Scope

The primary scope of this implementation guide is to provide guidance for the use of SNOMED CT in the HL7 V3 Clinical Statement pattern. The intent is to guide implementers in the construction of instances based on models derived from that pattern. These include models covering the representation of clinical information from the perspective of various HL7 domains including Structured Documents (CDA release 2), Patient Care, Orders and Observations and models using the Clinical Statement CMET[2](file:///C%3A%5C%5CUsers%5C%5CLisa%5C%5CDocuments%5C%5C05%20Professional%5C%5C90%20HL7%5C%5C00%20Standard%20-%20TermInfo%5C%5CTermInfo%20Course%2020130506%5C%5Chtml%5C%5Cinfrastructure%5C%5Cterminfo%5C%5Cterminfo.htm%22%20%5Cl%20%22fn2)

The guidance in this document should also be applied to the use of SNOMED CT in other HL7 V3 models that share features with the Clinical Statement model, unless domain specific requirements prevent this.

While other code systems (such as LOINC or ICD9) may be required or even preferable in some situations, these situations are outside the scope of this guide. Where a particular constraint profile requires the use of other code systems, that profile should complement and not contradict recommendations stated here.