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# INDUSTRY STANDARD OF THE PEOPLE'S REPUBLIC OF CHINA

# WS/T 500.9-2016

## Specification for sharing document of electronic medical record - Part 9: General surgery record

**(English Translation)**

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## Foreword

The WS/T 500 EHR Sharing Document Specification is divided into the following 53 sections.

--- Part 1. medical records summary;

--- Part 2. Door (urgent) medical records;

--- Part 3. Emergency medical records;



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--- Part 4. Western prescriptions;

--- Part 5. Chinese medicine prescription;

--- Part 6. Inspection Report;

--- Part 7. Inspection Report;

--- Part 8. Treatment records;

--- Part 9. General surgical records;

--- Part 10. preoperative anesthesia visit records;

--- Part 11. Anesthetic records;

--- Part 12. Postoperative anesthesia visit records;

--- Part 13. Transfusion records;

--- Part 14. Record to be produced;

--- Part 15. vaginal birth records;

--- Part 16. Cesarean section records;

--- Part 17. General nursing records;

--- Part 18. Serious (critically ill) nursing records;

--- Part 19. Surgical nursing records;

--- Part 20. vital signs measurement records;

--- Part 21. record of access;

--- Part 22. Records of high value supplies;

--- Part 23. admission assessment;

--- Part 24. Nursing plan;

--- Part 25. discharge assessment and guidance;

--- Part 26. Surgical Informed Consent Form;

--- Part 27. Anesthetic informed consent;

--- Part 28. Blood Transfusion Treatment Consent;

--- Part 29. special examination and special treatment consent;

--- Part 30. Critically ill (heavy) notice;

--- Part 31. Other informed consent forms;



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--- Part 32. Inpatient medical records home page;

--- Part 33. Chinese medical records Home;

--- Part 34. admission records;

--- Part 35. Discharge records within 24 hours;

--- Part 36. admission record of death within 24 hours;

--- Part 37. In-patient record of the first course of disease records;

--- Part 38. In-hospital record of routine disease course records;

--- Part 39. In-hospital records of superior physician rounds record;

--- Part 40. records of in-patient records of difficult case history;

--- Part 41. Inpatient records of the transfer records;

--- Part 42. records of hospitalization course transfer records;

--- Part 43. In-patient history record summary;

--- Part 44. Inpatient records of disease records;

--- Part 45. In-patient records of consultation records;

--- Part 46. In-hospital record of preoperative summary;

--- Part 47. preoperative record of in-hospital discussion;

--- Part 48. In-hospital records of the first course of disease records;

--- Part 49. hospitalization record of discharge records;

--- Part 50. In-hospital records of death records;

--- Part 51. In-hospital records of death cases discussion records;

--- Part 52. Hospital doctor's advice;

--- Part 53. discharge summary.

This section is part 9 of the WS/T 500.

This section drafted in accordance with GB/T 1.1-2009 given rules.

This section drafted by. Zhejiang Provincial Health Information Center, Shengjing Hospital Affiliated to China Medical University, West China Hospital of Sichuan University.

## 1 Scope

This part of WS/T 500 specifies document templates for general surgery records and a series of constraints on document headers and document bodies.



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This section applies to the general record of electronic medical records in the norms of collection, transmission, storage, sharing exchange and the development of information systems application.

## 2 Normative references

The following documents for the application of this document is essential. For dated references, only the dated version applies to this article Pieces. For undated references, the latest edition (including all amendments) applies to this document.

WS/T 482 Health Information Sharing Document Preparation Specification

## 3 Terms and abbreviations

WS/T 482 defined terms and abbreviations apply to this document.

## 4 Document content structure

The contents of the business documents are shown in Table 1, and the examples of documents are shown in Appendix A.

Table 1 treatment record document content table

Document composition information module cardinality document header document Activity Class Information 1.1 Patient Information 1.1 Creator Information 1.1 Data entry information 0.1 document Manager Information 1.1 Related activities information 0. * document body Past history section Preoperative diagnosis Chapter 1.1 Surgery Chapter 1.1 Blood loss chapter 0.1 Transfusion chapter 0.1 Anesthesia chapter



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