



Case Report Requirements

(rev September 2025)

- Case Reports must be double spaced, using US (8.5 x 11 inches) page settings (A4 settings not accepted) and leaving at least one-inch margins on all sides.
- The font must be Times New Roman, font size 12
- Case Reports must be a minimum of five (5) pages and a maximum of ten (10) pages.
 - Applicants may provide supplemental information in Appendices appended at the end of the Report (in the same PDF)
 - Appendix materials (images, video, lab charts/reports, diagnostic reports, etc.) will not count towards the total page count
- Submissions must be in English and must be grammatically correct. Applicants whose native language is not English are advised to seek assistance from a fluent English speaker.
- A minimum of four (4) references are required and must include:
 - A minimum of one (1) textbook published within the last ten (10) years; and
 - A minimum of one (1) journal article published within the last ten (10) years
- Case Reports must be saved as PDFs for submission. Other document types will not be accepted.

Formatting the Case Report

Your Case Report *must include* the following sections. See the Application Instructions packet for your application year for a more thorough description of expectations for Case Reports. Also, please review the [weighted scale](#) that will be used to review and score the Reports, and Case Report examples from previous years.

- Header:
 - Use the Header/Footer option in your word processing software
 - If you don't know how to use this function, reach out to the [Credentialing Committee Chairs](#)
 - The header must appear on every page of the Report, not including the appendices.
 - The header must include:
 - First line: Applicant number and area of specialization (e.g., "Applicant #123, Oncology")
 - Second line: Case census entry number (from the case census form)
 - Third line: Date of first treatment by applicant
 - Fourth line: Patient name and/or ID number



- Signalment:
 - Species
 - Breed
 - Age
 - Sex
 - Reproductive status

- History:
 - Presenting complaint
 - Relevant history prior to presentation
 - Any medications the patient was taking prior to presentation

- Patient status on presentation:
 - Physical exam findings including, but not limited to:
 - Weight in kg
 - Temperature
 - Heart rate
 - Pulse rate
 - Respiratory rate and character
 - Level of consciousness
 - Body systems review of abnormal findings
 - Problem list

- Veterinarian's differential diagnosis

- Veterinarian's initial assessment of prognosis

- Interventions
 - Initial diagnostics and results
 - Laboratory
 - Diagnostic imaging
 - Other diagnostic procedures
 - Discussion of test selections and potential alternatives
 - Treatment plan, including but not limited to:
 - Fluid therapy
 - Medications
 - Monitoring performed
 - Other therapeutic modalities



- Case Management
 - Relevant diagnostic tests performed and their results
 - If the patient was seen multiple times for the same issue/diagnosis, each visit should be reported separately
 - For hospitalized patients, these results should be reported on a daily basis
 - Changes to treatment plan, and the reasons for those changes
 - Patient status (e.g., appetite, eliminations, vitals, etc.), with specific attention to changes and response to treatment
 - Medications, including reason for use
 - Other interventions, including reasons for performing, potential complications, expected therapeutic value, modifications required (if any), and patient-specific concerns.

- Final Outcome
 - If euthanized, explain reasons for euthanasia and include necropsy results, if available.
 - If patient died, explain potential reasons and include necropsy results, if available.
 - If discharged from hospital, or from the applicant's care, include:
 - All client education performed
 - If handouts or other written communications were prepared and provided by the applicant, those may be included as an appendix and referenced in the Report
 - All medications
 - Any therapeutic diets prescribed, including nutritional calculations

- Discussion
 - Pathophysiology and pathology, **especially as it relates to or was expressed in the specific patient** that is the subject of the Report.
 - Disease process, including etiology, **especially as it relates to or was expressed in the specific patient** that is the subject of the Report.
 - Diagnostics performed, **whether results were expected or not**, and **why**
 - Goals of therapy
 - Explanation of why each diagnostic test/procedure, treatment, monitoring parameter, etc. were justified given the **specific patient and disease process**
 - How the applicant's advanced skills influenced or did not influence the **specific patient's** course of treatment and/or outcome.
 - How the applicant's advanced knowledge of their specialty influenced or did not influence the **specific patient's** course of treatment and/or outcome.