USCDI United States Core Data for Interoperability

United States Core Data for Interoperability

Version 7 | July 2026

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The USCDI is a standardized set of health data classes and data elements for nationwide, interoperable health information exchange.

A USCDI **Data Class** is an aggregation of Data Elements by a common theme or use case.

A USCDI **Data Element** is a piece of data defined in USCDI for access, exchange, or use of electronic health information.

Version History

Version #	Description of Change	Version Date
Version 7	Publication	July 2026

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- Weight-for-length Percentile (Birth - 24 Months)
- Head Occipital-frontal Circumference Percentile (Birth- 36 Months)

DATA CLASS

ADVERSE EVENTS

Unintended effects associated with clinical interventions.

Exclusions: This data class does not include patient safety analyses, internal risk management documentation, or patient safety work product as defined under the Patient Safety and Quality Improvement Act of 2005 (42 U.S.C. 299b 21 et seq.) and implementing regulations (42 CFR part 3). It is not intended to define data elements for the exchange of Patient Safety Organization (PSO) investigations, safety reviews, or facility level reporting activities.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Adverse Event Condition Change to patient condition that could be an unintended effect of clinical interventions. Examples include but are not limited to rash, fever, etc. Usage note: Include for at least immunizations and medications.	• SNOMED Clinical Terms® (SNOMED CT®) U.S. Edition, March 2026 Release
Adverse Event Outcome Resulting patient status or consequence following an unexpected condition change or clinical event. Examples include but are not limited to hospitalized, recovered, recovered with sequelae, and death. Usage note: Include for at least immunizations and medications.	

DATA CLASS

ALLERGIES AND INTOLERANCES

Harmful or undesired physiological responses associated with exposure to a substance.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Medication Allergy Intolerance Pharmacologic agent believed to cause a harmful or undesired physiologic response following exposure.	• RxNorm® Full Monthly Release, July 6, 2026
Drug Class Allergy Intolerance Pharmacologic category for an agent believed to cause a harmful or undesired physiologic response following exposure.	• SNOMED Clinical Terms® (SNOMED CT®) U.S. Edition, March 2026 Release
Non-Medication Allergy Intolerance Non-pharmacologic agent believed to cause a harmful or undesired physiologic response following exposure. Examples include but are not limited to latex, eggs, pollen, and peanuts.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release
Reaction Harmful or undesired physiologic response following exposure to a substance.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release
Allergy Intolerance Criticality Estimate of the potential clinical harm, or seriousness, of a reaction to an identified substance.	

DATA CLASS

CARE PLANS

Information that guides treatment of the patient and recommendations for future treatment.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Assessment and Plan of Treatment Health professional's conclusions and working assumptions that will guide treatment of the patient.	
Care Plan Shared plan informed by members of a coordinated care team that details conditions, needs, and goals along with strategies for addressing them. Usage notes: Includes problems, health concerns, assessments, goals, and interventions from across care settings. Examples include but are not limited to clinical care plans, condition-specific care plans, coordinated care plan.	

DATA CLASS

CARE TEAM MEMBERS

Information about a person who participates or is expected to participate in the care of a patient.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Care Team Member Name	
Care Team Member Identifier Sequence of characters used to uniquely refer to a member of the care team. Examples include but are not limited to National Provider Identifier (NPI) and National Council of State Boards of Nursing Identifier (NCSBN ID).	
Care Team Member Role Responsibility of an individual within the care team. Examples include but are not limited to primary care physician and caregiver.	
Care Team Member Location Place where care is delivered by a care team member. Examples include but are not limited to clinic address and location description.	
Care Team Member Telecom Phone or email contact information for a care team member.	• ITU-T E.123, Series E: Overall Network Operation, Telephone Service, Service Operation and Human Factors, International operation - General provisions concerning users: Notation for national and international telephone numbers, email addresses and web addresses (incorporated by reference in § 170.299); and • ITU-T E.164, Series E: Overall Network Operation, Telephone Service, Service Operation and Human Factors, International operation - Numbering plan of the international telephone service: The international public telecommunication numbering plan

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Healthcare Agent Person legally authorized to make healthcare decisions on behalf of a patient when the patient is unable to do so because of an illness or injury.	

