate clinical notes.

B. Clinical Note Sections and Details:

i. In order for clinicians to effectively develop and exchange clinical notes, standard clinical note types, sections, and/or details may be needed.

   a. In many cases, organizations and systems may use clinical note types to assist in determining the required note details. Without the identification and adoption of standard clinical note types it may be difficult to determine standard required clinical note sections and details.

   b. There are types of clinical notes that require similar sections, such as patient information, provider information, reason for encounter, medications, and allergies.

   c. There are also types of clinical notes, such as operative reports, procedure notes, and specialty progress notes where the clinical note sections or details may be substantially different. An example may be a section such as estimated blood loss, which would be relevant to an operative report.

   d. Without the development of standard clinical note sections and details, clinicians may use free text descriptions for common sections, which may

create challenges in reviewing patient progress and documentation over a period of time.

C. Clinical Note Source and Identification:

i. In order for clinicians to effectively exchange clinical notes, systems may need to be capable of generating a method to uniquely identify a clinical note, its author, and additional document source and identification details.

   a. If systems do not have capabilities to uniquely identify provider organizations and individual providers, it may be difficult to exchange clinical notes between providers. Additional standards work may be required to support unique provider identification.

   b. If systems do not have capabilities to uniquely identify clinical notes, it may be difficult for providers to distinguish between multiple types of clinical notes that may have been developed for a patient during a single patient encounter except when viewing the clinical note. Structured and/or coded information associated with clinical notes may assist providers in distinguishing between different clinical notes for a patient.

D. Patient Data Access and Communication:

i. Clinical notes may be exchanged to coordinate or support a consultation or transfer of care. If a care setting determines that it is not able to accept a patient for consultation or from a transfer of care, the patient data may still be accessed by this setting. There is a need to consider the duration for which patient information is accessible by recipients of this information.

   a. Without processes that define the duration that patient data is accessible, patient information may be sent or accessible to a setting that did not accept the patient or for a patient that is longer its responsibility.

ii. Clinical notes developed within a setting may be updated (e.g., amended, replaced) after an initial information transfer of core data to the next provider of care has taken place. The updated information may need to be communicated to providers and other stakeholders. There is a need to consider the scope, mechanism, and timeframe within which updated information is communicated to recipients.

   a. Without processes that define the method and duration to send or receive updated patient information, information exchanged between care settings may be incomplete, or of questionable integrity. Providers may also receive updates for patients who are no longer their responsibility.

iii. Clinical notes containing mental health information may require additional security and privacy protections to support capabilities for limited or “need to know” access to mental health information.

   a. Without sufficient security and privacy considerations for mental health information within clinical notes and psychotherapy notes, adoption of information exchange between care settings of mental health information may be limited or unable to support “need to know” information exchange.

