EHI Export Documentation

Export Zip File Content:

Contains a Folder with the patient(s) name and record number with the following folder structure:

- PatientName PatientLastName – Record Number
- Readme
    - AuthorizationDocuments
    - PatientDocuments

File	Description
ReadMe.txt	Contains a weblink to this document.
CCD.XML	Consolidated-CDA documents formated as C-CDA R2.1: C-CDA Templates for Clinical Notes R2.1 Companion Guide, Release 2
PatientRecord.XML	Contains all the Electronic Heatlh Information of the patient that's not captured in a CCD document.
PatientFinancialData.XML	Contains all the financial information of the patient stored in our systems.

Accessing the Export Module

Users can access the Data Export functionality within the Evolution EHR through the designated export module. This module has been developed to manage the complexities of large-scale data exports, seamlessly accommodating the export needs for an individual patient, multiple patients, or the entire patient database within our system.

Applying Patient Data Filters

The export module, users have the ability to filter and select patient data based on several criteria:

- **Dates**: Filter by either Discharge Date or Admission Date to target specific patient records.
- **Patient Type**: Select patients based on their categorization within the system.
- **Patient Name and Last Name**: Search and select patients using their first and last names.
- **Patient Insurance**: Filter patients based on their insurance provider.

Data Visualization and Selection

Upon applying the filters, the queried data will be displayed in a user-friendly grid on the Evolution Export Module interface. This visualization allows users to:

- Inspect patient data visually.
- Select individual patients.
- Choose all patients displayed in the current query.

Note: Data visualization is not available when selecting the 'All Patients' export option.

4. Initiating the Export Process

After finalizing the selection of patients, the export process can be initiated. Evolution EHR will retrieve the relevant EHI, ensuring that the data aligns with the applied filters. The system will then proceed to compile and export the data, maintaining high standards of accuracy and security.

5. Securing and Retrieving Exported Data

The exported data for each patient will be stored in a secure folder, organized into individual ZIP files of each patient for ease of management. Users will be notified upon the completion of the export process and can then access the secured folder to retrieve the exported files.

PatientRecord.XML Dictionary

1. **Encoding and Declaration**: The document starts with an XML declaration specifying the encoding and version.
2. **Root Element**: The root element is **<PATIENT_RECORD>**, which contains all the patient-related information.
3. **Patient Information (<PatientInfo>) Section**:
    - Contains details about the patient's personal information, including name, birth date, gender, address, phone number, marital status, race, ethnicity, language, and guardian information.
    - The **birthTime** element should be modified to **<BirthDate>** and use the ISO 8601 date format, such as **<BirthDate>1980-01-01</BirthDate>**.

Field	Description
RECORDNUMBER	Unique identifier for the patient's record.
NAME	Container for the patient's name, including given, paternal (last name), and maternal (last name) parts.
BIRTHTIME	Date of birth of the patient in ISO 8601 format (YYYY-MM-DD).
GENDER	Gender of the patient (e.g., Male, Female, Other).
ADDRESS	Container for the patient's address information, including street, city, state, and zip code.
PHONENUMBER	Phone number of the patient.
MARITALSTATUS	Marital status of the patient (e.g., Single, Married, Divorced).
RACE	Race of the patient (e.g., White, Black, Asian).
ETHNICITY	Ethnicity of the patient (e.g., Hispanic or Latino, Not Hispanic or Latino).
LANGUAGE	Language spoken by the patient.
GUARDIAN	Container for guardian information, including name, relation, address, and phone number.

PatientInfo XML Sample

```
<PatientInfo>
        <RecordNumber>12345</RecordNumber>
        <name>
            <given>John</given>
            <lastNamePaternal>Doe</lastNamePaternal>
            <lastNameMaternal>Johnson</lastNameMaternal>
        </name>
        <birthTime>1980-01-01</birthTime>
        <gender>Male</gender>
        <address>
            <street>1234 Elm St</street>
            <citY>Anytown</citY>
            <state>AA</state>
            <ZipCode>12345</ZipCode>
        </address>
        <phoneNumber>(123)456-7890</phoneNumber>
        <maritalStatus>Single</maritalStatus>
        <race>White</race>
        <ethnicity>Not Hispanic or Latino</ethnicity>
        <language>English</language>
        <guardian>
            <name>
                <given>Jane</given>
                <lastNamePaternal>Doe</lastNamePaternal>
                <lastNameMaternal>Johnson</lastNameMaternal>
            </name>
            <relation>Mother</relation>
            <address>
                <street>1234 Elm St</street>
                <citY>Anytown</citY>
                <state>AA</state>
                <ZipCode>12345</ZipCode>
            </address>
            <phoneNumber>(123) 456-7890</phoneNumber>
        </guardian>
    </PatientInfo>
```