DATA CLASS

CLINICAL NOTES

Narrative patient data relevant to the context identified by note types.
Usage note: Clinical Notes data elements are content exchange standard agnostic. They should not be interpreted or associated with the structured document templates that may share the same name.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Consultation Note Narrative summary of care provided in response to a request from a clinician for an opinion, advice, or service. Examples include but are not limited to dermatology, dentistry, and acupuncture.	• Logical Observation Identifiers Names and Codes (LOINC®) version 2.82 ◦ At minimum: Consult note (LOINC code 11488-4)
Discharge Summary Note Narrative summary of a patient's admission and course in a hospital or post-acute care setting. Usage note: May contain admission and discharge dates and locations, discharge instructions, and reason(s) for hospitalization. Examples include but are not limited to dermatology discharge summary, hematology discharge summary, and neurology discharge summary.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82 ◦ At minimum: Discharge summary (LOINC code 18842-5)
Emergency Department Note Narrative summary of care delivered in an emergency department.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82 ◦ At minimum: Emergency department note (LOINC code 34111-5)
History & Physical Narrative summary of current and past conditions and observations used to inform an episode of care. Examples include but are not limited to admission, surgery, and other procedure.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82 ◦ At minimum: History and physical note (LOINC code 34117-2)

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Operative Note Narrative summary of a surgical procedure. Usage note: May include procedures performed, operative and anesthesia times, findings observed, fluids administered, specimens obtained, and complications identified.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82 ◦ At minimum: Surgical operation note (LOINC code 11504-8)
Procedure Note Narrative summary of non-operative procedure. Examples include but are not limited to interventional cardiology, gastrointestinal endoscopy, and osteopathic manipulation.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82 ◦ At minimum: Procedure note (LOINC code 28570-0)
Progress Note Narrative summary of a patient's interval status during an encounter. Examples include but are not limited to hospitalization, outpatient visit, and treatment with a post-acute care provider, or other healthcare encounter.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82 ◦ At minimum: Progress note (LOINC code 11506-3)
Referral Note Narrative summary requesting an opinion, advice, or service from a clinician. Examples include but are not limited to primary care referral to dermatology, dentistry, and acupuncture.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82 ◦ At minimum: Referral note (LOINC code 57133-1)

DATA CLASS

CLINICAL TESTS

Non-imaging and non-laboratory tests performed that result in structured or unstructured findings specific to the patient to facilitate the diagnosis and management of conditions.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Clinical Test Non-imaging or non-laboratory test. Examples include but are not limited to electrocardiogram (ECG), visual acuity exam, macular exam, and graded exercise testing (GXT).	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Clinical Test Result/Report Findings of clinical tests.	

DATA CLASS

DIAGNOSTIC IMAGING

Tests that result in visual images requiring interpretation by a credentialed professional.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Diagnostic Imaging Test Tests that generate visual images and require interpretation by qualified professionals. Examples include but are not limited to computed tomography-head, radiograph-chest, and ultrasound-pelvis.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Diagnostic Imaging Result/Report Interpreted results of imaging tests. Usage note: Includes structured and unstructured (narrative) components.	
Diagnostic Imaging Reference Information that can be used to access a diagnostic imaging study. Examples include but are not limited to imaging study endpoint weblink, unique identifiers, and contextual information needed to retrieve a diagnostic imaging study.	

DATA CLASS

ENCOUNTER INFORMATION

Information related to interactions between healthcare providers and patients.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Encounter Type Category of healthcare service. Examples include but are not limited to office visit, telephone assessment, and home visit.	
Encounter Identifier Sequence of characters by which an encounter is known.	
Encounter Diagnosis Coded diagnoses associated with an episode of care.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release • International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) April 2026
Encounter Date and Time Dates and times related to an encounter. Examples include but are not limited to scheduled appointment time, check in time, and start and stop times.	
Encounter Location Place where a patient's care is delivered.	• National Healthcare Safety Network (NHSN) Healthcare Facility Patient Care Location (HSLOC) Version 2022 • SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release
Encounter Disposition Place or setting where the patient went after a hospital stay or encounter.	

