

CAQ - CASE DOCUMENTATION INSTRUCTIONS

Case documentation represents a key aspect of the applicant's knowledge, and demonstrates practical experience and exposure in the required clinical areas. All cases submitted shall be kept confidential. The patient's identity, with the exception of their initials, is not required. If present, patients' identity will remain within the case review process and not be published or discussed for purposes other than accrediting the applicant. Patient names appearing on charts or studies may be blocked out, with only their initials, or other suitable means of identification, showing.

Cases submitted for review will be evaluated with the following goals in mind:

- Clear and concise documentation, including well-organized diagnostic, evaluative and therapeutic regimes;
- Where appropriate, examples of interdisciplinary consultation and long-term preventative health care;
- Appropriate and timely selection of laboratory and imaging studies and response to pertinent findings;
- Where germane to the case presented, biomechanical evaluations sufficiently detailed to include and justify the pathomechanical diagnosis made and therapeutic regime chosen. The evaluation is expected to include orthometric findings, gait analysis and manual muscle testing. This is especially true where surgical and/or orthotic options are considered.

Cases may be rejected for lack of diversity and/or complexity and/or longitudinal care. Rejected cases will be cause for non-selection to the examination process. There is no appeal of rejected cases.

Initial submission of Form 111 which must be submitted by January 15, 2022

- An **initial list** of 10 cases are due by **January 15, 2022** and are to be submitted on Case Summary Index Form 111.
- A minimum of 8 categories must be utilized. If **only** 8 categories are utilized additional 2 cases may be submitted in the "supplemental section".
- The Case Documentation Review Committee will identify 3 cases for which complete documentation is required.
 - 1) Enter a diagnosis, patient's initials, # visits and supporting data on **all** of the lines in which you make an entry. The diagnosis must be the **podiatric** diagnosis. For example, in the Diabetes, Endocrine, Metabolic category, do not simply write "diabetes" as the diagnosis.
 - 2) Although some diagnoses may not have extensive supporting data, where present, please make sure to check the appropriate boxes. This issue cannot be overemphasized. Cases with significant supportive documentation is normally expected, as it provides the reviewers with insight regarding an applicant's thoroughness in case management. Cases without sufficient supporting documentation may well be viewed as inadequate.
 - 3) Radiographs and other imaging studies should be included in the "imaging studies" box.
 - a. For CT or MRI studies include only the images that demonstrate pathologic findings
 - b. Relevant images must be presented in a .jpeg or .pdf format. **We will not accept Discs from the Radiology Department.**
 - c. If hard copy or electronic copy of the actual study is not available and only the written radiology report is present, do **not** check the imaging studies box. Instead, check the **consultation** box and subsequently submit the report.
 - d. Where both the images and the written report are present, check both boxes.

Rules for Selecting Cases

- 1) Cases attended while in a residency program are not eligible.
- 2) All cases submitted for the examination year must have been performed **within seven years of the year submitted**.
- 3) Cases submitted for review in a previous year may not be resubmitted.
- 4) Make certain that all of your records are **complete** for **all 10 cases** **before** you submit the initial list.
- 5) **It is forbidden to use the same patient more than once**. If two patients have the same initials, differentiate them by including a middle initial, (i.e. TAM and TRM).
- 6) The applicant must be the predominant practitioner of record for podiatric management.