4. **Authorizations (<Authorizations>) Section**:

   - Contains authorization information, including document type, status, provider name, witness name, revised date, signed date, comments, document address, and extension.
   - Dates in ISO 8601 format, similar to the birth date.
   - Documents saved at AuthorizationDocuments Folder

Field	Description
Authorization	An array containing authorization data for the patient.
DocumentType	The type of the authorized document (e.g., Medical Report).
DocumentStatus	The status of the authorized document (e.g., Approved).
ProviderName	The name of the healthcare provider who authorized the document.
WITNESS_NAME	The name of the witness for the authorization.
REVISEDDATE	The date when the authorization was revised (ISO 8601 format).
SIGNEDDATE	The date when the authorization was signed (ISO 8601 format).
COMMENTS	Additional comments or notes related to the authorization.
DocumentAddress	The file path or URL where the authorized document is stored.
EXTENSION	The file extension of the authorized document (e.g., pdf).

Authorization XML Sample:

```
<Authorizations>
   <Authorization>
    <!-- Authorization data for the first entry -->
    <DocumentType>Medical Report</DocumentType>
    <DocumentStatus>Approved</DocumentStatus>
    <ProviderName>Dr. Smith</ProviderName>
    <WITNESS_NAME>Jane Doe</WITNESS_NAME>
    <REVISEDDATE>2023-11-16</REVISEDDATE>
    <SIGNEDDATE>2023-11-15</SIGNEDDATE>
    <COMMENTS>Authorization granted for further medical procedures</COMMENTS>
    <DocumentAddress>/local/export/folder/medical_report1.pdf</DocumentAddress>
    <EXTENSION>pdf</EXTENSION>
    </Authorization>
     <Authorization>
       <!-- Authorization data for the second entry -->
       <!-- Include details for each additional authorization entry -->
    </Authorization>
        <!-- Add more Authorization entries as needed -->
</Authorizations>
```

Care Plans (<CarePlans>) Section:

- Includes details about care plans, such as plan ID, plan name, account number, notes, status, assignment date, review date, assignee, completion information, focuses, and interventions.
- Dates within this section in ISO 8601 format.

Field	Description
CarePlan	An array containing details of care plans for the patient.
CarePlanID	The unique identifier for the care plan.
CarePlanName	The name or title of the care plan.
RecordNumber	The record number associated with the patient.
AccountNumber	The account number associated with the patient.
CarePlanNote	Detailed notes or description of the care plan.
PlanStatus	The status of the care plan (e.g., Active).
AssignDate	The date when the care plan was assigned (ISO 8601 format).
ReviewDate	The date when the care plan is scheduled for review (ISO 8601 format).
AssignBy	The name of the healthcare provider who assigned the care plan.
CompletedBy	The name of the healthcare provider who completed the care plan.
CompletedOn	The date when the care plan was completed (ISO 8601 format).
Focuses	An array containing details of focus areas within the care plan.

CarePlan section XML Sample

```
<CarePlans>
        <CarePlan>
            <CarePlanID>1</CarePlanID>
            <CarePlanName>Cardiovascular Health</CarePlanName>
            <RecordNumber>12345</RecordNumber>
            <AccountNumber>67890</AccountNumber>
            <CarePlanNote>Manage cardiovascular health through lifestyle
changes.</CarePlanNote>
            <PlanStatus>Active</PlanStatus>
            <AssignDate>2023-01-15</AssignDate>
            <ReviewDate>2023-12-31</ReviewDate>
            <AssignBy>Dr. Smith</AssignBy>
            <CompletedBy>Nurse Johnson</CompletedBy>
            <CompletedOn>2023-06-30</CompletedOn>
            <Focuses>
                <Focus>
                    <FocusID>101</FocusID>
                    <FocusDesc>Blood Pressure Management</FocusDesc>
                    <FocusRole>Cardiologist</FocusRole>
                    <FocusTargetDate>2023-06-30</FocusTargetDate>
                    <FocusCompletedDate>2023-06-15</FocusCompletedDate>
                    <FocusNote>Control blood pressure within healthy
limits.</FocusNote>
                    <ExpectedResultDesc>Lower blood pressure</ExpectedResultDesc>
                    <ResultTargetDate>2023-06-30</ResultTargetDate>
                    <ResultCompletedBy>Nurse Johnson</ResultCompletedBy>
                    <PatResultNote>Steady progress</PatResultNote>
                    <CarePlanId>1</CarePlanId>
                    <PatResultStatus>Completed</PatResultStatus>
                    <PatFocusStatus>Completed</PatFocusStatus>
                    <FocusIncompletedDate>2023-06-20</FocusIncompletedDate>
                    <FocusIncompletedBy>Dr. Smith</FocusIncompletedBy>
                    <Interventions>
                        <Intervention>
                            <InterventionID>1001</InterventionID>
                            <FocusID>101</FocusID>
                            <InterventionDate>2023-06-10</InterventionDate>
                            <NursingOrder>Administer medication</NursingOrder>
                            <InterventionStatus>Completed</InterventionStatus>
                            <UserName>Nurse Johnson</UserName>
                        </Intervention>
                        <!-- Add more Intervention elements if needed -->
                    </Interventions>
                </Focus>
                <Focus>
                    <!-- Focus details for the second focus -->
                    <Interventions>
                        <!-- Intervention details for the second focus -->
                    </Interventions>
                </Focus>
            </Focuses>
        </CarePlan>
        <!-- Add more CarePlan elements if needed -->
</CarePlans>
```