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Appointment Scheduled healthcare event for a specific date/time. Usage note: Appointment is used to schedule and coordinate healthcare services and participation and is distinct from an Encounter.	

DATA CLASS

FACILITY INFORMATION

Physical place of available services or resources.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Facility Identifier Sequence of characters representing a physical place of available services or resources.	
Facility Type Category of service or resource available in a location. Examples include but are not limited to hospital, laboratory, pharmacy, ambulatory clinic, long-term and post-acute care facility, and food pantry.	
Facility Name Word or words by which a facility is known.	
Facility Address Physical location of available services or resources.	
Facility Telecom Phone or email contact information for a physical place of available services or resources.	• ITU-T E.123, Series E: Overall Network Operation, Telephone Service, Service Operation and Human Factors, International operation - General provisions concerning users: Notation for national and international telephone numbers, email addresses and web addresses (incorporated by reference in § 170.299); and • ITU-T E.164, Series E: Overall Network Operation, Telephone Service, Service Operation and Human Factors, International operation - Numbering plan of the international telephone service: The international public telecommunication numbering plan

DATA CLASS

FAMILY HEALTH HISTORY

Family member health condition(s) that are relevant to a patient's care.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Family Health History Family member health condition(s) that are relevant to a patient's care.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release • International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) April 2026

DATA CLASS

GOALS AND PREFERENCES

Desired state to be achieved by a person or a person's elections to guide care.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Patient Goal Desired outcomes of patient's care. Examples include but are not limited to blood pressure control, functional ability, nutrition, and food security.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release
Treatment Intervention Preference Person's goals, preferences, and priorities for care and treatment in case that person is unable to make medical decisions because of a serious illness or injury. Examples include but are not limited to thoughts on cardiopulmonary resuscitation, mental health treatment preferences, and thoughts on pain management.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Care Experience Preference Person's goals, preferences, and priorities for overall experiences during their care and treatment. Examples include but are not limited to religious beliefs, dislikes and fears, and thoughts and feelings to be shared.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Advance Directive Observation Information about a patient or provider authored document indicating its location, content, type, and verification status. Usage note: May include structured or unstructured data, whether a person has one or more advance directive documents, the type of advance directive, the location of the document, and whether it has been verified. Such documents may be used should a person be unable to communicate their wishes, preferences, or priorities to their provider. Examples include but are not limited to an indication that a living will is on file, a reference to the location of durable medical power of attorney, and the validating provider.	

DATA CLASS

HEALTHCARE INFORMATION ATTRIBUTES

Contextual information that provides supporting details for healthcare data.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Diagnostic Report Date and Time Date and time a report containing test results or clinical interpretation was made available to providers.	
Indication Sign, symptom, or medical condition that is the reason for a care activity. Usage note: Indication may be included with a procedure, medication, and an order.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release • International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) April 2026
Performance Date and Time Date and time a care activity is performed. Examples include but are not limited to vaccine and medication administration times, surgery start time, and time ultrasound performed.	
Reason Not Performed Explanation or justification provided when a planned care activity or practice guideline is not carried out. Usage note: Include with at least procedure, immunization, and medication.	

