Digital Imaging and Communications in Medicine (DICOM)

Supplement 75: Relevant Patient Information Query Service Class

DICOM Standards Committee, Working Group 8 Structured Reporting

1300 N. 17th Street, Suite 1847

Rosslyn, Virginia 22209 USA

VERSION: Final Text, 13 January 2004

Table of Contents

2 Foreword 4
Scope and Field of Application 4
4 Part 4 Addendum 7
Annex X Relevant Patient Information Query Service Class (Normative) 8
6 X.1 OVERVIEW 8
X.2 DIMSE-C SERVICE GROUP 8
8 X.2.1 C-FIND Operation 8
X.3 ASSOCIATION NEGOTIATION 10
10 X.4 DIMSE-C C-FIND SERVICE 10
X.4.1 Conventions 10
12 X.4.2 Service Definition 10
X.4.3 Relevant Patient Information Model SOP Classes 11
14 X.5 RELEVANT PATIENT INFORMATION QUERY EXAMPLE (INFORMATIVE) 13
Part 6 Addendum 21
16 Part 16 Addendum 22
Annex A DCMR Templates (Normative) 22
18 RELEVANT PATIENT INFORMATION TEMPLATES 23
TID 9000 Relevant Patient Information For Breast Imaging 23
20 TID 9001 Gynecological History 24
TID 9002 Medication, Substance, Environmental Exposure 26
22 TID 9003 Previous Procedure 27
TID 9004 Indicated Problem 29
24 TID 9005 Risk Factor 30
TID 9006 Obstetric History 31
26 TID 351 Previous Reports 31
TID 9007 General Relevant Patient Information 32
28 Annex B DCMR Context Groups (Normative) 34
CID 6080 GYNECOLOGICAL HORMONES 34
30 CID 6081 BREAST CANCER RISK FACTORS 34
CID 6082 GYNECOLOGICAL PROCEDURES 35
32 CID 6083 PROCEDURES FOR BREAST 35
CID 6084 MAMMOPLASTY PROCEDURES 36
34 CID 6085 THERAPIES FOR BREAST 36
CID 7451 FAMILY MEMBER 36
36 CID 6086 MENOPAUSAL PHASE 37
CID 7450 PERSON ROLES 37
38 CID 6087 GENERAL RISK FACTORS 38
CID 6088 OB-GYN MATERNAL RISK FACTORS 38
40 CID 6089 SUBSTANCES 39
CID 6090 RELATIVE USAGE, EXPOSURE AMOUNT 40

CID 6091 RELATIVE FREQUENCY OF EVENT VALUES 40
2 CID 6092 QUANTITATIVE CONCEPTS FOR USAGE, EXPOSURE 40
CID 6093 QUALITATIVE CONCEPTS FOR USAGE, EXPOSURE AMOUNT 41
4 CID 6094 QUALITATIVE CONCEPTS FOR USAGE, EXPOSURE FREQUENCY 41
CID 6095 NUMERIC PROPERTIES OF PROCEDURES 41
6 CID 6096 PREGNANCY STATUS 42
CID 6097 SIDE OF FAMILY 42
8 CID 6018 CLOCKFACE LOCATION OR REGION 42
Annex D DICOM Controlled Terminology Definitions (Normative) 43
10 Annex G English Code Meanings of Selected Codes (Normative) 48
Annex Y Relevant Patient Information Templates (Normative) 48

12

Foreword

This Supplement to the DICOM Standard proposes a Relevant Patient Information Query Service Class, to provide the capability for an SCU to query for non-persistent relevant patient information from an SCP, and specify the Template structure in which the information is to be returned.

This document is a Supplement to the DICOM Standard. It is an extension to the following parts of the published DICOM Standard:

Part 4 Service Class Specifications

Part 6 Data Dictionary

Part 16 Content Mapping Resource (DCMR)

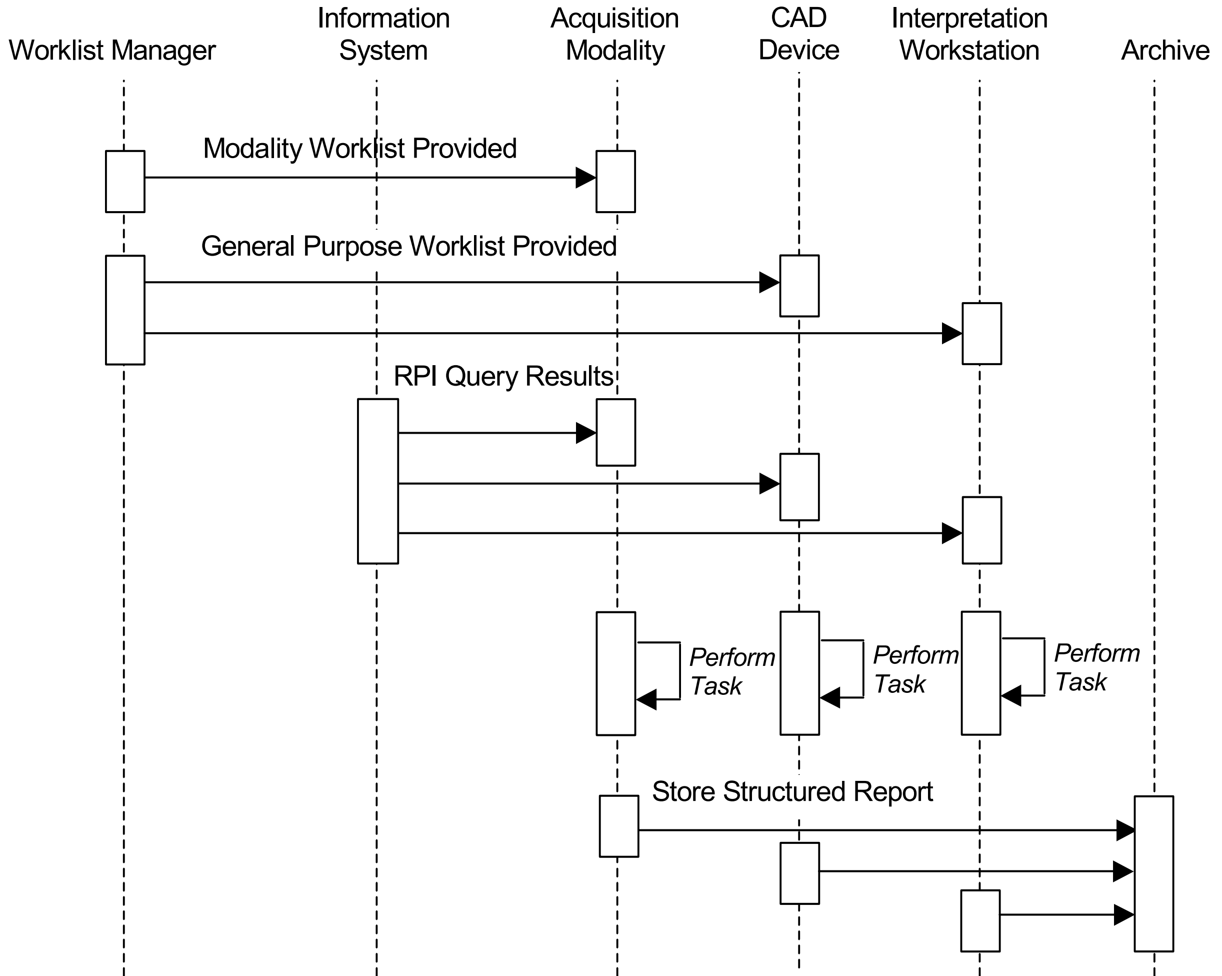
Scope and Field of Application

This Supplement includes the definition of the Relevant Patient Information Model and the Relevant Patient Information Model Query SOP Classes.

The Relevant Patient Information Model provides a means to exchange specific information from a patient's medical history, captured in the form of a Content Sequence as used in Structured Reporting. The associated SOP Classes support the query (C-FIND) of Relevant Patient Information (RPI) from information or reporting systems that typically possess this information.

Systems that need to capture a patient's relevant information at a given point in time, for use during image acquisition, Computer Aided Detection (CAD) processing, or image interpretation, would use this query mechanism. The relevant patient information would be received in the form of a Content Sequence, which could be parsed and used by the system to do its work, and potentially be incorporated into a Structured Report composite object instance created by the image acquisition, CAD processing, or image interpretation system.

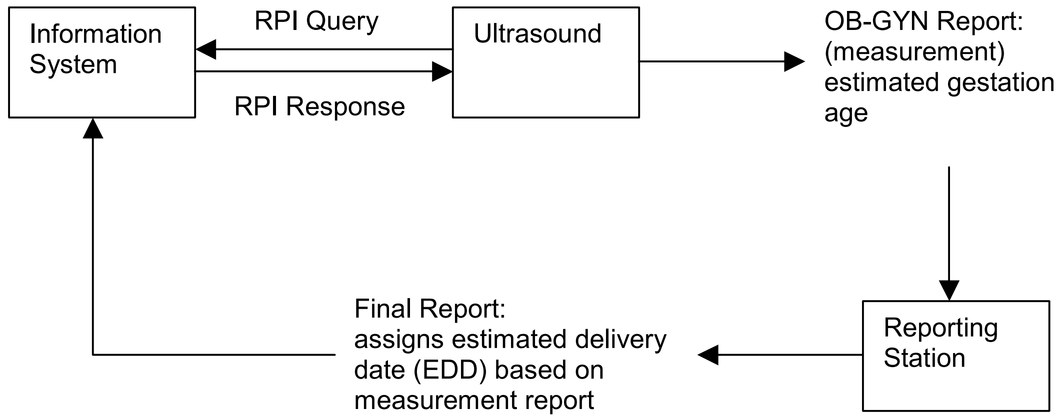
The following diagram shows possible uses of the RPI query in conjunction with an Acquisition Modality, a CAD device, and an Interpretation Workstation:



A Modality, CAD device, or Interpretation workstation obtains a worklist item (Modality Worklist or General Purpose Worklist),

- Using the Patient ID from the worklist item, the Modality, CAD device, or Interpretation workstation performs a query for Relevant Patient Information,
- The information from the Relevant Patient Information query response is used for various purposes. For example, a technologist at a Modality uses the Relevant Patient information for appropriateness and/or performance of the correct procedure. A CAD device uses the information as input to its algorithms, or a radiologist at the Interpretation workstation uses the information as input to his/her interpretation report.
- The Modality, CAD device, or Interpretation workstation produces a Structured Report that may contain the Relevant Patient information.

