DOWNLOAD PDF NOTES FOR A CASE HISTORY.

Chapter 1 : How to Write a Case Brief for Law School | LexisNexis

Notes for A Case History. A Man and Two Women - British Edition A Man and Two Women - American Edition Spies I Have Known and other stories - British Edition; Stories - American Edition.

How to write a case brief for law school: Excerpt reproduced from Introduction to the Study of Law: This section will describe the parts of a brief in order to give you an idea about what a brief is, what is helpful to include in a brief, and what purpose it serves. Case briefs are a necessary study aid in law school that helps to encapsulate and analyze the mountainous mass of material that law students must digest. The case brief represents a final product after reading a case, rereading it, taking it apart, and putting it back together again. Who will read your brief? Most professors will espouse the value of briefing but will never ask to see that you have, in fact, briefed. You are the person that the brief will serve! Keep this in mind when deciding what elements to include as part of your brief and when deciding what information to include under those elements. What are the elements of a brief? Different people will tell you to include different things in your brief. Most likely, upon entering law school, this will happen with one or more of your instructors. While opinions may vary, four elements that are essential to any useful brief are the following: Because briefs are made for yourself, you may want to include other elements that expand the four elements listed above. Depending on the case, the inclusion of additional elements may be useful. For example, a case that has a long and important section expounding dicta might call for a separate section in your brief labeled: Whatever elements you decide to include, however, remember that the brief is a tool intended for personal use. To the extent that more elements will help with organization and use of the brief, include them. On the other hand, if you find that having more elements makes your brief cumbersome and hard to use, cut back on the number of elements. At a minimum, however, make sure you include the four elements listed above. Elements that you may want to consider including in addition to the four basic elements are: In the personal experience of one of the authors, this element was used to label cases as specific kinds e. This element allowed him to release his thoughts without losing them so that he could move on to other cases. In addition to these elements, it may help you to organize your thoughts, as some people do, by dividing Facts into separate elements: One subject in which Procedure History is virtually always relevant is Civil Procedure. When describing the Judgment of the case, distinguish it from the Holding. Remember that the purpose of a brief is to remind you of the important details that make the case significant in terms of the law. It will be a reference tool when you are drilled by a professor and will be a study aid when you prepare for exams. A brief is also like a puzzle piece. The elements of the brief create the unique shape and colors of the piece, and, when combined with other pieces, the picture of the common law takes form. A well-constructed brief will save you lots of time by removing the need to return to the case to remember the important details and also by making it easier to put together the pieces of the common law puzzle. The simple answer is: But what parts of a case are relevant? When you read your first few cases, you may think that everything that the judge said was relevant to his ultimate conclusion. Even if this were true, what is relevant for the judge to make his decision is not always relevant for you to include in your brief. Remember, the reason to make a brief is not to persuade the world that the ultimate decision in the case is a sound one, but rather to aid in refreshing your memory concerning the most important parts of the case. What facts are relevant to include in a brief? You should include the facts that are necessary to remind you of the story. If you forget the story, you will not remember how the law in the case was applied. You should also include the facts that are dispositive to the decision in the case. For instance, if the fact that a car is white is a determining factor in the case, the brief should note that the case involves a white car and not simply a car. To the extent that the procedural history either helps you to remember the case or plays an important role in the ultimate outcome, you should include these facts as well. What issues and conclusions are relevant to include in a brief? There is usually one main issue on which the court rests its decision. This may seem simple, but the court may talk about multiple issues, and may discuss multiple arguments from both sides of the case. Be sure to distinguish the issues from the arguments made by the parties. The relevant issue or issues, and corresponding conclusions, are the ones for which the court made a final decision and which are binding.