5. **Consults and Referrals (<ConsultsAndReferrals>) Section**:

   - Contains information about consultations, including provider details, purpose, priority, date, diagnostics, status, created by, canceled by, cancel reason, and comments.
   - Dates in ISO 8601 format.

Field	Description
ConsultationEntry	An array containing details of consult and referral entries.
Provider	The name of the healthcare provider or specialist being consulted or referred to.
Specialization	The specialization or medical field related to the consultation or referral.
Purpose	The purpose or reason for the consultation or referral.
Priority	The priority level of the consultation (e.g., High, Medium, Low).
Date	The date of the consultation or referral (ISO 8601 format).
Diagnostics	Diagnostic tests or procedures recommended for the consultation or referral.
Status	The status of the consultation or referral (e.g., Scheduled, Completed).
CreatedBy	The name of the healthcare provider who created the consultation or referral entry.
CancelledBy	The name of the healthcare provider who cancelled the consultation or referral, if applicable.
CancelReason	The reason for the cancellation, if applicable.
Comments	Additional comments or notes related to the consultation or referral.

Consult and Referrals XML sample

```
<ConsultsAndReferrals>
        <ConsultationEntry>
            <Provider>Dr. Anderson</Provider>
            <Specialization>Cardiology</Specialization>
            <Purpose>Cardiac Consultation</Purpose>
            <Priority>High</Priority>
            <Date>2023-11-20</Date>
            <Diagnostics>ECG, Blood Pressure</Diagnostics>
            <Status>Scheduled</Status>
            <CreatedBy>Nurse Smith</CreatedBy>
            <CancelledBy/>
            <CancelReason/>
            <Comments>Consultation requested for further evaluation.</Comments>
        </ConsultationEntry>
        <!-- Add more ConsultationEntry elements as needed -->
        <ConsultationEntry>
            <!-- Another Consultation entry goes here -->
        </ConsultationEntry>
</ConsultsAndReferrals>
```

6. **Diet (<Diet>) Section**:

- Provides details about a patient's diet, including age, admission date and time, diagnosis, doctor, diet description, created date and time, station, room/bed number, and comments.
- Dates and times should be converted to ISO 8601 format.

Field	Description
DietEntry	An array containing details of diet-related entries.
PATAGE	The age of the patient to whom the diet entry pertains.
ADMISSIONDATETIME	The date and time of admission for the diet entry (ISO 8601 format).
PATADMITDIAGNOSIS	The diagnosis related to the patient's admission.
Doctor	The name of the doctor or healthcare provider responsible for the diet plan.
DIETDESC	The description of the diet plan (e.g., Low Sodium Diet).
CREATEDON	The date and time when the diet entry was created (ISO 8601 format).
NSTATION	The name or identifier of the nutrition station.
ROOMBEDNO	The room and bed number where the patient is located.
COMMENTS	Additional comments or notes related to the diet plan.

Diet Section XML Sample

```
<Diet>
    <DietEntry>
        <PATAGE>43</PATAGE>
        <ADMISSIONDATETIME>2023-11-16 08:30:00</ADMISSIONDATETIME>
        <PATADMITDIAGNOSIS>Influenza</PATADMITDIAGNOSIS>
        <Doctor>Dr. Smith</Doctor>
        <DIETDESC>Low Sodium Diet</DIETDESC>
        <CREATEDON>2023-11-16 10:45:00</CREATEDON>
        <NSTATION>CC001 - Nutrition Station</NSTATION>
        <ROOMBEDNO>101 - Bed A</ROOMBEDNO>
        <COMMENTS>Follow prescribed diet plan.</COMMENTS>
    </DietEntry>
    <!-- Add more DietEntry elements as needed -->
    <DietEntry>
        <!-- Another Diet entry goes here -->
    </DietEntry>
</Diet>
```

7. **Documents (<Documents>) Section**:

- Contains information about documents, including document name, creation date, creator, and document address.
- The creation date should be converted to ISO 8601 format.
  - Documents saved at PatientDocuments Folder