Ultrasound OB-GYN Workflow Scenario:



2

During the first trimester exam, a report is created that assigns an estimated delivery date (EDD).

4 At the time of the 2nd trimester exam, the Information System provides the EDD to the Ultrasound in the Relevant Patient Information Query response.

6

2

4

6

8

10

12

14

Part 4 Addendum

16

18

Item #1: Add Annex X Relevant Patient Information Query Service Class (Normative)

Annex X Relevant Patient Information Query Service Class (Normative)

X.1 OVERVIEW

The Relevant Patient Information Query Service Class defines an application-level class-of-service that facilitates the access to relevant patient information such as it is known at the time of query.

The query information model consists of two entities with a one-to-one relationship: the Patient and the Patient Information.

The Patient Information may be general, or specific to a particular imaging or procedure domain. A general SOP Class is defined along with some additional domain specific SOP Classes.

X.2 DIMSE-C SERVICE GROUP

One DIMSE-C Service is used in the construction of SOP Classes of the Relevant Patient Information Query Service Class. The following DIMSE-C operation is used.

— C-FIND

X.2.1 C-FIND Operation

SCPs of the Relevant Patient Information Query Service Class are capable of processing queries using the C-FIND operation as described in PS 3.7. The C-FIND operation is the mechanism by which queries are performed. The SCP shall provide Relevant Patient Information for at most one matching patient in the C-FIND response.

X.2.1.1 C-FIND Service Parameters

X.2.1.1.1 SOP Class UID

The SOP Class UID identifies the Relevant Patient Information Model and Template against which the C-FIND is to be performed. Support for the SOP Class UID is implied by the Abstract Syntax UID of the Presentation Context used by this C-FIND operation.

X.2.1.1.2 Priority

The Priority Attribute defines the requested priority of the C-FIND operation with respect to other DIMSE operations being performed by the same SCP.

Processing of priority requests is not required of SCPs. Whether or not an SCP supports priority processing and the meaning of the different priority levels shall be stated in the Conformance Statement of the SCP.

X.2.1.1.3 Identifier

Both the C-FIND request and response contain an Identifier encoded as a Data Set (see PS 3.5).

X.2.1.1.3.1 Request Identifier Structure

An Identifier in a C-FIND request shall contain:

- Key Attributes with values to be matched against the values of Attributes specified in the SOP Class.

- Content Template Sequence (0040,A504), which shall include a single sequence item containing the Template Identifier (0040,DB00) and Mapping Resource (0008,0105) attributes, to identify the template structure to use in the matching C-FIND responses.

The Key Attributes and values allowable for the query are defined in the SOP Class definition for the Relevant Patient Information Model.

X.2.1.1.3.2 Response Identifier Structure

The C-FIND response shall not contain Attributes that were not in the request or specified in this section.

An Identifier in a C-FIND response shall contain:

- Key Attributes with values corresponding to Key Attributes contained in the Identifier of the request.
- Content Template Sequence (0040,A504), which shall include a single sequence item containing the Template Identifier (0040,DB00) and Mapping Resource (0008,0105) attributes, to identify the template structure used in the C-FIND response. The values shall be the same as specified in the Request Identifier.

X.2.1.1.3.3 Relevant Patient Information Templates

Templates used in the Relevant Patient Information query are defined in PS 3.16.

The template specified in the Request Identifier shall not use by-reference relationships.

X.2.1.1.4 Status

Table X.2-1 defines the status code values that might be returned in a C-FIND response. Fields related to status code values are defined in PS 3.7.

Table X.2-1
C-FIND RESPONSE STATUS VALUES

Service Status	Further Meaning	Status Codes	Related Fields
Failed	Out of Resources	A700	(0000,0902)
	Identifier Does Not Match SOP Class	A900	(0000,0901) (0000,0902)
	Unable to process	C000	(0000,0901) (0000,0902)
	More than one match found	C100	(0000,0901) (0000,0902)
	Unable to support requested template	C200	(0000,0901) (0000,0902)
Cancel	Matching terminated due to Cancel request	FE00	None
Success	Success. Matching is complete - No final Identifier is supplied.	0000	None
Pending	Current Match is supplied.	FF00	Identifier

Note: Status Codes are returned in DIMSE response messages (See PS 3.7). The code values stated in column "Status Codes" are returned in Status Command Element (0000,0900).

X.3 ASSOCIATION NEGOTIATION

Association establishment is the first phase of any instance of communication between peer DICOM AEs. The Association negotiation procedure specified in PS 3.7 shall be used to negotiate the supported SOP Class.

SOP Class Extended Negotiation is not defined for this Service Class.

X.4 DIMSE-C C-FIND SERVICE

The DIMSE-C C-FIND service is the operation by which relevant patient information is queried and provided.

X.4.1 Conventions

Key Attributes in the Request Identifier serve two purposes. They may be used as Matching Key Attributes and Return Key Attributes. Matching Key Attributes may be used for matching (criteria to be used in the C-FIND request to determine whether an entity matches the query). Return Key Attributes may be used to specify desired return Attributes (what elements in addition to the Matching Key Attributes have to be returned in the C-FIND response).

Matching Key Attributes may be of Type "required" (R) or "optional" (O). Return Key Attributes may be of Type 1, 1C, 2, 2C, 3 as defined in PS 3.5.

X.4.2 Service Definition

Two peer DICOM AEs implement this Relevant Patient Information Query Service Class with one serving in the SCU role and one serving in the SCP role. The SOP Class is implemented using the DIMSE-C C-FIND service as defined in PS 3.7.

Only a baseline behavior of the DIMSE-C C-FIND is used in this Service Class.

A C-FIND service conveys the following semantics:

— The SCU requests that the SCP perform a match for the Matching Keys and return values for the Return Keys that have been specified in the Identifier of the request, against the Relevant Patient Information that the SCP possesses.

Note: In this Annex, the term "Identifier" refers to the Identifier service parameter of the C-FIND service as defined in PS 3.7.

— The SCP generates a C-FIND response for at most one match with an Identifier containing the values of all Matching Key Attributes and all known Return Key Attributes requested. The response contains one relevant patient information instance in the form that matches the Template that was requested. This response shall contain a status of Pending.

— When the process of matching is complete, with zero or one match, a C-FIND response is sent with a status of Success and no Identifier.

— A Failed response to a C-FIND request indicates that the SCP is unable to process the request. This shall be used to indicate that the requested template is not supported by the SCP, or that more than one match was found by the SCP.

— The SCU may cancel the C-FIND service by issuing a C-FIND-CANCEL request at any time during the processing of the C-FIND service. The SCP will interrupt all matching and return a status of Canceled.

Note: The SCU needs to be prepared to receive C-FIND responses sent by the SCP until the SCP finally processes the C-FIND-CANCEL request.

X.4.3 Relevant Patient Information Model SOP Classes

X.4.3.1 Relevant Patient Information Model

In order to serve as a Service Class Provider (SCP) of one or more Relevant Patient Information Model SOP Classes, a DICOM Application Entity (AE) possesses relevant information about patients. This information is organized into a Relevant Patient Information Model.

The SOP Classes are composed of both the Information Model and a DIMSE-C Service Group.

X.4.3.1.1 E/R Model

The E/R Model consists of Patient and Patient Information, with no relationship to other Information Entities in the DICOM Information model.

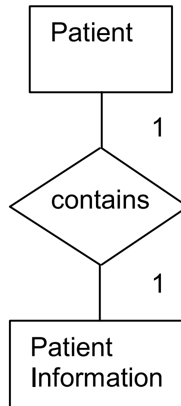


Figure X.4-1 Relevant Patient Information E/R Model

X.4.3.1.4 Relevant Patient Information Attributes

Table X.4-1 defines the Attributes of the Relevant Patient Information Model:

Table X.4-1 Attributes for the Relevant Patient Information Model

Description / Module	Tag	Matching Key Type	Return Key Type	Remark / Matching Type
Specific Character Set	(0008,0005)	-	1C	This attribute is required if expanded or replacement character sets are used. See C.2.2.2 and C.4.1.1.
Patient				
Patient's Name	(0010,0010)	-	1	
Patient ID	(0010,0020)	R	1	Shall be present in the Request Identifier. Shall be retrieved with Single Value Matching. Note: Since only one response is expected, this is a unique key.

Description / Module	Tag	Match-ing Key Type	Return Key Type	Remark / Matching Type
Issuer of Patient ID	(0010,0021)	R	2	Shall be retrieved with Single Value Matching. In situations where there are multiple issuers, this key constrains matching of Patient ID (0010,0020) to a domain in which the Patient ID (0010,0020) is unique.
Patient's Birth Date	(0010,0030)	-	2	
Patient's Sex	(0010,0040)	-	2	
All other Attributes of the Patient Identification module		-	3	
All other Attributes of the Patient Demographic module		-	3	
Patient Information				
Observation DateTime	(0040,A032)	-	1	
Value Type	(0040,A040)	-	1	See X.4.3.1.4.1.
Concept Name Code Sequence	(0040,A043)	-	1	See X.4.3.1.4.1.
Content Sequence	(0040,A730)	-	2	See X.4.3.1.4.1.

