Logbook Guidelines for
Certification in Clinical Genetics and Genomics
for the 2017 Examination
as of 10/5/2015

Purpose: The purpose of the logbook is to document that the applicant has had direct and meaningful involvement in the genetic evaluation, counseling and management of patients and/or families and has received appropriate clinical supervision. The logbook cases should provide evidence of a well-rounded experience in all categories involving a range of roles in evaluation, risk assessment, genetic counseling and management. Categories and genetic diagnoses covered in the logbook should include the broad spectrum of prenatal, pediatric and adult genetics with a wide variety of diagnoses. The diagnostic categories should include, but are not limited to, intellectual impairment, chromosomal disorders, multiple malformation syndromes, metabolic diseases, prenatally diagnosed abnormalities, neurological disorders, common complex disorders, and cancer.

Submission Requirements: Logbooks must be completed in accordance with the written instructions provided in this document. Before submitting a logbook to the program director for review, the applicant must use the online data check program to correct any errors the program identifies. The training director and residency program director will then review the logbook and electronically submit approval to the ABMGG Administrative Office by the stated deadline. Failure to follow these procedures will result in the logbook being returned to the applicant for revision, which may delay review of the applicant’s credentials and the determination of active candidate status. In addition, late fees may be incurred.

Case Selection:

1. All cases must be obtained through an ACGME-accredited clinical genetics residency or a CCMG-accredited medical genetics training program.

2. Supervision for case encounters in genetics clinics must be provided by faculty who are ABMGG-certified, ABGC-certified, or CCMG-certified. For cases obtained during rotations in specialty clinics, e.g., oncology, neurology, it is recommended that supervisors be certified by their appropriate ABMS certifying board(s). All supervisors must be identified in the training program’s accreditation documents as members of the training faculty.

3. All 150 cases must be obtained during the inclusive dates of the applicant’s medical genetics training. No more than 5 cases may be obtained in any one day.

4. Each logbook entry must document a face-to-face interaction between the applicant and an individual patient and/or family. Evaluation, management, or counseling performed via telephone or in group counseling sessions will not be accepted.
5. A given patient or family may appear only once in an applicant’s logbook, regardless of the number of encounters with that patient or family.

6. No more than 25 cases may have a genetic counselor listed as the primary supervisor.

**NOTE:** for residents in a categorical clinical genetics residency using the ACGME logbook system, all cases will be downloaded into the ABMGG logbook system. You will need to select which cases to submit for logbook entry and review each entry to make sure the conversion is accurate and complete.

**Description of Logbook Headings/Columns:**

- **Entry Number:** Access to the logbook at the start of the training program allows applicants to enter up to 300 cases while in training. You must select 150 cases to submit for logbook review. The applicant must be able to identify each case by its entry number if questions arise about a logbook entry. Patient names and bona fide hospital or clinic numbers may not be used anywhere in the logbook. Logbooks containing specific information regarding the identity of any patient will not be reviewed.

- **Date:** The date in month/day/year [MM/DD/YYYY] format identifies when the patient was seen.

- **Patient Age Category:** For each case, the patient’s age must be defined as Infant, Child, Adolescent, or Adult. Age refers to age of the patient on the date of the clinic visit. Note: in Primary Genetic Category 3 (next section), the pregnant woman (or adolescent) is the patient so Adult or Adolescent are the only appropriate options.

- **Primary Genetic Category:** For each case, use the numbers 1 through 4, as outlined below, to identify the single category that best describes the indication for the clinic visit. A minimum of 15 cases and a maximum of 50 cases must be documented in each category.

**Category 1 Diagnostic evaluation:** Evaluation of infants, children, or adults with signs or symptoms of a genetic condition.

**Note:** Individuals with signs or symptoms of a genetic disorder, including those with a personal history of cancer seeking genetic evaluation/risk assessment and infants who were found to have true or false positive newborn screening tests, should be logged in this category.

**Examples:** Congenital anomalies, intellectual disability/developmental delay, inborn errors of metabolism suspected by symptoms or newborn screening, Mendelian disorders, common complex disorders, cancer, and cytogenetic abnormalities.
Category 2 Genetic risk assessment: Evaluation of asymptomatic or presymptomatic individuals with known or suspected risk factors for a genetic condition, including family history.

Note: Individuals with a known genetic disorder who are seen for routine medical surveillance for potential sequelae of that disorder, e.g., Turner syndrome for aortic dilation, should not be logged in this category but instead in Category 4.

Examples: Asymptomatic or presymptomatic individuals at risk for carrying an autosomal, X-linked, or mitochondrial gene mutation because of the following: (a) recurrent reproductive loss or familial chromosome rearrangements, such as balanced translocations; (b) a family history of cancer; (c) a family history of adult-onset neurological disorders; and (d) a family history of other genetic conditions or common complex disorders.

Category 3 Prenatal genetics: Assessment of fetal genetic risk in a current pregnancy with or without prenatal testing.

Examples: fetal risk assessment for aneuploidy, abnormal prenatal test results such as fetal abnormalities on ultrasound examination, fetal molecular testing or abnormal maternal serum screens, and teratogen exposures. The term “advanced maternal age” as a diagnosis should be avoided. It is recommended that abnormal serum screening or fetal risk assessment for aneuploidy comprise no more than 5 cases.