DATA CLASS

HEALTH INSURANCE INFORMATION

Data related to an individual's insurance coverage for healthcare.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Health Insurance Coverage Status Presence or absence of healthcare insurance.	
Health Insurance Coverage Type Category of healthcare payers, insurance products, or benefits. Examples include but are not limited to Medicaid, commercial, HMO, Veterans Benefits Administration, Medicare Part D, and dental.	• Source of Payment Typology (SOPT), version 9.2
Relationship to Health Insurance Subscriber Relationship of a patient to the primary insured person.	
Health Insurance Member Identifier Sequence of characters used to uniquely refer to an individual with respect to their insurance.	
Health Insurance Subscriber Identifier Sequence of characters used to uniquely refer to the individual that selects insurance benefits.	
Health Insurance Group Identifier Sequence of characters used to uniquely refer to a specific health insurance plan.	
Health Insurance Payer Identifier Sequence of characters used to uniquely refer to an insurance payer.	
Health Insurance Coverage Period Time frame when the policy is in force.	

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Health Insurance Payer Issuer of the policy.	
Health Insurance Plan Health insurance offering or package.	
Health Insurance Plan Identifier Sequence of characters used to uniquely refer to an insurance plan.	

DATA CLASS

HEALTH STATUS ASSESSMENTS

Assessments of a health-related matter of interest, importance, or worry to a patient, patient's authorized representative, or patient's healthcare provider that could identify a need, problem, or condition.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Functional Status Assessment of a person's ability to perform activities of daily living and activities across other situations and settings. Examples include but are not limited to Functional Assessment Standardized Items (FASI) and Timed Up and Go (TUG).	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Disability Status Assessment of a patient's physical, cognitive, or psychiatric disabilities. Examples include but are not limited to American Community Survey, Veterans RAND Health Survey, and Patient-Reported Outcomes Measurement Information System (PROMIS).	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Mental/Cognitive Status Assessment or screening for the presence of a mental or behavioral problem. Examples include but are not limited to Confusion Assessment Method (CAM) and Patient Health Questionnaire (PHQ).	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Pregnancy Status State or condition of being pregnant or intent to become pregnant. Examples include but are not limited to pregnant, not pregnant, and unknown.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Alcohol Use Evaluation of a patient's consumption of alcohol. Examples include but are not limited to history of alcohol use, alcohol use disorder identification test, and alcohol intake assessment.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Substance Use Evaluation of a patient's reported use of drugs or other substances for non-medical purposes or in excess of a valid prescription. Examples include but are not limited to substance use disorder score, and substance use knowledge assessment.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Physical Activity Evaluation of a patient's current or usual exercise. Examples include but are not limited to frequency of muscle-strengthening physical activity, days per week with moderate to strenuous physical activity, and minutes per day of moderate to strenuous physical activity.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
SDOH Assessment Screening questionnaire-based, structured evaluation for a Social Determinants of Health-related risk. Examples include but are not limited to food, housing, transportation security, and health literacy.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Tobacco and Nicotine Product Use Assessment of a patient's tobacco and nicotine product use behaviors. Such products may include smokeless tobacco, cigarettes, cigars, pipe tobacco, waterpipes (or hookah), nicotine pouches, heated tobacco products, e-cigarettes, and other electronic nicotine delivery systems. Examples include but are not limited to duration and frequency of use, mode of consumption, and type of product used, and exclude prescribed nicotine replacement therapies.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release
Nutrition Assessment Assessment of a person's dietary intake.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82

DATA CLASS

IMMUNIZATIONS

Record of vaccine administration.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Immunization Vaccine product administered, planned, or reported.	Both standards are required: • CVX– Vaccines Administered, updates through June 30, 2026 • National Drug Code (NDC), updates through July 8, 2026
Immunization Lot Number Sequence of characters representing a specific quantity of manufactured material within a batch of a vaccine product.	
Immunization Status State of an immunization event. Examples include but are not limited to completed, entered in error, and not done.	
Immunization Record Source Indicator that the information source is responsible for the administration of the vaccine. Examples include but are not limited to organization responsible for administering the immunization and an external record.	

