Sample Aphp Messages for Review

We will use this page to keep track of how sample Aphp messages look like during step of the development process. At this point, the latest version of the document being generated is as follows,

Complete APHP CDA message (8th August 2014)

```
<?xml version="1.0" encoding="UTF-8"?>
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  <templateId root="1.3.6.1.4.1.19376.1.5.3.1.1.16.1.4"/>
  <templateId root="1.3.6.1.4.1.19376.1.5.3.1.1.16.1.1"/>
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/city><state>Telangana</state><country>India</country><postalCode>500000</postalCode></addr>
      <telecom nullFlavor="UNK"/>
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        <name><given>Sakhsi</given><family>Gupta</family></name>
        <administrativeGenderCode code="F" codeSystem="2.16.840.1.113883.5.1"/>
        <birthTime value="19700104"/>
        <maritalStatusCode code="MARRIED"/>
        <ethnicGroupCode code="Asian"/>
      </patient>
      <providerOrganization>
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        <name>OpenMRS</name>
        <telecom nullFlavor="UNK"/>
        <addr><county> </county></addr>
      </providerOrganization>
    </patientRole>
  </recordTarget>
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    <time value="20140808090034"/>
    <assignedAuthor>
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        <softwareName>OpenMRS</softwareName>
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    </assignedAuthor>
  </author>
  <custodian>
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  </custodian>
  <participant typeCode="IND">
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patient's next of kin"/>
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/city><country>India</country></addr>
      <telecom value="tel: + " use=""/>
      <associatedPerson>
        <name><given>Mahendra</given><family>Gupta</family></name>
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  </participant>
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Father of Baby"/>
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/city><country>India</country></addr>
      <telecom value="tel: + " use=""/>
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      </associatedPerson>
    </associatedEntity>
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        <name><family>Gupta</family><given>Mahendra</given></name>
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  </participant>
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/city><country>India</country></addr>
      <telecom nullFlavor="UNK"/>
      <associatedPerson>
        <name><family>Bajaj</family><given>Ramesh</given></name>
      </associatedPerson>
    </associatedEntity>
  </participant>
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          </assignedPerson>
          <representedOrganization>
            <id root="2.16.840.1.113883.19.5"/>
            <name>OpenMRS</name>
            <telecom nullFlavor="UNK"/>
            <addr><county> </county></addr>
          </representedOrganization>
        </assignedEntity>
      </performer>
    </serviceEvent>
  </documentationOf>
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      <component>
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OF PRESENT ILLNES"/>
          <title>This contains a narrative description of the patient's Present Illness histroy</title>
          <text><paragraph>This patient was only recently discharged for a recurrent GI bleed as described
below. She presented to the ER today c/o a dark stool yesterday but a normal brown stool today. She was
hypotensive in the 80?s resolved after.



Lab at discharge: Glucose 112, BUN 16, creatinine 1.1, electrolytes normal. H. pylori antibody pending.
Admission hematocrit 16%, discharge hematocrit 29%. WBC 7300, platelet count 256,000. Urinalysis normal.



Urine culture: No growth. INR 1.1, PTT 40.She was transfused with 6 units of packed red blood cells with GI
evaluation 12 September: Colonoscopy showed single red clot.



