

CASE SUMMARY INDEX FORM 111-CAQ – 2021

Last Name _____, First _____

- A list of ten (10) cases are due January 15, 2022 and are to be submitted on this form. List cases in each of the 10 categories (A-J).
- See “DESCRIPTION OF CATEGORIES FOR CASE SUBMISSION” on the CAQ-Exam Information Guide our website before creating your list of cases.
- A minimum of 8 categories must be utilized. If **only** 8 categories are utilized additional 2 cases may be submitted in the “supplemental section” at the end of this form.
- It is **imperative** that the 10 case submissions reflect a level of sophistication and relevance to the subject area under which they are listed. Reviewers will expect the cases to reflect the comprehensive evaluation of the stated diagnosis.
- **You cannot use the same patient more than once.**
- If two patients have the same initials, differentiate them by including a middle initial, i.e. TAM and TRM.

CATEGORY / CASE #	PRIMARY DIAGNOSIS	PATIENT INITIALS	# OF VISITS	Consultation	Imaging Studies	Lab Reports
A. Infection Diagnosis and Medical						
1 _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Infection Surgical Peri-op Management						
2 _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Offloading Medical Management						
3 _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Offloading Surgical Peri-op Management						
4 _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Offloading Prevention of Ulcers						
5 _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Debridement						
6 _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Skin Substitute Application and Appropriate						
7 _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Peripheral Artery Disease Testing						
8 _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Imaging						
9 _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Collaborative Care						
10 _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental Cases (IF NEEDED)						

_____ S1 _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category					
_____ S2 _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category					

I attest that all patients submitted in this form are or were my patients, under my direct supervision and responsibility, and that no patients have been entered more than once (any duplicate initials represent different patients). I understand and agree that if ABPM discovers a breach of these rules, it will be grounds for barring me from the CAQ process.

Signature _____ Date _____