Case Study Rubric:

Categories	Scales
Abstract	3= Provides a thorough summary of all required headings
	2= Provides a summary of all headings but is not thorough in content
	1= Provides an abstract that does not adequately summarize the case.
	0= Provides no abstract
Background: (briefly summarizes the condition of interest that the case is focused on)	 3=provides adequate introduction to the case study's topic condition along with relevant information that orients the reader specific to the topic of interest. 2= provides non-specific background information that does not tie in well
	to the case study's topic.
	1= provides a very generic background.
	0 = provides an inappropriate background and/or was very difficult to read and/or understand
Patient: (age, sex, sport of individual, primary complaint and pertinent aspects of his/her medical history)	3 = thorough, relevant, and understandable patient demographics, chief complaint, and any pertinent medical history; mentions no previous medical history, if relevant.
	2 = generic patient data provided, provides chief complaint, may or may not discuss medical history.
	1= some patient data missing or unclear; very wordy and does not communicate effectively the exact primary complaint and/or medical history.
	0 = no relevant information provided concerning this patient, injury or patient/client was identified, and/or was very difficult to read and understand.
Findings:	3 = provides a stepwise temporal outline that details the objective findings.
(swelling, point tenderness, ROM and muscle function, special tests performed, referrals and subsequent diagnostic tests)	2 = provides incomplete but orderly objective findings.
	1= provides a few random objective findings.
	0 = very difficult to read or understand basic objective findings
Differential Diagnoses: (differential diagnosis and/or diagnosis, severity of disease, a concise summary of the physical findings)	3= provides a concise set of potential diagnoses that are relevant to the information provided in the patient and findings sections.
	2= provides a general list of diagnoses that are not specific to the information provided in the patient and findings sections.
	1= lists the diagnosis rather than a set of differential diagnoses
	0 = very difficult to read and understand basic premise.
Treatment or intervention: (treatment: surgical, modalities, physical rehabilitation, etc.)	3= provides a final diagnosis along with a chronological and detailed list of interventions.
	2 = provides a minimum amount of information specific to interventions or does not list interventions in a precise, chronological order.
	1= provides a generic, non-detailed summary of treatments provided
	0= provides no real interventions nor a legitimate timeline.
Uniqueness: (expected results from intervention)	3= provides a strong case as to why this particular condition is unique from other related events.
	2= provides a weak case as to why this condition is unique, or fails to
	make a compelling case as to why this condition is unique.
	1= fails to provide evidence as to why this case is unique from others, or
	claims that the uniqueness is due to the condition or event being 'rare'. 0= does not expound upon why the case is unique.
	3= provides a clear and concise summary of the facts of the case study as
Conclusion:	well as what medicine can learn from this case.
(a brief description of what makes this case unique)	2= provides a wordy or overly-summarized summary of the case.
	1= provides information that does not adequately summarize the case
	0 = fails to provide a real conclusion to the case study.

Formatting	3= Thoroughly follows formatting guidelines as outlined for case study
	2= Generally follows formatting guidelines with minimal errors
	1= Submits case study with several significant formatting errors
	0 = Fails to adhere to general formatting requirements
Grammar	3= No grammatical/spelling errors
	2= Minimal grammatical/spelling errors (e.g. < five errors)
	1= Several significant grammatical/spelling errors (e.g. > five errors)
	0 = Case study is difficult to read due to the level of grammatical/spelling
	errors
Professional Writing	3= Uses clear and coherent writing style consistent with professional
	writing standards: sentences can stand alone, solid flow, professional
	terminology
	2= Generally clear writing with minimal deviation from professional writing standards
	1= Several significant deviations from professional writing standards
	0 = Often incomprehensible writing style due to significant deviation from
	professional writing standards

Formatting a Clinical Case Study:

The clinical case study will be evaluated for content using the above qualifications, along with formatting requirements as follows:

Prepare your case study in accordance with the following requirements (failure to follow the formatting requirements will likely result in an automatic disqualification of your case study):

- 1. The case study must be typed in Microsoft Word.
- 2. Top, bottom, right, and left margins of the body of the case study should be set at 1" using the standard 8.5" x 11" format. Use either Arial or Times New Roman 11 or 12pt. font with single spacing.
- 3. Provide a title page formatted only with individual double-spaced lines that include the following (in this order): Title of the case study (limited to 20 words), your full name and your faculty sponsor's full name (use "and" between your respective names), your university, and the date of the case study submission.
- 4. On the next page, format an abstract that includes each of the following headings and is no more than 400 words from the word "Background" to the number representing the word count. Begin entering the body of the abstract flush left in a single paragraph with no indentions. Use no patient identifiers, no first-person terminology (e.g. "I', "we", "me") and no specific dates (e.g. January 13th, 2017). The text of the abstract body must be structured with headings as follows:
 - **Background** detail the background of the associated injury or condition
 - **Patient** provide patient demographics, the chief complaint, and mechanism
 - **Findings** report on special tests, ROM/MMT findings, and other measures
 - **Differential Diagnosis** list those conditions most likely to exist based on the patient and findings sections
 - Treatment detail the actual diagnosis as well as the treatment plan and expected or achieved outcomes
 - Uniqueness explain what makes this case study different from all other previously reported cases
 - Conclusion sum up the case study and then discuss what medicine can learn from the case
 - Word count a total word count of the case study body, including all headings and section content
- 5. On the next page, begin the body of the case study using the same headings as required for the abstract and same formatting guidelines listed above. There is no minimum or maximum length; rather, it is expected that the case study is of adequate length to include all relevant material
- 6. Citations must be included in the body of the case study only (not the abstract). On the first new page after the body of the case study, format a bibliography page using AMA or APA style.
- 7. When complete, save the case study as "(*Last Name*) Case study NATASWC (*year*)".
- 8. Submit the case study using the directions included in the Student Writing Contest instructions.

Grading of the Clinical Case Study:

Abstract (3 points)
Main case study body
Formatting (3 points)
Grammar (3 points)
Professional writing (3points):
Total possible: 33 points