



Standard Specification for Healthcare Document Formats¹

This standard is issued under the fixed designation E2184; the number immediately following the designation indicates the year of original adoption or, in the case of revision, the year of last revision. A number in parentheses indicates the year of last reapproval. A superscript epsilon (ϵ) indicates an editorial change since the last revision or reapproval.

1. Scope

1.1 This specification addresses requirements for the headings, arrangement, and appearance of sections and subsections when used within an individual's healthcare documents. This specification will facilitate identification and retrieval of health information in a manner that will enhance the quality and efficiency of health services. Use of this specification in conjunction with XML DTDs (extensible markup language document type definitions) and the EHR (electronic health records) would further enhance efficiency in time and cost. This specification applies across multiple healthcare settings in which healthcare documents are generated, such as hospitals, clinics, skilled nursing facilities, ambulatory care facilities, outpatient surgery centers, and private healthcare providers' offices.

1.2 This specification addresses the headings, arrangement, and appearance of sections and subsections of healthcare documents, however generated (dictation/transcription, speech recognition, touch-screen entry, and so forth) and whether displayed electronically or on paper. It does not address the titles of healthcare documents or the content of sections and subsections.

1.2.1 The author of a healthcare document may choose to summarize subsection information within a general section rather than creating subsections.

1.3 The format and content of patient-identifying data are addressed in Guide E1384.

1.4 Issues of confidentiality and security are addressed in Guide E1869, Guide E1902, Guide E1762, Guide E1985, Guide E1986, Guide E1987, Guide E1988, Specification E2084, Guide E2085, and Guide E2086, as well as in Specification E2147.

1.5 Issues of XML DTDs are addressed in Specification E2182 and Guide E2183.

2. Referenced Documents

2.1 ASTM Standards:²

E1384 Practice for Content and Structure of the Electronic

Health Record (EHR)²

E1762 Guide for Electronic Authentication of Health Care Information²

E1869 Guide for Confidentiality, Privacy, Access, and Data Security Principles for Health Information Including Electronic Health Records²

E1902 Specification for Management of the Confidentiality and Security of Dictation, Transcription, and Transcribed Health Records²

E1985 Guide for User Authentication and Authorization²

E1986 Guide for Information Access Privileges to Health Information²

E1987 Guide for Individual Rights Regarding Health Information^{3 2}

E1988 Guide for Training of Persons who have Access to Health Information^{3 2}

E2084 Specification for Authentication of Healthcare Information Using Digital Signatures^{3 2}

E2085 Guide on Security Framework for Healthcare Information^{3 2}

E2086 Guide for Internet and Intranet Healthcare Security^{3 2}

E2147 Specification for Audit and Disclosure Logs for Use in Health Information Systems²

E2182 Specification for Clinical XML DTDs in Healthcare²

E2183 Guide for XML DTD Design, Architecture and Implementation

3. Terminology

3.1 Definitions:

3.1.1 *alias, n*—heading synonymous with and which shall be replaced by the specified heading. No alias (synonym) shall be used in place of the specified heading. The aliases presented are examples only, that is, no attempt has been made to identify all potential aliases.

3.1.2 *amendment, n*—a correction or addendum to a document.

3.1.3 *author, n*—the person originating content for a healthcare document.

3.1.4 *document, n*—see *healthcare document*.

¹ This specification is under the jurisdiction of ASTM Committee E31 on Healthcare Informatics and is the direct responsibility of Subcommittee E31.15 on Health Information Capture and Documentation.

Current edition approved Jan. 10, 2002. Published March 2002. DOI: 10.1520/E2184-02.

² Annual Book of ASTM Standards, Vol 14.01.

³ Withdrawn. The last approved version of this historical standard is referenced on www.astm.org.

3.1.5 *format, n*—the arrangement of the content of a health-care document for display. In this specification, format refers to the sequencing of the sections and subsections used in a healthcare document, the appearance of their headings, their line spacing, and their alignment.

3.1.6 *healthcare document, n*—healthcare information, however generated, pertinent to a specific individual and recorded to serve a specific use.

3.1.7 *healthcare information, n*—worded, numeric, imaged, or data-streamed material used to communicate the healthcare experience of, and related services for, an individual.