The court may discuss intermediate conclusions or issues, but stay focused on the main issue and conclusion which binds future courts. What rationale is important to include in a brief? This is probably the most difficult aspect of the case to determine. Remember that everything that is discussed may have been relevant to the judge, but it is not necessarily relevant to the rationale of the decision. The goal is to remind yourself of the basic reasoning that the court used to come to its decision and the key factors that made the decision favor one side or the other. A brief should be brief! Overly long or cumbersome briefs are not very helpful because you will not be able to skim them easily when you review your notes or when the professor drills you. On the other hand, a brief that is too short will be equally unhelpful because it lacks sufficient information to refresh your memory. Try to keep your briefs to one page in length. This will make it easy for you to organize and reference them. Do not get discouraged. Learning to brief and figuring out exactly what to include will take time and practice. The more you brief, the easier it will become to extract the relevant information. While a brief is an extremely helpful and important study aid, annotating and highlighting are other tools for breaking down the mass of material in your casebook. The remainder of this section will discuss these different techniques and show how they complement and enhance the briefing process. Annotating Cases Many of you probably already read with a pencil or pen, but if you do not, now is the time to get in the habit. Cases are so dense and full of information that you will find yourself spending considerable amounts of time rereading cases to find what you need. An effective way to reduce this time is to annotate the margins of the casebook. Your pencil or pen will be one of your best friends while reading a case. It will allow you to mark off the different sections such as facts, procedural history, or conclusions , thus allowing you to clear your mind of thoughts and providing an invaluable resource when briefing and reviewing. You might be wondering why annotating is important if you make an adequate, well-constructed brief. By their very nature briefs cannot cover everything in a case. Even with a thorough, well-constructed brief you may want to reference the original case in order to reread dicta that might not have seemed important at the time, to review the complete procedural history or set of facts, or to scour the rationale for a better understanding of the case; annotating makes these tasks easier. Whether you return to a case after a few hours or a few months, annotations will swiftly guide you to the pertinent parts of the case by providing a roadmap of the important sections. Your textual markings and margin notes will refresh your memory and restore specific thoughts you might have had about either the case in general or an individual passage. Annotations will also remind you of forgotten thoughts and random ideas by providing a medium for personal comments. In addition to making it easier to review an original case, annotating cases during the first review of a case makes the briefing process easier. With adequate annotations, the important details needed for your brief will be much easier to retrieve. Without annotations, you will likely have difficulty locating the information you seek even in the short cases. It might seem strange that it would be hard to reference a short case, but even a short case will likely take you at least fifteen to twenty-five minutes to read, while longer cases may take as much as thirty minutes to an hour to complete. No matter how long it takes, the dense material of all cases makes it difficult to remember all your thoughts, and trying to locate specific sections of the analysis may feel like you are trying to locate a needle in a haystack. An annotation in the margin, however, will not only swiftly guide you to a pertinent section, but will also refresh the thoughts that you had while reading that section. When you read a case for the first time, read for the story and for a basic understanding of the dispute, the issues, the rationale, and the decision. As you hit these elements or what you think are these elements make a mark in the margins. When a case sparks an idea â€" write that idea in the margin as well â€" you never know when a seemingly irrelevant idea might turn into something more. Finally, when you spot a particularly important part of the text, underline it or highlight it as described below. With a basic understanding of the case, and with annotations in the margin, the second read-through of the case should be much easier. You can direct your reading to the most important sections and will have an easier time identifying what is and is not important. Continue rereading the case until you have identified all the relevant information that you need to make your brief, including the issue s , the facts, the holding, and the relevant parts of the analysis. Pencil or pen â€" which is better to use when annotating? Our recommendation is a mechanical pencil. Mechanical pencils make finer markings than regular pencils, and also than ballpoint pens. Although you might think a pencil might smear more than a pen, with its

sharp point a mechanical pencil uses very little excess lead and will not smear as much as you might imagine. A mechanical pencil will also give you the freedom to make mistakes without consequences. When you first start annotating, you may think that some passages are more important than they really are, and therefore you may resist the urge to make a mark in order to preserve your book and prevent false guideposts. With a pencil, however, the ability to erase and rewrite removes this problem. Like annotating, highlighting may seem unimportant if you create thorough, well-constructed briefs, but highlighting directly helps you to brief. It makes cases, especially the more complicated ones, easy to digest, review and use to extract information. Highlighting takes advantage of colors to provide a uniquely effective method for reviewing and referencing a case. If you prefer a visual approach to learning, you may find highlighting to be a very effective tool. If annotating and highlighting are so effective, why brief? Because the process of summarizing a case and putting it into your own words within a brief provides an understanding of the law and of the case that you cannot gain through the process of highlighting or annotating.

