i2i Common Record Definitions

Contents

Overview

This document contains a detailed description of proprietary flat file formats for the purpose of transferring data records to i2i Population Health. The file formats represent the structural requirements for each data type to be transferred to i2i. The intended data sources are Patient Management (PM) and/or Electronic Health Record (EHR) systems.

File Format Summary

The flat file structure of the data to be transferred has general requirements across all data types. The data must be exported into separate ASCII files for each data type described in this document. All data records contained in a single file must be of the same data type. Each data record is delimited by a CR/LF (carriage return and linefeed), including the last record. If there is no CR/LF at end of the last record, this record will fail to process successfully. Each data record is comprised of multiple data fields, each containing a specific data element. These data fields are delimited by pipe "|" characters.

Each file must have a unique filename including the data type name. Name uniqueness is necessary so as not to overwrite previous files with the same file name. The files must use a .upd extension.

The data is designated as either Core or Non-Core data. Core data is extracted and represented in most PM/EHR systems using standard data modules, such as demographics, charges, vitals, appointments, etc. In contrast, Non-Core data is data that can be represented in non-standard ways due to the differences between PM/EHR systems; for example, there are many ways to express Smoking Status, Exercise Counseling, Diet Counseling, etc. Some data types may be optional, depending on the customer's usage of the i2i Products. For example, Referral and Pharmacy data are generally considered to be optional and including this data is dependent on contract details.

Initial and Updated Data Export Files

The first thing i2iTracks must receive from a new PM/EHR system interface is a backload export of its most current data. These exported files must be placed into a pre-determined folder by the external software into a directory specified by i2i Population Health. Any subsequent updates to the data should be exported to the same pre-determined folder. The frequency of these updates varies based on the needs of the customer. It typically ranges from once every 10-15 minutes (for appointment and referral data) to once per day (for demographics and EHR data).

Data Type Definitions

PMS Records:

Record Type	Core and Non-Core Data Standard/Optional	Export File Name Must Include
Patient Related Data Files		
Patients	Core/Standard	PAT9
Patient Procedures	Core/Standard	PATPROC6
Patient Appointments	Core/Standard	PATAPPT7
Patient Payers	Core/Standard	PATPAYER3
Patient Merges	Non-Core/Optional	PATMERGE3
Library Files/Master Files		
Procedure Types	Core/Standard	PROC4
Diagnosis Types	Core/Standard	DIAG4
Races	Core/Standard	RACE3
Ethnicities	Core/Standard	ETHNICITY3
Languages	Core/Standard	LANG3
Appointment Types	Core/Standard	APPT3
Appointment Locations	Core/Standard	APPTLOC3
Appointment Resources	Core/Standard	APPTRES3
Appointment Status	Core/Standard	APPTSTAT3
Payers	Core/Standard	PAYER2
Providers	Core/Standard	PROV7
Facilities	Core/Standard	FAC3
Homeless Status	Core/Standard	HOMELESS3
Migrant Status	Core/Standard	MIGRANT3

EHR Records:

Record Type	Core and Non-Core Data Standard/Optional	Export File Name Must Include
Patient Related Data Files		
Patient Allergies	Core/Standard	PATALLERGY4
Patient Problems	Core/Standard	PATPROBLEM4
Patient Vitals	Core/Standard	PATVITAL5
Patient Immunizations	Core/Standard	PATIMMUN4
Patient Medications	Core/Standard	PATMED3
Patient Events	Non-Core/Optional	PATEVENT5
Library Files/Master Files		
Allergies	Core/Standard	ALLERGY3
Problems	Core/Standard	PROBLEM5
Event Types	Non-Core/Optional	EVENTTYPE4
Event Values	Non-Core/Optional	EVENTVALUE3

Lab records:

Record Type	Core and Non-Core Data Standard/Optional	Export File Name Must Include
Patient Related Data Files		
Patient Lab Results	Core/Standard	PATLAB6

Referral records:

Record Type	Core and Non-Core Data Standard/Optional	Export File Name Must Include
Patient Related Data Files		
Patient Referrals	Core/Optional	PATREF3
Library Files/Master Files		
Referral Sources	Core/Optional	REFSOURCE2
Referral Specialties	Core/Optional	REFSPEC2
Referral Types	Core/Optional	REFTYPE2
Referral Insurances	Core/Optional	REFINS2

Pharmacy records:

Record Type	Core and Non-Core Data Standard/Optional	Export File Name Must Include
Patient Related Data Files		
Patient Prescriptions	Core/Optional	PATRX3

Patient Management Records

Patient Record

A record of this type is required for each patient that exists in the PM/EHR system.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PAT9)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D): U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify/Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	50	The value that uniquely identifies this patient.
4	LookupID	Char	50	The unique identifier that a user would enter for patient lookup in i2iTracks. In many cases, this value is the same as the ID value.
5	FirstName	Char	255	The patient's first name
6	MiddleName	Char	255	The patient's middle name
7	LastName	Char	255	The patient's last name
8	DOB	Date	30	The patient's date of birth (YYYY-MM-DD)
9	MedRecNum	Char	50	The patient's medical record number
10	SSN	Char	50	The patient's social security number (XXX-XX-XXXX)
11	Gender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
12	RaceID	Char	100	The ID of the patient's race (from the Race Record)
13	EthnicityID	Char	100	The ID of the patient's ethnicity (from the Ethnicity Record)
14	LanguageID	Char	100	The ID of the patient's language (from the Language Record)
15	ProviderID	Char	100	The ID of the patient's primary provider (from the Provider Record)
16	ProviderID2	Char	100	The ID of the patient's secondary provider (from the Provider Record) (Optional)
17	LocationID	Char	100	The ID of the patient's primary facility (from the Facility Record)
18	FinClassID	Char	100	The ID of the patient's default payer or financial classification (from the Payer Record)
19	CanBeContacted	Char	1	Y = Patient can be contacted N = Patient cannot be contacted
20	Address1	Char	255	The first line of the patient's address
21	Address2	Char	255	The second line of the patient's address
22	City	Char	255	The city in which the patient resides
23	State	Char	50	The state in which the patient resides (Use uppercase with a 2 character abbreviation)
24	ZipCode	Char	50	The zip code in which the patient resides
25	HPhone	Char	50	The patient's home phone number
26	WPhone	Char	50	The patient's work phone number
27	CPhone	Char	50	The patient's cell phone number
28	IsRespParty	Char	1	Whether or not the patient is the responsible party: Y = Yes, N = No.
29	RespFirstName	Char	255	The responsible party's first name (Optional)

30	RespMiddleName	Char	255	The responsible party's middle name (Optional)
31	RespLastName	Char	255	The responsible party's last name (Optional)
32	RespAddress1	Char	255	The first line of the responsible party's address(Optional)
33	RespAddress2	Char	255	The second line of the responsible party's address (Optional)
34	RespCity	Char	255	The city in which the responsible party resides(Optional)
35	RespState	Char	50	The state in which the responsible party resides (Use uppercase with 2 character abbreviation) (Optional)
36	RespZipCode	Char	50	The zip code in which the responsible party resides
37	RespHPhone	Char	50	The responsible party's home phone number (Optional)
38	RespWPhone	Char	50	The responsible party's work phone number (Optional)
39	IsActive	Char	1	Whether or not the patient is active: Y = Yes, N = No (Optional)
40	IsDeceased	Char	1	Whether or not the patient is deceased: Y = Yes, N = No (Optional)
41	DeceasedDate	Date	30	Deceased as of date (YYYY-MM-DD) (Optional)
42	HomelessStatusID	Char	100	The ID of the patient's homeless status (from the Homeless Status Record) (Optional)
43	MigrantStatusID	Char	100	The ID of the patient's migrant status (from the Migrant Status Record) (Optional)
44	Email Address	Char	255	The Email address for patient (Optional)
45	CommPref	Char	2	The Communication Preference for patient 1 = Email 2 = Home Phone 3 = Work Phone 4 = Main Address 5 = Cell Phone (Optional)

Example Record:

