Flow Diagram — Case Reports and CARE guidelines

**Initial Patient Assessment**
- Presenting Symptoms and
  - 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 your diagnoses
  - Update during follow-up assessment

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

**Initial Therapeutic Interventions**
- Therapeutic Interventions
  - Types of Interventions
    (clinician directed - medical/surgical, self-care, team care)
  - Administration of Interventions
    (dosage, strength, duration)
  - Changes in Interventions (with rationale)

**Follow-up Assessment of Outcomes and Interventions**
- Follow-up visits
  - Clinician and patient assessment of outcomes
  - Review relevant diagnoses and interventions
  - Intervention adherence and tolerance
  - Adverse or unanticipated events
  - Repeat follow-up visit assessments

**Case Report writing following the CARE guidelines**