X.4.3.1.4.1 Relevant Patient Information Attribute Descriptions

Concept Name Code Sequence (0040,A043) in a C-FIND Response shall have one sequence item that identifies the Root node concept of the returned structure. This shall be the same as the Concept Name of the first row of the template identified in the Content Template Sequence (0040,A504) in the Identifier. The Concept Name Code Sequence (0040,A043) shall always be sent zero length in the Request Identifier.

The Value Type (0040,A040) applies to the Concept Name Code Sequence (0040,A043), and shall be the same as the Value Type (0040,A040) of the first row of the template identified in the Content Template Sequence (0040,A504) in the Identifier.

The Content Sequence (0040,A730) is a potentially recursively nested Sequence of Items, as described in PS 3.3, SR Document Content Module. The Content Sequence shall always be sent zero length in the Request Identifier. The Content Sequence in the data set of the Response shall contain the content items of the requested template.

X.4.3.2 Conformance Requirements

An implementation may conform to the Relevant Patient Information Model SOP Classes as an SCU and/or as an SCP.

The Conformance Statement shall be in the format defined in PS 3.2.

X.4.3.2.1 SCU Conformance

An implementation which conforms to one or more of the Relevant Patient Information Model SOP Classes shall support queries against the Relevant Patient Information Model described in Section X.4.3.1 using the baseline C-FIND SCU Behavior described in Section X.4.2.

An implementation which conforms to one or more of the Relevant Patient Information Model SOP Classes as an SCU shall state in its Conformance Statement which SOP Class(es) it supports, and which Root template(s) it may request in a query if not specified by the SOP Class. The Conformance Statement shall also state the definition of any supported template extensions.

X.4.3.2.2 SCP Conformance

An implementation which conforms to one or more of the Relevant Patient Information Model SOP Classes shall support queries against the Relevant Patient Information Model described in Section X.4.3.1 using the baseline C-FIND SCP Behavior described in Section X.4.2.

An implementation which conforms to one or more of the Relevant Patient Information Model SOP Classes as an SCP shall state in its Conformance Statement which SOP Class(es) it supports, and which Root template(s) it will support in a query response if not specified by the SOP Class. The Conformance Statement shall also state the definition of any supported template extensions.

An implementation which conforms to one or more of the Relevant Patient Information Model SOP Classes as an SCP shall state in its Conformance Statement how it makes use of Specific Character Set (0008,0005) when interpreting queries, performing matching, and encoding responses.

X.4.3.3 SOP Classes

The Relevant Patient Information Model SOP Classes in the Relevant Patient Information Query Service Class identify the Relevant Patient Information Model, and the DIMSE-C operation supported. In some instances a Root template is specified. The following Standard SOP Classes are identified:

SOP Class Name	SOP Class UID	Root Template
General Relevant Patient Information Query	1.2.840.10008.5.1.4.37.1	TID 9007 General Relevant Patient Information, or from the list in PS 3.16
Breast Imaging Relevant Patient Information Query	1.2.840.10008.5.1.4.37.2	TID 9000 Relevant Patient Information for Breast Imaging
Cardiac Relevant Patient Information Query	1.2.840.10008.5.1.4.37.3	TID 3802 Patient History, Cath

Note: The list of Root templates for the General Relevant Patient Information Query is extensible.

X.5 RELEVANT PATIENT INFORMATION QUERY EXAMPLE (INFORMATIVE)

The following is a simple and non-comprehensive example of a C-FIND Request for the Relevant Patient Information Query Service Class, specifically for the Breast Imaging Relevant Patient Information Query SOP Class, requesting a specific Patient ID, and requiring that any matching response be structured in the form of TID 9000 Relevant Patient Information for Breast Imaging.

C-FIND Request:

SR Tree Depth	Nesting	Attribute	Tag	VR	VL (hex)	Value
		Affected SOP Class UID	(0000,0002)	UI	0018	1.2.840.10008.5.1.4.37.2
		Command Field	(0000,0100)	US	0002	0020H [C-FIND-RQ]
		Message ID	(0000,0110)	US	0002	0010H
		Priority	(0000,0700)	US	0002	0000H [MEDIUM]
		Data Set Type	(0000,0800)	US	0002	0102H
		Patient's Name	(0010,0010)	PN	0000	
		Patient ID	(0010,0020)	LO	0008	MR975311
		Patient's Birth Date	(0010,0030)	DA	0000	
		Patient's Sex	(0010,0040)	CS	0000	
		Observation DateTime	(0040,A032)	DT	0000	
1		Value Type	(0040,A040)	CS	0000	
1		Concept Name Code Sequence	(0040,A043)	SQ	0000	
		Content Template Sequence	(0040,A504)	SQ	ffffffff	
	%item					
	>	Mapping Resource	(0008,0105)	CS	0004	DCMR
	>	Template Identifier	(0040,DB00)	CS	0004	9000
	%enditem					
	%endseq					
1		Content Sequence	(0040,A730)	SQ	0000	

The following is a simple and non-comprehensive example of a C-FIND Response for the Relevant Patient Information Query Service Class, answering the C-FIND Request listed above, and structured in the form of TID 9000 Relevant Patient Information for Breast Imaging as required by the Affected SOP Class.

C-FIND Response #1:

SR Tree Depth	Nesting	Attribute	Tag	VR	VL (hex)	Value
		Affected SOP Class UID	(0000,0002)	UI	0018	1.2.840.10008.5.1.4.37.2
		Command Field	(0000,0100)	US	0002	8020H [C-FIND-RSP]
		Message ID Being Responded To	(0000,0120)	US	0002	0010H
		Data Set Type	(0000,0800)	US	0002	0102H
		Status	(0000,0900)	US	0002	FF00H [Pending]
		Patient's Name	(0010,0010)	PN	0008	Doe^Jane
		Patient ID	(0010,0020)	LO	0008	MR975311
		Patient's Birth Date	(0010,0030)	DA	0008	19541106
		Patient's Sex	(0010,0040)	CS	0002	F
		Observation DateTime	(0040,A032)	DT	000E	20021114124623
1		Value Type	(0040,A040)	CS	000A	CONTAINER
1		Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1	%item					
1	>	Code Value	(0008,0100)	SH	0006	111511
1	>	Coding Scheme Designator	(0008,0102)	SH	0004	DCM

SR Tree Depth	Nesting	Attribute	Tag	VR	VL (hex)	Value
1	>	Code Meaning	(0008,0104)	LO	0030	Relevant Patient Information for Breast Imaging
1	%enditem					
1	%endseq					
		Content Template Sequence	(0040,A504)	SQ	ffffffff	
	%item					
	>	Mapping Resource	(0008,0105)	CS	0004	DCMR
	>	Template Identifier	(0040,DB00)	CS	0004	9000
	%enditem					
	%endseq					
1		Content Sequence	(0040,A730)	SQ	ffffffff	
1.1	%item					
1.1	>	Relationship Type	(0040,A010)	CS	0010	HAS CONCEPT MOD
1.1	>	Value Type	(0040,A040)	CS	0004	CODE
1.1	>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.1	%item					
1.1	>>	Code Value	(0008,0100)	SH	0006	121049
1.1	>>	Coding Scheme Designator	(0008,0102)	SH	0004	DCM
1.1	>>	Code Meaning	(0008,0104)	LO	0018	Language of Content Item and Descendants
1.1	%enditem					
1.1	%endseq					
1.1	>	Concept Code Sequence	(0040,A168)	SQ	ffffffff	
1.1	%item					
1.1	>>	Code Value	(0008,0100)	SH	0002	en
1.1	>>	Coding Scheme Designator	(0008,0102)	SH	0008	RFC3066
1.1	>>	Code Meaning	(0008,0104)	LO	0008	English
1.1	%enditem					
1.1	%endseq					
1.1	%enditem					
1.2	%item					
1.2	>	Relationship Type	(0040,A010)	CS	0008	CONTAINS
1.2	>	Value Type	(0040,A040)	CS	0004	NUM
1.2	>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.2	%item					
1.2	>>	Code Value	(0008,0100)	SH	0006	121033
1.2	>>	Coding Scheme Designator	(0008,0102)	SH	0004	DCM
1.2	>>	Code Meaning	(0008,0104)	LO	000C	Subject Age
1.2	%enditem					
1.2	%endseq					
1.2	>	Measured Value Sequence	(0040,A300)	SQ	ffffffff	
1.2	%item					
1.2	>>	Measurement Units Code Sequence	(0040,08EA)	SQ	ffffffff	
1.2	%item					
1.2	>>>	Code Value	(0008,0100)	SH	0002	a