PAT9|U|13.0|13.0|WILLIAM|E|TURNER|1969-11-16|13.0|201-40-3215|M|FP|14|17|23|32|5|1|Y| 5213 El Mercado Pkwy|Suite C|Santa Rosa|CA|95403|(707)654-9388|(707)568-1212| (707)555-1234||||||||||Y|N||SH|M|WilliamT6@yahoo.com|1

Patient Procedure Record

A record of this type is required for each procedure that occurred for a patient during a visit.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATPROC6)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	PatientID	Char	50	The ID of the patient (from the Patient Record)
5	PatientFirstName	Char	255	The patient's first name
6	PatientMiddleName	Char	255	The patient's middle name
7	PatientLastName	Char	255	The patient's last name
8	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD)
9	PatientMedRecNum	Char	50	The patient's medical record number
10	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX)
11	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
12	PatientAddress1	Char	255	The first line of the patient's address
13	PatientAddress2	Char	255	The second line of the patient's address
14	PatientCity	Char	255	The city in which the patient resides
15	PatientState	Char	50	The state in which the patient resides (Use uppercase with a 2 character abbreviation)
16	PatientZIP	Char	50	The zip code in which the patient resides
17	PatientHomePhone	Char	50	The patient's home phone number
18	PatientWorkPhone	Char	50	The patient's work phone number
19	FacilityID	Char	100	The ID of the facility at which the visit occurred (from the Facility Record)
20	ProviderID	Char	100	The ID of the provider for the visit (from the Provider Record)
21	VisitDate	Date	30	The date on which the visit occurred (YYYY-MM-DD)
22	PostDate	Date	30	The date on which the visit was entered in the external software (YYYY-MM-DD)
23	ProcedureID	Char	100	The ID of the procedure type (from the Procedure Type Record)
24	DiagnosisID1	Char	100	The type ID of the primary diagnosis that applies to the procedure (from the Diagnosis Type Record)
25	DiagnosisID2	Char	100	The type ID of the secondary diagnosis that applies to the procedure (from the Diagnosis Type Record)
26	DiagnosisID3	Char	100	The type ID of the tertiary diagnosis that applies to the procedure (from the Diagnosis Type Record)
27	DiagnosisID4	Char	100	The type ID of the 4th diagnosis that applies to the procedure (from the Diagnosis Type Record)
28	DiagnosisID5	Char	100	The type ID of the 5th diagnosis that applies to the procedure (from the Diagnosis Type Record)
29	DiagnosisID6	Char	100	The type ID of the 6th diagnosis that applies to the procedure (from the Diagnosis Type Record)

30	DiagnosisID7	Char	100	The type ID of the 7th diagnosis that applies to the procedure (from the Diagnosis Type Record)
31	DiagnosisID8	Char	100	The type ID of the 8th diagnosis that applies to the procedure (from the Diagnosis Type Record)
32	DiagnosisID9	Char	100	The type ID of the 9th diagnosis that applies to the procedure (from the Diagnosis Type Record)
33	DiagnosisID10	Char	100	The type ID of the 10th diagnosis that applies to the procedure (from the Diagnosis Type Record)
34	DiagnosisID11	Char	100	The type ID of the 11th diagnosis that applies to the procedure (from the Diagnosis Type Record)
35	DiagnosisID12	Char	100	The type ID of the 12th diagnosis that applies to the procedure (from the Diagnosis Type Record)
36	PayerID	Char	100	The ID of the payer or financial classification for this procedure (from the Payer Record)
37	ToothCode	Char	50	The tooth code for the procedure (for Dental interface records)
38	SurfaceCode	Char	50	The surface code for the procedure (for Dental interface records)
39	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

PATPROC6|U|17-361|13.0|WILLIAM|E|TURNER|1969-11-16|13.0|201-40-3215| M|
5213 El Mercado Pkwy|Suite C|Santa Rosa|CA|95403|(707)654-9388| (707)568-1212|157| 34|2003-11-26|2003-11-26|S0500|367.1|||||||||||| 56|||

Patient Appointment Record

A record of this type is required for each appointment that has been scheduled for a patient.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATAPPT7)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record.
4	PatientID	Char	50	The ID of the patient (from the Patient Record).
5	PatientFirstName	Char	255	The patient's first name
6	PatientMiddleName	Char	255	The patient's middle name
7	PatientLastName	Char	255	The patient's last name
8	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD)
9	PatientMedRecNum	Char	50	The patient's medical record number
10	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX)
11	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
12	PatientAddress1	Char	255	The first line of the patient's address
13	PatientAddress2	Char	255	The second line of the patient's address
14	PatientCity	Char	255	The city in which the patient resides
15	PatientState	Char	50	The state in which the patient resides (Use uppercase with a 2 character abbreviation)

16	PatientZIP	Char	50	The zip code in which the patient resides
17	PatientHomePhone	Char	50	The patient's home phone number
18	PatientWorkPhone	Char	50	The patient's work phone number
19	TypeID	Char	100	The ID of the appointment type (from the Appointment Type Record)
20	LocationID	Char	100	The ID of the location for which the appointment was scheduled (from the Appointment Location Record)
21	ProviderID	Char	100	The ID of the provider for the appointment (from the Provider Record)
22	ResourceID	Char	100	The ID of the resource for the appointment (from the Appointment Resource Record)
23	ScheduledDate	Date	30	The date for which the appointment was scheduled (YYYY-MM-DD)
24	ScheduledTime	Time	30	The time for which the appointment was scheduled (HH:MM:SS)
25	ActualDuration	Char	5	Actual duration in minutes.
26	Reason	Char	255	A note that describes reason for the appointment.
27	Status	Char	255	Any value will be accepted, then all values in this field should be mapped in Tracks to reflect one of the following Tracks statuses: Completed, Rescheduled, Cancelled, No Show
28	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

PATAPPT7|U|82397|13.0|WILLIAM|E|TURNER|1969-11-16|13.0|201-40-3215| M|
5213 El Mercado Pkwy|Suite C|Santa Rosa|CA|95403|(707)654-9388| (707)568-1212|16| 21|123||2004-09-09|11:00:00|30|FOLLOW UP|Patient Cancelled|

Patient Payer Record

A record of this type is required for each patient/payer combination.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATPAYER3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	SourceID	Char	50	The value that identifies the source of the record. (Please contact i2i Population Health to obtain this value)
4	ID	Char	100	The value that uniquely identifies this record.
5	PatientID	Char	50	The ID of the patient (from the Patient Record).
6	PatientFirstName	Char	255	The patient's first name
7	PatientMiddleName	Char	255	The patient's middle name
8	PatientLastName	Char	255	The patient's last name
9	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD)

10	PatientMedRecNum	Char	50	The patient's medical record number
11	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX)
12	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
13	PatientAddress1	Char	255	The first line of the patient's address
14	PatientAddress2	Char	255	The second line of the patient's address
15	PatientCity	Char	255	The city in which the patient resides
16	PatientState	Char	50	The state in which the patient resides (Use uppercase with 2 character abbreviation)
17	PatientZIP	Char	50	The zip code in which the patient resides
18	PatientHomePhone	Char	50	The patient's home phone number
19	PatientWorkPhone	Char	50	The patient's work phone number
20	PatientEmail	Char	100	The patient's email address
21	RespPartyID	Char	50	The ID of the responsible party
22	RespPartyFirstName	Char	255	The responsible party's first name
23	RespPartyMiddleName	Char	255	The responsible party's middle name
24	RespPartyLastName	Char	255	The responsible party's last name
25	RespPartyDOB	Date	30	The responsible party's date of birth (YYYY-MM-DD)
26	Relationship	Char	255	The responsible party's relationship to the patient
27	PayerID	Char	100	The ID of the payer
28	PayerName	Char	255	The name of the payer
29	PayerSequence	Char	10	The billing sequence within the patient's payer group
30	IsActive	Char	1	Whether or not the patient payer is active: Y = Yes, N = No
31	SubscriberID	Char	50	The policy's subscriber ID
32	GroupID	Char	50	The policy's group ID
33	EffectiveDate	Date	30	The policy's effective date (YYYY-MM-DD)
34	TerminationDate	Date	30	The policy's termination date (YYYY-MM-DD)
35	EligibilityVerifiedDate	Date	30	The policy's eligibility verification date (YYYY-MM-DD)
36	EligibilityUserFirstName	Char	255	The first name of the eligibility user
37	EligibilityUserMiddleName	Char	255	The middle name of the eligibility user
38	EligibilityUserLastName	Char	255	The last name of the eligibility user

