

# Health & Care Information Model:

## nl.zorg.process.RegistrationData-v1.1.1

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# 1. nl.zorg.process.RegistrationData-v1.1.1

DCM::CoderList	
DCM::ContactInformation.Address	*
DCM::ContactInformation.Name	*
DCM::ContactInformation.Telecom	*
DCM::ContentAuthorList	
DCM::CreationDate	10-12-2024
DCM::DeprecatedDate	
DCM::DescriptionLanguage	nl
DCM::EndorsingAuthority.Address	
DCM::EndorsingAuthority.Name	PM
DCM::EndorsingAuthority.Telecom	
DCM::Id	2.16.840.1.113883.2.4.3.11.60.40.3.22.1
DCM::KeywordList	
DCM::LifecycleStatus	Final
DCM::ModelerList	
DCM::Name	nl.zorg.process.RegistratieGegevens
DCM::PublicationDate	15-04-2024
DCM::PublicationStatus	Prepublished
DCM::ReviewerList	
DCM::RevisionDate	08-04-2024
DCM::Supersedes	nl.zorg.process.RegistratieGegevens-v1.1
DCM::Version	1.1.1
HCIM::PublicationLanguage	EN

## 1.1 Revision History

Publicatieversie 1.0 (10-06-2022)

Publicatieversie 1.1 (15-10-2023)

Bevat: ZIB-1774.

Publicatieversie 1.1.1 (15-04-2024)

Bevat: ZIB-2165, ,ZIB-2129.

## 1.2 Concept

When recording information on a medical concept about a patient in a health professional's patient record, additional information arises which does not so much contain data about the concept itself but relates to the registering process, such as when and by whom the information was registered.

