Instructions for case logs

- Please use only the “Case Log Template” Excel sheet provided
- Case log should be built sequentially, with a new patient number assigned to new patients as defined below.
- Sort by patient # and date, so that all visits for each patient appear together. This allows you and the committee to accurately track follow-up visits.
- Update your case log frequently to prevent loss of data or excessive time rebuilding information.
- Maintain your case log until the completion of your residency. You are only required to submit your case log if the Education Committee requests it. In that case please submit it electronically by email attachment to Alexis (itchypet@aol.com).
- Case logs not in compliance with these instructions will be sent back to the resident for correction

Column	Definition
Patient#	This is the running tally of patients that you have primary case responsibility for. This is also the number that counts towards the 500 patient minimum. Numbers should be sequential and assigned on the first visit of a new patient. Assign a single number per new patient, and use the same number for each follow-up (visit or phone) for the same patient. Examples of a new patient include the following: - a patient you have never seen before - a patient you took over from your mentor or another resident (and then maintained primary responsibility for during follow ups) - a past patient that now develops a substantially different or not commonly associated dermatologic disease (i.e. initially diagnosed with atopy, now has pemphigus foliaceus). - a consult can be assigned a number in your case log if you were heavily involved in the patient’s dermatologic evaluation, diagnosis, treatment recommendations and follow up. Please do not include the following: phone consultations, online consultations, internal consultations that you did not re-evaluate, rechecks for other clinicians that you did not re-evaluate, patients that are being counted as primary cases by other residents.
Date	Date of visit
Case #	This is your institutional case or file #
Name	Include patient name and client’s last name
Visit #	Sequential number of visits you have received the patient as primary clinician. Initial visit you see the patient for the first time = 1. First follow-up exam = 2, Second follow-up = 3, etc. For phone follow-up mark with phone.
Signalment	Species, Breed, Gender, Age
Diagnosis	To you highest level of understanding or working diagnosis. You may say “suspect pemphigus” or “Superficial Pyoderma, probably atopy.” You may be descriptive “chronic nodular pododermatitis with draining tracts.” Do not need exhaustive list of differential diagnoses.
Plan	Be brief. 3-4 words. It is not necessary to write a complete description of the diagnostic and therapeutic plan. Example, “treat secondary infections; reassess 3 weeks”