Appendix 1: Checklist for Case Reports Focusing on Diagnosis/Prognosis

Emphasis is on the diagnostic or prognostic aspect of patient care. May cover the process and logic associated with differential diagnosis (i.e., clinical decision making), unusual or difficult diagnostic/prognostic events, missed diagnoses, etc. Concentrate detail in patient history and physical examination and in conclusion or decisions made based on the examination. Challenge readers to deduce the diagnosis and to determine how the diagnosis relates to care of patient. May include interventions and outcomes, but detailed description is not expected there.

I. Title

☐ State that the manuscript is a case report.
☐ Maximum length = 150 characters (including punctuation and spaces)

II. Abstract

☐ Word limit = 275 words or fewer
☐ Structure: Background and Purpose, Case Description, Outcomes, Discussion
☐ State manuscript word count at end of abstract.

III. Body of Manuscript

☐ Manuscript word count = 3,500 words or fewer (excluding abstract and references)

A. Background and Purpose

☐ Provide scholarly discussion on the current issues related to the diagnostic/prognostic aspect of the case (e.g., current state of knowledge, problems with differential diagnoses, mimicking or missed diagnoses).
☐ Provide rationale for why the diagnostic/prognostic approach needs to be demonstrated in a case.
☐ End with a purpose statement that clearly indicates the focus is related to diagnosis/prognosis (e.g., "The purpose of this case report is to demonstrate the diagnostic process in...").

B. Case Description: Patient History and Systems Review

☐ Provide detailed demographic characteristics and history (e.g., chief complaints, other relevant medical history, prior or current services related to the current episode, comorbidities) to demonstrate that the patient is appropriate for the diagnostic/prognostic approach.
☐ Use relative dates (e.g., years or months or days relative to onset of injury or to start of treatment) rather than absolute dates (i.e., calendar dates). Reader will more easily grasp the chronology of events when the amount of time since the event or start of treatment is reported (don't force the reader to calculate the amount of time).
☐ Explain patient/family goals for physical therapy.

C. Clinical Impression #1
Explain the primary problem.

Describe the potential differential diagnoses.

Identify additional information (not provided in the initial patient interview or history) that needed to be requested from the patient; explain how this additional information pertains to the diagnostic/prognostic aspect of the case.

Describe the plan for the examination (eg, test selection).

Explain why this particular patient is a good candidate for the purpose of the case report.

D. Examination

Describe examination procedures that are consistent with clinical impression #1 and with the diagnostic/prognostic focus of the case.

Clearly explain the rationale for using each test and measure.

Describe the examination procedures so that others could replicate them; wherever possible, include figures, tables, and supplemental appendixes and videos.

Cite available studies on reliability and validity of measurements. If not available, acknowledge this fact, and provide a presumptive argument for the potential of reliability and validity.

Clearly explain all examination data.

E. Clinical Impression #2

Provide a statement confirming or denying the initial impressions.

Give a working diagnosis/prognosis.

Indicate the plan of action (eg, proceed with intervention, further testing, referral for other consultation).

State why the patient continues to be appropriate for the case. If the decision is to proceed to treatment, state the plan for intervention based on the current data.

Include the plan for follow-up evaluation of outcomes (measures, time points). If further examination is required, address this next, indicating the additional tests and why particular tests are chosen.

F. Clinical Impression #3 (optional)

If further examination was performed, state how the course of action was revised based on the additional information.

G. Intervention

(If the case report does not have an intervention associated with it, proceed to the outcomes section.)

Provide a general description of the physical therapy and/or medical/surgical interventions provided (eg, surgery, radiation therapy).

Provide a general description of the intervention strategy, tactics, and procedures.

Use tables, figures, and appendixes for the details, including only enough detail for reader to understand what was done; extensive details should not be necessary.

Clearly link the intervention back to the diagnostic/prognostic decision-making process.
H. Outcome

☐ Briefly describe the outcome measures, and cite evidence for reliability and validity.

☐ If reliability and validity have not been estimated for a measure, acknowledge this, and make presumptive arguments that the measurements would be reasonably reliable and valid for the purpose of the case.

☐ Present the outcomes over the time points indicated in the follow-up plan above.

☐ Compare follow-up outcomes to baseline. Tables and figures can be used to enhance the description.