Category 4 Management/continuing care: Medical management or additional consultation or evaluation of individuals with a known genetic diagnosis.

Examples: Inborn errors of metabolism, multiple congenital anomalies, cytogenetic abnormalities, hereditary cancers, neurological disorders, intellectual impairment/developmental delay, connective tissue disorders, and skeletal dysplasias.

- Diagnosis: Within any given category, no more than 5 cases may have the same specific diagnosis. Variations in genotype or phenotype of a specific diagnosis, such as age of onset or particular mutation, are not considered sufficient to count as separate diagnoses. A minimum of 10 cancer cases is required, with no more than 5 of a specific type of cancer.

It is required that at least 10 cases in Category 2 and at least 15 cases distributed between Categories 1 and 4 pertain to conditions whose clinical ONSET is typically in adolescence or adulthood. Examples include Huntington disease, Friedreich ataxia, adult Pompe disease, myotonic dystrophy, hereditary breast and ovarian cancer, Lynch syndrome, FXTAS, schizophrenia. An adolescent or adult patient whose condition was present at birth (e.g. PKU) or first manifested soon after birth (e.g. Prader-Willi syndrome) would not qualify as one of the 15 required cases in Categories 1 and 4 with disease onset in adolescence or adulthood. It is
the age at onset and not the age of diagnosis or the age at which the trainee saw the patient that should be taken into account in satisfying this requirement.

In addition to the numerical requirement, logbooks will be evaluated for overall case diversity, complexity of case experience, and distribution of diagnoses within categories. For example, a logbook recording the minimum number of 15 cases in Category 3 must have a diverse case set of fetal aneuploidy screening, teratogenesis, maternal genetic conditions in pregnancy and fetal malformations or other conditions. Similarly, review is based on variety in late childhood or adult-onset disorder, i.e., not all cases should be cancer related.

For each case, enter the diagnosis using the guidelines below.

1. Primary diagnosis must be listed first. For example, “Breast cancer, positive family history” not “Family history of breast cancer.”

2. Use the most specific diagnosis for each case when known, e.g., Fragile X syndrome, or a broader designation when the specific diagnosis is unknown, e.g., Intellectual disability, unknown cause.

3. Log only those cases for which the diagnostic evaluation is complete. For example, “5p deletion syndrome” not “Rule out chromosome anomaly”. If making a specific diagnosis was the reason for the referral, for example, is this Marfan syndrome?, use “Marfan syndrome” if the diagnostic evaluation is complete and this is the diagnosis or “Marfan syndrome, excluded” if the diagnostic evaluation is complete and this diagnosis was excluded but a more specific diagnosis could not be made. If a more specific diagnosis could be made, such as Shprintzen-Goldberg syndrome, use the more specific diagnosis.

4. Do not use abbreviations. For example, do not substitute MCA for multiple congenital anomalies.

5. If more than one patient or family with the same genetic category, age category, diagnosis, visit date, trainee role(s), and supervisor are recorded, clearly indicate that entries are not duplicated records or members of the same family, as follows: Neurofibromatosis, patient or family 1; Neurofibromatosis, patient or family 2.

6. For Primary Genetic Category 2 patients, list not only the diagnosis but also the reason for classification in this primary genetic category. For example: enter “Trisomy 18, previously affected child” not just “Trisomy 18.” A diagnosis without a justification will not satisfy the requirement, and it will be assumed that the case entry is a patient affected with the condition.

- **Trainee’s Roles:** Check all of the boxes that indicate your role(s) in the clinical evaluation, counseling and management for each case. A minimum of 5 roles must be specified for each case. At least 10 cases must be obtained for each role; however, it is recommended that at least 15 cases be obtained for each role.
1. **Medical history** involves obtaining pertinent medical information, such as pregnancy history, developmental milestones, and environmental exposures, by patient interview and review of medical records.

2. **Pedigree** includes eliciting information for the construction of a pedigree that includes at a minimum all first and second-degree relatives using standard symbols.

3. **Physical examination** entails performing a complete physical examination or, if more appropriate, a targeted examination, to assess the system(s) of concern or to look for manifestations of a Mendelian condition in individuals who present for evaluation of a common complex disorder.

4. **Management/Evaluation plan** involves determining recommendations for appropriate tests and/or assessments of medical or psychosocial care for a patient/family.

5. **Testing options/results** includes explaining the technical and medical aspects of diagnostic and screening methods and reproductive options, including associated risks, benefits, and limitations, as well as interpreting and communicating testing results.


7. **Inheritance/risk counseling** involves educating the patient or family about recurrence/occurrence risks and modes of inheritance of the disorder.

8. **Discussion of diagnosis/natural history** includes conveying genetic medical information about the diagnosis, etiology, natural history, prognosis, and treatment/management of the disorder(s) in question.

9. **Psychosocial support/counseling** involves providing short-term, patient or family-centered counseling, psychosocial support, and anticipatory guidance to the family, as well as addressing patient concerns.

10. **Information access** includes literature review and database searches, as well as identification of resources for the patient or family and referring healthcare provider.

11. **Documentation and follow-up** involves writing a consultation report or letter to the family or healthcare provider and recording adequate follow-up notes.

   - **Supervisor:** Include the full name, degree(s), and type of certification of the supervisor who was present and was directly responsible for your activities regarding that case.