Chapter 2 : Stories - Homage for Isaac Babel, Notes for a Case History Summary & Analysis

Case notes are records of information and form a foundation for other core documents. They are records of interactions with the children, families, and persons relevant to a given case or incident. Good case notes employ strategic, insightful inquiry and an understanding of larger case processes.

A detailed exploration of the symptoms the patient is experiencing that have caused the patient to seek medical attention. Physical examination The physical examination is the recording of observations of the patient. This includes the vital signs , muscle power and examination of the different organ systems, especially ones that might directly be responsible for the symptoms the patient is experiencing. The plan documents the expected course of action to address the symptoms diagnosis, treatment, etc. Orders and prescriptions[edit] Written orders by medical providers are included in the medical record. These detail the instructions given to other members of the health care team by the primary providers. Progress notes[edit] When a patient is hospitalized, daily updates are entered into the medical record documenting clinical changes, new information, etc. These often take the form of a SOAP note and are entered by all members of the health-care team doctors, nurses, physical therapists, dietitians, clinical pharmacists, respiratory therapists , etc. They are kept in chronological order and document the sequence of events leading to the current state of health. Test results[edit] The results of testing, such as blood tests e. Often, as in the case of X-rays , a written report of the findings is included in lieu of the actual film. Other information[edit] Many other items are variably kept within the medical record. As such, there is great variability in rules governing production, ownership, accessibility, and destruction. There is some controversy regarding proof verifying the facts, or absence of facts in the record, apart from the medical record itself. It is often information to locate the patient, including identifying numbers, addresses, and contact numbers. It may contain information about race and religion as well as workplace and type of occupation. It is common to also find emergency contact information located in this section of the medical chart. Production[edit] In the United States , written records must be marked with the date and time and scribed with indelible pens without use of corrective paper. Errors in the record should be struck out with a single line so that the initial entry remains legible and initialed by the author. Electronic versions require an electronic signature. US law and customs[edit] In the United States , the data contained within the medical record belongs to the patient, whereas the physical form the data takes belongs to the entity responsible for maintaining the record [13] per the Health Insurance Portability and Accountability Act. Factors complicating questions of ownership include the form and source of the information, custody of the information, contract rights, and variation in state law. HIPAA gives patients the right to access and amend their own records, but it has no language regarding ownership of the records. Twenty-one states have laws stating that the providers are the owners of the records. Only one state, New Hampshire , has a law ascribing ownership of medical records to the patient. In cases where the provider is an employee of a clinic or hospital, it is the employer that has ownership of the records. By law, all providers must keep medical records for a period of 15 years beyond the last entry. In that ruling, an appeal by a physician, Dr. The patient, Margaret MacDonald, won a court order granting her full access to her own medical record. The courts ruled otherwise. Legislation followed, codifying into law the principles of the ruling. It is that legislation which deems providers the owner of medical records, but requires that access to the records be granted to the patient themselves. It states, amongst other things, the statutory duty of medical personnel to document the treatment of the patient in either hard copy or within the electronic patient record EPR. The information must include virtually everything that is of functional importance for the actual, but also for future treatment. This documentation must also include the medical report and must be archived by the attending physician for at least 10 years. The law clearly states that these records are not only memory aids for the physicians, but also should be kept for the patient and must be presented on request. In addition, an electronic health insurance card was issued in January which is applicable in Germany Elektronische Gesundheitskarte or eGK , but also in the other member states of the European Union European Health Insurance Card. It contains data such as: Furthermore, it can contain medical data if agreed to by the patient. However, due to the limited storage space

