Content and Structure of the Psychiatric Case Report for the Exam

General Content Guidelines:

The case report must be the student's own work, not a compiled summary of existing medical records. It should provide a coherent and consistent picture of the need for the patient's admission to psychiatric care. Ideally, the current complaints and the history section should be the most detailed; psychopathological abnormalities should be documented in the psychiatric status section, and the diagnostic and differential diagnostic sections should demonstrate that the student is capable of differentiating between the most common psychiatric conditions at the level expected of a candidate taking the comprehensive exam. The case report should be approximately 3 A4 pages in length; texts longer than this are highly likely to contain irrelevant or redundant information.

Structure and organization of the case report:

Patient demographics (initials, age, gender)

Circumstances of the current admission: time of admission, method of transport (if applicable), and the event, condition, or symptom(s) justifying the admission. Was the admission urgent or scheduled? Is the admission at the patient's own request, or is the patient yielding to pressure from their environment, or were coercive measures used (e.g., physical restraint, medication)? Is a judicial review required? Is the patient under guardianship?

Current complaints, history: Complaints (physical, psychological) present in the period prior to admission and their progression over time. Essentially, a description of the answer to the question: "What complaints did the patient have prior to admission?

"What changes occurred that you believe led to the admission?" When describing the patient's current symptoms, provide a snapshot of their current presentation and their progression over the past 1–2 weeks, primarily using the patient's own words. In this section, you can accurately describe the characteristic, specific features of the patient's behavior and appearance.

Medical History: Essentially a brief summary of the somatic and psychiatric history, highlighting relevant care.

Somatic Medical History: Significant health problems, medical examinations, and hospitalizations (information provided by the patient and data gathered from available medical records).

Psychiatric medical history: primarily events and stages that can be corroborated by medical records (description of changes over time, symptoms, and diagnoses). We do not expect detailed summaries copied from previous records, but rather a brief summary of psychiatric hospitalizations (reason for admission, diagnostic process, treatment). If the patient is receiving regular psychiatric follow-up (care), the most important events in the care process may also be included here.

Addictions, recreational drugs.

Biographical analysis, major life events: Structure of the family of origin and relationships with its members. Early childhood, schooling, entry into the workforce, work performance. Development of interpersonal relationships. Interests, leisure activities, hobbies. The formation and development of a new family of one's own.

It is important to specifically ask about possible psychological trauma: losses, deaths, and life changes (divorce, change of job, change of residence). Key factors defining the patient's current life situation.

Heterogeneous Anamnesis: A description of data and opinions obtained from relatives, acquaintances, and individuals who know the patient directly—provided they are available, willing to cooperate, and able to provide information about the patient's life and the course of their illness. The examinee should strive to obtain information regarding facts and life events that are particularly important for assessing the illness (e.g., whether something actually happened or not, whether the patient's assessment of certain matters is realistic, etc.). When taking a heteroanamnesis, we must respect the patient's right to privacy and observe mandatory confidentiality.

Status:

Internal Medicine Status: A patient of average build and moderate nutritional status. Visible mucous membranes show moderate congestion. Tongue is moist, without coating. No edema, jaundice, or cyanosis. Pharyngeal and cervical structures, as well as the thyroid gland, are normal. No abnormal lymph nodes are palpable. Proportional chest. Full, sharp, non-resonant percussion sound; equal intercostal movement; soft-celled basal breath sounds. Adequately pointed, rhythmic heart sounds. Abdomen at the level of the chest. No pathological resistance, tenderness, or defense. Liver and spleen not palpable. Kidneys are mobile and not tender to percussion. Musculoskeletal system structurally and functionally intact. Peripheral pulses are readily palpable on both sides.

Neurological status: Nuchal reflex absent; no meningeal irritation signs. Skull and spine structurally intact. Pupils are round, equal in size, and dilated; direct and consensual light reflexes are preserved; they respond well to convergence and accommodation. Eye movements are free; cranial nerve innervation is intact. Muscle tone and strength are preserved throughout the body; tests for latent paresis are negative. The patient is alert; symmetrical deep tendon reflexes are present; no pathological reflexes are noted. Superficial and deep sensation is preserved on the face, extremities, and trunk. Purposeful movements can be performed; movement is coordinated, and there is no dysdiadochokinesis. The patient remains stable in the Romberg position; there is no trunk or limb ataxia. Autonomic functions are intact.

Mental status: Vigilance and integration of consciousness are preserved. Orientation is preserved both self- and other-referentially, as well as in space and time. Attention can be aroused and directed; goal orientation is preserved. No perceptual or sensory disturbances, nor any indirect signs suggesting such disturbances, are observed. Thinking is intact in both form and content. Memory for encoding, retention, and recall is preserved. Mood is neutral. Emotional

reactions are appropriate to the situation and the information presented, both in quality and intensity. No symptoms of anxiety—whether subjective, behavioral, or vegetative—are observed (or: they are within a range appropriate for the medical examination setting). Based on the medical history, his activity level and willingness to cooperate show no deviation from previous observations and are consistent with his personality and personal expectations. His appetite is average.

His sexual activity is appropriate for his age, situation, and personality. His psychomotor function is at an average pace and shows no structural abnormalities. His speech is at an average speed, grammatically correct, logical, and purposeful. He maintains appropriate eye contact; his facial expressions and gestures are consistent with his speech and show no abnormalities. His behavior is appropriate for the situation, and his critical thinking skills are intact. His intellectual functioning is appropriate for his age, situation, and level of education. No suicidal intent, urges, or thoughts can be identified. His insight into his condition is adequate and realistic.

Opinion, Diagnosis: The examiner should strive to establish a BNO 11 diagnosis and to document the relevant criteria of the DSM-5 diagnostic system.

Differential Diagnosis: Describe the possible diagnoses, along with the arguments for and against each, based on which the examinee should take a position regarding the most likely primary diagnosis and the main diagnosis justifying treatment. In the absence of a definitive diagnosis, the examinee should highlight the symptom, symptoms, or cluster of symptoms that most strongly justify the admission.

Examination Plan (briefly): In addition to standard routine examinations, the plan should primarily list psychological, radiological, and other tests and consultations that confirm the diagnosis or help establish its basis. In addition to confirming the probable diagnosis, the purpose of the examination plan is to assess the differential diagnostic possibilities as accurately as possible.

The examinations should also include an explanation of why the student is requesting the examination and what they expect from it.

Treatment Plan (briefly): Based on the primary diagnosis justifying the treatment, describe the possible and necessary pharmacological and other therapeutic interventions. First and foremost, the main therapeutic approaches and medications or drug classes should be specified. A more detailed explanation should be provided only in special cases.