SR Tree Depth	Nesting	Attribute	Tag	VR	VL (hex)	Value
1.2	>>>	Coding Scheme Designator	(0008,0102)	SH	0004	UCUM
1.2	>>>	Coding Scheme Version	(0008,0103)	SH	0004	1.4
1.2	>>>	Code Meaning	(0008,0104)	LO	0004	Year
1.2	%enditem					
1.2	%endseq					
1.2	>>	Numeric Value	(0040,A30A)	DS	0002	48
1.2	%enditem					
1.2	%endseq					
1.2	%enditem					
1.3	%item					
1.3	>	Relationship Type	(0040,A010)	CS	0008	CONTAINS
1.3	>	Value Type	(0040,A040)	CS	000A	CONTAINER
1.3	>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.3	%item					
1.3	>>	Code Value	(0008,0100)	SH	0008	R-20767
1.3	>>	Coding Scheme Designator	(0008,0102)	SH	0004	SRT
1.3	>>	Code Meaning	(0008,0104)	LO	0016	Gynecological History
1.3	%enditem					
1.3	%endseq					
1.3	>	Continuity of Content	(0040,A050)	CS	0008	SEPARATE
1.3	>	Content Sequence	(0040,A730)	SQ	ffffffff	
1.3.1	%item					
1.3.1	>>	Relationship Type	(0040,A010)	CS	0008	CONTAINS
1.3.1	>>	Value Type	(0040,A040)	CS	0004	NUM
1.3.1	>>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.3.1	%item					
1.3.1	>>>	Code Value	(0008,0100)	SH	0006	111519
1.3.1	>>>	Coding Scheme Designator	(0008,0102)	SH	0004	DCM
1.3.1	>>>	Code Meaning	(0008,0104)	LO	0020	Age at First Full Term Pregnancy
1.3.1	%enditem					
1.3.1	%endseq					
1.3.1	>>	Measured Value Sequence	(0040,A300)	SQ	ffffffff	
1.3.1	%item					
1.3.1	>>>	Measurement Units Code Sequence	(0040,08EA)	SQ	ffffffff	
1.3.1	%item					
1.3.1	>>>>	Code Value	(0008,0100)	SH	0002	a
1.3.1	>>>>	Coding Scheme Designator	(0008,0102)	SH	0004	UCUM
1.3.1	>>>>	Coding Scheme Version	(0008,0103)	SH	0004	1.4
1.3.1	>>>>	Code Meaning	(0008,0104)	LO	0004	Year
1.3.1	%enditem					
1.3.1	%endseq					
1.3.1	>>>	Numeric Value	(0040,A30A)	DS	0002	28
1.3.1	%enditem					
1.3.1	%endseq					

SR Tree Depth	Nesting	Attribute	Tag	VR	VL (hex)	Value
1.3.1	%enditem					
1.3.2	%item					
1.3.2	>>	Relationship Type	(0040,A010)	CS	0008	CONTAINS
1.3.2	>>	Value Type	(0040,A040)	CS	0004	NUM
1.3.2	>>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.3.2	%item					
1.3.2	>>>	Code Value	(0008,0100)	SH	0008	11977-6
1.3.2	>>>	Coding Scheme Designator	(0008,0102)	SH	0002	LN
1.3.2	>>>	Code Meaning	(0008,0104)	LO	0004	Para
1.3.2	%enditem					
1.3.2	%endseq					
1.3.2	>>	Measured Value Sequence	(0040,A300)	SQ	ffffffff	
1.3.2	%item					
1.3.2	>>>	Measurement Units Code Sequence	(0040,08EA)	SQ	ffffffff	
1.3.2	%item					
1.3.2	>>>>	Code Value	(0008,0100)	SH	0002	1
1.3.2	>>>>	Coding Scheme Designator	(0008,0102)	SH	0004	UCUM
1.3.2	>>>>	Coding Scheme Version	(0008,0103)	SH	0004	1.4
1.3.2	>>>>	Code Meaning	(0008,0104)	LO	0006	Unity
1.3.2	%enditem					
1.3.2	%endseq					
1.3.2	>>>	Numeric Value	(0040,A30A)	DS	0002	2
1.3.2	%enditem					
1.3.2	%endseq					
1.3.2	%enditem					
1.3	%endseq					
1.3	%enditem					
1.4	%item					
1.4	>	Relationship Type	(0040,A010)	CS	0008	CONTAINS
1.4	>	Value Type	(0040,A040)	CS	000A	CONTAINER
1.4	>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.4	%item					
1.4	>>	Code Value	(0008,0100)	SH	0006	111513
1.4	>>	Coding Scheme Designator	(0008,0102)	SH	0004	DCM
1.4	>>	Code Meaning	(0008,0104)	LO	001C	Relevant Previous Procedures
1.4	%enditem					
1.4	%endseq					
1.4	>	Continuity of Content	(0040,A050)	CS	0008	SEPARATE
1.4	>	Content Sequence	(0040,A730)	SQ	ffffffff	
1.4.1	%item					
1.4.1	>>	Relationship Type	(0040,A010)	CS	0008	CONTAINS
1.4.1	>>	Value Type	(0040,A040)	CS	0004	CODE
1.4.1	>>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.4.1	%item					

SR Tree Depth	Nesting	Attribute	Tag	VR	VL (hex)	Value
1.4.1	>>>	Code Value	(0008,0100)	SH	0006	111531
1.4.1	>>>	Coding Scheme Designator	(0008,0102)	SH	0004	DCM
1.4.1	>>>	Code Meaning	(0008,0104)	LO	0012	Previous Procedure
1.4.1	%enditem					
1.4.1	%endseq					
1.4.1	>>	Concept Code Sequence	(0040,A168)	SQ	ffffffff	
1.4.1	%item					
1.4.1	>>>	Code Value	(0008,0100)	SH	0008	P1-48142
1.4.1	>>>	Coding Scheme Designator	(0008,0102)	SH	0004	SRT
1.4.1	>>>	Code Meaning	(0008,0104)	LO	0010	Cyst aspiration
1.4.1	%enditem					
1.4.1	%endseq					
1.4.1	>>	Content Sequence	(0040,A730)	SQ	ffffffff	
1.4.1.1	%item					
1.4.1.1	>>>	Relationship Type	(0040,A010)	CS	000E	HAS PROPERTIES
1.4.1.1	>>>	Value Type	(0040,A040)	CS	0004	CODE
1.4.1.1	>>>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.4.1.1	%item					
1.4.1.1	>>>>	Code Value	(0008,0100)	SH	0006	G-C171
1.4.1.1	>>>>	Coding Scheme Designator	(0008,0102)	SH	0004	SRT
1.4.1.1	>>>>	Code Meaning	(0008,0104)	LO	000A	Laterality
1.4.1.1	%enditem					
1.4.1.1	%endseq					
1.4.1.1	>>>	Concept Code Sequence	(0040,A168)	SQ	ffffffff	
1.4.1.1	%item					
1.4.1.1	>>>>	Code Value	(0008,0100)	SH	0008	T-04030
1.4.1.1	>>>>	Coding Scheme Designator	(0008,0102)	SH	0004	SNM3
1.4.1.1	>>>>	Code Meaning	(0008,0104)	LO	000C	Left breast
1.4.1.1	%enditem					
1.4.1.1	%endseq					
1.4.1.1	%enditem					
1.4.1.2	%item					
1.4.1.2	>>>	Relationship Type	(0040,A010)	CS	000E	HAS PROPERTIES
1.4.1.2	>>>	Value Type	(0040,A040)	CS	0004	DATETIME
1.4.1.2	>>>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.4.1.2	%item					
1.4.1.2	>>>>	Code Value	(0008,0100)	SH	0006	122146
1.4.1.2	>>>>	Coding Scheme Designator	(0008,0102)	SH	0004	DCM
1.4.1.2	>>>>	Code Meaning	(0008,0104)	LO	0012	Procedure Datetime
1.4.1.2	%enditem					
1.4.1.2	%endseq					
1.4.1.2	>>>	DateTime	(0040,A120)	DT	0008	19990825
1.4.1.2	%enditem					
1.4.1	%endseq					
1.4.1	%enditem					

SR Tree Depth	Nesting	Attribute	Tag	VR	VL (hex)	Value
1.4	%endseq					
1.4	%enditem					
1.5	%item					
1.5	>	Relationship Type	(0040,A010)	CS	0008	CONTAINS
1.5	>	Value Type	(0040,A040)	CS	000A	CONTAINER
1.5	>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.5	%item					
1.5	>>	Code Value	(0008,0100)	SH	0006	111515
1.5	>>	Coding Scheme Designator	(0008,0102)	SH	0004	DCM
1.5	>>	Code Meaning	(0008,0104)	LO	0016	Relevant Risk Factors
1.5	%enditem					
1.5	%endseq					
1.5	>	Continuity of Content	(0040,A050)	CS	0008	SEPARATE
1.5	>	Content Sequence	(0040,A730)	SQ	ffffffff	
1.5.1	%item					
1.5.1	>>	Relationship Type	(0040,A010)	CS	0008	CONTAINS
1.5.1	>>	Value Type	(0040,A040)	CS	0004	CODE
1.5.1	>>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.5.1	%item					
1.5.1	>>>	Code Value	(0008,0100)	SH	0008	F-01500
1.5.1	>>>	Coding Scheme Designator	(0008,0102)	SH	0004	SRT
1.5.1	>>>	Code Meaning	(0008,0104)	LO	000C	Risk factor
1.5.1	%enditem					
1.5.1	%endseq					
1.5.1	>>	Concept Code Sequence	(0040,A168)	SQ	ffffffff	
1.5.1	%item					
1.5.1	>>>	Code Value	(0008,0100)	SH	0006	111559
1.5.1	>>>	Coding Scheme Designator	(0008,0102)	SH	0004	DCM
1.5.1	>>>	Code Meaning	(0008,0104)	LO	0024	Weak family history of breast cancer
1.5.1	%enditem					
1.5.1	%endseq					
1.5.1	>>	Content Sequence	(0040,A730)	SQ	ffffffff	
1.5.1.1	%item					
1.5.1.1	>>>	Relationship Type	(0040,A010)	CS	000E	INFERRED FROM
1.5.1.1	>>>	Value Type	(0040,A040)	CS	0004	CODE
1.5.1.1	>>>	Concept Name Code Sequence	(0040,A043)	SQ	ffffffff	
1.5.1.1	%item					
1.5.1.1	>>>>	Code Value	(0008,0100)	SH	0006	111537
1.5.1.1	>>>>	Coding Scheme Designator	(0008,0102)	SH	0004	DCM
1.5.1.1	>>>>	Code Meaning	(0008,0104)	LO	001E	Family Member with Risk Factor
1.5.1.1	%enditem					
1.5.1.1	%endseq					
1.5.1.1	>>>	Concept Code Sequence	(0040,A168)	SQ	ffffffff	
1.5.1.1	%item					

