

## Guidelines for Residency Case Studies

We expect the resident write up cases in the format included on the “Resident Case Outline”. The resident does not have to submit these cases in the form of progress notes or exactly in SOAP format, although the supervisor should evaluate the Objective and Assessment sections very carefully for details emphasized in the Case Outline. If the resident is not able to see a patient from start to finish, they should ask the supervisor to look at the chart for evaluation or intervening progress. Also, they should look up the diagnosis and recommended O&P treatments in their texts to further illuminate their write-ups. Remember, the resident needs to provide information supportive of the Rx with respect to function, expectations, and component decisions and recommendations in the Assessment section, based upon objective information and relevant history. This serves as the “proof” that the Rx is appropriate.

Typically a good case write up can be achieved in 1-2 typewritten pages. Also, depending on the residency, the resident could orally present their chosen case to colleagues at a regular office round table. The written format can be single spaced, and in point form. By using the attached case outline, the resident satisfies the documentation requirements of ABC, JCAHO, and Medicare. Typically, clinical documentation of this format is also required for justification letters to insurers and HMO’s to obtain anything beyond basic O&P services for clients.

Again, the resident can use the case guidelines to help create case write-ups. The Objective and Assessment sections are especially relevant.

## **RESIDENCY CASE OUTLINE**

**NAME, DATE, HT, WT, AGE, SEX, OCCUPATION**

### **PRESCRIPTION (Rx)**

**Name of referring physician**

**Appropriate terminology to describe components (HCFA)**

### **DIAGNOSIS (Dx) - Determined by:**

**Referring physician on Rx**

**Available medical history**

**Communication with Patient**

### **HISTORY (Hx)**

**DOI, Surgery, Prior Treatment, Progress in recovery, Past prosthetic or orthotic treatment, Any other information medically relevant**

### **OBJECTIVE FINDINGS**

**Physical exam, Muscle test, ROM, Shrinkage, Angular change/deformity, Gait, Length of residual limb, Biomechanical description of functional loss or instability, Condition of current prosthesis or orthosis**

### **ASSESSMENT**

**For initial evaluation, new prosthesis/orthosis, or return visit after a prolonged absence:**

- **Info supportive of the Rx with respect to function, expectations, and component decisions and recommendations**
- **Gait analysis**
- **Current prosthesis/orthosis evaluation/opinion**
- **Analysis/prediction of function (K level for prosthetics)**
- **Analysis of mental status, motivation level**
- **Prognosis**
- **Analysis of current problem**
- **Level of independence**
- **Description of functional loss and expected outcome of intervention**

### **PLAN/PROGRESS**

- **Current Service provided at this particular patient encounter**
- **Summary of overall treatment plan including other disciplines**
- **time schedule**
- **achievement of goals or justification of failure to achieve goals**
- **return visit**

### **PATIENT/FAMILY EDUCATION**

**Document specific instructions that were given and printed documents that accompanied service; e.g. donning and doffing instructions, care and maintenance, precautions and limitations of the prosthesis or orthosis, wearing schedules**