DATA CLASS

LABORATORY

Analysis of clinical specimens to obtain information about the health of a patient.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Test Analysis of specimens derived from humans which provide information for the diagnosis, prevention, treatment of disease, or assessment of health.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Value/Result Documented findings of a tested specimen including structured and unstructured components.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release
Specimen Type Substance being sampled or tested. Examples include but are not limited to nasopharyngeal swab, whole blood, serum, urine, and wound swab.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release
Result Status State or condition of a laboratory test.	
Result Unit of Measure Unit of measurement to report quantitative results.	• The Unified Code of Units for Measure, Revision 2.2
Result Reference Range Upper and lower limit of quantitative test values expected for a designated population of individuals. Usage note: Reference range values may differ by patient characteristics, laboratory test manufacturer, and laboratory test performer.	• The Unified Code of Units for Measure, Revision 2.2

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Result Interpretation Categorical assessment of a laboratory value, often in relation to a test's reference range. Examples include but are not limited to high, low, critical high, and normal.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release • Health Level 7® (HL7) Code System ObservationInterpretation
Specimen Source Site Body location from where a specimen was obtained. Examples include but are not limited to right internal jugular, left arm, and right eye.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release
Specimen Identifier Sequence of characters assigned by a laboratory for an individual specimen. Example includes but is not limited to accession number.	
Specimen Condition Information about a specimen, including the container, that is used to determine a laboratory's criteria for acceptability. Usage note: This may include information about the contents of the container, the container, and the label. Examples include but are not limited to hemolyzed, clotted, container leaking, and missing patient name.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release • HL7 Code System SpecimenCondition
Specimen Collection Method Technique or procedure used to obtain a specimen. Examples include but are not limited to venipuncture, swab, biopsy, aspiration, and catheter collection.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Specimen Collection Date and Time Date and time when the specimen was obtained.	

DATA CLASS

MEDICAL DEVICES

Instrument, apparatus, machine, equipment, implant, software, hardware, or related component or accessory intended to diagnose, treat, cure, mitigate, or prevent disease, or to affect the structure or function of the body.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Unique Device Identifier Numeric or alphanumeric code that uniquely identifies a medical device. Usage note: Contains a device identifier (DI) and, depending on device risk class, may contain one or more production identifiers (PI).	• FDA Unique Device Identification (UDI) System
Device Type Kind of instrument, machine, appliance, implant, software, and similar medical device.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release

DATA CLASS

MEDICATIONS

Pharmacologic agents used in the diagnosis, cure, mitigation, treatment, or prevention of disease.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Medication Pharmacologic agent used in the diagnosis, cure, mitigation, treatment, or prevention of disease.	• RxNorm Full Monthly Release, July 6, 2026 Optional: • National Drug Code (NDC), updates through July 8, 2026
Dose Amount of a medication for each administration.	
Dose Unit of Measure Units of measure of a medication. Examples include but are not limited to milligram (mg) and milliliter (mL).	• The Unified Code for Units of Measure, Revision 2.2
Route of Administration Physiological administration path of a therapeutic agent into or onto a patient. Examples include but are not limited to oral, topical, and intravenous.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release • National Cancer Institute Thesaurus (NCIt) v26.04d, FDA Structured Product Labeling (SPL) Terminology
Medication Dispense Status State of a medication with regards to dispensing or other activity. Examples include but are not limited to dispensed, partially dispensed, and not dispensed.	

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Medication Instructions Directions for administering or taking a medication. Usage note: May include route, quantity, timing/frequency, and special instructions (PRN, sliding scale, taper). Examples include but are not limited to prescription directions for taking a medication, and package instructions for over-the-counter medications.	
Medication Adherence Statement of whether a medication has been consumed according to instructions. Examples include but are not limited to taking as directed, taking less than directed, and not taking.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release
Medication Administration Information about the event of a patient consuming or otherwise being given a medication. Examples include but are not limited to date and time a patient ingested a tablet and who administered an injection.	
Medication Dispense Quantity Quantity of medication dispensed and requested to be dispensed. Examples include but are not limited to 480 mL of oral solution dispensed to a patient and 30 tablets ordered to be dispensed by a pharmacy.	

DATA CLASS

ORDERS

Provider-authored request for the delivery of patient care services.