Field	Description
DocumentEntry	An array containing details of document-related entries.
documentName	The name or title of the document (e.g., "MedicalReport.pdf").
CreatedDate	The date when the document was created (ISO 8601 format).
CreatedBy	The name of the individual who created the document.
DocumentAddress	The file path or location where the document is stored.
TemplateID	An identifier for the document template, if applicable.
PATACCTNUM	The patient's account number, if applicable.
RTFDATA	Base64-encoded content of the document, if applicable.
CHANGEDBY	The name of the individual who made changes to the document.
CHANGEDON	The date and time when changes were made to the document (ISO 8601 format).
SIGNEDBY	The name of the individual who signed the document, if applicable.
SIGNEDON	The date and time when the document was signed (ISO 8601 format), if applicable.
RESIGNEDBY	The name of the individual who re-signed the document, if applicable.
RESIGNEDON	The date and time when the document was re-signed (ISO 8601 format), if applicable.

DISMISSEDBY	The name of the individual who dismissed the document, if applicable.
DISMISSEDON	The date and time when the document was dismissed (ISO 8601 format), if applicable.
DISMISSEDREASON	The reason for dismissing the document, if applicable.
RETRACTIONBY	The name of the individual who retracted the document, if applicable.
RETRACTIONON	The date and time when the document was retracted (ISO 8601 format), if applicable.
RETRACTIONREASON	The reason for retracting the document, if applicable.

Documents Section XML Sample

```
<Documents>
        <DocumentEntry>
            <documentName>MedicalReport.pdf</documentName>
            <CreatedDate>2023-11-22</CreatedDate>
            <CreatedBy>Dr. Smith</CreatedBy>
            <DocumentAddress>/path/to/MedicalReport.pdf</DocumentAddress>
        </DocumentEntry>
        <!-- Add more DocumentEntry elements as needed -->
        <DocumentEntry>
            <!-- Another Document entry goes here -->
        </DocumentEntry>
    </Documents>
```

8. **Education Section (<EducationSection>) Section**:

- Includes educational entries with classification, description, verbal education, response, creation date, user details, user type, and notes.
- Dates in this section should be updated to ISO 8601 format.

Field	Description
EducationEntry	An array containing details of educational entries.
EdClassification	The classification or category of the education entry (e.g., "Class A").
Description	Description or details of the education entry.
VerbalEducation	Verbal education provided or received.
Response	Response to the education provided or received.
CreatedDate	The date when the education entry was created (ISO 8601 format).
User	The name or identifier of the user associated with the education entry.
UserType	The type or role of the user (e.g., "Nurse," "Patient").
EdNotes	Additional notes or comments related to the education entry.

Education Section XML Sample

```
<EducationSection>
        <EducationEntry>
            <EdClassification>Class A</EdClassification>
            <Description>Educational Description 1</Description>
            <VerbalEducation>Verbal Education 1</VerbalEducation>
            <Response>Response to Education 1</Response>
            <CreatedDate>2023-11-16</CreatedDate>
            <User>User A</User>
            <UserType>Nurse</UserType>
            <EdNotes>Notes for Education 1</EdNotes>
        </EducationEntry>
        <EducationEntry>
            <EdClassification>Class B</EdClassification>
            <Description>Educational Description 2</Description>
            <VerbalEducation>Verbal Education 2</VerbalEducation>
            <Response>Response to Education 2</Response>
            <CreatedDate>2023-11-17</CreatedDate>
            <User>User B</User>
            <UserType>Patient</UserType>
            <EdNotes>Notes for Education 2</EdNotes>
        </EducationEntry>
    </EducationSection>
```

9. **Epidemiology (<Epidemiology>) Section**:

    - Provides epidemiology information, including description, reported date, start date, preventive notes, provider name, and status.
    - Dates should be converted to ISO 8601 format.

Field	Description
EpidemiologyEntry	An array containing details of epidemiology entries.
EpidemiologyDescription	Description of the epidemiology entry (e.g., "Influenza").
REPORTEDON	Date when the epidemiology was reported (ISO 8601 format).
STARTDATE	Start date of the epidemiology period (ISO 8601 format).
PREVENTIVENOTES	Notes or instructions related to preventive measures.
PROVIDERNAME	Name of the healthcare provider associated with the entry.
STATUS	Status of the epidemiology entry (e.g., "Active").

