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Brief description of Clinical Case study formats: a basic review

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Abstract

Clinical case documents are very essential for analyzing the patient health status and these formats also help clinicians to clear information about the patient illness and to prepare therapy for the patient. Here we have 3 different types of clinical case presentation formats and those formats are helping physicians to manage the patient illness very easily.

Keywords: Clinical case documentation formats, SOAP Analysis, FARM Note, Core Analysis, Physicians.

Introduction

At any clinical case handling clinicians and Heath care providers were needed to follow a specified format for taking the case details about the subject. Medical records and Medication-related problems are to be identified by evaluation of documents by the health care workers and physicians, and additional practitioners specializing. All the health care workers are habituated to writing progress notes in the format of Subjective, Objective, Assessment, and Plan. It will help health care workers identify based on the clinical manifestations; clinicians suggest some laboratory identification by the evidence of clinical manifestation. Both of these things help to assess the current patient's condition. It will help make a treatment plan for the patients [1, 2].

We are having 3 Basic Case study formats.

Those are

1. SOAP Note
2. FARM Note
3. CORE Analysis

1. SOAP Note

It is the most widely used method in the Clinical Settings for Documentation Purposes based in a structured and organized manner.

Basically, it's having an abbreviated form that is

1. S-Subjective
2. O-Objective
3. A-Assessment
4. P-Plan

S-Subjective

Subjective Analysis has information about the experiences, Personal Views, and Feelings of the patients or some of those closest to them while admitted to the Hospital in the inpatient department. This Subjective information is helpful to health care providers to make assessments preparing are a plan for existing experiences, Personal Views, and Feelings of illness.

O-Objective

In this Section, The objective data is nothing but Clinical investigations like Blood Chemistry Tests, CT scans, MRT, etc. By doing all of the Tests we can get a clear picture of the disease.

A-Assessment

Hereby the examining the Subjective data and Objective data physicians can easily assess the diseases.

P-Plan

After the assessment is done successfully, physicians make a pharmacotherapy to treat the diseases

2. FARM Note [3,4,5,6]

Patient data or medication regimens are solely comprised in the following FARM notes if a difference is applied to the therapeutic problem standing managed in the note behind the original pharmaceutical care plan has existed reported. The pharmacist utilizes the patient profile PWDT and FARM notes kept inpatient pharmacy diagram as the base for resuming pharmacist-patient connections when the patient produces to the pharmacy or if it is readmitted to the health plan structure. A FARM note is a pharmacist's replication of a physician's improvement note in an organized method to track drug-related problems and techniques. It contains methods for pinpointing and evaluating existing or possible medication-related problems, defining a cure plan, and following up on problems properly.

- F – Findings relevant to patient-specific information
- A – Assessment - a result in successful findings.
- R – Resolution (including preventative)
- M – Monitoring (and follow-up)

Documentation of pharmaceutical care is essential to the continuity of care protest of clinician competence, contact among health care providers, proof of health assistance to patient care, and support of professional assistance.

Findings

It usually contains an overview of the relevant data received after collection and via review of patient data. The medical data contained in the note should contain both subjective and objective findings which show drug-related issues. It allows for additional frameworks, optimal data analysis, and retrieval capabilities.

Assessment

It has a pharmacist evaluation of the current situation. It should outline the review procedure that led to the decision on the issue, whether it was accomplished or did not exist, and whether active intervention existed or was not needed. The harshness or quickness of the issue should be displayed by saying whether the interventions should be created immediately or within one day, one week, or longer. The therapeutic endpoint or output described may be short-term goals or long-term goals.

Resolution

Based on the initial study emphasizes the actions presented to resolve the drug-related problem. Specific suggestions contain non-pharmacologic treatments like dietary changes or assisting devices. Pharmacologic therapy must mention a precise drug, dose, route, plan, and course of therapy. The rationale for choosing a particular therapy should be depicted. Alternative therapy in case of emergency switching-off of drugs must be enlightened. Patient counseling provided must be exaggerated. In case of any withholding of data from the patient, the reason behind it must be insisted.

Monitoring

A procedure for follow-up monitoring of the patient must be documented and nicely accomplished, including asking the patient, collecting laboratory data, and conducting continued physical examinations essential to select the planned efficacy. Whether it is a FARM or SOAP note followed by medical professionals identifies every drug-related issue and says the pharmacist's results followed, an investigation of the findings, resolution of the issue based upon the investigation, parameters, and timing of follow-up monitoring. The data should be provided in a standardized and logical system.

Conclusion

Clinical case documents are very essential for Clinicians to clear information about the patient illness and to prepare therapy for the patient. Here we have 3 different types of clinical case presentation formats and those formats are helping physicians to manage the patient illness very easily.

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