



Standard Practice for Description of Reservation/Registration-Admission, Discharge, Transfer (R-ADT) Systems for Electronic Health Record (EHR) Systems¹

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1. Scope

1.1 This practice identifies the minimum information capabilities needed by an ambulatory care system or a resident facility R-ADT system. This practice is intended to depict the processes of: patient registration, inpatient admission into health care institutions and the use of registration data in establishing and using the demographic segments of the electronic health record. It also identifies a common core of informational elements needed in this R-ADT process and outlines those organizational elements that may use these segments. Furthermore, this guide identifies the minimum general requirements for R-ADT and helps identify many of the additional specific requirements for such systems. The data elements described may not all be needed but, if used, they must be used in the way specified so that each record segment has comparable data. This practice will help answer questions faced by designers of R-ADT capabilities by providing a clear description of the consensus of health care professionals regarding a uniform set of minimum data elements used by R-ADT functions in each component of the larger system. It will also help educate health care professionals in the general principles of patient care information management as well as the details of the constituent specialty areas.

1.2 *This standard does not purport to address all of the safety concerns, if any, associated with its use. It is the responsibility of the user of this standard to establish appropriate safety and health practices and determine the applicability of regulatory requirements prior to use.*

¹ This practice is under the jurisdiction of ASTM Committee E31 on Healthcare Informatics and is the direct responsibility of Subcommittee E31.25 on Healthcare Data Management, Security, Confidentiality, and Privacy. This guide was prepared in collaboration with the American Health Information Management Assn.

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2. Referenced Documents

2.1 ASTM Standards:²

E1384 Practice for Content and Structure of the Electronic Health Record (EHR)

E1633 Specification for Coded Values Used in the Electronic Health Record

E1714 Guide for Properties of a Universal Healthcare Identifier (UHID)

E1715 Practice for An Object-Oriented Model for Registration, Admitting, Discharge, and Transfer (RADT) Functions in Computer-Based Patient Record Systems

E1869 Guide for Confidentiality, Privacy, Access, and Data Security Principles for Health Information Including Electronic Health Records

2.2 ANSI Standards:³

ANS X3.38 Identification of States of the United States for Information Interchange

ANS X3.47 Structure of the Identification of Name Populated Places and Related Entities of the States of the United States

NCCLS LIS-5A Specification for Transferring Clinical Observations Between Independent Computer Systems

NCCLS LIS-8A Guide for Functional Requirements of Clinical Laboratory Information Management Systems

NCCLS LIS-9A Guide for Coordination of Clinical Laboratory Services within the Electronic Health Record Environment and Networked Architectures

² For referenced ASTM standards, visit the ASTM website, www.astm.org, or contact ASTM Customer Service at service@astm.org. For *Annual Book of ASTM Standards* volume information, refer to the standard's Document Summary page on the ASTM website.

³ Available from American National Standards Institute (ANSI), 25 W. 43rd St., 4th Floor, New York, NY 10036, <http://www.ansi.org>.