Epidemiology Section XML Sample

```
<Epidemiology>
        <EpidemiologyEntry>
            <EpidemiologyDescription>Influenza</EpidemiologyDescription>
            <REPORTEDON>2023-11-16</REPORTEDON>
            <STARTDATE>2023-11-15</STARTDATE>
            <PREVENTIVENOTES>Follow hygiene practices</PREVENTIVENOTES>
            <PROVIDERNAME>Dr. Johnson</PROVIDERNAME>
            <STATUS>Active</STATUS>
        </EpidemiologyEntry>
        <!-- Add more EpidemiologyEntry elements as needed -->
    </Epidemiology>
```

10. **Intake Output Log (<IntakeOutputLog>) Section**:

- Contains data related to a patient's intake, output, and medication log, including dates and times.
- Dates and times should be modified to ISO 8601 format.

Field	Description
Date	An array containing entries for specific dates.
Patient	Patient-specific information for the date.
ID	Patient's identifier.
Name	Patient's name.
Provider	Healthcare provider information for the date.
ProviderID	Identifier of the healthcare provider.
ProviderName	Name of the healthcare provider.
Specialty	Specialization of the healthcare provider.
Shift	Information about different shifts in a day.
type	Type of shift (e.g., "Morning," "Afternoon," "Night").
Intake	Details of intake during the shift.
Output	Details of output during the shift.
Medication	Details of medication administered during the shift.
DailyTotals	Total intake, total output, and net total for the day.

Intake and Output XML Sample

```
<IntakeOutputLog>
  <Date value="YYYY-MM-DD">
   <Patient>
     <ID>12345</ID>
     <Name>John Doe</Name>
     <Provider>
       <ProviderID>56789</ProviderID>
       <ProviderName>Dr. Jane Smith</ProviderName>
       <Specialty>Cardiology</Specialty>
      </Provider>
   <Shift type="Morning">
    <Intake>
     <Item type="Water" time="08:00" amount="200" unit="ml"/>
     <Item type="IV Fluids" time="09:00" amount="500" unit="ml"/>
   <!-- More intake items as needed -->
    </Intake>
    <Output>
     <Item type="Urine" time="10:00" amount="300" unit="ml"/>
     <Item type="Stool" time="11:00" amount="100" unit="ml"/>
    <!-- More output items as needed -->
    </Output>
    <Medication>
    <Med type="Antibiotic" time="08:30" dose="250" unit="mg"/>
    <!-- More medication items as needed -->
    </Medication>
   </Shift>
   <!-- Repeat structure for afternoon and night shifts -->
   <DailyTotals>
     <IntakeTotal unit="ml">1200</IntakeTotal>
     <OutputTotal unit="ml">600</OutputTotal>
     <NetTotal unit="ml">600</NetTotal>
   <!-- Net Total = Intake Total - Output Total -->
   </DailyTotals>
 </Patient>
           <!-- Additional patient entries as needed -->
 </Date>
        <!-- Additional date entries as needed -
</IntakeOutputLog>
```

11. **Clinical Documents (<ClinicalDocuments>) Section**:

- Includes clinical document entries with various details, including creation, change, sign, resign, dismiss, retraction information, and encoded data.
- Dates and times should be updated to ISO 8601 format.
- RTFDATA Field is a Base64Encoded String

Field	Description
DocumentEntry	An array containing details of clinical document entries.
TemplateID	Identifier for the document template used.
PATACCTNUM	Patient's account number associated with the document.
RTFDATA	Base64-encoded document data.
CREATEDBY	Name of the user who created the document.
CREATEDON	Date when the document was created (ISO 8601 format).
CHANGEDBY	Name of the user who made changes to the document.
CHANGEDON	Date when the document was last changed (ISO 8601 format).
SIGNEDBY	Name of the user who signed the document.
SIGNEDON	Date when the document was signed (ISO 8601 format).
RESIGNEDBY	Name of the user who re-signed the document.
RESIGNEDON	Date when the document was re-signed (ISO 8601 format).
DISMISSEDBY	Name of the user who dismissed the document.
DISMISSEDON	Date when the document was dismissed (ISO 8601 format).
DISMISSEDREASON	Reason for dismissing the document.
RETRACTIONBY	Name of the user who retracted the document.
RETRACTIONON	Date when the document was retracted (ISO 8601 format).
RETRACTIONREASON	Reason for retracting the document.