SR Tree Depth	Nesting	Attribute	Tag	VR	VL (hex)	Value
1.5.1.1	>>>>	Code Value	(0008,0100)	SH	0008	S-101A1
1.5.1.1	>>>>	Coding Scheme Designator	(0008,0102)	SH	0004	SRT
1.5.1.1	>>>>	Code Meaning	(0008,0104)	LO	0004	Aunt
1.5.1.1	%enditem					
1.5.1.1	%endseq					
1.5.1.1	%enditem					
1.5.1	%endseq					
1.5.1	%enditem					
1.5	%endseq					
1.5	%enditem					
1	%endseq					

C-FIND Response #2:

SR Tree Depth	Nesting	Attribute	Tag	VR	VL (hex)	Value
		Affected SOP Class UID	(0000,0002)	UI	0018	1.2.840.10008.5.1.4.37.2
		Command Field	(0000,0100)	US	0002	8020H [C-FIND-RSP]
		Message ID Being Responded To	(0000,0120)	US	0002	0010H
		Data Set Type	(0000,0800)	US	0002	0101H
		Status	(0000,0900)	US	0002	0000H [Success]

2

4

Part 6 Addendum

6

8

10

Item #2: Add the following UID to Part 6 Annex A Registry of DICOM Unique Identifiers (UID):

12

UID Value	UID Name	UID Type	Part
1.2.840.10008.5.1.4.37.1	General Relevant Patient Information Query	SOP Class	PS 3.4
1.2.840.10008.5.1.4.37.2	Breast Imaging Relevant Patient Information Query	SOP Class	PS 3.4
1.2.840.10008.5.1.4.37.3	Cardiac Relevant Patient Information Query	SOP Class	PS 3.4

14

2

4

6

8

Part 16 Addendum

10

Item #3: Add the following Templates to Part 16 Annex A DCMR Templates (Normative):

Annex A DCMR Templates (Normative)

12

14

RELEVANT PATIENT INFORMATION TEMPLATES

TID 9000 Relevant Patient Information For Breast Imaging

This template collects a patient's relevant information as it relates to breast imaging. This template, together with its subordinate templates, describes the history of a patient's reproductive system, hormone medications, past procedures, risk factors, and indicated problems as they relate to breast health.

TID 9000
RELEVANT PATIENT INFORMATION FOR BREAST IMAGING
Type: Extensible

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
1			CONTAINER	EV (111511, DCM, "Relevant Patient Information for Breast Imaging")	1	M		
2	>	HAS CONCEPT MOD	INCLUDE	DTID (1204) Language of Content Item and Descendants	1	M		
3	>	CONTAINS	INCLUDE	DTID (3114) Patient Assessment	1	U		
4	>	CONTAINS	INCLUDE	DTID (9001) Gynecological History	1	U		
5	>	CONTAINS	INCLUDE	DTID (9002) Medication, Substance, Environmental Exposure	1	U		$ContainerConcept= EV (111512, DCM, "Medication History") $CodeConcept= EV (111516, DCM, "Medication Type") $CodeValue = DCID (6080) Gynecological Hormones

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
6	>	CONTAINS	INCLUDE	DTID (9003) Previous Procedure	1	U		$ProcedureList = DCID (6083) Procedures for Breast, DCID (6082) Gynecological Procedures $ProcedureModifier = DCID (6058) Procedure Modifiers for Breast $NumConceptName= DCID (6095) Numeric Properties of Procedures $LateralityValue = DCID (6022) Side $ProcedureResult = DCID (6063) Interventional Procedure Results $ComplicationValue= DCID (6062) Interventional Procedure Complications
7	>	CONTAINS	INCLUDE	DTID (9004) Indicated Problem	1	U		$ProblemList = DCID (6055) Breast Clinical Finding or Indicated Problem $LateralityValue = DCID (6022) Side $LocationValue = DCID (6018) Clockface Location or Region , DCID (6020) Quadrant Location
8	>	CONTAINS	INCLUDE	DTID (9005) Risk Factor	1	U		$RiskList = DCID (6081) Breast Cancer Risk Factors $FamilyList = DCID (7451) Family Member

2 **TID 9001 Gynecological History**

This general template collects the details of a patient's reproductive system history, such as
4 number of births, and gynecological surgery history.

TID 9001
6 **GYNECOLOGICAL HISTORY**
Type: Extensible

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
1			CONTAINER	EV (R-20767, SRT, ”Gynecological History”)	1	M		

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
2	>	HAS OBS CONTEXT	CODE	EV (111534, DCM, "Role of person reporting")	1	U		DCID (7450) Person Roles
3	>	CONTAINS	DATE	EV (11955-2, LN, "Date of last menstrual period")	1	U		
4	>	CONTAINS	NUM	EV (111518, DCM, "Age when first menstrual period occurred")	1	U		UNITS = EV (a,UCUM,"Year")
5	>	CONTAINS	NUM	EV (111519, DCM, "Age at First Full Term Pregnancy")	1	U		UNITS = EV (a,UCUM,"Year")
6	>	CONTAINS	NUM	EV (11977-6, LN, "Para")	1	U		UNITS = EV (1,UCUM,"no units")
7	>	CONTAINS	NUM	EV (11639-2, LN, "Term")	1	U		UNITS = EV (1,UCUM,"no units")
8	>	CONTAINS	NUM	EV (11637-6, LN, "Preterm")	1	U		UNITS = EV (1,UCUM,"no units")
9	>	CONTAINS	NUM	EV (11636-8, LN, "Living")	1	U		UNITS = EV (1,UCUM,"no units")
10	>	CONTAINS	NUM	EV (11636-8, LN, "LBW or IUGR")	1	U		UNITS = EV (1,UCUM,"no units")
11	>	CONTAINS	NUM	EV (11996-6, LN, "Gravida")	1	U		UNITS = EV (1,UCUM,"no units")
12	>	CONTAINS	NUM	EV (11612-9, LN, "Aborta")	1	U		UNITS = EV (1,UCUM,"no units")
13	>	CONTAINS	NUM	EV (33065-4, LN, "Ectopic Pregnancies")	1	U		UNITS = EV (1,UCUM,"no units")
14	>	CONTAINS	NUM	EV (111520, DCM, "Age at Menopause")	1	U		UNITS = EV (a,UCUM,"Year")
15	>	CONTAINS	NUM	EV (111521, DCM, "Age when hysterectomy performed")	1	U		UNITS = EV (a,UCUM,"Year")
16	>>	HAS CONCEPT MOD	CODE	EV (R-404ED, SRT, "Extent")	1	U		EV (R-404F1, SRT, "Complete") or EV (R-404FE, SRT, "Partial")
17	>	CONTAINS	NUM	EV (111522, DCM, "Age when left ovary removed")	1	U		UNITS = EV (a,UCUM,"Year")
18	>	CONTAINS	NUM	EV (111523, DCM, "Age when right ovary removed")	1	U		UNITS = EV (a,UCUM,"Year")
19	>	CONTAINS	CODE	EV (111543, DCM, "Breast feeding history")	1	U		DCID (230) Yes-No

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
20	>>	HAS PROPERTIES	NUM	EV (111544, DCM, “Average breast feeding period”)	1	U		UNITS = EV (wk,UCUM,”Week”)
21	>	CONTAINS	CODE	EV (111532, DCM, ”Pregnancy Status”)	1	U		DCID (6096) Pregnancy Status

2 **TID 9002 Medication, Substance, Environmental Exposure**

This general template provides detailed information on a patient’s medication or substance use,
4 or exposure to environmental factors, including type and duration of use or exposure.

Parameter Name	Parameter Usage
$ContainerConcept	Coded term for the concept name of the CONTAINER, identifying it as medication, substance, or environmental exposure history.
$CodeConcept	Coded term for the concept name of the CODE, identifying it as medication, substance, or environmental exposure.
$CodeValue	Coded term or Context Group for value of the medication, substance, or environmental exposure.

6 **TID 9002**
MEDICATION, SUBSTANCE, ENVIRONMENTAL EXPOSURE
8 **Type: Extensible**

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
1			CONTAINER	$ContainerConcept	1	M		
2	>	CONTAINS	CODE	$CodeConcept	1-n	M		$CodeValue
3	>>	HAS CONCEPT MOD	CODE	EV (G-C032, SRT, ”Classification”)	1	U		
4	>>	HAS OBS CONTEXT	CODE	EV (111534, DCM, ”Role of person reporting”)	1	U		DCID (7450) Person Roles
5	>>	HAS PROPERTIES	NUM	EV (111524, DCM, ”Age Started”)	1	U		UNITS = EV (a,UCUM,”Year”)
6	>>	HAS PROPERTIES	NUM	EV (111525, DCM, ”Age Ended”)	1	U		UNITS = EV (a,UCUM,”Year”)
7	>>	HAS PROPERTIES	DATETIME	EV (111526, DCM, ”Datetime Started”)	1	U		
8	>>	HAS PROPERTIES	DATETIME	EV (111527, DCM, ”Datetime Ended”)	1	U		

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
9	>>	HAS PROPERTIES	NUM	EV (G-7290, SRT, ”Duration”)	1	U		UNITS = DCID (6046) Units of Follow-up Interval
10	>>	HAS PROPERTIES	CODE	EV (111528, DCM, ”Ongoing”)	1	U		DCID (230) Yes-No
11	>>	HAS PROPERTIES	TEXT	EV (111529, DCM, ”Brand Name”)	1	U		
12	>>	HAS PROPERTIES	NUM	DCID (6092) Quantitative Concepts for Usage, Exposure	1	U		The unit of measure shall be quantity per unit of time
13	>>	HAS PROPERTIES	CODE	DCID (6093) Qualitative Concepts for Usage, Exposure Amount	1	U		DCID (6090) Relative Usage, Exposure Amount
14	>>	HAS PROPERTIES	CODE	DCID (6094) Qualitative Concepts for Usage, Exposure Frequency	1	U		DCID (6091) Relative Frequency of Event Values

2 **Content Item Descriptions**

Row 3 “Classification”	No context group is provided for the value set, but it is recommended that values from a standard external coding scheme, such as SRT or NDC, be used.
Rows 13 & 14	If both of these content items are instantiated, the concept names selected for each should match. For example, use “Relative dose amount” as the concept name for row 13 with “Relative dose frequency” as the concept name for row 14.