## 1.3 Mindmap

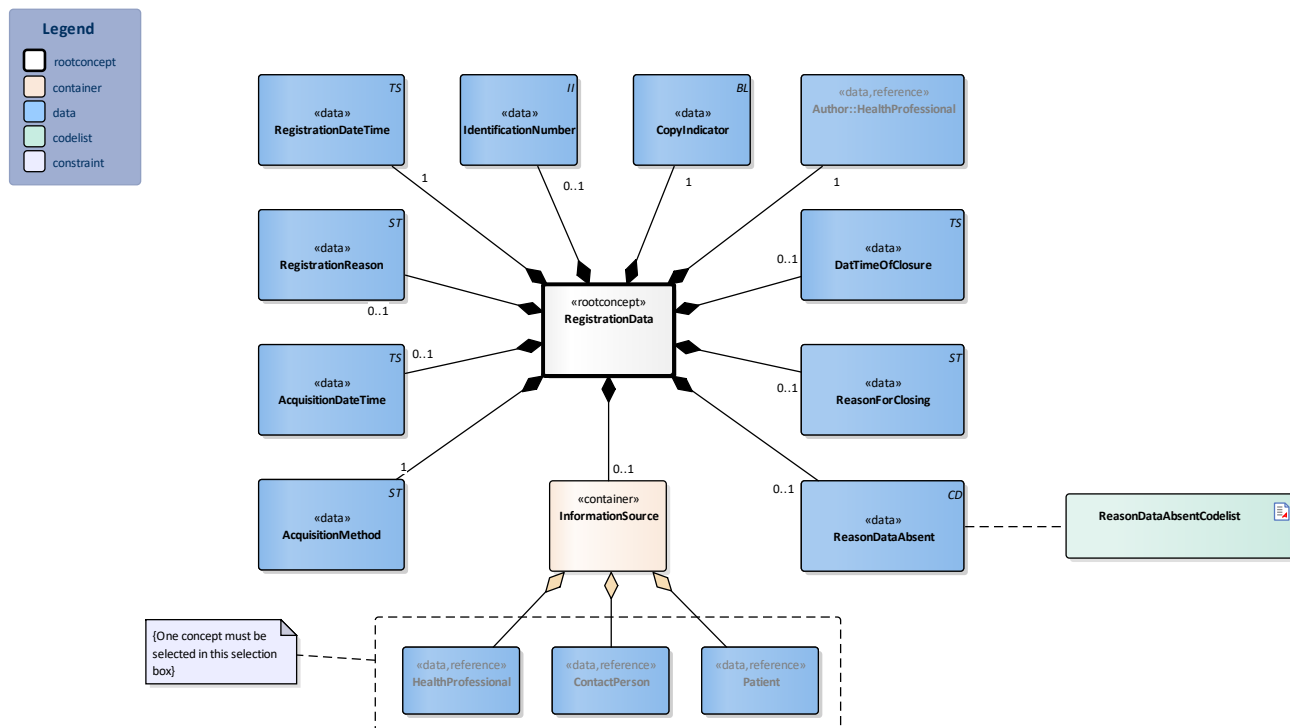
## 1.4 Purpose

Registration data mainly provides an administrative overview of who has registered information in the EPR and when. In addition to a timeline with the information available in the EPR, this data also offers the possibility of logging.

## 1.5 Patient Population

## 1.6 Evidence Base

## 1.7 Information Model



«rootconcept»	RegistrationData
<b>Definitie</b>	Root concept of the RegistrationData process data information model. This root concept contains all data elements of the RegistrationData process data information model.
<b>Datatype</b>	
<b>DCM::ConceptId</b>	NL-CM:22.1.1
<b>Opties</b>	

«data»	IdentificationNumber
<b>Definitie</b>	Globally unique number that identifies the instantiation of the information model. The number is composed of an identification of the issuer organization and a unique number assigned by this organization.
<b>Datatype</b>	II
<b>DCM::AssigningAuthority</b>	AssigningAuthority OID: OID: AssigningAuthorityOID
<b>DCM::ConceptId</b>	NL-CM:22.1.12
<b>DCM::DefinitionCode</b>	SNOMED CT: 396278008 Identification number
<b>Opties</b>	

«data»	Author::HealthProfessional
<b>Definitie</b>	The person who has is responsible for entering the information in de patient's record. It concerns not only own observations, but also information received from third parties. The author has decided to include the information in the file if necessary with source reference.
<b>Datatype</b>	
<b>DCM::ConceptId</b>	NL-CM:22.1.2
<b>DCM::ReferencedConceptId</b>	NL-CM:17.1.1 This is a reference to the rootconcept of information model HealthProfessional.

<b>Opties</b>	
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<b>«data»</b>	<b>RegistrationDateTime</b>
<b>Definitie</b>	Date and time when the information was recorded in the patient record.
<b>Datatype</b>	TS
<b>DCM::ConceptId</b>	NL-CM:22.1.3
<b>Opties</b>	

<b>«data»</b>	<b>RegistrationReason</b>
<b>Definitie</b>	Description of the reason for including the information in the patient record.
<b>Datatype</b>	ST
<b>DCM::ConceptId</b>	NL-CM:22.1.4
<b>Opties</b>	

<b>«data»</b>	<b>DatTimeOfClosure</b>
<b>Definitie</b>	Date and time at which it is recorded in the patient record that the information is no longer relevant, for example because the information is outdated, no longer requires attention, etc.
<b>Datatype</b>	TS
<b>DCM::ConceptId</b>	NL-CM:22.1.5
<b>Opties</b>	

<b>«data»</b>	<b>ReasonForClosing</b>
<b>Definitie</b>	Reason why updating the information, or following changes in the the concept in question is no longer considered relevant. For example, in the case of a condition, this does not mean that the disease is no longer present, but merely that the holder of the patients record no longer considers the condition as an aspect to be taken into account during care provision.
<b>Datatype</b>	ST
<b>DCM::ConceptId</b>	NL-CM:22.1.6
<b>Opties</b>	

<b>«data»</b>	<b>AcquisitionMethod</b>
<b>Definitie</b>	The way in which the information is obtained by the patient record holder.
<b>Datatype</b>	ST
<b>DCM::ConceptId</b>	NL-CM:22.1.8
<b>Opties</b>	

<b>«data»</b>	<b>AcquisitionDateTime</b>
<b>Definitie</b>	Date and when relevant time when the information became available. This may be an earlier time than the date/time when the information was entered in the patient record.
<b>Datatype</b>	TS
<b>DCM::ConceptId</b>	NL-CM:22.1.9
<b>Opties</b>	

<b>«data»</b>	<b>ReasonDataAbsent</b>
<b>Definitie</b>	Reason why no data is available for the value of a concept. This includes, for example, all 'Unknown' variants, but also 'Indeterminate', 'Specimen unsatisfactory', etc.
<b>Datatype</b>	CD
<b>DCM::ConceptId</b>	NL-CM:22.1.10