Clinical Documents Section XML Sample

```
<ClinicalDocuments>
        <DocumentEntry>
            <TemplateID>1001</TemplateID>
            <PATACCTNUM>987654321</PATACCTNUM>
            <RTFDATA>Base64EncodedStringHere</RTFDATA>
            <CREATEDBY>Dr. Alice Smith</CREATEDBY>
            <CREATEDON>2023-11-21T10:00:00</CREATEDON>
            <CHANGEDBY>Nurse John Doe</CHANGEDBY>
            <CHANGEDON>2023-11-22T15:30:00</CHANGEDON>
            <SIGNEDBY>Dr. Emily Johnson</SIGNEDBY>
            <SIGNEDON>2023-11-23T09:20:00</SIGNEDON>
            <RESIGNEDBY>Nurse Michael Brown</RESIGNEDBY>
            <RESIGNEDON>2023-11-24T11:45:00</RESIGNEDON>
            <DISMISSEDBY>Dr. David Wilson</DISMISSEDBY>
            <DISMISSEDON>2023-11-25T14:10:00</DISMISSEDON>
            <DISMISSEDREASON>Change in patient condition</DISMISSEDREASON>
            <RETRACTIONBY>Admin Lisa Green</RETRACTIONBY>
            <RETRACTIONON>2023-11-26T16:55:00</RETRACTIONON>
            <RETRACTIONREASON>Patient request</RETRACTIONREASON>
        </DocumentEntry>
        <!-- Additional DocumentEntry elements as needed -
</ClinicalDocuments>
```

12. **Scales (<Scales>) Section**:

- Provides information about scales, including scale name, questions, score description, creation date, and creator.
- The creation date should be converted to ISO 8601 format.

Field	Description
Scale	An array containing details of scales used.
ScaleName	Name or title of the scale (e.g., "Morse Fall Scale").
Questions	Array of questions and answers related to the scale.
QuestionText	Text of the scale question.
Answer	Answer to the scale question.
AnswerValue	Numeric value associated with the answer.
ScaleScoreDescription	Description of the scale score (e.g., "Low Risk").
CreatedDate	Date when the scale entry was created (ISO 8601 format).
CreatedBy	Name of the user who created the scale entry.

Scales Section XML Sample

```
<Scales>
        <!-- Scale 1 -->
        <Scale>
            <ScaleName>Morse Fall Scale</ScaleName>
            <!-- Questions bracket -->
            <Questions>
                <questionEntry>
                    <QuestionText>Question 1</QuestionText>
                    <Answer>Answer A</Answer>
                    <AnswerValue>5</AnswerValue>
                </questionEntry>
                <questionEntry>
                    <QuestionText>Question 2</QuestionText>
                    <Answer>Answer C</Answer>
                    <AnswerValue>10</AnswerValue>
                </questionEntry>
                <!-- Add more questions as needed -->
            </Questions>
            <ScaleScoreDescription>Low Risk</ScaleScoreDescription>
            <CreatedDate>2023-11-16T12:34:56</CreatedDate>
            <CreatedBy>User123</CreatedBy>
        </Scale>
        <!-- Scale 2 and so on -->
 </Scales>
```

PatientFinancialData.XML Dictionary

1. **Encoding and Declaration**: The document starts with an XML declaration specifying the encoding and version.

2. **Patient Account Section**: Holds the primary account information of the patient, including basic admission details.

Field Name	Description
INVOICENUM	Unique invoice number
MEDRECNUM	Medical record number
PATACCTNUM	Patient account number
PATCATEGORY	Category of the patient (e.g., OPD, IPD)
ADMISSIONDATETIME	Date and time of admission
DISCHARGEDATETIME	Date and time of discharge
ADMISSIONTYPE	Type of admission (e.g., Emergency, Routine)
ADMITTEDFROM	Code indicating where the patient was admitted from
PATIENTTYPECODE	Code representing the type of patient
PATSTARTILLNESS	Date when the illness started
EMPLOYMENTRELATED	Indicator if related to employment
ACCIDENTRELATED	Indicator if related to an accident
OTHERACCIDENTRELATED	Indicator for other accident-related issues
PATREFERRALNUM	Referral number for the patient
TYPEOFBILL	Type of bill (e.g., hospital, clinic)
STATEMENTFROM	Statement start date
STATEMENTTO	Statement end date

3. **Demographics Section:** Contains detailed demographic information of the patient.

Field Name	Description
PATLASTNAME	Patient's last name
PATMATLASTNAME	Patient's maternal last name
PATFIRSTNAME	Patient's first name
PATMIDNAME	Patient's middle name
PATADDR1	Patient's primary address
PATADDR2	Secondary address line
PATCITY	City of residence
PATSTATE	State of residence

PATZIPCODE	ZIP code of residence
PATBIRTHDATE	Patient's date of birth
PATGENDER	Gender of the patient
PATHOMEPHONE	Home phone number
PATMARITALSTATUS	Marital status
PATEMPLOYER	Employer's name
PATSOCSECNUM	Social security number

4. **Financial Section -** Provides a summary of financial balances related to the patient's account.

Field Name	Description
INVBALANCE	Total invoice balance
INVPAYTOTAL	Total amount paid
INVPENDBALANCE	Pending balance after payments

5. **Diagnoses Section**: Lists all diagnoses associated with the patient's visit.