32kB , some information is deposited on servers. United States[edit] In the United States , the most basic rules governing access to a medical record dictate that only the patient and the health-care providers directly involved in delivering care have the right to view the record. The patient, however, may grant consent for any person or entity to evaluate the record. The rules become more complicated in special situations. Capacity When a patient does not have capacity is not legally able to make decisions regarding his or her own care, a legal guardian is designated either through next of kin or by action of a court of law if no kin exists. Those without capacity include the comatose , minors unless emancipated , and patients with incapacitating psychiatric illness or intoxication. Medical emergency In the event of a medical emergency involving a non-communicative patient, consent to access medical records is assumed unless written documentation has been previously drafted such as an advance directive Research, auditing, and evaluation Individuals involved in medical research, financial or management audits , or program evaluation have access to the medical record. They are not allowed access to any identifying information, however. Risk of death or harm Information within the record can be shared with authorities without permission when failure to do so would result in death or harm, either to the patient or to others. Information cannot be used, however, to initiate or substantiate a charge unless the previous criteria are met i. MacDonald gave patients the right to copy and examine all information in their medical records, while the records themselves remained the property of the healthcare provider. There is also some confusion among providers as to the scope of the patient information they have to give access to, but the language in the supreme court ruling gives patient access rights to their entire record. Also, the legislation gives patients the right to check for any errors in their record and insist that amendments be made if required. Destruction[edit] In general, entities in possession of medical records are required to maintain those records for a given period. In the United Kingdom , medical records are required for the lifetime of a patient and legally for as long as that complaint action can be brought. Generally in the UK, any recorded information should be kept legally for 7 years, but for medical records additional time must be allowed for any child to reach the age of responsibility 20 years. Please help improve this section by adding citations to reliable sources. Unsourced material may be challenged and removed. April Learn how and when to remove this template message The outsourcing of medical record transcription and storage has the potential to violate patient-physician confidentiality by possibly allowing unaccountable persons access to patient data. Falsification of a medical record by a medical professional is a felony in most United States jurisdictions. Governments have often refused to disclose medical records of military personnel who have been used as experimental subjects. Data breaches[edit] Given the series of medical data breaches and the lack of public trust, some countries have enacted laws requiring safeguards to be put in place to protect the security and confidentiality of medical information as it is shared electronically and to give patients some important rights to monitor their medical records and receive notification for loss and unauthorized acquisition of health information. The United States and the EU have imposed mandatory medical data breach notifications. This law established standards for patient privacy in all 50 states, including the right of patients to access to their own records. HIPAA provides some protection, but does not resolve the issues involving medical records privacy. You may improve this article , discuss the issue on the talk page , or create a new article , as appropriate. December Learn how and when to remove this template message The federal Health Insurance Portability and Accessibility Act HIPAA addresses the issue of privacy by providing medical information handling guidelines. Professional secrecy applies to practitioners, psychologists, nursing, physiotherapists, occupational therapists, nursing assistants, chiropodists, and administrative personnel, as well as auxiliary hospital staff. The maintenance of the confidentiality and privacy of patients implies first of all in the medical history, which must be adequately guarded, remaining accessible only to the authorized personnel. However, the precepts of privacy must be observed in all fields of hospital life:

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Chapter 3 : Post-it Note - Wikipedia

Case Note Sample Narratives. An assessor's case notes have the ability to "tell the story" of a consumer's medical and social situation in a.

