Resident Case Log Ground Rules
Review Committee for Epilepsy

General Information
- The resident is responsible for logging in his/her own patient data.
- A login and password is assigned to each resident by the program director.
- The program director is able to review each resident's data file, but will be unable to alter or change information entered.
- Depending upon computer/Internet access, it is recommended that residents keep a written record of patients evaluated until they are able to enter the information into the Case Log System.

Data Collection
- For each case logged, residents should enter the following data elements: evaluation; institution; name of attending physician; clinical setting; patient year of birth; and diagnosis(es).
- The diagnosis(es) may either be entered using the tab for categories of disease provided or typed in directly by the resident.

Clinical Setting
- A resident should log any patient for whom he/she assumed a significant management responsibility; a rule of thumb for whether or not to log a case is that the interaction should have been important enough to warrant a written note in the chart.
  - Inpatient
    - Consult service
    - Primary service
      Please note: Any single patient should be entered only once per resident. Intensive care patients are listed separately.
  - Outpatient
    - Clinic
      - New patient
      - Follow-up if new to resident or if seen in continuity clinic where each visit should be documented
    - Consult
      - Emergency
      - Non-neurology outpatient clinics
  - If admitted from an outpatient setting, a patient can be counted as both an outpatient and an inpatient if two different residents evaluate that patient (e.g., one resident evaluates the patient in the Emergency Room (ER) and another resident admits and/or manages the patient on the inpatient service).
  - If admitted from an outpatient setting, the patient can be counted as an inpatient if the same resident evaluated the patient as an outpatient and also manages or consults on that patient on an inpatient service.

- o Only residents who are directly involved in the examination and management of a patient may count that patient in their log. Work/attending rounds do not count as patient encounters except for those residents who have examined the patient and are directly involved in the management (e.g., admitting resident and upper-level resident).
- o Patients who are evaluated by residents during cross-coverage periods (call and days off) should be counted by the cross-covering resident if their cross coverage necessitates significant and active management responsibility (e.g., if called to assess and treat a worsening neurologic deficit after admission for stroke, the cross-covering resident should enter the patient in his/her log); passive responsibility for patients does not qualify.
- Any single patient should be entered only once per resident, except for continuity clinic patients who should be entered each time they are seen. Continuity clinic patients and ER consults are listed separately.