Example Record:

PATPAYER3|U|PM_SYSTEM|1645_13.0|13.0|WILLIAM|E|TURNER|1969-11-16| 13.0| 201-40-3215|M|5213 El Mercado Pkwy|Suite C|Santa Rosa|CA|95403| (707)654-9388| (707)568-1212|WilliamT6@yahoo.com|23568|Joan|T|Turner| 1967-02-05|Spouse|45EG689| AETNA|1|1|4512|1156|2015-01-01||2015-01-01| Sam|F|Bollinger

Patient Merge Record

A record of this type is required when one Patient record is to be merged into another Patient record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATMERGE3).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The ID of the Patient Merge record.
4	FromPatientID	Char	50	The ID of the source patient record which is to be merged into the destination patient record
5	ToPatientID	Char	50	The ID of the destination patient record into which the source patient record is to be merged
6	MergedDate	Date	30	The date that the source patient record was merged into the destination patient record in source the PM/EHR System (YYYY-MM-DD)

Example Record:

PATMERGE3|U|345|106.5|203.4|2016-05-01

Procedure Type Record

A record of this type is required for each procedure type that can be referenced in the Patient Procedure table.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PROC4)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the procedure type
5	Description	Char	255	The description of the procedure type
6	OfficeCode	Char	50	The office code of the procedure type
7	Code	Char	50	The code of the procedure type
8	CodeType	Char	5	The code type ID of the procedure code: UNKNOWN = 0 CPT = 7 SNOMED = 8 MEDCIN = 12
9	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

PROC4|U|1238|New Patient Visit||99201|99201|7|

Diagnosis Type Record

A record of this type is required for each diagnosis type that can be referenced in the Patient Diagnosis table.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always DIAG4)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the diagnosis type
5	Description	Char	255	The description of the diagnosis type
6	OfficeCode	Char	50	The office code of the diagnosis type
7	Code	Char	50	The code of the diagnosis type
8	CodeType	Char	5	The code type ID of the diagnosis type: UNKNOWN = 0 SNOMED = 8 ICD9 = 9 ICD10 = 10 ICD10PCS = 11 MEDCIN = 12
9	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

DIAG4|U|2458|Lipoprotein deficiency||E78.6|E78.6|10|

Race Record

A record of this type is required for each race that can be referenced in the Patient Record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always RACE3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the race
5	Description	Char	255	The description of the race
6	Code	Char	50	The code of the race
7	CodeType	Char	5	The code type of the race: CDCRaceEthnicity = 2 LOINC = 3

Example Record:

RACE3|U|32|JAPANESE|JAPANESE||

Ethnicity Record

A record of this type is required for each ethnicity that can be referenced in the Patient Record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always ETHNICITY3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the ethnicity
5	Description	Char	255	The description of the ethnicity
6	Code	Char	50	The code of the ethnicity
7	CodeType	Char	5	The code type of the ethnicity: CDCRaceEthnicity = 2 LOINC = 3

Example Record:

ETHNICITY3|U|14|HISPANIC|HISPANIC||

Language Record

A record of this type is required for each language that can be referenced in the Patient Record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always LANG3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the language
5	Description	Char	255	The description of the language

Example Record:

LANG3|U|53|Spanish|Spanish

Appointment Type Record

A record of this type is required for each appointment type that can be referenced in the Patient Appointment Record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always APPT3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the appointment type
5	Description	Char	255	The description of the appointment type
6	Abbreviation	Char	255	The abbreviation for the appointment type
7	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

APPT3|U|46|WELL CHILD CHECKUP||WCC|

Appointment Location Record

A record of this type is required for each location that can be referenced in the Patient Appointment Record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always APPTLOC3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the appointment location
5	Description	Char	255	The description of the appointment location
6	FacilityID	Char	100	The ID of the facility that contains the appointment location (from the Facility Record)
7	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

APPTLOC3|U|12|BEHAVIORAL HEALTH||15|Behavioral Services

Appointment Resource Record

A record of this type is required for each resource that can be referenced in the Patient Appointment Record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always APPTRES3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the appointment resource
5	Description	Char	255	The description of the appointment resource
6	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

APPTRES3|U|45|X-Ray Lab||Ancillary Services

Appointment Status Record

A record of this type is required for each appointment status that can be referenced in the Patient Appointment Record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always APPTSTAT3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the appointment status
5	Description	Char	255	The description of the appointment status
6	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

APPTSTAT3|U|7|Patient Cancelled||

Payer Record

A record of this type is required for each payer that can be referenced in the Patient Record (FinClassID), Patient Procedure Record (PayerID), and the Patient Payer Record (PayerID).

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PAYER2)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the payer
5	Description	Char	255	The description of the payer

Example Record:

PAYER2|U|82397|AETNA|

Provider Record

A record of this type is required for each provider that can be referenced in the Patient Record, the Patient Visit Record, and the Patient Appointment Record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PROV7)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the provider
5	Description	Char	255	The description of the provider
6	FacilityID	Char	100	The ID of the provider's primary facility
7	Prefix	Char	255	The prefix of the provider
8	FirstName	Char	255	The first name of the provider
9	MiddleName	Char	255	The middle name of the provider
10	LastName	Char	255	The last name of the provider
11	Suffix	Char	255	The suffix of the provider
12	Phone1	Char	50	The main phone number of the provider
13	Email	Char	255	The email of the provider
14	ProviderType	Char	255	The type of the provider
15	NPI	Char	50	The NPI of the provider
16	TaxID	Char	50	The Tax ID of the provider
17	SpecialtyCode	Char	50	The Specialty Code of the provider
18	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

PROV7|U|29|DON JOHNSON, MD||12|DR|DON|ROBERT|JOHNSON|MD|999-999-9999|
djohnson@doctorjohnson.com|PEDIATRICS|5555555555|||

Facility Record

A record of this type is required for each facility that can be referenced in the Patient Record, the Patient Procedure Record, and the Appointment Location Record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always FAC3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the facility
5	Description	Char	255	The description of the facility
6	Contact	Char	255	The name of the contact person for the facility
7	Phone1	Char	50	The primary phone number for the facility
8	Phone2	Char	50	The secondary phone number for the facility
9	Fax	Char	50	The fax number for the facility
10	Email	Char	255	The email address for the facility
11	Address1	Char	255	The first line of the facility's address
12	Address2	Char	255	The second line of the facility's address
13	City	Char	255	The city in which the facility resides
14	State	Char	50	The state in which the facility resides (uppercase, 2 character abbreviation)
15	ZIP	Char	50	The zip code in which the facility resides
16	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

FAC3|U|15|i2i Health Center||DR. JOHN SMITH|(707) 575-7511||
(866) 820-4221||5213 El Mercado Pkwy # A||Santa Rosa|CA|95403|

Homeless Status Record

A record of this type is required for each homeless status that can be referenced in the Patient Record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always HOMELESS3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the homeless status
5	Description	Char	255	The description of the homeless status

Example Record:

HOMELESS3|U|5|SHELTER|SHELTER

Migrant Status Record

A record of this type is required for each migrant status that can be referenced in the Patient Record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always MIGRANT3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record
4	Name	Char	255	The name of the migrant status
5	Description	Char	255	The description of the migrant status

Example Record:

