INTRODUCTION: A patient’s medical record is a transcription of events having occurred in relation to one’s health, including previous office visits, diagnoses, hospitalizations, screening and diagnostic test results, procedures, and treatment records. Healthcare providers are expected to document each encounter properly and utilize previous records to guide treatment.

PURPOSE: This project gives physician assistant students the opportunity to apply medical knowledge to practical case scenarios and to utilize the various components of a patient’s chart to ensure comprehensive care for the patient.

METHODS: Students will receive the medical record of Penny Adams, which includes pertinent information needed to complete each case. Throughout their didactic year, six case scenarios are presented, each including assignments related to various aspects of the medical record. As Penny ages, new documentation is added to her medical record. Each scenario pertains to the current student's course topics, including preventive medicine, dermatology, endocrinology, obstetrics/gynecology, musculoskeletal, and neurology. Case assignments involve documenting patient encounters, developing assessments and plans, writing progress notes and admission orders, and discussing end of life care. Additionally, students can review the cumulative chart to ensure milestones are met, medications are appropriate, and vaccinations and preventive screenings are up-to-date.

EXPECTED OUTCOMES: This project was created due to a gap in the current curriculum and will serve as “positive risk taking” to enhance the PA curriculum. By completing these assignments, students are able to gain experience using proper medical documentation to become better prepared for patient encounters during the clinical year. Initial student feedback will become the first control group for future adaptations.