**Appendix**

**Clinical Reasoning in Admission Note**

**Assessment & PLan (CRANAPL) Tool**

1. **SUMMARY STATEMENT**

A concise summary statement that highlights the person and their presentation. Elements may come from 3 domains: (i) who person is [age, gender, race…], (ii) past medical history, and (iii) information related to the incident hospitalization [ details from the history, exam, and testing].

0 = absent

1 = one or two elements addressed

2 = all three elements present

1. **LEADING OR MOST LIKELY DIAGNOSIS STATED AND EXPLAINED**

Explanation and reasoning for the leading diagnosis might include the following: epidemiology, key features, risk factors

0 = leading diagnosis absent/not stated

1 = stated but no explanation

2 = stated and rationale / explanation noted

1. **CERTAINTY OR UNCERTAINTY EXPLICITYLY ACKNOWLEDGED**

Writer alludes to confidence or uncertainty associated with the leading diagnosis (e.g. use of words like: probably, most likely, definitely, unsure).

0 – No 1 – Yes

1. **DIFFERENTIAL DIAGNOSIS (DDx) AND SUPPORTING RATIONALE**

Alternative diagnostic possibility(ies) listed and explanation of the reasoning of why they are being considered (e.g. reasons they fit, or do not fit, with the presentation or their likelihood relative to the leading diagnosis).

0 = absent (no DDx)

1 = DDx present but no explanation

2 = DDx present AND explanation described

1. **PLAN FOR DIAGNOSIS**

Delineation of the diagnostic plan and listing reason(s) for diagnostic testing.

0 = absent/not stated

1 = stated but no explanation

2 = stated and rationale / explanation noted

1. **PLAN FOR TREATMENT**

Description of the therapeutic plan and listing reason(s) for the treatments ordered.

0 = absent/not stated

1 = stated but no explanation

2 = stated and rationale / explanation noted

1. **LENGTH OF STAY ESTIMATION**

 0 – No 1 – Yes

1. **DISCHARGE PLANNING / DISPOSITION**

Does the assessment and plan comment on the what needs to happen before the patient is to be discharged OR the likely setting to which the patient will be discharged (e.g. home/rehab…)?

0 – No 1 – Yes

1. **POTENTIAL FOR UPGRADE IN STATUS**

Does the assessment and plan comment on what needs to be done if the patient were to get sicker acutely, the likelihood that this might occur, the fragility of the patient’s condition, or things that they are worried about?

0 – No 1 – Yes

**TOTAL SCORE:**