

CASE STUDY FORMAT

A. INTRODUCTION

- Patient unit
- **Patient Profile**
Patient's name (Initial only)
Age
Gender
Educational attainment
Chief complaint
Admitting Diagnosis
Date of Admission
How many day from 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)

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 MV/CVC/CVP /urine catheter /NGT etc					

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