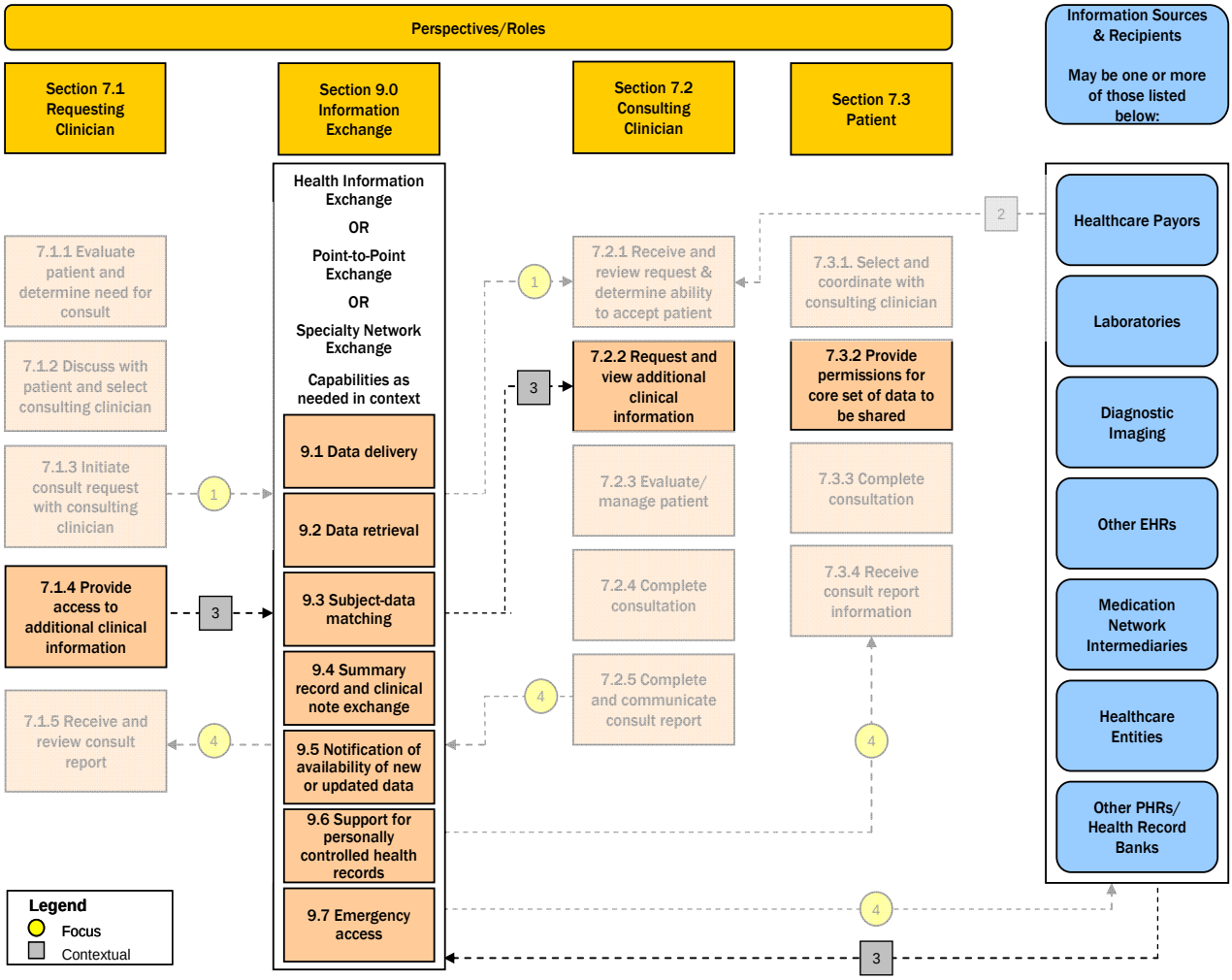
6.0 References to Prior Use Case Scenarios

The 2009 Clinical Note Details Extension/Gap Document focuses on the exchange of clinical notes between EHRs and other systems. Specific events and information exchanges have been selected from previous use cases for contextual purposes.

The 2008 Consultations and Transfers of Care Use Case contains a scenario which describes the communication of information required for a consultation request, completion of a consultation, and coordination of a transfer of care. The 2008 Public Health Case Reporting Use Case contains a scenario which describes the communication of requirements by various sources and the incorporation of these requirements into EHRs. The events and information flows which are pertinent to the 2009 Clinical Note Details Extension/Gap are shown in bold. All other events and information flows have been faded out.