Field Name	Description
DXINDICATOR	Indicator of diagnosis type (P, S, etc.)
DXCODE	Diagnosis code (e.g., J00)
DXDESC	Description of the diagnosis
DXPOA	Indicator of present on admission
CODESET	Code set used for diagnosis

6. **Procedures Section**: Details of medical procedures performed on the patient.

Field Name	Description
OPCODE	Procedure code
OPINDICATOR	Indicator of type of procedure
OPDATE	Date of the procedure
OPDESC	Description of the procedure

7. **ValueCodes Section**: Contains value codes and amounts related to the patient's account and billing.

Field Name	Description
CODE	Value code
AMOUNT	Amount associated with the value code

8. **Conditions Section**: Lists any conditions related to the patient's treatment or billing.

Field Name	Description
CONDITION	Condition code
DESC	Description of the condition

9. **Insurances Section**: Insurance details associated with the patient's account.
   a. PlanDetails Subsection

Field Name	Description
PLANID	Insurance plan ID
PLANNAME	Name of the insurance plan
PLANADDR1	Address line 1 of the insurance plan
PLANADDR2	Address line 2 of the insurance plan
PLANCITY	City of the insurance plan
PLANSTATE	State of the insurance plan
PLANCOUNTRY	Country of the insurance plan
PLANZIPCODE	ZIP code of the insurance plan

   b. ContractDetails Subsection

Field Name	Description
PATCONTRACTNUM	Patient's contract number with the insurance
RELATIONSHIPTOHOLDER	Relationship of patient to the policyholder
HOLDERCONTRACTNUM	Contract number of the policyholder
EFFECTIVEDATE	Effective date of the insurance
EXPIRATIONDATE	Expiration date of the insurance
MEDICARETYPE	Type of Medicare if applicable

   c. HolderDetails Subsection

Field Name	Description
HOLDERPATLASTNAME	Policyholder's last name
HOLDERMATLASTNAME	Policyholder's maternal last name
HOLDERFIRSTNAME	Policyholder's first name
HOLDERMIDDLENAME	Policyholder's middle name
HOLDERBIRTHDATE	Policyholder's birth date
HOLDERGENDER	Gender of the policyholder
HOLDEREMPLOYER	Policyholder's employer

   d. GroupDetails Subsection

Field Name	Description
GROUPNUM	Insurance group number
GROUPNAME	Name of the insurance group

e. FinancialDetails Subsection

Field Name	Description
REVENUECODE	Revenue code for billing
BALANCE	Insurance balance
PAYTOTAL	Total amount paid by insurance
PENDBALANCE	Pending balance of insurance

f. ProviderDetails Subsection

Field Name	Description
PROVIDERNUM	Provider number
REPNAME	Representative name for billing

g. AdditionalInfo Subsection

Field Name	Description
IPDPOS	Inpatient place of service code
OPDPOS	Outpatient place of service code
PRN2NDCARR	Indicator for secondary carrier
EXSECPROV	Indicator for secondary provider
GROUPREV	Indicator for group revenue
INCREFDOC	Indicator for including referring doctor
INCPATREFNUM	Included patient reference number
PPS	Indicator for Prospective Payment System
FLD81_TAXO	Taxonomy field 81
SEND_ADD_REMARKS	Indicator for additional remarks
SEND_QUAL_FLD14	Indicator for qualifier in field 14
SUPADT	Indicator to suppress admission date/time
SUPF18	Indicator to suppress field 18 in form
SUPRESS_UB04_FLD_69	Suppress field 69 in UB04 form
SUPRESS_UB04_FLD_70	Suppress field 70 in UB04 form

10. Doctors Section: Information about doctors who attended to the patient.

Field Name	Description
DOCTORID	Unique identifier of the doctor
TYPE	Type of doctor (e.g., Attending, Consulting)
DOCTORFIRSTNAME	First name of the doctor
DOCTORMIDNAME	Middle name of the doctor
DOCTORLASTNAME	Last name of the doctor

DOCTORMATLASTNAME	Maternal last name of the doctor
UPINNUMBER	UPIN number of the doctor
LICENSE	Doctor's license number
TAXONOMYCODE	Taxonomy code of the doctor

a. DoctorProvider Subsection

Field Name	Description
PLANID	Insurance plan ID associated with the doctor
SEQUENCE	Sequence number
IDTYPE	Type of provider ID
PROVIDERNUM	Provider number

