Case Report Check List

(Adopted for **QA** Proficiency Level 2) **Charles L. Blum, DC**

Based on the article by Green BN, Johnson CD. **Writing A Better Case Report**, *J Sports Chiropr & Rehabil*. 2000 Jun;14(2):46-47. (Was adapted from: Keating JC. **Towards a Philosophy of the Science of Chiropractic: A Primer for Clinicians**. Stockton, CA: Stockton Foundation for Chiropractic Research; 1992:419-20.)

See case report patient consent form (after check list) and have patient sign consent form before submitting this case report for publication.

INTRODUCTION

1.	What specific health problem is associated with this case report and its significance (e.g., prevalence, incidence, morbidity, financial and social costs)?
2.	What literature has been reviewed on this problem in relation to any diagnosis and treatment?
3.	How is this case report important and contribute to further understanding in health care?
4.	Please state your paper's purpose or thesis clearly.
	E REPORT Assessment:
1.	Describe the patient's characteristics.
2.	Define and describe the patient's health history clearly.

3.	Clearly describe the patient's examination in terms of positive results and significant negative results.
4.	What outcome assessment measures were utilized for clinical measurements?
5.	Fully describe any novel diagnostic or assessment strategies that were utilized.
6.	What does the literature say about the validity or reliability of the procedure used?
7.	What is the patient's diagnosis?
	atment/Intervention:
1.	In a clear manner describe the treatment or intervention.
2.	Clearly describe the treatment so it could be replicated by anyone reading this paper.
RES	SULTS
1.	Any outcome assessment measures mentioned in the case report should have its data reported here.

2.	What may be any possible side effects or risks associated with the treatment rendered?
3.	Attempt to distinguish between short versus long-term outcomes associated with the treatmen rendered?
DISC	CUSSION
1.	Clearly describe your interpretation of the results.
2.	Can you propose a mechanism for the observed changes?
3.	What flaws might there be with your study and how could it be improved in the future?
4.	Is there any differential diagnosis associated with this case report?
5.	Why might some question your conclusion that the treatment was responsible for the observed changes?
6.	What are the limitations associated with applying this study to other patients?

CONCLUSION

у. С	early address the purpose of this case report as presented in the introduction.
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REFERENCES

Each journal commonly has their own recommended format for references but one of the most common is the Vancouver Style, while it would be good to check the journal directly the following is one of many sites that offer a clear description of how to write references in this style. [http://www.lib.murdoch.edu.au/find/citation/vancouver.html (last accessed 11-01-07)]

STRUCTURED ABSTRACT

The case report should have a structured abstract, a summary of the article usually around 150 - 250 words. There are specific formats for an abstract and each journal has their particular preference. Information for what is needed to write "Structured Abstracts for Case Reports" is located at: [http://www.soto-

usa.org/Newsletter/DCInternetEdition/dc_internet_ed_vol_3_no3Abstrak/StructuredAbstracts.htm (last accessed 11-01-07)]

KEYWORDS

Keywords are usually key words or phrases that an indexer can use to cross-index your paper. It is best to use Index Medicus Medical Subject Headings (MeSH). To find the MeSH terms you may want to contact a chiropractic librarian or explore on-line: [http://www.nlm.nih.gov/mesh/meshhome.html (last accessed 11-01-07)]. Also another source of key words can be found in the Chiropractic Subject Headings (ChiroSH): 2006 edition: [http://www.chiroindex.org/htmls/ChiroSH2006.pdf (last accessed 11-01-07)].

PATIENT CONSENT FORM

While historically patient consent forms were not needed for case reports, in the effort to protect patient's confidential information and prevent unwanted information from being released, journals will likely be requesting "patient consent forms." See the following consent form that can be used for most journals.

Patient Consent for Publication

The following information must be provided in order for this form to be processed accurately.
Title:
Author(s):
I hereby give my consent for images or other clinical information relating to my case to
be reported in the
(Journal)
I understand that my name, initials, or any protected health information such as my identification number, billing information, address, etc. will not be published and that efforts will be made to conceal my identity, but that anonymity cannot be guaranteed.
I understand that the material may be published in the above journal, on above journal's Web site and in products derived from the journal. As a result, I understand that the material may be seen by the general public.
Name of patient
Signature of patient (or signature of the person giving consent on behalf of the patient)
If you are not the patient, what is your relationship to him or her? (The person giving consent should be a substitute decision maker or legal guardian or should hold power of attorney for the patient.)
Why is the patient not able to give consent? (e.g., is the patient a minor, incapacitated, or deceased?)
If images of the patient's face or distinctive body markings are to be published, the following section should be signed in addition to the first section:
I give permission for images of my face or distinctive body markings to be published and recognize that I might therefore be identifiable even though my name and initials will not be published.
Signature of patient (or signature of the person Date giving consent on behalf of the patient)

Please complete all required fields before returning to the journal