**Recommended structure of the required case report**

* **Patient's personal details** (initials, age, weight, height)
* Date of admission and discharge (if known)
* **Medical history** - complete, including epidemiological history, vaccinations, etc.
* **Current illness**, reason for admission
* **Physical examination**
* **Results** of laboratory and imaging tests (only the most important, i.e. usually from admission and discharge and the most pathological)
* **Differential diagnosis** based on the patient's symptoms and/or laboratory results
* **Course** of the hospital stay
* **Treatment** during hospitalisation
* Final or probable diagnosis
* \*Recommendations after discharge

\*If the hospital stay has already ended