3.1.8 *health record, n*—healthcare information retrievable from one or more sources, however displayed, pertinent to an individual, used to describe and measure that individual's health status and health care over time and across settings, to facilitate healthcare management through one or more episodes of care, including preventive or health maintenance activities.

3.1.9 *medical transcriptionist, n*—a medical language specialist who interprets and transcribes dictation by physicians and other healthcare professionals regarding patient assessment, workup, therapeutic procedures, clinical course, diagnosis, prognosis, and so forth, in order to document patient care and facilitate delivery of healthcare services. **AAMT (1)⁴**

3.1.10 *practitioner, n*—an individual who is qualified to practice a health care profession, for example, physician, nurse, or physical therapist. Practitioners are often required to be licensed as defined by law.

3.1.11 *provider, n*—a business entity that furnishes health care to a consumer; it includes a professionally licensed practitioner who is authorized to operate a healthcare delivery facility. **E1384**

3.2 Acronyms:

3.2.1 **AAMT**—American Association for Medical Transcription

3.2.2 **CPT-4**—Physician's Current Procedural Terminology—Fourth Edition **(2)**

3.2.3 **DTD**—document-type definition

3.2.4 **ICD-9-CM**—International Classification of Diseases, Ninth Edition, Clinical Modification **(3)**

3.2.5 **JCAHO**—Joint Commission on Accreditation of Healthcare Organizations

3.2.6 **SOAP**—Subjective, Objective, Assessment, Plan

3.2.7 **XML**—extensible markup language

4. Significance and Use

4.1 This specification is intended to result in consistency in the names of headings of sections and subsections (when used), their arrangement, and their appearance in individuals' health-care documents.

4.2 Primary benefits of this consistency in presentation include: (1) facilitating identification and retrieval of health information in a manner that will enhance the quality and efficiency of health services, patient safety, and patient privacy, (2) providing easier access to relevant health information within a record, (3) enabling greater information sharing within

and among enterprises, and (4) promoting greater efficiency in transcription and other forms of data capture. Secondary benefits include improved access to health information for reimbursement, legal, research, and statistical purposes.

4.3 Consistent with provider policy, the application of this specification is the responsibility of the author of the healthcare document, the medical transcriptionist or other person responsible for entering information into the healthcare document, or a combination thereof.

4.4 **Annex A1** specifies the headings of sections and subsections (when used), their arrangements, and their appearance in history and physical examination reports, consultation reports, emergency department notes, clinic notes, nurses notes, therapists notes, treatment summaries (including discharge, transfer, and death summaries). These headings for sections and subsections may also appear in other healthcare documents.

5. Specifications

5.1 *Sections and Subsections: Headings, Arrangement, and Appearance*—The specified headings shall be utilized for sections and subsections when used within individual health-care documents, shall be ordered and arranged as listed, and shall be presented with the appearance specified. Definitions are offered to clarify the meanings of the headings. Sample aliases are noted to identify some terms that shall be converted to assure a uniform specified heading; other aliases shall be similarly converted. Comments are included as appropriate.

5.1.1 Arrangement:

5.1.1.1 *Section Headings*—When used, section headings shall be placed in the sequence specified and shall be left-margin aligned. Each section and its heading shall be separated from the previous section by a line space or the equivalent. The initial entry regarding a section (even if that initial entry is a subsection heading) shall begin on the line immediately following the section heading and shall be left-margin aligned.

5.1.1.2 *Subsection Headings*—When used, subsection headings shall be placed in the sequence specified and shall be left-margin aligned under their respective sections. When a subsection heading is the initial entry following a section heading, that subsection heading shall be entered on the line immediately following the section heading. Each subsection and its heading shall be separated from the previous section or subsection by a line space or the equivalent.

5.1.1.3 *Inclusion*—None of the sections or subsections is required, but if such information is included, the specified headings shall be used.

5.1.1.4 *Content Following Section or Subsection Headings*—Content following headings shall begin on the next line and shall be aligned at the left margin throughout, below the heading. No content shall follow on the same line as a section or subsection heading. Multiple paragraphs within sections and subsections shall be separated by a line space.

5.1.2 Appearance:

5.1.2.1 Section heading terms shall be in uppercase letters (for example, PAST HISTORY).

5.1.2.2 Subsection heading terms shall be in initial capital letters followed by lowercase letters with the exception of conjunctions, articles, and prepositions.

