

A.O.B.S.

INSTRUCTIONS FOR CLINICAL EXAMINATION CASE PREPARATION

- 1 Submission of typed/computer generated segregated totals and logs (listed in chronological order) as follows:

Cases submitted are to be from the start of your practice to the submission date OR Candidates who have been in practice longer than a year should submit logs for the most recent 12-month period (January-December).

You must be the surgeon of record and you must have dictated the operative reports on cases submitted (dictation for cases performed on or after 11-1-04)

Segregated consecutive cases with mortalities to include:

- ◆ Date
- ◆ Hospital case number (Plastic & Reconstructive Surgery MUST INCLUDE pre- and post-op photographs and CPT codes)
- ◆ Patient age and gender
- ◆ Operative procedure ◆ Pathology
- ◆ Pre- & Post-op diagnosis ◆ Length of stay & termination date
- ◆ Complications & Hospital re-admission within 30 days
- ◆ Logs should be segregated according to the segregated totals sheet and listed in chronological order within category
- ◆ Mortalities are to be listed on the Mortality Log Sheet only

Logs are to be certified by one of the following:

This certification may be a separate letter or they may sign the the first sheet of your logs.

- ◆ Administrator or
- ◆ Chief of Service - or
- ◆ Medical Records Director

If all information is not provided you will be denied on this portion of the examination.

- 2 The Board will review logs & select a minimum of ten (10) cases plus all mortalities for review.
- 3 Each Candidate is to submit **clinical case reviews** of each case with appropriate chart copies to include: (*Make 3 copies, keep 1 copy & send 2 copies to the Board Office.*)

- ◆ case summary
- ◆ history and physical
- ◆ admission note
- ◆ all labs, x-ray, pathology
- ◆ pertinent office records
- ◆ anesthesia record
- ◆ operative report face sheet
- ◆ O.R. worksheet
- ◆ autopsy, if applicable
- ◆ pathology report
- ◆ all orders
- ◆ all consults
- ◆ progress notes (Dr. only)
- ◆ discharge summary
- ◆ CPT codes, Pre- and Post-op photographs for Plastic&Recon.

Keep the two sets completely separate and marked as Set 1 and Set 2

- 4 Case reviews must be submitted to AOBS Office no later than 45 days prior to exam.
- 5 A Board member and co-examiner will conduct an interview with candidate to review the cases.

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STEP
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GUIDELINES FOR PREPARATION OF CASES FOR BOARD REVIEW

1 Pre-Op Evaluation Elements:

- 1 Chief complaint
- 2 Hx of chief complaint
- 3 Associated medical problems
- 4 Work-up of above including:
 - lab
 - diagnostics
 - operative & pathology reports from previous biopsy or surgery
 - special studies (such as angiograms) PRE- and POST-OPERATIVE pictures and CPT coding are required by plastic & reconstruction section.
- 5 Medical history
- 6 Surgical history
- 7 Medications
- 8 Allergies
- 9 Review of systems including musculoskeletal complaints
- 10 Complete physical findings as related to procedure planned or problem examined
- 11 Working diagnosis (including pre-op staging)
- 12 Rationale for surgery
 - Need for surgery versus medical therapy
 - Procedure planned

The above can be in the form of hospital consult, office notes, history and physical or combination thereof.

2 Operative Elements:

- 1 Appropriate procedure for problem found at time of surgery
- 2 Operative note: rationale - readable - realistic
- 3 Operative time
- 4 Blood loss
- 5 Complications: acceptable - unacceptable, all should be listed regardless of how small or large
- 6 Pathology report including any special studies on tissue

- ### **3**
- 1 Care (inpatient or outpatient) appropriate to situation but must cover therapy until point of discharge from surgeon's care
 - 2 Length of stay (appropriate for inpatient diagnosis)
 - 3 Stable at time of discharge (if inpatient)
 - wound healing
 - other medical problems addressed
 - results of all cultures, tests and x-rays addressed in record

If abnormalities are found in pre-op testing for outpatients, these items should also be addressed in records submitted from office chart.

- 4 Follow-up care indicated in chart (for oncologic and non-oncologic problems) including:
 - need for further testing, consultations, treatment, etc.
 - medications
 - specialized nursing needs
 - restrictions of activities
 - diet
- 5 Post-op staging
- 6 Discharge summary (this should include hospital discharge summary as well as dictated discharge summary when patient is discharged to the care of their referring physician.)

Your clinical examination begins with the submission of the cases requested.

If not complete and well organized, you may fail the examination.

All requested information as outlined in this document is to be included.

Do not include items not asked for, i.e., insurance forms, nurses orders.

All patient identifying information must be completely obliterated.

APPEARANCE OF SUBMITTED MATERIALS

Each Clinical Case Review should be submitted to the Board office in a neat and orderly fashion.

On the next page are some samples and notes for making your materials acceptable for Board review. **A case summary MUST be included.**

A case summary is different than the discharge summary. The case summary details the case from first presentation through discharge and is a recap of the whole case.



Example of Case Review presented in pressboard binder with metal fastener - tab label examples

CASE SUMMARY	AUTOPSY, IF APPLICABLE
HISTORY AND PHYSICAL	PATHOLOGY REPORT
ADMISSION NOTE	ALL ORDERS
ALL LAB, X-RAY, PATHOLOGY	ALL CONSULTS
PERTINENT OFFICE RECORDS	PROGRESS NOTES (Dr. only)
ANESTHESIA RECORD	DISCHARGE SUMMARY
OPERATIVE REPORT	



Example of Case Review presented Paper Tape Binding

Inside the booklet are tab labels for each part of the case

You may present your cases in 3-ring binders, GBC bound, coil bound, spiral bound, in report covers or file folders. You may clip or rubber band each one.

CASE PREPARATION NOTE: During your preparation of the cases, if one or more of the tabs (example: consults) has nothing to present, insert a sheet that lets the examiners know that there is nothing to submit for this tab.

EXAMINATION NOTE: You may bring additional information with you to the examination in order to defend your cases.

Neatness is required for the cases to be reviewed by the Board.

Keep sets completely separate and mark as Set 1 and Set 2. Submit your exam fee check, completed Sign-Off Form and Business Agreement in an envelope and put at the top of the box.

Your name must be on the front cover of each folder/binder/etc.

DUE DATES	TASK	FEE
March 15th or August 15th	Submit segregated totals, logs and fee for May or September meeting review	\$1,000
45 days prior to exam date	Submit case reviews, sign-off form, Business Associate Agreement and fee.	\$2,000

We must receive the Business Associate Agreement, sign-off form and fee along with your charts. There will be no exception to this policy.

The due date means the items must be received by the AOBS Office.

ATTESTATION: The American Osteopathic Board of Surgery requests that the cases and medical records that you submit for review for your clinical examination reflect true and accurate information.

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