I. Discussion

☐ Provide a scholarly, critical analysis of how the diagnostic/prognostic dilemma—if any—was resolved, and how the process guided further decision making from a treatment and/or prognostic perspective.

☐ Compare the case to other relevant reports in the literature, and provide rationale for how this case makes a novel contribution and improves existing diagnostic/prognostic decision-making strategies.

☐ Offer suggestions for future research.

IV. References

☐ Cite no more than 30.

V. Tables and Figures

☐ Use no more than 6 tables and figures total.
Appendix 2: Checklist for Case Reports Focusing on Intervention

Emphasis is on the intervention aspect of patient care. May cover the development of a new intervention or a modification to an existing intervention to deal with a clinical problem. Concentrate detail in the rationale for the new or modified intervention, the development process, the direct application to the patient, and the setting in which it is used. Remember that the patient history and examination should indicate why the patient is appropriate for the new or modified intervention. Include the outcome, but less detail is needed there.

I. Title

☐ State that the manuscript is a case report.
☐ Maximum length = 150 characters (including punctuation and spaces)

II. Abstract

☐ Word limit = 275 words or fewer
☐ Structure: Background and Purpose, Case Description, Outcomes, Discussion
☐ State manuscript word count at end of abstract.

III. Body of Manuscript

☐ Manuscript word count = 3,500 words or fewer (excluding abstract and references)

A. Background and Purpose

☐ Provide an underlying theoretical basis for the development of a new intervention or for the modification of an existing intervention.
☐ Provide a scholarly discussion on the gaps in the literature and in practice for treating the target problem, based on biological, physiological, biomechanical, psychosocial, or any other knowledge and theory.
☐ End with a purpose statement that clearly indicates the focus of the case as it relates to the intervention (eg, "The purpose of this case report is to describe the development and demonstrate the use of a new intervention for ...").

B. Case Description: Patient History and Systems Review

☐ Provide detailed demographic characteristics and history (eg, chief complaints, other relevant medical history, prior or current services related to the current episode, comorbidities) in sufficient detail to demonstrate that the patient is appropriate for the intervention.
☐ Use relative dates (eg, years or months or days relative to onset of injury or to start of treatment) rather than absolute dates (ie, calendar dates). Reader will more easily grasp the chronology of events when the amount of time since the event or start of treatment is reported (don't force the reader to calculate the amount of time).
☐ Explain patient/family goals for physical therapy.

C. Clinical Impression #1
Explain why you believe that the patient is a good candidate for the intervention, based on the data collected thus far.

Describe the plan for examination for further determining whether the patient is appropriate for this type of intervention (ruling in or ruling out relevant differential diagnoses, prognostic factors that suggest appropriateness for the intervention approach).

D. Examination

Describe any tests needed to confirm that the patient is appropriate for the intervention as stated in the first clinical impression.

Clearly explain all examination data.

E. Clinical Impression #2

Discuss why the patient is appropriate for use of the target intervention, based on the examination data.

Describe the plan for examination to determine the outcome of the intervention (measures to be used, follow-up time points), offering hypotheses about what should be observed if the intervention were to be successful.

F. Intervention

Describe the intervention, including how the intervention was developed and how it was applied to the patient, in sufficient detail that others can replicate the procedure.

May use tables, figures, and appendixes to enhance the detailed description.

Provide the parameters of the intervention (ie, intensity, frequency, and duration) and rules for progression.

State changes in treatment over time, along with the rationale for the changes.

List any co-interventions that the patient may have received but that are not directly related to the purpose of the case; detailed descriptions may not be necessary.

G. Outcome

If not already in the examination section, provide operational definitions of the outcome measures and their purpose, and cite evidence for reliability and validity. Priority is given to validated outcome measures. If reliability and validity have not been estimated for a measure, acknowledge this, and make presumptive arguments that the measurements would be reasonably reliable and valid for the purpose of the case.

Present the outcomes over the time points indicated in the follow-up plan.

Compare follow-up outcomes to baseline.

Use tables and figures to enhance the description.

H. Discussion

Reflect back on how the intervention may have assisted in addressing the target problem. This should be done in the context of other co-interventions that may have been provided. The key points of development and application should be tied back to the rationale for the treatment and literature on
previous treatment approaches for a similar problem.

☐ Offer suggestions for further research.