4 **TID 9003 Previous Procedure**

This general template provides detailed information on a patient’s previous procedure, surgery, or
6 treatment.

Parameter Name	Parameter Usage
$ProcedureList	Coded term or Context Group for value of Previous Procedure
$ProcedureModifier	Coded term or Context Group for value of Previous Procedure Modifier
$NumConceptName	Coded term or Context Group for the concept name of a numeric property of the Previous Procedure
$LateralityValue	Coded term or Context Group for value of Laterality
$ProcedureResult	Coded term or Context Group for value of Result of Procedure
$ComplicationValue	Coded term or Context Group for value of Complication

2

TID 9003
PREVIOUS PROCEDURE
Type: Extensible

4

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
1			CONTAINER	EV (111513, DCM, ”Relevant Previous Procedures”)	1	M		
2	>	CONTAINS	CODE	EV (111531, DCM, ”Previous Procedure”)	1-n	M		$ProcedureList
3	>>	HAS CONCEPT MOD	CODE	EV (111464, DCM, “Procedure Modifier”)	1-n	U		$ProcedureModifier
4	>>	HAS OBS CONTEXT	CODE	EV (111534, DCM, ”Role of person reporting”)	1	U		DCID (7450) Person Roles
5	>>	HAS PROPERTIES	NUM	$NumConceptName	1-n	U		
6	>>	HAS PROPERTIES	CODE	EV (G-C171, SRT, ”Laterality”)	1	U		$LateralityValue
7	>>	HAS PROPERTIES	DATETIME	EV (122146, DCM, ”Procedure Datetime”)	1	U		
8	>>	HAS PROPERTIES	NUM	EV (R-42009, SRT, ”Number of occurrences”)	1	U		UNITS = EV (1,UCUM,”no units”)
9	>>	HAS PROPERTIES	CODE	EV (DD-60002, SRT, ”Complication of procedure”)	1-n	U		$ComplicationValue
10	>>>	HAS PROPERTIES	CODE	EV (111466, DCM, ”Severity of Complication”)	1	U		DCID (251) Severity of Complication
11	>>	HAS PROPERTIES	CODE	EV (122177, DCM, ”Procedure Result”)	1	U		$ProcedureResult
12	>>	HAS PROPERTIES	INCLUDE	TID (4207) Pathology Results	1-n	U		

6

TID 9004 Indicated Problem

This general template provides information about indicated problems presented by a patient. For example, indicated breast problems relating to the purpose for a mammographic examination.

Parameter Name	Parameter Usage
$ProblemList	Coded term or Context Group for value of Indicated Problem
$LateralityValue	Coded term or Context Group for value of Laterality
$LocationValue	Coded term or Context Group for value of Location

TID 9004
INDICATED PROBLEM
Type: Extensible

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
1			CONTAINER	EV (111514, DCM, ”Relevant Indicated Problems”)	1	M		
2	>	CONTAINS	CODE	EV (111533, DCM, ”Indicated Problem”)	1-n	M		$ProblemList
3	>>	HAS OBS CONTEXT	CODE	EV (111534, DCM, ”Role of person reporting”)	1	U		DCID (7450) Person Roles
4	>>	HAS OBS CONTEXT	DATETIME	EV (111535, DCM, ”Datetime problem observed”)	1	U		
5	>>	HAS PROPERTIES	CODE	EV (G-C171, SRT, ”Laterality”)	1	U		$LateralityValue
6	>>	HAS PROPERTIES	CODE	EV (G-C0E3, SRT, ”Finding site”)	1	U		$LocationValue
7	>>	HAS PROPERTIES	NUM	EV (G-7290, SRT, “Duration”)	1	U		
8	>>	HAS PROPERTIES	CODE	EV (R-407E7, SRT, “Frequency”)	1	U		DCID (6091) Relative Frequency of Event Values
9	>>	HAS PROPERTIES	DATETIME	EV (111536, DCM, “Datetime of last evaluation”)	1	U		
10	>>	HAS PROPERTIES	TEXT	EV (122106, DCM, “Comment”)	1	U		

TID 9005 Risk Factor

2 This general template provides detailed information on the risk factors for a patient, related to medical history for themselves and family members.

Parameter Name	Parameter Usage
$RiskList	Coded term or Context Group for value of Risk Factor
$FamilyList	Coded term or Context Group for value of Family Member with Risk Factor

4

TID 9005
6 **RISK FACTOR**
Type: Extensible

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
1			CONTAINER	EV (111515, DCM, ”Relevant Risk Factors”)	1	M		
2	>	CONTAINS	CODE	EV (F-01500, SRT, ”Risk factor”)	1-n	M		$RiskList
3	>>	HAS CONCEPT MOD	CODE	EV (111530, DCM, “Risk Factor modifier”)	1	U		EV (G-0002, SRT, “Family history of”)
4	>>	HAS CONCEPT MOD	NUM	EV(18185-9, LN, ”Gestational Age”)	1	UC	IFF value of row 2 is (G-0305, SRT, “History of – premature delivery”)	
5	>>	HAS OBS CONTEXT	CODE	EV (111534, DCM, ”Role of person reporting”)	1	U		DCID (7450) Person Roles
6	>>	HAS PROPERTIES	NUM	EV (111538, DCM, ”Age at Occurrence”)	1	U		UNITS = EV (a,UCUM,”Year”)
7	>>	HAS PROPERTIES	NUM	EV (G-7290, SRT, “Duration”)	1	U		UNITS = DCID (6046) Units of Follow-up Interval
8	>>	HAS PROPERTIES	TEXT	EV (121106, DCM, “Comment”)	1	U		
9	>>	INFERRED FROM	CODE	EV (111537, DCM, ”Family Member with Risk Factor”)	1-n	U		$FamilyList
10	>>>	HAS CONCEPT MOD	NUM	EV (111538, DCM, ”Age at Occurrence”)	1	U		UNITS = EV (a,UCUM,”Year”)
11	>>>	HAS CONCEPT MOD	CODE	EV (111539, DCM, ”Menopausal phase”)	1	U		DCID (6086) Menopausal Phase

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
12	>>>	HAS CONCEPT MOD	CODE	EV (111540, DCM, ”Side of Family”)	1	U		DCID (6097) Side of Family

2

TID 9006 Obstetric History

This general template collects the details of a patient’s obstetric history for a current pregnancy.
4 Information regarding previous pregnancies is conveyed using the Gynecological History Template.

6

TID 9006
OBSTETRIC HISTORY
8 **Type: Extensible**

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
1		CONTAINS	CONTAINER	EV (R-20658, SRT, ”Obstetric History”)	1	M		
2	>	CONTAINS	DATE	DCID (12003) OB-GYN Dates	1-n	U		
3	>	CONTAINS	NUM	EV (18185-9, LN, ”Gestational Age”)	1	U		UNITS= EV (d,UCUM, “Day”)
4	>	CONTAINS	TEXT	EV (121106, DCM, “Comment”)	1-n	U		

10

Content Item Descriptions

Row 3 “Gestational Age”	Observation DateTime (0040,A032) for Content Item shall be present, in order to convey the date and time at which this Gestational Age was established.

12

TID 351 Previous Reports

This general template provides a means to reference previous structured reporting composite
14 object instances.

TID 351
16 **PREVIOUS REPORTS**
Type: Extensible

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
1			CONTAINER	EV (111549, DCM, ”Previous Reports”)	1	M		
2	>	CONTAINS	COMPOSITE		1-n	M		

18

Content Item Descriptions

Row 2	Concept Name may be the Root Concept Name (title) of a Structured Report composite object instance.

20

TID 9007 General Relevant Patient Information

2 This template collects a patient's relevant information for general purpose use. This template, together with its subordinate templates, describes the history of a patient's reproductive system,
4 medications, substance use, environmental exposure, past procedures, risk factors, and indicated problems.

6 **TID 9007**
GENERAL RELEVANT PATIENT INFORMATION
8 **Type: Extensible**

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
1			CONTAINER	EV (111517, DCM, ”Relevant Patient Information”)	1	M		
2	>	HAS CONCEPT MOD	INCLUDE	DTID (1204) Language of Content Item and Descendants	1	M		
3	>	CONTAINS	INCLUDE	DTID (3114) Patient Assessment	1	U		
4	>	CONTAINS	INCLUDE	DTID (9002) Medication, Substance, Environmental Exposure	1	U		$ContainerConcept= EV (111512, DCM, ”Medication History”) $CodeConcept= EV (111516, DCM, ”Medication Type”)
5	>	CONTAINS	INCLUDE	DTID (9002) Medication, Substance, Environmental Exposure	1	U		$ContainerConcept= EV (111545, DCM, ”Substance Use History”) $CodeConcept= EV (111546, DCM, ”Used Substance Type”) $CodeValue= BCID (6089) Substances
6	>	CONTAINS	INCLUDE	DTID (9002) Medication, Substance, Environmental Exposure	1	U		$ContainerConcept= EV (111547, DCM, ”Environmental Exposure History”) $CodeConcept= EV (111548, DCM, ”Environmental Factor”)
7	>	CONTAINS	INCLUDE	DTID (9003) Previous Procedure	1	U		$LateralityValue= BCID (244) Laterality
8	>	CONTAINS	INCLUDE	DTID (9004) Indicated Problem	1	U		$LateralityValue= BCID (244) Laterality
9	>	CONTAINS	INCLUDE	DTID (9005) Risk Factor	1	U		$RiskList= BCID (6087) General Risk Factors $FamilyList= DCID (7451) Family Member
10	>	CONTAINS	INCLUDE	DTID (9001) Gynecological History	1	U		

