CASE STUDY FORMAT

A. INTRODUCTION

- Patient Profile
  Patient's name (Initial only)
  Age
  Gender
  Educational attainment
  Attending Physician
  Chief complaint
  Admitting Diagnosis
  Date of Admission
- Brief Statement of your client's case
- Rationale for choosing the case

B. **ASSESSMENT** (Narrative)

- General Survey
- History of Present Illness (reason for admission)
- Client's personal and Family History
- Past Health History (Diet, Lifestyle, Psychosocial, Immunizations, Previous Illness, Allergy, Nutritional Assessment)
- Physical Assessment (Head to Toe, per system)*

Body Part	Normal Findings	Patient Findings	Significance
Skin			
Head, Eyes , Ears , Nose			
Respiratory			
Cardiovascular			
Gastrointestinal			
Urinary			
Musculo skeletal			
Nervous System			

C. Anatomy And Physiology of the Affected Organ or System

D. Pathophysiology / Etiology of the Disease (Narrative as well as Diagram)

(Starting from risk Factors / causes, ending up with clinical manifestation)

E. Laboratory/ Diagnostic Tests*

Laboratory Tests/ Diagnostic Tests	Normal Range	Patient Findings/ Result	Significance

F. IMPLEMENTATION

- Comprehensive Nursing Process *

Nursing Diagnosis	Goal/ Planning	Intervention	Rationale	Expected Outcome/ Evaluation

G. Discussion of Treatment Modalities (Cite Medical or Surgical Interventions done) *

Procedure	Cite Patient Based Indication	Patient Preparation	Frequency / Schedule Of Treatment	Nursing responsibility	Evaluation
Example: Tracheostomy Care					
Suctioning					
Oxygenation					
Wound Dressing					
IV Therapy					
Specify Other procedure					

H. Drug Study / Pharmacology *

Drug	Classification, Mechanism of Action	Indication,	Contraindication	Side Effect	Nursing Responsibility
Name of Drug , Dosage, Frequency, Route of Administration					

I. DISCHARGE PLAN

- Discuss according to the following aspects:
  - ✓ Medications
  - ✓ Exercise
  - ✓ Treatment
  - ✓ Hygiene
  - ✓ Occupation
  - ✓ Diet
  - ✓ Spiritual, Social Aspect

*** Please Follow Table Format**