Usage notes: Orders convey a provider's intent to have a service performed on or for a patient, or to give instructions on future care.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Medication Order Provider-authored request for the dispensing of a therapeutic agent.	• RxNorm® Full Monthly Release, July 6, 2026
Laboratory Order Provider-authored request for the performance of a laboratory test.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Diagnostic Imaging Order Provider-authored request for the performance of a diagnostic imaging study.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Clinical Test Order Provider-authored request for the performance of a non-laboratory or non-imaging test.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82
Procedure Order Provider-authored request for the performance of a diagnostic or therapeutic intervention.	

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Portable Medical Order Provider-authored request for end-of-life or life-sustaining care for a person who has a serious life-limiting medical condition. Usage note: These are meant to follow a person regardless of when and where such an order might be needed (e.g., hospital, care facility, community, home). There are variations in requirements and names for portable medical orders based on jurisdiction. Examples include, but are not limited to, POLST (Portable Medical Order for Life-Sustaining Treatment), MOLST (Medical Orders for Life-Sustaining Treatment), and out-of-hospital DNR (do-not-resuscitate).	
Medical Device Order Provider-authored request for medical devices. Examples include but are not limited to pacemaker, home blood pressure monitor, therapeutic footwear, insulin infusion pump, and continuous positive airway pressure (CPAP) machine.	
Nutrition Order Provider-authored request for therapeutic diet, nutrition support, and nutrition to promote and maintain health. Examples include but are not limited to nothing by mouth (NPO), cardiac diet, Mediterranean diet, low fermentable oligosaccharides, disaccharides, monosaccharides, and polyols (FODMAP) diet, whole food diet, clear liquid diet, enteral nutrition, and nutritional supplement.	

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Referral Order Provider-authored request to another provider, specialist, or organization for care services. Examples include but are not limited to referral orders to a wound care specialist, housing services, and skilled nursing facility.	

DATA CLASS

PATIENT DEMOGRAPHICS/INFORMATION

Data used to categorize individuals for identification, records matching, and other purposes.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
First Name	
Last Name	
Middle Name **(Including middle initial)**	
Name Suffix Name component following family name that may be used to describe a person's position in a family.	
Previous Name	
Date of Birth Known or estimated year, month, and day of the patient's birth.	
Date of Death Known or estimated year, month, and day of the patient's death.	
Race	Both standards are required: • The Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, as revised, October 30, 1997 • CDC Race and Ethnicity Code Set Version 1.4 July 2026

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Ethnicity	Both standards are required: • The Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, as revised, October 30, 1997 • CDC Race and Ethnicity Code Set Version 1.4 July 2026
Tribal Affiliation Tribe or band with which an individual associates.	
Sex Documentation of a specific instance of sex.	Both values must be supported: • SNOMED CT U.S. Edition: 248152002 (Female) • SNOMED CT U.S. Edition: 248153007 (Male)
Preferred Language	• IETF (Internet Engineering Task Force) Request for Comment (RFC) 5646, “Tags for Identifying Languages”, September 2009 Adopted at 45 CFR 170.207(g)(2)
Interpreter Needed Indication of whether a person needs language interpretation services.	• Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release
Current Address Place where a person is located or may be contacted. Usage note: If the address pattern is not supported in the standard, implementations should align as closely as possible and avoid truncating any values.	• Project US@ Technical Specification for Patient Addresses, Final Version 1.0

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Previous Address Prior place where a person may have been located or could have been contacted. Usage note: If the address pattern is not supported in the standard, implementations should align as closely as possible and avoid truncating any values.	• Project US@ Technical Specification for Patient Addresses, Final Version 1.0
Phone Number Numbers and symbols to contact an individual when using a phone.	Both standards are required: • ITU-T E.123, Series E: Overall Network Operation, Telephone Service, Service Operation and Human Factors, International operation - General provisions concerning users: Notation for national and international telephone numbers, email addresses and web addresses, February 2001 • ITU-T E.164, Series E: Overall Network Operation, Telephone Service, Service Operation and Human Factors, International operation - Numbering plan of the international telephone service, The international public telecommunication numbering plan, November 2010 Adopted at 45 CFR 170.207(q)(1)
Phone Number Type Contact point when using a phone. Examples include but are not limited to home, work, and mobile.	
Email Address Unique identifier of an individual's email account that is used to send and receive email messages.	
Related Person's Name Name of a person with a legal or familial relationship to a patient.	