this is latest observation</paragraph></text>
        </section>
      </component>
      <component>
        <section>
          <templateId root="1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1"/>
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Complaint"/>
          <title>This contains a narrative description of the patient's chief complaint</title>
          <text><paragraph>Latest Obs 1</paragraph></text>
        </section>
      </component>
      <component>
        <section>
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          <templateId root="1.3.6.1.4.1.19376.1.5.3.1.3.16"/>
          <code code="29762-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Social
History"/>
          <title>The social history section shall contain a narrative description of the person’s beliefs, home
life, community life, work life, hobbies, and risky habits</title>
          <text>
<table>
<thead>
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<tr>
<th>Social History Element</th>
<th>Description</th>
<th>Effective Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td ID = "_5" >Type of tobacco product</td>
<td>Traditional tobacco product</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_6" >Alcohol use status</td>
<td>Never</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_7" >Patient-generated history: Social history section text</td>
<td>This is patient's social history.....................</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_8" >Illicit Drug Consumption</td>
<td>Never</td>
<td>07-14-2014</td>
</tr>
</tbody>
</table>
</text>
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              <code code="266918002" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
displayName="Type of tobacco product">
                <originalText><reference value="#_5"/></originalText>
              </code>
              <statusCode code="completed"/>
              <effectiveTime value="20140808090035"/>
              <value xsi:type="ED">Traditional tobacco product</value>
            </observation>
          </entry>
          <entry typeCode="DRIV">
            <observation classCode="OBS" moodCode="EVN">
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displayName="Alcohol use status">
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              </code>
              <statusCode code="completed"/>
              <effectiveTime value="20140808090035"/>
              <value xsi:type="ED">Never</value>
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Patient-generated history: Social history section text">
                <originalText><reference value="#_7"/></originalText>
              </code>
              <statusCode code="completed"/>
              <effectiveTime value="20140808090035"/>
              <value xsi:type="ED">This is patient's social history.....................</value>
            </observation>
          </entry>
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            <observation classCode="OBS" moodCode="EVN">
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displayName="Illicit Drug Consumption">
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SYSTEMS"/>
          <title>The review of systems section shall contain a narrative description of the responses the
patient gave to a set of routine questions on the functions of each anatomic body system.</title>
          <text>
<table>
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<tr>
<th>Review of System Element</th>
<th>Description</th>
<th>Effective Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td ID = "_9" >Review of systems, HEENT</td>
<td>HEARING DIFFICULTIES</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_10" >Review of systems, general</td>
<td>WEIGHT GAIN</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_11" >Review of systems, Obstetrical/Pregnancy</td>
<td>Abdominal pain</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_12" >Review of systems, gastrointestinal</td>
<td>NEGATIVE</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_13" >Review of systems, genitourinary</td>
<td>MENSTRUATING</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_14" >Review of systems, musculoskeletal</td>
<td>Joint pain</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_15" >Review of systems, cardiopulmonary</td>
<td>Cough</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_16" >Review of systems, developmental</td>
<td>MEMORY PROBLEMS</td>
<td>07-14-2014</td>
</tr>
<tr>
```

<td ID = "_17" >Review of systems, central nervous system</td>
<td>FOCAL WEAKNESS</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_21" >Age of menarche</td>
<td>1</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_22" >CURRENTLY USING BIRTH CONTROL</td>
<td>true</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_20" >Duration of menstrual period</td>
<td>2</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_19" >Total Mensus Monthly</td>
<td>2 to 4 times a month</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_18" >LAST MENSTRUAL PERIOD</td>
<td>2014-07-01 00:00:00</td>
<td>07-14-2014</td>
</tr>
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OF FAMILY MEMBER DISEASES "/>
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Content Modules</title>
          <text>
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<th>Family History Element</th>
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</thead>
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<td ID = "_86" >History of Cystic Fibrosis</td>
<td>UNKNOWN</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_83" >Maternal Metabolic Disorder</td>
<td>NO</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_94" >Family History of Thalassemia</td>
<td>YES</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_93" >Family History of Canavan Disease</td>
<td>NO</td>

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<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_99" >Pregnancy Complication, Habitual Aborter</td>
<td>NO</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_80" >Autism</td>
<td>UNKNOWN</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_98" >Family History of Tay-Sachs</td>
<td>UNKNOWN</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_89" >Hemophilia</td>
<td>YES</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_85" >History of Huntington's Chorea</td>
<td>NO</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_97" >Family History of Down's Syndrome</td>
<td>NO</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_84" >History of Mental Retardation</td>
<td>NO</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_82" >Chrosomosal Disorder</td>
<td>NO</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_81" >Dysmorphism (Birth Defect)</td>
