

## CARE Checklist – 2016: Information for writing a case report

Title Key Words	Topic		Item Checklist item description	Line/Page
Introduction				
Timeline         5         Information from this case report organized into a timeline (table or figure)           Patient Information         6a 6b Chief complaint—what prompted this visit? Relevant history including past interventions and outcomes           Physical Exam         7         Relevant physical examination findings           Diagnostic Assessment         8a 8b Diagnostic reasoning including other diagnoses considered and challenges of Consider tables or figures linking assessment, diagnoses and interventions Prognostic characteristics where applicable           Interventions         9a 7 Types such as life-style recommendations, treatments, medications, surgery Intervention administration such as dosage, frequency and duration Note changes in intervention with explanation Other concurrent interventions           Follow-up and Outcomes         10a 10b Clinician assessment (and patient or client assessed outcomes when appropriate) Important follow-up diagnostic evaluations Assessment of Intervention adherence and tolerability, including adverse events           Discussion         11a Strengths and limitations in your approach to this case Specify how this case report informs practice or Clinical Practice Guidelines (CPG) How does this case report informs practice or Clinical Practice Guidelines (CPG) How does this case report suggest a testable hypothesis?           Patient Perspective         12 When appropriate include the assessment of the patient or client on this episode of care           Informed Consent         13 Informed consent from the person who is the subject of this case report is required by most journals	ostract	3b	Case summary: chief complaint, diagnoses, interventions, and outcomes	
Patient Information 6a	troduction	4	The current standard of care and contributions of this case—with references (1-2 paragraphs)	
Chief complaint—what prompted this visit? Relevant history including past interventions and outcomes  Physical Exam  7 Relevant physical examination findings  Diagnostic Assessment  8a Evaluations such as surveys, laboratory testing, imaging, etc. Diagnostic reasoning including other diagnoses considered and challenges 8c Consider tables or figures linking assessment, diagnoses and interventions Prognostic characteristics where applicable  Interventions  9a Types such as life-style recommendations, treatments, medications, surgery Intervention administration such as dosage, frequency and duration Note changes in intervention with explanation Outcomes  10a Clinician assessment (and patient or client assessed outcomes when appropriate) Important follow-up diagnostic evaluations Assessment of intervention adherence and tolerability, including adverse events  Discussion  11a Strengths and limitations in your approach to this case Specify how this case report informs practice or Clinical Practice Guidelines (CPG) 11b How does this case report suggest a testable hypothesis? Conclusions and rationale  Patient Perspective  12 When appropriate include the assessment of the patient or client on this episode of care Informed Consent  13 Informed consent from the person who is the subject of this case report is required by most journals	meline	5	Information from this case report organized into a timeline (table or figure)	
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Additional Information 14 Acknowledgement section; Competing Interests; IRB approval when required	formed Consent	13	Informed consent from the person who is the subject of this case report is required by most journals	
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