MIGRANT3|U|7|SEASONAL|SEASONAL

EMR Records

Patient Allergy Record

A record of this type is required for each of the patient's allergies.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATALLERGY4).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record.
4	PatientID	Char	50	The ID of the patient (from the Patient Record).
5	PatientFirstName	Char	255	The patient's first name
6	PatientMiddleName	Char	255	The patient's middle name
7	PatientLastName	Char	255	The patient's last name
8	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD)
9	PatientMedRecNum	Char	50	The patient's medical record number
10	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX)
11	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
12	PatientAddress1	Char	255	The first line of the patient's address
13	PatientAddress2	Char	255	The second line of the patient's address
14	PatientCity	Char	255	The city in which the patient resides
15	PatientState	Char	50	The state in which the patient resides (Use uppercase with 2 character abbreviation)
16	PatientZIP	Char	50	The zip code in which the patient resides
17	PatientHomePhone	Char	50	The patient's home phone number
18	PatientWorkPhone	Char	50	The patient's work phone number
19	AllergyID	Char	255	The ID of the allergy (from the Allergy Record).
20	AllergyName	Char	255	The name of the allergy.
21	AllergyType	Char	10	DA = Drug Allergy, FA = Food Allergy, OA = Other Allergy.
22	ReactionDesc	Char	255	Short, textual description of the specific allergy reaction (convulsions, sneeze, rash, etc.).
23	IdentifiedDate	Date	30	The date on which the allergy was identified (YYYY-MM-DD).
24	IdentifiedTime	Time	30	The time at which the allergy was identified (HH:MM:SS).
25	Status	Char	10	A = Active, N = Not Active.
26	StatusDate	Date	30	The effective date of the status (YYYY-MM-DD).
27	StatusTime	Time	30	The effective time of the status (HH:MM:SS).

Example Record:

PATALLERGY4|U|1234|13.0|WILLIAM|E|TURNER|1969-11-16|13.0|201-40-3215| M|
5213 El Mercado Pkwy|Suite C|Santa Rosa|CA|95403|(707)654-9388| (707)568-1212|55|Peanuts|
FA|Rash|2006-01-01|8:00:00|A|2009-01-01| 14:00:00

Patient Problem Record

A record of this type is required for each of the patient's problems.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATPROBLEM4).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record.
4	PatientID	Char	50	The ID of the patient (from the Patient Record).
5	PatientFirstName	Char	255	The patient's first name.
6	PatientMiddleName	Char	255	The patient's middle name.
7	PatientLastName	Char	255	The patient's last name.
8	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD).
9	PatientMedRecNum	Char	50	The patient's medical record number.
10	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX).
11	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
12	PatientAddress1	Char	255	The first line of the patient's address.
13	PatientAddress2	Char	255	The second line of the patient's address.
14	PatientCity	Char	255	The city in which the patient resides.
15	PatientState	Char	50	The state in which the patient resides (Use uppercase with 2 character abbreviation).
16	PatientZIP	Char	50	The zip code in which the patient resides.
17	PatientHomePhone	Char	50	The patient's home phone number.
18	PatientWorkPhone	Char	50	The patient's work phone number.
19	ProblemID	Char	100	The ID of the problem (from the Problem Record).
20	ProblemName	Char	255	The name of the problem.
21	ProblemICDCode	Char	50	The ICD code that represents the problem (if available).
22	IdentifiedDate	Date	30	The date on which the problem was identified (YYYY-MM-DD).
23	IdentifiedTime	Time	30	The time at which the problem was identified (HH:MM:SS).
24	OnsetDate	Date	30	The date on which the problem began (YYYY-MM-DD).
25	OnsetTime	Time	30	The time at which the problem began (HH:MM:SS).
26	StopDate	Date	30	The date on which the problem ended (YYYY-MM-DD).
27	StopTime	Time	30	The time at which the problem ended (HH:MM:SS).
28	StopReason	Char	20	The reason the problem ended.
29	Qualifier	Char	20	The name of the problem qualifier.
30	Status	Char	10	A = Active, N = Not Active, R = Resolved.
31	StatusDate	Date	30	The effective date of the status (YYYY-MM-DD).
32	StatusTime	Time	30	The effective time of the status (HH:MM:SS).
33	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

PATPROBLEM4|U|2345|13.0|WILLIAM|E|TURNER|1969-11-16|13.0|201-40-3215| M|5213 El Mercado Pkwy|Suite C|Santa Rosa|CA|95403|(707)654-9388| (707)568-1212|78|Essential (primary) hypertension|I10|2002-06-01| 8:00:00|1995-1-1|||||A|2009-02-01|9:00:00|

Patient Vital Record

A record of this type is required for each of the patient's vitals.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATVITAL5).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record.
4	PatientID	Char	50	The ID of the patient (from the Patient Record).
5	PatientFirstName	Char	255	The patient's first name.
6	PatientMiddleName	Char	255	The patient's middle name.
7	PatientLastName	Char	255	The patient's last name.
8	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD).
9	PatientMedRecNum	Char	50	The patient's medical record number.
10	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX).
11	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
12	PatientAddress1	Char	255	The first line of the patient's address.
13	PatientAddress2	Char	255	The second line of the patient's address.
14	PatientCity	Char	255	The city in which the patient resides.
15	PatientState	Char	50	The state in which the patient resides (Use uppercase with 2 character abbreviation).
16	PatientZIP	Char	50	The zip code in which the patient resides.
17	PatientHomePhone	Char	50	The patient's home phone number.
18	PatientWorkPhone	Char	50	The patient's work phone number.
19	TypeID	Char	50	The ID of the vital type. Must be one of the following: BPDIA = Diastolic BP (First BP Taken), BPSYS = Systolic BP (First BP Taken), BPDIA2 = Diastolic BP (Second BP Taken), BPSYS2 = Systolic BP (Second BP Taken), BPDIA3 = Diastolic BP (Third BP Taken), BPSYS3 = Systolic BP ((Third BP Taken), HEIGHT = Height (Inches), PAINSCORE = Pain Score, PULSE = Pulse, RESP = Respirations, TEMP = Temperature (F), WEIGHT = Weight (lbs), PHQ = PHQ Value, HEADCIRCUM = Head Circumference (cm), LMP = Last Menstrual Period Date (Use DateValue column).
20	NumValue	Decimal	20	The numeric value for the vital.

21	DateValue	Date	30	The date value for the vital. (YYYY-MM-DD).
22	ObservationDate	Date	30	The date on which the value was observed (YYYY-MM-DD).
23	ObservationTime	Time	30	The time at which the value was observed (HH:MM:SS).
24	GroupID	Char	50	Identifies the group of vitals that were taken at the specified date and time.

Example Record:

PATVITAL5|U|456|12345.1|Bob|J|Smith|1985-01-01|123456A|555-55-5555|
M|12345 Pine St.||Santa Rosa|CA|95403|(707) 555-5555||HEIGHT|67.5||
2009-02-05|14:30:00|3421

Patient Immunization Record

A record of this type is required for each event that occurs for a patient immunization.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATIMMUN4).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	SourceID	Char	50	The value that identifies the source of the record. (Please contact i2i Population Health to obtain this value)
4	SourceDetails	Char	255	Details about the source of this record. For example: If the record came from an HL7 file interface, then this field might contain the name of the HL7 file that contained the record.
5	ID	Char	100	The value that uniquely identifies the event (only needs to be unique with regard to the source).
6	PatientID	Char	50	The ID of the patient (from the patient management system).
7	PatientFirstName	Char	255	The patient's first name.
8	PatientMiddleName	Char	255	The patient's middle name.
9	PatientLastName	Char	255	The patient's last name.
10	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD).
11	PatientMedRecNum	Char	50	The patient's medical record number.
12	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX).
13	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
14	PatientAddress1	Char	255	The first line of the patient's address.
15	PatientAddress2	Char	255	The second line of the patient's address.
16	PatientCity	Char	255	The city in which the patient resides.
17	PatientState	Char	50	The state in which the patient resides (Use uppercase with 2 character abbreviation).
18	PatientZIP	Char	50	The zip code in which the patient resides.
19	PatientHomePhone	Char	50	The patient's home phone number.
20	PatientWorkPhone	Char	50	The patient's work phone number.
21	VaccineName	Char	255	The name of the vaccine that was given.
22	VaccineCVX	Char	20	The CVX code for the vaccine that was given.