IV. References

☐ Cite no more than 30.

V. Tables and Figures

☐ Use no more than 6 tables and figures total.
Appendix 3: Checklist for Case Reports Focusing on Application of Theory to Practice

Case demonstrates how a theoretical principle was used to develop an intervention, examination procedure, administrative/educational process, etc. Fully explain the theory, the implication of the theory for practice, and the development of an intervention or test procedure, etc, based on the principles of the theory. Supply detail about the patient or setting sufficient to show that the case is appropriate for demonstrating application of the theory. Outcomes may be reported, but with less emphasis.

I. Title
☐ State that the manuscript is a case report.
☐ Maximum length = 150 characters (including punctuation and spaces)

II. Abstract
☐ Word limit = 275 words or fewer
☐ Structure: Background and Purpose, Case Description, Outcomes, Discussion
☐ State manuscript word count at end of abstract.

III. Body of Manuscript
☐ Manuscript word count = 3,500 words or fewer (excluding abstract and references)

A. Background and Purpose
☐ Discuss thoroughly the theory to be demonstrated, citing the major references related to the theory.
☐ Discuss how you believe the theory could be applied to physical therapist practice, citing supporting literature; may relate to how the theory could be applied to an evaluation or intervention approach.
☐ End with a purpose statement that clearly indicates that the focus of the case is to demonstrate how the theory was applied to some aspect of physical therapist practice (eg, “The purpose of this case report is to demonstrate how [name of theory] was used to develop an intervention approach for…”).

B. Case Description: Patient History and Systems Review
☐ Provide detailed demographic characteristics and history (eg, chief complaints, other relevant medical history, prior or current services related to the current episode, comorbidities) in sufficient detail to demonstrate that the patient is appropriate for the demonstration of theory to practice.
☐ Use relative dates (eg, years or months or days relative to onset of injury or to start of treatment) rather than absolute dates (ie, calendar dates). Reader will more easily grasp the chronology of events when the amount of time since the event or start of treatment is reported (don’t force the reader to calculate the amount of time).
☐ Explain patient/family goals for physical therapy.

C. Clinical Impression #1
☐ Explain why you believe that the patient is a good candidate for the approach, based on the data collected thus far.
Describe the plan for examination to further determine whether the patient is appropriate for this type of approach.

D. Examination

- Describe any tests needed to confirm that the patient is appropriate for the approach, as stated in the above clinical impression.
- Clearly explain all examination data.
- Provide a statement confirming that the patient is appropriate for the approach, based on the examination data.

E. Clinical Impression #2

- Discuss why the patient is appropriate for use of the approach based on the examination data.
- Describe the plan for examination to determine the outcome of the approach (measures to be used, follow-up time points), providing hypotheses of what should be observed if the approach were to be successful.

F. Approach

- Describe the approach (evaluation, intervention, or both) in detail. Details of how the approach was developed should be in the context of the theory being demonstrated. Descriptions of the approach should provide enough detail that readers can replicate them.
- May use tables, figures, and appendixes to enhance the detailed description.
- Provide the parameters of the approach (ie, intensity, frequency, and duration) and rules for progression.
- State changes in treatment over time, along with the rationale for the changes.
- List any co-interventions that the patient may have received but that are not directly related to the demonstration of the theory; detailed descriptions may not be necessary.

G. Outcome

- If not already in the examination section, provide operational definitions of the outcome measures and their purpose, and cite evidence for reliability and validity. Priority is given to validated outcome measures. If reliability and validity have not been estimated for a measure, acknowledge this, and make presumptive arguments that the measurements would be reasonably reliable and valid for the purpose of the case.
- Present the outcomes over the time points as indicated in the follow-up plan above.
- Compare follow-up outcomes to baseline.
- May use tables and figures to enhance the description.

H. Discussion

- Reflect back on how the approach adequately demonstrates the application of the theory to practice. The key points of development and application of the approach should be tied back to the original theory. Discuss whether the outcomes might suggest that the theory was successfully applied.
- Refer to previous literature to explain how it relates to application of this theory to practice as
presented in the case.

Offer suggestions for further research.

IV. References

Use no more than 30.