You have to write clinical case notes, but what type of charting should you do? But who needs them? There used to be a time when clinicians did not regularly keep clinical notes. The idea was that if no notes were taken, there were no notes to be subpoenaed. Notes are helpful in a number of ways. Keeping notes is a way for the clinician to document their clinical assessment, interventions and result or follow-up. Good notes provide documentation the therapist is following acceptable standards of care, utilizing appropriate interventions, describing the results of these interventions and documenting the disposition of the case. Psychotherapists keep track of the effectiveness of clinical interventions and the progress of their clients via notes. Notes serve as a memory aid. A clinician records conversations with other clinicians for collaboration, consultation or to help facilitate referrals. If you work in a multidisciplinary treatment setting notes offer different clinicians a way to stay informed based on the observations and interventions of other clinicians. The following is intended to provide you with a way to structure and input your clinical cases or contacts. HIPAA intends to set minimum standards that only preempts less strict state standards. However, if a state has more stringent standards for greater access to records, or more privacy protections than federal law, the state law will prevail. The client has the right, or privilege, that their information will be kept confidential. Consider the case information in the client file a legal document that can be subpoenaed and which you may have liability for. The opening note usually contains the following information. To more easily describe this information I have created some fictional clients. Client states he stays with father every other weekend. Client states the relationship has been difficult for the last 2 months, but seems to be getting worse. Client states he feels rejected by his friends and is not sure why this is happening. This information comes from your clinical assessment. States last physical exam was 6 months ago. History Describe length of symptoms, any similar symptoms in the past and what attempts were made to decrease symptoms. Client states some difficulties in other work relationships. Thinking is clear and linear. Affect is somewhat guarded initially, but quickly moves to tearfulness when describing difficulties with supervisor. Affect is congruent with content. What follows the Opening Note is a specific type of charting note. I will provide examples of three types of charting notes. Narrative Narrative notes are time based notes. They are often used in medical settings to show the chronology of events. When needing to make charting notes, but not having information for an Opening Note, Narrative Notes may be preferred. Caller was told named therapist was off for the day and would be back in a few days. Caller was offered the first available appointment with named therapist. Caller stated feeling increasingly despondent and described suicidal ideation. Caller was informed that that this author could see caller later this day at 3 PM. Caller was able to make a verbal no harm contract with this author at least until appointment time. Caller understood and provided home number. Caller was given number to Suicide Prevention if needed before scheduled appointment time. Spoke with name of person at Mobile Crisis. Informed Mobile Crisis of concerns regarding Nancy D. Mobile Crisis stated they would contact person and call this author back with result. Spoke with name of person at Mobile Crisis who stated she was equally concerned, but discovered that Nancy D. Person at Mobile Crisis stated she called local law enforcement who conducted a health and safety check and determined Nancy D. Left message regarding scheduled appointment and that this author would call back regarding any future appointments. Describe what the problem is that brought the client through the door or the focus of the session. What are your general observations about this client? What did you do? What will you do next? Supported client in use of positive coping skills. Encourage client to use current supports. Will see client on date. Will focus on coping skills, further assess past relationship difficulties. How does the client describe their problem? This is usually a quote or statement from the client describing their subjective description of the problem. What did you observe about this client? These are written as factual notations. What is your plan with this client? Denies kids are at risk. No history of violence, child abuse. Not sure what to do. States divorce is not an option. Difficulty reaching out for support. Seems to blame self as reason

husband drinks. Supportively confront belief she is the cause of his drinking. Encourage attendance in Al-Anon for group support and to confront negative self ideations. Will continue to establish goals. Client states her initial level of stress has decreased. Client reports sleeping, concentration has improved. Referral to Options for Women Over Forty was provided client; which she declined at this time. Client states feeling more able to cope with difficult work environment. No further services are requested at this time. A few final words about charting. Interns and newly licensed therapists tend to write volumes in their charts. It is hard to know what are the important pieces of information to include. As time goes along, most clinicians get efficient in their charting. This is likely a function of having to keep up on multiple charts and being able to learn abbreviations for certain clinical words. A simple standard can be that your charting should enable anyone who reads your notes to: Understand what brought the client into treatment. What was done about their presenting problem. What were the results of your interventions. What was the disposition of the client. Charting takes time and can be tedious. It is good to get into the habit of establishing regular time to get your charting done. Click Case Notes for a nice introduction to charting notes.

Chapter 4 : How to Write a First Interview Summary Case Note If You Are a Medical Social Worker | calend

Effective Documentation and Case Notes for Employment Services Guide Feb Page 1 Introduction This guide provides instructions for Employment Services Providers on how to document information in a manner appropriate.

Chapter 5 : Notes for A Case History

For instance, if the fact that a car is white is a determining factor in the case, the brief should note that the case involves a white car and not simply a car. To the extent that the procedural history either helps you to remember the case or plays an important role in the ultimate outcome, you should include these facts as well.

Chapter 6 : Medical record - Wikipedia

First case to use the "Brandeis brief"; recognized a hour work day for women laundry workers on the grounds of health and community concerns. Hammer v. Dagenhart ().

Chapter 7 : Court Cases | CourseNotes

Use the appropriate medical terms for problems so that a one can quickly review the history of the problem by glancing at past visit notes. Be sure the problems in the "assessment/plan" section correspond to those listed in the subjective section.

Chapter 8 : Docket: Family Court Case History

WRITING A PSYCHIATRIC CASE HISTORY General Instructions: This model case history is quite comprehensive. Most case histories are under 10 pages.

Chapter 9 : Clinical Case Notes

A Post-it Note (or sticky note) is a small piece of paper with a re-adherable strip of glue on its back, made for temporarily attaching notes to documents and other surfaces.