23	VaccineCPT	Char	20	The CPT code for the vaccine that was given.
24	GivenDate	Date	30	The date the vaccine was given (YYYY-MM-DD).
25	GivenBy	Char	255	The provider who administered the vaccine.
26	LotNumber	Char	50	The lot number.
27	ManufName	Char	255	The name of the manufacturer.
28	ManufMVX	Char	20	The MVX code for the manufacturer.
29	ExpirationDate	Date	30	The expiration date for the vaccine (YYYY-MM-DD).
30	Route	Char	20	The route of administration: ID = Intradermal, IM = Intramuscular, IN = Intranasal, IV = Intravenous, PO = Oral, OTH = Other, SC = Subcutaneous, TD = Transdermal.
31	Site	Char	20	The administrative site: LT = Left Thigh, LA = Left Arm, LD = Left Deltoid, LG = Left Gluteous Medius, LVL = Left Vastus Lateralis, LLFA = Left Lower Forearm, RA = Right Arm, RT = Right Thigh, RVL = Right Vastus Lateralis, RG = Right Gluteous Medius, RD = Right Deltoid, RLFA = Right Lower Forearm.
32	VisID	Date	20	The date the Vaccine Information Statement was given to the patient. (YYYY-MM-DD).
33	Notes	Char	8000	Notes.
34	HistoricalVaccine	Char	1	Whether or not this record is a historical vaccine: Y = Yes, N = No.
35	Refused	Char	1	Whether or not this record has been refused by patient: Y = Yes, N = No.
36	RefusedDate	Date	30	The date of patient refusal.
37	Rejected	Char	1	Whether or not this record has been rejected : Y = Yes, N = No.
38	ReasonRejected	Char	8000	The reason why this record was rejected.

Example Record:

PATIMMUN4|U|NEIGHBORHOOD_CLINIC||123|12345.1|Bob|J|Smith|1985-01-01| 123456A|555-55-5555|M|12345 Pine St.||Santa Rosa|CA|95403|
(707) 555-5555||DTP-Hib|22|90720|2009-01-01|John Smith, MD|12345678| GlaxoSmithKline|SKB|2009-06-01|IM|LA||Notes||N||N|

Patient Medication Record

A record of this type is required for each event that occurs for a patient's medication.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATMED3).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	SourceID	Char	50	The value that identifies the source of the record. (Please contact i2i Population Health to obtain this value)
4	SourceDetails	Char	255	Details about the source of this record. (For example: If the record came from an HL7 file interface, then this field might contain the name of the HL7 file that contained the record.)
5	ID	Char	100	The value that uniquely identifies the event (only needs to be unique with regard to the source).
6	PatientID	Char	50	The ID of the patient (from the patient management system).
7	PatientFirstName	Char	255	The patient's first name.
8	PatientMiddleName	Char	255	The patient's middle name.
9	PatientLastName	Char	255	The patient's last name.
10	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD).
11	PatientMedRecNum	Char	50	The patient's medical record number.
12	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX).
13	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
14	PatientAddress1	Char	255	The first line of the patient's address.
15	PatientAddress2	Char	255	The second line of the patient's address.
16	PatientCity	Char	255	The city in which the patient resides.
17	PatientState	Char	50	The state in which the patient resides (Use uppercase with 2 character abbreviation).
18	PatientZIP	Char	50	The zip code in which the patient resides.
19	PatientHomePhone	Char	50	The patient's home phone number.
20	PatientWorkPhone	Char	50	The patient's work phone number.
21	PrescriptionID	Char	50	Prescription ID.
22	StartDate	Date	30	Start Date for Medication (YYYY-MM-DD).
23	StopDate	Date	30	Stop Date for Medication (YYYY-MM-DD).
24	PrescriberID	Char	100	The ID of the prescribing provider.
25	PrescriberName	Char	255	The name of the prescribing provider.
26	PrescriberDEANumber	Char	50	The DEA number of the prescribing provider.
27	DatePrescribed	Date	30	The date on which the drug was prescribed (YYYY-MM-DD).
28	DrugNDC	Char	50	Drug NDC number.
29	DrugNDCClean	Char	50	The 11 digit form of the Drug NDC number without the dashes.
30	DrugID	Char	100	Drug ID.
31	DrugName	Char	255	Drug name.
32	DrugDesc	Char	255	Drug description.
33	DrugAbbrev	Char	50	Drug abbreviation.

34	DrugGenericID	Char	100	Generic drug ID.
35	DrugGenericName	Char	255	Generic drug name.
36	DrugDosageForm	Char	50	Drug dosage form.
37	DrugStrength	Char	100	Drug strength.
38	DrugRoute	Char	100	Drug route of administration.
39	QuantityPrescribed	Decimal	9,2	Quantity prescribed.
40	SIG	Char	255	The SIG (i.e. 1T BID).
41	SIGDesc	Char	512	The full wording of the SIG (i.e. Take one tablet twice a day).
42	Notes	Char	8000	Notes.
43	Rejected	Char	1	Whether or not this record has been rejected: Y = Yes, N = No.
44	ReasonRejected	Char	8000	The reason why this record was rejected.

Example Record:

PATMED3|U|EHR_MEDS||123|12345.1|Bob|J|Smith|1985-01-01|123456A|
555-55-5555|M|12345 Pine St.||Santa Rosa|CA|95403|(707)555-5555|| 3434|2003-12-31|2005-01-02|123|Dr. Phil Smith|AA1234567|2003-12-31| 64764030114||456|ACTOS 30MG|ACTOS 30MG TABLET|ACTOS30|5678| PIOGLITAZONE HCL|Tablet|30 mg|Oral|30|1T QD|
Take one tablet every day|Notes|N|

Allergy Record

A record of this type is required for each allergy type that can be referenced in the Patient Allergy record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always ALLERGY3)
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	255	The value that uniquely identifies this record.
4	Name	Char	255	The name of the allergy.
5	Description	Char	255	The description of the allergy.
6	AllergyType	Char	10	DA = Drug Allergy, FA = Food Allergy, OA = Other Allergy.
7	Code	Char	50	The code of the allergy.
8	CodeType	Char	5	The code type of the allergy.

Example Record:

ALLERGY3|U|55|Peanut|Peanut Allergy|FA||

Problem Record

A record of this type is required for each problem type that can be referenced in the Patient Problem record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PROBLEM5).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record.
4	Name	Char	255	The name of the problem.
5	Description	Char	255	The description of the problem.
6	Code	Char	50	The code that represents the problem (single code only).
7	CodeType	Char	5	The code type ID of the problem code above: UNKNOWN = 0 SNOMED = 8 ICD9 = 9 ICD10 = 10 ICD10PCS = 11 MEDCIN = 12
8	SNOMEDCodes	Char	500	Comma-separated list when using multiple SNOMED codes.
9	ICD9Codes	Char	500	Comma-separated list when using multiple ICD9 codes.
10	ICD10Codes	Char	500	Comma-separated list when using multiple ICD10 codes.
11	ICD10PCSCodes	Char	500	Comma-separated list when using multiple ICD10PCS codes.
12	MEDCINCodes	Char	500	Comma-separated list when using multiple MEDCIN codes.
13	DataGroupID	Char	50	The ID for this record's data group (Optional) (Value to be determined by i2i Population Health)

Example Record:

PROBLEM5|U|78|Diabetes mellitus|Diabetes mellitus|||73211009,609568004 |||||

Event Records

Patient Event Record

The Patient Event Record is used to capture data that does not fall into standard EHR data types such as Medications, Vitals, Problem List, etc. This data type can be used to capture Meaningful Use data: Smoking Status and Cessation, Drug and Alcohol Dependency, etc. One record will be sent for each patient status event. A patient's event status could change over time. For example, a patient may have 1 record exported during a period of time when the patient is a smoker; then, if this patient quits smoking, a second record would be exported with a different ID, signifying the patient quit smoking at a later period of time.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATEVENT5).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record.
4	SourceID	Char	50	The value that identifies the source of the record. (Please contact i2i Population Health to obtain this value)
5	PatientID	Char	50	The ID of the patient (from the Patient Record).
6	PatientFirstName	Char	255	The patient's first name.
7	PatientMiddleName	Char	255	The patient's middle name.
8	PatientLastName	Char	255	The patient's last name.
9	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD).
10	PatientMedRecNum	Char	50	The patient's medical record number.
11	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX).
12	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
13	PatientAddress1	Char	255	The first line of the patient's address.
14	PatientAddress2	Char	255	The second line of the patient's address.
15	PatientCity	Char	255	The city in which the patient resides.
16	PatientState	Char	50	The state in which the patient resides (Use uppercase with 2 character abbreviation).
17	PatientZIP	Char	50	The zip code in which the patient resides.
18	PatientHomePhone	Char	50	The patient's home phone number.
19	PatientWorkPhone	Char	50	The patient's work phone number.
20	EventDate	Date	30	The date on which the event occurred (YYYY-MM-DD).
21	EventTypeID	Char	100	The type of the event (from the Event Type Record).
22	EventValue	Char	512	The value of the event.
23	LastSourceEditDate	Date	30	The last edit date for the source record (YYYY-MM-DD) (Only for use with Source/Destination Tracks systems)

Example Records:

PATEVENT5|U|2403345|EHR_SYSTEM|13.0|WILLIAM|E|TURNER|1969-11-16|13.0| 201-40-3215|M|5213 El Mercado Pkwy|Suite C|Santa Rosa|CA|95403| (707)654-9388|(707)568-1212|2012-06-01|0102|Received Exercise Counseling|

Event Type Record

A record of this type is required for each Event Type that can be referenced in a Patient Event record. The Event Type is used to create a supporting library for Patient Events in order to show a pick list of all possible Event Types. One record will be sent for each unique Event Type.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always EVENTTYPE4).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The value that uniquely identifies this record.
4	SourceID	Char	50	The value that identifies the source of the record. (Please contact i2i Population Health to obtain this value)
5	Name	Char	255	The name of the event type.
6	CategoryName	Char	255	The category name of the event type.
7	Description	Char	255	The description of the event type.
8	Code	Char	50	The code that represents the problem (single code only).
9	CodeType	Char	5	The code type ID of the problem code above: UNKNOWN = 0 SNOMED = 8 ICD9 = 9 ICD10 = 10 ICD10PCS = 11 MEDCIN = 12
10	EventCount	Int	10	The number of events for the source record (Only for use with Source/Destination Tracks systems)
11	FirstEventDate	Date	30	The first event date for the source record (YYYY-MM-DD) (Only for use with Source/Destination Tracks systems)
12	LastEventDate	Date	30	The last event date for the source record (YYYY-MM-DD) (Only for use with Source/Destination Tracks systems)
13	LastSourceEditDate	Date	30	The last edit date for the source record (YYYY-MM-DD) (Only for use with Source/Destination Tracks systems)

Example Records:

EVENTTYPE4|U|0102|EHR_SYSTEM|Smoking Cessation|Education|
Smoking Cessation Class||||||
EVENTTYPE4|U|0103|EHR_SYSTEM|Number of Cigarettes per day|Education |Cigarette Quantity||||||

Event Value Record

A record of this type is required for each Event Value that can be referenced in the Patient Event record. The Event Value is used to create a supporting library for Patient Events in order to show a pick list of all possible Event Values for each Event Type. One record will be sent for each unique Event Value.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always EVENTVALUE3).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	EventTypeID	Char	100	The type of the event (from the Event Type Record).
4	SourceID	Char	50	The value that identifies the source of the record. (Please contact i2i Population Health to obtain this value)
5	Value	Char	512	The event value.
6	EventCount	Int	10	The number of events for the source record (Only for use with Source/Destination Tracks systems)
7	LastEventDate	Date	30	The last event date for the source record (YYYY-MM-DD) (Only for use with Source/Destination Tracks systems)
8	LastSourceEditDate	Date	30	The last edit date for the source record (YYYY-MM-DD) (Only for use with Source/Destination Tracks systems)

Example Records:

EVENTVALUE3|U|0102|EHR_SYSTEM|Received Smoke Cessation|||
EVENTVALUE3|U|0103|EHR_SYSTEM|10|||

Lab Records

Patient Lab Result Record

A record of this type is required for each lab test result that is returned by the lab source for a patient.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATLAB6).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	SourceID	Char	50	The value that identifies the source of the record. (Please contact i2i Population Health to obtain this value)
4	SourceDetails	Char	255	Details about the source of this result. For example: If the result came from an HL7 file interface, then this field might contain the name of the HL7 file that contained the result.
5	ID	Char	100	The value that uniquely identifies the lab result (only needs to be unique with regard to the source).
6	PatientID	Char	50	The ID of the patient (from the patient management system).
7	PatientFirstName	Char	255	The patient's first name.
8	PatientMiddleName	Char	255	The patient's middle name.
9	PatientLastName	Char	255	The patient's last name.
10	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD).
11	PatientMedRecNum	Char	50	The patient's medical record number.
12	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX).
13	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
14	PatientAddress1	Char	255	The first line of the patient's address.
15	PatientAddress2	Char	255	The second line of the patient's address.
16	PatientCity	Char	255	The city in which the patient resides.
17	PatientState	Char	50	The state in which the patient resides (Use uppercase with 2 character abbreviation).
18	PatientZIP	Char	50	The zip code in which the patient resides.
19	PatientHomePhone	Char	50	The patient's home phone number.
20	PatientWorkPhone	Char	50	The patient's work phone number.
21	PlacerOrderNumber	Char	50	The value that uniquely identifies the lab request that initiated the performing of the test. Usually referred to as the "Requisition Number."
22	FillerOrderNumber	Char	50	The unique identifier that the laboratory assigned to the request.
23	OrderingProviderID	Char	100	The ID of the provider who ordered the test.
24	OrderingProviderName	Char	255	The name of the provider who ordered the test.
25	ProducerID	Char	50	The ID of the laboratory that produced the result.
26	ProducerName	Char	255	The name of the laboratory that produced the result.

27	ProducerStreet	Char	255	The street of the laboratory that produced the result.
28	ProducerCity	Char	50	The city of the laboratory that produced the result.
29	ProducerState	Char	50	The state of the laboratory that produced the result.
30	ProducerZipCode	Char	50	The zip code of the laboratory that produced the result.
31	ProducerMedicalDirector	Char	255	The medical director of the laboratory that produced the result.
32	ObserverID	Char	50	The ID of the individual who was responsible for the observation.
33	ObserverName	Char	255	The name of the individual who was responsible for the observation.
34	ProductID	Char	100	The ID of the ordered product (from the Lab Product Type Record) that initiated the performing of the test.
35	ProductCode	Char	50	The code of the ordered product that initiated the performing of the test.
36	ProductName	Char	255	The name of the ordered product that initiated the performing of the test.
37	TestID	Char	100	The ID of the test (from the Lab Test Type Record) to which this result applies.
38	TestCode	Char	50	The code of the test to which this result applies. (Usually referred to as the “Test Code”).
39	TestName	Char	255	The name of the test to which this result applies.
40	LOINCCode	Char	50	The LOINC code for the test.
41	LOINCName	Char	255	The LOINC name for the test.
42	CollectionDate	Date	30	The date on which the lab specimen was collected (YYYY-MM-DD).
43	CollectionTime	Time	30	The time at which the lab specimen was collected (HH:MM:SS).
44	OrderReportDate	Date	30	The report date for the lab order that included this result (YYYY-MM-DD). (Usually the same as ReportDate.)
45	OrderReportTime	Time	30	The report time for the lab order that included this result (HH:MM:SS). (Usually the same as ReportTime).
46	OrderStatus	Char	1	The status of the lab order that included this result: F = Final, P = Preliminary, C = Correction, X = Canceled, N = Not Needed. (Usually the same as Status).
47	ReportDate	Date	30	The date on which the lab result was reported (YYYY-MM-DD).
48	ReportTime	Time	30	The time at which the lab result was reported (HH:MM:SS).
49	Status	Char	1	The status of the lab result: F = Final, P = Preliminary, C = Correction, X = Canceled, N = Not Needed.
50	Fasting	Char	1	Whether or not the patient fasted :

