# (ONC Update) Clinical Test or Result Form Element

Last modified on 02/03/2026 12:05 pm EST

The Clinical Test or Result form element allows healthcare providers to document clinical tests and their results in a structured format that maintains LOINC codification. This feature is part of the ONC HTI-1 certification updates to support USCDI v3 Health Status Assessments.

**Overview** | **Adding Clinical Test & Result** | **Search & Select a Clinical Test** | **Code Attachments** | **Documenting Clinical Test & Result in Clinical Note**

## Related articles

- ONC Update: Clinical Form Management & Clinical Note
- ONC HTI-1 Updates: USCDI v3

## Overview

The Clinical Test or Result element enables providers to:
- Document clinical tests such as EKG, ultrasound, and laboratory tests
- Capture test results in a standardized, structured format
- Ensure LOINC-based codification for interoperability
- Include test data in CCDA exports

## Adding Clinical Test & Result in Clinical Form Management

Users can insert one or more Clinical Test & Result elements into a clinical form. Each element allows for single clinical test entries.

### Steps to Add the Element

1. Navigate to **Clinical Form Management**

2. Open or create a form

3. Select **Clinical Field** from the form elements

4. Choose **Clinical Test or Result** as the observation type

5. Configure the test parameters

## Search & Select a Clinical Test

A single-select search field labeled "**Clinical Test**" enables users to search for tests from the LOINC database.

### Search Results Include:
- **Clinical Test Name** - The descriptive name of the test

- **LOINC Code** - The standardized LOINC identifier

## Once Selected:

- **Label/Description** - Auto-populated based on the LOINC code but can be edited by the user
- **LOINC Code** - Stored and used to codify the entry (not editable by the user)
- **Unit of Measure** - Derived from the selected LOINC and displayed as read-only

# Code Attachments

Upon selecting a test, the LOINC code is automatically attached and cannot be edited.

## Additional Code Attachments

Users may optionally add additional code attachments at the form level, including:
- **CPT** - Current Procedural Terminology codes
- **HCPCS** - Healthcare Common Procedure Coding System codes
- **ICD-10** - International Classification of Diseases codes
- **Custom codes** - Practice-specific or other coding systems

This flexibility allows providers to associate multiple relevant codes with a single test for billing and documentation purposes.

# Documenting Clinical Test & Result in Clinical Note

When using the Clinical Test or Result form element in a clinical note, providers can document:

## Result Value

Users can enter either:
- **Numeric result** - For quantitative tests (e.g., "120" for blood pressure)
- **Text result** - For qualitative tests (e.g., "Positive", "Negative", "Normal")

## Test Date

Users can enter the **Date** when the test was performed or resulted using the date picker field.

> ℹ️ If both DATE and RESULT fields are empty, nothing will render in the Clinical Note PDF. This prevents incomplete or placeholder entries from appearing in patient documentation.

## Narrative Note Display

A customized note field is automatically generated for each test entry using the following default format:
`{{Question}} on {{dateValue}}: {{value}}`

Example Output:

"Blood Glucose on 01/15/2026: 105 mg/dL"

## Customization

This note format is **editable within the form builder**, allowing you to tailor the text output for display in the clinical note. You can modify the template to match your practice's documentation style or clinical preferences.

## Structured Data Capture

- Data is captured in a structured format suitable for LOINC-based codification
- Maintains data integrity and standardization
- Enables accurate data retrieval and reporting

## Clinical Note Display

- Test results appear in the clinical note using the customized note format
- Readable and professional presentation
- Integrates seamlessly with other clinical documentation

## CCDA Integration

- Data is included in Consolidated Clinical Document Architecture (CCDA) exports
- Stored in a way that reflects the HL7 CCD structure
- Supports interoperability with other healthcare systems
- Enables seamless data exchange for continuity of care