<td>NO</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_90" >Family History of Sick Cell Trait</td>
<td>YES</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_95" >Family History of Neural Tube Defect</td>
<td>NO</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_88" >Blood Disorders</td>
<td>NO</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_87" >History of Muscular Dystrophy</td>
<td>YES</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_96" >Family History of Congenital Heart Defect</td>
<td>UNKNOWN</td>
<td>07-14-2014</td>
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</tr>
<tr>
<td ID = "_92" >Family History of Familial Dysautonomia</td>
<td>NO</td>
<td>07-14-2014</td>
</tr>
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<td ID = "_91" >Family History of Sick Cell Disease</td>
<td>YES</td>
<td>07-14-2014</td>
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displayName="History of Cystic Fibrosis"/>
                  <text><reference value="#_86"/></text>
                  <statusCode code="completed"/>
                  <effectiveTime value="20140808090035"/>
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                  <targetSiteCode xsi:type="CE" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"/>
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              </component>
            </organizer>
          </entry>
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              <subject typeCode="SBJ">
                <relatedSubject classCode="PRS">
                  <code code="10157-6" codeSystem="2.16.840.1.113883.5.111" codeSystemName="RoleCode"/>
                  <addr><country> </country></addr>
                  <telecom nullFlavor="UNK"/>
                  <subject>
                    <name/>
                    <administrativeGenderCode code="A"/>
                    <birthTime nullFlavor="UNK"/>
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                </relatedSubject>
              </subject>
              <component>
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                <methodCode codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"/>
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            </component>
          </organizer>
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<td>07-15-2014</td>
</tr>
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<td>1</td>
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```
<td>07-17-2014</td>
</tr>
<tr>
<td ID = "_3410162-6" >Gravida</td>
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<td>07-14-2014</td>
</tr>
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<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_4010162-6" >number of full term pregnancies</td>
<td>1</td>
<td>07-16-2014</td>
</tr>
<tr>
<td ID = "_3210162-6" >TOTAL NUMBER OF LIVING CHILDREN</td>
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</tr>
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<td ID = "_3010162-6" >Number of preterm births</td>
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</tr>
<tr>
<td ID = "_3310162-6" >Number of abortions/miscarriages</td>
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<td>07-14-2014</td>
</tr>
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</tr>
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displayName="PREGNANCY STATUS"/>
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displayName="Total Births"/>
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displayName="Pregnancy Finding"/>
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displayName="gestational age at birth (weeks)"/>
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displayName="ESTIMATED DATE OF CONFINEMENT"/>
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displayName="HISTORY OF INFECTION"/>
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patient may have contracted prior to the patient's current condition</title>
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<tr>
<th>History Of Infection Element</th>
<th>Description</th>
<th>Effective Dates</th>
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<tr>
<td ID = "_52" >History of Genital Herpes</td>
<td>NO</td>
<td>07-22-2014</td>
</tr>
<tr>
<td ID = "_73" >viral illness since LMP</td>
<td>UNKNOWN</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_50" >PATIENT LIVES WITH CONFIRMED TB CASE</td>
<td>UNKNOWN</td>
<td>07-21-2014</td>
</tr>
<tr>
<td ID = "_72" >Rash since LMP</td>
<td>NO</td>
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<td>07-14-2014</td>
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<td ID = "_53" >Exposed to Genital Herpes</td>
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<tr>
<td ID = "_76" >History of Hepatitis C</td>
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<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_54" >HIV INFECTED</td>
<td>NEGATIVE</td>
<td>07-22-2014</td>
</tr>
<tr>
<td ID = "_71" >History of STD</td>
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<td>08-07-2014</td>
</tr>
<tr>
<td ID = "_78" >History of Syphilis</td>
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<tr>
<td ID = "_77" >history of Hepatitis B infection</td>
<td>YES</td>
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<tr>
<td ID = "_74" >History of Gonorrhea</td>
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</tr>
<tr>
<td ID = "_75" >History of Chlamydia</td>
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displayName="PATIENT LIVES WITH CONFIRMED TB CASE"/>
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Rash since LMP"/>
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displayName="Exposed to Genital Herpes"/>
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displayName="History of Hepatitis C"/>
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displayName="history of Hepatitis B infection"/>
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            <observation classCode="OBS" moodCode="EVN">
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              <templateId root="1.3.6.1.4.1.19376.1.5.3.1.1.16.5.6"/>
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displayName="History of Chlamydia"/>
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              <statusCode code="completed"/>
              <effectiveTime value="20140808090037"/>
              <value xsi:type="ED">NO</value>
              <interpretationCode code="N" codeSystem="2.16.840.1.113883.5.83"/>
              <methodCode codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"/>
              <targetSiteCode xsi:type="CE" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"/>
            </observation>
          </entry>
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              <id root="6ac85fe7-3f74-4bcb-8ae5-2a046bbde01d"/>