				Y = Yes, N = No, U = Unknown.
51	Value	Char	2000	The value.
52	ValueType	Char	1	The value type : N = Number, T = Text, L = List.
53	Units	Char	50	The value units (i.e. mg/dL).
54	IsNormal	Char	1	Whether or not the value is normal : Y = Yes, N = No, U = Unknown.
55	AbnormalReason	Char	10	The reason why the value is abnormal: H = High, L = Low, HH = Very High, LL = Very Low, U = Unknown. (Leave blank if value is normal).
56	AbnormalAlert	Char	1	Whether or not the abnormal value is an “alert value”: Y = Yes, N = No, U = Unknown. (Leave blank if value is normal).
57	Reference Range	Char	255	The text that describes the reference range for the lab result.
58	SpecimenSourceID	Char	50	Specimen source ID.
59	SpecimenSourceName	Char	50	Specimen source name/description.
60	SpecimenSourceCodingSys	Char	50	Coding system (if any) for the specimen source ID.
61	SpecimenSourceNotes	Char	8000	Notes associated with the specimen source.
62	SpecimenReceivedDate	Date	30	The date on which the specimen was received by the lab.
63	SpecimenReceivedTime	Time	30	The time at which the specimen was received by the lab.
64	Notes	Char	8000	Notes associated with the lab result.
65	Notes2	Char	8000	The second part of the notes (if the notes exceed 8000 characters).
66	Order Notes	Char	8000	Notes associated with the lab order that initiated the performing of the test.
67	Rejected	Char	1	Whether or not this result has been rejected: Y = Yes, N = No.
68	ReasonRejected	Char	8000	The reason why this result was rejected.

Example Record:

PATLAB6|U|SuperLabs|File_1234.HL7|ID_Xy_1234|1234.1|Jane|Middle|Smith|1975-01-01|1234.1|555-55-5555|F|555 A. Street||Santa Rosa|CA|95403| (707) 555-5555 ||Placer_O1234|Filler_SA1234|OrdProv_1234|SMITH, ROBERT|99D999|My Diagnostics|123 Main St|Sunny|CA|90277|Dr. Bob Jones| 123456|Dr. Phil Jones|42545|42545|THYROXINE, FREE, DIRECT|42545|42545| THYROXINE, FREE, DIRECT|3024-7|T4 Free SerPl-mCnc|2006-09-14|10:30:00| 2006-09-15|06:03:00|F|2006-09-15|03:20:00|F|N|1.34|N|ng/dL|Y|||0.8-1.8 |||||||Lab Notes||Order Notes|N|

Referral Records

Patient Referral Record

A record of this type is required for each event that occurs for a patient's referral.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATREF3).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The ID of the patient referral record.
4	PatientID	Char	50	The ID of the patient (from the patient management system).
5	PatientFirstName	Char	255	The patient's first name.
6	PatientMiddleName	Char	255	The patient's middle name.
7	PatientLastName	Char	255	The patient's last name.
8	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD).
9	PatientMedRecNum	Char	50	The patient's medical record number.
10	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX).
11	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
12	PatientAddress1	Char	255	The first line of the patient's address.
13	PatientAddress2	Char	255	The second line of the patient's address.
14	PatientCity	Char	255	The city in which the patient resides.
15	PatientState	Char	50	The state in which the patient resides (Use uppercase with 2 character abbreviation).
16	PatientZIP	Char	50	The zip code in which the patient resides.
17	PatientHomePhone	Char	50	The patient's home phone number.
18	PatientWorkPhone	Char	50	The patient's work phone number.
19	ReferredDate	Date	30	The date of the patient referral.
20	ReferredByProviderID	Char	100	The ID of the Provider who created the referral.
21	ReferredFromLocationID	Char	100	The Facility ID of the Provider who created the referral.
22	ReferredToSourceID	Char	100	The ID of the Referring Provider.
23	ReferredToSpecialtyID	Char	100	The ID of the Referring Provider's specialty.
24	ReferralTypeID	Char	100	The ID of the Referral Type.
25	Priority	Char	1	The priority status for this referral (A, U). Default = Leave blank, A = ASAP, U = Urgent
26	Reason	Char	255	The reason for the referral
27	InsPlanID	Char	100	Patient Insurance Plan related to the referral.
28	InsOtherName	Char	255	A different name for the Insurance Plan.
29	InsAuthNum	Char	50	The Insurance authorization number.
30	InsAuthBy	Char	255	The name of the Insurance authorization party.
31	InsNumVisitsAuth	Int	20	The number of visits the authorization allows.
32	InsAuthExpDate	Date	30	The date that the authorization expires.
33	ProcID1	Char	100	The 1st procedure associated with the referral.
34	ProcID2	Char	100	The 2nd procedure associated with the referral.
35	ProcID3	Char	100	The 3rd procedure associated with the referral.

36	ProcID4	Char	100	The 4th procedure associated with the referral.
37	ProcID5	Char	100	The 5th procedure associated with the referral.
38	ProcID6	Char	100	The 6th procedure associated with the referral.
39	DiagID1	Char	100	The 1st diagnosis associated with the referral.
40	DiagID2	Char	100	The 2nd diagnosis associated with the referral.
41	DiagID3	Char	100	The 3rd diagnosis associated with the referral.
42	DiagID4	Char	100	The 4th diagnosis associated with the referral.
43	DiagID5	Char	100	The 5th diagnosis associated with the referral.
44	DiagID6	Char	100	The 6th diagnosis associated with the referral.
45	Notes	Char	8000	Notes.
46	*Status	Char	2	The Referral Status should be NULL if referrals will be closed in i2i Tracks; otherwise, use: X = Cancelled, C = Completed, or NC = Not Completed.
47	*StatusDate	Date	30	The Date of the Referral Status should be NULL if referrals will be closed in i2i Tracks; otherwise, enter the last date that the Referral Status was updated (YYYY-MM-DD).

* Please contact i2i Population Health to determine whether Referrals will be closed in i2i Tracks or if Status and Status Date will be imported into i2i Tracks.

Example Record:

PATREF3|U|56423|1234.1|Jane|Middle|Smith|1975-01-01|1234.1|
555-55-5555|F|555 A. Street||Santa Rosa|CA|95403|(707) 555-5555| |2014-01-01|65|5|34|8|3||Fractured Radial Head|78954||123|John Turner| 1|2014-03-01|99213||||||813.05||||||Fx radius head-closed|C|2014-03-28

Referral Source Record

A record of this type is required for each referral source that can be referenced in the Patient Referral record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always REFSOURCE2).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The ID of the Referral Source.
4	Name	Char	255	The Referral Source name.
5	Description	Char	255	The Referral Source description.
6	Contact	Char	255	The Referral Source contact.
7	Phone1	Char	50	The Referral Source main phone number.
8	Phone2	Char	50	The Referral Source additional phone number.
9	Fax	Char	50	The Referral Source fax number.
10	Email	Char	255	The Referral Source email address.
11	Address1	Char	255	The Referral Source address line 1.
12	Address2	Char	255	The Referral Source address line 2.
13	City	Char	255	The Referral Source city.
14	State	Char	50	The Referral Source state.
15	ZIP	Char	50	The Referral Source zip code.
16	NPI	Char	50	The Referral Source NPI number.
17	TaxIDNum	Char	50	The Referral Source tax ID number.
18	Notes	Char	8000	Notes regarding the Referral Source.