6.1 Reference to Prior Use Case: 2008 Consultations and Transfers of Care (Scenario 1)

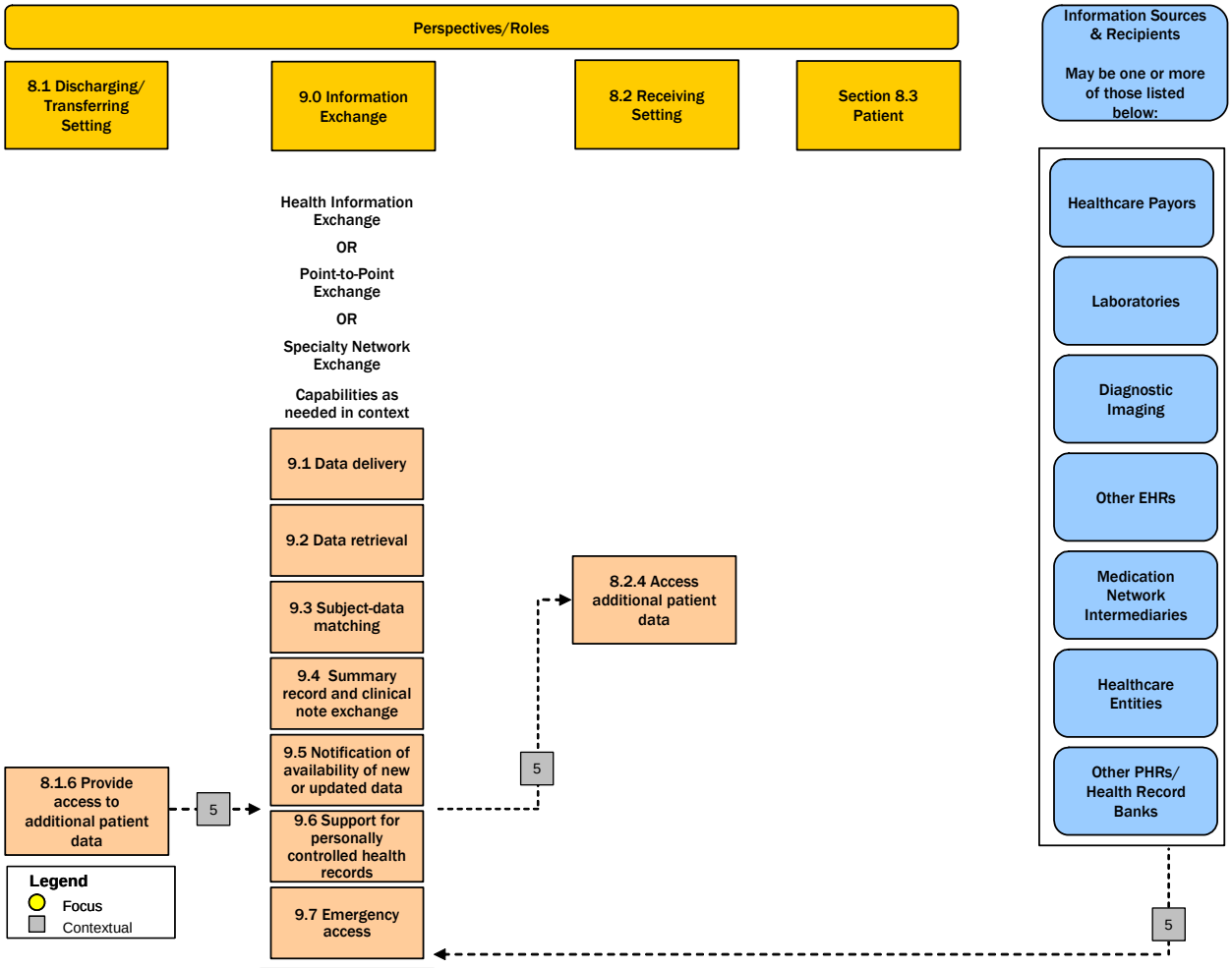
Figure 6-1. Consultations



As expressed in the 2008 Consultations and Transfers of Care events 7.1.4, 7.2.2 and information flow 3; clinical notes may be communicated via health information exchange activities and incorporated into EHRs and other systems. Therefore, information flow 3 should be referenced when addressing Clinical Note Details.