              <code code="302812006" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
displayName="History of human papilloma virus"/>
              <text><reference value="#_79"/></text>
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              <value xsi:type="ED">UNKNOWN</value>
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              <targetSiteCode xsi:type="CE" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"/>
            </observation>
          </entry>
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      </component>
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          <code code="11348-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="HISTORY
OF PAST ILLNESS"/>
          <title>The History of Past Illness section shall contain a narrative description of the conditions
the patient suffered in the past. It shall include entries for problems as described in the Entry Content
Modules</title>
          <text>Text as described above</text>
          <entry>
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                <text>dehydration fever</text>
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CT" displayName="DIAGNOSIS LIST"/>
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                </effectiveTime>
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CT" displayName="SIGN/SYMPTOM NAME"/>
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                <statusCode code="completed"/>
                <effectiveTime>
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                </effectiveTime>
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CT" displayName="SIGN/SYMPTOM START DATE"/>
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            </entryRelationship>
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CT" displayName="SIGN/SYMPTOM DURATION"/>
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                  <text>HOURS</text>
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CT" displayName="DURATION UNITS"/>
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                  <effectiveTime>
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CT" displayName="SIGN/SYMPTOMS ONSET (QUALITATIVE)"/>
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                  </effectiveTime>
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CT" displayName="NEW COMPLAINTS"/>
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                  <statusCode code="completed"/>
                  <effectiveTime>
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                    <high nullFlavor="UNK"/>
                  </effectiveTime>
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displayName="PAST MEDICAL HISTORY ADDED"/>
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              </entryRelationship>
              <entryRelationship typeCode="SUBJ" inversionInd="false">
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displayName="Diagnosis date"/>
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                  <code code="282291009" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"/>
                  <text>Patient suffered from following disease in past



1)Fever

2)Malaria

3)Memory loss</text>
                  <statusCode code="completed"/>
                  <effectiveTime>
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displayName="Past medical history added (text)"/>
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                  <text>PAST MEDICAL HISTORY</text>
                  <statusCode code="completed"/>
                  <effectiveTime>
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                    <high nullFlavor="UNK"/>
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CT" displayName="Findings"/>
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                  <effectiveTime>
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CT" displayName="Functional limitation"/>
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                  <text>Illness</text>
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                  <effectiveTime>
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                    <high nullFlavor="UNK"/>
                  </effectiveTime>
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CT" displayName="Condition"/>
                </observation>
              </entryRelationship>
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          </entry>
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EXAMINATION"/>
          <title>The physical exam section shall contain only the required and optional subsections performed.<
/title>
          <text>Text as described above</text>
          <component>
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              <code code="8716-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Coded
Vital Signs"/>
              <title>The vital signs section contains coded measurement results of a patient’s vital signs.<
/title>
              <text>
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<th>Vital Signs Element</th>
<th>Description</th>
<th>Effective Dates</th>
</tr>
</thead>
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<td ID = "_49" >HEAD CIRCUMFERENCE</td>
<td>21</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_45" >DIASTOLIC BLOOD PRESSURE</td>
<td>85</td>
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<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_48" >Weight (kg)</td>
<td>63</td>
<td>07-14-2014</td>
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<tr>
<td ID = "_43" >Pulse</td>
<td>15</td>
<td>07-14-2014</td>
</tr>
<tr>
<td ID = "_41" >Respiratory rate</td>
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<td>07-21-2014</td>
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<td ID = "_47" >Height (cm)</td>
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<td>07-14-2014</td>
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<td ID = "_46" >Temperature (C)</td>
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</tr>
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<td ID = "_42" >Blood oxygen saturation</td>
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<tr>
<td ID = "_44" >SYSTOLIC BLOOD PRESSURE</td>
<td>115</td>
<td>07-14-2014</td>
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displayName="Vital signs"/>
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                  <effectiveTime value="20140808090039"/>
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LOINC" displayName="HEAD CIRCUMFERENCE"/>
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                      <effectiveTime value="20140808090039"/>
                      <value xsi:type="PQ" value="21" unit="cm"/>
