

Health & Care Information Model:

nl.zorg.Admission-v3.0

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1. nl.zorg.Admission-v3.0

DCM::CoderList	Zib-centrum
DCM::ContactInformation.Address	*
DCM::ContactInformation.Name	*
DCM::ContactInformation.Telecom	*
DCM::ContentAuthorList	*
DCM::CreationDate	1-12-2021
DCM::DeprecatedDate	
DCM::DescriptionLanguage	nl
DCM::EndorsingAuthority.Address	
DCM::EndorsingAuthority.Name	*
DCM::EndorsingAuthority.Telecom	
DCM::Id	2.16.840.1.113883.2.4.3.11.60.40.3.15.4
DCM::KeywordList	Opname, Deelopname, Ziekenhuisopname
DCM::LifecycleStatus	Final
DCM::ModelerList	Zib-centrum
DCM::Name	nl.zorg.Opname
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DCM::PublicationStatus	Published
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DCM::RevisionDate	08-04-2025
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HCIM::PublicationLanguage	EN

1.1 Revision History

Publicatieversie 1.0 (10-06-2022)

Publicatieversie 2.0 (15-10-2023)

Bevat: ZIB-1773, ZIB-1824.

Publicatieversie 3.0 (23-04-2025)

Bevat: ZIB-2560, ZIB-2566, ZIB-2659, ZIB-2602.

1.2 Concept

The stay of a patient or client in a healthcare facility in the context of a (partial) admission or emergency room visit. A (partial) admission is the entire or partial stay of a patient or client in a department equipped for nursing in a health care institution, for example, an inpatient ward, day care unit, emergency care, or observatory. This HCIM therefore applies to a whole admission, part of an admission, or emergency room visit in both past and present.

1.3 Mindmap

1.4 Purpose

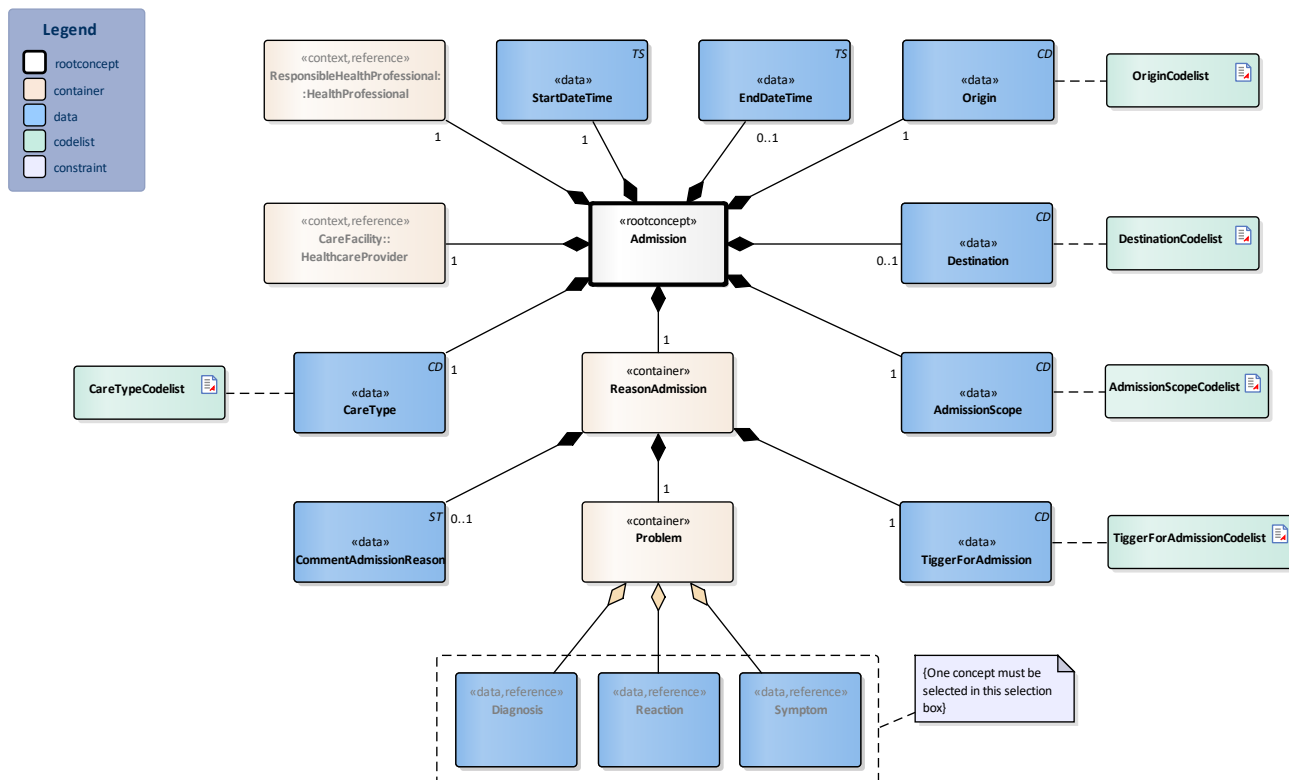
Admissions or emergency room visits occur in a healthcare facility for the purpose of treating, observing or examining a patient or client.

