Case Notes Guidelines

DIAGNOSIS AT ADMISSION: There should be only one primary diagnosis

PRESENTING DATA: This is the clinical presentation of the patient at the time of admission and will include data such as the patient's complaints, vitals, lab work, physical exam, radiology, etc. Possibilities of complaints include, but are not limited to, pain, discomfort, wounds, vomiting, dizziness, fainting, syncope, burning, diaphoresis, numbness, change in normal body function (where?). These can either be seen by the clinician or be felt by the patient.

COMPLICATING CONDITIONS AND RISK FACTORS: This is the prior medical history of the patient, including family history. Possibilities include, but are not limited to, past and current medications, diabetes, previous MI/stroke, hypertension, obesity, COPD, dementia, trauma, eating disorder, psychological disorders, hypercholesterolemia, kidney dysfunction, cancer, osteoporosis, liver dysfunction, GI dysfunction, etc.

TREATMENTS AND PROCEDURES: What was done to help the patient and why. This should include all procedures and medications that were administered, why they were performed/administered, and what the outcomes were.

YOUR COMMENTS: Any other information that you deem pertinent.

The following resources may be helpful in writing your reports (including your research paper):

Available at Penfield Library

1. Physicians' Desk Reference (PDR)
2. Harrison's Principles of Internal Medicine
3. Merck Manual
4. Stedman's Medical Dictionary

Available Online (see www.oswego.edu/biology/mackenzie for the links)

1. PubMed (Medical Journal Search Engine)
2. Online Mendelian Inheritance of Man (NCBI)
3. Online Medical Dictionary
4. Online Textbooks (NCBI)