## Continuity of Care Document (CCD) Story

<table>
<thead>
<tr>
<th>Subjective</th>
<th>Reason for Visit</th>
<th>Reason for Referral</th>
<th>Chief Complaint</th>
<th>Chief Complaint Reason for Visit</th>
<th>Chief Complaint</th>
<th>Health Concerns</th>
<th>Allergies &amp; Intolerances</th>
<th>Review of Systems</th>
<th>History Present Illness</th>
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<tbody>
<tr>
<td>History Past Illness</td>
<td>Social History</td>
<td>Family History</td>
<td>Objective</td>
<td>Problem</td>
<td>Medical (Gen) History</td>
<td>Medications</td>
<td>Immunizations</td>
<td>Implants</td>
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<tr>
<td>Medical Equipment</td>
<td>Procedures</td>
<td>Results</td>
<td>Vital Signs</td>
<td>Admission Diagnosis</td>
<td>Admission Meds</td>
<td>Course of Care</td>
<td>Hospital Course</td>
<td>Hospital Consultations</td>
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<tr>
<td>Preoperative Diagnosis</td>
<td>Surgery Description</td>
<td>Op Note Surgical Procedure</td>
<td>Operative Note Fluids</td>
<td>Surgical Drains</td>
<td>Complications</td>
<td>Hospital Discharge Studies Sum</td>
<td>Hospital Discharge Physical</td>
<td>Advance Directives</td>
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<td>Payers</td>
<td>Encounters</td>
<td>Physical Exam</td>
<td>Findings</td>
<td>Health Status Eval/Outcomes</td>
<td>General Status</td>
<td>Functional Status</td>
<td>Mental Status</td>
<td>Nutrition</td>
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<tr>
<td>Assessment</td>
<td>Postprocedure Diagnosis</td>
<td>Postoperative Diagnosis</td>
<td>Discharge Diagnosis</td>
<td>Assessment &amp; Plan</td>
<td>Plan of Treatment</td>
<td>Goals</td>
<td>Planned Procedure</td>
<td>Instructions</td>
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<td>Hospital Discharge Instructions</td>
<td>Discharge Medications</td>
<td>Discharge Diet</td>
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### Optional Fields
- Subjective
- Objective
- Assessment

### Required Fields
- History Past Illness
- Current Illness
- History Present Illness
- Medical Equipment
- Medications Administered
- Preoperative Diagnosis
- Postoperative Diagnosis
- Procedure
- Procedure Indications
- Procedure Description
- Procedure Specimens
- Procedure Est. Blood Loss
- Procedure Findings
- Procedure Implants
- Advance Directives
- Physical Exam
- Health Status Eval/Outcomes
- General Status
- Functional Status
- Mental Status
- Nutrition
- Postoperative Diagnosis
- Assessment & Plan
- Plan of Treatment
- Hospital Discharge Instructions
- Discharge Medications
- Discharge Diet

### KEY
- Subjective
- Objective
- Assessment
- Plan

### Legend
- Optional
- Required
<table>
<thead>
<tr>
<th>Document Type</th>
<th>Required Sections</th>
<th>Optional Sections</th>
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</thead>
</table>
| **Continuity of Care Document (CCD) [V3] (Summarization of Episode Note)** | **Allergies and Intolerances Section (entries required) [V3]**  
**Medications Section (entries required) [V2]**  
**Problem Section (entries required) [V3]**  
**Results Section (entries required) [V3]**  
**Social History Section [V3]**  
**Vital Signs Section (entries required) [V3]** | **Advance Directives Section (entries optional) [V3]**  
**Encounters Section (entries optional) [V3]**  
**Family History Section [V3]**  
**Functional Status Section [V2]**  
**Immunizations Section (entries required) [V3]**  
**Medical Equipment Section [V2]**  
**Mental Status Section [V2]**  
**Nutrition Section**  
**Pavers Section [V3]**  
**Plan of Treatment Section [V2]**  
**Procedures Section (entries required) [V2]** |
| 34133-9 (required) | 2.16.840.1.113883.10.20.22.1.2:2014-06-09 |