                      <interpretationCode code="N" codeSystem="2.16.840.1.113883.5.83"/>
                      <methodCode codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
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                    </observation>
                  </component>
                </organizer>
              </entry>
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                <organizer classCode="CLUSTER" moodCode="EVN">
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displayName="Vital signs"/>
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LOINC" displayName="DIASTOLIC BLOOD PRESSURE"/>
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                    <value xsi:type="PQ" value="85" unit="mmHg"/>
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                    <methodCode codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
                    <targetSiteCode xsi:type="CE" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
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LOINC" displayName="Respiratory rate"/>
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LOINC" displayName="Blood oxygen saturation"/>
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LOINC" displayName="SYSTOLIC BLOOD PRESSURE"/>
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General Appearance Section"/>
              <title>The general appearance section shall contain a description of the overall, visibly-
apparent condition of the patient</title>
              <text>Text as described above</text>
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              <code code="TBD" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Visible
Implanted Medical Devices Section"/>
              <title>The visible implanted medical devices section shall contain a description of the medical
devices apparent on physical exam that have been inserted into the patient, whether internal or partially
external.</title>
              <text>Text as described above</text>
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INTEGUMENTARY SYSTEM"/>
              <title>The integumentary system section shall contain a description of any type of integumentary
system exam.</title>
              <text>Text as described above</text>
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              <title>The head section shall contain a description of any type of head exam</title>
              <text>Text as described above</text>
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              <code code="10197-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="EYE"/>
              <title>The eyes section shall contain a description of any type of eye exam</title>
              <text>Text as described above</text>
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Nose, Mouth and Throat"/>
              <title>The ears, nose, mouth, and throat section shall contain a description of any type of ears,
nose, mouth, or throat exam</title>
              <text>Text as described above</text>
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              <title>The ears section shall contain a description of any type of ear exam</title>
              <text>Text as described above</text>
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/>
              <title>The nose section shall contain a description of any type of nose exam</title>
              <text>Text as described above</text>
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              <code code="10201-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="MOUTH
and THROAT and TEETH"/>
              <title>The mouth, throat, and teeth section shall contain a description of any type of mouth,
throat, or teeth exam</title>
              <text>Text as described above</text>
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/>
              <title>The neck section shall contain a description of any type of neck exam</title>
              <text>Text as described above</text>
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ENDOCRINE SYSTEM"/>
              <title>The endocrine system section shall contain a description of any type of endocrine system
exam</title>
              <text>Text as described above</text>
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THORAX+LUNGS"/>
              <title>The thorax and lungs section shall contain a description of any type of thoracic or lung
exams</title>
              <text>Text as described above</text>
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WALL"/>
              <title>The chest wall section shall contain a description of any type of chest wall exam.</title>
              <text>Text as described above</text>
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BREASTS"/>
              <title>The breast section shall contain a description of any type of breast exam.</title>
              <text>Text as described above</text>
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              <title>The heart section shall contain a description of any type of heart exam</title>
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RESPIRATORY SYSTEM"/>
              <title>The respiratory system section shall contain a description of any type of respiratory exam<
/title>
              <text>Text as described above</text>
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ABDOMEN"/>
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HEMATOLOGIC+LYMPHATIC+IMMUNOLOGIC SYSTEM"/>
              <title>The lymphatic system section shall contain a description of any type of lymphatic exam<
/title>
              <text>Text as described above</text>
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VESSELS"/>
              <title>The vessels section shall contain a description of any type of vessels exam</title>
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MUSCULOSKELETAL SYSTEM"/>
              <title>The musculoskeletal system section shall contain a description of any type of
musculoskeletal exam</title>
              <text>Text as described above</text>
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NEUROLOGIC SYSTEM"/>
              <title>The neurologic system section shall contain a description of any type of neurologic exam<
/title>
              <text>Text as described above</text>
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GENITALIA"/>
              <title>The genitalia section shall contain a description of any type of genital exam</title>
              <text>Text as described above</text>
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RECTUM"/>
              <title>The rectum section shall contain a description of any type of rectal exam</title>
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