V. Tables and Figures

Use no more than 6 tables and figures total.
Appendix 4: Checklist for Case Reports Focusing on Clinical Measurement Procedures

Emphasis is on introducing a new clinical measurement procedure or modifying an existing procedure to deal with a specific problem or measurement topic. The difference between this category and diagnosis/prognosis is that the focus is on one specific procedure. Concentrate detail in the scientific rationale or theory for the procedure, the conditions under which the procedure should be used, and a thorough description of the procedure so that readers could replicate it (supplemental videos may be appropriate). The case demonstrates the clinical use of the test. If evidence of reliability or validity is not yet available in the literature, provide your own preliminary data, or make strong theoretical and presumptive arguments that the procedure provides reliable and valid measurements and has the potential to influence decision making.

I. Title

☐ States that the manuscript is a case report.
☐ Maximum length = 150 characters (including punctuation and spaces)

II. Abstract

☐ Word limit = 275 words or fewer
☐ Structure: Background and Purpose, Case Description, Outcomes, Discussion
☐ State manuscript word count at end of abstract.

III. Body of Manuscript

☐ Manuscript word count = 3,500 words or fewer (excluding abstract and references)

A. Background and Purpose

☐ Provide a scholarly discussion on the gaps in the literature for measurement of the target problem or clinical outcome that provides the rationale for either developing the new procedure or modifying an existing one.
☐ Provide the underlying theoretical basis for the development of the new test or modification. (This could be based on biological, physiological, biomechanical, psychosocial, measurement, or any other knowledge and theory.)
☐ End with a purpose statement clearly indicates that the focus relates to the clinical measurement procedure (eg, The purpose of this case report is to demonstrate the use of a new clinical measurement procedure for...).

B. Case Description: Patient History and Review of Systems

☐ Provide detailed demographic characteristics and history (eg, chief complaints, other relevant medical history, prior or current services related to the current episode, comorbidities) demonstrate that the patient is appropriate for the target measurement procedure.
☐ Use relative dates (eg, years or months or days relative to onset of injury or to start of treatment) rather than absolute dates (ie, calendar dates). Reader will more easily grasp the chronology of events when the amount of time since the event or start of treatment is reported (Don't force the reader to calculate the amount of time.).

C. Clinical Impression #1
Explain why the patient is a good candidate for the measurement procedure, based on the data collected thus far.

Describe the plan for examination to further determine whether the patient is appropriate for this type of measurement procedure (ruling in or ruling out relevant differential diagnoses.)

D. Examination

Describe tests needed to confirm that the patient is appropriate for the measurement procedure, as stated in clinical impression #1.

Clearly explain all examination data.

Provide a statement confirming that the patient is appropriate for the measurement procedure, based on the examination data.

E. Clinical Impression #2

Describe how the results of the measurement procedure will influence decision making.

F. Measurement Procedure

Describe the measurement procedure, including how the measure was developed and how it is applied to the patient, in sufficient detail that others can replicate the procedure.

May use tables, figures, and appendixes to enhance the detailed description.

List the basic rules and criteria used to interpret the results or scoring of the procedure.

G. Clinical Impression #3

Present the results and interpretation of the measurement procedure.

Describe how the results fit in with the other history and examination data to inform further decisions about interventions, referrals, etc.

If the procedure results in intervention, describe the intervention plan.

H. Outcome (optional)

If an intervention or consultation was performed based on the result of the measurement procedure, report the outcome of the intervention or consultation.

Compare outcome measures to pretreatment measures.

I. Discussion

Reflect back on how the measurement procedure helped identify the patient's problem(s) and assisted in treatment planning and evaluating clinical outcomes.

Presumptive arguments might be introduced for the procedure's validity based on the case.

Offer suggestions for further study of reliability, validity, and other measurement properties.

IV. References

Cite no more than 30.

V. Tables and Figures
Use no more than 6 tables and figures total.
Appendix 5. Checklist for Case Reports Focusing on Administrative/Educational Processes

Case describes or demonstrates the development and implementation of new administrative/educational processes or modifications to existing approaches to address special problems or needs. Detail is concentrated in the rationale for the new or modified process, steps taken to develop the process, and the direct application of the process in the context of the intended target population and setting in which it would be used.

I. Title

☐ States that the manuscript is a case report.
☐ Maximum length = 150 characters (including punctuation and spaces)

II. Abstract

☐ Word limit = 275 words or fewer
☐ Structure: Background and Purpose, Case Description, Outcomes, Discussion
☐ State manuscript word count at end of abstract.