1.5 Patient Population

1.6 Evidence Base

The codelists for Origin and Destination generally correspond to the 'Landelijke Basisregistratie Ziekenhuiszorg' (National Basic Registration Hospital Care)

1.7 Information Model



«rootconcept»	Admission	
Definitie	Root concept of the Admission information model.This root concept contains all data elements of the Admission information model.	
Datatype		
DCM::ConceptId	NL-CM:15.4.1	
Opties		

«data»	CareType	
Definitie	The type of care that has been or will be provided to the patient during the (partial) admission. This is related, among other things, to the severity category of the care.	
Datatype	CD	
DCM::ConceptId	NL-CM:15.4.2	
DCM::ValueSet	CareTypeCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.5
Opties		

«data»	StartDateTime	
Definitie	Date and time when the (partial) admission will start or was started.	
Datatype	TS	
DCM::ConceptId	NL-CM:15.4.3	
Opties		

«data»	EndDateTime	
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Definitie	Date and time on which the (partial) admission ended. For a future or ongoing admission, the end date can be empty.	
Datatype	TS	
DCM::ConceptId	NL-CM:15.4.4	
Opties		

«data»	Origin	
Definitie	Location where the patient comes from prior to the (partial) admission. This will mainly be used at the start of hospitalisation.	
Datatype	CD	
DCM::ConceptId	NL-CM:15.4.9	
DCM::ValueSet	OriginCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.3
Opties		

«data»	Destination	
Definitie	Location where the patient will go after the (partial) admission. This will mainly be used at the end of hospitalization.	
Datatype	CD	
DCM::ConceptId	NL-CM:15.4.10	
DCM::ValueSet	DestinationCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.2
Opties		

«data»	AdmissionScope	
Definitie	AdmissionScope indicates whether it is a overall admission or a partial admission.	
Datatype	CD	
DCM::ConceptId	NL-CM:15.4.11	
DCM::ValueSet	AdmissionScopeCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.4
Opties		

«container»	ReasonAdmission	
Definitie	Container of the ReasonAdmission concept.This container contains all data elements of the ReasonAdmission concept.	
Datatype		
DCM::ConceptId	NL-CM:15.4.5	
Opties		

«data»	TiggerForAdmission	
Definitie	The specific reason for the admission in relation to the diagnosis and/or treatment of the problem.	
Datatype	CD	
DCM::ConceptId	NL-CM:15.4.7	
DCM::DefinitionCode	SNOMED CT: 59021000146108 Reason for admission	
DCM::ValueSet	TiggerForAdmissionCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.1
Opties		

«container»	Problem	
Definitie	Container of the Problem concept.This container contains all data elements of the Problem concept.	

Datatype		
DCM::ConceptId	NL-CM:15.4.14	
Opties		

«data»	Diagnosis	
Definitie	The diagnosis as the reason for the admission.	
Datatype		
DCM::ConceptId	NL-CM:15.4.15	
DCM::ReferencedConceptId	NL-CM:5.6.1	This is a reference to the rootconcept of information model Diagnosis.
Opties		

«data»	Reaction	
Definitie	The adverse reaction to a substance or radiation as the reason for admission.	
Datatype		
DCM::ConceptId	NL-CM:15.4.16	
DCM::ReferencedConceptId	NL-CM:5.3.1	This is a reference to the rootconcept of information model Reaction.
Opties		

«data»	Symptom	
Definitie	The symptom as the reason for the admission.	
Datatype		
DCM::ConceptId	NL-CM:15.4.17	
DCM::ReferencedConceptId	NL-CM:5.5.1	This is a reference to the rootconcept of information model Symptom.
Opties		