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Relationship Type Relationship of a person to a patient. Examples include but are not limited to parent, next-of-kin, guardian, and custodian.	
Occupation Type of work of a person. Examples include but are not limited to infantry, business analyst, and social worker.	• Occupational Data for Health, version 20260427
Occupation Industry Type of business that compensates for work or assigns work to an unpaid worker or volunteer. Examples include but are not limited to U.S. Army, cement manufacturing, and children and youth services.	• Occupational Data for Health, version 20260427
Accommodation Supports and services necessary to access care, including modifications, tools, and technologies. Examples include but are not limited to sign language interpreters, wheelchair accessibility requirements, and sensory accommodation.	
Deceased Indicator Indicates if the person is deceased or not.	
Patient Identifier Sequence of characters assigned by an organization to refer to a patient. Examples include but are not limited to Medical Record Number.	

DATA CLASS

PROBLEMS

Condition, diagnosis, or reason for seeking medical attention.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Problem Condition, diagnosis, or reason for seeking medical attention. Examples include but are not limited to diabetes, asthma, homelessness, food insecurity, and lead exposure.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release • International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) April 2026
Health Concern Health-related issue or worry. Examples include but are not limited to weight gain and cancer risk.	
Date of Diagnosis Date of first determination by a qualified professional of the presence of a problem or condition affecting a patient.	
Date of Onset Date or estimated date when signs or symptoms of a condition began. Usage note: This may be a specific day, week, month, or year, or it may be an estimate.	
Date of Resolution Date of subsiding or termination of a symptom, problem, or condition.	
Condition Status State of a disease, problem, or condition at a given point in time. Examples include but are not limited to active, resolved, recurrence, and remission.	

DATA CLASS

PROCEDURES

Activity performed for or on a patient as part of the provision of care.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Procedure Activity performed for or on a patient as part of the provision of care. Examples include but are not limited to suture placement, gait training, knee replacement, and education about food pantry program.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release • Current Procedural Terminology (CPT®) 2026, as maintained and distributed by the American Medical Association, for physician services and other healthcare services, and Healthcare Common Procedure Coding System (HCPCS) July 2026, as maintained and distributed by HHS • Code on Dental Procedures and Nomenclature (CDT) 2026, maintained and distributed by the American Dental Association Optional: • 2025 International Classification of Diseases, Tenth Revision, Procedure Coding System (April 2026 ICD-10-PCS)
Reason for Referral Explanation or justification for a referral or consultation.	• SNOMED Clinical Terms (SNOMED CT) U.S. Edition, March 2026 Release • International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) April 2026
Procedure Status Status of planned or performed activity. Examples include but are not limited to in-progress, completed, and not done.	

DATA CLASS

PROVENANCE

The metadata, or extra information about data, regarding who created the data and when it was created.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Author Actor that created or revised the data. Usage note: The actor may be a provider, a patient, a device, an outside medical record, or something else. The source of the information can be used to form assessments about its quality, reliability, trustworthiness, or can indicate where to go to determine the origins of the information.	
Author Role Function performed by the actor that participated in the creation or revision of data. Usage note: The source of the information can be used to form assessments about its quality, reliability, trustworthiness, or can indicate where to go to determine the origins of the information. Examples include but are not limited to provider, patient, family member, and device.	
Author Time Stamp Date and time of author action.	
Author Organization Organization associated with author.	

DATA CLASS

VITAL SIGNS

Physiologic measurements of a patient that indicate the status of the body's life sustaining functions.

