Reg-ent℠ | Sections and Elements

Patient Demographics Section	This records the patient whose health information is described by the clinical document.
Encounters Section	This section lists and describes any healthcare encounters pertinent to the patient's current health status or historical health history. It may include visits, appointments, as well as non face-to-face interactions. This section may contain all encounters for the time period being summarized, but should include notable encounters.
Problem Section	This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed.
Medications Section	The Medications section defines a patient's current medications and pertinent medication history. At a minimum, the currently active medications are to be listed, with an entire medication history as an option. The section may also include a patient's prescription and dispense history.
Procedures Section	This section defines all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section is intended to include notable procedures, but can contain all procedures for the period of time being summarized. This section contains procedure templates represented with three RIM classes: Act, Observation, and Procedure. Procedure act is for procedures the alter that physical condition of a patient (Splenectomy). Observation act is for procedures that result in new information about a patient but do not cause physical alteration (EEG). Act is for all other types of procedures (dressing change).
Orders and Result Observation Section	The Results section contains the results of observations generated by laboratories, imaging procedures, and other procedures. The scope includes observations such as hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. The section often includes notable results such as abnormal values or relevant trends, and could contain all results for the period of time being documented. Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory.
Vital Signs Section	The Vital Signs section contains relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, and pulse oximetry. The section should include notable vital signs such as the most recent, maximum and/or minimum, baseline, or relevant trends. Vital signs are represented in the same way as other results, but are aggregated into their own section to follow clinical conventions.
Payer Section	The Payers section contains data on the patient's payers, whether a 'third party' insurance, self-pay, other payer or guarantor, or some combination of payers, and is used to define which entity is the responsible fiduciary for the financial aspects of a patient's care. Each unique instance of a payer & all the pertinent data needed to contact, bill to, and collect from that payer should be included. Authorization information can be used to define pertinent referral, authorization tracking number, procedure, therapy, intervention, device, or similar authorizations for the patient or provider, or both should be included. At a minimum, the patient's pertinent current payment sources should be listed. The sources of payment are represented as a Coverage Activity, which identifies all of the insurance policies or government or other programs that cover some or all of the patient's healthcare expenses. The policies or programs are sequenced by preference.

Social History Observation Section	This section contains data defining the patient's occupational, personal (e.g. lifestyle), social, and environmental history and health risk factors, as well as administrative data such as marital status, race, ethnicity and religious affiliation. Social history can have significant influence on a patient's physical, psychological and emotional health and wellbeing so should be considered in the development of a complete record.
Allergies Section	This section lists and describes any medication allergies, adverse reactions, idiosyncratic reactions, anaphylaxis/anaphylactoid reactions to food items, and metabolic variations or adverse reactions/allergies to other substances (such as latex, iodine, tape adhesives) used to assure the safety of health care delivery. At a minimum, it should list currently active and any relevant historical allergies and adverse reactions.
Advance Directive Section	This section contains data defining the patient's advance directives and any reference to supporting documentation. The most recent and up-to-date directives are required, if known, and should be listed in as much detail as possible. This section contains data such as the existence of living wills, healthcare proxies, and CPR and resuscitation status. If referenced documents are available, they can be included in the CCD exchange package.
Plan of Care Section	The Plan of Care section contains data that defines pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only, which are indicated by the @moodCode of the entries within this section. All active, incomplete, or pending orders, appointments, referrals, procedures, services, or any other pending event of clinical significance to the current care of the patient should be listed unless constrained due to privacy issues. The plan may also contain information about ongoing care of the patient and information regarding goals and clinical reminders. Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and health-care quality improvements, including widely accepted performance measures. The plan may also indicate that patient education will be provided.
Family History Section	The Family History section contains information about patient's relatives and diagnoses for relatives.
Immunization Section	The Immunizations section defines a patient's current immunization status and pertinent immunization history. The primary use case for the Immunization section is to enable communication of a patient's immunization status. The section should include current immunization status, and may contain the entire immunization history that is relevant to the period of time being summarized.
Patient Lab Order Section	This section describes Lab ordered data.
Patient Notes Section	This section describes any data about patient in Notes format or XML format with 'Section Name' for which data is documented.
End of Life Care Section	This section contains plan which have information about ongoing care of the patient and information regarding goals and clinical reminders.
Clinical Event Section	This section contains all patients clinical events data.
Eprescriptions Section	This section includes patient's prescription and dispense history.
Ancillary Data Section	Audiograms, imaging studies and reports, pathology reports, and patient-reported outcome results. The associated metadata file is required regarding what type of file has been sent over (i.e., audiogram file, scan file, ultrasound file).