⁴ The boldface numbers in parentheses refer to the list of references at the end of this standard.

letters, which shall be in all lowercase letters (for example, Alcohol and Substance Abuse).

5.1.2.3 Content following headings shall be in uppercase and lowercase according to standard language usage, with the exception that the term ALLERGIES and any SUBSTANCE to which the individual is allergic shall be in all uppercase letters.

ANNEX

(Mandatory Information)

A1. HEADINGS FOR SECTIONS AND SUBSECTIONS OF HISTORY AND PHYSICAL EXAMINATION REPORTS AND RELATED HEALTHCARE DOCUMENTS

A1.1 *Headings for sections and subsections*—The headings below shall be applied to sections and subsections when used within history and physical examination reports, consultation reports, emergency department notes, clinic notes, nurses notes, therapists notes, treatment summaries (including discharge, transfer, and death summaries). The headings may also apply to other healthcare documents.

A1.1.1 In certain instances specific formats for portions of healthcare documents are in accepted usage, for example, SOAP notes and problem oriented medical reports. When the section or subsection terms in the following list are utilized within such format conventions, this standard specification shall be applicable to such use.

A1.2 *Patient-identifying Data*—Patient-identifying data are addressed in Guide [E1384](#).

A1.3 Section Heading: CHIEF COMPLAINT(S)

A1.3.1 *Definition*—The patient's stated reason(s) for presenting, (typically presented as one complaint in the patient's own words).

A1.3.2 CHIEF COMPLAINT replaces Presenting Complaint, Primary Complaint, Complaint, CC, Presenting Problem, and other aliases.

A1.3.3 *Comments*—If there are multiple complaints of equal significance to the patient, identify them collectively as CHIEF COMPLAINTS. When multiple complaints are prioritized by the patient, present the primary one as the CHIEF COMPLAINT and include others in a subsection with the heading Additional Complaints.

A1.3.3.1 Additional Complaints.

A1.4 Section Heading: REASON FOR ENCOUNTER

A1.4.1 *Definition*—Condition, diagnosis, or treatment plan for which the individual is entered into a service, whether inpatient or outpatient. More formal statement than CHIEF COMPLAINT and presented in practitioner's terms rather than patient's.

A1.4.2 REASON FOR ENCOUNTER replaces Reason for Admission, Reason for Visit, Reason for Service, and other aliases.

6. Keywords

6.1 appearance; arrangement; format; headings; healthcare document; sections; subsections

A1.5 Section Heading: HISTORY OF PRESENT ILLNESS

A1.5.1 *Definition*—History related to the Chief Complaint or Reason for Encounter, or both.

A1.5.2 HISTORY OF PRESENT ILLNESS replaces HPI, Present Illness, PI, History of Present Health, and other aliases.

A1.6 Section Heading: PAST HISTORY

A1.6.1 *Definition*—The individual's significant health history other than that pertinent to the current reason for seeking healthcare services. If any information on the individual's past history is included in the document, it shall be included in this section. This section may include information on medical, surgical, psychiatric, social, family, dental/oral, perinatal, medication, immunization, alcohol and substance abuse, diet, education, work history, and so forth, in narrative form or as subsections.

A1.6.2 PAST HISTORY replaces Past Medical History, PMH, Health History, and other aliases.

A1.6.3 *Subsection Headings*:

A1.6.3.1 Medications. Enter non-current medications here. Address current medications in [A1.8](#).

A1.6.3.2 Immunizations

A1.6.3.3 Education

A1.6.3.4 Habits

A1.6.3.5 Social

A1.6.3.6 Family

A1.6.3.7 Medical

A1.6.3.8 Surgical

A1.6.3.9 Psychiatric (Psychiatric replaces Mental and other aliases.)

A1.6.3.10 Obstetrical/Gynecologic

A1.6.3.11 Dental/Oral

A1.6.3.12 Alcohol and Substance Abuse (This topic may be addressed in the subsection Habits rather than within its own subsection.)

A1.6.3.13 Diet

A1.6.3.14 Work History

A1.7 Section Heading: ALLERGIES

A1.7.1 *Definition*—Hypersensitivity to specified medications and other substances. All of the individual's known allergies shall be listed here, even though they may be listed on