6.2 Reference to Prior Use Case: 2008 Consultations and Transfers of Care (Scenario 2)

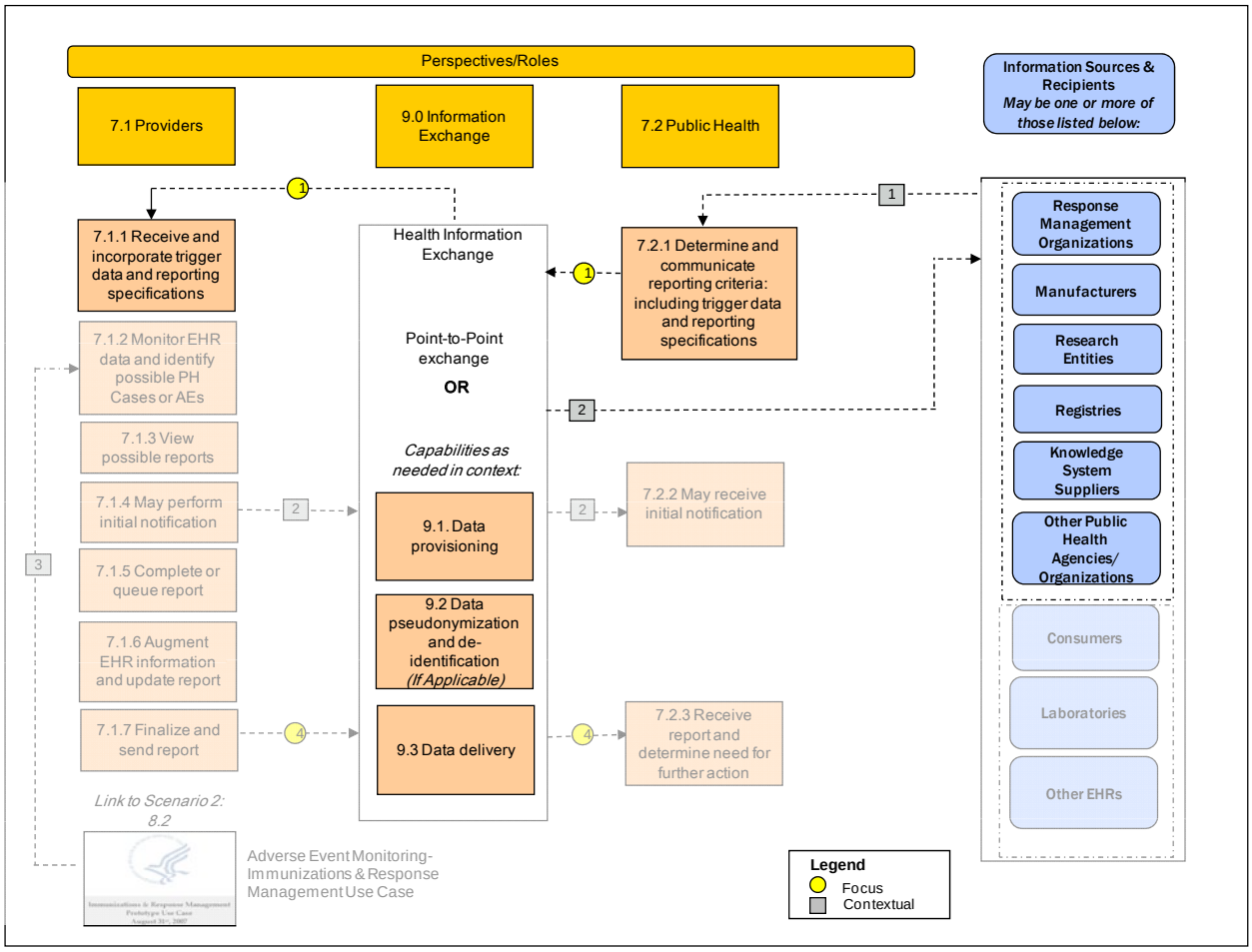
Figure 6-2. Transfers of Care



As expressed in the 2008 Consultations and Transfers of Care events 8.1.6, 8.2.4 and information flow 5; clinical notes may be communicated via health information exchange activities and incorporated into EHRs and other systems. Therefore, information flow 5 should be referenced when addressing Clinical Note Details.

6.3 Reference to Prior Use Case: 2008 Public Health Case Reporting (Scenario 1)

Figure 6-3. Reporting from EHRS



As expressed in the 2008 Public Health Case Reporting Use Case events 7.1.1, 7.2.1 and information flow 1; reporting criteria, including trigger data and reporting specifics may be communicated via health information exchange activities and incorporated into provider systems (e.g., EHRs and/or public health systems).