	NL	Rel with Parent	VT	Concept Name	VM	Req Type	Condition	Value Set Constraint
11	>	CONTAINS	INCLUDE	DTID (9006) Obstetric History	1	U		
12	>	CONTAINS	INCLUDE	DTID (3802) Patient History, Cath	1	U		
13	>	CONTAINS	INCLUDE	DTID (351) Previous Reports	1	U		

2

2 *Item #4: Add the following Context Groups to Part 16 Annex B DCMR Context Groups (Normative):*

Annex B DCMR Context Groups (Normative)

4
CID 6080 GYNECOLOGICAL HORMONES

Context ID 6080
6 **Gynecological Hormones**
Type: Extensible Version: 20040112
8 Note: Some of these terms were obtained from BI-RADS®

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		C-B1700	Contraceptives
SRT		C-A0900	Estrogen product
SRT		C-A1204	Progesterone product
SRT		C-781E0	Tamoxifen
DCM		111542	Unspecified gynecological hormone

10
CID 6081 BREAST CANCER RISK FACTORS

Context ID 6081
12 **Breast Cancer Risk Factors**
Type: Extensible Version: 20040112
14 Note: Some of these terms were obtained from BI-RADS®

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
DCM		111550	Personal breast cancer history
DCM		111551	History of endometrial cancer
DCM		111552	History of ovarian cancer
DCM		111553	History of high risk lesion on previous biopsy
DCM		111554	Post menopausal patient
SRT		F-84430	Nulliparous
DCM		111555	Late child bearing (after 30)
DCM		111556	BRCA1 breast cancer gene
DCM		111557	BRCA2 breast cancer gene
DCM		111558	BRCA3 breast cancer gene
SRT		G-0325	Family history of breast cancer
DCM		111559	Weak family history of breast cancer

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
DCM		111560	Intermediate family history of breast cancer
DCM		111561	Very strong family history of breast cancer
DCM		111562	Family history of prostate cancer
DCM		111563	Family history unknown
SRT		R-207AD	No family history of breast carcinoma

2 **CID 6082 GYNECOLOGICAL PROCEDURES**

Context ID 6082

4 **Gynecological Procedures**

Type: Extensible Version: 20040112

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		P0-05CCA	Endometrial biopsy
SRT		P1-8330D	Hysterectomy
SRT		P1-03151	Dilation and curettage

6

CID 6083 PROCEDURES FOR BREAST

8 **Context ID 6083**

Procedures for Breast

10 **Type: Extensible Version: 20040112**

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
DCM		111564	Nipple discharge cytology
Include CID 6050			
Include CID 6084			
Include CID 6085			

2 **CID 6084 MAMMOPLASTY PROCEDURES**

Context ID 6084
4 **Mammoplasty Procedures**
Type: Extensible Version: 20040112

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		P1-48501	Breast implantation
SRT		P1-48830	Reduction mammoplasty
SRT		P1-48820	Breast reconstruction
SRT		P1-48520	Removal of breast implant

6
CID 6085 THERAPIES FOR BREAST

8 **Context ID 6085**
Therapies for Breast
10 **Type: Extensible Version: 20040112**

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		P0-0058E	Chemotherapy
SRT		P5-C0000	Radiation therapy
SRT		P0-007AC	Hormone therapy
SRT		P1-67D40	Bone marrow transplant

12 **CID 7451 FAMILY MEMBER**

Context ID 7451
14 **Family Member**
Type: Extensible Version: 20040112

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		S-10121	Natural mother
SRT		S-10131	Natural father
SRT		S-10151	Natural sister
SRT		S-10161	Natural brother
SRT		S-101A1	Aunt
SRT		S-101A2	Uncle
SRT		S-10154	Half-sister

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		S-10164	Half-brother
SRT		S-10115	Natural grand-mother
SRT		S-10116	Natural grand-father
SRT		S-10181	Natural daughter
SRT		S-10191	Natural son
SRT		S-101A9	Female first cousin
SRT		S-101AA	Male first cousin

2 **CID 6086 MENOPAUSAL PHASE**

Context ID 6086

4 **Menopausal Phase**

Type: Extensible Version: 20040112

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		R-41FFF	Before menopause
SRT		R-422A5	During menopause
SRT		R-410C3	After menopause
SRT		D7-76202	Postsurgical menopause
SRT		D7-76200	Artificial menopause state

6

CID 7450 PERSON ROLES

8 **Context ID 7450**

Person Roles

10 **Type: Extensible Version: 20040112**

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
DCM		121025	Patient
SRT		J-00552	Healthcare professional
SRT		S-11090	Friend
Include CID 7451			
Include CID 7452			

2 **CID 6087 GENERAL RISK FACTORS**

Context ID 6087
4 **General Risk Factors**
Type: Extensible Version: 20040112

6 This context group collects risk factor terms from specialized risk factor context groups into one aggregate list for general purpose use.

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
Include CID 6081			
Include CID 6088			

8

CID 6088 OB-GYN MATERNAL RISK FACTORS

10 **Context ID 6088**
OB-GYN Maternal Risk Factors
12 **Type: Extensible Version: 20040112**

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		G-023F	History of – diabetes mellitus
SRT		G-0269	History of - hypertension
SRT		G-0244	History of - obesity
SRT		G-02D0	History of – regular medication
SRT		G-0338	History of substance abuse
SRT		G-0335	History of – cardiovascular disease
DCM		111565	Uterine malformations
SRT		G-0304	History of - ectopic pregnancy
DCM		111566	Spontaneous Abortion
DCM		111567	Gynecologic condition
DCM		111568	Gynecologic surgery
SRT		G-031E	History of - eclampsia
SRT		G-031F	History of – severe pre-eclampsia
DCM		111569	Previous LBW or IUGR birth
DCM		111570	Previous fetal malformation/syndrome
SRT		G-0305	History of – premature delivery
DCM		111571	Previous RH negative or blood dyscrasia at birth
SRT		G-0319	History of infertility
DCM		111572	History of multiple fetuses

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		D8-20100	Multiple pregnancy
DCM		111573	Current pregnancy, known or suspected malformations/syndromes
DCM		111574	Family history, fetal malformation/syndrome

2 **CID 6089 SUBSTANCES**

Context ID 6089

4 **Substances**

Type: Extensible Version: 20040112

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		C-21005	Ethyl alcohol
SRT		F-618FF	Amphetamine
SRT		F-6166C	Marijuana derivative
SRT		F-61C76	Cocaine
SRT		F-61AC4	Heroin
SRT		C-63A10	Lysergic acid diethlyamide
SRT		F-6169A	Mescaline
SRT		C-6A180	Phencyclidine
SRT		F-61A95	Methadone
SRT		F-618D7	Morphine
SRT		F-618FE	Methlyphenidate
SRT		C-F3310	Chewing tobacco
SRT		C-F3302	Cigarette smoking tobacco
SRT		F-61117	Caffeine

6

CID 6090 RELATIVE USAGE, EXPOSURE AMOUNT

2

Context ID 6090
Relative Usage, Exposure Amount
4 **Type: Extensible Version: 20040112**

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104
DCM		111575	High
DCM		111576	Medium
DCM		111577	Low

6

CID 6091 RELATIVE FREQUENCY OF EVENT VALUES

Context ID 6091
8 **Relative Frequency of Event Values**
Type: Extensible Version: 20040112

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		R-40377	Continuous
SRT		G-7154	Frequent
SRT		R-40365	Mid-frequency
SRT		G-7155	Infrequent
SRT		R-40B16	As required
SRT		R-4112F	Single event

10

CID 6092 QUANTITATIVE CONCEPTS FOR USAGE, EXPOSURE

12 **Context ID 6092**
Quantitative Concepts for Usage, Exposure
14 **Type: Extensible Version: 20040112**

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		G-C0B7	Dosage
DCM		111578	Dose frequency
DCM		111579	Rate of exposure
DCM		111580	Volume of use

CID 6093 QUALITATIVE CONCEPTS FOR USAGE, EXPOSURE AMOUNT

2

Context ID 6093
Qualitative Concepts for Usage, Exposure Amount
4
Type: Extensible Version: 20040112

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
DCM		111581	Relative dose amount
DCM		111582	Relative amount of exposure
DCM		111583	Relative amount of use

6

CID 6094 QUALITATIVE CONCEPTS FOR USAGE, EXPOSURE FREQUENCY

Context ID 6094
8
Qualitative Concepts for Usage, Exposure Frequency
Type: Extensible Version: 20040112

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
DCM		111584	Relative dose frequency
DCM		111585	Relative frequency of exposure
DCM		111586	Relative frequency of use

10

CID 6095 NUMERIC PROPERTIES OF PROCEDURES

12

Context ID 6095
Numeric Properties of Procedures
14
Type: Extensible Version: 20040112

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
DCM		111465	Needle Gauge
DCM		111467	Needle Length

CID 6096 PREGNANCY STATUS

Context ID 6096

Pregnancy Status

Type: Extensible Version: 20040112

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		F-81890	not pregnant
SRT		F-84094	possible pregnancy
SRT		F-84000	patient currently pregnant
SRT		R-41198	Unknown

CID 6097 SIDE OF FAMILY

Context ID 6097

Side of Family

Type: Extensible Version: 20040112

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
DCM		111541	Maternal
SRT		R-40333	Paternal

Item #5: Modify the following Context Groups in Part 16 Annex B:

CID 6018 CLOCKFACE LOCATION OR REGION

Context ID 6018

Clockface Location or Region

Type: Extensible Version: ~~20011231~~20040112

Note: In future extensions, Clockface Location or Region terms that are not derived from BI-RADS® should be added to this context group.