«context»	ResponsibleHealthProfessional::HealthProfessional	
Definitie	The health professional who is responsible during the (partial) admission. The information about the health professional can also include the specialism and role of the health professional.	
Datatype		
DCM::ConceptId	NL-CM:15.4.12	
DCM::ReferencedConceptId	NL-CM:17.1.1	This is a reference to the rootconcept of information model HealthProfessional.
Opties		

«context»	CareFacility::HealthcareProvider	
Definitie	The physical location of the healthcare provider where the (partial) admission has taken place or will take place.	
Datatype		
DCM::ConceptId	NL-CM:15.4.13	
DCM::ReferencedConceptId	NL-CM:17.2.1	This is a reference to the rootconcept of information model HealthcareProvider.
Opties		

«data»	CommentAdmissionReason	
Definitie	Comment on the reason for the (partial) admission, insofar as this cannot be sufficiently expressed in the other elements.	
Datatype	ST	
DCM::ConceptId	NL-CM:15.4.8	

DCM::DefinitionCode	LOINC: 48767-8 Annotation comment [Interpretation] Narrative	
Opties		

«document»	TiggerForAdmissionCodelist	
Definitie		
Datatype		
DCM::ValueSetBinding	Extensible	
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.15.4.1	
DCM::ValueSetInclude OTH	True	
DCM::ValueSetStatus	Active	
HCIM::ValueSetLanguage	--	
Opties		

AanleidingOpnameCodelijst			OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.1	
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Procedure	71388002	SNOMED CT	2.16.840.1.113883.6.96	Uitvoeren verrichting
Administration of medication	18629005	SNOMED CT	2.16.840.1.113883.6.96	Medicatietoediening
Observation regime	225308005	SNOMED CT	2.16.840.1.113883.6.96	Observatie
Rehabilitation therapy	52052004	SNOMED CT	2.16.840.1.113883.6.96	Revalidatie
Safety procedure	370886002	SNOMED CT	2.16.840.1.113883.6.96	Veiligheid patiënt en/of omgeving
Respite care of patient	105386004	SNOMED CT	2.16.840.1.113883.6.96	Respijtzorg
Encounter for acute problem	180201000146103	SNOMED CT	2.16.840.1.113883.6.96	Contact vanwege acuut probleem

«document»	DestinationCodelist	
Definitie		
Datatype		
DCM::ValueSetBinding	Extensible	
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.15.4.2	
DCM::ValueSetInclude OTH	True	
DCM::ValueSetStatus	Active	
HCIM::ValueSetLanguage	--	
Opties		

BestemmingCodelijst			OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.2	
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Home	264362003	SNOMED CT	2.16.840.1.113883.6.96	Eigen woonomgeving, niet zijnde een instelling
Left against medical advice	445060000	SNOMED CT	2.16.840.1.113883.6.96	Tegen advies in vertrokken [DEPRECATED]
Rehabilitation hospital	80522000	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor revalidatie
Long term care facility	42665001	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor

				verpleging/verzorging
Psychiatric hospital	62480006	SNOMED CT	2.16.840.1.113883.6.96	GGZ instelling
Hospital	22232009	SNOMED CT	2.16.840.1.113883.6.96	Ander ziekenhuis
Died in hospital	183676005	SNOMED CT	2.16.840.1.113883.6.96	Overleden [DEPRECATED]
Morgue	225737007	SNOMED CT	2.16.840.1.113883.6.96	Mortuarium
Hospice	284546000	SNOMED CT	2.16.840.1.113883.6.96	Hospice
Hospital abroad	155621000146109	SNOMED CT	2.16.840.1.113883.6.96	Ziekenhuis buitenland
Site of care	43741000	SNOMED CT	2.16.840.1.113883.6.96	Instelling (anders)
Discharge to other location within hospital premises	115841000146105	SNOMED CT	2.16.840.1.113883.6.96	Afdeling binnen zelfde instelling

