Flow Diagram — Case Reports following the CARE guidelines

Initial Patient Assessment

- Presenting symptoms related to this episode of care
  - Patient demographic information
  - Medical, family, and psychosocial history
  - Past Interventions and treatments
  - Current medication and treatment
  - Co-morbidities

- Physical examination
  - Document relevant physical findings

- Timeline
  - Milestones linked to patient visits for this episode of care
  - Begin with relevant medical history through final visit

- Diagnostic evaluation
  - Laboratory testing, imaging, questionnaires
  - Diagnostic Challenges
  - Diagnostic reasoning and differential diagnosis

Initial Therapeutic Intervention(s)

- Therapeutic interventions
  - Types of Interventions
    - (clinician directed, self-care, team care)
  - Intervention Administration
    - (dosage, strength, duration)

Follow-up Visits and Assessment of Outcomes and Interventions

- Follow-up visits
  - Clinician and patient assessment of outcomes
  - Review relevant diagnoses and interventions
  - Intervention adherence, tolerance, and adverse events
  - Follow-up interventions (rationale for changes)
  - Repeat follow-up and final visit assessments

Case Report writing following the CARE guidelines