In the case of Clinical Note Details, Knowledge Suppliers/Sources may communicate clinical note requirements via health information exchange activities. Clinical note requirements may also be incorporated from clinical documentation systems, such as EHRs. Therefore, information flow 1 should be referenced when addressing Clinical Note Details.

7.0 Information Exchange

The information exchange requirements for the effective selection and communication of clinical notes may comprise:

- The ability to communicate a clinical note template based upon function, clinical condition, specialty, and/or care setting.
- The ability to utilize a template to facilitate development of clinical note details.
- The ability to communicate relevant clinical notes to the next provider of care to support a consultation or transfer of care.
- The ability to communicate replacement, amended, and annotated clinical notes to the next provider of care.
- The ability for a consulting clinician or clinician at a receiving facility to view a list of clinical notes available for a patient.
- The ability to view a clinical note for a patient from another organization within the consulting clinician's or receiving facility's EHR.
- The ability to compare or view a patient's progress over time using a specific type of clinical note and/or specific section within clinical notes.

Examples of information exchange capabilities described above and in Section 3.0 may include: Data Delivery, Routing, Data Retrieval, Subject Data Matching, Notification of New or Updated Data, and Emergency Access. Descriptions of each of these are in the previous 2006 – 2008 AHIC Use Cases.

The functional capabilities may be fully or partially provided by a variety of organizations including: health information exchange organizations, integrated care delivery networks, provider organizations, health record banks, specialty networks, and others.

While not described in this section, Health Information Exchange (HIE), Point-to-Point, or Specialty Network exchanges may assist in the completion of the processes described in this extension/gap. Examples of these exchanges can be found in the previous 2006 – 2008 AHIC Use Cases.

8.0 Clinical Note Details Dataset Considerations

The following non-exhaustive information categories and limited examples illustrate some of the information needs from this extension/gap document. An analysis of the dataset and examples of common clinical note types and sections are included in Appendix B.

A. **Clinical Note Identification –** Specific information which assists in the communication and tracking of a clinical note may be considered. This information may include patient, clinician, and other encounter or service identification details.

B. **Condition / Diagnosis –** Specific information which assists in the communication of reason for the encounter or service may be considered. The use of available standards and code sets for condition, diagnosis, procedures, and chief complaint may be valuable.

C. **Service Type –** Specific information which assists in the description of the type of service provided.

D. **Provider Role –** Specific attributes which assist in the identification and designation of the service provider role. A service provider may have multiple roles.

E. **Service Location –** Specific information which assists in the description of the encounter location or place of service may be considered.

F. **Clinical Note Type -** Determining and standardizing all clinical note types and names may not be practical. Focusing on commonly used clinical notes, such as those addressed by standards may be valuable. Specific information that further describes the document should also be considered.

G. **Clinical Note Section Type –** Determining and standardizing sections for all clinical note types may not be practical and should be prioritized for commonly used clinical notes, such as History and Physical, Diagnostic Report, Discharge Summary, Procedure Report, Operative Report, Progress/Office Visit Note, Plan of Care, and Triage Note. Specific information that further describes the document and identifies required or optional sections may be considered.

Appendix A: Glossary

The 2006 – 2008 AHIC Use Cases contained general terms and their contextual descriptions. Listed below are the new terms that are specific to this extension/gap.

Authoring Clinician: A clinician that completes a clinical note during or following completion of a patient visit, to document the care provided.

Clinical Notes Knowledge Supplier: Entities that using data, vocabulary, technology, and industry practices to provide information and tools that are made available and may be executable to entities delivering health care. These knowledge suppliers may provide information on clinical note types and structures that could be used in EHRs to assist authoring clinicians in developing clinical notes.

Clinical Note Libraries: The listings of all possible clinical note types that may be selected by a clinician for documentation or access. Clinical note libraries also include section detail for relevant note types.

Clinical Note Section: Common information types which may be included within a particular clinical note type. One or more information types may be used within a clinical note template.

Clinical Note Type: Clinical documentation category that distinguishes the purpose of a clinical note from other clinical notes and documents.