III. Body of Manuscript

☐ Manuscript word count = 3,500 words or fewer (excluding abstract and references)

A. Background and Purpose

☐ Provide enough review of the literature to justify the development or demonstration of the process. Explain what has been done or not been done currently or in the past that justifies a change in the process or a modification of an existing process.
☐ End with a purpose statement that clearly indicates the focus of the case is to demonstrate an administrative/educational process (e.g., "The purpose of this case report is to describe the development and demonstrate the implementation of an X management approach in outpatient physical therapy clinics to...")

B. Case Description: Target Setting

☐ Provide details about the setting for which the process will be developed and in which it will be implemented.
☐ The description may include previous or current data about the setting sufficient to justify why this setting needs the process and why the facility is appropriate for it.
☐ State directly why this setting is appropriate for the demonstration of the process, based on the data provided in this section.
☐ Use relative dates (e.g., years or months or days relative to start of event or process) rather than absolute dates (i.e., calendar dates). It is usually easier to grasp the chronology of events when the amount of time since the event or start of the process is reported (don't force the reader to calculate the amount of time).

C. Development of the Process
Provide a detailed description of the steps taken to develop the process.
Support the rationale for each developmental step by the literature or other solid rationale.
Discuss any other special considerations—such as, but not limited to, stakeholder consultations—that were taken into account in developing the process.
Describe the plan to determine the outcome of implementing the process (measures, follow-up time points), providing hypotheses of what should be observed if the approach were to be successful.

D. Application of the Process

Provide details of how the approach was implemented in the target setting.
Discuss the technical aspects of implementing the process, and identify the time-dependent factors (eg, frequency, duration).
Describe any training procedures that were used for those involved in implementation of the process.
Explain what was done to get acceptance by staff involved with implementing the process.

E. Outcome

Discuss the outcomes of the actions taken to implement the process, consistent with the stated plan for determining outcome.
Operationally define measurement procedures, if used.
Cite evidence for reliability or validity, if available. If such information is not available, acknowledge this, and make a presumptive argument.

F. Discussion

Reflect back on how well the implementation of the process achieved its goals, based on the outcome data. Care must be taken to keep this discussion in the context of the case and not make generalized conclusions about use of the process in other settings.
Discuss any difficulties encountered during the development and implementation of the process that could have affected the outcome.
Refer to previous literature to explain how the application of the process in the case may or may not enhance administrative/educational processes in physical therapy.
Provide suggestions for further research.

IV. References

Use no more than 30.

V. Tables and Figures

Use no more than 6 tables and figures total.
# Appendix 6: Checklist for Case Reports Focusing on Risk Management

Case describes risk management or demonstrates how risk management was handled. May cover such topics as accidents, adverse events, emergencies, and risk reduction strategies that are associated with physical therapist practice. Emphasis is on describing the nature of the risk, the rationale for dealing with the risk, methods for resolving or reducing the risk, and involvement of any other personnel or agencies.

## I. Title
- States that the manuscript is a case report.
- Maximum length = 150 characters (including punctuation and spaces)

## II. Abstract
- Word limit = 275 words or fewer
- Structure: Background and Purpose, Case Description, Outcomes, Discussion
- State manuscript word count at end of abstract.

## III. Body of Manuscript
- Manuscript word count = 3,500 words or fewer (excluding abstract and references)

### A. Background and Purpose
- Include a thorough review of the risk management topic (accidents, adverse events, emergencies), including the nature and prevalence of the problem and how it can affect physical therapist practice. Other consequences of the risks—such as legal, punitive, or budgetary and financial burdens—should be discussed to justify the importance of the topic.
- End with a purpose statement that clearly indicates the focus of the case is to demonstrate risk management in practice (eg, "The purpose of this case report is to describe an approach designed to prevent an adverse event X in the care of a patient with...").

### B. Case Description: Details of the Risk Management Topic
- Detailed description of the patient involved (history, pertinent examination data, the plan of care, and any other events leading up to the risk management concern) or other entity.
- Discuss the current best-evidence guidelines (if they exist) to manage the risk and the expected consequences of deviating from the guidelines.
- Use relative dates (eg, years or months or days relative to start of event or process) rather than absolute dates (ie, calendar dates). It is usually easier to grasp the chronology of events when the amount of time since the event or start of the process is reported (don't force the reader to calculate the amount of time).