Example Record:

REFSOURCE2|U|123|Scott Smith||Harriet Smith|707-555-1234||| ss@ssclinic.com |789 Grand Ave||Santa Rosa|CA|95403|1231231234||Notes

Referral Specialty Record

A record of this type is required for each referral specialty that can be referenced in the Patient Referral record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always REFSPEC2).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The ID of the Referral Specialty.
4	Name	Char	255	The Referral Specialty name.
5	Description	Char	255	The Referral Specialty description.

Example Record:

REFSPEC2|U|123|Orthopedic|Orthopedic Practitioner

Referral Type Record

A record of this type is required for each referral type that can be referenced in the Patient Referral record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always REFTYPE2).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The ID of the Referral Type.
4	Name	Char	255	The Referral Type name.
5	Description	Char	255	The Referral Type description.

Example Record:

REFTYPE2|U|45|Abdominal Ultrasound|Abdominal Ultrasound and Evaluation

Referral Insurance Plan Record

A record of this type is required for each referral insurance plan that can be referenced in the Patient Referral record.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always REFINS2).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	ID	Char	100	The ID of the Referral Insurance Plan.
4	Name	Char	255	The Referral Insurance Plan name.
5	Description	Char	255	The Referral Insurance Plan description.
6	Contact	Char	255	The Referral Insurance Plan contact.
7	Phone1	Char	50	The Referral Insurance Plan main phone number.
8	Phone2	Char	50	The Referral Insurance Plan additional phone number.
9	Fax	Char	50	The Referral Insurance Plan fax number.
10	Address1	Char	255	The Referral Insurance Plan address line 1.
11	Address2	Char	255	The Referral Insurance Plan address line 2.
12	City	Char	255	The Referral Insurance Plan city.
13	State	Char	50	The Referral Insurance Plan state.
14	ZIP	Char	50	The Referral Insurance Plan zip code.
15	Notes	Char	8000	Notes regarding the Referral Insurance Plan.

Example Record:

REFINS2|U|123|BLUE CROSS||Harold Tucker|707-555-1234|||78 Grant Ave|| Santa Rosa|CA|95403|
Notes

Pharmacy Records

Patient Prescription Record

A record of this type is required for each event that occurs for a patient's prescription.

Index	Field	Type	Max Size	Details
1	RecordType	Char	50	The record type (always PATRX3).
2	RecordAction	Char	1	The action performed on the record (U, I, M, or D) U = Upsert (inserts new record/updates existing) I = Insert a new record only M = Modify or Update an existing record only D = Delete a record (Also supports Legacy record actions of A and E)
3	SourceID	Char	50	The value that identifies the source of the record. (Please contact i2i Population Health to obtain this value)
4	SourceDetails	Char	255	Details about the source of this record. (For example: If the record came from an HL7 file interface, then this field might contain the name of the HL7 file that contained the record).
5	ID	Char	100	The value that uniquely identifies the event (only needs to be unique with regard to the source).
6	PatientID	Char	50	The ID of the patient (from the patient management system).
7	PatientFirstName	Char	255	The patient's first name.
8	PatientMiddleName	Char	255	The patient's middle name.
9	PatientLastName	Char	255	The patient's last name.
10	PatientDOB	Date	30	The patient's date of birth (YYYY-MM-DD).
11	PatientMedRecNum	Char	50	The patient's medical record number.
12	PatientSSN	Char	20	The patient's social security number (XXX-XX-XXXX)
13	PatientGender	Char	1	The patient's gender: M = Male, F = Female, U = Unknown.
14	PatientAddress1	Char	255	The first line of the patient's address.
15	PatientAddress2	Char	255	The second line of the patient's address.
16	PatientCity	Char	255	The city in which the patient resides.
17	PatientState	Char	50	The state in which the patient resides (Use uppercase with 2 character abbreviation).
18	PatientZIP	Char	50	The zip code in which the patient resides.
19	PatientHomePhone	Char	50	The patient's home phone number.
20	PatientWorkPhone	Char	50	The patient's work phone number.
21	PrescriptionID	Char	50	Prescription ID.
22	EventType	Char	1	P = Prescribed, F = Filled, C = Currently Taking, X = Discontinued.
23	EventDate	Date	30	The date on which the event occurred (YYYY-MM-DD).
24	PrescriberID	Char	100	The ID of the prescribing provider.
25	PrescriberName	Char	255	The name of the prescribing provider.
26	PrescriberDEANumber	Char	50	The DEA number of the prescribing provider.
27	DatePrescribed	Date	30	The date on which the drug was prescribed (YYYY-MM-DD).

28	DrugNDC	Char	50	Drug NDC number.
29	DrugNDCClean	Char	50	11 digit form of Drug NDC number without dashes.
30	DrugID	Char	100	Drug ID.
31	DrugName	Char	255	Drug name.
32	DrugDesc	Char	255	Drug description.
33	DrugAbbrev	Char	50	Drug abbreviation.
34	DrugGenericID	Char	100	Generic drug ID.
35	DrugGenericName	Char	255	Generic drug name.
36	DrugDosageForm	Char	50	Drug dosage form.
37	DrugStrength	Char	50	Drug strength.
38	DrugRoute	Char	50	Drug route of administration.
39	QuantityPrescribed	Char	20	Quantity prescribed.
40	EstimatedDaysSupply	Char	20	Estimated days of supply.
41	SIG	Char	255	The SIG (i.e. 1T BID).
42	SIGDesc	Char	512	The full wording of the SIG (i.e. Take one tablet twice a day).
43	NewRefill	Char	1	Whether this a New or Refilled Prescription: N = New, R = Refill.
44	OriginalRefills	Char	20	Original number of refills.
45	OriginalFillDate	Date	30	The date on which the prescription was originally filled (YYYY-MM-DD).
46	RemainingRefills	Char	20	Number of refills remaining.
47	Notes	Char	8000	Notes.
48	Rejected	Char	1	Whether or not this record has been rejected: Y = Yes, N = No.
49	ReasonRejected	Char	8000	The reason why this record was rejected.

Example Record:

PATRX3|U|MyPharmacy|FileA.HL7|123|12345.1|Bob|J|Smith|1985-01-01| 123456A|555-55-5555|M|12345 Pine St.||Santa Rosa|CA|95403|
(707) 555-5555||3434|P|2006-01-02|123|Dr. Phil Smith|AA1234567|
2006-01-02|64764030114|64764030114|456|ACTOS|ACTOS 30MG TABLET|
ACTOS30|5678|PIOGLITAZONE HCL|Tablet|30 mg|Oral|30|30|1T QD|
Take one tablet every day|N|4|2006-01-03|3|Notes|N|

Revision history

Date	UPD Common Version	Description
4/3/2015	3.1.0.1	Initial document creation
4/14/2015	3.1.2.2	Added PROV5 specifications and rearranged EHR definitions
4/16/2015	3.1.2.3	Added LMP vital definition to correctly sync to existing vital element
5/4/2015	3.2.1.0	Added patient payer (PATPAYER2) and payer (PAYER2) specifications
8/3/2015	3.2.2.0	Added appointment status (APPTSTAT2) and new versions of race, ethnicity, and allergies (RACE3, ETHNICITY3, & ALLERGY3)
10/5/2015	3.2.2.1	Created a new Problem version (PROBLEM4), which includes the new code list fields.
11/3/2015	3.2.2.2	Core and Non-Core/Required and Optional
12/9/2015	3.2.2.3	Clarified VIS ID description in Immunizations.
2/19/2016	3.2.2.4	Added new Patient Problem (PATPROBLEM3) and Patient Vitals (PATVITAL4) definitions.
3/14/2016	3.2.2.5	Edited Patient Referral (PATREF2) to include demographics and status fields.
6/30/2016	3.2.2.6	Changed all i2i Systems references to i2i Population Health.
7/28/2016	3.2.2.7	Added a number of new format file specifications including PATMERGE3. Edited and reformatted all definitions
10/17/2016	3.2.2.8	Added centimeter (cm) designation to Vitals for Head Circumference measurement.
11/28/2016	3.2.2.9	Changed PATIMMUN4 Historical Vaccine to 1 character specification for ‘Y’ or ‘N’.