Clinicians: Clinicians are healthcare providers with patient care responsibilities, including physicians, advanced practice nurses, physician assistants, nurses, psychologists, pharmacists, dentists, oral surgeons, and other licensed and credentialed personnel involved in treating patients. References to “clinicians” in this document are intended to be for specific cases where only a clinician can fill the given role.

Consulting Clinician: A clinician who performs services as a part of a consultation request on behalf of a patient.

Receiving Clinician: A clinician who cares for a patient subsequent to a patient transfer.

Appendix B: Analysis and Examples

Multiple industry efforts have been initiated in the past or are currently in progress to identify the dataset for clinical notes. An analysis of the dataset and examples of common clinical note types are included in Appendix B. The information, dataset, and examples provided in Appendix B are intended to serve as examples and do not constitute a comprehensive set of clinical note information. These examples are not intended to be inclusive of all activities in this area.

Clinical note standardization efforts have been initiated by many public sector healthcare organizations such as the Department of Defense (AHLTA) and Veterans Administration (VistA) and private, academic, and research healthcare institutions using both internally-developed and vendor EHRs. Clinical documentation standards such as HL7 Clinical Document Architecture (CDA), ASTM Continuity of Care Record (CCR), and PDF for Healthcare, and standards initiatives such as HL7's Structured Documents Work Group, CDA4CDT, Integrating the Healthcare Enterprise's (IHE) Patient Care Coordination Technical Committee have reviewed, researched, and/or developed document formats and dataset recommendations for various clinical note types. The Healthcare Information Technology Standards Panel (HITSP) has initiated or completed activities for clinical documentation associated with 2006-2008 AHIC Use Cases. The Joint Commission (TJC) also has specific requirements for information that must be available during transitions in care and policies surrounding clinical care that may impact documentation needs.

A coordinated effort that facilitates collaboration and participation from the public and private sector, including healthcare organizations, clinical stakeholders, and standards development organizations (SDOs) is needed to select standards, identify gaps, and drive standards development and selection for gap areas.

The following non-exhaustive information categories and limited examples are provided as background information for future standards efforts to provide direction on information needs for clinical notes:

Clinical Note Identification – Specific information which assists in the communication and tracking of a clinical note may be considered. This information may include:

- Patient Identification Information
- Authoring Clinician Identification Information
- Date of Encounter/Time Intervals
- Identification Information for Data Entry Individual
- Status of Note (e.g. Preliminary, Final)

Condition / Diagnosis – Specific information which assists in the communication of reason for the encounter or patient service may be considered. The use of available standards and code sets for condition, diagnosis, procedures, and chief complaint may be valuable.

Service Type – Specific information which assists in the identification of the type of service provided. This information may include:

- Correspondence
    - Email
    - Telephone
    - Laboratory Follow-up
    - Test Follow-up
    - Medication Refill
- Diagnostic Procedure or Test
    - Cardiology
        - Cardiac Catheterization
        - Echocardiogram
        - Electrocardiogram
        - Electrophysiology Study
        - Tilt Table Test
    - Radiology
        - Imaging
- Evaluation and Management
    - Consultation
    - Discharge
    - Disease Management
    - Health Maintenance

- Hospital Admission/Initial Evaluation
- Pre-Operative
- Physical Exam
- Subsequent Evaluation

- Interventional Procedure
  - Radiology Procedure
    - Angiography
    - Angioplasty
    - Biopsy
    - Embolization
    - Epidural
    - Nerve Block
    - RF Ablation
    - Vascular
  - Surgical/Operative Procedure
- Screening

Provider Role – Specific attributes which assist in the identification and designation of the service provider role. A service provider may have multiple roles. This information may include:

- Role, Training, or Professional Level
  - Case Manager
  - Clinical Nurse Specialist
  - Clinical Pharmacist
  - Clinical Psychologist
  - Dietician

- EMS
- Licensed Practice Nurse (LPN)
- Licensed Vocational Nurse (LVN)
- Medical Home Provider
- Medical Student
- Nurse Practitioner
- Occupational Therapist
- Physical Therapist
- Physician
  - Attending Physician
  - Specialty Physician
- Physician Assistant
- Psychiatrist
- Radiology Technician
- Registered Nurse
- Resident
- Respiratory Therapist
- Social Worker
- Speech Therapist
- Student Nurse