<b>DCM::ValueSet</b>	ReasonDataAbsentCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.22.1.1
<b>Opties</b>		

<b>«data»</b>	<b>CopyIndicator</b>	
<b>Definitie</b>	Indication that the data has been obtained from the EPR of another healthcare professional/healthcare provider.	
<b>Datatype</b>	BL	
<b>DCM::ConceptId</b>	NL-CM:22.1.11	
<b>Opties</b>		

<b>«container»</b>	<b>InformationSource</b>	
<b>Definitie</b>	Container of the InformationSource concept. This container contains all data elements of the InformationSource concept. If the recorded information has not been assessed by the attending physician, the source of the information can be recorded.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:22.1.13	
<b>Opties</b>		

<b>«data»</b>	<b>HealthProfessional</b>	
<b>Definitie</b>	The health professional who is the source of the information.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:22.1.14	
<b>DCM::ReferencedConceptId</b>	NL-CM:17.1.1	This is a reference to the rootconcept of information model HealthProfessional.
<b>Opties</b>		

<b>«data»</b>	<b>ContactPerson</b>	
<b>Definitie</b>	The contact person who is the source of the information.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:22.1.15	
<b>DCM::ReferencedConceptId</b>	NL-CM:3.1.1	This is a reference to the rootconcept of information model ContactPerson.
<b>Opties</b>		

<b>«data»</b>	<b>Patient</b>	
<b>Definitie</b>	The patient as information source	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:22.1.16	
<b>DCM::ReferencedConceptId</b>	NL-CM:0.1.1	This is a reference to the rootconcept of information model Patient.
<b>Opties</b>		

<b>«document»</b>	<b>ReasonDataAbsentCodelist</b>	
<b>Definitie</b>		
<b>Datatype</b>		
<b>DCM::ValueSetBinding</b>	Extensible	
<b>DCM::ValueSetId</b>	2.16.840.1.113883.2.4.3.11.60.40.2.22.1.1	
<b>HCIM::ValueSetLanguage</b>	EN	
<b>Opties</b>		
<b>RedenAfwezigheidGegevensCodelijst</b>		<b>OID: 2.16.840.1.113883.2.4.3.11.60.40.2.22.1.1</b>

Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Indeterminate	82334004	SNOMED CT	2.16.840.1.113883.6.96	Niet bepaald
Specimen unsatisfactory	142251000146108	SNOMED CT	2.16.840.1.113883.6.96	Monster ongeschikt
Unknown	UNK	NullFlavor	2.16.840.1.113883.5.1008	Onbekend
Asked but unknown	ASKU	NullFlavor	2.16.840.1.113883.5.1008	Gevraagd, maar onbekend
Not asked	NASK	NullFlavor	2.16.840.1.113883.5.1008	Niet gevraagd

Legend	
<b>Definitie</b>	
<b>Datatype</b>	
<b>Opties</b>	

Constraint	
<b>Definitie</b>	One concept must be selected in this selection box
<b>Datatype</b>	
<b>Opties</b>	

## 1.8 Example Instances

RegistratieGegevens	
Identificatienummer	01229993999444
RegistratieDatumTijd	16-05-2016 13:15
DatumVanVerkrijgen	14-05-2016
WijzeVanVerkrijgen	Brief
KopieIndicator	Waar
Informatiebron : Zorgverlener	
ZorgverlenerIdentificatieNummer	21870932
ZorgverlenerRol	Hoofdbehandelaar
Specialisme	Neuroloog
ZorgverlenerNaam	
Initialen	J.H.R.
Geslachtsnaam	Peters
Adres	
Straat	Simon Smitweg
Huisnummer	1
Woonplaats	Leiderdorp
Postcode	2353 GA
AdresSoort	Werkadres
Land	Nederland
Auteur : Zorgverlener	
ZorgverlenerIdentificatieNummer	88844558
Zorgverlener Rol	Verwijzer
Specialisme	Huisarts
Zorgverlener Naam	
Initialen	G.J.
Geslachtsnaam	de Vries

## 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**

## **1.16 Functional Model**

## **1.17 Traceability to other Standards**

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