

CARE Checklist of information to include when writing a case report



Item No	Checklist item description	Reported on Page Number/Line Number	Reported on Section/Paragraph
1	The diagnosis or intervention of primary focus followed by the words "case report"		
2	2 to 5 key words that identify diagnoses or interventions in this case report, including "case report"		
3a	Background: state what is known and unknown; why the case report is unique and what it adds to existing literature.		
3b	Case Description: describe the patient's demographic details, main symptoms, history, important clinical findings, the main diagnosis, interventions, outcomes and follow-ups.		
3c	Conclusions: summarize the main take-away lesson, clinical impact and potential implications.		
4	One or two paragraphs summarizing why this case is unique (may include references)		
5a	De-identified patient specific information		
5b	Primary concerns and symptoms of the patient		
5c	Medical, family, and psycho-social history including relevant genetic information		
5d	Relevant past interventions with outcomes		
6	Describe significant physical examination (PE) and important clinical findings		
7	Historical and current information from this episode of care organized as a timeline		
8a	Diagnostic testing (such as PE, laboratory testing, imaging, surveys).		
8b	Diagnostic challenges (such as access to testing, financial, or cultural)		
8c	Diagnosis (including other diagnoses considered)		
8d	Prognosis (such as staging in oncology) where applicable		
9a	Types of therapeutic intervention (such as pharmacologic, surgical, preventive, self-care)		
9b	Administration of therapeutic intervention (such as dosage, strength, duration)		
9c	Changes in therapeutic intervention (with rationale)		
	No 1 2 3a 3b 3c 4 5a 5b 5c 5d 6 7 8a 8b 8c 8d 9a	The diagnosis or intervention of primary focus followed by the words "case report" 2 to 5 key words that identify diagnoses or interventions in this case report, including "case report" 3a Background: state what is known and unknown; why the case report is unique and what it adds to existing literature. 3b Case Description: describe the patient's demographic details, main symptoms, history, important clinical findings, the main diagnosis, interventions, outcomes and follow-ups. 3c Conclusions: summarize the main take-away lesson, clinical impact and potential implications. 4 One or two paragraphs summarizing why this case is unique (may include references) 5a De-identified patient specific information 5b Primary concerns and symptoms of the patient 5c Medical, family, and psycho-social history including relevant genetic information 5d Relevant past interventions with outcomes 6 Describe significant physical examination (PE) and important clinical findings 7 Historical and current information from this episode of care organized as a timeline 8a Diagnostic testing (such as PE, laboratory testing, imaging, surveys). 8b Diagnostic challenges (such as access to testing, financial, or cultural) 8c Diagnosis (including other diagnoses considered) 8d Prognosis (such as staging in oncology) where applicable 7 Types of therapeutic intervention (such as pharmacologic, surgical, preventive, self-care) 9b Administration of therapeutic intervention (such as dosage, strength, duration)	The diagnosis or intervention of primary focus followed by the words "case report" 2 to 5 key words that identify diagnoses or interventions in this case report, including "case report" 3a Background: state what is known and unknown; why the case report is unique and what it adds to existing literature. 3b Case Description: describe the patient's demographic details, main symptoms, history, important clinical findings, the main diagnosis, interventions, outcomes and follow-ups. 3c Conclusions: summarize the main take-away lesson, clinical impact and potential implications. 4 One or two paragraphs summarizing why this case is unique (may include references) 5a De-identified patient specific information 5b Primary concerns and symptoms of the patient 5c Medical, family, and psycho-social history including relevant genetic information 5d Relevant past interventions with outcomes 6 Describe significant physical examination (PE) and important clinical findings 7 Historical and current information from this episode of care organized as a timeline 8a Diagnostic testing (such as PE, laboratory testing, imaging, surveys). 8b Diagnostic challenges (such as access to testing, financial, or cultural) 8c Diagnosis (including other diagnoses considered) 8d Prognosis (such as staging in oncology) where applicable 9a Types of therapeutic intervention (such as pharmacologic, surgical, preventive, self-care) 9b Administration of therapeutic intervention (such as dosage, strength, duration)

Follow-up and Outcomes	10a	Clinician and patient-assessed outcomes (if available)		
	10b	Important follow-up diagnostic and other test results		
	10c	Intervention adherence and tolerability (How was this assessed?)		
	10d	Adverse and unanticipated events		
Discussion	11a	A scientific discussion of the strengths AND limitations associated with this case report		
	11b	Discussion of the relevant medical literature with references		
	11c	The scientific rationale for any conclusions (including assessment of possible causes)		
	11d	The primary "take-away" lessons of this case report (without references) in a one paragraph conclusion		
Patient Perspective	12	The patient should share their perspective in one to two paragraphs on the treatment(s) they received		
Informed Consent	13	Did the patient give informed consent? Please provide if requested	Yes	No