Service Location – Specific information which assists in the description of the encounter location or place of service may be considered. This information may include:

- Outpatient Facility/Clinic
  - Primary Care Clinic

    - Specialty Clinic (e.g., Cardiology, Gastroenterology, Neurology)
    - School-based Clinic
- Inpatient Facility
    - Acute Care Hospital
    - Emergency Room
    - Inpatient Rehabilitation Facility
    - Ancillary (e.g., Radiology, Rehabilitation, Therapy)
    - Skilled Nursing Facility
    - Long-Term Assisted Care Facility
- Home

Clinical Note Type - Determining and standardizing all clinical note types and names is not practical. Focusing on commonly used clinical notes, such as those addressed by LOINC, SNOMED, HL7, and other standards may be valuable. Specific information that further describes the document should also be considered. This information may include:

- Ambulatory Encounter or Clinic Visit
    - Primary Care
    - Specialty (e.g., Cardiology, Gastroenterology, Neurology, Obstetrics)
- Cardiology Report
    - Catheterization Lab Report
    - Echocardiogram Report
- Dietary Note
- Discharge Summary
- Emergency Department Report
- History and Physical
    - Admission History and Physical

    - Medical Student History and Physical
    - Psychiatric History and Physical
- Mental/Behavioral Health Report
- Interdisciplinary Note (e.g., Nurses, Respiratory Therapy, Social Worker)
    - Assessment
    - Flow sheet
    - Progress Note
    - Re-Assessment
- Operative Report
    - Anesthesia Pre-operative Report
    - Pre-operative Report
    - Operative Report
- Pathology Report
- Plan of Care
- Procedure Report
- Progress Report
- Psychotherapy Note
- Radiology Report
- Therapy Progress Note or Report
    - Occupational Therapy
    - Physical Therapy
    - Speech Therapy
    - Residential Treatment Facility
    - Nursing Facility

- Triage Note

Clinical Note Section Type – Determining and standardizing sections for all clinical note types is not practical and should be prioritized for commonly used clinical notes, such as: History and Physical, Diagnostic Reports, Discharge Summary, Procedure Reports, Operative Reports, and Progress/Office Visit Notes. Specific information that further describes the document and identifies required or optional sections should also be considered. Common clinical note section types are provided below for History and Physical and Operative Notes as examples:

- History and Physical
    - Patient Demographic and Administrative Information
        - Sex
        - Age
        - Date of Birth
        - Gender (Biological, Social)
        - Ethnicity
        - Zip Code
        - Height
        - Weight
    - Chief Complaint/Reason for Encounter
    - Consultation Report
    - History of Present Illness
        - Condition with Pertinent Positives and Pertinent Negatives
        - Duration
        - Onset
    - Review of Systems
        - Pertinent Negatives

- Pertinent Positives

- Past Medical History
- Allergies
- Medications with Indications
  - Reconciliation Information (Stopped, Modified/Added, Complete List for Encounter)
  - Home Meds, OTCs, Herbals
- Diagnosis or Preliminary Diagnosis
- Problem List
- Social History
  - Smoking, Alcohol Use
  - Occupation, Work Status or School
  - Primary Language
  - Education Level
  - Marital Status or Significant Support System
  - Religious Needs
- Family History
- Vital Signs
  - Temperature
  - Blood Pressure
  - Heart Rate
  - Pain Scale
  - Respirations
  - O2 Saturation

  - Physical Examination
  - Assessment and Planned/Performed Interventions
  - Immunizations
- Operative Report
  - Surgeon and Staff Identification
  - Preoperative Diagnosis
  - Postoperative Diagnosis
  - Surgery Date, Details and Description
  - Operative Note Findings
  - Anesthesia Information
  - Estimated Blood Loss
  - Specimens Removed
  - Procedure(s)
  - Indications
  - Intra-operative Complications
  - Disposition
  - Plan
  - Operative Note Fluids
  - Surgical Drains
  - Biomedical Devices and Implants