Case Report Requirements Outline

- 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 your 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 an AIMVT mentor, or 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 your mentor or to the Credentialing Committee Chair
    - The header must appear on every page of the Report, not including the appendices.
    - The header must include:
        - First line: Applicant's name and area of specialization (e.g., "Jane Doe, Oncology")
        - Second line: Case Log number (from Case Log 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 for hospitalized patients
    - 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.