«document»		OriginCodelist		
Definitie				
Datatype				
DCM::ValueSetBinding	Extensible			
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.15.4.3			
DCM::ValueSetIncludeOTH	True			
DCM::ValueSetStatus	Active			
HCIM::ValueSetLanguage	--			
Opties				
HerkomstCodelijst		OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.3		
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Home	264362003	SNOMED CT	2.16.840.1.113883.6.96	Eigen woonomgeving, niet zijnde een instelling
Rehabilitation hospital	80522000	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor revalidatie
Long term care facility	42665001	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor verpleging/verzorging
Psychiatric hospital	62480006	SNOMED CT	2.16.840.1.113883.6.96	GGZ instelling
Hospital	22232009	SNOMED CT	2.16.840.1.113883.6.96	Ander ziekenhuis
Newborn nursery unit	427695007	SNOMED CT	2.16.840.1.113883.6.96	In dit ziekenhuis geboren
Liveborn born in hospital	442311008	SNOMED CT	2.16.840.1.113883.6.96	In dit ziekenhuis geboren [DEPRECATED]
Hospice	284546000	SNOMED CT	2.16.840.1.113883.6.96	Hospice
Hospital abroad	155621000146109	SNOMED CT	2.16.840.1.113883.6.96	Ziekenhuis buitenland
Site of care	43741000	SNOMED CT	2.16.840.1.113883.6.96	Instelling (anders)
Accident and Emergency department	225728007	SNOMED CT	2.16.840.1.113883.6.96	SEH
Outpatient environment	440655000	SNOMED CT	2.16.840.1.113883.6.96	Poliklinische afdeling
Discharge to other location within hospital premises	115841000146105	SNOMED CT	2.16.840.1.113883.6.96	Afdeling binnen zelfde instelling
Incident site	702869004	SNOMED CT	2.16.840.1.113883.6.96	Locatie van incident

«document»		AdmissionScopeCodelist		
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Definitie				
Datatype				
DCM::ValueSetBinding	Required			
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.15.4.4			
DCM::ValueSetIncludeOTH	True			
DCM::ValueSetStatus	Active			
HCIM::ValueSetLanguage	--			
Opties				
OpnameScopeCodelijst			OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.4	
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Total admission	TA	OpnameScope	2.16.840.1.113883.2.4.3.11.60.40.4.29.1	Gehele opname
Admission part	PA	OpnameScope	2.16.840.1.113883.2.4.3.11.60.40.4.29.1	Opnamedeel

«document»	CareTypeCodelist			
Definitie				
Datatype				
DCM::ValueSetBinding	Extensible			
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.6 0.40.2.15.4.5			
DCM::ValueSetInclude OTH	True			
DCM::ValueSetStatus	Active			
HCIM::ValueSetLanguage	--			
Opties				
ZorgTypeCodelijst		OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.4.5		
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Regular nursing care	180121000146103	SNOMED CT	2.16.840.1.113883.6.96	Verlenen van reguliere verpleegkundige zorg
Medium care	180141000146109	SNOMED CT	2.16.840.1.113883.6.96	Verlenen van 'medium care' aan patiënt
High care	180151000146107	SNOMED CT	2.16.840.1.113883.6.96	Verlenen van 'high care' aan patiënt
Intensive care	180131000146101	SNOMED CT	2.16.840.1.113883.6.96	IC-zorg [DEPRECATED]
Care of intensive care unit patient	133903000	SNOMED CT	2.16.840.1.113883.6.96	Verlenen van zorg aan patient op intensivereafdeling
Care of accident and emergency unit patient	290191000146103	SNOMED CT	2.16.840.1.113883.6.96	Verlenen van zorg aan patiënt op spoedeisende hulp

	Legend
Definitie	
Datatype	
Opties	

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

1.8 Example Instances

Opname	
BeginDatumTijd	16-04-2022
Herkomst	Eigen woonomgeving
ZorgType	Reguliere verpleging
OpnameScope	Gehele opname
RedenOpname	
AanleidingOpname	Uitvoeren verrichting
Probleem	
Diagnose	Polsfractuur
VerantwoordelijkBehandelaar	
ZorgverlenerNaam	J.H.R. Peters
Zorginstelling	
OrganisatieNaam	Universitair Medisch Centrum Groningen (UMCG)

1.9 Instructions

1.10 Interpretation

1.11 Care Process

1.12 Example of the Instrument

1.13 Constraints

1.14 Issues

1.15 References

1. Landelijke Basisregistratie Ziekenhuiszorg [Online] Beschikbaar op: https://www.dhd.nl/klanten/klantenservice/handleidingen_formulieren/Documents/Handleiding%20LBZ.pdf [Geraadpleegd: 29 juni2017].

1.16 Functional Model

1.17 Traceability to other Standards

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