Coding Scheme Designator (0008,0102)	Coding Scheme Version (0008,0103)	Code Value (0008,0100)	Code Meaning (0008,0104)
*Include ~~**CONTEXT GROUP**~~**CID** 6019*			
SRT		**T-D3050**	**Chest wall**

2 *Item #6: Add the following definitions to Part 16 Annex D DICOM Controlled Terminology Definitions (Normative):*

4
Annex D DICOM Controlled Terminology Definitions (Normative)

This Annex specifies the meanings of codes defined in DICOM, either explicitly or by reference to
6 another part of DICOM or an external reference document or standard.

Code Value (0008,0100)	Code Meaning (0008,0104)	Definition
111511	Relevant Patient Information for Breast Imaging	Historical patient health information of interest to the breast health clinician.
111512	Medication History	Information regarding usage by the patient of certain medications, such as hormones.
111513	Relevant Previous Procedures	Interventional or non-interventional procedures previously performed on the patient, such as breast biopsies.
111514	Relevant Indicated Problems	Abnormal conditions experienced by the patient which serve as the reason for performing a procedure, such as a breast exam.
111515	Relevant Risk Factors	Personal, familial, and other health factors that may indicate an increase in the patient's chances of developing a health condition or disease, such as breast cancer.
111516	Medication Type	A classification of a medicinal substance, such as hormonal contraceptive or antibiotic.
111517	Relevant Patient Information	Historical patient health information for general purpose use.
111518	Age when first menstrual period occurred	The age of the patient at the first occurrence of menses.
111519	Age at First Full Term Pregnancy	The age of the patient at the time of her first full term pregnancy.
111520	Age at Menopause	The age of the patient at the cessation of menses.
111521	Age when hysterectomy performed	The age of the patient at the time her uterus was removed.
111522	Age when left ovary removed	The age of the patient at the time she had her left ovary removed.
111523	Age when right ovary removed	The age of the patient at the time she had her right ovary removed.
111524	Age Started	The age of a patient on the first occurrence of an event, such as the first use of a medication.

Code Value (0008,0100)	Code Meaning (0008,0104)	Definition
111525	Age Ended	The age of a patient on the last occurrence of an event, such as the last use of a medication.
111526	Datetime Started	The date and time of the first occurrence of an event, such as the first use of a medication.
111527	Datetime Ended	The date and time of the last occurrence of an event, such as the last use of a medication.
111528	Ongoing	An indicator of whether an event is still in progress, such as the use of a medication or substance, or environmental exposure.
111529	Brand Name	Product name of a device or substance, such as medication, to identify it as the product of a single firm or manufacturer.
111530	Risk Factor modifier	A descriptor that further qualifies or characterizes a risk factor.
111531	Previous Procedure	A prior non-interventional exam or interventional procedure performed on a patient.
111532	Pregnancy Status	Describes the pregnancy state of a referenced subject.
111533	Indicated Problem	A symptom experienced by a patient that is used as the reason for performing an exam or procedure.
111534	Role of person reporting	The function of the individual who is reporting information on a patient, which could be a specific health care related profession, the patient him/herself, or a relative or friend.
111535	Datetime problem observed	The date and time that a symptom was noted.
111536	Datetime of last evaluation	The date and time of the most recent evaluation of an indicated problem.
111537	Family Member with Risk Factor	A patient’s biological relative who exhibits a health factor that may indicate an increase in the patient's chances of developing a particular disease or medical problem.
111538	Age at Occurrence	The age at which an individual experienced a specific event, such as breast cancer.
111539	Menopausal phase	The current stage of an individual in her gynecological development.
111540	Side of Family	An indicator of paternal or maternal relationship.
111541	Maternal	Relating to biological female parentage.

Code Value (0008,0100)	Code Meaning (0008,0104)	Definition
111542	Unspecified gynecological hormone	A gynecological hormone (e.g., contraceptive, estrogen, Tamoxifen) for which the specific type is not specified.
111543	Breast feeding history	An indicator of whether or not a patient ever provided breast milk to her offspring.
111544	Average breast feeding period	The average length of time that a patient provided breast milk to her offspring.
111545	Substance Use History	Information regarding usage by the patient of certain legal or illicit substances.
111546	Used Substance Type	A classification of a substance, such as alcohol or a legal or illicit drug.
111547	Environmental Exposure History	Information regarding exposure of the patient to potentially harmful environmental factors.
111548	Environmental Factor	A classification of a potentially harmful substance or gas in a subject's environment, such as asbestos, lead, or carcinogens.
111549	Previous Reports	Previous Structured Reports that could have relevant information for a current imaging service request.
111550	Personal breast cancer history	An indication that a patient has had a previous malignancy of the breast.
111551	History of endometrial cancer	Indicates a previous occurrence of cancer of the lining of the uterus.
111552	History of ovarian cancer	Indicates a previous occurrence of cancer of the lining of the ovary.
111553	History of high risk lesion on previous biopsy	Indicates a prior diagnosis of pre-cancerous cells or tissue removed for pathologic evaluation.
111554	Post menopausal patient	A female patient whose menstrual periods have ceased.
111555	Late child bearing (after 30)	A female patient whose first child was born after the patient was 30 years old.
111556	BRCA1 breast cancer gene	The first level genetic marker indicating risk for breast cancer.
111557	BRCA2 breast cancer gene	The second level genetic marker indicating risk for breast cancer.
111558	BRCA3 breast cancer gene	The third level genetic marker indicating risk for breast cancer.
111559	Weak family history of breast cancer	A patient's biological aunt, grandmother, or female cousin was diagnosed with breast cancer. Definition from BI-RADS®.

Code Value (0008,0100)	Code Meaning (0008,0104)	Definition
111560	Intermediate family history of breast cancer	A patient's biological mother or sister was diagnosed with breast cancer after they had gone through menopause. Definition from BI-RADS®.
111561	Very strong family history of breast cancer	A patient's biological mother or sister was diagnosed with breast cancer before they had gone through menopause, or more than one of the patient's first-degree relatives (biological mother or sister) were diagnosed with breast cancer after they had gone through menopause. Definition from BI-RADS®.
111562	Family history of prostate cancer	Previous diagnosis of a malignancy of the prostate gland in a biological relative.
111563	Family history unknown	The health record of a patient's biological relatives is not known.
111564	Nipple discharge cytology	The study of cells obtained from fluid emitted from the breast.
111565	Uterine malformations	A developmental abnormality resulting in an abnormal shape of the uterus.
111566	Spontaneous Abortion	A naturally occurring premature expulsion from the uterus of the products of conception – the embryo or a nonviable fetus.
111567	Gynecologic condition	An ailment/abnormality or state of the female reproductive tract.
111568	Gynecologic surgery	A surgical operation performed on any portion of the female reproductive tract.
111569	Previous LBW or IUGR birth	Prior pregnancy with a low birth weight baby or a fetus with Intrauterine Growth Restriction or Retardation.
111570	Previous fetal malformation/syndrome	History of at least one prior pregnancy with fetal anatomic abnormality(s).
111571	Previous RH negative or blood dyscrasia at birth	History of delivering a Rhesis Isoimmunization affected child(ren) or a child(ren) with another blood disorder.
111572	History of multiple fetuses	History of at least one pregnancy that contained more than one fetus (e.g., twins, triplets, etc.)
111573	Current pregnancy, known or suspected malformations/syndromes	At least one fetus of this pregnancy has an anatomic abnormality(s) that is known to exist, or a "marker" is present that suggests the abnormality(s) may be present.
111574	Family history, fetal malformation/syndrome	Biological relatives have previously conceived a fetus with an anatomic abnormality(s).

Code Value (0008,0100)	Code Meaning (0008,0104)	Definition
111575	High	A subjective descriptor for an elevated amount of exposure, use, or dosage, incurring high risk of adverse effects.
111576	Medium	A subjective descriptor for a moderate amount of exposure, use, or dosage, incurring medium risk of adverse effects.
111577	Low	A subjective descriptor for a limited amount of exposure, use, or dosage, incurring low risk of adverse effects.
111578	Dose frequency	A measurement of the rate of occurrence of which a patient takes a certain medication.
111579	Rate of exposure	The quantity per unit of time that a patient was or is being exposed to an environmental irritant.
111580	Volume of use	The quantity per unit of time that a medication or substance was or is being used.
111581	Relative dose amount	A qualitative descriptor for the amount of a medication that was or is being taken.
111582	Relative amount of exposure	A qualitative descriptor for the amount of present or past exposure to an environmental irritant.
111583	Relative amount of use	A qualitative descriptor for the amount of a medication or substance that was or is being used.
111584	Relative dose frequency	A qualitative descriptor for the frequency with which a medication was or is being taken.
111585	Relatve frequency of exposure	A qualitative descriptor for the frequency of present or past exposure to an environmental irritant.
111586	Relative frequence of use	A qualitative descriptor for the frequency with which a medication or substance was or is being used.
122146	Procedure Date~~T~~time	~~**Procedure DateTime**~~**The date and time on which a procedure was performed on a patient.**

Item #7: Add the following definitions to Part 16 Annex G English Code Meanings of Selected Codes (Normative):

Annex G English Code Meanings of Selected Codes (Normative)

Coding Scheme Designator (0008,0102)	Coding Scheme Version	Code Value (0008,0100)	Code Meaning (0008,0104)
SRT		P1-48501	Breast implantation
			Implant procedure
SRT		P1-48520	Removal of breast implant
			Explantation

Item #8: Add the following Annex to Part 16:

Annex Y Relevant Patient Information Templates (Normative)

The following templates are appropriate to use as Root templates for the Relevant Patient Information Query Service Class:

- TID 9007 General Relevant Patient Information.
- TID 9000 Relevant Patient Information for Breast Imaging.
- TID 9001 Gynecological History
- TID 9002 Medication, Substance, Environmental Exposure
- TID 9003 Previous Procedure
- TID 9004 Indicated Problem
- TID 9005 Risk Factor
- TID 9006 Obstetric History
- TID 3802 Patient History, Cath.