

**Virginia Department of Health**  
**Electronic Case Report Data Elements**

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**Prepared by:**

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## Data Element Specifications

The tables below outline the data elements requested for electronic lab report submission.

Data Element	Use	Element Type	Definition
<b>Date of the Report</b>	R	Header	The date on which the reporting party (e.g., physician, nurse practitioner, physician assistant, etc.), completes collection of minimum data for the eICR
<b>id</b>	R	Header	This id is the globally unique identifier for the document
<b>templateId</b>	R	Header	Asserts conformance to the C-CDA template, which is the key mechanism for senders and receivers of C-CDA documents
<b>code</b>	R	Header	This code specifies the particular kind of document (e.g., History and Physical, Discharge Summary, Progress Note)
Patient Class	RE	Patient	Whether patient is outpatient, inpatient, emergency, urgent care
Patient ID Number	RE	Patient	Patient social security number, medical record number, or other identifying value as required or allowed under jurisdictional laws governing health data exchange
<b>Patient Name</b>	R	Patient	<b>All names for the patient, including legal names and aliases. Must include the name type (i.e., legal or alias), first name, middle name, and last name</b>
Patient Phone	RE	Patient	All phone numbers and phone number types for the patient
Patient Email	RE	Patient	The email address for the patient
Parent/Guardian Name	RE	Patient	All names for the patient's parent or guardian, including legal names and aliases (if patient age is < 18 years). Must include name type (i.e., legal or alias), first name, middle name, and last name
Parent/Guardian Phone	RE	Patient	All phone numbers and phone number types for the parent/guardian
Parent/Guardian Email	RE	Patient	The email address for the patient's parent/guardian.
Street Address	RE	Patient	All addresses for the patient, including current and residential addresses. Must include street address, apartment or suite number, city or town, county, state, zip code, and country
<b>Birth Date</b>	R	Patient	<b>The patient's date of birth</b>
Patient Sex	RE	Patient	The patient's biological sex (not gender)
Race	RE	Patient	The patient's race
Ethnicity	RE	Patient	The patient's ethnicity
Preferred Language	RE	Patient	The patient's preferred language
Occupation	RE	Patient	The patient's occupation
Pregnant	RE	Patient	The patient's pregnancy status
Reason for Visit	RE	Patient	Provider's interpretation for the patient's visit for the reportable event
Death Date	RE	Patient	The patient's date of death

Use codes: R- Required to be sent; RE- Required to be sent but can be empty if information is not available; O- Optional

Data Element	Use	Element Type	Definition
Immunization Status	RE	Patient	Should include current immunization status, and may contain the entire immunization history that is relevant to the period of time being summarized.
Travel History Date	RE	Patient	Date patient traveled
Travel History Location- Text	RE	Patient	Free text describing the travel history details and location can be entered using the text element.
Travel History Location- Coded	RE	Patient	Code to indicate location of patient travel
Travel History Location- Address	RE	Patient	Address of location where patient traveled
Insurance Type	O	Patient	
Past pregnancy indication	RE	Patient	
Date of past pregnancy completion	RE	Patient	
Estimated date of delivery	RE	Patient	The estimated date of when the patient will give birth
Provider ID	RE	Provenance	Identification code for the care provider (e.g., NPI)
Provider Name	RE	Provenance	The first and last name of the healthcare provider
Provider Phone	RE	Provenance	The provider's phone number with area code
Provider Fax	RE	Provenance	The provider's fax number with area code
Provider Email	RE	Provenance	The provider's email address
Provider Facility/Office Name	RE	Provenance	The provider facility's full name, not necessarily where care was provided to patient
Provider Address	RE	Provenance	The geographical location or mailing address of the provider's office or facility. Address must include street address, office or suite number (if applicable), city or town, state, and zip code
Facility ID Number	RE	Provenance	Identification code for the facility (e.g., Facility NPI)
<b>Facility Name</b>	<b>R</b>	<b>Provenance</b>	<b>The facility's name</b>
Facility Type	RE	Provenance	The type of facility where patient received or is receiving healthcare for the reportable condition (e.g., hospital, ambulatory, urgent care, etc.)
Facility Phone	RE	Provenance	The facility's phone number with area code
Facility FAX	RE	Provenance	The facility's fax number with area code
Facility Address	RE	Provenance	The mailing address for the facility where patient received or is receiving healthcare for the reportable condition. Must include street address, city/town, county, state, and zip code
Hospital Unit	RE	Provenance	
Sending Application	RE	Provenance	The name of the sending application
Provider County	RE	Provenance	The county where the provider is located
<b>Visit Date/Time</b>	<b>R</b>	<b>Clinical</b>	<b>Date and time of the provider's most recent encounter with the patient regarding the reportable condition</b>
Admission Date/Time	RE	Clinical	Date and time when the patient was admitted to the treatment facility; e.g., hospital
Discharge Date/Time	RE	Clinical	Date and time when the patient was discharged from the treatment facility; e.g., hospital
Date of Onset	RE	Clinical	The date of symptoms for the reportable event

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Data Element	Use	Element Type	Definition
Symptoms (list)	RE	Clinical	List of patient symptoms (structured) for the reportable event
<b>Lab Order Code (Trigger)</b>	<b>RE</b>	<b>Clinical</b>	
<b>Laboratory Results (Trigger)</b>	<b>RE</b>	<b>Clinical</b>	
Filler Order Number	RE	Clinical	
<b>Diagnoses (Trigger)</b>	<b>R</b>	<b>Clinical</b>	<b>The healthcare provider's diagnoses of the patient's health condition (all)</b>
Date of Diagnosis	RE	Clinical	The date of provider diagnosis
Medications Administered (list)	RE	Clinical	List of medications administered for the reportable event
Medications administered time -single	RE	Clinical	
Medications administered time -start	RE	Clinical	
Medications administered time -end	RE	Clinical	
Medication frequency per day	RE	Clinical	
Medication frequency series	RE	Clinical	
Medication route	RE	Clinical	
Medication site	RE	Clinical	
Medication dose	RE	Clinical	
Lab test(s) Performed	RE	Clinical	
Treatments/ Procedures	RE	Clinical	
Treatment date	RE	Clinical	
specimen collection date/time	RE	Clinical	

**Additional information for HIV/AIDS Case investigation that would be helpful to have are:**

- Transmission Risk: Male-Sex-with-Male (MSM); Injection Drug Use (IDU); Bisexual; Heterosexual contact with (a) HIV infected; (b) Bisexual male; (c) Injection Drug User; Transfusion recipient; Other risk (specify)
- Name/Address of Lab
- Signs/symptoms, opportunistic infections, treatment history and date, exposure, date and type of last negative HIV test, date of first positive HIV test, out of state diagnosis, etc.
- Contact of Person Completing the Form: Name, Address, Phone Number