### C. Clinical Impression
- Explain why you believe that the current situation represents the risk management issue.
- Describe what you believe needs to be done to correct, minimize, or prevent the risk at this point,
and summarize the next course of action.

Discuss plans for determining the outcome of the action plan.

D. Actions Taken to Address the Risk

- Describe in detail the actions taken to address the risk.
- Provide the rationale for the actions taken, using pertinent literature.
- If the actions involve the addition of an intervention, describe it in detail so that the reader can replicate it.
- If the actions involve interaction with other professionals, describe the purpose and nature of these interactions.

E. Outcome

- Discuss the results of the actions taken to address the risk, consistent with the stated plan for determining outcome.
- Operationally define measurement procedures, if used.
- Cite evidence for reliability or validity, if available. If such information is not available, acknowledge this, and make a presumptive argument.

F. Discussion

- Reflect back on how well the actions used adequately addressed the risk; take care to keep this discussion in the context of the case and not make generalized conclusions about how to address the risk.
- Provide suggestions for further research.

IV. References

- Use no more than 30.

V. Tables and Figures

- Use no more than 6 tables and figures total.
Appendix 7: Checklist for 'Full,' Traditional Case Reports

Case describes risk management or demonstrates how risk management was handled. May cover such topics as accidents, adverse events, emergencies, and risk reduction strategies that are associated with physical therapist practice. Emphasis is on describing the nature of the risk, the rationale for dealing with the risk, methods for resolving or reducing the risk, and involvement of any other personnel or agencies.

I. Title
☐ States that the manuscript is a case report.
☐ Maximum length = 150 characters (including punctuation and spaces)

II. Abstract
☐ Word limit = 275 words or fewer
☐ Structure: Background and Purpose, Case Description, Outcomes, Discussion
☐ State manuscript word count at end of abstract.

III. Body of Manuscript
☐ Manuscript word count = 3,500 words or fewer (excluding abstract and references)

A. Background and Purpose
☐ Include a thorough review of the risk management topic (accidents, adverse events, emergencies), including the nature and prevalence of the problem and how it can affect physical therapist practice. Other consequences of the risks--such as legal, punitive, or budgetary and financial burdens--should be discussed to justify the importance of the topic.
☐ End with a purpose statement that clearly indicates the focus of the case is to demonstrate risk management in practice (eg, "The purpose of this case report is to describe an approach designed to prevent an adverse event X in the care of a patient with...").

B. Case Description: Details of the Risk Management Topic
☐ Detailed description of the patient involved (history, pertinent examination data, the plan of care, and any other events leading up to the risk management concern) or other entity.
☐ Discuss the current best-evidence guidelines (if they exist) to manage the risk and the expected consequences of deviating from the guidelines.
☐ Use relative dates (eg, years or months or days relative to start of event or process) rather than absolute dates (ie, calendar dates). It is usually easier to grasp the chronology of events when the amount of time since the event or start of the process is reported (don't force the reader to calculate the amount of time).

C. Clinical Impression
☐ Explain why you believe that the current situation represents the risk management issue.
☐ Describe what you believe needs to be done to correct, minimize, or prevent the risk at this point,
and summarize the next course of action.

☐ Discuss plans for determining the outcome of the action plan.

D. Actions Taken to Address the Risk

☐ Describe in detail the actions taken to address the risk.

☐ Provide the rationale for the actions taken, using pertinent literature.

☐ If the actions involve the addition of an intervention, describe it in detail so that the reader can replicate it.

☐ If the actions involve interaction with other professionals, describe the purpose and nature of these interactions.

E. Outcome

☐ Discuss the results of the actions taken to address the risk, consistent with the stated plan for determining outcome.

☐ Operationally define measurement procedures, if used.

☐ Cite evidence for reliability or validity, if available. If such information is not available, acknowledge this, and make a presumptive argument.

F. Discussion

☐ Reflect back on how well the actions used adequately addressed the risk; take care to keep this discussion in the context of the case and not make generalized conclusions about how to address the risk.

☐ Provide suggestions for further research.

IV. References

☐ Use no more than 30.

V. Tables and Figures

☐ Use no more than 6 tables and figures total.