PatientFinancialData.XML Sample:

```
<?xml version="1.0" encoding="UTF-8"?>
<PatientAccount INVOICENUM="140704" MEDRECNUM="0000000324" PATACCTNUM="2011200321"
PATCATEGORY="OPD" ADMISSIONDATETIME="2015-09-17T10:34:00" DISCHARGEDATETIME="2015-09-
18T08:19:00" ADMISSIONTYPE="Emergency" ADMITTEDFROM="2" PATIENTTYPECODE="2"
PATSTARTILLNESS="2014-09-02T00:00:00" EMPLOYMENTRELATED="0" ACCIDENTRELATED="0"
OTHERACCIDENTRELATED="0" PATREFERRALNUM="REF1234" TYPEOFBILL="131"
STATEMENTFROM="09/17/2015" STATEMENTTO="09/18/2015">
    <Demographics>
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PATFIRSTNAME="NESTOR" PATMIDNAME="I" PATADDR1="PORTAL PRUEBA PRUEBA FISICA"
PATADDR2="PORTAL PRUEBA PRUEBA FISICA2" PATCITY="SAN JUAN" PATSTATE="PR"
PATZIPCODE="00925" PATBIRTHDATE="1963-01-01T00:00:00" PATGENDER="M"
PATHOMEPHONE="7876202474" PATMARITALSTATUS="S" PATEMPLOYER="COMPANÍA DE FOMENTO
INDUSTRIAL" PATSOCSECNUM="222222222" />
    </Demographics>
    <Financial>
        <Balance INVBALANCE="125.00" INVPAYTOTAL="0.00" INVPENDBALANCE="125.00" />
    </Financial>
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COLD]" DXPOA=" " CODESET="0" />
        <Diagnosis DXINDICATOR="S" DXCODE="J0140" DXDESC="ACUTE PANSINUSITIS,
UNSPECIFIED" DXPOA=" " CODESET="0" />
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of Right Lung Lobe, Percutaneous Endoscopic Approach" />
        <Procedure OPCODE="0FJD8ZZ" OPINDICATOR="S" OPDATE="2015-09-18"
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    </Procedures>
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        <ValueCode CODE="A1" AMOUNT="100.00" />
        <ValueCode CODE="B2" AMOUNT="50.00" />
    </ValueCodes>
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        <Condition CONDITION="R52" DESC="Pain, unspecified" CODESET="0" />
        <Condition CONDITION="M54.5" DESC="Lower back pain" CODESET="0" />
    </Conditions>
    <Insurances>
        <Insurance COORDINATENUM="1">
            <PlanDetails PLANID="227" PLANNAME="First Plus Medicare Advantage"
                 PLANADDR1="PO Box 144090" PLANADDR2=""
                 PLANCITY="Arecibo" PLANSTATE="PR" PLANCOUNTRY="Puerto Rico"
PLANZIPCODE="00966" />
            <ContractDetails PATCONTRACTNUM="123601010" RELATIONSHIPTOHOLDER="18"
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                     EXPIRATIONDATE="2016-09-17T00:00:00" MEDICARETYPE="" />
            <HolderDetails HOLDERPATLASTNAME="CARRASQUILLO"
HOLDERMATLASTNAME="CARRASQUILLO2"
                   HOLDERFIRSTNAME="NESTOR" HOLDERMIDDLENAME="IVAN"
HOLDERBIRTHDATE="1963-01-02T00:00:00"
                   HOLDERGENDER="M" HOLDEREMPLOYER="" />
            <GroupDetails GROUPNUM="" GROUPNAME="" />
            <FinancialDetails REVENUECODE="0450" BALANCE="105.00" PAYTOTAL="0.00"
PENDBALANCE="105.00" />
            <ProviderDetails PROVIDERNUM="1154391415" REPNAME="FACTURACION REPRESENTANTE
2DO PISO" />
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                    SEND_ADD_REMARKS="0" SEND_QUAL_FLD14="0" SUPADT="0" SUPF18="1"
                    SUPRESS_UB04_FLD_69="0" SUPRESS_UB04_FLD_70="0" />
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    </Insurances>
    <Doctors>
        <Doctor DOCTORID="1444" TYPE="A" DOCTORFIRSTNAME="CARMEN" DOCTORMIDNAME="R"
DOCTORLASTNAME="BALLESTER" DOCTORMATLASTNAME="FRANK" UPINNUMBER="" LICENSE="L13454"
TAXONOMYCODE="111NI0900X">
            <DoctorProvider PLANID="227" SEQUENCE="1" IDTYPE="XX"
PROVIDERNUM="1234567990" />
        </Doctor>
        <Doctor DOCTORID="1444" TYPE="C" DOCTORFIRSTNAME="CARMEN" DOCTORMIDNAME="R"
DOCTORLASTNAME="BALLESTER" DOCTORMATLASTNAME="FRANK" UPINNUMBER="" LICENSE="L13454"
TAXONOMYCODE="111NI0900X">
            <DoctorProvider PLANID="227" SEQUENCE="1" IDTYPE="XX"
PROVIDERNUM="1234567990" />
        </Doctor>
    </Doctors>
</PatientAccount>
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