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Systolic Blood Pressure	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2
Diastolic Blood Pressure	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2
Average Blood Pressure Arithmetic average of systolic and diastolic components of two of more blood pressure readings in a specified time period or according to a specified algorithm or protocol. Examples include but are not limited to 3-day morning and evening home monitoring, clinical encounter repeat average, and 24-hour ambulatory measurement.	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2
Heart Rate	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2
Respiratory Rate	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Body Temperature	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2
Body Height	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2
Body Weight	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2
Pulse Oximetry	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2
Inhaled Oxygen Concentration	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2
BMI Percentile (2 - 20 years)	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2

DATA ELEMENT	APPLICABLE VOCABULARY STANDARD(S) Standards listed are required. If more than one is listed, at least one is required unless otherwise noted. Standards versions represent the most recent available at time of publication.
Weight-for-length Percentile (Birth - 24 Months)	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2
Head Occipital-frontal Circumference Percentile (Birth - 36 Months)	Both standards are required. • Logical Observation Identifiers Names and Codes (LOINC) version 2.82 • The Unified Code of Units for Measure, Revision 2.2

Changes between USCDI v6 and USCDI v7

New Data Elements	• Accommodation • Adverse Event Condition • Adverse Event Outcome • Allergy Intolerance Criticality • Appointment • Condition Status • Deceased Indicator • Device Type • Diagnostic Imaging Reference • Diagnostic Report Date and Time • Facility Telecom • Health Insurance Coverage Period • Health Insurance Payer • Health Insurance Plan • Health Insurance Plan Identifier • Healthcare Agent • Immunization Record Source • Immunization Status • Medical Device Order • Medication Administration • Medication Dispense Quantity • Nutrition Assessment • Nutrition Order • Patient Identifier • Procedure Status • Reason Not Performed • Referral Note • Referral Order • Specimen Collection Date and Time • Specimen Collection Method • Tobacco and Nicotine Product Use (significantly revised data element)

New Data Classes	• Adverse Events • Healthcare Information Attributes
Data Elements Reclassified	• Health Concern • Indication • Performance Time
Data Element Names Revised	• Diagnostic Imaging Result/Report • Health Concern • Health Insurance Coverage Status • Health Insurance Coverage Type • Health Insurance Group Identifier • Health Insurance Member Identifier • Health Insurance Payer Identifier • Health Insurance Subscriber Identifier • Immunization • Immunization Lot Number • Medication • Medication Dispense Status • Patient Goal • Problem • Procedure • Relationship to Health Insurance Subscriber • Specimen Condition • Test • Value/Result
Data Element Definitions Revised	• Author Role • Discharge Summary Note • Indication • Patient Goal • Performance Time • Problem • Procedure • Unique Device Identifier

Applicable Standards Added	• Health Insurance Coverage Type • Specimen Collection Method • Tobacco and Nicotine Product Use • Patient Goal • Pregnancy Status
Consolidated into Another Data Element	• SDOH Goals • SDOH Interventions • SDOH Problems/Health Concerns
Data Class Definition Revised	• Medical Devices
Data Class Name Revised	• Care Plans

Changes between Draft USCDI v7 and USCDI v7

New Data Elements	• Specimen Collection Date and Time
Data Element Names Revised	• Adverse Event Condition • Diagnostic Report Date and Time • Encounter Date and Time • Performance Date and Time • Tobacco and Nicotine Product Use
Data Element Definitions Revised	• Accommodation • Adverse Event Condition • Adverse Event Outcome • Appointment • Condition Status • Health Insurance Coverage Period • Healthcare Agent • Immunization Record Source • Immunization Status • Medical Device Order • Medication Administration • Medication Dispense Quantity • Nutrition Order • Patient Identifier • Reason Not Performed • Referral Order • Tobacco and Nicotine Product Use • Unique Device Identifier
Applicable Standard Added	• Specimen Collection Method
Applicable Standard Removed	• Accommodation
Data Class Definition Revised	• Adverse Events • Medical Devices